NATIONAL INSTITUTE FOR HEALTH AND   
CARE EXCELLENCE

Quality standards

Consultation summary report: Postnatal care (update)

Quality Standards Advisory Committee post-consultation meeting: 12 July 2022

1. Introduction

The draft quality standard for postnatal care (update) was made available on the NICE website for a 4-week public consultation period between 12 May and 09 June 2022. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 34 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

1. Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

4. Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form.

1. General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

* General agreement that the quality standard accurately reflects the key areas for quality improvement.
* Appreciation of improved focus on health inequalities and social determinants of health, and greater consideration of combi-feeding choices.
* Consideration of language used throughout, including suggestions to use ‘information and support’ rather than ‘advice, ‘woman and partner’ rather than ‘parents’, and making it clearer in definitions of who could count as a ‘partner’.
* Request to explain what is covered in ‘routine’ postnatal care.
* Consider expanding statements covering postnatal midwife and health visitor visits to include elements of GP assessments.
* Consider emphasising the role of partners in achieving outcomes.
* More emphasis on the need for effective communication including listening to women to ensure a woman-centred approach.
* Include Wales-specific bodies in the audience descriptors.
* More emphasis on the need to signpost to third sector support.
* Consider greater emphasis on women’s mental health by midwives and health visitors

Equality and diversity considerations

* Highlight inequalities in outcomes for women known to social services and the needs of those in contact with the criminal justice system.
* Highlight additional needs of parents with FASD or suspected FASD
* When there is a need to translate, specify the use of translator services rather than family members.

### Consultation comments on data collection

* General agreement that local systems and structures are in place to collect data, but these may vary nationally and may not always be linked.
* Data may not be recorded without nationally mandated reporting.
* Suggested that re-instatement of the national infant feeding survey will provide useful data.

### Consultation comments on resource impact

* General agreement that statements would be achievable given resources needed
* Some concern that workforce and service shortages could affect achievement without additional resources

1. Summary of consultation feedback by draft statement
   1. Draft statement 1

Women who are transferring between services in the postnatal period have relevant information shared between healthcare professionals to support their care. **[new 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

* There was general agreement that this statement was a welcomed priority area for quality improvement.
* Highlight that women who have lost babies close to or at full term still need care and should be covered by this statement.
* Include peri-natal mental health services in the audience descriptor.
* The rationale should stipulate that this covers secondary care providers for circumstances where women and/or their baby need care in a different service.
* Some disappointment about shift from language on continuity of care.
* Electronic patient records should be mentioned as the sharing method.
* Specific suggestions on the type of information that should be shared.

Measures

* Process measures with local data collection may prove time consuming.

Equality and diversity considerations

* Include consideration of those less likely to be in contact with primary care and community- based services such as people experiencing homelessness and traveller populations.

### Issues for consideration

* Should we progress this statement to the final quality standard?
* Are there any specific issues that the committee wish to discuss for this statement? The NICE team can strengthen the supporting information with the feedback received.
  1. Draft statement 2

Parents are given information and advice about breastfeeding and formula feeding before transfer to community care or before the midwife leaves after a home birth. **[2013, updated 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

* There was general agreement that this statement was a welcomed priority area for quality improvement.
* Some concern that the statement appears to move away from supporting breastfeeding as optimal feeding and normalising formula feeding.
* Highlight that information and advice should be personalised. Concern that women may be overloaded with information that is not relevant to them, which could have safety implications.
* Highlight that information on breastfeeding and formula feeding should have been given to parents in the antenatal period.
* Consider amending statement wording to ‘information and advice about feeding and caring for your baby’.
* Consider amending statement wording to ‘information about and support for infant feeding’.
* Consider adding advice on expressing milk to the statement.
* Include physical concerns that may affect feeding choices in the rationale.
* The statement does not include combination feeding which is the reality for many families.

Measures

* Change wording in the structure measure from ‘parents’ to ‘mother and ideally partner’ to avoid confusion on how many people are covered under parents.
* Questioned whether the statement is likely to reduce rates of admission for feeding complications given that there is a lack of clarity on when formula supplementation is needed.
* Separate process measures for breastfeeding and formula feeding suggested.
* Data for measures is available from the UNICEF Baby Friendly audits.

Definitions

* There was concern that the definition suggests that information on formula feeding should be withheld from those who are breastfeeding which may leave them unprepared if they experience complications.
* Information and advice should cover when breastfeeding should be stopped, for example if having developed lesions on the breast or nipples.
* Information and advice should cover how to access feeding advice when needed including third sector.
* Information and advice should cover that there is more than just one option for formula and that the best option is not necessarily the most expensive.
* Combine elements of definition on relactation and supplementation with formula into one.
* Consider greater emphasis on the need for information to be impartial.
* Dispute of the assertion that ‘First infant formula is the only formula milk that babies need in their first year of life’ and that differences between different formulas should be recognised, rather than only the difference between breast milk and formula.

Equality and diversity considerations

* Include consideration of feeding choices for women who are separated from their baby e.g because they are in prison or following social services involvement.
* Include parents with fetal alcohol spectrum disorder.

### Issues for consideration

* Should the statement wording be amended to reflect that information should be personalised?
* Are the measures appropriate?
* Should we progress this statement to the final quality standard?
* Are there any other specific issues that the committee wish to discuss for this statement? The NICE team can strengthen the supporting information with the feedback received.
  1. Draft statement 3

Parents are given information and advice, within 24 hours of the birth, about symptoms and signs of serious illness in the baby that require them to contact emergency services. **[2013, updated 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

* There was general agreement that this statement was a welcomed priority area for quality improvement.
* Consider amending statement wording to ‘within 24 hours of the birth or before discharge following the delivery/birth episode’.
* Consider amending the statement to ‘as soon as possible’ to cover conditions that can cause serious illness in less than 24 hours, for example group B streptococcal infection.
* Consider amending the statement to ‘how to recognise symptoms and signs’ and ‘how to contact emergency services’.
* Consider including how to reduce the likelihood of infections in babies.
* Consider adding midwifery postnatal helplines to the supporting information.
* Refer to the need for context specific information and advice in the rationale.

Definitions

* Align the definition list of serious illnesses with those in [NG195 Neonatal infection: antibiotics for prevention and treatment](https://www.nice.org.uk/guidance/ng195).
* Consider adding ‘extremely agitated with inconsolably crying’ as a sign of serious illness.
* Consider adding pale/chalk-like stools as a sign of serious illness.

Equality and diversity considerations

* Include consideration of need for further training and awareness regarding darker skin tones for signs and symptoms that reference skin colour.

### Issues for consideration

* Should the statement wording be amended to reflect that information should be provided before transfer to community care based on NG195 rec 1.1.12?
* Should we progress this statement to the final quality standard?
* Are there any other specific issues that the committee wish to discuss for this statement? The NICE team can strengthen the supporting information with the feedback received.
  1. Draft statement 4

Parents receive face-to-face feeding support at each postnatal contact. **[new 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

* There was general agreement that this statement was a welcomed priority area for quality improvement.
* Consider amending the statement to ‘face-to-face support with infant feeding’.
* Consider amending the statement to ‘at each standard postnatal contact’.
* Consider amending the statement to ‘face-to-face infant feeding support at each postnatal contact specific to their individual needs’.
* There should be reference to the ante-natal advice received.
* There should be reference to potential for parental decisions on feeding approaches to change over time.
* There should be additional detail on observations and assessments that should take place, as well as examples of support and when/how to discuss different feeding options.
* Consider greater emphasis on the need for information to be impartial.
* Support should include contact details for feeding support outside of postnatal contacts, and highlight the importance of continuity of carer.

Measures

* There was some support for including breastfeeding at 6 to 8 weeks as an outcome while others suggested it was inappropriate.

### Issues for consideration

* Should the statement wording be amended: face to face support with infant feeding and routine postnatal contacts?
* Should we progress this statement to the final quality standard?
* Are there any other specific issues that the committee wish to discuss for this statement? The NICE team can strengthen the supporting information with the feedback received.
  1. Draft statement 5

Parents are given advice about safer practices for bed sharing during their first postnatal midwife and health visitor home visits. **[2013, updated 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

* There was general agreement that this statement was a welcomed priority area for quality improvement, and that it could stop parents hiding that they do this.
* The advice should be given prior to discharge or before the midwife leaves after a home birth.
* There was concern that the quality statement and underpinning guidance do not align with international guidance which recommends no bed sharing before the baby is 12 weeks old.

Measures

* Measurement based on patient surveys may be too time consuming to complete.

Definitions

* Advice should include explanations of why practices increase risk and what options can be alternatives.
* Advice should include not to bedshare if the baby was born prematurely (before 37 weeks).
* The information and advice should cover ways to minimise the risk of SIDS associated with unsafe sleep environments.
* Other suggestions on what information and advice should cover.

### Issues for consideration

* Is the timing in the statement appropriate?
* Should advice about premature babies be included given the remit of the QS?
* Should we progress this statement to the final quality standard?
* Are there any other specific issues that the committee wish to discuss for this statement? The NICE team can strengthen the supporting information with the feedback received.
  1. Draft statement 6

Women have a GP assessment 6 to 8 weeks after giving birth. **[new 2022]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

* There was general agreement that this statement was a welcomed priority area for quality improvement.
* It should be clear in the quality standard and in practice that the assessment is for the woman’s health, and should be separate from any checks for the baby.
* Assessments should feature a strong mental health focus, including PTSD screening and any relevant referrals.
* Assessments at this stage may be too late for first assessment on mental health after birth and may not align with referral wait times.
* Assessments should be thorough and personalised.
* Assessments should feature discussion of breast changes during breastfeeding, and what should be checked.
* Women who have had a caesarean section should also be assessed for perineal healing.

Equality and diversity considerations

* Include consideration of women in contact with social services, in prison, or separated from their baby shortly after birth.
* Women who do not respond should receive follow up.

### Issues for consideration

* Should we progress this statement to the final quality standard?
* Are there any other specific issues that the committee wish to discuss for this statement? The NICE team can strengthen the supporting information with the feedback received.

1. Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

* Information and advice about the signs and symptoms of serious illness in the mother (discussed at prioritisation)
* Ongoing assessment of maternal physical and mental health (discussed at prioritisation)
* Promoting emotional attachment (discussed at prioritisation)
* Continuity of carer (discussed at prioritisation)
* Coping with crying (discussed at prioritisation)
* Vitamin D supplementation

© NICE 2022. All rights reserved. Subject to [Notice of rights](https://www.nice.org.uk/terms-and-conditions#notice-of-rights).

# Appendix 1: Quality standard consultation comments table – registered stakeholders

| **ID** | **Organisation name** | **Statement or question number** | **Comments**  Please insert each new comment in a new row |
| --- | --- | --- | --- |
|  | Action on Postpartum Psychosis | General | We agree with other stakeholders that the quality standard should ideally include a clear statement on assessment of mental health at each postnatal contact – or at the very least, a direct link to QS115 particularly Statements 4 and 5 which have direct relevance to routine postnatal care. It is concerning that universal services may focus solely on the Postnatal Care Quality Standard, and we believe that removing the statement on mental health could reinforce separation between physical and mental health care in the postnatal period and further reduce parity of esteem. |
|  | Baby Sleep Information Source | General | Baby Sleep Information Source (Basis) is the outreach and engagement arm of the Durham Infancy & Sleep Centre, a research centre of Durham University. We were involved in creating current guidance on safer bed-sharing (with Lullaby Trust and UNICEF UK Baby Friendly Initiative) and provide training to health professionals on this topic. Because of our focus on parent-infant sleep we will confine our comments to Statement 5 of the Quality Standard only. |
|  | Beat SCAD | General | While we fully appreciate that the 2013 version of QS37, with 11 quality statements ([Overview | Postnatal care | Quality standards | NICE](https://www.nice.org.uk/guidance/qs37)) was unwieldy and needed tightening up, we are extremely concerned that former quality statement 2 “Maternal health – potentially serious conditions” is no longer included in the proposed revised Quality Standard.  Beat SCAD is fully aware that NG194 has section 1.2 [Recommendations | Postnatal care | Guidance | NICE](https://www.nice.org.uk/guidance/ng194/chapter/Recommendations#postnatal-care-of-the-woman) all about maternal health. However, when you first visit the guideline itself [Overview | Postnatal care | Guidance | NICE](https://www.nice.org.uk/guidance/ng194) the very first thing you see is that there are three quality standards linked to it relating to:  postnatal care  contraception  developmental follow up of young children.  **The draft copy for QS37 with its six new Quality Statements does not mention the health of mothers - AT ALL. We believe this is a serious omission.**  The proposed new Quality Statement 3 says “Parents are given information and advice, within 24 hours of the birth, about symptoms and signs of serious illness in the baby that require them to contact emergency services.”  Beat SCAD strongly believes there should be a Quality Statement for the mother too, along the lines of “Parents are given information and advice, within 24-72 hours of the birth, about symptoms and signs of serious illness in the mother that require them to contact emergency services.”  During the consultation period running up to the creation of the draft quality standard earlier this year, 13 of 28 stakeholders suggested quality improvement areas around the postnatal health of the mother. (see link to briefing paper here [Consultation | Postnatal care (update) | Quality standards | NICE](https://www.nice.org.uk/guidance/indevelopment/gid-qs10150/consultation/html-content-2) and table 2 on p8)  The most recent MBRRACE report, published 2021, says “Cardiac disease remains the largest single cause of maternal deaths.”  Table 2.3 on page 8 [MBRRACE-UK\_Maternal\_Report\_2021\_-\_FINAL\_-\_WEB\_VERSION.pdf (ox.ac.uk)](https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf) shows that between 2013 and 2019, there were 243 maternal deaths due to cardiac disease.  **SCAD – Spontaneous Coronary Artery Dissection - is a serious cause of Acute Coronary Syndrome in women that is often missed and misdiagnosed.**  The PCR EAPCI Percutaneous Interventional Cardiovascular Medicine text book (May 2021): [Percutaneous interventional cardiovascular medicine The PCR-EAPCI Textbook (pcronline.com)](https://www.pcronline.com/eurointervention/textbook/pcr-textbook/) (behind paywall) says:  “Pregnancy-associated SCAD (P-SCAD; usually defined as SCAD occurring during gestation or within 12-months of delivery) accounts for around 5-10% of SCAD cases. SCAD reportedly occurs in 1.81 per 100,000 pregnancies, accounting for 10% - 22% of ACS events in pregnancy and 23-67% of post  partum ACS with most post-partum events occurring within the first few weeks of delivery. There is growing evidence that P-SCAD is associated with a more severe phenotype with more proximal and extensive dissections and larger infarcts. Fatal P-SCAD is an uncommon but recognised cause of maternal death. SCAD has also been observed in association with multi-parity and pre-eclampsia in some series.”  Beat SCAD supports P-SCAD survivors. Many have been told they are “too young and too full of oestrogen” for anything to be wrong with their heart. They are checked for pre-eclampsia and pulmonary embolism but troponin blood tests (the only way to rule out a cardiac event) are often not done. We have patients living with heart failure, or on the heart transplant list because of lack of awareness of SCAD among medical professionals.  Pregnancy related Spontaneous Coronary Artery Dissection was often thought of as a threat **during** pregnancy, but the most recent study (May 2022) [Pregnancy and Spontaneous Coronary Artery Dissection: Lessons From Survivors and Nonsurvivors (ahajournals.org)](https://www.ahajournals.org/doi/epdf/10.1161/CIRCULATIONAHA.122.059635?fbclid=IwAR0VluxCRkDA_0BLHDdKI8oXLVxGRjgbRoUQ25OEJuh2ZKAH35I0wDeyCCg) notes that **the most dangerous period in the study was actually in the month after delivery.** In the study, only five of the 82 P-SCAD cases occurred during pregnancy. **Among the 13 fatal cases, 10 happened after pregnancy**.  Beat SCAD understands that Quality Standards and NICE guidelines can’t read like a textbook, or cover specific conditions, but, given that the leading cause of maternal death in the UK overall is cardiac events, we strongly believe more emphasis should be put on identifying cardiac symptoms in recently pregnant women. **To that end we believe that the failure to include any reference at all to “symptoms and signs of serious illness in the mother” after birth in the revised draft for QS37 is a serious omission.**  Beat SCAD believes:  More information should be shared by midwives with new mothers about the risks of serious cardiac health problems for recently pregnant women.  More specific information should be shared with new mothers about what cardiac symptoms could look and feel like.  A Quality Statement should be included in QS37 along the lines of: “Parents are given information and advice, within 24 hours of the birth, about symptoms and signs of serious illness in the mother that require them to contact emergency services.” |
|  | Better Breastfeeding | General | It is stated at the start that the words woman/mother will be used to describe the person giving birth and the word parents will be used for those responsible for the baby. However, in an attempt to combine the breastfeeding and bottlefeeding statements they have become unclear by referring to parents instead of mothers when referring to breastfeeding. We strongly discourage the attempt to combine the breastfeeding and bottlefeeding statements as they are very different and the way the statements are now written it appears that a) the decision to breastfeed belongs to both parents rather than to the mother and b) that fathers and partners require the same amount of support and advice with feeding their babies as mothers do. This (a) is a very dangerous message to convey as it could result in the false impression (of healthcare professionals and of parents themselves) that someone other than the mother herself can make a decision about whether to breastfeed. The second message (b) fails to accurately convey the much greater need for support required by breastfeeding mothers than that required for parents who are bottlefeeding. Breastfeeding is a highly complex physiological and psychosocial process, with implications for mother and infant physical and mental health. Bottlefeeding is not and the two cannot safely be conflated in the way that is being attempted here. |
|  | Birth Companions | General | We welcome the improved focus on health inequalities and the social determinants of health in this standard, and the recognition of women’s complex needs in the postnatal period. However, we recommend the inequalities highlighted in MBRRACE Saving Lives, Improving Mothers’ Care relating to women known to social services should be highlighted alongside those linked to ethnicity and deprivation. In the latest report 17% of the women who died were ’known to social services’, rising from 12% in 2012-14. Of those cases where maternal death was caused by suicide, 37% were known to social services, and 16% were subject to ongoing social services proceedings relating to their child, or had been separated from their infant. This evidence should be spotlighted at key points throughout the standard, along with the ethnicity and deprivation evidence, to encourage greater collaboration between those providing PN care and Local Authority social services teams.  Equally, the current NICE CG110 guidance on complex social factors doesn’t take into account the specific needs of those women who are in contact with the criminal justice system – in prison or in the community – which has a significant impact on their access to and experience of PN care. Reference to this should also be built into sections highlighting inequalities, multi-agency working and system co-dependencies. |
|  | British Maternal & Fetal Medicine Society | General | No comments to make. |
|  | British Pregnancy Advisory Service | General | Suggested Improvement area 4.1 (organisation and delivery of postnatal care)  We believe this area should be prioritised for inclusion in the quality standard. The ability of parents to make informed choices and decisions relies on the effective communication of information. Figures indicate that since the Covid-19 pandemic fewer numbers of women are receiving important information regarding postnatal maternal health.  Including the organisation and delivery of postnatal care as part of the postnatal quality standards, with a focus on listening to women when they express concern and the effective communication of information, would help to ensure a more women-centred approach. |
|  | British Pregnancy Advisory Service | General | Statement 5 and 6 of the quality standard should be combined into one ‘infant feeding’ statement. We agree with the approach outlined in the information and support section of the briefing (4.4) - that women should be given information about all feeding methods before and after the birth to support informed decision making. All women and their partners should then be given the information and support they need to feed their baby regardless of their choice of method.  However the language of the selected recommendations in this section of this briefing does not support the approach outlined above. For example:  Recommendation 1.5.10 ‘Make face-to-face breastfeeding support integral to the standard postnatal contacts for women who breastfeed. Continue this until breastfeeding is established and any problems have been addressed.’ We suggest this recommendation be reworded to ensure a more women-centred approach that prioritises choice of method such as, “Make face-to-face breastfeeding support integral to the standard postnatal contacts for women who breastfeed. Work with women to address feeding issues and establish suitable feeding methods.”  Recommendation 1.5.16 in the briefing states: “Before and after the birth, discuss formula feeding with parents who are considering or who need to formula feed, taking into account that babies may be partially formula fed alongside breastfeeding or expressed breast milk.” Only giving information on formula feeding to those parents who are considering or need to formula feed, implies that this information should only be given to parents who have expressly mentioned formula feeding. When compared to recommendation 1.5.2 on breastfeeding which simply states “Before and after the birth discuss breast feeding and provide information” the phrasing of 1.5.16 implies that providers should avoid speaking about formula where possible. This does not match the aim of giving women information about all feeding methods before and after the birth to support informed decision making as stated further up in the briefing. It is impossible for women to make informed decisions if certain information is withheld unless it is request. This recommendation should be reworded to say “Before and after the birth discuss formula feeding, taking into account that babies may be partially formula fed alongside breastfeeding or expressed breast milk.”  Recommendation 1.5.17 in the briefing (information about formula feeding) should be modified to include information on why some people choose to formula feed, rather than just an explanation of formula feeding in relation to breastfeeding. Formula feeding has practical advantages. This is why many parents continue to use this method. Bottles can be prepared and given to the baby by anybody, making it easier for parents to are night feeds and to go out without the baby. This means that other adults, such as grandparents, friends or relatives, can provide more practical help and support to new mothers and feel more involved in the baby's care. For some, particularly new parents, information on why some people choose to formula feed will be vital in helping them make an informed choice on feeding methods. Again guidance must centre women and parents and give them all the information so they are able to make truly informed choices. Guidance needs to reflect the flexibility and open-mindedness that health professionals need when engaging with new mothers, and focus less on increased breastfeeding rates than the truly optimal outcome: fed and healthy infants.  Questions:  Do we need to focus separately on breastfeeding and formula feeding?  No, the focus should be on infant feeding and ensuring that women and parents are able to make informed choices about the best feeding methods for them and their babies.  What is the priority for improvement?  Ensuring that all women and parents are given evidenced-based information and supported in their feeding choices. Including the ability to access face-to-face support. Evaluated, structured programmes should be used for both breast and bottle feeding to enable equitable care and reduce inequalities in infant feeding support. |
|  | British Specialist Nutrition Association Ltd | General | We welcome and recognise the progress made with the update of the draft of *Postnatal care quality standard*, in particular, in light of the comments made concerning the previous draft of the document.  We believe this new, updated draft will have made the essential difference for parents – especially in reference to the levels of guilt parents might experience regarding their feeding choices (1).  We also note and are pleased to see, that the overall structure of the updated draft of the *quality standard*, in our view, gives greater consideration to the experience of combi-feeding that remains the choice many parents make.  We would welcome further understanding of how this advice aligns to Baby Friendly Initiative.  References: 1- Jackson L.,Fallon V.,Harrold J.,Pascalis L.(2022) ‘Maternal guilt and shame in the postpartum infant feeding context: A concept analysis’. *Midwifery J*., **105**,103205. <https://doi.org/10.1016/j.midw.2021.103205> |
|  | Fatherhood Institute | General | Our thoughts  We are responding to this in a slightly unusual way, only making general comments. This is because that is our area of expertise, and our recommendations to the Committee during the drafting of the Postnatal Guideline were useful. Some of our recommendations that were adopted by the Committee in the drafting of the Postnatal Guideline have been lost in the drafting of the Quality Standards, which is why we address them here. We to address the issues in separate rows below. |
|  | Fatherhood Institute | General | terminology  (1) **the terminology used – ‘parents’ rather than ‘woman + partner’** (which is used in the Postnatal Guideline) **makes it far less obvious to the HCPs following the Quality Standard that partners are to be included.** This is because the term ‘parents’ is widely used across perinatal services (and many other services – e.g. Early Years) to mean the plural of mother – i.e. “parents = mothers”. There is an extensive literature on this. The result is that, when service providers hear the term ‘parents’ they are not alerted to the fact that the intention is for the father of the child/ the mother’s partner, to be included and addressed. We know that, at the outset you define the term ‘parent’ to include people other than the woman/ mother but this is not sufficient to focus the minds of those reading the Quality Standard on the intention the woman/ mother’s partner is to be specifically addressed, too.  We therefore suggest that the term ‘parents’ be changed to woman + partner or mother + partner – as suggested in the row below.  Note that the term ‘partner’ is used TWENTY times in the Postnatal Guideline but **not once** in the Draft Quality Standard. |
|  | Fatherhood Institute | General | suggested redraft of quality statements 2-5  SUGGESTED RE-DRAFT (the text in red just shows the suggested change)  [Statement 2](file:///T:\QS\Work%20programme\1.%20QS%20in%20development\Postnatal%20care%20(update)\6.%20Consultation\Responses\Fatherhood%20Institute.docx#_Quality_statement_2:) The m**other and her partner** are given information and advice about breastfeeding and formula feeding before transfer to community care or before the midwife leaves after a home birth. **[2013, updated 2022]**  [Statement 3](file:///T:\QS\Work%20programme\1.%20QS%20in%20development\Postnatal%20care%20(update)\6.%20Consultation\Responses\Fatherhood%20Institute.docx#_Quality_statement_3:) The m**other and her partner partner** are given information and advice, within 24 hours of the birth, about symptoms and signs of serious illness in the baby that require them to contact emergency services. **[2013, updated 2022]**  [Statement 4](file:///T:\QS\Work%20programme\1.%20QS%20in%20development\Postnatal%20care%20(update)\6.%20Consultation\Responses\Fatherhood%20Institute.docx#_Quality_statement_4:) The m**other and her partner** receive face-to-face feeding support at each postnatal contact. **[new 2022]**  [Statement 5](file:///T:\QS\Work%20programme\1.%20QS%20in%20development\Postnatal%20care%20(update)\6.%20Consultation\Responses\Fatherhood%20Institute.docx#_Quality_statement_5:) The m**other and her partner** are given advice about safer practices for bed sharing during their first postnatal midwife and health visitor home visits. **[2013, updated 2022]** |
|  | Fatherhood Institute | General | ‘conditionality’ of tone  (2) **The next issue is the “conditional” tone about the presence/ existence of the woman’s partner.**  The text as drafted casts doubt on this. In fact (see RATIONALE in the row below this one) there are almost new mothers in the UK parenting without the involvement of their infant’s biological father – even where the parents are not co-resident at the time of the birth  **THE TEXT IN THE QUALITY STANDARD**  *The term ‘partner’ refers to the woman’s chosen supporter. This could be the baby's father, the woman’s partner, a family member or friend, or anyone who they feel supported by or wish to involve. The term 'parents' refers to those with the main responsibility for the care of a baby. This will often be the mother and the father, but many other family arrangements exist, including single parents.*  **OUR SUGGESTION (see suggested text in red below)**  *The term ‘partner’ refers to the woman’s chosen supporter. This* ***can*** *be the baby's father, the woman’s partner, a family member or friend, or anyone who they feel supported by or wish to involve. The term 'parents' refers to those with the main responsibility for the care of a baby. While this will* ***usually*** *be the mother and the father, many other family arrangements exist, including mothers* ***who live separately from their baby’s father – a minority of whom will not be engaging with her/ their infant*** |
|  | Fatherhood Institute | General | family structure/ engagement of biological fathers at time of birth in the UK  **RATIONALE: EVIDENCE FOR PRESENCE OF THE BIOLOGICAL FATHER IN LIFE OF THE MOTHER AND INFANT**  Fewer than 4% of fathers of newborns in the UK neither lives with, nor is regularly present in his newborn’s daily life: 14.4% of parents are not cohabiting when their infant is born but one third of these (5% describe themselves as a couple, and another one third (5%) as ‘friends’ (many of these move in together later) Only 4.4% of the mothers say they are not in a relationship with their infant’s father, but even among these couples about one quarter of the fathers are actually involved with mother and infant. (Kiernan & Smith, 2003)  95% of biological parents in all countries of the UK currently jointly register their baby’s birth (ONS, 2020a)  a mother’s’ partner is almost invariably the infant’s biological father: only 1:1000 births is registered to two women (ONS, 2016); and fewer than 2% of new mothers have a cohabiting or non-cohabiting male partner who is not their infant’s biological father (Bradaw et al., 2013).  where ‘parents’ are two fathers or two mothers, they are NOT uncomfortable with the term ‘father’ or ‘mother’: in fact they self-define in these roles. |
|  | Fatherhood Institute | General | page 6 – bullet point 6: ‘parental responsibility’  **THE TEXT IN THE QUALITY STANDARD**  who has parental responsibility for the baby, if known  **OUR SUGGESTION**  who has parental responsibility for the baby, if known  **RATIONALE**  Delete ‘if known’. This drafting is again weirdly conditional, given that 95% of mothers’ partners (almost invariably the biological father of the infant) have Parental Responsibility since their name will be on the birth certificate. |
|  | Fatherhood Institute | General | final comments  We would stress (and HCPs should be helped to understand) that their goals e.g. better breastfeeding rates (initiation and maintenance) are more likely to be reached when the mother’s partner (usually the father) is engaged. We cover all this in our new report, BRINGING BABY HOME funded by the Nuffield Foundation which can be found here: <http://www.fatherhoodinstitute.org/2022/contemporary-fathers-in-the-uk/>  Here are a few key points from this research review:  Enlisting the father as the mother’s support by addressing him directly and drawing him in is vital because:  he has his own unique relationship with the infant – including through genetic bequests  the new mother’s mental health is poorer when e does not feel supported by her baby’s father (Parfitt & Ayers,  2014)  new mother’s mental health is poorer when he is less available at home than other fathers (Twamley et al., 2013).  Engaging the new father is also vital in order for HCPs to make the most of this ‘teachable moment; in terms of helping him address his own health behaviours. Health behaviours within families are interdependent and it is hard to get a mother to (for example) eat healthily, exercise and NOT smoke when her partner’s health behaviours are negative. Also, new fathers’ negative health behaviours have independent impacts on their infant.  at least 18% of new mothers live with a smoking adult –in almost all cases their baby’s father (Harrison et al., 2020)  women who had stopped smoking in pregnancy but whose husband continued to smoke in the year after the birth, were at increased risk of relapse (Prady et al., 2012)  24% of children whose father is obese are obese themselves (9%) (National Statistics, 2017)  couple obesity and overweight are strongly correlated (Brown et al., 2013) fathers’ heavy alcohol use doubles the risk of an insecure mother-infant attachment (Eiden & Leonard, 1996) |
|  | FTWW: Fair Treatment for the Women of Wales | General | FTWW would urge the Committee to consider expanding Statements on postnatal midwife and health visitor visits to include some elements of the GP assessment mentioned in Statement 6, particularly those pertaining to a review of the mother’s mental health and general wellbeing. This is essential to ensure early identification of emerging issues, enabling timely referral to appropriate support. |
|  | FTWW: Fair Treatment for the Women of Wales | General | About this quality standard  This section makes clear that the Quality Standard will apply in England and Wales, so we would advise including Wales-specific bodies in references to ‘What the quality statement means for different audiences’, ‘Service providers’, and ‘Commissioners’ throughout. For example, the Committee might consider referencing ‘health boards’ in addition to ‘NHS hospital trusts’. This is important as NICE Quality Standards will be read and referenced by service-users in Wales who may require that further clarity. |
|  | GPs championing perinatal care | General | GPCPC are in favour of this document generally. |
|  | Lactation Consultants of Great Britain | General | LCGB thanks the NICE Postnatal Care Quality Standards Committee for their work on these great new quality standards, and looks forward to their implementation. |
|  | Pelvic Obstetric & Gynaecological Physiotherapy (POGP) | General | There should be funding in place for services to refer onto eg mental health services, birth trauma, postnatal advice classes, physiotherapy, continence services. |
|  | Royal College of Nursing | General | No comments. |
|  | Royal College of Paediatrics and Child Health | General | These standards are non-contentious. They need to be linked directly to curricula for (especially) midwife training. |
|  | Royal College of Paediatrics and Child Health | General | A proforma for each standard needs to be used like the proforma for postnatal examination of babies. This should contain the points raised by each standard, which are lengthy, and will allow an aide memoir for each interaction and indeed a framework for those interactions. |
|  | Royal College of Paediatrics and Child Health | General | This commenter is happy with this draft. |
|  | Royal College of Paediatrics and Child Health | General | We think this draft is clear and helpful, especially around feeding and importance of good education for those who chose to bottle feed. |
|  | Royal College of Paediatrics and Child Health | General | We believe it would be useful for vitamin D supplementation to be included as this is still often missed. |
|  | Royal College of Paediatrics and Child Health | General | Introduction  “This quality standard covers routine postnatal care in the first 8 weeks after birth.”  We think it would be helpful to add a statement about what is meant by ‘routine postnatal care’. For example, where mothers are well and getting routine care, but their babies have needed NICU care and have been transferred – is this included? |
|  | Royal College of Paediatrics and Child Health | General | Overall, we feel that the guideline advises on many aspects of good clinical care and guidance that should be given to mums (and partners etc), but we feel there is a place of these national interventions which remain key public health interventions and an important aspect of neonatal care/screening/intervention. |
|  | The Breastfeeding Network | General | We welcome this important quality standard, which we hope will improve standards of postnatal care for infants, mothers and families. |
|  | The Breastfeeding Network | General | We note the use of the word “advice” throughout the document. BfN does not advocate giving “advice” to parents and carers, as this can be disempowering. We suggest this be rephrased as giving “information and support”. Some specific examples of this are addressed below. |
|  | UNICEF UK Baby Friendly Initiative | General | We welcome this work to improve care for babies, their mothers, and families/carers in the postnatal period. |
|  | UNICEF UK Baby Friendly Initiative | General | We welcome and support Quality Statements (QS) 1,3,4,5 and 6. We have concerns about the safety and feasibility of Statement 2. See details below. |
|  | UNICEF UK Baby Friendly Initiative | General | We recommend that where the Quality Statements use the word ‘*advice’* that this is amended to be more enabling for the parent/primary carer (see below for each statement where applicable). |
|  | UNICEF UK Baby Friendly Initiative | General | We recommend reviewing the wording around feeding methods. Some examples have been provided for consideration in the text:  Breastfeeding is a method of feeding  Bottle feeding is a method of feeding; parents may be bottle feeding expressed breastmilk or infant formula. |
|  | Action on Postpartum Psychosis | Question 1 | No – There is no provision in the draft quality standard for advice about signs and symptoms of serious illness in the mother requiring urgent care (whether a physical or mental illness). Postpartum psychosis is a severe, acute postnatal mental illness in which symptoms escalate rapidly – usually during the first two weeks after a baby’s birth. MBRACE reports consistently highlight suicide as the leading cause of maternal death, and a high proportion of these suicides are due to postpartum psychosis. Given the acuity and risks associated with postpartum psychosis, we believe that this condition should be included in advice given to parents within 24 hours of birth. Crucially, partners and family members are often the first to report symptoms of PP therefore provision of advice for partners on the signs and symptoms to be aware of, and how to seek urgent help should be prioritised.  See CG192 1.5.12 If a woman has sudden onset of symptoms suggesting postpartum psychosis, refer her to a secondary mental health service (preferably a specialist perinatal mental health service) for immediate assessment (within 4 hours of referral) |
|  | Baby Sleep Information Source | Question 1 | The provision of bedsharing information to parents is a crucial aspect of quality improvement for postnatal care. In the course of our research we have found many parents receive out of date information from their midwife or health visitor, or have no conversation with a practitioner about this topic. |
|  | Better Breastfeeding | Question 1 | Important statements in the earlier QS have been lost. In particular those relating to a structured programme for improving breastfeeding and the specific reference to training and assessment of competencies. Better Breastfeeding have used those statements in conversations with commissioners to help drive improvements, and their loss will very likely result in lower standards of training and of competencies. These statements should be added back to the draft standard. |
|  | British Specialist Nutrition Association Ltd | Question 1 | We broadly agree that draft quality standard accurately reflect the key areas for quality improvement, but we note some particular concerns, outlined in our comments below – in particular with statements 2 and 4. |
|  | FTWW: Fair Treatment for the Women of Wales | Question 1 | On the whole, FTWW believes that the draft quality standard accurately reflects the key areas for quality improvement. However, we would urge emphasis on the need for information on feeding to be unbiased and impartial, particularly given the number of mothers who report experiencing undue pressure to breastfeed when their individual circumstances (such as emergency deliveries, and / or health issues) have made it more challenging. Some describe escalating peri-natal anxiety and depression as a direct result of attitudinal bias towards them and their difficulties breastfeeding.  FTWW would also ask that there be more reference to awareness of mental health during and after pregnancy on the part of midwives and health visitors so that mothers and families in need of support can be identified early and offered appropriate support as soon as possible. Early intervention can prevent escalating and deteriorating mental health problems that become more intractable the longer they go on so this should be a key part of any quality statement pertaining to midwifery and health visiting. FTWW would also like to see this Postnatal Quality Standard being inclusive of those who suffer late / full-term baby loss, both with regards to awareness and support for their mental health and emotional wellbeing, as well as treatment for any physical issues or injuries sustained.  Finally, we wonder whether there is a need to consider referencing ‘signposting’ as a key component of this Quality Standard. Whilst it is not necessary to name particular agencies, it may be worthwhile including a reminder to users that they should be adequately prepared to signpost their clients to relevant third sector support. |
|  | GPs championing perinatal care | Question 1 | We believe it does. |
|  | Healthcare Safety Investigation Branch (HSIB) | Question 1 | **Does this draft quality standard accurately reflect the key areas for quality improvement?**  Yes |
|  | Institute of Health Visiting | Question 1 | The iHV agrees with the 6 statements, however based on the evidence, the iHV propose that 3 additional key areas for quality improvement are required which include:  **Key area 1 - The parent-infant relationship**  The postnatal care standard provides an ideal opportunity to support secure infant-parent attachment to reflect the importance of infant mental health. There is a large body of evidence supporting the case that a ‘secure’ attachment is associated with optimal outcomes across all domains in childhood, and both insecure and disorganised attachment are associated with a range of later psychopathologies. Insecure and disorganised attachment are common, particularly in disadvantaged populations, pointing to the need to ensure that the promotion of attachment, and the early identification of attachment difficulties are included in routine postnatal care. This will help to provide parity of esteem between physical and mental health. There needs to be particular the focus on both parents. Involving partners and other family members can help them to provide support and care for the mother/birthing parent, ultimately promoting their mental health and ability to care for the baby. Strengthening this statement will align with the current ambitions of the [Long Term Plan](https://www.longtermplan.nhs.uk/) and the government’s recent [Start for Life Policy](https://www.gov.uk/government/publications/the-best-start-for-life-a-vision-for-the-1001-critical) which identifies perinatal and infant mental health as a priority area.    [Prevention in Mind](https://www.basw.co.uk/resources/prevention-mind-all-babies-count-spotlight-perinatal-mental-health) enables Health Care Professionals (HCPs) to ‘think family’ which enables practice to be consistently family inclusive. Consideration can be given to the mother in her family context; the needs of the whole family; holding in mind that what affects the parent will affect the baby; and what affects the baby will affect the parent; ways in which family members can be involved in the mother’s care; and supporting family members as individuals, as partners/relatives to the mother, as parents/relatives to the baby.  To also consider: [The Perinatal Frame of Mind](http://tinyurl.com/y4sy9fxg) which sets out components of best practice when working with mothers/birthing parents and their families at every stage of perinatal care. The Perinatal Frame of Mind means thinking about the needs of multiple family members and, specifically, the ability to be aware of the father/partner’s mental health and how this affects the mother and baby; how the pregnancy affects the father/partner and other family members’ mental health and wellbeing; and how the absence of a partner or lack of support from the family may affect the mother, baby and mother-baby relationship.  **Key area 2 - Coping with crying**  Infant crying is normal, but it is also a stressful and distressing condition for parents and care givers to cope with, affecting their sleep, parenting capacity, physical and mental health. It can trigger depression and anxiety, cause early cessation of breast feeding as well as the early introduction of solids (Sung 2018). Excessive crying can trigger abusive head trauma and the consequences can be life changing and catastrophic for infants involved (2).  Raising awareness of infant crying with advice on ways to manage crying has been own to be effective at improving parental reaction to crying and specifically in reducing incidents of abusive head trauma (3). ICON has been highlighted in the independent Child Safeguarding Practice Review Panel’s third national review: ‘The myth of Invisible Men’ Safeguarding children under one from non-accidental injury caused by make carers (published 16/09/2021) (4)  Key messages are delivered at 5 postnatal key touch points:  At the hospital before discharge.  By the community midwife in the baby’s first 10 days.  By the health visitor in the first 14 days.  By the health visiting again at 6-8 weeks.  By the GP at the six-to-eight-week postnatal check.  References:  Sung, V (2018) Infantile Colic Australian Prescriber Aug 20181(4): 105–110. Published online <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6091773/>  ICON (2020a) (Infant Crying is Normal; Comforting Methods can help; It’s Ok to Walk Away; Never, Ever shake a Baby) <https://iconcope.org/>  ICON (2020b) <https://iconcope.org/wp-content/uploads/2020/09/CS51689-NYY-ICON-LEAFLET-v2.pdf>  Child safeguarding practice review panel (2021) [https://assets.publiing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/1017944/The\_myth\_of\_invisible\_men\_safeguarding\_children\_under\_1\_from\_non-accidental\_injury\_caused\_by\_male\_carers.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1017944/The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf)  **Key area 3 - Continuity of carer**  Continuity of carer is a safety critical component of effective postnatal care: it is important for relationship building, improving access to care (particularly for marginalised groups that currently experience poor access to services), eliciting need, identifying risk factors and increasing engagement in support and early intervention.  Continuity of Carer is a national recommendation set out in the Better Births National Maternity Review (1) and reinforced recently as a key driver of maternity failings in the Ockenden Review (2). Evidence from a number of studies has identified that providing continuity of carer improves safety critical outcomes for mothers, families and their babies. Continuity of health visitor is also important, particularly for families with higher levels of need and less resilience or agency to ask for help when needed.  Ideally, the health visitor should meet families during pregnancy for the initial assessment of need. An accurate assessment cannot be undertaken in a single ‘snapshot’ appointment as the period from pregnancy to 6 weeks postnatally is a dynamic period of change for many families that is affected by the interrelationships between a multitude of risk and resilience factors, including the parents’ physical and mental health, the infant’s physical and mental health, as well as the wider determinants of health and the context in which families live. The holistic assessment of need is built upon during the new birth contact and the 6-week postnatal contact – this enables the health visitor to build on their existing knowledge of the family’s individual circumstances and work in partnership with them to develop a more accurate and shared understanding of their current risk and resilience factors and support needs (3,5,6,7).  Through developing early effective relationships with families and working closely with midwifery services and other partners, health visitors can provide seamless support and care, using a strength-based approach as families transition through services. Working with parents and families, health visitors identify the most appropriate level of support for their individual needs. Health visitors work with many different health care professionals, services, and charities within local communities. By having health visitors involved from the earliest opportunity, families can be supported at all key milestones and referrals can be made to additional support services and peer groups as needed.  Mothers value being treated as an individual, with a personalised service that is responsive to their individual circumstances and needs, rather than a “one-size fits all” approach. Positive experiences were linked to continuity of health visitor and a non-judgemental strengths-based approach that was based on client-led goals and a shared understanding of their priorities. Parents want continuity of health visitor so that they can build a positive, trusting relationship with them and feel that their needs are understood – this was found to be the most important factor in parents’ satisfaction with the health visiting service (4).  **References**  Implementing Better Births: Continuity of Carer (2017) <https://www.england.nhs.uk/wp-content/uploads/2017/12/implementing-better-births.pdf>  House of Commons Inquiry (2022) Ockenden report: Findings, conclusions and essential actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust. <https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf>  Healthy child programme 0 to 19: health visitor and school nurse commissioning (<https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning#history>)  PHE Early years high impact area 1: Supporting the transition to parenthood (<https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/early-years-high-impact-area-1-supporting-the-transition-to-parenthood>  What parents want for a health visiting service (iHV 2020) <https://ihv.org.uk/wp-content/uploads/2020/01/HV-Vision-Channel-Mum-Study-FINAL-VERSION-24.1.20.pdf>  Davis H, Day C (2010) Working in Partnership: The Family Partnership Model. Pearson, London.  Day C (2016) Promoting early infant development <https://www.nursinginpractice.com/clinical/womens-health/promoting-early-infant-development/> |
|  | NHS England and Improvement | Question 1 | Overall changes appear helpful. New Statements are in line with NHSEI recommendations for postnatal improvement (like statement 1 on sharing information between services on handover) and also some of our key initiatives subsequently, like Statements 2 and 4 on breastfeeding and Statement 6 on the maternal postnatal check. Cannot see any reference to ICON: baby crying. |
|  | Royal College of Midwives | Question 1 | Yes, the current quality standards reflect the key areas for quality improvement. Continuity of care is a priority and should be included, there is strong evidence to support midwifery continuity of care such models include continuity of care postnatally. RCM (2019) Midwifery Continuity of Carer (MCOC) Position Statement.   We recommend encouraging maternity systems to implement and support midwifery continuity of carer, given its well known positive effect on breastfeeding initiation and continuation as well as on physical and mental wellbeing and pregnancy/post-partum outcomes |
|  | Royal College of Obstetricians and Gynaecologists | Question 1 | Yes, QI initiatives related to these standards can potentially have a meaningful effect. |
|  | The Breastfeeding Network | Question 1 | We are pleased to see the emphasis placed on infant feeding in this quality standard. We support statements 1, 3, 4, 5, and 6, with some comments and suggestions on the specific wording below. We have some particular concerns about statement 2, which are detailed below. We would also suggest that the inclusion of a quality standard that specifically addresses promoting emotional attachment between the parents and baby would be beneficial. |
|  | UNICEF UK Baby Friendly Initiative | Question 1 | Statements 1,3,4,5 and 6 accurately reflect the key areas for quality improvement. |
|  | World Breastfeeding Trends UK | Question 1 | Yes |
|  | Action on Postpartum Psychosis | Question 2 | No Comment |
|  | Baby Sleep Information Source | Question 2 | We are unable to answer this question. |
|  | Better Breastfeeding | Question 2 | Existing systems seem inadequate to properly reflect whether breastfeeding information, advice and support has been sufficient. Asking whether a leaflet has been received, for example, could lead to a tickbox exercise where leaflets are prioritised over high-quality skilled support. A local survey is a good suggestion. It would require additional resources but such a survey could capture more nuanced information about experiences of breastfeeding support and would be worth investing in. |
|  | Fatherhood Institute | Question 2 | We would be delighted if the terminology were to include the word FATHER – e.g. “Mother and father/woman’s partner” rather than “Mother and her partner” – but that may be an ‘ask’ too far. Just seeing the word ‘partner’ regularly throughout the Quality Standard (as it is found in the Postnatal Guideline) would be really helpful |
|  | Institute of Health Visiting | Question 2 | Local systems and structures for data collection for the proposed quality measures is variable across the country. National mandated data reporting would need to be implemented to ensure this was put into place locally. |
|  | National FASD | Question 2 | Mother has FASD/suspected FASD |
|  | NHS England and Improvement | Question 2 | We would be surprised if not. A number of process measures relying in local audit will be challenging to capture. However, they are non-mandatory and ultimately constructive in the absence of national measures. NHSEI intends to produce best practice guidance on the content on the maternal postnatal check in 22/23, to include guidance on how provision of the check should be recorded in practice records. |
|  | Royal College of Midwives | Question 2 | Yes, LMS have their own systems in place to collect data around the quality standards measures |
|  | Royal College of Obstetricians and Gynaecologists | Question 2 | Yes to a large extent, but the increasing workload placed on local governance teams is a significant challenge, especially as a number of these measures relate to data on the service users perspective and are dealing with the primary/ secondary interface. With the right investment it could be feasible. |
|  | Royal College of Speech and Language Therapists | Question 2 | At present, data collection systems with health and social care disparate. The RCSLT asks speech and language therapists to contribute their anonymised patient data and therapy outcomes into a UK-wide database (the ROOT) that would support the profession to examine quality and meeting quality standards, which could be filtered for this area of practice. We also feel strongly that re-instating the **national infant feeding survey** would an effective data collection system in which these standards could be evaluated. We strongly believe that access to robust data allows us to evaluate progress and steps to improve outcomes. Good community support to makes a difference. |
|  | The Breastfeeding Network | Question 2 | Nationally, the UK Government has committed to reinstate the National Infant Feeding Survey – this could provide useful data on trends and experiences in infant feeding and support. |
|  | UNICEF UK Baby Friendly Initiative | Question 2 | Feedback from the National Infant Feeding Network (NIFN) is that the data collection systems/tools are not currently robust enough to collect this data and differ across the services (e.g. E3/ BadgerNet etc.) and do not always ‘talk’ to each other across the maternity and community service provision. Data collection files are not currently in place to collect this data. NIFN and UNICEF UK would be happy to work with you to help develop and pilot the data sets for QS 2, 4 and 5. |
|  | World Breastfeeding Trends UK | Question 2 | The emphasis on better support for infant feeding in the early postnatal period is very welcome but for monitoring progress it needs an outcome of data collected earlier than 6-8 weeks. We therefore suggest another data collection point at the midwife check at 10 days. This would be incorporated in the existing system collecting data for the Maternal and Infant dataset. Collection of data at 6-8weeks needs to be prioritised more to address the current large quantity of missing data and a new data point at 10 days would similarly need to be prioritised for the data to be useful. |
|  | Action on Postpartum Psychosis | Question 3 | No comment |
|  | Baby Sleep Information Source | Question 3 | Yes, it should be feasible to achieve this standard. Staff may need training in updated guidance and how to discuss this with parents. |
|  | Better Breastfeeding | Question 3 | Existing resources are unlikely to be sufficient to meet the need for feeding support to be offered at every postnatal contact. Investment in maternity infant feeding teams and in breastfeeding peer support programmes to facilitate home visits in the postnatal period would likely have a very significant impact on breastfeeding rates and in particular on hospital readmission rates for feeding problems. Therefore investing in these additional resources would likely result in an overall cost saving. |
|  | Institute of Health Visiting | Question 3 | Current workforce shortages would need to be taken into consideration across all the draft quality standards and a workforce plan is needed to deliver these standards in full.  When adequately resourced, health visitors provide a vital infrastructure of support to all families - preventing problems and identifying needs early to reduce the burden of costly late intervention. Health visitors identify and advocate for vulnerable babies and young children who cannot speak for themselves and are often invisible to other services. Health visitors are a highly skilled workforce and one of six essential services listed as central to the success of [The Best Start for Life Vision](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973112/The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf). There is an estimated shortfall of 5,000 health visitors (a loss of ⅓ of HVs since 2015) (1). A well-resourced national HV workforce plan is needed to address the shortages in the health visiting workforce and demand- driven workforce modelling is needed to deliver the Healthy Child Programme in full.  **Reference:**  Conti G & Dow A (2021) Rebuilding the health visiting workforce: costing policy. <https://bit.ly/3DSD8KE> |
|  | National FASD | Question 3 | Siblings with FASD |
|  | NHS England and Improvement | Question 3 | All of the statements should well be resourced locally. Particularly provision of the GP check, which received additional funding in April 2020. |
|  | Royal College of Midwives | Question 3 | Women and families are consistently less satisfied with postnatal care when compared with antenatal and intra-partum care. The same level of support available in pregnancy should be offered in the postnatal period, including personalised care provision centred on the needs of the woman, her baby and family.   The current content and timing of postnatal care is not meeting basic women’s needs. It is important for NICE to focus on appropriate resourcing and staffing needs specific to the postnatal periods.   This should include acute settings, currently midwives may be allocated six women and six babies on postnatal wards, if not more due to staffing pressures and despite the increased complexities (e.g. babies in transitional care); and community including breast feeding support and prioritising home visits provision and postnatal care for up to 28 days.   RCM (2014) Postnatal care planning. Pressure Points. <https://www.rcm.org.uk/media/2358/pressure-points-postnatal-care-planning.pdf>  CQC (2019) Maternity services survey.   In addition to the increases in complexity and acuity, demand for midwives is also being fuelled by national maternity policy commitments to improve the safety of maternity services, to provide women with more personalised care and greater continuity of carer as well as recognition of the increasing public health role that midwives play. Such initiatives, programmes and deliverables will increasingly require midwives with specialist knowledge and skills as well as making additional calls on the time of midwives and unfortunately, midwifery staffing numbers have not kept pace with these changes. Existing staffing shortages – estimated by the RCM and Government ministers alike to be in the region of 2,000 full-time equivalent midwives in England – are having a significant impact on the workload and pressures experienced by midwives.   RCM (2022). Safer staffing Position Statementhttps://www.rcm.org.uk/media/5936/rcm\_positionstatement\_safer\_staffing.pdf |
|  | Royal College of Obstetricians and Gynaecologists | Question 3 | Additional resources will definitely be required to facilitate monitoring of these standards across the primary/ secondary interface. Apart from dedicated manpower for this cause, there will need to be a realignment of manual and digital health records to ensure the required checklist of data is uniformly captured in all settings. The biggest challenge will be the new standard 6 of GPs seeing women 6-8 weeks after delivery. Whilst this has traditionally been the desired practice, this requirement is subject to a range of interpretations and the document needs to be clear about whether an assessment by other health professionals in a community setting on behalf of GPs will count as this standard having been met.  One of the questions asked is whether this type of system is auditable and are the resources in place to achieve this. There is a massive shortfall of midwives in the UK and anything which detracts from direct patient care is highly undesirable. If midwives are going to spend even more time entering data into a computer system, we are going to deny post-natal patients the very face-to-face care this is trying to achieve.  The Ockendon report was supposed to improve maternity services by addressing many issues where care is considered sub-standard but the impact on service delivery now means that a standard post natal ward round is taking 50% longer than previously due entirely to computer entry time. This means we are taking staff away from mothers. |
|  | Royal College of Speech and Language Therapists | Question 3 | Members of the RCSLT report a net loss of health visitors, children’s centres and sure start centres in practice, and it is considered by them that these would be the places to support these standards. The RCSLT considers it vital that these important services, where they exist, should be engaged with the standards and strive to meet them however It is important to look again at fully resourcing these important services in order for quality standards to be met in actuality. |
|  | UNICEF UK Baby Friendly Initiative | Question 3 | We believe that, with the correct data collection tools in place, QS 1,3,4,5, and 6 are achievable. Resources are required to train staff in data collection and to develop/implement the correct data collection fields across systems. Costs savings would be realised overtime alongside improvements in health and wellbeing outcomes. See:  The Lancet Breastfeeding Series, 2016 [unicef.org.uk/babyfriendly/lancet-increasing-breastfeeding-worldwide-prevent-800000-child-deaths-every-year/](https://www.unicef.org.uk/babyfriendly/lancet-increasing-breastfeeding-worldwide-prevent-800000-child-deaths-every-year/)  Commissioning Infant Feeding Services, 2016 [unicef.org.uk/babyfriendly/about/commissioning-guidance-infant-feeding/](https://www.unicef.org.uk/babyfriendly/about/commissioning-guidance-infant-feeding/)  Preventing Disease Saving Resources, 2012 [unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2012/11/Preventing\_disease\_saving\_resources.pdf](https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2012/11/Preventing_disease_saving_resources.pdf) |
|  | World Breastfeeding Trends UK | Question 3 | There is a resource implication but more use could be made of infant feeding support workers and employed peer supporters. More input at an early stage is likely to reduce the chance of infant feeding problems later. |
|  | Action on Postpartum Psychosis | Question 4 | No comment |
|  | Baby Sleep Information Source | Question 4 | We provide [training for NHS and Local Authority staff](https://www.basisonline.org.uk/hcp-infant-sleep-webinars/) across the UK in giving advice about safer practices for bed sharing. We have also produced various resources for [parents](https://www.basisonline.org.uk/parents-bed/) and [practitioners](https://www.basisonline.org.uk/basis-information-sheets/) on this topic, some of which have previously been endorsed by NICE |
|  | Better Breastfeeding | Question 4 | The Tower Hamlets Baby Feeding service is an exemplar of how to achieve the breastfeeding elements. The maternity infant feeding team and peer support offered at UCLH are also good examples of how postnatal breastfeeding support can be delivered prior to discharge from hospital. |
|  | NHS England and Improvement | Question 4 | Delivery of post-natal 6-8-week check in General Practice with administration of vaccinations is well established and offers great support to new mothers and baby, their partners and family |
|  | Royal College of Midwives | Question 4 | No |
|  | UNICEF UK Baby Friendly Initiative | Question 4 | Supported by UNICEF UK, The National Infant Feeding Network (NIFN) is a network of 800 infant feeding specialists and academics responsible for the support and education of 75,000 health professionals and 5,000 students across England and Northern Ireland, who in turn are responsible for caring for over 800,000 babies, mothers and their families every year. The Network would be happy to work with NICE to provide case studies to support QS 2,4, and 5 in relation to implementing the standards around infant feeding and safe bed sharing specifically. These are audited by services in order to achieve full UNICEF UK Baby Friendly Initiative accreditation. [unicef.org.uk/babyfriendly/accreditation/maternity-neonatal-health-visiting-childrens-centres/](https://www.unicef.org.uk/babyfriendly/accreditation/maternity-neonatal-health-visiting-childrens-centres/) |
|  | World Breastfeeding Trends UK | Question 4 | The Devon ‘Latch and Attach’ scheme: **Error! Hyperlink reference not valid.** |
|  | Action on Postpartum Psychosis | Statement 1 | We support this quality statement, particularly in the sharing of information between mental health services and universal services. It is important that any birth and postnatal plans for women under the care of specialist perinatal mental health services during pregnancy are shared with universal services to ensure that risks of relapse in the early postnatal period are well managed. |
|  | FTWW Fair Treatment for the Women of Wales | Statement 1 | In the Rationale, we would ask that it be made clear that communication between healthcare professionals at transfer of care includes peri-natal mental health services and, if required, onward referral into adult mental health at a later date. This is an important adjunct as this vulnerable population would particularly benefit from more straightforward transfer of information between personnel so as not to exacerbate trauma.  FTWW would urge the Committee to consider explicitly including those who have experienced baby loss at full-term or close to it in this Quality Standard, as these individuals will still need and be entitled to expect post-natal care. It is most important to use language sensitively throughout and be aware that those affected by baby loss should be included within Statements pertaining to identification, assessment, and support for of mental health, emotional wellbeing, physical health issues and / or treatment for birth injuries.  Regarding equality and diversity considerations, we would ask that specific consideration is given to homeless women, traveller populations, and those without recourse to public funds as these circumstances may present additional barriers to communication between both healthcare providers, potentially in disparate locations, and the individual themselves. |
|  | GPs championing perinatal care | Statement 1 | As GPs we think that this statement is important |
|  | Healthcare Safety Investigation Branch (HSIB) | Statement 1 | **Women who are transferring between services in the postnatal period have relevant information shared between healthcare professionals to support their care**  HSIB supports this statement: maternity investigations have made recommendations relating to the handover of care when a mother moves between services |
|  | Institute of Health Visiting | Statement 1 | **Statement**  The iHV recommends that babies (who may be at risk of poor health outcomes) and partners should also be included (in line with [Prevention in Mind](https://www.basw.co.uk/resources/prevention-mind-all-babies-count-spotlight-perinatal-mental-health), which presents evidence of the impact of parental issues on the health, wellbeing and safety of infants). Information on risk factors, such as mental health, domestic abuse or substance misuse, should be shared between agencies working with families during pregnancy and the postnatal period to support accurate and holistic assessments of risks and resilience factors, and care-planning to reduce the risk of harm to mothers, partners, babies, and family members and improve outcomes. The recent [The-independent-review-of-children’s-social-care](https://childrenssocialcare.independent-review.uk/wp-content/uploads/2022/05/The-independent-review-of-childrens-social-care-Final-report.pdf) has demonstrated how important it is for professionals to are information and ‘think family’.  The evidence supports the case that babies and partners are added to the rationale, quality measures, and ‘What the quality statement means for different audiences’ |
|  | Institute of Health Visiting | Statement 1 | **Relevant Information**  In addition to the list of information provided, we also recommends that the following areas are included (these are linked to increased risks of poorer outcomes and will form an important part of a holistic assessment of risk and resilience factors):  Previous baby loss/ miscarriage  Baby’s father details – including biological and/or current partner ([The myth of Invisible Men](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1017944/The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf))  If the mother, or family member has a disability  Language spoken and if a translator is needed.  Substance misuse, including alcohol consumption (to include mother or family member/partner)  Domestic abuse  BMI of mother/birthing parent and weight of baby  Smoking in the household (mother, partner, family members)  Parental social history (including care leavers)  Contraception, sexual health, and preconception advice for subsequent pregnancies  Birth marks are clearly documented in a body map and shared between agencies (to support smooth transition and prevent unnecessary activation of local bruising protocols)  Housing (refugee, asylum seeker, homeless) |
|  | Maternal Mental Health Alliance UK | Statement 1 | The details of this statement note that both physical and mental health (including present and past mental health) information must be shared. This emphasis on mental as well as physical health is vital to keep in the statement, as reflected by the evidence in the 2021 MBRRACE report. This noted that the recommendation in the previous 2015 report for ‘the clear duty on all health professionals to pass on relevant information’ had still not taken place in many of the more recent cases investigated. Particularly that ‘the GP should inform maternity services of any past psychiatric history and maternity services should ensure that the GP is made aware of a woman’s pregnancy and enquire of the GP about past psychiatric history.’ |
|  | National Childbirth Trust | Statement 1 | We reiterate our disappointment that the language of continuity of care across the perinatal period has been removed from these quality standards. However, we are pleased to see a focus on transfer of care between professionals and services in the postnatal period as we are aware of concerns among new parents experiencing their care during the transition from midwifery to health visiting services.  The statement will be hard to measure in terms of process as reviewing patient records for levels of data completeness may have to be done manually and thus be time-consuming for services that are already under resourced. The proposed outcome measurement is also problematic. The CQC maternity survey captures only midwifery and so will miss out on referrals to perinatal mental health teams, health visiting teams, etc. A local survey is feasible but is unlikely to be conducted routinely by enough Trusts to generate sufficient levels of data for comparison between areas and over time. |
|  | National FASD | Statement 1 | Should include information about prenatal alcohol exposure as per NICE QS 204, whether the mother has FASD or suspected FASD and if any siblings have FASD/suspected FASD |
|  | NHS England and Improvement | Statement 1 | Encourage sharing via Electronic Patient record with interoperability to ensure nothing lost in passing over records. |
|  | NHS Fife | Statement 1 | Quality statement 1 – agree on the principles of this quality measure. Information captured and transferred to community teams via Badgernet. This is not currently automated relies on user, would be more reliable if automated. Process and outcome measures currently not audited, this would require additional resources. Care Quality Commission not operational in Scotland would require additional national recourse to capture woman’s feedback. |
|  | Royal College of Midwives | Statement 1 | There is evidence to suggest that domestic violence and child abuse have been exacerbated by the coronavirus pandemic. It is vital that the care for women with social complexities, including those experiencing removal of their babies into local authority care, is improved.   ONS (2020) Domestic abuse during the coronavirus pandemic- England and Wales. [https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseduringthecoronaviruscovid19pandemicenglandandwales/november2020#domestic-abuse-during-the-coronavirus-covid-19-pandemic-data](https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseduringthecoronaviruscovid19pandemicenglandandwales/november2020%23domestic-abuse-during-the-coronavirus-covid-19-pandemic-data)  We would encourage including contraception in the handover between services, especially for women with high complexities (Multiple caesarean section, cardiac conditions, diabetes, pre-eclampsia etc) |
|  | Royal College of Paediatrics and Child Health | Statement 1 | We would suggest adding to Rationale section another example of transfer between services to include “between secondary care providers if the mother moves house or if the baby needs care in a different services (e.g. NICU or specialist care)”. |
|  | Royal College of Speech and Language Therapists | Statement 1 | We would recommend revising the reference on Page 6 – 1st 8 weeks after birth – to consider inclusion of what this means for the preterm baby. How do we support these vulnerable infants? |
|  | The Breastfeeding Network | Statement 1 | We support this statement and are pleased to see that the baby’s feeding is mentioned in the list of information that should be included in any transfer of care. We suggest the clarification that this include details of any feeding plan in place (for example, the plan to note any concerns on weight, and to enable the transition from formula top-ups to exclusive breastfeeding, or vice versa), or ongoing support required (for example with a tongue-tie awaiting referral/division). |
|  | UNICEF UK Baby Friendly Initiative | Statement 1 | We welcome and support this Quality Statement. |
|  | Action on Postpartum Psychosis | Statement 2 | Women who develop postpartum psychosis or other severe perinatal mental illness will also need to know how to access specialist information about breastfeeding and medication.  See CG192 1.4.4 Discuss breastfeeding with all women who may need to take psychotropic medication in pregnancy or in the postnatal period. Explain to them the benefits of breastfeeding, the potential risks associated with taking psychotropic medication when breastfeeding and with stopping some medications in order to breastfeed. Discuss treatment options that would enable a woman to breastfeed if she wishes and support women who choose not to breastfeed.  1.4.5 If needed, seek more detailed advice about the possible risks of mental health problems or the benefits and harms of treatment in pregnancy and the postnatal period from a secondary mental health service (preferably a specialist perinatal mental health service). This might include advice on the risks and possible harms of taking psychotropic medication while breastfeeding and how medication might affect a woman's ability to care for her baby (for example, sedation). |
|  | Better Breastfeeding | Statement 2 | As noted above, it is important to distinguish between advice on breastfeeding and advice on bottlefeeding/formula feeding. The attempt to conflate the two and the use of the word “parents” when referring to breastfeeding mothers has the potential to cause confusion about who is making decisions and about the level of support required for breastfeeding, which is necessarily much greater than that required for formula feeding. As well as information about breastfeeding itself, there should be information given about where to get further support (such as community support from breastfeeding peer supporters and National Breastfeeding Helpline). |
|  | Birth Companions | Statement 2 | Specific reference should be made in this statement’s equality and diversity considerations to the support of feeding choices for mothers separated from their babies. Many mothers in prison or separated due to children’s social services involvement wish to continue to express breastmilk for their baby, which is essential to supporting sustained attachment (in preparation for/ support of reunification plans) and in helping mothers deal with the emotional impact of separation. Healthcare professionals and service providers must ensure there is close working with social services and/ or prison and probation staff to support such choices. |
|  | British Association of Perinatal Medicine (RCPCH) | Statement 2 | Statements 2 & 4 "parents" given feeding advice is a bit confused in the denominators, and not sure how we would know the number of parents. Maybe "the mother and ideally her partner" (at least for Statement 2)? |
|  | British Specialist Nutrition Association Ltd | Statement 2 | Draft statement reads:  *“The possibility of relactation after a gap in breastfeeding”.*  *“For someone trying to establish and considering supplementing with formula feeding, the possible effects on breastfeeding success, and how to maintain adequate milk supply while supplementing”*.  Our comment:  We find that the two statements taken together might be confusing. They appear separately, but we suggest that they are combined into one statement, so that relactation is discussed with consideration to people who may have supplemented with formula. Further to this, we would suggest that the draft statement is expanded to consider the role that expressing plays in this. |
|  | British Specialist Nutrition Association Ltd | Statement 2 | Draft statement reads:  *“First infant formula is the only formula milk that babies need in their first year of life, unless there are specific medical needs”*.  Our comment:  There is clear evidence that the nutritional needs of children change over the first year of life (2). Follow-on formulas, designed for infants between 6 and 12 months of age ensure that babies receive the right amount of iron to support their development. This is especially relevant as the baby’s store of iron begins to deplete at around 6 months of age. The adapted nutritional profile of follow-on formulas are more suitable from 6 to 12 months. |
|  | British Specialist Nutrition Association Ltd | Statement 2 | Draft statement reads:  *“How to sterilize feeding equipment and prepare formula feeds safely, including a practical demonstration if needed”*.  Our comment:  Although we know that this content is not primarily designed to be parent-facing, we suggest that we provide a link to a standard set of advice regarding how to safely make up a feed (3). We suggest that advice is given on how to sterilise expressing equipment, how to safely express milk and how to store and use an expressed feed.  We suggest that we add to this statement to be clear about when such advice should be given – our view is that all parents should understand the above before their baby is born, in order to mitigate the risk that they do not understand this if they begin to feed from a bottle. |
|  | British Specialist Nutrition Association Ltd | Statement 2 | Draft statement reads:  *“How to bond with the baby when bottle feeding, through skin-to-skin contact, eye contact and the potential benefit of minimising the number of people regularly feeding the baby”*.  Our comment:  Firstly, we would like to reemphasise the importance of having information on this subject. We consider bonding with babies through non-feeding interactions very important. However, we think that these interactions are important for allbabies, not just bottle-fed babies, and we think the statement should reflect this. |
|  | British Specialist Nutrition Association Ltd | Statement 2 | Draft statement reads:  *“Information and advice about formula feeding for parents who are considering or who need to fully or partially formula feed, should include revisiting any or all of the following to meet individual needs: the differences between breast milk and formula milk”*.  Our comment:  We think there’s a piece missing here around health care professionals needing to understand the difference between milks as it’s a question any formula feeding parent is likely to ask.  ‘As part of the information and advice given about formula feeding for parents who are considering or who need to fully or partially formula feed, missing currently is any reference to providing information to parents about different types of formula milk. There are a number of different types of formula milk available, including formula milk for the dietary management of functional gastrointestinal disorders. Healthcare professionals should be able to provide information and guidance on this, in order to effectively support parents fully or partially formula feeding their baby (4)’.  References: 2- Zieglar E., Nelson S.,Jeter J. (2014) ‘Iron stores of breastfed infants during the first year of life’. *Nutrients*, **6**(5), 2023-2034. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4042569/>  3- National Health Services. (2022) *How to make up a feed*. Updated Jan 2021. Available from: <https://www.nhs.uk/start4life/baby/feeding-your-baby/bottle-feeding/how-to-make-up-a-feed/making-up-a-feed/>  4- National Institute for Health and Care Excellence. (2022) *Postnatal care (update) draft quality standards*. Updated May 2022. Available from: <https://www.nice.org.uk/guidance/indevelopment/gid-qs10150/consultation/html-content-2> [Accessed 7 June 2022]. |
|  | FTWW: Fair Treatment for the Women of Wales | Statement 2 | In the Rationale, we would ask that some amendments (in italics) be made as follows:  ‘Regardless of their feeding choices *or abilities*, giving parents the opportunity to discuss feeding will help them know what to expect…’  ‘Healthcare professionals acknowledge parents' *physical*, emotional, social, financial and environmental concerns about feeding options and are respectful of their feeding choices.  We would also ask that in the reference to ‘Information and advice about breastfeeding should include revisiting any or all of the following, to meet individual needs’ that those individual needs / circumstances are clearly noted to avoid unnecessary repetition which runs the risk of being considered undue pressure or harassment. It is worth remembering, for example, that those who have undergone emergency caesarean deliveries before term can encounter considerable challenges with breastfeeding <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4847344/> and are potentially at increased risk of developing perinatal mental health problems – repeating advice about breastfeeding when mother is not able to do so can exacerbate anxiety and depression. <https://www.sciencedaily.com/releases/2019/01/190123105845.htm> |
|  | GPs championing perinatal care | Statement 2 | We are in favour of this statement |
|  | Healthcare Safety Investigation Branch (HSIB) | Statement 2 | **Parents are given information and advice about breastfeeding and formula feeding before transfer to community care or before the midwife leaves after a home birth**  HSIB supports this statement: maternity investigations have made recommendations and identified findings relating to the provision of information about infant feeding |
|  | Infant Feeding Alliance | Statement 2 | Statements 2 and 4  We question the approach to infant feeding in this quality standard and the proposed outcome measures. We have considered the two statements that relate to infant feeding (statements 2 and 4) in one comment. This allows us to address the general ethos around feeding.  An outcome measure set in statement 4 is ‘Rates of exclusive or partial breastfeeding at 6 to 8 weeks after the birth’. Breastfeeding is not a health outcome. It is a process that may have a positive effect on health outcomes or it may have an adverse effect on health outcomes. Therefore, it is possible this outcome measure is at odds with another in statement 2: ‘Rates of newborn hospital attendances and admissions for feeding-related conditions’.  A recent review of the literature, which sought to quantify the health effects of different infant feeding methods, calculated that for every 71 exclusively breastfed babies, one is readmitted to hospital in the first month of life. These admissions are primarily due to dehydration, failure to thrive, excessive weight loss or hyperbilirubinemia. The researchers also calculated that for every 13 exclusively breastfed babies, one loses greater than 10% of their birthweight (Wilson and Wilson, 2018).  While it is unclear how these numbers needed to harm calculations apply in the UK context, we know that infant readmissions for feeding complications and jaundice more than doubled between 2006 and 2016 (Keeble and Kossorova, 2017).  So, we ask the panel to clarify: what is the priority here? Is the priority rates of breastfeeding? Or is it ensuring adequate nutrition for babies and thus preventing feeding-related admissions?  We do not think the present draft quality standard can expect to reduce rates of admissions for feeding complications. Far too much faith is placed in the effectiveness of breastfeeding support and observing feeds to resolve breastfeeding complications. In fact, there is little evidence for what helps to resolve the common problems that women report as reasons for stopping breastfeeding, such as pain, latching difficulties and low milk supply (McAndrew et al, 2012).  The latest Cochrane review for managing breastfeeding-related nipple pain found insufficient evidence to make recommendations (Dennis et al., 2014). We have been unable to identify any similar review of interventions to manage difficulties with latching or low milk supply. This matches what NICE found in its evidence reviews to inform the postnatal care guidelines (NICE, 2020). Yet, despite not having evidence for what helps to resolve breastfeeding problems, quality statement 4 suggests that if a healthcare professional observes ‘ongoing concerns with breastfeeding’, they ‘should consider:  - adjusting positioning and attachment to the breast  - giving expressed milk  - referring to additional support such as a lactation consultation or peer support  - assessing for tongue‑tie.’  Supplementation with formula is the only intervention we know of that is demonstrated to reduce infant hospital readmissions (Flaherman et al., 2013, 2018, 2019; Straňák et al., 2016). The quality standard lacks clarity on when formula supplementation is required and seems to minimise it as ‘sometimes, but not commonly, clinically indicated’. The rates of infant hospital admissions for feeding complications that we discussed above would suggest that insufficient breastmilk intake is not uncommon. Therefore, families need to know clearly when formula supplementation is required and to be prepared for it.  Another omission in the quality standard is the relationship between feeding and maternal mental health and wellbeing. Nowhere is it acknowledged that exclusive breastfeeding is not compatible with comfort and wellbeing for many women and does not allow sufficient sleep to prevent mental health problems for others. Many families in the UK resolve this problem by sharing feeds using bottles, which allows the mother to get a solid block of sleep, as NICE found in its evidence reviews for the postnatal care guidelines (e.g. Breastfeeding Barriers and Facilitators [Q]). We ask the panel for clarity on the point ‘strategies to manage fatigue when breastfeeding’ in statement 2, since we know of no other strategy for getting more sleep other than sharing feeds with another person.  NICE has a duty to present evidence-based, balanced information on the benefits and risks of different feeding methods so that parents can make informed decisions. Unfortunately, according to these quality statements, parents should receive information that reflects a distorted picture of the evidence. There is no evidence for some of the claims, for instance, that breastfeeding ‘soothes and comforts a baby’ any more than bottle feeding does, or that families who bottle feed need special advice about how to bond with their baby. The latter claim is as offensive as it is lacking evidence.  The health claims for breastfeeding largely rely on observational data that cannot prove causation, but this is not made clear to parents. This distorted picture of the importance of breastfeeding may lead mothers to pursue breastfeeding beyond what is comfortable and sustainable for them or safe for their baby, should complications arise.  We note that combination feeding is absent from the quality standard, and that information is split between ‘breastfeeding’ and ‘formula feeding’, although this doesn’t represent the reality of many UK families.  Finally, we note that statement 2 appears to specify who can receive information about formula and under what circumstances: ‘Information and advice about formula feeding for parents who are considering or who need to fully or partially formula feed.’ We believe this is an attempt to steer women’s choices and is not in keeping with principles of informed decision-making. Withholding information about formula specifically from mothers who are breastfeeding risks leaving them unprepared in the case of any complications. This can surely not be deemed to support the aim of reducing ‘newborn hospital attendances and admissions for feeding-related conditions’.  Again, we ask: what is the priority is here and what outcomes matter to the panel? Outcome measures that we would like to see include:  Infants adequately fed, as measured by weight and by rates of admissions for feeding complications, such as hypoglycaemia, hypernatremia and jaundice  Good maternal mental health and sufficient sleep  Maternal comfort during feeds.  References  Dennis, C.L., Jackson, K., Watson, J., 2014. Interventions for treating painful nipples among breastfeeding women. Cochrane Database Syst. Rev. 12, CD007366. <https://doi.org/10.1002/14651858.CD007366.pub2>.  Flaherman, V.J., Aby, J., Burgos, et al., 2013. Effect of early limited formula on duration and exclusivity of breastfeeding in at-risk infants: an RCT. Pediatrics 131 (6), 1059-1065. <https://doi.org/10.1542/peds.2012-2809>.  Flaherman, V.J., Narayan, N.R., Hartigan-O’Connor, D., et al., 2018. The effect of early limited formula on breastfeeding, readmission, and intestinal microbiota: a randomized clinical trial. J. Pediatr. 196, 84–90. <https://doi.org/10.1016/j.jpeds.2017.12.073>.  Flaherman, V.J., Cabana, M.D., McCulloch, C.E., et al., 2019. Effect of early limited formula on breastfeeding duration in the first year of life: a randomized clinical trial. JAMA Pediatr 173 (8), 729–735. <https://doi.org/10.1001/jamapediatrics.2019.1424>.  Keeble, E., Kossarova, L., 2017. Focus on: Emergency hospital care for children and young people. Available from: <https://www.nuffieldtrust.org.uk/files/2018-10/1540142848_qualitywatch-emergency-hospital-care-children-and-young-people-full.pdf>. Accessed date: 8 June 2022.  McAndrew, F., Thompson, J., Fellows, L., et al., 2012. Infant Feeding Survey 2010. Health and Social Care Information Centre. Available from: <https://sp.ukdataservice.ac.uk/doc/7281/mrdoc/pdf/7281_ifs-uk-2010_report.pdf>, Accessed date: 8 June 2022  National Institute for Health and Care Excellence, 2020, Postnatal care: evidence reviews. Available from: <https://www.nice.org.uk/guidance/ng194/evidence/evidence-reviews-april-2021-9076791277?tab=evidence>. Accessed date: 8 June 2022  Straňák, Z., Feyereislova, S., Čern., M., et al., 2016. Limited amount of formula may facilitate breastfeeding: randomized, controlled trial to compare standard clinical practice versus limited supplemental feeding. PloS One 11 (2), e0150053. <https://doi.org/10.1371/journal.pone.0150053>.  Wilson, J., Wilson, B.H., 2018. Is the “breast is best” mantra an oversimplification? J.Fam. Pract. 67 (6), E1–E9. Available from: <https://www.mdedge.com/clinicianreviews/article/166932/pediatrics/breast-best-mantra-oversimplification>. Accessed date: 8 June 2022. |
|  | Institute of Health Visiting | Statement 2 | The iHV recommend that that quality statement 2 should be amended to:  ‘*Information and advice about feeding and caring for your baby’* to include the importance of close and loving relationships and responsive parenting in line with the UNICEF [Baby-Friendly-Initiative-Standards](https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2014/02/Guide-to-the-Unicef-UK-Baby-Friendly-Initiative-Standards.pdf)  To include:  Close and loving relationships  Responsive parenting  Responsive feeding  Baby brain development |
|  | Institute of Health Visiting | Statement 2 | **Rationale:**  To include that information should have been given in the antenatal period by the midwifery and health visiting service about infant feeding, parent-infant relationships, in line with the BFI standards. |
|  | Institute of Health Visiting | Statement 2 | **Information and advice about breastfeeding and formula feeding**  The iHV recommend changing this to: *Information and advice about feeding and caring for your baby*.  The iHV agree with the list of information and advice that should be given but also recommend that the following areas are also included in line with [Baby-Friendly-Initiative-Standards](https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2014/02/Guide-to-the-Unicef-UK-Baby-Friendly-Initiative-Standards.pdf)  close and loving relationships  Skin to skin contact  Responsive parenting  Baby brain development  Feeding in special circumstances (preterm baby, twins or multiples, breastfeeding older babies or children)  Baby and the family (how family members can help care for and become close to baby)  and vitamin D in line with NHS start for Life: <https://www.nhs.uk/start4life/baby/baby-vitamins/> |
|  | Kit Tarka Foundation | Statement 2 | Women and birthing people who are breastfeeding should be advised that if they develop lesions on their breast or nipples they should stop feeding from that breast immediately and seek advice from their GP or midwife as soon as possible. The lesions should be tested for HSV and treated accordingly. See [kittarkafoundation.org/neonatal-herpes-info-and-advice](http://kittarkafoundation.org/neonatal-herpes-info-and-advice) for more information.  HSV can be spread during breastfeeding if the mother has HSV lesions on the breast or nipple. Lesions can also indicate HSV has been passed from infant to mother. As neonatal herpes has such a high mortality rate if the baby is not treated immediately, it is important in these cases to act quickly.  A recent survey (results and report at [kittarkafoundation.org/babies-at-risk](https://www.kittarkafoundation.org/babies-at-risk)) only 41% of women who were breastfeeding said they would stop feeding from that breast and contact a health professional should they develop a blister or lesion on their nipple. |
|  | National Childbirth Trus | Statement 2 | We note with concern the revisions to the existing breastfeeding and formula feeding statements.  Overall, there appears to be a move away from supporting the continuation of breastfeeding despite the benefits of breastfeeding for baby and woman being highlighted on p.10 of the document. As noted in our previous response, breastfeeding support should remain a priority as whilst breastfeeding initiation rates are relatively high, continued breastfeeding up to and beyond 6-8 weeks rapidly drops off. There is clear evidence that the majority of women cease breastfeeding before they wish too, frequently as a result of a lack of support. Dellen et al. found that access to a breastfeeding support programme reduced the risk of breastfeeding cessation by 66% (Dellen et. al., 2019), highlighting the need for specialist breastfeeding support and information.  Information and advice from midwives, even when combined with feeding support at each midwife/health visitor postnatal visit (as per statement 4), is insufficient if the healthcare professional does not have advanced training in breastfeeding support. We recommend that the statements around breastfeeding and formula feeding are broadened to include reference to support across sectors so that it includes specialist practitioners rather than limiting it to midwives and health visitors. This is currently even more pertinent given the ongoing understaffing in both maternity and health visiting services and that many women access infant feeding support outside of the NHS. |
|  | National FASD | Statement 2 | E& D should include the information that parents with FASD/suspected FASD may need more than just accessible documents eg direct demonstration (ow not tell) and feeding charts to aid memory.  FASD is more common than autism and differs from a generic learning disability but will require support to access information given as per the equality act 2010. The United Nations Convention on the Rights of the Child and the United Nations Convention on the Rights of Persons with Disabilities, the Equality Act 2010 and the Human Rights Act 1998 state that: Parents with learning disabilities must be given every opportunity to ow that they can parent safely and be good enough parents, with appropriate support |
|  | NHS England and Improvement | Statement 2 | Very supportive of this statement as it is offering support to all types feeding and not isolating mums who may not be successful with breastfeeding. Suggest one of the pieces of information given to the woman is how e can access feeding advice when e needs it. Babies don’t necessarily time their feeds around when the midwife or health visitor is there. Some women complain they give up breastfeeding just because they don’t get the right support at the right time. Successive CQC surveys ow a significant % of women struggle to get support in the community out of hours. |
|  | NHS Fife | Statement 2 | Quality statement 2 – agree with the principle of the statement. The majority of the process and outcomes are audited through the UNICEF Baby Friendly audits. Would question the requirement for a separate audit process if units are already UNICEF accredited |
|  | Royal College of Midwives | Statement 2 | In the context of the ongoing ‘cost of living crisis’ and following the findings of the [recent updated infant milk cost report by First Steps nutrition](https://infantmilkinfo.org/costs/), with the crisis hitting low income families the hardest, and formula prices rising alongside the costs of other foods, fuel and more, it is crucial to discuss the cost of formula milk and its nutritional impact as well as benefits of breastfeeding with families.   There is a wide range in the prices of infant formulas available on the market, and only one (own-brand) infant formula which is cheap enough to be purchased with Healthy Start vouchers. The latest UNICEF report exposes the aggressive marketing practices used by the formula milk industry – many of which are not compliant with the International Code of formula milk marketing regulation - and highlights impacts on families' decisions about how to feed their infants and young children. And yet all infant formulas must meet the same regulations regarding nutrition composition. Breastfeeding is the optimal way of feeding infants, but where breastfeeding is not possible or desired, all infant formulas can meet a healthy baby’s nutritional needs from birth to around 6 months, and from 6-12 months alongside appropriate complementary foods.   It is pivotal reminding families and healthcare professionals working with them that there is no ‘best formula’ despite what company marketing may suggest, and the price differences between brands are not related to health or nutrition benefits.   Additionally, informing women and families about social/societal barriers and challenges to breastfeeding success maybe useful to manage anxieties and expectations. |
|  | Royal College of Speech and Language Therapists | Statement 2 | The RCSLT would recommend including reference to the role of breastfeeding as ‘optimal’ feeding (including long-term feeding), with evidence to support the benefits of this for infant and mother, relationships, health, education and economy. Some references to support this are:  [Potential economic impacts from improving breastfeeding rates in the UK | Archives of Disease in Childhood (bmj.com)](https://adc.bmj.com/content/100/4/334)  [Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK (unicef.org.uk)](https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2012/11/Preventing_disease_saving_resources_policy_doc.pdf)  [Cost analysis of breastfeeding outcomes in the UK | NPEU (ox.ac.uk)](https://www.npeu.ox.ac.uk/research/projects/104-cost-analysis-breastfeeding)  **Quality measures**  The RCSLT would like to see it referenced that information needs to be independent of formula marketing companies.  On Page 9 – outcomes in quality measures – one of the outcomes proportions of infants being breastfed or formula fed. This would be provided by the national infant feeding survey (see above).  On Page 10- information about Breastfeeding and formula feeding. Bullet point; health benefits – We think the benefits should be expanded to include ort and long term breastfeeding with particular reference to: infection protection, neuro development, benefits of different durations of breastfeeding. This would consider the benefits of long term breast feeding and the support needed for this. There are a few areas where the RCSLT feels further detail or expansion of points would be valuable:  On Page 10-11 –suggest adding a bullet point to refer to the role in bonding and relationship building and support for maternal mental health as an added benefit  10th bullet point: The point related to the signs of effective feeding should be expanded to consider behaviour, output and growth (including reference to what this means)  11th bullet point: Expressing breast milk – prop feeding dangers and bottle feeding. We wonder if this should this be moved to later in the bottle feeding section  15th bullet point: Strategies to manage fatigue when breast feeding – rephrase to: strategies to manage fatigue when having a new baby  There could be a distinction made between breast and bottle feeding – responsive bottle feeding – breast milk feeding and move away from calling bottle feeding infant formula feeding. |
|  | The Breastfeeding Network | Statement 2 | General  We are concerned that this statement does not take into consideration the need for individualised information on infant feeding.  A mother who has decided to exclusively breastfeed, has initiated this course of action and who does not have any medical reason to supplement with formula could be undermined by the explicit provision of information on feeding with infant formula. To provide this would be counter to the UNICEF Baby Friendly Initiative (BFI) guidelines on providing information on formula feeding (https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2018/02/Guidelines-on-providing-information-for-parents-about-formula-feeding.pdf).  Similarly, a mother who has decided to exclusively formula feed, is assured in this decision and has already initiated it, does not need additional information on breastfeeding at this point. |
|  | The Breastfeeding Network | Statement 2 | Quality standard statement and rationale  We suggest the following amended wording  Quality statement 2: Information *about and support for infant* feeding  Quality statement suggested wording:  Before transfer to community care or before the midwife leaves after a home birth, women who are breastfeeding are given information about and support for effective breastfeeding. Parents who are feeding their baby with infant formula are given information on and support for safe bottle feeding. All parents are given information on when and how to access further infant feeding support.  Rationale  Revisiting information about *infant* feeding before transfer to community care or before the midwife leaves after a home birth will support parents to make informed decisions about feeding their baby. Regardless of *the method of infant* feeding, giving parents the opportunity to discuss infant feeding will help them know what to expect, what support is available, when to seek help, and will allow any questions or concerns they have to be addressed. This will reduce the chance of feeding problems occurring at home and the need for readmission. |
|  | The Breastfeeding Network | Statement 2 | Quality measures: Process  It may make more sense to separate this into two data collection fields. We suggest:  Process:  Before transfer to community care or before the midwife left after a home birth;  Breastfeeding mothers (including those giving expressed breast milk): Proportion of women who had a live birth who received *individualised* information about and support for breastfeeding.  Parents who are feeding their baby with infant formula: Proportion of mothers who had a live birth who received *individualised* information on and support for safe bottle-feeding.  Numerator –  Before transfer to community care or before the midwife left after a home birth:  The number in the denominator who received information on and support for breastfeeding  The number in the denominator who received on and support for safe formula feeding  Denominator –  The number of women who had a live birth and initiated breastfeeding (including giving expressed breastmilk)  The number of women who had a live birth and were feeding their baby with infant formula  Note: some parents may fall into both categories. |
|  | The Breastfeeding Network | Statement 2 | Quality measures: outcome  Outcome: suggested wording:  b) Proportion of parents who were satisfied with *information about and support for* breastfeeding *and/or* feeding *with infant formula* given before transfer to community care or before the midwife left after a home birth.  Numerator – the number in the denominator who were satisfied with *information about and support for* breastfeeding *and/or* feeding *with infant formula* given before transfer to community care or before the midwife left after a home birth.  Denominator – the number of parents of babies. |
|  | The Breastfeeding Network | Statement 2 | What this quality statement means for different audiences  We suggest the following amended wording:  Service providers (such as NHS hospital trusts or community providers) ensure that healthcare professionals have the skills and knowledge to give *individualised information about and support for* breastfeeding and *feeding with infant formula* to parents before transfer to community care or before the midwife leaves after a home birth. Providers ensure that accessible information about breastfeeding and *feeding with infant formula,* including how to get support locally, is available.  Healthcare professionals (such as midwives) give *individualised information on and support for* breastfeeding and/*or* *feeding with infant formula to* parents before transfer to community care or before the midwife leaves after a home birth. Healthcare professionals check that parents understand the information they have been given, and how it relates to them. Healthcare professionals acknowledge parents' emotional, social, financial and environmental concerns about feeding options and are respectful of their feeding choices.  Commissioners (integrated care systems and clinical commissioning groups) commission services that provide *individualised information about and support for* breastfeeding and *feeding with infant formula* before transfer to community care or before the midwife leaves after a home birth.  Parents of babies are given *individualised information about and support for* breastfeeding and/*or feeding with infant formula* before they are discharged from the hospital or birth team. |
|  | The Breastfeeding Network | Statement 2 | Information and advice about breastfeeding and formula feeding  We suggest the following amended text:  Information *about and support for* breastfeeding should include revisiting any or all of the following, to meet individual needs:  • nutritional benefits *of breastmilk* for the baby  • health *and wellbeing* benefits for both the baby and woman, *in the ort and long term*  • how it can have benefits even if only done for a ort time  • how it can soothe and comfort the baby  • how the partner *and other caregivers* can support breastfeeding, including the value of their involvement and support, and how they can comfort and bond with the baby *by means other than feeding*  • how milk is produced, how much is produced in the early stages, the supply-and-demand nature of breastfeeding *and how feedback inhibitor of lactation (FIL) works and how responsive breastfeeding supports milk supply*  • responsive breastfeeding, *including how to recognise early feeding cues and the benefits of responding to them, and that the mother can breastfeed to comfort her baby or for her own comfort and convenience.*  • how often babies typically need to feed and for how long, taking into account individual variation *and how to recognise if feeding is taking place effectively, including suck-swallow patterns.*  • different feeding positions, *that different positions will be more comfortable for different mother-baby dyads and how these can support effective attachment at the breast.*  • *The benefits of skin-to-skin contact, how it can be helpful in establishing breastfeeding and how to do it safely (https://www.bapm.org/resources/sudden-and-unexpected-postnatal-collapse-supc).*  • signs of effective feeding that ow the baby is getting enough milk (it is not possible to overfeed a breastfed baby)  *• What to do if you are concerned your baby is not getting enough breastmilk – contact a healthcare professional for urgent assessment and support before supplementing with infant formula.*  • expressing breast milk (by hand or with a breast pump) as part of breastfeeding and how it can be *a useful tool for some mothers, but is not an essential part of breastfeeding and not recommended in the first few weeks if not necessary as it can result in oversupply;* safe storage and preparation of expressed breast milk; *responsive bottle-feeding of expressed milk* and the dangers of ‘prop’ feeding (when a baby’s feeding bottle is propped against a pillow or other support, rather than the baby and the bottle being held when feeding)  • normal breast changes after the birth, *and those that should be assessed by a healthcare professional*  • *That pain when breastfeeding can usually be reduced by adjusting positioning and attachment, and when to seek support*  • breastfeeding complications (for example, mastitis, breast abscess) and when to seek help  • strategies to manage *common challenges* when breastfeeding, *and when to seek support*  • Information on where to seek help and support: breastfeeding support available locally (e.g. peer support, drop-in groups), and the contact details for the National Breastfeeding Helpline (0300 100 0212, <https://www.nationalbreastfeedinghelpline.org.uk/> for webchat)  • *How to maximise and protect use and supply of breastmilk if supplementation with infant formula is clinically indicated*  • how *pregnancy, childbirth and* breastfeeding can affect body image, identity *and confidence*  • that the information given may change as the baby grows  • the possibility of relactation after a gap in breastfeeding  • safe medicine use when breastfeeding*. Explain that whilst many patient information leaflets either state that the medicine is not compatible with breastfeeding or that the patient must speak to a doctor or pharmacist first, this is usually because trials have not been carried out specifically into safety whilst breastfeeding. It does not always mean that the medicine cannot be taken, and many are in fact compatible. They should always check with their doctor or pharmacist, and can also check with The Breastfeeding Network’s Drugs in Breastmilk (DiBM) service (https://www.breastfeedingnetwork.org.uk/detailed-information/drugs-in-breastmilk/), or ask their healthcare professional to refer to the UK Drugs in Lactation Advisory service (UKDILAS) in any situation of uncertainty or where they are advised that a medicine is not compatible with breastfeeding.*  *Information about and support for formula* feeding for parents who are considering or who need to fully or partially formula feed, should include revisiting any or all of the following to meet individual needs:  • the differences between breast milk and *infant formula*  • that first infant formula is the only formula milk that babies need in their first year of life, unless there are specific medical needs  • how to sterilise feeding equipment and prepare *infant* formula feeds safely, including a practical demonstration if needed  • for someone trying to establish breastfeeding and considering supplementing with *infant* formula, the possible effects on breastfeeding ~~success~~, and how to maintain adequate milk supply while supplementing. *If supplementation is medically indicated, a feeding plan should be put in place to support, protect and maximise breastfeeding and facilitate a transition back to exclusive breastfeeding if this is desired, with a referral to appropriate support for this*  • *information about* responsive bottle feeding and help to recognise feeding cues  • positions for holding a baby for bottle feeding and the dangers of 'prop' feeding  • *information* about how to pace bottle feeding and how to recognise signs that a baby has had enough milk (because it is possible to overfeed a formula-fed baby), and about ways other than feeding that can comfort and soothe the baby  • how to bond with the baby when bottle feeding, through skin-to-skin contact, eye contact and the potential benefit of minimising the number of people regularly feeding the baby. |
|  | UNICEF UK Baby Friendly Initiative | Statement 2 | We have ***concerns*** about this Quality Statement – see details below. |
|  | UNICEF UK Baby Friendly Initiative | Statement 2 | Concerns  With the current wording, we have concerns that this QS:  Is not specific to individual women’s/parents’ needs about their infant feeding  Is not safe; it is well known that women/parents are overloaded with information and will not retain information that is not relevant to them. Therefore, specific information relevant to them about safety may be lost, e.g. signs of effective feeding and what is in a nappy are different for an infant who is breastfed vs fed with infant formula. Failure to understand this may compromise being able to recognise when a baby is at risk.  8 out of 10 women do not meet their breastfeeding goals (Mc Andrew et al, 2012) a quality statement should reflect the current evidence, by supporting exclusive breastfeeding where this is the mother’s goal and avoid normalising supplements of infant formula which will have a direct impact on exclusive/partial breastfeeding rates in the UK. This QS normalises the use of infant formula for all babies. |
|  | UNICEF UK Baby Friendly Initiative | Statement 2 | Question 1  This draft QS does not accurately reflect the key areas for quality improvement. We suggest amends to the wording:  Quality Statement 2: Information and ~~advice~~ *support* about ~~babies’~~ *infant* feeding  Quality Statement to read:  Before transfer to community care or before the midwife leaves after a home birth, women who are breastfeeding are given information and support about effective breastfeeding and how to get breastfeeding off to a good start. Parents/carers who are bottle feeding their baby with expressed breastmilk or infant formula are given information on how to bottle feed responsively and prepare feeds safely. All parents are given information on how to access further support if required.  Rationale  Revisiting *individualised* information and support about ~~breastfeeding and formula~~ *infant* feeding before transfer to community care or before the midwife leaves after a home birth will support parents *to feed their babies effectively and as safely as possible*. Regardless of the *method of infant* feeding ~~choices~~, giving parents the opportunity to discuss *infant* feeding, *specific to their needs*, will help them know what to expect, what support is available, when to seek help, and will allow any questions or concerns they have to be addressed. This will reduce the chance of feeding problems occurring at home and the need for readmission. |
|  | UNICEF UK Baby Friendly Initiative | Statement 2 | **Question 2**  **Process – this may need to be divided into two data collection fields.**  Before transfer to community care or before the midwife left after a home birth:  Breastfeeding mothers: Proportion of women who had a live birth who received information and ~~advice about~~ support to get breastfeeding off to a good start  Parents who are feeding their baby with infant formula: Proportion of women who had a live birth and who are feeding their baby with infant formula who received information on how to bottle feed safely.  Numerator –  Before transfer to community care or before the midwife left after a home birth:  The number in the denominator who received information about breastfeeding  The number in the denominator who received information about bottle feeding their baby with infant formula. |
|  | UNICEF UK Baby Friendly Initiative | Statement 2 | **Question 2**  **Outcome: Suggested amends to wording**  b) Proportion of parents who were satisfied with *individualised* information *and support* ~~and advice~~ about breastfeeding ~~and~~ *or* ~~formula~~ bottlefeeding their baby with infant formula given before transfer to community care or before the midwife left after a home birth.  Numerator – the number in the denominator who were satisfied with information *and support* ~~and advice~~ about breastfeeding ~~and~~ *or* ~~formula~~ bottlefeeding their baby with infant formulagiven before transfer to community care or before the midwife left after a home birth.  Denominator – the number of parents of babies. *Questions: if the number of ‘parents’ is recorded, does this mean some information will be recorded twice if there are two parents? What happens when they are breastfeeding and bottle feeding with infant formula?*  At Stage 3 of the UNICEF UK Baby Friendly Initiative journey, services audit and collect data of parents’ experiences on their infant feeding journey: [unicef.org.uk/babyfriendly/accreditation/maternity-neonatal-health-visiting-childrens-centres/stage-3-parents-experiences/](https://www.unicef.org.uk/babyfriendly/accreditation/maternity-neonatal-health-visiting-childrens-centres/stage-3-parents-experiences/) |
|  | UNICEF UK Baby Friendly Initiative | Statement 2 | **Question 3**  **It is not achievable to collect combined data on breastfeeding and babies who are fed with infant formula. A flow of questions with a filter system is required to ensure the data collection questions are applicable and relevant to each individual woman/parent/primary caregiver.**  E.g. Stem question  How are you currently feeding your baby?:  Breastfeeding  Breastfeeding and bottle feeding with expressed breast/donor milk  Breastfeeding and bottle feeding with infant formula  Bottle feeding with infant formula.  Parents would then need to be filtered to the next question/information source accordingly. This would ensure that all information shared is relevant and individualised, and that all key messages in relation to safety are communicated and meaningful. This would also avoid:  Overloading the parent with information  Wasting staff time (thereby maximising efficiency and reducing costs)  Normalising bottle feeding a baby with infant formula and undermining the importance of breastfeeding and the use of breastmilk on the ort- and long-term health outcomes. |
|  | UNICEF UK Baby Friendly Initiative | Statement 2 | What the quality statement means for different audiences  Amended wording in *italics*  Service providers (such as NHS hospital trusts or community providers) ensure that healthcare professionals have the skills and knowledge to give *individualised* information and *support* ~~advice~~ about breastfeeding and *bottle feeding a baby with infant formula* ~~feeding~~ to parents *as required* before transfer to community care or before the midwife leaves after a home birth. Providers ensure that accessible information about ~~breastfeeding and formula~~ infant feeding, including how to get support locally, is available.  Healthcare professionals (such as midwives) give *individualised* information *and support* ~~and advice~~ about breastfeeding and *bottle* feeding *a baby with infant formula* to parents before transfer to community care or before the midwife leaves after a home birth. Healthcare professionals check that parents understand the information they have been given, and how it relates to them. Healthcare professionals acknowledge parents' emotional, social, financial and environmental concerns about feeding options and are respectful of their *infant* feeding choices.  Commissioners (integrated care systems and clinical commissioning groups) commission services that provide *individualised* information ~~and advice~~ *and support* about breastfeeding and *bottle feeding a baby with infant formula* before transfer to community care or before the midwife leaves after a home birth.  Parents of babies are given *individualised* information and *support about breastfeeding and bottle feeding a baby with infant formula* ~~advice~~ before they are discharged from the hospital or birth team. |
|  | UNICEF UK Baby Friendly Initiative | Statement 2 | Information and advice about breastfeeding and formula feeding  *Amends in italics*  Information and ~~advice~~ *support* about breastfeeding should include revisiting ~~any or all of~~ the following to meet individual needs:  nutritional benefits of breastfeeding *and the use of breastmilk for the baby and how this impacts on the ort- and long-term health and wellbeing outcomes*  health benefits for ~~both~~ the baby, *their mother and family and how this impacts on the ort- and long-term health and wellbeing outcomes*  how ~~it~~ *maximising* *the use of human milk and breastfeeding can impact health and wellbeing outcomes, ~~have benefits~~ even if only done for a ort time*  how *breastfeeding* can soothe and comfort the baby, *supporting mothers to build a close and loving relationship with their baby*  how the partner can support breastfeeding, including the value of their involvement and support, and how they can comfort and bond with the baby  *how breastmilk is produced; how the hormones impact when/how breastmilk is produced in the early stages; ~~and the~~ the supply-and-demand feedback mechanism; and how the feedback inhibitor of lactation works*  *how to recognise baby’s feeding cues and responsively breastfeed*  how often babies typically ~~need to~~ feed *in a 24 hour period* and for how long, ~~taking into account individual variation~~ recognising suck, swallow patterns and effective milk transfer  *different positions for breastfeeding and how they can be used to support the baby to effectively attach to the breast*  signs of effective feeding that ow the baby is getting enough milk (it is not possible to overfeed a breastfed baby)  expressing breastmilk (by hand or with a breast pump) as part of breastfeeding and how it can be useful; safe storage and preparation of expressed breastmilk; and the dangers of ‘prop’ feeding (when a baby’s feeding bottle is propped against a pillow or other support, and instead *learning to responsively bottle feed the baby and being able to recognise when the baby has had enough)*  normal breast changes after the birth  *coping with breastfeeding challenges and when knowing when to seek help and how to recognise effective feeding*  breastfeeding complications (for example, mastitis, breast abscess) and when to seek help  *strategies to overcome the common breastfeeding challenges and how to seek help and support*  *how to maximise breastmilk use when infant formula may be clinically indicated*  *how recovery from pregnancy and birth and* breastfeeding can affect body image, identity *and self confidence*  that the information given may change as the baby grows  the possibility of relactation after a gap in breastfeeding  safe medicine use when breastfeeding.  Information ~~and advice~~ about formula feeding for parents who are considering or who need to fully or partially formula feed should include revisiting ~~any or all of~~ the following to meet individual needs:  the differences between breastmilk and *infant formula*  that first infant formula is the only infant formula that babies need in their first year of life ~~unless there are specific medical needs~~  how to sterilise feeding equipment and prepare *infant formula* feeds safely, including a practical demonstration if needed  for someone trying to establish breastfeeding and considering supplementing with *infant formula,* the possible effects on breastfeeding success, and how to maintain adequate milk supply while supplementing  ~~advice~~ *information about responsive bottle feeding and help to recognise feeding cues*  positions for holding a baby for bottle feeding and the dangers of 'prop' feeding  information about how to pace bottle feeding and how to recognise signs that a baby has had enough milk (because it is possible to overfeed a formula-fed baby), and ~~advice about~~ ways other than feeding that can comfort and soothe the baby  how to bond with the baby when bottle feeding, through skin-to-skin contact, eye contact and the potential benefit of minimising the number of people regularly feeding the baby. |
|  | World Breastfeeding Trends UK | Statement 2 | It is important that mothers are offered the information listed in the standard, according to their needs, but I am concerned the standard may be misinterpreted as that the information is only offered before transfer to community care, and for a home birth that would be soon after giving birth, at a time when e needs to focus on her baby. It needs to be clear in the Standard that the expectation is that information about infant feeding has already been offered antenatally. The information offered postnatally reinforces and expands on what has been offered antenatally and is tailored to the individual’s need as e starts to experience feeding her baby.  The standard states ‘healthcare professionals have the skills and knowledge to give information and advice about breastfeeding and formula feeding’; we would like to see this specify Unicef UK Baby Friendly Initiative training as a minimum standard; this would align with the statement in the NHS Long Term Plan that all maternity services are expected to work towards achieving Baby Friendly accreditation. |
|  | Action on Postpartum Psychosis | Statement 3 | See comment on Q1 - a statement is needed on the signs and symptoms of serious illness in the mother |
|  | British Association of Perinatal Medicine (RCPCH) | Statement 3 | Maternity care has changed considerably and earlier discharge before 24 hours is now the norm for a mother-baby pair. Could they please consider changing this standard to 24hours OR before discharge following the delivery/birth episode (i.e. when midwives leave a home/birth centre after a home/birth centre birth (which is often at 2 hours) or when a woman takes her baby home from the consultant unit before 24 hours which would include the majority of women-baby pairs. This would help direct women to seek help for their baby if they have concerns - they could direct women to the NHS parent information leaflets and other local/national resources.  There was a high-profile coroner's inquest where a baby with sepsis became unwell overnight and arrived in A&E in a non-resuscitatable state <24 hours after a home birth and the Coroner found the Trust wanting partly because had information been provided sooner to the parents (than the 24 hour standard) on concerning signs of illness in the baby and clear direction of who to contact for these urgent signs of ill health (which can be difficult for parents to be certain of e.g. moaning) this baby may still be alive and well today. |
|  | British Association of Perinatal Medicine (RCPCH) | Statement 3 | It notes only that jaundice in the first 24 hours is serious. |
|  | GPs championing perinatal care | Statement 3 | We are in favour of this statement. However, it may be helpful to include contact with midwifery postnatal helplines as well as emergency services, given the comments in the Ockenden Review  “Kayleigh Griffiths gave birth to her daughter Pippa Griffiths at home in April 2016. Pippa died the day after her birth due to neonatal meningitis from Group B streptococcus infection. Kayleigh Griffiths had phoned midwifery staff about Pippa’s feeding, breathing and other symptoms a number of times overnight after her birth and before e died, but had been reassured” p9 1.30 |
|  | Group B Strep Support | Statement 3 | We welcome the statement for parents to be given information and advice about symptoms and signs of serious illness in the baby that require them to contact emergency services.  However, not giving as soon as possible will mean that some babies will ow signs of infection before it is given, notably group B Streptococcal infections, most of which ow in a baby’s first 12 hours of life.  We note too that this recommendation is different from that of NICE’s Neonatal Infection: antibiotics for prevention and treatment guideline [NG195], which states:  1.1.12 Before any baby is transferred home from the hospital or midwifery-led unit (or in the immediate postnatal period in the case of babies born at home), advise parents and carers to seek urgent medical help (for example, from NHS 111, their GP, or an accident and emergency department) if they are concerned that their baby:  is owing abnormal behaviour (for example, inconsolable crying or listlessness), **or**  is unusually floppy, **or**  has an abnormal temperature unexplained by environmental factors (lower than 36°C or higher than 38°C), **or**  has abnormal breathing (rapid breathing, difficulty in breathing or grunting), **or**  has a change in skin colour (for example where the baby becomes very pale, blue/grey or dark yellow), **or**  has developed new difficulties with feeding.  Give the advice both in person, and as written information and advice for them to take away. **[2021]**  Would it be possible to:  cross-reference to the NICE’s Neonatal Infection: antibiotics for prevention and treatment guideline [NG195]?  Recommend the information is given promptly after birth, and by no later than 24 hours of the birth? |
|  | Group B Strep Support | Statement 3 | We note that the list of signs of serious illness are different from those listed in NICE’s Neonatal Infection: antibiotics for prevention and treatment guideline [NG195], and that that guideline is not referenced. Would it be possible to harmonise the list of signs and symptoms between the two guidelines, and cross reference and signpost to NICE’s Neonatal Infection: antibiotics for prevention and treatment guideline [NG195] for further information where required? |
|  | Healthcare Safety Investigation Branch (HSIB) | Statement 3 | **Parents are given information and advice, within 24 hours of the birth, about symptoms and signs of serious illness in the baby that require them to contact emergency services**  HSIB supports this statement: maternity investigations have made recommendations and identified findings relating to supporting parents to recognise serious illness. |
|  | Institute of Health Visiting | Statement 3 | **Statement**  The iHV recommend that women/birthing parents are added to this statement. [The MBRRACE](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) report highlighted how in 2017-19, 191 women died during or up to six weeks after the end of pregnancy, from causes associated with their pregnancy, among 2,173,810 women giving birth in the UK.  The iHV recommend that women/birthing parents are added to the rationale, quality measures, and ‘What the quality statement means for different audiences’ |
|  | Institute of Health Visiting | Statement 3 | The iHV recommend including signs and symptoms of common and serious health problems in the woman/birthing partner in the postnatal period. |
|  | Institute of Health Visiting | Statement 3 | The iHV recommend adding ‘extremely agitated with inconsolably crying’ as a serious sign of illness – See Healthier Together RAG rating of serious illness under 3 months of age: <https://what0-18.nhs.uk/worried-your-baby-unwell-under-3-months-2/worried-about-your-baby/fever-high-temperature> |
|  | Kit Tarka Foundation | Statement 3 | We are concerned that this guideline does not make reference to reducing the likelihood of infections in newborn babies by following strict hygiene measures.  The guideline presents an opportunity to remind parents that there are steps they can take to reduce the chances of infection in their babies postnatally. Our main area of concern is reducing herpes infections in babies as the mortality rates in infected babies are so high. Simple hygiene measures additionally protect against other common infections which can cause serious illness in young babies (including RSV, varicella, group B streptococcus etc)  Information on keeping new babies safe from infection should be given including advice about regular handwashing for parents and visitors before holding the baby and the risks of allowing other people to kiss their baby especially if they have a cold sore. Parents should be advised that should they get a cold sore they should cover and treat with topical acyclovir before holding their baby. It should be noted that the babies of women who have a history of herpes infection are most likely protected against new infections but caution should still be exercised. See [kittarkafoundation.org/neonatal-herpes-info-and-advice](http://kittarkafoundation.org/neonatal-herpes-info-and-advice) for more information.  We know from the BPSU surveillance study due to published later this year that HSV infections in babies are on the rise and mortality rates among babies with disseminated HSV infection are incredibly high. Details of the project and interim results can be seen at [kittarkafoundation.org/research](file:///C:\Users\sarah\Downloads\kittarkafoundation.org\research).  Because some herpes infections do not produce symptoms, the virus can be passed on without anybody realising but there are some simple things parents can do to reduce the risk. We believe parents should be informed of these steps during pregnancy and reminded of the importance postnatally.  It is known from a recent survey of over 1,500 expectant and new parents (see [kittarkafoundation.org/babies-at-risk](file:///C:\Users\sarah\Downloads\kittarkafoundation.org\babies-at-risk)) that many (59%) are not aware of the dangers of herpes infections in a baby. We also found that many parents and visitors are not following recommended hygiene practices so it is clear further antenatal and postnatal guidance is needed. 45% of parents would allow friends and family to kiss their young baby and 1 in 3 parents would not ask friends and family to wash their hands before holding their baby. |
|  | National FASD | Statement 3 | E& D should include the information that parents with FASD/suspected FASD may need more than just accessible documents eg direct demonstration (ow not tell) and feeding charts to aid memory. |
|  | NHS England and Improvement | Statement 3 | Good detailed inclusion list of illnesses. For women who have had a complex birth, within 24 hours is not the ideal time to give information that women need to remember after discharge home. For a few (e.g. those who have had a general anaesthetic) this is the wrong time. It may be helpful to add that this should be re-iterated before transfer to community care or before the midwife leaves after a home birth.  On symptoms and signs of serious illness, parents should be given advice on how to seek advice when needed. Navigating the NHS can be difficult enough at the best of times, but more challenging when you have a new baby |
|  | NHS Fife | Statement 3 | Quality statement 3 – agree with the principle of the statement. Information provided via Ready Steady Baby and local information leaflets. Currently process measures are not audited or captured on maternal electronic records. This would require additional resources. Infant Deaths captured via Scotti Child Death reviews which is now being established .Baby Check scoring system would need to be supported with follow up. Unsure how to reliably capture all parent contact with emergency services as this could be via various services .Language regarding signs and symptoms could be more parent friendly e.g. focal neurological signs |
|  | Royal College of Midwives | Statement 3 | We would recommend encouraging maternity services to spell out that healthcare professionals should not be using family members to translate but only professional translation services – the use of ‘advocate’ can have different meanings. It is pivotal that all information provided are accessible and tailored to their needs, taking into consideration all barriers (e.g. neurodiversity, language).   It refers to skin colour as ‘pale’ ‘ashen’ ‘yellow’ – recognition and training needed regarding darker skin tones. There are few piece of research being carried out at present in the UK . The aim of those is to review neonatal testing and practice in Black and Asian newborns.   It is widely recognised that there are ethnic inequalities in neonatal health and care provision. There are concerns regarding routine perinatal practices such as Apgar scores in which skin colour is a key element of neonatal examination which may mediate disadvantaging babies with darker skin. The same applies to recognition of signs and symptoms of serious illnesses. Emphasis must be put on the need for more training for healthcare professionals regarding the latter. |
|  | Royal College of Paediatrics and Child Health | Statement 3 | Although not a definite ‘999’ type emergency, should all mums be advised to report if their baby has pale/chalk-like stools? This may be due to biliary atresia, for which to overall outcome for the baby is better if early diagnosis and earlier intervention. |
|  | The Breastfeeding Network | Statement 3 | We suggest that this quality statement should also take into account the context and situation of the mother and baby. Giving information should be combined with close monitoring of all mothers and babies by health care professional staff wherever possible, and especially if mother and baby are in a clinical or hospital setting. In many instances, close monitoring can fully prevent or significantly modify illness in babies.  We also suggest that this quality statement be expanded to include ensuring parents feel enabled to raise concerns, ask questions and to know that they will be listened to and not dismissed and that action will be taken in a timely fashion to any concerns they raise.  We suggest that the rationale should be broadened to be context specific. Parents are not the only actors in the immediate hours, days and weeks after birth. Providing information to parents is important but the rationale should address the need for high levels of situation specific awareness from health care professionals.  We suggest that in addition to the signs and symptoms of illness, the quality standard could cover principles of safe care postnatally, which would enable parents and healthcare professionals to be more easily alert to any symptoms in their baby, and themselves. For example (items taken from the BAPM framework on SUPC*,* https://www.bapm.org/resources/sudden-and-unexpected-postnatal-collapse-supc):  Supporting parents to remain engaged with their baby  Keeping the baby close  Enabling parents to raise concerns  Ensuring staffing levels are sufficient to uphold high standards of alertness and care  We also suggest that the information on jaundice be expanded to recognise that a yellow skin colour may harder to detect on darker skin tones, although yellowing may be visible on the palms of the hands, soles of the feet and whites of the eyes. Other symptoms include dark, yellow urine (a newborn baby's urine should be colourless) and pale-coloured poo (it should be yellow or orange) ([Newborn jaundice - NHS (www.nhs.uk)](https://www.nhs.uk/conditions/jaundice-newborn/) |
|  | UNICEF UK Baby Friendly Initiative | Statement 3 | We welcome and support this Quality Statement. We suggest amends to the wording:  Within 24 hours of the birth *all* parents are given information ~~and advice~~ *on how to recognise* symptoms and signs of serious illness in *their* baby *and how to* contact emergency services. |
|  | Action on Postpartum Psychosis | Statement 4 | Face-to-face breastfeeding support for women in recovery from postpartum psychosis will need to be informed by specialist advice on breastfeeding and medication, and on supporting mother-infant bonding during formula feeding if a woman chooses not to, or is unable to, breastfeed. (See CG192 1.4.4 and 1.4.5 as above comment on Statement 2) |
|  | Better Breastfeeding | Statement 4 | As noted above, it is important to distinguish between the sort of support required for breastfeeding and for formula feeding, both in terms of who is feeding the baby and the intensity of the support required. The conflation of the two and the use of the word “parents” instead of “mothers” is likely to result in the incorrect allocation of resources and to give the impression that mothers’ choices about breastfeeding belong to someone other than her. This is a potential human rights issue and risks putting mothers in danger of coercive control that appears to be endorsed by health professionals. It is therefore essential that the language is completely clear. The use of the word “parents” here is not clear.  The loss of the statement on a structured programme (such as the Unicef Baby Friendly Initiative) is unfortunate. There should be some standards against which the training of and competencies of healthcare professionals can be measured. Simply providing a training record does not convey whether that training or competencies are sufficient. This statement needs further elaboration to be meaningful.  The statement should elaborate on who/how the breastfeeding support is being provided and when referral is appropriate. The skillset for providing breastfeeding support may not lie with the midwife. In addition, if a midwife arrives when a baby has already fed then they may not be able to observe a feed at that postnatal contact. The wording of the statement is quite restrictive in how it envisages breastfeeding support will be offered. For example, in Tower Hamlets all mothers are contacted by the Baby Feeding Team, who are highly trained in breastfeeding support but are not midwives. They are able to visit mothers at home and offer dedicated breastfeeding support. Similarly, in Islington this support is offered by the breastfeeding peer supporters, not healthcare professionals.  While we welcome the suggestion that breastfeeding/feeding should be discussed at every postnatal contact, the actual direct face-to-face support may sometimes happen at other times and be delivered by those who are not midwives or health professionals. Support may also come in the form of referral by midwives or health visitors to an additional service - ideally at home. |
|  | British Specialist Nutrition Association Ltd | Statement 4 | Overall, our comment on this statement:  We find that the structure and logical flow of this section (i.e., amount of support offered, concerns about feeding, type of support offered) is practical and helpful. However, these sections seem to be targeted towards one type of feeding over the other. In our opinion, the majority of advice given would be suitable for all types of feeding. While we fully understand that different methods of feeding bring with them different worries and concerns, and therefore different support and advice is appropriate, we believe that the default for any advice and support given to parents should be comprehensive of all types of feeding, with particular aspects called out where needed. Clearly, there is support which will be needed to be provided for breast or bottle or expressing feeding parents only (e.g., advice about latching, advice on how to make up a formula feed, advice on how to store expressed milk), but, on the whole, the advice and support covered in this section is suitable for all.  We would also suggest that this section is expanded to cover the type of advice that parents receive ante-nataly. While we fully believe that breastfeeding is best, such support should cover bottle feeding also, including owing parents how to make up a bottle and expressing (pumping, and storing expressed feeds) in a safe way. |
|  | British Specialist Nutrition Association Ltd | Statement 4 | *Draft statement reads:*  “Regardless of their feeding choices, parents value face-to-face feeding support. This support should be an integral part of routine postnatal contacts. Individualised support, including assessment and observation of feeding, can give parents the knowledge and understanding they need. This helps them establish good feeding practice and make informed decisions about feeding their baby”**.**  *Our comment:*  We fully agree with the statement as written. However, we would suggest complementing it with the encouragement to understand that such decisions change over time – Health Care Professionals (HCP) should not make the assumption that because parents are comfortable with their feeding choice at the first face-to-face appointment, they will remain so – it would be prudent to ensure that these questions are asked in an open and non-judgemental way at every visit – although this is alluded to in the text, we suggest it be made more explicit. |
|  | British Specialist Nutrition Association Ltd | Statement 4 | Draft statement reads:  *“Service providers ensure there is capacity to observe a feed within 24 hours of the birth and to provide breastfeeding assessment, with another observation of a feed within the first week.*  *Healthcare professionals observe a feed within 24 hours of the birth and assess breastfeeding, with another observation of a feed within the first week. They help to resolve any ongoing concerns”.*  Our comment:  We suggest more explicit wording about what observations and assessments should be provided for all parents – whether they are breastfeeding, formula feeding or expressing. In line with Baby Friendly advice, we suggest being explicit about what ‘red flags’ Health Care Providers need to be looking for.  We think that feeding observations should be offered to all bottle feeding and expressing parents in order to provide an opportunity to resolve concerns, ask questions, etc., and this should also be clear in the introduction – it is evident in the definitions section that the support should be provided for all. |
|  | British Specialist Nutrition Association Ltd | Statement 4 | Draft statement reads:  *“Face-to-face feeding support*  *This should include assessment of breastfeeding to identify and address any concerns. Healthcare professionals should:*  *ask about:*  *any concerns the parents have about their baby's feeding*  *how often and how long the feeds are*  *rhythmic sucking and audible swallowing*  *if the baby is content after the feed*  *if the baby is waking up for feeds*  *the baby's weight gain or weight loss*  *the number of wet and dirty nappies*  *the condition of the breasts and nipples*  *observe a feed within the first 24 hours after the birth, and at least 1 other feed within the first week”*.  Our comment:  In our view, this support needs to be offered to all parents – regardless of whether they are breastfeeding, bottle feeding, expressing or a mixture of these. Of course, there remain some advice specific to breastfeeding (e.g., condition of nipples), but the majority of the listed factors are common to all types of feeding. |
|  | British Specialist Nutrition Association Ltd | Statement 4 | Draft statement reads:  ***“****Encourage and support and discuss options of feeding outside the house.*  *Draft Statement:*  *If there are ongoing concerns with breastfeeding, healthcare professionals should consider:*  *observing additional feeds*  *other actions, such as:*  *adjusting positioning and attachment to the breast*  *giving expressed milk*  *referring to additional support such as a lactation consultation or peer support*  *assessing for tongue‑tie.”*  We believe it’s important to highlight the conditions in which formula should be discussed with breastfeeding parents – a weight loss of 10% or more at any stage needs careful assessment, and under such circumstances, other feeding options should be considered (5). |
|  | British Specialist Nutrition Association Ltd | Statement 4 | Draft statement reads:  *“Face-to-face formula feeding support should include:*  *advice about responsive bottle feeding and help to recognise feeding cues*  *offering to observe a feed*  *positions for holding a baby for bottle feeding and the dangers of 'prop' feeding*  *advice about how to pace bottle feeding and how to recognise signs that a baby has had enough milk (because it is possible to overfeed a formula-fed baby)*  *advice about ways other than feeding that can comfort and soothe the baby*  *how to bond with the baby when bottle feeding, through skin-to-skin contact, eye contact and the potential benefit of minimising the number of people regularly feeding the baby”.*  Our comment:  With the exception of the last comment about minimising the number of people who regularly feed the baby, these pieces of advice are suitable for all parents and not just formula feeding parents. We suggest that, regardless of feeding method, parents should be advised how to feed responsively and how to assess hunger and satiety cues.  References: 5- Department of Health (2009) Using the new UK – World Health Organization 0-4 years growth chart. Available at: <https://www.rcpch.ac.uk/sites/default/files/Using_the_growth_charts.pdf> [Accessed 7 June 2022] |
|  | GPs championing perinatal care | Statement 4 | We are in favour of this statement |
|  | Institute of Health Visiting | Statement 4 | **Structure**  iHV recommend changing the statement to: ‘*face to face support with infant feeding’* |
|  | Institute of Health Visiting | Statement 4 | **Face to face infant feeding support**  In line with [Baby-Friendly-Initiative-Standards](https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2014/02/Guide-to-the-Unicef-UK-Baby-Friendly-Initiative-Standards.pdf), the iHV recommend including:  The baby is calm and relaxed when feeding  The baby has regained birth weight (by 10-14 days)  Normal skin colour  Ask if dummy or nipple shields are used and provide advice |
|  | Lactation Consultants of Great Britain | Statement 4 | One overarching comment is that there seems to be a strong push towards face-to-face feeding support at postnatal contacts, which may actually be detrimental in terms of staff time, the needs and circumstances of a family, and speed of response. Certainly, we would prefer to see a balanced mix of face-to-face and remote support, tailored to the needs of the individual family and as clinically indicated at any given time. Certainly post pandemic we have a lot to reflect upon about the benefits of a more hybrid approach, as appropriate. |
|  | National Childbirth Trust | Statement 4 | As comment 2.  We also welcome the retention of exclusive or partial breastfeeding at 6 to 8 weeks after birth. |
|  | National FASD | Statement 4 | E& D should include the information that parents with FASD/suspected FASD may need more than just accessible documents eg direct demonstration (ow not tell) and feeding charts to aid memory. |
|  | NHS England and Improvement | Statement 4 | Very supportive of this new measure regarding feeding and face to face support. Recommend that this reads ‘each standard postnatal contact’ (think this is the wording in the guidance). Telephone contact for feeding support in between these can be helpful and appropriate. |
|  | NHS Fife | Statement 4 | Quality statement 4 – agree with the principle of the statement. Would be very challenging to observe feed between two and seven days. In line with UNICEF standards feeding assessments would be undertaken which may lead to a feed being observed. Feeding assessment is the UNICEF measure, would need additional resources to capture this whilst ideal may not be necessary or improve outcomes. Would require additional audit and may not capture other feeding support agencies input as this may be recorded separately. |
|  | Royal College of Midwives | Statement 4 | This is a crucial quality standard pivotal to the success of breastfeeding initiation and continuation, face to face feeding support is a positive addition to this quality standards update.   Continuity of carer is well known to have a positive impact on the success of breastfeeding, due to the relationship of trust and support created during pregnancy between the named midwife and the woman and her family. We would encourage highlighting this aspect and encouraging services to provide Midwifery Continuity of carer throughout pregnancy and the postnatal period wherever possible. |
|  | Royal College of Speech and Language Therapists | Statement 4 | The RCSLT feels some tweaks and restructuring could be made to this statement for coherency, including:  Page 20 face to face feeding support – separate breast and bottle feeding. Asking about concerns should come up to straight after face to face feeding support and include assessment of breast feeding  Add a point about signs of effective positioning and attachment for breast feeding  Add a point about asking about pain linked to nipple damage  Page 21 – Bullet point: Giving expressed milk – re-phrase to supporting expressing to increase lactation and potentially give supplemental EBM feeds  **Face to face formula feeding support** – 1st bullet point – move to under face to face feeding support  Re-phrase advice about responsive feeding and recognise feeding cues  3rd bullet point – positions for bottle feeding – description about how you hold a baby for bottle feeding, hold close and dangers of prop feeding |
|  | The Breastfeeding Network | Statement 4 | We welcome this quality standard regarding face-to-face support for infant feeding. Within the definitions of terms used, we suggest the following additions:  This should include assessment of breastfeeding to identify and address any concerns. Healthcare professionals should:  • ask about:  *How e is determining when and for how long to feed her baby (to a schedule, responsive, awareness of feeding cues, allowing baby to complete feed themselves, offering both breasts?)*  *Whether the mother is experiencing any pain or discomfort, and when this occurs.*  *Whether any feeds have been given by means other than feeding directly at the breast.*  *Whether a dummy is being used.*  We would also suggest that the quality standard should clarify that a full breastfeed should be observed, from start to finish.  Within the other actions healthcare providers could consider if there are problems with breastfeeding, we suggest adding:  *Supporting the mother to [*adjust positioning and attachment to the breast*]. The mother should be guided and empowered to do this herself, not have it done for/to her.*  *Discussing the importance of feeding responsively, rather than to a schedule, or trying to space out feeds. Discussing recognising and responding to early feeding cues.*  *Discussing use of a dummy, if used, and how this can mask feeding cues.*  Discussing if any supplementary feeds have been given, for what reason, in what form and how this could impact breastfeeding. |
|  | UNICEF UK Baby Friendly Initiative | Statement 4 | We welcome and support this Quality Statement. We suggest these additions to the wording:  Parents receive face-to-face *infant* feeding support at each postnatal contact *specific to their individual needs.* |
|  | World Breastfeeding Trends UK | Statement 4 | This is a really important standard for helping mothers achieve their breastfeeding intentions and thus addressing the current rapid decline in rates. |
|  | Action on Postpartum Psychosis | Statement 5 | No comment |
|  | Baby Sleep Information Source | Statement 5 | We are very pleased to see the QS expressed as giving advice about safer practices for bed sharing. This wording is important because such advice alerts parents to the possibility they might bedshare unintentionally / accidentally with non-judgemental guidance about how to plan ahead to ensure their baby’s safety. In our work with parents we have found a common assumption is that they will be chastised or shamed by health professionals for bed-sharing with their baby, and therefore hide this fact in conversations with practitioners. This prevents conversations about bed-sharing safety, leading to unwitting implementation of unsafe practices. |
|  | Baby Sleep Information Source | Statement 5 | Where parents are advised to avoid bedsharing because of the specified factors increasing the risk to the baby’s safety it is important to explain why such scenarios increase the baby’s risk of SIDS/accidents, and what options parents might implement instead. Our research has found that parents want to understand **why** some behaviours (e.g. bed-sharing with a preterm infant) are riskier, and often have very specific questions (e.g. ‘if my partner who is a smoker has a shower and changes his clothes before bed can he bed-are with me and our baby?’). Ensuring these conversations involve explanations (rather than instructions) means parents are more likely to understand, engage with, and follow the guidance. |
|  | Baby Sleep Information Source | Statement 5 | In our training sessions with practitioners we often hear that they have lacked confidence or knowledge to discuss the research evidence around bedsharing issues and to answer parents’ questions. Lack of confidence/knowledge causes practitioners to avoid such conversations or to give a simple ‘no bed-sharing’ message, which means parents do not receive individualised guidance tailored to their circumstances. |
|  | British Association of Perinatal Medicine (RCPCH) | Statement 5 | surely this advice should be given before discharge from the maternity unit? |
|  | GPs championing perinatal care | Statement 5 | We are in favour of this statement |
|  | Institute of Health Visiting | Statement 5 | **Safe practices for bed sharing**.  The iHV has been alerted to professional concern that the current postnatal NICE guidance is not aligned with international safe sleeping guidance from the American Academy of Paediatrics (AAP), the Australian, the Canadian, the European Foundation for the care of the Newborn Infant (EFCNI), Irish and New Zealand **which all advocate no bed sharing/co-sleeping with infants under 12 weeks of age due to the increased risk of SIDS even if no adverse conditions are present.** (See links below for the guidance from these countries).  Tapin et al October 2021 noted the following: “The International SIDS Community has set policy based on meta-analysis 1-4 and a priority for safety: In 2004–2005, the European Concerted Action on SIDS (ECAS) (1) comprising case–control studies in 20 European regions and a Scotti study (2) **owed significant risk for babies under 8 and 11 weeks respectively bed-sharing with non-smoker(s).** In Edmonton Canada, the International SIDS Community asked for a meta-analysis of all relevant data. An individual participant data meta-analysis of case–control studies (ECAS, Scotland, Ireland, Germany and New Zealand with 1472 cases and 4679 controls) **confirmed significant risk for young babies under 12 weeks bed-sharing in the absence of additional hazards** (3) An extreme sensitive analysis **confirmed significant risk for babies under 8 weeks bed-sharing with non-smoking adult(s) who did not drink or take drugs** (4).  The iHV is aware that there is disagreement between scientists over this and welcome the opportunity for the NICE postnatal care, Quality Standard to be modified in view of the international evidence on this. We are aware that the SIDS/SUDI statistics vary considerable from country to country with Scotland having higher rates that England.  **Relevant international links**  American Academy of Paediatrics [https://www.healthychildren.org/Engli/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx](https://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx)  Australian safe sleeping guidance <https://rednose.org.au/section/safe-sleeping>  Canadian guidance <https://www.canada.ca/en/public-health/services/health-promotion/childhood-adolescence/stages-childhood/infancy-birth-two-years/safe-sleep/safe-sleep-your-baby-brochure.html>  European Foundation for the care of the Newborn Infant (EFCNI) <https://www.efcni.org/health-topics/going-home/safe-sleep/>  Ireland [https://www2.hse.ie/conditions/cot-death/where-baby-ould-sleep/](https://www2.hse.ie/conditions/cot-death/where-baby-should-sleep/)  New Zealand Birth – 6 weeks  <https://www.health.govt.nz/your-health/pregnancy-and-kids/first-year/first-6-weeks/keeping-baby-safe-bed-first-6-weeks>  and 6 weeks to 6 months <https://www.health.govt.nz/your-health/pregnancy-and-kids/first-year/6-weeks-6-months/keeping-baby-safe-bed-6-weeks-6-months>  **References:**  1.Carpenter RG, Irgens LM, Blair PS, et al. Sudden unexplained infant death in 20 regions in Europe: case control study. Lancet 2004;363:185–91.  2. Tappin D, Ecob R, Brooke H. Bedsharing, room sharing, and sudden infant death syndrome in Scotland: a case- control study. J Pediatr 2005;147:32–7.  3. Carpenter R, McGarvey C, Mitchell EA, et al. Bed sharing when parents do not smoke: is there a risk of SIDS? An individual level analysis of five major case– control studies. BMJ Open 2013;3:e002299.  4. Carpenter JR, Smuk M. Missing data: a statistical framework for practice. Biom J 2021;63:1–33.  5. Tappin, D, Mitchell, E. Carpnter, J. Hauck, F, Allan, L. 2021 “Bed sharing is a risk for sudden unexpected death in infancy” Archives of Disease in Childhood Vol 0 No 0 |
|  | National Childbirth Trust | Statement 5 | We welcome the recognition that parents often are a bed with their baby and that clear information and advice is provided to optimise safety when parents bedshare with their baby.    Surveys of local parents are problematic as a means of data collection as it may be done differently between Trusts and across areas and so the data may not be comparable. It’s also less likely that the survey will be conducted given the time constraints on NHS staff at this time. |
|  | NHS England and Improvement | Statement 5 | This is crucial and a key issue which needs to be highlighted to new parents |
|  | NHS Fife | Statement 5 | Quality statement 5 – agree with the principle of the statement. Information provided via various sources. Safe sleep assessment on Badgernet, separate system used by Health visitors unable to comment on Heath Visitors processes. .Included in the UNICEF Baby Friendly audits could be duplication. Alignment with UNICEF would standardize this measure.  Advice regarding number of units of alcohol differs from the Lullaby trust which recommends no alcohol; this could be confusing for parents. |
|  | Royal College of Midwives | Statement 5 | Investigations into SIDS have identified that many of these deaths happen in a context of an unsafe sleep environment. A high proportion of babies who die unexpectedly live in an environment of social disadvantage. To minimise the risk of SIDS associated with unsafe sleep environments, midwives and others involved in antenatal and early postnatal care, should provide families with consistent safer sleep advice following NICE guidance on postnatal care, that is also tailored to the context of each baby and family.   Some baby slings have been associated with SIDS due to their bag-aped style which can lead to the baby curling up in the sling, pressing their chin towards the chest. Parents should be encouraged to follow the manufacturer advice on slings/carrier and get advice from reliable resources on how to safely use them (please see [www.basisonline.org.uk](file:///\\nice.nhs.uk\data\H&SC\QS\Work%20programme\1.%20QS%20in%20development\Postnatal%20care%20(update)\6.%20Consultation\www.basisonline.org.uk%20) and the RCM guidance on safer sleep RCM 2021 - Safer sleep guidance).   Also reliable and up-to-date information about thermal regulation, smoking, dummies, breastfeeding, breathing regulation and their effect or not on the risk of SIDS in term and pre-term babies must be discussed with families at every contact postnatally both in hospital and at home. |
|  | Royal College of Speech and Language Therapists | Statement 5 | The RCSLT supports the advice on how to enable safe bed sharing. |
|  | The Breastfeeding Network | Statement 5 | We support this quality statement |
|  | The Lullaby Trust | Statement 5 | Under Definition of Terms… Include not to bedshare if baby was born prematurely (before 37 weeks). |
|  | The Lullaby Trust | Statement 5 | We would also suggest not bedsharing if either parent has drunk **any** alcohol – units are difficult for parents to measure/keep track of. |
|  | The Lullaby Trust | Statement 5 | The definitions of ‘safer practices for bedsharing’ should also include: “make sure the baby won’t fall out of bed or get trapped between the mattress and the wall.” |
|  | The Lullaby Trust | Statement 5 | Also include “…keep pillows, sheets, blankets away from the baby or any other items that could obstruct their breathing or cause them to overheat.” |
|  | The Lullaby Trust | Statement 5 | We are going to our Scientific Advisory Group next week to discuss two additional pieces guidance – not to bedshare if mother smoked in pregnancy as a contributary factor of blunted arousal and for families to always have a separate safe sleep space available in case the contributary factors change night by night, i.e. if either parent has had a drink, have a high temperature etc. |
|  | The Lullaby Trust | Statement 5 | Healthcare professionals’ section. Include wording from page 23 in this section: ‘and the circumstances that strongly advise against it’ |
|  | The Lullaby Trust | Statement 5 | Agree with the sentence in the Rationale section: ‘This advice may be repeated several times but giving it at the first midwife and health visitor home visits will highlight and reinforce it early.’ We would also strongly advocate for conversations to take place postnatally prior to discharge and hope this is included elsewhere in the Standard. |
|  | UNICEF UK Baby Friendly Initiative | Statement 5 | We welcome and support this Quality Statement. We suggest amends to the wording:  Parents are given ~~advice~~ *information and support* about safer practices for bed sharing during their first postnatal midwife and health visitor home visits. |
|  | Action on Postpartum Psychosis | Statement 6 | We note that this is the only quality statement which mentions assessing psychological and emotional wellbeing and discussing the symptoms and signs of potential postnatal mental health problems and how to seek help. For women with postpartum psychosis, in most cases the GP assessment at 6-8 weeks will be too late to identify symptoms and ensure appropriate urgent treatment in a Mother & Baby Unit. |
|  | Better Breastfeeding | Statement 6 | The GP postnatal check should include questions about baby feeding and referral to additional or specialist support services when required. It should be understood that there is a close interaction between breastfeeding and maternal mental health. |
|  | Birth Companions | Statement 6 | Women with social services involvement should be highlighted in the equality and diversity considerations in this statement in particular, as well as more generally. The same applies to women in prison. We have been aware for some time of women in the prison estate not receiving any/ adequate postnatal GP assessments. This is an issue that has been raised with HMPPS and NHS Health and Justice, but the particular vulnerabilities of this population are acute and under-recognised. Equally, mothers who are separated from their baby at or shortly after birth may not receive a postnatal GP assessment without focused and specialised efforts to engage them, and their physical and mental health needs therefore go unaddressed. |
|  | EMDR ASSOCIATION UK | Statement 6 | We strongly recommend that women are specifically screened for PTSD at the 6-week post-natal GP visit, especially if there has been a traumatic birth experience. There should be a guaranteed referral for evidence-based treatment and women should be offered the choice of Trauma-Focused CBT (cognitive behavioural therapy) or EMDR (eye movement desensitisation and reprocessing). |
|  | FTWW: Fair Treatment for the Women of Wales | Statement 6 | The Rationale states that, ‘Carrying out an assessment of women’s physical and psychological health and wellbeing 6 to 8 weeks after giving birth will prevent delays in diagnosing and treating any problems and improve health outcomes’.  We believe that this is potentially too late in the post-natal period to be making a first assessment of mental health, particularly as in many instances there is a 6-month post-birth cut off for referrals into over-stretched specialist peri-natal mental health support services. FTWW would advise that midwives and health visitors receive additional training to identify and refer vulnerable parents and that consideration be given to making this an additional Statement inserted prior to Statement 6 / GP Assessment. |
|  | GPs championing perinatal care | Statement 6 | We are in favour of this statement. However, we regret that there is no comment about GPs making an assessment of perceived trauma experienced. In addition women who have caesarean sections may have perineal problems, despite not having a vaginal birth |
|  | GPs championing perinatal care | Statement 6 | For statement 6 we think local data collection may be difficult without using GP electronic records. In addition we are unclear why collecting rates of unplanned hospital attendance for women within 3 months of giving birth would be a suitable measure for assessing if a satisfactory GP postnatal assessment for women has taken place. This might be a useful outcome measure for all sorts of reasons, but not in relation to QS 6 specifically. GPs need evidence-based guidelines to perform this check and may need additional training and updating to perform it |
|  | Maternal Mental Health Alliance UK | Statement 6 | The details of this statement note that both the physical and mental health of the mother must be discussed by the GP in the 6-8 week postnatal check.  This emphasis on the inclusion of mental health (and that sufficient time is given in the appointment to discuss this properly) is vital to keep in the statement. However, there is a need to also look at how this can be strengthened given the findings of the National Maternity Survey 2021, which noted that 32% of women felt their GP did not spend enough time talking to them about their mental health during their 6-8 week check.  Furthermore, several of the recommendations in the 2021 MBRRACE report talk about the importance of mental health checks. This report notes that the most vulnerable mothers with additional risks such as changes to mental health medication during pregnancy, those with substance abuse histories or any history of bipolar disorder / psychosis should have a mental health review in the early postpartum period and all mothers should be assessed for any ‘red flags’ such as expressions of incompetency as a mother or estrangement from the infant. |
|  | National Childbirth Trust | Statement 6 | We are pleased to see the inclusion of a statement specifically about GP checks for women’s physical and psychological wellbeing. Using a national dataset, i.e. the CQC Maternity Survey, will provide robust and useful evidence. |
|  | National FASD | Statement 6 | Postnatal contraceptive advice should include information about unplanned pregnancy and the risks of prenatal alcohol exposure. |
|  | NHS England and Improvement | Statement 6 | This is well established in practice and offers a good opportunity to review any physical or mental health issues, to discuss support, and also to offer contraception. Important to be clear at every opportunity that this appointment is for the woman’s health and is a distinct appointment to the baby check. A significant % of women report their check being just a few questions hurried into the end of the NIPE. |
|  | NHS Fife | Statement 6 | Quality statement 6 – agree with the principle of the statement. Unable to comment as GP service in Scotland are managed differently and outwith the remit of maternity services.  Would it always be necessary for a GP to undertake the postnatal check, for low risk women who have only ever received midwifery care during pregnancy should this be a midwife who undertakes the check |
|  | Royal College of Midwives | Statement 6 | Mental health outcomes are as important as physical ones, hence in the current context of growing rates of PTSD associated with birth trauma and the consequences of the pandemic on women’s mental health, supporting new mothers and families in the transition into parenthood is paramount.   The GP assessment at 6-8 weeks must be thorough and personalised to the woman’s needs and an interpreter service must be used if needed.   There is growing evidence that postnatal care provision should include services such as birth debriefing and be integrated with mental health services.   Please see the LSE/CPEC report on increasing access to treatment for women with common mental health problems during the perinatal period. <https://maternalmentalhealthalliance.org/wp-content/uploads/economic-case-increasing-access-treatment-women-common-maternal-mental-health-problems-report-lse-2022-mmha.pdf>  A positive initial interaction post-birth and in the early postnatal period is crucial and has long lasting consequences on the physiology and behaviour of mother and infant. There is proven impact of early parenting on optimal neurological development of the infant. It is crucial that the postnatal guideline covers the window of opportunities presented by postnatal care for early years public health and social care interventions, especially those focussing on early years nutrition and mental health support and guidance.   RCM, Emotional wellbeing & Infant Development: <https://www.rcm.org.uk/media/4645/parental-emotional-wellbeing-guide.pdf> |
|  | Royal College of Paediatrics and Child Health | Statement 6 | As this guideline covers the first 8 weeks of baby’s life, we feel there should be reference to the new born screening as this should be part of routine care for all babies in their first 8 weeks of life. This includes screening examinations (within 72 hours, again at 6-8 weeks), new born hearing screening, new born blood spot. This can also help to avoid needing separate guidelines for these areas and avoid duplications. Other treatments that are part of routine care of all babies, which aren’t mentioned in the guideline are prophylaxis against vitamin k deficiency bleeding, and routine childhood immunisation (1st is at 8 weeks old) and BCG vaccination in eligible groups. |
|  | The Breastfeeding Network | Statement 6 | Within the section “What the quality statement means for different audiences”, we suggest the following amendment: Women who have given birth are invited to have a postnatal check with a GP 6 to 8 weeks after giving birth. *It is made clear to them that this appointment* will cover *their own* physical and mental health, *and is separate to the 6-8 week baby check.* The GP will refer them for any help they may need. *If a partner attends the check with them, they will be given time to discuss issues confidentially.*  Within the definition of terms section, we suggest the following additions:  [any conditions that existed before or arise during pregnancy that require on-going management, such as gestational diabetes], *and mental health issues. Medication regimes may have changed during pregnancy and need reassessing. Prescriberssh should refer to UKDILAS (*[*https://www.sps.nhs.uk/home/about-sps/get-in-touch/medicines-information-services-contact-details/breastfeeding-enquiries/*](https://www.sps.nhs.uk/home/about-sps/get-in-touch/medicines-information-services-contact-details/breastfeeding-enquiries/)*) or the Breastfeeding Network Drugs in Breastmilk Service (*[*https://www.breastfeedingnetwork.org.uk/detailed-information/drugs-in-breastmilk/*](https://www.breastfeedingnetwork.org.uk/detailed-information/drugs-in-breastmilk/)*) for detailed information on safe prescribing to breastfeeding mothers.*  When assessing “nipple and breast discomfort and symptoms of inflammation”, we suggest GPs also discuss and assess breast changes during pregnancy and breastfeeding, and discuss what is normal, and what is not and should be checked. Symptoms of breast cancer could be missed at this time, if mothers are not aware of this.  We also suggest that the appointment should include sensitively checking when the mother’s last smear test was done, as this could have been missed during pregnancy.  Within the equality and diversity section, we suggest the addition that women who do not respond to invitations for 6-8 week check appointments, or who do not attend arranged appointments should be followed up, with every effort at contact made and appointments offered at home or a nearby health related location. GP and health visiting services could co-ordinate to ensure this takes place. |
|  | UNICEF UK Baby Friendly Initiative | Statement 6 | We welcome and support this Quality Statement |

Note: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

## Registered stakeholders who submitted comments at consultation

* Better Breastfeeding
* Action on Postpartum Psychosis
* Baby Sleep Information Source
* Beat SCAD
* Birth Companions
* British Maternal & Fetal Medicine Society
* British Pregnancy Advisory Service
* British Specialist Nutrition Association Ltd
* EMDR ASSOCIATION UK
* Fatherhood Institute
* FTWW Fair Treatment for the Women of Wales
* GPs championing perinatal care
* Group B Strep Support
* Healthcare Safety Investigation Branch (HSIB)
* Infant Feeding Alliance
* Institute of Health Visiting
* Kit Tarka Foundation
* Lactation Consultants of GB
* Maternal Mental Health Alliance UK
* National Childbirth Trust
* National FASD
* NHS England and Improvement
* NHS Fife
* Pelvic Obstetric & Gynaecological Physiotherapy
* Royal College of GPs
* Royal College of Midwives
* Royal College of Nursing
* Royal College of Obstetricians and Gynaecologists
* Royal College of Paediatrics and Child Health
* Royal College of Speech and Language Therapists
* The Breastfeeding Network
* The Lullaby Trust
* UNICEF UK Baby Friendly Initiative
* World Breastfeeding Trends UK