# Maternal and child nutrition: nutrition and weight management in pregnancy, and nutrition in children up to 5 years

**Consultation on draft guideline - Stakeholder comments table**
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| AIMS | Guideline | General | General | suggest summarising risks/benefits of each supplement into a "quick reference" table | Thank you for your comment. Risks and benefits of vitamins is beyond the remit of this guideline. |
| AIMS | Guideline | General | General | Despite the Recommendations opening with the statement "People have the right to be involved in discussions and make informed decisions about their care" much of the language is directive and does not support autonomy. People should be given evidence about the benefits and risks and supported to make their own decisions about managing their own nutrition. | Thank you for your comment. In the recommendations, which are directed, for the most part, at healthcare professionals, we use words such as "Discuss", "Offer", "Reassure". For example, the role of the healthcare professionals is to share with the person what the current UK recommendations are on supplementations in pregnancy and while breastfeeding, but it is ultimately up to the person to make the decision for themselves. The expectation is that through discussions with and advice from the healthcare professionals, people are enabled to make their own decisions about their nutrition and their care. |
| AIMS | Guideline | General | General | The scope of the guideline is far-reaching and encompasses many professional groups. Much (particularly around delivery of dietary and exercise advice) sounds like it is intended to be delivered by community midwives; from a credibility and training point of view, is this appropriate? Particular example around re- | Thank you for your comment. We do not want to be overly prescriptive about who the recommendations are aimed at, because this can vary depending on the individual case or local arrangements. Regarding the recommendation on physical activity, we believe healthcare professionals who typically meet pregnant people, such as midwives or GPs, would be able to give basic advice on how to be or start being physically active in pregnancy. The recommendation |

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| | | | | starting exercise and the support required for that. Suggest clarification of roles and responsibilities. | is not referring to any particular 'exercise'. The resources included in the recommendation give further advice that healthcare professionals and pregnant people can use. |
| AIMS | Guideline | General | General | suggest inclusive language with respect to breast feeding *and chest feeding.*<br>A mention of induced lactation would be wise, as adoptive/surrogate/AMAB parents will likely require additional support. | Thank you for your comment. We recognise that some people use the term 'chest feeding', however, in the guideline we only use the term breastfeeding throughout. This is in line with the current NICE style. NICE is constantly researching and redeveloping its style guide to take into account developments in language from various sources, including stakeholder feedback. Your comment will be forwarded to the team reviewing and updating the NICE style guide.<br>Induced lactation was not something that was within the remit of the guideline's evidence reviews and it would likely require an evidence review to appropriately address issues around this so no recommendations have been made related to it. |
| AIMS | Guideline | 014 - 015 | General | as above this should say "offer to discuss if appropriate."<br><br>re physical activity - who is giving this advice? Reads as if CMW but not clear how practical this is - are midwives trained? Should the guideline summarise advice? | Thank you for your comment. Please see response to your earlier comment around 'discuss' versus 'offer to discuss'.<br><br>The recommendation is aimed at any healthcare professional who might discuss maternal health during pregnancy, you're right this might often be a midwife. We think they are sufficiently trained to give general advice about physical activity in pregnancy. A reference to helpful |

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| | | | | | infographics are included in the recommendation which summarise the guidance. |
| AIMS | Guideline | 005 | 017 | "ensure that information about the importance of folic acid supplementation…" should say "ensure that information about the benefits and risks of folic acid supplementation…" (It does have potential side effects Side effects of folic acid - NHS (www.nhs.uk), can cause allergic reactions and may be contraindicated in people with certain health conditions. There are also implications of mixing it with some other medicines or supplements.) | Thank you for your comment. The committee did not think this was necessary to highlight in the recommendations. In general, folic acid is very well tolerated and any potential side effects are usually mild and the benefits of taking it outweigh any risks, so it is an important public health message to talk about the importance of taking it if a person is planning pregnancy to prevent neural tube defects or other congenital malformations in the baby. However, the committee agreed it is important to provide information to people about interaction of folic acid with other medicines, hence they have now referred to NHS advice on taking folic acid with other medicines and herbal supplements in the guideline. |
| AIMS | Guideline | 006 | 007 | As above<br>"Invite discussion on the importance of…" | Thank you for your comment. We have made an editorial decision not to use the wording suggested. The expectation is that the discussions are always held sensitively and according to the individual's needs and circumstances. |
| AIMS | Guideline | 006 | 023 - 024 | should include the actual rates of neural tube defects and other congenital malformations for those who do and do not take folic acid. | Thank you for your comment. Information on the rates of neural tube defects and other congenital malformations was outside the scope of this guideline and therefore there was no evidence review conducted in this area. |
| AIMS | Guideline | 006 | 030 | should add "however there are some potential side effects that include...(list and say how | Thank you for your comment. |

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| | | | | common these are). Also add "That folic acid can also affect the way other medicines work or be affected by them, so you should check with your doctor if you are taking any of the following medicines (list) or taking any herbal remedies or vitamin or mineral supplements."<br>Not providing this information is potentially putting people at risk. | The committee did not think this was necessary to highlight in the recommendations. In general, folic acid is very well tolerated and any potential side effects are usually mild and the benefits of taking it outweigh any risks, so it is an important public health message to talk about the importance of taking it if a person is planning pregnancy to prevent neural tube defects or other congenital malformations in the baby. However, the committee agreed it is important to provide information to people about interaction of folic acid with other medicines, hence they have now referred to NHS advice on taking folic acid with other medicines and herbal supplements in the guideline. |
| AIMS | Guideline | 007 | 026 | Welcome less stigmatising review in line with evidence | Thank you for the comment. |
| AIMS | Guideline | 008 | 001 | Is this necessary? We don't recall previous guideline of higher preeclampsia risk indicating higher dose folic acid | Thank you for your comment. This was based on the evidence reviewed and the committee thought this was something that should be captured in the recommendations. |
| AIMS | Guideline | 008 | 009 - 010 | The wording "Provide encouragement…" is not supportive of autonomy. People have the right to decide not to take a recommended supplement and not to be harassed with "follow-up reminders" if this is the case. It would be more appropriate to say "offer targeted information, support and follow-up reminders." | Thank you for your comment. We have amended the recommendation based on your feedback. |

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| AIMS | Guideline | 008 | 011 | Request consent to send follow-up reminders… | Thank you for your comment, we did not think this needs to be explicitly stated. |
| AIMS | Guideline | 009 | General | Comments on Vitamin D - similarly should include a warning about taking excess vitamin D | Thank you for your comment. This recommendation has been reworded to include the importance of taking recommended dosages of vitamin supplements including vitamin D. |
| AIMS | Guideline | 010 | 017 | Suggest collaboration with other agencies representing Black and Brown service-user voices. However - This feels highly problematic. Nothing is fundamentally wrong with these bodies. Suggest change to reflect the UK setting/climate and consider more sensitive language.<br><br>(does the diabetes guideline consider BMI thresholds in different ethnicities?) - would like at least a mention https://doi.org/https://doi.org/10.1016/S2213-8587(21)00088-7<br>Global majorities are not helped by this guideline | Thank you for your comment. We agree the wording was insensitive. We have amended the wording of the recommendation based on your feedback and made it clearer why certain people are at an increased risk of vitamin D deficiency in the UK setting.<br><br>Regarding BMI thresholds for different ethnicities. The comment does not make it clear which diabetes guideline you are referring to but the NICE guideline on diabetes in pregnancy NG3 and the NICE guideline on Type 2 diabetes in adults NG28 refer to adjusting BMI thresholds based on ethnicity.<br><br>Thank you for the reference, which we have checked and is ineligible for inclusion as it is out of scope for this guideline. |
| AIMS | Guideline | 010 | 028 | Not all would consider a vegan or vegetarian diet to be "restricted"; its a healthy norm for many | Thank you for your comment. We understand not all would consider vegan diet restrictive (note, the recommendation does not mention vegetarian diet) but it's a term used for |

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| | | | | | diets which limits certain foods so we think it is appropriate. |
| AIMS | Guideline | 011 | 007 | Look at evidence for this - does it undermine BF? | Thank you for your comment. We're not entirely sure what you mean by this comment. If you mean that we should look at evidence on vitamin D supplementation for babies and how it might interact with breastfeeding, this was not within the scope of this guideline. The recommendations on vitamin D supplementation that the guideline is referring to are the current UK government guidance. |
| AIMS | Guideline | 011 | 025 | Page 37 seems to suggest that the evidence behind these recommendations is rather lacking. "advise parents and carers that babies and children "should" be given supplements… inappropriate catch-all and may undermine confidence where families are already providing nutritionally optimal diets. | Thank you for your comment. The recommendations are referring to existing UK government guidance on vitamin supplementation for pregnant and breastfeeding people and children under 5. The evidence the committee reviewed was about interventions to improve uptake of this existing government guidance and this evidence was limited, as the rationale section states. |
| AIMS | Guideline | 013 | General | Section 1.2.2 Healthy eating in pregnancy<br>Overall, the section reads well, however the reviewers felt that the tone is somewhat patronising at times. We recommend that (in recognition of the huge variation of health, opinions, education levels and personal priorities that are reflected, language such as "offer to discuss the following if appropriate" and "offer information on if desired" would be appropriate | Thank you for your comment. The expectation is that the discussions that healthcare professionals have with people are always tailored to the individual and take into account the individual's needs and circumstances; this is reflected in the recommendations. The depth and the detail of these discussions will vary depending on the individual and should always be sensitive to the individual's needs and preferences. The NICE guideline on patient experience in adult NHS services, which is referenced, goes into more detail about this. |

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| | | | | rather than a blanket direction to discuss this with anyone who is pregnant. | |
| AIMS | Guideline | 016 | 015 | risks associated with gaining weight - quantify "excessive" and specify what the risks are along with the scale of the "risk" | Thank you for your comment. The guideline refers to the IOM/NAM estimated total healthy weight changes in pregnancy according to pre-pregnancy BMI. Excessive gestational weight would be weight change beyond these estimated ranges.<br>The risks associated with excessive gestational weight gain very depending on the person's pre-pregnancy BMI, and details on this are reported in evidence review F.<br><br>Reporting on the scale of risk was not prioritised by the committee and therefore evidence on this was not reviewed. |
| AIMS | Guideline | 017 | 008 | Where a person declines to be weighed, respect their choice and avoid coercion | Thank you for your comment. We expect healthcare professionals to be respectful of a person's choice and not coerce. The recommendation says 'offer to measure' so it is the person's choice. |
| AIMS | Guideline | 017 | General | Explain how BMI calculation would affect the care offered to them (not the plan of care, as this assumes that the recommendation will be accepted by the pregnant person) | Thank you for your comment. We do not go into detail in this guideline about the potential aspects of care that might be affected based on BMI. Different risk assessments where BMI may play a role are covered in the NICE antenatal care guideline, for example risk assessment for venous thromboembolism or gestational diabetes. |

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| AIMS | Guideline | 018 | 010 - 013 | This is not clear about who it is that has the concern - the pregnant person or the midwife. If the latter, as routine weighing during pregnancy is not recommended, is this supposing that the midwife is making a judgement about weight gain based on the person's appearance? If so, any conversation needs very sensitive handling and a comment on that should be included. As above, the wording should be 'offer to discuss…" | Thank you for your comment. The recommendations on excessive weight gain and low weight gain have been clarified to state that these are in situations where the individual has monitored their weight or there has been weight monitoring due to a clinical reason. |
| AIMS | Guideline | 018 | 015 - 018 | It is not clear what is meant by "ensure routine monitoring of the baby…" Does this refer to ultrasound scans to monitor fetal growth, rather than just the normal offer of fundal height measurement? If so it should say "Give information on the actual risks if a baby is large-for-gestational age and offer to arrange regular ultrasound growth scans. Explain the accuracy of growth scans and the implications for the care they will be offered if the baby is suspected to be large-for-gestational age. Support the person's decision whether or not to accept growth scans." | Thank you for your comment. This refers to the routine symphysis fundal height measurements. According to the NICE guideline on antenatal care, if there are concerns that the symphysis fundal height is large for gestational age, an ultrasound scan for fetal growth and wellbeing should be considered. |

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| AIMS | Guideline | 019 | 003 | Section 1.2.15 Low weight gain - corresponding comments as above | Thank you for your comment. Please see our responses to your earlier comments. |
| AIMS | Guideline | 020 | General | AIMS recognises arguments in support of breastfeeding, However, we suggest the section should open with this something about supporting people's feeding choices, helping them to explore their options…then supporting continued bf if that is what they want. | Thank you for your comment. We have amended the recommendations in this section so that there is now one overarching recommendation at the beginning of the section to ask, in a sensitive and non-judgmental way, how baby's feeding is going, if there are any new or ongoing issues or questions, and to seek to address them. This would relate to breastfeeding, formula feeding, or both. The recommendations then refers to the specific sections on breastfeeding support and formula feeding support. |
| AIMS | Guideline | 021 | 006 - 007 | Recommends asking about feeding… but if problems are raised, then what? Signpost to where? | Thank you for your comment. We have amended the recommendations in this section so that there is now one overarching recommendation at the beginning of the section to ask how baby's feeding is going, if there are any new or ongoing issues or questions, and to seek to address them. Addressing them could also mean referring or signposting appropriately. |
| AIMS | Guideline | 031 | 031 | Parenting advice (reward charts etc) outside scope of guideline and does not respect other parenting philosophies. Suggest limit to "avoid food-based rewards". | Thank you for your comment. Evidence review O about interventions to promote healthy eating and drinking practices for children from 12 months to 5 years includes behavioural interventions, for example, role modelling or interventions using praise and rewards. So this is not outside the scope of this guideline. |
| AIMS | Guideline | 043 | 018 | AIMS recognises the argument that contact may be less frequent after this point, but concerned | Thank you for your comment. The cut-off of 8 weeks in the guideline is not implying there should be a change in infant |

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| | | | | that such an early age (8 weeks) may give the impression that 8 weeks is a recognised stopping point thus undermining normal-term breastfeeding. | feeding at that point but merely that there is another NICE guideline (postnatal care) that covers the time period up to 8 weeks after birth. We realise the cut-off of 8 weeks is arbitrary when it comes to infant feeding so we have ensured that there are cross-references between the guidelines so that they would be read in conjunction with each other. |
| Association of Clinical Psychologists (UK) | Guideline | 021 - 022 | 029 – 031 & 001 – 009 | 1.3.4 ACP-UK would like recognition of the challenges some people have with breastfeeding, and<br>acknowledgment that a variety of factors can make breastfeeding more difficult, including (but not limited to) birth trauma, premature birth, high needs babies, other young children, lack of a supportive partner, lack of time (for example if the mother needs to work). ACP-UK would also like to see a note that acknowledges what the experience might be like for parents who will experience a great deal of pressure from well-meaning clinicians telling them that, 'breast is best' without recognising where the parents are at emotionally, socially and/or psychologically. ACP-UK would also like to see some acknowledgement that considers other added complexities, for example, if the baby is poorly and requires expressed breast milk; is there | Thank you for your comment. We agree that there are various factors that can make breastfeeding challenging and this is what the guideline is trying to address. We have amended the recommendations so that there is now one overarching recommendation at the beginning of the section to ask how baby's feeding is going, if there are any new or ongoing issues or questions, and to seek to address them. Furthermore, the discussion points in recommendation 1.3.4 have been amended so that it now says to discuss "The person's experience of breastfeeding and its emotional impact, including feeding decisions and challenges."<br>The separate discussion point is about "The level of support available from partners, family and friends to continue breastfeeding."<br><br>The section on supporting continued breastfeeding when returning to work or study addresses some of these challenges you mention. |

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| | | | | access to pumps, cleaning equipment and spares, fridges and facilities to support this to happen? ACP-UK has first-hand experience with these issues and from extensive practice in this area and sees it as a huge problem.<br>• Associations between pressure to breastfeed and depressive, anxiety, obsessive-compulsive, and eating disorder symptoms among postpartum women<br>• Perceived pressure to breastfeed negatively impacts postpartum mental health outcomes over time | It should be noted that care for preterm and low birth weight babies was outside the scope of this guideline so any issues around breastfeeding for preterm babies have not been included in the guideline.<br><br>Regarding the comment about having access to pumps, cleaning equipment and spares, fridges and facilities when the baby is unwell and needs expressed milk. It is not clear if this is referring to the home setting and potential financial difficulties to access the equipment or a hospital setting not having these? If this relates to the individual's challenge to access this equipment, it should be noted that the committee have added a recommendation about healthcare professionals being aware that parents from a low income or disadvantaged background may need more support to continue breastfeeding, including signposting to government and local schemes for advice and support. |
| Association of Clinical Psychologists (UK) | Guideline | 023 - 024 | 005 – 008 & 009 – 031 & 001 – 010 | 1.3.8 and 1.3.9 ACP-UK does not feel these two statements go far enough to acknowledge the challenges of working/studying and breastfeeding. ACP-UK would like to see more acknowledgement that practically it can be very difficult to breastfeed at work/while studying even if the Equality Act says you have the right to do so and despite employers being in theory supportive. | Thank you for your comment. We recognise continuing breastfeeding after return to work or study can be very challenging, which is why this section was included in the scope of the guideline. We have amended the recommendation based on your feedback to include more about discussing any perceived challenges and possible solutions with the person. |

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| | | | | A work toilet, for instance, is neither safe nor hygienic. | |
| Association of Clinical Psychologists (UK) | Guideline | General | General | ACP-UK supports recognition of the fact that there is emphasis on being sensitive, culturally appropriate and recognising that socio-economic status can impact on food and eating. ACP-UK would like to see practical tools and resources for professionals to go alongside this recommendation, which can be hard to do in practice. For example, it is hard to be culturally appropriate with little or no knowledge of what people in a particular culture eat. Some guidance on how to have those conversations, as well as ideas for non-westernised foods that are suitable would be helpful. | Thank you for your comment. The committee wanted to highlight the importance of culturally adapted information, and they agreed that training healthcare providers on awareness of diversity in diet amongst different ethnic communities is beneficial. The committee agreed that these areas may need support and investment, such as covering training costs, to implement these recommendations. Implementation of the recommendations will be determined locally. Your comments will also be considered by NICE where relevant support activity is being planned. |
| Association of Clinical Psychologists (UK) | Guideline | General | General | ACP-UK points out that the guideline is very focused on how breastfeeding is the best option and not very focused on the psychological impact of strongly recommending this for both parents and children. ACP-UK understands and acknowledges that breastfeeding is better nutritionally, but there is an undeniable impact on parents who are made to feel like failures for being unable to breastfeed for whatever reason. | Thank you for your comment. The committee agree psychological impact is important to consider, and therefore they agreed to amend the recommendations to state that discussions should include considerations of any practical issues with breastfeeding as well as its emotional impact, including feeding decisions and challenges that may affect the experience and motivation to breastfeed. |

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| Association of Clinical Psychologists (UK) | Guideline | 006 | 025 | 1.1.3 ACP-UK would like an additional bullet inserted to specifically note the importance of folic acid on cognitive development. Folic acid is not just important to prevent neural tube defects; it actively improves cognitive development in children<br>• Prenatal Folate and Choline Levels and Brain and Cognitive Development in Children: A Critical Narrative Review - PMC (nih.gov) | Thank you for your comment. The evidence for the impact of folic acid on cognitive development was not reviewed within the guideline and so recommendations cannot be made on this topic. |
| Association of Clinical Psychologists (UK) | Guideline | 009 | 010 | 1.1.8 ACP-UK would like to see the italicised text (or something similar) added to the sentence starting, 'Provide encouragement for anyone who is not taking the recommended folic acid supplement*, including taking the time to find out any reasons or concerns,* and then by giving targeted information ... | Thank you for your comment. We have amended the recommendation based on your feedback. |
| Association of Clinical Psychologists (UK) | Guideline | 013 | 018 | 1.2.3 ACP-UK would like a person's needs and circumstances taken into account including assessment of their psychological state and their ability to understand and retain information about healthy eating. For example, mood issues can make it challenging for people to cook for themselves. | Thank you for your comment. We think this is covered in the recommendation by taking into account the person's needs and circumstances, but we have clarified this further by adding that this should include any difficulties with eating or communication. |

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| Association of Clinical Psychologists (UK) | Guideline | 018 | 011 | 1.2.14 Under bullet point 1, ACP-UK would like the sentence expanded to, 'ask for further details *and explore concerns and barriers*, and discuss healthy eating ...' | Thank you for your comment. We have amended the recommendation based on your and other stakeholders' feedback so the potential reasons are explored. |
| Association of Clinical Psychologists (UK) | Guideline | 019 | 012 | 1.2.15 ACP-UK would like an additional bullet point added, 'Consider referral to eating disorders services for people where their eating is a concern.' | Thank you for your comment. The committee thought that considering and asking about the person's psychological and physical wellbeing in general is important as there may be many underlying reasons for low or excessive weight gain. The committee thought concerns about eating disorders would be captured by this. |
| Association of Clinical Psychologists (UK) | Guideline | 021 | 013 | 1.3.2 ACP-UK suggests that the sentence starting 'Psychological factors such as the emotional impact of, and motivation to continue, breastfeeding' should be expanded to include, 'and validate the person's feelings around, and concerns about, breastfeeding.' | Thank you for your comment. The committee agreed to change the wording in this particular point based on stakeholder feedback, but they did not agree to use the wording suggested by you. The committee thought that while validating a person's experiences is important, it is also important that the healthcare professional can address and clarify potential misconceptions or misunderstandings that some concerns around breastfeeding may be. |
| Association of Clinical Psychologists (UK) | Guideline | 021 | 025 | 1.3.2 ACP-UK feel that the final bullet point doesn't take into account people with babies who have allergies or intolerances. ACP-UK would like to see this bullet re-worded to reflect this. | Thank you for your comment. This is likely most applicable to infants who develop allergy to cow's milk protein. The committee did not think this needs to be highlighted here as the prevalence of this is low in breastfed infants. We expect that clinicians are able to advise breastfeeding |

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| | | | | | parents accordingly in special circumstances such as this one. |
| Association of Clinical Psychologists (UK) | Guideline | 033 | 001 | Under recommendations for research, ACP-UK would like to see more consideration given to the impact of clinician pressure on success to breastfeed.<br>• Associations between pressure to breastfeed and depressive, anxiety, obsessive-compulsive, and eating disorder symptoms among postpartum women<br>• Perceived pressure to breastfeed negatively impacts postpartum mental health outcomes over time | Thank you for your comment. Research recommendations can only be made on topics that have been reviewed within the guideline. Clinician pressure on success to breastfeed was not specifically reviewed within the guideline, and therefore the committee are unable to make a research recommendation on this topic. |
| Better Breastfeeding | Guideline | General | General | In our comments on the draft scope in October 2021 we raised our concern that the new guideline would not include breastfeeding in the antenatal and postnatal periods (pregnancy through to 8 weeks postnatal). Not only would this mean that recommendations to commissioners would be fragmented, it also meant that important recommendations in the previous Maternal and Child Nutrition guideline that had not been taken up in the new Postnatal Care guidance would now | Thank you for your comment. Recommendations on breastfeeding in this guideline are for the time period from 8 weeks after birth and beyond. The NICE postnatal care guideline includes recommendations on breastfeeding for the antenatal period and up to 8 weeks postpartum. We appreciate that the cut-off of 8 weeks after birth is arbitrary, but we have ensured there are cross-references |

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| | | | | be lost entirely. This has unfortunately been proved to be the case.<br><br>In particular, the previous recommendation 11 on the old guideline included the advice to commissioners to provide proactive peer support, that is externally accredited, within 48 hours of transfer home. There are a large number of services across the country that were designed based on this recommendation – these include exemplary services where mothers' satisfaction with the service and breastfeeding rates are high. Those designing new services will not have the benefit of this recommendation and those services will not be as effective as a result of this and other omissions. | between the guidelines so that it's easy for people to follow both guidelines' recommendations on breastfeeding. Where services are already existing and well-functioning, not having a NICE guideline on it does not mean these services should cease to exist or would not be as effective. |
| Better Breastfeeding | Guideline | General | General | The new guideline no longer has the comprehensive scope of the previous version – it begins in pregnancy, where weight management of the mother is discussed but not planning for breastfeeding. It then skips to breastfeeding from 8 weeks onward. The guideline is now less effective and requires commissioners to read at least 3 separate documents – antenatal care, postnatal care, maternal and child nutrition. This will inevitably lead to poorly designed services. | Thank you for your comment. We will ensure appropriate cross-referencing between the guidelines so that they will not be read in isolation. |

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| Better Breastfeeding | Guideline | General | General | In our comments on the draft scope in October 2021 we also noted that the section on Healthy Start was omitted. This is unfortunate as while the document refers to Healthy Start vitamins and payments, it no longer highlights how those receiving the payments (and therefore on a low income and less likely to breastfeed, for example) should receive tailored advice and support to breastfeed. While recommendation 1.5.10 does refer to this in relation to nutrition for ages 1-5 years, the timeframe necessarily fails to include antenatal breastfeeding advice and breastfeeding support postnatally and during the first year. | Thank you for your comment. The committee has added a new recommendation which states that parents from a low income or disadvantaged background may need more support to continue breastfeeding. It also recommends signposting to government and local schemes that can offer advice and help to access healthy food and drinks (including Healthy Start) and income support schemes. |
| Better Breastfeeding | Guideline | 020 - 022 | General | The section on breastfeeding past 8 weeks is adequate. However, as explained above, it is entirely artificial and unhelpful to begin this section at 8 weeks. Most if not all the recommendations in this section should apply to the postnatal period (before 8 weeks) as well. | Thank you for your comment. We realise the cut-off of 8 weeks is arbitrary when it comes to infant feeding so we have ensured that there are cross-references between the guidelines so that they would be read in conjunction with each other. |
| Better Breastfeeding | Guideline | 030 - 032 | General | While the section on nutrition from 6 months to one year has a single reference to the continuing importance of breastmilk, the section on "Healthy eating and drinking for children from 1 up to 5 years" does not refer even once to the importance of breastfeeding past 1 year despite a huge amount of evidence of the continued benefit of | Thank you for your comment. We have now added this by mentioning breastmilk as a preferred drink alongside water and milk. |

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| | | | | breastfeeding to both mothers and babies, which is acknowledged in Section 1.3.2 (page 21, lines 3-4). | |
| British Dietetic Association | Guideline | General | General | The management of vitamin A deficiency is difficult during pregnancy. People who have very malabsorptive bariatric surgery procedures (e.g. duodenal switch, one anastomosis gastric bypass with long biliopancreatic limb, single anastomosis duodenal ileal bypass with sleeve gastrectomy) are at risk of developing deficiencies of fat-soluble vitamins A, E and K and require high doses of these vitamins. Given that during pregnancy, women are advised to avoid high sources of vitamin A and supplements containing retinol, there is a high risk of fat-soluble vitamin deficiencies. Although these surgical procedures are performed in low number in the UK, women may have these procedures outside of the UK. We are seeing an increasing number of women with pregnancy following these procedures. The lack of clear guidance about upper safe levels of vitamin A in supplements during pregnancy makes it challenging to treat vitamin A deficiency. We would welcome a review of evidence for vitamin A and pregnancy. | Thank you for your comment. Vitamin A during pregnancy was not reviewed in this guideline. The committee are unable to make a research recommendation on this topic as research recommendations can only be made on topics that have specifically been reviewed within the guideline. |

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| British Dietetic Association | Guideline | 018 - 019 | 010 - 012 | 1.2.14 & 1.2.15 excessive and low weight gain in pregnancy. The guidelines state that if there are concerns about excessive or low weight gain that steps should be followed – how would the excessive or low weight gain be identified by the health care team? Again this isn't clear in the current guideline. | Thank you for your comment. The recommendations on excessive weight gain and low weight gain have been clarified to state that these are in situations where the individual has monitored their weight or there has been weight monitoring due to a clinical reason. |
| British Dietetic Association | Guideline | 006 | 018 | 1.1.3 As Healthy start vitamins are much less expensive than other pregnancy vitamins, consideration should be given to making these more widely available for any pregnancy woman to purchase these in pharmacies and supermarkets perhaps labelled as 'NHS recommended'. | Thank you for your comment. This is not within the remit of NICE but we have amended the related recommendations to clarify that Healthy Start vitamins are low cost and can be purchased if a person is not eligible to get them for free. |
| British Dietetic Association | Guideline | 007 | 004 | Although Healthy Start vitamins are a good source of folic acid and other vitamins, eligibility for these vitamins as free supplements does not occur until women are at least 10 weeks pregnant which is towards the end of the time when folic acid would be most beneficial.<br><br>Women should be advised that they can purchase Healthy Start vitamins if they are not eligible to | Thank you for your comment. The recommendation has been amended to include how to obtain Healthy Start vitamins for free or at low cost, as suggested. |

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| | | | | have them free, these are a much less expensive option than other pregnancy vitamins. | |
| British Dietetic Association | Guideline | 007 | 012 | There is ambiguity in clinical practice about when high dose folic acid should be stopped. If there is no benefit to taking 5mg folic acid for those requiring it after 12 weeks of pregnancy, it should be stated that women should be advised to stop taking 5mg after 12 weeks of pregnancy or once a dating scan has confirmed that the woman is more than 12 weeks pregnant. | Thank you for your comment. The committee thought that there could be other benefits of taking folic acid throughout pregnancy, however, this was not reviewed. The committee agreed not to state when to stop taking it but the recommendations are clear when it should be taken. |
| British Dietetic Association | Guideline | 007 | 026 | Rec 1.1.5 We welcome the review of the evidence base and the recommendation that there is no need for anyone planning pregnancy with a BMI >25kg/m2 to take more than 400 micrograms of folic acid/day if they do not have other risk factors. | Thank you for the comment. |
| British Dietetic Association | Guideline | 008 | 005 | Rec 1.1.7 We welcome the recommendation that if a person has had bariatric surgery and is planning a pregnancy or is pregnant, they should contact their bariatric surgery unit. This may be a challenge in practice because if the person is more than two years post-surgery in the NHS, they will need a referral back. In addition, some will have had surgery in another country, and may not have access to aftercare. Many NHS bariatric | Thank you for your response. Your comment will be considered by NICE where relevant support activity is being planned. The discussion on resource use considerations in evidence review B has been modified to state that additional resources may be required. We have also added a sentence in the Rationale and Impact section of the guideline to acknowledge some change in practice resulting from the recommendation. |

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| | | | | centres are commissioned to give two years follow-up after bariatric surgery. They are not commissioned to give support to patients in the private sector or who have had surgery abroad. There needs to be recognition that this will increase the workload, especially of specialist dietitians, in bariatric surgery centres. Furthermore, it is not uncommon for women who have had bariatric surgery to present when already pregnant, having either not received advice prior to conception or having not followed it. The delay in obtaining advice from an NHS bariatric centre where someone has been discharged or had treatment abroad means that any existing vitamin or mineral deficiency may be left untreated resulting in potentially very poor pregnancy outcomes. Ideally preconception advice regarding basic supplementation of Multivitamin and Mineral supplements (including vitamin A content as below), and any supplementary Iron, Folic Acid, Calcium, Vitamin D, Folic Acid and Vitamin B12 to be started in advance of the referral to an NHS bariatric centre, would reduce some of these risks. This advice could be based on professional consensus if a full evidence base is not available. | |

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| British Dietetic Association | Guideline | 012 | 004 | Dietitians welcome the opportunity to discuss healthy eating in pregnancy and provide practical, tailored advice to individuals. However in practice, very few dietitians are employed in maternal health services and those that are mainly work with pregnant people who require nutrition support or advice for diabetes in pregnancy. We recommend that further investment is made to enable more dietitians to work in maternal health where they could support midwives and other clinical staff with education on diet and nutrition | Thank you for your comment. These recommendations are aimed at a range of healthcare professionals, and in some cases this may be dietitians, particularly in relation to diabetes in pregnancy, as you also state. The expectation is not that there would be a large expansion of need for dietitians based on the recommendations in this guideline. |
| British Dietetic Association | Guideline | 015 | 010 | 1.2.6 We're pleased to see the importance of sensitive communication being highlighted here. It can be a real concern for midwives around talking about weight with women during pregnancy and previously this has been identified as an area they'd value more training and support on. What provision will be given to ensure health care professionals feel confident to have these conversations sensitively? | Thank you for your comment. The committee thought it was an important thing to highlight. It should be noted that the recommendations have been amended based on consultation feedback and the emphasis of the discussions should be on healthy eating and physical activity, not weight as such.<br>The training of healthcare professionals is not within the remit of NICE. |
| British Dietetic Association | Guideline | 016 | 009 | In clinical practice many pregnant women report that they do not have scales and so they are unlikely to monitor weight changes. There is also much misunderstanding about metric and imperial weights, the latter are more usually used in discussions as indeed they are in discussing the | Thank you for your comment. Please note the recommendations on this topic were changed based on stakeholder feedback and the focus now is much more on healthy eating and physical activity than weight. However, the committee acknowledge some individuals want to monitor their weight during pregnancy and they have |

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| | | | | weights of babies. We recommend that where materials are produced around the topic of weight change in pregnancy, that both imperial and metric measures are given. This should also apply to measures of height. By communicating using measures that are most usually understood, we are more likely to be able to support weight change in pregnancy. | included a recommendation on how to support this, including advice on where to access weighing scales in the community. |
| British Dietetic Association | Guideline | 016 | 015 | If discussions about the risks of excessive and inadequate weight gain are to be had, then this can only be given in the context of providing clear advice about expected weight gain.<br>There would seem to be no benefit in discussing the risks of excessive or inadequate weight gain if no attempt is made to monitor weight change during pregnancy. This would be equivalent to discussing the risks of high or low blood pressure without measuring blood pressure. If professionals are not monitoring weight change then presumably it could be assumed that weight change does not actually matter. Research by Newson et al., (2022) found that women thought that as midwives had not mentioned weight, then | Please note the recommendations on this topic were changed based on stakeholder feedback and the focus now is much more on healthy eating and physical activity than weight. Routine monitoring of weight throughout pregnancy is not recommended. If an individual wants to monitor their weight during pregnancy, the guideline has a recommendation about how to support this. In these instances, further information about the risks of excessive or low weight gain could be discussed.<br><br>Thank you for the reference, which we have checked and is ineligible for inclusion as it is out of scope for this guideline. |

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| | | | | it must not be a problem (https://doi.org/10.1111/hex.13514). | |
| British Dietetic Association | Guideline | 016 | 026 | Clarification regarding what constitutes a 'nutritionally balanced diet' may be needed for patients and for other health professionals (e.g. midwives). | Thank you for your comment. This level of detail was not included in the guideline. The guideline refers to government guidance on diet, including the Eatwell Guide. |
| British Dietetic Association | Guideline | 017 | 003 | Rather than offering to measure weight and height, we would recommend 'seeking consent' to measure height and weight. If women do not consent, this should be recorded and a visual measure of BMI should be recorded to identify women who may have low, normal or raised BMI. Other clinicians may be monitoring women remotely and would need to have some indication of BMI to make clinical judgements on care (for anaesthesia for example). | Thank you for your comment. We think the current wording is appropriate and have not changed it as suggested. We do not think a 'visual measure of BMI' is appropriate. |
| British Dietetic Association | Guideline | 017 | 009 | Would suggest that the measures are made and recorded without the need to give the information to the patient, unless they request to know. It would not normally be needed to give the results of blood pressure monitoring or urine testing and recording of height and weight can be made without the need for description which may reduce the sensitivity of the issue | Thank you for your comment. We think the wording in the recommendation is sufficient to ensure an individual has a choice not to hear the measurements, so we have not changed the wording of the recommendation. |

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| British Dietetic Association | Guideline | 017 | 012 | To reduce the likelihood of excessive or inadequate weight gain in pregnancy and the associated risk, there are good reasons why consent should be sought to monitor weight during pregnancy.This may not be needed or practical at every appointment for instance at home visits, but could be implemented when women attend hospital or clinic appointments where there are standardised scales, ideally at least once during each trimester. By recording weight in a graphical format, inadequate or excessive gain should be more easily identified and consent sought to discuss this with the mother.<br>It may be especially important to identify where women are losing weight or failing to gain weight as this may indicate problems that can be addressed such as financial or social issues, mental health issues and appropriate referrals can be made. | Thank you for your comment. The committee agreed there is no evidence to suggest that routine monitoring of weight throughout pregnancy is needed so this is not recommended. |
| British Dietetic Association | Guideline | 017 | 013 | We welcome the recommendation that women should be weighed regularly where there is clinical reason to do so such as hyperemesis gravidarum and gestational diabetes. It is vitally important to identify where women are unable to | Thank you for your comment. While routine weight monitoring is not recommended, the guideline recognises there may be clinical reasons where weight monitoring may be beneficial. |

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| | | | | meet their nutrition requirements and would benefit from tailored dietary advice and/or nutrition support.<br>When women are admitted to hospital during their pregnancy they should be weighed and have nutrition screening in line with NICE guideline CG32 and Quality Standard QS24. | It should be noted that pregnant people are not included within the scope of CG32. |
| British Dietetic Association | Guideline | 017 | 021 | 1.2.13 – We're pleased to see the guidance on estimated total weight change being highlighted. What feels unclear is how the midwife or heath care professional should use this information to support the women in their care. If a woman isn't being weighed routinely in pregnancy how will this be used to help support women? This could be clearer in the guidance. | Thank you for your comment. Based on stakeholder feedback the recommendations have been amended and clarified. The reference to the NAM/IOM estimated total weight change during pregnancy is given in the context of an individual choosing to monitor their weight during pregnancy. The guideline no longer recommends these are discussed with everyone. |
| British Dietetic Association | Guideline | 017 | 022 | In the absence of UK guidance we welcome the reference to the US IOM/NAM guidelines on weight gain in pregnancy and recommendation that these guidelines should be included in the document either at this point or as an appendix for reference.<br>It is not mentioned whether the NAM guidance for twin pregnancy should also be used as a reference.<br>The reference related only to where there is obesity and it is unclear if the other categories of | Thank you for your comment. Based on stakeholder feedback the recommendations have been amended and clarified. The reference to the NAM/IOM estimated total weight change during pregnancy is now given in the context of an individual choosing to monitor their weight during pregnancy. The guideline no longer recommends these are discussed with everyone.<br>We are aware of the estimated weight change ranges for twin pregnancies and this is mentioned in the rationale section. |

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| | | | | BMI in the NAM guidance should be used as reference | The IOM/NAM estimates relate to all pre-pregnancy BMI categories but the reason why obesity is mentioned in the link is due to the name of the report we're referring to. |
| British Dietetic Association | Guideline | 018 | 010 | Action on excessive weight gain could only be taken where there is monitoring of weight gain although there may be some contexts in which the mother describes this situation | Thank you for your comment. The recommendation on excessive weight gain has been clarified that this is in situations where the individual has monitored their weight or there has been weight monitoring due to a clinical reason. |
| British Dietetic Association | Guideline | 019 | 002 | We agree that there are many dietary patterns which may be appropriate in gestational diabetes and recommend that women have access to individualised advice from a dietitian to help them make appropriate choices to manage the condition and to help women to navigate the variety of information that they may come across.<br><br>Furthermore, there are no clear recommendations for patients who may have been following a calorie restricted diet in order to lose weight in advance of pregnancy. This is often advised in the context of accessing fertility treatment for women that have previously been living with overweight /obesity. Clear advice that women should be advised against further weight loss/dietary restriction once pregnant is needed. We should also be aware that some women | Thank you for your comment. The NICE guideline on diabetes in pregnancy, which this section refers to, includes a recommendation about referral to a dietitian for those with gestational diabetes.<br><br>The committee have now included a recommendation in the guideline that intentional weight loss during pregnancy is not recommended. |

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| | | | | experience a fear of weight gain during pregnancy and timely advice from a qualified dietitian would be appropriate in this case. | |
| British Dietetic Association | Guideline | 019 | 003 | Inadequate weight gain could only be identified by regular weight monitoring or possibly if this was reported by the mother. It would not be appropriate to rely solely on maternal reporting where some women are unable/unwilling to take responsibility for monitoring their weight and identify inadequate weight gain. | Thank you for your comment. The committee agreed there is no evidence to support routine weight monitoring during pregnancy so this is not recommended. The recommendations on excessive weight gain and low weight gain have been clarified to state that these are in situations where the individual has monitored their weight or there has been weight monitoring due to a clinical reason. |
| British Dietetic Association | Guideline | 019 | 012 | It is unclear why a test for gestational diabetes is recommended in the absence of other risk factors for gestational diabetes. There is no previous guideline which suggests that inadequate weight gain would be a risk factor for the development of gestational diabetes, although weight loss in conjunction with other symptoms such as glycosuria or ketonuria, could indicate the development of various forms of diabetes during pregnancy.<br>From the various studies cited, might it be possible that where inadequate weight gain correlates with gestational diabetes that this may be due to women restricting their diets with the | Thank you for your comment. Based on your and other stakeholder's feedback the committee revisited the evidence on this and agrees that the association between low weight gain in pregnancy and gestational diabetes could be due to interventions after diagnosis of gestational diabetes. Because of the uncertainty of causal link between low weight gain and gestational diabetes, they agreed to remove the consideration for testing for gestational diabetes from the recommendation. |

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| | | | | purpose of controlling blood sugar levels rather than being causative which may indicated that they have not received appropriate advice and/or medication. | |
| British Dietetic Association | Guideline | 019 | 017 | We welcome the recommendation that women who develop gestational diabetes should be given individualised dietary advice and recommend that this should be provided by a registered dietitian who will be able to provide advice which supports appropriate blood glucose levels, adequate weight gain and a diet which will provide an appropriate intake of nutrients during pregnancy based on the individuals preferred eating patterns. Dietary advice may need to be revised during the course of the pregnancy with gestational diabetes to take into account physiological changes which occur during pregnancy such as increased energy requirements in the last trimester of pregnancy. With the increase in incidence of gestational diabetes, more dietitians may be required to provide this care.<br><br>Although there is a lack of convincing evidence that a particular diet is better than another in | Thank you for your comment. The NICE guideline on diabetes in pregnancy, which this section refers to, includes a recommendation about referral to a dietitian for those with gestational diabetes.<br><br>The evidence review also considered neonatal outcomes (large for gestational age, neonatal hypoglycaemia, and neonatal mortality and morbidity) but the review did not identify a particular diet to be harmful. |

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| | | | | managing GDM, ketogenic /very low carbohydrate diets may be inappropriate due to risks to the fetus (and so should not be recommended). | |
| British Dietetic Association | Guideline | 020 | General | Breastfeeding rates in those who are living with obesity are lower and there are a thought to be a variety of reasons for this (Reduced breastfeeding rates among obese mothers: a review of contributing factors, clinical considerations and future directions \| International Breastfeeding Journal \| Full Text (biomedcentral.com). Given the additional barriers for people living with obesity, and the wider benefits of breastfeeding for preventing obesity in children we'd suggest this is highlighted in the guideline – highlighted as an area for the health care team to consider and identify if further support for the mother might be needed? | Thank you for your comment and providing this information. Association between obesity and breastfeeding rates is beyond the remit of this guideline, and therefore we are unable to make recommendations or research recommendations on this topic.<br><br>The reference provided has been reviewed, however it does not meet the protocol inclusion criteria for the breastfeeding reviews. |
| British Society of Paediatric Dentistry | Guideline | General | General | The British Society of Paediatric Dentistry (BSPD) welcomes publication of this guideline aimed at improving nutrition in pregnancy and childhood. Nutrition and diet during pregnancy, infancy and early childhood have considerable impact on the occurrence of Early Childhood | Thank you for your comment. |

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| | | | | Caries (ECC), a disease of sizeable medical, economic, and social impact in the UK. | |
| British Society of Paediatric Dentistry | Guideline | General | General | Recommendations for research:<br>There is some evidence relating folic acid deficiency to the occurrence of cleft lip and palate. Further work is required to clarify this relation.<br>There is growing evidence that low vitamin D status during pregnancy is related to increased occurrence of dental hypoplasia and dental caries in primary and permanent teeth of children. Further work is required to clarify these relationships. | Thank you for your comment.<br>The recommendations on folic acid refer to neural tube defects and other congenital malformations, this could be cleft lip and palate.<br>Folic acid deficiency and impact of low vitamin D levels during pregnancy were not reviewed in this guideline. The committee are unable to make a research recommendation on this topic as research recommendations can only be made on topics that have specifically been reviewed within the guideline. |
| British Society of Paediatric Dentistry | Guideline | 002 | General | BSPD fully support the inclusion of 'dentists and dental professionals' in the list of Healthcare Professionals. Pregnant women and young children are priority groups within the dental healthcare system and should receive advice and encouragement from dental professionals. Within BSPD's blueprint we state that every child should have a 'dental home'. | Thank you for the comment. |

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| British Society of Paediatric Dentistry | Guideline | 005 | 016 | Fluoride dietary supplements. In the past, there have been recommendations to provide fluoride dietary supplements to infants and children. BSPD would not support this, other than for specific categories of children recommended by a dental professional. Far better is the support for community water fluoridation. | Thank you for your comment. Fluoride dietary supplements to infants and children are beyond the scope of this guideline. |
| British Society of Paediatric Dentistry | Guideline | 006 | 018 | BSPD supports the intention to recommend folic acid fortification of white flour and supplementation, as there is some evidence that folic acid deficiency is related to the occurrence of cleft lip and palate. Such anomalies are well-known to paediatric dentists and orthodontists, and of considerable impact economically, socially, and on a child's quality of life. | Thank you for your comment. Folic acid fortification of white flour is beyond the scope of this guideline, but we are aware of a government decision about this and this is reflected in the recommendations. |
| British Society of Paediatric Dentistry | Guideline | 009 | 003 - 021 | BSPD supports the intention to recommend vitamin D supplementation during pregnancy and childhood, as there is good evidence that low vitamin D status in pregnancy, infancy and childhood is related to increased risk of dental hypoplasia (abnormal tooth development) and dental caries in primary and possibly permanent teeth. We support the intention to recommend free provision of Healthy Start vitamins, as a positive contribution to oral health. | Thank you for the comment. |

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| British Society of Paediatric Dentistry | Guideline | 012 | 001 | BSPD welcomes and supports the intention to advise healthy eating in pregnancy. It is well-known that mothers' diets influence the diets of their children, and that dietary intake in infancy and childhood strongly influences the occurrence of Early Childhood Caries. | Thank you for the comment. |
| British Society of Paediatric Dentistry | Guideline | 020 | General | Breast feeding and infant feeding. Overall, breast feeding is positively associated with good oral health in infancy and childhood, but there is moderate evidence that breast feeding after 12 months is associated with increased risk of Early Childhood Caries and this evidence is stronger if breast feeding continues after 24 months. BSPD recommends that mothers wishing to continue breast feeding after 12 months seek advice from health professionals regarding care of the child's teeth. | Thank you for your comment. Impact of breastfeeding on oral health was not reviewed in this guideline, and therefore we are unable to make specific recommendations on this topic. The guideline cross refers to the NICE guideline on oral health promotion for local authorities and partners where further guidance on oral health is provided. |
| British Society of Paediatric Dentistry | Guideline | 027 | 012 | Healthy eating behaviours in babies and children. It is important that dentists and dental professionals are encouraged to give advice on this topic which has considerable impact on child oral health – this is implied in the wording of the first sentence of this section. | Thank you for your comment. As stated, the recommendations in this section are for all healthcare professionals in all settings where NHS or local authority funded<br>care is provided. |
| British Society of | Guideline | 029 | 011 | BSPD supports this list of topics to discuss. We strongly recommend the early introduction (from 6 months) of a free-flowing or open-top cup, to | Thank you for your comment. The list includes in this section "Introducing cups and beakers alongside solid foods" and we have added to the section on healthy eating |

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| Paediatric Dentistry | | | | reduce the time that milk is in contact with the teeth, as per the Department of Health recommendations. | in children from 12 months to 5 years that drinks should be given in cups and bottles with teats should be avoided. |
| British Society of Paediatric Dentistry | Guideline | 031 | 017 | BSPD strongly supports this list of recommendations. Reducing intake of 'free sugars' (non-milk extrinsic sugars), both amount and frequency, is paramount in the prevention of dental caries. | Thank you for the comment. |
| British Society of Paediatric Dentistry | Guideline | 032 | 010 | BSPD strongly supports the recommendation for healthy eating and drinking to be prioritised in early years settings. | Thank you for your comment. |
| British Society of Paediatric Dentistry | Guideline | 035 | 012 | The habit persists in some communities for mothers to add sugar (sucrose) to a bottle of formula feed ("to make the baby strong"). BSPD strongly suggests that in these NICE guidelines a clear warning is added to caution against such activity. There is good evidence that adding sugars to formula milk is related to increased risk of dental caries, apart from increasing energy intake. BSPD would also recommend that infants and children should not be left with a bottle to suckle whilst asleep or to aid falling asleep. | Thank you for your comment. The recommendations in this guideline are not intending to go into the detail of what the safe and appropriate formula practices are but reference is made to other resources which give more detailed advice. |
| Danone UK & Ireland | Evidence review L | 015 - 016 | 048 – 049 & | **[This text was identified as confidential and has been removed].** | Thank you for your comment. The committee discussed the prevalence of combination feeding and the importance of being inclusive towards all infant feeding methods. The |

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| | | | 001 – 002 | | committee amended recommendations on baby's feeding to better acknowledge combination feeding and amended the recommendation on formula feeding so that healthcare professionals should give non-commercial, evidence-based, consistent advice about safe and appropriate formula feeding practices, as well as direct parents to additional non-commercial, evidence-based, consistent sources and advice. |
| Danone UK & Ireland | Evidence review L | 015 | 035 - 038 | **[This text was identified as confidential and has been removed].** | Thank you for your comment. Evidence from 1 study reported parents receiving advice from healthcare professionals, whilst the other evidence contributing to this finding reported on advice from reputable bodies and from helplines. Based on this, the committee based the strength of their recommendation on the amount of evidence, whilst also using their clinical knowledge and experience. The recommendations have been amended to highlight the importance of discussing information in a sensitive, non-judgemental manner. |
| Danone UK & Ireland | Evidence review L | 018 | 021 - 024 | We would ask NICE whether there is scope to reconvene and revisit the recommendations made in the draft guideline in light of the publication of 2023 Infant Feeding Survey, or if they have plans to build this into their updates to the draft guideline at a later date. | Thank you for your comment. Unfortunately the Infant Feeding Survey did not publish in time for this guideline. The development period for the guideline has concluded but we will pass this comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. |
| Danone UK & Ireland | Evidence review L | 018 | 040 - 041 | This finding is concerning, and we would ask that NICE take steps to address this within the | Thank you for your comment. The recommendations on breastfeeding and formula feeding have been amended so |

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| | | | | guidelines. This could include emphasising the need for HCPs to provide non-judgemental, unbiased, and balanced support regardless of parents' choice or decision to formula or combination feed. | that there is now one overarching recommendation at the beginning of the section to ask, in a sensitive and non-judgmental way, how baby's feeding is going, if there are any new or ongoing issues or questions, and to seek to address them. This would relate to breastfeeding, formula feeding, or both. The recommendations also say to give non-commercial, evidence-based, consistent advice about safe and appropriate formula feeding practices, as well as direct parents to additional non-commercial, evidence-based, consistent sources and advice about formula feeding. |
| Danone UK & Ireland | Evidence review L | 019 | 007 - 012 | We welcome recognition by the committee that commissioners and service providers must ensure HCPs are equipped to provide adequate information on formula feeding, and would encourage NICE to explicitly include these sources of information within the guidance to allow for this, including guidance from the Royal College of Nursing, as referred to separately in our response. | Thank you for your comment. We hope that our recommendation for commissioners and service providers about ensuring that healthcare professionals provide independent and non-commercial, evidence-based, consistent advice on safe and appropriate formula feeding will help to improve healthcare professionals' knowledge and confidence in providing parents with independent and non-commercial, evidence-based, consistent advice on safe and appropriate formula feeding. Different sources have already been included in the recommendations. |
| Danone UK & Ireland | Guideline | General | General | Danone recognises the importance of breastfeeding to offer babies the best nutritional start to life and supports evidence-based advice that promotes breastfeeding for parents in the UK. However, breastfeeding exclusively is not an | Thank you, we have received your comments and responded to them. |

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| | | | | option for some families – it is either not possible, not suitable, or they choose not to. Whatever the reason for not breastfeeding exclusively, parents or carers should be able to access support and guidance about healthy infant nutrition in a balanced and non-judgemental way. Through unpublished research commissioned by Danone, which we will reference throughout our response, we know that parents' experiences vary greatly between different feeding methods and that it's important for parents to receive more information on all feeding types to allow them to make an informed choice. However, we also found that healthcare professionals (HCPs) feel they are more able to advise parents on breastfeeding than formula feeding. Barriers HCPs mentioned include a lack of information from trusted sources around infant formula, and current policies being too restrictive around what advice they can offer. It is important that all HCPs feel able to give the advice they would wish to, and can receive scientific and factual information on products from manufacturers. As such, Danone felt it is important to respond to NICE's draft consultation on maternal and child nutrition to ensure that a | |

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| | | | | holistic approach to advice on infant feeding is considered and implemented across the UK | |
| Danone UK & Ireland | Guideline | 021 - 022 | 029 – 031 & 001 – 009 | **Rec 1.3.4** - Danone strongly agree that conversations on infant nutrition should provide information to support informed decision making but are concerned that recommendation 1.3.4 does not include consideration of the whole spectrum of infant nutrition, including formula feeding. It is our belief that to enable parents and carers to make fully informed decisions that are tailored to their personal needs, they must be provided with independent and robust evidence on all potential options. The committee should consider making the guidelines clearer on what 'informed decision making' means in this context – and what role there is for the provision of guidance and support on all forms of infant nutrition. | Thank you for your comment. The guideline emphasises support for parents regardless of the feeding method. However, the guideline relies on current UK government advice which is that exclusive breastfeeding is recommended for the first 6 months and breastfeeding continued after introduction of solids. Informed decision making would mean understanding the benefits, harms and implications of their decision and healthcare professionals have an important role in supporting this. |
| Danone UK & Ireland | Guideline | 025 - 026 | 019 - 023 & 001 - 006 | **[This text was identified as confidential and has been removed].** | Thank you for your comment. We hope that our recommendation for commissioners and service providers about ensuring that healthcare professionals provide independent and non-commercial, evidence-based, consistent advice on safe and appropriate formula feeding will help to improve healthcare professionals' knowledge and confidence in providing parents with independent and |

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| | | | | | non-commercial, evidence-based, consistent advice on safe and appropriate formula feeding. |
| Danone UK & Ireland | Guideline | 021 | 001-026 | **Rec 1.3.2** - It is important that any conversation with parents on continuing or re-establishing exclusive breastfeeding are non-judgemental, respectful, and do not make parents feel pressured in any way. A study of UK mothers' experiences of breastfeeding support found that mothers often had feelings of pressure, guilt, and blame regarding their feeding experiences and reported varying levels of support from health professionals, family, and friends. As such, there should be greater consideration for the mental health impact of breastfeeding, and how support around breastfeeding can further influence this impact. To this end, recommendation 1.3.2 should build on its guidance to discuss 'psychological factors' around breastfeeding and should include Maternal and child nutrition Consultation on draft guideline – deadline for comments 5pm on 11/09/24 email: mandcnutrition@nice.org.uk Please return to: mandcnutrition@nice.org.uk guidance on proactively asking parents about mental health and breastfeeding to ensure any issues are addressed as early as possible. We also feel there should be recognition of the role | Thank you for your comment. The committee agreed to amend the recommendations in this section so that there is now one overarching recommendation at the beginning of the section to ask, in a sensitive and non-judgmental way, how baby's feeding is going, if there are any new or ongoing issues or questions, and to seek to address them. This would relate to breastfeeding, formula feeding, or both. The recommendation then refers to both sections on supporting breastfeeding and supporting formula feeding. Recommendations in both of these sections have been amended so that combination feeding is acknowledged. Furthermore, in the supporting continued breastfeeding section, one of the discussion points has been amended to say "the person's experience of breastfeeding and its emotional impact, including feeding decisions and challenges" to capture the potential challenges that a person might experience. Finally, this section also emphasises that discussions around breastfeeding should not feel rushed and information provided should be tailored to the person's needs, preferences, beliefs, culture and circumstances and be supportive, non-judgemental and respectful. |

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| | | | | that maternal choice has in motivating infant feeding decisions. This should be included in conversations around continuing or re-establishing exclusive breastfeeding and parents' choice should be respected to avoid a negative impact on mental health | |
| Danone UK & Ireland | Guideline | 022 | 010 - 014 | **[This text was identified as confidential and has been removed].** | Thank you for your comment. We think that the recommendations in the guideline address the points you're making. |
| Danone UK & Ireland | Guideline | 025 | 006-011 | **[This text was identified as confidential and has been removed].** | Thank you for your comment. The expectation is that healthcare professionals will offer support and advice on safe and appropriate formula feeding for those who need it. The recommendations have been amended and now say parents who formula feed should be offered non-commercial, evidence-based, consistent advice about safe and appropriate formula feeding practices, and they should be directed to additional sources and advice. |
| Danone UK & Ireland | Guideline | 025 | 012-018 | **Rec 1.3.13** - In our engagement with HCPs, it is clear that a good conversation around infant feeding must be parent-centred, balanced, and compassionate to a family's current situation, among other elements. We believe that in order to be able to have good conversations around infant feeding with parents, HCPs must first understand the family's current situation – including their | Thank you for your comment. Based on stakeholder feedback, we have now amended the recommendations on breastfeeding and formula feeding so that they are more reflective of the reality of parents feeding their babies. For example, there is now one overarching recommendation at the beginning of the section asking parents, in a sensitive and non-judgmental way, how baby's feeding is going, if there are any new or ongoing |

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| | | | | needs, challenges, and what matters most to them. Recommendation 1.3.13 should be reframed to account for this; it should be recommended that HCPs seek to understand the family's individual needs and wants before commencing conversations around infant feeding to find the best option for them, whether that be exclusive breastfeeding, formula, or combination feeding. Additionally for recommendation 1.3.13, the guidelines should be clearer on the importance of face-toface conversations about infant feeding, as well as what formats of information about formula feeding or combination feeding are the most helpful for parents. | issues or questions, as well as seeking to address them. This could be about breastfeeding, formula feeding, or both. The recommendations on formula feeding have also been amended and now say parents who formula feed should be offered non-commercial, evidence-based, consistent advice about safe and appropriate formula feeding practices, and they should be directed to additional sources and advice. |
| Danone UK & Ireland | Guideline | 028 | 012 - 017 | **Rec 1.5.3** - Danone welcomes NICE's flexible approach to introducing solid foods with the inclusion of 'around 6 months', acknowledging babies' development and their needs are unique to them. | Thank you for your comment. This is in line with UK government guidance. |
| Danone UK & Ireland | Guideline | 035 | 001 - 004 | **Research recommendation 5** - Given the lack of current data around this issue in the UK, Danone welcomes the research recommendation. We are keen to understand more about the scope of the review and would ask that NICE provide further information on this if possible. We are also concerned that the research question alone will | Thank you for your comment. Research recommendations are extracted and recorded on the NICE research recommendation database which is monitored by funders. When the research is completed, it will hopefully inform future updates of this guideline. NICE is unable to make any further comments on the research/review at this stage. |

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| | | | | not address the gaps identified in the evidence review – while a focus on poverty and food insecurity is undoubtedly important, the evidence review indicates that there is a need for additional research on the causes contributing to the lack of high-quality support on formula feeding being provided to all parents. The full findings of the evidence review should be reflected within the guidelines. | |
| Department of Health and Social Care | Guideline | 006 | 025 | We are not aware of evidence to support the specific 3-month timeframe for folic acid supplementation ahead of conception. If the specific 3-month timeframe is not evidence based, should this be noted and state that the recommendation is pragmatic advice based on committee consensus? | Thank you for your comment. NHS advice on folic acid and pregnancy states that "It's recommended you take folic acid as soon as you start trying for a baby (ideally for 3 months before) and during the first 12 weeks of pregnancy." and the committee agreed it is helpful to give some practical advice on when to start taking folic acid so they included it in the recommendation. (https://www.nhs.uk/medicines/folic-acid/pregnancy-breastfeeding-and-fertility-while-taking-folic-acid/) Although they realise it won't be possible to predict the timing of conception, it will give people a prompt to start taking folic acid months before starting to try for a baby. |
| Department of Health and Social Care | Guideline | 009 | 016 | Should a bullet be added to this section to cover risk of too high intakes of vitamins if multiple supplements are taken? I.e., not to take 'super' doses etc? See paragraphs 87 to 90 of the Committee on Toxicity Statement on the potential | Thank you for your comment. We have amended the wording in the recommendation to emphasise the importance of taking recommended dosages. |

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| | | | | effects of excess vitamin D intake during preconception, pregnancy and lactation | |
| Department of Health and Social Care | Guideline | 013 | 005 - 010 | Advise changing from 'healthy foods' to 'healthier foods'. Defining an individual food / drink as 'healthy' is difficult. We use the term 'healthier' as this is more realistic / less restrictive (i.e. reduced fat cheese is a healthier version, although it is still high in saturated fat, salt). We think it is too limiting to describe foods as simply healthy or not healthy. In terms of behaviour change, switching to healthier food would be seen as more attainable. | Thank you for your comment. The committee discussed this issue at length during the development of the guideline and again after your feedback. The decision is to keep 'healthy', this is because of a few reasons:<br>• Saying something is 'healthier' would require explaining what this is in relation to (healthier than what?). Otherwise this could create more confusion.<br>• Stating that people should be eating 'healthier' foods includes an assumption that people are not already eating healthily and this can be perceived as patronising.<br>• While we agree that healthy foods or healthy eating more generally is not easily achievable to many people, we think this is still the aim and we should not modify this important public health message.<br>The conclusion was that the wording in the recommendations is kept as it is, but we include in the recommendations the recognition that for some people healthy eating may be a longer-term goal. |
| Department of Health and Social Care | Guideline | 014 | 010 | Advise changing from 'healthy foods' to 'healthier foods'. Defining an individual food / drink as 'healthy' is difficult. We use the term 'healthier' as this is more realistic / less restrictive (i.e. reduced | Thank you for your comment. The committee discussed this issue at length during the development of the guideline |

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| | | | | fat cheese is a healthier version, although it is still high in saturated fat, salt). We think it is too limiting to describe foods as simply healthy or not healthy. In terms of behaviour change, switching to healthier food would be seen as more attainable. | and again after your feedback. The decision is to keep 'healthy', this is because of a few reasons:<br>• Saying something is 'healthier' would require explaining what this is in relation to (healthier than what?). Otherwise this could create more confusion.<br>• Stating that people should be eating 'healthier' foods includes an assumption that people are not already eating healthily and this can be perceived as patronising.<br>• While we agree that healthy foods or healthy eating more generally is not easily achievable to many people, we think this is still the aim and we should not modify this important public health message.<br>The conclusion was that the wording in the recommendations is kept as it is but we include in the recommendations the recognition that for some people healthy eating may be a longer term goal. |
| Department of Health and Social Care | Guideline | 016 | 003 | Add in: 'and between any future pregnancies' into 'the importance of maintaining or starting a healthy diet and physical activity during the pregnancy' | Thank you for your comment. The committee agree that it is important to have a healthy diet and undertake physical activity before pregnancy. However, we are unable to make recommendations in this area as healthy eating and physical activity before and after pregnancy is outside the remit of this guideline. |
| Department of Health | Guideline | 017 | 006 - 008 | Recommend adding a link to the RCPCH child BMI charts Body mass index (BMI) chart \| | Thank you for your comment. This has been added as suggested. |

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| and Social Care | | | | RCPCH. At present the line just states BMI percentile but not which one. For the UK it's the RCPCH charts. | |
| Department of Health and Social Care | Guideline | 027 | 016 | No other NICE guideline covers monitoring healthy growth in children so we recommend considering including it in maternal and child nutrition guideline to ensure the correct growth charts are used by HCP's working in the UK (note: this would align with Personal Child Health record (PCHR) aka 'red book').<br>Recommend text: Child growth should be monitored using UK WHO growth charts http://www.rcpch.ac.uk/growthcharts/ if there are concerns regarding height, under or over weight refer to NICE faltering growth guideline and/or NICE overweight and obesity for children >2 years' | Thank you for your comment. Monitoring healthy growth in children was not within the scope of this update. |
| Department of Health and Social Care | Guideline | 029 | 030 | Advise changing from 'healthy foods' to 'healthier foods'. Defining an individual food / drink as 'healthy' is difficult. We use the term 'healthier' as this is more realistic / less restrictive (i.e. reduced fat cheese is a healthier version, although it is still high in saturated fat, salt). We think it is too limiting to describe foods as simply healthy or not healthy. In terms of behaviour change, switching | Thank you for your comment. The committee discussed this issue at length during the development of the guideline and again after your feedback. The decision is to keep 'healthy'. Where this same comment was given in other sections of the guideline, we have provided a response with more reasoning. The committee felt that in the context of this particular recommendation being about introducing solid foods to babies, it would be particularly problematic |

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| | | | | to healthier food would be seen as more attainable. | and strange to assume that babies should be eating 'healthier' foods (compared to what?). |
| Department of Health and Social Care | Guideline | 031 | 013 - 019 | Advise changing from 'healthy foods' to 'healthier foods'. Defining an individual food / drink as 'healthy' is difficult. We use the term 'healthier' as this is more realistic / less restrictive (i.e. reduced fat cheese is a healthier version, although it is still high in saturated fat, salt). We think it is too limiting to describe foods as simply healthy or not healthy. In terms of behaviour change, switching to healthier food would be seen as more attainable. | Thank you for your comment. The committee discussed this issue at length during the development of the guideline and again after your feedback. The decision is to keep 'healthy'; this is because of a few reasons. Saying something is 'healthier' would require explaining what this is in relation to (healthier than what?). Otherwise this could create more confusion.<br>Stating that parents should be providing 'healthier' foods to their children includes an assumption that they are not already doing this and this can be perceived as patronising.<br>While we agree that healthy foods or healthy eating more generally is not easily achievable to many families, we think this is still the aim and we should not modify this important public health message.<br>The conclusion was that the wording in the recommendations is kept as it is, but we include in the recommendations the recognition that for some families healthy eating may be a longer-term goal. |
| Department of Health and Social Care | Guideline | 039 | 016 | Advise changing from 'healthy foods' to 'healthier foods'. Defining an individual food / drink as 'healthy' is difficult. We use the term 'healthier' as this is more realistic / less restrictive (i.e. reduced | Thank you for your comment. The committee discussed this issue at length during the development of the guideline |

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| | | | | fat cheese is a healthier version, although it is still high in saturated fat, salt). We think it is too limiting to describe foods as simply healthy or not healthy. In terms of behaviour change, switching to healthier food would be seen as more attainable. | and again after your feedback. The decision is to keep 'healthy', this is because of a few reasons:<br>• Saying something is 'healthier' would require explaining what this is in relation to (healthier than what?). Otherwise this could create more confusion.<br>• Stating that people should be eating 'healthier' foods includes an assumption that people are not already eating healthily and this can be perceived as patronising.<br>• While we agree that healthy foods or healthy eating more generally is not easily achievable to many people, we think this is still the aim and we should not modify this important public health message.<br>The conclusion was that the wording in the recommendations is kept as it is, but we include in the recommendations the recognition that for some people healthy eating may be a longer-term goal. |
| Department of Health and Social Care | Guideline | 048 | 015 - 017 | Advise changing from 'healthy foods' to 'healthier foods'. Defining an individual food / drink as 'healthy' is difficult. We use the term 'healthier' as this is more realistic / less restrictive (i.e. reduced fat cheese is a healthier version, although it is still high in saturated fat, salt). We think it is too limiting to describe foods as simply healthy or not healthy. In terms of behaviour change, switching | Thank you for your comment. The committee discussed this issue at length during the development of the guideline and again after your feedback. The decision is to keep 'healthy'. Where this same comment was given in other sections of the guideline, we have provided a response with more reasoning. The committee felt that in the context of this particular recommendation being about introducing solid foods to babies, it would be particularly problematic |

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| | | | | to healthier food would be seen as more attainable. | and strange to assume that babies should be eating 'healthier' foods (compared to what?). |
| Department of Health and Social Care | Guideline | 49 | 007 - 015 & 022 - 027 | Advise changing from 'healthy foods' to 'healthier foods'. Defining an individual food / drink as 'healthy' is difficult. We use the term 'healthier' as this is more realistic / less restrictive (i.e. reduced fat cheese is a healthier version, although it is still high in saturated fat, salt). We think it is too limiting to describe foods as simply healthy or not healthy. In terms of behaviour change, switching to healthier food would be seen as more attainable. | Thank you for your comment. The committee discussed this issue at length during the development of the guideline and again after your feedback. The decision is to keep 'healthy', this is because of a few reasons. Saying something is 'healthier' would require explaining what this is in relation to (healthier than what?). Otherwise this could create more confusion.<br>Stating that parents should be providing 'healthier' foods to their children includes an assumption that they are not already doing this and this can be perceived as patronising.<br>While we agree that healthy foods or healthy eating more generally is not easily achievable to many families, we think this is still the aim and we should not modify this important public health message.<br>The conclusion was that the wording in the recommendations is kept as it is, but we include in the recommendations the recognition that for some families healthy eating may be a longer-term goal. |

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| Elizabeth Bryan Multiple Births Centre | Evidence review H | 055 | 001-005 | We note this comment in Evidence Review H. *The committee agreed that the evidence from single pregnancies could be extrapolated to women with multiple pregnancies and hence agreed that all recommendations would apply to both women with single and multiple pregnancies.* This is clear for the reader regarding the committee's position on the evidence gaps for multiple pregnancy and inclusion within recommendations – however this is not consistent in other Evidence reviews where no mention is given to the absence of evidence for multiple pregnancy (even when explicit in search strategy) and then extrapolation of recommendations to multiple pregnancies (see comments 3 &7) | Thank you for your comment.<br><br>Multiple pregnancy was included in most of the evidence reviews, however very limited evidence was available for this population group.<br><br>For some topics (e.g. interventions for weight change in pregnancy and gestational diabetes), the committee agreed that the evidence for single pregnancy could be extrapolated to multiple pregnancy. In such instances, it has been clarified that the recommendations apply to both single and multiple pregnancies and a statement has been added in the committee discussion of evidence in the evidence review to that effect. For topics where the committee did not consider it appropriate to extrapolate evidence from single pregnancy to multiple pregnancy (e.g. breast-feeding interventions, weight change during pregnancy), no specific recommendations were made for multiple pregnancy, and this is explained in the committee discussion section of the evidence in the evidence review. Some review protocols did not consider single and multiple births separately (e.g. formula feeding and breastfeeding when returning to work or study); in such instances no specific recommendations were made for multiple births, |

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| | | | | | and this has been noted in the committee discussion of evidence section in the evidence review.<br><br>Where appropriate, this guideline now cross refers to the NICE guideline on Twin and triplet pregnancy, as this provides advice on diet, lifestyle and nutritional supplements for multiple pregnancies. |
| Elizabeth Bryan Multiple Births Centre | Evidence Reviews A - E | General | General | We note that multiple pregnancy was included in the searches within the evidence reviews regarding supplements, however it would appear little evidence was discovered. We appreciate that overall evidence was not strong, but the gaps that are also evident for multiple births are not specifically addressed in the summation of the findings of reviews A-E. Noting this would support benchmarking this absence of evidence and support interpretation of the recommendations in the guideline to this population. | Thank you for your comment.<br><br>Multiple pregnancy was included in the evidence reviews, however very limited, if any, evidence was available and the committee were not able to make specific recommendations for this group of people. Generally, the discussions around vitamin supplementations apply to everyone. They have now added a cross-reference to the NICE guideline on Twin and triplet pregnancy, as this provides advice on diet, lifestyle and nutritional supplements for multiple pregnancies. This guideline recommends that the same advice about diet, lifestyle and nutritional supplements is given as in routine antenatal care.<br><br>The committee made research recommendations on digital technologies to increase uptake of folic acid supplementation, high dose folic acid supplementation and vitamin D supplementation during pregnancy for people |

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| | | | | | with a BMI that is within the overweight or obesity weight categories; all of these research recommendations included both single and multiple pregnancy populations. |
| Elizabeth Bryan Multiple Births Centre | Evidence Reviews A - E | General | General | Note these are research recommendations in the NICE Twin and Triplet pregnancy guideline documents<br>**8. Nutritional supplements**<br>**Is dietary supplementation with vitamins or minerals, or dietary manipulation in terms of calorie intake, effective in twin and triplet pregnancies? [2011]**<br>**9. Diet and lifestyle advice**<br>**Is dietary advice specific to twin and triplet pregnancies effective in improving maternal and fetal health and wellbeing? [2011]**<br>There is no suggestion in the evidence reviews for this guideline update, where multiple pregnancies were included in the search, that these have been addressed. As such we ask the committee if they would consider any revised research recommendations regarding nutritional supplements in multiple pregnancies? | Thank you for your comment. Multiple pregnancies were included in the protocols and in the searches; however, no evidence was available for this population for most of the reviews. Hence, the committee did not make any specific recommendations for this group. This is detailed in the discussion of the evidence in the evidence reports.<br><br>This guideline now cross refers to the NICE guideline on Twin and triplet pregnancy, as this provides advice on diet, lifestyle and nutritional supplements for multiple pregnancies. This guideline recommends that the same advice about diet, lifestyle and nutritional supplements is given as in routine antenatal care.<br><br>The committee made research recommendations on digital technologies to increase uptake of folic acid supplementation, high dose folic acid supplementation and vitamin D supplementation during pregnancy for people with a BMI that is within the overweight or obesity weight categories; all of these research recommendations included both single and multiple pregnancy populations. |
| Elizabeth Bryan | Guideline | 005 | 002 | Section on vitamin supplementation: Please outline how this advice applies to multiple and | Thank you for your comment. All available evidence was in those with single pregnancies. There was no evidence for |

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| Multiple Births Centre | | | | singleton pregnancy to avoid any uncertainty over whether the advice or doses are different in multiple pregnancy. | women with multiple pregnancies, hence the committee did not make any specific recommendations for this group. This guideline now cross refers to the NICE guideline on Twin and triplet pregnancy, as this provides advice on diet, lifestyle and nutritional supplements for multiple pregnancies. |
| Elizabeth Bryan Multiple Births Centre | Guideline | 005 | 006 | Regarding: *The recommendations in this section should be read in conjunction with:* Please consider including a link to NICE Guideline NG137 Twin and Triplet Pregnancy (this is pertinent to the increased risk of anaemia recognised with the recommendation of an additional FBC at 20-24 weeks and possible need for early supplementation with iron or folic acid (1.2.2 – 1.2.4, NG137) which differs from the guidance in the antenatal care guidelines) | Thank you for your comment. The committee agree, and the guideline now cross refers to the NICE guideline on Twin and triplet pregnancy, as this provides advice on nutritional supplements for multiple pregnancies. |
| Elizabeth Bryan Multiple Births Centre | Guideline | 013 | 012 | In the section:<br>*'For example, reassure people that they do not need to 'eat for two' and that they do not need a special diet during pregnancy, but it is important to eat a variety of different foods every day to get the right balance of nutrients for them and their baby.'*<br>While we understand the nature of the myth the committee is aiming to dispel here the language leaves uncertainty about the inclusion of multiple | Thank you for your comment.<br><br>The committee agreed it is appropriate to leave this statement as 'eat for two', as it is referring to the mother and baby not multiple pregnancy.<br><br>There was no evidence that any particular diet would be beneficial during pregnancy so this is what the committee recommended. In the evidence review on interventions for helping to achieve healthy and appropriate weight change |

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| | | | | pregnancies. There are conflicting views on increased calorie intake in twin and triplet pregnancy and it would be helpful to have a view on this expressing the guideline and to what extent the evidence reviews might inform this recommendation. An additional comment to indicate if multiple pregnancies are included in the advice '*do not need a special diet during pregnancy,'* would be helpful. | during pregnancy, all available evidence was in those with single pregnancies. The committee agreed that the evidence from single pregnancies could be extrapolated to people with multiple pregnancies and hence agreed that all recommendations would apply to both women with single and multiple pregnancies.<br><br>The committee referred to the section on diet, lifestyle and nutritional supplements in the NICE guideline on Twin and triplet pregnancy, as this provides diet and lifestyle advice for multiple pregnancies. |
| Elizabeth Bryan Multiple Births Centre | Guideline | 020 | 007 | In the section on Breastfeeding and formula feeding, we feel it would be beneficial to acknowledge that twin and triplet parents may require additional support to breastfeed and specialist support with managing all infant feeding. N.B: The NICE Twin and Triplet pregnancy guideline suggests women be given advice on breastfeeding by specialist core team for multiple pregnancies (1.3.5) which could be referenced. | Thank you for your comment. Most of the evidence on breastfeeding interventions was in single births (only 2 studies included both single and multiple births), therefore the committee did not make any specific recommendations for multiple births.<br><br>The review protocol for the evidence review on formula feeding did not consider single and multiple births separately; therefore, the committee did not make specific recommendations for multiple births. |
| Elizabeth Bryan Multiple | Guideline | 027 | 014 | There is no mention of prematurity in this section, or any links to documents detailing complementary feeding guidance for preterm babies. The European Food Safety Agency | Thank you for your comment. Care of preterm babies is out of scope of this guideline. |

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| Births Centre | | | | position statement from 2019 states that complementary feeding in preterm babies could be considered (alongside signs of readiness) at 6 months corrected age. This is also the guidance given to parents and carers by the Bliss charity. It would be useful for some guidance or links to guidance to be included in this section. | |
| Elizabeth Bryan Multiple Births Centre | Guideline | 029 | 052 | In the points listed for health professionals consider including families with twins, triplets or more may require additional practical advice regarding introducing solids to twin or triplet siblings as indicated by the readiness of each individual child. (There is no mention of multiple birth families in Evidence review N and we would expect there may have been little multiple-specific content in the papers identified, it would be useful to know if the advice is considered transferable – See comment below) | Thank you for your comment.<br><br>The review protocol for Evidence review N (interventions to promote appropriate and timely introduction to solids (complementary feeding) for babies from 6 to 12 months) did not consider single and multiple births separately; therefore the committee did not make specific recommendations for multiple birth. This has been noted in the committee discussion of evidence section in the evidence review. |
| Elizabeth Bryan Multiple Births Centre | Guideline | 041 | 025 | We note the committee recognises there are different estimates for weight change in twin pregnancies and this is mentioned in the section on rationale for recommendations. However, in the guidance points 1.2.8-1.2.13 there is no mention of multiple pregnancy and point 1.2.13 is specific about singleton pregnancy. There are no | Thank you for your comment.<br><br>There was no evidence to support weighing everyone throughout pregnancy, therefore the committee agreed that this should only be offered when there is a clinical need. Based on stakeholder feedback, the committee revisited the recommendations related to weight in |

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| | | | | recommendations regarding weight gain in the Twin and Triplet pregnancy guideline leaving uncertainty for professionals about how to advise and discuss pregnancy weight gain in this population. Can the committee consider clarification in the guideline on this issue even if that is to further highlight the uncertainty and need for additional research. | pregnancy and concluded that the focus of discussions should be on healthy eating and physical activity, not weight, while recognising that some people might want to monitor their weight. The recommendations have been amended accordingly.<br><br>Quantitative evidence was unable to determine the optimal weight change during pregnancy, however, there are estimates of healthy total weight change in singleton pregnancy according to the pre-pregnancy BMI (separate estimates exist for twin pregnancies) that healthcare professionals can refer to (table 1 in the National Academy of Medicine's report on the current understanding of gestational weight gain among women with obesity and the need for future research). Similar estimates have been made for twin pregnancies but these are even less certain and the committee did not refer to them in the recommendation although these are acknowledged in the rationale section.<br>The topic of weight change in pregnancy was not prioritised for a research recommendation. |
| Feed | Guideline | General | General | The guideline positions infant feeding as a dichotomous concept when in reality, according to the most up to date infant feeding statistics in the UK, most women who breastfeed are actually combination feeding. Not recognising this has the | Thank you for your comment. Based on stakeholder feedback, the committee discussed the recommendations in the breastfeeding and formula feeding sections again. They acknowledged the importance of supporting parents in infant feeding regardless of the method. They amended |

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| | | | | potential to alienate women from having open and honest conversations with their healthcare providers on infant feeding. Combination feeding has increased breastfeeding rates in the lowest demographics in recent years, so if the aim is to increase breastfeeding outcomes then allowing a space to discuss combination feeding is vital.<br><br>Our Advocate group at Feed raised concerns around fully informing parents about all methods of infant feeding, not just those who request more information on alternative methods to exclusive breastfeeding.<br><br>*"When my daughter would not initially feed well when she was first born, the fact that the ward had formula that they gave me without judgement or question was so important in those early, vulnerable moments. My daughter breastfed really well, I think hugely because I knew I could feed her using formula if needed. It took the pressure of us both, resulting in a much better outcome overall. Everyone should have all the options laid open to them; in my case, my daughter having formula literally had the most* | the recommendations so that combination feeding is now acknowledged in both supporting continued breastfeeding and supporting safe and appropriate formula feeding sections. There is now one overarching recommendation at the beginning of the section to ask, in a sensitive and non-judgmental way, how baby's feeding is going, if there are any new or ongoing issues or questions, and to seek to address them. This would relate to breastfeeding, formula feeding, or both. The recommendations then refer to the specific sections on breastfeeding support and formula feeding support and each of these sections cross-refer to each other, recognising that both may be relevant. |

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| | | | | *positive impact on my breastfeeding journey."* Hannah, Feed Advocate.<br><br>*"I am particularly supportive of combination feeding and can't quite believe this [the current NICE guidelines for consultation] is the current state of guidelines!"* Bekka, Feed Advocate.<br><br>"*Focusing solely on breastfeeding or formula feeding doesn't reflect the reality of some mother's experiences. We must emphasize the need for open conversations about combined feeding"* Anonymous, Feed Advocate. | |
| Feed | Guideline | General | General | Whilst mention has been made to the cost-of-living crisis in relation to formula feeding, the guidance does not address the unique needs of breastfeeding mothers, nor the impact of food insecurity on breastfeeding. There is well established international evidence to show food insecurity directly impacts milk quality and quantity and research from Canada demonstrates food insecurity is a reason for early cessation of breastfeeding. Most of this is qualitative research but quantitative research has analysed the presence of micronutrient and fatty acid components of the maternal diet in breastmilk, | Thank you for your comment. The committee recognises the impact that poverty, cost-of living crisis and food insecurity can have on breastfeeding, although this was not something that came up in the qualitative evidence review about facilitators and barriers for continuing breastfeeding. They are also aware that breastfeeding rates are lowest in the most disadvantaged populations groups. They have added a recommendation about being aware that parents from a low income or disadvantaged background may need more support to continue breastfeeding, and healthcare professionals should also signpost to government and local schemes that can offer |

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| | | | | with one study showing the impact of the maternal diet on infant growth. There is a clear relationship between food insecurity and early breastfeeding cessation which requires specific attention in the guidelines.<br><br>• Frank L, Waddington M, Sim M, Rossiter M, Grant S, Williams PL. The cost and affordability of growing and feeding a baby in Nova Scotia. Can J Public Health. 2020 Aug;111(4):531-542. doi: 10.17269/s41997-020-00306-5. Epub 2020 Mar 11. PMID: 32162282; PMCID: PMC7438422.<br>• Carretero-Krug A, Montero-Bravo A, Morais-Moreno C, Puga AM, Samaniego-Vaesken ML, Partearroyo T, Varela-Moreiras G. Nutritional Status of Breastfeeding Mothers and Impact of Diet and Dietary Supplementation: A Narrative Review. Nutrients. 2024 Jan 19;16(2):301. doi: 10.3390/nu16020301. PMID: 38276540; PMCID: PMC10818638.<br>• Fledderjohann J, Vellakkal S, Stuckler D. Breastfeeding, pregnant, and non-breastfeeding nor pregnant women's food | advice and help to access healthy food and drinks and income support schemes.<br>The committee's expert view was that breastmilk quality is usually unaffected by food insecurity (except in extreme cases), however, they know that infant feeding practices, decisions and concerns can be influenced by it. However, when prioritising areas for research recommendations, this was not prioritised and instead, the influence of poverty and food insecurity on formula feeding practices was prioritised.<br><br>Thank you for the references, which we have checked against our review protocols and concluded that they are not relevant for inclusion as they are out of scope for this guideline. |

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| Feed | Guideline | General | General | This guideline points to healthy start as an answer for many of the issues around healthy eating and vitamins etc. However, the recent Faculty of Public Health briefing that examined the evidence around heathy start and the impact on child health outcomes made the following evidenced based recommendations to the government:<br>• Remove the variance of value and purchasing power of Healthy Start vouchers to provide consistency for parents by extending the £8.50 weekly value to eligible children until age five and increasing the value annually in line with inflation.<br>• Extend eligibility to all children living in households receiving Universal Credit to provide additional fruit and vegetable consumption for children most at risk of eating below the recommended 5-a-day minimum.<br>• Increase uptake by raising public awareness and ensuring the application process is accessible and straightforward; consider auto-enrolment or an opt-out process to increase uptake. | Thank you for your comment. Changing the Healthy Start scheme is not within the remit of NICE but the challenges with the scheme have been acknowledged in the relevant evidence reviews. We agree that the Healthy Start scheme alone is not enough to resolve food insecurity in families. The recommendations in the guideline try to recognise that healthy eating can be a challenge due to cost for some people. The recommendations advise signposting to various government or local schemes for support, including the Healthy Start scheme. In addition to this, the recommendations on healthy eating in pregnancy include discussion about "healthy food and drink options that are acceptable and available for the person", recognising that cost of some foods may make them unavailable to people. In the same section, the recommendations say that when discussing healthy eating in pregnancy, "take into account the person's needs and circumstances" and "consider additional support for young pregnant people and those from low income or disadvantaged backgrounds", and "take into account affordability and people's resources when giving advice about a healthy diet and cooking". The recommendations on introducing solids include "take into account the family's circumstances and living conditions" and discussion points include "the cost of healthy food and where to get support". In the healthy eating in children section, the recommendations include "take into account |

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| | | | | • Commission further research: particularly looking at the cost-effectiveness of a universal programme and increasing the monetary value.<br>• Ensure the programme is provided to all children seeking asylum in a simple and accessible way that does not impact asylum claims.<br><br>These recommendations were made as the Healthy Start Voucher Scheme is simply not enough to resolve food insecurity for families with young children.<br>Evidence from Canada suggests similar in the context of benefits and infant feeding; the value of benefits provided by the Canadian government is simply not enough to cover the costs of raising a family according to nutritional public health requirements.<br><br>• Frank L, Waddington M, Sim M, Rossiter M, Grant S, Williams PL. The cost and affordability of growing and feeding a baby in Nova Scotia. Can J Public Health. 2020 Aug;111(4):531-542. doi: 10.17269/s41997-020-00306-5. Epub | the family's circumstances, and sensitively tailor the discussion and advice around healthy eating and drinking to the child's and family's needs, circumstances, preferences and understanding. Give particular consideration to children from low income or disadvantaged backgrounds, for example, by providing additional support for their families" and recommended discussion points include "Concerns about the cost of healthy food and where to get support".<br><br>It is not within the remit of NICE guidelines to change national policies; these examples show that the guideline is trying to address the issues around food insecurity.<br><br>Thank you for the references, which we have checked against our review protocols. They are ineligible for inclusion as they are out of scope for this guideline. |

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| | | | | 2020 Mar 11. PMID: 32162282; PMCID: PMC7438422.<br><br>Our own research highlighted the high number of food insecure families who currently do not qualify for welfare benefits and for those who do, the benefits are not enough to cover outgoings.<br><br>"My partner earns £40 over the allowance we are no longer entitled to this [Healthy Start]. Yet we struggle month after month"<br><br>Nina, Essex, Food Insecure, Combi-Feeding<br><br>"I think all families should be entitled to benefits and things like healthy start vouchers regardless of income. Whilst on maternity leave my monthly income was more than halved. When being assessed to receive benefits we did not qualify for any, as myself and my husbands joint yearly incomes before my maternity pay was taken into account. They did not ask about our outgoings as | |

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| | | | | they said these did not matter but they definitely do"<br><br>Nancy, Perthshire, Food Insecure, Formula Feeding<br><br>"I find the healthy start vouchers are so low you cannot get a months supply of any baby milk with them. The amount received in healthy start vouchers needs to change to include enough for the whole month. They should increase it for the first year for milk only and then for cows milk and fruit and vegetables but do it on an average cost of the supermarket now as prices has increased dramatically."<br><br>Kristin, North Yorkshire, Food Insecure, Formula Feeding<br><br>"We don't qualify for any benefits so meeting all our outgoings is a struggle."<br><br>Rose, Hampshire, Food Insecure, Breastfeeding | |

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| | | | | Telling people to eat in a certain way sets them up to fail, stigmatising those who are unable to follow healthy eating recommendations and yet not providing enough money to ensure families can follow the guidelines adequately. This needs consideration if healthcare providers are directing families towards Healthy Start as an answer, but it is not enough. Healthcare providers need the skills to have conversations about income maximisation and a recognition that further support is likely needed for those who are just managing. | |
| Feed | Guideline | General | General | While it is potentially out of scope for guidelines on maternal and infant nutrition, it is not yet addressed in alternative guidelines for postpartum health. Therefore we suggest that breastfeeding grief is recognised in the guidance, and that it is possibly recommended that healthcare providers receive training on this topic. Understanding that when a mother does not meet her breastfeeding goals, for whatever reason, she is at increased risk of mental health sequalae, in particular breastfeeding grief. | Thank you for your comment. This was not directly covered in the evidence reviews for this guideline, however, we think this could be picked up in discussions around baby's feeding, which should be sensitive and non-judgemental. For example, a discussion point we recommend is "The person's experience of breastfeeding and its emotional impact, including feeding decisions and challenges" and potential emotional impact of stopping breastfeeding for whatever reason would be picked up by this. |

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| | | | | *"There is no mention of recognition of mental health issues in mothers brought on by the pressures around infant feeding or the impact of such breastfeeding pressure in general. Could we encourage a link for healthcare professionals to direct women to their local mental health services at all"* Sarah, Feed Advocate | |
| Feed | Guideline | General | General | The Feed Advocate group wished to highlight the need for skills and training of healthcare professionals in having conversation with pregnant women and new mums about weight. While the guidelines highlight the sensitive nature of some of these conversations, it does not directly address the shame and stigma some mothers feel about their weight in the antenatal and postpartum periods, particularly if they are considered overweight or obese. Professionals need to be considerate of this, use supportive language, and implement realistic goal setting to avoid shaming and disengagement. In addition, the rhetoric around postpartum weight loss, and the pressure a mum feels to "get her body back" needs to be acknowledged by healthcare professionals as equally damaging and harmful to mothers in the postpartum period. | Thank you for your comment. Please note that the recommendations related to weight in pregnancy have been changed based on stakeholder feedback and in the recommendations, there is now less focus on discussions around weight, instead the focus should be on healthy eating and physical activity. And as you say, the guideline already emphasises the need for these discussions around weight to be sensitive and avoiding stigma.<br><br>We agree that some further training for healthcare professionals might be beneficial, however, training of healthcare professionals is beyond the remit of NICE. We recognise the concerns you raise about the rhetoric around postpartum weight, but it should be noted that weight the postpartum period is outside the scope of this guideline. |

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| Feed | Guideline | General | General | The Feed Advocate group also wished to raise concerns around online infant feeding information. They feel the guidelines should give some direction for healthcare professionals with regards to the rise in dis- and mis- information found on the internet around infant feeding. Healthcare professionals represent reliable and conflict free sources of information. They should be able to have conversations with new parents about evidenced based practice, fact checking, sources etc, encouraging open conversations around new information and directing parents to reliable sources of information. | Thank you for your comment. We recognise the mis- and disinformation that is available. This is why the recommendations on breastfeeding say that information provided should be clear, evidence-based and consistent, and the recommendations on formula feeding include that commissioners and service providers should ensure that healthcare professionals provide independent and non-commercial, evidence-based, consistent advice on safe and appropriate formula feeding; and that parents are provided non-commercial, evidence-based, consistent advice about safe and appropriate formula feeding practices, and they are directed to additional non-commercial, evidence-based, consistent advice sources and advice. |
| Feed | Guideline | General | General | The Feed Advocate group also wished to raise the consideration of specific subgroups of women post-partum who are at increased risk of breastfeeding difficulties due to health conditions including traumatic births and blood loss during delivery. Some women may experience delayed or reduced milk supply due to factors around their own health and their pregnancy that healthcare professionals need to be aware of, as these women may require more support in establishing breastfeeding. Ensuring there is good communication and continuity of care for these | Thank you for your comment. We agree with you that there are people who may need more support in establishing breastfeeding. However, this is likely more relevant within the first 8 weeks after birth, which is covered in the NICE postnatal care guideline and not this guideline, which focuses on baby's feeding beyond the first 8 weeks after birth. Regardless, the recommendations in both guidelines make it clear that support should be tailored to the individual's needs and circumstances. |

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| | | | | women will help to ensure their complex needs are identified and adequately addressed.<br><br>*"I know that women with birth trauma are a specific group which may help for clarity in NICE guidelines. And birth trauma as you will know is sadly common and is known to affect supply" Sarah, Feed Advocate* | |
| Feed | Guideline | General | General | Feed has a patient and public Involvement group, Feed Advocates, which is made up of patients, members of the public and organisations who volunteer to provide input into Feed's work. This submission has been completed with input from the Advocate group to reflect the lived experiences of families today, and is referenced throughout the submission. Where quotes have been given, Advocates have consented for either their name to be made public with their quote, or else their quote made public with anonymous name.<br><br>*"Thank you for everything like this [consulting the Advocates on response to guidelines] you're doing. If we succeeded in getting guidelines like this amended it will improve the experiences of so many women." Rebekka, Feed Advocate.* | Thank you for your comments. |

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| Feed | Guideline | 010 | 004 - 005 | This section needs clarification. If an infant is having 500mls of formula a day, they do not require supplements. Only infants having less than 500mls of infant formula milk will require supplements. | Thank you for your comment. We have changed this recommendation by adding a table about vitamin supplements for children so hopefully this is clear now. |
| Feed | Guideline | 010 | 013 | NICE health topics on vitamin D state that pregnant women and breastfeeding women are at risk of vitamin D deficiency and require supplementation regardless of time of year. Clarity is required on vitamin D supplementation in the current guidance for specificity and accuracy<br><br>Vitamin D supplement use in specific populations: Vitamin D: supplement use in specific population groups (nice.org.uk)<br><br>Risk factors \| Background information \| Vitamin D deficiency in adults \| CKS \| NICE | Thank you for your comment. The recommendations refer to the most up-to-date UK government guidance on vitamin D supplementation during pregnancy. See NHS advice on vitamins, supplements and nutrition in pregnancy.<br><br>According to SACN vitamin D and health report from 2016 the reference nutrient intake (RNI) for pregnant and breastfeeding women and population groups at risk of vitamin D deficiency is the same as that for the UK general population. The majority of people will be able to meet requirements for vitamin D from exposure to sunlight between late March/early April to the end of September.<br><br>Population groups at risk of vitamin D deficiency are those:<br>• with dark skin<br>• with minimal sunshine exposure due to not spending time outdoors (for example, if they are housebound or living in care homes or other settings with limited outdoor access) |

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| | | | | | • who cover almost all their skin when outdoors<br>These groups are advised to consider taking a daily vitamin D supplement (10µg /400 IU per day) all year round.<br><br>NICE will review PH56 content to ensure it is up to date with current UK government advice. |
| Feed | Guideline | 011 | 022 - 025 | All pregnant and breastfeeding women are at risk of vitamin D deficiency. Vitamin D supplements are not required if the infant is consuming 500mls of formula a day. The wording in the current guidance does not make it clear that infants are also an at risk population.<br><br>Suggest: Commissioners and service providers should offer free vitamin D supplements for anyone who is pregnant or breastfeeding. Commissioners and service providers should offer free vitamin D supplements for children under 5, if they have an increased risk of vitamin D deficiency (see recommendation 1.1.12). [2024] | Thank you for your comment. This recommendation was based on cost-effectiveness evidence on pregnant and breastfeeding women and their children, that concluded that it was cost-effective to give free vitamin D supplementation to those who had medium to dark skin but it was unlikely to be cost-effective if their skin tone was light. In addition to considering skin tone, the current government advice on pregnant and breastfeeding people at an increased risk of vitamin D deficiency who need supplementation throughout the year also includes those with little or no exposure to sunlight. The current UK government advice is that all children under 5 should receive vitamin D supplementation (except infants who receive more than 500ml of formula milk per day), however, the evidence showed the intervention to be cost-effective only for those with darker skin. We have clarified the groups in the recommendation. |

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| Feed | Guideline | 016 | 022 - 024 | • There is evidence that malnutrition in pregnancy impacts post-delivery lactation in both under and overweight individuals when diet is not adequately nutritious. Healthcare professionals should be aware of this and it should be discussed pre-conception and antenatally with women. Pasha VC, Gerchow L, Lyndon A, Clark-Cutaia M, Wright F. Understanding Food Insecurity as a Determinant of Health in Pregnancy Within the United States: An Integrative Review. Health Equity. 2024 Mar 21;8(1):206-225. doi: 10.1089/heq.2023.0116. PMID: 38559844; PMCID: PMC10979674.<br>• Di Renzo GC, Tosto V. Food insecurity, food deserts, reproduction and pregnancy: we should alert from now. J Matern Fetal Neonatal Med. 2022 Dec;35(25):9119-9121. doi: 10.1080/14767058.2021.2016052. Epub 2021 Dec 17. PMID: 34918992.<br>• Andreae G, Scott S, Nguyen G, Bell Z, Mehmood H, Sermin-Reed L, Heslehurst | Thank you for your comment. Impact of malnutrition in pregnancy on lactation was not within the scope of this guideline. Very little qualitative evidence in breast feeding review reported on women's beliefs that nutrition impacted breastfeeding. Based on the limited evidence and their experience, the committee agreed that maintaining a healthy and balanced diet was important but did not think any special diet is needed during pregnancy, other than avoiding specific foods and drinks.<br><br>Thank for providing these references, which we have checked against our breastfeeding review protocols. The references provided assess the impact of food insecurity in pregnant women and therefore does not meet the review protocol inclusion criteria. |

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| | | | | N. Food insecurity among pregnant women living in high-income countries: a systematic review. Lancet. 2022 Nov;400 Suppl 1:S17. doi: 10.1016/S0140-6736(22)02227-9. Epub 2022 Nov 24. PMID: 36929959; PMCID: PMC9691051.<br>Nguyen G, Bell Z, Andreae G, Scott S, Sermin-Reed L, Lake AA, Heslehurst N. Food insecurity during pregnancy in high-income countries, and maternal weight and diet: A systematic review and meta-analysis. Obes Rev. 2024 Jul;25(7):e13753. doi: 10.1111/obr.13753. Epub 2024 May 1. PMID: 38693587. | |
| Feed | Guideline | 021 | 011 - 012 | The evidence for these statements is equivocal. We note the evidence supplied by NICE for this as a premise is: *"The committee also discussed, based on their expertise, how partial breastfeeding (that is supplementing with formula milk) compromises breast milk supply and may lead to stopping breastfeeding altogether and agreed that this should be discussed."*<br><br>There is an *association* between formula introduction and early cessation of breastfeeding, but the relationship is likely bidirectional and influenced by a number of factors. In addition, | Thank you for your comment. The committee agreed to amend the recommendations in this section so that combination feeding is better acknowledged. There is now one overarching recommendation at the beginning of the section to ask, in a sensitive and non-judgmental way, how baby's feeding is going, if there are any new or ongoing issues or questions, and to seek to address them. This would relate to breastfeeding, formula feeding, or both. The recommendation then refers to both sections on supporting breastfeeding and supporting formula feeding. Recommendations in both of these sections have been amended so that combination feeding is acknowledged, including how to maintain breast milk supply. |

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| | | | | many of the observational studies are cross sectional and confounded by factors such as maternal socioeconomic status, marital status, household income and education. Thus, while *"choosing to mix feed an infant is strongly associated with stopping breastfeeding, even in the absence of lactation problems"* (Michalopoulou et al, 2023), there is no evidence that *the supplementation itself* is the causative factor as opposed to an indicator.<br><br>Public Health Scotland's annual infant feeding statistics demonstrate that combination feeding supports breastfeeding, especially in lower SIDM groups, as exemplified by a 10% reduction in exclusive formula feeding and concurrent increase in breastfeeding recorded.<br><br>PHS: Infant feeding statistics - Financial year 2022 to 2023 - Infant feeding statistics - Publications - Public Health Scotland<br><br>This decrease in exclusive formula feeding is due to combination feeding, suggesting formula milk is playing a role in *protecting* breastfeeding for some women. This is particularly true for those in the | We have checked the references you provided against our review protocols. The first reference is ineligible for inclusion as it is out of scope for this guideline. The other two references are ineligible for inclusion because only articles published after 27th March 2018 (date when the search for evidence review Q in the postnatal care guideline was run) were included in evidence review K, and these two references were published in 2015. |

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| | | | | lowest social demographic groups, where combination feeding has increased the most. This is in keeping with randomised controlled trial data which demonstrates the introduction of formula has no impact on breastfeeding cessation (Flaherman et al 2023).<br><br>Norway is often heralded as the gold standard for breastfeeding, as it has a 98% initiation rate, and 80% are still breastfeeding at 6 months. However, of those 80%, only 9% are *exclusively* breastfeeding. Norway embraces the culture of mixed feeding which supports women to continue breastfeeding.<br><br>All of our Advocates raised concerns with this statement . They felt that cultural changes around equity of parenting, such as shared parenting leave, which have been adopted more rapidly in Scandinavian countries and are now being adopted in the UK, are not well reflected in UK guidance and policy. In contrast, UK policies, including the current guidance, remains traditional, putting much of the onus of feeding a child onto the mother. Our Advocate group feel | |

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| | | | | that the Scandinavian duel parenting models support formula feeding fathers, which in turn supports breastfeeding mothers. This has been reflected in qualitative research. This model has worked well in other countries and should be consider by NICE.<br><br>There is a risk here that the lived experience of most women in the UK today will be neglected, and a tool that helps extend breastfeeding duration is dismissed as damaging, due to the reliance on expert opinion above evidence.<br><br>• Flaherman VJ, Murungi J, Bale C, Dickinson S, Chen X, Namiiro F, Nankunda J, Pollack LM, Laleau V, Kim MO, Allison DB, Ginsburg AS, Braima de Sa A, Nankabirwa V. Breastfeeding and Once-Daily Small-Volume Formula Supplementation to Prevent Infant Growth Impairment. Pediatrics. 2024 Jan 1;153(1):e2023062228. doi: 10.1542/peds.2023-062228. PMID: 38062778.<br>• Norwegian Directorate for Health, University of Oslo & Norwegian Food | |

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| | | | | Safety Authority (2008) The Norwegian Infant Nutrition Survey Among Six Months Old Infants, 2006–2007. Oslo: Norwegian Directorate for Health, University of Oslo & Norwegian Food Safety Authority; available at http://www.helsedirektoratet.no/vp/multimedia/archive/00054/IS-1535_54649a.pdf<br>• Dietrich Leurer M, Misskey E. "Be positive as well as realistic": a qualitative description analysis of information gaps experienced by breastfeeding mothers. International breastfeeding journal. 2015 Dec;10:1-1.<br>Graffy J, Taylor J. What information, advice, and support do women want with breastfeeding? Birth. 2005 Sep;32(3):179-86. doi: 10.1111/j.0730-7659.2005.00367.x. PMID: 16128971. | |
| Feed | Guideline | 021 | 013 | In addition to recognition of the psychological burden of breastfeeding, we suggest including here the psychological burden of being unable to continue breastfeeding. This should also include encouraging healthcare professionals to be aware of local services and support groups for new mothers within their locality and make referrals if necessary. | Thank you for your comment. The committee agreed to amend the recommendation so that the point of discussion now says: "The person's experience of breastfeeding and its emotional impact, including feeding decisions and challenges", this may include discontinuing breastfeeding and the emotional impact that can have. |

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| | | | | | The recommendations also include signposting to local support groups, and providing additional support to supplement face-to-face support, so the expectation is that healthcare professionals would be aware of their local services to give this advice. |
| Feed | Guideline | 021 | 025 - 026 | Lactation is more physiologically demanding than pregnancy, requiring 300 extra calories a day for a healthy women, and 600 for malnourished women. In addition, there is evidence that the composition of maternal diet impacts breast milk composition, which may impact infant growth. Thus, while there is no requirement to follow a "special diet" whilst breastfeeding, a discussion with a qualified healthcare provider on following a healthy balanced diet while breastfeeding is required.<br><br>• Carretero-Krug A, Montero-Bravo A, Morais-Moreno C, Puga AM, Samaniego-Vaesken ML, Partearroyo T, Varela-Moreiras G. Nutritional Status of Breastfeeding Mothers and Impact of Diet and Dietary Supplementation: A Narrative Review. Nutrients. 2024 Jan 19;16(2):301. doi: 10.3390/nu16020301. PMID: 38276540; PMCID: PMC10818638. | Thank you for your comment. Very little qualitative evidence was identified that reported on women's beliefs that nutrition impacted breastfeeding. There was no quantitative data identified on this topic as this was not within the scope of the guideline. However, based on the committee's expert knowledge, they included in the recommendation that no specific diet (except for vitamin D supplementation) is needed while breastfeeding but highlighted that a healthy diet is always recommended.<br><br>Thank you for the references, which we have checked against our review protocols. They are ineligible for inclusion as they are mostly out of scope for this guideline. The last reference was published after the search date for the evidence review protocol and therefore cannot be included. This evidence will be flagged for surveillance for any future updates for this guideline. |

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| | | | | • Fledderjohann J, Vellakkal S, Stuckler D. Breastfeeding, pregnant, and non-breastfeeding nor pregnant women's food consumption: A matched within-household analysis in India. Sex Reprod Healthc. 2016 Mar;7:70-7. doi: 10.1016/j.srhc.2015.11.007. Epub 2015 Dec 8. PMID: 26826049; PMCID: PMC4744087.<br>• Di Maso M, Eussen SRBM, Bravi F, Moro GE, Agostoni C, Tonetto P, Quitadamo PA, Salvatori G, Profeti C, Kazmierska I, Vacca E, Decarli A, Stahl B, Bertino E, Ferraroni M. Dietary Intake of Breastfeeding Mothers in Developed Countries: A Systematic Review and Results of the MEDIDIET Study. J Nutr. 2021 Nov 2;151(11):3459-3482. doi: 10.1093/jn/nxab258. PMID: 34386823.<br>• Di Renzo GC, Tosto V. Food insecurity, food deserts, reproduction and pregnancy: we should alert from now. J Matern Fetal Neonatal Med. 2022 Dec;35(25):9119-9121. doi: 10.1080/14767058.2021.2016052. Epub 2021 Dec 17. PMID: 34918992. | |

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| | | | | • Karbasi, S. et al. (2022) 'The association of maternal dietary quality and the antioxidant-proxidant balance of human milk', International breastfeeding journal, 17(1)<br>• Keikha, M. et al. (2017) 'Macro- and Micronutrients of Human Milk Composition: Are They Related to Maternal Diet? A Comprehensive Systematic Review', Breastfeeding medicine, 12(9).<br><br>Our research awaiting publication demonstrates women who are from food insecure homes report concern over milk quality and quantity. (survey of families n=135 and professionals / professional organisations n=45).<br><br>Milk supply was specifically mentioned by 23% families responding to the survey, 14% of food secure responders and 32% of food insecure responders. | |

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| | | | | "Breastfeeding only works well if mother is eating enough food. I have to eat extra food to breastfeed."<br>Crystal, West Midlands, Food Secure, Combi-Feeding<br><br>"I intended on breastfeeding but was unable to sustain it."<br>Sasha, Cambridgeshire, Food Insecure, Formula Feeding<br><br>"Not eating properly makes having a good breast milk supply challenging."<br>Rose, Hampshire, Food Insecure, Breastfeeding<br><br>"I worry about if having too little/poor quality food will affect my milk supply."<br>Lindsay, Hampshire, Food Insecure, Breastfeeding<br><br>Professionals<br><br>"We have some mothers who are going without food for themselves due to food poverty, so that they can buy formula, especially mothers who are working and still struggling." | |

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| | | | | Florence, Specialist Health Visitor in Infant Feeding, Essex<br><br>"Most new parents in poverty do not have a nutritional diet due to cost sadly."<br>Sophie, CEO, Essex 1127398-1127380-121387825<br><br>"They all put their children first before feeding themselves." Alan, Food Bank Manager, London<br><br>Our professionals noted maternal diet and stress effects milk supply.<br><br>Impact on infants' breast fed<br><br>"Stress impacts on milk supply. Poor nutritional status impacts on milk supply."<br>Florence, Specialist Health Visitor in Infant Feeding, Essex<br><br>"I see more people now wanting to breastfeed to save money than a few years ago, but there is not the support to help them."<br>Beth, Infant Feeding Specialist, Surrey | |

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| | | | | "If a mother has insufficient nutrition for her health and wellbeing, this may influence her ability to breastfeed responsively and also if she's stressed and anxious then this could negatively impact her getting breastfeeding/lactation established and potentially on her ongoing breastmilk supply." Charlie, Infant Feeding Advisor, Clackmannanshire & Stirlingshire<br><br>Feed has been contacted numerous times by women with concerns that because they are not eating enough, their milk is not enough to sustain a healthy baby, given their own nutritional deficits. This is not a well-researched issue in developed countries, most data are from developing countries. There are some animal studies that demonstrates *"Food Restriction decreases milk production and can affect milk composition with decreased lactose and protein concentrations and increased fat concentration".*<br><br>• Leduc A, Souchet S, Gelé M, Le Provost F, Boutinaud M. Effect of feed restriction on dairy cow milk production: a review. Journal of Animal Science. 2021 Jul 1;99(7):skab130. | |

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| | | | | • Tallo-Parra O, Carbajal A, Monclús L, Manteca X, Lopez-Bejar M. Hair cortisol and progesterone detection in dairy cattle: interrelation with physiological status and milk production. Domestic animal endocrinology. 2018 Jul 1;64:1-8.<br>• Seymour DJ, Kim JJ, Doelman J, Cant JP. Feed restriction of lactating cows triggers acute downregulation of mammary mTOR signaling and chronic reduction of mammary epithelial mass. Journal of Dairy Science. 2024 Apr 4.<br><br>Human studies include:<br><br>• Di Renzo GC, Tosto V. Food insecurity, food deserts, reproduction and pregnancy: we should alert from now. J Matern Fetal Neonatal Med. 2022 Dec;35(25):9119-9121. doi: 10.1080/14767058.2021.2016052. Epub 2021 Dec 17. PMID: 34918992.<br>• Carretero-Krug A, Montero-Bravo A, Morais-Moreno C, Puga AM, Samaniego- | |

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| | | | | Vaesken ML, Partearroyo T, Varela-Moreiras G. Nutritional Status of Breastfeeding Mothers and Impact of Diet and Dietary Supplementation: A Narrative Review. Nutrients. 2024 Jan 19;16(2):301. doi: 10.3390/nu16020301. PMID: 38276540; PMCID: PMC10818638.<br>• Rocquelin G, Tapsoba S, Dop MC, Mbemba F, Traissac P, Martin-Prével Y. Lipid content and essential fatty acid (EFA) composition of mature Congolese breast milk are influenced by mothers' nutritional status: impact on infants' EFA supply. Eur J Clin Nutr. 1998 Mar;52(3):164-71. doi: 10.1038/sj.ejcn.1600529. PMID: 9537300.<br>• Ajeeb TT, Gonzalez E, Solomons NW, Vossenaar M, Koski KG. Human milk microbiome: associations with maternal diet and infant growth. Front Nutr. 2024 Mar 11;11:1341777. doi: | |

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| | | | | 10.3389/fnut.2024.1341777. PMID: 38529196; PMCID: PMC10962684.<br><br>We urge NICE to consider the evidence on maternal diet and breastmilk composition. It is biologically plausible that if a mother is not eating properly, her own health and the health of her infant will be at risk. Telling women "your milk is enough and all your baby needs" is inadequate approach to caring for women from food insecure homes and is likely driving early cessation of breastfeeding, regardless of whether the impact of food insecurity on milk quality and quantity is real or perceived. Having an honest discussion about the impact of diets on lactation, gives women the tools to plan and prioritise. Helping them find sources of affordable nutritious food might be the support they need to continue breastfeeding. Instead, the current guidance sets women up to fail by telling them to ignore their own judgement around milk quality and quantity without good evidence. | |
| Feed | Guideline | 021 | 027 | In addition to helping families support breastfeeding, if the mother wishes, we would like clarification to be offered on the term "as appropriate". Many women feel both pressure to | Thank you for your comment. 'As appropriate' was included in the recommendation because it was considered important to not assume that all breastfeeding mothers/parents want to involve their partners or family |

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| | | | | breastfeed and pressure to stop breastfeeding. This pressure comes from both healthcare workers and family. Our Advocate group has raised concern over this statement specifically in relation to mental health, where breastfeeding is negatively impacting mental health to the detriment of the mother infant dyad relationship. This is a time where infant needs are often prioritised over maternal needs and the negative consequences for both can be long lasting.<br><br>"I did find the lack of consideration of maternal mental health and the lack of consideration of those who have been unable to successfully breastfeed quite a gap in the guidance" Sarah, Feed Advocate. | members. We recognise the impact, both positive and negative, that partners and family members can have on the individual. |
| Feed | Guideline | 025 | General | There needs to be information and discussion with all parents on:<br>1. All first infant formula milks are nutritionally equivalent. The most expensive is as nutritionally good as the least expensive.<br>2. No additional supplements found in some formulas provide any measured benefit. If an ingredient has been found to benefit | Thank you for your comment. This section does not go into detail regarding the advice given, instead several links for further advice is provided. Some of these links include advice on types of infant formula.<br><br>The NICE guideline on postnatal care, which the guideline also links to, includes recommendations on formula feeding and recommends discussion about formula feeding with parents who are considering or who need to formula feed before (already in the antenatal period) and |

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| | | | | babies, by law it must be added to all first infant formula milks.<br>3. There is no harm in switching between brands.<br><br>This information needs to be shared with all families, as evidence demonstrates most infants will receive some formula at some point in the first 12 months. Equipping parents with this information before they make the first purchase is vital to ensure they are making fully informed decisions.<br><br>Our research has found there remains much misunderstanding from families and professionals around formula milk. Parents feel that in paying premium, their babies are getting the best.<br><br>For example, from our CONFIDENTIAL: UNPUBLISHED RESEARCH:<br><br>"Don't know what I would have done if I didn't have enough for Kendamil (as I believe it's the most nutritional formula milk) but even then it's been an added £100 on the food shop that we can't really afford on maternity leave." | after birth. The discussion points listed in these recommendations include, for example, that first infant formula is the only formula milk that babies need in the first year of life, unless there are specific medical needs. |

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| | | | | Anna, Cumbria, Food Insecure, Combi-Feeding<br><br>"I have found that the families I support who use formula will use the more expensive milks (that they can't afford) as they feel they are getting the best for their babies. It can be challenging to help them to understand that the cheaper formula brands are just as good"<br>Jo, Pregnancy Outreach Worker, East Lothian | |
| Feed | Guideline | 035 | 001 - 003 | There is very limited to no evidence on the impact of the cost-of-living crisis on breastfeeding in the UK context. We suggest this is added as another area of research need as there is plenty of international evidence to suggest that women living in food insecure homes initiate breastfeeding at similar rates as food secure women, but cease earlier due to concerns over supply, milk quality and stress. Furthermore, if women are offered money to buy extra food for themselves then they breastfeed for longer. This must be assessed in the UK context.<br><br>• Francis J, Mildon A, Tarasuk V, Frank L. Household food insecurity is negatively associated with achievement of prenatal | Thank you for your comment. The committee agreed that parents from low-income backgrounds may need additional support to continue breastfeeding. They included an additional recommendation in the guideline to address this and have signposted to local and government schemes that can offer advice and help to access healthy food and drinks in the recommendation.<br><br>As the committee have now made a recommendation, they did not make any research recommendations on this topic.<br><br>Thank you for the references, which we have checked against our review protocols. They are ineligible for inclusion as they are mostly out of scope for this guideline. The final reference was published after the search date for the evidence review protocol and therefore cannot be |

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| | | | | intentions to feed only breast milk in the first six months postpartum. Front Nutr. 2024 Jan 31;11:1287347. doi: 10.3389/fnut.2024.1287347. PMID: 38356859; PMCID: PMC10865492.<br>• Na M, Shamim AA, Mehra S, Labrique A, Ali H, Wu LS, Shaikh S, Klemm R, Christian P, West KP. Maternal nutritional status mediates the linkage between household food insecurity and mid-infancy size in rural Bangladesh. Br J Nutr. 2020 Jun 28;123(12):1415-1425. doi: 10.1017/S0007114520000707. Epub 2020 Feb 27. PMID: 32102702.<br>• Gross RS, Mendelsohn AL, Arana MM, Messito MJ. Food Insecurity During Pregnancy and Breastfeeding by Low-Income Hispanic Mothers. Pediatrics. 2019 Jun;143(6):e20184113. doi: 10.1542/peds.2018-4113. Epub 2019 May 14. PMID: 31088893; PMCID: PMC6564052. | included. This evidence will be flagged for surveillance for any future updates for this guideline. |

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| | | | | • Gross RS, Mendelsohn AL, Arana MM, Messito MJ. Food Insecurity During Pregnancy and Breastfeeding by Low-Income Hispanic Mothers. Pediatrics. 2019 Jun;143(6):e20184113. doi: 10.1542/peds.2018-4113. Epub 2019 May 14. PMID: 31088893; PMCID: PMC6564052.<br>• Frazier CM, Dharod J, Labban J, Raynor AN, Villasenor M, Hernandez M, Ramos-Castillo I. Breastfeeding: How is it related to food insecurity and other factors among low-income mothers? Healthcare Women Int. 2023 Mar;44(3):234-245. doi: 10.1080/07399332.2021.1929992. Epub 2021 Jul 19. PMID: 34280071; PMCID: PMC10719584<br>• Tuthill EL, Maltby AE, Odhiambo BC, Akama E, Dawson-Rose C, Cohen CR, Weiser SD. Financial and Food Insecurity are Primary Challenges to Breastfeeding for Women Living with HIV in Western Kenya: A Longitudinal Qualitative Investigation. AIDS Behav. 2023 | |

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| | | | | Oct;27(10):3258-3271. doi: 10.1007/s10461-023-04046-8. Epub 2023 Apr 12. PMID: 37043052; PMCID: PMC10577374.<br>• Yalçın SS, Erat Nergiz M, Yalçın S. Evaluation of breastfeeding and infant feeding attitudes among syrian refugees in Turkey: observations of Syrian healthcare workers. Int Breastfeed J. 2023 Aug 9;18(1):38. doi: 10.1186/s13006-023-00579-9. PMID: 37559070; PMCID: PMC10413606<br>• Tuthill EL, Maltby AE, Odhiambo BC, Hoffmann TJ, Nyaura M, Shikari R, Cohen CR, Weiser SD. "It has changed my life": unconditional cash transfers and personalized infant feeding support- a feasibility intervention trial among women living with HIV in western Kenya. Int Breastfeed J. 2023 Nov 27;18(1):64. doi: 10.1186/s13006-023-00600-1. PMID: 38012644; PMCID: PMC10680175<br><br>There is a general assumption in the literature that if mothers are concerned about their milk | |

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| | | | | supply, this is a perception and not a reality. There is little robust research comparing perceived milk supply and actual milk yield, and whilst there is an association to maternal self-efficacy, there is no data looking in the UK at maternal malnutrition and milk yield. As an association between food restriction and reduced milk production has been demonstrated in mammalian studies, it is plausible that a similar mechanism exists in the human. This is an area NICE should explore as healthcare professionals often dismiss concerns around milk insufficiency as 'perceived' leading to women feeling gaslit when they raise this as a concern. If the intention is to increase the number of women breastfeeding, then investigating their concerns over milk insufficiency is a logical next step.<br><br>Whelan C, O'Brien D, Hyde A. Mother's Emotional Experiences of Breastfeeding with Primary Low Milk Supply in the First Four Months Postpartum: An Interpretative Phenomenological Analysis. Breastfeeding Medicine. 2024 Mar 1;19(3):197-207. | |

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| Feed | Guideline | 046 | 017-022 | The NICE 2021 guideline Post Natal Care exacerbates the issue around the discussion of formula milk.<br>• Overview \| Postnatal care \| Guidance \| NICE<br><br>The guideline 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."<br><br>This approach relies on parents raising the subject of formula feeding with their healthcare professionals, who NICE themselves have identified that women feel judged by. Why would parents talk about a stigmatising subject with people who are encouraging them to exclusively breastfeed? The result is that parents seek information and advice elsewhere, including from infant formula companies and baby clubs. There is no provision within the current guidelines to discuss formula feeding with *all* parents, which, given most parents will use formula at some point, | Thank you for your comment on the NICE postnatal care guideline, which was not updated at this stage. If and when this guideline is updated in the future, we encourage you to take part in the stakeholder consultations. However, we hope that the maternal and child nutrition guideline has addressed some of the concerns you have raised. For example, the recommendations emphasise the need for sensitive and non-judgemental discussions on baby's feeding, asking about and discussing the baby's feeding at every health contact and supporting informed decision making and providing evidence-based, non-commercial, consistent advice and resources. |

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| | | | | feels like a risky oversight. This has been identified by the Competition and Markets Authority as an area that needs urgent action, given that formula companies are stepping into "educate" parents on their formula needs.<br><br>The CMA recently published an update on their INFANT FORMULA AND FOLLOW-ON FORMULA MARKET STUDY identifying significant concerns within the market. Of note they recognise:<br><br>• We also have concerns that parents and carers do not have the information they need to make well-informed purchasing decisions.<br>• These concerns are amplified given the vulnerable circumstances in which many decisions are made when parents and carers first choose infant formula, and in light of ongoing cost of living pressures. As well as a lack of switching by existing customers, those who are choosing an infant formula brand for the first time are generally not choosing cheaper options as prices have risen. | |

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| | | | | The way in which parents and carers behave in this market, understandably driven by a desire to do what is best for their baby, with price used by some as a proxy for quality. For many, the decision to formula feed is made in vulnerable circumstances, for clinical reasons, in healthcare settings after birth. Many parents and carers are, naturally, not focused on comparing products and prices when they need to make a decision to start buying formula, and once they have found a product that works well for their baby they are reluctant to switch. | |
| GP Infant Feeding Network | Guideline | General | General | Many thanks to the Guideline Committee for acting on our previous feedback (on the draft scope consultation) and expanding guidance on preconception folic acid and the nutritional needs of those breastfeeding. The amended Guideline title still appears to limit the maternal scope to pregnancy only and we would encourage the Committee to review this accordingly. | Thank you for your comment. We have made an editorial decision not to change the name of the guideline but it is made clear in the introductory text that this guideline partially applies to the preconception period as well. |
| GP Infant Feeding Network | Guideline | General | General | Good to see the Guideline update now uses the term 'introducing solid foods' instead of 'wean' and 'weaning'. Please continue to work with the NHS Website and Start for Life to update the | Thank you for your comment. Updating the NHS and Start for Life websites are not within the remit of NICE but we agree with you and hope other resources will also stop using 'weaning' in this context. |

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| | | | | language in their resources in the same way (page 27, lines 27 and 29). | |
| GP Infant Feeding Network | Guideline | General | General | As raised in our feedback on the draft scope we are disappointed by the absence of any comments within the 2024 update to preserve the vital messaging from PH11 Recommendation 15 on Prescribing. We continue to believe that use of the British National Formulary (BNF) alone is inadequate as a source of information for prescribing in pregnancy and lactation. Excluding reference to the supplementary sources of prescribing information currently included in PH11 will impact on Doctors' awareness of the prescribing options for those pregnant and breastfeeding. This risks Doctors inappropriately avoiding prescribing or giving inappropriate advice to cease breastfeeding earlier than intended (with impacts on individual health, informed choice and Public Health).<br><br>We would encourage the Guideline Committee to add a line to acknowledge this issue in the Guideline update- as a minimum this could be linking to NICE NG194 (Section 1.5.6). Please consider adding links to: | Thank you for your comment. The committee agree that using medicines can sometimes be, or may be perceived to be, a contraindication for breastfeeding, so the committee included a recommendation about clinicians using appropriate sources for safe medicine use and prescribing during breastfeeding so that breastfeeding can continue despite the need to take medicines, with a link to UKDILAS resources. Bumps was not considered to be relevant as it is about medicines during pregnancy.<br><br>The committee are aware that The Breastfeeding Network's Drugs in Breastmilk Service is often used in practice for advice on safe use of medicines during breastfeeding and this is mentioned in the rationale section. |

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| | | | | • BUMPS: https://www.medicinesinpregnancy.org<br>• UK Teratology Information Service (UKTIS) http://www.uktis.org for pregnancy<br>• The NHS Specialist Pharmacy Service (UKDILAS): https://www.sps.nhs.uk/home/about-sps/get-in-touch/medicines-information-services-contact-details/breastfeeding-medicines-advice-service/#:~:text=ukdilas<br>• The Breastfeeding Network Drugs in Breastmilk Information Service https://www.breastfeedingnetwork.org.uk/detailed-information/drugs-in-breastmilk/ for lactation | |
| GP Infant Feeding Network | Guideline | General | General | Very positive to see the Guideline update continue to recommend the provision of independent, non-commercial, evidence-based consistent information on all topics. Staff will need training on this topic see: https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/international-code-marketing- | Thank you for your response. Your comments will be considered by NICE where relevant support activity is being planned. |

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| | | | | breastmilk-substitutes-resources/guide-to-working-within-the-code/ | |
| GP Infant Feeding Network | Guideline | General | General | As compared to PH11 the Recommendations in the 2024 update for health care professionals on Breastfeeding and Formula Feeding (Section 1.3) are not targeted at specific professional groups. In contrast PH11 Recommendations 7 to 15 are directed at different groups including Midwifery, Commissioners, Hospital Doctors and GPs. There is a risk that, using the 2024 Guidance, there is less clarity regarding 'professional ownership' of the Section 1.3 recommendations. We would be concerned that Doctors, including GPs, may not understand which are their responsibilities in this area as these are no longer as explicit. | Thank you. The committee have edited the text in consideration of stakeholder comments and added some examples of healthcare professionals and practitioners with skills and competencies in infant feeding for clarity. In general the committee did not want to specify the professionals in the recommendations because there can be local variation in how services are delivered. |
| GP Infant Feeding Network | Guideline | General | General | We note that the current PH11 makes explicit reference to Training (Recommendation 1) and the role of Professional Bodies in competency setting and CPD. PH11 Recommendation 7 references the need for breastfeeding policy, staff training, supporting staff who themselves may be breastfeeding and the identification of a health professional lead for implementation of these | Thank you for your comment. Training of staff, configuration and delivery of services is outside the scope of this guideline and would need to be determined locally. |

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| | | | | practices. These points are absent from the 2024 update and weaken the Public Health impact.<br><br>While many Hospital and Community/Health Visiting Services are accredited by the Unicef Babyfriendly Initiative there are no specific BFI standards for General Practice/Primary Care and no requirements for the BFI Community standards to be upheld there. Without a Recommendation for training around maternal and infant nutrition the level of care provided by Doctors and Primary Care will be inconsistent. | |
| GP Infant Feeding Network | Guideline | 020 - 023 | General | We would like to highlight a gap in Section 1.3 as it does not currently include specific reference to the responsibilities of child-care settings to facilitate continued breastfeeding or breastmilk feeding and storage as the previous version PH11 Recommendation 20 did. Babies less than 6 months of age whose diet consists of milk only may also be placed in child-care settings and currently the 2024 Guideline does not address this. Reference is made to the role of Early Years settings in Section 1.5.13 but this only refers to babies over 1 year of age and not to milk feeding specifically. | Thank you for your comment. This was not something that came up in the qualitative evidence review M, however, it is an important issue and we have added a consideration about the childcare setting facilitating provision and storage of breastmilk to the recommendation about issues to discuss in the section on supporting continued breastfeeding after return to work or study. |

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| | | | | Could the Committee please consider this omission and add reference to the fact that, not only do employers/education providers of parents have a duty to provide space and storage for breastmilk expression but child-care providers will need to store this milk and offer it to babies. Their staff also need to be trained to safely prepare infant formula feeds and to bottle feed babies expressed breastmilk and/or infant formula. | |
| GP Infant Feeding Network | Guideline | 020 - 023 | General | There is no explicit reference to the management of breastfeeding problems beyond 8 weeks after birth or to maternal medical issues impacting on infant feeding in Section 1.3. The 2024 update has removed specific content from PH11 Recommendations 1, 7 and 15 which relate to doctors' training, skills and prescribing. While this may be out of the new scope for the 2024 update, we would ask the Guideline Committee to please consider adding a line to reference that doctors working with infants and those pregnant or breastfeeding should also be appropriately trained to manage medical issues relating to breastfeeding beyond 8 weeks after birth (this | Thank you for your comment. We have amended the recommendations in this section so that there is now a recommendation about asking how the baby's feeding is going and if there are any new or continuing issues or questions and seeking to address them, these could include medical issues affecting breastfeeding or other 'problems' with breastfeeding. We have also added a recommendation about safe prescribing and medicine use while breastfeeding so that continued breastfeeding can be facilitated. Finally, we have amended the beginning of the section to state that "Unless otherwise stated, these recommendations are for all healthcare professionals and practitioners with skills and competencies in babies' feeding, for example, midwives, health visitors, maternity |

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| | | | | could be linked to NICE NG194 Sections 1.5.6-1.5.15 for further detail). | support workers, GPs, paediatricians and breastfeeding peer supporters." |
| GP Infant Feeding Network | Guideline | 010 | 010-024 | We are concerned that the wording about Vitamin D supplements in this section (1.1.11) is not aligned with NICE NG56 and the Chief Medical Officers' Letter of 2012 (https://assets.publishing.service.gov.uk/media/5a7c59a3ed915d338141e3af/dh_132508.pdf).<br>The 2024 update section 1.1.11 currently states that 'anyone who is pregnant or breastfeeding' should take a Vitamin D supplement 'between September and March, or throughout the year if they are at increased risk of Vitamin D deficiency…' and goes on to list darker skin and little exposure to the sun as risk factors. This appears at odds with Recommendation 1 of NICE PH56 (https://www.nice.org.uk/guidance/ph56/chapter/Recommendations#recommendation-1-increase-access-to-vitamin-d-supplements) which also lists '*pregnant and breastfeeding women*' as a specific at-risk group for Vitamin D deficiency, as does the CMOs' letter of 2012.<br>As such the current wording of section 1.1.11 appears to suggest that some of those pregnant | Thank you for your comment. The recommendations refer to the most up-to-date UK government guidance on vitamin D supplementation during pregnancy. See NHS advice on vitamins, supplements and nutrition in pregnancy.<br><br>Content in NHS websites is not within the remit of NICE to amend. It is not clear from the comment what exactly is confusing in these websites. The NHS site on vitamin D states that "Children from the age of 1 year and adults need 10 micrograms (mcg) of vitamin D a day. This includes pregnant and breastfeeding women, and people at risk of vitamin D deficiency." This is referring to the reference nutrient intake (RNI) for vitamin D, not intake from supplements. Earlier it says "From about late March/early April to the end of September, the majority of people should be able to make all the vitamin D they need from sunlight on their skin."<br><br>According to SACN vitamin D and health report from 2016, the RNI for pregnant and breastfeeding women is the same as that for the UK general population and. And as noted above, the majority of people will be able to meet |

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| | | | | or breastfeeding would not need to take Vitamin D during April-August if they do not have one of the risk factors listed in the bullet points from lines 16-24.<br><br>We believe from our understanding of the CMO advice the wording should reflect that *all* those pregnant or breastfeeding should take daily Vitamin D *at all* times during the year, and this should either be via daily Healthy Start Vitamins or a daily Vitamin D supplement of 10 micrograms if not taking Healthy Start Vitamins. Please can the Guideline Committee as a priority review and edit the wording of this section for, which currently may risk a proportion of those pregnant or breastfeeding missing out on Vitamin D supplements.<br><br>Please also note the wording of the NHS Website page on Vitamin D which is referenced on page 10 line 20 (https://www.nhs.uk/conditions/vitamins-and-minerals/vitamin-d/) is currently also confusing with regards to the recommendations for pregnancy and breastfeeding and the separate page for pregnancy | their requirements for vitamin D from skin exposure to sunlight between late March/April to end of September.<br><br>Population groups at risk of vitamin D deficiency are those:<br>• with dark skin<br>• with minimal sunshine exposure due to not spending time outdoors (for example, if they are housebound or living in care homes or other settings with limited outdoor access)<br>• who cover almost all their skin when outdoors.<br>These groups are advised to consider taking a daily vitamin D supplement (10µg /400 IU per day) all year round.<br><br>NICE will review PH56 content to ensure it is up to date with current UK government advice. |

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| | | | | https://www.nhs.uk/pregnancy/keeping-well/vitamins-supplements-and-nutrition/ also advises taking Vitamin D between September and March when pregnant or breastfeeding. This guidance needs to be consistent and clearer. | |
| GP Infant Feeding Network | Guideline | 011 | 010 - 011 & 017 - 018 | We would be grateful if the Guideline Committee can amended/clarify the wording here so it is clear if babies from 6-12 months still need additional Vitamin A, and C supplements if they are already receiving more than 500ml of infant formula per day. | Thank you for your comment. We have amended this recommendation by producing a table which hopefully makes the guidance clearer. |
| GP Infant Feeding Network | Guideline | 021 | 001 - 003 | We would suggest that the wording in the this section be slightly changed to '…breastfeeding alongside solid foods up to 2 years or beyond' as per the WHO/UNICEF recommendation: https://www.who.int/news-room/fact-sheets/detail/infant-and-young-child-feeding#:~:text=WHO%20and%20UNICEF%20recommend%3A,years%20of%20age%20or%20beyond. | Thank you for your comment. The recommendations in this section have been amended based on stakeholder feedback and this particular point is now covered in the discussion points when discussing breastfeeding: "The importance of continuing breastfeeding alongside solid foods for the first year, and the value of continuing until around 2 years or beyond." |

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| GP Infant Feeding Network | Guideline | 026 | 018 - 020 | The recommendation to 'weigh healthy babies at 8, 12 and 16 weeks and 1 year at the time of routine immunisations' may be difficult to carry out in practice if there is no specific ownership of the responsibility to provide this. GP Practices, who commonly carry out infant immunisation are not funded to do this and often do not own digital scales suitable for infant weighing. This will require Commissioning as a specific service if a Health Visiting weight clinic is not already available locally and will have cost implications. | Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned. We note that the recommendation to weigh healthy babies at 8, 12 and 16 weeks and at 1 year is not new. It was included in the NICE PH11 guideline (recommendation 17), published in 2011, and has only been amended regarding its wording in this guideline update. Implementation of the recommendation should be a collective effort between GP practices and health visitors. |
| GP Infant Feeding Network | Guideline | 027 | 018 | In the 2024 update the weblink at this line goes to the Overview page of NICE NG30 (2015) rather than directly linking to the relevant oral health advice for children. Please consider also adding this link, which takes the reader directly to the Gov Summary guidance tables for dental teams (Table 1: Prevention of dental caries in children 0-6 years of age) and contains the information previously included in NICE PH11 Recommendation 19: https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention/chapter-2-summary-guidance-tables-for-dental-teams#table1. | Thank you for your comment. The NG30 recommendations are relevant for patients as well as for children's parents or carers. Furthermore, the first recommendation in this guideline leads to the UK Government website on Delivering better oral health: an evidence-based toolkit for prevention. We have decided not to include a reference to a specific section on this page. |

**Maternal and child nutrition: nutrition and weight management in pregnancy, and nutrition in children up to 5 years**

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| GPCPC (GPs championing perinatal care) | Guideline | General | General | General query asked by the committee<br>1. Would it be challenging to implement of any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives.<br><br>We think the guideline is very aspirational and describes an NHS that we don't recognise as GPs. There simply isn't time or resource to ensure that this can be implemented<br><br>For example:<br>Common current practice is to prescribe 5mg Folic Acid daily for women with BMI>30. This includes pre-conception advice given by Fertility Units. Awareness raising and training updates will need to occur in the relevant medical, maternity and community services so that parents are not given conflicting information which may cause distress and distrust of health care providers. Additionally NICE CKS on Folic acid will need to | Thank you for your response. Your comments will be considered by NICE where relevant support activity is being planned. |

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| | | | | be updated to reflect advice regarding BMI >25 https://cks.nice.org.uk/topics/pre-conception-advice-management/management/advice-for-all-women/ | |
| GPCPC (GPs championing perinatal care) | Guideline | General | General | 2. Would implementation of any of the draft recommendations have significant cost implications?<br>Yes.<br>For example with reference to Questions 1 and 2 re: challenge to implementation and significant cost implications:<br>Rec1.5.1 Referral to local cookery class or group is not currently an option in all geographic areas so this recommendation would be challenging to implement and would have cost implications as services would have to be set up and/or be commissioned.<br><br>Rec 1.5.5: there is currently no routine check in place for babies of this age | Thank you for your response. Your comments will be considered by NICE where relevant support activity is being planned. Referral to cookery classes or groups is given as an example of promoting healthy eating. The committee recognises that these are not available in all places and there might be resource implications for setting these up in some areas. The rationale sections and the discussion sections in relevant evidence reviews have been amended to acknowledge the current (un)availability of these types of interventions. The guideline acknowledges that there is currently no routine check in place for babies 4-5 months old and that this will have resource implications in some areas. |
| GPCPC (GPs championin | Guideline | General | General | It is positive to see the updated Guideline has completely removed the terms 'wean' and 'weaning' and instead now refers only to 'introducing solid foods'. Unfortunately, the NHS | Thank you for your comment. It is beyond the remit of the guideline committee to advise change in language in other NHS guidance. |

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| g perinatal care) | | | | Website and Start for Life resources linked to the Guideline continue to use the term 'weaning' (page 27, lines 27 and 29). This terminology confounds the cultural shift that the 2024 Guideline is intending to support with regards to continued breastfeeding and we would ask the Guideline Committee to raise this with the NHS Website and Start for Life to assist the intended shift by changing the language used in their topic titles | |
| GPCPC (GPs championing perinatal care) | Guideline | General | General | *We are concerned at the absence of any comments within the 2024 update to preserve the vital messaging from PH11 Recommendation 15 on Prescribing. Doctors' concerns about the safety of prescribing in pregnancy and lactation and parental concerns about breastfeeding alongside medication can be major barriers to the continuation of breastfeeding. Acknowledgement of the importance of the use of specialist prescribing sources and the fact that not prescribing or advising cessation of breastfeeding are not 'no risk' options was important from a public health perspective, as well as being important for the care of individuals. Perinatal mental health is a key area impacted by these* | Thank you for your comment. The committee agree that using medicines can sometimes be, or may be perceived to be, a contraindication for breastfeeding, so the committee included a recommendation about clinicians using appropriate sources for safe medicine use and prescribing during breastfeeding so that breastfeeding can continue despite the need to take medicines, with a link to UKDILAS resources. Bumps was not considered to be relevant as it is about medicines during pregnancy. |

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| | | | | *issues, and medication can inappropriately be withheld with risk to the pregnant person, or advice given to cease breastfeeding inappropriately (when this is not desired) when doctors are not confident with appropriate prescribing in pregnancy and lactation.*<br><br>*We would encourage the Guideline Committee to add a line to acknowledge this issue, or as a minimum link to the relevant section of NICE NG194 Section 1.5.6. If possible also link to:*<br><br>*BUMPS: https://www.medicinesinpregnancy.org*<br><br>*And the NHS Specialist Pharmacy Service (UKDILAS): https://www.sps.nhs.uk/home/about-sps/get-in-touch/medicines-information-services-contact-details/breastfeeding-medicines-advice-service/#:~:text=ukdilas*<br><br>*See also: https://www.sps.nhs.uk/articles/why-breastfeeding-is-important-and-how-pharmacy-can-help/* | |

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| GPCPC (GPs championing perinatal care) | Guideline | General | General | It is very encouraging to see the Guideline continue to make reference to the provision of independent, non-commercial, evidence-based consistent information on all topics. | Thank you for the comment. |
| GPCPC (GPs championing perinatal care) | Guideline | General | General | Regarding changes from NICE PH11:<br>As compared to PH11 the Recommendations in the 2024 update for health care professionals on Breastfeeding and Formula Feeding (Section 1.3) are not targeted at specific professional groups. In contrast PH11 Recommendations 7 to 15 are directed at different groups including Midwifery, Commissioners, Hospital Doctors and GPs. There is a risk that, using the 2024 Guidance, there is less clarity regarding 'professional ownership' of the Section 1.3 recommendations. We would be concerned that Doctors, including GPs, may not understand which are their responsibilities in this area as these are no longer as explicit. | Thank you. The committee have edited the text in consideration of stakeholder comments and added some examples of healthcare professionals and practitioners with skills and competencies in infant feeding for clarity. In general the committee did not want to specify the professionals in the recommendations because there can be local variation in how services are delivered. |
| GPCPC (GPs championin | Guideline | General | General | Regarding changes from NICE PH11:<br>PH11 makes explicit reference to Training (Recommendation 1) and the role of Professional Bodies in competency setting and CPD. | Thank you for your comment. Training of staff, configuration and delivery of services is outside the scope of this guideline and would need to be determined locally. |

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| g perinatal care) | | | | Additionally, PH11 Recommendation 7 references the need for breastfeeding policy, staff training, supporting staff who themselves may be breastfeeding and the identification of a health professional lead for implementation of these practices. This point is absent from the 2024 update.<br><br>The 2024 update does state Section 1.3 should be read in conjunction with the Unicef Babyfriendly Initiative (page 20, line 17). Unicef BFI is an extremely detailed programme with hospital standards and community standards but currently there are no specific standards for General Practice/Primary Care and no requirement for the community standards to be upheld there. The removal from PH11 of the specific content on training from Recommendation 1 and the above-mentioned aspects from Recommendation 7 reduces the Public Health impact of the 2024 update in the primary care setting. | |
| GPCPC (GPs championin | Guideline | 020 - 023 | General | We would like to highlight a gap in the recommendations with regards to the key role of child-care settings. Section 1.3 is directed at | Thank you for your comment. This was not something that came up in the qualitative evidence review M, however, it is an important issue and we have added a consideration |

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| g perinatal care) | | | | healthcare professionals and breastfeeding peer supporters and does not include any specific reference to the responsibilities of child-care settings to facilitate continued breastfeeding or breastmilk feeding and storage as the previous version PH11 Recommendation 20 did. The text in the 2024 update (Sections 1.3.7 to 1.3.10) is directed at employers and the education providers of *parents* (we assume). Babies less than 6 months of age whose diet consists of milk only may also be placed in child-care settings and currently the 2024 Guideline does not address this. Reference is made to the role of Early Years settings in Section 1.5.13 but this only refers to babies over 1 year of age and not to milk feeding specifically.<br><br>Could the Committee please consider this omission and add reference to the fact that, not only do employers/education providers of parents have a duty to provide space and storage for breastmilk expression but child-care providers will need to store this milk and offer it to babies. Their staff also need to be trained to safely prepare infant formula feeds and to bottle feed babies expressed breastmilk and/or infant formula. | about the childcare setting facilitating provision and storage of breastmilk to the recommendation about issues to discuss in the section on supporting continued breastfeeding after return to work or study. |

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| GPCPC (GPs championing perinatal care) | Guideline | 020 - 023 | General | There is no explicit reference to the management of breastfeeding problems beyond 8 weeks after birth or to maternal medical issues impacting on infant feeding in Section 1.3. The 2024 update has removed specific content from PH11 Recommendations 1, 7 and 15 which relate to doctors' training, skills and prescribing. While this may be out of the new scope for the 2024 update, we would ask the Guideline Committee to please consider adding a line to reference that doctors working with infants and those pregnant or breastfeeding should also be appropriately trained to manage medical issues relating to breastfeeding beyond 8 weeks after birth (this could be linked to NICE NG194 Sections 1.5.6-1.5.15 for further detail). | Thank you for your comment. We have amended the recommendations in this section so that there is now a recommendation about asking how the baby's feeding is going and if there are any new or continuing issues or questions and seeking to address them, these could include medical issues affecting breastfeeding or other 'problems' with breastfeeding. We have also added a recommendation about safe prescribing and medicine use while breastfeeding so that continued breastfeeding can be facilitated. Finally, we have amended the beginning of the section to state that "Unless otherwise stated, these recommendations are for all healthcare professionals and practitioners with skills and competencies in babies' feeding, for example, midwives, health visitors, maternity support workers, GPs, paediatricians and breastfeeding peer supporters." |
| GPCPC (GPs championing perinatal care) | Guideline | 010 | 010 - 024 | Vitamin D supplements<br>We are concerned that the wording in this section (1.1.11) is not aligned with NICE NG56 and the Chief Medical Officers' Letter of 2012 (https://assets.publishing.service.gov.uk/media/5a7c59a3ed915d338141e3af/dh_132508.pdf).<br>The 2024 update section 1.1.11 currently states that 'anyone who is pregnant or breastfeeding' | Thank you for your comment. The recommendations refer to the most up-to-date UK government guidance on vitamin D supplementation during pregnancy. See NHS advice on vitamins, supplements and nutrition in pregnancy.<br><br>Content in NHS websites is not within the remit of NICE to amend. It is not clear from the comment what exactly is |

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| | | | | should take a Vitamin D supplement 'between September and March, or throughout the year if they are at increased risk of Vitamin D deficiency…' and goes on to list darker skin and little exposure to the sun as risk factors. This appears at odds with Recommendation 1 of NICE PH56 (https://www.nice.org.uk/guidance/ph56/chapter/Recommendations#recommendation-1-increase-access-to-vitamin-d-supplements) which also lists '*pregnant and breastfeeding women*' as a specific at-risk group for Vitamin D deficiency, as does the CMOs' letter of 2012.<br>As such the current wording of section 1.1.11 appears to suggest that some of those pregnant or breastfeeding would not need to take Vitamin D during April-August if they do not have one of the risk factors listed in the bullet points from lines 16-24.<br>We believe from our understanding of the CMO advice the wording should reflect that *all* those pregnant or breastfeeding should take daily Vitamin D *at all* times during the year, and this should either be via daily Healthy Start Vitamins or a daily Vitamin D supplement of 10 micrograms if not taking Healthy Start Vitamins. Please can | confusing in these websites. The NHS site on vitamin D states that "Children from the age of 1 year and adults need 10 micrograms (mcg) of vitamin D a day. This includes pregnant and breastfeeding women, and people at risk of vitamin D deficiency." This is referring to the reference nutrient intake (RNI) for vitamin D, not intake from supplements. Earlier it says "From about late March/early April to the end of September, the majority of people should be able to make all the vitamin D they need from sunlight on their skin."<br><br>According to SACN vitamin D and health report from 2016, the RNI for pregnant and breastfeeding women is the same as that for the UK general population and. And as noted above, the majority of people will be able to meet their requirements for vitamin D from skin exposure to sunlight between late March/April to end of September.<br><br>Population groups at risk of vitamin D deficiency are those:<br>• with dark skin<br>• with minimal sunshine exposure due to not spending time outdoors (for example, if they are housebound or living in care homes or other settings with limited outdoor access)<br>• who cover almost all their skin when outdoors. |

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| | | | | the Guideline Committee as a priority review and edit the wording of this section, which currently may risk a proportion of those pregnant or breastfeeding missing out on Vitamin D supplements.<br><br>Please also note the wording of the NHS Website page on Vitamin D which is referenced on page 10 line 20 (https://www.nhs.uk/conditions/vitamins-and-minerals/vitamin-d/) is currently also confusing with regards to the recommendations for pregnancy and breastfeeding and the separate page for pregnancy https://www.nhs.uk/pregnancy/keeping-well/vitamins-supplements-and-nutrition/ also advises taking Vitamin D between September and March when pregnant or breastfeeding. This guidance needs to be consistent and clearer. | These groups are advised to consider taking a daily vitamin D supplement (10µg /400 IU per day) all year round.<br><br>NICE will review PH56 content to ensure it is up to date with current UK government advice. |
| GPCPC (GPs championing perinatal care) | Guideline | 011 | 007 - 009 | We wonder if the Vitamin D recommendations should be repeated or a link inserted in section on breastfeeding recommendation, p20, after line 17, otherwise people may not remember this!? | Thank you for your comment. We have added a reference to the recommendation on vitamin D supplementation to the recommendations on breastfeeding as suggested. |

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| GPCPC (GPs championing perinatal care) | Guideline | 011 | 010 - 011 & 017 - 018 | We would be grateful if the Guideline Committee can amended or clarify the wording here so it is clear if babies from 6-12 months still need additional Vitamin A, and C supplements if they are already receiving more than 500ml of infant formula per day. | Thank you for your comment. We have amended this recommendation by producing a table which hopefully makes the guidance clearer. |
| GPCPC (GPs championing perinatal care) | Guideline | 021 | 001 | Rec 1.3.2: We welcome the draft guidance bringing NICE guidance in line with the World Health Organisation recommendations that breastfeeding is continued alongside complementary foods up to age 2 or beyond [1]. We suggest that amending the recommendation to "*until around 2 years **or beyond***" may further align recommendations with WHO advice, promote autonomy of breastfeeding dyads who may wish to continue beyond two years, as well as inform healthcare professionals that breastfeeding beyond two years is a valid and recommended practice worldwide.<br><br>https://www.who.int/news-room/fact-sheets/detail/infant-and-young-child- | Thank you for your comment, we have made the suggested change. |

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| | | | | feeding#:~:text=WHO%20and%20UNICEF%20recommend%3A,years%20of%20age%20or%20beyond. | |
| GPCPC (GPs championing perinatal care) | Guideline | 021 | 022 - 024 | *Practical suggestions and tips for convenience, such as having a stockpile of expressed breast milk. See NHS Start for Life advice on expressing breast milk*."<br><br>It is not usually recommended to "stockpile" breastmilk when breastfeeding. Whilst expression of breast milk may be a family's choice, recommending every breastfeeding mother expresses milk to stockpile risks complications such as oversupply, mastitis, nipple trauma, consequences of oversupply for the infant (such as reflux and discomfort). Recommending stockpiling also misunderstands the physiology of lactation, which is sensitive to a demand/supply.<br><br>1. https://laleche.org.uk/too-much-milk-and-oversupply/ | Thank you for your comment. The committee has amended the recommendation so that it now recommends discussion of practical suggestions and tips for convenience, such as how to safely express and store breast milk. We have now also added the link to the Start for Life advice on storing breastmilk, thank you for suggesting that. |

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| | | | | 2. https://www.bfmed.org/assets/ABM%20Protocol%20%2336.pdf page 367.<br><br>In the previous guidelines "hand expression" and "safe storage" were discussed in much more detail and they may be instrumental in establishing breastfeeding. In the new guidance there is a link to NHS Start for Life advice but this does not contain detailed guidance for storage<br><br>We would recommend that this Start for Life weblink re: safely storing breastmilk be added at this location to more obviously add back the previous detail from PH11 Recommendation 12 on storing breastmilk: https://www.nhs.uk/start-for-life/baby/feeding-your-baby/breastfeeding/expressing-your-breast-milk/storing-breast-milk/ | |
| GPCPC (GPs championing perinatal care) | Guideline | 022 | 010 - 014 | In Section 1.3.6 please consider adding that providers of 'additional support' should also have 'appropriate training' (as per the equivalent text in section 1.3.7). As the 2024 update no longer contains PH11 Recommendation 1 on Training it is important that this is highlighted here. | Thank you for your comment, the recommendation has been amended as suggested. |

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| GPCPC (GPs championing perinatal care) | Guideline | 023 | 001 - 004 | Rec 1.3.7: We welcome the inclusion of guidance on safely returning to work or education whilst breastfeeding. We suggest that it may be useful to include a point for healthcare professionals caring for those who have returned to work whilst lactating, to be vigilant for signs and symptoms of mastitis, and be familiar in how to take a history, examine, and formulate a management plan for suspected mastitis. https://www.bfmed.org/assets/ABM%20Protocol%20%2336.pdf page 367 | Thank you for your comment. An earlier recommendation in the guideline about asking at every health contact how the baby's feeding is going, and if there are any new or continuing issues or questions should capture concerns about mastitis so this has not been included in this section. |
| GPCPC (GPs championing perinatal care) | Guideline | 025 | 012 | Rec 1.3.13: We welcome the inclusion of discussion about **combination feeding.** The draft guidance includes a link to an NHS website on **mixed feeding**, which has vital information on understanding the physiology of timing formula feeds alongside breastfeeding. For ease and understanding of non-experts accessing guidance, choosing one term, either "combination" or "mixed" feeding, may be helpful. | Thank you for your comment and suggestion. Our preference is to use the term 'combination feeding'. It's unfortunate this does not match with the wording used in the NHS website. |
| GPCPC (GPs | Guideline | 026 | 018 - 020 | 1.4.2: Weigh healthy babies at 8, 12 and 16 weeks and at 1 year, at the time of routine | Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned. We note that the recommendation to weigh |

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| championing perinatal care) | | | | immunisations. If there is concern, see NICE guideline on faltering growth.<br>Most routine immunisations take place in GP practices and there is currently no expectation or funding for GPs or practice nurses to do this. Health visitors in England have no routine baby checks under the Healthy Child Programme for universal services to have any contact between 6-8 weeks and 9-12 months. In addition GP practices may not own digital scales, nor have the resources to maintain them as expected Rec 1.4.3 | healthy babies at 8, 12 and 16 weeks and at 1 year is not new. It was included in the NICE PH11 guideline (recommendation 17), published in 2011, and has only been amended regarding its wording in this guideline update. Implementation of the recommendation should be a collective effort between GP practices and health visitors. |
| GPCPC (GPs championing perinatal care) | Guideline | 027 | 018 | In the 2024 update the weblink at this line goes to the Overview page of NICE NG30 (2015) rather than directly linking to the relevant oral health advice for children. Please consider also adding this link, which takes the reader directly to the Gov Summary guidance tables for dental teams (Table 1: Prevention of dental caries in children 0-6 years of age) and contains the information previously included in NICE PH11 Recommendation 19: https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention/chapter-2-summary-guidance-tables-for-dental-teams#table1. | Thank you for your comment. The NG30 recommendations are relevant for patients as well as for children's parents or carers. Furthermore, the first recommendation in this guideline leads to the UK Government website on Delivering better oral health: an evidence-based toolkit for prevention. We have decided not to include a reference to a specific section on this page. |

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| GPCPC (GPs championing perinatal care) | Guideline | 028 | 022 | Rec: 1.5.5 When the baby is between 4 and 5 months old, arrange an opportunity for parents to find out more about introducing their baby to solid food from the age of 6 months. This could be a face-to-face or online appointment, phone consultation or group session.<br><br>There is currently no routine contact between parents and GP practices at this time. There is currently no routine contact between parents and health visitors at this time. Who is it anticipated will carry this out? This has massive implications for services and they cannot meet them at present | Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned. In the Rationale and Impact section of the guideline it is acknowledged that there may be resource implications around implementation of this recommendation, as not all areas offer this appointment. The recommendation has been amended to clarify that health visiting teams or other community health services should coordinate this appointment. |
| GPCPC (GPs championing perinatal care) | Guideline | 031 | 009 - 010 | Rec: 1.5.11: interventions that improve families' skills and confidence to include healthy foods in their diet such as 'cook and eat' classes<br>These services are currently not available. This has implications for equality and diversity and could potentially increase health inequalities | Thank you for your comment. We recognise these may not be available in all areas currently but we hope the recommendation will change this. |
| GPCPC (GPs championin | Guideline | 038 | 002 | Availability of Health Start Scheme: although the document states that there is not universal availability of the Healthy Start scheme and that many people do not manage to access it, even if | Thank you for your comment. The committee recognise the issues with accessing Healthy Start scheme and this is why the guideline refers to Healthy Start scheme multiple times so that healthcare professionals would discuss this |

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| g perinatal care) | | | | eligible. In Oxfordshire the failure to take it up "estimated total across the county of nearly £360,000. That's over £260 a year per family". https://news.oxfordshire.gov.uk/giving-children-a-healthy-start/. The availability should be addressed by the guideline and maybe a recommendation to make local authorities work harder to get there. At the moment with current underfunding of local authorities there is a massive disincentive to help poor families get all the help they should | with parents and pregnant people and more eligible people would reach it. |
| Hywel Dda University Health Board | Guideline | 014 | 011 | Agree that the use of cooking groups and sessions based in their communities can support skill-based development and confidence along with social support however many cooking groups have limited governance regarding their content and messaging therefore it maybe beneficial to include in the statement the importance that cookery classes or groups are based around healthy eating principals and that are appropriate to the group. | Thank you for your comment. We have made a small amendment to the recommendation based on your feedback and now refer to classes or groups that promote healthy eating. |
| Hywel Dda University Health Board | Guideline | 017 | 009 | Agree that weight and BMI should be shared sensitively and also include the direction to ask permission to discuss a persons weight and the | Thank you for your comment. |

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| | | | | degree of the BMI. This is consistent with NICE CG 189 1.2.12 | |
| Hywel Dda University Health Board | Guideline | 025 | 002 | Within this section should there be guidance on the use of formula prep machines. Many queries are raised regarding their efficacy with limited evidence regarding their ability to reach the desired temperature needed for safety. Noted that the guidance has a link to information on this on the Better Health website. | Thank you for your comment. This section does not go into detail regarding the advice given, instead several links for further advice is provided. Some of these links include advice on using formula prep machines. |
| Hywel Dda University Health Board | Guideline | 029 | 028 | Add in the term 'free' alongside sugars as it is the free sugars consumed which have an impact on health as opposed to natural sugars e.g. milk sugars. There is a risk that this could be interpreted that all sugar should be limited if the term free is not included. | Thank you for your comment. This was not considered necessary. The point here is to be aware of the hidden sugars in commercially manufactured products that may advertise as having 'no added sugar'. |
| Infant Feeding Alliance | Guideline | 021 | 001 - 005 | Regarding the recommendation to discuss exclusive breastfeeding at every contact, it is important to recognise that parents have varying priorities. For those who have stopped breastfeeding or chosen not to, repeatedly bringing up breastfeeding can feel overwhelming, unsupportive and even coercive.<br><br>We ask healthcare professionals to respect individual decisions and to provide support that aligns with the family's preferences. Therefore, | Thank you for your comment. The committee agreed to amend the recommendations in this section so that there is now one overarching recommendation at the beginning of the section to ask, in a sensitive and non-judgmental way, how baby's feeding is going, if there are any new or ongoing issues or questions, and to seek to address them. This would relate to breastfeeding, formula feeding, or both. The recommendation then refers to both sections on supporting breastfeeding and supporting formula feeding. Recommendations in both of these sections have been amended so that combination feeding is acknowledged. |

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| | | | | they should begin by asking what *parents* want to discuss and whether they want information on feeding. This approach would align with shared decision-making and allow parents to guide the conversation based on their own needs and circumstances.<br><br>If women express an interest in re-establishing breastfeeding or ask for information to support this, it is essential to consider the available evidence. Many women in this situation will have supplemented due to insufficient milk supply or other medical issues. How realistic is it to expect the successful re-establishing of breastfeeding, especially if breastfeeding has stopped altogether? Healthcare professionals should also have an open honest discussion about the potential physical and psychological demands of this intensive process on the mother. They need to ensure that women are fully informed before making decisions that could adversely affect their well-being. | Furthermore, in the supporting continued breastfeeding section, one of the discussion points has been amended to say "the person's experience of breastfeeding and its emotional impact, including feeding decisions and challenges" to capture the potential challenges that a person might experience. Finally, this section also emphasises that discussions around breastfeeding should not feel rushed and information provided should be tailored to the person's needs, preferences, beliefs, culture and circumstances and be<br>supportive, non-judgemental and respectful. |

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| Infant Feeding Alliance | Guideline | 021 | 008 – 010 | The singular emphasis on the potential benefits of breastfeeding contradicts the principles of shared decision-making. Those principles acknowledge that individuals must weigh the risks and benefits of their options, according to their own unique circumstances, experiences and values.<br><br>To support informed decision-making, guidance should present clear evidence-based information about the absolute risks and benefits of different feeding methods in relation to specific health outcomes. For example, the guidance should provide data on the likelihood of a baby developing a gastrointestinal infection severe enough to require medical care when breastfed, compared to when formula fed or mixed fed. Similarly, data should be provided about the probability of a baby developing jaundice severe enough to require phototherapy or an exchange transfusion when exclusively breastfed as compared to other feeding methods. This approach should apply to all benefits and risks claimed in the recommendations.<br><br>The guideline recommends health professionals refer to the NHS Start for Life leaflet. This | Thank you for your comment. The scope of this guideline did not include a review question about absolute risks and benefits of different feeding methods so evidence on this has not been reviewed and therefore no specific recommendations on the risks and benefits of different feedings methods have been made. The guideline largely refers to existing government guidance, including on breastfeeding, and this remains that exclusive breastfeeding for the first 6 months is recommended.<br><br>However, we have amended the recommendations based on stakeholder feedback. For example, there is now one overarching recommendation at the beginning of the section to ask how baby's feeding is going, if there are any new or ongoing issues or questions, and to seek to address them. This could be about breastfeeding or formula feeding, or both. We have also amended the recommendations so that combination feeding, which is a reality for some, is highlighted more. We recognise that there can be challenges regardless of the feeding method, and healthcare professionals and peer supporters should support the families in these situations.<br><br>Regarding your feedback on NHS Start for Life resources, these are not within the remit of NICE. The information |

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| | | | | document is vague and at times patronising, oversimplifying the challenges many women face in statements such as, 'once you've mastered it [breastfeeding], you'll probably find it's the easiest and most satisfying way to feed your baby'. For some women, breastfeeding never becomes easy or satisfying, due to ongoing pain, latching difficulties or supply issues. For many it remains exhausting and demanding. Downplaying these struggles risks alienating mothers who face difficulties and may lead them to feel like they're failing.<br><br>Some of the claims in the leaflet are rooted in value judgments rather than scientific evidence. The statements 'breast milk is tailor-made for your baby' and 'always available' ignore the fact that formula is specifically designed to meet babies' nutritional needs and is convenient for many families. They also fail to acknowledge that delayed and insufficient milk supply is common (Wilde, 2021) and therefore breastmilk alone may not always be available in sufficient quantity to meet a baby's needs. | provided on those pages are aligned with current UK government advice. |

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| | | | | The vague language around long-term benefits – such as breast milk helping to 'improve your baby's long-term health' or 'helping with digestion of solid foods – lacks sufficient evidence. Without clear, well-supported research, these claims risk generating scepticism from parents seeking factual, evidence-based guidance.<br><br>Start for Life's assertion that 'breastfeeding is a lovely way to feel close and strengthen the bond' is lacking scientific evidence and unintentionally suggests that mothers who don't breastfeed are missing out on this connection. This risks unnecessary guilt and distress for those who cannot or choose not to breastfeed. Bonding happens in many ways, and this kind of language puts emotional pressure on mothers to conform to a singular ideal.<br><br>Therefore, we request that the committee reference a more evidence-based source. This should recognise that women need to make individualised decisions based on their personal circumstances. It should outline the absolute risks and benefits of different feeding methods, | |

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| | | | | including the challenges women and babies experience when breastfeeding. | |
| Infant Feeding Alliance | Guideline | 021 | 011 – 012 | The recommendation regarding formula supplementation and its impact on breastmilk supply completely misrepresents a critical issue. In reality, mothers turn to formula because their milk supply is insufficient, not the other way around.<br><br>There is substantial evidence showing that delayed or insufficient milk supply is common (e.g. Wilde, 2021). In many cases, formula supplementation isn't just an option, it's essential – ensuring babies get the nutrition they need, preventing dehydration and avoiding conditions such as jaundice.<br><br>Alarmingly, rates of hospital readmissions for complications related to insufficient feeding, such as jaundice, have been rising (Keeble and Kossorova, 2017; Jones et al., 2018; Keeble and Fisher, 2021; Nuffield Trust, 2024), clearly indicating that current guidelines are failing to address these problems. Currently, parents | Thank you for your comment. The committee's expert view is that problems with breast milk supply when exclusively breastfeeding are actually uncommon in practice, but they recognise that there can be a perception of insufficient milk supply which leads to people deciding to supplement with formula and it is important that people receive appropriate support in these situations. Based on stakeholder feedback, the committee agreed to amend the recommendations in this section so that combination feeding is better acknowledged. There is now one overarching recommendation at the beginning of the section to ask how baby's feeding is going, if there are any new or ongoing issues or questions, and to seek to address them. This would relate to breastfeeding, formula feeding, or both. The recommendation then refers to both sections on supporting breastfeeding and supporting formula feeding. Recommendations in both of these sections have been amended so that combination feeding is acknowledged, including how to maintain breast milk supply and cross-references between these sections are made because both can be relevant. Furthermore, the supporting continued breastfeeding section is clear that |

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| | | | | cannot be confident that healthcare providers will advise them to supplement when necessary, leaving babies at risk and parents feeling unsupported.<br><br>The suggestion that mothers who supplement with formula are compromising their baby's health and causing their own low milk supply is both inaccurate and harmful. These decisions are made in the best interests of the baby, even when made by mothers against medical pressure to continue breastfeeding. Blaming mothers is not only misleading, it erodes their trust in healthcare professionals.<br><br>Health professionals must be realistic. Exclusive breastfeeding is not sufficient for all babies and pretending otherwise endangers babies and places unrealistic pressure on mothers. We call on healthcare providers to recognise the real pressing challenges of low milk supply and offer support that is non-judgmental and tailored to individual families. This shift is critical to empowering parents in their decisions about their baby's health, rather than making them feel | discussions shouldn't feel rushed and information provided should be tailored to the person's needs, preferences, beliefs, culture and circumstances and be supportive, non-judgemental and respectful. The overarching recommendation in the beginning of the feeding section also makes it clear that discussions should be held in a sensitive and non-judgmental way. Therefore, we reject the suggestion that the guideline places blame on anyone about their feeding practices and choices. |

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| | | | | blamed or undermined by the system meant to support them. | |
| Infant Feeding Alliance | Guideline | 022 | 015 – 019 | The research supporting this recommendation, outlined in Appendix J, is narrowly focused on superficial factors, such as timing, format and mode of breastfeeding support (e.g. individual vs group sessions), while ignoring the core issue: what is the support and what is it actually supposed to achieve? It is baffling that there is so little clarity on which specific problems are being addressed or how this support is meant to help.<br><br>Research clearly shows that women often stop breastfeeding due to significant and distressing difficulties, including pain, latching issues and concerns about milk supply (McAndrew et al., 2012). Yet, instead of concrete and meaningful interventions for these real challenges, we are offered vague, substance-free recommendations. It is not just frustrating, it's irresponsible. Without clearly defining the supports and demonstrating their effectiveness, this guidance leaves mothers navigating these challenges without the information they need. | Thank you for your comment. Evidence review J focuses on types of interventions (and their format) to improve breastfeeding rates while qualitative evidence review K on facilitators and barriers to maintaining breastfeeding informed the recommendations around the content of the support. The current UK government guidance is to recommend exclusive breastfeeding for the first 6 months and continued breastfeeding after introduction of solid foods, but the reality in the UK is that breastfeeding rates are quite low. The guideline starts from this premise which is why evidence review J, for example, looked at what type of interventions could improve breastfeeding rates. At the same time, we recognise that formula feeding is very common but practices may not always be safe or appropriate and families need support in this so this is also addressed in the guideline.<br><br>It seems that the comment assumes there are problems with breastfeeding and that is why support is needed. This is of course sometimes the case, and the guideline addresses this but also starts from the position that supporting parents to feed their babies in the best possible way and according to their individual circumstances and |

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| | | | | What is worse, the aim of breastfeeding support is unclear. Is it to prevent formula use and persuade mothers to continue breastfeeding at all costs? Or is it to actually help women solve the difficulties they're facing? Women deserve full transparency about whether they are signing up for services designed to coerce them into breastfeeding, or services that genuinely address their challenges.<br><br>Mothers who feel pressured to continue breastfeeding, despite overwhelming difficulties may suffer unnecessary stress, guilt and anxiety, potentially damaging their mental health and their relationship with their child. Worse, inadequate guidance can lead to poor feeding outcomes, increasing the risk of malnutrition or health complications for the baby. And for the healthcare system, this failure erodes trust between families and professionals, making future interactions fraught and difficult.<br><br>It is completely unacceptable to expect women to make informed decisions about breastfeeding without being clear about the purpose of the support they are receiving. This lack of transparency directly contradicts the principles of | informed decisions is needed even if there are no problems as such.<br><br>It should be noted that the recommendations on infant feeding in this guideline start from 8 weeks after birth, while the first 8 weeks after birth are covered in the NICE postnatal care guideline. The qualitative evidence in review K did find some limited evidence on pain and latching to be barriers for breastfeeding, however, it is likely that these types of issues are more relevant and prominent in the first weeks after birth and are covered more in the NICE postnatal care guideline.<br><br>We recognise other challenges that breastfeeding parents may experience, including pressure, guilt, feeling judged or lack of support. These were evident in the qualitative evidence review K and these are reflected in the recommendations. However, based on feedback from you and other stakeholders, we have amended the recommendations on breastfeeding and formula feeding so that they are more reflective of the reality of parents feeding their babies. For example, there is now one overarching recommendation at the beginning of the section to ask how baby's feeding is going in a sensitive and non-judgemental way, if there are any new or ongoing issues or questions, and to seek to address them. This |

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| | | | | shared decision-making, which this guidance claims to support. The guidance not only falls short, but actively risks undermining mothers' confidence, health and well-being, while failing to achieve better outcomes for their children. | could be about breastfeeding, formula feeding, or both. Furthermore, the discussion points in recommendation 1.3.4 have been amended so that it now says to discuss "The person's experience of breastfeeding and its emotional impact, including feeding decisions and challenges." We believe the changes have improved the guideline. |
| Infant Feeding Alliance | Guideline | 025 | 012 – 018 | This recommendation seems to position healthcare workers as the 'formula police', requiring them to monitor and inquire about how a baby is fed at every visit, and putting parents in the position of having to justify their decision to use formula. The very act of asking parents to explain why they are considering formula feeds can feel more like an interrogation than a supportive conversation.<br><br>It is remarkable and concerning that at no point do the guidelines suggest asking parents how *they* are doing or what *their* experiences of feeding have been like. This raises a crucial question: is the goal to ensure parents continue breastfeeding, or is it to ensure that babies' nutritional needs are met in a way that is comfortable, sustainable and even enjoyable for the family, according to their own definitions? | Thank you for your comment. The recommendations in the section on breastfeeding and formula feeding have been amended based on stakeholder feedback and there is now one overarching recommendation at the beginning of the section about asking parents, in a sensitive and non-judgemental way, how the baby's feeding is going, if there are any new or ongoing issues or questions, and about seeking to address them. The recommendation is that these discussions are held at every health contact so that people would have an opportunity to discuss, but naturally the length of these discussions will depend on the needs and preferences of the individuals. We are also aware that there are limited routine health contacts beyond 8 weeks after birth so in reality these discussions would not be constant. We hope that the amendments to the recommendations have improved them so that they would not be interpreted as being intrusive or interrogative. |

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| | | | | Healthcare professionals should also consider that many parents are perfectly capable to make autonomous decisions about feeding without constant professional input. Beyond ensuring that babies' nutritional needs are met, healthcare professionals should respect parents' choices and refrain from unnecessary intrusion into families' private lives.<br><br>Parents should not feel they must defend or explain their choice to use formula, especially when the decision might stem from deeply personal, medical or logistical reasons. The focus should be on supporting families holistically, not coercing them into a specific feeding method. The current wording risks alienating parents and undermining the principles of person-centred care. | |
| Infant Feeding Alliance | Guideline | 023 – 024 | 001 – 031 & 001 – 028 | These recommendations assume that every woman returning to work or education wants to continue breastfeeding, which overlooks other important considerations. This is a significant oversight. | Thank you for your comment. These recommendations are about those who are breastfeeding and are thinking of or would like to continue breastfeeding when planning return to work or study. |

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| | | | | The burden of expressing milk while balancing work and childcare can be stressful, impacting a woman's well-being and her ability to fully enjoy both family and professional life. Many women may prioritise their professional development, studies or personal well-being over continuing breastfeeding.<br><br>Healthcare must remain supportive, not intrusive or moralistic, and recognise that women have the right to make choices according to their circumstances, values and priorities. As such, these recommendations need to be more flexible and should avoid placing undue pressure on women to continue breastfeeding.<br><br>Healthcare professionals should respect women's priorities and offer balanced advice when asked, including guidance on how to reduce or stop breastfeeding and transition to bottles or formula. We would ask the committee to include recommendations on how to reduce and/or stop breastfeeding comfortably and safely, avoiding the risk of engorgement and mastitis, for those women who wish to do so. | As you suggest, there are many considerations around returning to work or study and balancing work/study and childcare can be challenging. This is why discussions such as those described in the recommendations could be helpful. We absolutely agree that healthcare professionals must remain supportive and recognise that everyone has a right to make choices according to their circumstances, values and priorities.<br><br>The topic of how to reduce or stop breastfeeding was not within the scope of this guideline and therefore has not been covered. |

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| Institute of Health Visiting | Guideline | 005-006 | 016 | Section 1.1.1 Only states physical places. Suggest that digital platforms such as websites/apps be included. Evidence shows that adoption of digital technologies has significantly increased in recent years, with registrations to the NHS App increasing from 2 million in 2021 to 30 million in 2023 https://www.england.nhs.uk/long-read/inclusive-digital-healthcare-a-framework-for-nhs-action-on-digital-inclusion/, demonstrating that service users are increasingly utilising digital platforms to access healthcare information. Information should also be available to service users in a format they can access and understand https://www.england.nhs.uk/wp-content/uploads/2017/10/accessible-info-standard-overview-2017-18.pdf | Thank you for your comment. The recommendation has been amended to include availability of folic acid information in both online and healthcare settings. |
| Institute of Health Visiting | Guideline | 015-016 | 010 | Consider including risks of losing weight/dieting during pregnancy, as the NHS states that losing weight in pregnancy is generally not recommended.https://www.nhs.uk/pregnancy/related-conditions/existing-health-conditions/overweight/#:~:text=If%20you%20are%20obese%2C%20usually,to%20all%20your%20antenatal%20appointments. | Thank you for your comment. The committee agreed to add a recommendation to highlight the risk of intentional weight loss during pregnancy due to potential adverse effects on the baby. |

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| Institute of Health Visiting | Guideline | 017-018 | General | There is no inclusion of monitoring underweight – only low weight gain which could be different to underweight.<br>Evidence shows that being underweight in pregnancy has a number of potential risks, which it may be important to reflect in this guideline<br>https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/tog.12792<br>https://www.rcm.org.uk/media/6875/discussing-weight-during-pregnancy-june-2022.pdf | Thank you for your comment. Routine weight monitoring during pregnancy is not recommended regardless of the pre-pregnancy or booking appointment BMI, but the guidance recognises there may be clinical indications for checking weight during pregnancy, such as hyperemesis gravidarum. The evidence that the committee reviewed focused on the association of weight change during pregnancy based on pre-pregnancy BMI on different outcomes, not on the association of pre-pregnancy BMI on these outcomes. Recommendations on healthy eating and physical activity in pregnancy apply for all pregnancies regardless of the pre-pregnancy BMI. |
| Institute of Health Visiting | Guideline | 012 | 014 | Stating there is no need for a special diet during pregnancy could be misleading as there are foods and drinks to avoid in pregnancy (see NHS Guidance: https://www.nhs.uk/pregnancy/keeping-well/foods-to-avoid/ ), such as alcohol, unpasteurised cheeses etc. By saying no special diet is needed could be interpreted as no changes need to be made.<br>https://www.nice.org.uk/guidance/qs98/chapter/quality-statement-1-healthy-eating-in-pregnancy | Thank you for your comment. We agree and have amended the wording based on your comment. |

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| Institute of Health Visiting | Guideline | 013 | 005-006 | Suggest rewording to avoid multiple uses of and, for example:<br>'The benefits of healthy foods and drinks, as well as healthy eating habits for the pregnant person, baby and the wider family'. | Thank you for your comment, we have amended the text as suggested. |
| Institute of Health Visiting | Guideline | 013 | 007-008 | Suggest rewording to avoid multiple uses of and, for example:<br>'Foods and drinks that should be encouraged, as well as foods and drinks to 7 avoid during pregnancy'. | Thank you for your comment, we have amended the wording based on your feedback. |
| Institute of Health Visiting | Guideline | 014 | 018 | Suggest removing 'exercise habits' as evidence shows that the term physical activity is more acceptable to most people as a conversation starter.<br>https://research.canterbury.ac.uk/centre-for-sport-physical-education-and-activity-research/wp-content/uploads/sites/9/2023/04/spear@cccu-This-Mum-Moves-Final-Report-2021.pdf<br>https://www.frontiersin.org/articles/10.3389/fspor.2020.00072/full<br>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1424733/ | Thank you for your comment. We have kept the wording as it is, we think there may be a place to use both terms. As the third reference you provide states, 'exercise' means a different thing to physical activity and as part of the discussions, we would like to a get an overview of the person's exercise habits as well. |
| Institute of Health Visiting | Guideline | 017 | 011 | Not sharing a person's weight/BMI with them at all may imply to professionals that they then do not need to have a conversation about healthy weight if the person has a weight classed as overweight | Thank you for your comment. The guideline does not recommend discussions around 'healthy weight' during pregnancy. The focus of the discussions should be on healthy eating and physical activity. |

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| | | | | or obese, but has asked not to be told this. Guidelines recommend sensitive and respectful conversations about the risks of obesity in pregnancy, however it may be difficult to discuss these messages if the person does not see them in the personal context of their own weight. https://link.springer.com/content/pdf/10.1186/s12884-023-05343-9.pdf https://www.nice.org.uk/guidance/ph27/resources/weight-management-before-during-and-after-pregnancy-pdf-1996242046405 https://obgyn.onlinelibrary.wiley.com/doi/10.1111/1471-0528.15386 | |
| Institute of Health Visiting | Guideline | 021 | 008 | Include the environmental and financial benefits of breastfeeding (lower carbon footprint, less plastic, less water use, greater resilience through significant/catastrophic events such as pandemics). https://www.unicef.org.uk/babyfriendly/breastfeeding-and-climate-change/#:~:text=Breastmilk%20requires%20no%20packaging%2C%20shipping,pollution%2C%20nor%20waste%20scarce%20resources. https://www.unicef.org.uk/babyfriendly/news-and-research/baby-friendly-research/research- | Thank you for your comment. It is beyond the remit of this guideline to make recommendations on environmental and financial benefits of breastfeeding. |

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| | | | | supporting-breastfeeding/research-on-breastfeeding-and-climate-change/ https://www.unicef.org.uk/babyfriendly/about/benefits-of-breastfeeding/#:~:text=Baby%20Friendly's%20report%20Preventing%20disease,hospital%20admissions%20and%20GP%20consultations. | |
| Institute of Health Visiting | Guideline | 022 | 004 | Include 'non-judgemental' as mothers have reported that they fear being judged over their feeding choices which can prevent them having open conversations with health care professionals regarding infant feeding. https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2018/10/Having-meaningful-conversations-with-mothers.pdf | Thank you for your comment. The recommendation has been edited as suggested. |
| Institute of Health Visiting | Guideline | 027 | 012 | Missing word, should read;<br>'Unless otherwise stated, these recommendations are for all healthcare professionals'. | Thank you, we have corrected the typo. |
| Institute of Health Visiting | Guideline | 031 | 021 | Eatwell guidelines are for over 2 years of age, suggest removing the word 'around' to avoid confusion. https://assets.publishing.service.gov.uk/media/5ba8a50540f0b605084c9501/Eatwell_Guide_booklet_2018v4.pdf | Thank you for your comment. We have used the word 'around' because this is what is stated in the recommendation S.52 in the SACN report: feeding young children aged 1 to 5 years - GOV.UK (www.gov.uk). |

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| King's College London | Guideline | 016<br>019 | 024<br>012 | The evidence cited that refers to an increased risk of gestational diabetes in individuals that achieve a low weight gain during pregnancy (singleton and twin pregnancy) is intrinsically flawed as all referenced studies define weight change from pre or early pregnancy through to end or near end of pregnancy. This period of time goes significantly beyond the diagnosis of gestational diabetes at around 26 gestational weeks, and thus encompasses the period of gestational diabetes management. It is not uncommon for individuals who undertake a strict diet and increase physical activity to either have no or little weight gain, or indeed weight loss, whatever their starting BMI, after gestational diabetes is diagnosed. Please see Influence of GDM Diagnosis and Treatment on Weight Gain, Dietary Intake and Physical Activity in Pregnant Women with Obesity: Secondary Analysis of the UPBEAT Study - PMC (nih.gov) where we demonstrate through a secondary analysis of a cohort of pregnant women with obesity that more women with GDM (26.6%) gained less weight than NAM recommendations in the third trimester post gestational diabetes diagnosis, compared to 0.6% of women without GDM. | Thank you for your comment. Based on your and other stakeholder's feedback the committee revisited the evidence on this and agrees that the association between low weight gain in pregnancy and gestational diabetes could be due to interventions after diagnosis of gestational diabetes. Because of the uncertainty of causal link between low weight gain and gestational diabetes, they agreed to remove the consideration for testing for gestational diabetes from the recommendation. |

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| | | | | Without the granularity of timing within the evidence, it is incorrect to interpret the given data as a sequential causal association between reduced weight gain and the development of gestational diabetes. Indeed, it is more plausible that the reduction in weight gain occurs post diagnosis. It is my view that this association must be removed from the guideline, as well as the recommendation to screen for GDM in those with low weight gain. | |
| La Leche League Great Britain | Guideline | 011 | 007 - 009 | An alternative to directly supplementing breastfed infants with 400IU vitamin D daily is a maternal dose of 6400IU vitamin D daily (Hollis, B. W., Wagner, C. L., Howard, C. R., Ebeling, M., Shary, J. R., Smith, P. G., Taylor, S. N., Morella, K., Lawrence, R. A., & Hulsey, T. C. (2015). Maternal Versus Infant Vitamin D Supplementation During Lactation: A Randomized Controlled Trial. *Pediatrics*, *136*(4), 625–634. https://doi.org/10.1542/peds.2015-1669) | Thank you for your comment. Recommendations on Vitamin D for those who are pregnant or breastfeeding is in line with the UK government advice. The guideline did not review evidence comparing vitamin D supplementation in infants with maternal vitamin D supplementation. Thank you for the reference, which we have checked and is ineligible for inclusion as the intervention and comparator was not relevant to our review Vitamin D review protocol. |
| La Leche League Great Britain | Guideline | 021 | 004 | Breastfeeding should be encouraged to continue for 2 years AND BEYOND in line with WHO guidelines. | Thank you for your comment. We have amended this to say "around 2 years or beyond". |

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| La Leche League Great Britain | Guideline | 043 | 023 | "until the child is at least 2 years" – add and beyond to make this clearer | Thank you for your comment. We have amended the text so that it's clear breastfeeding could continue beyond the second year. |
| La Leche League Great Britain | Guideline | 044 | 036 | Also add a cost associated with increasing breastfeeding support and subsequently breastfeeding rates is increased access to International Board Certified Lactation Consultants (IBCLC) who are the gold standard in lactation education. NHS trusts should be encouraged to employ and train IBCLCs. | Thank you for your response. We have now amended the wording to include 'practitioners' in addition to HCPs and peer supporters so this could include lactation consultants. It is beyond the remit of the guideline to recommend that NHS employ and train IBCLCs. |
| Medicines Optimisation Team, NICE | Evidence Review A | 011 | 015 | Typo "…neurodevelopmental disorders other **the** NTDs…" Should this read "…other **than** NTDs"? | Thank you for your comment. We have amended the wording according to your comment. |
| Medicines Optimisation Team, NICE | Evidence Review A | 012 | 023 | Change "formulations" to "tablet strengths" as mentioned above as there are liquid formulations available, although this isn't very practical | Thank you for your comment. The committee specifically wanted to ensure different formulations are mentioned in the recommendations so that different options are available for people, particularly children, who may struggle to take tablets. |
| Medicines Optimisation Team, NICE | Guideline | 009 | 003 - 005 | I found this hard to read. Could you move "with people" to earlier in the sentence? i.e "Discuss with people the importance of vitamin supplements during and after pregnancy, and for children under 5 years, at opportunities such as:" | Thank you for your comment. We have amended the wording to make it flow better. |

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| Medicines Optimisation Team, NICE | Guideline | 009 | 024 | It would be helpful to link here to the NHS page Vitamins for children as it talks about vitamin A and C too | Thank you for your comment. This link appears in the specific recommendation about vitamin supplements for children. |
| Medicines Optimisation Team, NICE | Guideline | 009 | 032 | For consistency change "NHS web page on B vitamins" to "NHS advice on B vitamins" | Thank you, we have corrected the typo. |
| Medicines Optimisation Team, NICE | Guideline | 036 | 016 | Change 'formulations' to 'tablet strengths' as there are liquid formulations available, although this wouldn't be very practical | Thank you for your comment. The committee specifically wanted to ensure different formulations are mentioned in the recommendations so that different options are available for people, particularly children, who may struggle to take tablets. |
| Medicines Optimisation Team, NICE | Guideline | 036 | 019 | Are you able to clarify what is meant by 'other populations'? Do you mean non-pregnant populations? | Thank you for your comment. Yes, we meant other populations than those in the preconception period or during pregnancy. The text has been amended in the rationale for the recommendation for clarity. |
| Medicines Optimisation Team, NICE | Guideline | 036 | 020 | Reword "There is also likely little difference" to "There is also likely **to be** little difference" | Thank you for your comment. The text has been amended as suggested. |
| National Child Mortality Database | Guideline | 009 | 020 | Consider adding link to DHSC information - https://www.e-lfh.org.uk/pathways-healthy-child/index.html<br>This is a set of resources that includes action for provision of advice on vitamin D supplements for | Thank you for your comment. So not to inundate readers with references, we have had to be selective of which ones we include. The link you refer to may be useful but includes so much content that is not specific to the topics |

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| | | | | babies who are exclusively breastfed, vitamin supplements for all infants and the provision of information about free Healthy Start vitamin drops. Associated links are provided to help professionals in their work and for signposting parents. | of the guideline, so we have decided not to include this reference. |
| National Child Mortality Database | Guideline | 009 | 020 | Consider adding link to Healthy Pregnancy Pathway - https://e-lfh.org.uk/healthy-pregnancy-pathway/antenatal/universal.html which includes details about antenatal nutrition and supplements. | Thank you for your comment. So not to inundate readers with references, we have had to be selective of which ones we include. The link you refer to may be useful but includes so much content that is not specific to the topics of the guideline, so we have decided not to include this reference. |
| National Child Mortality Database | Guideline | 029 | 018 | NCMD thematic report on trauma deaths included data relating to choking and identified common causes of choking in infants. Grapes and sausages were the two most common foods that were choked on, and this can be prevented by slicing the items lengthwise. Consider including a line asking professionals to highlight this technique to families to reduce the risk of choking. | Thank you for your comment. The committee agree this is important although the committee did not want to be too detailed in the recommended discussion points. The recommendation on discussions about introducing solid foods has been updated to include safe and appropriate preparation of foods. |
| NHS England | Guideline | General | Geneal | A child's disabilities (including hidden disabilities) should be taken into account when discussing approaches to feeding. | Thank you for your comment. We have amended recommendation 1.5.9 to say that the child's needs should also be taken into account. This could include disabilities (including hidden disabilities). |

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| NHS England | Guideline | General | General | Whilst the additions are helpful, overall this is now a lengthy document that will consume significant NHS staff time to read. There is some repetition and more concise language could be used (e.g. 1.2.2 page 13) | Thank you for your comment. We have edited the recommendation you're referring to and made other editorial changes as well to improve the guideline, such as include some tables and boxes to make the guideline more reader-friendly. We hope these changes have improved the guideline. |
| NHS England | Guideline | General | General | We recommend including reference to the importance of Communication: Communicate with and try to understand the person you are caring for. Check with the person themselves, their family member or carer or their hospital or communication passport for the best way to achieve this. Use simple, clear language, avoiding medical terms and 'jargon' wherever possible. Some people may be non-verbal and unable to tell you how they feel. Pictures may be a useful way of communicating with some people, but not all. Reference specifically in relation to the point about healthy eating and the importance of vitamin supplements, | Thank you for your comment. The guideline's recommendations make some references to communication, for example recommendations 1.1.3 and 1.1.11 talk about providing information in a person's preferred format and relevant to their individual circumstances and level of understanding.<br>However, overall issues related to communication are covered by other NICE guidance, such as our foundational guidelines on patient experience and shared decision making, which we refer to in the guideline. These highlight many of the areas that you have mentioned (for example, establishing the most effective way of communicating with patients and their families and carers, use of pictures and avoiding jargon). |
| NHS England | Guideline | General | General | We suggest flagging the importance of being aware of reasonable adjustments from sensory issues that might arise from certain formulations | Thank you for your feedback. The committee specifically agreed to mention different formulations of vitamin supplements so that people who may struggle with tablet |

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| | | | | of vitamins (tablet or liquid form preferred, taste etc). | form would have other options; this is captured in the committee's discussion section of the evidence report. However, making reasonable adjustments as required by the Equality Act is a statutory requirement and so this requirement would not be repeated in each individual NICE guideline. However, the guideline cross-refers to NICE's core guidance on patient experience and shared-decision making, which reference the Equality Act and highlight the importance of individualised care and shared-decision making. |
| NHS England | Guideline | General | General | We suggest include a reference to making reasonable adjustments: This is a legal requirement as stated in the Equality Act 2010 and is important to help you make the right diagnostic and treatment decisions for an individual. You can ask the person and their carer or family member what reasonable adjustments should be made. Adjustments aim to remove barriers, do things in a different way, or to provide something additional to enable a person to receive the assessment and treatment they need. Possible examples include; allocating a clinician by gender, taking blood samples by thumb prick rather than needle, providing a quiet space to see the patient away from excess noise and activity. | Thank you for your comment. Making reasonable adjustments as required by the Equality Act is a statutory requirement and so this requirement would not be repeated in each individual NICE guideline. However, the guideline cross-refers to NICE's core guidance on patient experience and shared-decision making, which reference the Equality Act and highlight the importance of individualised care and shared-decision making. |

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| NHS England | Guideline | General | General | Be aware of diagnostic overshadowing: This occurs when the symptoms of physical ill health are mistakenly either attributed to a mental health or behavioural problem or considered inherent to the person's learning disability or autism diagnosis. People with a learning disability or autism have the same illnesses as everyone else, but the way they respond to or communicate their symptoms may be different and not obvious. | Thank you for your comment. |
| NHS England | Guideline | 013 | 017 | Health professionals need to be sensitive to any eating difficulties or restricted eating that autistic people might have. | Thank you for your comment. We have added this to the recommendations as a factor to consider. |
| NHS England | Guideline | 015 | 006 | This is another example of the comment above; saying the same thing twice in one sentence. | Thank you for your comment. Sitting for long periods is given as a typical example of sedentary behaviour but they are not the same thing. |
| NHS England | Guideline | 019 | 012 | Should this include consideration of a physical and mental health assessment since there are many conditions that could impact on low weight gain (or loss) in pregnancy that could potentially be missed if the focus is confined to gestational diabetes. | Thank you for your comment. The recommendation has been amended based on your feedback. Also, the recommendation to consider testing for gestational diabetes has been removed based on stakeholder feedback and committee's further consideration of the evidence. |
| NHS England | Guideline | 022 | 015 | This seems to repeat information found on p21 line 21 and p22 line 10 | Thank you for your comment. They all have a different purpose or meaning. The recommendation you are referring to is about offering face-to-face breastfeeding |

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| | | | | | support group sessions. Line 21 on p21 (in the consultation version) on the other hand is about discussing this with the breastfeeding person. The recommendation on p22 line 10 (in the consultation version) refers to additional support to supplement face-to-face support. |
| NHS England | Guideline | 023 | 002 | There may be some jobs in which adjustments cannot be made to support safely expressing breast milk despite best efforts of the employer and individual (e.g. those involving travel) and so perhaps "…it is rarely necessary to stop" might be a fairer statement and avoid inadvertently stigmatising those who do need to stop or reduce. | Thank you for your comment. We recognise it may be challenging in some circumstances for employers to organise this but the aim should still be that continuation of breastfeeding is supported. |
| NHS England | Guideline | 027 | 012 | Typo: "are for all healthcare" | Thank you, we have corrected the typo. |
| NHS Greater Glasgow and Clyde - Growth and Nutrition Advisory Service | Guideline | General | General | Healthy start is mentioned throughout document. Healthy start vitamins not available for children in Scotland. On Healthy start page – Scotland is not included (link to appropriate information could be included here). | Thank you for your comment. NICE provides national guidance and advice to improve health and social care in England so Scottish pathways are not reflected in the guideline. Decisions on how NICE guidelines apply in other UK countries are made by ministers in the Welsh Government, Scottish Government and Northern Ireland Executive. |
| NHS Greater | Guideline | 026 | 018 | 1.4.2: Universal pathway differs in Scotland Should this be included? https://www.gov.scot/binaries/content/documents/ | Thank you for your comment. NICE provides national guidance and advice to improve health and social care in England so Scottish pathways are not reflected in the |

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| Glasgow and Clyde - Growth and Nutrition Advisory Service | | | | govscot/publications/advice-and-guidance/2015/10/universal-health-visiting-pathway-scotland-pre-birth-pre-school/documents/00487884-pdf/00487884-pdf/govscot%3Adocument | guideline. Decisions on how NICE guidelines apply in other UK countries are made by ministers in the Welsh Government, Scottish Government and Northern Ireland Executive. |
| NHS Greater Glasgow and Clyde - Growth and Nutrition Advisory Service | Guideline | 026 | 021 | 1.4.3 What reference are you using for the medical device standard? | Thank you for your comment. Please note this section of the guideline was not consulted on. We have simplified the recommendation as maintenance and calibration of weighing scales are standard good practice. |
| Nottinghamshire Healthcare NHS Foundation Trust | Guideline | General | General | I feel like calcium deserves a specific mention in this document that requirements are increased during breastfeeding and likely a supplement is required. I searched the whole document and calcium wasn't mentioned. | Thank you for your comment. Calcium supplementation during pregnancy is outside the scope of this guideline. |
| Nottinghamshire Healthcare NHS | Guideline | 028 - 030 | 001 - 028 & 001 - 031 & | Rec. 1.5.1-1.5.8 – Its good that from 6 months intro of solids is emphasised and that this message should be regularly reinforced. | Thank you for your comment. |

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| Foundation Trust | | | 001 - 007 | | |
| Nottinghamshire Healthcare NHS Foundation Trust | Guideline | 021 - 22 | 029 - 014 | 1.3.4 and 1.3.5 really good to see the emphasis on the importance of face to face support, to supplement other resources. | Thank you for your comment. |
| Nottinghamshire Healthcare NHS Foundation Trust | Guideline | 023 - 024 | 001 - 031 & 001 - 028 | Rec. 1.3.7-1.3.10 – Good it emphasises support for returning to work and breastfeeding. | Thank you for your comment. |
| Nottinghamshire Healthcare NHS Foundation Trust | Guideline | 010 | 010 - 015 | Rec. 1.1.11 – In line with UK government guidance, advise anyone who is pregnant or breastfeeding about the following:<br>• That they should take a vitamin D supplement (10 micrograms or 400 international units [IU] a day) between September and March, or throughout the year if they are at increased risk of vitamin D deficiency because they, for example…<br>I didn't think the Winter months were relevant here, I thought it was all pregnant or breastfeeding women – am sure this is what the BDA food facts says. | Thank you for your comment. The recommendations refer to UK government guidance on vitamin D supplementation during pregnancy and this is the current government advice for vitamin D supplements, see NHS advice on vitamins, supplements and nutrition in pregnancy. |

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| Nottinghamshire Healthcare NHS Foundation Trust | Guideline | 010 | 010 - 015 | Rec. 1.1.11 - Vitamin D – it says take vitamin D in Winter if breastfeeding or pregnant and throughout the year **if at risk** of low vitamin D – it would be better to say take vitamin D for everybody who is pregnant or breastfeeding (that's what we are saying now, not sure why this has changed?) | Thank you for your comment. The recommendations refer to UK government guidance on vitamin D supplementation during pregnancy and this is the current government advice for vitamin D supplements, see NHS advice on vitamins, supplements and nutrition in pregnancy. |
| Nottinghamshire Healthcare NHS Foundation Trust | Guideline | 011 | 015 - 021 | Rec. 1.1.12 – Could be clearer on vitamin supplementation for children.<br>It says "Children aged 1 to 4 years should be given a daily supplement containing 10 micrograms (400 IU) of vitamin D. • From 6 months up until 5 years, children should also be given daily supplements containing vitamins A and C, in addition to vitamin D. • Those eligible for free Healthy Start vitamins can receive the free 20 vitamin drops (which contain vitamins A, C and D and are suitable from 21 birth) up to their 4th birthday."<br>Its confusing talking about 4 years and 5 years. If having 500 ml formula in 24 hours, they don't need extra vitamins, I don't think this is very clear. AN easier way to say this would be that **all** babies from birth to 5 yrs need Vit D **unless taking more than 500 mls formula**, should it say the same for vitamins A and C? | Thank you for your comment. We have amended this recommendation by producing a table which hopefully makes the guidance clearer. |

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| Nottinghamshire Healthcare NHS Foundation Trust | Guideline | 017 | 012 - 014 | Rec. 1.2.10 – Do not routinely offer to weigh people throughout their pregnancy unless there is a clinical reason to do so (for example, gestational diabetes, hyperemesis gravidarum or thromboprophylaxis).<br>How are we expected to monitor for excessive weight gain or monitor low weight gain in pregnancy if this isn't routinely done? One recommendation advised testing for GDM in BMI >30 but you wouldn't know if someone's BMI had increased during pregnancy without the routine weighing. | Thank you for your comment. The committee agreed there is no evidence to support routine weight monitoring during pregnancy so this is not recommended, unless there are specific clinical indications for this. The recommendations on excessive weight gain and low weight gain have been clarified to state that these are in situations where the individual has monitored their weight or there has been weight monitoring due to a clinical reason. Testing for GDM is recommended if BMI at booking appointment (the only time in pregnancy when weight measurement is routinely recommended) is 30 or more. |
| Nottinghamshire Healthcare NHS Foundation Trust | Guideline | 021 | 025 - 028 | Some good additions on breastfeeding, in particular good to read:<br>Reassurance that there is no need to follow a special diet while breastfeeding. [2024] (Rec. 1.3.2).<br>Rec. 1.3.3 - Provide information and encouragement for partners and other family members to support continued breastfeeding, as appropriate. [2024]<br>These are both helpful points. | Thank you for your comment. |
| Nottinghamshire Healthcare NHS | Guideline | 025 | 006 - 011 | Rec. 1.3.12 – Its really good that adherence to not advertising formula milk/bottles etc is emphasized. I think it should highlight the value of first steps nutrition information on formula milk as | Thank you for your comment. First Steps Nutrition Trust resources are now mentioned in the rationale section as something the committee were aware are evidence-based and non-commercial sources of information. |

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| Foundation Trust | | | | this is non biased, code-complaint source of information on formula milk. Infant milks for health workers — First Steps Nutrition Trust | |
| Royal College of General Practitioners | EIA | General | General | We are pleased that the equality and health inequalities assessment (EHIA) reflects a strong commitment to inclusivity, particularly in addressing diverse groups' needs (e.g., ethnicity, socioeconomic status, gender identity). | Thank you for your comment. |
| Royal College of General Practitioners | Guideline | General | General | We think it is important to consider creating more accessible format, such as visual aids or flowcharts, to help healthcare professionals quickly reference key recommendations. | Thank you for your comment. Sometimes NICE develops visual summaries of their guidelines, however, this was not prioritised for this guideline. |
| Royal College of General Practitioners | Guideline | General | General | We suggest providing a list of available resources (e.g., referral networks, support groups, accessible food programs) which could help address some of the socioeconomic challenges mentioned. | Thank you for your comment. The local services vary so we have not included such resources in the guideline. Although the guideline does refer to e.g. the Healthy Start scheme in the recommendations. Your comment will be considered by NICE where relevant support activity is being planned. |
| Royal College of General Practitioners | Guideline | General | General | We question why there is no mention of omega 3 supplements - This is standard in USA and in some Trust websites in the UK to reduce premature births. Superdrug sells pregnancy vitamins with Omega 3. Additionally there is the need to remind women not to take cod liver oil ( which is much cheaper). | Thank you for your comment. Omega 3 supplements and cod liver oil were not within the scope of this guideline. |

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| Royal College of General Practitioners | Guideline | General | General | We are concerned that there is no mention about introducing allergenic foods e.g nuts, eggs etc at 4 to 5 months despite the evidence now that suggests that they are good at preventing allergies – this is a major omission. | Thank you for your comment. The UK government Scientific Advisory Committee on Nutrition recommendation is "Advice on complementary feeding should state that foods containing peanut and hen's egg can be introduced from around 6 months of age and need not be differentiated from other solid foods.", see S.47 on page xix on Feeding in the first year of life: SACN report - GOV.UK (www.gov.uk). The recommendations align with this. |
| Royal College of General Practitioners | Guideline | General | General | Overall, the guideline provides a comprehensive structure for the updated guidelines, consolidating new and existing recommendations on maternal and child nutrition and integrating relevant evidence. It emphasises critical areas like vitamin supplementation, healthy eating, weight management, and physical activity during pregnancy. | Thank you for your comment. |
| Royal College of General Practitioners | Guideline | 014 | 015 | Rec 1.2.5 – We believe the guidance on physical activity could be further detailed by incorporating examples of safe exercises tailored to different trimesters and specific conditions. | Thank you for your comment. The evidence for physical activity interventions included a wide range in terms of intensity, type, frequency and duration. The interventions ranged from light to vigorous intensity, with the majority being of moderate intensity. Types of physical activity included Pilates, walking, jogging, cycling, swimming, dance, rowing, and strength or resistance training. Length and number of sessions ranged from 15-60 minutes per session usually at a minimum of 3 days per week. Some |

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| | | | | | interventions gradually increased intensity of physical activity to a minimum of 30 or 45 minutes for most days in the week. The interventions were not conducted by trimester and the outcomes were also not reported by trimester. There was no sufficient information on physical activity interventions in different medical conditions. For these reasons, the committee were unable make specific recommendations for each trimester for type/duration/intensity of physical activity during pregnancy. |
| Royal College of General Practitioners | Guideline | 019 | 012 | Rec 1.2.15 – We question if this might sound ambiguous- from a primary care perspective, would we then refer to the midwifery/gynaecology team? Research suggests women in this category seem to do better in terms of rates of pre-eclampsia and caesarean section, and that glycaemic control should be more relaxed. In terms of follow-up (which is what primary care should do mostly) should we be doing the same? Repeat HbA1c etc? | Thank you for your comment. The recommendations on weight management in pregnancy were changed based on stakeholder feedback and the focus now is much more on healthy eating and physical activity than weight. Routine monitoring of weight throughout pregnancy is not recommended. If an individual wants to monitor their weight during pregnancy, the guideline has a recommendation about how to support this. In these instances, further information about the risks of excessive or low weight gain could be discussed. Concerns about low weight gain might be raised based on the individual's own monitoring or because there was a clinical reason for checking the person's weight during pregnancy. If this came up in the primary care setting and there was a real concern that some further investigations or care is needed, |

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| | | | | | the expectation is that the healthcare professional would refer or signpost to relevant services.<br><br>Based on stakeholder feedback, the committee revisited the evidence on the association of low weight gain in pregnancy and gestational diabetes and agreed to remove this recommendation, as there is much uncertainty whether the association observed in the evidence could be due to clinical interventions taken up due to the gestational diabetes diagnosis. |
| Royal College of Midwives | Guideline | General | General | We note that the word women has been almost completely removed from this document. To prevent exclusion of women (as a protected characteristic), the RCM strongly recommends an inclusive gender additive approach such as women and pregnant (or birthing) people. It is also noted that NICE's 'Final scope' document states the following but that this is not reflected in the draft circulated:<br>"This guideline will use the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but who are pregnant or have given birth. Similarly, when the term 'parents' is used, this should be taken to include anyone who has main | Thank you for your comment. The guideline has been edited according to the current NICE style guide principles, and we use neutral language where this is reasonable and additive language (women and people…) where needed. The intention is not to exclude women. The scope of the guideline was published in 2021 and some of the editorial principles have since changed. The current version of the NICE style guide sets out how NICE approaches language to achieve consistency in our communications and ensure our guidance is safe, clear and inclusive for all our audiences.<br>The style guide is available on the NICE website in the interest of openness and transparency.<br>In developing the advice in NICE's style guide, we have considered academic research, feedback from stakeholders, and advice and publications from |

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| | | | | responsibility for caring for a baby or child." (p.6, 3.1). | organisations including NHS England, NHS Digital, NHS Scotland, the Health Service Executive (Republic of Ireland), the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists. |
| Royal College of Midwives | Guideline | General | General | The RCM notes that NICE continues to refer to a policy of "shared decision making". This is not appropriate within maternity care where national recommendations for many years have been for women and birthing people to have agency over making their own informed decisions (refer to 'Better Births' report (2016), the RCM's 'Informed Decision Making' position statement and NMC Standards for Midwives). While many of the principles relating to shared decision making are reflected in the informed decision making framework, our concerns relate to the concept that NICE's shared decision making guideline implies the decision is made jointly, thereby suggesting our midwife members should influence decisions. We cannot support this principle as it goes against NMC regulatory standards which outline that midwives are responsible for enabling and respecting women's and birthing people's human rights, which includes the decisions they make regarding their care. | Thank you for your comment. NICE uses the term shared decision making, although we realise that in maternity services this is often referred to as 'informed decision making' (see NHSE Personalised care and support planning guidance: Guidance for local maternity systems). The principles are still the same that the healthcare professional brings their expertise by providing evidence-based information about the benefits, harms and implications of the options to enable the individual to make a decision about their care based on their personal circumstances, needs and preferences. More information about shared decision making is available on the NICE website: https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making |

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| Royal College of Midwives | Guideline | General | General | We request that it is noted that BMI is not an evidence-based measurement of health for pregnant and postpartum women and birthing people but that it is recognised that low (<18.5) and high (≥30) BMI are associated with some adverse maternal, neonatal and child health outcomes. These outcomes are multifactorial and in some cases may be a result of the impact of weight stigmatisation and restrictive BMI-related policies and guidelines, rather than the perceived physical health of the woman or person in terms of their BMI calculation. The RCM supports evidence based practice such as continuity of carer in helping to reduce these adverse outcomes and to improve maternal and infant heath. | Thank you for comment. The guideline only refers to pre-pregnancy or booking appointment BMI in relation to pregnancy. The committee acknowledges the limitations of BMI as a measure of health and recognises that health outcomes are almost always multifactorial. The recommendations in the guideline emphasise that any discussions around weight in pregnancy should be sensitive and avoid stigma. Based on stakeholder feedback, the committee have changed the recommendations around weight in pregnancy so that the focus of the discussions should be on healthy eating and physical activity, not on weight. |
| Royal College of Midwives | Guideline | 015 - 017 | 018 - 021 | Rec 1.2.7: "Discuss healthy weight change during pregnancy" – the RCM contests that there is adequate evidence for midwives to do this and that they would not be able to provide women with evidence based information on how to safely achieve this. Additionally, in order to assess effectiveness of this advice, services or women may expect midwives to implement inappropriate routine weighing at antenatal appointments which isn't supported by evidence and may cause | Thank you for your comment which the committee took on board. They agreed that discussions and interventions during pregnancy should focus on healthy eating and physical activity instead of weight, so they changed the recommendations so that this is emphasised and expectation that weight change in pregnancy is discussed with everyone was removed. As you say, routine monitoring of weight throughout pregnancy is not recommended, unless there is a clinical indication for this. However, if the individual wants to monitor their own |

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| | | | | unnecessary harm through increased surveillance and stress.<br><br>The RCM has previously called for more research into the topic of safe weight gain in pregnancy and stated that midwives need better training and tools for providing this information and support to women. This is supported by the Royal College of Obstetricians and Gynaecologists (RCOG) statement in their 2018 guidance (green-top guideline no 72, p.4): "there is lack of consensus on optimal gestational weight gain. Until further evidence is available, a focus on a healthy diet may be more applicable than prescribed weight gain targets". The data referred to by the National Academy of Medicine is from 2009 and we are unaware of any more recent data to suggest RCOG's statement is no longer valid. We therefore request removal of the requirement to discuss healthy weight gain from both recommendations 1.2.7 and 1.2.13. We also request that the committee join us in calling for urgent research in this area and include this within the guidance. | weight, the guideline includes a recommendation about how to provide support in this situation.<br><br>The committee did not prioritise a research recommendation on this topic. The decision on whether to include a research recommendation is based on whether there is promising evidence to suggest that research would add value, but also whether this is an area of importance to the guideline topic and feasible to carry out. They thought that there was already a lot of literature on this topic and adding more, particularly without standardised methods and definitions, would unlikely be useful in providing meaningful findings. They recognised the limited evidence on trimester-specific weight change which could potentially be more useful in practice, but the committee's view was that pre-pregnancy or between-pregnancy BMI is a more important factor to focus on, rather than weight change in pregnancy. However,<br>weight management before or after pregnancy is outside the scope of this guideline. |

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| Royal College of Midwives | Guideline | 009 | 028 | Due to existing health inequalities in healthcare experienced by the global majority who are more likely to experience vitamin D deficiency, the RCM requests that NICE explicitly states that where Healthy Start vitamins are not available, service providers are required to provide pregnant women with Vitamin D supplements during pregnancy, postpartum and for their babies. MBRRACE-UK has highlighted disparities in vitamin D provision. The Healthy Start voucher scheme does not currently go far enough in addressing equitable access to vital vitamin supplementation for at risk groups and many of the at risk groups during pregnancy are not eligible for the Healthy Start voucher scheme or choose not to access it. | Thank you for your comment. The last recommendation in this section addresses the need to provide free vitamin D supplements to those at an increased risk of vitamin D insufficiency. |
| Royal College of Midwives | Guideline | 010 | 010 - 024 | Section 1.1.11: We are concerned regarding advice to separate pregnant women and people into two groups whereby some are advised to take vitamin D seasonally and those at higher risk of deficiency are advised to take it all year. This presents two issues for our midwife members. Firstly, it requires midwives to identify which women are at higher risk where some of the criteria are subjective, changeable and difficult to define. How can length of time or exposure to enough sunlight according to an individual's | Thank you for your comment. The recommendations refer to UK government guidance on vitamin D supplementation during pregnancy. See NHS advice on vitamins, supplements and nutrition in pregnancy. It was not within the remit of NICE to change these recommendations. The SACN report on Vitamin D and Health does not make recommendations about vitamin D supplementation but sets the reference nutrient intake (RNI) for vitamin D. For pregnant and breastfeeding women and population groups |

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| | | | | clothing or outdoor activity be objectively assessed and measured by a midwife? It may also be difficult for pregnant women and people to define their own risk status as personal perceptions may vary substantially. Secondly, pregnant women and people eligible for Healthy Start vitamins receive a multivitamin and so midwives would additionally need to reassure women not at higher risk that continuing to take vitamin D all year is safe.<br><br>We therefore support the Scientific Advisory Committee on Nutrition's (SACN) recommendation to advise Vit D supplementation throughout the year to all populations "as a precautionary measure, to cover population groups in the UK identified to be at risk of having a serum 25(OH)D concentration < 25 nmol/L (see paragraph 11.2 above) as well as unidentified individuals in the population at risk of having a serum 25(OH)D concentration < 25 nmol/L in summer."(2023) | at risk of vitamin D deficiency, the RNI is the same as for the general population.<br><br>Population groups considered to be at increased risk of vitamin D deficiency are those with minimal sunshine exposure as a result of not spending time outdoors (e.g. frail and institutionalised people) or habitually wearing clothing that covers most of the skin while outdoors and those from minority ethnic groups with dark skin.<br><br>The UK government advises that majority of people will be able to receive all the vitamin D they need from exposure to sunlight during the summer months.<br>Population groups at risk of vitamin D deficiency (see above) are advised to consider taking a daily vitamin D supplement (10µg /400 IU per day) all year round. |
| Royal College of Midwives | Guideline | 015 | 013 | Rec 1.2.6: We request that it is specifically highlighted that qualitative evidence overwhelmingly demonstrates that women and people with raised body mass index (BMI) have | Thank you for your comment. We recognise these negative experiences and therefore have included the recommendation you're commenting on about sensitive communication and avoiding stigma. We did not review |

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| | | | | negative experiences during the puerperium due to judgemental care, policies and guidelines that lead to hurt, embarrassment, humiliation, guilt and feelings of objectification and alienation. We request that it is also highlighted that pregnant women and people experience weight stigmatisation in all domains of life, including healthcare, education, mass media, the workplace and even close relationships, and that this has short and long-term negative consequences for the health of the woman or pregnant person and their infant. | qualitative evidence on this topic as such so we have not included further detail in the recommendation. |
| Royal College of Midwives | Guideline | 025 | 021 | We recommend adding First Steps Nutrition Trust as a reliable source of impartial advice for professionals and parents: Infant Milks — First Steps Nutrition Trust | Thank you for your comment. First Steps Nutrition Trust has now been mentioned in the rationale section as a source the committee are aware is evidence-based and reliable. This was already mentioned in the committee's discussion section. |
| Royal College of Midwives | Guideline | 033 | 026 | Research recommendation 2: We support the committee's call for research into the safest and most effective dose for folic acid supplementation before and during pregnancy for women and people at high risk but also request that the committee specifically add to this call the need to research whether weight-adjusted doses of folic acid would be beneficial. While we agree that evidence currently doesn't support a higher dose | Thank you for your comment. The research recommendation proposes that subgroup analysis according to BMI would be conducted. While acknowledging the limitations of BMI categories, the committee's view was that weight-adjusted dose of folic acid would be very complicated in practice and would therefore not be a feasible research recommendation. |

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| | | | | for women with a higher BMI, the absence of evidence does not disprove that there may be benefits to a weight-adjusted dose. | |
| Royal College of Midwives | Guideline | 034 | 001 | Research recommendation 3: We support the committee's call for research into optimum doses of vitamin D during pregnancy for women and people with a raised BMI but request that the committee change this to research into weight-adjusted doses of vitamin D, rather than framing by BMI. This is to reduce the impact of an approach that reinforces healthcare obesity stigmatisation and to prevent potential underdosing of tall women with a higher weight who may still fall into a 'normal' BMI category. | Thank you for your comment. While acknowledging the limitations of BMI categories, the committee's view was that weight-adjusted dose of vitamin D would be very complicated in practice and would therefore not be a feasible research recommendation. |
| Royal College of Nursing | Guideline | General | General | The draft guideline was shared with members of the Royal College of Nursing who work in children and young people's health and midwifery and women's health. The comments reflect the views of our reviewers. Thank you for the opportunity to review and comment. | Thank you for your comments on the draft guideline. |
| Royal College of Nursing | Guideline | General | General | The draft guideline seems comprehensive. There is nothing to add to it at this stage. | Thank you for your feedback. |

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| Royal College of Physicians | General | General | General | The RCP is grateful for the opportunity to comment on this draft guideline. In doing so, we have liaised with the Joint Committee for Obstetric Medicine. | Thank you for your comments. |
| Royal College of Physicians | Guideline | 007 | 012 | 1.1.4: Offer a high-dose folic acid supplement (5 mg a day)<br>This should also include: have medical conditions that may cause malabsorption for example inflammatory bowel disease (this is in line with national and European guidelines for IBD) | Thank you for your comment. This is not included in the current UK government guidance and this was not a population reviewed in our evidence review so it has not been included in the recommendation. |
| Royal College of Physicians | Guideline | 010 | 010 | 1.1.11: Similarly In terms of the vitamin D section is it worth highlighting that certain medical conditions would warrant higher dose vitamin D e.g. in women with Multiple sclerosis. May be this could be phrased as 'women with any medical condition where long term Vit D is recommended and/or has any malabsorption syndrome, should take at least 400 mcg and the dose may need to be higher.' | Thank you for your comment. The recommendations refer to UK government guidance on vitamin D supplementation during pregnancy or childhood. We recognise there may be individual circumstances where long-term use or higher dose of vitamin D is required but this has not been commented on as this was not reviewed for this guideline. The committee did review evidence, but did not find any, on the appropriate dose of vitamin D for those with a pre-pregnancy BMI over 25, so they made a research recommendation on this. |
| Royal College of Physicians | Guideline | 019 | 003 | 1.2.15: There is more than gestational diabetes to exclude for women with low weight gain including underlying serious disease such as cancer and/or psychological causes. As written, it looks like just GDM needs to be excluded. | Thank you for your comment. Based on stakeholder feedback this recommendation has been amended so that consideration to test for GDM has been removed and further exploration of potential reasons for low weight gain has been added, including physical and psychological wellbeing. |

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| Slimming World | Guideline | 018 - 019 | General | 1.2.14 & 1.2.15 excessive and low weight gain in pregnancy. The guidelines state that if there are concerns about excessive or low weight gain that steps should be followed – how would the excessive or low weight gain be identified by the health care team? Again, this isn't clear in the current guideline. | Thank you for your comment. The recommendations on excessive weight gain and low weight gain have been clarified to state that these are in situations where the individual has monitored their weight or there has been weight monitoring due to a clinical reason. |
| Slimming World | Guideline | 014 | 015 | 1.2.5 Physical activity in pregnancy. There is often a perception that it might be dangerous to be active during pregnancy and can lead to people avoiding activity all together. It would be helpful for the guideline to address this and the importance of addressing this myth. | Thank you for your comment. We think that the recommendation already conveys the thought that being physically active is not dangerous as such and indeed it is important during pregnancy, so we have not changed the recommendation. |
| Slimming World | Guideline | 015 | 010 | 1.2.6 Weight management in pregnancy. We're pleased to see the importance of sensitive communication being highlighted here. It can be a real concern for midwives around talking about weight with women during pregnancy and previously this has been identified as an area they'd value more training and support on. What provision will be given to ensure health care professionals feel confident to have these conversations sensitively? | Thank you for your comment. The committee thought it was an important thing to highlight. It should be noted that the recommendations have been amended based on consultation feedback and the emphasis of the discussions should be on healthy eating and physical activity, not weight as such.<br>The training of healthcare professionals is not within the remit of NICE. |

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| Slimming World | Guideline | 017 | 021 | 1.2.13 – we're pleased to see the guidance on estimated total weight change being highlighted. What feels unclear is how the midwife or heath care professional should use this information to support the women in their care. If a woman isn't being weighed routinely in pregnancy how will this be used to help support women? This could be clearer in the guidance. | Thank you for your comment. Based on stakeholder feedback the recommendations have been amended and clarified. The reference to the NAM/IOM estimated total weight change during pregnancy is given in the context of an individual choosing to monitor their weight during pregnancy. The guideline no longer recommends these are discussed with everyone. |
| Slimming World | Guideline | 020 | General | Breastfeeding rates in those who are living with obesity are lower and there are a thought to be a variety of reasons for this (Reduced breastfeeding rates among obese mothers: a review of contributing factors, clinical considerations and future directions \| International Breastfeeding Journal \| Full Text (biomedcentral.com). Given the additional barriers associated for people living with obesity, and the wider benefits of breastfeeding for preventing obesity in children we'd suggest this is highlighted in the guideline – highlighted as an area for the health care team to consider and identify if further support for the mother might be needed? | Thank you for your comment. This did not come up in the qualitative evidence we reviewed on facilitators and barriers for continued breastfeeding so the committee did not highlight this in the recommendations. However, we acknowledge in the committee's discussion section in evidence review J and K that breastfeeding can have the benefit of preventing childhood obesity. |

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| The Association for the Study of Obesity | General | General | General | Good to see people first language used in relation to obesity in the guideline. The same is not applied to the evidence review documents consistently (e.g. document d "obese" is in the title | Thank you for your comment. We have changed the terminology as suggested in the guideline documents including titles of the evidence reviews. |
| The Association for the Study of Obesity | Guideline | 008 | 005 | Rec 1.1.7 – This recommendation will be a challenging change in practice because many bariatric centres are under immense pressure with long backlogs. They may not have the capacity to do this without resource or agreed commissioning. A growing number of people (including women of reproductive age) are having bariatric surgery overseas and may not have a reliable point of contact for individualised, specialised advice. This is an essential clinical recommendation but is likely to add to cost and stretch resources without appropriate planning. | Thank you for your response. Your comment will be considered by NICE where relevant support activity is being planned. The discussion on resource use considerations in evidence review B has been modified to state that additional resources may be required. We have also added a sentence in the Rationale and Impact section of the guideline to acknowledge some change in practice resulting from the recommendation. |
| The Association for the Study of Obesity | Guideline | 008 | 009 | Rec 1.1.8 - The point on those not taking folic acid would benefit from an approach which goes a step further than information sharing around the risks of not taking it. As with many situations, women may well know this information but are unable to implement this advice because of a range of external factors eg: domestic abuse. Perhaps worth a comment such as 'explore any barriers to taking folic acid and signpost | Thank you for your comment. We have amended the recommendation based on your feedback. |

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| | | | | accordingly' eg: social prescriber or safeguarding expert | |
| The Association for the Study of Obesity | Guideline | 011 | General | For the increasing numbers of women who are pregnant after successful bariatric surgery and as fertility improves, there could perhaps be a separate section or link out to monitoring and specialised care. Eg see from BOMSS: 'Women, who become pregnant post-bariatric surgery, should be treated as a specialist obstetric population with specific needs. This includes access to specialist dietetic support and close monitoring of nutrition. They should undergo nutritional screening every trimester.' British Obesity and Metabolic Surgery Society Guidelines on perioperative and postoperative biochemical monitoring and micronutrient replacement for patients undergoing bariatric surgery—2020 update - O'Kane - 2020 - Obesity Reviews - Wiley Online Library (Section 9.8) For example, Vitamin A deficiency may occur after bariatric surgery, and those who have very malabsorptive procedures such as the duodenal switch are at high risk of vitamin A deficiency | Thank you for your comment. Detailed recommendations for those who have had bariatric surgery were not made as there was no evidence available for this group from the evidence reviews that were conducted for this guideline update. |
| The Association for the | Guideline | 011 | General | Consider whether to add a link to NICE antenatal guideline here as a prompt to review medications which do not have safety evidence for pregnancy | Thank you for your comment. We decided not to include the reference here because it does not directly relate to the recommended vitamin supplementations. |

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| Study of Obesity | | | | alongside vitamin review. For example, some women may have been on weight loss drugs to promote fertility prior to pregnancy. | |
| The Association for the Study of Obesity | Guideline | 012 | 006 | Also consider a link to special populations such as women with diabetes in pregnancy in this section? Can see it lower down but these women may also feel more inclined to adjust their diet to treat glucose excursions. Recommendations \| Diabetes in pregnancy: management from preconception to the postnatal period \| Guidance \| NICE | Thank you for your comment. We have not included a link to the diabetes in pregnancy guideline here as the links here are more general and applicable to a wider pregnant population. A link to the diabetes in pregnancy guideline is indeed given in the section that is specific to this. |
| The Association for the Study of Obesity | Guideline | 017 | 018 | This is unlikely to be practical as most specialist obesity services have long waiting times and do not accept pregnant women. Most interventions are not suitable eg: medical therapy, bariatric surgery. Would a better option be referral to a health professional in the maternity services who has an obesity role (e.g. specialist midwife, dietitian etc) who then can link into a specialist service as needed? Obviously depends on local pathways and resources. | Thank you for your comment. We agree that local pathways and resources vary. The recommendation includes both specialist obesity services and specialist practitioners, which could be specialist midwife or a dietitian. |
| The Association for the Study of Obesity | Guideline | 017 | 021 | Rec 1.2.13 -Table 1 in this document doesn't provide guidelines on how to take these factors into account – this is going to be very subjective / open to interpretation by the individual | Thank you for your comment. The recommendations on this have been changed based on stakeholder feedback and the specific points you're referring to have been removed. |

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| | | | | practitioner, leading to inequalities in advice provided. | |
| The Association for the Study of Obesity | Guideline | 018 | 010 | Rec 1.2.14 - This recommendation is in conflict with recommendation 1.2.10 (Do not routinely offer to weigh people throughout their pregnancy unless there is a clinical reason to do so (for example, gestational diabetes, hyperemesis gravidarum or thromboprophylaxis). [2024]) - how will a health professional be able to determine if there are concerns about excessive weight gain if this is not being monitored? Concerns about health professionals making judgements based on how big the pregnant woman looks visually? Potentially open to weight stigma in these circumstances. | Thank you for your comment. The recommendations on excessive weight gain and low weight gain have been clarified that these are in situations where the individual has monitored their weight or there has been weight monitoring due to a clinical reason. |
| The Association for the Study of Obesity | Guideline | 021 | 001 | Rec 1.3.2 -Certain women may be in a position where breastfeeding feels challenging or they feel they can not produce sufficient milk to meet needs. This can lead to significant guilt and distress. Could a comment to consider these circumstances be mentioned? Appreciate later on there is a comment on a non-judgemental approach overall. | Thank you for your comment. We have amended the recommendations in this section so that there is now one overarching recommendation at the beginning of the section to ask, in a sensitive and non-judgmental way, how baby's feeding is going, if there are any new or ongoing issues or questions, and to seek to address them. This would relate to breastfeeding, formula feeding, or both. Furthermore, in the supporting continued breastfeeding section, one of the discussion points has been amended to say "the person's experience of breastfeeding and its emotional impact, including feeding decisions and |

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| | | | | | challenges" to capture the potential challenges that a person might experience. |
| The Association for the Study of Obesity | Guideline | 035 | 001 | Research recommendation 5 - It is good to see this research recommendation, however, food insecurity is also a driver of maternal obesity, poor diet, and inadequate GWG (see https://onlinelibrary.wiley.com/doi/10.1111/obr.13753) as well as gestational diabetes, poor mental health, dental problems (see https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1004450) and not currently a feature of support for UK maternity services to provide for pregnant women and people | Thank you for your comment. Research recommendations can only be made on topics that have been directly reviewed within the guideline. We did not specifically review the association between food insecurity and pregnancy; therefore we are unable to make a research recommendation in this area. |
| The Breastfeeding Network | Guideline | General | General | The information on prescribing to breastfeeding parents in the existing PH11 document (recommendation 15) has not been included here.<br><br>We suggest the inclusion of an additional subsection in *1.3 Breastfeeding and formula feeding*, entitled "**Taking medication whilst breastfeeding"** that incorporates the information from PH11 recommendation 15 and includes the following: | Thank you for your comment. The committee agreed to include a recommendation about using appropriate sources for safe medicine use and prescribing during breastfeeding to enable continued breastfeeding despite the need to take medicines, with a link to UKDILAS. However, because we did not review evidence on this topic and it was not something that our qualitative evidence review on facilitators and barriers for maintaining breastfeeding highlighted, we have not included any more detailed recommendations on this. The committee are aware that The Breastfeeding Network's Drugs in Breastmilk Service is often used in practice for advice on safe use of medicines during breastfeeding and this has |

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| | | | | Ask the parent if they are taking or need to take any medication, whether prescribed or over the counter.<br>Inform breastfeeding parents that many common medications can be taken whilst breastfeeding. The benefits of breastfeeding frequently outweigh any theoretical risk the medication could pose to the breastfed baby or child. They should always read the patient information leaflet before taking any medication. If the patient information leaflet is unclear about whether the medication is compatible with breastfeeding, or says it should not be taken whilst breastfeeding, this does not always mean the medication is unsafe to be taken whilst breastfeeding. It may be that due to a lack of clinical trials, the medicine has not been licenced for use in breastfeeding. The parent should discuss this with their prescriber or pharmacist, who can consult resources including the Specialist Pharmacy Service Drugs in Lactation Advice Service (UKDILAS), LACTMED and Hales Medications and Mothers Milk for information specific to breastfeeding to aid decision making. Parents can also make direct contact with the Drugs in Breastmilk Information service (DiBM) provided by The Breastfeeding | been captured in the committee's discussion section and the rationale section. |

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| | | | | Network, which is run by registered pharmacists trained in breastfeeding support. https://www.breastfeedingnetwork.org.uk/drugs-factsheets/.<br><br>Commissioners, Integrated Care Boards and Health Board prescribing committees should ensure that local prescribing guidelines include information on prescribing to breastfeeding parents, including listing suitable evidence-based resources to consult for further information. These should include UKDILAS, LACTMED and Hales Medications and Mothers Milk. | |
| The Breastfeeding Network | Guideline | 023 - 025 | General | Section **Continuing breastfeeding after returning to work or study**<br>This section does not cover the question of whether it will be necessary for the parent to express whilst at work/study, or whether their baby/child will need milk in their absence. This will be dependent on the age of the baby/child, whether they are established on solid food and the predictability and duration of the period of separation. These factors should be discussed with the parent to allow them to make an informed | Thank you for your comment. We have amended the recommendation based on your feedback by adding a discussion point about the need to express breast milk, and facilities for expressing milk (depending on the age of the child and duration of separation). However, we have not added all the detail you suggest but many of these points are covered in section 1.5 Healthy eating behaviours in babies and children from 6 months and up to 5 years. |

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| | | | | decision about how they will manage their return to work or study.<br><br>We suggest the topics to discuss should include:<br><br>Whether the parent will need to express milk whilst at work/study. Depending on the age of the baby/child and predictability and duration of the period of separation, expressing may be necessary for comfort, to maintain milk supply and/or to store milk for future consumption by the baby/child, but this will not always be the case.<br><br>Whether the baby/child will need milk whilst the breastfeeding parent is away at work/study.<br>• If the baby/child will need milk whilst the breastfeeding parent is away, support the parent to make an informed decision about how they will provide this. The first choice would be expressed breast milk. This is best for health and protects breastmilk supply. However, if expressing sufficient milk is not possible or desired, provide information on giving formula milk alongside continued breastfeeding (or | |

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| | | | | cow's milk if the child is over 1 year), including protecting breastmilk supply.<br>• If the baby/child is over 6 months and established on solids, they may not need milk feeds whilst the parent is away (depending on duration of separation and how much infant is eating). They may be able make up breastmilk consumption when they are with the breastfeeding parent. This is reassuring for the parent to know if the infant will not accept milk from a bottle or cup, or if expressing breastmilk is not possible or desired.<br>• If the baby/child is over 6 months, milk can be given in a free-flow cup rather than a bottle. It is better for dental health to avoid introducing a bottle after 6 months.<br>• Expressed breastmilk can also be combined with food, such as porridge, if the baby/child is unwilling to drink it.<br>• If baby/child is over 1 year, they can drink whole cows' milk if milk is needed and expressed breastmilk is not available. Breastfeeding can continue alongside this. Formula milk is not required. | |

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| The Breastfeeding Network | Guideline | 001 | 012 - 021 | We suggest that the recommendation that people who are pregnant or breastfeeding should take a vitamin D supplement (10 micrograms or 400 international units [IU] a day) between September and March, or throughout the year if they are at increased risk of vitamin D deficiency be simplified to recommend that all pregnant and breastfeeding people take a vitamin D supplement of 10 micrograms or 400 international units [IU] a day. The guidelines from the Royal College of Obstetricians and Gynaecologists (RCOG) make this simpler recommendation. The rationale and impact section notes that some people find the information on taking vitamins confusing, so simplifying it could improve uptake. | Thank you for your comment. The recommendation is referencing government guidance on vitamin D supplementation, and it was not within our remit to change the government guidance on this. We have, however, amended the wording in the recommendation so that it is made clearer why it is recommended only during certain months of the year. |
| The Breastfeeding Network | Guideline | 011 | 022 - 025 | Whilst we consider offering free vitamin D supplements for anyone who is pregnant or breastfeeding, and for children under 5, if they have an increased risk of vitamin D deficiency, a valuable intervention, we note that the responsibility for providing such interventions lies with PHE/OHID, rather than with NHS commissioners. | Thank you for your comment. Decisions around extending provision of Healthy Start vitamins, for example, for more pregnant and breastfeeding people and children under 5 are done on a local level. For example, some councils already provide free Healthy Start vitamins for all pregnant and breastfeeding people and children under 5 regardless of their eligibility to the wider Healthy Start scheme. |
| The Breastfeeding Network | Guideline | 021 | 001 - 003 | *"At each health contact, provide information, advice and reassurance 2 about continuing or re-establishing exclusive breastfeeding until the* | Thank you for your comment. The committee agreed and we have amended the recommendations in this section so that there is now one overarching recommendation at the |

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| | | | | *baby is around 6 months old and about the importance of continuing breastfeeding alongside solid foods until around 2 years".*<br><br>This statement does not acknowledge that some families who are combination feeding (feeding some formula milk alongside breastfeeding) may need or wish to continue doing so. Not acknowledging this potentially stigmatises these families, who may need additional support to maintain breastfeeding. We suggest amending to: "At each health contact, provide information, reassurance and support about continuing breastfeeding. If the parent is exclusively breastfeeding, provide encouragement and reassurance to continue. If the parent is combination-feeding, discuss whether they would like to reestablish exclusive breastfeeding, or how they can continue to combination-feed successfully, if this is necessary or preferred. Discuss and provide information about the importance of continuing breastfeeding alongside solid foods until around 2 years" | beginning of the section to ask, in a sensitive and non-judgmental way, how baby's feeding is going, if there are any new or ongoing issues or questions, and to seek to address them. This would relate to breastfeeding, formula feeding, or both. Furthermore, in both sections on supporting breastfeeding and supporting formula feeding, reference is made to combination feeding and how they can maintain their breast milk supply. |

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| The Breastfeeding Network | Guideline | 021 | 011 - 012 | *"Discuss...The importance of feeding only breast milk to maintain breastfeeding as supplementing with formula milk compromises breast milk supply."*<br><br>This point implies that breastfeeding must be exclusive to continue. We agree that that exclusive breastfeeding should be encouraged and supported, and that introducing formula supplements can reduce milk supply, which can result in an early end to breastfeeding. Introducing formula supplements should not be suggested or encouraged if not clinically indicated. However, sometimes formula supplements are necessary, and furthermore, families have the right to choose to use formula alongside breastfeeding if they wish to, without stigma or judgement. We are concerned that this point could instil a belief that breastfeeding must be exclusive to continue. This is counterproductive, as if parents believe that they cannot continue to breastfeed alongside giving formula, they may stop breastfeeding entirely. This is something we have heard in our experience of supporting parents with infant feeding. Parents should be supported to make an | Thank you for your comment. We have amended the recommendation based on your feedback and have added a cross-reference to the section on safe and appropriate formula feeding. We have also amended the recommendations so that combination feeding, a reality for many, is recognised and support for continuing breastfeeding if supplementing with formula is highlighted. |

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| | | | | informed decision about this, and then receive high-quality support to carry out their choice. If supplementation is supported by a trained breastfeeding supporter, it is possible to continue breastfeeding successfully alongside formula supplements in the long term, or to return to exclusive breastfeeding when supplements are no longer required.<br><br>We suggest rephrasing this point to:<br>"Discuss... The supply and demand nature of breastmilk production and the potential negative impact of introducing formula milk supplements on breastmilk supply and ability to continue breastfeeding. Refer to section 1.3.14 (formula feeding) for more detailed discussion points around introducing formula milk if required, to support parents to make an informed decision, and to continue breastfeeding alongside formula milk supplements if clinically indicated or desired." | |
| The Breastfeeding Network | Guideline | 021 | 022 - 023 | "*Practical suggestions and tips for convenience, such as having a stockpile of expressed breast milk.*" | Thank you for your comment. The committee has amended the recommendation so that it now recommends discussion of practical suggestions and tips for convenience, such as how to safely express and store breast milk. |

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| | | | | Suggesting a "stockpile" of expressed breastmilk as a practical tip puts pressure on people who are breastfeeding to express, which may be impractical, time consuming and demoralising, as not all breastfeeding parents are able to express in large quantities. A "stockpile" also requires significant freezer space, which not all parents will have access to. Expressing and storing a significant quantity of breastmilk is not necessary for most people and should not be suggested unless there is a clear rationale for it. As an alternative tip, we suggest:<br><br>".... such as learning how to express and store breastmilk, either by hand or with a pump, in case it is useful in the future" | |
| The Breastfeeding Network | Guideline | 025 | 012 - 016 | *"At every health contact, ask about how the baby's feeding is going. If the baby is breastfed and the parents are thinking about introducing formula, or if they require further information about formula feeding or combination feeding, discuss their reasons for thinking about formula milk in a sensitive, non-judgemental way to help them make an informed decision."* | Thank you for your comment. Based on stakeholder feedback, we have now amended the recommendations on breastfeeding and formula feeding so that they are more reflective of the reality of parents feeding their babies. For example, there is now one overarching recommendation at the beginning of the section asking parents, in a sensitive and non-judgmental way, how baby's feeding is going, if there are any new or ongoing issues or questions, as well as seeking to address them. |

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| | | | | We agree with this. However, for clarity, we suggest amending to, "*discuss their reasons for thinking about formula milk in a sensitive, non-judgemental way* ... and ensure they are aware that if they decide to introduce formula, it is possible to do so alongside breastfeeding (i.e. combination-feeding) ... *to help them make an informed decision.*<br><br>Although exclusive breastfeeding is always preferred, it is important that parents who need or decide to introduce formula milk are aware that they can do so alongside breastfeeding, and do not have to stop breastfeeding entirely to use formula. | This could be about breastfeeding, formula feeding, or both. The committee have included an additional recommendation to cover combination feeding, re-establishing exclusive breastfeeding, sustaining breastfeeding and maintaining breast milk supply. Furthermore, the discussion points in recommendation 1.3.4 have been amended so that it now says to discuss "The person's experience of breastfeeding and its emotional impact, including feeding decisions and challenges." We believe the changes have improved the guideline. |
| UK Preconception Partnership | Evidence Review A | 006 | 018 - table 1 | We recommend considering child outcomes (also under Benefits and Harms p.12, line 5), as increased cancer risk has been found in children of mothers with epilepsy using high-dose folic acid supplements in pregnancy (https://link.springer.com/article/10.1007/s10309-023-00602-3). | Thank you for your comment. The committee did not prioritise cancer risk as an outcome when agreeing the protocol for this review. We are therefore unable to include them in the review at this stage. |
| UK Preconception Partnership | Evidence Review A | 007 | 037 - 038 | The folic acid dose required for people using antiseizure medications (ASM) has not been investigated, and current guidelines are based on non-epilepsy and non-ASM exposed pregnancies. | Thank you for your comment. The folic acid recommendation has been amended to include 'specialist clinics with women with pre-existing medical conditions' to |

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| | | | | The individualised need of these groups "not stratified" in this guideline, has not been considered to have condition/treatment specific requirements. The current guideline is reviewing population level data and recommending interventions for epilepsy which is a heterogeneous condition. The potential for seizure aetiology and ASM related causes for folate deficiency have not been included in the evidence included in the guidelines and needs to be recognised in a separate research recommendation to avoid health inequalities in safety advise for managing nutrition in epilepsy maternities and managing child nutrition in children born to people with epilepsy with and without antiseizure medicine exposure. | consider pregnant women with all medical conditions including epilepsy. |
| UK Preconception Partnership | Guideline | General | General | Throughout the guideline, we suggest replacing potentially stigmatising language such as "healthy eating" and "habits" with "dietary behaviours" or "dietary patterns". | Thank you for your comment. We do not think 'healthy eating' is particularly stigmatising language. However, we have made an editorial decision to change "eating habits" to "dietary habits" because we think this is more appropriate language. |
| UK Preconception Partnership | Guideline | General | General | We foresee the following challenges to implement the draft recommendations, and have made suggestions that could help overcome the challenges: | Thank you for your response. Your comments will be considered by NICE where relevant support activity is being planned. We have acknowledged potential staff training needs where relevant. |

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| | | | | 1. There will be a need for training and education to update health professionals' knowledge. We recommend the development of standardised training packages and the use of online platforms for continuous education.<br>2. Resources will need to be allocated to ensure funding and staffing are in place to implement the recommendations. This could be supported through collaboration with private sectors and provision of financial incentives.<br>3. Compliance to uniform and standardised implementation of the guideline is important and should be monitored, for example through regularly reporting on metrics (performance indicators). Moreover, establishing feedback loops where healthcare providers can report challenges and successes in implementing the guideline may help identify areas that need more support or adjustment.<br>Addressing the needs of different population groups may be challenging. We recommend the development of inclusive health policies that can ensure all individuals have equal access to nutrition support. | |
| UK Preconcepti | Guideline | 015 - 016 | 021 - 023 | When referring to factors that can affect weight change during pregnancy, we recommend adding | Thank you for your comment. We recognise that there are many factors that may have a direct or indirect impact on |

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| on Partnership | | | | wellbeing and mental health (https://pubmed.ncbi.nlm.nih.gov/31063018/; https://pubmed.ncbi.nlm.nih.gov/36930325/). | the person's weight. In the text you're referring to, we are listing tangible physiological factors in pregnancy that impact overall weight gain during pregnancy.<br><br>Thank you for the references, which we have checked and are ineligible for inclusion as they are out of scope for this guideline. |
| UK Preconception Partnership | Guideline | 001 | 008 | To accurately capture the scope of the guideline, and for consistency, we recommend stating that 'The guideline covers nutrition and weight management in pregnancy for anyone who **may become pregnant**, is planning to become pregnant, or is already pregnant..'. (the addition of 'for anyone who may become pregnant' is in line with statements in the Guideline for example on page 6 [lines 7 & 18]. | Thank you for your comment. We have amended the wording based on your feedback. |
| UK Preconception Partnership | Guideline | 001 | General | We recommend reference in the introduction to the role of partners and fathers before, during and after pregnancy in supporting optimal nutrition and health for women, children and families (https://pubmed.ncbi.nlm.nih.gov/28983715/; https://www.tandfonline.com/doi/full/10.1080/23293691.2024.2345099). | Thank you for your comment. In the section "Who is it for?" we mention families and partners so we think this is sufficiently captured. |
| UK Preconcepti | Guideline | 002 | General | When listing healthcare professionals working in the NHS who are responsible for maternal and child nutrition, we recommend explicit mention of | Thank you for your comment. We have added specialist nurses to the list. |

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| on Partnership | | | | specialist nurses and midwives (e.g. epilepsy, diabetes). | |
| UK Preconception Partnership | Guideline | 002 | General | Second last bullet point under 'Who is it for'; we suggest stating 'Anyone who **may become pregnant**, is planning a pregnancy or who is pregnant, ..'. | Thank you for your comment. The guideline is partially applicable to people who may become pregnant but because this text is referring to the target audience of the guideline, those planning to become pregnant is more accurate here as we would not expect people who are not planning pregnancy to seek this guidance. |
| UK Preconception Partnership | Guideline | 002 | General | When referring to 'anyone' (e.g. anyone who is planning or may become pregnant), we recommend using gender-sensitive language, or a comment somewhere in the guideline that 'anyone' refers to people who can become pregnant, irrespective of their gender identity (https://onlinelibrary.wiley.com/doi/10.1111/hex.14181). | Thank you for your comment. We have used the word 'anyone' as this word is already indefinite and as such gender-sensitive. We have been careful to use gender-sensitive language throughout the guideline. |
| UK Preconception Partnership | Guideline | 005 | 006 | We recommend adding the following relevant resources to the list: NHS page on pregnancy planning (https://www.nhs.uk/pregnancy/trying-for-a-baby/planning-your-pregnancy/), NICE CKS on Preconception care (https://cks.nice.org.uk/topics/pre-conception-advice-management/), NICE CKS on Epilepsy (https://cks.nice.org.uk/topics/epilepsy/), NICE guideline on Diabetes in pregnancy: management | Thank you for your comment. We have added the reference to the NHS advice on planning pregnancy because it provides the government guidance on folic acid supplementation we are referring to in the recommendations. So not to inundate readers with references, we have had to be selective of which ones we include so we have not added all the suggested links to the list. |

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| | | | | from preconception to the postnatal period (https://www.nice.org.uk/guidance/ng3/). | |
| UK Preconception Partnership | Guideline | 005 | 015 | We recommend reference to 'between' i.e. folic acid before, between and during pregnancies. The interconception period may not be considered if it is not explicitly mentioned, and preconception folic acid supplement use is lower before second and subsequent pregnancies (https://pubmed.ncbi.nlm.nih.gov/36810878/). | Thank you for the comment. We are referring to government advice on folic acid supplementation before and during pregnancy. This does not explicitly include supplementation between pregnancies so we have not added this. |
| UK Preconception Partnership | Guideline | 005 | 019 | We recommend adding specialist services to the list (e.g. preconception care clinics and maternal medicine networks) as well as healthcare settings supporting chronic condition management in secondary and tertiary healthcare for conditions such as epilepsy. | Thank you for your comment. We have added to the list specialist clinics for those with medical conditions. |
| UK Preconception Partnership | Guideline | 006 | 004 | We recommend family hubs be specifically stated here (for consistency with the vitamin D section). | Thank you for your comment. We have amended the wording to capture different types of health and social care hubs that may exist in the community, family hubs being one example. |
| UK Preconception Partnership | Guideline | 006 | 010 | We recommend adding 'reproductive health' to the list of relevant appointments when the importance of folic acid can be discussed. | Thank you for your comment. We have added a bullet point 'reproductive health' to the recommendation as suggested. |
| UK Preconcepti | Guideline | 007 | 012 | We recommend replacing 'offer' with 'prescribe' when referring to high-dose folic acid supplements. | Thank you for your comment. We recognise that high-dose folic acid needs to be prescribed by a clinician, however, our preferred wording in this instance is to say 'offer' which |

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| on Partnership | | | | | is the normal NICE terminology for strong recommendations. |
| UK Preconception Partnership | Guideline | 007 | 012 | We suggest stating '..to anyone who **may become pregnant**, is planning to become pregnant, or is in the first 12 weeks of pregnancy, ..'. | Thank you for your comment. In the case of high-dose folic acid, the committee did not want to include those 'who may become pregnant' because of the lack of evidence on the potential side effects of long-term use of high-dose folic acid so the recommendation should be targeted mainly for those who are planning pregnancy or are already pregnant. The evidence review only looked at people planning to become pregnant or those in early pregnancy. |
| UK Preconception Partnership | Guideline | 007 | 025 | Section 1.1.3 (page 6) on providing information in the person's preferred format etc is also relevant to section 1.1.4, and may be better placed after line 25 on page 7. | Thank you for your comment. We have amended the recommendations so that this applies to all discussions about folic acid, regardless of the recommended dose. |
| UK Preconception Partnership | Guideline | 007 | 026 - 030 | **[This text was identified as confidential and has been removed]** | Thank you for your comment. The trial was published after the search date for the evidence review protocol and therefore cannot be included. This evidence will be flagged for surveillance for any future updates for this guideline. |
| UK Preconception Partnership | Guideline | 008 | General | There appears to be no reference to iron in the guideline, despite very extensive literature on iron deficiency before and during pregnancy and its consequences for maternal health, pregnancy outcomes and offspring development (e.g. https://pubmed.ncbi.nlm.nih.gov/32184147/; https://pubmed.ncbi.nlm.nih.gov/35427520/). | Thank you for your comment. Iron and iodine supplementation before and during pregnancy was not included in the scope of this guideline. Current UK government guidance does not recommend routine iron or iodine supplementation for every pregnancy. |

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| | | | | There are also no references to iodine in the guideline, despite extensive literature on iodine deficiency before and during pregnancy affecting around 1 in 10 women in the UK and its consequences for offspring neurocognitive development (e.g. https://pubmed.ncbi.nlm.nih.gov/33184453/; https://pubmed.ncbi.nlm.nih.gov/29767745/; https://pubmed.ncbi.nlm.nih.gov/23706508/). | Thank you for the references, which we have checked. They are ineligible for inclusion as they are out of scope for this guideline. |
| UK Preconception Partnership | Guideline | 009 | 003 | We recommend reference to secondary and tertiary healthcare visits, for example epilepsy clinic appointments where vitamin D deficiency secondary to antiseizure medicines use is managed. | Thank you for your comment. We have added specialist clinics for existing medical conditions to the list. |
| UK Preconception Partnership | Guideline | 012 | General | While noting that weight management for women before and after pregnancy is not covered by this update but by the update to the NICE guidelines on weight management, there is moderate-certainty evidence that preconception physical activity is associated with a reduced risk of gestational diabetes and pre-eclampsia (https://pubmed.ncbi.nlm.nih.gov/34970757/). We recommend a mention of the importance of physical activity before and between pregnancies. | Thank you for your comment. Weight management before and after pregnancy is outside the remit of this guideline.<br><br>Thank you for the reference, which we have checked and is ineligible for inclusion as it is out of scope for this guideline. |
| UK Preconcepti | Guideline | 013 | 010 - 011 | In addition to mentioning 'Healthy food and drink options that are acceptable and available for the | Thank you for your comment. We think the word 'available' also includes the aspect of affordability. We agree this is |

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| on Partnership | | | | person', we recommend adding 'affordable' here as food insecurity disproportionally impacts women. | an important consideration and one of the reasons for including this line in the recommendations. |
| UK Preconception Partnership | Guideline | 013 | 019 - 020 | In addition to mentioning 'Provide tailored, non-judgemental and culturally sensitive information that is in the person's preferred format', we recommend adding 'inclusive' here. | Thank you for your comment. We are not quite sure what 'inclusive' information in this context would mean. We hope that tailoring the information to the individual and being non-judgemental and culturally sensitive would suffice. |
| UK Preconception Partnership | Guideline | 016 | 015 | We recommend adding further complications associated with excessive weight gain in pregnancy (including increased risk of pre-term birth, stillbirth, thrombosis, difficult or prolonged labour, post-partum haemorrhage, shoulder dystocia, anaesthetic complications and wound complications in the postpartum period) and with low maternal weight gain (e.g. increased risk of preterm birth and small for gestational age) (https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/1471-0528.15386; https://pubmed.ncbi.nlm.nih.gov/21623738/; https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/tog.12792). | Thank you for your comment. Evidence showed that there was an association between inadequate weight gain and baby being small for gestational age among those with pre-pregnancy BMI in the underweight and healthy weight ranges and this is captured in the recommendations.<br><br>Other outcomes listed in the comment were not prioritised by the guideline committee during protocol setting of the evidence review. Therefore, we have not reviewed the evidence for this and so recommendations cannot be made regarding these outcomes.<br><br>Thank you for the references, which we have checked against the relevant evidence review protocol. The first reference to the RCOG Green Top Guidance is ineligible for inclusion due to study design. The second reference to a systematic review is ineligible for inclusion due to 18/55 studies with an ineligible study design, 7/55 studies with |

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| | | | | | ineligible country, and 30/55 conducted in North America, Europe or Oceania after 1989 so the cohorts are likely to have been included in evidence review F. The final reference is ineligible for inclusion due to ineligible study design. |
| UK Preconception Partnership | Guideline | 018 | 011 - 014 | We recommend reference to discussing wellbeing and mental health if there are concerns about excessive weight gain during pregnancy (https://pubmed.ncbi.nlm.nih.gov/31063018/; https://pubmed.ncbi.nlm.nih.gov/36930325/). | Thank you for your comment. We have amended the recommendation based on your and other stakeholders' feedback so the potential reasons are explored, including psychological wellbeing. |
| UK Preconception Partnership | Guideline | 018 | 019 | We recommend adding consideration of referral to antenatal clinic if risk changes with excessive weight gain as women may need an anaesthetic risk assessment (https://www.bjaed.org/article/S2058-5349(21)00003-2/fulltext; https://www.publichealth.hscni.net/sites/default/files/CMACE-RCOG%20Joint%20Guideline-Management%20of%20women%20with%20obesity%20in%20pregnancy.pdf). | Thank you for your comment. BMI at booking appointment is a more appropriate trigger for risk assessment as routine monitoring of weight in pregnancy is not recommended. |
| UK Preconception Partnership | Guideline | 019 | 002 | In the section on low weight gain in pregnancy, we recommend mention of weight loss in pregnancy related to severe hyperemesis gravidarum. This is common and associated with small for gestational age, preterm birth and other adverse outcomes for mother and baby | Thank you for your comment. The recommendation has been amended to explore potential reasons for low weight gain, including physical and psychological wellbeing. While routine monitoring throughout pregnancy is not recommended, the guidance recognises there may be clinical indications where this might be needed, for |

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| | | | | (https://pubmed.ncbi.nlm.nih.gov/36924660/; https://pubmed.ncbi.nlm.nih.gov/23360164/; https://pubmed.ncbi.nlm.nih.gov/35367190/). A full review of hyperemesis gravidarum and management is not needed here, but healthcare professionals and patients should be signposted to the RCOG Green-top guideline (https://www.rcog.org.uk/guidance/browse-all-guidance/green-top-guidelines/the-management-of-nausea-and-vomiting-of-pregnancy-and-hyperemesis-gravidarum-green-top-guideline-no-69/) which is mentioned in section 1.4 and 1.4.7 in the NICE Antenatal care guideline [NG201] (https://www.nice.org.uk/guidance/ng201/chapter/Recommendations#interventions-for-common-problems-during-pregnancy). | example hyperemesis gravidarum. The NICE guideline on antenatal care refers to the RCOG Green-Top guideline. |
| UK Preconception Partnership | Guideline | 019 | 004 - 007 | We recommend reference to discussing wellbeing and mental health if there are concerns about low weight gain during pregnancy (https://pubmed.ncbi.nlm.nih.gov/31063018/; https://pubmed.ncbi.nlm.nih.gov/36930325/). | Thank you for your comment. The recommendation has been amended based on your feedback. |
| UK Preconception Partnership | Guideline | 033 | 004 | We recommend changing this recommendation to 'Approaches to increase uptake..' rather than 'Digital technologies to increase uptake..'. The evidence summarised on page 35 suggests other approaches would be beneficial (e.g. posters and | Thank you for your comment. In evidence review C, there was some evidence available for folic acid information/education provision through educational sessions, leaflets/brochures etc, hence the committee decided not to recommend further research for these |

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| | | | | leaflets). Our research has also shown that migrant women, women without university degrees and those from low-income households are less aware of the benefits of preconception folic acid supplement use (https://pubmed.ncbi.nlm.nih.gov/36151510/). Focusing only on digital technologies may increase inequalities for those who experience digital exclusion and/or have low literacy levels. Approaches such as school-based education, public health campaigns and community events, while considering appropriate use of easy-to-understand and inclusive language, are likely to be more equitable and effective (https://pubmed.ncbi.nlm.nih.gov/36151510/; https://www.medrxiv.org/content/10.1101/2024.02.13.24302690v1; https://onlinelibrary.wiley.com/doi/full/10.1111/hex.14181). | interventions. There was no evidence available for digital technologies to establish its effectiveness in delivering interventions to increase folic acid uptake. Therefore, the committee agreed that further research in this area was particularly important as it is becoming more common in healthcare services, and this would help inform future updates of this guideline.<br><br>The impact of social differences (e.g. age, socio economic status, geography etc.) on digital technologies would be explored with subgroup analysis in the research; this has been captured in the research recommendation. |
| UK Preconception Partnership | Guideline | 033 | 006 | When referring to 'to increase uptake', we recommend adding 'and reduce inequalities in uptake'. | Thank you for your comment. The committee decided not to include reducing inequalities to the research question, as this would change the objective of the research which was to increase uptake of folic acid. The research should be conducted in all relevant people including groups who may experience inequalities. Subgroup analysis according to age, socio economic status and deprivation, |

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| | | | | | comorbidities, geographical variation and ethnicity have been included in the research recommendation (see Appendix K in evidence report C) to understand the effectiveness of digital technologies in these sub-groups. |
| UK Preconception Partnership | Guideline | 034 | General | We would like to suggest additional recommendations for research:<br>1. The role of partners and fathers: how can involvement of partners and fathers (before, during and after pregnancy) support optimal maternal and child nutrition?<br>2. Preconception micronutrient supplementation: a recent study documented that 9 in 10 women of a group trying to conceive had low or marginal B-vitamin/vitamin D status (https://pubmed.ncbi.nlm.nih.gov/38051700/) and that supplementation improves pregnancy and offspring outcomes (https://pubmed.ncbi.nlm.nih.gov/33782086/; https://pubmed.ncbi.nlm.nih.gov/38287349/). Further research is needed to clarify optimal doses and timing, along with strategies to support micronutrient status in minoritised groups. This is particularly pertinent as the move towards more plant-based diets will likely worsen micronutrient status. | Thank you for your comment. Research recommendations can only be made on areas directly reviewed within a guideline. The topics suggested have not been reviewed in this guideline, therefore the committee are not able to make research recommendations in these areas. |

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| | | | | Pregnancy after bariatric surgery: what recommendations should be given to women who may become pregnant and who are pregnant and who have had bariatric surgery? | |
| UK Preconception Partnership | Guideline | 037 | 013 | We suggest referring to '**best** practice', as recommendations on high-dose folic acid supplement use do not reflect current day-to-day clinical practice. | Thank you for your comment. The text has been amended as suggested. |
| UK Preconception Partnership | Guideline | 038 | 011 - 013 | **[This text was identified as confidential and has been removed]** | Thank you for your comment. Evidence on vitamin D supplementation in non-pregnant women was outside the scope of this guideline, so evidence on this was not reviewed.<br>Since the evidence review specifically looked at people in the overweight or obesity weight categories, studies that did not report results stratified by BMI were not included.<br><br>Thank you for the references, which we have checked against our review protocol. The first reference is ineligible for inclusion as the population is menopausal women, which is outside the scope of the guideline. The following two references are ineligible for inclusion because they report outcomes that are not in the review protocol, and the final reference is ineligible for inclusion as it is out of scope. |

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| UK Preconception Partnership | Guideline | 050 | 025 | We suggest adding 'and among women from Black ethnic background'. (https://pubmed.ncbi.nlm.nih.gov/36810878/). | Thank you for your comment. We have amended this section based on your feedback and added reference to the study you are referring to. According to the findings, the uptake of folic acid was lowest among Black women but it was also lower in other ethnic minority groups compared to White women so we have not singled out Black women. |
| UNICEF UK Baby Friendly Initiative | Guideline | 020 | 017 | Please amend to: The UNICEF UK Baby Friendly Initiative | Thank you, we have corrected this. |
| UNICEF UK Baby Friendly Initiative | Guideline | 022 | 005 | Suggest adding a bullet to say that support should be predictable or reliable and timely. Also add a bullet to say that there should be specialist support for particular challenges including both physical and emotional | Thank you for your comment. We have not made the suggested additions. We think that 'evidence-based and consistent' would cover the aspect of it being predictable and reliable. We do not think it is needed to add 'timely' as overall the recommendations say that baby's feeding should be discussed at every health contact.<br><br>It is part of standard clinical practice for healthcare professionals to refer or signpost to further support if there are particular concerns so this has not been added. |
| UNICEF UK Baby Friendly Initiative | Guideline | 025 | 006 | 1.3.12 Would it be possible to add a comment or a link to information about why prep machines should be avoided? As an example a link to First Steps Nutrition could be added to provide | Thank you for your comment. This section does not go into detail regarding the advice given, instead several links for further advice is provided. Some of these links include advice on using formula prep machines. First Steps Nutrition Trust resources are now mentioned in the |

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| | | | | information on types of infant formula and prep machines. | rationale section as something the committee were aware are evidence-based and non-commercial sources of information. |
| UNICEF UK Baby Friendly Initiative | Guideline | 025 | 019 | 1.3.14 Please amend to Better Health Start for Life/UNICEF UK Baby Friendly Initiative Guide to bottle feeding | Thank you for your comment. The text has been amended as suggested. |
| University Hospitals Birmingham NHS SH Foundation Trust | Guideline | 021 | 022 - 024 | I am concerned regarding recommendations of 'tips for convenience – stock piling expressed breast milk'. Although we would recommend options of expressed breast milk for lifestyle convenience or clinical concerns, we do not encourage stock piling for the following reasons:<br>• Breast milk nutrition develops and matures as the baby grows.<br>Physiology of lactation may be contraindicated with responsive breastfeeding as excessive expressing may lead to additional challenges of engorgement. | Thank you for your comment. The committee has amended the recommendation so that it now recommends discussion of practical suggestions and tips for convenience, such as how to safely express and store breast milk. |
| University of East Anglia | Guideline | 005 | 010 | The link to NHS advice on vitamins, supplements and nutrition in pregnancy lists the foods that contain iron for preventing anaemia as lean meat, green leafy vegetables, dried fruit and nuts. I suggest this list is updated and expanded, using the foods cited as rich in iron in the SACN Iron and Health Report | Thank you for your comment. Updating the website you're referring to is not within the remit of NICE. |

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| | | | | (https://www.gov.uk/government/publications/sacn-iron-and-health-report) page 51, namely cereals, vegetables, nuts, eggs, fish and meat. Vegetables should be categorised as dark green leafy vegetables, and legumes and dried fruit should be added to the list. | |
| West Hertfordshire Hospitals NHS Trust | Guideline | 028 | 002 | **[This text was identified as confidential and has been removed].** | Thank you for your comment. According to the page and line number information provided this is referring to the second line of the heading of the section on Introducing solid foods (complementary feeding) for babies between 6 months and 1 year. We are not sure what is meant by this comment and therefore are unable to give a response. |
| West Hertfordshire Hospitals NHS Trust | Guideline | 028 | 022 | **[This text was identified as confidential and has been removed].** | Thank you for your comment. The UK government Scientific Advisory Committee on Nutrition recommendation is "Advice on complementary feeding should state that foods containing peanut and hen's egg can be introduced from around 6 months of age and need not be differentiated from other solid foods.", see S.47 on page xix on Feeding in the first year of life: SACN report - GOV.UK (www.gov.uk). |
| WHO Collaborating Centre in Nutritional Epidemiology | Evidence review R | 045 | 031 - 037 | "Referring to the SACN guidance which states that commercially manufactured foods and drinks marketed specifically for infants and young children are not needed, the committee agreed that the benefits of homemade foods should be discussed as highly processed or commercial | Thank you for your comment. The recommendations have been amended to mention the role of breast milk in healthy eating and drinking for children from 1 up to 5 years. The recommendations already included discussing the benefits of homemade food without adding sugar, salt or sweetening agents, and the committee also added |

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| | | | | foods may be high in salt and sugar and have lack of different textures and flavours, and that snacks that are offered should be based on whole foods, not commercial snack products"<br><br>This point noted in report R is not adequately represented in the recommendations.<br><br>Suggest amending page 31, line 15-16 "The importance of a balanced and diverse diet, comprised of 3 meals a day, 2 healthy snacks *(based on whole foods and not commercial snack foods)* and water or milk"<br><br>Further, we feel additional bullets relating to comments above that commercial foods lack texture and tend to be sweet are needed. See page 21, comments relating to textures, chewing ability and page 23 relating to unsuitability of commercial snack foods. | "including nutrition, taste and texture" to this point. They also added that "commercial foods and drinks are not needed to meet nutritional requirements". |
| WHO Collaborating Centre in Nutritional | General | General | General | Between Feb 2025 and January 2028 we (Janet Cade and Diane Threapleton are co-PIs) will undertake an NIHR-commissioned PRP study (ref 37-01-06) on Nutrition in the early years (age 1-5) looking at dietary intakes in 2000+ children to | Thank you for your response. We will pass your comment to the NICE surveillance team which monitors guidelines to ensure that they are up to date. |

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| Epidemiology | | | | understand the role of nutrition, portions, commercial foods and plant-based diets in growth and dental health outcomes. Findings from this work should help to address some uncertainties that exist in current recommendations to children in this age group. | |
| WHO Collaborating Centre in Nutritional Epidemiology | Guideline | 013 | 019 | We encourage HCPs to provide tailored information by taking a quick 24h recall using an online tool such as myfood24. This is designed to provide helpful feedback on whether individuals are meeting nutrient requirements or not. This will provide clear guidance and direction on areas of improvement needed. | Thank you for your comment. This is not something we will include in the guideline but helpful to know about such a tool. |
| WHO Collaborating Centre in Nutritional Epidemiology | Guideline | 016 | 007 - 008 | "but that there is lack of evidence about what the optimal weight change per week in each trimester should be."<br><br>You have omitted to include a research recommendation to address this uncertainty. | Thank you for your comment. The committee did not prioritise a research recommendation on this topic. The decision on whether to include a research recommendation is based on whether there is promising evidence to suggest that research would add value, but also whether this is an area of importance to the guideline topic and feasible to carry out. They thought that there was already a lot of literature on this topic in general and adding more, particularly without standardised methods and definitions, would unlikely be useful in providing meaningful findings. They recognised the limited evidence on trimester-specific weight change which could potentially be more useful in practice, but the committee's view was |

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| | | | | | that pre-pregnancy or between-pregnancy BMI is a more important factor to focus on, rather than weight change in pregnancy. However, weight management before or after pregnancy is outside the scope of this guideline. |
| WHO Collaborating Centre in Nutritional Epidemiology | Guideline | 016 | 022 - 023 | "The risks associated with gaining too little weight during the pregnancy regardless of pre-pregnancy BMI"<br><br>Please see this recent cohort study on low gestational weight gains in pregnant women with obesity and no association with detrimental outcomes/reduced risk of detrimental outcomes [https://pubmed.ncbi.nlm.nih.gov/38555927/]. Saying 'regardless of pre-pregnancy BMI' here may be inappropriate and is not supported by evidence. We currently do not have any interventional and little observational data showing that gaining 'too little weight' (and what is too little, as you acknowledge, we don't know what optimal weight gains should be: Guideline doc, page 16, line 7-8) is detrimental. It may well be beneficial for women with overweight or obesity and to make lower gains or even lose weight during pregnancy (whilst maintaining highly nutritious diets). Benefits of lower weight gains/weight loss may be seen on both maternal | Thank you for your comment.<br><br>Thank for providing this reference, which we have checked against our review protocol. This study was not included in the evidence review as it was published after the search date for the evidence review and reports a composite maternal and neonatal outcomes which is not relevant to our review protocol. This evidence will be flagged for surveillance for any future updates for this guideline.<br><br>The evidence presented in evidence review F support the wording 'regardless of pre-pregnancy BMI' as the evidence showed an association between SGA and inadequate weight change in all pre-pregnancy BMI categories, as well as in the analysis where there was no stratification according to pre-pregnancy BMI.<br><br>The nuanced discussion about 'too little weight gain' depending on pre-pregnancy BMI has been included in the evidence review discussion section and is also highlighted in the guideline. |

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| | | | | and child outcomes in women entering pregnancy with obesity but we don't currently know what's best. We propose a research recommendation on this topic and modification of the wording here to reflect this uncertainty.<br><br>'Recommendations for research: Research and dietary interventions, including with digital technology, to explore lower weight gains in women with pre-pregnancy/early pregnancy overweight or obesity'. | In Evidence review G, dietary interventions were considered for all BMI ranges including obesity BMI ranges. However, only some studies reported weight change based on recommended ranges during pregnancy according to pre-pregnancy BMI ranges. Due to these concerns, as well as uncertainty and the quality of the evidence, the committee decided not to make specific recommendations on interventions for gestational weight change. The decision on whether to include a research recommendation is based on whether there is promising evidence to suggest that research would add value, but also whether this is an area of importance to the guideline topic and feasible to carry out. They thought that there was already a lot of literature on this topic in general and adding more, particularly without a standardised methods and definitions, would unlikely be useful in providing meaningful findings. They recognised the limited evidence on trimester-specific weight change which could potentially be more useful in practice but the committee's view was that pre-pregnancy or between-pregnancy BMI is a more important factor to focus on, rather than weight change in pregnancy. However, weight management before or after pregnancy is outside the scope of this guideline.<br><br>. |

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| WHO Collaborating Centre in Nutritional Epidemiology | Guideline | 019 | 016 | Providing individualised advice requires knowledge of individual intakes. This can be achieved through online tools. Self-management in women with gestational diabetes has been shown to be effective with myfood24. https://pubmed.ncbi.nlm.nih.gov/30142898/ | Thank you for your comment. There was no evidence for self-monitoring interventions in the evidence review, therefore the committee did not make any recommendations for these interventions. The reference provided has been checked, it does not meet the study design inclusion criteria, as it is a mixed methods prospective observational study. Our protocol inclusion criteria were RCTs, systematic reviews of RCTs and individual patient data (IPD) meta-analysis of RCTs. |
| WHO Collaborating Centre in Nutritional Epidemiology | Guideline | 029 | 009 - 010 | "The benefits of homemade foods (without adding sugar, salt or sweetening agents)."<br><br>We agree with this point but would like to add more detail:<br>"The benefits of homemade foods (without adding sugar, salt or sweetening agents) and that have varied textures and flavours that don't rely on sweet tastes). | Thank you for your comment. The recommendation has been amended based on your suggestion. |
| WHO Collaborating Centre in Nutritional Epidemiology | Guideline | 029 | 009 - 010 | "The benefits of homemade foods (without adding sugar, salt or sweetening agents)."<br><br>To complement this point and address documented concerns with commercially | Thank you for your comment. The committee agree, and to address the effects of consumption of commercial foods, they have added to the discussion points about introducing solids that commercial foods and drinks are not needed to meet nutritional requirements. |

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| | | | | available complementary foods, we recommend adding additional bullets:<br><br>• "Inform parents that commercial foods are not necessary to achieve balanced diets".<br>As stated in SACN report ["Commercially manufactured foods and drinks marketed specifically for infants and young children are not needed to meet nutritional requirements", https://www.gov.uk/government/publications/sacn-report-feeding-young-children-aged-1-to-5-years/feeding-young-children-aged-1-to-5-years-summary-report]<br><br>• "Highlight/educate parents about some of the concerns with commercial foods, supporting informed choice for feeding including that baby food contents are not regulated, and they may be nutritionally inappropriate like being high in sugar (including from fruit ingredients) and low in energy (too watery)"<br><br>Supported by the comment in Evidence review R, page 40, line 33-37 that 'food packets could be misleading or misinterpreted as being according | |

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| | | | | to recommendations, as the evidence reported that parents paid no attention to the nutritional contents of foods marketed for babies as they assumed it had to have the right nutrients suitable for babies. The committee also noted there is often an assumption among parents that marketed foods are suitable and healthy as advertised thus influencing their food choices"<br><br>Please also refer to our WHO Nutrient and Promotion Profile Model https://iris.who.int/handle/10665/364678 for published concerns with commercially available complementary foods and see page 15 regarding energy density concerns | |
| WHO Collaborating Centre in Nutritional Epidemiology | Guideline | 029 | 011 | Relating to drinking from cups<br><br>Page 42, line 20-23 from Evidence review R: "The committee also discussed that in line with current advice, parents should be advised to introduce the use of cups and beakers alongside solid food so that the baby will gradually learn to drink from a cup, as baby bottles are no longer recommended from 1 year of age due to oral health concerns" | Thank you for your comment. In response to stakeholder comments, we have added to the section on healthy eating in children from 12 months to 5 years that drinks should be given in cups and bottles with teats should be avoided.<br><br>To address the effects of consumption of commercial foods, the committee have added that commercial foods and drinks are not needed to meet nutritional requirements in the recommended discussion points about introducing solids. |

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| | | | | This point should also be included in section 1.5.12.<br><br>Further, the need to avoid drinking from spouts (pouches) and avoid drinks like fruit shoots should be emphasised both in section 1.5.7 and 1.5.12, providing parents with a little understanding of the risks to dental health and potential to overconsume highly sweet foods (when drinking foods via spouts). Rapid consumption of highly sweet foods is a concern for commercial foods which tend to rely on macerated fruit to provide highly sweet foods and where most of the energy is from sugar (e.g. fruit purees). Please also refer to our WHO Nutrient and Promotion Profile Model https://iris.who.int/handle/10665/364678 for published concerns with commercially available complementary foods and see page 18 for concerns around excessive sugar levels. | |
| WHO Collaborating Centre in Nutritional Epidemiology | Guideline | 029 | 012 | "Foods and drinks to avoid"<br><br>We support this point but propose expanding it: "Foods and drinks to avoid including sweet snacks (even when made from fruit), flavoured drinks, juice, and cordial etc." | Thank you for your comment. We have not added such level of detail in these discussion points. |

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| WHO Collaborating Centre in Nutritional Epidemiology | Guideline | 029 | 026 - 029 | "Being aware of potentially misleading information and marketing from commercial baby food companies that conflicts with UK government guidance, for example, age of introduction, hidden sugar content and snack foods."<br><br>We strongly support this statement and recommending proving parents with more information to inform and guide their feeding choices such as:<br>-extending the point about snack foods to note that they are unnecessary (SACN 2023).<br>-that commercial foods sold as suitable from 4 months are often highly sweet and watery, providing less energy than breastmilk or infant formula (page 15 and 18 https://iris.who.int/handle/10665/364678)<br>-commercial foods are often unsuitable, lacking varied textures, flavours, relying on sweet taste profile and high sugar content (from added sugars, concentrated fruit juice or from fruit ingredients) and are heavily/persuasively marketed to play on vulnerabilities of parents with young children and position themselves as the optimal feeding choice (re marketing, see page 22 https://iris.who.int/handle/10665/364678). | Thank you for your comment. To address the effects of consumption of commercial foods, the committee have now added that commercial foods and drinks are not needed to meet nutritional requirements in the recommended discussions points about introducing solids. |

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| WHO Collaborating Centre in Nutritional Epidemiology | Guideline | 031 | 001 - 004 | "Being aware of potentially misleading information and marketing from commercial food companies that conflicts with UK government guidance, for example, hidden sugar content and pre-packaged snack foods."<br><br>We strongly support this statement and recommending proving parents with more information to inform and guide their feeding choices such as:<br>-extending the point about snack foods to note that they are unnecessary (SACN 2023).<br>-that commercial foods sold as suitable from 4 months are often highly sweet and watery, providing less energy than breastmilk or infant formula (page 15 and 18 https://iris.who.int/handle/10665/364678)<br>-commercial foods are often unsuitable, lacking varied textures, flavours, relying on sweet taste profile and high sugar content (from added sugars, concentrated fruit juice or from fruit ingredients) and are heavily/persuasively marketed to play on vulnerabilities of parents with young children and position themselves as the optimal feeding choice (re marketing, see page 22 https://iris.who.int/handle/10665/364678). | Thank you for your comment.<br>To address the effects of consumption of commercial foods, the committee have added that commercial foods and drinks are not needed to meet nutritional requirements in the recommended discussion points about introducing solids. |

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| WHO Collaborating Centre in Nutritional Epidemiology | Guideline | 031 | 017 - 019 | That formula milks are not needed, sugar-sweetened drinks should not be given, and fruit juice should be limited (no more than 150 ml per day).<br><br>We support this point but think that caution needed here as healthcare providers/parents may interpret this to mean that non-caloric or low-caloric sweeteners are preferrable. SACN conclude there are no toxicological concerns but insufficient evidence in terms of type 1 diabetes and BMI [pages 262-264 https://assets.publishing.service.gov.uk/media/662a4a4d690acb1c0ba7e616/SACN-Feeding-young-children-aged-1-to-5-full-report-revised.pdf]. Further, long-term use through childhood is not well documented nor is understanding of long-term consequences on taste preferences and body size, metabolic function or microbiome changes that track into later life.<br><br>We propose a statement such as "There is an absence of evidence on the potential harms from non and low-caloric sweeteners in commercially | Thank you for your comment. This is a good point and we have amended this to "sweetened drinks should not be given". |

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| | | | | available foods in young children and suggest that parents are informed that foods containing these are avoided in children under 5 years".<br><br>This is a potential area for further research. | |
| WHO Collaborating Centre in Nutritional Epidemiology | Guideline | 031 | 024 - 026 | "Ensuring that snacks offered between meals are low in sugar and salt (for example, vegetables, fruit, plain (not flavoured) milk, bread and homemade sandwiches with savoury fillings)."<br><br>We agree and suggest this list is expanded to include plain yogurts, low-salt crackers/oatcakes, and plain nuts (non-whole nuts such as chopped, flaked or nut butters) | Thank you for your comment. This list is not exhaustive, and the committee have provided a few examples. |
| WHO Collaborating Centre in Nutritional Epidemiology | Guideline | 032 | 017 | In addition to role modelling, we have shown that young children eat more fruit/vegetables if they are eating at a table and have the fruit/veg cut up. https://pubmed.ncbi.nlm.nih.gov/23254183/ Whilst these results were from primary aged children we consider these points important for younger ages too. | Thank you for your comment. The committee agree on the importance of families eating together, and how parents and carers can set a good example through their own food choices is highlighted in Table 3 in the guideline. |
| WHO Collaborating Centre in Nutritional | Guideline | 033 | 003 | Consider making a recommendation for research around use of digital technologies to support healthy eating in pregnancy, women with gestational diabetes and young children. You | Thank you for your comment.<br>The committee recognises the potential of digital technologies in promoting healthy eating in pregnancy; |

**Maternal and child nutrition: nutrition and weight management in pregnancy, and nutrition in children up to 5 years**

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| Epidemiology | | | | have digital technologies to promote folic acid uptake. Why not have this for overall diet intake too? | however, they did not prioritise this area for a research recommendation. |
| Wirral Community Health and Care NHS Foundation Trust | Guideline | General | General | Can we add in somewhere the importance of breastfeeding conversations during antenatal contacts please? | Thank you for your comment. Breastfeeding conversations in the antenatal period are covered by the NICE guideline on postnatal care (which covers breastfeeding in the antenatal period and the 8 weeks after birth). This guideline covers breastfeeding support beyond 8 weeks after birth. We will ensure cross-references between the guidelines. |
| Wirral Community Health and Care NHS Foundation Trust | Guideline | 010 | 004 | Healthy start vitamins contain vitamin C – SACN report 2024 (Feeding young children aged 1 to 5 years - summary report - GOV.UK (www.gov.uk)) have shown intakes of vitamin C exceeded the RNI across all age groups, therefore clinicians should be aware high levels of vitamin C can have some GI side effects. | Thank you for your comment. This was not reviewed by the committee and no comment has been made on this in the guideline. |
| Wirral Community Health and Care NHS Foundation Trust | Guideline | 013 | 012 | Can we include here an emphasis on fresh foods and avoidance of ultra processed foods whereever possible? | Thank you for your comment. This has not been added as the recommendations do not go into such detail to explain what is or isn't healthy. A reference to the UK government dietary advice is given. |
| Wirral Community Health and | Guideline | 021 | 025 | No evidence to support a 'specific' diet when breastfeeding but can we mention the aim should continue to be to use fresh foods and minimise | Thank you for your comment. The recommendation has been amended to highlight the importance of having a healthy diet while breastfeeding. |

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| Care NHS Foundation Trust | | | | ultra processed foods where possible – food has a big impact on mood and this can have a bigger impact on a tired, breastfeeding parent | |
| Wirral Community Health and Care NHS Foundation Trust | Guideline | 029 | 008 | Can we reword this sentence "Offering a variety of foods, flavours and textures (not all sweet)." To include the word fresh - 'Offering a variety of FRESH foods, flavours and textures (not all sweet). | Thank you for your comment. This was not added. It is not clear what fresh in this context means, fresh as opposed to what? Frozen? Processed? |
| Wirral Community Health and Care NHS Foundation Trust | Guideline | 029 | 012 | Can we include here in brackets at the end of the sentence (with emphasis on the avoidance of ultra processed foods) | Thank you for your comment. We think that emphasising the benefits of home-made foods is sufficient. |
| Wirral Community Health and Care NHS Foundation Trust | Guideline | 031 | 017 | I think we should remove the statement "no more than 150mls per day" as this is still too much for some children depending on the rest of their diet. SACN report 2024 (Feeding young children aged 1 to 5 years - summary report - GOV.UK (www.gov.uk)) states that fruit juice (100% fruit juice and smoothies) contributed nearly 11% to free sugars intake in children aged 1.5 to 4 years. | Thank you for your comment. This is the current government recommendation so we have kept it. |
| Wirral Community Health and | Question 1 | | | I don't think so, there have been so many changes for clinicians to practice that people are reluctant to change – staff training would good to | Thank you for your response. Your comments will be considered by NICE where relevant support activity is being planned. The need for staff training has been noted |

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| Care NHS Foundation Trust | | | | discuss in more detail the evidence base behind the recommendations and why they are important. Again a good working group to implement and support would be good with a mix of AHPs, health visitors, community GP etc | in the How the recommendations might affect practice sections, where relevant. |
| Wirral Community Health and Care NHS Foundation Trust | Question 2 | | | Possibly for trusts who are not baby friendly, and had previously stopped weaning contacts for families etc – however this shouldn't be difficult to amend with a good working group to implement | Thank you for your comment. |
| World Breastfeeding Tends Initiative UK (WBTi UK) | Guideline | 020 | 008 - 009 | Change to'...for all healthcare professionals, including IBCLCs, who discuss babies' feeding, as well as breastfeeding peer supporters, including breastfeeding counsellors.'<br>IBCLC = International Board-Certified Lactation Consultant | Thank you. The committee have edited the text in consideration of stakeholder comments to say "all healthcare professionals and practitioners with skills and competencies in babies' feeding" and added some examples. |
| World Breastfeeding Tends Initiative UK (WBTi UK) | Guideline | 021 | 004 | Replace 'around' by ' at least', otherwise it implies that breastfeeding stops at 2 years | Thank you for your comment. We have amended this to say "around 2 years or beyond". |

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| World Breastfeeding Tends Initiative UK (WBTi UK) | Guideline | 021 | 012 | Add at end of sentence ',decreases the baby's immune protection and adversely affects the baby's gut microbiome.' | Thank you for your comment. Without reviewing the evidence on this, we are not able to provide such detail in the recommendation. |
| World Breastfeeding Tends Initiative UK (WBTi UK) | Guideline | 021 | 026 | Add at end of sentence ', but a healthy diet particularly benefits the mother's health as the mother's body prioritises milk production over maintenance of her body.' | Thank you for your comment. The recommendation has been amended to highlight the importance of having a healthy diet while breastfeeding. |
| World Breastfeeding Tends Initiative UK (WBTi UK) | Guideline | 022 | 014 | Add at end of sentence 'including breastfeeding counsellors'. Breastfeeding counsellors are peer supporters in that they are required to have had personal experience of breastfeeding to be eligible to train but they have much more training than those called peer supporters.<br>It would be useful as part of the document to list the different roles that can provide support in addition to health professionals – infant feeding support workers (who may be maternity support workers), IBCLCs (who are specialist lactation professionals), peer supporters (who may be NHS or third sector-trained) and breastfeeding counsellors. | Thank you for your comment. The recommendation has been edited to include appropriately trained healthcare professionals or peer supporters as suggested. |

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| World Breastfeeding Tends Initiative UK (WBTi UK) | Guideline | 024 | 019 | The ACAS advice is very brief and not the document 'Accommodating breastfeeding employees in the workplace', which used to exist. | Thank you for pointing this out. It seems this was changed during the development of the guideline and we have now updated the link and wording in the recommendation. Unfortunately the advice is now more limited. |
| World Breastfeeding Tends Initiative UK (WBTi UK) | Guideline | 029 | 010 | Add at end of sentence ',and the potential risks of ultra-processed foods.' This First Steps Nutrition Trust (FSNT) report is relevant: 'Ultra-processed foods in the diets of infants and young children in the UK' https://static1.squarespace.com/static/59f75004f09ca48694070f3b/t/6481134fdf3b065bf460fe05/1686180705852/FSN_UPF+Report_Digital+for+web%2C+June+2023.pdf | Thank you for your comment. The committee thought that emphasising the benefits of home-made foods is sufficient but to address the effects of consumption of commercial foods, they have added to the discussion points that commercial foods and drinks are not needed to meet nutritional requirements. |

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*