Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Abbott Nutrition	Short	2		World Health Organisation WHO guidelines. Addition of catch up growth and guidance on parameters for weight and longitudinal growth.	Thank you for your comment. Defining targets for catch-up growth falls outside of the scope of the guideline. Low weight for height is recognised in recommendation 1.2.4 (linear growth and BMI).
Abbott Nutrition	Short	3		Faltering growth led by organic and inorganic factors need to e explain what these are.	Thank you for your comment. In recommendations 1.2.9 to 1.2.11 we explain that it may not always be possible to identify a cause and that many factors may contribute to the problem of faltering growth. In other words, it may not be possible to find any specific organic cause (resulting from a disease or disorder) or inorganic cause (where there is no identifiable disease or disorder). We therefore highlight possible contributing factors for milk-fed infants (1.2.10) and for older infants and children (1.2.11). Recommendation 1.2.6 outlines an approach to clinical assessment and where necessary investigation to try to understand the factors underlying faltering growth in individual infants and children. The Committee wanted to avoid unnecessary investigations and these matters are discussed in the evidence to recommendation section in the full guideline (see section 5.3.4.7).

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Abbott Nutrition	Short	4		Section 1 Faltering growth can occur due to nutritional deficiencies such a zinc, calcium and iron. ESPGHAN, ESPEN and ECFS guidelines for cystic fibrosis support oral nutritional supplementation. Further zinc supplementation may be required according to clinical indications. Nutritional deficiencies can lead to faltering growth this needs to be mentioned.	Thank you for your comment. In relation to the need for investigations (including tests for specific nutritional deficits), the Committee agreed that infants and children initially presenting with faltering growth and no signs or symptoms of a particular underlying causative condition, are unlikely to need further tests because it is unlikely that an unrecognised condition will be found. The Committee believed that in current practice, where there are concerns about faltering growth in infants and children, the infant or child is subjected to too many tests even if there are no signs or symptoms of other conditions or disorders. Our reasoning for not recommending other specific investigations is described in section 5.3.4.7 and its subsections.
Abbott Nutrition	Short	5		Section 1.2 Add in 2 centiles the difference between weight and height	Thank you for your comment. The primary concern is weight and thresholds are described in recommendation 1.2.1. If there is a concern then it is recommended that length or height should be measured and plotted (recommendation 1.2.2) and if there are concerns about an infant's length or a child's length or height, mid-parental height should be determined if possible. If the child's length or height centile is below the range predicted from parental heights (more than 2 centile spaces below the mid-parental centile) healthcare professionals are advised to be aware that this could suggest undernutrition or a primary growth disorder (recommendation 1.2.3). The Committee believed that these were logical

					steps and that both weight and height were sufficiently covered by these recommendations.
Abbott Nutrition	Short	5		Section 1.2l Guidance to add “Weight falling through centile spaces, low weight for height or no catch up from a low birth weight”.	Thank you for your comment. The primary concern is weight and thresholds are described in recommendation 1.2.1. If there is a concern then it is recommended that length or height should be measured and plotted (recommendation 1.2.2) and if there are concerns about an infant's length or a child's length or height, mid-parental height should be determined if possible. If the child's length or height centile is below the range predicted from parental heights (more than 2 centile spaces below the mid-parental centile) healthcare professionals are advised to be aware that this could suggest undernutrition or a primary growth disorder (recommendation 1.2.3). The Committee believed that these were logical steps and that both weight and height were sufficiently covered by these recommendations.
Abbott Nutrition	Short	10		1.2.23 For infants or children with faltering growth despite other interventions consider a high energy formula or oral nutritional supplements.	Thank you for your comment. The focus of this recommendation is on oral liquid nutritional supplement which is usually prescribed by a dietitian whereas a high-energy infant formula could be acquired over the counter which was not the option that the Committee wanted to recommend. To clarify this difference we have now added a definition for 'oral liquid supplement' to indicate that this would usually happen after referral (see terms used in this guideline in the short version and glossary in the full guideline). The Committee

					agreed that usual liquid intake (such as liquid supplements or formula) should be reviewed, as drinking too much milk or too many energy-dense drinks, may supress the child's appetite and therefore, stop the child eating food at regular times. This is explained in section 5.2.4.7 of the full guideline.
Abbott Nutrition	Short	10		1.2.24 *Decision on whether oral nutritional supplementation should be continued. Take into account weight gain.* What weight gain is expected and how often should one review? **Ref: ESPGHAN guidelines on Practical Approach to Paediatric Enteral Nutrition: A Comment by the ESPGHAN Committee on Nutrition:; Braegger , Christian[*e]; et al** JPGN July 2010 - Volume 51 - Issue 1 - p 110–122	Thank you for your comment. The expected weight change before stopping oral nutritional supplements will be based on clinical judgement as it largely depends on the severity of faltering growth the infant or child is presenting with. For further information about this, please see section 5.4.7.2 in the full guideline. The suggested reference has been retrieved and assessed for inclusion, however the ESPGHAN guidelines address a different population of infants and children, i.e. those in need of enteral nutrition rather than those where there are concerns about faltering growth. For this reason, this reference was not included. Please refer to Appendix D - section 11 for further details about the inclusion criteria for 'interventions to manage faltering growth'.
Abbott Nutrition	Short	10		1.2.25 *Only consider enteral tube feeding for infants and children with faltering growth when: there are serious weight concerns.* Refer to ESPGHAN guidelines above.	Thank you for your comment. We agree that some symptoms of the organic disorders that are highlighted in your comment are related to growth. However, there would be further

				This could place infants and children at increased risk of further malnutrition. How do you define serious? In clinical conditions such as those infants and children with neurological disability, cardiac conditions and dysphagia tube feeding may be the only viable option and a clinician wouldn't wait for severe weight loss to occur.	symptoms of those organic conditions that may mean that longer term tube feeding is necessary. This would then be a consequence of the organic condition rather than faltering growth which is a separate condition. The Committee therefore agreed that tube feeding would be the exception rather than the rule for infants and children with faltering growth and should be discontinued as soon as possible. The Committee intentionally did not want to define 'serious' weight concerns because they wanted to leave room for clinical judgement. Tube feeding would then be considered if there are 'serious concerns about weight gain' but also after other interventions were unsuccessful and in addition to multidisciplinary assessment. The ESPGHAN guidelines address a different population of infants and children, i.e. those in need of enteral nutrition rather than those where there are concerns about faltering growth. For this reason, this reference was not included.
Abbott Nutrition	Short	18		Section 1 Evidence to suggest that oral nutritional supplementation has positive outcomes in paediatric patients Huynh JNS 2016 Huynh BDA 2015 Huynh CN 2013 As per literature search	Thank you for the references provided. These have been retrieved and assessed for inclusion, however they did not meet the protocol inclusion criteria, because: • Huynh 2015 was a non-comparative study • Huynh 2016 and Huynh 2013 were conducted in low to middle income countries.

					For further details regarding the inclusion criteria for section 5.4.2 (Dietary advice and supplementation) see Appendix D - section 11.
Abbott Nutrition	Full	46	42-46	The guideline refers to checking BMI body mass index. The WHO growth charts do not include BMI for infants under 2 years so only applicable for over 2 years.	Thank you for your comment. The Committee agreed and have now added to this section of the full guideline that this is referring to children over the age of 2 years (see section 5.2.7.2). However, we would like to highlight that this is indicated in the related recommendation where we already stated 'If there is concern about faltering growth or linear growth in a child over 2 years of age, determine the BMI centile ...'
Abbott Nutrition	Full	48		5.2.8 Definition of faltering growth only refers to weight. Length and combined centiles need to be considered to ensure correct feeding regimes.	Thank you for your comment. The primary concern is weight and thresholds are described in recommendation 1.2.1. If there is a concern then it is described that length or height should be measured and plotted (recommendation 1.2.2) and if there are concerns about an infant's length or a child's length or height mid parental height should be determined if possible. If the child's length or height centile is below the range predicted from parental heights (more than 2 centile spaces below the mid-parental centile) be aware this could suggest undernutrition or a primary growth disorder (recommendation 1.2.3). The Committee believed that these were logical steps and that both weight and height were sufficiently covered by these recommendations.
Abbott Nutrition	Full	100		Table 42	Thank you for your comment.

				Products: Dialamine is a specialised product and would not normally be used as first-line for faltering growth. The products mentioned are not age specific and some are not suitable for under 3 years. In the current market Abbott Nutrition products suitable for faltering growth are; Similac High Energy Suitable from birth to 18 months Paediasure Suitable form 8-30kg Paediasure Fibre Suitable from 8-30kg Paediasure Plus Suitable from 8-30kg Paediasure Plus Juice Suitable from 8-30kg PaediaSure Compact Suitable from 8-30kg In addition to the above whole protein feeds, PaediaSure Peptide is a partially hydrolysed oral nutritional supplement indicated for children 8-30kg, with or at risk of faltering growth who also present with gastrointestinal tolerance issues and/or malabsorption.	It was not intended that the products be taken to represent clinically appropriate supplementation, rather that they give indicative costs for supplementation. Nevertheless, it is clear how this might be misinterpreted by parents (and perhaps even clinicians) and consequently the British Specialist Nutrition Association was contacted to provide a more clinically appropriate list and the table has therefore been updated to reflect this. The table has been updated, and Abbott may find the inclusion of Paediasure, Paediasure Fibre, Paediasure Peptide, Paediasure Plus, Paediasure Plus Fibre, Paediasure Plus Juice and Similac High Energy of particular relevance.

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Abbott Nutrition	Full	100		Table 43 Semi skimmed milk is not suitable below 2 years of age	Thank you for your comment. It was not intended that the products be taken to represent clinically appropriate supplementation, rather that they give indicative costs for supplementation. Nevertheless, it is clear how this might be misinterpreted by parents (and perhaps even clinicians) and consequently the table has been entirely replaced with an updated list of 'natural' oral supplements.
Abbott Nutrition	Full	101		5.4.2.5.1 Define oral supplementation	Thank you for your comment. The term 'oral supplementation' has been defined as follows: ' An oral nutritional supplement would often be a prescribed high energy liquid feed used under the supervision of a paediatric dietitian'. This has also been added to the glossary.
Abbott Nutrition	Full	102		5.4.2.6.3 Nutrient-dense formula and energy-supplemented formula Definition of term required.	Thank you for your comment. The study referenced (Clarke 2007) reported that nutrient-dense formula has more energy (up to 52% more), more protein (up to 73%) and more minerals, such as sodium, potassium, iron and zinc than energy-dense formula. This information has been added to section 5.4.2.3 in the full guideline.
Abbott Nutrition	Full	102		5.4.2.6.3 Nutrient-enriched formula Definition of term required.	Thank you for your comment. The study referenced (Fewtrell 2001) reported that nutrient-enriched formula has a higher protein content (approximately 30%) than the standard formula. In addition, the formula has a higher protein-to-energy ratio and contains more minerals,

					such as calcium (31 mg more), phosphorus (8 mg more), sodium (5 mg more) and potassium (21 mg more). This information has been added to section 5.4.2.3 in the full guideline.
Abbott Nutrition	Full	103	35-38	Finally, the Committee agreed that enteral tube feeding should be reserved and considered for severe faltering growth with the aim to discontinue this as soon as possible. This This statement does not consider long term tube feeding in organic faltering growth such as Gastrointestinal, cardiac and neourodisability related conditions	Thank you for your comment. The Committee agreed that some symptoms of the organic disorders that are highlighted in your comment are related to growth. However, there would be further symptoms of those organic conditions that may mean that longer term tube feeding is necessary. This would then be a consequence of the organic condition rather than faltering growth which is a separate condition. The Committee therefore agreed that tube feeding would be the exception rather than the rule for infants and children with faltering growth and should be discontinued as soon as possible. The Committee's discussion of these issues is described in section 5.4.2.7 in the full guideline.
Abbott Nutrition	Full	103	44-45	Refer instead to parent, carer or family instead of woman or mother.	Thank you for your comment. This has now been corrected.
Abbott Nutrition	Full	105		5.4.2.9 High energy liquid feed supplements Definition of term is required.	Thank you for your comment. The table provides a summary of a research recommendation. We have described that the 'intervention' in the suggested research study could define high-energy liquid feed supplements as equivalent to at least 20% of daily energy requirement. There are many factors that could later influence the exact nature of the supplement within

					the context of a study if it were to be carried out based on our recommendation. We therefore did not propose a more specific definition.
Abbott Nutrition	Full	105	36-38	*Further research is important to establish whether their effectiveness justifies their cost and the suppressant effect on appetite.* Cost should not be the first priority. Safety, quality and nutritional completeness should all be considered. There is evidence on appetite contrary to the statement. Fiore et al International Paediatrics 2002 Huynh Clinical Nutrition 2013 Huynh 2016	Thank you for your comment. All decisions to spend public money should be preceded by a consideration of whether the opportunities foregone by spending that money are of higher value than the opportunity purchased. This is the so-called 'opportunity cost' of spending the money. The total amount of money spent on an intervention will not affect whether the Committee recommend it or not provided the intervention is cost effective. This means that the safety, quality and nutritional completeness of the intervention taken holistically is greater than the safety, quality and nutritional completeness of the treatment at the margin of the cost effectiveness threshold (this is the shadow price of health in the NHS, currently somewhere between £20,000 and £30,000). Consequently the Committee believed that the statement is correct in that research needs to establish cost effectiveness before the intervention should be recommended on the NHS.
Association for Family Therapy and Systemic Practice	Short	3		1.1 Weight loss for newborn infants can be very anxiety-provoking for families and also for health professionals. It is important that midwives, health visitors and primary care staff have access to effective support and consultation to support them	Thank you for your comment. The Committee recognised the emotional impact that faltering growth can have on parents. This is described in section 7.7 of the full guideline. Even though support needs of healthcare professionals were outside the scope of this guideline, we have

				communicating sensitively and effectively and working collaboratively when faltering growth is identified, as anxiety can invite professionals to be more directive and intervene precipitously which can increase parental anxiety and interfere in the processes of bonding, feeding and for breast-feeding mothers establishment of breast feeding. It would be good if the recommendations could recognise the importance of support and consultation to support healthcare staff (and as a result families) when raising, assessing and intervening when weight loss concerns are identified, to enable practitioners to keep collaboration more in mind than anxiety.	added the possible emotional impact of faltering growth on healthcare professionals to the discussion ('evidence to recommendation' section in section 7.7.2 of the full guideline).
Association for Family Therapy and Systemic Practice	Short	4		1.1.7 Mothers who are breastfeeding can feel judged by the assumption implicit in advising formula supplementation that they are unable to adequately feed their infant. At this point, in particular, it is very important to be involving mothers in discussion about options and what would effectively support their choices whilst further assessment / intervention is offered (rather than advising). Linking breastfeeding mothers to local breastfeeding support groups can be a way to lend strength and support to their choice if they wish to continue to breastfeed.	Thank you for your comment. The Committee was very conscious of the sensitivities for parents and carers regarding the feeding of their babies or children and regarding concerns about faltering growth generally. This awareness is highlighted in the recommendation that the emotional impact of such concerns should be recognised (recommendation 1.4.1). Advising supplementation was regarded as a significant step (recommendation 1.2.17) and the Committee made a recommendation on supporting the mother to continue breastfeeding (1.2.18). This would also help avoid an assumption by the mother that her breastfeeding has failed. The recommendations on breastfeeding in the NICE guideline on 'Postnatal

				It would be helpful to have recommendations about the criteria by which supplementary formula feeding is recommended, as this does not appear to be defined, and whether other assessments or interventions might be helpful at this stage, rather than only mentioning supplementation with infant formula. If there is insufficient evidence to provide a recommendation on when to consider discussing supplementary feeding then it would be helpful if this were stated and decisions about this situated within professional judgement and consultation with the family.	care up to 8 weeks after birth' (CG37) are also relevant (recommendations 1.1.4 and 1.2.16). The Committee made recommendations highlighting the information and support needs of parents or carers (section 1.4). The Committee has also reworded recommendations 1.1.7 and 1.2.18 to make clear that expressing breast milk is intended to promote milk supply, and that the expressed milk should be fed to the infant in addition to the infant formula supplement. Regarding the importance of breastfeeding local support the Committee recommended providing information on available support and considered this an important matter (recommendation 1.4.1). There was a lack of evidence regarding specific criteria for supplementation. The Committee recognised this would be dependent on the individual context and would, as you indicate, require clinical expertise and judgement in each case. Regarding additional or alternative strategies, recommendations were provided referencing feeding support for breastfed infants (recommendations 1.1.3 and 1.2.16), which cross-reference recommendations in the NICE guideline on 'Postnatal care up to 8 weeks after birth' (CG37) and also other approaches to management where relevant (recommendations 1.2.19, 1.2.20, 1.2.21, 1.2.23, 1.2.25 and 1.2.26). CG37 is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please

					see the following link: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update).
Association for Family Therapy and Systemic Practice	Short	4		1.2.3 Parents or carers may not be biologically-related to the infant or child (for example adoptive parents, foster carers or some same-sex parents) this recommendation does not encourage recognition of this and if applied universally would not represent an inclusive practice.	Thank you for your comment. The recommendation was reworded to read '… if possible obtain the biological parents' heights …' to address this issue.
Association for Family Therapy and Systemic Practice	short	6	16-17	1.2.6 It would be helpful if the 'appropriate training and expertise' recommendation could include the ability to build a positive alliance with the family. Observation can increase the sense of hierarchy in relationships between health care professionals and families, as there can be a sense of evaluation. Building a positive alliance and involving the family in the observation and interpretation can help to provide a better foundation if interventions are suggested or recommended.	Thank you for your comment. The Committee acknowledged individuals involved in the care of children with faltering growth should have appropriate training and expertise to carry out observations of feeding (see recommendations 1.1.2 and 1.2.7). In the full guideline we have now added to the discussion section that this '… could be a health visitor or a trained lay person – usually with Baby Friendly Initiative accreditation' (see section 4.3.2 of the full guideline). The Committee agreed that such training would usually include not only practical skills, but also training in dealing with emotional issues and how to create a positive relationship with the family.
Association for Family Therapy and Systemic Practice	short	6	21	1.2.7 Again, inclusion of 'in a collaborative way' here would help to set a positive expectation for professionals and families alike	Thank you for your comment. The Committee agreed that a collaborative approach is very important to create a positive relationship with parents. However, this particular

					recommendation relates directly to what the healthcare professional should consider (e.g. performing a clinical assessment or providing interventions). Based on this a collaborative plan should then be developed (see recommendation 1.2.15).
Association for Family Therapy and Systemic Practice	Short	6	22-27	1.2.7 Might the inclusion of other relevant physical conditions which may contribute to weight concerns be useful, here (such as undiagnosed congenital heart conditions which can significantly increase energy requirements)? I have experience with a family where an undiagnosed congenital heart condition was the main factor in early weight loss, but clinical signs were not spotted by primary care or community health staff. Inclusion of other conditions as examples may help to alert healthcare staff to other clinical signs and symptoms which may not be immediately obvious (e.g. increased sweating and head bobbing, for this family) but which would warrant a specialist assessment, In terms of prevalence I believe congenital heart conditions are more common in infants than the other conditions mentioned.	Thank you for your comment. In relation to the need for investigations, the Committee agreed that infants and children initially presenting with faltering growth and no signs or symptoms of a particular underlying causative condition, are unlikely to need further tests because it is unlikely that an unrecognised condition will be found. The Committee believed that in current practice, where there are concerns about faltering growth in infants and children, the infant or child is subjected to too many tests even if there are no signs or symptoms of other conditions or disorders. Our reasoning for not recommending other specific investigations is described in section 5.3.4.7 and its subsections.
Association for Family Therapy and	Short	6	1-2	1.2.4 The phrase 'If there is concern about faltering growth or linear growth in a child over 2 years of age,' is not very easy to	Thank you for your comment. The Committee agreed that in the order of recommendations the phrasing of 1.2.4 makes

Systemic Practice				understand as faltering growth is a threshold term indicating growth is not as expected, whereas linear growth is a descriptive term meaning growth in length / height. Phrasing more similar to 1.2.3 would be easier to understand or alternatively: 'faltering growth, or concerns about linear growth in a child under 2 years…' or 'concerns about faltering growth, and/or concerns about linear growth in a child under 2 years…'	sense. Recommendation 1.2.1 describes thresholds for concern, recommendation 1.2.2 then talks about measuring length or height and then recommendation 1.2.3 indicates when length or height is lower than expected from parental height. Recommendation 1.2.4 makes sense in this context indicating that both faltering growth and linear growth could be a concern. The Committee therefore decided to keep the current wording of recommendation 1.2.4.
Association for Family Therapy and Systemic Practice	Short	7	5	1.2.8 A reminder here that if there is maternal postnatal depression or anxiety present it is not necessarily the cause of faltering growth. Often mothers can feel blamed when these associations are made and possible links need to be raised sensitively, with adequate support available for the family from a source other than the person raising concerns.	Thank you for your comment. We have reflected on this and reworded the recommendation by deleting 'causes and contributing' which means that it is now referring to factors 'associated with faltering growth' rather than causing it. There was evidence for this association but we agree that this may not be a causal relationship. There is now no suggestion in the recommendation about cause. However, while cause and effect may operate in either or both directions in terms of maternal depression/anxiety, the same is not true for preterm birth and neurodevelopment which implicitly contribute to faltering growth rather than the other way round. The new wording of the recommendation allows the healthcare professional to consider these possibilities.
Association for Family Therapy and	Short	7	6-8	1.2.9 Not clear on the purpose of this recommendation. Is it to encourage health	Thank you for your comment.

Systemic Practice				professionals to instigate fewer investigations? To confine themselves to vigilance only with Cystic fibrosis and Coeliac disease? To help health professionals manage the expectations of parents about investigations? More context for the awareness raising may be helpful. As noted above primary care and community healthcare staff may not always have sufficient expertise available to recognise some clinical symptoms at an early stage	In relation to the need for investigations, the Committee agreed that infants and children initially presenting with faltering growth and no signs or symptoms of a particular underlying causative condition, are unlikely to need further tests because it is unlikely that an unrecognised condition will be found. However, further investigations may be needed when a clinical examination suggests signs or symptoms of an underlying condition (see recommendation 1.2.6 in the short guideline and section 5.3.4.7.2 in the full guideline). The Committee believed that in current practice, where there are concerns about faltering growth in infants and children, the infant or child is subjected to too many tests even if there are no signs or symptoms of other conditions or disorders. Our reasoning for not recommending other specific investigations is described in section 5.3.4.7 and its subsections.
Association for Family Therapy and Systemic Practice	Short	7	15-17	1.2.11 This reminder is appreciated (see point 7 above)	Thank you for your comment.
Association for Family Therapy and Systemic Practice	Short	7	28	1.2.12 Physical conditions which increase energy requirements might also be relevant to include here (see 6 above)	Thank you for your comment. The Committee recognised that some children might have increased energy requirements due to an underlying disorder. However, the recommendations made on indications for investigation would usually identify those with an underlying disorder (see recommendation 1.2.6). Such children would be referred to specialist care

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					where their energy requirements might need specific consideration.
Association for Family Therapy and Systemic Practice	Short	8	15-17	1.2.15 Welcome the collaborative tone to this one	Thank you for your comment.
Association for Family Therapy and Systemic Practice	Short	13		1.4.4 This recommendation could again be more collaborative by suggesting that healthcare professionals ask families about their existing support networks and encourage people to utilise these, as well as offering information about other sources of support.	Thank you for your comment. General principles of communication, information provision and shared decision making are covered by the NICE guideline on 'Patient experience in adult NHS services: improving the experience of care for people using adult NHS services' (CG138 - https://www.nice.org.uk/guidance/cg138) to which we cross-refer (this guideline also refers to inclusion of family members). The remaining recommendations in this section are therefore specific to faltering growth.
Association for Improvements in the Maternity Services		General	General	We are so pleased that the “failure to thrive” label has been changed and that it is now recognized that in the majority of cases parents are not guilty of neglect and should not be made to feel so. We have observed mothers trying to push food into infants who clearly did not want it as a result of their own fear of professional action against them.	Thank you for your comment.
Association for Improvement	short	General	General	Post-natal care. Since the ten-days of postnatal midwifery visits wasdiscontinued,	Thank you for your comment.

s in the Maternity Services				mothers receive only 1 home visit from a midwife after a hospital birth (often with discharge the same day). This is bewildering, especially for primigravidae . More confidence with breastfeeding, and quicker recovery from early weight loss in babies might be avoided with longer midwifery involvement, especially with continuity of midwife.	The practicalities of general postnatal care are not part of the scope of this guideline and are relevant to the NICE guideline on 'Postnatal care up to 8 weeks after birth' (CG37). This guideline is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update).
Association for Improvements in the Maternity Services	Short	3	78	Recognizing Faltering Growth. We have had a small cluster of mother over the years who insist that their child's growth is not "faltering", but the normal pattern of growth for other children in their family. We are glad that size and build of parents is now recognized as a contributory factor, and this has been mentioned by some clients.(also premature birth and small for dates, also now recognized as risk factors.). But slow familial pattern of growth, though uncommon, may be a separate issue. Once again, professionals should listen to mothers who know their own children and families well, and respect that knowledge.	Thank you for your comment. The Committee agreed that several factors should be taken into consideration when using thresholds to recognise faltering growth. Amongst these factors, the Committee highlighted parental height and the importance of assessing the infant's or child's linear growth in relation to this, in order to identify those with constitutional short or lean stature (please see recommendation 1.2.3 and section 5.2.7.2 in the full guideline).
Association for Improvements in the	short	3	58	Breastfeeding Support. We are delighted that the importance of this is recognized. Failure of maternity and health visiting services to provide knowledgeable support is a common criticism in our postbag. The	Thank you for your comment.

Maternity Services				fact that all health visitors who,according to PSSRU data (2015) cost £46,994 WTE p.a. and £454.14 per child intervention,(p.144, Full Guideline) are not trained in breastfeeding support, is scandalous. *(See point one on our second sheet for further data)*	
Association for Improvements in the Maternity Services	short	7		Current Practice. We have had a few cases of criticism of paediatric nutritionists who were(1) clearly unsympathetic to parents who were vegan, and did not respect or work with them co-operatively (2) Did not make an effort to understand, and work with, parents from overseas who had culturally different food patterns. Respectful and understanding attitudes to parents are essential, as well as cultural training.	Thank you for your comment. The Committee agreed that when assessing a child in whom growth concerns have been raised, cultural background as well as the family's eating habits should be considered. More detail about this has been provided in section 5.4.3.7.5 (see the full guideline). In the same section we have also described the importance of providing developmentally and culturally appropriate individualised information about feeding and mealtime behaviour. The importance of tailored, individualised information and support (taking into account cultural background) is also highlighted in the information and support section of the full guideline (section 7.7.2) to which we have now also added 'taking into account the food choices that are made by the family'. The Committee agreed that healthcare professionals should be sensitive and show empathy as well as compassion and respect by acknowledging and discussing the parents' or carers' concerns. Information provision should be individualised, taking into account parents' and carers' socioeconomic, cultural, religious and ethnic

					environment, in line with CG138 [Patient experience in adult NHS services (https://www.nice.org.uk/guidance/cg138)], which is referenced in recommendation 1.4.2 in the short guideline.
Association for Improvements in the Maternity Services	Short	12		1.3.2 Community Care Team. It is essential that the health visitor on the team should have training in breast feeding. After receiving so many complaints about health visitors not knowing about breast feeding, giving wrong advice, and insisting on topping up with formula , we tried to find out from Public Health England and the Institute of Health Visiting what percentage of HVs have had breast feeding Training, since this is designated a High Impact area by the Department of Health (1) .Neither of them knew. Tappin et al have shown that breast feeding is more likely to be discontinued if HVs have not had breast feeding training(2) 1 Public Health England (2016) Earlly Years High Impact Area 3 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/563921/Early_years_high_impact_area3_breastfeeding.pdf	Thank you for your comment and for the references provided. It is recognised that appropriate training is important in providing good support to the mother-infant dyad while breastfeeding as per CG37 [Postnatal care up to 8 weeks after birth]. This guideline is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update). The 'primary care team' should include a health visitor who would have the relevant training and expertise – usually with Baby Friendly Initiative accreditation to provide such support (see section 6.7 where this is discussed). Thank you for the reference provided. Tappin 2016 did not meet any of the inclusion criteria for the review questions in the guideline because the study was conducted in a general population of babies rather than in those where there are concerns about faltering growth. For more details about inclusion criteria, please see Appendix D.

				2. David Tappin et al (2006) The effect of health visitors on breast -feeding in Glasgow. International Breastfeeding Journal 1.11. https://internationalbreastfeedingjournal.biomedcentral.com/articles/10.1186/1746-4358-1-11	
Association for Improvements in the Maternity Services	Full		17.8 54 7.	Information and Support We have two problems with this section. Firstly it concentrates on the giving of information – much of which is now available on the internet, but it does not mention the importance of LISTENING, lack of which is a common problem reported by parents Their knowledge and experience of their own children as parents is disrespected and not acknowledged, whereas the knowledge of professionals is invariably considered superior. Only when parents feel heard and understood do they take in and respect the information given. Ignoring or discounting information from parents has been cited in avoidable mortality and morbidity studies, eg. Confidential Enquiries into Maternal deaths and child deaths. Cultural competence is not mentioned either. (see point 4	Thank your comment. The recommendations have been reordered in light of your comment to place greater emphasis on the recognition of the emotional impact that concerns about faltering growth can have on parents and carers (the related recommendation is now the first in this section – 1.4.1). The Committee agreed that healthcare professionals should be sensitive and show empathy as well as compassion and respect by acknowledging and discussing the parents' or carers' concerns. Information provision should be individualised, taking into account parents' and carers' socioeconomic, cultural, religious and ethnic environment, in line with CG138 (Patient experience in adult NHS services [https://www.nice.org.uk/guidance/cg138]), which is referenced in recommendation 1.4.2 in the short guideline. There was no evidence identified for the 'information and support' topic and the Committee

				in our first section.] Secondly, Support only exists if the recipient feels supported,, not when the professional thinks or records that it has been provided. We have seen many cases where professionals recorded that they provided "support" and the parents' responses were unprintable... Parents are expected to discuss their concerns or issues. There seems to be no recognition of the fact that these are nowadays frequently concealed because of lack of confidentiality and multi-agency sharing of data. On our confidential help-line we often are given information about worries which parents dare not share for fear of being referred to social services and having children taken for adoption. We welcome NICE research recommendations on getting parents' Views, but suggest this should be piloted on consumer groups	therefore drafted a research recommendation. This includes specification of what should be investigated. Whether or not this may include any pilot work is left to the researchers who would design the protocols for such a study.
Association for Improvements in the	Full	34 &36	. .	4.2.5 Economic Evidence. This section does not mention health benefits 4.3.3	Thank you for your comment. Although the benefits to the mother of breastfeeding are known, they are outside the scope of the guideline for economic analysis. Breastfeeding is

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

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Maternity Services				To the mother who breast feeds of reduction of breast and ovarian cancer risk. Although no economic evidence may exist on faltering growth diagnosis and care, there is economic evidence on breast feeding. Julie Smith has written a number of publications on the economic value of breast milk eg (1) (1) Julie P Smith (2013) 'Lost Milk?' Counting the economic value of Breast milk in the Gross Domestic Product.	included in this guideline only in relation to the topic of faltering growth rather than being a topic for all infants. Breastfeeding for all infants is covered in CG37 (Postnatal care up to 8 weeks after birth). CG37 is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update). NICE methodology dictates that benefits to gross domestic product (GDP) of the kind counted in the Smith paper cited are not counted as economic benefits for the purpose of health economic analysis. This is because such an assumption could lead to the conclusion that people who earn less are less worth treating in some way, which is not consistent with NHS care. Consequently we are unable to consider benefits to GDP as a benefit of breastfeeding in any formal analysis.
Association for Improvements in the Maternity Services	Full	35	31	4.3.2. Threshold and measurement of weight loss. We are pleased that breast fed babies are to be used as the norm for this.	Thank you for your comment.
Association for Improvements in the Maternity Services	full	61	9	Poor Appetite "Parents may (sic) have good knowledge of this". We would suggest professionals always start by assuming parents know their own children and have good knowledge of them; this approach encourages	Thank you for your comment. The Committee agreed with this approach and this sentence has been rephrased in light of your comment (the section now reads '… it is important

				parental trust and is the best start to a constructive relationship.	to ask parents about the child's observed behaviour during feeding').
Association for Improvements in the Maternity Services	Full	62		5.3.2.7.5 We are pleased that the complexity of interactions is highlighted here, as well as causality, and the need for support. The past culture of suspicion and blame has been damaging and has led to distrust of professionals. In the home we have seen mothers trying to push food into resistant children for fear of the health visitor..	Thank you for your comment.
Association for Improvements in the Maternity Services	Full	92	31-7	Tongue Tie. Although this is not included as no evidence has been found of association with faltering growth, we have had a steady trickle of complaints that professionals insisted it was not a problem but when mothers insisted on treatment, breast feeding and weight problems were solved.	Thank you for your comment. Given that we did not identify any evidence for the effectiveness of division of tongue tie in the context of faltering growth, the Committee did not include it in the recommendations.
Association of Breastfeeding Mothers	Short	3		1.1.2 No mention is made of the expected rate of weight gain in the early weeks of life. We are concerned that this may lead to some babies who are experiencing feeding difficulties slipping through the net. For example, a baby who does not lose much weight after birth but who then does not begin to gain at a satisfactory rate may not be flagged up for assessment, even though	Thank you for your comment. Section 1.1 covers early weight loss after birth where some weight loss is normal (see the preamble to the section), whereas section 1.2 covers concerns about faltering growth. The Committee considered a weight loss of above 10% in the early days of life as a possible reason for concern and other thresholds for concerns about faltering growth after the early days are covered in

				we feel that a very slow rate of gain would be a significant concern.	recommendation 1.2.1. An average expected weight gain was not considered to be helpful since the guidance applies to those infants and children where concerns about weight have been raised. This therefore means that these infants and children are already outside what would be the average. However, where there are concerns it was agreed that a management plan should be established which would set specific goals for each infant or child (see recommendation 1.2.15).
Association of Breastfeeding Mothers	Short	3		1.1.2 The guideline states that an observation of a feeding should be done by 'an individual with appropriate training and expertise'. However, we are concerned that, depending on whereabouts in the country the mother and baby live, they may not have access to a person with appropriate training and experience.	Thank you for your comment. The Committee agreed that direct observation by an appropriately trained individual was sometimes necessary and required consideration. For that reason they made recommendations on the composition of the primary care team involved in the care of children with faltering growth and the availability of access to relevant healthcare professionals (recommendations 1.3.3 and 1.3.4) to enable such expert assessment to take place when required. These recommendations are intended for general application throughout the country.
Association of Breastfeeding Mothers	Short	4		1.1.3 Again, there is no mention of a slow rate of gain in the early days warranting feeding support.	Thank you for your comment. Section 1.1 covers early weight loss after birth where some weight loss is normal (see the preamble to the section), whereas section 1.2 covers concerns about faltering growth. The Committee considered a weight loss of above 10% in the early days of life as a possible reason for concern and other thresholds for concerns about

					faltering growth after the early days are covered in recommendation 1.2.1. An average expected weight gain was not considered to be helpful since the guidance applies to those infants and children where concerns about weight have been raised. This therefore means that they are already outside what would be the average. However, where there are concerns it was agreed that a management plan should be established which would set specific goals for each infant or child. The guideline recommends that healthcare professionals should be aware that most infants who lose weight will have returned to their birth weight by 3 weeks of age.
Association of Breastfeeding Mothers	Short	4		1.1.6 We would like to see a stronger recommendation for supplementation with the mother's own milk, if supplementation is needed, making it clearer that supplementation with formula is a last resort.	Thank you for your comment. The Committee agreed with your comment to advise against formula feeding instead of breastfeeding and have covered this with several recommendations. Recommendations 1.1.3 and 1.2.15 cross-reference the NICE guideline on 'Postnatal care up to 8 weeks after birth' (CG37), which has several recommendations against 'supplementation with formula'. We have also reworded recommendations 1.1.7 and 1.2.18 to indicate clearly that the infant should be fed with expressed breast milk to promote milk supply. CG37 is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link:

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					https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update).
Association of Breastfeeding Mothers	Short	4		1.1.7 The information about supplementation does not provide guidance about at what stage a supplement should be considered, and also how much supplement may be appropriate to offer, or what other strategies may be helpful. Some babies may improve their weight gain by improving positioning and attachment and effectiveness and frequency of feeds. We are concerned that babies who would respond to other measures may be supplemented unnecessarily or too early.	Thank you for your comment. The Committee recognised that decisions on the need to supplement and on the volume of supplements to be offered are important. However, they did not think it was appropriate or possible to make specific recommendation on these matters. This would be highly dependent on the individual context and would require clinical expertise and judgement in each case. Regarding additional or alternative strategies, recommendations were provided that referencing feeding support for breastfed infants (recommendations 1.1.3 and 1.2.16, which cross-reference recommendations in the NICE guideline on 'Postnatal care up to 8 weeks after birth' (CG37), and also other approaches to management where relevant (recommendations 1.2.19, 1.2.20, 1.2.21, 1.2.23, 1.2.25 and 1.2.26). The Committee has reworded recommendations 1.1.7 and 1.2.18 to make clear that expressing breast milk is intended to promote milk supply, and that the expressed milk should be fed to the infant in addition to the infant formula supplement. CG37 is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update).

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Association of Breastfeeding Mothers	Short	5		1.2.1 We feel that it would be useful to state the time period over which crossing centiles might be used as a threshold for concern e.g. a baby born on 75th centile who crosses 2 centiles over the period of a year vs a baby who crosses 2 centiles over just a few months.	Thank you for your comment. The Committee were not able to make recommendations on the potential significance of the period of time over which crossing of centiles might take place. They did not identify evidence to support such recommendations and were not able to do so based on their own knowledge and expertise. Recommendation 1.2.1 was intended to give some guidance on thresholds for concern regarding faltering growth. The rate of weight loss might be important but clinical judgement would be needed and the individual clinical context would need to be taken into account.
Association of Breastfeeding Mothers	full		19	5.4.1.6 Mentioning that timely onward referral for breastfeeding support may be needed. A full breastfeeding history needs to be taken including previous breastfeeding and risk factors for example blood loss. The expressed breastmilk with higher fat content can be given in the early days with faltering growth. In the case of a baby who has lost just over 10 percent of birth weight on day 3 where mum starts expressing as her milk comes in, this can be particularly useful.	Thank you for your comment. As described in recommendation 1.1.2 a detailed feeding history should be taken in line with the NICE guideline on 'Postnatal care up to 8 weeks after birth' (CG37). This should then be followed by feeding support if necessary which is also described in CG37. There is extensive guidance on breastfeeding in CG37 which can then be followed and applied to assess or provide support to mothers of infants where there are concerns about weight loss in the early days of life or faltering growth after the early days. CG37 is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link:

					https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update).
Association of Breastfeeding Mothers	full		23	5.4.1.6 Mentioning that onward referral for breastfeeding support may be needed would so that the local situation can be included in care pathways.	Thank you for your comment. As described in recommendation 1.1.2 a detailed feeding history should be taken in line with the NICE guideline on 'Postnatal care up to 8 weeks after birth' (CG37). This should then be followed by feeding support if necessary that is also described in CG37. There is extensive guidance on breastfeeding in CG37 which can then be followed and applied to assess or provide support to mothers of infants where there are concerns about weight loss in the early days of life or faltering growth after the early days. CG37 is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update).
British Dietetic Association	Short	5	3-13	There are also other definitions which are characteristics of faltering growth; should they be included (for example a difference of 2 or more centiles between weight and length with weight being lower than length) ?	Thank you for your comment. The Committee made a recommendation on thresholds for concern about faltering growth in recommendation 1.2.1. This was not intended as a 'definition' and indeed the evidence reviewed did not provide a basis for any exact definition. The Committee was aware that a range of views and

					practices exist in identifying infants and children about whom there should be concern about weight gain and undernutrition, but the recommendation regarding thresholds for concern about faltering growth in this guideline was believed to be most useful, in that it takes account of the important variable of birthweight. Regarding the identification of infants or children who are underweight (weight low in relation to length or height) the Committee recommended clinical assessment (recommendation 1.2.6), measuring the weight and length or height and plotting these on a growth chart (recommendation 1.2.2) and, in the case of children over 2 years, calculation of the BMI (recommendation 1.2.4).
British Dietetic Association	Full	35	4	Spelling error 'lose' should be 'lost'	Thank you for your comment. This has now been corrected.
British Dietetic Association	Full	35	43	Agree that recommendations should be based on breastfed infants, especially if the studies have shown they lose more weight.	Thank you for your comment.
British Dietetic Association	Full	37	28	Agree that this section needs to be a preface / different section.	Thank you for your comment. This different section (early weight loss) is in chapter 4 of the full guideline which is a separate chapter to that covering faltering growth after the early days of life.
British Dietetic Association	Full	46	42	It is not routine to calculate and plot BMI in young children, particularly under 2 years of age. This would involve a significant change of practice. I see you have clarified	Thank you for your comment. Recommendation 1.2.4 starts with 'If there is concern about faltering growth or linear growth in a

				this on page 49 line 11. Will this be clearer in the guideline?	child over 2 years of age, determine the BMI centile'. It is therefore already specified that this would apply to children over 2 years of age.
British Dietetic Association	Full	48	43	Dropping 1 centile is not uncommon, but we would not always class this patient as faltering, even if under the 9th centile (if they then continued to track on the lower centile). It is important to stress that this is not used to 'define' faltering growth, but to highlight the need for further assessment.	Thank you for your comment. The Committee agreed that this threshold defines the need for further assessment. Please note that this section refers to 'thresholds for concern', as specified in the stem of recommendation 4 (see full guideline).
British Dietetic Association	Full	62	15-29	Fussy eating/behaviour causing faltering growth: dietitians with limited experience on this should receive further training in children behaviour for example as this is not something that is studied in detail at university.	Thank you for your comment. The scope of this guideline is limited to the management of children with faltering growth and we are unable to make recommendations for the level of training professionals involved in the care of infants and children with faltering growth may need, however it is a requirement in the NHS that any person providing care is competent to do so.
British Dietetic Association	Full	80-81		Psychology need to be more involved in faltering growth in terms of anxiety, social/financial issues etc	Thank you for your comment. Psychological factors were considered in some of the review questions, but no evidence was identified. The Committee, however, referred to such psychological factors in the recommendations based on consensus. For instance, depression and anxiety were highlighted as being associated with faltering growth (see recommendation 1.2.8). Equally, it is acknowledged that faltering growth has an emotional impact on parents and carers (see recommendation 1.4.1).

					The Committee agreed that social issues should be taken into account in the assessment of infants and children in whom there are concerns about faltering growth and have added this to recommendation 1.2.6 (in the short version of the guideline).
British Dietetic Association	Full	84	26	The document does not make much reference to symptoms/conditions that may contribute to faltering growth, such as significant vomiting as seen in gastro-oesophageal reflux disease (GORD) or cow's milk protein allergy – surely they should be mentioned in brief somewhere in the assessment?	Thank you for your comment. The Committee agreed that faltering growth could present with an underlying disorder, and that further investigations may be needed when a clinical examination suggests signs or symptoms of an underlying condition (see recommendation 1.2.6 in the short guideline and section 5.3.4.7.2 in the full guideline). For this reason, they recommended that clinical judgement should be used in these cases and that infants and children showing symptoms or signs of an underlying disorder should be referred to an appropriate paediatric specialist care service.
British Dietetic Association	Full	89	5	There appears to be a variation in the level of training and ability across Health Visitors – there should be an appropriate level of education and training in order to support mealtime observations.	Thank you for your comment. Specifying training standards for healthcare professionals was outside the scope of this guideline. However, the Committee acknowledged individuals involved in the care of infants and children with faltering growth should have appropriate training and expertise to carry out observations of feeding (see recommendations 1.1.2 and 1.2.7). One such training level is the Baby Friendly Initiative accreditation which is mentioned in the full guideline as an example of a relevant level of expertise.

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

British Dietetic Association	Full	100	Table 42	It was interesting to see that nutritional supplements were shown to have no impact on weight as practitioners regularly used supplements for nutrition support Why have these particular supplements been chosen? They are not that routinely used in children and do not provide micronutrients and protein, which are also likely to be lacking in the diet if poor intake. Liquid supplements are more likely to be used. It also does not mention high calorie infant formulas here as an alternative to standard formula. Should this not be mentioned? I know you mention the lack of evidence for liquid supplements but surely it is all in the selection of the right child? A Dietitian should be best placed to advise on this, which you have stated in your guideline.	Thank you for your comment. It was not intended that the products be taken to represent clinically appropriate supplementation, rather that they give indicative costs for supplementation. Nevertheless, it is clear how this might be misinterpreted by parents (and perhaps even clinicians) and consequently the British Specialist Nutrition Association was contacted to provide a more clinically appropriate list and the table has therefore been updated to reflect this.
British Dietetic Association	Full	103	29	Capacity for reviewing children monthly, dietetic or other health professional otherwise, is likely lacking.	Thank you for your comment. The focus of this paragraph is that 'oral liquid nutritional supplement' is not a long-term solution and should be considered only in those cases 'in which assessing feeding practices was not possible (i.e. child refusing oral intake; family poverty) or did not have an adequate effect.' To ensure that this is not continued unnecessarily the effectiveness of this should then be monitored. Since this affects only a small subgroup of infants and children we

					believe that this should not substantially change current practice.
British Dietetic Association	Full	112	2-15	Excellent and appropriate list of discussion points. You did not mention about excessive fluid intake here through which you eluded to on page 111 line 29	Thank you for your comment. With these points, the Committee wanted to highlight some examples of practices that can suppress appetite, but they did not want to include these in the recommendations as an exhaustive list of all the practices that can lead to this would depend on too many factors. The Committee agreed that it should therefore be left to clinical judgement.
British Dietetic Association	Full	118	2-17	Very sensible recommendations	Thank you for your comment.
British Dietetic Association	Full	153	30-38	Comprehensive list of appropriate health professionals. Hopefully this document can be used to obtain more funding, as I doubt most areas have access to all on the list (particularly clinical psychology).	Thank you for your comment.
British Specialist Nutrition Association (BSNA) Ltd	Short	2		No mention of WHO guidelines on catch up growth and what to aim for	Thank you for your comment. Defining targets for catch-up growth falls outside of the scope of the guideline.
British Specialist Nutrition Association (BSNA) Ltd	Short	3		Need to explain organic and inorganic factors that lead to faltering growth	Thank you for your comment. In recommendations 1.2.9 to 1.2.11 we explain that it may not always be possible to identify a cause and that many factors may contribute to the problem of faltering growth. In other words, it may not be possible to find any specific organic cause

					(resulting from a disease or disorder) or inorganic cause (where there is no identifiable disease or disorder). We therefore highlight possible contributing factors for milk-fed infants (1.2.10) and for older infants and children (1.2.11). Recommendation 1.2.6 outlines an approach to clinical assessment and where necessary investigation to try to understand the factors underlying faltering growth in individual infants and children. The Committee wanted to avoid unnecessary investigations and these matters are discussed in the evidence to recommendation section in the full guideline (see section 5.3.4.7).
British Specialist Nutrition Association (BSNA) Ltd	Short	4		Section 1 Need to mention nutritional deficiencies such as zinc, calcium, iron, etc. can lead to FG	Thank you for your comment. In relation to the need for investigations (including tests for specific nutritional deficits), the Committee agreed that infants and children initially presenting with faltering growth and no signs or symptoms of a particular underlying causative condition, are unlikely to need further tests because it is unlikely that an unrecognised condition will be found. The Committee believed that in current practice, where there are concerns about faltering growth in infants and children, the infant or child is subjected to too many tests even if there are no signs or symptoms of other conditions or disorders. Our reasoning for not recommending other specific investigations is described in section 5.3.4.7 and its subsections.
British Specialist Nutrition	Short	5		Section 1.2 Add the following:-	Thank you for your comment.

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Association (BSNA) Ltd				2 centiles difference between weight and height	The primary concern is weight and thresholds are described in recommendation 1.2.1. If there is a concern then it is recommended that length or height should be measured and plotted (recommendation 1.2.2) and if there are concerns about an infant's length or a child's length or height, mid-parental height should be determined if possible. If the child's length or height centile is below the range predicted from parental heights (more than 2 centile spaces below the mid-parental centile) healthcare professionals should be aware that this could suggest undernutrition or a primary growth disorder (recommendation 1.2.3). The Committee believed that these were logical steps and that both weight and height were sufficiently covered by these recommendations.
British Specialist Nutrition Association (BSNA) Ltd	Short	7		Section 1.2 Add the following:- Weight falling through centile spaces, low weight for height or no catch up from a low birth weight'	Thank you for your comment. Weight falling through centile spaces is recognised within the thresholds for concern for faltering growth as defined in section 1.2. Defining targets for catch-up growth falls outside of the scope. A current weight below the second centile for age is recognised as a threshold for concern at any age. Low weight for height is recognised in recommendation 1.2.4 (linear growth and BMI).
British Specialist Nutrition Association (BSNA) Ltd	Short	10		1.2.23 Include the following (in red) in this sentence. Consider a trial of a high energy formula for infants or oral nutritional supplement for	Thank you for your comment. The focus of this recommendation is on oral liquid nutritional supplement which is usually prescribed by a dietitian whereas a high-energy infant formula

				infants or children with continuing faltering growth despite other interventions.	could be acquired over the counter which was not the option that the Committee wanted to recommend. To clarify this difference, we have now added a definition for 'oral liquid supplement' (see terms used in this guideline in the short version and glossary in the full guideline) to indicate that this would usually happen after referral. The Committee agreed that usual liquid intake (such as liquid supplements or formula) should be reviewed, as drinking too much milk or too many energy-dense drinks, may supress the child's appetite and therefore, stop the child eating food at regular times. This is explained in section 5.2.4.7 of the full guideline.
British Specialist Nutrition Association (BSNA) Ltd	Short	10		1.2.24 *Regularly reassess infants and children receiving an oral nutritional supplement for faltering growth to decide if it should be continued. Take into account: □Weight change.* This is not clear, what weight change to expect before stopping ONS and how regularly should you reassess? Please refer to the ESPGHAN guidelines on Practical Approach to Paediatric Enteral Nutrition: A Comment by the ESPGHAN Committee on Nutrition: Braegger, Christian; Decsi, Tamas; Dias, Jorge Amil; Hartman, Corina; Kolaček, Sanja; Koletzko, Berthold; Koletzko, Sibylle; Mihatsch, Walter; Moreno, Luis; Puntis, John; Shamir,	Thank you for your comment. The Committee recognised the points made, however they did not want to be overly prescriptive about the frequency of weighing or the expected weight change before stopping oral nutritional supplements. They agreed that this needs to be based on clinical judgement as it will largely depend on the severity of faltering growth the infant or child is presenting with. For further details about this, please see section 5.4.2.7.2 in the full guideline. The ESPGHAN guidelines address a different population of infants and children, i.e. those in need of enteral nutrition rather than those where there are concerns about faltering growth. For this reason, this reference was not included.

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				Raanan; Szajewska, Hania; Turck, Dominique; van Goudoever, Johannes Journal of Pediatric Gastroenterology & Nutrition: July 2010 - Volume 51 - Issue 1 - p 110–122 doi: 10.1097/MPG.0b013e3181d336d2	Please refer to Appendix D - section 11 for further details about the inclusion criteria for 'interventions to manage faltering growth'.
British Specialist Nutrition Association (BSNA) Ltd	Short	10		1.2.25 *Only consider enteral tube feeding for infants and children with faltering growth when: there are serious weight concerns.* How do you define serious? There are scenarios where you would not wait for serious weight changes, example in neurodisabled children/children with swallowing difficulties Please refer to the ESPGHAN guidelines mentioned above Decision to tube feed should be based on assessment of nutritional risk	Thank you for your comment. The Committee agreed that neurodisability and swallowing difficulties can be related to growth. However, there would be further symptoms of those conditions, apart from growth, that may mean that tube feeding without delay would be considered to be necessary. This would then be a consequence of the neurodisability or swallowing difficulty rather than faltering growth which is a separate condition. The Committee therefore agreed that tube feeding would be the exception rather than the rule for infants and children with faltering growth and should be discontinued as soon as possible. The Committee intentionally did not want to define 'serious' weight concerns because they wanted to leave room for clinical judgement. Tube feeding would then be considered if there are 'serious concerns about weight gain' but also after other interventions were unsuccessful and in addition to multidisciplinary assessment. The ESPGHAN guidelines address a different population of infants and children, i.e. those in need

					of enteral nutrition rather than those where there are concerns about faltering growth. For this reason, this reference was not included. Please refer to Appendix D - section 11 for further details about the inclusion criteria for 'interventions to manage faltering growth'.
British Specialist Nutrition Association (BSNA) Ltd	Short	18		Contrary to the statement there is evidence to suggest that ONS has positive outcomes in paediatric patients See below literature search	Thank you for your comment. The literature search for nutritional interventions yielded four randomised controlled trials for the use of nutritional supplementation in infants and children with faltering growth. However, there was insufficient evidence to draw clear conclusions about the effectiveness of high-energy liquid supplements (studies were small and results uncertain). Therefore the Committee decided to make a research recommendation specific to high-energy liquid supplements to establish whether these improve weight gain in infants or children with faltering growth. The references provided have been retrieved and assessed for inclusion, however they did not meet the protocol inclusion criteria, because: • Huynh 2015 was a non-comparative study • Huynh 2016 and Huynh 2013 were conducted in low to middle income countries.

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

					For further details regarding the inclusion criteria for section 5.4.2 (Dietary advice and supplementation) see Appendix D - section 11.
British Specialist Nutrition Association (BSNA) Ltd	Full	46	42-46	The guideline refers to checking BMI, however, this would not apply to a 0-2-year-old where the WHO growth charts do not include BMI.	Thank you for your comment. The Committee agreed and have now added to this section of the full guideline that this is referring to children over the age of 2 years (see section 5.2.7.2). However, we would like to highlight that this is indicated in the related recommendation where we already stated 'If there is concern about faltering growth or linear growth in a child over 2 years of age, determine the BMI centile ...'
British Specialist Nutrition Association (BSNA) Ltd	Full	48		5.2.8 The thresholds for defining faltering growth only refers to weight whereas in practice, length/height centile is also significant. Weight is considered in the context of length as an infant may be on a low centile for both weight and length ad increased energy provision in this scenario could be detrimental if overfed. A recommendation that considers centile gap between weight and length/height may be useful.	Thank you for your comment. The primary concern is weight and thresholds are described in recommendation 1.2.1. If there is a concern then it is described that length or height should be measured and plotted (recommendation 1.2.2) and if there are concerns about an infant's length or a child's length or height mid parental height should be determined if possible. If the child's length or height centile is below the range predicted from parental heights (more than 2 centile spaces below the mid-parental centile) be aware this could suggest undernutrition or a primary growth disorder (recommendation 1.2.3). The Committee believed that these were logical steps and that both weight and height were sufficiently covered by these recommendations.
British Specialist	Full	100		Table 42	Thank you for your comment.

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

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Nutrition Association (BSNA) Ltd				Products listed in Table 42 are not fully representative of the market for faltering growth and there is a product included (Dialamine) that is a specialised product and would not normally be used as first-line for faltering growth. There are some products that are not suitable for children under 3 years of age (Calogen Extra, Caloreen Powder and Prosource Jelly) and it may be misunderstood by some prescribers that these products can be used for all ages. Products could be categorised in to age groups to prevent prescribing errors. Also, the table header refers to mg but the products are measured in grams. If the named products are intended to give a representation of the market, a list of products fitting these criteria are detailed below: Procal powder (Vitaflo) suitable from 1 year onwards Procal shot (Vitaflo) suitable from 3 years onwards Paediasure (Abbott) see product label for suitability Paediasure Fibre (Abbott) see product label for suitability Paediasure Peptide (Abbott) see product label for suitability Paediasure Plus (Abbott) see product label for suitability	It was not intended that the products be taken to represent clinically appropriate supplementation, rather that they give indicative costs for supplementation. Nevertheless, it is clear how this might be misinterpreted by parents (and perhaps even clinicians) and consequently the entire table has been replaced with your suggestions.

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				Paediasure Plus Fibre (Abbott) see product label for suitability Paediasure Plus Juice (Abbott) see product label for suitability Similac High Energy (Abbott) see product label for suitability SMA PRO High Energy see product label for suitability (SMA Nutrition)	
British Specialist Nutrition Association (BSNA) Ltd	Full	100		5.4.2.5.1 The term 'oral supplementation' is used but with no clarification of this term included. Advise further information within text or glossary.	Thank you for your comment. We have now added oral 'liquid' supplement and have included an entry in the glossary to define this term.
British Specialist Nutrition Association (BSNA) Ltd	Full	102		5.4.2.6.3 The terms 'nutrient-dense formula' and 'energy-supplemented formula' are used, but no further clarification on what these are is provided. Advise further information within text or glossary.	Thank you for your comment. The study referenced (Clarke 2007) reported that nutrient-dense formula has more energy (up to 52% more), more protein (up to 73%) and more minerals, such as sodium, potassium, iron and zinc than energy-dense formula. This information has been added to section 5.4.2.3 in the full guideline.
British Specialist Nutrition Association (BSNA) Ltd	Full	103		5.4.2.7.2 Enhancing the nutrient density of a child's diet should be subject to the same level of review detailed on page 103 lines 32 and 33 to ensure that if increasing the energy and nutrient density of food is not working to avoid further growth faltering. It would also be useful to give some indication of when to review an intervention i.e. timing of review	Thank you for your comment. The Committee agreed that goals need to be set, but did not want to be too prescriptive about review intervals. These would depend on many factors. However, the notion of review is covered in recommendation 1.2.15 where we describe a collaborative plan with parents which includes information on 'when reassessment to review

					progress and achievement of growth goals should happen'.
British Specialist Nutrition Association (BSNA) Ltd	Full	103	35-38	*Finally, the Committee agreed that enteral tube feeding should be reserved and considered for severe faltering growth with the aim to discontinue this as soon as possible. They therefore agreed that a multi-disciplinary approach for tube feeding is necessary which should include the goals to indicate that tube feeding is no longer needed* *This statement is not taking into account the need for long-term tube / lifelong feeding in organic faltering growth such as cardiology and neurodisability.* *Decision to tube feed must be based on clinical need and assessment of nutritional risk*	Thank you for your comment. The Committee agreed that some symptoms of the organic disorders that are highlighted in your comment are related to growth. However, there would be further symptoms of those organic conditions that may mean that longer term tube feeding is necessary. This would then be a consequence of the organic condition rather than faltering growth which is a separate condition. The Committee therefore agreed that tube feeding would be the exception rather than the rule for infants and children with faltering growth and should be discontinued as soon as possible. The Committee's discussion of these issues is described in section 5.4.2.7 in the full guideline.
British Specialist Nutrition Association (BSNA) Ltd	Full	102	40 & 45	*The term 'nutrient-enriched formula' is used, but no further clarification on what this is, is provided. Advise further information within text or glossary.*	Thank you for your comment. The study referenced (Fewtrell 2001) reported that nutrient-enriched formula has a higher protein content (approximately 30%) than the standard formula. In addition, the formula has a higher protein-to-energy ratio and contains more minerals, such as calcium (31 mg more), phosphorus (8 mg more), sodium (5 mg more) and potassium (21 mg more). This information has been added to section 5.4.2.3 in the full guideline.

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

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British Specialist Nutrition Association (BSNA) Ltd	Full	103	44 & 45	Refers to 'woman' and 'mother' but maybe more inclusive to refer to the family or parent?	Thank you for your comment. This has now been corrected.
British Specialist Nutrition Association (BSNA) Ltd	Full	104	34	Include a point about regular (this will vary depending on the clinical situation and setting and will be guided by the clinician) review to ensure efficacy of the approach include weight change, linear growth, food intake and the views of parents/carers	Thank you for your comment. The Committee did not want to be too prescriptive about review intervals. These would depend on many factors. However, the notion of review is covered in recommendation 1.2.15 where we describe a collaborative plan with parents which includes information on 'when reassessment to review progress and achievement of growth goals should happen'.
British Specialist Nutrition Association (BSNA) Ltd	Full	104	39	Include a point about regular review to ensure efficacy of the approach include weight change, linear growth, food intake and the views of parents/carers	Thank you for your comment. The Committee did not want to be too prescriptive about review intervals. These would depend on many factors. However, the notion of review is covered in recommendation 1.2.15 where we describe a collaborative plan with parents which includes information on 'when reassessment to review progress and achievement of growth goals should happen'.
British Specialist Nutrition Association (BSNA) Ltd	Full	105		5.4.2.9 The term 'high energy liquid feed supplements' is used but with no clarification of this term included. Advise further information within text or glossary.	Thank you for your comment. The table provides a summary of a research recommendation. We have described that the 'intervention' in the suggested research study could define high-energy liquid feed supplements as equivalent to at least 20% of daily energy

					requirement. There are many factors that could later influence the exact nature of the supplement within the context of a study if it were to be carried out based on our recommendation. We therefore did not propose a more specific definition.
British Specialist Nutrition Association (BSNA) Ltd	Full	105	2	Milk and milky drinks can be a good source of nutrition so perhaps specify their use away from meal times?	Thank you for your comment. The Committee advises to avoid drinking too much milk or too many energy-dense drinks as these may suppress the child's appetite and may stop the child eating food at regular times.
British Specialist Nutrition Association (BSNA) Ltd	Full	105	36-38	*Further research is important to establish whether their effectiveness justifies their cost and the suppressant effect on appetite.* The reference to the effect on appetite seems a strong statement based on the evidence available. It is worth remembering that STP patient care priorities are in the following order: safety, quality of products and services, then money and thus financial consideration should be the last consideration for optimum patient care.	Thank you for your comment. Although the Committee agreed that the appetite suppressant effect is not clearly established, the Committee believed that in saying supplements 'may' suppress appetite and displace normal diet they have added a reasonable amount of uncertainty to the claim. In addition, the section you highlight is a research recommendation, meaning that we believe it is important to establish more definitively whether there is an appetite suppressant effect of supplementation, and that there is currently insufficient evidence to make a strong recommendation on the issue. Consequently as long as the sentence is quoted in context it will be clear that the uncertainty around the existence of an appetite suppressant effect is high.
British Specialist	Full	106		Table 45: Research recommendation rationale	Thank you for your comment and the references provided.

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Nutrition Association (BSNA) Ltd				*High energy liquid nutritional supplements are widely used in children with low intake or poor weight gain but it is not clear if they are effective and they may have adverse effects on appetite, causing or exacerbating previously confirmed feeding behaviour problems.* *See below literature search*	The Committee agreed that the evidence is not sufficient to conclude that high-energy liquid nutritional supplements are effective and have therefore recommended further research in this area. Such research can then be used for future updates of this guideline.
Child Growth Foundation	Short	General	General	What about parents who are not persistent? What about parents who miss appointments? What about referral to geneticist/specialists if rare genetic disease is possible? There are no timescales for referral. Depending on ages of child and amount of weight loss, surely this should be considered. I.e if a 1 week old baby loses ½ kg it is more serious than a 6 month old. I doubt there would be a feeding specialist available to many patients.	Thank you for your comment. We do agree that lack of persistence and missed appointments can be a concern for healthcare professionals involved in the management of faltering growth. Dealing with these concerns requires professional judgement and the Committee did not make specific recommendations on these matters. The Committee made recommendations on the identification of organic disease which is to be found in the minority of children with faltering growth (see recommendation 1.2.6). They particularly emphasised the fact that investigations do not usually reveal such a disorder if there are no other clinical concerns (see recommendation 1.2.13). The Committee did not make recommendations on the timescale for referral as this also requires

					clinical judgement in the context of the individual child. Regarding the significance of specific weight losses in different age groups, we agree that this would be a matter for clinical consideration and the age of the child would be relevant to this consideration. Therefore the Committee did not make recommendations on specific amounts of weight loss and their significance. Recommendation 1.2.1 does provide specific guidance on thresholds for concern based on falls across centile spaces. The Committee recognised the importance of infant feeding specialists when needed and recommendation 1.3.3 specifically advises that the primary care team should have access to this expertise.
Child Growth Foundation	Short	General	General	The document is very nutritional based and think no mention anywhere that faltering growth could be caused by an endocrine condition or consideration of IUGR/SGA children. Children with growth conditions are notoriously poor feeders. And as a parent there is such guilt if a child is not feeding properly. While this guideline relates to faltering growth it may be appropriate to include the	Thank you for your comment. The Committee agreed that faltering growth could present with an underlying disorder, including endocrine and other organic disorders and that further investigations/referral may be needed when the clinical examination suggests signs or symptoms of a causative condition. This is reflected in recommendation 1.2.6 and in section 5.3.4.7.2 in the full guideline. Being born small for gestational age was considered as a potential risk factor for

				importance of recognising symptoms of reflux which may account for the faltering growth.	faltering growth in the review. However, the evidence was inconclusive and the studies used criteria to identify faltering growth that were not acceptable to the Committee. The Committee believes that infants born with intrauterine growth restriction or who were born small for gestational age may show some 'catch up' growth, but some remain small compared to the general population. For further details, please see section 5.3.3.6 and section 5.3.3.7.5 in the full guideline. The Committee recognised that parents may indeed feel guilty and this complex aspect is indirectly addressed in recommendation 1.2.11, which highlights the fact that a range of factors may contribute to faltering growth including the complex matter of infant/child - parent/carer interactions. The section on information and support (1.4) then emphasises the importance of explanation and discussion with parents. Finally, recommendation 1.4.1 highlights the emotional impact on parents and carers.
Child Growth Foundation	Short	4	6	Provide feeding support – in my opinion this is not on offer in many areas	Thank you for your comment. The Committee agreed that direct observation and feeding support by an appropriately trained individual was sometimes necessary and required consideration. For that reason they made recommendations on the composition of the primary care team involved in the care of infants and children with faltering growth and the availability of access to relevant healthcare professionals

					(recommendations 1.3.3 and 1.3.4) to enable such expert assessment to take place when required. These recommendations are intended for general application throughout the country.
Child Growth Foundation	Short	7	1	There is no mention of IUGR / SGA as a condition. Additionally, what about the many children born with rare diseases?	Thank you for your comment. The Committee agreed that faltering growth could present with an underlying disorder, including endocrine and other organic disorders and that further investigations/referral may be needed when the clinical examination suggests signs or symptoms of a causative condition. This is reflected in recommendation 1.2.6 and in section 5.3.4.7.2 in the full guideline. Being born small for gestational age was considered as a potential risk factor for faltering growth in the review. However, the evidence was inconclusive; the studies used criteria to identify faltering growth that were not acceptable to the Committee. The Committee believed that infants born with intrauterine growth restriction or who were born small for gestational age may show some 'catch-up' growth, but some remain small compared to the general population. For further details, please see section 5.3.3.6 and section 5.3.3.7.5 in the full guideline. The scope of the guideline does not include the management of infants or children with an 'underlying disorder'. Those born with intrauterine growth restriction or who were small for gestational age would likely be assessed in a specialist setting and their management regarding weight and linear growth would be informed by that assessment. If,

					unusually, they have not been assessed in this way then the guideline recommendation of indications for referral (1.2.31) will enable such a specialist assessment. The Committee recognised that faltering growth can be due to an unrecognised underlying disorder, and that further investigations may be needed in some individuals (see recommendations 1.2.6, 1.2.13, 1.2.14 and 1.2.31 in the short guideline and section 5.3.4.7.2 in the full guideline). The Committee believed that their recommended approach would reduce the risk of unnecessary investigation and identify those with disorders including rare diseases.
Child Growth Foundation	Short	7	18	For a child with conditions such as Silver Russell Syndrome / IUGR / SGA most of these points are not appropriate. Also, consider including Reflux as a contributory factor.	Thank you for your comment. The Committee agreed that faltering growth could present with an underlying disorder, including endocrine and other organic disorders and that further investigations/referral may be needed when the clinical examination suggests signs or symptoms of a causative condition. This is reflected in recommendation 1.2.6 and in section 5.3.4.7.2 in the full guideline. Being born small for gestational age was considered as a potential risk factor for faltering growth in the review. However, the evidence was inconclusive; the studies used criteria to identify faltering growth that were not acceptable to the Committee. The Committee believed that

					infants born with intrauterine growth restriction or who were born small for gestational age may show some 'catch-up' growth, but some remain small compared the general population. For further details, please see section 5.3.3.6 and section 5.3.3.7.5 in the full guideline. The scope of the guideline does not include the management of babies or children with an 'underlying disorder'. Those born with intrauterine growth restriction or who were small for gestational age would likely be assessed in a specialist setting and their management regarding weight and linear growth would be informed by that assessment. If, unusually, they have not been assessed in this way then the guideline recommendation of indications for referral (1.2.31) will enable such a specialist assessment. The Committee believed that in current practice, where there are concerns about faltering growth in infants and children, the infant or child is subjected to too many tests even if there are no signs or symptoms of other conditions or disorders. Our reasoning for not recommending other specific investigations is described in section 5.3.4.7 and its subsections.
Child Growth Foundation	Short	9	16	For a child with severe reflux, 'grazing' or eating little and often can be the best way to get calories into them. It should not be a blanket guideline – 'one size doesn't fit all'	Thank you for your comment. The Committee have revised the recommendation and 'avoid grazing' has now been removed in light of your comment.

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				For some families grazing is the key to weight gain. Some children will simply not want to or can't eat much at one time and a little and often approach is what works.	
Child Growth Foundation	Short	11	9	Many parents are anxious about their baby's weight gain and would prefer more regular monitoring	Thank you for your comment. The Committee recognised that if weight or length are measured too frequently, minor fluctuations in the values recorded are likely, which could lead to unwarranted anxiety for parents, carers and healthcare professionals and unnecessary investigations or interventions. The inclusion of the word 'usually' in the recommendation highlights that clinical judgement can be used if there is severe weight loss or other indications that more frequent weighing would be necessary. We have now described this more explicitly in section 5.5.7 and its subsections.
Child Growth Foundation	Short	11	14	The general health of the child should be considered. If a child has been ill (cold, virus), food intake would have been reduced.	Thank you for your comment. The Committee believed that the infant's or child's general health would be considered as part of the 'clinical assessment' that should be carried out and is recommended twice in this guideline, once for weight loss in the early days of life and once for possible faltering growth (recommendations 1.1.2 and 1.2.6 respectively). The Committee believed that this would be commonly understood by healthcare professionals.
Child Growth Foundation	Short	12	12	Are these primary care specialists ALWAYS available? Very unlikely in most cases.	Thank you for your comment.

					The Committee reflected on this and have added 'for example' to the end of the preamble of this recommendation because not all of these primary care professionals may be relevant for all infants and children. For instance, a midwife may not be the appropriate specialist for an older infant or child. Furthermore, these professionals would not need to be available at all times. The Committee agreed that direct observation by an appropriately trained individual was sometimes necessary and required consideration. For that reason they made recommendations on the composition of the primary care team involved in the care of children with faltering growth and the availability of access to relevant healthcare professionals (recommendation 1.3.3) to enable such expert assessment to take place when required. These recommendations are intended for general application throughout the country.
Child Growth Foundation	Short	12	25	What kind of information on faltering growth or weight loss would be provided, is available? Information on different causes of faltering growth is a must. It causes a lot of anxiety when parents are kept in the dark. Many parents know nothing of IUGR. It is important that the support for parents is considered and help provided if necessary. Life with a child with faltering growth concerns (also may have development concerns) is hard and it could cause some parents to break.	Thank you for your comment. It is recognised that parents and carers often go through periods of intense anxiety and uncertainty, feeling emotionally upset and healthcare professionals play an important role in this context (see recommendation 1.4.1). The information delivered to parents and carers should be individualised and tailored to the particular circumstances as well as the cultural background of the parents or carers and the infant or child. The guideline provides information about risk factors for faltering growth, which could be used as part of

					information provision for parents and carers (please see section 5.3.3 in the full guideline).
Child Growth Foundation	Short	13	2	Parental heights should be taken into account. Growth/endocrine conditions and rare diseases should be considered, More information should be available for IUGR/SGA	Thank you for your comment. The issue of parental height is addressed in recommendation 1.2.3. The Committee agreed that faltering growth could present with an underlying disorder, including endocrine and other organic disorders and that further investigations/referral may be needed when the clinical examination suggests signs or symptoms of a causative condition. This is reflected in recommendation 1.2.6 and in section 5.3.4.7.2 in the full guideline. Being born small for gestational age was considered as a potential risk factor for faltering growth in the review. However, the evidence was inconclusive; the studies used criteria to identify faltering growth that were not acceptable to the Committee. The Committee believed that infants born with intrauterine growth restriction or who were born small for gestational age may show some 'catch-up' growth, but some remain small compared the general population. For further details, please see section 5.3.3.6 and section 5.3.3.7.5 in the full guideline. The scope of the guideline does not include the management of babies or children with an ‘underlying disorder’. Those born with intrauterine growth restriction or who were small for gestational age would likely be assessed in a

					specialist setting and their management regarding weight and linear growth would be informed by that assessment. If, unusually, they have not been assessed in this way then the guideline recommendation of indications for referral (1.2.31) will enable such a specialist assessment.
Child Growth Foundation	Short	13	10	Patient support groups such as Child Growth Foundation would be an excellent resource for the parents.	Thank you for your response.
Child Growth Foundation	Short	14	18	Surely this is not in the best interest of the child, to delay if 'better value for money'.	Thank you for your comment. The Committee was not suggesting that implementation ought to be delayed. The text in brackets was provided as an example and it may be better to deliver recommendations in this guideline as a package rather than individually.
Coeliac UK	Short	6	25	The NICE guideline for recognition, assessment and management of coeliac disease [NG20] recommends **offering** serological testing for children with faltering growth (recommendation 1.1.1). The draft faltering growth guideline recommendation 1.2.7 states that investigations for coeliac disease should be 'considered'. This should be updated to be brought in line with guideline NG20 to emphasise the need to carry out testing for children who present with faltering growth.	Thank you for your comment. The NICE guideline on 'Coeliac disease: recognition, assessment and management' (NG20) refers to a child with faltering growth, whereas the recommendation in this guideline addresses the steps a healthcare professional should take when there is 'concern about faltering growth'. This difference is important and therefore warrants a change from 'offer' to 'consider'. In our case, faltering growth is not a definitive diagnosis and therefore the Committee believed that there should be room for clinical judgement.

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				We agree with the recommendation to only offer testing for coeliac disease if gluten containing foods have been included in the diet as this is in line with guidance from NG20.	
Department of Health	general	General	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Thank you for your comment.
La Leche League GB	**Full**	33	13 onwards	Section 4.2 We are delighted that within intervention for faltering growth, a section to support breastfeeding is included. We are concerned that no information is provided on the weight loss associated due to IV fluids administered to the mother during labor, though research from 2011 shows that some of a newborn's initial weight loss may be due to the infant regulating its hydration and not related to a lack of breast milk.1 According to the study, a weight loss greater than 7% may be completely unrelated to breastfeeding and due instead to excess IV fluids mothers receive within the final 2 hours before delivery. According to this study, these excess IV fluids inflate babies' birth weight in utero and act as a diuretic after birth. Babies whose mothers received more IV fluids before birth urinated more during their first 24 hours and as a result lost more weight. Number of wet	Thank you for your comment. The Committee acknowledged that infants of mothers who received intravenous fluids before birth may show larger weight loss in the early days of life. The studies included in chapter 4 (weight loss in the early days of life) included large cohorts of children. These large cohort studies included mothers who had received intravenous fluids but separate weight loss thresholds could not be extracted for the corresponding groups of babies. The Committee recognised that a larger fluid loss would be likely for these babies in the early days of life, but felt that the 10% threshold should still be an initial cause for concern. Intravenous fluid during labour may then be an issue that can be discussed as part of the clinical assessment. The Committee acknowledged that weight loss in the first days of life is normal and usually relates to body fluid adjustments (please see the preamble to the first section of the short version of the guideline). We provided a threshold of 10% as a

				diapers during the first 24 hours predicted infant weight loss. This was true whether the babies were born vaginally or by c-section. Another study2 published earlier this year had similar findings. This weight loss has no correlation with breastfeeding and milk intake. The authors suggest that if clinicians want to use weight loss as a gauge of milk intake, they calculate baby's weight loss not from birth weight, but from their weight at 24 hours. According to their findings, this could neutralize the effect of the mother's IV fluids on newborn weight loss. REFERENCES: 1- Joy Noel-Weiss, A Kirsten Woodend, Wendy E. Peterson, William Gibb and Dianne L Groll. An observational study of associations among maternal fluids during parturition, neonatal output, and breastfed newborn weight loss. International Breastfeeding Journal, 2011 2- Pediatrics, January 2011, VOLUME 127 / ISSUE 1 Excess Weight Loss in First-Born Breastfed Newborns Relates to Maternal Intrapartum Fluid Balance Caroline J. Chantry, Laurie A. Nommsen-Rivers, Janet M. Peerson, Roberta J. Cohen, Kathryn G. Dewey	possible reason for concern and 7% is therefore within the normal range. The studies you cite were not included in the guideline because they did not match our review question and protocol. Our question was 'What are the normal limits of maximal weight loss in the first two weeks of life?' which is essentially a different question to 'What are the effects of IV fluids during labour on newborn weight loss?' which is the topic of the references that you highlighted. See Appendix D for the inclusion criteria related to this review question.

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

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Lactation Consultants of Great Britain (LCGB)	**Short**	3	*21*	**Remove** *"Consider observation of feeding"*	Thank you for your comment. The Committee reflected on this and agreed not to remove this. Without this consideration the context of the subsequent bullet point would be removed. The subsequent bullet states that it should be ensured that observation of feeding is carried out by an individual with appropriate training and expertise. This can only happen if it has been considered necessary in the first instance. If the wording you are referring to is removed it would make observation of feeding obligatory for any infant who has lost more than 10% of weight in the early days of life. However, the Committee agreed that there should be some flexibility to allow healthcare professionals to use their clinical judgement (e.g. it is possible that some infants who have lost 10.1% of their weight in the early days of life and who are regaining weight steadily, might not need such observation of feeding).
Lactation Consultants of Great Britain (LCGB)	Short	4	1-2	Retain "ensure observation of feeding, if needed, is done by an individual with 1 appropriate training and expertise **in evaluating latch, positioning and effective milk transfer** (in relation to breastfeeding) and bottle feeding	Thank you for your comment. We have cross-referenced the NICE guideline on 'Postnatal care up to 8 weeks after birth' (CG37) which provides recommendations on what to assess. In the full guideline we have now also added to the discussion section that this '… could be a health visitor or a trained lay person – usually with Baby Friendly Initiative accreditation' to indicate the usual level of expertise (see section 4.3.2 of the full guideline). The Committee agreed that this would involve training in the assessment of

					evaluating latch, positioning and effective milk transfer. CG37 is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update).
Lactation Consultants of Great Britain (LCGB)	Full	General	22	4.3.5 Part of the issue and the necessity for this guideline is that we are currently missing two fundamental aspects of service. 1. Skilled assessment and support for effective milk transfer and establishing of milk supply while in hospital for the breastfeeding dyad. 2. Skilled assessment and support for effective milk transfer in the community. This applies to the 80%+ of women who want to breastfeed their babies for the sake of their infants and their own health. (A proportion of formula-feeding mothers also report that they do not get enough guidance while in hospital on correctly making up bottles of formula. [Infant Feeding Survey 2010]) Breastfeeding attachment and positioning and milk transfer issues are easy to identify and correct both in hospital and in the early days at home by someone who has had the appropriate training.	Thank you for your comment. The Committee recognised that appropriate training is important in providing good support to the mother-infant dyad while breastfeeding as per CG37 [Postnatal care up to 8 weeks after birth] includes recommendations on assessment and support for breastfeeding in hospital and the community. CG37 is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update). Specifying training standards for healthcare professionals was outside the scope of this guideline. However, the Committee acknowledged that individuals involved in the care of infants and children with faltering growth should have appropriate training and expertise to carry out observations of feeding (see recommendations 1.1.2 and 1.2.7). One such training level is the Baby Friendly Initiative accreditation which is mentioned

				However, this level of training is not yet mandatory nor even generally provided during entry or post-graduate level for all HCPs dealing with mothers. Most midwives, health visitors, health care assistants, GPs and paediatricians do not yet receive this basic training, unless they have received the minimum training in a Baby Friendly Initiative setting. (WBTi Report UK, 2016) So often when a baby's weight is faltering after hospital discharge, no-one has shown the mother how to check that her baby is getting enough milk, nor observed how the mother feeds her baby while at home. (WBTi Report UK, 2016) Very few authorities "operate a 'rapid response system' with the infant feeding team providing intensive support in the community. Admission in these cases may be avoided" as stated in Table 16, p39. If this sort of rapid response care pathway was resourced and made mandatory, in every community nationwide, not only would most readmissions be avoided but babies and mothers would remain healthier. Such a care pathway would include links to local peer group support, tongue-tie assessment and treatment; further information and links to charities that support breastfeeding. The service would enable the well documented potential savings of billions of pounds to	in the full guideline as an example of a relevant level of expertise. The guideline recommends to 'take a detailed history to assess feeding' and to consider 'direct observation of feeding' by an individual with appropriate training and expertise. The Committee believed that such assessment in addition to the cross-reference to CG37 (Postnatal care up to 8 weeks after birth) would ensure that issues such as 'whether the baby gets enough milk' and 'how the mother feeds her baby at home' would be taken into consideration in the assessment (regardless of whether the infant is breastfed or formula fed). CG37 is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update). The guideline includes recommendations about management of infants who lost more than 10% of their weight in the early days of life, which aims to avoid delay in assessment and in the provision of interventions and referral if necessary. Furthermore, the Committee recommended to establish a clear pathway to seek advice and medical or specialist feeding assessment if there were any concerns about weight loss or an apparently unwell infant. It was considered that this pathway was likely to provide improvements in the

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				the NHS in both the short and the longer term, not just around readmissions for growth faltering. Any such initiative is predicted to pay for itself within the year.(Lancet, Jan 2016) This care pathway would be suggested if the mother is breastfeeding, or chose initially to breastfeed but is now mixed feeding due to difficulties, or formula feeding but would prefer to breastfeed. (Breastfeeding can be re-enabled in the early weeks with such a skilled support pathway and determination). If the mother chose to formula feed and the infant is still losing weight after the first few days, then referral to a paediatrician is very likely warranted and necessary.	quality of life of parents and carers as well as in the overall infant's health. Such a pathway was assessed as a cost effective option.
Lactation Consultants of Great Britain (LCGB)	Full	General		We are concerned that the introduction fails to capture that some of these children with faltering growth will be infants and may be exclusively milk fed, i.e. under 6 months of age. This will include exclusively breast fed infants, mix fed infants as well as a formula fed population. Optimizing human milk (breastfeeding) should be a primary concern, as evidence supports this as the biological norm to promote human health and development. i.e. UK government & WHO guidelines, Lancet breastfeeding series.	Thank you for your comment. The Committee recognised the importance of optimising human milk and the health benefits that this practice has on infant or children, including the attachment relationship between child and mother. Unfortunately the literature search for breastfeeding interventions in infants or children with faltering growth yielded a very limited evidence base. Along with this, the introduction was not intended to be a textbook statement about breastfeeding, therefore no amendment was made as the current statement was considered to be sufficient.

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				Breastfeeding has been shown to reduce the risk and incidence of maternal neglect even in adverse circumstances. http://www.ncbi.nlm.nih.gov/pubmed/19171613 Pediatrics. **2009 Feb;123(2):483-93. doi: 10.1542/peds.2007-3546.** Does breastfeeding protect against substantiated child abuse and neglect? A 15-year cohort study.**Strathearn L**	The suggested reference has been retrieved and assessed for inclusion, however it does not meet the protocol inclusion criteria. The 'breastfeeding support' review question (see section 5.4.1 in the full guideline) focused on health educational interventions, peer or professional support and physical, pharmacological and behavioural interventions in relation to breastfeeding for infants and children in whom weight gain concerns have been raised. The suggested publication looks at the association between maltreatment and breastfeeding duration, and the main population is not infants or children in whom weight concerns had been raised, therefore it was not included in the relevant review question. For further details about the inclusion criteria, please see Appendix D - Section 10.
Lactation Consultants of Great Britain (LCGB)	Full	General	General	In addition, **the issue of nipple pain is highly relevant to faltering growth**, as milk transfer is often compromised. See research below: Int J Environ Res Public Health. 2015 Sep 29;12(10):12247-63. doi: 10.3390/ijerph121012247. **Nipple Pain in Breastfeeding Mothers: Incidence, Causes and Treatments.** Kent JC et al https://www.ncbi.nlm.nih.gov/pubmed/26426034 **Background:** Persistent nipple pain is one of the most common reasons given by mothers for ceasing exclusive	Thank you for your comment and for the reference provided. It is recognised that there may be certain conditions that limit effective milk transfer. However, these possible conditions were not part of the scope for this guideline, therefore we are unable to make recommendations about nipple pain. For the same reason, the suggested reference was not included in the guideline. For further details about the inclusion criteria, please see the related protocol in Appendix D.

				breastfeeding. We aimed to determine the frequency of nipple pain as a reason for consultation, the most common attributed aetiologies, and the effectiveness of the advice and treatment given. **METHODS:** All consultations at the Breast Feeding Centre of Western Australia (WA) were audited over two six-month periods in 2011 (n = 469) and 2014 (n = 708). Attributed cause(s) of nipple pain, microbiology results, treatment(s) advised, and resolution of pain were recorded. **RESULTS:** Nipple pain was one of the reasons for consultation in 36% of cases. The most common attributed cause of nipple pain was incorrect positioning and attachment, followed by tongue tie, infection, palatal anomaly, flat or inverted nipples, mastitis, and vasospasm. Advice included correction of positioning and attachment, use of a nipple shield, resting the nipples and expressing breastmilk, frenotomy, oral antibiotics, topical treatments, and cold or warm compresses. Pain was resolving or resolved in 57% of cases after 18 days (range 2-110). **CONCLUSION:** The multiple attributed causes of nipple pain, possibly as a result	

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				of a cascade of events, suggests that **effective early lactation management for prevention of nipple pain and early diagnosis and effective treatment are crucial to avoid early weaning.**	
Lactation Consultants of Great Britain (LCGB)	full	General	General	**Recommendation: ensure all health professionals in contact with the mother and baby dyad have been trained in supporting effective breastfeeding and assessing milk transfer.** *(Currently, this is not mandatory part of paediatricians, obstetricians, nurses, GPs or Health visitors' training. (WBTi Report UK)*	Thank you for your comment. We recommend that observations of feeding should be carried out by an individual with appropriate training and expertise (see recommendations 1.1.2 and 1.2.7) and have described that this '… could be a health visitor or a trained lay person – usually with Baby Friendly Initiative accreditation' (see section 4.3.2). However, a paediatric doctor carrying out a clinical assessment of an infant or child with faltering growth fed on solids may not need this accreditation. We therefore believe that such a prescriptive approach is not necessary.
Lactation Consultants of Great Britain (LCGB)	Full	General		**Recommendation: Enable the mother to identify when her baby is not feeding effectively, and enable her to identify adjustments she can make to improve milk transfer.**	Thank you for your comment. The Committee believed that this issue is not restricted to mothers of babies where there are concerns about weight loss or faltering growth. This would therefore fall into the remit of CG37 (Postnatal care up to 8 weeks after birth). This guideline is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update).

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Lactation Consultants of Great Britain (LCGB)	Full	General		**Recommendation: Provide skilled assessment of infant positioning and attachment before the mother and baby dyad leave hospital.**	Thank you for your comment. The Committee believed that this issue is not restricted to mothers of babies where there are concerns about weight loss or faltering growth. This would therefore fall into the remit of CG37 (Postnatal care up to 8 weeks after birth). This guideline is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update).
Lactation Consultants of Great Britain (LCGB)	Full	General	General	Note: Ineffective tongue movement also impacts bottlefeeding and can result in failure to thrive even when a baby is bottle fed. There are further impacts when the baby is introduced to solid food, with an impact on dentition (because the child cannot use its tongue effectively to remove food debris stuck to teeth or cheeks, between teeth cleaning, so caries are more common). There is often a follow-on impact on speech. **The impact of Ankyloglossia on faltering growth needs more attention, guidance and action to resolve it than it currently given in these guidelines.**	Thank you for your comment and for the reference provided. The Committee discussed ankyloglossia (tongue-tie) and elected not to make a specific recommendation for or against particular interventions for tongue tie. The NICE Interventional Procedure Guideline (IPG149) 'Division of ankyloglossia (tongue-tie) for breastfeeding', featured in this discussion. The Committee's decision not to refer directly to tongue-tie was based on the quality of the evidence in IPG149 and the fact that no evidence related to tongue-tie in infants with faltering growth was identified (please see section 5.4.1.5.5 in the full guideline for a discussion of this).
Lactation Consultants	Full	General	General	**Recommendation: Provide skilled assessment of tongue function at birth**	Thank you for the reference provided.

of Great Britain (LCGB)				**and before the mother/infant dyad leave hospital and provide prompt treatment if tongue-tie is suspected.** **See also:** **http://www.tongue-tie.org.uk/tongue-tie-information-leaflet.html**	The Committee discussed ankyloglossia (tongue-tie) and elected not to make a specific recommendation for or against particular interventions for tongue tie. The NICE Interventional Procedure Guideline (IPG149) 'Division of ankyloglossia (tongue-tie) for breastfeeding' featured in this discussion. The Committee's decision not to refer directly to tongue-tie was based on the quality of the evidence in IPG149 and the fact that no evidence related to tongue-tie in infants with faltering growth was identified (please see section 5.4.1.5.5 of the full guideline). The information leaflet was not included in the evidence review because it did not meet the inclusion criteria (i.e. it was not a comparative research study).
Lactation Consultants of Great Britain (LCGB)	Full	Introduction	22-24	**Currently states:** **Children with faltering growth may be identified by routine growth monitoring or by parental or** **health professional concern. Standard management is usually community based, with** **support and advice provided to increase energy intake and manage challenging feeding** **behaviour. Some children will be referred to paediatric dietitians or paediatricians for further assessment and management.** **Add in following support and advice on line 22 " from the infant feeding team, or**	Thank you for your comment. This section is a concise introduction to why the guideline is needed and is not meant to be comprehensive or provide recommendations. The Committee agreed that there are many routes by which concerns could be raised (by parents, healthcare professionals or other relevant individuals). We recommend to 'provide community-based care' (see recommendation 1.3.2) and also provide recommendations on increased energy intake and feeding or eating behaviours that may contribute to the problem (see recommendations 1.2.10 and, 1.2.11). We therefore did not make changes to the introductory text.

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				specialist infant feeding service for further assessment and management to optimize breastfeeding, improve milk transfer and increase maternal milk supply, alongside appropriate supplementation should that be necessary." **Ref BFI require specialist services from July 2017** **Example from practice: A community-based clinical lead in Brighton and Hove holds both the breastfeeding and faltering growth clinical lead role within the 0-19 programme. Brighton and Hove also have an IBCLC-led specialist breastfeeding clinic, to which babies would be referred by GPs and HVs for assessment and management.**	
Lactation Consultants of Great Britain (LCGB)	Full	introduction	32-35	**The cause of faltering growth in the absence of a specific underlying health condition is likely to be complex and multifactorial. In the past, child neglect or socioeconomic and educational disadvantage were often considered to be likely contributors. While neglected children may be undernourished, neglect is an uncommon explanation for faltering growth.**	Thank you for your comment. The Committee acknowledged that (see recommendation 1.2.9): • a range of factors may contribute to the problem, and it may not be possible to identify a clear cause • there may be difficulties in the interaction between an infant or child and the parents or carers that may contribute to the problem, but this may not be the primary cause.

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				Insert after multifactorial: Early skilled help to establish and continue breastfeeding is key to ensuring a good maternal milk supply and good milk transfer to the baby.	They also recognised that social factors should be assessed (which has now been added to recommendation 1.2.6). Safeguarding concerns are mentioned as a reason for referral to an appropriate paediatric specialist care service. The Committee, however, intentionally avoided mentioning this elsewhere because they agreed that neglect is an uncommon explanation for faltering growth as you state. It is recognised that appropriate training is important in providing good support to the mother-infant dyad while breastfeeding as per CG37 (Postnatal care up to 8 weeks after birth). This guideline is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update). Please note that the scope of this guideline is limited to the management of faltering growth in infants and children and we are unable to make recommendations for the level of training professionals involved in the care of infants and children with faltering growth may need. Despite this, it is recognised in the full guideline that health visitors involved in the care of infants and children with faltering growth would usually have Baby Friendly Initiative accreditation (see section 4.3.3 in the full guideline). For this reason, no amendment was made as the current statement was considered to be sufficient.

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

Lactation Consultants of Great Britain (LCGB)	Full	38	1-3	4.3.2 "The Committee agreed that it would be important to evaluate an infant's feeding as recommended if the weight loss was sufficient to raise some concern (more than 10%) and that the individual who observes the feeds has the relevant and appropriate expertise to do this." Suggest replacing this statement with: "The committee agreed that it would be important to evaluate every child's feeding by someone with the relevant and appropriate expertise in the first 24 hours. A weight loss of more than 10% may then be avoided, and any underlying issues that might lead to abnormal weight loss would be identified more easily." Reason: The current lack of consistent training provided to front line staff on effective milk transfer means that excessive weight loss may be iatrogenic rather than indicating an underlying problem in the infant or mother.	Thank you for your comment. The Committee reflected on this and agreed that this could be misunderstood. The recommendations in this section have now been revised by removing the reference to babies regaining their birth weight by 3 weeks which could be interpreted as having to wait 3 weeks before action is taken. The timeframe to intervene in those infants and children who have lost more than 10% is specified as the early days of life (first days after birth as stated in the preamble to the first section) which means once a 10% threshold has been reached an assessment should take place (see recommendation 1.1.2) regardless of whether this level of weight loss would occur in the first, second or third day. This recommendation also states that observation of feeding is done by an individual with appropriate training and expertise (for example, in relation to breastfeeding and bottle feeding). The Committee agreed that such training should include assessment of effective milk transfer.
Lactation Consultants of Great Britain (LCGB)	Full	38	6-8	4.3.2 "The infant who has lost more than 10% of their birth weight or who had not returned to their 6 birth weight by 3 weeks should be assessed for signs of effective feeding, milk transfer, urine 7 and stool output, and signs of illness including jaundice and dehydration." Suggest replacing these lines with:	Thank you for your comment. The Committee reflected on this and agreed that this could be misunderstood. The recommendations in this section have now been revised by removing the reference to babies regaining their birth weight by 3 weeks which could be interpreted as having to wait 3 weeks before any action is taken.

				The infant who has lost more than 10% of their birth weight or who had not returned to their 6 birth weight by 2 weeks should be re-assessed for signs of effective feeding, milk transfer, urine and stool output, and signs of illness including jaundice and dehydration. Reason: every child should be assessed properly in the first 24 hours and supported thereafter by well trained staff. If there is still an issue at 10 days to 2 weeks, the mother and baby dyad should be re-assessed by more highly skilled staff in the infant feeding pathway rapid response team. The rate for stopping breastfeeding is steepest in that first 10 days to 2 weeks, so intervention needs to be much earlier and more effective. Three weeks is too long to wait, as the mother and baby are likely to be distressed and their health compromised. By three weeks the mother is likely to have introduced artificial breastmilk substitute or switched to it completely, due to lack of effective support to resolve her breastfeeding difficulties. A delay in identifying a baby that is not removing milk effectively typically results in a mother's supply dipping If the baby is not distressed, (rare, but it happens) - then that is often an indication that the baby has some other underlying issue that needs to be addressed urgently.	The timeframe to intervene in those infants and children who have lost more than 10% is specified as the early days of life (first days after birth as stated in the preamble to the first section) which means once a 10% threshold has been reached an assessment should take place (see recommendation 1.1.2) regardless of whether this level of weight loss would occur in the first, second or third day.

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

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Lactation Consultants of Great Britain (LCGB)	Full	38	8-11	4.3.2 "In relation to the time to regain weight the Committee agreed that the 3 weeks that were reported in the evidence were a good estimate for the time after which concerns should be raised. The Committee considered that appropriate interventions and support could then be offered." I disagree with this statement for the reasons stated in my comments in 3 above. Reason: Three weeks is too late. This current statement maintains the status quo where the largest proportion of worried mothers have already given up breastfeeding in the first two weeks because of concerns over insufficient milk, pain or inadequate weight gain. Intervention needs to be sensitive, skilled, and much earlier to prevent difficulties occurring, not be left until the dyad requires significant intervention or re-admission.	Thank you for your comment. The Committee reflected on this and agreed that this could be misunderstood. This was deleted from the recommendation as well as from section 4.3.2 to avoid a possible delay in assessment and interventions. The related text in the discussion (section 4.3.2) has been reworded with regard to the 3-week period to return to birth weight.
Lactation Consultants of Great Britain (LCGB)	Full	38	9-10	4.4.2 Remove line 9 "consider direct observation of feeding". Retain lines 10-12 "ensure observation of feeding…" Insert new line "Refer to an infant feeding care pathway that includes a rapid response route to a Lactation Consultant clinic and/or Community team / specialist infant feeding service.	Thank you for your comment. We reflected on this and agreed not to remove this. Without this consideration the context of the subsequent bullet point would be removed. It can only be ensured that this is carried out by an individual with the appropriate training and expertise if this has been considered at necessary in the first instance. It is possible that a baby who has lost 10.1% and is regaining weight steadily might not need this. In the full guideline we have now also

					added to the discussion section that this '… could be a health visitor or a trained lay person – usually with Baby Friendly Initiative accreditation' to indicate the usual level of expertise (see section 4.3.2 of the full guideline).
Lactation Consultants of Great Britain (LCGB)	Full	38	15-16	4.3.2 *"The Committee thought that such a pathway would help minimise the harms of delayed admission or assessment when it was necessary."* **Suggest** "The Committee thought that such a pathway would prevent many admissions and delay the need for admission while an assessment and immediate support to remediate any underlying (feeding) difficulties was carried out."	Thank you for your comment. The Committee reflected on this and have reworded this to read 'The Committee thought that such a pathway could prevent the need for admission while an assessment is carried out and interventions and support could be provided.'
Lactation Consultants of Great Britain (LCGB)	Full	58	Table 27	5.3.2.3 *Feeding and eating behaviour (appetite, oromotor dysfunction, avoidant eating behaviour, poor appetite* This study does not distinguish between oromotor dysfunction and positioning and attachment difficulties. Positioning and attachment difficulties may lead to avoidant feeding behaviours (arching, crying and turning away) but are unlikely to lead to poor appetite on part of the baby, although falling asleep quickly at the breast but waking and crying when put down may be interpreted as this. The mothers finding her baby with this behaviour and faltering growth may turn to	Thank you for your comment. The Committee interpreted the results of the study with caution as it did not control for confounding factors, which may have resulted in a bias in the conclusions of the study. For this reason, the outcomes reported by this study were rated as very low or low quality, which was taken into consideration when drafting the recommendations.

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				artificial breastmilk substitutes if not supported adequately with skilled help, often within the first week of the baby's life.	
Lactation Consultants of Great Britain (LCGB)	Full	61	13-14	5.3.2.7.2 *In milk fed infants it is important to assess feeding cues, attachment to feed and milk transfer.* LCGB would fully support this statement and would recommend that it is emphasised in the revised guidelines	Thank you for your comment. The necessity of assessing feeding cues has been reflected in section 5.3.2.7.2 and also in the recommendations (see recommendation 1.2.10 in the short guideline).
Lactation Consultants of Great Britain (LCGB)	Full	61	30-31	5.3.2.7.2 *When a child is diagnosed with faltering growth, parents often experience a sense of guilt or blame which can originate from themselves or others.* While this statement may be true, what is almost never acknowledged currently is the impact of the lack of mandatory training provided to frontline NHS health professionals on effective breastfeeding support and providing skilled help to the mothers choosing to breastfeed. (see WBTi Report UK 2016) This really matters. LCGB members are daily witnesses to the efforts to which mothers will go to resolve infant feeding difficulties that lead to faltering growth, and maintain their choice to breastfeed for the health of their infants and themselves. LCGB are also witness to the evidence that much of the difficulties	Thank you for your comment. The Committee recognised that appropriate training is important in providing good support to the mother-infant dyad while breastfeeding as per CG37 (Postnatal care up to 8 weeks after birth). CG37 is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update). However, specifying training standards for healthcare professionals was outside the scope of this guideline. However, the Committee acknowledged individuals involved in the care of children with faltering growth should have appropriate training and expertise to carry out observations of feeding (see recommendations 1.1.2 and 1.2.7). One such training level is the Baby Friendly Initiative accreditation which is mentioned

				would be completely prevented with better, more skilled help in the neonatal period, when the available, skilled input by NHS staff should be greatest. LCGB and the various voluntary organisations who support breastfeeding mothers are trying to "pick up the pieces" that are the inevitable consequences, while this training deficit remains. Their support cannot substitute for universal, mandatory skills to help women breastfeed effectively, that needs to be available through health professionals to support every mother delivering in the UK.	in the full guideline as an example of a relevant level of expertise.
Lactation Consultants of Great Britain (LCGB)	Full	62	10	5.3.2.8 **Recommendation** Although implied in the recommendations, considering feeding environment and parent/carer interaction as contributors to faltering growth, I feel it is worth adding a note specifically in regards to bottle fed infants (EBM or formula) about limiting the number of people who feed the baby and therefore enhancing the attachment between (preferably) mother and baby. J Am Acad Child Adolesc Psychiatry. 1998 Nov;37(11):1217-24. Child Dev. 1997 Aug;68(4):571-91.	Thank you for your comment. The Committee recognised the importance of the feeding environment as well as parent/carer interactions as contributory factors for faltering growth and this has been highlighted in the guideline (see recommendations 1.2.10 and 1.2.11). However, we did not identify evidence that limiting the number of people feeding the infant helps them to gain weight. Thank you also for the references provided. We have retrieved them and assessed them for inclusion. Please see details below. - De Wolf 1997: the population did not match the protocol because participants were not infants or children with faltering growth. Therefore it was not included.

					- Chatoor 1998: the population did not match the protocol because it included 'children with infantile anorexia', which was not clearly defined. Furthermore, the assessment of attachment was not carried out during feeding or mealtimes (as specified in the protocol of this review question), but evaluated in a laboratory. Therefore this study was not included. Further details about the inclusion criteria can be found in Appendix D - section 6.
Lactation Consultants of Great Britain (LCGB)	Full	64	6	*5.3.3.1* Insert additional bullet sub points under *breastfeeding*: • Ineffective milk transfer (poor attachment and positioning - (refer to skilled feeding pathway) • Potential ankyloglossia (tongue tie - anterior or posterior) (refer to skilled feeding pathway)	Thank you for your comment. This section summarises the potential risk factors that the Committee prioritised for inclusion. These were kept intentionally broad (i.e. breastfeeding) to include issues such as ineffective milk transfer and ankyloglossia. However, no evidence was identified to show that these are risk factors that are directly related to faltering growth.
Lactation Consultants of Great Britain (LCGB)	Full	82	20	*5.3.3.7.1* Birth Complications - Caesarean - There is new evidence, provided at the Baby friendly conference May 2017 (Dr. Matthew Hyde, Microbirth presentation) of very reduced peaks in oxytocin during breastfeeding by mothers who had given birth by caesarean section. This is a plausible explanation (although not the only factor) of why many Caesarean mothers have difficulty with effective milk transfer	Thank you for your comment. We did not find any studies reporting mode of birth as a potential risk factor for future faltering growth and could therefore not make specific recommendations related to this. However, if there was an effect on milk supply for all women who have caesarean sections (as the study you reference seems to suggest) than this would fall under the remit of general postnatal care which is

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				with the consequences of some faltering growth. The reason this may not have shown up much in faltering growth associated with caesareans, is that babies are routinely supplemented with formula due to perceived (and probably actual) low milk supply/transfer after caesareans.	relevant to the NICE guideline on 'Postnatal care up to 8 weeks after birth' (CG37). CG37 is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update).
Lactation Consultants of Great Britain (LCGB)	Full	85	2-10	5.3.4.2 Very little mention is made throughout the guidelines of the specific causative conditions factors of: non structural, entirely preventable ineffective milk transfer (poor positioning and attachment), estimated as affecting 86% of babies with breastfeeding difficulties who attend breastfeeding clinics. (Dr. Mike Woolridge, when Breastfeeding Support Clinic Director, personal communication): Poor milk transfer in breastfeeding mothers leads to faltering growth in their infants. The solution is to fix the ineffective transfer issues, not supplement the infant with an artificial breastmilk substitute, which then creates its own problems (see Lancet reference).	Thank you for your comment. The review question for 'specific causative conditions' in faltering growth listed four main causative conditions, namely coeliac disease, urinary tract infection, hypothyroidism, and chronic renal disease. Ineffective milk transfer is not a condition as such, but rather a risk factor or contributory factor which can be assessed, observed and addressed. Therefore the suggested reference is not included in the guideline. For further information about inclusion criteria of this specific review question, please see Appendix D - section 5.
Lactation Consultants of Great Britain (LCGB)	full	91	34-37	5.4.1.5.2 *'members of the Committee described how many women choose to switch to formula feeding in the first few months of infancy. The Committee agreed that health*	Thank you for your comment. The Committee reflected on this and the paragraph has been reworded to highlight the benefits of breastfeeding and how healthcare professionals should support mothers in the continuation of breastfeeding whenever possible.

				professionals should explain the benefits and support the continuation of breastfeeding wherever possible' These lines perpetuate the common misconception that women who initially choose to breastfeed "choose" to switch to formula feeding. This is rarely a free choice - over 80% of women who gave up breastfeeding in the first 6 weeks wish they could have continued for longer (Infant Feeding survey 2010). They come up against issues that they cannot resolve without access to thoroughly trained, skilled help - and that effective, skilled help is not provided within the NHS except in a few small areas - otherwise we would have much better breastfeeding rates than we do currently. Most women do not need additional explanation of the benefits - they are already aware of them and informed their original decision to breastfeed. What they do require is effective, well trained support for the continuation of breastfeeding, from their health professionals charged with their care.	
Lactation Consultants of Great Britain (LCGB)	Full	92	3-4	5.4.1.5.2 information provision and support are provided in 3 chapters 5.3 and 7.	Thank you for your comment. This has been amended to say 'sections 5.4 and 7'.

				Support is not provided much in section 5.3.	
Lactation Consultants of Great Britain (LCGB)	Full	92	11-12	5.4.1.5.2 However, where there are growth concerns, breastmilk could be expressed and given in addition to breast feeds. This is helpful, but the most important intervention would be to provide effective, skilled support in evaluating and enabling effective milk transfer. Suggestion: the guidelines should state: The most helpful intervention would be to provide effective, skilled support in evaluating and enabling effective milk transfer. Where this is not possible immediately or current care is not sufficiently effective in increasing milk transfer, breastmilk could be expressed and given in addition to breast feeds. This should be seen as an interim workaround until the mother can access the effective feeding care pathway.	Thank you for your comment. In recommendation 20 in section 5.4.1.6, it is specified that the child's feeding or mealtimes should be observed by an individual with appropriate training and expertise.
Lactation Consultants of Great Britain (LCGB)	Full	92	15-17	5.4.1.5.5 *The Committee discussed the use of galactagogues, which are commonly used*	Thank you for your comment. No evidence was identified for the effectiveness of galactagogues as an intervention for faltering growth. We have now also removed 'which are

				(for 15 example, domperidone, fenugreek, metoclopramide). Without evidence of effectiveness and 16 with the theoretical risk of side effects, the Committee decided not to recommend them. While caution on galactogogues is understandable, the actual and thoroughly documented (as opposed to theoretical) side effects of switching to formula feeding as an alternative to breastfeeding in case of faltering growth are well known for the infant. In addition, the mother's risk of breast and ovarian cancer would not be reduced if she stops breastfeeding and switches to formula. Lancet 2016) A protocol on domperidone in cases of low milk supply from the International Breastfeeding Centre is given at the link below: http://ibconline.ca/information-sheets/domperidone/ Fenugreek may have a side effect of making perspiration smell like maple syrup, but Fenugreek is considered safe for nursing mothers when used in moderation and is on the U.S. Food and Drug Administration's GRAS list (Generally Recognized As Safe). As with most medications and herbs, various side effects	commonly used' from the statement and replaced 'theoretical side effects' with 'possible side effects' because there was no evidence that they were commonly used and the Committee was aware that there was the possibility of side effects. Thank you also for the reference provided. We have retrieved it and assessed it for inclusion but it did not meet the inclusion criteria. None of the references provided directly investigate the effectiveness of these galactagogues in the context of faltering growth.

				have been noted; see the side effects and safety information below. Per Hale [Hale 2012], "The transfer of fenugreek into milk is unknown, untoward effects have only rarely been reported." Hale classifies it in Lactation Risk Category L3 (moderately safe). It is true that there have been almost no clinical trials on fenugreek, but its use on supporting breastfeeding is traditional and goes back to ancient times. It is a common and widely used food ingredient.	
Lactation Consultants of Great Britain (LCGB)	Full	92	15-17	5.4.1.5.5 Studies have shown that Metoclopramide can increase milk supply by 60-100%. Details are available in *Thomas Hale's Medications and Mothers Milk. 2017* In terms of risk/benefit analysis, amounts that may be transferred in milk are minimal (micrograms as opposed to milligrams) compared to those used in reflux therapy in paediatric patients. Only 1 in 5 breastfeeding infants had any detectable levels of metoclopramide in their blood. If the child was switched to formula to address faltering growth, reflux would be far more common, so the likelihood of	Thank you for the reference provided. We have retrieved it and assessed it for inclusion. However, the reference does not address the effectiveness of metoclopramide in the context of faltering growth and was therefore not included.

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				exposure to metoclopramide plus the many other drugs to treat the illnesses associated with formula feeding would be very much greater.	
Lactation Consultants of Great Britain (LCGB)	Full	92	25 - 26	5.4.1.5.3 *it is likely that relatively small investments made in breastfeeding support early will be cost-effective given the accumulation of QALYs and costs offset over the lifetime of the child.* It is not only likely, it is thoroughly confirmed that investments in breastfeeding support are the most cost-effective interventions in the NHS. (Lancet 2016) I suggest replacing this line with: *' it is now certain that relatively small investments made in breastfeeding support early will be highly cost-effective given the accumulation of QALYs and costs offset over the lifetime of the child and mother.'* *http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)01044-2/abstract?cc=y=*	Thank you for your comment. The reference cited looks only at resource use, and relates to a non-faltering growth population. In addition, it contains a payer perspective that is not recognised by NICE. Consequently it is not included as health economic evidence in this guideline on faltering growth, and we believe the original wording better reflects the state of the evidence.
Lactation Consultants of Great	Full	92	27-28	5.4.1.5.5	Thank you for your comment. No evidence was identified for the effectiveness of galactagogues as an intervention for faltering

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Britain (LCGB)				*As the Committee chose not to recommend galactagogues, none of the recommendations represent a significant resource impact from what is already typically done in the NHS.* These galactogogues are inexpensive in terms of other drugs available / widely used in the NHS - fenugreek in particular is very cheap. Compared to the well-documented risks, hospital admissions and high costs incurred with artificial feeding, (Lancet 2016 reference above) I would suggest that the Committee recommends galactogogues to support breastfeeding and provides clear guidelines for their use.	growth. For this reason, the Committee decided not to prioritise the use of galactagogues. However, it is accepted that the phrasing of the particular sentence you highlighted implies that galactagogues might be expensive when in fact what was meant was that evidence for their cost effectiveness was not found. The sentence has been amended to state that no evidence was found, to make this distinction clear.
Lactation Consultants of Great Britain (LCGB)	Full	92	35	5.4.1.5.2 ……women choose to switch to formula feeding. The use of the word choose promotes the idea that it is within the mother's control whether or not to introduce formula milk, when so often it is a decision she is forced to make for want of consistent, quality support and information in the early postpartum period.	Thank you for your comment. This paragraph has been reworded to highlight the benefits of breastfeeding and how healthcare professionals should support mothers in the continuation of breastfeeding whenever possible.

				...has to make the decision to introduce formula… may be a better way of putting it.	
Lactation Consultants of Great Britain (LCGB)	Full	92	35, 36 & 37	5.4.1.5.5 **Tongue-tie** - This does need to be recognised and stated within the guidelines as an issue that can lead to faltering growth. The guidelines state "*The Committee's decision not to directly refer to tongue-tie was based on the quality of the evidence in IPG149 and the fact that no evidence related to tongue-tie in infants with faltering growth was identified."* In contradiction to the above statement, supporting evidence is provided in the references below.	Thank you for your comment. Division of tongue tie was listed as one of the interventions in this review, but the literature search yielded no evidence regarding this intervention, or any other intervention in the context of breastfeeding in faltering growth. For further details about the inclusion criteria in the 'interventions to support breastfeeding' review, please see Appendix D - section 10. Thank you for the references provided. We have addressed them separately in the responses below.
Lactation Consultants of Great Britain (LCGB)	Full	92	35, 36 & 37	5.4.1.5.5 https://www.ncbi.nlm.nih.gov/pubmed/26404342 **Persistent Nipple Pain in Breastfeeding Mothers Associated with Abnormal Infant Tongue Movement.** "Infants of breastfeeding mothers with persistent nipple pain have been shown to apply stronger vacuums to the breast and	Thank you for the reference provided. This study was not included for the following reason: the breastfeeding mothers included in this study did not have infants who presented with faltering growth or with growth concerns. Furthermore, this study was observational and only randomised controlled trials were prioritised for inclusion in this review. For further details about the inclusion criteria in the 'interventions to support breastfeeding' review, please see Appendix D -section 10.

				transfer less milk during one monitored feed." **Poor positioning and also abnormal infant tongue movement reduce effective milk transfer and induce maternal pain.** **This will lead to faltering growth if the skilled help to promote effective breastfeeding is not provided, and also if the baby's abnormal tongue movement is not addressed.**	
Lactation Consultants of Great Britain (LCGB)	Full	92	35, 36 & 37	5.4.1.5.5 https://www.ncbi.nlm.nih.gov/pubmed/24101770 **Evidence of improved milk intake after frenotomy**: a case report. Garbin et al, 2013. Ankyloglossia (tongue tie) is a well-recognized cause of breastfeeding difficulties and, if untreated, can cause maternal nipple pain and trauma, ineffective feeding, **and poor infant weight gain.** In some cases, this condition will result in a downregulation of the maternal milk supply. Milk-production measurements (24-hour) for a breastfeeding infant with ankyloglossia revealed the ineffective feeding of the infant (78 mL/24 hours), and a low milk supply (350 mL/24 hours) was diagnosed.	Thank you for the reference provided. This study was not included for the following reason: there were no concerns about faltering growth in the infants included in the study. Furthermore, the study was observational and only randomised controlled trials were prioritised for inclusion in this review. For further details about the inclusion criteria in the 'interventions to support breastfeeding' review, please see Appendix D - section 10.

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				Appropriate management increased milk supply (1254 mL/24 hours) but not infant milk intake (190 mL/24 hours). **Test weighing convincingly revealed the efficacy of frenotomy, increasing breastfeeding milk transfer from 190 to 810 mL/24 hours**. Post-frenotomy, breastfeeding almost completely replaced bottle-feeding of expressed breast milk. This case study confirms that ankyloglossia may reduce maternal milk supply and that frenotomy can improve milk removal by the infant. Milk-production measurements (24-hour) provided the evidence to confirm these findings.	
Lactation Consultants of Great Britain (LCGB)	Full	92	35, 36 & 37	5.4.1.5.5 See link to effective diagnosis and management provided by Unicef Baby Friendly site http://www.drjain.com/	Thank you for the reference provided. This study was not included as it is not a peer-reviewed publication and therefore does not meet the inclusion criteria for this review. Please see Appendix D for the related evidence review protocol.
Lactation Consultants of Great Britain (LCGB)	Full	92	35, 36 & 37	5.4.1.5.5 Further research on the need for skilled support and the impact of ankyloglossia on infant feeding: Nurs Womens Health. 2014 Apr-May;18(2):122-9. doi: 10.1111/1751-486X.12108. https://www.ncbi.nlm.nih.gov/pubmed/24750651	Thank you for the reference provided. This study was not included for the following reason: there were no concerns about faltering growth in the infants included in the study. Furthermore, the study was observational and only randomised controlled trials were prioritised for inclusion in this review. For further details about the inclusion criteria in the

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				Ankyloglossia its impact breastfeeding. Henry L, Hayman R. **Abstract** This article contrasts two very different experiences of one mother breastfeeding her two sons to demonstrate the potential impact of ankyloglossia on breastfeeding. When too restrictive, ankyloglossia, also known as tongue-tie, can cause the newborn to ineffectively suckle at the breast. Breastfeeding difficulties can occur, such as long feedings or damaged nipples. When nurses, lactation consultants and other providers recognize this situation, they can refer women for further care and treatment, which can ultimately lead to breastfeeding success.	'interventions to support breastfeeding' review, please see Appendix D - section 10
Lactation Consultants of Great Britain (LCGB)	Full	92	35, 36 & 37	5.4.1.5.5 Breastfeed Med. 2014 Nov;9(9):430-7. doi: 10.1089/bfm.2014.0072. Epub 2014 Oct 7. Tongue-tie and breastfeeding in newborns-mothers' perspective.Riskin A https://www.ncbi.nlm.nih.gov/pubmed/25290824 **CONCLUSIONS:**	Thank you for the reference provided. This study was not included for the following reason: there were no concerns about faltering growth in the infants included in the study. Furthermore, the study was observational and only randomised controlled trials were prioritised for inclusion in this review. For further details about the inclusion criteria in the 'interventions to support breastfeeding' review, please see Appendix D - section 10

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

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				TT infants had significantly more breastfeeding problems in the first month, but similar rates and durations of breastfeeding. Early diagnosis and lactation consultation may assist mother-infant dyads substantially. Mothers whose infants underwent frenotomies for breastfeeding more frequently found the procedure alleviated breastfeeding problems.	
Lactation Consultants of Great Britain (LCGB)	Full	92	44	**5.4.1.5.6** *(suggested addition)……..* ***good quality*** information and support, ***from qualified, experienced practitioners***	Thank you for your comment. This sentence has been amended and now reads: '… observation and assessment of breastfeeding as well as comprehensive information and support from a healthcare professional with the relevant expertise are important aspects in the promotion of breastfeeding …'.
Lactation Consultants of Great Britain (LCGB)	Full	93	12	5.4.1.6 Recommendations Suggest adding another bullet point "Ensure that your PCG provides a skilled infant feeding care pathway to which you can refer the mother and infant dyad".	Thank you for your comment. A pathway of care is recommended in 1.3.1 in the 'organisation of care' section. The Committee believed it sits better there than in the section on interventions.
Lactation Consultants of Great Britain (LCGB)	Full	93	28	**5.4.1.6** *(suggested addition)* ***consider physical issues in the mother for causes of low milk supply***	Thank you for your comment. It is recognised that there may be certain conditions that limit effective milk transfer. However, these possible conditions were not part of the scope for this guideline, therefore the Committee is unable to make recommendations on them.
Lactation Consultants	Full	151	37-46	6.7.2	Thank you for your comment.

of Great Britain (LCGB)				*'an infant feeding specialist (who could be a health visitor or a trained person – usually with Baby Friendly Initiative accreditation)'* LCGB would recommend that the care pathway includes a qualified Lactation Consultant, as the allied health professional. IBCLC Lactation Consultants are recognised throughout the world as holding the premier global credential in breastfeeding. IBCLC is the only internationally recognised professional qualification for lactation. Knowledgeable in all areas, an IBCLC can help with both basic and complex breastfeeding challenges. LCGB's members advise and consult on practice and protocols related to infant feeding in the UK and work in a variety of situations using their specialist skills and knowledge.	The Committee intentionally referred to an 'infant feeding specialist' to be more inclusive. This could be a health visitor or another person with appropriate expertise (e.g. a lactation consultant). The choice of who it would be would also be dependent on other factors such as individual circumstances and preferences, as well as the age of the child. For example, a lactation consultant would not be appropriate for a child with faltering growth. The Committee therefore agreed to keep the wording as it was.
Lactation Consultants of Great Britain (LCGB)	Full	153	32	*infant feeding specialist* Suggest adding: (preferably an International Board Certified Lactation Consultant)	Thank you for your comment. The Committee intentionally referred to an 'infant feeding specialist' to be more inclusive. This could be a health visitor or another person with appropriate expertise (e.g. a lactation consultant). The choice of who it would be would also be dependent on other factors such as individual circumstances and preferences, as well as the age of the child. For example, a lactation consultant would not be appropriate for a child with faltering

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

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					growth. The Committee therefore agreed to keep the wording as it was.
Lactation Consultants of Great Britain (LCGB)	Appendix D		Inter venti on	13 Key area G: Service configuration (question G1.)36 *and Infant feeding specialists* / lactation consultants	Thank you for your comment. The Committee intentionally referred to an 'infant feeding specialist' to be more inclusive. This could be a health visitor or another person with appropriate expertise (e.g. a lactation consultant). The choice of who it would be would also be dependent on other factors such as individual circumstances and preferences, as well as the age of the child. For example, a lactation consultant would not be appropriate for a child with faltering growth. The Committee therefore agreed to keep the wording as it was.
Lactation Consultants of Great Britain (LCGB)		Disclo sure		*Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry* **Recommendation:** **NICE should also insist on disclosure from anyone with any past or current, direct or indirect links to, or funding from to the formula milk manufacturing industry**	Thank you for your comment. While stakeholders are asked to disclose links with the tobacco industry, there is no requirement for stakeholders to declare other interests at this time.
Liverpool Community Health	Short	19	10	Comment on section 4 Frequency of Monitoring The current Royal College of Paediatrics and Child Health guideline for growth monitoring, at the time of routine	Thank you for your comment. The Committee recognised that if weight or length are monitored too frequently, minor fluctuations in the values recorded are likely, which could lead to unwarranted anxiety for parents, carers and healthcare professionals and unnecessary

				immunisation, harks back to a time when most Health Visiting services provided “Well Baby clinics” in conjunction with immunisation sessions. The Healthy Child Program has emphasis on the five core home visits. In our area to meet these targets there has been a reduction in “Well Baby Clinics” because there is no evidence available on the role of or effectiveness of the well-baby clinic. When “Well Baby Clinics” were associated to immunisation clinics they provided the opportunity for all who attended for vaccination to also have growth monitoring by the Health Visiting Service. We have had to introduce a system of growth monitoring at the five core visits to try and reach all of our babies. However, this has challenges because staff need to carry scales and height measures in and out of people’s homes.	investigations or interventions. Excessively frequent weighing may lead to longer term trends being missed. The Committee balanced the potential harms and benefits of growth monitoring by recommending different frequencies of measurement depending on the age of the infant or child and the severity of faltering growth (please see section 5.5.7 and its subsections in the full guideline).
National Childbirth Trust (NCT)	Short	8	10-13	NCT has concerns regarding the practicality of this request for the parents of a fully breastfed baby. There is a presumption here that parents can measure amount consumed which is not viable when the baby is feeding directly from the breast.	Thank you for your comment. This recommendation intentionally starts with 'consider' asking to keep a food diary indicating that this may not always be applicable. If the baby is exclusively breastfed it is implicit that 'food types' and 'mealtime issues' would not apply and that such a diary may therefore not be requested or required.

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

National Childbirth Trust (NCT)	Short	11	26-28	Feedback from NCT breastfeeding supporters is that many families are referred to hospital for weighing and feeding support when there are concerns about faltering growth. As this recommendation states that many of these babies should not be admitted to hospital, we suggest that this section is more explicit about community-based support.	Thank you for your comment. The Committee agreed that community-based support is preferable to referral to a hospital. They thought that this would, however, be better placed in a section on 'organisation of care' rather than in the intervention section. Placing it in the intervention section would also mean that it would have to be stated again in the section on 'weight loss in the early days of life' and the Committee agreed that having a separate section would indicate that this would be an overarching issue across groups. They therefore recommended to 'provide community-based care for infants and children where there are concerns about faltering growth' (see recommendation 1.3.2) or weight loss in the early days of life. Our reasoning for this is described in detail in the full guideline (see section 6.7 and its subsections).
National Childbirth Trust (NCT)	Full/ Short	General	General	NCT welcomes the holistic approach evidenced in the full guideline with regard to faltering growth in babies in their early days, with its references to alertness, nappies etc. However we feel this approach is not replicated in the short guideline as it very much focuses on weight loss and makes no or little mention of the other factors. We feel it is likely that few health professionals will have the time or inclination to read the full guidance and will instead focus on the short, therefore missing key information.	Thank you for your comment. The information in the full guideline summarises the discussion that led to this cross-reference and therefore references some of the issues that you raise (i.e. alertness, nappies etc.) whereas the short version is a summary of the recommendations without the evidence or other context. There are many such factors included in the NICE guideline on ‘Postnatal care up to 8 weeks after birth’ (CG37) to which we cross-refer. Once the guideline is in a digital format and with the

					publication of the NICE pathway it will be easier to navigate from one document to another which will enable the reader to find relevant information in either of the two guidelines. CG37 is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link: https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update).
National Childbirth Trust (NCT)	Full	29	22 onwards	NCT feels strongly that evidence considered should include the volume of intravenous fluids mothers received during labour which can affect hydration of the baby. Cochrane review "Intravenous fluids for reducing the duration of labour in low risk nulliparous women" DOI: 10.1002/14651858.CD007715.pub2 found "If mothers received more than 200 mL/hour of fluids, their babies were 3.2 times more likely to experience excess weight loss at three days compared to mothers who had less than 100 mL/hour of fluids " based on two studies: Chantry CJ, Nommsen-Rivers LA. Excess weight loss in first-born breastfed newborns relates to maternal intrapartum fluid balance. Pediatrics2011;127(1):171-9. Noel-Weiss J, Woodend AK, Peterson WE, Gibb W, Groll D. An observational study of associations among maternal fluids	Thank you for your comment. The Committee acknowledged that infants of mothers who received intravenous fluids before birth may show larger weight loss in the early days of life. The studies included in chapter 4 (weight loss in the early days of life) included large cohorts of children. These large cohort studies included mothers who had received intravenous fluids but separate weight loss thresholds could not be extracted for the corresponding groups of babies. The Committee recognised that a larger fluid loss would be likely for these babies in the early days of life, but felt that the 10% threshold should still be an initial cause for concern. Intravenous fluid during labour may then be an issue that can be discussed as part of the clinical assessment. A discussion of this has now been included in section 4.3.2 in the full guideline. The Cochrane review and the associated references were not included in our review because they answer a different question to that posed by

				during parturition,neonatal output,and breastfed newborn weight loss. International Breatsfeeding Journal 2011;6(9):1-10.	our protocol. The purpose of the Cochrane review and the other studies that you cite is to study the effectiveness of intravenous fluids during labour (including outcomes related to the baby). The review question that we asked was 'What are the normal limits of maximal weight loss in the first two weeks of life?' which is essentially a different question. These studies were therefore not included in the guideline in the guideline (see Appendix D for the inclusion criteria related this review protocol).
National Childbirth Trust (NCT)	Full	36-37		Regarding Quality of Evidence, NCT shares the GDG's concern that there is limited quality research on this issue, which has been conducted in an environment which is relevant and meaningful to UK parents, and supports the Research Recommendations featured in pages 157-159.	Thank you for your comment.
National Childbirth Trust (NCT)	Full	33 & 35	35 28	In places typos appear to reduce clarity. eg Table 14, col 4 first para Increased use of commas may help, and possibly word missing.	Thank you for your comment. This has now been amended.
National Childbirth Trust (NCT)	Full	35	33-35	"The Committee agreed that if healthcare workers were aware of usual weight loss patterns after birth that they could reassure parents and avoid unnecessary interventions for the baby." NCT welcomes this recognition and that it features in the early pages on the short guideline. We	Thank you for your comment. Your comments will be considered by NICE where relevant support activity is being planned.

				would like NICE to consider producing implementation tools that feature such key information.	
National Childbirth Trust (NCT)	Full	36 & 92	33-36 20-28	NCT welcomes the recognition that "it is likely that relatively small investments made in breastfeeding support early will be cost-effective given the accumulation of QALYs and costs offset over the lifetime of the child". The suggestion of faltering growth – sometimes triggered at less than the 10% threshold – has often led to a recommendation to 'top up' with formula milk, which in itself often leads to the cessation of breastfeeding, through reduction in the demand and supply mechanism and mothers' loss of confidence in breastfeeding. The perception of 'insufficient milk' is one of the most common reasons for stopping breastfeeding, especially in the early weeks. This makes the reduction in breastfeeding support in England and Wales in particular of vital importance. NCT does not disagree with the conclusion of the ***economic benefits and harms*** section that "none of the recommendations represent a significant resource impact from what is already typically done in the NHS", however it is within public health budgets that the largest cuts have taken place.	Thank you for your comment. The health economic analysis did identify that the use of health visitors as specified in the 'organisation of care' section of the guidance is cost saving to the NHS. It would therefore be difficult to cut these services related to faltering growth as this would increase downstream costs. Health visitors can provide relevant breastfeeding assessment and support. The Committee therefore believed that the implementation of the recommendations would improve care for infants and children with faltering growth in the areas you outline, particularly because this service configuration is cost effective. The Committee discussed whether to directly refer to PH11, but decided not to because that guidance addresses what should be done in the 'normal population' rather than the actions to take when there are concerns about faltering growth. However, we refer to PH11 in our protocol on monitoring as it provides details about how often infants should be weighed when there are no growth concerns (please see Appendix D).

				Faltering growth is most likely to be identified in the community. Health visitors and peer supporters are now mainly employed via Local Authorities and the latter in particular have been cut completely in some areas. There is insufficient breastfeeding support available to women when starting to breastfeed and when they experience difficulties, such as faltering growth. With reference to Q4 above, what would help users overcome any challenges is provision of infant feeding support in line with the NICE PH11 recommendations but community services are not meeting these.	
National Childbirth Trust (NCT)	Full	37	7-8	NCT feels it is worth mentioning assessment of stool and urine output as part of this. Normal stooling pattern is generally indicative of reasonable breastmilk supply. Many health professionals use NCT's "What's in a nappy" sheets or similar https://www.nct.org.uk/sites/default/files/related_documents/What%27s%20in%20a%20nappy%20%28ENGLISH%20VERSION%29%20FINAL%20WITHOUT%20BLEED.pdf	Thank you for your comment. The Committee recognised that this is important and assessment of stool and urine output has been mentioned in section 4.3.2 in the full guideline.

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

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National Childbirth Trust (NCT)	Full	61	30-31	We feel this is a very important point, not to be lost and suggest removing the qualification in this sentence: "When a child is diagnosed with faltering growth, parents often experience a sense of guilt or blame which can originate from themselves or others. Healthcare professionals will need to be aware of this and ~~may need to~~ provide reassurance and support."	Thank you for your comment. The Committee reflected on this and agreed to keep this statement as it was. It may not always be the case that parents have these feelings and therefore the qualification 'can' in the first sentence is followed by 'may' in the following sentence.
National Childbirth Trust (NCT)	Full	64 80	6 23-25	NCT feels strongly that mentioning breastfeeding as a potential risk factor adds to the lack of confidence in breastfeeding which is still so apparent. We suggest this line is amended to read 'insufficient breastmilk' or 'infrequent or ineffective breastfeeding'. Emond et al (2007) found: "Weak sucking was equally important in breastfed and bottle-fed infants: one in six infants in the cohort was reported by their parent to have weak sucking, and growth faltering was nearly twice as likely in this group." In relation to breastfeeding >6 months: (note NOT <6months as quoted here on line 25) The paper is not always clear whether they are referring to exclusive breastfeeding, predominant breastfeeding or continuing breastfeeding while solid foods are	Thank you for your comment. The clinical evidence statements (5.3.3.6) reflect what was reported in the study, while the evidence to recommendations section (5.3.3.7) describes how the evidence was used to draft recommendations. In light of your comment, the clinical evidence statements have been amended to better reflect what the study reported ('duration of breastfeeding' and 'weak sucking'). We have now provided additional information about this study in section 5.3.3.7.2. It is now described that there was uncertainty about whether the infants in the study were exclusive breastfed, predominantly breastfed or were breastfed while solid foods were being introduced which makes interpretation of the findings difficult.

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				introduced, which is what WHO and UK Departments of Health recommend. For example: p3 "An alternative explanation is that mothers may sense that the infant is not ready to wean (eg, not demanding solids, or showing immature oral–motor skills when offered tastes of solid food), and they continue to breastfeed." Therefore reverse causation needs to be mentioned. This paragraph needs rewriting to reflect the findings of the study and to clarify whether this is exclusive breastfeeding, as is likely; otherwise it is at odds with current recommendations. Emond, Drewett, Blair, Emmett (2007). Postnatal factors associated with failure to thrive in term infants in the Avon Longitudinal Study of Parents and Children. Archives of Disease in Childhood, 92(2). http://adc.bmj.com/content/92/2/115?ct=ctl92%2F2%2F115l92%2F2%2F115	
National Childbirth Trust (NCT)	Full	157	33-34	NCT welcomes the research recommendation on the experiences and concerns of parents of children with faltering growth.	Thank you for your comment.
National Childbirth Trust (NCT)	Appendix A	11	17-18	NCT welcomes this acknowledgment regarding the uncertain clinical value of repeatedly weighing infants. We would like to see this feature clearly in the short	Thank you for your comment. Appendix A refers to the scope of the guideline. The topics in the scope have been addressed in the

				guideline and in information for parents. Our breastfeeding supporters report that parents often feel they should have their baby weighed frequently, even when the baby is thriving.	guideline, including the frequency of weighing (see recommendation 1.2.27).
NHS England	Short			1.2.12 -1.2.13- 1.2.14 The dietary assessment should consider which infant formula has been chosen by the carer and if dietary restrictions are in place(infant may have been put on restricted diet by family/carers)	Thank you for your comment. We believe that this would be covered by 'take a detailed feeding or eating history' and 'consider direct observation of feeding or meal times'. The Committee did not want to be too prescriptive about the content of these assessments or observations since there are many factors that would be taken into consideration (breast or formula feeding, food choices, behaviours with food or at meal times etc). This has to be carried out using an individualised approach which is highlighted throughout the guideline, see for instance sections 6.7.2 and 7.7.2 of the full guideline. We have now also added this to the specific section that provides the rationale for this recommendation (please see section 5.3.4.7.5).
NHS England	short			1.1.2, 1.2.7 This section mentions assessment of dehydration but does not mention specific elements of the clinical assessment to observe such as vomiting & diarrhoea symptoms as well as eating behaviour	Thank you for your comment. The Committee did not want to be too prescriptive about the content of the clinical assessment because this would need to be individualised and there would be many possible factors to consider. They also believed that the notion of a clinical assessment would be commonly understood by healthcare professionals. However, we have added further details about possible symptoms of

					dehydration to section 4.3.2 and the need for an individualised approach to section 5.3.4.7.2 which provide the discussion for recommendations 1.1.2 and 1.2.7.
NHS England	Short			1.2.7 There are a wide range of clinical conditions that may lead to growth problems. This section highlights a possible need to investigate for2 common conditions (coeliac disease & UTIs) that can lead to faltering growth. The list can be long but may consider other medical causes that need early identification in order to improve outcomes eg metabolic disease, endocrine problems such as hypothyroidism, congenital cardiac abnormalities	Thank you for your comment. In relation to the need for investigations, the Committee agreed that infants and children initially presenting with faltering growth and no signs or symptoms of a particular underlying causative condition are unlikely to need further tests because it is unlikely that an unrecognised condition will be found. The Committee believed that in current practice, where there are concerns about faltering growth in infants and children, the infant or child is subjected to too many tests even if there are no signs or symptoms of other conditions or disorders. Our reasoning for not recommending other specific investigations is described in section 5.3.4.7 and its subsections.
NHS England	Short			1.2.7, 1.2.12, 1.2.19 The guideline has not mentioned advice on appropriateness of the timing of commencing weaning of infants. Weaning may lead to nutritional deficits if done too early or too late	Thank you for your comment. The timing of weaning is not an issue that is specific to infants with faltering growth or those that lose weight in the early days of life. This falls into the scope of general postnatal care which is relevant to the NICE guideline on 'Postnatal care up to 8 weeks after birth' (CG37). This guideline is currently in the process of being updated, so we have forwarded your comment to the relevant team at NICE (please see the following link:

					https://www.nice.org.uk/guidance/indevelopment/gid-ng10070 for documents related to this update).
Nutricia Advanced Medical Nutrition	Short	2		No mention of WHO guidelines on catch up growth and what to aim for	Thank you for your comment. Defining targets for catch-up growth falls outside of the scope of this guideline.
Nutricia Advanced Medical Nutrition	Short	3		Need to explain organic and inorganic factors that lead to faltering growth	Thank you for your comment. In recommendations 1.2.9 to 1.2.11 we explain that it may not always be possible to identify a cause and that many factors may contribute to the problem of faltering growth. In other words, it may not be possible to find any specific organic cause (resulting from a disease or disorder) or inorganic cause (where there is no identifiable disease or disorder). We therefore highlight possible contributing factors for milk-fed infants (1.2.10) and for older infants and children (1.2.11). Recommendation 1.2.6 outlines an approach to clinical assessment and, where necessary, investigation to try to understand the factors underlying faltering growth in individual infants and children. The Committee wanted to avoid unnecessary investigations and these matters are discussed in the 'evidence to recommendation' section in the full guideline (see section 5.3.4.7).
Nutricia Advanced Medical Nutrition	Short	4		Section 1 Need to mention nutritional deficiencies such as zinc, calcium, iron, etc can lead to FG	Thank you for your comment. In relation to the need for investigations (including tests for specific nutritional deficits), the Committee agreed that infants and children initially presenting with faltering growth and no signs or symptoms of a

					particular underlying causative condition, are unlikely to need further tests because it is unlikely that an unrecognised condition will be found. The Committee believed that in current practice, where there are concerns about faltering growth in infants and children, the infant or child is subjected to too many tests even if there are no signs or symptoms of other conditions or disorders. Our reasoning for not recommending other specific investigations is described in section 5.3.4.7 and its subsections.
Nutricia Advanced Medical Nutrition	Short	5		Section 1.2 add the following:- 2 centiles difference between weight and height	Thank you for your comment. The primary concern is weight and thresholds are described in recommendation 1.2.1. If there is a concern then it is recommended that length or height should be measured and plotted (recommendation 1.2.2) and if there are concerns about an infant's length or a child's length or height, mid-parental height should be determined if possible. If the child's length or height centile is below the range predicted from parental heights (more than 2 centile spaces below the mid-parental centile) healthcare professionals are advised to be aware that this could suggest undernutrition or a primary growth disorder (recommendation 1.2.3). The Committee believed that these were logical steps and that both weight and height were sufficiently covered by these recommendations.
Nutricia Advanced Medical Nutrition	Short	5		Section 1.2 Add the following:-	Thank you for your comment. Weight falling through centile spaces is recognised within the thresholds for concern for faltering growth

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				Weight falling through centile spaces, low weight for height or no catch up from a low birth weight'	as defined in section 1.2. Defining targets for catch-up growth falls outside of the scope. A current weight below the second centile for age is recognised as a threshold for concern at any age. Low weight for height is recognised in recommendation 1.2.4 (linear growth and BMI).
Nutricia Advanced Medical Nutrition	Short	10		1.2.23 Include the following (in red) in this sentence. Consider a trial of a high energy infant formula or oral nutritional supplement for infants or children with continuing faltering growth despite other interventions.	Thank you for your comment. The focus of this recommendation is on oral liquid nutritional supplement which is usually prescribed by a dietitian whereas a high-energy infant formula could be acquired over the counter which was not the option that the Committee wanted to recommend. To clarify this difference we have now added a definition for 'oral liquid supplement' (see terms used in this guideline in the short version and the glossary in the full guideline) to indicate that this would usually happen after referral. The Committee agreed that usual liquid intake (such as liquid supplements or formula) should be reviewed, as drinking too much milk or too many energy-dense drinks, may suppress the infant's or child's appetite and therefore, stop the child eating food at regular times. This is explained in section 5.2.4.7 of the full guideline.
Nutricia Advanced Medical Nutrition	Short	10		1.2.24 *Regularly reassess infants and children receiving an oral nutritional supplement for faltering growth to decide if it should be continued. Take into account: □ Weight change.*	Thank you for your comment. The Committee recognised the points made, however they did not want to be overly prescriptive about the frequency of weighing or the expected weight change before stopping oral nutritional supplements. They agreed that this needs to be

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				This is not clear, what weight change to expect before stopping ONS and how regularly should you reassess? **Please refer to the ESPGHAN guidelines on Practical Approach to Paediatric Enteral Nutrition: A Comment by the ESPGHAN Committee on Nutrition:; Braegger, Christian[*]; Decsi, Tamas[†]; Dias, Jorge Amil[‡,4]; Hartman, Corina[§,3]; Kolaček, Sanja[‖]; Koletzko, Berthold[¶]; Koletzko, Sibylle[¶,4]; Mihatsch, Walter[#]; Moreno, Luis[**]; Puntis, John[††]; Shamir, Raanan[§,1]; Szajewska, Hania[‡‡]; Turck, Dominique[§§,2]; van Goudoever, Johannes[‖‖]** Journal of Pediatric Gastroenterology & Nutrition: July 2010 - Volume 51 - Issue 1 - p 110–122 doi: 10.1097/MPG.0b013e3181d336d2	based on clinical judgement as it will largely depend on the severity of faltering growth the infant or child is presenting with. For further details about this, please see section 5.4.2.7.2 in the full guideline. The suggested reference has been retrieved and assessed for inclusion, however the population is not directly related to infants and children in whom growth concerns have been raised, they present in intensive care unit settings or with co-existing conditions that increase their energy requirements. For these reasons, this reference was not included in the guideline review. Please refer to Appendix D - section 11 for further details about the inclusion criteria for 'interventions to manage faltering growth'.
Nutricia Advanced Medical Nutrition	Short	10		1.2.25 *Only consider enteral tube feeding for infants and children with faltering growth when: there are serious weight concerns.* How do you define serious? There are scenarios where you would not wait for serious weight changes, example in neurodisabled children/children with swallowing difficulties Please refer to the ESPGHAN guidelines mentioned above	Thank you for your comment. The Committee agreed that neurodisability and swallowing difficulties can be related to growth. However, there would be further symptoms of those conditions, apart from growth, that may mean that tube feeding without delay would be considered necessary. This would then be a consequence of the neurodisability or swallowing difficulty rather than faltering growth which is a separate condition. The Committee therefore agreed that tube feeding would be the exception rather than the rule for

					infants and children with faltering growth and should be discontinued as soon as possible. The Committee intentionally did not want to define 'serious' weight concerns because they wanted to leave room for clinical judgement. Tube feeding would then be considered if there are 'serious concerns about weight gain' but also after other interventions were unsuccessful and in addition to multidisciplinary assessment. The ESPGHAN guidelines address a different population of infants and children, i.e. those in need of enteral nutrition rather than those where there are concerns about faltering growth. For this reason, this reference was not included in the guideline.
Nutricia Advanced Medical Nutrition	Short	18		Section 1 Contrary to the statement there is evidence to suggest that ONS has positive outcomes in paediatric patients See attached literature search	Thank you for your comment. The literature search for nutritional interventions yielded four randomised controlled trials for the use of nutritional supplementation in infants and children with faltering growth. However, there was insufficient evidence to draw clear conclusions about the effectiveness of high-energy liquid supplements (studies were small and results uncertain). Therefore the Committee decided to make a research recommendation specific to high-energy liquid supplements to establish whether these improve weight gain in infants and children with faltering growth.

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					Thank you also for the reference provided. This has been retrieved and assessed for inclusion, but it does not meet the protocol inclusion criteria because it reports on results for adults (≥ 18 years old) rather than infants or children. For further details regarding the inclusion criteria for section 5.4.2 (Dietary advice and supplementation) see Appendix D - section 11.
Nutricia Advanced Medical Nutrition	Full	103	20	Enhancing the nutrients density of a child's diet should be subject to the same level of review detailed on page 103 lines 32 and 33 to ensure that if increasing the energy and nutrient density of food is not working to avoid further growth faltering. It would also be useful to give some indication of when to review an intervention i.e. timing of review	Thank you for your comment. The Committee agreed that goals need to be set, but did not want to be too prescriptive about review intervals. These would depend on many factors. However, the notion of review is covered in recommendation 1.2.15 where we describe a collaborative plan with parents which includes information on 'when reassessment to review progress and achievement of growth goals should happen'.
Nutricia Advanced Medical Nutrition	Full	103	35-38	*Finally, the Committee agreed that enteral tube feeding should be reserved and considered for severe faltering growth with the aim to discontinue this as soon as possible. They therefore agreed that a multi-disciplinary approach for tube feeding is necessary which should include the goals to indicate that tube feeding is no longer needed* This statement is not taking into account the need for long term tube / lifelong	Thank you for your comment. The Committee agreed that some symptoms of the organic disorders that are highlighted in your comment are related to growth. However, there would be further symptoms of those organic conditions that may mean that longer term tube feeding is necessary. This would then be a consequence of the organic condition rather than faltering growth which is a separate condition. The Committee therefore agreed that tube feeding would be the exception rather than the rule for

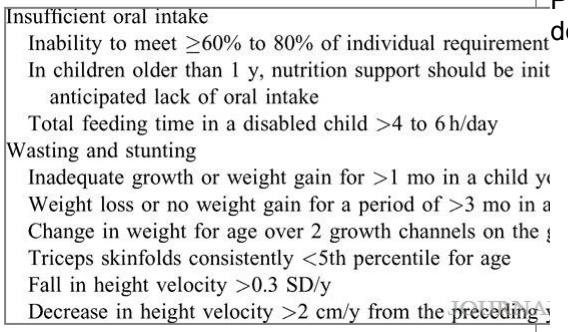
				feeding in organic faltering growth such as cardiology and neurodisability.	infants and children with faltering growth and should be discontinued as soon as possible. The Committee's discussion of these issues is described in section 5.4.2.7 in the full guideline.
Nutricia Advanced Medical Nutrition	Full	103	44 & 45	Refers to 'woman' and 'mother' but maybe more inclusive to refer to the family or parent?	Thank you for your comment. This has now been corrected.
Nutricia Advanced Medical Nutrition	Full	104	34	Include a point about regular review to ensure efficacy of the approach include weight change, linear growth, food intake and the views of parents/carers	Thank you for your comment. The Committee did not want to be too prescriptive about review intervals. These would depend on many factors. However, the notion of review is covered in recommendation 1.2.15 where we describe a collaborative plan with parents which includes information on 'when reassessment to review progress and achievement of growth goals should happen'.
Nutricia Advanced Medical Nutrition	Full	104	39	Include a point about regular review to ensure efficacy of the approach include weight change, linear growth, food intake and the views of parents/carers	Thank you for your comment. The Committee did not want to be too prescriptive about review intervals. These would depend on many factors. However, the notion of review is covered in recommendation 1.2.15 where we describe a collaborative plan with parents which includes information on 'when reassessment to review progress and achievement of growth goals should happen'.
Nutricia Advanced Medical Nutrition	Full	105	2	Milk and milky drinks can be a good source of nutrition so perhaps specify their use away from meal times?	Thank you for your comment. The Committee advises to avoid drinking too much milk or too many energy-dense drinks as these may

					suppress the child's appetite and may stop the child eating food at regular times.
Nutricia Advanced Medical Nutrition	Full	105	36-38	*Further research is important to establish whether their effectiveness justifies their cost and the suppressant effect on appetite.* The reference to the effect on appetite seems a strong statement based on the evidence available.	Thank you for your comment. Although the Committee agreed that the appetite suppressant effect is not clearly established, they believed that in saying supplements 'may' suppress appetite and displace normal diet' they have added a reasonable amount of uncertainty to the claim. In addition, the section you highlight is a research recommendation, meaning that we believe it is important to establish more definitively whether there is an appetite suppressant effect of supplementation, and that there is currently insufficient evidence to make a strong recommendation on the issue. Consequently as long as the sentence is quoted in context it will be clear that the uncertainty around the existence of an appetite suppressant effect is high.
Nutricia Advanced Medical Nutrition	Full	106		Table 45: Research recommendation rationale *High energy liquid nutritional supplements are widely used in children with low intake or poor weight gain but it is not clear if they are effective and they may have adverse effects on appetite, causing or exacerbating previously confirmed feeding behaviour problems.* *See attached literature search below*	Thank you for your comment and the references provided. The Committee agreed that the evidence is not sufficient to conclude that high-energy liquid nutritional supplements are effective and have therefore recommended further research in this area. Such research can then be used for future updates of this guideline. The references that you highlighted have been retrieved and assessed for inclusion. Please find details about these below:

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.

				<u>Evidence to support enteral nutrition (ONS and tube feeds) in paediatric patients</u> **Practical Approach to Paediatric Enteral Nutrition: A Comment by the ESPGHAN Committee on Nutrition** **ESPGHAN Committee on Nutrition:; Braegger, Christian*; Decsi, Tamas†; Dias, Jorge Amil‡,4; Hartman, Corina§,3; Kolaček, Sanja‖; Koletzko, Berthold¶; Koletzko, Sibylle¶,4; Mihatsch, Walter#; Moreno, Luis**; Puntis, John††; Shamir, Raanan§,1; Szajewska, Hania‡‡; Turck, Dominique§§,2; van Goudoever, Johannes‖‖** **Journal of Pediatric Gastroenterology & Nutrition: July 2010 - Volume 51 - Issue 1 - p 110–122** **doi: 10.1097/MPG.0b013e3181d336d2** Enteral nutrition support (ENS) involves both the delivery of nutrients via feeding tubes and the provision of specialised oral nutritional supplements. ENS is indicated in a patient with at least a partially functioning	The ESPGHAN guideline (Braegger 2010) relates to general nutritional intake rather than faltering growth and is therefore not directly applicable in our context.

				digestive tract when oral intake is inadequate or intake of normal food is inappropriate to meet the patients' needs. The aim of this comment by the Committee on Nutrition of the European Society for Pediatric Gastroenterology, Hepatology, and Nutrition is to provide a clinical practice guide to ENS, based on the available evidence and the clinical expertise of the authors. Statements and recommendations are presented, and future research needs highlighted, with a particular emphasis placed on a practical approach to ENS. Among the wide array of enteral formulations, standard polymeric feeds based on cow's-milk protein with fibre and age adapted for energy and nutrient content are suitable for most paediatric patients. Whenever possible, intragastric is preferred to postpyloric delivery of nutrients, and intermittent feeding is preferred to continuous feeding because it is more physiological. An anticipated duration of enteral nutrition (EN) exceeding 4 to 6 weeks is an indication for gastrostomy or enterostomy. Among the various gastrostomy techniques available,	

				percutaneous endoscopic gastrostomy is currently the first option. In general, both patients and caregivers express satisfaction with this procedure, although it is associated with a number of well-recognised complications. We strongly recommend the development and application of procedural protocols that include scrupulous attention to hygiene, as well as regular monitoring by a multidisciplinary nutrition support team to minimise the risk of EN-associated complications.  Insufficient oral intake Inability to meet ≥60% to 80% of individual requirement In children older than 1 y, nutrition support should be init anticipated lack of oral intake Total feeding time in a disabled child >4 to 6 h/day Wasting and stunting Inadequate growth or weight gain for >1 mo in a child y Weight loss or no weight gain for a period of >3 mo in a Change in weight for age over 2 growth channels on the Triceps skinfolds consistently <5th percentile for age Fall in height velocity >0.3 SD/y Decrease in height velocity >2 cm/y from the preceding **Marino LV; Meyer R; Cooke ML (2013). "Cost Comparison between Powdered Versus Energy Dense Infant Formula for Undernourished Children in a Hospital Setting." e-SPEN Journal 8(4): e145-e149**	Marino 2013: this study was carried out in a middle income country, which is not a setting that matches our protocol (high income countries) and it was therefore not included. Please refer to Appendix D - section 11 for further details about the inclusion criteria.

				Department of Paediatrics, St. Mary's Campus, Imperial College, Norfolk Place, London W2 1PG, United Kingdom l.marino@imperial.ac.uk, Great Ormond Street Hospital for Sick Children, London, United Kingdom , School of Child and Adolescent Health, University of Cape Town, Cape Town, South Africa , Department of Paediatrics, St. Mary's Campus, Imperial College, Norfolk Place, London W2 1PG, United Kingdom, Marino, L.V., Department of Paediatrics, St. Mary's Campus, Imperial College, Norfolk Place, London W2 1PG, United Kingdom **http://www.sciencedirect.com/science/article/pii/S2212826313000274** Background & aims: Ready to use (RTU) infant formulas became available for use in South African hospitals in 2005. However, a major barrier to use these formulae has been the perceived high product cost compared to the product cost of powdered infant formula (PIF). The aim of this cost comparative analysis was to determine the entire cost of these two feeding models.	

				Methods: This retrospective cost analysis used patient data generated from the Red Cross War Memorial Children Hospital (RCWMH), Cape Town, South Africa from 2007 to 2008. The annual cost of administering an energy dense RTU infant feed was compared to a fortified PIF, using published data of undernutrition at 34%. Only direct costs associated with the preparation and delivery were included in the analysis. Results: The fortified PIF versus RTU for 1 day per undernourished child cost 16.52Euros and 19.61Euros for the enriched PIF with sunflower and MCT oil respectively, versus the cost of the energy dense RTU feed of 12.51Euros per day. Conclusions: The decision to feed undernourished infants with enriched PIF versus energy dense RTU feed should not be based not only on the cost of the product, but also the hidden costs, as shown by this publication. © 2013 European Society for Clinical Nutrition and Metabolism.	
Royal College of General Practitioners	Short	General	General	Really clear document, good practical tips which could be initially used with faltering growth, before the point of needing referral is reached. The draft guideline recognises	Thank you for your comment.

				the importance of primary care staff, and also discourages over-investigation. It would be useful to encourage the clinical IT suppliers to GPs and health visitors to incorporate growth charts in their systems and allow simple calculation and plotiing of place on centiles. At present there is over reliance on parents bringing their red books to consultations, The guideline does not specifiy address plotting growth in premature children or children with an identifiable syndrome with specific adjusted growth charts	The matter of IT support in general practice was not identified as an area for review in the guideline scope and so the Committee did not consider this. They were aware that appropriate growth charts are readily available to healthcare professionals. The Committee recognised that children with particular disorders might require specific growth charts. However, such children, having an underlying organic disorder would be referred to specialist care. Recommendation 1.2.2 advises the use of the UK WHO growth charts, and these incorporate allowance for prematurity when necessary.
Royal College of General Practitioners	Short	5	14	Measurement of length. A link/information on how to do this accurately would be helpful.	Thank you for your comment. Implementation activity is currently being planned by NICE which may include how length is measured.
Royal College of General Practitioners	Short	14	1-3	The link to resources does not work	Thank you for your comment. This link is not yet active, but will be when the guideline is published.
Royal College of Nursing	General	General	General	The Royal College of Nursing welcomes proposals to develop guideline for the recognition and management of faltering growth in children.	Thank you for your comment.

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

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Royal College of Nursing	General	General	General	We note that the guideline highlights the important role of the health visitor in detecting faltering growth and in providing support to parents concerning infant feeding. The RCN supports this recognition however, we are concerned about the declining numbers and therefore availability of Health Visitors and School Nurses who are needed for the effective implementation of this guideline. The evidence on the declining numbers of these professionals is highlighted in our recent report - The Best Start: The Future of Children's Health Valuing school nurses and health visitors in England https://www.rcn.org.uk/professional-development/publications/pub-006200	Thank you for your comment. The guideline focuses on good clinical practice and highlights the central role of the health visitor in the recognition and management of faltering growth. Although the recent report that you have cited was not identified and did not match our evidence review protocol criteria (it is a report rather than a peer reviewed research study) we have made reference to it in the 'evidence to recommendation' section for the 'organisation of services' chapter (see section 6.7.5). We have recommended that health visitors should be involved in the care of infants and children with faltering growth and the Committee felt that your report supports this conclusion.
Royal College of Nursing	General	General	General	The RCN recently published revised standards around weighing children, which may inform this guideline - Standards for the Weighing of Infants, Children and Young People in the Acute Health Care Setting - RCN guidance for children's nurses and nurses working with children and young people https://www.rcn.org.uk/professional-development/publications/pub-006135	Thank you for your comment and your reference to the RCN report. This report did not meet the inclusion criteria for our evidence search and therefore it did not directly influence the recommendations made. However, we have made reference to the report in the discussion of recommendations on thresholds for concern as the Committee was aware of this information and it did inform their deliberations (please see section 5.2.7.2).
Royal College of	short			1.2.25	Thank you for your comment.

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Paediatrics and Child Health				What is the 'appropriate multi-disciplinary assessment'? : as above : add a reference to an Appendix or a description or details about that here?	The short version of the guideline is a summary of all the recommendations. The full guideline includes the evidence and the descriptions of the discussions that led from the evidence to the recommendations (i.e. the rationale for why recommendations were made). The Committee intentionally used the word 'appropriate' to indicate that there is a need to tailor this decision to the circumstances of the individual infant or child based on the clinical judgment of the multidisciplinary team. This was already described in section 5.4.2.7.2 of the full guideline. We have expanded the relevant paragraph of this section to make this more explicit.
Royal College of Paediatrics and Child Health	short	4	13	'illness' (?) – we are not clear what this means – as this is for a broad audience, based on local experience of similar guidelines . Aware of the issues of lists but better to give some specific concerns e.g. about feeding, lethargic, few wet nappies, increasing jaundice, vomiting, colour, breathing fast when feeding etc. So either in text or perhaps a cross ref to this in an appendix? Local experience of Faltering growth MDT based guidance development & feedback : non paediatricians , particularly HVs, asked what to look for re 'illness' 'unwell' and meaning of 'symptoms' (and signs) so these were changed to be helpful as this is a guideline	Thank you for your comment. In the 'consideration of clinical benefits and harms' section (see section 4.3.2 in the full guideline) related to the 'weight loss in the early days of life' question (chapter 4 in the full guideline), the primary consideration would be dehydration (because weight loss in the early days of life would usually be due to fluid loss), and so this is given as an important example in the recommendation. Other disorders that might be responsible for weight loss are uncommon and very diverse, and we do not think that providing a limited list of signs would be helpful, and might even be misleading. They might include signs of sepsis (a complex entity the signs related to which are to be found in the NICE guideline on 'Neonatal infection (early onset): antibiotics for prevention and treatment' (CG149).

					Clearly a wide range of disorders might be responsible for weight loss. The key point was that the Committee expected any healthcare professional responsible for assessing young infants would have an appropriate level of paediatric expertise and knowledge. We have however altered the wording of the relevant bullet to make clear the need to look both for dehydration and for other potentially relevant disorders. It now reads: 'perform a clinical assessment looking for evidence of dehydration, or of an illness or disorder that might account for the weight loss'.
Royal College of Paediatrics and Child Health	short	6	16	**Appropriate training and expertise**?: what is this defined as, because there are often assumptions about this e.g. from HV managers who can assume levels of expertise among HVs – despite local University training - and whose lead HV colleague for faltering growth confirms this deficit . **I.e.** Make no assumptions about training: It is not uncommon for there to be gaps amongst HVs in their training details around feeding and medical symptoms - experience of an HV led Faltering Growth MDT i.e. not a Dr only perspective: So: what level of training and who provides this and who has (enough) expertise?	Thank you for your comment. Specifying training standards for healthcare professionals was outside the scope of this guideline. However, the Committee acknowledged individuals involved in the care of infants and children with faltering growth should have appropriate training and expertise to carry out observations of feeding (see recommendations 1.1.2 and 1.2.7). One such training level is the Baby Friendly Initiative accreditation which is mentioned in the full guideline (see section 4.3.3 in the full guideline). The Committee believed that individuals with such training and expertise would have access to relevant information (from various sources) and therefore did not want to be prescriptive about any particular sources.

				We suggest that this guidance should provide information about training and development of expertise - otherwise what is new or helpful in improving practice from NICE. Plus refs to sources of information about how to assess, what to look for – and there are neat points and prompts about this. What is needed and no assumptions is particularly important as this is for non-experts and managers in the locality who provide over sight of /commission services Trust /HV management or CCG Commissioners. HV and Drs training is often limited in practice.	
Royal College of Paediatrics and Child Health	short	6	15	**Strongly** consider observation of meal or feeding at home (i.e. do this if there are concerns about the cause of F Growth – '…**unless another cause has been identified but bear in mind medical cause and feeding can co-exist and one can be missed e.g. in CHD** ….'	Thank you for your comment. The Committee agrees that there are conditions that cause growth concerns, and that further investigations may be needed when a clinical examination suggests signs or symptoms of such an underlying condition (see recommendation 1.2.6 in the short guideline and section 5.3.4.7.2 in the full guideline). However, faltering growth due to an underlying condition without any signs or symptoms of an underlying condition is very rare (see section 5.3.4).
Royal College of	short	6	18	Are there indications to refer to a Dr?	Thank you for your comment.

Paediatrics and Child Health					Recommendation 1.2.31 describes when to refer to a paediatric specialist service, i.e. if there are symptoms that may indicate an underlying disorder, a failure to respond to interventions delivered in primary care, slow linear growth or unexplained short stature, rapid weight loss or severe undernutrition, or safeguarding concerns.
Royal College of Paediatrics and Child Health	short	7	5	Maternal eating disorder	Thank you for your comment. No evidence was found to support 'maternal eating disorder' as a factor associated with faltering growth and so it was not included in recommendation 1.2.8.
Royal College of Paediatrics and Child Health	short	7	9	Clinical signs and symptoms, meaning …as above – local survey – not familiar terminology to all non-medics	Thank you for your comment. The Committee considered that in this context the reference to symptoms and signs is clear. The recommendation is aimed at healthcare professionals in a primary care setting (recommendation 1.3.2) who might need to consider referral to paediatric services who would have the necessary skills to perform the clinical assessment. The Committee also believed that these healthcare professionals would readily understand the reference to symptoms and signs.
Royal College of Paediatrics and Child Health	short	7	13	Ref May be difficult to identify the cause – *consider that there may be factors in the child and or factors in the parent*	Thank you for your comment. We agree that identifying causes may be difficult but on reflection the Committee decided to keep the two bullets as they are. The first bullet sets out the multi-faceted nature of the condition whereas the second bullet highlights that there could also be

					difficulties in interactions between the infant or child and the parents or carers. We have intentionally not specified whether either relates directly to the child or parent because the Committee agreed that there needs to be an individualised approach to the assessment and that a specific cause may never be identified. A more explicit discussion of this has now been added to the full guideline (please see section 5.3.2.7.2).
Royal College of Paediatrics and Child Health	short	8		Next section does not give a sense of the step wise approach to assessment nor does it give any clear advice to an HV (or GP perhaps) on need an how to provide brief early consideration of whether there is an underlying medical condition requiring involvement of a Dr/paed. Lots of clinical examples of occasional presumed feeding problem but secondary to an underlying medical disorder. I.e. from feeding history, consider and exclude primary medical issues from story and observations of child (then brief examination), then basic advice and interventions, and review, Then next step of routine observation at home and ideally at a meal at home; 3 day food diary (but help to make this achievable by not being too complex) Give an e.g. of a simple 3 day diary in appendix).	Thank you for your comment. The Committee believed that there was a stepwise approach in these recommendations. First, concerns for weight are identified (recommendation 1.2.1) then measurements are taken and recorded (recommendations 1.2.2 to 1.2.5). In recommendation 1.2.6 the stepwise assessment is described as starting with clinical, developmental and social assessment, and then progressing through taking a feeding history and considering observing feeding or meal times. The final step would be to test for urinary tract infections or coeliac disease. Healthcare professionals should only carry out further investigations if they are indicated based on the clinical assessment. The recommendation then outlines some contributory factors and interventions. Recommendation 1.2.31 describes when to refer to a paediatric specialist service, i.e. if there are symptoms that may indicate an underlying disorder, a failure to respond to interventions delivered in

				Later section on Referral: Suggest cross reference to this here. Then step up to reasons to refer to a GP or paediatrician: e.g. breathless or tiring at mealtimes in infancy; crying a lot; misc. behaviours ('Sx') or wording that is widely meaningful – or else not a practical guideline. Add: what food aversion looks like, and explain co ercion , even though the committee must have discussed and avoided 'force feeding' or …parental pressure to feed … [as this is not rare in some groups] but need to be able to ask carefully and diplomatically and observe. Plus what to do with a food diary: context of short supply of paed dieticians – the HV should be able to assess the diary or should have access to a lead HV who can, then if doubt , next step a dietician may see the diary and advise without an appointment with the parent or may see the parent but must be in close liaison with HV who (step wise) should follow this advice up at home if not progressing. In persistent faltering growth: consider if there is compliance with prof advice (lots of clinical e.g. of inconsistencies between report and practice).	primary care, slow linear growth or unexplained short stature, rapid weight loss or severe undernutrition, or safeguarding concerns. Usually, supporting material such as examples of food diaries are not included in guideline material, but relevant implementation support activity is currently being planned and this will be considered. We looked for evidence related to adherence but have not identified studies that reported this as an outcome. We could therefore not make a direct comment on this. Regarding the term food aversion, the Committee wished to retain this in the guideline as they consider it is widely used. However, it is now included in the glossary to provide some explanatory text. The Committee agreed that lack of persistence and missed appointments can be a concern for healthcare professionals involved in the management of faltering growth. Dealing with these concerns requires professional judgement and the Committee did not make specific recommendations on these matters.

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

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Royal College of Paediatrics and Child Health	Short	8	13	1.2.12 Small point : first paras seem to duplicate – so combine /edit	Thank you for your comment. The Committee intentionally drafted these as two separate recommendations because they are essentially different (recommendation 1.2.10 is for milk-fed infants and recommendation 1.2.11 is for both milk-fed and bottle-fed infants). The two recommendations should therefore remain as they are.
Royal College of Paediatrics and Child Health	short	10		1.2.24 If progress is not good : Give stepwise approach i.e. Re- observe at home at a mealtime; e.g. of what to check for: exactly what's being given, how made up, taken, breast feeding (and cross ref to advice on the basics of this) supplements being made up correctly and being given; mealtime routines; aversive features etc. [all findings from local practice], For example, make no assumptions if progress isn't being made : story, observations , check what is going in, consider if any features of a medical condition **especially in infants**.	Thank you for your comment. This recommendation is related to the assessment of whether the oral liquid supplement has worked with the aim to discontinue it if it is no longer necessary. The Committee agreed that infants or children should not be left using this indefinitely. Issues related to progress are otherwise covered by recommendations 1.2.15 (planning and goal setting) and when to refer to a paediatric specialist (recommendation 1.2.31). The Committee therefore agreed that the issues of reassessment and referral were sufficiently covered.
Royal College of Paediatrics and Child Health	short	10		1.2.25 As above: do not start enteral feeding without quality home observations and home interventions (i.e.….what, ref above), i.e. do not start a tube based on only a hospital outpatient perspective [various examples about the ways OPD info has been interpreted in isolation]. Faltering	Thank you for your comment. The Committee recommended home observation at initial assessment (see recommendation 1.2.6) which should be carried out by an individual with appropriate training and expertise. Home interventions are then described in recommendations 1.2.16 to 1.2.23. Therefore tube

				growth MDT experience i.e. what is said in a clinic may not reflect what is happening at home	feeding would be considered when all other options have been exhausted (as stated in the final bullet of recommendation 1.2.25 – when to commence enteral tube feeding). The Committee agreed that enteral tube feeding should be reserved and considered for severe faltering growth with the aim to discontinue this as soon as possible. They also discussed that tube feeding is not usually necessary and if considered should be based on a multi-disciplinary assessment and approach and should include consideration of the goals to indicate when tube feeding is no longer needed. The reasoning for making these recommendations is described in section 5.4.2.7.2 of the full guideline.
Royal College of Paediatrics and Child Health	short	11	22	Symptoms and signs are medical terms that may not be meaningful to all non-medics [based on long experience thought may be] so require explanation. Edit throughout: is this rather a narrow hospital based perspective.	Thank you for your comment. The Committee considered that in this context the reference to symptoms and signs is clear. The recommendation is aimed at healthcare professionals in a primary care setting (recommendation 1.3.2) who might need to consider referral to paediatric services, and they would have the necessary skills to perform the clinical assessment. The Committee believed that they will readily understand the reference to symptoms and signs.
Royal College of Paediatrics and Child Health	short	12		1.2.2 Virtual 'team' depending on age i.e. no midwife if > 10days. 'Team' meaningful in practice? 'Joint working '?	Thank you for your comment. We have now added 'for example' to indicate that this would not always include all of these healthcare professionals (such as the midwife). However, we feel that a notion of a team is appropriate

					regardless of whether it is a 'virtual' or 'joint working' arrangement.
Royal College of Paediatrics and Child Health	short	12		1.2.3 **This has to be realistic** e.g.: access to a clinical psychologist for faltering growth is very unlikely or uncommon these days. Tertiary advice is limited and not ideal for families and resources and not essential if a local service develops the basics. **But is an opportunity** to make best use of existing people e.g. advise establishing a lead HV for faltering growth and a lead nursery nurse or equivalent for this to do or advise and develop expertise and share this. And **a multi-disciplinary team discussion and review** process of difficult cases is cheaper and achievable and as /more effective than an MDisc clinic of professionals seeing each child.	Thank you for your comment. 'Access' to those healthcare professionals does not mean that all of them have to be available for every family with an infant or child where there are concerns about faltering growth. It will depend on the individual circumstances of the child and their parents. The tailored approach to this is discussed in the full guideline in section 6.7 and its subsections. Whether or not this access is through a multidisciplinary team discussion or a clinic is left intentionally open according to existing service provision. We have reflected on the recommendations in this section and agree that a recommendation on a lead healthcare professional is important. The Committee has therefore drafted a new recommendation for this (see recommendation 1.3.4).
Royal College of Paediatrics and Child Health	Short	12	1	We feel that your guidance has some helpful detail but in the **Organisation of care** is missing an opportunity to move forward in a **practical** way from a traditional FTT approach, by **making better use of resources** through recommending the **co-ordination of professional assessments and interventions. This seems essential.** Your recommendations are rather vague	Thank you for your comment. We have reflected on this and the Committee decided that the coordination of care was an issue that had so far been missing in the guideline. A new recommendation was drafted to address this ('1.3.4 Consider identifying a lead healthcare professional to coordinate care and to act as the first point of contact for parents of children with faltering growth,

				despite evidence around this topic and others. Our commenters Trust has long experience of managing Faltering Growth: working in a tiered community based, but hospital linked, multi-disciplinary approach using very limited and mainly existing resources. [We have gathered data and reviewed the learning from complex cases and presented case but have not published these -sorry.] For over 15 years we have managed the wide range of complexities associated with faltering growth: complex medical conditions, gastrostomies, NGT, ASD, aversive feeding, parental mental health/ LDs/ eating disorders/DV/ safeguarding/ cultural issues. We prevented children being sent to costly specialist units ,or travelling long distances to out of area clinics , and successfully resolved these growth and eating problems locally at relatively low cost The keys from our experience were [based on inter Trust agreed local pathways a bit like your early suggestions] a lead HV for the topic and one (or 2) nursery nurse or similar who built up experience in feeding in homes, but worked alongside the family HV as needed, and dealt with initial steps and assessments and interventions.	for example if several professionals are involved'). This recommendation encapsulates several concepts (a) identification of a lead healthcare professional, (b) coordination of care, and (c) first point of contact. The reason for adding this new recommendation is described in the full guideline (see section 6.7.2). The Committee did not want to be too prescriptive about which type of professional should be involved (e.g. the health visitor) because the age range for this guideline is quite large and a GP or another healthcare professional may well be an appropriate first point of contact for slightly older infants or children. We believe that the new recommendation in conjunction with the recommendation on access to relevant healthcare professionals will improve services and addresses the point that you raised.

				Then if needed escalated the issues to an MDT advisory meeting. The MDT included in addition, an interested paediatrician (community in this case); good liaison between hospital dieticians and hospital paeds and, especially, periodic meetings to discuss more complex cases or queries. Thes meetings were held at the hospital so that hospital staff such as various paed dieticians or Consultants could attend at scheduled child specific times, plus family HVs and sometimes a nursery key worker, coming in. And we had the great benefit of a liaison SW, by engaging Social care management in the value of what we were dealing with: Early help / DV/ etc. and the small amount of time required from the liaison SW. At one time we had a psychologist in the meetings and then a community mental health rep for camhs, so can see what was most helpful from these less accessible professionals. One of the major learning points was the value of home observations and working – because of the discrepancies between what was reported and what was observed or revealed, and the practical implementation of advice that was required – and that	

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

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				minimised hospital attendance and probably optimised progress. Sorry that this is anecdotal and that NICE aims for evidence, but we know it also resorts to consensus. Our system was similar to several published systems and we used much of their guidance, but relied on the **co-ordination of slightly enhanced existing resources** so this was relatively cheap. Your list of possible professionals '…**ensure access to** …' as you suggest is very different for a commissioning manager or CCG from advising best use of professionals in a practical cost effective co-ordinated **system.**	
Royal College of Paediatrics and Child Health	Short	13	After 26	Symptoms and signs.	Thank you for your comment. The Committee considered that in this context the reference to symptoms and signs is clear. This recommendation is aimed at healthcare professionals in a primary care setting (recommendation 1.3.2) who might need to consider referral to paediatric services, and they would have the necessary skills to perform the clinical assessment. The Committee believed that such healthcare professionals will readily understand the reference to symptoms and signs.
Royal College of	Full	Gener al		Are the aims and perspective clear? Are these making best use of routine widely	Thank you for your comment.

Paediatrics and Child Health				available services, and resources, basing this in the community but giving clarity about when Medical input is required and dieticians (who are a pressed resource often) Multi-disciplinary or linked roles. Post neonate Infancy differs from older.	The aims of the guideline were consulted on with stakeholders before guideline development was started. Individual topics and the perspective taken in each of the evidence reviews are described in protocols (see Appendix D). The Committee agreed that even though there was currently variation in practice on how care for faltering growth or weight loss in the early days of life is organised, care would usually be started in the community. They therefore recommended a pathway of care, a community team and access to other professionals if necessary. The economic analysis showed this to be a cost effective model of care. The guideline also describes a pathway to referral to appropriate paediatric specialist care service (see recommendation 1.2.31). The Committee also added a recommendation on a lead healthcare professional as a first point of contact who would coordinate care (see section 1.3 of the short version). We also agree that post-neonate infancy differs from older infants or children and have therefore divided the guideline into two distinct populations 'Weight loss in the early days of life' and 'Faltering growth after the early days of life' (see sections 1.1 and 1.2 of the short guideline and specifically the preamble to 1.1 which provides the rationale for this division).
Royal College of Paediatrics	Full	38	17	Recommendation to refer to paediatric services may need some clarification eg. routine outpatient service vs Emergency	Thank you for your comment.

and Child Health				Department vs rapid access outpatient clinic. Will undoubtedly be regional variation but important opportunity to provide education/training to colleagues working in the community that this is an important and potential serious clinical presentation.	Whether referral would need to be to outpatient, emergency or any other service would depend on many factors, such as severity of weight loss, whether there are any symptoms or signs of an underlying condition, failure to respond to interventions or where there are safeguarding concerns (see recommendation 1.2.31). It will also depend on local service arrangements. The Committee therefore thought that no change to these recommendations was required.
Royal College of Paediatrics and Child Health	Full	49	23	Mid-parental centile is not a commonly performed calculation and it may be worth including a link to an online calculator so clinicians can calculate this immediately eg. http://ebmcalc.com/HeightPotential.htm	Thank you for your comment. As specified in recommendation 7 (full guideline), mid parental height should be considered if possible. The Committee did not want to be overly prescriptive about any specific tool that healthcare professionals should use.
Royal College of Paediatrics and Child Health	Full	49	15	Again, may be helpful to include an online BMI calculator to reduce risk of calculation error eg. http://www.nhs.uk/Tools/Pages/Healthyweightcalculator.aspx	Thank you for your comment. The Committee agreed that the use of BMI calculators may be useful for some professionals, however they did not intend to be overly prescriptive about any specific tool that should be used.
Royal College of Paediatrics and Child Health	Full	49	27	Given target audience of health professionals (including health visitors, midwives etc) it may be worth putting Personal Child Health Record (*red book*) as most parents, carers and health professionals still talk about the “red book”	Thank you for your comment. In light of your comment, a statement to the effect that the Personal Child Health Record (PCHR) is often called the 'red book' has now been added to section 5.2.7.5 in the full guideline.
Royal College of Paediatrics	Full	61	23	Given most children with faltering growth never get to see a paediatricians but are managed in the community, it may be worth	Thank you for your comment.

and Child Health				including some online resources that health professionals can recommend to parents/carers around healthy eating eg. Eat Well guide http://www.nhs.uk/Livewell/Goodfood/Pages/the-eatwell-guide.aspx NHS Choices http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/childrens-meal-ideas.aspx Start4Life https://www.nhs.uk/start4life/first-foods	These online resources have been included as examples in section 5.3.2.7.2 in the full guideline.
Royal College of Paediatrics and Child Health	Full			appendix Give a three day diary eg	Thank you for your comment. Examples related to implementation of guidance are usually not included in guideline documents but may feature in future implementation support for the guideline.
The Patients Association		General	General	The Patients Association exists to listen to patients and speak up for change. For over fifty years we have campaigned for health and social care services that provide high quality and safe care. We want to see a culture where patients and their carers are valued as expert partners and recognised as individuals, where transparency thrives and where patients, their families, carers and staff are empowered to raise concerns. We believe that health and social care services should be accountable, and act on	Thank you for your comment.

				feedback in order to learn and improve. In our work we advise people on aspects of health and social care that matters to them, often when things have gone wrong and they need to seek redress.	
The Patients Association		General	General	Our comments focus particularly on undernutrition, and draw on a qualitative study we have recently conducted. The study involved structured interviews with 40 health and social care professionals working on child undernutrition, across four sites: Birmingham, Tower Hamlets, Bradford and Cornwall. Additionally four discussion groups and eight interviews were held with parents in Cornwall and Bradford. These included Romanian, Czechoslovakian and black Muslim women (Bradford), and a children's centre and playgroups in a deprived rural locality (Cornwall). The final report is due to be published shortly.	Thank you for highlighting this study. This evidence could not be included in our review as the study is not yet published. The search cut-off for this guideline was January 2017. Studies published after this date can be considered in future updates of the guideline.
The Patients Association	Short	12-13	1-28, 1-13	Our report identifies a lack of understanding and knowledge among parents as a key problem that often needs to be addressed in cases of undernutrition. We feel that the guideline should offer more explicit guidance on this.	Thank you for your comment. The Committee agreed that parents do not always have knowledge and understanding of how to address undernutrition and therefore recommended a variety of support approaches, including feeding

				Specifically, we recommend greater support for professionals, and more interventions that involve providing advice and information to parents.	support (recommendation 1.2.15) discussions about mealtime behaviours and food choices (recommendations 1.2.18 and 1.2.19 respectively). The topic of the support needs for healthcare professionals was outside the scope of this guideline. Further to the advice highlighted above, information and support needs of parents are highlighted in section 1.4.
The Patients Association	Short	12-13	1-28, 1-13	We recommend adding to this section a recommendation that professionals are trained and supported to take an effective and appropriate approach when supporting parents. Our report suggests that this will involve: - Advising parents without making them feel as though judgment is being passed on them – parents report anxiety about this - Ensuring that parents understand the advice they have received, and that it is consistent – some parents report that advice appears contradictory and confusing - Taking account of the pressures faced by parents in terms of time and affordability – these can hamper the preparation of appropriate food - Securing the engagement of parents with any intervention or	Thank you for your comment. Even though recommendations about training and support for healthcare professionals were outside the scope of the guideline we discussed in the full guideline (section 7.7) the importance of consistent information provision and the need to tailor information to individual circumstances. We also describe in this section the emotional impact of faltering growth. These recommendations were based on consensus and we did not identify any published literature on this. The evidence you refer to in your comment could not be included in our review as the study is not yet published. The search cut-off, for this guideline was January 2017. Studies published after this date can be considered in future updates of the guideline. The Committee agreed that healthcare professionals should be sensitive and show empathy as well as compassion and respect by acknowledging and discussing the parents' or

				support – this emerged as a significant barrier in a proportion of cases. We also recommend that this section should include a brief recommendation on the importance of translators, providing written material in appropriate languages, and an understanding of cultural issues such as views about what is considered a healthy weight for a child. Providing these services effectively carries resource implications.	carers' concerns. Information provision should be individualised, taking into account parents' and carers' preferences and views (which could be based on their socioeconomic, cultural, religious and ethnic environment), in line with CG138 [Patient experience in adult NHS services (https://www.nice.org.uk/guidance/cg138)], which is referenced in recommendation 1.4.2 in the short guideline. CG138 also provides guidance on communication with patients including use of interpreters when needed.
The Patients Association	Short	12-13	1-28, 1-13	Professionals should be supported to recognise socio-economic and cultural indicators that can be associated with undernutrition, in order both to identify it as the cause of faltering growth, and to address them as a solution to the problem.	Thank you for your comment. We looked for evidence of associations between socio-economic status and faltering growth and no evidence was identified to suggest such a link. However, the Committee reflected on this and agreed that social factors, considered broadly, should be taken into account. They have added this to the recommendation on 'clinical and developmental assessment' (recommendation 1.2.6). Reasons for this are explained in section 5.3.4.7.2. The Committee did not want to refer to 'cultural indicators', as this is somewhat vague, and is just one aspect of a broad consideration of social factors.

Faltering growth

Consultation on draft guideline - Stakeholder comments table
18/04/17 to 01/06/17

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The Patients Association	Short	12-13	1-28, 1-13	Delivering appropriate advice on nutrition and cooking would require a community-based service, providing sessions for new and prospective parents, and undertaking outreach into communities with particular needs. Establishing these services effectively carries resource implications.	Thank you for your comment. The guidance only applies to interventions for infants with a high percentage of weight loss in the early days of life (>10%) or infants and children where there are concerns about faltering growth. This would therefore not mean that all new parents or prospective parents would require such sessions. In fact our health economic analysis indicated that in circumstance of excessive weight loss in the early days of life or faltering growth after the early days, interventions provided by health visitors in the community would be cost saving.
The Patients Association	Short	8	1-9	In this section and others, the guideline struggles to identify undernutrition clearly as one of the possible causes of faltering growth, and therefore does not include recommendations to professionals about how to tackle it in an explicit and accessible way.	Thank you for your comment. In this guideline the term faltering growth is intended to refer to slower rate of weight gain in infants and young children than is expected for age and sex. In some cases this may result in a state of undernutrition. Recognition of undernutrition is addressed in recommendation 1.2.4. Broadly the principles of management outlined for those with faltering growth may be relevant, even in those who have become undernourished. The guideline recommends that those with severe undernutrition and those at risk of it be discussed with or referred to paediatric specialist care as appropriate (see recommendation 1.2.31). The Committee did not consider it appropriate to make recommendations on the specialist topic of treating the severely malnourished.

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The Patients Association	Short	9	6-24	This section offers guidance that applies to undernutrition arising from poor or inadequate food choices being made by parents, and to problems arising from behavioural issues to do with eating. We recommend pulling out the issues relating to nutrition more explicitly and addressing them separately – professionals following the guidance as drafted here may focus on behavioural issues when the nutritional content of the food on offer could be a more significant problem.	Thank you for your comment. The Committee intentionally kept nutritional and behavioural issues together because they agreed that the relationship between mealtime behaviours and nutritional intake is complex and cannot easily be separated. The Committee therefore decided that all the possible contributing factors should be discussed with the parents or carers, because these may interact with each other (for instance, a food aversion may impact on parent-child interactions or mealtime behaviour). On reflection the Committee therefore decided to keep the recommendation as it is.
The Patients Association	Short	9	20-24	We recommend expanding this advice to provide greater direction on how to advise on food choices. Our report found that this was a crucial problem area in respect of undernutrition. Firstly, parents need to be supported to understand basic concepts of nutrition, including the idea that different foods have different nutritional values, and that quantity of food is not the same as nutritional adequacy. Our report found that problems can arise when, for instance, parents are unaware of the poor nutritional quality of ready meals or fast food.	Thank you for your comment. Much of what you refer to is covered in our recommendations. For instance recommendations 1.2.9 (for milk-fed infants) and 1.2.10 (for infants and children eating solids) highlight contributing factors related to 'ineffective breast or bottle feeding' or 'types of foods offered'. The implication of this is that healthcare professionals would provide the appropriate advice, if these are the identified problems. This could include information on the nutritional value of food. However, the Committee did not want to be too prescriptive about how this would be done to allow for clinical judgement according to individual circumstances.

				Secondly, advice and support should be timely, including both antenatal advice and advice when infants are weaned. Thirdly, support must include advice, including practical support, on how to cook with fresh ingredients; simple recipes using available and affordable ingredients should be provided. Finally, our study found that while professionals often indicated they felt there was adequate information available for distribution, feedback from parents and study of professionals' behaviour in practice does not bear this out. Some professionals indicated that they prepare and distribute their own advice resources, while parents told us they did not feel they had enough clear information. The written resources available are either insufficient, or insufficiently signposted to professionals – the guideline should ideally signpost to appropriate resources, in this or a later section.	NICE is currently planning implementation support activities for this guideline. This may include links to relevant information, such as NHS advice on nutrition.
The Patients Association	Short	10	1-6	This is sound advice, but a recommendation on supporting parents to understand basic concepts about nutrition and to prepare healthy meals should be included alongside it.	Thank you for your comment. Recommendations 1.2.9 (for milk-fed infants) and 1.2.10 (for infants and children who eat solids) highlight contributing factors related to 'ineffective

					breast or bottle feeding' or 'types of foods offered'. The implication of this is to provide the appropriate advice if these are the identified problems which could include information on the nutritional value of food. However, the Committee did not want to be too prescriptive about how this would be done to allow for clinical judgement according to individual circumstances. NICE is currently planning implementation support activities for this guideline. This may include links to relevant information, such as NHS advice on nutrition.
The Patients Association	Short	12	2-5	The findings of our report support the need for a referral pathway when undernutrition is suspected as the cause of faltering growth. Among the professionals we interviewed, there was much uncertainty about what to do, how and when. Signposting to appropriate example pathways within the guideline would the helpful.	Thank you for your comment. In thresholds for concern (recommendation 1.2.1) it is stated that weight below the second centile should always raise concern regardless of birthweight. Recommendation 1.2.21 further states that referral to a dietitian may be necessary if there is a 'further increase in the nutrient density of their diet beyond that achieved through advice on food choices'. It is also stated in recommendation 1.2.31 that rapid weight loss or severe undernutrition would warrant a discussion with or referral to an appropriate paediatric specialist care service. We therefore believe that clear guidance for referral is provided that leaves room for clinical judgement.
The Patients Association	Full/ Short	General	General	Elements of our recommendations may duplicate items in NICE Public Health Guideline 11 – Maternal and Child Nutrition. Where this is the case, there should be	Thank you for your comment. The Committee took several guidelines into consideration to reach consensus about

				clear signposting from one guideline to another.	recommendations (CG37 - Postnatal care in the first 8 weeks of life and PH11 - Maternal and child nutrition). The Committee discussed whether to directly refer to PH11, but decided not to because that guidance recommends what should be done in the 'normal population' rather than the actions to take when there are concerns about faltering growth. However, we refer to PH11 in our protocol on monitoring (as a comparator) as it provides details about how often infants should be weighed when there are no growth concerns (please see Appendix D). The details of this discussion are described in section 5.4.1.5 and its subsections in the full guideline to which we have now added the reason for not directly cross-referencing to PH11.

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