Postnatal care

Quality standard
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www.nice.org.uk/guidance/qs37

Contents

This standard is based on NG194, CG98 and NG195.

This standard should be read in conjunction with QS22, QS32, QS35, QS3, QS15, QS57, QS75, QS64, QS60, QS46, QS94, QS98, QS109, QS112, QS115, QS128, QS129, QS169, QS192, QS197 and QS122.

Quality statements

Statement 1Women who are transferring between services in the postnatal period have relevant information shared between healthcare professionals to support their care. **[new 2022]**

Statement 2 Parents are given personalised information and advice about feeding their baby before transfer to community care or before the midwife leaves after a home birth. **[2013, updated 2022]**

Statement 3 Parents are given information and advice, before transfer to community care or before the midwife leaves after a home birth, about symptoms and signs of serious illness in the baby that require them to contact emergency services. **[2013, updated 2022]**

Statement 4Parents receive face-to-face feeding support at each routine postnatal contact. **[new 2022]**

Statement 5Parents are given advice about safer practices for bed sharing at each routine postnatal contact. **[2013, updated 2022]**

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

In 2022 this quality standard was updated, and statements prioritised in 2013 were updated **[2013, updated 2022]** or replaced **[new 2022]**. For more information, see update information.

The previous version of the quality standard for postnatal care is available as a pdf.

Quality statement 1: Communication between healthcare professionals at transfer of care

Quality statement

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

Rationale

Women will transfer between services and healthcare professionals during the postnatal period, for example, from secondary to primary care and from midwifery to health visitors. Promptly sharing relevant information when transferring between services supports a seamless transfer of care. It also helps healthcare professionals support individual needs for all birth outcomes, including those of vulnerable women who may be at higher risk of adverse outcomes. Healthcare professionals will have all the relevant information they need to plan and provide ongoing care and interventions, and women will not need to repeat information to different healthcare professionals.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

a) Proportion of transfers of women into a service in the postnatal period where a notification of transfer has taken place to relevant healthcare professionals and the woman or the parents.

Numerator – the number in the denominator where a notification of transfer has taken place to relevant healthcare professionals and the woman or the parents.

Denominator – the number of transfers of women into a service in the postnatal period.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from electronic patient records.

b) Proportion of women transferring into a service in the postnatal period with a record of complete relevant information provided by the transferring service.

Numerator – the number in the denominator with a record of complete relevant information provided by the transferring service.

Denominator – the number of women transferring into a service in the postnatal period.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from electronic patient records.

Outcome

Proportion of women who agreed that their healthcare professionals in the postnatal period always appeared to be aware of the relevant history for them and their baby.

Numerator – the number in the denominator who agreed that their healthcare professionals in the postnatal period always appeared to be aware of the relevant history for them and their baby.

Denominator – the number of women who had a live birth.

Data source: Data could be collected from a local survey of women who had a live birth after the postnatal period. The Care Quality Commission maternity survey includes data on the proportion of women who said that the midwife or midwifery team they saw or spoke to always appeared to be aware of the medical history for them and their baby.

What the quality statement means for different audiences

Service providers (such as NHS hospital trusts, community providers, mental health providers and primary care) have clear processes and systems in place for sharing information when care for women transfers between services in the postnatal period to support their ongoing care. Service providers ensure that healthcare professionals notify relevant healthcare professionals and the woman or the parents that care has been transferred to another service. Service providers monitor the timeliness and completeness of information sharing at transfer of care in the postnatal period.

Healthcare professionals (such as obstetricians, midwives, health visitors, psychiatrists and GPs) ensure that they share all relevant information for women at transfer of care between services in the postnatal period to support their ongoing care. They also notify relevant healthcare professionals and the woman or the parents that care has been transferred to another service.

Commissioners (integrated care systems, local authorities and NHS England) ensure that they commission services that share relevant information for women at transfer of care between services in the postnatal period to support their ongoing care. Commissioners work together to ensure that systems are in place to enable information to be shared quickly and easily between services in the postnatal period.

Women who have given birth know when their care has been transferred to another service during the first 8 weeks after birth. They have relevant information about them shared between healthcare professionals so that they feel supported by the different teams.

Source guidance

Postnatal care. NICE guideline NG194 (2021), recommendation 1.1.8

Definitions of terms used in this quality statement

Postnatal period

The first 8 weeks after birth. [NICE's guideline on postnatal care, overview]

Relevant information

This should include information about:

- the pregnancy, birth, postnatal period and any complications
- the plan of ongoing care, including any condition that needs long-term management
- problems related to previous pregnancies that may be relevant to current care
- previous or current mental health concerns
- female genital mutilation (mother or previous child)
- who has parental responsibility for the baby, if known
- next of kin
- safeguarding issues
- concerns about the woman's health and care, raised by her, her partner or a healthcare professional
- concerns about the baby's health and care, raised by the parents or a healthcare professional
- the baby's feeding.

[NICE's guideline on postnatal care, recommendation 1.1.8]

Equality and diversity considerations

There is a risk that the needs of vulnerable women could be overlooked if the sharing of information at transfer of care between services in the postnatal period is inadequate. This includes young women, women experiencing homelessness, and women who have physical or cognitive disabilities, severe mental health illness or difficulty accessing postnatal care services. It is a priority to ensure that potential known or suspected problems for vulnerable women are not missed by healthcare professionals at transfer of care.

Quality statement 2: Information and advice about babies' feeding

Quality statement

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

Rationale

Revisiting information and advice about the babies' feeding before transfer to community care or before the midwife leaves after a home birth will support parents to make informed decisions. Discussions should acknowledge the parents' emotional, social, financial and environmental concerns and respect feeding choices, while highlighting the nutritional and health benefits of breastfeeding. Giving parents the opportunity to discuss feeding will help them know what to expect, what support is available, when to seek help, and will address any questions or concerns they have. This will reduce the chance of feeding problems occurring at home and the need for readmission.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of women who had a live birth who received personalised information and advice about feeding their baby before transfer to community care or before the midwife left after a home birth.

Numerator – the number in the denominator who received personalised information and advice about feeding their baby before transfer to community care or before the midwife left after a home birth.

Denominator – the number of women who had a live birth.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

a) Rates of new-born hospital attendances and admissions for feeding-related conditions.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from attendance and admissions data. NHS Digital's Hospital Episode Statistics includes data on admissions for feeding-related conditions such as weight loss, dehydration and jaundice.

b) Proportion of parents who were satisfied with information and advice about feeding their baby given before transfer to community care or before the midwife left after a home birth.

Numerator – the number in the denominator who were satisfied with information and advice about feeding their baby given before transfer to community care or before the midwife left after a home birth.

Denominator – the number of parents of babies.

Data source: Data could be collected from a local survey of parents of babies following transfer to community care. The Care Quality Commission maternity survey collects information about women's experiences of maternity care including satisfaction with support with infant feeding.

What the quality statement means for different audiences

Service providers (such as NHS hospital trusts or community providers) ensure that healthcare professionals have the skills and knowledge to give personalised information and advice about the babies' feeding to parents before transfer to community care or before the midwife leaves after a home birth. Providers ensure that accessible information about the babies' feeding, including how to get support locally, is available.

Healthcare professionals (such as midwives) give personalised information and advice about the babies' feeding to parents before transfer to community care or before the midwife leaves after a home birth. Healthcare professionals check that parents understand the information they have been given, and how it relates to them. Healthcare professionals acknowledge parents' emotional, social, financial and environmental concerns about feeding options and are respectful of their feeding choices.

Commissioners (integrated care systems) commission services that provide personalised information and advice about the babies' feeding before transfer to community care or before the midwife leaves after a home birth.

Parents of babies are given personalised information and advice about feeding their baby before they are discharged from the hospital or birth team.

Source guidance

Postnatal care. NICE guideline NG194 (2021), recommendations 1.1.5, 1.1.10, 1.5.1 to 1.5.3, 1.5.12, 1.5.16 to 1.5.17 and 1.5.19

Definitions of terms used in this quality statement

Information and advice about feeding their baby

Information and advice about breastfeeding should include revisiting any or all of the following, to meet individual needs:

- nutritional benefits for the baby
- health benefits for both the baby and woman
- how it can have benefits even if only done for a short time
- how it can soothe and comfort the baby
- how the partner can support breastfeeding, including the value of their involvement

and support, and how they can comfort and bond with the baby

- how milk is produced, how much is produced in the early stages, and the supply-and-demand nature of breastfeeding
- responsive breastfeeding
- how often babies typically need to feed and for how long, taking into account individual variation
- feeding positions and how to help the baby attach to the breast
- signs of effective feeding that show the baby is getting enough milk (it is not possible to overfeed a breastfed baby)
- expressing breast milk (by hand or with a breast pump) as part of breastfeeding and how it can be useful; safe storage and preparation of expressed breast milk; and the dangers of 'prop' feeding (when a baby's feeding bottle is propped against a pillow or other support, rather than the baby and the bottle being held when feeding)
- normal breast changes after the birth
- pain when breastfeeding and when to seek help
- breastfeeding complications (for example, mastitis or breast abscess) and when to seek help
- strategies to manage fatigue when breastfeeding
- supplementary feeding with formula milk that is sometimes, but not commonly, clinically indicated
- how breastfeeding can affect body image and identity
- that the information given may change as the baby grows
- the possibility of relactation after a gap in breastfeeding
- safe medicine use when breastfeeding.

Information and advice about formula feeding for parents who are considering it, or who need to fully or partially formula feed, should include revisiting any or all of the following to meet individual needs:

- the differences between breast milk and formula milk
- that first infant formula is the only formula milk that babies need in their first year of life, unless there are specific medical needs
- how to sterilise feeding equipment and prepare formula feeds safely, including a practical demonstration if needed
- for someone trying to establish breastfeeding and considering supplementing with formula feeding, the possible effects on breastfeeding success, and how to maintain adequate milk supply while supplementing
- advice about responsive bottle feeding and help to recognise feeding cues
- positions for holding a baby for bottle feeding and the dangers of 'prop' feeding
- advice about how to pace bottle feeding and how to recognise signs that a baby has had enough milk (because it is possible to overfeed a formula-fed baby), and advice about ways other than feeding that can comfort and soothe the baby
- how to bond with the baby when bottle feeding, through skin-to-skin contact, eye contact and the potential benefit of minimising the number of people regularly feeding the baby.

[NICE's guideline on postnatal care, recommendations 1.5.2, 1.5.3, 1.5.12, 1.5.17 and 1.5.19 and expert opinion]

Equality and diversity considerations

Parents should be given information that they can easily access and understand themselves, or with support, so they can communicate effectively with healthcare services. Clear language should be used, and the content and delivery of information should be tailored to individual needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate. People should have access to an interpreter or advocate if needed. The interpreter or advocate should not be a member of the woman's family, her legal guardian or her partner, and they should communicate with the woman in her preferred language. For parents with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Quality statement 3: Symptoms and signs of illness in babies

Quality statement

Parents are given information and advice, before transfer to community care or before the midwife leaves after a home birth, about symptoms and signs of serious illness in the baby that require them to contact emergency services. **[2013, updated 2022]**

Rationale

Babies may experience serious health conditions in the immediate hours, days and weeks after the birth, which can lead to severe illness or in rare cases, death. Providing parents with information and advice about the symptoms and signs of serious illness will enable them to seek help as soon as possible if their baby is seriously ill.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of women who had a live birth who received information and advice, before transfer to community care or before the midwife left after a home birth, about symptoms and signs of serious illness in the baby that require them to contact emergency services.

Numerator – the number in the denominator who received information and advice, before transfer to community care or before the midwife left after a home birth, about symptoms and signs of serious illness in the baby that require them to contact emergency services.

Denominator – the number of women who had a live birth.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

a) Incidence of infant mortality within the first 8 weeks after birth.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records. The NHS Digital Maternity Services Data Set collects data on neonatal deaths. The Healthcare Quality Improvement Partnership's MMBRACE-UK perinatal mortality surveillance report publishes rates of perinatal death.

b) Proportion of parents who feel informed about symptoms and signs of serious illness in the baby.

Numerator – the number in the denominator who feel informed about symptoms and signs of serious illness in the baby.

Denominator – the number of parents of babies.

Data source: Data could be collected from a local survey of parents of babies.

What the quality statement means for different audiences

Service providers (such as NHS hospital trusts and community providers) ensure there are local processes to inform and advise parents, before transfer to community care or before the midwife leaves after a home birth, about the symptoms and signs of serious illness in the baby that require them to contact emergency services. Providers ensure that accessible information about the symptoms and signs of serious illness in babies is available for parents, which could include information about the Baby Check scoring system.

Healthcare professionals (such as midwives) give information and advice to parents, before transfer to community care or before the midwife leaves after a home birth, about the symptoms and signs of serious illness in the baby that require them to contact emergency services. Healthcare professionals could include information about the Baby Check scoring system which may help parents decide whether to seek advice from a healthcare professional if they think their baby may be unwell. Healthcare professionals check that parents understand the information they have been given, and how it relates to them.

Commissioners (integrated care systems) commission services that provide information and advice to parents, before transfer to community care or before the midwife leaves after a home birth, about symptoms and signs of serious illness in the baby that require them to contact emergency services.

Parents of babies are given advice, before they are discharged from the hospital or birth team, about symptoms and signs of serious illness in the baby that mean they need to contact emergency services.

Source guidance

- Postnatal care. NICE guideline NG194 (2021), recommendations 1.3.2, 1.3.10, 1.3.12, 1.4.9 and 1.4.10
- Neonatal infection: antibiotics for prevention and treatment. NICE guideline NG195 (2021) recommendation 1.1.12
- Jaundice in newborn babies under 28 days. NICE guideline CG98 (2010, updated 2016) recommendation 1.1.1

Definitions of terms used in this quality statement

Contact emergency services

Calling 999 or 112 in the UK. [Gov.uk webpage on 999 and 112: the UK's national emergency numbers]

Symptoms and signs of serious illness in the baby

Parents should be made aware:

- of the possible significance of a change in the baby's behaviour or symptoms, such as refusing feeds or changes in their level of responsiveness
- that fever may not be present in young babies with a serious infection
- that the presence or absence of individual symptoms or signs may be of limited value in identifying or ruling out serious illness in a young baby.

The following symptoms and signs are, however, suggestive of serious illness in a baby:

- appearing pale, ashen, mottled or blue (cyanotic)
- unresponsive or unrousable
- having a weak, abnormally high-pitched or continuous cry
- abnormal breathing pattern, such as:
  - grunting respirations
  - increased respiratory rate (over 60 breaths per minute)
  - chest indrawing
- temperature over 38°C or under 36°C
- non-blanching rash
- bulging fontanelle
- neck stiffness
- seizures
- focal neurological signs
- diarrhoea associated with dehydration
- frequent forceful (projectile) vomiting
- bilious vomiting (green or yellow-green vomit)
- within the first 24 hours after the birth:
  - has not passed urine

  - has not passed faeces (meconium)
  - develops a yellow skin colour (jaundice)
- is showing abnormal behaviour (for example, inconsolable crying or listlessness), or
- is unusually floppy, or
- has developed new difficulties with feeding.

[NICE's guideline on postnatal care, recommendations 1.3.2, 1.4.4 and 1.4.7 to 1.4.9, NICE's guideline on neonatal infection, recommendation 1.1.12 and NICE's guideline on jaundice in newborn babies under 28 days, recommendation 1.1.1]

Equality and diversity considerations

Parents should be given information they can easily access and understand themselves, or with support, so they can communicate effectively with healthcare services. Clear language should be used, and the content and delivery of information should be tailored to individual needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate. People should have access to an interpreter or advocate if needed. The interpreter or advocate should not be a member of the woman's family, her legal guardian or her partner, and they should communicate with the woman in her preferred language. For parents with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

It may be difficult to recognise jaundice in some babies with darker skin tones. Information and advice about how to check the baby for jaundice should be useful across all skin tones: examination of the sclerae, gums and blanched skin in bright (preferably natural) light.

Quality statement 4: Face-to-face feeding support

Quality statement

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

Rationale

Regardless of their feeding choices, parents value face-to-face feeding support. This support should be an integral part of routine postnatal contacts. Individualised support, including assessment and observation of feeding, can give parents the knowledge and understanding they need. This helps them establish good feeding practice and make informed decisions about feeding their baby. If there are ongoing concerns, healthcare professionals can arrange additional contacts to observe feeds until feeding is established and any problems have been addressed.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence that healthcare professionals have the knowledge and skills they need to provide face-to-face feeding support.

Data source: Data can be collected from information recorded locally by provider organisations, for example, from training records.

Process

a) Proportion of women who had a live birth who had an observation of a feed within 24 hours of the birth.

Numerator – the number in the denominator who had an observation of a feed within 24 hours of the birth.

Denominator – the number of women who had a live birth.

Data source: Data can be collected from information recorded locally by provider organisations, for example, from patient records.

b) Proportion of women who breastfeed who had an observation of a feed between 2 and 7 days after the birth.

Numerator – the number in the denominator who had an observation of a feed between 2 and 7 days after the birth.

Denominator – the number of women who breastfeed (exclusively or partially).

Data source: Data can be collected from information recorded locally by provider organisations, for example, from patient records.

c) Proportion of routine postnatal contacts that include face-to-face feeding support.

Numerator – the number in the denominator that include face-to-face feeding support.

Denominator – the number of routine postnatal contacts.

Data source: Data can be collected from information recorded locally by provider organisations, for example, from patient records.

Outcome

a) Rates of exclusive or partial breastfeeding at 6 to 8 weeks after the birth.

Data source: Included within the NHS Digital Maternity Services Data Set, Office for Health

Improvement and Disparities' breastfeeding statistics, and the NHS Digital Community Services Data Set.

b) Proportion of parents who are satisfied with postnatal support with feeding.

Numerator – the number in the denominator who are satisfied with postnatal support with feeding.

Denominator – the number of parents of babies.

Data source: Data could be collected from a local survey of parents of babies. The Care Quality Commission maternity survey collects information about women's experiences of maternity care including satisfaction with support with infant feeding.

What the quality statement means for different audiences

Service providers (such as NHS hospital trusts and community providers) ensure that processes are in place, and healthcare professionals have the knowledge and skills they need, to provide face-to-face feeding support to parents at each routine postnatal contact. Service providers ensure there is capacity to observe a feed within 24 hours of the birth and to provide a breastfeeding assessment, with another observation of a feed within the first week.

Healthcare professionals (such as midwives and health visitors) provide face-to-face feeding support to parents at each routine postnatal contact. Healthcare professionals observe a feed within 24 hours of the birth and assess breastfeeding, with another observation of a feed within the first week. They help to resolve any ongoing concerns.

Commissioners (such as integrated care systems and local authorities) commission services that provide face-to-face feeding support to parents at each routine postnatal contact. This includes observation of a feed within 24 hours of the birth, and breastfeeding assessment, with another observation of a feed within the first week.

Parents of babies receive face-to-face support with feeding their baby at each routine postnatal appointment so that they can get any help and advice they may need.

Source guidance

Postnatal care. NICE guideline NG194 (2021), recommendations 1.1.10, 1.5.10, 1.5.14, 1.5.18, and 1.5.19

Definitions of terms used in this quality statement

Face-to-face feeding support

This should include assessment of breastfeeding to identify and address any concerns. Healthcare professionals should:

- ask about:
    - any concerns the parents have about their baby's feeding
    - how often and how long the feeds are
    - rhythmic sucking and audible swallowing
    - if the baby is content after the feed
    - if the baby is waking up for feeds
    - the baby's weight gain or weight loss
    - the number of wet and dirty nappies
    - the condition of the breasts and nipples
- observe a feed within the first 24 hours after the birth, and at least 1 other feed within the first week.

If there are ongoing concerns with breastfeeding, healthcare professionals should consider:

- observing additional feeds
- other actions, such as:
    - adjusting positioning and attachment to the breast

  - giving expressed milk
  - referring to additional support such as a lactation consultation or peer support
  - assessing for tongue-tie.

Face-to-face formula feeding support should include:

- advice about responsive bottle feeding and help to recognise feeding cues
- offering to observe a feed
- positions for holding a baby for bottle feeding and the dangers of 'prop' feeding
- advice about how to pace bottle feeding and how to recognise signs that a baby has had enough milk (because it is possible to overfeed a formula-fed baby)
- advice about ways other than feeding that can comfort and soothe the baby
- how to bond with the baby when bottle feeding, through skin-to-skin contact, eye contact and the potential benefit of minimising the number of people regularly feeding the baby.

[NICE's guideline on postnatal care, recommendations 1.5.13 to 1.5.15 and 1.5.19]

Routine postnatal contact

Contact from a healthcare professional that is part of the standard pathway of postnatal care. This includes the first contact on the postnatal ward by a midwife, the first home visit by a midwife, and the first home visit by a health visitor. [NICE's guideline on postnatal care, recommendations 1.1.10, 1.1.14 and 1.1.15]

Equality and diversity considerations

Providing continuity of carer is particularly important to support younger women and those from a low income or disadvantaged background to continue breastfeeding.

Parents should be given information they can easily access and understand themselves, or with support, so they can communicate effectively with healthcare services. Clear language should be used, and the content and delivery of information should be tailored to individual needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate. People should have access to an interpreter or advocate if needed. The interpreter or advocate should not be a member of the woman's family, her legal guardian or her partner, and they should communicate with the woman in her preferred language. For parents with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Quality statement 5: Safer practices for bed sharing

Quality statement

Parents are given advice about safer practices for bed sharing at each routine postnatal contact. **[2013, updated 2022]**

Rationale

Parents sharing a bed with their baby is common practice but there is often confusion and mixed messages about it. Giving parents advice at each routine postnatal contact about safer practices for bed sharing and when bed sharing is strongly advised against (such as avoiding certain sleeping positions or places, or after consuming drugs or alcohol), will support them to establish safer infant sleeping habits.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of routine postnatal contacts that include advice about safer practices for bed sharing.

Numerator – the number in the denominator that include advice about safer practices for bed sharing.

Denominator – the number of routine postnatal contacts.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

a) Incidence of sudden infant death syndrome (SIDS).

Data source: Office for National Statistics' data on unexplained deaths in infancy, England and Wales.

b) Proportion of parents who know about safer practices for bed sharing.

Numerator – the number in the denominator who know about safer practices for bed sharing.

Denominator – the number of parents of babies.

Data source: Data could be collected from a local survey of parents of babies.

What the quality statement means for different audiences

Service providers (such as NHS hospital trusts and community providers) ensure that healthcare professionals are trained to discuss safer practices for bed sharing with parents. They ensure that processes are in place to discuss safer practices for bed sharing at each routine postnatal contact.

Healthcare professionals (midwives and health visitors) ensure that they can explain safer practices for bed sharing, and that they give parents advice about this at each routine postnatal contact. Healthcare professionals check that parents understand the information they have been given, and how it relates to them.

Commissioners (such as integrated care systems and local authorities) ensure that they commission services that advise parents about safer practices for bed sharing at each routine postnatal contact.

Parents of babies are given advice about safer practices when sharing a bed with their baby when they see health visitors and midwives. This should include how to keep their baby safer when sharing a bed with their baby and when they should not share a bed with their baby.

Source guidance

Postnatal care. NICE guideline NG194 (2021), recommendations 1.3.13 and 1.3.14

Definitions of terms used in this quality statement

Routine postnatal contact

Contact from a healthcare professional that is part of the standard pathway of postnatal care. This includes the first contact on the postnatal ward by a midwife, the first home visit by a midwife, and the first home visit by a health visitor. [NICE's guideline on postnatal care, recommendations 1.1.10, 1.1.14 and 1.1.15]

Safer practices for bed sharing

Advice about bed sharing should include:

- safer practices for bed sharing, including:
    - making sure the baby sleeps on a firm, flat mattress, lying face up (rather than face down or on their side)
    - not sleeping on a sofa or chair with the baby
    - not having pillows or duvets near the baby
    - not having other children or pets in the bed when sharing a bed with a baby
- advice not to share a bed with their baby if their baby was low birth weight or if either parent:
    - has had 2 or more units of alcohol
    - smokes
    - has taken medicine that causes drowsiness
    - has used recreational drugs.

[NICE's guideline on postnatal care, recommendations 1.3.13 and 1.3.14]

Equality and diversity considerations

Parents should be given information that they can easily access and understand themselves, or with support, so they can communicate effectively with healthcare services. Clear language should be used, and the content and delivery of information should be tailored to individual needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate. People should have access to an interpreter or advocate if needed. The interpreter or advocate should not be a member of the woman's family, her legal guardian or her partner, and they should communicate with the woman in her preferred language. For parents with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Quality statement 6: GP postnatal check for women

Quality statement

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

Rationale

Carrying out an assessment of women's physical and psychological health and wellbeing 6 to 8 weeks after giving birth will prevent delays in diagnosing and treating any problems and improve health outcomes. There should be enough time allowed to focus on the woman's mental and physical health needs and respond to any concerns she may have. GPs will be able to refer women to other healthcare services including specialist services for ongoing investigation, management and support if needed.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of women who had a GP assessment 6 to 8 weeks after giving birth.

Numerator – the number in the denominator who had a GP assessment 6 to 8 weeks after giving birth.

Denominator – the number of women who gave birth.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from electronic health records for postnatal check. This could be collected in a way that disaggregates the data for vulnerable groups to observe and react to potential inequalities.

Outcome

a) Proportion of women who had a GP assessment 6 to 8 weeks after giving birth who are satisfied that the GP spent enough time talking to them about their physical and mental health.

Numerator – the number in the denominator who are satisfied that the GP spent enough time talking to them about their physical and mental health.

Denominator – the number of women who had a GP assessment 6 to 8 weeks after giving birth.

Data source: Data could be collected from a local survey of women who gave birth. The Care Quality Commission maternity survey includes data on the proportion of women who had a postnatal check and said their GP 'definitely' spent enough time talking to them about their own physical and mental health.

b) Rates of unplanned hospital attendance for women within 3 months of giving birth.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records or from NHS Digital's Hospital Episode Statistics.

What the quality statement means for different audiences

Service providers (primary care) ensure that all women are offered an appointment for a GP assessment to take place 6 to 8 weeks after giving birth. Service providers ensure appointment times are long enough for a full assessment.

Healthcare professionals (GPs) ensure that they are aware of the requirements for, and carry out, assessments for women 6 to 8 weeks after giving birth.

Commissioners (NHS England) commission services that offer a GP assessment to all women 6 to 8 weeks after giving birth with appointment times that are long enough for a full assessment. Commissioners monitor GP postnatal assessments and work with providers to identify and address any inequalities in take up.

Women who have given birth are invited to have a postnatal check with a GP 6 to 8 weeks after giving birth. This will cover their physical and mental health. The GP will refer them for any help they may need.

Source guidance

Postnatal care. NICE guideline NG194 (2021), recommendation 1.2.7

Definitions of terms used in this quality statement

GP assessment

NHS England's update to the GP contract agreement 2020/21 to 2023/24 states that, in line with NICE guidance, the maternal check should focus on:

- a review of the mother's mental health and general wellbeing, using open questioning
- the return to physical health following childbirth, and early identification of pelvic health issues
- family planning and contraception issues
- any conditions that existed before or arise during pregnancy that require ongoing management, such as gestational diabetes.

NICE's guideline on postnatal care states that the assessment carried out by a GP should include the following areas, taking into account the time since the birth. The GP should respond to any concerns, which may include further investigation and referral to specialist services in either secondary care or other healthcare services such as physiotherapy:

- asking about their general health and whether there are any concerns and assessing their general wellbeing, which may include:
  - symptoms and signs of potential postnatal mental health problems and how to seek help

    - symptoms and signs of potential postnatal physical problems and how to seek help
    - the importance of pelvic floor exercises, how to do them and when to seek help
    - fatigue
    - factors such as nutrition and diet, physical activity, smoking, alcohol consumption and recreational drug use
    - contraception
    - sexual intercourse
    - safeguarding concerns, including domestic abuse
- assessing psychological and emotional wellbeing
- assessing physical health, including:
    - for all women:
        - symptoms and signs of infection
        - pain
        - vaginal discharge and bleeding
        - bladder function
        - bowel function
        - nipple and breast discomfort and symptoms of inflammation
        - symptoms and signs of thromboembolism
        - symptoms and signs of anaemia
        - symptoms and signs of pre-eclampsia
    - for women who have had a vaginal birth:
        - perineal healing
    - for women who have had a caesarean section:

    - wound healing
    - symptoms of wound infection
- giving the woman the opportunity to talk about her birth experience, and providing information about relevant support and birth reflection services, if needed.

[NICE's guideline on postnatal care, recommendations 1.2.1 to 1.2.3 and 1.2.5]

Equality and diversity considerations

Healthcare professionals should be aware that the 2020 MBRRACE-UK reports on maternal and perinatal mortality showed that women and babies from some minority ethnic backgrounds and those who live in deprived areas have an increased risk of death and may need closer monitoring. GP practices should consider the best way to engage with women in these groups to encourage them to attend for a postnatal check. This could include joint working with health visitors or local groups.

Healthcare professionals should consider the best methods to invite women from vulnerable groups, including women known to social services, women in contact with the criminal justice system and women separated from their baby shortly after birth, to attend a GP assessment 6 to 8 weeks after they have given birth. It will be important to tailor the invitation to individual needs and preferences. In some cases, a phone call may be preferable to a letter or text message, and it may be necessary to arrange the appointment rather than expecting the woman to arrange it for themselves. The invitation should be accessible to people who do not speak or read English. Women who do not attend should receive a follow-up invitation.

Women should have access to an interpreter or advocate if needed. The interpreter or advocate should not be a member of the woman's family, her legal guardian or her partner, and they should communicate with the woman in her preferred language. For women with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Update information

September 2022: This quality standard was updated, and statements prioritised in 2013 were replaced. The topic was identified for update following a review of quality standards. The review identified:

- updated guidance on postnatal care.

Statements are marked as:

- **[new 2022]** if the statement covers a new area for quality improvement
- **[2013, updated 2022]** if the statement covers an area for quality improvement included in the 2013 quality standard and has been updated.

The previous version of the quality standard for postnatal care is available as a pdf.

Minor changes since publication

November 2022: We added a link to the previous version of this quality standard.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact statement for the NICE guideline on postnatal care to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Royal College of Midwives
- Birth Companions
- General Practitioners Championing Perinatal Care
- Royal College of Paediatrics and Child Health
- EMDR Association UK
- Royal College of Nursing (RCN)