NICE National Institute for Health and Care Excellence

NICE support for commissioning postnatal care

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1 Introduction

Implementing the recommendations from NICE guidance and other NICE-accredited guidance is the best way to support improvements in the quality of care or services, in line with the statements and measures that comprise the NICE quality standards. This report:

- considers the resource impact of implementing the changes needed to achieve the quality standard at a local level
- identifies where potential cost savings can be made
- highlights the areas of care in the quality standard that have potential implications for commissioners
- directs commissioners and service providers to a package of support tools that can help them implement NICE guidance and redesign services.

NICE quality standards are concise sets of statements designed to drive measurable quality improvements within a particular area of health or care. They draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement. For more information see NICE quality standards.

NHS England's CCG outcomes indicator set is part of a systematic approach to promoting quality improvement. The outcomes indicator set provides clinical commissioning groups (CCGs) and health and wellbeing boards with comparative information on the quality of health services commissioned by

CCGs and the associated health outcomes. The set includes indicators derived from NICE quality standards. By commissioning services in line with the quality standards, commissioners can contribute to improvements in health outcomes.

Commissioners can use the quality standards to improve services by including quality statements and measures in the service specification of the standard contract and establishing key performance indicators as part of tendering. They can also encourage improvements in provider performance by using quality standard measures in association with incentive payments such as Commissioning for Quality and Innovation (CQUIN). NICE quality standards provide a baseline against which improvements can be measured and rewarded, enabling commissioners to address gaps in service provision, support best practice and encourage evidence-based care.

This report on the postnatal care quality standard should be read alongside:

- Postnatal care. NICE quality standard 37 (2013).
- Patient experience in adult NHS services. NICE quality standard 15 (2012).
- Postnatal care: routine postnatal care of women and their babies. NICE clinical guideline 37 (2006).

Commissioners should also be aware that the quality standard for postnatal care forms part of a set of maternity quality standards, of which antenatal care, intrapartum care and postnatal care will form the core pathway. The full set of quality standards, including all the maternity quality standards that should be considered when commissioning and providing high-quality maternity services are:

- Antibiotics for neonatal infection. NICE quality standard 75 (2014).
- Feverish illness in children under 5 years. NICE quality standard 64 (2014).
- Constipation in children and young people. NICE quality standard 62 (2014).
- Induction of labour. NICE quality standard 60 (2014).
- Neonatal jaundice . NICE quality standard 57 (2014).

- Multiple pregnancy. NICE quality standard 46 (2013).
- Hypertension in pregnancy. NICE quality standard 35 (2013).
- Caesarean section. NICE quality standard 32 (2013).
- Antenatal care. NICE quality standard 22 (2012).
- Specialist neonatal care. NICE quality standard 4 (2010).

  VTE prevention. NICE quality standard 3 (2010).

2 Overview of postnatal care

Postnatal care is the individualised care provided to meet the needs of a mother and her baby following childbirth. Although the postnatal period is uncomplicated for most women and babies, care during this period needs to address any variation from expected recovery after birth. For the majority of women, babies and families the postnatal period ends 6–8 weeks after the birth. However for some women and babies, the postnatal period should be extended in order to meet their needs. This is particularly important where a woman or baby has developed complications and remains vulnerable to adverse outcomes. For example, this could include women who have poor support networks, have developed a postnatal infection or other health problem that is continuing to impact on their daily lives, or women who are at risk of mental health problems or infant attachment problems.

This support for commissioning includes the core care and support which every woman, their baby and if appropriate, their partner and family should receive during the postnatal period. This includes recognising women and babies with additional care needs and referring them to specialist services.

3 Commissioning and resource implications

Using the quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the NHS Outcomes Framework 2013/14 and the Public Health Outcomes Framework 2013–2016.

The cost of achieving the quality standard for postnatal care depends on current local practice and the progress organisations have made in implementing NICE and NICE-accredited guidance.

Under the new maternity services pathway payment system that came into effect in April 2013, the payment system is split into 3 modules, each of which is paid separately. These are antenatal care, the delivery, and postnatal care.

The antenatal pathway payment system begins when the pregnant woman has her first antenatal appointment or attendance with her maternity provider. The antenatal pathway payment (standard, intermediate or intensive) is based on information collected at the antenatal assessment appointment (usually undertaken at around 10 weeks' gestation) when the health and social care risk assessment is carried out.

There are 2 delivery pathway prices, split by whether there were complications and comorbidities or not. The price includes all postpartum care of the mother and well/healthy baby/babies until transfer to community postnatal care.

The postnatal pathway payment system usually begins after the woman and baby/babies have been transferred to community postnatal care and ends once the woman has been transferred to primary care. If the care normally delivered under the postnatal pathway is provided while the woman remains in the hospital, the postnatal care provider is still entitled to payment for that element of the pathway. The postnatal pathway payment (standard, intermediate or intensive) is based on likely resource usage during the postnatal period.

Services should be commissioned from and coordinated across all relevant agencies in the postnatal pathway, and commissioners should be aware of the potential impact of the pathway funding system.

Commissioners are reminded of the equality and diversity considerations in each of the quality statements. Communication and information-giving between women (and their families) and members of the maternity team is a key aspect of the quality statements. Information should be accessible to women, including women who do not speak or read English and those with additional needs such as physical, sensory or learning disabilities.

Table 1 summarises the commissioning and resource implications for commissioners working towards achieving this quality standard. Commissioners and providers may wish to work together to seek assurance that the quality statements are being achieved in line with the quality measures detailed in the quality standard. See section 4 for more detail on commissioning and resource implications.

Table 1 Potential commissioning and resource implications of achieving the quality standard for postnatal care

Quality statement	Commissioning implications	Estimated resource impact
1 - Continuity of care	Demonstrating evidence of practice and monitoring to ensure that individualised postnatal care plans are reviewed and documented at each postnatal contact. Measuring women's satisfaction with the continuity and content of their postnatal care.	Cost impact not expected to be significant.
2 - Maternal health – life-threatening conditions	Demonstrating evidence of practice and monitoring to ensure that women are advised, within 24 hours of the birth, of the symptoms and signs of life-threatening conditions that require them to access emergency treatment. Measuring outcomes and whether women feel informed about symptoms and signs of postnatal life-threatening conditions.	Cost impact not expected to be significant.
3 - Infant health – life-threatening conditions	Demonstrating evidence of practice and monitoring to ensure that women or the main carers of babies are advised, within 24 hours of the birth, of the symptoms and signs of potentially life-threatening conditions in the baby that require emergency treatment. Measuring outcomes and whether women and main carers feel informed about symptoms and signs of potentially-life threatening conditions in the baby.	Cost impact not expected to be significant.
4 - Infant health – safer infant sleeping	Demonstrating evidence of practice and monitoring to ensure that the association between co-sleeping and sudden infant death syndrome	Cost impact not expected to be significant.

	(SIDS) is discussed at each postnatal contact with women, their partner or the main carer. . Measuring outcomes and whether women, their partners or the main carers of babies know about the association between co-sleeping and SIDS.	
5 - Breastfeeding	Demonstrating evidence of practice and monitoring to ensure that women receive breastfeeding support from a service that uses an evaluated structured programme. Measuring outcomes at defined points and women's satisfaction with breastfeeding support.	Increase in costs if there is an increase in the number of women receiving skilled breastfeeding support and services are expanded or new services established. Savings may be possible from a reduction in the incidence of certain childhood diseases because of the health benefits of breastfeeding.
6 - Formula feeding	Demonstrating evidence of practice and monitoring to ensure that information about bottle feeding is discussed with women or the main carers of formula-fed babies. Measuring outcomes and women's and main carers' satisfaction with feeding support.	Expected to be cost saving from a reduction in the rates of gastroenteritis resulting in hospital admissions, and a corresponding reduction in treatment costs.
7 - Infant health – physical examination	Demonstrating evidence of practice, monitoring and measuring outcomes to ensure that babies have a complete 6–8 week physical examination by a competent practitioner.	Increased costs associated with this statement are likely to be associated with monitoring the competency of practitioners undertaking the complete 6-8 week physical examination. Longer-term savings may be possible where earlier treatment improves the health of the baby.
8 - Maternal health – weight management	Demonstrating evidence of practice, monitoring and measuring outcomes to ensure that women have their BMI assessed and recorded at the 6–8 week postnatal check, women with a BMI of 30 kg/m^2 or more are offered a referral for advice on healthy eating and physical activity, and that there are adequate numbers of trained staff to deliver the services to postnatal women.	Increase in services commissioned will lead to costs being incurred. Any reduction in obesity levels has the potential to result in savings from reduced adverse events in future pregnancies and additional benefits to the health of the infant and the wider family.
9 - Emotional wellbeing and	Demonstrating evidence of practice, monitoring and measuring	Broadly cost neutral.

infant attachment	outcomes to ensure that women have their emotional wellbeing, including their emotional attachment to their baby, assessed at each postnatal contact.	
10 - Maternal health – mental wellbeing	Demonstrating evidence of practice, monitoring and measuring outcomes to ensure that women who have transient psychological symptoms (‘baby blues’) that have not resolved at 10–14 days after the birth have an assessment for mental health problems.	Broadly cost neutral.
11 - Parent-baby attachment	Demonstrating evidence of practice, monitoring and measuring outcomes to ensure that parents or main carers with infant attachment problems receive services designed to improve their relationship with their baby. Measuring parental or main carer satisfaction with services to support parenting skills.	Setting up or expanding services designed to improve parent-baby relationships may lead to an increase in costs and will depend on existing local provision. It is possible these costs will be significant if there is currently no service provision.

4 Commissioning implications and cost impact

This section considers the commissioning implications and potential resource impact of implementing the recommendations to achieve the NICE quality standard for postnatal care.

4.1 Continuity of care

Quality statement 1:

The woman and baby's individualised postnatal care plan is reviewed and documented at each postnatal contact.

Postnatal care should be a continuation of the care the woman received during her pregnancy, labour and birth. Planning and regularly reviewing the content and timing of care, for individual women and their babies, and communicating this (to the woman, her family and other relevant postnatal

care team members) through a documented care plan can improve continuity of care.

In line with NICE clinical guideline 37 (recommendation 1.1.3 [key priority for implementation]) commissioners should check that there is evidence of local arrangements to ensure that women and their babies' individualised postnatal care plans are reviewed and documented at each postnatal care contact[1].

The individualised postnatal care plan should be documented and developed with the woman, ideally in the antenatal period or as soon as possible after birth. Commissioners should ensure that plans are comprehensive and include as a minimum:

- Relevant factors from the antenatal, intrapartum and immediate postnatal period.
- Details of a named midwife[2] or health visitor, including a 24-hour telephone number to enable the woman to contact her named healthcare professional or an alternative professional should he or she not be available.
- Details of the healthcare professionals involved in the woman's care and that of the baby, including roles and contact details.
- Plans for the postnatal period, including:
  - specific plans for managing pregnancy-related conditions such as gestational hypertension, pre-eclampsia, thromboembolism, gestational diabetes, postnatal wound care and mental health conditions
  - details about adjustment to motherhood, emotional wellbeing and family support structures
  - plans for feeding, including specific advice about either breastfeeding support or formula feeding

[1] Women and their babies should receive the number of postnatal contacts appropriate to their care needs. A postnatal contact is a scheduled postnatal appointment, which may occur in the woman or baby's home or another setting such as a GP practice or children's centre. Where a woman remains in hospital following delivery, her postnatal care plan should be reviewed on a daily basis until her transfer home and then reviewed at each subsequent contact.

[2] A midwife or health visitor is the named registered professional responsible for providing all or most of the woman's postnatal care. If the named midwife or health visitor is not available, then they should coordinate the woman's care (definition adapted from 'Maternity matters: choice, access and continuity of care in a safe service').

– plans for contraceptive care[3].

Commissioners may also find it helpful to refer to the NICE support for commissioning antenatal care and the NICE support for commissioning for hypertension in pregnancy when considering continuity of care and postnatal care planning.

Implementing this quality statement is not anticipated to lead to significant additional costs for the NHS because any additional reviews of individualised postnatal care plans and documentation that occur as a result of the quality statement are anticipated to take place during existing postnatal contacts.

The Maternity services secondary uses data set[4] will collect data on the date on which the care plan was created or changed and covers antenatal, birth and postnatal care plans (global numbers 17201890 and 17201900).

Commissioners may also wish to refer to the Care Quality Commission Maternity Services Survey 2013, which collected information about women's experiences of maternity care.

4.2 Maternal health – life-threatening conditions

Quality statement 2:

Women are advised, within 24 hours of the birth, of the symptoms and signs of conditions that may threaten their lives and require them to access emergency treatment.

[3] Definition adapted with expert group consensus from NICE clinical guideline 37, Recommendation 1.1.3.

[4] The maternity and children's data set has been developed to help achieve better outcomes of care for mothers, babies and children. The data set will provide comparative, mother and child-centric data that will be used to improve clinical quality and service efficiency; and to commission services in a way that improves health and reduces inequalities. It incorporates a maternity services secondary uses data set available from: http://www.ic.nhs.uk/maternityandchildren

Women are at increased risk of experiencing serious health events in the immediate hours, days and weeks following the birth, some of which could lead to maternal death or severe morbidity. In line with NICE clinical guideline 37, commissioners should therefore ensure that women are given accurate, evidence-based verbal and written information about the symptoms and signs of potentially life-threatening conditions within 24 hours of the birth that may prompt them to access immediate emergency treatment if needed.

Commissioners can refer to NICE clinical guideline 37 (recommendation 1.2.1 table 2), for details of the signs and symptoms of potentially life-threatening conditions and RCOG good practice No. 14 (section 5), which details the symptoms and signs that are suggestive of potentially life-threatening mental health conditions in women. Commissioners may also signpost providers to the Royal College of Obstetricians and Gynaecologists guidance Sepsis following pregnancy, Bacterial[5] for guidance on the management of sepsis in the first 6 weeks after birth. Sepsis remains an important cause of maternal death, accounting for around 10 deaths per year in the UK. Severe sepsis with acute organ dysfunction has a mortality rate of 20–40%, rising to around 60% if septic shock develops[6].

Commissioners should ensure that if women are too unwell to receive this information within the first 24 hours after the birth, providers discuss the information when they have recovered sufficiently to identify any symptoms or signs of life-threatening conditions. Commissioners should also ensure that women are given a 24-hour contact number if they need to seek urgent maternity advice (for example, the labour ward triage number).

Commissioning organisations are not expected to incur additional costs as a result of this statement. Accurate, evidence-based, written information that is

[5] Royal College of Obstetricians and Gynaecologists (2012) Sepsis following pregnancy, Bacterial . Green top guideline no 64b, Section 17. NICE accredited.

[6] Sepsis may be defined as infection plus systemic manifestations of infection; severe sepsis may be defined as sepsis plus sepsis-induced organ dysfunction or tissue hypoperfusion. Septic shock is defined as the persistence of hypoperfusion despite adequate fluid replacement therapy.

appropriate for different levels of literacy and different cultures and languages may need to be developed if it does not currently exist and if it cannot be accessed free of charge online. Such provision may lead to some additional costs for providers, but these are not anticipated to be significant.

The Maternity services secondary uses data set[7] will collect data on maternal deaths (global number 17207470) and commissioners may also find it helpful to refer to the Confidential Enquiries into Maternal Deaths (now undertaken by MBRRACE-UK) which reports on rates of maternal death. MBRRACE are expanding their work programme to include severe maternal morbidity.

4.3 Infant health – life-threatening conditions

Quality statement 3:

Women or main carers of babies are advised, within 24 hours of the birth, of the symptoms and signs of potentially life-threatening conditions in the baby that require emergency treatment.

Babies may experience serious health conditions in the immediate hours, days and weeks following the birth which can lead to severe illness or, in rare cases, death. In line with NICE clinical guideline 37 (recommendation 1.4.2 [key priority for implementation]) commissioners should ensure that women or the main carers are given accurate, evidence-based, verbal and written information about the symptoms and signs that might indicate their baby has a serious health problem. This may result in emergency treatment being sought

[7] The maternity and children's data set has been developed to help achieve better outcomes of care for mothers, babies and children. The data set will provide comparative, mother and child-centric data that will be used to improve clinical quality and service efficiency; and to commission services in a way that improves health and reduces inequalities. It incorporates a maternity services secondary uses data set available from: http://www.ic.nhs.uk/maternityandchildren

more promptly[8]. This information should be provided within 24 hours of the birth. The list of symptoms and signs of life-threatening conditions in the baby (0–3 months) is available in the NICE quality standard for postnatal care[9].

Commissioners should ensure that if the baby is unwell and in hospital, the information is provided to the mother or main carer before the baby's discharge. Commissioners should also ensure that women or main carers of babies are given a 24-hour contact number if they need to seek urgent advice (for example, the labour ward triage number).

Commissioning organisations are not expected to incur significant additional costs as a result of this statement. Accurate, evidence-based, written information that is appropriate for different levels of literacy and different cultures and languages may need to be developed if it does not currently exist or if it cannot be accessed free of charge online. Such provision may lead to some additional costs for providers, but these are not anticipated to be significant.

The Maternity services secondary uses data set[10] (once implemented) will collect data on neonatal deaths (global number 17209680) once implemented.

The Confidential Enquiries into Perinatal Deaths (now undertaken by MBRRACE-UK) reports on rates of perinatal death. MBRRACE are expanding their work programme to include severe infant morbidity.

[8] For the majority of babies the main carer will be the mother. For some babies the main carer could be a close relative, for example the baby's father or grandparent, or for looked-after babies this could be a foster parent.

[9] The list has been adapted with expert group consensus from information provided within the Department of Health Birth to Five book (no longer in print but available for download) and NICE clinical guideline 160 on Feverish illness in children.

[10] The maternity and children's data set has been developed to help achieve better outcomes of care for mothers, babies and children. The data set will provide comparative, mother and child-centric data that will be used to improve clinical quality and service efficiency; and to commission services in a way that improves health and reduces inequalities. It incorporates a maternity services secondary uses data set available from: http://www.ic.nhs.uk/maternityandchildren

4.4 Infant health – safer infant sleeping

Quality statement 4:

Women, their partner or the main carer are given information on the association between co-sleeping and sudden infant death syndrome (SIDS) at each postnatal contact.

Although the cause of SIDS is unknown, there are specific behaviours that may make SIDS more likely. There is some evidence that where co-sleeping occurs there may be an increase in the number of cases of SIDS. Commissioners should ensure that information is given to women, their partners or the main carers about the association between co-sleeping and sudden infant death syndrome within 24 hours of the birth and at each postnatal contact; including 10–14 days after the birth and at the 6–8 week postnatal check[11]. Local arrangements should be in place to enable opportunities for women, their partner or the main carer to be given information to support them to establish safer infant sleeping habits which may reduce the likelihood of SIDS.

Commissioners should specify that providers are competent to deliver accurate and evidence-based verbal and written information about the association between co-sleeping and SIDS. Accurate, evidence-based, written information that is appropriate for different levels of literacy and different cultures and languages may need to be developed if it does not currently exist and if it cannot be accessed free of charge online. Such provision may have some cost implications for provider organisations, but these are not expected to be significant. Discussions are expected to occur during existing postnatal contacts and therefore not incur any additional costs.

Commissioners may find it helpful to refer to the Office for National Statistics report Unexplained deaths in infancy – England and Wales, 2010.

[11] The frequency of 'at every postnatal contact' is based on topic expert group consensus.

4.5 Breastfeeding

Quality statement 5:

Women receive breastfeeding support from a service that uses an evaluated structured programme.

Breastfeeding contributes to the health of both the mother and child in the short and longer term. For example, babies who are not breastfed are many times more likely to acquire infections such as gastroenteritis in their first year[12]. Commissioners should ensure that service providers make women aware of these benefits, and that women who choose to breastfeed are supported by an evidence-based service that delivers an externally audited, structured programme that encourages breastfeeding, using the Baby Friendly Initiative as a minimum standard.

Locally developed breastfeeding support services should be coordinated and monitored across all maternity care providers (including hospital, primary, community and children's centre settings). Services should include activities to raise awareness of the benefits of – and how to overcome the barriers to – breastfeeding, breastfeeding peer-support programmes, education and information for pregnant women on how to breastfeed, and proactive support during the postnatal period (the support may be provided by a volunteer). Training for health professionals[13] and joint working between health professionals and peer supporters is important. Special consideration will also be needed for circumstances in which mothers and their babies may have been separated for any reason, for example if the baby has been admitted to neonatal care or the baby has been taken into care.

[12] NICE public health guidance 11 on Maternal and child nutrition. Available from http://publications.nice.org.uk/maternal-and-child-nutrition-ph11

[13] All people involved in delivering breastfeeding support should receive the appropriate training and undergo assessment of competencies for their role. This includes employed staff and volunteer workers and all sectors for example hospitals, community settings, children's centres, peer supporter services.

The NICE shared learning database[14] provides examples of services that may be useful for commissioners and providers.

Improved access to breastfeeding peer support describes a volunteer breastfeeding peer support service that is delivered in partnership with midwifery, health visitors, children's centres and volunteers and engages with women during both the antenatal and postnatal period, while responding to meet the needs of mothers and families from different socio-economic and cultural backgrounds[15].

Wigan Breast Feeding Network Peer Support Service is commissioned in partnership by the NHS and local authority to provide a breast feeding peer support service in partnership with the local Trust, health visiting service and local authority for women in the antenatal and postnatal periods. Additional support is offered for those women who are under 20 years old by a specialist support worker.

There are likely to be associated costs if there is an increase in the number of women receiving breastfeeding support from existing services and services are expanded or new services are established. Some of these costs may be offset by savings as a result of increased breastfeeding rates. The costing report for NICE clinical guideline 37 stated that potential savings are linked to a reduction in the incidence of certain childhood diseases because of the health benefits of breastfeeding. It estimated that a 10% increase in breastfeeding rates could lead to savings of around £5000 per 100,000 population from reduced cases of gastroenteritis in infants. Other longer term benefits may also be possible, for example reduced rates of breast cancer in women.

[14] The NICE shared learning database offers examples on how commissioners and providers have used NICE guidance to create innovative and effective local implementation programmes for service improvement.

[15] This is a Shared learning example of implementation for NICE public health guidance 11 on maternal and child nutrition.

The Maternity services secondary uses data set[16] will collect data on 'baby first feed breast milk status' (global number 17205882), 'baby breast milk status (at discharge from hospital)' including exclusive and partial breast milk feeding (global number 17207550).

The Children and Young People's Health Services Secondary Uses Data Set once implemented, will collect data on 'breast feeding status' (global number 17101340) including 'Exclusively breast milk feeding', Partially breast milk feeding' and 'No breast milk feeding at all' and also data on observation date (breastfeeding status) (global number 17104440).

Commissioners may also wish to refer to the Infant Feeding Survey 2010 which collected self-report data on the prevalence and duration of breast-feeding in the first 8 to 10 months after the baby was born and the Care Quality Commission Maternity Services Survey 2010 which collected information about women's experiences of maternity care and included a section on 'Feeding your baby'.

4.6 Formula feeding

Quality statement 6:

Information about bottle feeding is discussed with women or main carers of formula-fed babies.

Babies who are fully or partially formula fed can develop infections and illnesses if their formula milk is not prepared safely. In a small number of babies these cause serious harm and are life-threatening, and require the

[16] The maternity and children's data set has been developed to help achieve better outcomes of care for mothers, babies and children. The data set will provide comparative, mother and child-centric data that will be used to improve clinical quality and service efficiency; and to commission services in a way that improves health and reduces inequalities. It incorporates a maternity services secondary uses data set available from: http://www.ic.nhs.uk/maternityandchildren

baby to be admitted to hospital. Commissioners should assure themselves that there is evidence of local arrangements to demonstrate that information about bottle feeding is being discussed with women or main carers of the formula-fed baby and that they are given consistent, evidence-based advice about how to sterilise feeding equipment and safely prepare formula-milk.

Commissioners may wish to signpost to the Department of Health and Food Standards Agency (2012) leaflet Start4Life guide to bottle feeding, which is available for use but it is not currently translated and may therefore lead to some additional costs for providers if translation is required.

Overall, implementation of this quality statement is expected to lead to cost savings from a reduction in the rates of gastroenteritis resulting in hospital admission and a corresponding reduction in treatment costs. The national tariff cost for an episode of gastrointestinal disorder (healthcare resource group PA26B Other Gastrointestinal or Metabolic Disorders without CC) is £586 for a non-elective episode.

Commissioners may wish to refer to the Infant Feeding Survey 2010 which collected self-report data on how mothers prepared powdered formula feed in the last 7 days, including whether they had followed all 3 recommendations for making up feeds (only making 1 feed at a time; making feeds within 30 minutes of the water boiling; and adding the water to the bottle before the powder).

Commissioners may find it useful to refer to the Care Quality Commission Maternity Services Survey 2010 which collected information about women's experiences of maternity care and includes a section on 'Feeding your baby'.

4.7 Infant health – physical examination

Quality statement 7:

Babies have a complete 6–8 week physical examination.

The purpose of the examination is to identify babies more likely to have conditions that would benefit from further investigation and management. This includes an overall physical examination as well as screening for eye problems, congenital heart defects, developmental dysplasia of the hip and undescended testicles. Most babies will be healthy, but the small number of babies who do have serious problems will benefit from prompt identification. Early treatment can improve the health of the baby and prevent or reduce disability.

Commissioners will need to assure themselves that there is evidence of local arrangements to ensure that babies are having a complete physical examination at 6–8 weeks after the birth as recommended in NICE clinical guideline 37 (recommendations 1.4.13). Examinations should be carried out in line with those listed in recommendation 1.4.11 together with an assessment of social smiling and visual fixing[17]. Commissioners should also check that practitioners are competent to carry out the complete 6–8 week physical examination as detailed in Newborn and Infant Physical Examination Standards and Competencies (March 2008).

Expert opinion is that most babies receive a complete physical examination, but it does not always occur before the baby is 10 weeks old. Increased costs associated with this quality statement are likely to be associated with monitoring the competency of practitioners undertaking the complete 6–8 week physical examination. Longer-term savings may be possible where earlier treatment improves the health of the baby.

4.8 Maternal health – weight management

Quality statement 8:

Women with a body mass index (BMI) of 30 kg/m^2 or more at the 6–8 week postnatal check are offered a referral for advice on healthy eating and physical activity.

[17] NICE clinical guideline 37 recommendation 1.4.13 and the Newborn and Infant Physical Examination Standards and Competencies (March 2008) detail the components of the 6–8 week physical examination.

Women who are obese (BMI of 30 kg/m^2 or more) during pregnancy face increased risks of complications that include gestational diabetes, miscarriage, pre-eclampsia, thromboembolism and maternal death. Risks for the infant include fetal death, stillbirth, shoulder dystocia, and macrosomia. Infants of obese women face health risks in childhood including diabetes and obesity in later life.

Commissioners should ensure that local arrangements are in place for women to have their BMI assessed and recorded at the 6–8 week postnatal check, and for women with a BMI of 30 kg/m^2 or more to have the risks of obesity explained to them (risks not only for them, but for their unborn child if they become pregnant again). Commissioners should commission individual and group-based services to enable women with a BMI of 30 kg/m^2 or more at the 6–8 week postnatal check to be offered a referral for advice on healthy eating and physical activity. This may then improve their health, their infant's health and the health of the wider family. It may also improve the outcomes of future pregnancies.

The NICE shared learning database provides examples of implementation of NICE public health guidance 27.

The Monday clinic; implementing a maternal obesity service describes a midwifery-led service that encourages obese, pregnant women to make positive healthy lifestyle changes in the antenatal period that would be sustainable after the birth.

The local workforce should have sufficient numbers of trained staff with expertise and competencies in healthy eating and/or physical activity, including weight management for women in the postnatal period. This may include midwives, health visitors, obstetricians, dietitians, GPs, nurses, midwifery assistants, support workers and those working in weight management programmes (commercial or voluntary)[18].

[18] Adapted with expert group consensus from NICE public health guidance 27, recommendations 3 and 4.

Offering a referral to women with a BMI of 30 kg/m^2 or more at the 6–8 week postnatal check for advice on healthy eating and physical activity may increase costs associated with commissioning these services. The costing report for PH27 estimates that this could apply to around 115,000 women in England (225 per 100,000 population) each year, while the cost of a referral to a weight loss programme was estimated at £56. However, since women who are obese when they become pregnant face an increased risk of complications during pregnancy and childbirth, it is expected that a reduction in obesity has the potential to result in savings from reduced adverse events in future pregnancies and likely additional benefits for her infant's health and the health of the wider family.

Commissioners may also find it helpful to refer to the NICE support for commissioning and others using the quality standard for antenatal care.

4.9 Emotional wellbeing and infant attachment

Quality statement 9:

Women have their emotional wellbeing, including their emotional attachment to their baby, assessed at each postnatal contact.

The baby's relationship with the mother (or main carer) has a significant impact on the baby's social and emotional development. In turn, the woman's ability to provide a nurturing relationship is partly dependent on her own emotional wellbeing[19]. Commissioners will need to assure themselves that there is evidence of local arrangements for women to have their emotional wellbeing, including their emotional attachment to their baby, assessed at each postnatal contact in line with NICE clinical guideline 37 (recommendation 1.2.22 [key priority for implementation] and 1.4.5). This may

[19] Emotional wellbeing. NICE PH40 defines emotional wellbeing as 'being happy and confident and not anxious or depressed'.

lead to earlier detection of problems[20,21]. Commissioners will need to ensure that referral pathways are in place and that services have sufficient capacity for women who are identified as having emotional wellbeing needs and/or emotional attachment needs to be referred for assessment and further support from local services such as health visiting, family nurse partnerships and attachment services, such as those detailed in quality statement 11.

Assessing women's emotional wellbeing at each postnatal contact is expected to increase the number of women identified with emotional wellbeing needs. Although this may lead to an increase in associated support and/or treatment costs in the short term, these costs are expected to be offset by a reduction in supporting and treating women whose symptoms would otherwise have become more severe.

4.10 Maternal health – Mental wellbeing

Quality statement 10:

Women who have transient psychological symptoms ('baby blues') that have not resolved at 10–14 days after the birth should be assessed for mental health problems[22].

Women experience emotional changes in the immediate postnatal period which usually resolve within 10–14 days after the birth. Women who are still feeling low in mood, anxious, experiencing negative thoughts or lacking

[20] Mother to baby emotional attachment. This involves the formation of a secure bond between the mother and the baby, in which mother responds sensitively and appropriately to the baby's signals, providing an environment in which the baby feels secure.

[21] Women and their babies should receive the number of postnatal contacts which are appropriate to their care needs. A postnatal contact is a scheduled postnatal appointment which may occur in the woman or baby's home or another setting such as a GP practice, children's centre or this could be a hospital setting where women and/or the baby requires extended inpatient care.

[22] NICE clinical guideline 37 recommendation 1.2.25 provides 'tearfulness, feelings of anxiety and low mood' as examples of the symptoms and signs of unresolved transient psychological symptoms.

interest in their baby at 10–14 days after the birth may be at increased risk of mental health problems. These women should receive an assessment of their mental wellbeing.

In line with NICE clinical guideline 37 (recommendation 1.2.25), commissioners should therefore specify that women are asked about resolution of symptoms of baby blues at 10–14 days after birth. Commissioners will also need to ensure that referral pathways are in place and there is sufficient expertise available for those women whose symptoms have not resolved to be assessed for postnatal depression and, if symptoms persist, to be evaluated further (urgent action).

Commissioners may wish to check that healthcare professionals consider the use of self-report measures such as the Edinburgh Postnatal Depression Scale (EPDS), Hospital Anxiety and Depression Scale (HADS) or Patient Health Questionnaire-9 (PHQ-9) as part of the subsequent assessment process.

Any increase in the number of women assessed for mental health problems is likely to increase the number of women identified with and treated for postnatal depression at an earlier stage. Costs may therefore increase in the short term, but these are likely to be offset by a reduction in the costs associated with treating women identified with postnatal depression at a later stage.

4.11 Parent-baby attachment

Quality statement 11:

Parents or main carers who have infant attachment problems receive services designed to improve their relationship with their baby.

Problems with parent-to-baby attachment may result in the baby developing emotional, psychological or behavioural issues in childhood. Commissioners should commission services for parents or main carers with infant attachment

problems that are designed to improve their relationship with their baby. Group-based parent-training programmes designed to promote emotional attachment and improve parenting skills should be available to parents who wish to access them in line with NICE clinical guideline 37 (recommendation 1.4.8).

Providing family-based interventions could improve attachment, thereby providing the building blocks for the child to develop healthy behaviours and mental wellbeing. Services will need to be sensitive to a wide range of attitudes, expectations and approaches in relation to parenting. NICE public health guidance 40 (recommendation 3) provides guidance about the types of services that may provide additional parenting support, for example a series of intensive home visits delivered by an appropriately trained nurse, baby massage and video interaction and can be considered alongside the Health Visitor Implementation Plan 2011-15. Commissioners can refer to the early implementer site NHS Blackpool and the 'Hello Baby' service, which is a 5-week course for new mothers who have had, or who have, perinatal depression or attachment difficulties with their babies. The Oxford Parent Project is a further example of a service aimed at supporting families by offering one to one support and group sessions through children's centres and GP practices.

Commissioners may also wish to consider the needs of parents of babies who are vulnerable to poor relationships with their babies who may need additional intensive support. Services should take into account the parent's first language, and this may influence the commissioning needs locally.

Setting up or expanding services designed to improve parent-baby relationships may lead to an increase in local costs for example, via additional investment in appropriately trained nurses. The costing statement for PH40 indicates that these costs will depend on existing local provision but it is possible these costs will be significant where there is currently no service provision.

5 Other useful resources

5.1 Policy documents

- Department of Health (2011) Health visitor implementation plan 2011–15: a call to action.
- Department of Health (2010) Maternity and early years: making a good start to family life.
- Department of Health (2010) Tackling health inequalities in infant and maternal health outcomes: report of the Infant Mortality National Support Team.

5.2 Useful resources

- NHS England (2012) Commissioning maternity services. A resource pack to support clinical commissioning groups.

5.3 NICE pathways

- Antenatal care
- Antenatal and postnatal mental health
- Antibiotics for early–onset neonatal infection
- Feverish illness in children
- Neonatal jaundice
- Multiple pregnancy
- Maternal and child nutrition.
- Physical activity.
- Antibiotics for early-onset neonatal infection.
- Postnatal care.
- Diet.
- Social and emotional wellbeing for children and young people.

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