

Jaundice in newborn babies under 28 days

Quality standard

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[nice.org.uk/guidance/qs57](https://www.nice.org.uk/guidance/qs57)

Contents

Introduction	4
Why this quality standard is needed	4
How this quality standard supports delivery of outcome frameworks	5
Coordinated services.....	6
List of quality statements.....	8
Quality statement 1: Information for parents or carers.....	9
Quality statement.....	9
Rationale	9
Quality measures	9
What the quality statement means for service providers, healthcare professionals and commissioners ..	10
What the quality statement means for patients and carers	10
Source guidance.....	10
Definitions of terms used in this quality statement	11
Equality and diversity considerations.....	12
Quality statement 2: Measurement of bilirubin level in babies more than 24 hours old.....	13
Quality statement.....	13
Rationale	13
Quality measures	13
What the quality statement means for service providers, healthcare professionals and commissioners ..	14
What the quality statement means for patients and carers	14
Source guidance.....	15
Definitions of terms used in this quality statement	15
Equality and diversity considerations.....	16
Quality statement 3: Management of hyperbilirubinaemia: treatment thresholds	17
Quality statement.....	17
Rationale	17
Quality measures	17

What the quality statement means for service providers, healthcare professionals and commissioners ..	18
What the quality statement means for patients and carers	18
Source guidance.....	18
Definitions of terms used in this quality statement	18
Using the quality standard.....	20
Quality measures	20
Levels of achievement	20
Using other national guidance and policy documents.....	20
Information for commissioners	20
Information for the public	21
Diversity, equality and language	22
Development sources.....	23
Evidence sources.....	23
Policy context	23
Definitions and data sources for the quality measures	23
Related NICE quality standards	24
Published	24
Future quality standards	24
Quality Standards Advisory Committee and NICE project team	25
Quality Standards Advisory Committee.....	25
NICE project team	27
About this quality standard.....	28

This standard is based on CG98 and CG37.

This standard should be read in conjunction with QS4, QS37 and QS105.

Introduction

This quality standard covers the recognition and management of neonatal jaundice in newborn babies (both term and preterm) from birth to 28 days in primary care (including community care) and secondary care. It does not cover babies with jaundice who need surgery to correct the underlying cause, or the management of conjugated hyperbilirubinaemia in babies. For more information see the [topic overview](#).

Why this quality standard is needed

Jaundice refers to the yellow colouration of the skin and the whites of the eyes caused by a raised level of bilirubin (hyperbilirubinaemia). Jaundice is one of the most common conditions needing medical attention in newborn babies; approximately 60% of term (gestational age of 37 weeks or more) and 80% of preterm babies develop jaundice in the first week of life. For most babies, this early jaundice (or 'physiological jaundice'^[1]) is not a sign of underlying disease and is generally harmless. Breastfed babies are more likely than formula-fed babies to develop physiological jaundice within the first week of life. Prolonged jaundice – that is, jaundice that lasts longer than the first 14 days of life – is also seen more commonly in these babies. Prolonged jaundice is generally harmless, but can be a sign of serious liver disease. Jaundice that develops in the first 24 hours of life can indicate underlying disease and needs urgent assessment.

Even if there is no underlying disease, unconjugated bilirubin, which is potentially toxic to neural tissue, can penetrate the blood–brain barrier. This can cause both short-term and long-term neurological dysfunction, known as bilirubin encephalopathy or kernicterus, which can have significant life-altering implications for babies and their families. The risk of kernicterus is increased in babies with particularly high bilirubin levels and for certain groups, such as preterm babies. However, kernicterus can be prevented if jaundice is identified early and treated effectively. Although neonatal jaundice is common, kernicterus is rare.

High levels of bilirubin can be controlled by placing the baby under a lamp emitting light in the blue spectrum, which is known as phototherapy. Light energy of the appropriate wavelength converts the bilirubin in the skin into a harmless form that can be excreted in the urine. Phototherapy has proved to be a safe and effective treatment for jaundice in newborn babies, reducing the need to

perform an exchange transfusion of blood (the only other means of removing bilirubin from the body).

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measureable quality improvements within a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health:

- [NHS Outcomes Framework 2014–15](#)
- Improving outcomes and supporting transparency: a public health outcomes framework for England 2013–2016, [Part 1](#) and [Part 1A](#).

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 [NHS Outcomes Framework 2014–15](#)

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	<p><i>Improvement areas</i></p> <p>Reducing deaths in babies and young children</p> <p>1.6i Infant mortality*</p> <p>1.6ii Neonatal mortality and stillbirths</p>
4 Ensuring that people have a positive experience of care	<p><i>Improvement areas</i></p> <p>Improving women and their families' experience of maternity services</p> <p>4.5 Women's experience of maternity services</p>

<p>5 Treating and caring for people in a safe environment and protecting them from avoidable harm</p>	<p><i>Improvement areas</i></p> <p>Improving the safety of maternity services</p> <p>5.5 Admission of full-term babies to neonatal care</p>
<p>Alignment across the health and social care system</p> <p>*Indicator shared with Public Health Outcomes Framework (PHOF)</p>	

Table 2 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
<p>4 Healthcare public health and preventing premature mortality</p>	<p><i>Objective</i></p> <p>Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities</p> <p><i>Indicators</i></p> <p>4.1 Infant mortality</p> <p>4.11 Emergency readmissions within 30 days of discharge from hospital</p>

Coordinated services

The quality standard for neonatal jaundice specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole neonatal jaundice care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to babies with neonatal jaundice in all settings.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality neonatal jaundice service are listed in [Related quality standards](#).

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All healthcare professionals involved in assessing, caring for and treating babies with neonatal jaundice in any setting should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard.

Role of parents and carers

Quality standards recognise the important role parents and carers have in supporting babies with neonatal jaundice. Healthcare professionals should ensure that parents and carers are involved in the decision-making process about investigations, treatment and care.

^[1] Neonatal jaundice. NICE clinical guideline 98 (2010).

List of quality statements

Statement 1. Parents or carers of newborn babies have a discussion with healthcare professionals and are given written information about neonatal jaundice within 24 hours of the birth, including what to look for and who to contact if they are concerned.

Statement 2. Babies with suspected jaundice who are more than 24 hours old have their bilirubin level measured within 6 hours of a healthcare professional suspecting jaundice or a parent or carer reporting possible jaundice.

Statement 3. Babies with hyperbilirubinaemia are started on treatment in accordance with standardised threshold tables or charts.

Quality statement 1: Information for parents or carers

Quality statement

Parents or carers of newborn babies have a discussion with healthcare professionals and are given written information about neonatal jaundice within 24 hours of the birth, including what to look for and who to contact if they are concerned.

Rationale

Early identification of neonatal jaundice is essential to ensure that babies receive appropriate treatment for either underlying disease or for hyperbilirubinaemia caused by physiological jaundice in order to prevent complications and achieve the best clinical outcomes. Advising parents or carers about what to look for and when to contact a healthcare professional will help to ensure rapid access to treatment if needed. This is particularly important in the context of early discharge from maternity units. Giving parents or carers information about neonatal jaundice will also reassure them that it is common, usually transient and harmless, and that normal feeding and normal care of the baby can usually continue (including extra support with breastfeeding). This will reduce their anxiety if their baby does develop jaundice and needs investigations or treatment. Parents or carers of newborn babies receive a large amount of information, which is why a discussion, in addition to written information, is important.

Quality measures

Structure

a) Evidence of local availability of written information about neonatal jaundice for parents or carers of newborn babies.

Data source: Local data collection.

b) Evidence of local arrangements to ensure telephone access to a relevant healthcare professional for parents or carers who are concerned about neonatal jaundice.

Data source: Local data collection.

Process

Proportion of newborn babies whose parents or carers have a discussion with healthcare

professionals and receive written information about neonatal jaundice within 24 hours of the birth, including what to look for and who to contact if they are concerned.

Numerator – the number of babies in the denominator whose parents or carers have a discussion with healthcare professionals and receive written information about neonatal jaundice within 24 hours of the birth, including what to look for and who to contact if they are concerned.

Denominator – the number of newborn babies.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers ensure the availability of written information about neonatal jaundice (including what to look for and who parents or carers can contact if they are concerned) and that healthcare professionals understand and act on the need to discuss this with parents or carers of newborn babies.

Healthcare professionals ensure that they discuss neonatal jaundice with parents or carers of newborn babies and give them written information within 24 hours of the birth, including what to look for and who to contact if they are concerned.

Commissioners ensure that they commission services in which written information on neonatal jaundice is available and there is telephone access to relevant healthcare professionals for parents or carers who are concerned about jaundice.

What the quality statement means for patients and carers

Parents or carers of newborn babies have a discussion with healthcare professionals and are given written information about jaundice within 24 hours of the baby being born. This includes information about how to check whether the baby might have jaundice, as well as who to contact if they are concerned.

Source guidance

- Neonatal jaundice (NICE clinical guideline 98), recommendation [1.1.1](#) (key priority for implementation)

- Postnatal care (NICE clinical guideline 37), recommendation [1.4.16](#)

Definitions of terms used in this quality statement

Information about neonatal jaundice

Information about neonatal jaundice should be tailored to the needs and expressed concerns of parents or carers of newborn babies. The information should be provided through discussion backed up by written information. Care should be taken to avoid causing unnecessary anxiety to parents or carers. The combination of discussion and written information should cover:

- factors that influence the development of significant hyperbilirubinaemia
- how to check the baby for jaundice (signs and symptoms to look for):
 - check the naked baby in bright and preferably natural light
 - note that examination of the sclerae, gums and blanched skin is useful across all skin tones
- who to contact if they suspect jaundice, jaundice is getting worse, or their baby is passing pale chalky stools or dark urine
- the importance of recognising jaundice in the first 24 hours and of seeking urgent medical advice
- the fact that neonatal jaundice is common, and reassurance that it is usually transient and harmless
- reassurance that support will be provided to continue with normal feeding (including extra advice and support with breastfeeding) and normal care of the baby.

[Adapted from Postnatal care ([NICE clinical guideline 37](#)) recommendation 1.4.16, Neonatal jaundice ([NICE clinical guideline 98](#)) recommendations 1.1.1 (key priority for implementation) and 1.2.5, and Postnatal care ([NICE quality standard 37](#)) statement 3]

A [neonatal jaundice parent information factsheet](#) and [information for the public about neonatal jaundice](#) are available from NICE.

Equality and diversity considerations

Information about neonatal jaundice should be accessible to parents or carers with additional needs such as physical, sensory or learning disabilities, and to parents or carers who do not speak or read English. Parents or carers of babies with neonatal jaundice in any setting should have access to an interpreter or advocate if needed.

Extra support with visual checks for jaundice in babies and checking nappies for pale stools or dark urine should be provided to parents or carers with sight impairments.

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

Quality statement 2: Measurement of bilirubin level in babies more than 24 hours old

Quality statement

Babies with suspected jaundice who are more than 24 hours old have their bilirubin level measured within 6 hours of a healthcare professional suspecting jaundice or a parent or carer reporting possible jaundice.

Rationale

Visual inspection is used to recognise jaundice but is not very good for assessing the clinical severity of the jaundice. Although bilirubin should not be measured routinely in babies who are not visibly jaundiced, measuring bilirubin levels in babies with suspected or obvious visible jaundice assesses the degree of jaundice and determines whether the baby needs further investigations or treatment. Measuring the bilirubin level as soon as possible (within 6 hours) in babies with suspected jaundice will ensure that those with rapidly rising bilirubin levels are identified promptly for treatment. Bilirubin can be measured by taking a blood sample (serum bilirubin) or, within defined circumstances (see [Definitions](#)), using a transcutaneous bilirubinometer (followed by a blood test if needed). Transcutaneous bilirubinometers, although not as accurate as measuring serum bilirubin, are more accurate than visual inspection alone, are non-invasive, can be used in the community and provide instant results.

Quality measures

Structure

Evidence of local protocols and adequate access to bilirubin measurement, to ensure that babies with suspected jaundice who are more than 24 hours old have their bilirubin level measured within 6 hours of a healthcare professional suspecting jaundice or a parent or carer reporting possible jaundice.

Data source: Local data collection.

Process

a) Proportion of babies with suspected jaundice who are more than 24 hours old who have their bilirubin level measured.

Numerator – the number of babies in the denominator having their bilirubin level measured.

Denominator – the number of babies with suspected jaundice who are more than 24 hours old.

Data source: Local data collection.

b) Proportion of babies with suspected jaundice who are more than 24 hours old who have their bilirubin level measured within 6 hours of a healthcare professional suspecting jaundice or a parent or carer reporting possible jaundice.

Numerator – the number of babies in the denominator having their bilirubin level measured within 6 hours of a healthcare professional suspecting jaundice or a parent or carer reporting possible jaundice.

Denominator – the number of babies with suspected jaundice who are more than 24 hours old who have had their bilirubin measured.

Data source: Local data collection.

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers ensure adequate access to bilirubin measurement and have local education and protocols in place that enable healthcare professionals to measure, within 6 hours, bilirubin levels in babies with suspected jaundice who are more than 24 hours old.

Healthcare professionals ensure that they measure, within 6 hours, bilirubin levels in babies with suspected jaundice who are more than 24 hours old.

Commissioners ensure that they commission services with adequate access to bilirubin measurement that enable healthcare professionals to measure, within 6 hours, bilirubin levels in babies with suspected jaundice who are more than 24 hours old.

What the quality statement means for patients and carers

Babies with suspected jaundice who are more than 24 hours old have their bilirubin level measured within 6 hours of the possible jaundice being noted (bilirubin is the substance that causes the yellow colour seen in jaundice). This may be done by a healthcare professional at the baby's home,

but it may need to be done at a hospital.

Source guidance

- Neonatal jaundice (NICE clinical guideline 98), recommendations [1.2.14](#) and [1.2.15](#) (key priority for implementation).

Definitions of terms used in this quality statement

Measurement of bilirubin level

When measuring the bilirubin level in babies more than 24 hours old:

- use a transcutaneous bilirubinometer in babies with a gestational age of 35 weeks or more (always use serum bilirubin measurement to determine the bilirubin level in babies less than 35 weeks' gestational age)
- if a transcutaneous bilirubinometer is not available, measure the serum bilirubin
- if a transcutaneous bilirubinometer measurement indicates a bilirubin level greater than 250 micromol/litre check the result by measuring the serum bilirubin
- always use serum bilirubin measurement for babies at or above the relevant treatment thresholds for their postnatal age, and for all subsequent measurements
- do not use an icterometer.

[Adapted from Neonatal jaundice ([NICE clinical guideline 98](#)) recommendation 1.2.15]

Within 6 hours

The 6-hour timeframe begins when a healthcare professional suspects jaundice or when a parent or carer reports possible jaundice.

[Expert opinion]

Transcutaneous bilirubinometer

A device that uses reflected light to measure the yellow colour (bilirubin level) in the skin.

Equality and diversity considerations

Some parents or carers may find it difficult to access postnatal care for their baby after discharge from hospital; for example, they may be unable to afford to travel to their local clinic or hospital. This quality statement focuses on the period after the initial 24 hours after birth (and so in many cases after discharge from hospital). It promotes equitable access to postnatal care by making reference to the use (where clinically indicated) of transcutaneous bilirubinometers, which can be used in the community.

Quality statement 3: Management of hyperbilirubinaemia: treatment thresholds

Quality statement

Babies with hyperbilirubinaemia are started on treatment in accordance with standardised threshold tables or charts.

Rationale

Once jaundice in babies is recognised, it is important to know when and how to treat it. Phototherapy is an effective treatment for significant hyperbilirubinaemia and can reduce the need for exchange transfusion (a procedure involving a complete changeover of blood), which is necessary only in the most severe cases. The consistent use of treatment thresholds, alongside NICE guidance, will help to ensure a balance between the thresholds being low enough to prevent complications (such as kernicterus) but not so low that phototherapy is used unnecessarily.

Quality measures

Structure

Evidence of local arrangements to ensure the use of standardised treatment threshold tables or charts when starting treatment for babies with hyperbilirubinaemia.

Data source: Local data collection.

Process

Proportion of babies identified with hyperbilirubinaemia who are started on treatment in accordance with standardised threshold tables or charts.

Numerator – the number of babies in the denominator who are started on treatment in accordance with standardised threshold tables or charts.

Denominator – the number of babies identified with hyperbilirubinaemia.

Data source: Local data collection.

Outcome

Incidence of kernicterus.

Data source: Local data collection. The ICD-10 code for Kernicterus is P57. Data available via [Hospital episode statistics \(HES\) online](#) or the [Neonatal Critical Care Minimum Data Set](#).

What the quality statement means for service providers, healthcare professionals and commissioners

Service providers ensure that healthcare professionals have access to, and are competent to use, standardised threshold tables or charts when deciding whether to start (or not start) treatment for babies with hyperbilirubinaemia.

Healthcare professionals ensure that they use standardised threshold tables or charts when deciding whether to start (or not start) treatment for babies with hyperbilirubinaemia.

Commissioners ensure that they commission services in which healthcare professionals have access to, and are competent to use, standardised threshold tables or charts when deciding whether to start (or not start) treatment for babies with hyperbilirubinaemia.

What the quality statement means for patients and carers

Babies with high levels of bilirubin receive treatment according to tables or charts that tell the healthcare team whether to start (or not start) treatment. The information used when making decisions about when to start treatment includes how high the baby's bilirubin level is, the age of the baby when the bilirubin was measured, and the baby's maturity at the time of birth (that is, how many weeks of pregnancy they were born after).

Source guidance

- Neonatal jaundice (NICE clinical guideline 98), recommendations [1.3.4](#) (key priority for implementation) and [1.2.13](#).

Definitions of terms used in this quality statement

Standardised threshold tables or charts

These are tables or charts that help healthcare professionals to implement treatment thresholds

for phototherapy and exchange transfusion in accordance with [NICE clinical guideline 98](#). These include [treatment threshold graphs](#) published on the NICE website. All tables or charts should take into account serum bilirubin level, gestational age and postnatal age.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its [Indicators for Quality Improvement Programme](#). If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's [What makes up a NICE quality standard?](#) for further information, including advice on using quality measures.

Levels of achievement

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, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in [Development sources](#).

Information for commissioners

NICE has produced [support for commissioning](#) that considers the commissioning implications and potential resource impact of this quality standard. This is available on the NICE website.

Information for the public

NICE has produced [information for the public](#) about this quality standard. Parents and carers can use it to find out about the quality of care they should expect their baby to receive, as a basis for asking questions about their baby's care, and to help make choices between providers of healthcare services.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments](#) are available.

Good communication between healthcare professionals and parents or carers of babies with neonatal jaundice is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Parents or carers of babies with neonatal jaundice in any setting should have access to an interpreter or advocate if needed.

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.

Development sources

Further explanation of the methodology used can be found in the quality standards [Process guide](#) on the NICE website.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- [Neonatal jaundice](#). NICE clinical guideline 98 (2010).
- [Postnatal care](#). NICE clinical guideline 37 (2006).

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Department of Health (2009) [Toolkit for high quality neonatal services](#).
- Department of Health (2008) [Neonatal taskforce bulletin](#).

Definitions and data sources for the quality measures

- Health and Social Care Information Centre. [Hospital episodes statistics \(HES\) online](#).
- Information Standards Board for Health and Social Care (2006) [Neonatal Critical Care Minimum Data Set](#).

Related NICE quality standards

Published

- [Postnatal care](#). NICE quality standard 37 (2013).
- [Specialist neonatal care](#). NICE quality standard 4 (2010).

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Antibiotics for neonatal infection.
- Blood transfusion in neonatology.
- Premature birth.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 4.

Membership of this committee is as follows:

Professor Damien Longson (Chair)

Associate Medical Director and Consultant Psychiatrist, Manchester Mental Health and Social Care Trust

Ms Alison Allam

Lay member

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Consultant Old Age Psychiatrist, Manchester Mental Health and Social Care Trust

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Mr Michael Varrow

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Head of Operations, Greater Manchester West Mental Health NHS Foundation Trust

The following specialist members joined the committee to develop this quality standard:

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Community Midwife, University Hospitals Leicester NHS Trust

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Lay member

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Project Manager

Jenny Harrison

Coordinator

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.

The methods and processes for developing NICE quality standards are described in the [quality standards process guide](#).

This quality standard has been incorporated into the NICE pathways for [neonatal jaundice](#) and [postnatal care](#).

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Changes after publication

April 2015: minor maintenance

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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](#)
- [Royal College of Obstetricians and Gynaecologists](#)
- [Royal College of General Practitioners](#)
- [British Association of Perinatal Medicine \(BAPM\)](#)
- [Bliss](#)
- [Royal College of Paediatrics and Child Health](#)