**NATIONAL INSTITUTE FOR HEALTH AND   
CARE EXCELLENCE**

**Quality standards**

**Briefing paper: Postnatal care (update)**

**Quality Standards Advisory Committee meeting**: 15 March 2022

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1. Introduction

This briefing paper presents a structured overview of potential quality improvement areas for postnatal care. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

This briefing paper includes a brief description of the topic, a summary of feedback on the current quality standard, and a summary of each of the suggested quality improvement areas and supporting information.

Recommendations selected from the key development source are included to help the committee in considering potential statements and measures.

* 1. Development source

The key development sources referenced in this briefing paper are:

* [Postnatal care. NICE guideline NG194](https://www.nice.org.uk/guidance/ng194) (2021)
* [Pelvic floor dysfunction: prevention and non-surgical management. NICE guideline NG210](https://www.nice.org.uk/guidance/ng210) (2021)
* [Maternal and child nutrition. NICE guideline PH11](https://www.nice.org.uk/guidance/ph11) (2008, updated 2014). This guideline is being updated and is expected to publish in 2023.

1. Overview
   1. Focus of quality standard

This quality standard covers routine postnatal care for women and their babies (and their partners and families, if appropriate) in the first 8 weeks after birth. It will update and replace the existing [NICE quality standard for postnatal care](https://www.nice.org.uk/guidance/qs37) (QS37).

* 1. Definition

Postnatal care refers to the care provided by healthcare professionals to help families adjust to their new life following the birth of a baby, and to spot and care for the families where complications arise. It is also an opportunity to promote health for any subsequent pregnancies. The postnatal period up to 8 weeks after birth has been identified as the most critical early weeks after birth.

* 1. Population

Approximately 700,000 women give birth in England and Wales each year. For women, their partners and their babies, this is a major life event that means considerable emotional and physical adjustment. This applies to all births but is perhaps most marked for those having their first child.

There have been significant societal changes that are relevant to postnatal care: women are now, on average, older when having their first baby, there is a higher prevalence of obesity, and postnatal discharge from hospital is happening increasingly early.

The [MBRRACE-UK report: saving lives, improving mothers' care (2021)](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) reported that there are higher postnatal mortality rates amongst older women and those under 20, those living in the most deprived areas and amongst women from particular ethnic minority groups. In particular, Black women had an over four‑fold difference and Asian women an almost two-fold difference in maternal mortality rates compared with white women. The [MBRRACE-UK report: perinatal mortality surveillance report (2021)](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) also highlights the higher neonatal mortality rates for babies of black and Asian ethnicity (43% higher for babies of Black and Black British ethnicity and 60% higher for babies of Asian or Asian British ethnicity compared with babies of White ethnicity) and babies born to mothers living in deprived areas (73% excess risk compared to babies born in the least deprived areas).

* 1. Current service delivery and management

Postnatal care has long been regarded as a 'Cinderella service' where in comparison with some other European countries, provision is scanty and inadequate. This approach risks missing an opportunity to have a profoundly beneficial effect on the lives of the babies and their families, now and in the future.

In a [National Childbirth Trust (NCT) survey: left to your own devices – the postnatal care experiences of 1,260 first-time mothers](https://www.nct.org.uk/sites/default/files/related_documents/Left%20to%20your%20own%20devices.pdf), 1 in 8 women were highly critical of their postnatal care. Their feedback reflects fragmentation of care, poor planning and communication between healthcare professionals, and insufficient advice about emotional recovery. Furthermore, women continue to report receiving insufficient or inconsistent information on baby's feeding, particularly after giving birth to their first baby.

The [CQC survey of women’s experiences of maternity care 2021](https://www.cqc.org.uk/publications/surveys/maternity-survey-2021) indicated that the COVID-19 pandemic had a significant impact on the way maternity care was delivered. The nature and frequency of postnatal appointments changed, with women being offered fewer appointments and often using remote consultation methods. The changes to the way services were delivered negatively affected women’s experiences of maternity care, particularly in the postnatal period. The National Perinatal Epidemiology Unit [National Maternity Survey (NMS): a national survey of health and care during the 2020 COVID-19 pandemic](https://www.npeu.ox.ac.uk/maternity-surveys) found that 52.9% of women were satisfied with the care they received after the birth of their baby compared with 76.9% in 2014.

* 1. Resource impact

We do not expect this quality standard to have a significant impact on resources. When [NICE’s guideline on Postnatal care](https://www.nice.org.uk/guidance/ng194) was developed, a resource impact statement was produced which noted that:

* the resource impact of implementing any single guideline recommendation in England will be less than £1 million per year (or £1,800 per 100,000 population) and
* the resource impact of implementing the whole guideline in England will be less than £5 million per year (or £9,000 per 100,000 population).

Postnatal care services are commissioned by clinical commissioning groups. Providers are NHS hospital trusts, community providers, primary care providers, and GPs.

1. Summary of suggestions
   1. Responses

In total 28 registered stakeholders responded to the 2-week engagement exercise.

* 25 stakeholders gave feedback on the current quality standard and/or suggested areas for quality improvement
* 3 stakeholders had no comments

6 specialist committee members gave feedback on the current quality standard and suggested areas for quality improvement

* 1. Feedback on the current quality standard

We asked stakeholders if the areas highlighted in the current [postnatal care quality standard (QS37)](https://www.nice.org.uk/guidance/qs37) are still priorities for quality improvement and asked them to respond to some specific proposals for updating the current statements as follows:

* Statement 5 on breastfeeding should be revised to make use of the updated recommendations on support for breastfeeding in the updated guideline on [postnatal care](https://www.nice.org.uk/guidance/ng194) (section 1.5)
* Statement 7 on the 6- to 8-week physical examination for babies should be removed as it overlaps with the [newborn and infant physical examination screening programme](https://www.gov.uk/government/publications/newborn-and-infant-physical-examination-programme-handbook/newborn-and-infant-physical-examination-screening-programme-handbook)
* Statement 9 on the assessment of emotional wellbeing should be removed as it is covered in statement 4 in the quality standard on [antenatal and postnatal mental health](https://www.nice.org.uk/guidance/qs115)

Stakeholders generally agreed that the areas highlighted in the current quality standard are still priorities for quality improvement. It was suggested that it is important that the quality standard covers the full scope of postnatal care to support commissioners to deliver holistic care and that it would be helpful to include links to closely related statements in other quality standards.

Table 1 summarises the feedback for individual statements, including responses to the proposals to remove statements 7 and 9.

Table 1 Feedback on current quality statements in the postnatal care QS (QS37)

|  |  |  |
| --- | --- | --- |
| **No.** | **Current statement** | **Stakeholder feedback** |
| 1 | Continuity of care- statement removed in 2021 because it was not in line with the updated guideline (focus was on a postnatal care plan) | * Concern that it has been removed as area is still a priority |
| 2 | Women are advised, at the first postnatal midwife contact, of the symptoms and signs of potentially serious conditions that require them to seek medical advice without delay. | * Statement could be better aligned with the recommendations in the updated guideline (NG194) |
| 3 | Women or main carers of babies are advised, within 24 hours of the birth, of the symptoms and signs of serious illness in the baby that require them to contact emergency services | * Statement could be better aligned with the recommendations in the updated guideline (NG194) |
| 4 | Women, their partner or main carers of babies have discussions with their healthcare professional about safer bed-sharing practices. | * Focus should be on safe sleeping |
| 5 | Women receive breastfeeding support from a service that uses an evaluated, structured programme | * There could be potential to combine the statements on infant feeding. * Agreement that the statement should be updated (details included in section 4.4) |
| 6 | Information about bottle feeding is discussed with women or main carers of formula-fed babies. | * There could be potential to combine the statements on infant feeding. |
| 7 | Babies have a complete 6‑ to 8‑week physical examination. | * Support to retain this statement although overlap with Newborn and Infant Physical Examination (NIPE) standards recognised * Important because it emphasises a shared responsibility to encourage attendance at the check * It could be removed but it is important to emphasise that it is still important. |
| 8 | Women with a body mass index (BMI) of 30 kg/m2 or more at the 6‑ to 8‑week postnatal check are offered a referral for advice on healthy eating and physical activity. | * Suggested this may be a lower priority. * There could be potential to broaden the scope to include other factors likely to influence future pregnancy outcome. |
| 9 | Women have an assessment of their emotional wellbeing, including bonding with their baby, at each postnatal contact. | * General agreement that this should not be removed. * The statement is currently vague. * There is an overlap with QS115 but the emphasis on infant mental health and wellbeing is important * Focus should be on the parent-infant relationship, including bonding and attachment and infant mental health |
| 10 | Mental wellbeing- statement removed in 2016 as covered by QS115 | * Appropriate to remove this |
| 11 | Parent-baby attachment- statement removed in 2021 because it was not in line with the updated guideline (focus was on the type of support that should be given when there are infant attachment problems). | * Unclear why this is no longer in line with the guideline |

Full details of all the responses to the questions about the current quality standard are given in appendix 2 for information.

* 1. Areas for quality improvement

The responses have been summarised in table 2 for further consideration by the committee. The table includes relevant responses from the questions on the current quality standard. We have not included the area on referral for advice on healthy eating and physical activity from the current quality standard as this was not highlighted as a priority by stakeholders.

Table 2 Summary of suggested quality improvement areas

| Area for improvement | Stakeholders |
| --- | --- |
| **Organisation and delivery of postnatal care**   * Awareness and communication * Continuity of care * Support for women with complex needs | * BPAS, BAMEHC, BC, LLLGB, SCMs, RCM, UUBFI * IHV, NCT, NHSE&I, RCM, SCMs * BC, BTA, RCM |
| **Postnatal care of the woman**   * Maternal health * Perineal care and pelvic floor health * 6-to-8-week postnatal check | * BSCAD, GPIFN, GPCPC, SCMs * GPIFN, GPCPC, NHSE&I, SCMs * GPIFN, GPCPC, NHSE&I, SCM, TBN |
| **Postnatal care of the baby**   * Symptoms and signs of illness in the baby * Physical examination * Bed sharing * Promoting emotional attachment | * SCMs, TLT * BAMEHC, BB, BTA, GPIFN, GPCPC, IHV, RCM, TBN, UUBFI * GPIFN, GPCPC, IHV, LLLGB, SCM, SCDT, TLT * BB, GPIFN, IFA, IHV, LCGB, LLLGB, NCT, NHSE&I, OPIP, PIF, RCM, SCMs, TBN, UUBFI, WBTI |
| **Supporting babies’ feeding**   * Information and support with feeding * Breastfeeding | * BSNA, BTA, IFA, IHV, LCGB, LLLGB, NHSE&I, SCMs * BB, GPIFN, GPCPC, KTF, LCGB, LLLGB, NCT, NHSE&I, RCPCH, SCMs, TBN, TLT, UUBFI, WBTI |
| **Additional areas**   * Neonatal care/infection * Mental health * Contraception after childbirth | * BB, KTF * RCM, SCM * BPAS |

Abbreviations:

* BAMEHC, BAME Health Collaborative
* BB, Better Breastfeeding
* BC, Birth Companions
* BPAS, British Pregnancy Advisory Service
* BSCAD, Beat SCAD
* BSNA, British Specialist Nutrition Association
* BTA, Birth Trauma Association
* GPCPC, GPs Championing Perinatal Care
* GPIFN, GP Infant Feeding Network
* IFA, Infant Feeding Alliance
* IHV, Institute of Health Visiting
* KTF, Kit Tarka Foundation
* LCGB, Lactation Consultants of GB
* LLLGB, La Leche League Great Britain
* NCT, National Childbirth Trust
* NHSE&I, NHS England and NHS Improvement
* OPIP, Oxford Parent Infant Project
* PIF, Parent-Infant Foundation
* RCM, Royal College of Midwives
* RCPCH, Royal College of Paediatric and Child Health
* SCDT, Scottish Cot Death Trust
* SCM, Specialist Committee Member
* TBN, The Breastfeeding Network
* TLT, The Lullaby Trust
* UUBFI, UNICEF UK Baby Friendly Initiative
* WBTI, World Breastfeeding Trends (UK)

Full details of all the suggestions provided are given in appendix 3 for information.

1. Suggested improvement areas

Section 4 presents a summary of the suggested improvement areas, with provisional recommendations that may support statement development and information on current UK practice.

* 1. Organisation and delivery of postnatal care

### Awareness and communication

Stakeholders highlighted the importance of effective communication throughout postnatal care so that women feel their opinion is valued and any concerns they have will be taken seriously by healthcare professionals. It was suggested that a failure to listen to women and their families is a contributor to poor experience and outcomes. There was concern that the COVID-19 pandemic has had a negative impact on communication with women. It was suggested that women should be offered face to face support wherever possible. Clarity on best practice when delivering virtual postnatal care is needed.

The importance of ensuring that healthcare professionals are aware of health inequalities was also highlighted. Healthcare professionals should have an awareness of different cultures so that they can help to reduce these inequalities. It was also suggested that access to interpretation services is currently variable.

#### Selected recommendations

NICE’s guideline on postnatal care (NG194):

1.1.1 When caring for a woman who has recently given birth, listen to her and be responsive to her needs and preferences.

1.1.2 Be aware that the [2020 MBRRACE-UK reports on maternal and perinatal mortality](https://www.npeu.ox.ac.uk/mbrrace-uk/reports) 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. The reports showed that:

* compared with white women (8 per 100,000), the risk of maternal death during pregnancy and up to 6 weeks after birth is:
  + 4 times higher in black women (34 per 100,000)
  + 3 times higher in mixed ethnicity women (25 per 100,000)
  + 2 times higher in Asian women (15 per 100,000; does not include Chinese women)
* the neonatal mortality rate is around 50% higher in black and Asian babies compared with white babies (17 compared with 25 per 10,000)
* women living in the most deprived areas are more than 2.5 times more likely to die compared with women living in the least deprived areas (6 compared with 15 per 100,000)
* the neonatal mortality rate increases according to the level of deprivation in the area the mother lives in, with almost twice as many babies dying in the most deprived areas compared with the least deprived areas (12 compared with 22 per 10,000).

1.1.5 When giving information about postnatal care, use clear language and tailor the timing, content and delivery of information to the woman's needs and preferences. Information should support shared decision making and be:

* provided face-to-face and supplemented by virtual discussions and written formats, for example, digital, printed, braille or Easy Read
* offered throughout the woman's care
* individualised and sensitive
* supportive and respectful
* evidence based and consistent
* translated by an appropriate interpreter to overcome language barriers.

1.1.6 Check that the woman understands the information she has been given, and how it relates to her. Provide regular opportunities for her to ask questions, and set aside enough time to discuss any concerns.

#### Current UK practice

The [CQC survey of women’s experiences of maternity care 2021](https://www.cqc.org.uk/publications/surveys/maternity-survey-2021) highlighted that:

* the proportion of women who said that they were ‘always’ treated with kindness and understanding while in hospital after the birth improved from 65% in 2013 to 76% in 2019 and decreased to 71% in 2021.
* 73% of women said the midwife or midwifery team they saw or spoke to ‘always’ took their personal circumstances into account when giving them advice, a decrease from 78% in 2019.

### Continuity of care

Stakeholders highlighted that continuity of carer is an important element within postnatal care. It helps to build relationships and improve engagement which supports improved access to care and early intervention leading to improved safety and outcomes for mothers and babies. It was suggested that continuity of carer should include midwives and health visitors.

It was also suggested that healthcare professionals, including midwives, health visitors and GPs, need to work closely together to provide seamless postnatal support and care. This should include clear and timely transfer of information so that women can receive the care they need. It was suggested that this could be in the form of a personalised postnatal care plan. There was concern that postnatal care is fragmented across different services and professional groups, with women and babies not always receiving the care and support they need in the most appropriate setting.

#### Selected recommendations

NICE’s guideline on postnatal care (NG194):

1.1.8 Ensure that there is effective and prompt communication between healthcare professionals when women transfer between services, for example, from secondary to primary care, and from midwifery to health visitor care. This should include sharing relevant 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
* the woman's 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.

1.1.9 Midwifery services should ensure that:

* the transfer of care from midwife to health visitor is clearly communicated between healthcare professionals and
* the woman or the parents are informed about the transfer of care from midwife to health visitor.

1.1.11 Before transfer from the maternity unit to community care, discuss the timing of transfer to community care with the woman, and ask her about her needs, preferences and support available.

1.1.13 Before transfer from the maternity unit to community care, or before the midwife leaves after a home birth, give women information about:

* the postnatal period and what to expect
* the importance of pelvic floor exercises
* what support is available (statutory and voluntary services)
* who to contact if any concerns arise at different stages.

1.5.9 Give breastfeeding care that is tailored to the woman's individual needs and provides:

* continuity of carer

#### Current UK practice

Continuity of midwifery care throughout antenatal, intrapartum and postnatal care is a national policy priority with rollout prioritised to tackle health inequalities. [Better Births Four Years on: A Review of Progress](https://www.england.nhs.uk/publication/better-births-four-years-on-a-review-of-progress/) reported that continuity of carer pathways had been implemented across nearly all trusts. In March 2019, 17% of women were placed on a continuity of carer pathway. The [NHS Long Term Plan](https://www.longtermplan.nhs.uk/) indicated that 35% of women should have been placed on a continuity of carer pathway by March 2020. The [CQC survey of women’s experiences of maternity care 2021](https://www.cqc.org.uk/publications/surveys/maternity-survey-2021) reported that the pandemic and subsequent national restrictions have impacted on continuity of carer, with schemes closed in some areas.

The [CQC survey](https://www.cqc.org.uk/publications/surveys/maternity-survey-2021) found that:

* 30% of women said they spoke to the same midwife at every postnatal check-up, compared with 28% in 2019.
* 11% of women said that at least one of the midwives who cared for them postnatally had also been involved in both their labour and antenatal care, up from 9% in 2019.
* 74% of women said that the midwife or midwifery team they saw or spoke to appeared to be aware of the medical history of them and their baby, down from 77% in 2019.

The National Perinatal Epidemiology Unit [National Maternity Survey (NMS): a national survey of health and care during the 2020 COVID-19 pandemic](https://www.npeu.ox.ac.uk/maternity-surveys) found that:

* More women reported that they had a named midwife or clinical team they could contact after giving birth (82% versus 77% in the 2014 NMS).
* The proportion of women who had contact with midwives who they did not know during the postnatal period increased between the 2014 NMS (40.3%) and the 2020 NMS (50.4%).

### Support for women with complex needs

Stakeholders indicated that more postnatal support, including specialist support, is needed for women with complex needs and those experiencing complex social factors such as housing problems, poverty, mental health problems, domestic abuse, sex work, language issues and asylum, immigration or trafficking. This should include women whose baby is removed into local authority care.

#### Selected recommendations

NICE’s guideline on postnatal care (NG194):

1.1.7 Follow the principles in the [NICE guideline on pregnancy and complex social factors](https://www.nice.org.uk/guidance/cg110) for women who may need additional support, for example:

* women who misuse substances
* recent migrants, asylum seekers or refugees, or women who have difficulty reading or speaking English
* young women aged under 20
* women who experience domestic abuse.

#### Current UK practice

The [CQC survey of women’s experiences of maternity care 2021](https://nhssurveys.org/https:/www.cqc.org.uk/publications/surveys/maternity-survey-2021surveys/survey/04-maternity/year/2021/) indicated that women with a mental health condition reported poorer than average experiences with postnatal care.

### Issues for consideration

**For discussion:**

* Continuity of carer is only specified for breastfeeding support in the guideline. Is a focus on providing continuity during transfer of care sufficient?
* Can we address some of the issues raised in the equality considerations for statements that are progressed?
* What is the priority for improvement?
* What is the key action that will lead to improvement?
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Postnatal care of the woman

Maternal health

Assessment of the woman’s physical and mental health at each postnatal contact to ensure they receive the care they may need, was identified as a priority. There was a concern to ensure that potentially serious conditions, such as cardiac conditions, birth trauma and mental health conditions are identified as quickly as possible to prevent mortality. The importance of giving women information about potentially serious conditions so that they can seek help as quickly as possible, was recognised.

#### Selected recommendations

NICE’s guideline on postnatal care (NG194):

1.2.1 At each postnatal contact, ask the woman about her general health and whether she has any concerns, and assess her general wellbeing. Discuss topics that may be affecting her daily life, and provide information, reassurance and further care as appropriate. Topics to discuss may include:

* the postnatal period and what to expect
* 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.

1.2.2 At each postnatal contact, assess the woman's psychological and emotional wellbeing. If there are concerns, arrange for further assessment and follow up.

1.2.3 At each postnatal contact by a midwife, assess the woman's physical health, including the following:

* for all women:
  + symptoms and signs of infection
  + pain
  + vaginal discharge and bleeding (see the section on postpartum 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 (see the section on perineal health)
* for women who have had a caesarean section:
  + wound healing
  + symptoms of wound infection.

1.2.4 At the first postnatal midwife contact, inform the woman that the following are symptoms or signs of potentially serious conditions, and she should seek medical advice without delay if any of these occur:

* sudden or very heavy vaginal bleeding, or persistent or increased vaginal bleeding, which could indicate retained placental tissue or endometritis
* abdominal, pelvic or perineal pain, fever, shivering, or vaginal discharge with an unpleasant smell, which could indicate infection
* leg swelling and tenderness, or shortness of breath, which could indicate venous thromboembolism
* chest pain, which could indicate venous thromboembolism or cardiac problems
* persistent or severe headache, which could indicate hypertension, pre‑eclampsia, postdural-puncture headache, migraine, intracranial pathology or infection
* worsening reddening and swelling of breasts persisting for more than 24 hours despite self-management, which could indicate mastitis
* symptoms or signs of potentially serious conditions that do not respond to treatment.

1.2.5 At each postnatal contact, give the woman the opportunity to talk about her birth experience, and provide information about relevant support and birth reflection services, if appropriate.

1.2.6 All healthcare professionals should ensure appropriate referral if there are concerns about the woman's health.

#### Current quality statements

NICE’s quality standard on postnatal care (QS124), statement 2:

Women are advised, at the first postnatal midwife contact, of the symptoms and signs of potentially serious conditions that require them to seek medical advice without delay.

NICE’s quality standard on antenatal and postnatal mental health (QS115), statement 4:

Women are asked about their emotional wellbeing at each routine antenatal and postnatal contact.

#### Current UK practice

The [CQC survey of women’s experiences of maternity care 2021](https://nhssurveys.org/surveys/survey/04-maternity/year/2021/) highlighted that:

* less than half of women (47%) were ‘definitely’ given information about their own physical recovery after the birth, down from 54% in 2019.
* 95% of women said that a midwife or health visitor asked them about their mental health postnatally when they were visited at home or seen in a clinic, the same as 2019.
* 56% of women said they ‘definitely’ were given information about any changes they might experience to their mental health after having their baby, down from 63% in 2019. More than a quarter (29%, up from 25% in 2019) only received this information ‘to some extent’ and 15%, up from 12% in 2019, said they did not receive this information.
* 79% of respondents were told who to contact if they needed advice about any changes to their mental health after the birth, which is consistent with data from 2019 (80%).

Perineal care and pelvic floor health

Stakeholders highlighted the importance of routine perineal care and promotion of pelvic floor health to avoid pain, incontinence and sexual dysfunction which can impact on mental health and infant feeding. It was suggested that perineal care is poorly undertaken and referral for support is often delayed. A focus on same-day referral to a specialist for wound breakdown and assessment of perineal pain was suggested.

It was highlighted that the [NHS Long Term Plan](https://www.longtermplan.nhs.uk/) included improved access to postnatal physiotherapy via referral to multidisciplinary pelvic health clinics to support women who need it to recover from birth.

#### Selected recommendations

NICE’s guideline on postnatal care (NG194):

1.1.13, 1.2.1, 1.2.3, 1.2.4 See previous section.

1.2.15 At each postnatal contact, as part of assessing perineal wound healing, ask the woman if she has any concerns and ask about:

* pain not resolving or worsening
* increasing need for pain relief
* discharge that has a strong or unpleasant smell
* swelling
* wound breakdown.

1.2.18 If the woman or the healthcare professional has concerns about perineal healing or if the woman asks for reassurance, offer or arrange an examination of the perineum by a midwife or a doctor.

1.2.20 If the perineal wound breaks down or there are ongoing healing concerns, refer the woman urgently to specialist maternity services (to be seen the same day in the case of a perineal wound breakdown).

1.2.21 Be aware that perineal pain that persists or gets worse within the first few weeks after the birth may be associated with symptoms of depression, long-term perineal pain, problems with daily functioning and psychosexual difficulties.

NICE’s guideline on pelvic floor dysfunction:

1.1.6 For women using maternity services, include information on pelvic floor dysfunction, how to prevent it, the symptoms, and how to access local services:

* in the booking information pack or patient portal
* at all midwife consultations and reviews
* at all consultations with an obstetrician
* in hospital postnatal wards.

1.1.7 Health visitors, midwives and GPs should discuss pelvic floor dysfunction with women at each postnatal contact.

1.3.11 Encourage women who are pregnant or who have recently given birth to do pelvic floor muscle training, and explain that it helps prevent symptoms of pelvic floor dysfunction.

1.3.13 Before discharging women from maternity services, and during routine postnatal care, encourage them to do pelvic floor muscle training.

#### Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

Postnatal check

Stakeholders highlighted the importance of a 6-to-8-week postnatal check carried out by a GP for all women. It was suggested that there is currently variation in the provision of these checks and some groups of women are much less likely to receive them. It was suggested that the postnatal check for women could be combined with the 6-to-8-week physical examination for babies (see section 4.3).

#### Selected recommendations

NICE’s guideline on postnatal care (NG194):

1.2.7 At 6 to 8 weeks after the birth, a GP should:

* carry out an assessment including the points in recommendations 1.2.1 to 1.2.5 and taking into account the time since the birth
* respond to any concerns, which may include referral to specialist services in either secondary care or other healthcare services such as physiotherapy.

#### Current UK practice

The National Perinatal Epidemiology Unit [National Maternity Survey (NMS): a national survey of health and care during the 2020 COVID-19 pandemic](https://www.npeu.ox.ac.uk/maternity-surveys) indicated that 84.1% of women had a postnatal check at their GP surgery, compared with 90.6% in 2018.

An [observational study of the provision of the maternal 6-week check in primary care in England 2015-18](https://jech.bmj.com/content/76/3/239) based on 34337 primary care records from the Clinical Practice Research Datalink, indicated that 89% of women saw a GP in the first 12 weeks post-partum. Sixty-two per cent of women had a 6-week check recorded, and a further 27% had consultations not classified as a 6-week check. Overall, 40% of women had a 6-week check at the recommended 6–8 weeks. Younger women, women who gave birth preterm or who were served by practices in more deprived areas were more likely to have a late or no 6-week check.

The [CQC survey of women’s experiences of maternity care 2021](https://www.cqc.org.uk/publications/surveys/maternity-survey-2021) highlighted that:

* 36% of women who had had a postnatal check said their GP ‘definitely’ spent enough time talking to them about their own physical health, down from 42% in 2019. Twenty-nine per cent said this happened ‘to some extent’, with over a third (35%, up from 29% in 2019) saying their GP did not spend enough time talking to them about their own physical health.
* 32% said the GP did not spend enough time talking to them about their own mental health, up from 30% in 2019.

The [National Childbirth Trust](https://www.nct.org.uk/about-us/media/news/nct-finds-quarter-new-mothers-are-not-asked-about-their-mental-health) highlighted that in a survey of 893 mothers in England in March 2021, 25% were not asked about their emotional or mental health at their 6 week routine GP check-up. 85% of mothers said the appointment was focused mainly or equally on the baby’s health and 15% had an appointment that was focused on their own health and wellbeing.

NHS England and Improvement introduced a requirement for GPs to lead the postnatal checks for all women in the 20/21 GP contract, at an additional cost of £12m p/a. NHS England and Improvement’s response to topic engagement indicated that there is some concern that this may not have had the impact expected.

Issues for consideration

**For discussion:**

* Is it helpful to combine the GP postnatal check for women and babies?
* What is the priority for improvement?
* What is the key action that will lead to improvement?
* Could we focus on a specific audience or setting?
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Postnatal care of the baby

Symptoms and signs of illness in babies

Stakeholders emphasised the importance of ensuring that families know when their baby may be seriously ill so that they can get help as soon as possible. It was suggested that it would be helpful to give families advice on assessing the baby’s wellbeing including the BabyCheck system and advice on using devices such as baby monitors. The importance of ensuring that healthcare professionals listen to parents’ concerns and holistically assess signs and symptoms at an early stage was highlighted.

#### Selected recommendations

NICE’s guideline on postnatal care (NG194):

1.3.1 At each postnatal contact, ask parents if they have any concerns about their baby's general wellbeing, feeding or development. Review the history and assess the baby's health, including physical inspection and observation. If there are any concerns, take appropriate further action.

1.3.2 Be aware that if the baby has not passed meconium within 24 hours of birth, this may indicate a serious disorder and requires medical advice.

1.3.10 Give parents information about:

* how to recognise if the baby is unwell, and how to seek help

1.3.11 Consider giving parents information about the Baby Check scoring system and how it may help them to decide whether to seek advice from a healthcare professional if they think their baby might be unwell.

1.3.12 Advise parents to seek advice from a healthcare professional if they think their baby is unwell, and to contact emergency services (call 999) if they think their baby is seriously ill.

1.4.1 Listen carefully to parents' concerns about their baby's health and treat their concerns as an important indicator of possible serious illness in their baby.

1.4.2 Healthcare professionals should consider using the Baby Check scoring system:

* to supplement the clinical assessment of babies for possible illness, particularly as part of a remote assessment and
* as a communication aid in conversations with parents to help them describe the baby's condition.

1.4.7 Be aware of the possible significance of a change in the baby's behaviour or symptoms, such as refusing feeds or a change in the level of responsiveness.

1.4.8 Be aware 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.

1.4.9 Recognise the following as 'red flags' for serious illness in young babies:

* appearing ill to a healthcare professional
* appearing pale, ashen, mottled or blue (cyanosis)
* 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/minute)
* chest indrawing
* temperature of 38°C or over 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).

1.4.10 If a baby is thought to be seriously unwell based on a 'red flag' (see recommendation 1.4.9) or on an overall assessment of their condition, arrange an immediate assessment with an appropriate emergency service. If the baby's condition is immediately life-threatening, dial 999.

#### Current quality statements

NICE’s quality standard on postnatal care (QS124), statement 3:

Women or main carers of babies are advised, within 24 hours of the birth, of the symptoms and signs of serious illness in the baby that require them to contact emergency services.

#### Current UK practice

The [CQC survey of women’s experiences of maternity care 2021](https://nhssurveys.org/surveys/survey/04-maternity/year/2021/) highlighted that there was a decline in the proportion of women who said that in the six weeks after the birth of their baby, they ‘definitely’ received help and advice from health professionals about their baby’s health and progress, if they needed this, from 71% in 2019 to 60% in 2021.

Physical examination

Stakeholders highlighted that the 6-to-8-week physical examination for babies is a priority to ensure any health problems are addressed as quickly as possible. It needs to be clear if this is just the GP check at 8 weeks or if the health visitor developmental check at 6-to-8 weeks is also included. The importance of a holistic approach was emphasised to ensure related issues are identified. It was recognised that the GP check is part of the national newborn screening programme, but it is important to emphasise that all healthcare professionals should promote the programme and encourage attendance. It was suggested that this area could be combined with the GP postnatal check for women.

#### Selected recommendations

NICE’s guideline on postnatal care (NG194):

1.3.3 Carry out a complete examination of the baby within 72 hours of the birth and at 6 to 8 weeks after the birth (see the [Public Health England newborn and infant physical examination [NIPE] screening programme](https://www.gov.uk/government/publications/newborn-and-infant-physical-examination-programme-handbook/newborn-and-infant-physical-examination-screening-programme-handbook)). This should include checking the baby's:

* appearance, including colour, breathing, behaviour, activity and posture
* head (including fontanelles), face, nose, mouth (including palate), ears, neck and general symmetry of head and facial features
* eyes: opacities, red reflex and colour of sclera
* neck and clavicles, limbs, hands, feet and digits; assess proportions and symmetry
* heart: position, heart rate, rhythm and sounds, murmurs and femoral pulse volume
* lungs: respiratory effort, rate and lung sounds
* abdomen: assess shape and palpate to identify any organomegaly; check condition of umbilical cord
* genitalia and anus: completeness and patency and undescended testes in boys
* spine: inspect and palpate bony structures and check integrity of the skin
* skin: colour and texture as well as any birthmarks or rashes
* central nervous system: tone, behaviour, movements and posture; check newborn reflexes only if concerned
* hips: symmetry of the limbs, Barlow and Ortolani's manoeuvres
* cry: assess sound.

1.3.4 At 6 to 8 weeks, assess the baby's social smiling and visual fixing and following.

1.3.5 Measure weight and head circumference of babies in the first week and around 8 weeks, and at other times only if there are concerns. Plot the results on the growth chart.

#### Current quality statements

NICE’s quality standard on postnatal care (QS124), statement 7:

Babies have a complete 6‑ to 8‑week physical examination.

#### Current UK practice

The infant examination carried out by GPs at 6 to 8 weeks after birth is not formally managed as part of the [national newborn and infant physical examination (NIPE) screening programme](https://www.gov.uk/government/publications/newborn-and-infant-physical-examination-programme-handbook/newborn-and-infant-physical-examination-screening-programme-handbook) and there are no national standards for it. Local commissioners are expected to provide scrutiny to oversee this part of the examination.

Bed sharing

Stakeholders highlighted that as bed-sharing is common practice for some families and may support breastfeeding, it is important to raise awareness so that they can avoid higher-risk bed sharing with their baby. There was some support for a focus on advice on how to bed share safely. Others suggested that the focus should be on situations when it is strongly advised not to bed share. A broader focus on safer sleeping rather than just bed sharing was also suggested.

There was some concern that the recommendations in the guideline are not based on all the available evidence and in particular do not reflect the risk to young babies under 12 weeks.

#### Selected recommendations

NICE’s guideline on postnatal care (NG194):

1.3.13 Discuss with parents 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.

1.3.14 Strongly advise parents 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.

#### Current quality statements

NICE’s quality standard on postnatal care (QS124), statement 7:

Women, their partner or main carers of babies have discussions with their healthcare professional about safer bed-sharing practices.

#### Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

Promoting emotional attachment

Stakeholders highlighted the importance of supporting parent-baby relationships and infant mental health, wellbeing and development by promoting emotional attachment. Timely support can promote positive parent-infant interactions, strengthen relationships and overcome the impact of any early trauma. It is important that any issues are identified, and families are given the support they may need. This should include advice on how to cope with a crying baby. It is important to involve partners and other family members.

A stakeholder also suggested that bonding and attachment should not be included as support from healthcare professionals can be intrusive and unhelpful.

#### Selected recommendations

NICE’s guideline on postnatal care (NG194):

1.3.15 Before and after the birth, discuss the importance of bonding and emotional attachment with parents, and the approaches that can help them to bond with their baby.

1.3.16 Encourage parents to value the time they spend with their baby as a way of promoting emotional attachment, including:

* face-to-face interaction
* skin-to-skin contact
* responding appropriately to the baby's cues.

1.3.17 Discuss with parents the potentially challenging aspects of the postnatal period that may affect bonding and emotional attachment, including:

* the woman's physical and emotional recovery from birth
* experience of a traumatic birth or birth complications
* fatigue and sleep deprivation
* feeding concerns
* demands of parenthood.

1.3.18 Recognise that additional support in bonding and emotional attachment may be needed by some parents who, for example:

* have been through the care system
* have experienced adverse childhood events
* have experienced a traumatic birth
* have complex psychosocial needs.

#### Current quality statements

NICE’s quality standard on postnatal care (QS124), statement 9:

Women have an assessment of their emotional wellbeing, including bonding with their baby, at each postnatal contact.

#### Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

Issues for consideration

**For discussion:**

* How have the updated recommendations on bed sharing been received in practice?
* What is the priority for improvement?
* What is the key action that will lead to improvement?
* Could we focus on a specific audience or setting?
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Supporting babies’ feeding

Information and support with feeding

Stakeholders indicated that women should be given information about all feeding methods before and after the birth to support informed decision making. All women and their partners should then be given the information and support they need to feed their baby regardless of their choice of method. This should include face to face support for all methods. It is important to recognise that many families choose a combination approach to feeding their baby. It was suggested that the focus should be on feeding babies and infant nutrition rather than specific feeding methods.

#### Selected recommendations

NICE’s guideline on postnatal care (NG194):

1.5.1 When discussing babies' feeding, follow the recommendations in the section on principles of care, and:

* acknowledge the parents' emotional, social, financial and environmental concerns about feeding options
* be respectful of parents' choices.

1.5.2 Before and after the birth, discuss breastfeeding and provide information and breastfeeding support. Topics to discuss may include:

* nutritional benefits for the baby
* health benefits for both the baby and the woman
* how it can have benefits even if only done for a short time
* how it can soothe and comfort the baby.

1.5.3 Give information about how the partner can support the woman to breastfeed, including:

* the value of their involvement and support
* how they can comfort and bond with the baby

1.5.9 Give breastfeeding care that is tailored to the woman's individual needs and provides:

* face-to-face support
* written, digital or telephone information to supplement (but not replace) face-to-face support
* continuity of carer
* information about what to do and who to contact if she needs additional support
* information for partners about breastfeeding and how best to support breastfeeding women, taking into account the woman's preferences about the partner's involvement
* information about opportunities for peer support.

1.5.10 Make face-to-face breastfeeding support integral to the standard postnatal contacts for women who breastfeed. Continue this until breastfeeding is established and any problems have been addressed.

1.5.12 Provide information, advice and reassurance about breastfeeding, so women (and their partners) know what to expect, and when and how to seek help. Topics to discuss include:

* 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 so the woman knows her baby is getting enough milk (it is not possible to overfeed a breastfed baby; see also recommendation 1.5.14)
* 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
* normal breast changes during pregnancy and 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 (also see the NICE guideline on faltering growth)
* how breastfeeding can affect the woman's 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.

1.5.16 Before and after the birth, discuss formula feeding with parents who are considering or who need to formula feed, taking into account that babies may be partially formula fed alongside breastfeeding or expressed breast milk.

1.5.17 Information about formula feeding should include:

* the differences between breast milk and formula milk
* that first infant formula is the only formula milk that babies need in the 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 women who are 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.

1.5.18 For parents who formula feed:

* have a one-to-one discussion about safe formula feeding
* provide face-to-face support
* provide written, digital or telephone information to supplement (but not replace) face-to-face support.

1.5.19 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), 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.

1.5.20 For parents who are thinking about supplementing breastfeeding with formula or changing from breastfeeding to formula feeding, support them to make an informed decision.

#### Current quality statements

NICE’s quality standard on postnatal care (QS124), statement 6:

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

#### Current UK practice

The [CQC survey of women’s experiences of maternity care 2021](https://www.cqc.org.uk/publications/surveys/maternity-survey-2021) highlighted that:

* The proportion of women to say that during their pregnancy midwives ‘definitely’ provided relevant information about feeding their baby decreased from 57% in 2019 to 52% in 2021.
* 82% of women indicated that their decisions about how they wanted to feed their baby were respected by midwives, compared with 85% in 2019. Women who fed their baby with breast milk (or expressed breast milk) only in the first few days after the birth were more likely to say that their decisions about how they wanted to feed their baby were ‘always’ respected by midwives (59%) compared with women who fed their baby both breast and formula (21%) or formula only (21%).
* 63% of women reported that midwives and other health professionals ‘always’ gave them active support and encouragement with feeding their baby, compared with 69% in 2019.
* Fifty-five per cent of women who needed it said that in the six weeks after the birth of their baby, they ‘definitely’ received help and advice from a midwife or health visitor about feeding their baby, down from 62% in 2019.
* Less than half of women (48%) were ‘always’ able to get support or advice about feeding their baby during evenings, nights or weekends if they needed it.

Breastfeeding

Stakeholders suggested that an evaluated, structured programme for breastfeeding support is important, although some felt that the requirements need to be clearer. It was suggested that the emphasis on evaluation by the UNICEF Baby Friendly Initiative (BFI) should be clearer. A well-integrated system of evidence-based support with co-ordinated commissioning across the NHS and local authorities with clear referral pathways between individual services was highlighted as a priority. It was suggested that access to specialist support is currently limited but should be included. It is important to reflect that the BFI has been updated since 2013. A stakeholder suggested that the BFI may not be an appropriate minimum standard for breastfeeding support.

Several stakeholders highlighted breastfeeding assessment and support within 24 hours of birth and again within the first week after birth as a specific priority. Other issues identified for breastfeeding support were highlighted as follows:

* Face to face support
* Involving partners
* Information provision
* Continuity of care
* When to seek help with breast and feeding problems
* Safe prescribing for breastfeeding women, particularly those with mental health conditions.

#### Selected recommendations

NICE’s guideline on maternal and child nutrition (PH11):

1 Professional bodies should ensure health professionals have the appropriate knowledge and skills to give advice on the following:

* + breastfeeding management, using the Baby Friendly Initiative (BFI) training as a minimum standard ([www.babyfriendly.org.uk](http://www.babyfriendly.org.uk))
* As part of their continuing professional development, train midwives, health visitors and support workers in breastfeeding management, using BFI training as a minimum standard.
* As part of their continuing professional development, train health professionals, including doctors, dietitians and pharmacists, to promote and support breastfeeding, using BFI training as a minimum standard.

7 Adopt a multifaceted approach or a coordinated programme of interventions across different settings to increase breastfeeding rates. It should include:

* + activities to raise awareness of the benefits of – and how to overcome the barriers to – breastfeeding
  + training for health professionals
  + breastfeeding peer‑support programmes
  + joint working between health professionals and peer supporters
  + education and information for pregnant women on how to breastfeed, followed by proactive support during the postnatal period (the support may be provided by a volunteer).
* Implement a structured programme that encourages breastfeeding, using BFI as a minimum standard. The programme should be subject to external evaluation.
* Ensure there is a written, audited and well‑publicised breastfeeding policy that includes training for staff and support for those staff who may be breastfeeding. Identify a health professional responsible for implementing this policy.

NICE’s guideline on postnatal care (NG194):

1.5.2, 1.5.3, 1.5.9, 1.5.10 and 1.5.12 See previous section

1.5.13 A practitioner with skills and competencies in breastfeeding support should assess breastfeeding to identify and address any concerns.

1.5.14 As part of the breastfeeding assessment:

* 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 woman's breasts and nipples
* observe a feed within the first 24 hours after the birth, and at least 1 other feed within the first week.

#### Current quality statements

NICE’s quality standard on postnatal care (QS124), statement 5 (also statement 4 in NICE’s quality standard on maternal and child nutrition (QS98):

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

#### Current UK practice

[NHS Digital’s Maternity Services Data set](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics) indicates that in 2020-21 72.7% of baby’s had a first feed of breast milk.

[The Office for Health Improvement and Disparities experimental statistics 2020 to 2021](https://www.gov.uk/government/statistics/breastfeeding-at-6-to-8-weeks-after-birth-annual-data-2020-to-2021) indicate that there was a breastfeeding rate of 47.6% at 6 to 8 weeks after birth. Breastfeeding prevalence ranged from 23.1 to 88.6% across 65 LA’s where suitable data was provided.

The [NHS Long Term Plan](https://www.longtermplan.nhs.uk/) included a commitment for all maternity services to be accredited through a process such as UNICEF’s Baby Friendly Initiative by 2023/24. [UNICEF accreditation statistics](https://www.unicef.org.uk/babyfriendly/about/accreditation-statistics-and-awards-table-2/) indicate that in January 2022 43% of maternity services and 67% of health visiting services were fully accredited and 95% of maternity services and 91% of health visiting services were working towards Baby Friendly accreditation. NHS England and Improvement’s response to topic engagement indicated that some services have struggled to maintain their accreditation during the COVID-19 pandemic due to staffing pressures.

The National Perinatal Epidemiology Unit [National Maternity Survey (NMS): a national survey of health and care during the 2020 COVID-19 pandemic](https://www.npeu.ox.ac.uk/maternity-surveys) indicated that 46.2% of women would have liked more help with breastfeeding their baby compared with 30.4% in 2018.

Issues for consideration

**For discussion:**

* Do we need to focus separately on breastfeeding and formula feeding?
* Do we need a more specific statement on breastfeeding given that an evaluated, structured programme is already included in the quality standard on maternal and child nutrition (QS98)?
* What is the priority for improvement?
* What is the key action that will lead to improvement?
* Could we focus on a specific audience or setting?
* Can we develop a specific, measurable statement?

**For decision:**

* Should this area be prioritised for inclusion in the quality standard?
  1. Additional areas

### Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However, they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or need further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the Advisory Committee meeting.

Table 3 Summary of information available for additional areas

| Suggested area for improvement | Within remit of NICE QS | In scope | Guideline recs | Relevant  existing QS |
| --- | --- | --- | --- | --- |
| Neonatal care/infection | Yes | No | Yes | Yes |
| Mental health | Yes | No | Yes | Yes |
| Contraception after childbirth | Yes | No | Yes | Yes |

### Neonatal care/infection

Stakeholders suggested a number of areas relating to neonatal care including:

* feeding for pre-term babies on transfer to the community
* information on how to reduce neonatal infection
* transitional care for term babies with a focus on the Avoiding Term Admissions into Neonatal Care (ATAIN) standards.

These suggestions have not been progressed within this quality standard as they overlap with other quality standards on [neonatal infection](https://www.nice.org.uk/guidance/qs75) (QS75), [intrapartum care](https://www.nice.org.uk/guidance/qs105) (QS105) and [developmental follow-up of children and young people born preterm](https://www.nice.org.uk/guidance/qs169) (QS169).

### Mental health

Stakeholders suggested that improved access to postnatal mental health support is a priority for quality improvement. This suggestion has not been progressed within this quality standard as it is included with the quality standard on [antenatal and postnatal mental health](https://www.nice.org.uk/guidance/qs115) (QS115).

### Contraception after childbirth

A stakeholder suggested that contraception after childbirth is a priority for quality improvement. This suggestion has not been progressed within this quality standard as it is included in the quality standard on [contraception](https://www.nice.org.uk/guidance/qs129) (QS129).

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# Appendix 1: Responses to NICE questions on current QS from registered stakeholders

| ID | Stakeholder | NICE question on current QS | Stakeholder comments | Supporting information |
| --- | --- | --- | --- | --- |
| **Question 1- Still priorities?** | | | | |
| 1 | BAME Health Collaborative | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | We agree all the areas consider are priority areas. We recommend considering language barrier, cultural beliefs and practices and family centred approach instead of mother and baby-centred approach |  |
| 2 | Beat SCAD | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | Yes, particularly QS 1 (Continuity of Care) and 2 (Maternal Health – potentially serious conditions) |  |
| 3 | Better Breastfeeding | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | Yes they are all still important priorities. |  |
| 4 | Birth Trauma Association | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | Agree they are still priorities |  |
| 5 | British Specialist Nutrition Association | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | BSNA would like to highlight additional priorities for quality improvement which are outlined in our comments below. |  |
| 6 | GP Infant Feeding Network | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | Yes |  |
| 7 | GPCPC (GPs championing perinatal care) | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | Yes, we agree |  |
| 8 | Institute of Health Visiting (iHV) | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | The iHV is in agreement that all the areas highlighted in the current postnatal care standard (QS37) should remain priorities for quality improvement to support improving health outcomes for babies.  England has widening health inequalities and poor infant mortality rates when compared to other European countries. The UK is fifth from bottom among 27 European countries for infant mortality (under one year of age). Infant mortality in England stalled between 2013 and 2018 at 3.9 per 1,000 livebirths, with a slight rise in 2017 to 4.0. In England and Wales infant mortality is more than twice as high in the most deprived areas compared with the least deprived areas. | Royal College of Paediatrics and Child Health (2020) State of Child Health. London: RCPCH (available at: <https://stateofchildhealth.rcpch.ac.uk>)  Maternity inequalities (race/ poverty/ access to healthcare for minorities or 'hard to reach' groups) are also linked to poor pregnancy outcomes MBBRACE <https://www.npeu.ox.ac.uk/mbrrace-uk> |
| 9 | La Leche League Great Britain | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | Yes. Lactation education, support and information remains an essential part of all health care staff knowledge. |  |
| 10 | Lactation Consultants of Great Britain | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | Yes |  |
| 11 | National Childbirth Trust (NCT) | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | Statement 1 has been removed but the reasoning has not been fully articulated beyond stating it is no longer in line with NICE guidance. Continuity of care (CoC) is a strong theme of national maternity policy and whilst the focus is on ante- and intrapartum CoC it should extend to the postnatal period. Given that there are continued discussions/concerns about the implementation of the continuity of care model, this should remain a priority for quality improvement.  We agree that statements 2-8 should remain a priority. We also agree that quality statement 10 should be removed as it is addressed in the Quality Standard on antenatal and postnatal mental health [QS115].  We do not support the removal of statement 9, as explained in our answer to question 4 below, and remain unclear as to how statement 11 is no longer in line with NICE guidance. |  |
| 12 | Parent-Infant Foundation | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | We strongly believe that Statement 9 should still be a priority. |  |
| 13 | Royal College of Midwives | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | Yes, the current quality standards are still priorities for quality improvement. Continuity of care (statement 1) is a priority and should be included, there is strong evidence to support midwifery continuity of care such models include continuity of care postnatally.  RCM (2019) [Midwifery Continuity of Carer (MCOC) Position Statement.](https://www.rcm.org.uk/media/2946/midwifery-continuity-of-carer-mcoc.pdf) |  |
| 14 | Royal College of Paediatric and Child Health (RCPCH) | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | Yes agree on the areas suggested |  |
| 15 | SCM1 | Are the areas highlighted in the current postnatal care quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | Yes |  |
| 16 | SCM2 | Are the areas highlighted in the current postnatal care quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | QS 4 should be “safe sleeping” and “preventing Sudden Infant Death Syndrome” SIDS rather than “bed sharing”. This appears to promote co-sharing. This can be included in safe sleeping and how to “co-share” safely. NB lots of SIDS with dads on sofas!  We are using lullaby Trust information for parents to raise awareness of SIDS  5 key priorities have been identified below  Breastfeeding and formula feeding could come under same QS as infant nutrition  Maternal mental Health and Bonding and attachment could come under same QS |  |
| 17 | SCM3 | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | Yes, however, it would be helpful to align the terminology of the QS to the current recommendations, particularly for QS 2 and 3. The current guideline refers to “Symptoms and signs of illness in babies”, offers more tools and provides a more holistic view of observing signs and symptoms of any illness rather than a serious illness in babies.  It would be helpful to include another QS around the organisation and delivery of postnatal care, as this is an area that will improve the quality of care provision significantly.  There should be a QS around perineal health as this is a new section in the guideline and it also features in the NHS Long-term plan as a priority area for maternity provides |  |
| 18 | SCM4 | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | I cannot comment on standards for mothers, but consider the existing standards for babies to remain important |  |
| 19 | SCM5 | Are the areas highlighted in the current postnatal care quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no  longer consider to be priorities and why? | I would recommend widening the scope of quality standard 8 to simultaneously address other parameters which influence future pregnancy outcome and are included in this document  <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942474/Maternity_high_impact_area_1_Improving_planning_and_preparation_for_pregnancy.pdf> |  |
| 20 | SCM6 | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | The current priorities are still areas for quality improvement. QS 8 – maternal health weight management would rank lower on the list of priorities. Feedback from our members would suggest that this is not always addressed in postnatal contacts, and when it is the impact of the way in which it is communicated is unhelpful to mother’s mental health and wellbeing. |  |
| 21 | Scottish Cot Death Trust | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | Yes |  |
| 22 | The Breastfeeding Network | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | We would consider all of the areas highlighted in the current postnatal quality standard to be areas for quality improvement, and would support the retention of all existing statements.  We are pleased to see QS statement 4 now gives information on safe bed sharing, as we know from the many women we support that safe bed sharing can facilitate breastfeeding and allow a mother to get more rest.  With regards to QS statement 6 on formula feeding, we would add that support for formula feeding should be given within an evaluated, structured framework, using the UNICEF baby friendly initiative (BFI) as a minimum standard, just as support for breastfeeding should. |  |
| 23 | The Lullaby Trust | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | Yes the areas are still priorities.  Under bed sharing, we would prefer to see this labelled as ‘co-sleeping’ and consider the additional risks of sofa sharing. |  |
| 24 | UNICEF UK Baby Friendly Initiative | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | A key omission is a QS on which all the other standards would follow. A QS that keeps the woman at the centre of postnatal care is required as QS1.  Quality statement 1: At each postnatal contact the woman is asked about how she feels about her and her baby’s wellbeing, she is listened to, and any concerns raised are actioned.  Rationale  Women are best placed to tell the health professional about her own and her baby’s health and wellbeing. Women should feel that their opinion is valued and any concerns raised will be heard, taken seriously and acted upon. If there is trust between the woman and the health professional she will share her concerns about her emotional and physical health, her baby’s health and wellbeing, infant feeding and her transition to parenthood. The woman’s story and effective communication between the woman and the health professional is the foundation on which all other care should be built and could help to promote positive health and wellbeing and prevent serious complications.  We believe that QS 7 & 9 continue to be a priority and should be retained.  It would be useful to have a statement which demonstrates how the postnatal care quality standards map to other NICE quality standards e.g. NICE quality standard on antenatal and postnatal mental health. Jaundice in newborn babies under 28 days etc. |  |
| 25 | World Breastfeeding Trends Initiative (UK) | Are the areas highlighted in the current [postnatal care](https://www.nice.org.uk/guidance/qs37) quality standard (QS37) still priorities for quality improvement? Please highlight any areas that you no longer consider to be priorities and why? | Yes |  |
| **Question 2- Statement 5** | | | | |
| 26 | BAME Health Collaborative | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | This statement should be updated and some information on basic breast-feeding hygiene, problems with feeding like flat nipples, cracked nipples should be added, we have added separate document to explain this |  |
| 27 | Better Breastfeeding | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | Yes this statement should be updated. The Unicef Baby Friendly Initiative programme has been significantly updated since 2013 and includes important considerations such as having a three-tier service of 1) routine care provided by health professionals 2) additional support and social support provided by peer supporters or breastfeeding counsellors 3) specialist support provided by eg. certified lactation consultants.  In terms of evaluation the data sources referred to are inadequate. There is poor collection of data on breastfeeding initiation and breastfeeding at 6-8 weeks. The CQC survey is inadequate in measuring mothers’ satisfaction with the breastfeeding support they receive. |  |
| 28 | Birth Companions | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | The reference to a ‘structured programme’ may preclude ad hoc or other forms of specialist provision deemed suitable at a key stage of a mother’s journey. We would suggest ‘appropriate’ or similar be used here to allow judgements to be made based on the individual mother’s needs. |  |
| 29 | Birth Trauma Association | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | Agree. It should be updated to say that women should be supported in their chosen method of infant feeding. |  |
| 30 | British Specialist Nutrition Association | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | BSNA commend the supportive structures recommended by the guidance for breastfeeding parents. In addition to this we would like to highlight that parents who are unable to, or choose not to breastfeed should be provided with the same supportive structures to those who breastfeed to ensure all mothers and parents benefit from equal practical and emotional support.  Although we agree that the statement needs to focus on breastfeeding, we believe that statements 5 and 6 should make specific reference to the lived reality of many parents which is that they combination feed their babies. (1)   1. The 2010 Infant Feeding Survey identified this reality with 23% of infants exclusive breastfeeding at 6 weeks although 55% were receiving some breastmilk. Unfortunately, this survey has not been conducted since then, so comparable up-to-date information is not available. | McAndrew F. et al. (2012) Infant Feeding Survey – UK, 2010. Health and Social Care Information Centre (Now NHS Digital). Available from: <https://digital.nhs.uk/data-and-information/publications/statistical/infant-feeding-survey/infant-feeding-survey-uk-2010>. [Accessed 02 Feb 2022]. |
| 31 | GP Infant Feeding Network | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | Yes we do agree that statement 5 should be updated.  It is critical that the delivery of breastfeeding support is continued via the use of an evaluated, structured programme to enable equitable care, reduce inequalities in infant feeding support and reduce the impact of breastfeeding problems (when they arise) on physical and mental health.  The statement could be updated and expanded to include the new aspects of NG194 with a focus on the critical provision of face-to-face support (NG194 1.5.9, 1.5.10) and time-critical breastfeeding assessment provision within the first 24 hours after birth and at least once more in the first week of life (NG194 1.5.14).  To provide care according to the scope of NG194 Recommendation 1.5, service provision needs to be integrated, with structured staff training on infant feeding, good communication between providers and easily accessible referral pathways (e.g. between breastfeeding support services and GP, between breastfeeding support services and perinatal mental health team and between breastfeeding support services and tongue tie assessment & treatment services).  Women’s/parents’ satisfaction with breastfeeding support should remain an important outcome measure. |  |
| 32 | GPCPC (GPs championing perinatal care) | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | Yes, we agree  Focus on recommendation 1.5.14 to observe a feed within first 24 hrs within birth and again within the first week after birth |  |
| 33 | Institute of Health Visiting (iHV) | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | The iHV is in agreement that statement 5 should be updated.  Statement 5 and 6 could be combined as an ‘infant feeding’ quality statement aligning to unicef baby friendly initiative (BFI) standards or a recognised equivalent quality assurance standard.  Suggested focus for this statement:  All health care professionals understand their role and responsibilities in supporting pregnant women/people and their partners to feed and care for their baby in ways which support optimum health and wellbeing.  <https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2014/02/Guide-to-the-Unicef-UK-Baby-Friendly-Initiative-Standards.pdf>  Desired outcomes   * increases in breastfeeding rates at 6-8 weeks * amongst parents who chose to formula feed, increases in those doing so as safely as possible in line with nationally agreed guidance * increases in the proportion of parents who introduce solid food to their baby in line with nationally agreed guidance * a reduction in the inequalities between key indicators of breastfeeding success and deciles of deprivation * improvements in parents’ experiences of infant feeding support |  |
| 34 | La Leche League Great Britain | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | Yes, this statement should be updated. Breastfeeding rates in the UK continue to be some of the lowest in the world. The focus should be on the equitable provision and access to accurate breastfeeding support. |  |
| 35 | Lactation Consultants of Great Britain | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | Breastfeeding support from an evaluated structured service is useful, however the important point is that this breastfeeding support should be sufficiently specialist and equipped to provide support to all families with any questions concerns or problems with breastfeeding, at any age and stage. It’s absolutely should be coordinated across the different sectors, which will mean commissioning will need to be co ordinated. |  |
| 36 | National Childbirth Trust (NCT) | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | Breastfeeding support should remain a priority as whilst breastfeeding initiation rates are relatively high, continued breastfeeding up to and beyond 6-8 weeks rapidly drops off. It is unclear, however, what an ‘evaluated structured programme’ means and further clarification should be provided in terms of expectations of the support to be delivered.  Impetus is needed to ensure women are provided with sufficient infant feeding support in the first few days and weeks after giving birth from a qualified practitioner (lactation consultant, breastfeeding counsellor, or midwife/health visitor with advanced training in breastfeeding support).  Women should be provided with support and advice that is individual to their circumstances and needs. |  |
| 37 | NHS England and NHS Improvement | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | We support a quality standard that is focused on infant feeding in the round (so breast or bottle fed), in line with revised NICE PN guidance.  However, within this the need remains for an evaluated, structured programme in delivering this support.  NHSEI considers this the clearest and most rigorous approach to ensuring consistent breastfeeding support across England. This is why the NHS Long Term Plan included the commitment for all maternity services not yet accredited through such a process - like UNICEF’s Baby Friendly Initiative (BFI) - to begin in 2019/20. This was with a view to all services achieving accreditation by 2023/24.  NHSEI continues its financial support offer for 38 services that haven’t achieved BFI accreditation, to do so by 23/24. However, in the COVID-19 pandemic, a significant number of already-accredited services have struggled to maintain their accreditation due to staffing pressures.  NICE’s continued focus on adopting a structured, evaluated programme is vital to ensure we can recover and build on the pre-pandemic position, and deliver on our Long Term Plan commitment.  However, we would welcome more direct guidelines and emphasis on local authority commissioned breastfeeding support. The quality standard applies up to 8 weeks after birth, while the majority of women will be discharged from NHS Maternity care at 10 days. There is a continued need for a holistic and seamless support offer that ideally is co-ordinated through Local Maternity Systems – which should include both NHS and local authority commissioners and providers in their boards.  CQC survey responses on postnatal breastfeeding support remain the most appropriate measure of compliance/performance. |  |
| 38 | Royal College of Midwives | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | Yes, discharge from community |  |
| 39 | Royal College of Paediatric and Child Health (RCPCH) | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | Yes, there is a need of written information provided and staff training |  |
| 40 | SCM1 | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | Yes. The recommendations around infant feeding (not just breastfeeding) were significantly updated in CG 194 and QS should be amended to reflect this |  |
| 41 | SCM2 | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | Yes. This should say providing breastfeeding support from a service that uses an evaluated, ADD EVIDENCE-BASED, structured programme.  Local Data collection is completely unworkable without a National or locally agreed system to collect such data. It might be that a proportionate sample of women who were no longer breastfeeding at the 6-8 week contact are asked about their reasons for no longer breastfeeding.  Data source b) would be better to collect status at the new birth contact so services can evaluate the drop off between midwifery and HV service offer  Definitions of terms used-Structured programme should be made clearer as some hospitals are interpreting this to mean outside the maternity offer -but still done internally- weekend offer  Breastfeeding support -ADD use UNICEF baby friendly curriculum as a minimum best practice standard and complete competencies of role at least every 2 years  QS 6 safely prepare formula milk ADD in line with DH Guidance  Quality measures -ADD Evidence of staff confidence in relation to infant formula and the risks associated with formula and bottle feeding aligning with evidence- based /credible (non -industry led sources such as first steps nutrition)  Data source outcome b) safely prepare formula milk and ADD- information on paced and responsive bottle feeding to avoid complications arising from simple overfeeding  c) what the QS mean for different audiences  services provider- ADD ensure information on paced and responsive bottle feeding discussed  ADD - Ensure staff receive appropriate evidence- based information on preparation, composition and feeding using bottles, teats and infant formula  Healthcare practitioners -discuss information and ADD mitigate risks associated with bottle feeding  Information about bottle feeding  Point 4 soothing the baby -ADD NBO Brazelton evidence- based tool could be used here |  |
| 42 | SCM3 | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | The new PN care guideline includes breastfeeding across antenatal and postnatal care as such, this statement will be of limited value.  The focus, in my view, should be around the provision of information across the pregnancy and postnatal period and ensuring practitioners have the relevant skills and competencies. |  |
| 43 | SCM4 | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | programmes for supporting breastfeeding need to be evaluated, and their efficacy reported and monitored |  |
| 44 | SCM6 | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | Providing breastfeeding support should remain a key part of the quality standard. Recommendations for the update would be inclusion of providing information and guidance for partners to support breastfeeding mothers, recognition that low income and younger mothers should be included in the equality and diversity considerations, the importance of continuity of care and face-to-face delivery of support. |  |
| 45 | Scottish Cot Death Trust | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | Yes |  |
| 46 | The Breastfeeding Network | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | We support the retention of a reference to use of an evaluated, structured programme for the delivery of breastfeeding support, and recognise that the UNICEF Baby Friendly Initiative (BFI) identified as the minimum standard for this. We would support the retention of this quality standard, and would further suggest that it be updated to reference the BFI specifically within the quality standard statement, in order to ensure the definition of an evaluated, structured programme is clear.  We would also support the inclusion of additional quality standard statements in regards to breastfeeding support. This is a complex, multifaceted area where there is much room for improvement, which cannot be adequately encapsulated in a single statement. While the UNICEF BFI should be regarded as a minimum standard, there is much that could be done over and above meeting BFI standards to improve the quality of breastfeeding support and breastfeeding rates. |  |
| 47 | UNICEF UK Baby Friendly Initiative | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | We agree that this statement should be retained and updated.  The focus could be clearer if the statement read:  QS 5: Women receive breastfeeding support from a service that uses an evaluated, externally audited, structured programme using the UNICEF UK Baby Friendly Initiative standards as a minimum standard.  Rationale: UNICEF UK Baby Friendly Initiative is an evidenced based, global initiative that provides a quality assurance framework to implementing quality standards within UK health services. The programme is recommended in all UK Governments policy documents and uses an evaluated, externally audited, structured programme, including staff training to ensure universal standards of care for babies their mothers and families across maternity, neonatal, health visiting and children’s centre services.  Implementing Baby Friendly standards ensures a whole systems approach – for example, as part of the Baby Friendly programme women should also be offered information on peer support and this should also be evaluated and structured.  We are not aware of another UK evidence‑based, externally audited, structured programme. |  |
| 48 | World Breastfeeding Trends Initiative (UK) | Statement 5 is focused on providing breastfeeding support from a service that uses an evaluated, structured programme. Do you agree that this statement should be updated? If so, what should the focus be? | It is important that there are (a) minimum standards of care required and (b) consistency across the UK . It is therefore essential to have an evaluated, structured programme that meets Baby Friendly Initiative standards as a minimum. However, there are some useful, additional points which would improve the quality of care. |  |
| **Question 3- Statement 7** | | | | |
| 49 | BAME Health Collaborative | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | We recommend keeping this section, though it is concise and in overlap with Newborn and Infant Physical Examination (NIPE) screening program as it will give guidance on basic new-born care and warning signs |  |
| 50 | Better Breastfeeding | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | No, it is an important point of contact for evaluation of both the parent and child (mental and physical). Without it some cases of faltering growth, neglect, abuse, illness etc would be missed. It is also an opportunity to assess the effectiveness and progress of feeding and monitor breastfeeding rates for the area. |  |
| 51 | Birth Trauma Association | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | We believe that the statement should be retained because the physical examination is important (even if it overlaps with another quality standard). |  |
| 52 | GP Infant Feeding Network | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | No we do not agree that statement 7 should be removed.  Although the Infant Physical Examination is mandated and covered by NIPE standards it is important that commissioners and healthcare professionals recognise the interdependency of the areas encompassed by postnatal care and that problems within one area may impact on another. For example- an infant with an undiagnosed congenital cardiac problem may present with feeding difficulties which may initially be perceived as a breastfeeding problem. Another example might involve bonding difficulties and/or social developmental delay where the mother/birth parent is suffering from postnatal mental health problems.  We believe the QS37 Standards should continue to address the full scope of postnatal care. Fragmenting postnatal care standards further is unlikely to support Commissioners to provide good quality, holistic care systems.  If statements/areas must be removed from QS37 we would encourage the Committee to refer to and link to the alternative standards which address these key areas on the webpage for QS37 so that all standards are easily accessible from one site. |  |
| 53 | GPCPC (GPs championing perinatal care) | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | No, it is still very important that this is done by staff that have been trained and competent to NIPE standards |  |
| 54 | Institute of Health Visiting (iHV) | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | The iHV is of the opinion that the 6–8-week physical examination for babies, should not be removed from the NICE postnatal guidance.  The 6–8-week physical examination is an integral and essential part of the Newborn Screening Programme. <https://www.nhs.uk/conditions/baby/newborn-screening/overview/> . Exclusion of this examination in the NICE postnatal guidelines may risk unwarranted variation in practices in terms of health care professionals ensuring that parents/carers bring their babies to the 6-8-week physical examination appointment.  Improving parents access to the Newborn Screening programme requires a ‘whole system’ approach with all practitioners working in the perinatal period promoting the programme (for example health visitors). Removal of the physical examination from the guideline risks fragmenting this shared responsibility, with practitioners not actively promoting this contact. As a consequence, there is a risk of a further decline in the number of babies attending for their 6-8-week physical examination (current uptake is already inadequate) and an associated increase in the number of babies not benefitting from the significant advantages that early identification of serious health conditions affords.  Early identification of developmental disorders is important to enable prompt diagnosis and tailored interventions, including supporting parents (Edmond & Law 2019). The safety net for babies who do not attend the 6-8-week physical examination, would usually be the health visitor who would be completing a 6-8-week review. However not all babies are seen face to face by the health visitor and recent evidence shows that on aggregate18.7% of babies did not receive a 6–8-week review by their health visitor; and due to significant variation in uptake between local authorities, the percentage of babies not receiving this review is much higher in some areas (OHID 2022). Of the 81.3% who did receive a contact, this may not have been face to face (see OHID 2021 experimental data for the percentage of face-to-face contacts completed by health visitors). The interim guidance that virtual contacts will continue to be counted as valid methods of delivery of the health visiting mandated reviews has been extended until the end of 2022 which poses significant risks for the identification of both clinical and safeguarding vulnerabilities (PHE 2021). | References:  Emond A, Law J, (2019) Supporting children with developmental disorders and disabilities IN Emond A (eds) (2019) Health for all children: fifth edition. RCPCH, London.  OHID (Feb 2022) Health Visiting Metrics 2021/22 Child and maternal health statistics - GOV.UK (www.gov.uk)  (OHID – August 2021) Experimental data of health visiting face to face contacts <https://files.digital.nhs.uk/31/C19DDB/csds-aug21-exp-hv.csv>  PHE (2021) <https://www.gov.uk/government/publications/childrens-public-health-0-to-5-years-national-reporting?utm_medium=email&utm_campaign=govuk-notifications&utm_source=11a89c36-3a94-4375-a2be-3dfd95593b00&utm_content=daily> |
| 55 | La Leche League Great Britain | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | Yes--As long as the baby’s health (including weight) is still being checked at 6-8 weeks, there is no need to duplicate the same statement in multiple guidelines. |  |
| 56 | Lactation Consultants of Great Britain | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | It is important that this type of check remains part of universal care received by families, but perhaps it does not need to be a separate NICE QS, so long as paediatric checks are standardised. |  |
| 57 | National Childbirth Trust (NCT) | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | Evidence from our stakeholders suggest that the 6-8 week check for babies is adequate, and this does not need to remain a focus for quality improvement. The main concern is that the 6-8 check can be so focussed on the baby that mother’s physical and mental health is not addressed. |  |
| 58 | NHS England and NHS Improvement | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | The Maternity team requests first and foremost a direct focus on provision of the Maternal 6-8 week GP check, as introduced in the GP contract in April 2020 and referenced in NICE NG194. We acknowledge that a focus on the baby check overlaps with NIPE requirements, but would be supportive of guidance giving the maternal and baby check parity of esteem. We also welcome continued emphasis on the vital role of General Practice in postnatal care. |  |
| 59 | Royal College of Midwives | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | No, this statement should be kept. |  |
| 60 | Royal College of Paediatric and Child Health (RCPCH) | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | It makes sense to remove this if there are local arrangements for ensuring the 6-8 week check is performed and this would be via S4N or there is a similar IT platform. |  |
| 61 | SCM1 | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | Insofar as there will be a finite number of QS, this is reasonable. However, if NICE has any influence to comment in the narrative or background about the importance that this screening programme is monitored in terms of proportion completed and quality this would be beneficial (i.e. that because NICE has removed it as a QS, this does not mean it is not important, it should just be measured via other systems) |  |
| 62 | SCM2 | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | The physical check by the GP is done at 8 weeks and beyond and no earlier so 6 weeks needs removing. Also, the health visitor does an in-depth 6-8 week development assessment on communication, personal-social, problem-solving, fine motor and gross motor skills at this stage. This is in addition to the physical examination and is an assessment of the baby’s skills and brain development through interactions with toys through play and interactions with parents  The baby is physically examined by the midwife at birth then a health visitor assessment is undertaken at 10-14 days and 6-8 weeks then by a GP at 8 weeks. The current QS is focused only on the GP examination, but all are equally important in the identification of issues in the postnatal period |  |
| 63 | SCM3 | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | Yes, agree |  |
| 64 | SCM4 | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | The examination of all infants at birth and ad at 6-8 weeks remains very important, and, whilst this statement overlaps with the NIPE programme the importance of this process must be emphasised and a link provided to the NIPE programme is not included explicitly here |  |
| 65 | SCM5 | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why | Agree |  |
| 66 | SCM6 | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | As this overlaps with the NIPE, I would be happy to agree that this is removed. |  |
| 67 | Scottish Cot Death Trust | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | Yes |  |
| 68 | The Breastfeeding Network | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | We recognise that this statement overlaps with the newborn and infant physical examination screening programme. However, we believe it is important to keep this examination visible as part of the postnatal care pathway, and would be concerned that removing it here would risk losing an opportunity to evaluate the success of the programme. |  |
| 69 | UNICEF UK Baby Friendly Initiative | Do you agree that statement 7 on the 6- to 8-week physical examination for babies should be removed? If not, please explain why. | This statement should not be removed.  This examination is carried out by different health professionals, at a different time and has a different emphasis. This examination complements the maternal postnatal check and helps to consider the mother/parent baby dyad as a whole, supporting both the physical and emotional wellbeing and transition to parenthood. Removing may risk losing an opportunity to assess wellbeing in the infant, assessment of infant feeding, attachment problems, participation in the immunisation programme and recognising any deviations from normal that may not have been picked up at the examination of the newborn baby at birth and if a parent does not access health services between these examinations. | See NICE Post Natal Guidance NG194 1.3.3, 1.3.4 and 1.3.5 |
| **Question 4- Statement 9** | | | | |
| 70 | BAME Health Collaborative | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | We recommend keeping this section though this is also in overlap with antenatal and post-natal mental health, as it gives opportunity to access the maternal wellbeing find out different factors which affect the maternal health mainly after difficult or traumatic delivery, look for evidence of any domestic abuse |  |
| 71 | Better Breastfeeding | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | No it should not be removed. Emotional wellbeing of the mother and baby are extremely important and since 2013 there has been significant research on both of these. For example it is understood now the interconnection between maternal mental health and mothers reaching their breastfeeding goals. This research base should be evaluated and incorporated into the new quality standard. The antenatal and postnatal mental health QS does not cover infant mental health and is focused on disorders that require intervention. All those providing postnatal care should be trained in assessing signs of healthy bonding and attachment and this should be part of routine care. |  |
| 72 | Birth Companions | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | No, we believe this should be reinforced across all relevant guidance, not only those specific to mental health. |  |
| 73 | Birth Trauma Association | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | We believe that the statement should be retained, again because the assessment of emotional wellbeing is important (even if it overlaps with another quality standard>) |  |
| 74 | GP Infant Feeding Network | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | No we do not believe that Statement 9 should be removed.  Statement 9 addresses parent-infant bonding (rather than just a focus on maternal wellbeing) and is therefore the only measure of infant mental health and wellbeing currently included in QS37 and QS115 as Statement 11 has already been removed previously.  The rationale proposed for removal that Statement 4 of NICE QS115 (Antenatal and Postnatal Mental Health) addresses this area is incorrect and if Statement 9 is removed from QS37 there will be no statement remaining which highlights an infant’s mental health. Infant mental health and parent-infant relationships influence an infants’ future physical and mental health (see: <https://parentinfantfoundation.org.uk/why-we-do-it/building-babies-brains/>)  Statement 9 should be retained and enhanced to better highlight infant mental health, include the quality of parent-infant interactions, and make recommendations on how localities can improve training and assessment/observations of infant mental health. Removing reference to bonding and parental-infant interactions also neglects to highlight early intervention opportunities for Family Wellbeing support and the prevention of Child Safeguarding issues.  As a Network supporting GPs with an interest in Infant Feeding care we would like to emphasise that the parent-infant relationship is also an important aspect of holistic breastfeeding and infant feeding support.  We encourage the Committee to seek expert advice on the retention and enhancement of Statement 9 from colleagues working in the fields of infant mental health, parent-infant relationships, Perinatal CAMHS and Children’s Services. |  |
| 75 | GPCPC (GPs championing perinatal care) | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | No. We think it is currently vague, but important as neither QS 37 nor QS 115 have any QS about assessment of infant mental health nor attachment. This is an important concept, expanded in the recent PN guideline and needs mention in the QS. It may need expert advice about how to phrase it. It needs to be amended |  |
| 76 | Institute of Health Visiting (iHV) | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | The iHV is of the opinion that statement 9 on the assessment of emotional wellbeing should not be removed in its entirety. The current postnatal care quality standard has a clear emphasis on the parent-infant relationship and regularly mentions attachment and bonding. The quality standard in the antenatal and postnatal mental health guidelines, only covers women’s emotional wellbeing, it does not cover bonding, attachment, relationships or infant mental health and wellbeing. Maternal mental health and babies' early relationships are connected but they are not the same thing. We would therefore recommend that a statement on infant mental health is retained with a focus on babies' emotional wellbeing and early relationships. Supporting infant mental health can prevent emotional disturbances from taking root and escalating into mental health problems across the life course. Without taking early action, we risk exposing children to unrecognised and unnecessary distress without access to effective treatment and thereby increase the need for later mental health support. | References:  Winston R, Chicot R. The importance of early bonding on the long-term mental health and resilience of children. London J Prim Care (Abingdon). 2016;8(1):12-14. Published 2016 Feb 24. doi:10.1080/17571472.2015.1133012 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5330336/>  <https://parentinfantfoundation.org.uk/useful-resources/resources-for-professionals/> |
| 77 | La Leche League Great Britain | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | No. Infant mental health is connected to parent mental health, especially in the early postnatal period. NICE guidelines on postnatal care already emphasis the need for skin-to-skin, breastfeeding support and protected time for the birth parent and partner to bond as soon as possible after birth. Continued emphasise on early skin-to-skin and access to infant feeding support should be clearly defined as a way to protect an infant's mental health in postnatal care. |  |
| 78 | Lactation Consultants of Great Britain | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | No; bonding is an important element for the whole family and is not simply covered by the NICE QS on maternal mental health. A check on this is very important. |  |
| 79 | National Childbirth Trust (NCT) | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | It is proposed that statement 9 is removed as the content is now covered in statement 4 of the Quality Standard on antenatal and postnatal mental health [QS115]. QS115 do not, however, make any reference to the relationship between mother and baby.  The existing statement itself highlights the importance of the baby’s relationship with the mother for the baby’s social and emotional development. As such, if it is not covered in an alternative statement, it should remain here.  To avoid repetition, we further suggest that this statement is revised so that it relates less to the mother’s emotional wellbeing, which is covered in QS115, and focuses specifically on the mother-baby bond and the baby’s development. |  |
| 80 | NHS England and NHS Improvement | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | While emotional wellbeing is covered in statement 4 in the quality standard on antenatal and postnatal mental health, we would welcome at the minimum signposting and reference to this standard where relevant in the new structure of QS37. Fragmented guidance increases burden on providers and risks lower compliance.  The antenatal and postanal mental health quality standards do not mention anything about bonding with the baby (while it is currently mentioned in the postnatal care standards). As there is no current plan to review the MH standards, we think removing the reference to it in the postnatal quality standards would create a clear gap.  Keeping a section on emotional wellbeing – even if it is shorted and signpost people to  the antenatal and postanal mental health quality standards – may help with our ambition to achieve parity between physical and mental health. If we only signpost to the mental health quality standards people may think that it is not within their remit, and emotional wellbeing is more than the presence or absence of mental health issues. |  |
| 81 | Oxford Parent Infant Project | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | No it should not be removed as it would only then focus on maternal mental health and well being. Nice are suggesting this should be removed ‘as it is covered in the quality standard on antenatal and postnatal mental health.’ This is incorrect. The current postnatal quality standard has a clear emphasis on the parent-infant relationship and regularly mentions attachment and bonding. The quality standard in the antenatal and postnatal mental health guidelines, which they say covers the same thing, only looks at woman’s emotional wellbeing. Attachment, bonding or relationships have been omitted and are key to woman’s mental health and wellbeing. It is crucial as a preventative measure for the future mental health and emotional well being of the baby that this question remains. I can’t stress enough, and at Oxpip we are experts in this field, that NICE keep a focus on the baby’s early experiences and relationships. Early intervention prevents more costly interventions in later childhood and adult life and can be dealt with more quickly and effectively with parentinfant psychotherapy for both parent and baby at an early stage |  |
| 82 | Parent-Infant Foundation | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | The rationale that is given for removing Statement 9 is that it is covered in statement 4 in the quality standard on antenatal and postnatal mental health. In fact, the two are different:  The quality standard for antenatal and postnatal mental health covers only “asking about mental health and wellbeing”. It does not contain any reference to assessing early bonding. In contrast, the quality standard for postnatal care explicitly states that women’s “bonding with their baby” should be assessed at each postnatal contact alongside womens’ emotional wellbeing. It also suggests that local data should be collected on the incidence of attachment problems. The postnatal quality standard, therefore, includes content that the antenatal and postnatal mental health statement does not. If this quality standard is lost, then there will be nothing in the quality standards about early relationships and bonding. This is a significant loss given the importance of the parent-infant relationship for a range of later outcomes.  Whilst maternal mental health and parent-infant relationships are closely connected, they are not the same thing. Some mothers may have struggles bonding with their baby, without having mental health problems (and the converse is also true). Furthermore, even if maternal mental illness and parent-infant relationship difficulties co-exist, treating mothers’ mental health difficulties will not always address difficulties in the early relationship – additional relational support is required.  Whilst there has been a step-change in the understanding of, and response to maternal mental health problems in the UK in recent years, the understanding of early relationship problems lags behind.  Many midwives and health visitors do not receive pre-qualification training in assessing early relationships and infant mental health. Nearly all areas of England now have perinatal mental health services, which will support local midwives and health visitors to understand and assess emotional wellbeing. However most areas of the country do not yet have specialised parent-infant relationship provision, so midwives and health visitors do not receive the same support and encouragement to assess early relationships or address any concerns.  Identifying and acting on early relationship difficulties in the postnatal period is likely to require workforce development and practice changes in many services. A NICE quality standard can facilitate this change and will encourage local commissioners and managers to consider how to develop their workforce and ensure that such assessment takes place.  We welcomed the strengthened content on promoting emotional attachment in the postnatal guideline. This should be reinforced by a clear quality standard relating to babies’ emotional wellbeing and parent-infant bonding. |  |
| 83 | Royal College of Midwives | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | No, statement 9 on assessment of emotional wellbeing should not be removed- furthermore more consideration should be given to emerging higher rates of birth trauma, how to support early parent-infant relationship and mental health. |  |
| 84 | Royal College of Paediatric and Child Health (RCPCH) | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | Agree |  |
| 85 | SCM1 | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | Not fully; although emotional wellbeing is covered in the QS for antenatal and postnatal mental illness, removal of emotional wellbeing from the Postnatal Care QS could mean that it is seen as being removed from ‘usual care’. If another QS can be actively signposted from another, this could be a good solution (i.e. cross ref the emotional wellbeing QS from this postnatal QS) |  |
| 86 | SCM2 | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | No I don’t think it should be removed as maternal mental health is critically important in the post-natal stage of care and early identification of mental health issues including post-natal depression can be identified and assessed using evidence-based tools and professional judgement during the post-natal period  There is compelling evidence that the bonding and attachment that takes place between mother and baby in the postnatal period is critically important at this early stage as it provides the foundations for later life. Promoting baby brain development is at the forefront of postnatal care in health visiting  As health visitors we are conducting New-born behavioural Observations (NBOs) on each baby with tools including the use of a torch, rattle and red ball and professional judgement. This is an evidence- based assessment and identifies bonding and attachment issues and baby’s habituation to sound, light and its ability to grasp and suck and regulate its own emotions and stress state. This also forms part of the physical examination QS. |  |
| 87 | SCM3 | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | The discussions about emotional attachment should begin antenatally and continue into the postnatal period. If the Antenatal QS already covers this, then to avoid repetition, I agree it can be removed otherwise, it should remain but with a change of focus to include both parents involved in the baby’s care. As the attachment can be affected by the woman’s physical recovery as well as emotional health. |  |
| 88 | SCM4 | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | The identification and management of problems with mother/infant interactions remains a priority |  |
| 89 | SCM5 | Do you agree that statement 9 on the assessment of  emotional wellbeing should be removed? If not, please  explain why | Agree |  |
| 90 | SCM6 | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | I do not agree that statement 9 should be removed from the QS, Whilst the antenatal and postnatal QS does account for the mental health and wellbeing of the mother, there doesn’t seem to be an explicit consideration of the importance of mother’s bonding with their baby, which is important for both the emotional wellbeing of the mother and the social and emotional development of the baby. |  |
| 91 | Scottish Cot Death Trust | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | Yes |  |
| 92 | The Breastfeeding Network | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | We accept that this statement is partially covered in statement 4 in the quality standard on antenatal and postnatal mental health: “Women are asked about their emotional wellbeing at each routine antenatal and postnatal contact.”.  However, the guideline and quality standard on antenatal and postnatal mental health seems to be focussed on diagnosable mental health conditions occurring during this period. The postnatal period is a time of significant emotional upheaval for all new parents and consideration of emotional wellbeing should not be limited to those suspected of having a mental health condition. The postnatal care guidelines state that  Removing this statement from this quality standard might risk the emotional wellbeing of those not displaying clear signs of mental health distress not being assessed as rigorously as it should be.  In addition, there is no mention of emotional attachment or bonding with the baby in the antenatal and postnatal mental health QS. We would suggest that this aspect of the QS particularly should be retained, referencing “promoting and supporting emotional attachment”. |  |
| 93 | UNICEF UK Baby Friendly Initiative | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | We strongly disagree that this statement should be removed. Particularly as QS 10 &11 have been removed.  We recognise that this is partially covered in the standards covering antenatal and postnatal mental health, but the emphasis is different focussing on diagnosable mental health conditions rather than emotional wellbeing for every mother and baby.  The transition to parenthood, infant feeding, positive attachment behaviours, emotional wellbeing and relationship building are inextricably linked. The impact of Covid-19 and separation of parents and their infants from support has highlighted this and is well documented in the literature.  In addition, there is an overwhelming body of evidence supporting investment in the first 1001 days specifically around emotional wellbeing and attachment. Failure to recognise and support this has an impact on brain development and the health and wellbeing of the baby, mother, and family in the short and long term.  Removing this statement from this quality standard risks the emotional wellbeing of the woman, her baby and the wider family. | <https://www.unicef.org.uk/babyfriendly/early-moments-matter/> |
| 94 | World Breastfeeding Trends Initiative (UK) | Do you agree that statement 9 on the assessment of emotional wellbeing should be removed? If not, please explain why. | No. There needs to be a focus on the baby – the baby’s early relationships and thus emotional wellbeing are different from the mother’s mental health. |  |

# Appendix 2: Suggestions from registered stakeholders

| ID | Stakeholder | Suggested key area for quality improvement | Why is this a key area for quality improvement? | Supporting information |
| --- | --- | --- | --- | --- |
| **Organisation and delivery of postnatal care** | | | | |
| **Awareness and communication** | | | | |
| 1 | **British Pregnancy Advisory Service** | Communication with all patients and new parents. | Research has shown that COVID-19 appears to have exacerbated previously reported failings in hospital based postnatal care and that shifts in how post-natal care is being delivered are negatively impacting many.  All maternity services should ensure they have clear lines of communication and women should be offered the option of face-to-face care wherever possible.  Guidance should be given on best practice for virtual post-partum care.  Clear communication to all patients of how care is being delivered should be a priority. | Please see research in the Midwifery Journal which highlights Users’ experiences of maternity care in the UK during the COVID-19 pandemic.  [“Anxious and traumatised”: Users’ experiences of maternity care in the UK during the COVID-19 pandemic - ScienceDirect](https://www.sciencedirect.com/science/article/pii/S0266613821001480?via%3Dihub) |
| 2 | **BAME Health Collaborative** | Language barrier and cultural awareness under all sections | As per MBRRACE 2018 PERINATAL MORTALITY SURVY Mortality rates are exceptionally high for babies of Black and Black British ethnicity: stillbirth rates are over twice those for babies of White ethnicity and neonatal mortality rates are 45% higher. Similarly, mortality rates remain high for babies of Asian and Asian British ethnicity: stillbirth and neonatal mortality rates are both around 60% higher than for babies of White ethnicity.  So having a cultural awareness in guidelines is important. | <https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/perinatal-surveillance-report-2018/MBRRACE-UK_Perinatal_Surveillance_Report_2018_-_final_v3.pdf> |
| 3 | **BAME Health Collaborative** | Cultural awareness under all sections | As per MABRRACE SURVY on and IMPROVING MOTHER CARE 2020 There is four-fold difference in maternal mortality rates amongst women from Black ethnic back- grounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to white women, emphasising the need for a continued focus on action to address these disparities | <https://www.npeu.ox.ac.uk/mbrrace-uk/reports> |
| 4 | **Birth Companions** | Interpretation provision | The provision of safe, appropriate, timely and accurate interpretation services is currently of key concern in supporting women from ethnically minoritised groups in the postnatal period. Current services are patchy and inconsistent.  Recent work has been done to explore interpretation in London maternity services, led by Rebecca Gilbert, Project Manager  London Maternity Clinical Networks  Caroline Moren at NCL LMS has also recently explored interpretation provision in her area | Further information on the impact of language issues and interpreting services is available in [Holding it all Together](https://www.birthcompanions.org.uk/resources/92-holding-it-all-together) and [Making Better Births a reality for women with multiple disadvantages](https://hubble-live-assets.s3.amazonaws.com/birth-companions/file_asset/file/35/RDA_BC-REPORT_WEB_FINAL.pdf) |
| 5 | **La Leche League Great Britain** | Health Care Professional-Equity and Diversity | Staff working with infants and parents in the postnatal period need on-going training and support that is founded in equity and diversity, including skilled breastfeeding support, to provide equitable care in order to reduce health inequalities for parents and infants. | See [NICE Guideline Postnatal Care](https://www.nice.org.uk/guidance/ng194/chapter/recommendations#organisation-and-delivery-of-postnatal-care) Principles of Care 1.1.2 |
| 6 | SCM1 | Key area for quality improvement 4 | Risk profiles and awareness of MBRRACE Report | NG194 specifies that healthcare professionals should be aware of the MBRRACE Report. Reducing health inequalities is crucial to reducing mortality and morbidity. The QS should look to reflect this |
| 7 | Royal College of Midwives | Key area for quality improvement 4 | Women centred care and public health approach | The whole guideline may benefit of a shift to women-centred care. Midwives are acutely aware of the need to work in partnership with women to give the necessary support, care, and advice throughout the perinatal period. It is important for NICE to focus on the long lasting effect of postnatal care, as early life experience affects health, wellbeing, cognitive development and emotional security in childhood as well adulthood. All interventions that improve child’s health and life chances should be considered and are fundamental for public health. Particularly in the current context of discontinued or scaled down postnatal care provision associated with the coronavirus pandemic and pressure on the service.  RCM (2017) [High quality midwifery care.](https://www.rcm.org.uk/media/2354/high-quality-midwifery-care.pdf)  Renfrew MJ, Cheyne H, Craig J, Duff E, Dykes F, Hunter B, Lavender T, Page L, Ross-Davie M, Spiby H & Downe S (2020) Sustaining quality midwifery care in a pandemic and beyond. Midwifery, 88, Art. No.: 102759. https://doi.org/10.1016/j.midw.2020.102759 |
| 8 | Royal College of Midwives | Key area for quality improvement 5 | Health inequalities | There is strong evidence to suggest that health inequalities (especially linked to ethnicity and social deprivation) remain a serious cause of concerns for women and babies accessing maternity care in the UK. NICE should take data from the MBRRACE and the NMPA in consideration and focus on how to improve postnatal care and address inequalities.  Cultural safety should also be considered as it is often overlooked although it can adversely impact postnatal outcomes. There is lack of awareness and understanding of cultural issues amongst health care professionals and how this affects quality and safety (e.g. uptake of neonatal screening or public health advice).  MBRRACE (2021) [Saving Lives, Improving Mother’s Care.](https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf)  NMPA (2021) [Ethnic and socio-economic inequalities in NHS maternity and perinatal care for women and their babies.](https://maternityaudit.org.uk/FilesUploaded/RCOG_Inequalities%20Report_Lay_Summary.pdf) |
| 9 | SCM5 | Key area for quality improvement 3  Listening to women’s and family voices | Failure to listen to women and families has been identified as a contributor to poor experiences and outcomes in maternity.  Recognising that national postnatal experiences do not compare to that reported in pregnancy and at birth, there is a need for services to evidence the quality improvements made based on service user feedback for postnatal care  provided by acute and community services | Please see the following documents for  need for improvement in postnatal care  and recommendations  <https://www.england.nhs.uk/wp-content/uploads/2020/03/better-births-four-years-on-progress-report.pdf>  <https://www.cqc.org.uk/publications/surveys/maternity-services-survey-2019>  <https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf>  <https://www.npeu.ox.ac.uk/maternity-surveys>  <https://www.nct.org.uk/about-us/media/news/nct-finds-quarter-new-mothers-are-not-asked-about-their-mental-health>  <https://www.nct.org.uk/about-us/media/news/nct-launches-new-report-maternity-services>  <https://www.gov.uk/government/publications/our-vision-for-the-womens-health-strategy-for-england/our-vision-for-the-womens-health-strategy-for-england>  <https://www.gettingitrightfirsttime.co.uk/reports/maternity-and-gynaecology-girft-report/> |
| 10 | **UNICEF UK Baby Friendly Initiative** | A key omission to the Postnatal Quality Standards is a QS on which all the other standards would follow. A QS that keeps the woman at the centre of postnatal care is required as QS1.  Quality statement 1: At each postnatal contact the woman is asked about how she feels about her and her baby’s wellbeing, she is listened to, and any concerns raised are actioned. | Rationale  Women are best placed to tell the health professional about her own and her baby’s health and wellbeing. Women should feel that their opinion is valued and any concerns raised will be heard, taken seriously and acted upon. If there is trust between the woman and the health professional, she will share her concerns about her emotional and physical health, her baby’s health and wellbeing, infant feeding and her transition to parenthood. The woman’s story and effective communication between the woman and the health professional is the foundation on which all other care should be built and could help to promote positive health and wellbeing and prevent serious complications.  Women and families need to understand what wellness looks like before they can be given information on understanding potentially serious conditions.  Covid-19 has demonstrated that when women are not seen postnatally their physical and mental wellbeing is impacted. | A recent report from the Health and Safety Executive Board highlighted that [Sudden Unexpected Postnatal Collapse](https://hsib-kqcco125-media.s3.amazonaws.com/assets/documents/hsib-national-learning-report-neonatal-collapse-alongside-skin-to-skin-contact.pdf) may have been prevented if the parents concerns had been heard, listened to and acted upon.  Good communication is essential, if the woman is listened to - care is improved, satisfaction with postnatal care will be improved and women’s confidence in their ability as a new parent.  NICE Post Natal Guidance NG 194 1.1.1, 1.4.1  The document below summarises the 6 steps from fiveXmore for Health professionals and mothers.  For women is it SPEAK UP and for HCPs it is to LISTEN to women.  [https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2020/MBRRACE-UK\_Maternal\_Report\_2020\_-\_Lay\_Summary\_v10.pdf](https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.npeu.ox.ac.uk%2Fassets%2Fdownloads%2Fmbrrace-uk%2Freports%2Fmaternal-report-2020%2FMBRRACE-UK_Maternal_Report_2020_-_Lay_Summary_v10.pdf&data=04%7C01%7CFrancescae%40unicef.org.uk%7Cfefdc34d4e9b4f645a4d08d9e7ec7d4f%7C2e8b3e917b2d435dacdaa68ba2653e5a%7C0%7C0%7C637795825157875949%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=AO%2BFJmxI5w3eR6h%2F%2BxRReWDh5XudLELtcwGh4FcLLbw%3D&reserved=0)  *‘Personalised care and support plans (PCSPs): Better Births describes the principle of personalised care as centred on the woman, her baby and her family, based around her needs and decisions, where there has been genuine choice, informed by unbiased information. The NHS Long Term Plan asks ICS to implement PCSPs in maternity services. Personalised care and support planning guidance: Guidance for local maternity systems describes how to implement PCSPs, including the need for a risk assessment at every contact.’ (page 25)*  [*https://www.england.nhs.uk/wp-content/uploads/2021/09/C0734-equity-and-equality-guidance-for-local-maternity-systems.pdf*](https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2021%2F09%2FC0734-equity-and-equality-guidance-for-local-maternity-systems.pdf&data=04%7C01%7CFrancescae%40unicef.org.uk%7Cfefdc34d4e9b4f645a4d08d9e7ec7d4f%7C2e8b3e917b2d435dacdaa68ba2653e5a%7C0%7C0%7C637795825157875949%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=kfP%2Bkp1WsjqIC1lr6%2BgPFrLnigJwvARa8nDemK4frf4%3D&reserved=0)  <https://www.unicef.org.uk/babyfriendly/covid-19/>  <https://www.unicef.org.uk/babyfriendly/news-and-research/baby-friendly-research/coronavirus-research/> |
| **Continuity of care** | | | | |
| 11 | **Institute of Health Visiting** | Continuity of carer | The iHV is of the opinion that continuity of carer should not be removed from the postnatal NICE guidance. The evidence is clear that continuity of carer is a safety critical component of effective postnatal care: it is important for relationship building, improving access to care (particularly for marginalised groups that currently experience poor access to services), eliciting need, identifying risk factors and increasing engagement in support and early intervention.  Continuity of Carer is a national recommendation set out in the Better Births National Maternity Review (1). Evidence from a number of studies has identified that providing continuity of carer improves safety critical outcomes for mothers, families and their babies.  Continuity of health visitor is also important, particularly for families with higher levels of need and less resilience or agency to ask for help when needed. Ideally, the health visitor should meet families during pregnancy for the initial assessment of need. An accurate assessment cannot be undertaken in a single ‘snapshot’ appointment as the period from pregnancy to 6 weeks postnatally is a dynamic period of change for many families that is affected by the interrelationships between a multitude of risk and resilience factors, including the parents’ physical and mental health, the infant’s physical and mental health, as well as the wider determinants of health and the context in which families live. The holistic assessment of need is built upon during the new birth contact and the 6-week postnatal contact – this enables the health visitor to build on their existing knowledge of the family’s individual circumstances and work in partnership with them to develop a more accurate and shared understanding of their current risk and resilience factors and support needs (2,3,5,6).  By developing early effective relationships with families and working closely with midwifery services and other partners, health visitors can provide seamless support and care, using a strength-based approach as families transition through services.  Working with parents and families, health visitors identify the most appropriate level of support for their individual needs.  Health visitors work with many different health care professionals, services and charities within local communities. By having health visitors involved from the earliest opportunity, families can be supported at all key milestones and referrals can be made to additional support services and peer groups as needed.  Mothers valued being treated as an individual, with a personalised service that was responsive to their individual circumstances and needs, rather than a “one-size fits all” approach. Positive experiences were linked to continuity of health visitor and a non-judgemental strengths-based approach that was based on client-led goals and a shared understanding of their priorities. Parents want continuity of health visitor so that they can build a positive, trusting relationship with them and feel that their needs are understood – this was found to be the most important factor in parents’ satisfaction with the health visiting service (4). | 1. Implementing Better Births: Continuity of Carer (2017) <https://www.england.nhs.uk/wp-content/uploads/2017/12/implementing-better-births.pdf> 2. Healthy child programme 0 to 19: health visitor and school nurse commissioning (<https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning#history>) 3. PHE Early years high impact area 1: Supporting the transition to parenthood (<https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/early-years-high-impact-area-1-supporting-the-transition-to-parenthood> 4. What parents want for a health visiting service (iHV 2020) <https://ihv.org.uk/wp-content/uploads/2020/01/HV-Vision-Channel-Mum-Study-FINAL-VERSION-24.1.20.pdf> 5. Davis H, Day C (2010) Working in Partnership: The Family Partnership Model. Pearson, London. 6. Day C (2016) Promoting early infant development <https://www.nursinginpractice.com/clinical/womens-health/promoting-early-infant-development/> |
| 12 | **National Childbirth Trust (NCT)** | Leadership for postnatal care | The National Maternity Safety Ambition (NMSA) is to halve the number of maternal deaths by 2025, alongside a reduction in stillbirths and neonatal deaths. However, only a minor reduction in the rate of maternal deaths has been made since the NMSA was published. As the majority of maternal deaths take place in the postnatal period, the improvement of postnatal care is of extreme and crucial urgency if the NMSA aim is to be achieved.  A key concern about postnatal care is its fragmentation across different services and professional groups which results in uncoordinated national and local action on postnatal. There are also fundamental issues such as a lack of consensus as to what constitutes the ‘postnatal’ period, and despite NICE guidance recommending a tailored postnatal care plan for each mother, in practice this does not happen as standard which impacts on the care women receive as change through the postnatal period.  Audit and evaluation of postnatal services is also inconsistent and of poor quality. Where evidence does exist, however, it indicates that women rate postnatal care much less favourably than ante- and intrapartum care (CQC, 2020).  All these issues point to the need for leadership to improve the experience of postnatal care across the board. | The most recent [MBRRACE report](https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf) (2021) shows that the majority of maternal deaths occur postnatally.  The most recent [Maternity Services Survey](https://www.cqc.org.uk/sites/default/files/20200128_mat19_statisticalrelease.pdf) (CQC, 2020) demonstrates the lower satisfaction with postnatal care compared with ante- and intrapartum care. |
| 13 | **National Childbirth Trust (NCT)** | Immediate postnatal care in hospital | The CQC Maternity Services shows that compared with intrapartum care, after birth women are less likely to be able to get assistance from staff when needed, and less likely to receive the information or explanations they needed. Moreover, a quarter of women indicated that they were not always treated with kindness and understanding after giving birth.  These findings echo what we have heard through the NCT community, with numerous women citing examples of being left to care for a newborn without assistance when not fully mobile after having a c-section or instrumental birth.  The lack of staffing on postnatal wards appears to be hampered, in part at least, by the exclusion of babies as patients. Staff on postnatal wards are expected to look after double the number of patients than are technically counted. | The most recent [Maternity Services Survey](https://www.cqc.org.uk/sites/default/files/20200128_mat19_statisticalrelease.pdf) (CQC, 2020) demonstrates the lower satisfaction with postnatal care compared with intrapartum care. |
| 14 | **National Childbirth Trust (NCT)** | Postnatal support in the community | Similarly to women’s experiences of postnatal care in hospital, care in the community is also lacking. Midwifery and health visiting support was particularly limited during the pandemic (Harrison et al, 2021) but prior to Covid-19, there were already concerns with over a quarter of women not being able to see a midwife as much as they wanted and a similarly proportion reporting that they did not have full confidence and trust in the midwife or midwifery team they saw after returning home (CQC, 2020).  There is also a concerning and growing trend of midwifery visits being conducted in hospital, the GP surgery or maternity hubs rather than at home. This shift in the location of support may result in a reduction in women accessing healthcare, which is particularly concerning given the rising rates of caesarean sections and instrumental births (NHS, 2021) for which women need post-operative care.  In the community there are also continued problems with the coordination of postnatal care. Whilst improvements have been made in some areas due to the roll out of continuity models of care in midwifery, postnatal care also comprises health visiting and GPs. As noted above, local coordination of support to ensure women do not fall between the gaps in services, particularly at a time of continued understaffing. The introduction of antenatal appointments with health visitors to start building the relationship has been recommended as a means to continue care beyond midwifery into the later postnatal stage. | The most recent [Maternity Services Survey](https://www.cqc.org.uk/sites/default/files/20200128_mat19_statisticalrelease.pdf) (CQC, 2020) demonstrates need for improved postnatal care pre-pandemic and the latest [national survey of women who have given birth during the pademic](https://www.npeu.ox.ac.uk/assets/downloads/maternity-surveys/reports/You_and_Your_Baby_2020_Survey_Report.pdf) (Harrison et al, 2021) highlights how the situation has worsened in the Covid-19 pandemic.  [NHS Maternity Statistics for 2020-21](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2020-21#highlights) show a continued increase in the rate of instrumental and caesarean births. |
| 15 | **NHS England and NHS Improvement** | Midwifery Continuity of Carer | There is considerable, high quality evidence of the benefits of Midwifery Continuity of Carer (MCoC) – having the same named midwife and team through your antenatal, intrapartum and postnatal care – for the safety and experience of maternity care.  In view of this evidence and the wishes of women using maternity services, there is now a national commitment for MCoC to become the default model of maternity care in England, to be implemented when providers have put in place the ‘building blocks’ for safe and sustainable change (including implementing full staffing), and with rollout prioritised to Black, Asian and mixed ethnicity of women, and those living in the most deprived neighbourhoods. There is a Long Term Plan commitment for 75% of these women to be on MCoC pathways by March 2024.  MCoC is referenced in the existing QS for antenatal care, and in the revised NG194. However, levels of implementation vary considerably across the country due to staffing pressures (COVID-19 is a greater or lesser factor of this in different areas), with just 13% of women currently thought to be on an MCoC pathway. We would therefore welcome emphasis on ensuring women are receiving continuity of carer from a named midwife who ordinarily provides their antenatal, intrapartum and postnatal care. In line with national guidance: <https://www.england.nhs.uk/wp-content/uploads/2021/10/B0961_Delivering-midwifery-continuity-of-carer-at-full-scale.pdf>. | Provision of MCoC can be assessed nationally through:   * Question F11 in the CQC Maternity Services Survey (9[% reporting positively in latest 2019 data](https://www.cqc.org.uk/sites/default/files/20200128_mat19_statisticalrelease.pdf)). 2021 Survey results to be published in coming days.   Monthly publication of [number of women placed by provider in the Maternity Services Data Set](https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics). |
| 16 | Royal College of Midwives | Key area for quality improvement 2 | Postnatal care service provision (Including staffing and resources) | Women and families are consistently less satisfied with postnatal care when compared with antenatal and intra-partum care. The same level of support available in pregnancy should be offered in the postnatal period, including personalised care provision centred on the needs of the woman, her baby and family.  The current content and timing of postnatal care is not meeting basic women’s needs. It is important for NICE to focus on appropriate resourcing and staffing needs specific to the postnatal periods.  This should include acute settings, currently midwives may be allocated six women and six babies on postnatal wards, if not more due to staffing pressures and despite the increased complexities (e.g. babies in transitional care); and community including breast feeding support and prioritising home visits provision and postnatal care for up to 28 days.  RCM (2014) Postnatal care planning. Pressure Points. <https://www.rcm.org.uk/media/2358/pressure-points-postnatal-care-planning.pdf>  CQC (2019) Maternity services survey. |
| 17 | SCM1 | Key area for quality improvement 3 | Handover of information from birth place to primary care | GPs need clear and timely information about the birth but also about other complications or morbidity to be able to follow up e.g. gestational diabetes, hypertensive disorders of pregnancy (although these may be specifically covered in their respective guidelines it is crucial that ‘standard’ postnatal care includes QS for signposting to following up complications / long term conditions. |
| 18 | SCM3 | Key area for quality improvement 3 | Communication between healthcare professionals at transfer of care | The evidence reviewed when developing the recommendations highlighted issues around this area. This will lead to dissatisfaction with women's care as they may have to repeat their history. In addition, it will negatively impact the quality of care for women as health care professionals may not have timely access to the information. |
| 19 | SCM5 | Key area for quality improvement 2  Auditable standard at the point of transfer from acute maternity services to  community services all mothers should be provided with a personalised postnatal care plan guidance that is compliant with evidence based NICE/ national guidance and pertinent to their short-, medium- and long-term health, and that this is shared with community team members who can  support on-going care. | In a period of six weeks after the birth, for her care alone, a mother will have contact with at least four different NHS health professional groups: the in hospital postnatal team, her local  community midwives, health visitor and General Practitioner. Also, postnatal care in the community is supported by services local to where the mother lives, which may or may not be provided by a team that has been involved in care in pregnancy and birth.  Recommendation of auditable standards  for NICE recommendation 1.1.8 is  needed to work through current model of postnatal care and reduce existing variation in care and health outcomes. | Please see these documents   1. For the need to improve on current system   <https://www.cqc.org.uk/publications/surveys/maternity-services-survey-2019>  <https://www.cqc.org.uk/publications/themes-care/safety-equity-engagement-maternity-services>  <https://www.england.nhs.uk/wp-content/uploads/2020/03/better-births-four-years-on-progress-report.pdf>   1. Reports highlight that ‘post pregnancy’ counselling is as important as pre-pregnancy counselling for future pregnancies and for joining up obstetric and medical care to optimise a woman’s long-term health   <https://www.npeu.ox.ac.uk/mbrrace-uk/reports>  <https://www.gov.uk/government/publications/our-vision-for-the-womens-health-strategy-for-england/our-vision-for-the-womens-health-strategy-for-england> |
| **Support for women with complex needs** | | | | |
| 20 | **Birth Companions** | Specialist support for women who have children’s social service involvement and may/ will be/ are separated from their baby in the postnatal period. | The [latest MBRRACE report](https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf) showed **social services were involved in the lives of 17% of the women who died.**  The report tells us that, of the women who died by suicide:   * **37% were known to social services** * **16% were subject to ongoing social services proceedings relating to their child, or had been separated from their infant**   Current care provision for these women is inconsistent and almost non-existent in many areas, as will be shown by research shortly to be published by the Centre for Child and Family Justice Research and the Nuffield Family Justice Observatory (expected Feb 2022) as part of their Born Into Care research. | Please see evidence in [Birth Companions’ Holding it all Together report](https://www.birthcompanions.org.uk/resources/92-holding-it-all-together), including recommendations on the need for a specialist pathway in maternity care.  The forthcoming report from the Nuffield Family Justice Observatory will include guidelines for maternity professionals in working with women at risk of separation/ experiencing separation at or shortly after birth. |
| 21 | **Birth Companions** | Care for women facing complex social factors | The existing NICE CG110 on complex social factors covers a limited range of issues/ experiences. In the context of postnatal care, and more widely across other NICE guidance, we believe this list of factors should be broadened to reflect the realities of deprivation, inequality and disadvantage, including the impact of the co-occurrence of multiple factors on pregnancy and birth.  Responses to these needs should focus on the creation/ protection of specialist midwifery roles and extended care pathways for women facing complex social factors. | See [Birth Companions’ Holding it all Together report](https://www.birthcompanions.org.uk/resources/92-holding-it-all-together) for more information, including a fuller list of complex social factors to be considered:  Housing problems • Poverty and/or no access to public funds • Perinatal mental health problems • Physical and/or learning disabilities • Substance misuse • Social services involvement, or history of safeguarding issues • Experiences of asylum, immigration or trafficking • Isolation • History of domestic abuse, sexual violence or human rights violations • Experience of detention or imprisonment • Language issues (for example, not speaking English) • Experience of sex work |
| 22 | **Birth Trauma Association** | Better care of women whose baby is taken into care at birth or have had Social Services involvement | Their suicide rate is much higher than other women (<https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf>) and their needs are often overlooked. |  |
| 23 | **Birth Trauma Association** | More support for younger women, women with a low income and women from a disadvantaged background | New motherhood can be very challenging indeed for women who don’t have financial resources or family backup, and we would like to see a quality statement recommend not just breastfeeding support for these women, but practical support. | (See eg Stack, R. J., & Meredith, A. (2018). The Impact of Financial Hardship on Single Parents: An Exploration of the Journey From Social Distress to Seeking Help. *Journal of family and economic issues*, *39*(2), 233–242. https://doi.org/10.1007/s10834-017-9551-6) |
| 24 | **Royal College of Midwives** | Key area for quality improvement 3 | Postnatal care for women with social complexities including safeguarding | There is evidence to suggest that domestic violence and child abuse have been exacerbated by the coronavirus pandemic. It is vital that the care for women with social complexities, including those experiencing removal of their babies into local authority care, is improved.  ONS (2020) Domestic abuse during the coronavirus pandemic- England and Wales. <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseduringthecoronaviruscovid19pandemicenglandandwales/november2020#domestic-abuse-during-the-coronavirus-covid-19-pandemic-data>  Ministry of Justice (2021) Family Court Statistics. <https://www.gov.uk/government/statistics/family-court-statistics-quarterly-october-to-december-2020/family-court-statistics-quarterly-october-to-december-2020>  NSPCC (2020) [Isolated and struggling. Social isolation and the risk of child maltreatment in lockdown and beyond.](https://learning.nspcc.org.uk/media/2246/isolated-and-struggling-social-isolation-risk-child-maltreatment-lockdown-and-beyond.pdf) |
| **Postnatal care of the woman** | | | | |
| **Maternal health** | | | | |
| 25 | **Beat SCAD** | Identification of cardiac symptoms in post-partum women. | *QS37, ‘Quality statement 2: Maternal health – potentially serious conditions’* says: “chest pain might indicate cardiac problems”.  However, chest pain is not the only cardiac symptom experienced by women with Acute Coronary Syndrome.  Cardiac symptoms may include any or all of the following: chest pain, pain referred to jaw or back, breathlessness, sweating, nausea, dizziness, arm numbness etc  Beat SCAD believes:   1. More information should be shared by midwives with new mothers about the risks of (albeit rare) serious cardiac health problems for recently pregnant women. 2. More specific information should be shared with new mothers about what cardiac symptoms could look and feel like.   Raised awareness could lead to earlier diagnosis and treatment. It could prevent significant numbers of MACE (Major Adverse Cardiac Events).  We understand that the guideline can’t read like a textbook, or cover specific conditions, but, given that the leading cause of maternal death is cardiac events, we feel more emphasis should be put on identifying cardiac symptoms in recently pregnant women than just listing ‘chest pain’. | Please see  [MBRRACE-UK Maternal Report 2019 - Infographic v1.0.pdf (ox.ac.uk)](https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20Infographic%20v1.0.pdf) which says: “In 2015-17, 209 women died during or up to six weeks after pregnancy, from causes associated with their pregnancy, among 2,280,451 women giving birth in the UK.  Of these 209 women, 23% (48 mothers) died from Cardiac Disease.”  The most recent MBRRACE report, published 2021, says “Cardiac disease remains the largest single cause of maternal deaths.”  Table 2.3 on page 8 [MBRRACE-UK\_Maternal\_Report\_2021\_-\_FINAL\_-\_WEB\_VERSION.pdf (ox.ac.uk)](https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf) shows that between 2013 and 2019, there were 243 maternal deaths due to cardiac disease.  and  The PCR EAPCI Percutaneous Interventional Cardiovascular Medicine text book (May 2021): [Percutaneous interventional cardiovascular medicine The PCR-EAPCI Textbook (pcronline.com)](https://www.pcronline.com/eurointervention/textbook/pcr-textbook/) (behind paywall) says:  “Pregnancy-associated SCAD (P-SCAD; usually defined as SCAD occurring during gestation or within 12-months of delivery) accounts for around 5-10% of SCAD cases. SCAD reportedly occurs in 1.81 per 100,000 pregnancies, accounting for 10% - 22% of ACS events in pregnancy and 23-67% of post  partum ACS with most post-partum events occurring within the first few weeks of delivery. There is growing evidence that P-SCAD is associated with a more severe phenotype with more proximal and extensive dissections and larger infarcts. Fatal P-SCAD is an uncommon but recognised cause of maternal death. SCAD has also been observed in association with multi-parity and pre-eclampsia in some series.”  and  [European Society of Cardiology, acute cardiovascular care association, SCAD study group: a position paper on spontaneous coronary artery dissection | European Heart Journal | Oxford Academic](https://academic.oup.com/eurheartj/article/39/36/3353/4885368#112271760)  Published in 2018 says 21–27% of myocardial infarctions in pregnancy and 50% of post-partum coronary events are reportedly due to SCAD.  and  [Women's experiences of cardiac pain: a review of the literature - PubMed (nih.gov)](https://pubmed.ncbi.nlm.nih.gov/18727283/) says: “Women experience coronary heart disease (CHD) differently than men. Presentations of cardiac pain for women can include vague signs and symptoms such as extreme fatigue, discomfort in the shoulder blades, and shortness of breath. Subsequently, the assessment, identification, treatment, and rehabilitation of women with CHD present challenging and unique opportunities for nurses because women experience a multiplicity of symptoms that are often not reported or recognized as cardiac in nature.” |
| 26 | **GP Infant Feeding Network** | Maternal Health (Physical and Mental) | Recent MMBRACE Saving Lives, Improving Mothers’ Care Reports highlight the major causes of maternal mortality. Cardiovascular disease and maternal suicide remain the major causes of death in the perinatal period (2021) and that there is a continued inequality of increased mortality rate for Black, Asian and Mixed Ethnicity women  [https://www.npeu.ox.ac.uk/mbrrace-uk - main](https://www.npeu.ox.ac.uk/mbrrace-uk#main) | Quality Statement 2 should be retained and links or reference to NICE QS115 standards should be considered for addition (as maternal mental health standards have already been retired from QS37). |
| 27 | **GPCPC (GPs championing perinatal care)** | Birth trauma. | Birth trauma is poorly recognised and can lead to problems with mental health and attachment. Within Long-term plan services are being developed in maternal mental health hubs  <https://www.england.nhs.uk/2021/04/dedicated-mh-services/> | There need to be clear pathways from secondary care to birth trauma services, including the option for self-referral of women and their partners |
| 28 | SCM3 | Key area for quality improvement 5 | Assessment and care of the woman, in relation to assessing physical health and emotional wellbeing | As there are no tools to assess this systematically, and the recommendation, therefore, QS would be helpful for the providers |
| 29 | SCM5 | Key area for quality improvement 1  Auditable standards are required to  provide quality assurance that  a) All mothers have a formal risk assessment that is completed and  recorded at each point of postnatal contact, like that recommended in pregnancy and  b) have personalised postnatal care tailored to the multiple complexities they may face | The National Maternal Mortality reports highlight  a) Highest risk of maternal mortality is in the postnatal period  b) No statistically significant change in this rate for over a decade and areas of improvement  c) Disparity in mortality rates between women from Black and Asian Ethnic groups and White  women  d) The interplay of multiple factors which influence clinical outcomes like socioeconomic deprivation, language difficulties, mental health  problems, domestic abuse, systemic and cultural barriers  There must be equity in access to care through pregnancy and that in the postnatal period, so that women have continued access to care by the most appropriately trained health professional | Please see the following documents  a) For national audit report- UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19  https://www.npeu.ox.ac.uk/mbrrac  e-uk/reports  b) For the need to prioritise this area for quality improvement  <https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/a-strong-start-in-life-for-children-and-young-people/maternity-and-neonatal-services/>  <https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/19/1907.htm#_idTextAnchor044>  Box 3 has Expert Panel  style Ratings for maternal  mortality  c) Recommended standards for  Maternity services  https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf |
| **Perineal care and pelvic floor health** | | | | |
| 30 | **GP Infant Feeding Network** | Maternal Pelvic Floor and Perineal Health Care | As well as pain, incontinence and sexual health problems, perineal and pelvic floor health can also have an impact on maternal mental health and infant feeding (e.g. pain and discomfort can impact feeding position and duration and hence adversely impact breastmilk production). Those breastfeeding can face difficulty accessing appropriate analgesia from prescribers.  Addition of this specific area is also in line with NHS England’s strategic plans to reduce long-term incontinence and sexual dysfunction. See <https://www.england.nhs.uk/2021/06/nhs-pelvic-health-clinics-to-help-tens-of-thousands-women-across-the-country/> | The updated NICE NG194 makes specific recommendations about timely review and urgent referral for treatment of maternal perineal wounds (Sections 1.2.15 and 1.2.20). |
| 31 | **GPCPC (GPs championing perinatal care)** | Perineal care. | Perineal care is well recognised as poorly undertaken and appropriate referral is often delayed when it should be viewed as urgent | See statement 1.2.20 about referral of perineal breakdown within 24 hours and consider using this as a QS |
| 32 | **NHS England and NHS Improvement** | Pelvic Health and Physical Recovery | The updated NG194 includes welcome reference to pelvic health and physical recovery, including the importance of pelvic floor exercises.  This aligns with the Long Term Plan commitment to improve the prevention, identification and timely access to NICE-recommended treatment of pelvic floor dysfunction around birth, through the establishment of Perinatal Pelvic Health Services. 14 Early Implementer Systems have been in operation in 21/22, with a similar number of Fast Followers expected to begin implementation in 22/23. PPHS will work closely with maternity services to ensure compliance with relevant NICE recommendations, such as the provision of supervised PFMT for SUI and POP, and ensuring that all women are offered non-surgical treatments and advice before surgical options are discussed.   We would welcome a Quality Standard aligned with the increased emphasis on pelvic health in NG194 – in particular that there is routine, direct enquiry. Also that women are receiving quality information on the potential risks of pelvic floor dysfunction; what they can do to prevent them (ie PFMT); and where they can seek support if they have concerns.  This could be included in a holistic section on the woman’s postnatal health, in line with the new simplified structure of NG194. |  |
| 33 | SCM1 | Key area for quality improvement 2 | Perineal care  NG194 now has a specific section for perineal care including same-day referral for wound breakdown and assessment of perineal pain. Significant burden of pathology for women in whom this is not addressed | Use of GP record data, audit of referral to maternity/obstetric assessment for perineal wound problems. |
| 34 | SCM3 | Key area for quality improvement 2 | Perineal health | About one in three women will experience urinary incontinence after childbirth, one in ten faecal incontinence, and one in twelve pelvic organ proplapse.  References: 85. Thom, D. & Rortveit, G. (2010) Prevalence of postpartum urinary incontinence: a systematic review. Acta Obstetricia et Gynecologica Scandinavica. 89 (12), 1511-22. Available from: <https://doi.org/10.3109/00016349.2010.526188>   1. 86. Johannessen, H.H., Wibe, A., Stordahl, A., Sandvik, L., Backe, B. & Mørkved, S. (2013) Prevalence and predictors of anal incontinence during pregnancy and 1 year after delivery: a prospective cohort study. BJOG. 121 (3), 269-280. Available from: <https://doi.org/10.1111/1471-0528.12438>   It is one of the ambitions for maternity, as stated in the NHS Long-term plan.  Therefore early identification and signposting to relevant specialists and physiotherapy are essential to support women. |
| 35 | **SCM6** | Perineal health | Again this is an area where our members report that their concerns are not fully taken into consideration, in particular perineal pain. Specific enquiry into perineal wound healing and pain should be made at each postnatal contact. | Please see section 1.2.15-1.2.22 of the NICE postnatal care guideline  [Recommendations | Postnatal care | Guidance | NICE](https://www.nice.org.uk/guidance/ng194/chapter/Recommendations#postnatal-care-of-the-woman) |
| **6-to-8-week postnatal check** | | | | |
| 36 | **GP Infant Feeding Network** | Maternal Health (Physical and Mental) | Recent MMBRACE Saving Lives, Improving Mothers’ Care Reports highlight the major causes of maternal mortality. Cardiovascular disease and maternal suicide remain the major causes of death in the perinatal period (2021) and that there is a continued inequality of increased mortality rate for Black, Asian and Mixed Ethnicity women  [https://www.npeu.ox.ac.uk/mbrrace-uk - main](https://www.npeu.ox.ac.uk/mbrrace-uk#main) | A universal maternal postnatal check at 6-8 weeks by a GP should be referenced (NICE NG194 section 1.2.7) and this is now mandated by NHS England. |
| 37 | **GPCPC (GPs championing perinatal care)** | Maternal postnatal examination at 6-8 weeks. | The maternal postnatal examination at 6-8 weeks has been funded recently. We are delighted to see that the GP is the recommended person to undertake the check. We would like the standard to state this this is a GP role and not possible to delegate | This would mean that GPs need training and resources to undertake this check. |
| 38 | **NHS England and NHS Improvement** | Provision of the Maternal Postnatal GP check at 6-8 weeks | The updated NG194 sets out that GPs should carry out an assessment of the mother’s health at 6-8 weeks, in particular covering such things as: Key risk factors in the postnatal period; Mental health and wellbeing; Pelvic health; and wider physical recovery, family planning, and ongoing management of emerging conditions.  NHSEI is in direct support of this requirement, and introduced a requirement for GPs to lead these checks for all women in the 20/21 GP contract, at an additional cost of £12m p/a.  This followed growing evidence that rates of mental and pelvic health issues perinatally are underreported, and research conducted for NHESI (note unpublished) by the NIHR Policy Research Unit for Maternal health that showed considerable variation in the provision in these checks, and that younger women, women in more deprived neighbourhoods, and women in the North of England were significantly less likely to receive a dedicated check for their own health, before the introduction of a requirement.    While we await evidence of the impact of this contractual requirement in the 2021 CQC Maternity Services survey, it is clear that the COVID-19 pandemic has frustrated efforts to publicise the introduction of this requirement, and the rolling out of best practice guidance from NHSEI and the RCGP. Surveys conducted by national organisations such as the NCT, and anecdotal reports from GP leads certainly suggest that the contractual requirement has not had the anticipated impact, with pandemic measures reducing the number of appointments available in primary care and bringing about a general reliance on telemedicine.  Therefore NHSEI would welcome a focus on the universal provision of these checks. This could be evidenced through the % of women reporting that they had sufficient time to discuss their physical and mental health in the CQC survey (F19 and F20).  This could be included in a holistic section on the woman’s postnatal health, in line with the new simplified structure of NG194.  We would also welcome a focus on maternity services ensuring a quality handover to General Practice to facilitate this. | Questions F19 and F20 in the CQC Maternity Services Survey ask women whether GPs spend enough time asking them about their physical and mental health. |
| 39 | SCM1 | Key area for quality improvement 1 | The GP 6-8 week maternal check.  NG194 now specifies it should be a GP who sees the woman and includes an extensive list of what should be covered. | Use of GP record data to assess the proportion of women having a check and its content (i.e. are all aspects of the check as listed in the NG194 recommendations covered?) |
| 40 | **The Breastfeeding Network** | All women to receive a maternal 6 week health check. | The maternal 6 week health check is recommended in the postnatal care guidelines, but recent research from Li et al (2021) shows that 40% of women did not have a 6 week check recorded between 2015 and 2018 and those who did not have a check recorded were more likely to be younger or from more deprived areas. The most recent report from MBRRACE showed that mothers from these demographics are at greater risk of perinatal death. Ensuring that all women receive this vital check, especially those from at risk groups, is of vital importance. | Li Y, Kurinczuk JJ, Gale C*, et al*  Evidence of disparities in the provision of the maternal postpartum 6-week check in primary care in England, 2015–2018: an observational study using the Clinical Practice Research Datalink (CPRD)  *J Epidemiol Community Health*Published Online First: 09 September 2021. doi: 10.1136/jech-2021-216640  https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK\_Maternal\_Report\_2021\_-\_FINAL\_-\_WEB\_VERSION.pdf |
| **Postnatal care of the baby** | | | | |
| **Symptoms and signs of illness in babies** | | | | |
| 41 | SCM3 | Key area for quality improvement 4 | Symptoms and signs of illness in babies, around “red flags” | This is a new recommendation to ensure parent’s concerns are listened to and signs and symptoms are identified at an early stage. Also as stated in the guideline recommendation it is important to look at signs and symptoms holistically. Therefore this QS will be important in illustrating impact when followed |
| 42 | SCM4 | Key area for quality improvement 1  Quality statement 3 should include the necessity of providers making available to parents authoritative and usable guidance on assessing their infant’s wellbeing – for example the BabyCheck system and advice on the use and limitations of use of commonly advertised devices for infants | Many families do not know where to access such information and use social media or manufacturers advertisements to obtain this information. (e.g the use of baby monitors, devices aimed at “improving” infant sleep, or the use of baby slings or carriers, | Evidence from our investigations of unexpected infant deaths has shown widespread lack of evidence-based information on these topics, sometimes directly related to inappropriate use of devices that have led to the deaths of infants. |
| 43 | **The Lullaby Trust** | Infant health – serious illness | The Lullaby Trust have read it and in our opinion the statement and associated measures are still relevant and factual in 2022.  Families need to be empowered to know when their baby might be seriously ill so they can access the appropriate help. This is particularly important for families living in deprivation, as the recent NCMD report showed. Information on access to routine community health services since lockdown shows that this is even more important.  Mention of the Baby Check tool in this area would be advantageous. | See National Child Mortality Database report on Child Mortality and Social Deprivation which highlights the importance of providing information on recognising illness:  <https://ncmd.info/wp-content/uploads/2021/05/NCMD-Child-Mortality-and-Social-Deprivation-report_20210513.pdf>  See Parent Infant Foundation report on the impact of the pandemic on families with young babies, which shows a difficulty in accessing advice form a GP or heath visitor:  <https://parentinfantfoundation.org.uk/wp-content/uploads/2021/11/211108-FINAL-No-one-wants-to-see-my-baby.pdf> |
| **Bed sharing** | | | | |
| 44 | **GP Infant Feeding Network** | Infant Health- Bed Sharing | The Lullaby Trust/UNICEF Baby Friendly Initiative and Basis have developed key messages for professionals on Safer Sleep for Babies: <https://www.lullabytrust.org.uk/wp-content/uploads/Safer-sleep-saving-lives-a-guide-for-professionals-web.pdf> | Updated recommendations have been made in NICE NG194 in sections 1.3.13 and 1.3.14. Focus should be on updating all staff involved in the care of families on the changes, how bed-sharing is common practice for many families at some point and conversations need to be initiated so that higher-risk bed sharing situations can be avoided or reduced. |
| 45 | **GPCPC (GPs championing perinatal care)** | Bed sharing. | The new guidelines differentiate types of bed sharing and highlight reasons to strongly advise not to bed-sharing. We think this is common sense and fits with most parents real experience and behaviour | See statement 1.3.14 and amend the statement to those that are mentioned as strongly advise |
| 46 | **Institute of Health Visiting** | Infant health – bed sharing | We recommend that NICE review the evidence for its safer sleeping statement and urge for rewording in light of international evidence which suggest that a more risk averse approach is warranted:  The iHV has been alerted to professional concern that the current postnatal NICE guidance is not aligned with international safe sleeping guidance from the American Academy of Paediatrics (AAP), the Australian, the Canadian, the European Foundation for the care of the Newborn Infant (EFCNI), Irish and New Zealand which all advocate no bed sharing/co-sleeping with infants under 12 weeks of age due to the increased risk of SIDS even if no adverse conditions are present. (See links opposite for the guidance from these countries). Tapin et al October 2021 noted the following: “The International SIDS Community has set policy based on meta-analysis 1-4 and a priority for safety: In 2004–2005, the European Concerted Action on SIDS (ECAS) (1) comprising case–control studies in 20 European regions and a Scottish study (2) showed significant risk for babies under 8 and 11 weeks respectively bed-sharing with non-smoker(s). In Edmonton Canada, the International SIDS Community asked for a meta-analysis of all relevant data. An individual participant data meta-analysis of case–control studies (ECAS, Scotland, Ireland, Germany and New Zealand with 1472 cases and 4679 controls) confirmed significant risk for young babies under 12 weeks bed-sharing in the absence of additional hazards (3) An extreme sensitive analysis confirmed significant risk for babies under 8 weeks bed-sharing with non-smoking adult(s) who did not drink or take drugs (4).The iHV is aware that there is disagreement between scientists over this and welcome the opportunity for NICE postnatal care, Quality Standard Statement 4: “Women, their partner or main carers of babies have discussions with their healthcare professional about safer bed-sharing practices” to be modified in view of the international evidence on this. We are aware that the SIDS/SUDI statistics vary considerable from country to country with Scotland having higher rates that England. | References  American Academy of Paediatrics <https://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx>  Australian safe sleeping guidance <https://rednose.org.au/section/safe-sleeping>  Canadian guidance <https://www.canada.ca/en/public-health/services/health-promotion/childhood-adolescence/stages-childhood/infancy-birth-two-years/safe-sleep/safe-sleep-your-baby-brochure.html>  European Foundation for the care of the Newborn Infant (EFCNI) <https://www.efcni.org/health-topics/going-home/safe-sleep/>  Ireland <https://www2.hse.ie/conditions/cot-death/where-baby-should-sleep/>  New Zealand Birth – 6 weeks  <https://www.health.govt.nz/your-health/pregnancy-and-kids/first-year/first-6-weeks/keeping-baby-safe-bed-first-6-weeks>  and 6 weeks to 6 months <https://www.health.govt.nz/your-health/pregnancy-and-kids/first-year/6-weeks-6-months/keeping-baby-safe-bed-6-weeks-6-months>  1.Carpenter RG, Irgens LM, Blair PS, et al. Sudden unexplained infant death in 20 regions in Europe: case control study. Lancet 2004;363:185–91.  2. Tappin D, Ecob R, Brooke H. Bedsharing, roomsharing, and sudden infant death syndrome in Scotland: a case- control study. J Pediatr 2005;147:32–7.  3. Carpenter R, McGarvey C, Mitchell EA, et al. Bed sharing when parents do not smoke: is there a risk of SIDS? An individual level analysis of five major case– control studies. BMJ Open 2013;3:e002299.  4. Carpenter JR, Smuk M. Missing data: a statistical framework for practice. Biom J 2021;63:1–33.  5. Tappin, D, Mitchell, E. Carpnter, J. Hauck, F, Allan, L. 2021 “Bed sharing is a risk for sudden unexpected death in infancy” Archives of Disease in Childhood Vol 0 No 0 |
| 47 | **La Leche League Great Britain** | Infant health – bed sharing | Sharing accurate and evidence-based information on how parents can breastfeed in a restful position, including sleeping on the same surface, reduces the likelihood of unsafe sleep practices which are the most common cause of infant suffocation. | See Unicef Guidance: [Caring for your baby at night](https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2018/08/Caring-for-your-baby-at-night-web.pdf) for safe breastfeeding, sleep and bottle feeding when tired.  See [NICE Guideline Postnatal Care](https://www.nice.org.uk/guidance/ng194/chapter/recommendations#postnatal-care-of-the-baby) Bedsharing 1.3.13 |
| 48 | SCM2 | Promote Safe Sleeping Practices to reduce the risk of preventable (SIDS) infant mortality in all areas and ensure information is accessible to all parents especially targeting those at most risk including young mothers and those who do not breastfeed their baby Key area for quality improvement 1 | The Office of National Statistics 2020 found that 196 babies in the UK still die every year due to SIDS. That’s 4 babies every week in the UK and the North West of England has a higher than National average rate. A systematic review of the literature (Horsley et al 2007) concludes that the evidence consistently suggests an association with falling asleep in bed or on the sofa or armchair with a baby and SIDS and is strongly associated with younger infants. Falling asleep with a baby in bed or on the sofa or armchair results in a higher incidence of SIDS. Therefore, Sudden Infant Death Syndrome (SIDS) is preventable and all forms of bed (sofa or armchair)-sharing should be avoided for these infants when an adult falls asleep. Young mothers are most affected and those that take alcohol or drugs and do not breastfeed their baby are most at risk | Please see Office of National Statistics, National Records of Scotland and Northern Ireland Statistics and Research Agency, 2020 which highlights findings of SIDS and the reasons why babies die of this preventable tragedy |
| 49 | **Scottish Cot Death Trust** | Infant health – bed sharing | Revisit Review N (NG194 Postnatal Care) with infant age re-designated as a ‘Risk factor (relating to co-sleeping)’ rather than a ‘Confounding factor’ with the critical outcome ‘All unexplained/unexpected infant deaths’ re-categorised as infants less than 3 months rather than 6 months as is currently the case.  The current review has missed important data which shows young babies are at inherent increased risk of SUDI in the absence of additional risk factors.  Firstly, infant age the most important remaining ‘risk factor’ for co-sleeping widely accepted since the meta-analysis in 2013 (1) is treated as a ‘confounding factor’ and therefore not searched for, included in the review or reported as a risk factor for co-sleeping, in its own right.  Secondly in the protocol ‘critical outcomes’ are defined as –  All unexplained/unexpected infant deaths:  • within the first 6 months  • within the first year  With regard to infant age as a risk factor, this should be:  - All unexplained/unexpected infant deaths:  • within the first 3 months  • within the first year  Infant age as a *modifiable* risk factor has therefore not been looked at by Review N - Co-sleeping risk factors.  (1)Carpenter R, McGarvey C, Mitchell EA, et al. Bed sharing when parents do not smoke: is there a risk of SIDS? An individual level analysis of five major case– control studies. BMJ Open 2013;3:e002299. | Designating infant age as a risk factor will also ensure inclusion rather than exclusion of the definitive meta-analysis of bed-sharing risk for young infants  Previous meta analyses have shown this increased risk. (1)  The 3-month cut-off is biologically plausible as babies develop head control in the first 3-4 months helping them to protect their airway (1)  This biologically plausible cut-off is backed up by case-control studies of Sudden Unexpected Death in Infancy where bed-sharing is largely a risk in the first 3 months of life. (1, 2, 3, 4)  (1)Carpenter R, McGarvey C, Mitchell EA, et al. Bed sharing when parents do not smoke: is there a risk of SIDS? An individual level analysis of five major case– control studies. BMJ Open 2013;3:e002299.  (2) Tappin D, Ecob R, Brooke H. Bed-sharing, roomsharing, and sudden infant death syndrome in Scotland: a casecontrol study. J Pediatr 2005;147:32–7.  (3) Carpenter RG, Irgens LM, Blair PS, et al. Sudden unexplained infant death in 20 regions in Europe: case control study. Lancet 2004;363:185–91.  (4) Blair PS, Sidebotham P, Pease A, et al. Bed-sharing in the absence of hazardous circumstances: is there a risk of sudden infant death syndrome? An analysis from two case-control studies conducted in the UK. PLoS One 2014;9:e107799. |
| 50 | **The Lullaby Trust** | Infant health – bed sharing | The Lullaby Trust have read it and in our opinion the statement and associated measures are still relevant and factual in 2022.  Bedsharing remains a risk for Sudden Infant Death Syndrome in some high-risk situations. Yet it is also a practice that is widely adopted. It is therefore very important, particularly for vulnerable families, that they are made aware of both the risks and how to make this sleeping place safer should they bed share, intentionally or not.  Providing information on safer sleeping is particularly important in trying to reduce inequalities as we know deprived families are at a greater risk.  Risks should ideally come before discussion about ‘safer’ bedsharing to conform with agreed safer sleep messages. We would also urge that a link to the increased risks for babies born prematurely is included. | See National Child Mortality Database Annual report for information on modifiable factors, and the importance of the broader issue of co-sleeping, and known risk factors:  <https://www.ncmd.info/wp-content/uploads/2021/06/NCMD_2nd_Annual_Report_June-2021_web-FINAL.pdf>  Out of Routine Report, July 2020, also refers to the risks of the wider issue of co-sleeping:  <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf>  See National Child Mortality Database report on Child Mortality and Social Deprivation which highlights the importance of providing information on safer sleep:  <https://ncmd.info/wp-content/uploads/2021/05/NCMD-Child-Mortality-and-Social-Deprivation-report_20210513.pdf>  Joint leaflet on safer sleep by Lullaby Trust and others that uses terminology around ‘bedsharing more safely’ rather than ‘safer bed sharing’ or ‘safe bedsharing’ :  <https://www.lullabytrust.org.uk/wp-content/uploads/Safer-sleep-for-babies-a-guide-for-parents-web.pdf> |
| 51 | **The Lullaby Trust** | Safer sleeping guidance | We know that babies die of SIDS with multiple, known risk factors. NCMD data has shown this is the case. It is therefore essential that all carers of babies are given the established safer sleep guidance, and not just the advice around bed sharing. | See National Child Mortality Database Annual report for information on modifiable factors, and the importance of the broader issue of co-sleeping, and known risk factors:  <https://www.ncmd.info/wp-content/uploads/2021/06/NCMD_2nd_Annual_Report_June-2021_web-FINAL.pdf>  Joint leaflet on safer sleep by Lullaby Trust and others that has established safer sleep guidance:  <https://www.lullabytrust.org.uk/wp-content/uploads/Safer-sleep-for-babies-a-guide-for-parents-web.pdf> |
| **Promoting emotional attachment** | | | | |
| 52 | **GP Infant Feeding Network** | Infant Mental Health and Parent-Infant Relationship | Infant Mental Health and parent-infant relationships are vital to the infants’ future physical and mental health. Wider training for staff and improvement in services’ ability to observe and respond to concerns about parent-infant relationships and infant mental health are needed. See:  <https://parentinfantfoundation.org.uk/why-we-do-it/why-relationships-matter/>  <https://parentinfantfoundation.org.uk/why-we-do-it/the-economic-case/> | We would encourage the Committee to seek expert advice on the retention and enhancement of Statement 9 from colleagues working in the field of infant mental health, parent-infant relationships and Perinatal CAMHS. |
| 53 | **Infant Feeding Alliance** | Bonding and attachment as part of healthcare quality standards | The private and personal matter of bonding and attachment should not be part of NICE quality standards and we are deeply concerned about quality statement 9, ‘Emotional wellbeing and bonding with the baby’. There is no evidence for the recommendation: ‘regular assessment of the woman's emotional wellbeing, including bonding with her baby, may lead to earlier detection of problems’ (as your own Evidence Review O concluded).  We suggest that such interference in family life could contribute to the very problems it seeks to prevent. As parents, we found that healthcare professional advice and focus on bonding undermined our confidence. We found it anxiety-inducing, intrusive and unhelpful, especially in the stressful postnatal period. We found that bonding happened when pressure was taken off us and we were given space to develop our relationships with our babies. Healthcare providers should not overstep healthcare provision into interference with family life. In our experience, this can cause unnecessary worry and stress and lead to distrust of healthcare providers.  Just as the 2019 review of the Baby Friendly Initiative found, we experienced exclusive breastfeeding promotion and support to have adverse effects on our wellbeing (Fallon et al., 2019). Some of us found it affected our bond with our baby in the short-term. Many of us found that exclusive breastfeeding contributed to difficulties with bonding with our babies, when it was difficult or painful, involved excessive sleep deprivation or frequent feeding and when it led to infant hospital readmission. For us, bottle feeding provided a solution and contributed to bonding with our baby. Current policy and practice that promote exclusive breastfeeding as an outcome measure will only continue to cause harm to women’s wellbeing, as described in the previous comment.  There is no one-size-fits all approach to bonding and attachment and you cannot prescribe how to fall in love. In our view: leave bonding and attachment out of healthcare guidelines. | References cited:  Fallon, V., Harrold, J., Chisholm, A., 2019. The impact of the UK Baby Friendly Initiative on maternal and infant health outcomes: a mixed-methods systematic review. Matern. Child Nutr. 15 (3), e12778. <https://doi.org/10.1111/mcn.12778>.  National Institute for Health and Care Excellence, 2020, Postnatal care: evidence reviews. Available from: <https://www.nice.org.uk/guidance/ng194/evidence/evidence-reviews-april-2021-9076791277?tab=evidence>. Accessed date: 4 February 2022 |
| 54 | **Institute of Health Visiting** | Coping with crying | Infant crying is normal, but it is also a stressful and distressing condition for parents and care givers to cope with, affecting their sleep, parenting capacity, physical and mental health. It can trigger depression and anxiety, cause early cessation of breast feeding as well as the early introduction of solids (Sung 2018). Excessive crying can trigger abusive head trauma and the consequences can be life changing and catastrophic for infants involved (ICON 2020) (2).  Raising awareness of infant crying with advice on ways to manage crying has been shown to be effective at improving parental reaction to crying and specifically in reducing incidents of abusive head trauma (3).  ICON (Infant Crying is Normal; Comforting Methods can help; It’s Ok to Walk Away; Never, Ever Shake a Baby)  Key messages are delivered at five key touch points:   * At the hospital before discharge. * By the community midwife in the baby’s first 10 days. * By the health visitor in the first 14 days. * By the health visiting again at three weeks. * By the GP at the six-to-eight-week postnatal check.   Key messages include:  I - Infant crying is normal and it will stop  C - Comfort methods can sometimes soothe the infant and the crying will stop  O - It is OK to walk away if the parent/carer has checked the baby is safe and the crying is getting to them  N - Never shake or hurt a baby  ICON has been mentioned in the independent Child Safeguarding Practice Review Panel’s third national review: ‘The myth of Invisible Men’ Safeguarding children under one from non-accidental injury caused by make carers (published 16/09/2021) (4) | 1. Sung, V (2018) Infantile Colic Australian Prescriber Aug 20181(4): 105–110. Published online https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6091773/ 2. ICON (Infant Crying is Normal; Comforting Methods can help; It’s Ok to Walk Away; Never, Ever Shake a Baby) <https://iconcope.org/> 3. <https://iconcope.org/wp-content/uploads/2020/09/CS51689-NYY-ICON-LEAFLET-v2.pdf> 4. Child safeguarding practice review panel (2021) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1017944/The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf> |
| 55 | **Institute of Health Visiting** | Parent Infant relationship | The iHV are of the opinion that quality statement 11 on parent-baby attachment should not be removed and it should be strengthened to reflect the importance of infant mental health. Strengthening this statement will help to raise the parity between physical and mental health. There needs to be particular the focus on both parents. Involving partners and other family members can help them to provide support and care for the mother, ultimately promoting the mother’s mental health and her ability to care for the baby. Strengthening this statement will align with the current ambitions of the Long Term Plan (1).  ‘Think Family’ (2) enables practice to be consistently family inclusive. Consideration can be given to:   * the mother in her family context * the needs of the whole family * holding in mind that what affects the parent will affect the baby, and what affects the baby will affect the parent * ways in which family members can be involved in the mother’s care * supporting family members as individuals, as partners/relatives to the mother, as parents/relatives to the baby.   To also consider: ‘The Perinatal Frame of Mind’ (3) which sets out components of best practice when working with mothers and their families at every stage of perinatal care. The Perinatal Frame of Mind means thinking about the needs of multiple family members and, specifically, the ability to be aware of:   * the father/partner’s mental health and how this affects the mother and baby * how the pregnancy affects the father/partner and other family members’ mental health and wellbeing * how the absence of a partner or lack of support from the family may affect the mother, baby and mother-baby relationship. | 1. NHS England. The NHS long term plan. 2019; Available from: <https://www.longtermplan.nhs.uk/> 2. Hogg, S., Prevention in mind: All Babies Count: spotlight on perinatal mental health. 2013: London 3. Health Education England, The competency framework for professionals working with women who have mental health problems in the perinatal period. 2018. <http://tinyurl.com/y4sy9fxg> |
| 56 | **Parent-Infant Foundation** | Parent-infant interaction and babies’ emotional wellbeing. (Promoting emotional attachment) | Early relationships between babies and their caregivers are critically important for many aspects of babies’ development.  When parents cannot provide their babies with the consistent nurturing care they need, and when there are difficulties in the early relationships, this can affect babies emotional wellbeing and development with potentially pervasive and lasting consequences. Timely, quality support can promote positive parent-infant interactions, strengthen relationships and mitigate against the impacts of early trauma. It is therefore critically important that early interactions and emotional wellbeing are assessed in the perinatal period, issues are identified, and action taken to ensure families receive the support they need.  During postnatal contacts with families, professionals can observe interactions between parents and their babies; discuss with parents their feelings about their babies and observe their level of attunement. Practitioners can use tools such as the MORS to assess the quality of parent-infant relationships. In addition, postnatal contacts provide an opportunity for practitioners to observe babies’ emotional wellbeing or any signs of early distress or relational trauma.  We welcomed the strengthened content on promoting emotional attachment in the postnatal guideline. In addition, PHE (now OHID) also adjusted their “high impact areas” for health visiting to cover babies’ mental health, alongside that of their mothers.  However,, despite these developments, there is still extensive work to do to ensure that services uniformly protect and promote healthy early relationships and offer timely, high-quality interventions to those who are struggling.  Early relationships and babies’ emotional wellbeing are still not well understood and accepted as a key part of the work of universal services in the perinatal period.  In addition, many practitioners working in universal services have not had the training to   * Understand the central importance of the parent-infant relationship for lifelong outcomes * Identify which parent-infant relationships are under strain and be able to access specialised consultation about what to do next.   Recent research with health visitors by Professor Jane Barlow reported that health visitors feel they do not have the time to assess parent-child interaction and lack confidence in the area of parent-infant relationships and mental health due to poor or insufficient training.  The same research also reported a lack of understanding among commissioners about both perinatal and parent-infant mental health. The report recounts how local specialist health visitors have to “repeatedly remind others about the importance of infant mental Health.”  A quality standard relating to early bonding/attachment could help to drive the system change needed.  Quality Standard 9 currently covers both maternal wellbeing and early bonding. As a minimum, this should be maintained. But we recommend going further, with the introduction of a distinct quality standard specifically around promotion and assessment of healthy parent-infant relationships (or “emotional attachment” as it is called in the guideline.)  This standard needs careful thought and we would be happy to support its development. A babies’ attachment style cannot be measured in the postnatal period, but other related concepts such as attunement and the quality of parent-infant interactions can be measured.  There is currently no universally used tool to measure parent-infant relationship, which makes monitoring the incidence of issues very difficult. Our work in local areas has shown that many assessments of babies and young children often do not directly address the parent-infant relationship, so are instances of early relational difficulty are likely to be missed.  Local commissioners and managers, therefore, need to consider how practitioners are trained to observe or assess early relationships; what tools they should use,and how population-level data should be captured and used to drive service development. A quality standard might encourage workforce development, the adoption and use of recognised assessment tools, collection and use of data, and the existence of clear referral pathways. | Homonchuk, O. and Barlow, J. (2022) Specialist Health Visitors in Perinatal and Infant Mental Health. *Department of Social Policy and Intervention, University of Oxford*  Pettit, A. (2008) ‘Health visitors’ experiences of using a tool in assessing infant attachment’, *Community Practitioner*, 81(11), 23–26.  Rowan, C., McCourt, C. and Bick, D. (2010) ‘Provision of perinatal mental health services in two English strategic health authorities: views and perspectives of the multi-professional team’, *Evidence-Based Midwifery*, 8(3), 98–106.  Wilson, P. *et al.* (2008) ‘Health visitors’ assessments of parent-child relationships: A focus group study’, *International Journal of Nursing Studies*, 45, 1137–1147. |
| 57 | Royal College of Midwives | Key area for quality improvement 1 | Mental health/emotional wellbeing | Bonding and parent-infant attachment should be part of this QI area. A positive initial interaction post-birth and in the early postnatal period is crucial and has long lasting consequences on the physiology and behaviour of mother and infant. There is proven impact of early parenting on optimal neurological development of the infant. It is crucial that the postnatal guideline covers the window of opportunities presented by postnatal care for early years public health and social care interventions.  RCM, Emotional wellbeing & Infant Development: <https://www.rcm.org.uk/media/4645/parental-emotional-wellbeing-guide.pdf> |
| 58 | SCM2 | Managing a crying baby especially in the postnatal period where babies of 2-4 months are most at risk Key area for quality improvement 4 | Abusive Head Trauma (AHT) also known as shaken baby syndrome is a leading cause of death in infants 2-4 months old and causes catastrophic brain injuries which can lead to death or significant long- term health and learning disabilities and is preventable  Despite Persistent incidence of 20-24 per 100,000 in the UK there is a lack of a fully co-ordinated multiagency prevention programme aimed at the prevention of AHT  Research points to persistent crying in babies being a trigger for some parents to lose control and shake a baby. 70% of babies are shaken by men so any prevention programme should include the male caregiver and be evidence based such as ICON:  I-Infant Crying is Normal  C- Comforting methods can help  O-Its OK to walk away  N- never shake a baby | Please see Berthold et al 2019 Do we get the message? Difficulties in the prevention of head trauma European Journal of Paediatrics 178 (2) 139-46  Also see babies cry you can cope smith 2019  Smith 2016 available at <https://www.wcmt.org.uk/fellows/reports/abusive-head-trauma-case-prevention>  See <https://Iconcope.org> |
| 59 | SCM2 | Key area for quality improvement 5 Promote Infant Mental health including bonding and attachment to support early intervention in the identification of any issues by utilising evidence-based programmes such as Brazelton’s NBO tool as recommended by NHS England national health Visiting Core Service Specification and NHS Health Education | There is compelling evidence that early attachment and bonding has a lasting long-term impact on a childs mental wellbeing. Delivery of evidence-based programmes of care using evidence- based tools such as Brazelton’s New Born Behavioural Observations (NBO) system to conduct assessments on all babies and mothers to identify any issues early in this area and promote infant mental health and good bonding and attachment with mother, father and baby | See <https://www.brazelton.co.uk>  See the National Health Visiting Core Service Specification (2015/16, NHS England) and Specialist Health Visitors in Perinatal and infant Mental Health (2016, NHS, Health Education England)  Use this guideline in conjunction with Postnatal Care QS37 QS9 |
| 60 | SCM6 | QS9 – Emotional wellbeing and bonding with the baby | Feedback from the birth trauma association support group members reveals that the standard for inquiry into the mother’s emotional wellbeing is extremely variable. Mother’s frequently report that concerns about their wellbeing and mental health are dismissed as ‘baby blues’ and that the impact on their lives is poorly misunderstood by practitioners caring for them. | Please see section 1.2.2 and 1.3.15-1.3.18 of the NICE Postnatal care guideline  [Recommendations | Postnatal care | Guidance | NICE](https://www.nice.org.uk/guidance/ng194/chapter/Recommendations#postnatal-care-of-the-woman) |
| 61 | World Breastfeeding Trends Initiative (UK) | Key area for quality improvement 3 | Re Quality Statement 9: To be retained and focus on bonding with the baby | How well the baby is attached to the carer is a major factor in the baby’s wellbeing. |
| **Supporting babies’ feeding** | | | | |
| **Information and support with feeding** | | | | |
| 62 | **British Specialist Nutrition Association** | Additional: Quality Statement 6: Formula Feeding | This statement should be updated to address the totality of support which should be provided to parents who are formula feeding:   * to address the stark disparity of support currently available to parents depending on how they feed their infant; * to provide sufficient support for parents who combinations feed; and * to prevent unnecessary psychological pressure on parents and to bring the quality statement in line with the current guideline on postnatal care. (1)   We know that breastfeeding is best for infants and it is right that parents are provided with all the right services and structures to support them to breastfeed their baby, as is evident in Quality Statement 5.  For parents who cannot or choose not to breastfeed and opt to formula feed, it is essential that they are provided with the correct services and structures to enable safe and supported feeding of their baby, and NICE recognise that this choice is respected. (2)  Quality Statement 6: Formula Feeding states “Information about bottle feeding is discussed with women or main carers of formula‑fed babies” with the rationale “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 baby to be admitted to hospital. The mother or main carer of the baby needs consistent, evidence-based advice about how to sterilise feeding equipment and safely prepare formula milk”.  This statement, as is, does not cover the need for support, as detailed in the current NICE guideline. (3)  We would encourage Quality Statement 6 to be brought into line with Quality Statement 5, focusing on the support that should be available to parents.  Both parents, and other key stakeholder organisations have been clear that ALL parents need support as well as safety information.  Whilst breastfeeding women should receive support, structured programmes and coordinated services, parents who formula feed are only provided with information and risks via the Quality Statement 6, and not support.  UNICEF/ BFI seeks to advocate for all babies regardless of feeding type (7) and we suggest that this position is incorporated into Quality Statement 6  We believe that all parents, however they choose to (or need to) feed their babies, should be offered a service which provides evidence-based support. We absolutely support consistent and evidence-based advice on safe formula preparation; however the current Quality Statement is limited to reducing risk, rather than providing much needed support to parents in a structured and supportive service.  The recently updated NICE guideline on postnatal care (NG194) (4) also address this point above. The guideline advises that parents who are formula feeding should receive face to face support, and the guideline details what this face to face support includes. The current Quality Standard does not reflect the updated guideline recommendations to provide support to parents choosing to formula feed and therefore Quality Statement 6 needs to be updated.  We need to reflect the lived experience of what we believe to be the majority of parents, which is combination feeding during all or part of their feeding journey  The current guidance statements also fail to address the fact that the majority of parents will not exclusively breastfeed or formula feed for the duration of their baby’s feeding journey. Parents may top up with formula to counteract weight loss in the early days, give baby a bottle of expressed milk to allow the breastfeeding parent some time off, or choose ongoing combination feeding with some formula, expressed breast milk and breastfeeding. The updated NICE guideline on postnatal care (NG194) recognises that feeding is not always clear cut and a combination of feeding methods is commonly used (5). This further demonstrates the clear need for the same support and services available to all parents feeding their infants, and that this should be reflected in this quality standard.  The current narrative places ALL parents under social and psychological pressure  We must finally consider the social and psychological pressure that is put on parents, and especially women, when breast and formula feeding are framed in a way where only risks of formula feeding are discussed and appropriate support is not provided for those who formula feed or combination feed.  A recent systematic review of scientific study (8) has shown that mothers feel guilt and shame regarding their feeding choices, whether they choose to formula feed or breastfeed.  The dichotomous narrative can lead to negative outcomes for both bottle fed and breastfed infants. Dr Vera Wilde (9) is calling for feeding policies which prioritise new-born nutritional needs, not breastfeeding, in a systematic review of cultural feeding practices over time.  In summary, the current Quality Statement 6: Formula Feeding needs to be updated:   * to address the totality of support which should be provided to parents using formula feeding; * to address the stark disparity in support currently available to parents depending on how they feed their infant * to address the fact that feeding is often not a ‘one or the other’ and combination feeding is common; * to prevent unnecessary psychological pressure on parents, and: * to bring the quality statement in line with the current guideline on postnatal care. | 1. National Institute for Health and Care Excellence. (2021) Postnatal Care (NICE Guideline NG194). Updated April 2021. 2. Please see NICE Guideline on Postnatal Care section 1.5.1 on planning and supporting babies feeding which recognises parent’s choices   *When discussing babies' feeding, follow the recommendations in the*[*section on principles of care*](https://www.nice.org.uk/guidance/ng194/chapter/recommendations#principles-of-care)*, and:*   * *acknowledge the parents' emotional, social, financial and environmental concerns about feeding options* * *be respectful of parents' choices.*  1. Please see NICE Guideline on Postnatal Care (NG194) section 1.5.18 which highlights that face to face support should be provided for formula feeding:   *For parents who formula feed:*   * *have a one-to-one discussion about safe formula feeding* * *provide face-to-face support* * *provide written, digital or telephone information to supplement (but not replace) face-to-face support.*  1. Please see NICE Guideline on Postnatal Care section 1.5.19 which details what face to face support should include for formula feeding support:   *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), 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.*  1. Please see NICE Guideline on Postnatal Care section 1.5.16 which recognises that parents may need to combination feed:   *Before and after the birth, discuss formula feeding with parents who are considering or who need to formula feed, taking into account that babies may be partially formula fed alongside breastfeeding or expressed breast milk.*   1. Please see NICE Guideline on Postnatal Care section 1.5.1 on planning and supporting babies feeding which recognises parent’s choices   *When discussing babies' feeding, follow the recommendations in the section on principles of care, and:*   * *acknowledge the parents' emotional, social, financial and environmental concerns about feeding options* * *be respectful of parents' choices.*  1. Unicef UK Baby Friendly Initiative. (2017) Unicef UK Baby Friendly Initiative Statement: How the Baby Friendly Initiative supports parents who formula feed. Available from: <https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2017/12/How-the-Baby-Friendly-Initiative-Supports-Parents-who-Formula-Feed.pdf> [Accessed 02 Feb 2022]. Please see page 6. 2. Jackson L. et al., (2021) Guilt, shame, and postpartum infant feeding outcomes: A systematic review. *Matern Child Nutr*. Jul;17(3):e13141. Available from: doi: 10.1111/mcn.13141. [Accessed 02 Feb 2022]. 3. Wilde VK. (2021) Breastfeeding Insufficiencies: Common and Preventable Harm to Neonates. *Cureus*.13(10):e18478. Available from: doi: 10.7759/cureus. [Accessed 02 Feb 2022]. |
| 63 | **Infant Feeding Alliance** | Infant feeding guidance | Current UK infant feeding policy and practice need urgent reform. They fail to:  – promote adequate nutrition for all babies as standard and protect them from the complications of insufficient feeding, including jaundice, excessive weight loss, hypernatraemia and hypoglycaemia  – consider the physical and mental health needs of the mother or birthing person and their family  – follow principles of personalised care, shared decision-making and informed choice.  The NICE postnatal care quality standards are in line with current policy and include outcome measures such as ‘rates of breastfeeding initiation’ and ‘rates of exclusive or partial breastfeeding’. In our view as parents, these are the wrong outcome measures. We think NICE’s priority should be to promote and protect the health of babies and mothers, not to promote and protect exclusive breastfeeding. The focus should be on feeding babies, not on feeding methods.  The artificial separation of the quality standards into ‘Breastfeeding’ and ‘Formula Feeding’ (statements 5 and 6) does not ensure the focus is on infant nutrition. Neither does it represent the experience of most UK families. Mixed feeding, perhaps the most common method of feeding a baby in the UK, is absent. The common reasons families begin formula supplementation, choose to mixed feed or decide to switch from breastfeeding to bottle feeding are also absent, e.g. low milk supply, latching problems, baby always being hungry, mastitis, maternal exhaustion and the desire to share the responsibility of feeding, to name a few.  The ‘Breastfeeding’ quality standard requires that breastfeeding support is evidence-based, referring to the Unicef Baby Friendly Initiative as the minimum standard. A recent review funded by Public Health England is the latest to find there is no evidence that the Baby Friendly Initiative increases breastfeeding or improves health outcomes (Fair et al., 2021). Your own evidence review, as part of the postnatal care guidelines update, did not score the Baby Friendly Initiative guidelines highly, stating, ‘Recommendations are quite vague and different options are not discussed’ (Evidence Review F).  But what would an evidence-based approach to breastfeeding support look like? This is unclear, since your own evidence reviews found no evidence for interventions to increase breastfeeding rates and were vague on what practical interventions actually help to solve breastfeeding problems (Evidence Reviews P, Q, R, S). The latest Cochrane review for managing breastfeeding-related nipple pain, one of the most common reasons women give for stopping breastfeeding, found insufficient evidence to make recommendations (Dennis et al., 2014). We have been unable to identify any similar review of interventions to manage problems with latching or low milk supply.  The ‘Breastfeeding’ quality standard lists women’s satisfaction with breastfeeding support as an outcome measure. We would point NICE to a recent review of the impact of the Baby Friendly Initiative on maternal and infant health outcomes, which found adverse effects on women’s mental health and emotional wellbeing (Fallon et al., 2019). We would also point to a number of studies showing women experiencing breastfeeding support as ‘pressure’ and describing being desperate to stop breastfeeding but feeling they had to continue (Ayers et al., 2019; Lee, E., 2007).  The ‘Formula Feeding’ quality standard requires that ‘mothers and main carers who totally or partially formula feed their baby, and breastfeeding mothers who plan to formula feed their baby’ are given ‘advice about how to sterilise feeding equipment and safely prepare formula milk’. We fail to see how limiting this advice to certain parents is sensible or safe, since parents who will need this information most urgently are those introducing formula under pressure in the early days of a baby’s life. The recommendation that parents should not receive information on formula if they are considering exclusively breastfeeding is based on the ‘Baby Friendly’ idea that bottle feeding shouldn’t be ‘reinforced as the cultural norm’ and women’s confidence in breastfeeding shouldn’t be ‘undermined’ (UNICEF UK, 2014). These ideas are based on ideology and cultural theory, not on evidence, and they should not guide clinical practice.  Your own evidence reviews for the postnatal care guidelines showed that parents felt unprepared for the realities of breastfeeding and for formula feeding if it was not planned, and that they did not feel informed about supplementation (Evidence Reviews P, Q, R, S). Meanwhile, Evidence Review T showed that women want information on formula feeding antenatally, but the committee disregarded this, concluding that it was ‘not feasible’ to give all women information on formula. The quality standards maintain the artificial separation between breastfeeding and formula feeding and wording is carefully chosen to make clear who is ‘allowed’ to receive information on formula. By refusing to provide parents with all information, NICE is undermining their autonomy.  The ‘Formula Feeding’ quality standard suggests women should receive information on ‘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’. There is no evidence that bottle feeding is associated with bonding problems. This statement is not evidence-based, is lifted from the Baby Friendly Initiative and is stigmatising and offensive. It has the potential to cause harm if families have found sustainable ways to feed their baby by sharing feeds between them or other family members. It may also be experienced as judgment and foster mistrust in healthcare providers.  Your Evidence Review Q for the postnatal care guidelines showed that parents are finding ways to survive the newborn period by sharing bottle feeding. We find it unconscionable that the quality standard problematises parents making use of their support network by involving family members or close friends to feed their babies. (We would also appeal to common sense here: it is in fact easier and more comfortable to make eye contact with a baby while bottle feeding than while breastfeeding!)  As parents, we have had enough! Evidence is mounting that, in line with our lived experience, the promotion of exclusive breastfeeding and the Baby Friendly Initiative are causing unintended harms. A recent review of the literature, which sought to quantify the health effects of different infant feeding methods, calculated that for every 71 exclusively breastfed babies, one is readmitted to hospital in the first month of life, primarily due to dehydration, failure to thrive, excessive weight loss or hyperbilirubinemia (Wilson and Wilson, 2018). They also calculated that for every 13 exclusively breastfed babies, one loses greater than 10% of their birthweight. While it is unclear how these numbers needed to harm calculations apply in the UK context, we know that infant readmissions for feeding complications and jaundice more than doubled between 2006 and 2016 (Keeble and Kossorova, 2017).  Recent reports from the US have also suggested rare but potentially catastrophic risks of the ‘Baby Friendly’ principles of mandatory rooming-in and skin-to-skin contact, including sudden unexpected postnatal collapse (SUPC) and newborn falls in hospital (Bass et al., 2017; Goldsmith, 2013). We also point to a recent HSIB investigation into a number of cases of SUPC in the UK that occurred when babies were in skin-to-skin contact (HSIB, 2020).  We urge NICE to reconfigure the infant feeding quality standards so that they are founded on evidence and on the needs of UK parents. We ask NICE to:  • Prioritise adequate infant nutrition. Prioritise preventing newborn babies suffering unnecessarily from the complications of insufficient feeding, including jaundice, dehydration and excessive weight loss.  • Give a balanced perspective on the health effects of different feeding options, including accurate statistics and clear representations of the absolute benefits and risks. This should use the full range of high-quality scientific evidence and acknowledge uncertainties in breastfeeding research.  • Give parents information about the strength of the evidence for infant feeding support, so they can make informed decisions about how to proceed with feeding.  • Recognise the ways in which infant feeding decisions interplay with other aspects of family life, such as sharing parenting responsibilities, sleep and looking after other children. Recognise that how we feed our babies is our right and we should not be slaves to a public health agenda.  • Consider the impact of sleep deprivation on women’s mental health, therefore acknowledging the key role that shared feeding plays in safeguarding maternal mental health.  • Remove as outcome measures ‘rates of breastfeeding’ and ‘rates of breastfeeding initiation’. Measures of success by which to judge quality standards should be: fully fed babies; protecting infants from the complications of insufficient feeding; families reporting enjoyable feeding experiences; parents reporting respectful and personalised care that considers their individual needs; women no longer reporting ‘pressure’ from healthcare authorities or feelings of ‘shame’ about how they feed their babies. | References cited:  Ayers, S., Crawley, R., Webb, R., et al., 2019. What are women stressed about after birth? Birth. 46, 678-685. <https://doi.org/10.1111/birt.12455>.  Bass, J., Gartley, T., Kleinman, R., 2016. Unintended Consequences of Current Breastfeeding Initiatives. JAMA Pediatr.170 (10):923-924. <https://doi.org/10.1001/jamapediatrics.2016.1529>.  Dennis, C.L., Jackson, K., Watson, J., 2014. Interventions for treating painful nipples among breastfeeding women. Cochrane Database Syst. Rev. 12, CD007366. <https://doi.org/10.1002/14651858.CD007366.pub2>.  Fair, F.J., Morrison, A., Soltani, H., 2021.The impact of Baby Friendly Initiative accreditation: An overview of systematic reviews. Matern. Child Nutr. 17( 4), e13216.  <https://doi.org/10.1111/mcn.13216>    Fallon, V., Harrold, J., Chisholm, A., 2019. The impact of the UK Baby Friendly Initiative on maternal and infant health outcomes: a mixed-methods systematic review. Matern. Child Nutr. 15 (3), e12778. <https://doi.org/10.1111/mcn.12778>.  Goldsmith, J., 2013. Hospitals should balance skin-to-skin contact with safe sleep policies. AAP News. 34 (11) 22. Available from: <https://www.aappublications.org/content/34/11/22>. Accessed date: 27 November 2020.  HSIB, 2020. National Learning Report Neonatal collapse alongside skin-to-skin contact. Available from: <https://www.hsib.org.uk/documents/238/hsib-national-learning-report-neonatal-collapse-alongside-skin-to-skin-contact.pdf>. Accessed date: 27 November 2020.  Keeble, E., Kossarova, L., 2017. Focus on: Emergency hospital care for children and young people. Available from: <https://www.nuffieldtrust.org.uk/files/2018-10/1540142848_qualitywatch-emergency-hospital-care-children-and-young-people-full.pdf>. Accessed date: 27 November 2020.  Lee, E., 2007. Health, morality, and infant feeding: British mothers' experiences of formula milk use in the early weeks. Sociol. Health Illness 29, 1075-1090. <https://doi.org/10.1111/j.1467-9566.2007.01020.x>  Moore, E.R., Bergman, N., Anderson, G.C., Medley, N, 2016. Early skin‐to‐skin contact for mothers and their healthy newborn infants. Cochrane Database Syst. Rev. 11, CD003519. <https://doi.org/10.1002/14651858.CD003519.pub4>.  National Institute for Health and Care Excellence, 2020, Postnatal care: evidence reviews. Available from: <https://www.nice.org.uk/guidance/ng194/evidence/evidence-reviews-april-2021-9076791277?tab=evidence>. Accessed date: 4 February 2022  UNICEF UK, 2014. Guidelines on providing information for parents about formula feeding. Available from: <https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2018/02/Guidelines-on-providing-information-for-parents-about-formula-feeding.pdf>. Accessed date: 27 November 2020.  Wilson, J., Wilson, B.H., 2018. Is the “breast is best” mantra an oversimplification? J.Fam. Pract. 67 (6), E1–E9. Available from: <https://www.mdedge.com/clinicianreviews/article/166932/pediatrics/breast-best-mantra-oversimplification>. Accessed date: 27 November 2020. |
| 64 | **Lactation Consultants of Great Britain** | Formula feeding | Please be clear on terminology here, and do not use the terms bottle feeding and formula feeding interchangeably. Bottles are used by parents and carers feeding breast milk, formula milk and other liquids, and formula can be fed by bottle, cup, tube and so on. |  |
| 65 | **La Leche League Great Britain** | Information on lactation continues throughout maternal care (antenatal as well as postnatal period) | Access to accurate and evidence-based information on the development and production of milk improves likelihood of breastfeeding after baby is born. | See NICE Postnatal care guideline [NG194] [1.5 Planning and supporting babies' feeding](https://www.nice.org.uk/guidance/ng194/chapter/recommendations#supporting-women-to-breastfeed) |
| **Breastfeeding** | | | | |
| 66 | **Better Breastfeeding** | Breastfeeding support   * Up to date antenatal breastfeeding education * Evaluations taking place in the antenatal period to identify high risk individuals and plan for barriers to breastfeeding.   3 clear pathways for care for those requiring general support with routine care, additional services and specialist services including, but not limited to, tongue-tie services. | Services and levels of care are currently a postcode lottery which has a huge impact on health inequalities. There is little access to specialist support.  Those needing specialist support (e.g. due to birth experience or medical conditions mother or baby) are often missed.  Services are fragmented (with particularly poor crossover between hospital and community-based care). They are hard to navigate, some care is duplicated and some missing altogether. A more joined-up model is needed. |  |
| 67 | **Better Breastfeeding** | Monitoring of breastfeeding rates | It is currently extremely difficult to evaluate the effectiveness of interventions on improving rates as there data collection is limited. Digital child health records have the potential to improve data collection very significantly. |  |
| 68 | **Better Breastfeeding** | Training and breastfeeding competencies | Statement 5 says “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 in all sectors, for example, hospitals, community settings, children's centres and peer supporter services.” This is very important and should be developed further with references to who should assess these competencies and what the benchmark is. |  |
| 69 | **GP Infant Feeding Network** | Breastfeeding | Prevalence of breastfeeding drops off considerably following high levels of initiation in the UK. See the last National Infant Feeding Survey (2010): <https://digital.nhs.uk/data-and-information/publications/statistical/infant-feeding-survey/infant-feeding-survey-uk-2010>  Common reasons for stopping breastfeeding in the early weeks are known to be difficulty latching, breast/nipple pain and the feeling that milk was ‘insufficient’, and by the time babies were 8-10 months old 63% of mothers who had stopped breastfeeding reported they would have liked to continue for longer. (See Chapter 6 results: <https://files.digital.nhs.uk/publicationimport/pub08xxx/pub08694/ifs-uk-2010-sum.pdf>)  The impact of breastfeeding difficulties/trauma on mental health need to be recognised and breastfeeding support and perinatal mental health services linked to ensure timely, respectful, skilled care which meets the needs of families and enables a positive experience of feeding. See the findings of Chaput et al (2016) as an example (<https://www.cmajopen.ca/content/4/1/E103.abstract?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&andorexacttitle=and&andorexacttitleabs=and&fulltext=breastfeed%252C+breastfeeding%252C+%2522breast+feed%2522%252C+%2522Baby+Friendly%2522%252C+breastmilk&andorexactfulltext=or&searchid=1&FIRSTINDEX=0&fdate=//&resourcetype=HWCIT> | Focus should be on face-to-face, high quality breastfeeding support from trained staff and enhancing care systems so that capacity for skilled assessment and treatment of breastfeeding problems is promptly available when needed.  The statement could be updated and expanded to include the new aspects of NG194 with a focus on the critical provision of face-to-face support (NG194 1.5.9, 1.5.10) and time-critical breastfeeding assessment provision within the first 24 hours after birth and at least once more in the first week of life (NG194 1.5.14). |
| 70 | **GPCPC (GPs championing perinatal care)** | Breastfeeding. | Plenty of evidence that the prevalence of breastfeeding falls over time, including substantially after the first six weeks | See statement within 1.5.14 to observe feed within 24 hours of birth and again within 7 days of birth would ensure that women are visited and given practical support that may currently not happen |
| 71 | **Kit Tarka Foundation** | Including lesions on the breast or nipples as a sign for concern | Women and birthing people who are breastfeeding should be advised that if they develop lesions on their breast or nipples they should stop feeding from that breast immediately and arrange to see their GP as soon as possible. The lesions should be tested for HSV and treated accordingly. See [kittarkafoundation.org/neonatal-herpes-info-and-advice](http://kittarkafoundation.org/neonatal-herpes-info-and-advice) for more information. | HSV can be spread during breastfeeding if the mother has HSV lesions on the breast or nipple. Lesions can also indicate HSV has been passed from infant to mother. As neonatal herpes has such a high mortality rate if the baby is not treated immediately, it is important in these cases to act quickly.  From our survey detailed above, only 41% of women who were breastfeeding said they would stop feeding from that breast and contact a health professional should they develop a blister or lesion on their nipple. |
| 72 | **Lactation Consultants of Great Britain** | Breastfeeding | Please be clearer about the need for specialist breastfeeding support from well qualified and experienced individuals with expertise, in addition to the universal provision of basic level breastfeeding support, which may be via an accredited program such as UNICEF UK baby friendly initiative. |  |
| 73 | **La Leche League Great Britain** | Equitable access to accurate lactation support | Parents are more likely to meet their breastfeeding goals, and children are more likely to be breastfed, thus improving population health, if breastfeeding support is available to all postnatally. | See NICE Postnatal care guideline [NG194] [1.5 Planning and supporting babies' feeding](https://www.nice.org.uk/guidance/ng194/chapter/recommendations#supporting-women-to-breastfeed) Role of the healthcare professional supporting breastfeeding |
| 74 | SCM1 | Key area for quality improvement 5 | Breastfeeding; understanding of healthcare professionals | NG194 outlines what healthcare professionals should understand about breastfeeding physiology and normal variation. Quality of professional support for women is dependent on healthcare professional knowledge and understanding. |
| 75 | SCM2 | Promote Breast feeding by supporting mothers who choose to breastfeed especially in the lower socioeconomic groups and young mothers with the implementation of evidence- based programmes of care including UNICEF Baby Friendly Initiatives delivered by fully trained staff Key area for quality improvement 2 | Evidence indicates that almost 68% of women in UK start to breastfeed but only 48% continue beyond 6-8 weeks. The UK remains one of the countries with the lowest breastfeeding rates in the world especially the lower socioeconomic groups including young mothers despite the well documented benefits to infant and maternal health including protection from SIDS, obesity, tooth decay, postnatal depression, breast cancer, respiratory, gastric and ear problems | Please see UK Health security Agency Breastfeeding Celebration Week -Supporting Mothers who breastfeed  Please also see office for Health Improvement and Disparities 2020/21 data file: breastfeeding at 6-8 weeks, 2020 to 2021 annual (November 2021 release) contains the full data obtained via the interim reporting system to collect health visiting activity at local authority resident level |
| 76 | SCM3 | Key area for quality improvement 1 | Breastfeeding ensuring practitioners have the relevant skills and competencies. | The quality of support provided to women varies across the UK. UNICEF, Baby friendly initiative stats indicate that the percentage of services with full Baby Friendly accreditation in the UK are:   * 43% of maternity services * 67% of health visiting services   <https://www.unicef.org.uk/babyfriendly/about/accreditation-statistics-and-awards-table-2/> |
| 77 | SCM6 | QS 5 - Breastfeeding | This is an area where our members report that the support available to breastfeeding mothers can vary across the country. There needs to be consistency in the availability of an evaluated, structured breastfeeding approach across the country, with face-to-face support available. There is also a need to include partners more in the provision of information and guidance to assist them in supporting women who choose to breastfeed their babies. | Please see section 1.5 of the NICE postnatal care guideline.  [Recommendations | Postnatal care | Guidance | NICE](https://www.nice.org.uk/guidance/ng194/chapter/Recommendations#postnatal-care-of-the-woman) |
| 78 | **The Breastfeeding Network** | Individualised, scheduled breastfeeding support delivered regularly at all postnatal healthcare appointments, in accordance with the UNICEF baby friendly initiative as a minimum standard. | Breastfeeding rates drop off significantly in the first 6 weeks after birth. Data published by the Nuffield Trust showed that in 2020, 72.3% of babies in England had breastmilk for their first feed, but by 6-8 weeks, only 48% of babies were receiving any breastmilk. 80% mothers who stop breastfeeding in the first six weeks report that they were not ready to do so (McAndrew et al, 2012). Two of the most common reasons for women stopping breastfeeding are pain and concern about having enough milk (Brown et al, 2014).  Pain can usually be resolved with assistance on positioning and attachment from a breastfeeding specialist. Low milk supply is, in most cases, either an unfounded concern that can be allayed by giving the parents accurate information about how breastfeeding works and how to know that their baby is getting enough milk, or an issue that has been caused by poor positioning and attachment or non-responsive feeding, and can be resolved with sufficient support. Less than 5% of mothers are physiologically unable to produce enough milk for their baby’s needs (Brown et al 2014).  Support should normalise typical baby behaviour and breastfeeding experiences that can be perceived as problematic (e.g. night waking, frequent feeding, breastfeeding for comfort, breastfeeding to sleep, wanting to remain in close contact with carer). Mohebati et al (2021) highlight the importance of managing the parent’s expectations of their infant’s behaviour, in particular crying, and explaining the impact of different caregiving styles on breastfeeding and milk production. Mothers should be supported to understand how milk supply is established, how to make the most of it and how to be confident that their baby is getting enough. The importance of responsive feeding and skin to skin contact should be covered.  Postnatal breastfeeding support should include a comprehensive breastfeeding assessment in the first week, including two fully observed feeds, one within the first 24 hours, as recommended in the NICE guideline on postnatal care, 2021. These should be conducted by a skilled breastfeeding specialist.  Understanding what is normal in the first week and beyond (for example, frequent feeding, not wanting to be put down) and what is not (for example, sleeping for long periods, lack of alertness, not crying) in addition to scheduled, skilled assessment and support in the early days could reduce readmission rates and requirements for formula supplementation.  For those parents who have needed or decided to supplement with formula, support should also emphasise that all breastfeeding is valuable, returning to exclusive breastfeeding can be possible if desired, and that combination feeding is also valuable and worthwhile if exclusive breastfeeding is not possible or desired.  The Cochrane review on breastfeeding support McFadden (2017) showed that scheduled breastfeeding support throughout the postnatal period, provided by trained healthcare professionals or volunteers, is effective at increasing breastfeeding rates. They also noted that strategies that relay on face-to-face support, and those that are tailored to the situation, are most effective.  Continuity of care is important – breastfeeding support should be provided by the same people throughout the postnatal period wherever possible. Use of peer supporters, who can bridge the gap between Midwife and HV lead care would enable this.  All healthcare professionals coming in contact with postnatal mothers should be trained in breastfeeding support to ensure consistency of message. They should fully understand the importance of breastfeeding, consistent with the UNICEF BFI. This includes understanding that not meeting breastfeeding goals is associated with poorer mental health outcomes in mothers (Brown, 2018). They should all be aware of who to refer or signpost onto if further support is required, with a clear hierarchy of escalation available. | <https://www.nuffieldtrust.org.uk/resource/breastfeeding#background>  McAndrew, F., Thompson, J., Fellows, L., Large, A., Speed, M., & Renfrew, M. J. (2012). Infant feeding survey 2010. Leeds: Health and Social Care Information Centre, 2(1).Brown et al, Can J Public Health, 2014, 105(3)).  Brown CR, Dodds L, Legge A, Bryanton J, Semenic S. Factors influencing the reasons why mothers stop breastfeeding. Can J Public Health. 2014 May 9;105(3):e179-85. doi: 10.17269/cjph.105.4244. PMID: 25165836; PMCID: PMC6972160.  Mohebati LM, Hilpert P, Bath S, Rayman MP, Raats MM, Martinez H, Caulfield LE. Perceived insufficient milk among primiparous, fully breastfeeding women: Is infant crying important? Matern Child Nutr. 2021 Jul;17(3):e13133. doi: 10.1111/mcn.13133. Epub 2021 Jan 5. PMID: 33399268; PMCID: PMC8189230.  NICE guideline on postnatal care, 2021  McFadden A, Gavine A, Renfrew MJ, Wade A, Buchanan P, Taylor JL, Veitch E, Rennie AM, Crowther SA, Neiman S, MacGillivray S. Support for healthy breastfeeding mothers with healthy term babies. Cochrane Database Syst Rev. 2017 Feb 28;2(2):CD001141. doi: 10.1002/14651858.CD001141.pub5. PMID: 28244064; PMCID: PMC6464485.  Brown A. (2018). What do women lose when they are prevented from meeting their Breastfeeding Goals? Clinical Lactation, Nov 1;9(4):200-7 |
| 79 | **The Breastfeeding Network** | Prescribing to breastfeeding mothers:  All HCPs who prescribe to postnatal women should understand the importance of breastfeeding and protect breastfeeding by consulting UKDILAS, LACTMED and DiBM before prescribing. | The MBBRACE report (Knight et al, 2021) recommends, particularly for women with mental health conditions:  “If psychotropic medication has been discontinued in advance of, or during, pregnancy, ensure women have an early postnatal review to determine whether they should recommence medication, carried out either by the GP or mental health service depending on the level of pre-existing mental health care.”  The report describes some tragic situations where de-prescribing or failure to prescribe could have contributed to maternal deaths.  From contacts to our Drugs in Breastmilk service (DiBM), we know that many women are concerned about taking medications whilst breastfeeding, or have been advised by healthcare professionals that these medications are not compatible with breastfeeding, even when this is not the case. This can be the case for a wide variety of medications, but is particularly common for psychotropic medications such as anti-depressants. Research on mothers with severe mental illness by Baker et al (2021) found that although very few women were taking psychotropic medication contraindicated for breastfeeding, over a quarter reported being advised against breastfeeding because of their medication. Many reported feeling unsupported with infant feeding due to inconsistent information about medication when breastfeeding and that breastfeeding intentions were de-prioritized for mental health care. This is particularly concerning given that not meeting breastfeeding goals is associated with poorer mental health outcomes in mothers (Brown 2018).  We are also aware of several mothers denied pain relief after birth or during procedures because of a lack of understanding on how drugs pass into breastmilk. This is a contravention of their human rights. Management of chronic medical conditions which affect many young women of childbearing age can be a cause of much discussion as to what drugs are suitable whilst breastfeeding, but there are many compatible options, as detailed in the resources below.  It is essential that the risks and benefits of taking a medication or not, to both the mother and child, are discussed, alongside the risks and benefits of breastfeeding or not, and that an informed choice is made. Whilst it will be possible to take many medications whilst breastfeeding, the mother may require reassurance that this is safe, and advice on safety considerations for the baby, for example, not bed-sharing if their medication makes them drowsy or sleep more deeply, and being aware of side effects to be alert for in the baby.  The British National Formulary and summary of product characteristics (SPC) for such medications frequently take an excessively conservative stance on prescribing to breastfeeding women. Reference to these alone could result in the woman not receiving necessary treatment, or discontinuing breastfeeding unnecessarily. We would therefore like to see the quality standard emphasise the importance of protecting breastfeeding wherever possible whilst also ensuring the mother receives the care that she needs. Prescribers should refer to the NHS Specialist pharmacy service UK Drugs in Lactation Advisory Service (UKDILAS) the Drugs in Lactation database (LactMed) and the Breastfeeding Network DiBM service for the most accurate information on prescribing to breastfeeding women, to allow fully informed, shared decision making.  These recommendations have been discussed within the Safer Medicines in Pregnancy and Breastfeeding Consortium to enable women and professionals to make evidence based decisions. | <https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf>  DiBM, <https://www.breastfeedingnetwork.org.uk/detailed-information/drugs-in-breastmilk>)  UKDILAS <https://www.sps.nhs.uk/articles/ukdilas/>,  LactMed, <https://www.ncbi.nlm.nih.gov/books/NBK501922/>  Baker N, Potts L, Jennings S, Trevillion K, Howard LM. Factors Affecting Infant Feeding Practices Among Women With Severe Mental Illness. Front Glob Womens Health. 2021 Apr 9;2:624485. doi: 10.3389/fgwh.2021.624485. PMID: 34816188; PMCID: PMC8593974.  Brown A. (2018). What do women lose when they are prevented from meeting their Breastfeeding Goals? Clinical Lactation, Nov 1;9(4):200-7  <https://www.gov.uk/government/publications/safer-medicines-in-pregnancy-and-breastfeeding-consortium> |
| 80 | **The Breastfeeding Network** | Information about and provision of breastfeeding support in a variety of mediums in addition to scheduled support. This should be targeted and tailored to the need to individuals, taking into account the additional needs of minority and disadvantaged groups. | All women should be given information on and access to further breastfeeding support in a variety of mediums, including face-to-face, peer support, group support (including walking groups, where walking with the baby in a push-chair or sling can also aid weight loss), phone support (including the National Breastfeeding Helpline contact details) and digital support, including information on websites and NBH webchat.  Assessments of both the National Breastfeeding helpline and the peer support services provided by The Breastfeeding Network showed how valuable these services are to women and that they can significantly enhance their ability to breastfeed successfully.  There are also lessons to be learned from the COVID-19 pandemic and the impact it had on infant feeding support. Research has shown that some women found breastfeeding easier during the lockdown, due to having more time to focus, fewer visitors, more privacy, greater responsive feeding, more partner support and a delayed return to work. However, others found the pandemic very challenging(Brown and Shenker 2021). Of those participants who had stopped breastfeeding during the pandemic, only 13.5% described themselves as ready to do so. The most common reason given for stopping was insufficient professional support, followed by physical issues such as difficulties with latch, exhaustion, insufficient milk and pain. Critically, this study showed that mothers with lower education, with more challenging living circumstances and from Black and minority ethnic backgrounds were more likely to find the impact of lockdown challenging and stop breastfeeding. These cohorts are already less likely to breastfeed(McAndrew et al 2012). The most recent MBRRACE report highlights inequalities in maternal mortality for these same groups, and we know that not meeting breastfeeding goals is associated with poorer mental health outcomes in mothers (Brown 2018).  This highlights the importance of ensuring women receive access to a support in a variety of mediums and that support is particularly targeted at and made accessible to these at risk groups. | <https://www.nationalbreastfeedinghelpline.org.uk/>  [BfN helpline evaluation final report Dec 2017 (4).docx (live.com)](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fbreastfeedingnetwork.org.uk%2Fwp-content%2FBfN%2520helpline%2520evaluation%2520final%2520report%2520Dec%25202017%2520(4).docx&wdOrigin=BROWSELINK)  [Impact - The Breastfeeding Network](https://www.breastfeedingnetwork.org.uk/evaluation/)  [BfN-Blake-Stevenson-Evaluation-report-V5-1Apr.pdf (breastfeedingnetwork.org.uk)](https://www.breastfeedingnetwork.org.uk/wp-content/uploads/2016/06/BfN-Blake-Stevenson-Evaluation-report-V5-1Apr.pdf)  <https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf>  Brown, A. and Shenker, N. (2021) Experiences of breastfeeding during COVID-19: Lessons for future practical and emotional support. Maternal and child nutrition 17:1  McAndrew, F., Thompson, J., Fellows, L., Large, A., Speed, M., & Renfrew, M. J. (2012). Infant feeding survey 2010. Leeds: Health and Social Care Information Centre, 2(1).Brown et al, Can J Public Health, 2014, 105(3)).  Brown A, Shenker N. Experiences of breastfeeding during COVID-19: Lessons for future practical and emotional support. Matern Child Nutr. 2021 Jan;17(1):e13088. doi: 10.1111/mcn.13088. Epub 2020 Sep 23. PMID: 32969184; PMCID: PMC7537017. |
| 81 | **The Breastfeeding Network** | Including partners in postnatal care and giving them information on how best to support breastfeeding. | Partners/supporters of breastfeeding mothers should be included in postnatal care and receive evidence-based information on how to support a breastfeeding mother. Breastfeeding interventions frequently target the individual behaviour of the mother, but she does not exist in a vacuum. Her family, friends and wider society will influence her breastfeeding journey. Research shows that the nature of the support provided by a partner can significantly impact on breastfeeding duration (Baldwin et al, 2021). The length of time that mothers intend to breastfeed for is correlated with the length of time her partner would like her to breastfeed for (Rempel et al 2017). However, some forms of support, such as practical support with feeding itself, can be detrimental to breastfeeding duration (Emmott et al, 2020). By contrast, being responsive to partner and functioning as a team may be most beneficial (Rempel 2017). Mothers who receive information and emotional support from a wide range of sources, including family, friends and health professionals, but were the only ones to actually feed their baby, were found to be most likely to be breastfeeding at two months, whereas mothers who received support from partners and maternal grandparents, including practical aspects of feeding their baby, but less support from healthcare professionals, were least likely to be breastfeeding at two months.  Mahesh et al (2018) showed that targeting fathers for breastfeeding promotion is associated with increased breastfeeding rates.  Baldwin et al (2021) describe the experiences of partners in the UK participating in the New Dad study, who felt uninformed about breastfeeding and unprepared to support their partner in breastfeeding their baby. They describe the influence that partner support can have on breastfeeding, and make recommend ways in which health professionals can provide breastfeeding information and support to fathers/partners. | Baldwin S, Bick D, Spiro A. Translating fathers' support for breastfeeding into practice. Prim Health Care Res Dev. 2021 Nov 3;22:e60. doi: 10.1017/S1463423621000682. PMID: 34728005; PMCID: PMC8569909.  Rempel LA, Rempel JK, Moore KCJ. Relationships between types of father breastfeeding support and breastfeeding outcomes. Matern Child Nutr. 2017 Jul;13(3):e12337. doi: 10.1111/mcn.12337. Epub 2016 Jul 27. PMID: 27460557; PMCID: PMC6865933.  Emmott EH, Page AE, Myers S. Typologies of postnatal support and breastfeeding at two months in the UK. Soc Sci Med. 2020 Feb;246:112791. doi: 10.1016/j.socscimed.2020.112791. Epub 2020 Jan 7. PMID: 31927156; PMCID: PMC7014584.  Mahesh PKB, Gunathunga MW, Arnold SM, Jayasinghe C, Pathirana S, Makarim MF, Manawadu PM, Senanayake SJ. Effectiveness of targeting fathers for breastfeeding promotion: systematic review and meta-analysis. BMC Public Health. 2018 Sep 24;18(1):1140. doi: 10.1186/s12889-018-6037-x. PMID: 30249216; PMCID: PMC6154400. |
| 82 | **The Lullaby Trust** | Breastfeeding | The Lullaby Trust have read it and in our opinion the statement and associated measures are still relevant and factual in 2022. |  |
| 83 | **UNICEF UK Baby Friendly Initiative** | All women should know how to access breastfeeding support in their local area including peer to peer support. All services should have an infant feeding specialist pathway in place that is effectively resourced and shared with the families to help women overcome breastfeeding challenges and meet their breastfeeding goals. | 8 out of 10 women stop breastfeeding before they want to [(McAndrew et al, 2012)](file:///C:\Users\francescae\Downloads\McAndrew%20F,%20Thompson%20J,%20Fellows%20L,%20et%20al:%20(2012)%20Infant%20Feeding%20Survey%202010,%20Health%20and%20Social%20Care%20Information%20Centre%20(website).%20%20%20https:\sp.ukdataservice.ac.uk\doc\7281\mrdoc\pdf\7281_ifs-uk-2010_report.pdf) often because of challenges in the early days and weeks. Breastfeeding rates in the UK are among the lowest in the world, with a direct negative impact on the health of children and of women, causing distress for women and their families, and resource implications for the NHS. Evidence shows that ongoing support is critically important.  Ongoing infant feeding support including Peer to peer support should be available to women, accessible and adequately resourced.  When specialist help is required – a specialist pathway should be available for all women. | See NICE Post Natal Guidelines NG194  <https://www.nice.org.uk/guidance/ng194/chapter/Recommendations>  1.5.9  1.5.13 – 1.5.15  Specialist Pathway guideline  <https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/implementing-standards-resources/specialist-services-guidance/>  Victora CG, Bahl R, Barros AJD, Franca GVA, Horton S, Krasevec J, Murch S, Sankar MJ, Walker N, Rollins NC (2016) Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. Lancet, Volume 387, No. 10017, pp.475–490, 30 January  Rollins NC, Bhandari N, Hajeebhoy N, Horton S, Lutter CK, Martines JC, Piwoz EG, Richter LM, Victora CG (2016) Why invest, and what it will take to improve breastfeeding practices? Lancet, Volume 387, No. 10017, pp. 491–504, 30 January  Renfrew MJ, Pokhrel S, Quigley M, McCormick F, Fox-Rushby J, Dodds R, Duffy S, Trueman P, Williams T (2012) Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK, Unicef UK Baby Friendly Initiative  McFadden A, Gavine A, Renfrew MJ, et al (2017) Support for healthy breastfeeding mothers with healthy term babies. Cochrane Database of Systematic Reviews , Issue 2. Art. No.: CD001141. DOI: 10.1002/14651858.CD001141.pub5. |
| 84 | **World Breastfeeding Trends Initiative (UK)** | Key area for quality improvement 1 | Re Quality Statement 5: Breastfeeding -  Include specialist support integrated into the structured programme because some mother need additional support , as mentioned in 5.15 of the Postnatal Care guideline) | Some mothers need more specialist support than those trained in the structured programme can offer.  The rapid drop-off in the percentage of mothers breastfeeding in the weeks following birth demonstrates that there is not enough effective support available. |
| 85 | **World Breastfeeding Trends Initiative (UK)** | Key area for quality improvement 2 | Re Quality Statement 5: Breastfeeding -  Specify that support is offered in a kind way that respects individual decisions of parents. (In line with 1.5.8 in the Postnatal Care guideline). | This is recognised in the Postnatal Care guideline so needs to be an explicit part of the feedback obtained from mothers. |
| 86 | **World Breastfeeding Trends Initiative (UK)** | Key area for quality improvement 4 | Re Quality Statement 5: Breastfeeding -  Improve local data collection. | Quantitative local data collection for national submission is used for 2 of the outcomes but at present there is a significant amount of missing data. |
| **Additional areas** | | | | |
| **Neonatal care/infection** | | | | |
| 87 | **Better Breastfeeding** | Community care for preterm infants | Feeding of pre term infants is often complex and, where it is supported well in hospital, often isn’t sufficiently well supported during the transition to home and longer term community care. |  |
| 88 | **Better Breastfeeding** | Transitional care for term babies | ATAIN standards (Avoiding Term Admissions into Neonatal Care) should be embedded into the new quality standard. |  |
| 89 | **Kit Tarka Foundation** | Informing women and birthing people how to reduce the likelihood of neonatal infection. | We are concerned that this guideline does not make reference to reducing the likelihood of infections in newborn babies by following strict hygiene measures.  The guideline presents an opportunity to remind parents that there are steps they can take to reduce the chances of infection in their babies postnatally. Our main area of concern is reducing herpes infections in babies as the mortality rates in infected babies are so high.  Information on keeping new babies safe from infection should be given including advice about regular handwashing for parents and visitors before holding the baby and the risks of allowing other people to kiss their baby especially if they have a cold sore. Parents should be advised that should they get a cold sore they should cover and treat with topical acyclovir before holding their baby. It should be noted that the babies of women who have a history of herpes infection are most likely protected against new infections but caution should still be exercised. See [kittarkafoundation.org/neonatal-herpes-info-and-advice](http://kittarkafoundation.org/neonatal-herpes-info-and-advice) for more information. | We know from the BPSU surveillance study due to published later this year that HSV infections in babies are on the rise and mortality rates among infected babies are incredibly high. Details of the project and interim results can be seen at [kittarkafoundation.org/research](file:///C:\Users\sarah\Downloads\kittarkafoundation.org\research)  Because some herpes infections do not produce symptoms, the virus can be passed on without anybody realising but there are some simple things parents can do to reduce the risk. We believe parents should be informed of these steps during pregnancy and reminded of the importance postnatally.  It is known from a recent survey of over 1,500 expectant and new parents (see [kittarkafoundation.org/babies-at-risk](file:///C:\Users\sarah\Downloads\kittarkafoundation.org\babies-at-risk)) that many (59%) are not aware of the dangers of herpes infections in a baby. We also found that many parents and visitors are not following recommended hygiene practices so it is clear further antenatal and postnatal guidance is needed. 45% of parents would allow friends and family to kiss their young baby and 1 in 3 parents would not ask friends and family to wash their hands before holding their baby. |
| **Mental health** | | | | |
| 90 | **Royal College of Midwives** | Key area for quality improvement 1 | Mental health/emotional wellbeing | Mental health outcomes are as important as physical ones. In the current context of growing rates of PTSD associated with birth trauma and the consequences of the pandemic on women’s mental health, supporting new mothers and families in the transition into parenthood is paramount. There is growing evidence that postnatal care provision should include services such as birth debriefing and be integrated with mental health services. The focus on personalised care should encompass not just antenatal and intra-partum care but be extended to postnatal care including perinatal mental services.  Please see the LSE/CPEC report on increasing access to treatment for women with common mental health problems during the perinatal period. <https://maternalmentalhealthalliance.org/wp-content/uploads/economic-case-increasing-access-treatment-women-common-maternal-mental-health-problems-report-lse-2022-mmha.pdf> |
| 91 | SCM2 | Promote Maternal/Paternal Mental Health and prevent Postnatal Depression especially targeting those at most risk in the postnatal period Key area for quality improvement 3 | Postnatal depression affects 1 in 10 mothers and fathers of a new baby and has a lasting impact on a baby’s emotional and physical health into adulthood yet is largely preventable. Inequalities exist and the risk of death is higher for those who living in deprived areas and those from ethnic minority background | Please see Royal College of Psychiatrists Post-natal Depression available from <https://www.rcpsych.ac.uk>  Please see 2020MBRACE-UK reports on maternal and perinatal mortality  Use this Guideline in conjunction with the guidance on Antenatal and Postnatal Mental Health (NICE Guidance CG192) |
| 92 | SCM6 | QS 10 – Maternal Mental health - mental wellbeing | Although this is listed as removed from the current QS as it is covered elsewhere, feedback from our members is that this is a neglected area in postnatal care where many women feel that their self-reported concerns are not taken into consideration and their needs are not met. Specific inquiry and onward referral where appropriate should be made at each postnatal contact. | Please see section 1.2.2 and 1.2.5 of the NICE postnatal care guideline  [Recommendations | Postnatal care | Guidance | NICE](https://www.nice.org.uk/guidance/ng194/chapter/Recommendations#postnatal-care-of-the-woman) |
| **Contraception after childbirth** | | | | |
| 93 | **British Pregnancy Advisory Service** | Contraception after childbirth should be mentioned as part of this QS | The British Pregnancy Advisory Service regularly sees women for abortion care who experience an unwanted pregnancy during the post-partum period. Any guideline on Postnatal care should include reference to the provision on contraceptive care during this period. | Contraception after childbirth is currently covered as part of the contraception Quality Standard:  <https://www.nice.org.uk/guidance/qs129/chapter/quality-statement-4-contraception-after-childbirth> |
| **Other comments (shared with guideline team)** | | | | |
| 94 | **BAME Health Collaborative** | We considered the Document in its entirety and submit the following comments/observations. Colour highlights (amended to italics) have been used in certain areas to point to the issues: |  |  |
| 95 | **BAME Health Collaborative** | Provision of family-centred care. Treat families with dignity and respect. Learn about and respect their values and beliefs so that health professionals can provide the best treatment possible. Assist spouses and other family members in developing confidence in their new role. With cultural humility, and engagement of the family unit, provide agreed culturally competent and safe care.  BAME women are different in terms of their culture, origin, beliefs, and behaviours. Traditions, values, language, and communication strategies vary with each indigenous community. Many of these women desire to infuse their lives and parenting with their cultural and societal values and beliefs. |  |  |
| 96 | **BAME Health Collaborative** | 1.1.2 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** | The phrase closer monitoring is non-descript; what sort of monitoring? Is it paying more attention to the concerns of the women and addressing these objectively, or clinical monitoring? |  |
| 97 | **BAME Health Collaborative** | 1.1.13 Before transfer from the maternity unit to community care, or before the midwife leaves after a home birth, give women information about the importance of pelvic floor exercises (see the NICE guideline on pelvic floor dysfunction) | The importance of pelvic floor exercises is accepted. However, it is paramount to state that women need to be signposted as to where to find these services |  |
| 98 | **BAME Health Collaborative** | 1.1.14 Ensure that the first postnatal visit by a midwife takes place within 36 hours after transfer of care from the place of birth or after a home birth. The visit should be face-to-face and usually at the woman's home, depending on her circumstances and preferences. | Virtual consultation should be considered where a face-to-face encounter is not possible  We suggest that if the visit at the woman’s home is not preferred, the midwife should sensitively explore why not; This is to ensure issues such as an abusive relationship, poor family dynamics in multi-generational living, poor housing conditions etc are not missed |  |
| 99 | **BAME Health Collaborative** | 1.2.1 At each postnatal contact, ask the woman about her general health and whether she has any concerns, and assess her general wellbeing. | .2.1 At each postnatal contact, ask the woman about her general health and whether she has any concerns *using open questions*, and assess her general wellbeing *including her body language to determine any hidden clues and if it is a safe environment*. |  |
| 100 | **BAME Health Collaborative** | 1.2.1  An addition BHC suggestion | Avoidance of cultural practices such as heating the abdomen with warm clothing and using cloth to tightly bind the abdomen; there is no scientific evidence that it promotes uterine involution and this practice could potentially predispose to uterine prolapse and skin burns. More research is required about the validity of these practices |  |
| 101 | **BAME Health Collaborative** | 1.2.1   * sexual intercourse * The effect of the arrival of a child on relationships | sexual intercourse **education; For example, when to start after a normal vaginal delivery, perineal trauma and caesarean section**  The effect of the arrival of a **new** child on **family relationships including partners and other children.** |  |
| 102 | **BAME Health Collaborative** | 1.3.1 At each postnatal contact, ask parents if they have any concerns about their baby's general wellbeing, feeding or development. Review the history and assess the baby's health, including physical inspection and observation. If there are any concerns, take appropriate further action. | 1.3.1 At each postnatal contact, ask parents if they have any concerns about their baby's general wellbeing, feeding or development. Review the history and assess the baby's health, including physical inspection and observation, **and document your findings**. If there are any concerns, take appropriate further action |  |
| 103 | **BAME Health Collaborative** | 1.3.11 Consider (why make this optional? – everyone should be given the information) giving parents information about the Baby Check scoring system and how it may help them to decide whether to seek advice from a healthcare professional if they think their baby might be unwell. |  |  |
| 104 | **BAME Health Collaborative** | 1.3.3 Carry out a complete examination of the baby within 72 hours of the birth and at 6 to 8 weeks after the birth (see the Public Health England newborn and infant physical examination [NIPE] screening programme). This should include checking the baby's:  • appearance, including colour, breathing, behaviour, activity and posture  • heart: position, heart rate, rhythm and sounds, murmurs and femoral pulse volume | 1.3.3 Carry out a complete examination of the baby within 72 hours of the birth and at 6 to 8 weeks after the birth (see the Public Health England newborn and infant physical examination [NIPE] screening programme). This should include checking the baby's:  • appearance, including colour (**what colour in black skinned babies? – this must be addressed**), breathing, behaviour, activity and posture  • heart: position, heart rate, rhythm and sounds, murmurs and femoral pulse volume – **are all health visitors and community midwives trained to do this ? or is this referring to the GP check? The healthcare worker who undertakes this needs to be made specific as midwives and health visitors may not be best placed to pick heart murmurs. In the real world, do GPs undertake the 6-8 week checks?** |  |
| 105 | **BAME Health Collaborative** | 1.3.11 Consider giving parents information about the Baby Check scoring system and how it may help them to decide whether to seek advice from a healthcare professional if they think their baby might be unwell. | Why make this optional? – everyone should be given the information |  |
| 106 | **BAME Health Collaborative** | 1.4.9 Recognise the following as 'red flags' for serious illness in *young babies*:  • appearing ill to a healthcare professional  • *appearing pale, ashen, mottled or blue (cyanosis)*  • unresponsive or unrousable  • *non-blanching rash*  • *under 16s:* this should not be there as we are talking of postnatal care symptoms, signs and initial assessment  • gastroesophageal reflux disease (GORD) *in children and young people:* diagnosing and investigating GORD *Postnatal care is up to 8 weeks – this is a postnatal guideline*  • diarrhoea and vomiting caused by gastroenteritis in under 5s: assessing dehydration and shock  *Under 5s is well above the postnatal period*  • urinary tract infection *in under 16s*: diagnosis. this should not be there as we are talking of postnatal care | 1.4.9 Recognise the following as 'red flags' for serious illness in *young babies* (what age – newborn babies preferably):  • appearing ill to a healthcare professional  • *appearing pale, ashen, mottled or blue (cyanosis)* – what colour will a black baby present with? A more objective approach is to use oxygen saturation monitors.  • unresponsive or unrousable  o *Include Nasal flaring*  *• non-blanching rash - what colour will a black baby present with?* |  |
| 107 | **BAME Health Collaborative** | 1.5.8 Those providing breastfeeding support should: | 1.5.8 Those providing breastfeeding support should:  • be respectful of women's personal space, cultural influences, preferences and *previous experience of infant feeding – However, long birth intervals may negate this and each baby latching on the breast is different*.  • balance the woman's preference for privacy to breastfeed and express milk in hospital with the need to carry out routine observations  • *Mothers must be informed of the importance of basic hygiene as well as keeping the bottles and other apparatus sanitised before use*  • *Expressed milk should be appropriately labelled before being placed in the communal fridges; Checks must be undertaken that the mother’s milk is being given to the correct baby*  • obtain consent before offering physical assistance with breastfeeding  • recognise the emotional impact of breastfeeding  • give women the time, reassurance and encouragement they need to gain confidence in breastfeeding. |  |
| 108 | **BAME Health Collaborative** | Administration of anti-D to mothers where it is clinically indicated and Vitamin K to babies | Is the administration of anti-D to Rhesus negative mothers /Rh positive babies relevant in this guideline?  Is the discussion about administration of Vitamin K relevant in this guideline? |  |
| 109 | **BAME Health Collaborative** | Breast care | Discussions about the need for patience for milk let down. Women should be reassured that this is normal and could take 2 - 3 days  Reassurance that colostrum is healthy as in certain communities it is regarded as ‘bad milk’/inferior because of the colour and consistency  Women should be advised about  • basic cleaning care before breast feeding  • Care of flat or cracked nipples and breast engorgement |  |
| 110 | **UNICEF UK Baby Friendly Initiative** | We recommend two important new Quality statements to be added to QS37 that based on the evidence require consideration.  All the Quality statements identified in this consultation are important and complement each other, prioritising them one over the other may not be helpful and risks losing an important area for improvement as identified in NG194. As outcomes improve supported by the evidence then the number of statements required may be reduced. |  |  |