NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Postnatal care

NICE quality standard

Draft for consultation

16 July 2013

12 May 2022

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| **This quality standard covers** routine postnatal care in the first 8 weeks after birth. It describes high-quality care in priority areas for improvement.  The quality standard uses the term 'woman' or 'mother' and includes all people who have given birth, even if they may not identify as women or mothers. The term ‘partner’ refers to the woman’s chosen supporter. This could be the baby's father, the woman’s partner, a family member or friend, or anyone who they feel supported by or wish to involve. The term 'parents' refers to those with the main responsibility for the care of a baby. This will often be the mother and the father, but many other family arrangements exist, including single parents.  This quality standard will update and replace the existing quality standard on [postnatal care](https://www.nice.org.uk/guidance/qs37) (published July 2013). The topic was identified for update following a review of quality standards. The review identified:   * updated guidance on postnatal care.   For more information see [update information](http://www.nice.org.uk/guidance/qsXXX/chapter/Update-information).  This is the draft quality standard for consultation (from 12 May to 9 June 2022). The final quality standard is expected to publish by September 2022. |

# Quality statements

[Statement 1](#_Quality_statement_1:) Women who are transferring between services in the postnatal period have relevant information shared between healthcare professionals to support their care. **[new 2022]**

[Statement 2](#_Quality_statement_2:) Parents are given information and advice about breastfeeding and formula feeding before transfer to community care or before the midwife leaves after a home birth. **[2013, updated 2022]**

[Statement 3](#_Quality_statement_3:) Parents are given information and advice, within 24 hours of the birth, about symptoms and signs of serious illness in the baby that require them to contact emergency services. **[2013, updated 2022]**

[Statement 4](#_Quality_statement_4:) Parents receive face-to-face feeding support at each postnatal contact. **[new 2022]**

[Statement 5](#_Quality_statement_5:) Parents are given advice about safer practices for bed sharing during their first postnatal midwife and health visitor home visits. **[2013, updated 2022]**

[Statement 6](#_Quality_statement_6:) Women have a GP assessment 6 to 8 weeks after giving birth. **[new 2022]**

In 2022 this quality standard was updated, and statements prioritised in 2013 were updated (2013, updated 2022) or replaced (new 2022). For more information, see [update information](#_Update_information_2).

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| Questions for consultationQuestions about the quality standard **Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?  **Question 2** Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?  **Question 3** Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment. Local practice case studies **Question 4** Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please provide details on the comments form. |

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

## Quality statement

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

## Rationale

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

## Quality measures

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

### Structure

Evidence of a local process for notifying that transfer of care during the postnatal period has taken place to relevant healthcare professionals and the woman or the parents.

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

### Process

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

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

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

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

### Outcome

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

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

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

**Data source:**Data could be collected from a local survey of women who had a live birth after the postnatal period. The [Care Quality Commission maternity survey](https://www.cqc.org.uk/publications/surveys/surveys) includes data on the proportion of women who said that the midwife or midwifery team they saw or spoke to always appeared to be aware of the medical history for them and their baby.

## What the quality statement means for different audiences

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

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

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

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

## Source guidance

[Postnatal care. NICE guideline NG194](https://www.nice.org.uk/guidance/ng194) (2021), recommendation 1.1.8

## Definitions of terms used in this quality statement

### Postnatal period

The first 8 weeks after birth. [[NICE’s guideline on postnatal care](https://www.nice.org.uk/guidance/ng194), overview]

### Relevant information

This should include information about:

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

[[NICE’s guideline on postnatal care](https://www.nice.org.uk/guidance/ng194), recommendation 1.1.8]

## Equality and diversity considerations

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

# Quality statement 2: Information and advice about babies’ feeding

## Quality statement

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

## Rationale

Revisiting information and advice about breastfeeding and formula feeding before transfer to community care or before the midwife leaves after a home birth will support parents to make informed decisions about feeding their baby. Regardless of their feeding choices, giving parents the opportunity to discuss feeding will help them know what to expect, what support is available, when to seek help, and will allow any questions or concerns they have to be addressed. This will reduce the chance of feeding problems occurring at home and the need for readmission.

## Quality measures

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

### Structure

Evidence that accessible information about breastfeeding and formula feeding, including how to get support locally, is available for parents.

**Data source:** Data can be collected from information provided locally by healthcare professionals and provider organisations, for example, leaflets.

### Process

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

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

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

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

### Outcome

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

**Data source:**Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from attendance and admissions data. [NHS Digital’s Hospital Episode Statistics](https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics) includes data on admissions for feeding-related conditions such as weight loss, dehydration and jaundice.

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

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

Denominator – the number of parents of babies.

**Data source:**Data could be collected from a local survey of parents of babies following transfer to community care. The [Care Quality Commission maternity survey](https://www.cqc.org.uk/publications/surveys/maternity-services-survey-2018) collects information about women's experiences of maternity care including satisfaction with support with infant feeding.

## What the quality statement means for different audiences

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

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

**Commissioners** (integrated care systems and clinical commissioning groups) commission services that provide information and advice about breastfeeding and formula feeding before transfer to community care or before the midwife leaves after a home birth.

**Parents of babies** are given information and advice about breastfeeding and formula feeding before they are discharged from the hospital or birth team.

## Source guidance

[Postnatal care. NICE guideline NG194](https://www.nice.org.uk/guidance/ng194) (2021), recommendations 1.1.10, 1.5.2, 1.5.3, 1.5.12, 1.5.16, 1.5.17 and 1.5.19

## Definitions of terms used in this quality statement

### Information and advice about breastfeeding and formula feeding

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

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

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

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

[[NICE’s guideline on postnatal care](https://www.nice.org.uk/guidance/ng194), recommendations 1.5.2, 1.5.3, 1.5.12, 1.5.17 and 1.5.19 and expert opinion]

## Equality and diversity considerations

Parents should be given information that they can easily access and understand themselves, or with support, so they can communicate effectively with healthcare services. Clear language should be used, and the content and delivery of information should be tailored to individual needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate. People should have access to an interpreter or advocate if needed. For parents with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

# Quality statement 3: Symptoms and signs of illness in babies

## Quality statement

Parents are given information and advice, within 24 hours of the birth, about symptoms and signs of serious illness in the baby that require them to contact emergency services. **[2013, updated 2022]**

## Rationale

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

## Quality measures

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

### Structure

Evidence of local processes to ensure that parents are given information and advice, within 24 hours of the birth, about the symptoms and signs of serious illness in the baby that require them to contact emergency services.

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

### Process

Proportion of women who had a live birth who received information and advice, within 24 hours of the birth, about symptoms and signs of serious illness in the baby that require them to contact emergency services.

Numerator – the number in the denominator who received information and advice, within 24 hours of the birth, about symptoms and signs of serious illness in the baby that require them to contact emergency services.

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

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

### Outcome

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

**Data source:**Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The [NHS Digital Maternity Services Data Set](https://digital.nhs.uk/data-and-information/data-insights-and-statistics/maternity-services-team) collects data on neonatal deaths. The [Healthcare Quality Improvement Partnership's MMBRACE-UK perinatal mortality surveillance report](https://www.hqip.org.uk/clinical-outcome-review-programmes/maternal-newborn-and-infant-outcome-review-programme/#.XaBg5qZYaGI) publishes rates of perinatal death.

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

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

Denominator – the number of parents of babies.

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

## What the quality statement means for different audiences

**Service providers** (such as NHS hospital trusts, community providers) ensure there are local processes to inform and advise parents, within 24 hours of the birth, about the symptoms and signs of serious illness in the baby that require them to contact emergency services. Providers ensure that accessible information about the symptoms and signs of serious illness in babies is available for parents, which could include information about the Baby Check scoring system.

**Healthcare professionals** (such as midwives) give information and advice to parents, within 24 hours of the birth, about the symptoms and signs of serious illness in the baby that require them to contact emergency services. Healthcare professionals could include information about the Baby Check scoring system which may help parents decide whether to seek advice from a healthcare professional if they think their baby may be unwell. Healthcare professionals check that parents understand the information they have been given, and how it relates to them.

**Commissioners** (integrated care systems and clinical commissioning groups) commission services that provide information and advice to parents within 24 hours of the birth, about symptoms and signs of serious illness in the baby that require them to contact emergency services.

**Parents of babies** are given advice within 24 hours of the birth about symptoms and signs of serious illness in the baby that mean they need to contact emergency services.

## Source guidance

* [Postnatal care. NICE guideline NG194](https://www.nice.org.uk/guidance/ng194) (2021), recommendations 1.3.2, 1.3.10, 1.3.12, 1.4.9 and 1.4.10
* [Jaundice in newborn babies under 28 days. NICE guideline CG98](https://www.nice.org.uk/guidance/cg98) (2010, updated 2016) recommendation 1.1.1

## Definitions of terms used in this quality statement

### Symptoms and signs of serious illness in the baby

Parents should be made aware:

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

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

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

[[NICE's guideline on postnatal care](https://www.nice.org.uk/guidance/ng194), recommendations 1.3.2, 1.4.4, 1.4.7, 1.4.8 and 1.4.9, [NICE's guideline on jaundice in newborn babies under 28 days](https://www.nice.org.uk/guidance/cg98), recommendation 1.1.1]

## Equality and diversity considerations

Parents should be given information they can easily access and understand themselves, or with support, so they can communicate effectively with healthcare services. Clear language should be used, and the content and delivery of information should be tailored to individual needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate. People should have access to an interpreter or advocate if needed. For parents with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

# Quality statement 4: Face-to-face feeding support

## Quality statement

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

## Rationale

Regardless of their feeding choices, parents value face-to-face feeding support. This support should be an integral part of routine postnatal contacts. Individualised support, including assessment and observation of feeding, can give parents the knowledge and understanding they need. This helps them establish good feeding practice and make informed decisions about feeding their baby.

## Quality measures

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

### Structure

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

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

### Process

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

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

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

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

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

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

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

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

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

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

Denominator – the number of postnatal contacts.

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

### Outcome

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

**Data source:**Included within the [NHS Digital Maternity Services Data Set](https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2017-18), [Office for Health Improvement and Disparities’ breastfeeding statistics](https://www.gov.uk/government/collections/breastfeeding-statistics), and the [NHS Digital Community Services Data Set](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/community-services-data-set).

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

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

Denominator – the number of parents of babies

**Data source:**Data could be collected from a local survey of parents of babies. The [Care Quality Commission maternity survey](https://www.cqc.org.uk/publications/surveys/maternity-services-survey-2018) collects information about women's experiences of maternity care including satisfaction with support with infant feeding.

## What the quality statement means for different audiences

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

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

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

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

## Source guidance

[Postnatal care. NICE guideline NG194](https://www.nice.org.uk/guidance/ng194) (2021), recommendations 1.1.10, 1.5.10, 1.5.14, 1.5.18, and 1.5.19

## Definitions of terms used in this quality statement

### Face-to-face feeding support

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

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

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

* observing additional feeds
* other actions, such as:
  + adjusting positioning and attachment to the breast
  + giving expressed milk
  + referring to additional support such as a lactation consultation or peer support
  + assessing for tongue‑tie.

Face-to-face formula feeding support should include:

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

[[NICE's guideline on postnatal care](https://www.nice.org.uk/guidance/ng194), recommendations 1.5.13, 1.5.14, 1.5.15 and 1.5.19]

## Equality and diversity considerations

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

Parents should be given information they can easily access and understand themselves, or with support, so they can communicate effectively with healthcare services. Clear language should be used, and the content and delivery of information should be tailored to individual needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate. People should have access to an interpreter or advocate if needed. For parents with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

# Quality statement 5: Bed sharing

## Quality statement

Parents are given advice about safer practices for bed sharing during their first postnatal midwife and health visitor home visits. **[2013, updated 2022]**

## Rationale

Parents commonly share a bed with their baby but there is often confusion and mixed messages about it. Giving parents advice about safer practices for bed sharing and the circumstances that strongly advise against it, will support them to establish safer infant sleeping habits. This advice may be repeated several times but giving it at the first midwife and health visitor home visits will highlight and reinforce it early.

## Quality measures

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

### Structure

Evidence of local processes to ensure that parents are given advice about safer practices for bed sharing during their first postnatal midwife and health visitor home visits.

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

### Process

a) Proportion of first postnatal midwife home visits that include advice about safer practices for bed sharing.

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

Denominator – the number of first postnatal midwife home visits.

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

b) Proportion of first postnatal health visitor home visits that include advice about safer practices for bed sharing.

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

Denominator – the number of first postnatal health visitor home visits.

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

### Outcome

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

**Data source:**[Office for National Statistics' data on unexplained deaths in infancy, England and Wales](https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/unexplaineddeathsininfancyenglandandwalesreferencetables).

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

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

Denominator – the number of parents of babies.

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

## What the quality statement means for different audiences

**Service providers** (such as NHS hospital trusts and community providers) ensure that healthcare professionals are trained to discuss safer practices for bed sharing with parents. They ensure that processes are in place to discuss safer practices for bed sharing at the first postnatal midwife and health visitor home visits.

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

**Commissioners** (such as integrated care systems, local authorities and clinical commissioning groups) ensure that they commission services that advise parents about safer practices for bed sharing at the first postnatal midwife and health visitor home visits.

**Parents of babies** are given advice about safety when sharing a bed with their baby at their first home visits from a midwife and a health visitor. This should include how to keep their baby safe when sharing a bed with their baby and when they should not share a bed with their baby.

## Source guidance

[Postnatal care. NICE guideline NG194](https://www.nice.org.uk/guidance/ng194) (2021), recommendations 1.3.13 and 1.3.14

## Definitions of terms used in this quality statement

### Safer practices for bed sharing

## Advice about bed sharing should include:

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

## [[NICE's guideline on postnatal care](https://www.nice.org.uk/guidance/ng194), recommendations 1.3.13 and 1.3.14]

### First postnatal midwife visit

The first postnatal midwife visit 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 parent’s home, depending on their circumstances and preferences. [[NICE’s guideline on postnatal care](https://www.nice.org.uk/guidance/ng194), recommendation 1.1.14]

### First postnatal health visitor visit

The first postnatal health visitor home visit may take place between 7 and 14 days after transfer of care from midwifery so that the timing of postnatal contacts is evenly spread out. [[NICE’s guideline on postnatal care](https://www.nice.org.uk/guidance/ng194), recommendation 1.1.15]

## Equality and diversity considerations

Parents should be given information that they can easily access and understand themselves, or with support, so they can communicate effectively with healthcare services. Clear language should be used, and the content and delivery of information should be tailored to individual needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate. People should have access to an interpreter or advocate if needed. For parents with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

# Quality statement 6: GP postnatal check for women

## Quality statement

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

## Rationale

Carrying out an assessment of women’s physical and psychological health and wellbeing 6 to 8 weeks after giving birth will prevent delays in diagnosing and treating any problems and improve health outcomes. GPs will be able to refer women to other healthcare services including specialist services for ongoing investigation, management and support if needed.

## Quality measures

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

### Structure

Evidence of local arrangements to ensure that all women are offered an appointment for a GP assessment 6 to 8 weeks after giving birth.

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

### Process

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

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

Denominator – the number of women who gave birth.

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

### Outcome

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

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

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

**Data source:**Data could be collected from a local survey of women who gave birth. The [Care Quality Commission maternity survey](https://www.cqc.org.uk/publications/surveys/surveys) includes data on the proportion of women who had a postnatal check and said their GP ‘definitely’ spent enough time talking to them about their own physical and mental health.

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

**Data source:**Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records or from [NHS Digital’s Hospital Episode Statistics](https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics).

## What the quality statement means for different audiences

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

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

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

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

## Source guidance

[Postnatal care. NICE guideline NG194](https://www.nice.org.uk/guidance/ng194) (2021), recommendation 1.2.7

## Definitions of terms used in this quality statement

### GP assessment

## [NHS England’s Update to the GP agreement 2020/21- 2023/24](https://www.england.nhs.uk/gp/investment/gp-contract/gp-contract-documentation-2020-21/) indicates that, in line with NICE guidance, the maternal check should focus on:

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

## [NICE’s guideline on postnatal care](https://www.nice.org.uk/guidance/ng194) indicates that the assessment carried out by a GP should include the following areas, taking into account the time since the birth. The GP should respond to any concerns, which may include further investigation and referral to specialist services in either secondary care or other healthcare services such as physiotherapy:

* asking about their general health and whether there are any concerns and assessing their general wellbeing, which may include:
  + symptoms and signs of potential postnatal mental health problems and how to seek help
  + symptoms and signs of potential postnatal physical problems and how to seek help
  + the importance of pelvic floor exercises, how to do them and when to seek help
  + fatigue
  + factors such as nutrition and diet, physical activity, smoking, alcohol consumption and recreational drug use
  + contraception
  + sexual intercourse
  + safeguarding concerns, including domestic abuse
* assessing psychological and emotional wellbeing
* assessing physical health, including:
  + for all women:
    - symptoms and signs of infection
    - pain
    - vaginal discharge and bleeding
    - bladder function
    - bowel function
    - nipple and breast discomfort and symptoms of inflammation
    - symptoms and signs of thromboembolism
    - symptoms and signs of anaemia
    - symptoms and signs of pre‑eclampsia
  + for women who have had a vaginal birth:
    - perineal healing
  + for women who have had a caesarean section:
    - wound healing
    - symptoms of wound infection
* giving the woman the opportunity to talk about her birth experience, and providing information about relevant support and birth reflection services, if needed.

[[NICE's guideline on postnatal care](https://www.nice.org.uk/guidance/ng194), recommendations 1.2.1, 1.2.2, 1.2.3 and 1.2.5]

## Equality and diversity considerations

Healthcare professionals should be aware that the [2020 MBRRACE-UK reports on maternal and perinatal mortality](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. GP practices should consider the best way to engage with women in these groups to encourage them to attend for a postnatal check. This could include joint working with health visitors or local groups.

Healthcare professionals should consider the best methods to invite women from vulnerable groups to attend a GP assessment 6 to 8 weeks after they have given birth. It will be important to tailor the invitation to individual needs and preferences. In some cases, a phone call may be preferable to a letter or text message, and it may be necessary to arrange the appointment rather than expecting the woman to arrange it for themselves. The invitation should be accessible to people who do not speak or read English. Women should have access to an interpreter or advocate if needed. For women with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

# Update information

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

* updated guidance on postnatal care.

Statements are marked as:

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

# About this quality standard

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

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

Information about [how NICE quality standards are developed](https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards) is available from the NICE website.

See our [webpage on quality standards advisory committees](http://www.nice.org.uk/Get-Involved/Meetings-in-public/Quality-Standards-Advisory-Committee) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10150/documents).

NICE has produced a [quality standard service improvement template](https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

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

## Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the [resource impact statement](https://www.nice.org.uk/guidance/ng194/resources) for the NICE guideline on postnatal care to help estimate local costs.

## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10150/documents) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

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

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