

Postnatal care

Quality standard

Published: 16 July 2013

www.nice.org.uk/guidance/qs37

Contents

Quality statements	5
Quality statement 1: Continuity of care	7
Quality statement 2: Maternal health – potentially serious conditions	8
Quality statement.....	8
Rationale	8
Quality measures	8
What the quality statement means for different audiences.....	9
Source guidance.....	9
Definitions of terms used in this quality statement	10
Equality and diversity considerations.....	11
Quality statement 3: Infant health – serious illness	12
Quality statement.....	12
Rationale	12
Quality measures	12
What the quality statement means for different audiences.....	13
Source guidance.....	13
Definitions of terms used in this quality statement	14
Equality and diversity considerations.....	15
Quality statement 4: Infant health – bed sharing	16
Quality statement.....	16
Rationale	16
Quality measures	16
What the quality statement means for different audiences	17
Source guidance.....	17
Definitions of terms used in this quality statement	17
Equality and diversity considerations.....	18
Quality statement 5: Breastfeeding	19

Quality statement.....	19
Rationale	19
Quality measures	19
What the quality statement means for different audiences	20
Source guidance.....	21
Definitions of terms used in this quality statement	21
Equality and diversity considerations.....	21
Quality statement 6: Formula feeding	22
Quality statement.....	22
Rationale	22
Quality measures	22
What the quality statement means for different audiences	23
Source guidance.....	23
Definitions of terms used in this quality statement	24
Equality and diversity considerations.....	24
Quality statement 7: Infant health – physical examination	26
Quality statement.....	26
Rationale	26
Quality measures	26
What the quality statement means for different audiences	27
Source guidance.....	27
Definitions of terms used in this quality statement	28
Quality statement 8: Maternal health – weight management	29
Quality statement.....	29
Rationale	29
Quality measures	29
What the quality statement means for different audiences	31
Source guidance.....	31

Definitions of terms used in this quality statement	31
Equality and diversity considerations.....	32
Quality statement 9: Emotional wellbeing and bonding with the baby	33
Quality statement.....	33
Rationale	33
Quality measures	33
What the quality statement means for different audiences	34
Source guidance.....	34
Definitions of terms used in this quality statement	34
Equality and diversity considerations.....	35
Quality statement 10: Maternal health – mental wellbeing	36
Quality statement 11: Parent–baby attachment	37
Update information.....	38
About this quality standard.....	39
Improving outcomes	39
Resource impact.....	40
Diversity, equality and language	40

This standard is based on PH11, PH27, CG192, NG194 and CG98.

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

Quality statements

In the statements, the term 'women' is used to refer to mothers of babies.

Statement 1 This statement has been removed. For more information, see [update information](#).

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.

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.

Statement 4 Women, their partner or main carers of babies have discussions with their healthcare professional about safer bed-sharing practices.

Statement 5 Women receive breastfeeding support from a service that uses an evaluated, structured programme.

Statement 6 Information about bottle feeding is discussed with women or main carers of formula-fed babies.

Statement 7 Babies have a complete 6- to 8-week physical examination.

Statement 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.

Statement 9 Women have an assessment of their emotional wellbeing, including bonding with their baby, at each postnatal contact.

Statement 10 This statement has been removed. In 2016, NICE published a separate [quality](#)

standard covering antenatal and postnatal mental health, which covers this area of care in more detail. For more details, see update information.

Statement 11 This statement has been removed. For more details, see update information.

NICE has developed guidance and a quality standard on people's experiences using adult social care services, adult NHS services and adult mental health services (see the NICE Pathways on people's experience in social care services, patient experience in adult NHS services and service user experience in adult mental health services).

Other quality standards that should be considered when commissioning or providing postnatal care include:

- Faltering growth. NICE quality standard 197
- Bronchiolitis in children. NICE quality standard 122
- Antenatal and postnatal mental health. NICE quality standard 115
- Neonatal infection. NICE quality standard 75
- Fever in under 5s. NICE quality standard 64
- Jaundice in newborn babies under 28 days. NICE quality standard 57
- Antenatal care. NICE quality standard 22

A full list of NICE quality standards is available from the quality standards topic library.

Quality statement 1: Continuity of care

This statement has been removed. For full details, see [update information](#).

Quality statement 2: Maternal health – potentially serious conditions

Quality statement

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.

Rationale

Women are at an increased risk of experiencing serious health events in the immediate hours, days and weeks following the birth, some of which could lead to maternal death or severe morbidity. Providing women with information about the symptoms and signs that may indicate a serious physical illness or mental health condition may prompt them to seek medical advice without delay and avoid unnecessary deaths and severe morbidity.

Quality measures

Structure

Evidence of local arrangements to ensure that 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.

Data source: Local data collection.

Process

The proportion of women who 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.

Numerator – the number in the denominator who 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.

Denominator – the number of women who have given birth.

Data source: Local data collection.

Outcome

a) Incidence of potentially avoidable maternal morbidity and mortality.

Data source: Local data collection. The [Healthcare Quality Improvement Partnership's Maternal, Newborn and Infant Clinical Outcome Review Programme](#) (undertaken by MBRRACE-UK) reports on rates of maternal death and severe maternal morbidity.

b) Women who have given birth feel informed about symptoms and signs of potentially serious postnatal conditions.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for women to be 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.

Midwives advise women, at the first postnatal contact, of the symptoms and signs of potentially serious conditions that require them to seek medical advice without delay.

Commissioners ensure that they commission services that advise women, at the first postnatal midwife contact, of the symptoms and signs of potentially serious conditions that require them to seek medical advice without delay.

Women are given advice by their midwife at their first postnatal contact about the symptoms and signs of potentially serious conditions that should prompt them to seek medical advice without delay.

Source guidance

- [Postnatal care. NICE guideline NG194 \(2021\), recommendation 1.2.4](#)

- [Antenatal and postnatal mental health: clinical management and service guidance. NICE guideline CG192 \(2014, updated 2020\)](#), recommendations 1.4.1, 1.4.3 and 1.4.6
- [Bacterial sepsis following pregnancy: green-top guideline no. 64b. Royal College of Obstetricians and Gynaecologists \(RCOG\) \(2012\)](#), section 17

Definitions of terms used in this quality statement

First postnatal midwife contact

The first postnatal midwife contact should take place within 36 hours after transfer of care from the place of birth or after a home birth. [[NICE's guideline on postnatal care](#), recommendation 1.1.14]

Symptoms and signs of potentially serious conditions

The following symptoms and signs are suggestive of potentially serious physical conditions in the woman:

- 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.

[[NICE's guideline on postnatal care](#), recommendation 1.2.4]

The following symptoms and signs are suggestive of potentially serious mental health conditions in

the woman:

- severe depression, such as feeling extreme unnecessary worry, being unable to concentrate due to distraction from depressive feelings
- severe anxiety, such as uncontrollable feeling of panic, being unable to cope or becoming obsessive
- the desire to hurt others or yourself, including thoughts about taking your own life
- confused and disturbed thoughts, which could include other people telling you that you are imagining things (hallucinations and delusions).

[Definition adapted with expert group consensus from [RCOG's good practice guidance on management of women with mental health issues during pregnancy and the postnatal period](#), section 5]

Equality and diversity considerations

Communication and information-giving between women (and their families) and members of the maternity team is a key aspect of this statement. Relevant adjustments will need to be in place for anyone who has communication difficulties, and for those who do not speak or read English. Written and verbal information should be appropriate for the woman's level of literacy, culture and language.

Quality statement 3: Infant health – serious illness

Quality statement

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.

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 the mother or main carer with verbal and written information about the symptoms and signs that might indicate their baby has a serious health problem may result in them contacting emergency services more promptly. This information should be provided within 24 hours of the birth.

Quality measures

Structure

Evidence of local arrangements to ensure that 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.

Data source: Local data collection.

Process

The proportion of women or main carers of babies who 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.

Numerator – the number in the denominator who 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.

Denominator – the number of mothers or main carers of babies.

Data source: Local data collection.

Outcome

a) Incidence of potentially avoidable infant morbidity and mortality.

Data source: Local data collection. The [NHS Digital Maternity Services Data Set](#) collects data on neonatal deaths. The [Healthcare Quality Improvement Partnership's perinatal mortality surveillance report](#) (MBRRACE-UK) reports on rates of perinatal death.

b) Women and main carers feel informed about symptoms and signs of serious illness in the baby.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for women or main carers of babies to be 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.

Healthcare practitioners advise women or main carers of babies, within 24 hours of the birth, of the symptoms and signs of serious illness in the baby that require them to contact emergency services.

Commissioners ensure that they commission services that advise women or main carers of babies, within 24 hours of the birth, of the symptoms and signs of serious illness in the baby that require them to contact emergency services.

Women or the main carer of the baby are given advice within 24 hours of the birth about symptoms and signs of serious illness in the baby, for which they need to contact emergency services.

Source guidance

- [Postnatal care. NICE guideline NG194 \(2021\)](#), recommendations 1.3.2, 1.3.10, 1.3.12, 1.4.9 and 1.4.10
- [Jaundice in newborn babies under 28 days. NICE guideline CG98 \(2010, updated 2016\)](#) recommendation 1.1.1

Definitions of terms used in this quality statement

Symptoms and signs of serious illness in the baby

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

- 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).
- 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, recommendations 1.3.2 and 1.4.9](#), [NICE's guideline on jaundice in newborn babies under 28 days](#), recommendation 1.1.1 and expert opinion]

Main carers of babies

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

Equality and diversity considerations

Communication and information-giving between women or main carers of babies (and their families) and members of the maternity team is a key aspect of this statement. Relevant adjustments will need to be in place for anyone who has communication difficulties, and for those who do not speak or read English.

Quality statement 4: Infant health – bed sharing

Quality statement

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

Rationale

There are risk factors associated with sudden unexpected death in infancy when bed sharing. Discussing safer bed-sharing practices and the circumstances in which bed sharing with a baby is strongly advised against with women, their partner or main carers of babies will support them to establish safer infant sleeping habits.

Quality measures

Structure

Evidence of local arrangements to ensure that women, their partner or main carers of babies have discussions with their healthcare professional about safer bed-sharing practices.

Data source: Local data collection.

Process

Proportion of postnatal contacts in which women, their partner or main carers of babies have discussions with their healthcare professional about safer bed-sharing practices.

Numerator – the number in the denominator in which women, their partner or main carers of babies have discussions with their healthcare professional about safer bed-sharing practices.

Denominator – the number of postnatal contacts.

Data source: Local data collection.

Outcome

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

Data source: [Office for National Statistics' data on unexplained deaths in infancy, England and Wales.](#)

b) Women, their partner and main carers of babies know about safer bed-sharing practices.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that information about safer bed-sharing practices is available, and that healthcare professionals are trained to discuss safer bed-sharing practices with women, their partner or main carers of babies.

Healthcare practitioners ensure that they understand and can explain safer bed-sharing practices, and that they have discussions about this with women, their partner or the main carers of babies.

Commissioners ensure that they commission services that provide information about safer bed-sharing practices, and that train healthcare professionals to discuss this with women, their partner or main carers of babies.

Women, their partner or main carers of babies have discussions about safer bed-sharing practices with their healthcare professional. This should include how to keep their baby safe if they share a bed with their baby and when they should not share a bed with their baby.

Source guidance

[Postnatal care. NICE guideline NG194 \(2021\), recommendations 1.3.13 and 1.3.14](#)

Definitions of terms used in this quality statement

Main carers of babies

For the majority of babies, the main carer will be the mother. For some babies, the main carer could

be a close relative, for example, the baby's father or grandparent, or for looked-after babies, this could be a foster parent. [Expert opinion]

Safer bed-sharing practices

Discussions about bed sharing should include:

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

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

Equality and diversity considerations

Communication and information-giving between women, their partners or main carers of babies (and their families), and members of the maternity team are key aspects of this statement. Relevant adjustments should be in place for people with communication difficulties, and those who do not speak or read English. Verbal and written information should be appropriate for the person's level of literacy, culture, language and family circumstances. Bed sharing can be intentional or a necessity, but all women, their partners or main carers of babies should be given information in a format they can understand, irrespective of their culture.

Quality statement 5: Breastfeeding

Quality statement

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

Rationale

Breastfeeding contributes to the health of both the mother and child in the short and longer term. Women should be made aware of these benefits and those who choose to breastfeed should be supported by a service that is evidence-based and delivers an externally audited, structured programme. Delivery of breastfeeding support should be coordinated across the different sectors.

Quality measures

Structure

Evidence of local arrangements for breastfeeding support to be provided through a service that uses an evaluated, structured programme.

Data source: Local data collection.

Process

a) Proportion of women who receive breastfeeding support through a service that uses an evaluated, structured programme.

Numerator – the number in the denominator who receive breastfeeding support through a service that uses an evaluated, structured programme.

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

Data source: Local data collection.

b) Proportion of women who wanted to continue breastfeeding but stopped before they had planned to.

Numerator – the number in the denominator who wanted to continue breastfeeding but stopped before they had planned to.

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

Data source: Local data collection.

Outcome

a) Rates of breastfeeding initiation.

Data source: The [NHS Digital Maternity Services Data Set](#) reports percentage of babies receiving breast milk as first feed.

b) Rates of exclusive or partial breastfeeding on discharge from hospital and at 6 to 8 weeks after the birth.

Data source: Contained within the [NHS Digital Maternity Services Data Set](#), [Public Health England's breastfeeding at 6 to 8 weeks after birth data reports](#), the [NHS Digital Community Services Data Set](#) and the [NHS England maternal 12-week risk assessment](#).

c) Women's satisfaction with breastfeeding support.

Data source: The [Care Quality Commission maternity services survey](#) collects information about women's experiences of maternity care and this includes a section on infant feeding.

What the quality statement means for different audiences

Service providers ensure that women receive breastfeeding support through a service that uses an evaluated, structured programme.

Healthcare practitioners ensure that women receive breastfeeding support through an integrated service that uses an evaluated, structured programme.

Commissioners ensure that they commission a service that delivers breastfeeding support through an evaluated, structured programme.

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

Source guidance

Maternal and child nutrition. NICE guideline PH11 (2008, updated 2014), recommendations 1 and 7

Definitions of terms used in this quality statement

Structured programme

All maternity care providers (whether working in hospital or in primary care) should implement an externally evaluated, structured programme that encourages breastfeeding, using the [UNICEF Baby Friendly Initiative](#) as a minimum standard. If providers implement a locally developed programme, this should be evidence-based, structured, and undergo external evaluation. The structured programme should be delivered and coordinated across all providers, including hospital, primary, community and children's centre settings. Breastfeeding outcomes should be monitored across all services. [Adapted from [NICE's guideline on maternal and child nutrition](#), recommendation 7]

Breastfeeding support

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.

Equality and diversity considerations

Breastfeeding support should be culturally appropriate and accessible to people with additional needs, such as physical, sensory or learning disabilities, and to people who do not speak or read English. Women should have access to an interpreter or advocate if needed. Special consideration will be needed if the mother and baby have been separated for any reason, for example, if the baby has been admitted to neonatal care or the baby has been taken into care.

Quality statement 6: Formula feeding

Quality statement

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

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.

Quality measures

Structure

Evidence of local arrangements to ensure that information about bottle feeding is discussed with women or main carers of formula-fed babies.

Data source: Local data collection.

Process

The proportion of women or main carers of formula-fed babies who have information about bottle feeding discussed with them.

Numerator – the number in the denominator who have information about bottle feeding discussed with them.

Denominator – the number of women or main carers of formula-fed babies.

Data source: Local data collection.

Outcome

a) Rates of hospital admissions for formula feeding-related conditions.

Data source: Local data collection.

b) Women's and main carers' knowledge of how to sterilise feeding equipment and safely prepare formula milk.

Data source: Local data collection, for example, use of patient surveys.

c) Women's and main carers' satisfaction with feeding support.

Data source: The [Care Quality Commission maternity services survey](#) collects information about women's experiences of maternity care and this includes a section on infant feeding.

What the quality statement means for different audiences

Service providers ensure that information about bottle feeding is discussed with women or main carers of formula-fed babies.

Healthcare practitioners discuss information about bottle feeding with women or main carers of formula-fed babies.

Commissioners ensure that they commission services in which information about bottle feeding is discussed with women or main carers of formula-fed babies.

Women or main carers of formula-fed babies have the opportunity to discuss information about bottle feeding.

Source guidance

[Postnatal care. NICE guideline NG194 \(2021\), recommendations 1.5.18 and 1.5.19](#)

Definitions of terms used in this quality statement

Formula-fed baby

This statement relates to mothers and main carers who totally or partially formula feed their baby, and breastfeeding mothers who plan to formula feed their baby. [Expert opinion]

Information about bottle feeding

The woman or main carer of the baby should have a one-to-one discussion about safe formula feeding and face-to-face support supplemented with written, digital or telephone information.

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 other ways than feeding that can comfort and soothe the baby
- how to bond with the baby when bottle feeding, through skin-to-skin contact, eye contact and the potential benefit of minimising the number of people regularly feeding the baby.

[[NICE's guideline on postnatal care](#), recommendations 1.5.18 and 1.5.19]

Main carers of babies

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

Equality and diversity considerations

Communication and information-giving between women or main carers of babies (and their families), and members of the maternity team is a key aspect of this statement. Relevant adjustments will need to be in place for anyone who has communication difficulties, and for those

who do not speak or read English. Verbal and written information should be appropriate in terms of women's (and their families) level of literacy, culture, language and family circumstances.

Quality statement 7: Infant health – physical examination

Quality statement

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

Rationale

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

Quality measures

Structure

a) Evidence of local arrangements to ensure that parents or main carers of babies are offered an appointment for the baby to attend for a 6- to 8-week physical examination.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that a system is in place to monitor the competency of practitioners undertaking a 6- to 8-week physical examination.

Data source: Local data collection.

Process

Proportion of babies who had a 6- to 8-week physical examination.

Numerator – the number in the denominator who had a 6- to 8-week physical examination.

Denominator – the number of babies aged 8 weeks.

Data source: Local data collection could include data collected for the [Public Health England newborn and infant physical examination \(NIPE\) screening programme](#).

Outcomes

a) Incidence of physical abnormalities in babies.

Data source: Local data collection.

b) Health outcomes associated with early intervention for babies with physical abnormalities.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that babies are offered a complete 6- to 8-week physical examination.

Healthcare practitioners ensure that they perform a complete 6- to 8-week physical examination of babies and that they maintain the necessary competencies for this role.

Commissioners ensure that they commission services that offer a complete 6- to 8-week physical examination for babies, which is carried out in a timely manner and by a competent practitioner.

The mother or main carer of the baby is given the opportunity for their baby to have a complete 6- to 8-week physical examination, which is carried out in a timely manner and by a competent practitioner.

Source guidance

[Postnatal care. NICE guideline NG194 \(2021\)](#), recommendations 1.3.3, 1.3.4 and 1.3.5

Definitions of terms used in this quality statement

6- to 8-week physical examination

The 6- to 8-week physical examination 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
 - social smiling and visual fixing and following
- measuring the baby's weight and head circumference and plotting the results on a growth chart.

[[NICE's guideline on postnatal care](#), recommendations 1.3.3, 1.3.4 and 1.3.5]

Quality statement 8: Maternal health – weight management

Quality statement

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.

Rationale

The woman's eating habits and physical activity levels could influence the health behaviour of the wider family, including children who are developing habits that may remain with them for life. Supporting the woman in the postnatal period to change her eating habits and physical activity levels may improve her health, her infant's health and the health of the wider family. It may also improve the outcomes of future pregnancies.

Women who are obese during pregnancy face increased risks of complications that include gestational diabetes, miscarriage, pre-eclampsia, thromboembolism and maternal death. Risks for the infant include fetal death, stillbirth, shoulder dystocia, and macrosomia. Infants of obese women face health risks in childhood including diabetes and obesity in later life.

Quality measures

Structure

a) Evidence of local arrangements to ensure that women have their BMI assessed and recorded at the 6- to 8-week postnatal check.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that women with a 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.

Data source: Local data collection.

c) Evidence of local arrangements to ensure that the local workforce has appropriate numbers of

staff trained to deliver healthy eating and physical activity services to postnatal women.

Data source: Local data collection.

Process

a) The proportion of women who have their BMI recorded at the 6- to 8-week postnatal check.

Numerator – the number in the denominator who have their BMI recorded.

Denominator – the number of women who attend a 6- to 8-week postnatal check.

Data source: Local data collection.

b) The proportion of women with a BMI of 30 kg/m² or more at the 6- to 8-week postnatal check who are offered a referral for advice on healthy eating and physical activity.

Numerator – the number in the denominator who are offered a referral for advice on healthy eating and physical activity.

Denominator – the number of women with a BMI of 30 kg/m² or more who attend a 6- to 8-week postnatal check.

Data source: Local data collection.

c) The proportion of women with a BMI of 30 kg/m² or more at the 6- to 8-week postnatal check who accept a referral for advice on healthy eating and physical activity.

Numerator – the number in the denominator who accept a referral for advice on healthy eating and physical activity.

Denominator – the number of women with a BMI of 30 kg/m² or more who attend a 6- to 8-week postnatal check.

Data source: Local data collection.

Outcome

Women feel able to make informed decisions about healthy eating, physical activity and weight

management for themselves and their family.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for women with a BMI of 30 kg/m² or more at the 6- to 8-week postnatal check to be offered a referral for advice on healthy eating and physical activity.

Healthcare practitioners offer women with a BMI of 30 kg/m² or more at the 6- to 8-week postnatal check a referral for advice on healthy eating and physical activity.

Commissioners ensure that they commission services that offer women with a BMI of 30 kg/m² or more at the 6- to 8-week postnatal check a referral for advice on healthy eating and physical activity.

Women who have a body mass index 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.

Source guidance

- [Maternal and child nutrition. NICE guideline PH11](#) (2008, updated 2014), recommendation 6
- [Weight management before, during and after pregnancy. NICE guideline PH27](#) (2010), recommendations 3 and 4

Definitions of terms used in this quality statement

Structured programme

Women should be offered a referral to an individual or group-based service that uses a structured programme. Services should deliver a structured programme that:

- addresses the reasons why women may find it difficult to lose weight, particularly after pregnancy
- is tailored to the needs of an individual or group

- combines advice on healthy eating and physical exercise (advising them to take a brisk walk or other moderate exercise for at least 30 minutes on at least 5 days of the week)
- identifies and addresses individual barriers to change
- provides ongoing support over a sufficient period of time to allow for sustained lifestyle changes.

Services should be delivered by an appropriately trained person. This is someone who can demonstrate expertise and competencies in healthy eating and/or physical activity, including weight management for women in the postnatal period. This may include midwives, health visitors, obstetricians, dietitians, GPs, nurses, midwifery assistants, support workers and those working in weight management programmes (commercial or voluntary).

Women who choose not to accept a referral should be given information about where they can get support on healthy eating and physical activity in future. [Adapted with expert group consensus from [NICE's guideline on weight management before, during and after pregnancy](#), recommendations 3 and 4, and [NICE's guideline on maternal and child nutrition](#), recommendation 6]

Equality and diversity considerations

Women should be able to access services that are appropriate to their cultural and religious beliefs, and that make relevant adjustments for anyone who has communication difficulties, and for those who do not speak or read English.

Quality statement 9: Emotional wellbeing and bonding with the baby

Quality statement

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

Rationale

The baby's relationship with the mother has a significant impact on the baby's social and emotional development. In turn, the woman's ability to provide a nurturing relationship is partly dependent on her own emotional wellbeing. Regular assessment of the woman's emotional wellbeing, including bonding with her baby, may lead to earlier detection of problems.

Quality measures

Structure

Evidence of local arrangements that women have an assessment of their emotional wellbeing, including bonding with their baby, at each postnatal contact.

Data source: Local data collection.

Process

Proportion of postnatal contacts that include an assessment of the woman's emotional wellbeing, including bonding with their baby.

Numerator – the number in the denominator that include an assessment of the woman's emotional wellbeing, including bonding with their baby.

Denominator – the number of postnatal contacts.

Data source: Local data collection.

Outcome

a) Incidence of postnatal mental health problems.

Data source: Local data collection.

b) Incidence of baby-to-mother emotional attachment problems.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place so that women have an assessment of their emotional wellbeing, including bonding with their baby, at each postnatal contact.

Healthcare practitioners ensure that they assess women's emotional wellbeing, including bonding with their baby, at each postnatal contact.

Commissioners ensure that they commission services that have local agreements to ensure women have an assessment of their emotional wellbeing, including bonding with their baby, at each postnatal contact.

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

Source guidance

Postnatal care. NICE guideline NG194 (2021), recommendations 1.2.2, 1.3.15 and 1.3.17

Definitions of terms used in this quality statement

Postnatal contacts

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

Emotional wellbeing

Being happy and confident and not anxious or depressed.

[[NICE's guideline on social and emotional wellbeing: early years, glossary](#)]

Bonding

Bonding is the positive emotional and psychological connection that the parent develops with the baby. [[NICE's guideline on postnatal care, terms used in this guideline section](#)]

Equality and diversity considerations

Communication between women (and their families) and members of the maternity team is a key aspect of this statement. Relevant adjustments will need to be in place for anyone who has communication difficulties, and for those who do not speak or read English.

Quality statement 10: Maternal health – mental wellbeing

This statement has been removed. In 2016, NICE published a separate [quality standard covering antenatal and postnatal mental health](#), which focuses on this area of care in more detail. For more details, see [update information](#).

Quality statement 11: Parent–baby attachment

This statement has been removed. For more details, see [update information](#).

Update information

April 2021: Changes have been made to align this quality standard with the updated [NICE guideline on postnatal care](#). Statements 1, 10 and 11 were removed because they are no longer in line with the NICE guideline. Maternal mental wellbeing, which was previously covered in statement 10, is now covered in the [NICE quality standard on antenatal and postnatal mental health](#). Statements 2, 3, 4 and 9 were amended to better reflect the wording in the updated guideline. For statements 2 and 3, the wording was changed from 'life threatening' to 'serious' conditions and illness, and the services to contact were updated in line with the guideline. The timescale for statement 2 was also changed from 'within 24 hours of birth' to the 'first postnatal midwife contact'. Statement 4 was amended to focus on discussing safer bed-sharing practices rather than giving information on the risks of co-sleeping. For statement 9, the wording was amended to focus on assessment of emotional wellbeing, including bonding and emotional attachment. Measures, data sources, links and references were also updated throughout.

June 2015: This quality standard has been updated to ensure alignment with the [NICE guidelines on postnatal care and antenatal and postnatal mental health](#). The guideline on postnatal care was updated in December 2014 to review the evidence on co-sleeping and sudden infant death syndrome, and new recommendations were added. Quality statement 4 on safer infant sleeping was updated in line with these recommendations.

Minor changes since publication

November 2019: The definitions for statement 3 have been changed to align with the updated [NICE guideline on fever in under 5s](#). References, data sources and policies have also been updated throughout.

December 2016: Data source updated for statement 5.

About this quality standard

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

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

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See the [webpage for this quality standard](#) for details of Topic Expert Group members who advised on this quality standard.

This quality standard has been included in the [NICE Pathway on postnatal care](#), which brings together everything we have said on a topic in an interactive flowchart.

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

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

Improving outcomes

This quality standard is expected to support delivery of the following national frameworks:

- [NHS outcomes framework](#)

- [Public health outcomes framework for England](#)
- [Quality framework for public health.](#)

Equivalent frameworks may be used in the devolved nations.

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 products for the NICE guideline on postnatal care](#) to help estimate local costs.

Diversity, equality and language

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

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

ISBN: 978-1-4731-0213-2

Endorsing organisation

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

Supporting organisations

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

- Maternal OCD
- Royal College of Midwives
- Royal College of Nursing (RCN)