NICE National Institute for Health and Care Excellence

Royal College of Obstetricians & Gynaecologists

NICE guideline

Postnatal care

NICE guideline
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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline replaces CG37.

This guideline is the basis of QS37, QS129 and QS169.

Overview

This guideline covers the routine postnatal care that women and their babies should receive in the first 8 weeks after the birth. It includes the organisation and delivery of postnatal care, identifying and managing common and serious health problems in women and their babies, how to help parents form strong relationships with their babies, and baby feeding. The recommendations on emotional attachment and baby feeding also cover the antenatal period.

The guideline uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but are pregnant or have given birth. Similarly, where the term 'parents' is used, this should be taken to include anyone who has main responsibility for caring for a baby.

The Royal College of Obstetricians and Gynaecologists has produced guidance on COVID-19 and postnatal care for all midwifery and obstetric services.

Who is it for?

- Healthcare professionals
- Commissioners and providers
- Women having routine postnatal care, and their families

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care. Parents and carers have the right to be involved in planning and making decisions about their baby's health and care, and to be given information and support to enable them to do this, as set out in the NHS Constitution and summarised in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

Please note that the Royal College of Obstetricians and Gynaecologists has produced guidance on COVID-19 infection and pregnancy for all midwifery and obstetric services.

This guideline uses the term 'woman' or 'mother' and includes all people who have given birth, even if they may not identify as women or mothers. 'Woman' is generally used but in some instances, 'mother' is used when referring to her in relation to her baby.

This guideline uses the term 'partner' to refer 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 the woman feels supported by or wishes 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.

1.1 Organisation and delivery of postnatal care

Principles of care

1.1.1 When caring for a woman who has recently given birth, listen to her and be responsive to her needs and preferences. Also see the NICE guideline on patient experience in adult NHS services.

1.1.2 Be aware that the 2020 MBRRACE-UK reports on maternal and perinatal mortality showed that women and babies from some minority ethnic backgrounds and those who live in deprived areas have an increased risk of death and may need closer monitoring. The reports showed that:

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

1.1.3 A woman may be supported by her partner in the postnatal period. Involve them according to the woman's wishes.

1.1.4 When caring for a baby, remember that those with parental responsibility have

the right be involved in the baby's care, if they choose.

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

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

For more guidance on communication, providing information (including different formats and languages) and shared decision making, see the NICE guidelines on patient experience in adult NHS services and shared decision making, and the NHS Accessible Information Standard.

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

1.1.7 Follow the principles in the NICE guideline on pregnancy and complex social factors for women who may need additional support, for example:

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

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on principles of care.

Full details of the evidence and the committee's discussion are in evidence review G: provision of information about the postnatal health of women.

Communication between healthcare professionals at transfer of care

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

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

- the baby's feeding.

1.1.9 Midwifery services should ensure that:

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

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on communication between healthcare professionals at transfer of care.

Full details of the evidence and the committee's discussion are in evidence review B: information transfer.

Transfer to community care

1.1.10 Before transfer from the maternity unit to community care, or before the midwife leaves after a home birth:

- assess the woman's health (see recommendations 1.2.2 and 1.2.3)
- assess the woman's bladder function by measuring the volume of the first void after giving birth
- assess the baby's health (including physical inspection and observation)
- if the baby has not passed meconium, advise the parents that if the baby does not do so within 24 hours of birth, they should seek advice from a healthcare professional (also see recommendation 1.3.12)
- make sure there is a plan for feeding the baby, which should include observing at least 1 effective feed.

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

preferences and support available.

1.1.12 When deciding on the timing of the transfer to community care, take into account the woman's preferences, the factors in recommendations 1.1.10 and 1.1.11 and any concerns, including any safeguarding issues (also see the NICE guideline on domestic violence and abuse).

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

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

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on transfer to community care.

Full details of the evidence and the committee's discussion are in evidence review A: length of postpartum stay.

First midwife visit after transfer of care from the place of birth or after a home birth

1.1.14 Ensure that the first postnatal visit by a midwife takes place within 36 hours after transfer of care from the place of birth or after a home birth. The visit should be face-to-face and usually at the woman's home, depending on her circumstances and preferences.

For a short explanation of why the committee made the recommendation and how it might affect practice, see the rationale and impact section on first midwife visit after transfer of care from the place of birth or after a home birth.

Full details of the evidence and the committee's discussion are in evidence review C: timing of first postnatal contact by midwife.

First health visitor visit

1.1.15 Be aware of the Department of Health and Social Care's Healthy Child Programme. Consider arranging the first postnatal health visitor home visit to take place between 7 and 14 days after transfer of care from midwifery care so that the timing of postnatal contacts is evenly spread out.

1.1.16 If a woman did not receive an antenatal health visitor visit, consider arranging an additional early postnatal health visitor visit.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on first health visitor visit.

Full details of the evidence and the committee's discussion are in evidence review D: timing of first postnatal contact by health visitor.

1.2 Postnatal care of the woman

Assessment and care of the woman

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

- the postnatal period and what to expect

- symptoms and signs of potential postnatal mental health problems and how to seek help
- symptoms and signs of potential postnatal physical problems and how to seek help
- the importance of pelvic floor exercises, how to do them and when to seek help (see the NICE guideline on pelvic floor dysfunction)
- fatigue
- factors such as nutrition and diet, physical activity, smoking, alcohol consumption and recreational drug use (also see the NICE guidelines on maternal and child nutrition, weight management before, during and after pregnancy, tobacco and the UK Chief Medical Officer's physical activity guidelines for women after birth)
- contraception (see the Faculty of Sexual & Reproductive Healthcare [FSRH] guideline on contraception after pregnancy)
- sexual intercourse
- safeguarding concerns, including domestic abuse (see the NICE guideline on domestic violence and abuse and the NICE guideline on child abuse and neglect).

1.2.2 At each postnatal contact, assess the woman's psychological and emotional wellbeing. Follow the recommendations on recognising mental health problems in pregnancy and the postnatal period and referral in the NICE guideline on antenatal and postnatal mental health. If there are concerns, arrange for further assessment and follow up.

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

- for all women:
  - symptoms and signs of infection
  - pain

  - vaginal discharge and bleeding (see the section on postpartum bleeding)
  - bladder function
  - bowel function
  - nipple and breast discomfort and symptoms of inflammation
  - symptoms and signs of thromboembolism
  - symptoms and signs of anaemia
  - symptoms and signs of pre-eclampsia
- for women who have had a vaginal birth:
  - perineal healing (see the section on perineal health)
- for women who have had a caesarean section (also see the NICE guideline on caesarean birth):
  - wound healing
  - symptoms of wound infection.

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

- sudden or very heavy vaginal bleeding, or persistent or increased vaginal bleeding, which could indicate retained placental tissue or endometritis
- abdominal, pelvic or perineal pain, fever, shivering, or vaginal discharge with an unpleasant smell, which could indicate infection
- leg swelling and tenderness, or shortness of breath, which could indicate venous thromboembolism
- chest pain, which could indicate venous thromboembolism or cardiac problems
- persistent or severe headache, which could indicate hypertension,

pre-eclampsia, postdural-puncture headache, migraine, intracranial pathology or infection

- worsening reddening and swelling of breasts persisting for more than 24 hours despite self-management, which could indicate mastitis
- symptoms or signs of potentially serious conditions that do not respond to treatment.

1.2.5 At each postnatal contact, give the woman the opportunity to talk about her birth experience, and provide information about relevant support and birth reflection services, if appropriate. See the section on traumatic birth, stillbirth and miscarriage in the NICE guideline on antenatal and postnatal mental health and the NICE guideline on post-traumatic stress disorder.

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

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

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

1.2.8 For guidance on care for women with symptoms or signs of sepsis, see the NICE guideline on sepsis. If the woman has confirmed or suspected puerperal sepsis, assess the baby for symptoms or signs of infection.

1.2.9 For postnatal care of women who have had hypertension or pre-eclampsia in pregnancy, see the NICE guideline on hypertension in pregnancy, in particular:

- postnatal investigation, monitoring and treatment:
  - for women with chronic hypertension
  - for women with gestational hypertension
  - for women with pre-eclampsia

- antihypertensive treatment during the postnatal period, including when breastfeeding
- advice and follow-up at transfer to community care.

1.2.10 For postnatal care of women with pre-existing diabetes or who had gestational diabetes, see the recommendations on postnatal care in the NICE guideline on diabetes in pregnancy.

1.2.11 For guidance on assessing the risk and preventing venous thromboembolism in women who have given birth, see the NICE guideline on venous thromboembolism and the Royal College of Obstetricians and Gynaecologists' guideline on reducing the risk of venous thromboembolism during pregnancy and the puerperium.

1.2.12 For guidance on assessing and managing urinary incontinence and pelvic organ prolapse in women who have given birth, see:

- the NICE guideline on urinary incontinence and pelvic organ prolapse in women
- the NICE guideline on pelvic floor dysfunction.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on assessment and care of the woman.

Full details of the evidence and the committee's discussion are in:

- evidence review F: content of postnatal care contacts
- evidence review H: tools for the clinical review of women
- evidence review I: assessment of secondary postpartum haemorrhage
- evidence review E: timing of comprehensive assessment.

Postpartum bleeding

1.2.13 Discuss with women what vaginal bleeding to expect after the birth (lochia), and advise women to seek medical advice if:

- the vaginal bleeding is sudden or very heavy
- the bleeding increases
- they pass clots, placental tissue or membranes
- they have symptoms of possible infection, such as abdominal, pelvic or perineal pain, fever, shivering, or vaginal bleeding or discharge has an unpleasant smell
- they have concerns about vaginal bleeding after the birth.

1.2.14 If a women seeks medical advice about vaginal bleeding after the birth, assess the severity, and be aware of the risk factors for postpartum haemorrhage in the NICE guideline on intrapartum care. Also be aware of the following factors, which may worsen the consequences of secondary postpartum haemorrhage:

- anaemia
- weight of less than 50 kg at the first appointment with the midwife during pregnancy (booking appointment).

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on postpartum bleeding.

Full details of the evidence and the committee's discussion are in evidence review I: assessment of secondary postpartum haemorrhage.

Perineal health

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

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

1.2.16 Advise the woman about the importance of good perineal hygiene, including daily showering of the perineum, frequent changing of sanitary pads, and hand washing before and after doing this.

1.2.17 Consider using a validated pain scale to monitor perineal pain.

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

1.2.19 If needed, discuss available pain relief options, taking into account if the woman is breastfeeding.

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

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

1.2.22 Be aware of the following risk factors for persistent postnatal perineal pain:

- episiotomy, or labial or perineal tear
- assisted vaginal birth
- wound infection or breakdown
- birth experienced as traumatic.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on perineal health.

Full details of the evidence and the committee's discussion are in evidence review J: perineal pain and evidence review H: tools for the clinical review of women.

1.3 Postnatal care of the baby

Assessment and care of the baby

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

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

1.3.3 Carry out a complete examination of the baby within 72 hours of the birth and at 6 to 8 weeks after the birth (see the NHS newborn and infant physical examination [NIPE] screening programme). This should include checking the baby's:

- appearance, including colour, breathing, behaviour, activity and posture
- head (including fontanelles), face, nose, mouth (including palate), ears, neck and general symmetry of head and facial features
- eyes: opacities, red reflex and colour of sclera
- neck and clavicles, limbs, hands, feet and digits; assess proportions and symmetry
- heart: position, heart rate, rhythm and sounds, murmurs and femoral pulse volume
- lungs: respiratory effort, rate and lung sounds

- abdomen: assess shape and palpate to identify any organomegaly; check condition of umbilical cord
- genitalia and anus: completeness and patency and undescended testes in boys
- spine: inspect and palpate bony structures and check integrity of the skin
- skin: colour and texture as well as any birthmarks or rashes
- central nervous system: tone, behaviour, movements and posture; check newborn reflexes only if concerned
- hips: symmetry of the limbs, Barlow and Ortolani's manoeuvres
- cry: assess sound.

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

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

1.3.6 For advice on identifying and managing jaundice, see the NICE guideline on jaundice in newborn babies under 28 days.

1.3.7 If there are concerns about the baby's growth, see the NICE guideline on faltering growth.

1.3.8 Carry out newborn blood spot screening in line with the NHS newborn blood spot screening programme.

1.3.9 Carry out newborn hearing screening in line with the NHS newborn hearing screening programme.

1.3.10 Give parents information about:

- how to bathe their baby and care for their skin
- care of the umbilical stump

- feeding (see recommendations on planning and supporting babies' feeding)
- bonding and emotional attachment (see recommendations on promoting emotional attachment)
- how to recognise if the baby is unwell, and how to seek help (see recommendations on symptoms and signs of illness in babies)
- established guidance on safer sleeping (including recommendations on bed sharing)
- maintaining a smoke-free environment for the baby (see also the NICE guideline on tobacco)
- vitamin D supplements for babies in line with the NICE guideline on vitamin D supplement use
- immunising the baby in line with UK Health Security Agency's routine childhood immunisations schedule.

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

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

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on assessment and care of the baby.

Full details of the evidence and the committee's discussion are in evidence review F: content of postnatal care contacts and evidence review L2: scoring systems for illness in babies.

Bed sharing

1.3.13 Discuss with parents safer practices for bed sharing, including:

- making sure the baby sleeps on a firm, flat mattress, lying face up (rather than face down or on their side)
- not sleeping on a sofa or chair with the baby
- not having pillows or duvets near the baby
- not having other children or pets in the bed when sharing a bed with a baby.

1.3.14 Strongly advise parents not to share a bed with their baby if their baby was low birth weight or if either parent:

- has had 2 or more units of alcohol
- smokes
- has taken medicine that causes drowsiness
- has used recreational drugs.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on bed sharing.

Full details of the evidence and the committee's discussion are in evidence review M: benefits and harms of bed sharing and evidence review N: co-sleeping risk factors.

Promoting emotional attachment

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

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

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

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

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

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

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

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on promoting emotional attachment.

Full details of the evidence and the committee's discussion are in evidence review O: emotional attachment.

1.4 Symptoms and signs of illness in babies

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

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

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

1.4.3 Follow the recommendations in the NICE guideline on neonatal infection on:

- assessing and managing the risk of early-onset neonatal infection after birth (within 72 hours of the birth)
- risk factors for and clinical indicators of possible late-onset neonatal infection (more than 72 hours after the birth).

1.4.4 Be aware that fever may not be present in young babies with a serious infection.

1.4.5 If the baby has a fever, follow the recommendations in the NICE guideline on fever in under 5s.

1.4.6 If there are concerns about the baby's growth, follow the recommendations in the NICE guideline on faltering growth.

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

1.4.8 Be aware that the presence or absence of individual symptoms or signs may be of limited value in identifying or ruling out serious illness in a young baby.

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

- appearing ill to a healthcare professional

- appearing pale, ashen, mottled or blue (cyanosis)
- unresponsive or unrousable
- having a weak, abnormally high-pitched or continuous cry
- abnormal breathing pattern, such as:
  - grunting respirations
  - increased respiratory rate (over 60 breaths/minute)
  - chest indrawing
- temperature of 38°C or over or under 36°C
- non-blanching rash
- bulging fontanelle
- neck stiffness
- seizures
- focal neurological signs
- diarrhoea associated with dehydration
- frequent forceful (projectile) vomiting
- bilious vomiting (green or yellow-green vomit).

See the following sections in other NICE guidelines for more information:

- fever in under 5s: clinical assessment of children with fever
- neonatal infection: assessing and managing the risk of early-onset neonatal infection after birth and risk factors for and clinical indicators of possible late-onset neonatal infection
- sepsis: identifying people with suspected sepsis
- meningitis (bacterial) and meningococcal disease: symptoms, signs and initial

assessment

- gastroesophageal reflux disease (GORD) in children and young people: diagnosing and investigating GORD
- diarrhoea and vomiting caused by gastroenteritis in under 5s: assessing dehydration and shock
- urinary tract infection in under 16s: diagnosis.

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

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on symptoms and signs of illness in babies.

Full details of the evidence and the committee's discussion are in evidence review L1: signs and symptoms of serious illness in babies and evidence review L2: scoring systems for illness in babies.

1.5 Planning and supporting babies' feeding

General principles about babies' feeding

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

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

For a short explanation of why the committee made the recommendation and how it might affect practice, see the rationale and impact section on general principles about babies' feeding.

Full details of the evidence and the committee's discussion are in evidence review T: formula feeding information and support.

Giving information about breastfeeding

1.5.2 Before and after the birth, discuss breastfeeding and provide information and breastfeeding support (see the section on supporting women to breastfeed). Topics to discuss may include (see also recommendation 1.5.12):

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

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

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

1.5.4 Inform women that vitamin D supplements are recommended for all breastfeeding women (see the NICE guideline on vitamin D).

1.5.5 Inform women and their partners that under the Equality Act 2010, women have the right to breastfeed in 'any public space'.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on giving information about breastfeeding.

Full details of the evidence and the committee's discussion are in:

- evidence review P: breastfeeding interventions
- evidence review Q: breastfeeding facilitators and barriers
- evidence review S: breastfeeding information and support.

Role of the healthcare professional supporting breastfeeding

1.5.6 Healthcare professionals caring for women and babies in the postnatal period should know about:

- breast milk production
- signs of good attachment at the breast
- effective milk transfer
- how to encourage and support women with common breastfeeding problems
- appropriate resources for safe medicine use and prescribing for breastfeeding women.

1.5.7 Encourage the woman to have early skin-to-skin contact with her baby so that breastfeeding can start when the baby and mother are ready.

1.5.8 Those providing breastfeeding support should:

- be respectful of women's personal space, cultural influences, preferences and previous experience of infant feeding
- balance the woman's preference for privacy to breastfeed and express milk in hospital with the need to carry out routine observations

- obtain consent before offering physical assistance with breastfeeding
- recognise the emotional impact of breastfeeding
- give women the time, reassurance and encouragement they need to gain confidence in breastfeeding.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on the role of the healthcare professional supporting breastfeeding.

Full details of the evidence and the committee's discussion are in evidence review Q: breastfeeding facilitators and barriers and evidence review S: breastfeeding information and support.

Supporting women to breastfeed

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

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

1.5.10 Make face-to-face breastfeeding support integral to the standard postnatal contacts for women who breastfeed. Continue this until breastfeeding is

established and any problems have been addressed.

1.5.11 Be aware that younger women and women from a low income or disadvantaged background may need more support and encouragement to start and continue breastfeeding, and that continuity of carer is particularly important for these women.

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

- how milk is produced, how much is produced in the early stages, and the supply-and-demand nature of breastfeeding
- responsive breastfeeding
- how often babies typically need to feed and for how long, taking into account individual variation
- feeding positions and how to help the baby attach to the breast
- signs of effective feeding so the woman knows her baby is getting enough milk (it is not possible to overfeed a breastfed baby; see also recommendation 1.5.14)
- expressing breast milk (by hand or with a breast pump) as part of breastfeeding and how it can be useful; safe storage and preparation of expressed breast milk; and the dangers of 'prop' feeding
- normal breast changes during pregnancy and after the birth
- pain when breastfeeding and when to seek help
- breastfeeding complications (for example, mastitis or breast abscess) and when to seek help
- strategies to manage fatigue when breastfeeding
- supplementary feeding with formula milk that is sometimes, but not commonly, clinically indicated (also see the NICE guideline on faltering growth)

- how breastfeeding can affect the woman's body image and identity
- that the information given may change as the baby grows
- the possibility of relactation after a gap in breastfeeding
- safe medicine use when breastfeeding.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on supporting women to breastfeed.

Full details of the evidence and the committee's discussion are in:

- evidence review P: breastfeeding interventions
- evidence review Q: breastfeeding facilitators and barriers
- evidence review S: breastfeeding information and support.

Assessing breastfeeding

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

1.5.14 As part of the breastfeeding assessment:

- ask about:
  - any concerns the parents have about their baby's feeding
  - how often and how long the feeds are
  - rhythmic sucking and audible swallowing
  - if the baby is content after the feed
  - if the baby is waking up for feeds

- the baby's weight gain or weight loss
- the number of wet and dirty nappies
- the condition of the woman's breasts and nipples

- observe a feed within the first 24 hours after the birth, and at least 1 other feed within the first week.

1.5.15 If there are ongoing concerns, 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.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on assessing breastfeeding.

Full details of the evidence and the committee's discussion are in evidence review R: tools for predicting breastfeeding difficulties.

Formula feeding

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

1.5.17 Information about formula feeding should include:

- the differences between breast milk and formula milk
- that first infant formula is the only formula milk that babies need in the first year of life, unless there are specific medical needs
- how to sterilise feeding equipment and prepare formula feeds safely, including a practical demonstration if needed
- for women who are trying to establish breastfeeding and considering supplementing with formula feeding, the possible effects on breastfeeding success, and how to maintain adequate milk supply while supplementing.

1.5.18 For parents who formula feed:

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

1.5.19 Face-to-face formula feeding support should include:

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

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

informed decision.

For a short explanation of why the committee made the recommendations and how they might affect practice, see the rationale and impact section on formula feeding.

Full details of the evidence and the committee's discussion are in evidence review T: formula feeding information and support.

Lactation suppression

1.5.21 Discuss lactation suppression with women if breastfeeding is not started or is stopped, breastfeeding is contraindicated for the baby or the woman, or in the event of the death of a baby. Follow the recommendations in the section on principles of care. Topics to discuss include:

- how the body produces milk, what happens when milk production stops, and how long it takes for milk production to stop
- self-help advice, such as:
  - avoiding stimulating the breast
  - wearing a supportive bra
  - using ice packs
  - over-the-counter pain relief
  - sparingly expressing milk to ease engorgement
- when to seek help
- medicines that can be prescribed to suppress lactation
- the advantages and disadvantages of the different methods of lactation suppression
- the possibility of becoming a breast milk donor (also see the section on screening and selecting donors in the NICE guideline on donor milk banks).

For a short explanation of why the committee made the recommendation and how it might affect practice, see the rationale and impact section on lactation suppression.

Full details of the evidence and the committee's discussion are in evidence review K: information for lactation suppression.

Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline.

Bonding and emotional attachment

Bonding is the positive emotional and psychological connection that the parent develops with the baby.

Emotional attachment refers to the relationship between the baby and parent, driven by innate behaviour and which ensures the baby's proximity to the parent and safety. Its development is a complex and dynamic process dependent on sensitive and emotionally attuned parent interactions supporting healthy infant psychological and social development and a secure attachment. Babies form attachments with a variety of caregivers but the first, and usually most significant of these, will be with the mother and/or father.

Continuity of carer

Better Births, a report by the National Maternity Review, defines continuity of carer as consistency in the midwifery team (between 4 and 8 individuals) that provides care for the woman and her baby throughout pregnancy, labour and the postnatal period. A named midwife coordinates the care and takes responsibility for ensuring the needs of the woman and her baby are met throughout the antenatal, intrapartum and postnatal periods.

For the purpose of this guideline, the definition of continuity of carer in the Better Births report has been adapted to include not just the midwifery team but any healthcare team involved in the care of the woman and her baby, including the health visitor team. It emphasises the importance of effective information transfer between the individuals within the team. Having continuity of carer means that a trusting relationship can be

developed between the woman and the healthcare professional(s) who cares for her. For more information, see the NHS Implementing Better Births: continuity of carer.

Effective feed

In general, effective feeding includes the baby showing readiness to feed, rhythmic sucking, calmness during the feed and satisfactory weight gain. For a first feed at the breast or with a bottle, effective feeding is shown by the baby latching to the breast or drawing the teat into mouth when offered and showing some rhythmic sucking.

First infant formula

First infant formula or 'first milk' is the type of formula milk that is suitable for a baby from birth to 12 months.

Low birth weight

A birth weight of less than 2,500 grams regardless of gestational age.

Nominal group technique

This is a structured method that uses the opinions of individuals within a group to reach a consensus. It involves anonymous voting with an opportunity to provide comments. Options with low agreement are eliminated and options with high agreement are retained. Using the comments that individuals provide, options with medium agreement are revised and then considered in a second round. For more information, see supplement 1 on methods.

Parental responsibility

See the government definition of parental responsibility.

Parents

Parents are 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.

Partner

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 the woman feels supported by or wishes to involve.

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.

Responsive feeding

Responsive feeding means feeding in response to the baby's cues. It recognises that feeds are not just for nutrition, but also for love, comfort and reassurance between the baby and mother (or parent in case of bottle feeding). Responsive breastfeeding also involves a mother responding to her own desire to feed for her comfort or convenience. Responsive bottle feeding involves holding the baby close, pacing the feeds and avoiding forcing the baby to finish the feed by recognising signs that the baby has had enough milk, and to reduce the risk of overfeeding. For more information, see the UNICEF Baby Friendly Initiative (BFI) information sheet on responsive feeding.

Recommendations for research

The guideline committee has made the following key recommendations for research.

1 Length of postpartum stay and first midwife visit after transfer of care

How does the length of postpartum stay and the timing of the first midwife visit after transfer of care affect unplanned or emergency health contacts for women and babies?

For a short explanation of why the committee made this recommendation for research, see the rationale section on timing of transfer to community care.

Full details of the recommendation for research are in evidence review A: length of postpartum stay.

See also the rationale section on first midwife visit after transfer of care from the place of birth or after a home birth.

Full details of the recommendation for research are in evidence review C: timing of first postnatal contact by midwife.

2 Timing of first health visitor visit

What is the most effective timing of the first postnatal contact by a health visitor?

For a short explanation of why the committee made this recommendation for research, see the rationale section on first health visitor visit.

Full details of the recommendation for research are in evidence review D: timing of first postnatal contact by health visitor.

3 Clinical tools to assess women's health

What tools for the clinical review of women (including pain scores) are effective during the first 8 weeks after birth?

For a short explanation of why the committee made this recommendation for research, see the rationale section on assessment and care of the woman.

Full details of the recommendation for research are in evidence review H: tools for the clinical review of women.

4 Perineal pain

What characteristics of perineal pain suggest the need for further evaluation?

For a short explanation of why the committee made this recommendation for research, see the rationale section on perineal health.

Full details of the recommendation for research are in evidence review J: perineal pain.

5 Breastfeeding support for parents with twins or triplets

What support with breastfeeding do parents of twins or triplets find helpful?

For a short explanation of why the committee made this recommendation for research, see the rationale section on supporting women to breastfeed.

Full details of the recommendation for research are in evidence review S: breastfeeding information and support.

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice.

Principles of care

Recommendations 1.1.1 to 1.1.7

Why the committee made the recommendations

The committee agreed that one of the key principles of care in the postnatal period is to listen to women and be responsive to their needs, in line with the findings of the Ockenden report on maternity services at the Shrewsbury and Telford hospital NHS trust. The NICE guideline on patient experience in adult NHS services gives comprehensive guidance on individualised and person-centred care.

The committee also agreed that healthcare professionals should be aware of the disproportionate maternal and neonatal mortality rates among women and babies from black, Asian and minority ethnic backgrounds and those living in deprived areas, as highlighted by the 2020 MBRRACE-UK reports on maternal and perinatal mortality. This increased risk of death indicates that closer monitoring and lower thresholds for further care or admission might be needed. Future research could help understand these disparities and what interventions could improve the outcomes.

The committee recognised that the home and family circumstances for women vary, and it is up to the woman who she may want to involve in her postnatal care. The committee also recognised the role of the baby's father or other parents (or whoever has parental responsibility) in the care of the baby.

There was evidence that information given in the postnatal period is often inconsistent, and this was supported by the committee's experience. There was some evidence that information may need to be repeated at different times by different healthcare professionals. The committee agreed that this is good practice given the number of healthcare professionals that new parents are likely to come into contact with. They discussed concerns about the wide range and varied quality of information available from

healthcare professionals, the internet and social media.

The evidence showed that healthcare professionals are a trusted source of information, so the committee agreed that it is important for healthcare professionals to provide evidence-based and consistent information throughout the woman's care. It should also take into consideration the individual needs and preferences of the woman. The evidence suggested that it is helpful to deliver information in different formats, for example, face-to-face discussions and printed or digital materials. The NICE guideline on patient experience in adult NHS services gives more information. The committee discussed the importance of allowing sufficient time for discussions.

The NICE guideline on pregnancy and complex social factors provides guidance for the antenatal period for specific groups. The committee agreed that the principles of care that are not specific to the antenatal period can also be applied to the postnatal period for potentially vulnerable groups of women.

How the recommendations might affect practice

There is some variation in what information is provided, and the recommendations may result in a change in practice for some centres, involving more training for healthcare professionals, and more time in postnatal appointments. The recommendations are expected to have a positive effect on women's experience of the healthcare service by increasing their confidence in the information provided. This may result in parents being more likely to follow the advice given, which may enable them to react more appropriately to difficulties and thereby reduce morbidity and mortality.

Return to recommendations

Communication between healthcare professionals at transfer of care

Recommendations 1.1.8 and 1.1.9

Why the committee made the recommendations

The evidence highlighted issues that should be communicated between healthcare professionals at transfer of care, including the woman's history in relation to her pregnancy

and birth experience, and any mental health problems or safeguarding issues. Based on this evidence and their knowledge and experience, the committee agreed the information that should be passed on when women transfer between services, so that healthcare professionals do not miss relevant information and the woman does not always have to repeat the same information to different healthcare professionals. What is relevant and the level of detail needed may vary depending on whether the healthcare professional is a GP, midwife or a health visitor.

The committee also emphasised the importance of seamless transfer of care from midwifery to health visitor care so that there is continuous care provision.

How the recommendations might affect practice

There is variation in practice regarding what information, if any, is transferred between the different teams. The recommendation should lead to clearer guidance, improve relevant transfer of information and improve care for women and babies.

Return to recommendations

Transfer to community care

Recommendations 1.1.10 to 1.1.13

Why the committee made the recommendations

Studies looking at varying transfer timings showed that there was no consistent evidence about the best time to transfer the care of women and their babies to community care. Based on their knowledge and experience, the committee agreed that the timing should depend on the health and wellbeing of the woman and the baby. This also applies to the departure of the midwife in the case of a home birth. This will help to safely manage potential complications, prevent readmissions in the immediate postnatal period, and take into account any safeguarding concerns so that the woman and the baby are not discharged to an unsafe environment.

Assessing the woman's bladder function to rule out urinary retention is important because undetected or unmanaged urinary retention can lead to serious long-term consequences such as urinary incontinence.

Not passing meconium (the baby's first bowel movement) within the first 24 hours can be a sign of bowel obstruction, so it is important that parents know to seek advice from a healthcare professional. This might be for example a midwife, a doctor or, if the baby is thought to be seriously unwell, the emergency services.

Observing at least 1 effective feed (regardless of the method of feeding) is important to establish feeding and lower the chance of feeding problems at home and the need for readmission.

The committee also agreed that in order to reassure women that they and their babies are being taken care of, they should be given information about what happens next, what support is available and who to contact in case of concerns. It is also important to highlight the importance of pelvic floor exercises soon after birth to prevent potentially long-term and serious conditions such as incontinence and pelvic organ prolapse.

No evidence on timing of transfer to home care was identified for twins or triplets, but the committee agreed that the same principles apply for multiple births as for singleton births.

Because of the lack of clear evidence, the committee made a recommendation for research on length of postpartum stay to assess how the length of the hospital stay after giving birth affects unplanned or emergency contacts with primary or secondary care.

How the recommendations might affect practice

There is wide variation in practice in how long women stay in hospital after giving birth. The committee noted that observing a feed before transfer is already current practice in settings that are UNICEF Baby Friendly Initiative (BFI)-accredited, but many providers in England do not have this accreditation. The recommendations should lead to more consistency. If potential problems are prevented or managed early, this could potentially lead to cost savings because of lower reattendance or readmission.

Return to recommendations

First midwife visit after transfer of care from the place of birth or after a home birth

Recommendation 1.1.14

Why the committee made the recommendation

There was little evidence and the committee had low confidence in it, so the committee used their knowledge and experience to agree the timing of the first midwife visit. Having the first visit within 36 hours after transfer of care would usually mean that the visit is not left too long, so that any health or support needs can be identified early.

The committee agreed that the first postnatal visit by the midwifery team should be by a midwife (and not, for example, by a maternity support worker), face-to-face and, depending on the woman's circumstances and preferences, in the home. This should enable a comprehensive assessment of the health and support needs of the woman and her baby.

Because of the lack of evidence, the committee made a recommendation for research on the first midwife visit after discharge to assess how the timing of the first midwife visit after the transfer of care affects unplanned or emergency contacts with primary or secondary care.

How the recommendation might affect practice

The recommendation should reduce variation in practice and improve care for women. The recommendation might affect practice because a midwife should attend the first postnatal visit, and in current practice this might be a maternity support worker or a student midwife instead. However, no significant resource implications are expected.

Return to recommendations

First health visitor visit

Recommendations 1.1.15 and 1.1.16

Why the committee made the recommendations

No evidence was found about when the first postnatal health visitor visit should take place, so the committee used their knowledge and experience to agree the timing. The aim is to involve health visitors when they are most needed, and spread the visits evenly throughout the postnatal period.

According to the Department of Health and Social Care's Healthy Child Programme, there should be 2 health visitor visits in the postnatal period. The first visit is often very soon after transfer of care from midwifery care (which usually takes places 10 to 14 days after birth). This creates a gap of several weeks before the second health visitor visit at around 6 to 8 weeks. The first 2 weeks after birth may be overwhelming for some families, with several visits from both the midwifery team and health visitors. Having the first postnatal health visitor visit 1 to 2 weeks after transfer of care from midwifery care will mean that the visits are more evenly spread out.

Although the Healthy Child Programme includes an antenatal visit by the health visitor, the committee agreed that this does not always happen. If this is the case, an additional early postnatal visit by the health visitor to replace the missed antenatal visit could be considered to enable the health visitor to get to know the family and their circumstances early on.

Because of the lack of evidence, the committee made a recommendation for research on the most effective timing of the first postnatal visit by a health visitor.

How the recommendations might affect practice

There is variation in when the first postnatal health visitor visit takes place. However, 1 of the key performance indicators of the Healthy Child Programme is that the first postnatal health visitor visit takes place between 10 and 14 days after birth, so the recommendation would mean a change in practice. The recommendation aims to reduce variation in practice and improve care for women and their babies. Some additional resources may be needed to organise an additional early postnatal visit by a health visitor in the exceptional circumstance when a mandated antenatal health visitor visit has not taken place; however, the resource impact of this is not considered to be large, and is likely outweighed by the potential benefits.

Return to recommendations

Assessment and care of the woman

Recommendations 1.2.1 to 1.2.12

Why the committee made the recommendations

The recommendations were not developed by the usual NICE guideline systematic review process because of the scale and complexity of the topic. Using the nominal group technique to vote on statements about the content of postnatal care contacts, the committee made recommendations through formal consensus because reaching consensus by committee discussion alone would be challenging. The statements were based on a review, including critical appraisal, of existing guidelines and systematic reviews. The committee based the recommendations on these and their knowledge and experience.

The committee agreed that at each postnatal contact, women's general health and wellbeing, including psychological and emotional health, should be assessed and women should be asked if they have any concerns. The committee also agreed the physical health areas that midwives should assess. In order to prevent serious outcomes, women should also be made aware of the signs and symptoms of potentially serious conditions so they can seek help. Women's physical health assessment is not in the remit of the health visitor but when there are concerns, either observed by the healthcare professional or expressed by the woman, all healthcare professionals, including health visitors, should refer or advise self-referral so that the woman can get appropriate assessment and care.

The committee acknowledged that some women may want to talk about their birth experience. In some cases, women might need additional support in coping with their experience.

No evidence was identified on the timing of the comprehensive routine postnatal check. Based on their knowledge and experience, the committee agreed this should ideally happen between 6 and 8 weeks after birth, as is current practice, to coincide with the NHS newborn and infant physical examination.

No evidence was identified about which tools are effective in the clinical postnatal review of women. A tool that has been tested and validated in an independent sample assessing postnatal physical and mental health problems could help identify those women who need additional care and support, so the committee made a recommendation for research on clinical tools to assess women's health.

References were made to NICE guidelines on different conditions that may affect women postnatally. A bacterial infection could be transmitted to the baby, so it is important to

assess the baby if the mother has suspected or confirmed puerperal sepsis.

How the recommendations might affect practice

By ensuring that women's physical and psychological health and wellbeing is comprehensively assessed, and any problems are managed appropriately, there may be an increase in referrals if problems are identified. The committee agreed that any referrals would prevent delays in diagnosing and treating problems, and improve care.

Return to recommendations

Postpartum bleeding

Recommendations 1.2.13 and 1.2.14

Why the committee made the recommendations

No relevant evidence was identified about how to assess early symptoms and signs of postpartum haemorrhage, so the committee used their knowledge and experience to make the recommendations. Discussing with women what to expect after birth helps women to distinguish between a normal amount of lochia (vaginal discharge containing blood, mucus and uterine tissue) and signs and symptoms of postpartum haemorrhage. Women should be advised to seek medical advice if they observe these signs or symptoms because postpartum haemorrhage can have severe consequences.

The committee agreed that although all women are at risk of secondary postpartum haemorrhage, some factors increase this risk and these should be taken into account when assessing the severity of blood loss. The risk factors for postpartum haemorrhage are listed in the NICE guideline on intrapartum care. The committee used their knowledge and experience to list other factors that might worsen the consequences of postpartum bleeding so that appropriate action can be taken.

How the recommendations might affect practice

It is not routine practice to discuss what blood loss to expect postnatally, so the recommendations will involve a minor change to current practice but will potentially improve outcomes by early identification of secondary postpartum haemorrhage.

Return to recommendations

Perineal health

Recommendations 1.2.15 to 1.2.22

Why the committee made the recommendations

Perineal pain and its complications are often overlooked and falsely considered to be part of normal postnatal healing. However, early identification and management of perineal pain may prevent long-term consequences and improve the woman's overall experience of postnatal care. To help healthcare professionals identify women with perineal pain and to prompt appropriate care, healthcare professionals should ask women if they have any perineal concerns.

Practical advice about how to maintain good perineal hygiene can prevent infection or complications. In order to assess changes in the severity of perineal pain over time, a validated pain score might help to give a clearer view. Physical examination of the perineum could help determine the severity or cause of the pain, or whether further action is needed. In some cases, medication might be needed to alleviate the pain.

The committee emphasised that women with perineal wound breakdown should be urgently referred to appropriate maternity services for further management to prevent further complications and potential long-term adverse outcomes.

There was evidence that prolonged perineal pain and severity of pain is associated with depressive symptoms. There was no other relevant evidence about perineal pain, but the committee agreed, based on their knowledge and experience, that it can have negative long-term implications. To help healthcare professionals identify women with persistent or worsening perineal pain and to prompt appropriate care, they should be aware of the factors that can increase the risk of persistent postnatal perineal pain.

Because of the lack of evidence about what characteristics of perineal pain suggest the need for further evaluation, a recommendation for research on perineal pain was made.

How the recommendations might affect practice

In current practice, some women only receive treatment for perineal complications when the situation has become serious. By ensuring that perineal pain is identified early and treated without delay, then further complications and long-term consequences can be avoided. There may be an increase in referrals to secondary care for women who are usually seen by their GP, but the recommendations should improve care and outcomes.

Return to recommendations

Assessment and care of the baby

Recommendations 1.3.1 to 1.3.12

Why the committee made the recommendations

Most of the recommendations in this section were not developed by the usual NICE guideline systematic review process because of the scale and complexity of the topic. Using the nominal group technique to vote on statements about the content of postnatal care contacts, the committee made recommendations through formal consensus because reaching consensus by committee discussion alone would be challenging. The statements were based on a review, including critical appraisal, of existing guidelines and systematic reviews. The committee based the recommendations on these, and their knowledge and experience.

The general wellbeing, feeding and development of the baby should be assessed at every postnatal contact so that any concerns can be identified early. Not passing meconium (the baby's first bowel movement) within the first 24 hours can be a sign of bowel obstruction, so it is important that healthcare professionals engaging with the family in the immediate postnatal period are aware of the need for advice from a doctor.

There was no reason for the committee to change the current recommended assessment criteria that healthcare professionals should use within 72 hours after the birth. The committee agreed that the same criteria could be used in the 6- to 8-week assessment. The recommendation about weight and head circumference measurement is based on guidance from the UK-WHO (World Health Organization) growth charts.

The recommendations refer to other NICE guidelines for guidance on specific clinical

situations, and relevant NHS screening programmes.

To help parents, healthcare professionals should also discuss and provide information about how to care for their baby. Established guidance exists on safer sleeping practices, and resources for these are available from, for example, UNICEF, Baby Sleep Information Source (Basis), and the Lullaby Trust.

Baby Check is a scoring system intended to help in the assessment of babies up to 6 months of age, taking into account the presence or absence of various symptoms and signs of illness. It gives an overall score to help in deciding whether the baby may need clinical assessment or care. Although the evidence base for the Baby Check was predominantly in relation to babies attending secondary care, there was evidence that in the community setting, it can identify babies who are likely to be well. Also, the studies included babies ranging from birth to 6 months and were not therefore specifically focused on those in the early weeks of life.

The Lullaby Trust has produced parent-friendly modified versions of the Baby Check scoring system, in the form of a mobile app and a downloadable booklet. Although the modifications are mostly related to the language used, the committee had some concerns because the modified versions have not been validated, and neither has the use of Baby Check by parents, as opposed to healthcare professionals. Finally, the committee noted that the Lullaby Trust's modified versions have adopted current practices regarding temperature measurement (armpit or ear), and this differs from the original Baby Check evaluations, which use rectal temperature.

Although Baby Check cannot therefore provide complete reassurance, the committee agreed that the Baby Check scoring system could be helpful to parents as a 'checklist' of symptoms and signs of possible illness when they are uncertain whether their baby might be unwell and deciding whether to seek advice from a healthcare professional. The committee agreed it would be best for parents to be given information about Baby Check in advance rather than when they are concerned about their baby's wellbeing.

How the recommendations might affect practice

The recommendations largely reflect current practice. There may be an increase in the use of Baby Check scoring system by parents. It is not known if this would have an impact on parents seeking advice from healthcare professionals, but the impact would not be expected to be large.

Return to recommendations

Bed sharing

Recommendations 1.3.13 and 1.3.14

Why the committee made the recommendations

There was evidence of varying quality from multiple studies about the different risk factors associated with sudden unexpected death in infancy when bed sharing (up to 1 year of age). Based on the evidence and their knowledge and experience, the committee agreed the safe bed sharing practices that should be discussed with all parents and the circumstances in which bed sharing with a baby should be strongly advised against. The evidence also showed an association between bed sharing and breastfeeding although there is uncertainty about the causality. Preterm babies are outside the remit of this guideline and are therefore not mentioned in the recommendations; however, the committee were aware of evidence showing an increased risk of sudden unexpected death in infancy when bed sharing with a baby born preterm.

How the recommendations might affect practice

In current practice, there is confusion and mixed messages from both healthcare professionals and within the community on the best practice for safe sleeping, including advice about never sharing a bed with a baby. These recommendations should lead to clear guidance, reduce variation in practice, and improve care for women and babies.

Return to recommendations

Promoting emotional attachment

Recommendations 1.3.15 to 1.3.18

Why the committee made the recommendations

There was limited evidence on how to promote attachment between the mother and baby, and it did not show any specific interventions to be effective, so the recommendations are based on the committee's knowledge and experience. The committee agreed to make the

recommendations for parents, not just the mother, because discussing and recognising the issues related to developing emotional attachment are relevant for other parental caregivers as well.

The committee agreed that discussions about emotional attachment should begin antenatally and continue into the postnatal period. The committee highlighted that emotional attachment will usually happen naturally if the primary carer is able to spend quality time with their baby. The value of such quality time is not always recognised as important by the parent(s) when there are so many other demands on parents' time in the postnatal period.

The committee recognised that attachment can also be affected by the woman's wellbeing, recovery from birth and other demands that parenthood brings. Therefore, it is important to discuss these issues with the parents to support them in building a relationship with their baby. It was considered important for the woman's partner (if there is one) to understand the various challenging aspects that the mother might be experiencing in the postnatal period, which might affect bonding and emotional attachment.

Based on their knowledge and experience, the committee highlighted particular groups of parents who may be more vulnerable to difficulties in attachment and may need more support.

How the recommendations might affect practice

There is variation in practice regarding what women are offered in support relating to emotional attachment. The recommendations should lead to clear guidance, reduce variation in practice and improve care for women.

Return to recommendations

Symptoms and signs of illness in babies

Recommendations 1.4.1 to 1.4.10

Why the committee made the recommendations

It is important to identify babies who are seriously ill early so that the condition can be managed and adverse outcomes can be avoided. In the committee's experience, parents' concern about 'something being not quite right' can sometimes be overlooked, but it can be an important sign of serious illness and should be taken seriously.

Baby Check is a scoring system intended to help in the assessment of babies up to 6 months of age, taking into account the presence or absence of various symptoms and signs of illness. It gives an overall score to help in deciding whether the baby may need clinical assessment or care. Based on the evidence in the secondary care setting, its sensitivity to identify those babies who are seriously ill varied. In the community setting, it was found to identify babies who are well suggesting that further assessment is not needed but the evidence regarding its accuracy in identifying seriously ill babies is lacking. Also, the studies in which it was being tested included babies ranging from birth to 6 months and were not therefore specifically focused on those in the early weeks of life as this guideline.

The Lullaby Trust has produced parent-friendly modified versions of the Baby Check scoring system, in the form of a mobile app and a downloadable booklet. Although the modifications are mostly related to the language used, the committee had some concerns because the modified versions have not been validated, and neither has the use of Baby Check by parents, as opposed to healthcare professionals. Finally, the committee noted that the Lullaby Trust's modified versions have adopted current practices regarding temperature measurement (armpit or ear), and this differs from the original Baby Check evaluations, which use rectal temperature.

For these reasons, the committee agreed that Baby Check should not be used in isolation to determine the need for further assessment or care but that it could be a helpful tool when used in addition to clinical judgement. Also, by focusing attention on important symptoms and signs, it could help during a remote assessment as a communication aid between healthcare professionals and parents.

The committee also noted that sometimes the presence of fever in young babies is not recognised as a serious concern. It is particularly important to note changes in the baby's wellbeing and behaviour.

There was evidence that single signs and symptoms are not necessarily useful predictors

of serious illness on their own. However, based on various other NICE guidelines, there are some 'red flag' symptoms and signs that indicate a serious illness that needs immediate action.

How the recommendations might affect practice

The recommendations should reinforce current good practice and improve care for babies. There may be an increase in the use of the Baby Check scoring system as a supplemental tool for healthcare professionals, particularly during remote appointments.

Return to recommendations

General principles about babies' feeding

Recommendation 1.5.1

Why the committee made the recommendation

Based on their knowledge and experience, the committee agreed that the choices parents make around feeding are not easy and sometimes their preferred choice might not be an option for them. Evidence among parents who bottle fed their babies showed that they sometimes felt judged by the healthcare professionals about their choices. Therefore, the committee agreed that as a general principle, discussions around feeding should be respectful and acknowledge the various consequences different feeding options may have.

How the recommendation might affect practice

There is some variation in practice, so the recommendation aims to improve the consistency of support given to parents about feeding their baby.

Return to recommendations

Giving information about breastfeeding

Recommendations 1.5.2 to 1.5.5

Why the committee made the recommendations

Based on their knowledge and experience, the committee agreed that discussion and support around breastfeeding should start in the antenatal period so that women are equipped to make decisions about feeding and are prepared to start breastfeeding when the baby is born. The discussions and support should continue in the postnatal period so that any questions and concerns can be addressed and women feel they are being supported.

There was good evidence about women being motivated by the many benefits of breastfeeding, so it is important to share these with the women. It is established knowledge that breastfeeding has nutritional and health benefits for the baby (such as lower rates of infection) and some health benefits for the woman (such as lower risk of breast cancer). There was evidence that women felt they were able to soothe and comfort the baby by breastfeeding.

The committee agreed that it is important to explain that breastfeeding can have benefits even if done for a short period of time. For example, colostrum (the breast milk that is produced in the first few days) is known to have various nutritional and health benefits for the baby.

The committee also agreed that parents should receive information about partners' involvement in supporting breastfeeding. The evidence showed that some women and their families believed that bottle feeding was a way for the baby to bond with their partner or other family members. The committee agreed that partners and family members should be given information about alternative ways to comfort and bond with the baby.

Because breastfeeding women may be at risk of vitamin D deficiency, they should be informed about the NICE recommendation about taking vitamin D supplementation.

There was evidence that some women thought that other people felt that breastfeeding in public is inappropriate or insensitive to other people's feelings, which can be a barrier for breastfeeding in public places. The committee agreed the importance of reassuring women and their partners that under the 2010 Equality Act, women have the right to breastfeed in 'any public space'.

How the recommendations might affect practice

The recommendations largely reflect current practice and should reinforce good practice across the country.

Return to recommendations

Role of the healthcare professional supporting breastfeeding

Recommendations 1.5.6 to 1.5.8

Why the committee made the recommendations

Feeding is an integral part of the postnatal period, so healthcare professionals should have the relevant knowledge to encourage breastfeeding and to support women to establish and continue breastfeeding. The BNF provides useful information on safe medicine use and prescribing for women who are breastfeeding. If needed, further advice is available from an NHS medicines information centre or other specialist sources.

The World Health Organization (WHO) recommends that breastfeeding is started early in order to facilitate establishment of breastfeeding, and the committee agreed that healthcare professionals caring for women and babies in the immediate postnatal period should encourage early skin-to-skin contact to help start breastfeeding when the baby and the mother feel ready.

The committee agreed that healthcare professionals should be sensitive to the individual preferences, experiences and values of the woman when supporting her with breastfeeding. There was evidence that after birth, women value having privacy in hospital, and a lack of privacy can be a barrier to breastfeeding and expressing breast milk. However, the committee noted that healthcare professionals also need to be able to carry out clinical observations of women easily, so recommended that these needs be balanced against each other.

The evidence also showed that varying experiences with breastfeeding can have an impact on the woman's emotional wellbeing, and women often need reassurance and encouragement to gain confidence.

How the recommendations might affect practice

In the committee's experience, some healthcare professionals caring for women and babies during the postnatal period may not have adequate knowledge to support women with breastfeeding and might need more training. The recommendations should reinforce best clinical practice and lead to better consistency of care.

Return to recommendations

Supporting women to breastfeed

Recommendations 1.5.9 to 1.5.12

Why the committee made the recommendations

There was evidence that women value breastfeeding care that provides individualised support and continuity of carer, and feel that 'remote' support (such as online or telephone support) can be a helpful addition but should not replace face-to-face support.

The evidence also showed that partners often feel that they lack knowledge and understanding of breastfeeding, and want to know how they can best support breastfeeding mothers.

There was evidence that women find peer support valuable. Through peer support, women can share their experiences and gain information and social contacts, which can provide ongoing support.

There was no evidence that extra interventions increase breastfeeding rates so the committee agreed that breastfeeding support should be an integral part of standard postnatal care contacts.

There was some evidence that younger women may have additional barriers to breastfeeding, such as feeling alone in the maternity unit, the feeling of needing to 'carry on with life' and therefore choosing to formula feed, and lack of peer support. Evidence also suggested that additional support may be beneficial for improving the rate of breastfeeding among women from low income or socially disadvantaged backgrounds.

The evidence showed that women value support and practical information about

breastfeeding, as well as information about the underlying physiology of breastfeeding. This will help them to recognise what is or is not normal, and when to seek help. The evidence also showed that some common features of breastfeeding, such as sore nipples, can discourage women if they do not know in advance what to expect.

There was no evidence about breastfeeding support for parents of twins or triplets, so the committee made a recommendation for research.

How the recommendations might affect practice

There is significant variation in the provision of practical and professional breastfeeding support, so the recommendations will support best practice in some settings and improve practice in other settings. They will reduce variation in practice and improve care for women and babies. Providing continuity of carer may have an impact on how services are organised, but no significant resource impact is expected.

Return to recommendations

Assessing breastfeeding

Recommendations 1.5.13 to 1.5.15

Why the committee made the recommendations

Assessing breastfeeding is an important part of postnatal contacts. None of the clinical tools identified in the evidence review were useful in identifying women who would not be breastfeeding (or exclusively breastfeeding) at follow up, which was considered an indication of breastfeeding difficulties, so the committee did not recommend any tools. The committee used their knowledge and experience to make the recommendations, in line with the principles in the UNICEF Baby Friendly Initiative (BFI) breastfeeding assessment tool, including asking the parents about any concerns and about indications of successful breastfeeding.

In addition, observing a feed twice in the first week can help establish good breastfeeding practice. Additional observations or interventions may be needed if there are ongoing concerns.

How the recommendations might affect practice

In current practice, observing a full feed in the first week might not always happen, so this may mean a change in practice and may have some impact on time needed at the postnatal contacts. The recommendations are based on the UNICEF BFI breastfeeding assessment tool, which is already widely used in practice. In places where it is not already used, the committee were aware that work is underway to reach that standard. The recommendations will improve and standardise practice.

Return to recommendations

Formula feeding

Recommendations 1.5.16 to 1.5.20

Why the committee made the recommendations

The committee recognised that babies can be formula fed in combination with breastmilk or they can be fed with formula milk only. There was good evidence about what information and support parents who formula feed find helpful, so the committee used the evidence together with their knowledge and experience to make the recommendations. Common themes in the evidence were the lack of impartial information about formula feeding, women feeling that they were not supported in their feeding choices, and the emotional impact that feeding choices can have on parents. The committee agreed that, as for women who breastfeed, women who formula feed should be supported regardless of their feeding choices. The recommendations reflect the key features of formula feeding support and the information that should be given to women and their families if they are formula feeding or are considering to formula feed and who need to formula feed because of a medical or other reason.

The evidence showed that women value face-to-face feeding support but also feel that additional information to support feeding can be helpful. The evidence showed that women who are formula feeding feel that they are not given the information or support they need, for example, about how to interpret and respond to the baby's behaviours and cues, and how to formula feed safely. Based on the committee's experience, it is important to give information about how to hold the baby and how feeding can be used as an opportunity to bond with the baby, and also advise parents against using a 'propped up' bottle during a feed because it can be harmful for the baby.

The evidence also showed that women were unaware of the impact introducing formula feeding could have on breastfeeding and felt unsupported by healthcare professionals when considering this. Therefore, the committee agreed it was important that women were supported to make an informed, guilt-free decision by providing balanced and evidence-based information.

How the recommendations might affect practice

The committee noted that there is significant variation in practice in providing formula feeding support, so the recommendations will support best practice in some settings and improve practice in other settings. Overall, they will improve consistency.

Return to recommendations

Lactation suppression

Recommendation 1.5.21

Why the committee made the recommendation

No evidence was identified on the information and support that should be given to women about lactation suppression. The committee discussed when discussions about lactation suppression should happen and what should be discussed, and used their knowledge and experience to agree the recommendation. The committee agreed that discussions should be sensitive and individualised according to the woman's situation. Practical advice about how to ease the process of milk drying up can be helpful for women, and in some cases, medicine to suppress lactation might also be appropriate to make the process quicker, although for most this is not needed.

Donating breast milk to a local breast milk bank, depending on the local services, could be valuable to some women who cannot breastfeed their own baby.

How the recommendation might affect practice

The recommendation largely reflects current practice and should reinforce best practice. To ensure that women understand the information they are given, and that information is being provided at the most appropriate time, some extra time from healthcare

professionals may be needed.

Return to recommendations

Context

Approximately 700,000 women give birth in England and Wales each year. For women, their partners and their babies, this is a major life event that means considerable emotional and physical adjustment. It applies to all births but is perhaps most marked for those having their first child. Healthcare professionals have the responsibility to help families adjust to their new life, but at the same time they have to be able to spot and care for the families where complications arise.

Postnatal care has for long been regarded as a 'Cinderella service' where in comparison with some other European countries, provision is scanty and inadequate. This approach risks missing an opportunity to have a profoundly beneficial effect on the lives of the babies and their families, now and in the future. In a National Childbirth Trust (NCT) survey: left to your own devices – the postnatal care experiences of 1,260 first-time mothers, 1 in 8 women were highly critical of their postnatal care. Their feedback reflects fragmentation of care, poor planning and communication between healthcare professionals, and insufficient advice about emotional recovery. Furthermore, women continue to report receiving insufficient or inconsistent information on baby's feeding, particularly after giving birth to their first baby.

This guideline addresses the organisation and delivery of postnatal care, including the relationship between the different agencies that share the responsibility for postnatal care; assessment and health of women; assessment and health of babies; how to help parents form strong relationships with their babies; and babies' feeding. It specifically does not cover issues covered by other NICE guidelines, in particular problems of mental health, preterm birth or specialist care (care beyond routine postnatal care), but refers to other NICE guidelines, where appropriate.

This guideline covers the postnatal period up to 8 weeks after birth. However, the sections on babies' feeding and emotional attachment also address the antenatal period because discussion around these is essential already during pregnancy. The postnatal period of course does not end at 8 weeks. A time point of 8 weeks was agreed in order to focus the guideline on the most critical early weeks after birth. The remit for some of the topics in this guideline was to address the needs of families giving birth to twins and triplets in addition to single babies. The evidence specific to twins and triplets was lacking and the consensus was that healthcare professionals and families dealing with twins or triplet births should use the recommendations of the guideline within the constraints of the

changed circumstances of having to care for more than 1 child.

The committee were aware of the higher postnatal mortality rates among women of black, Asian and minority ethnic origin and women living in deprived areas reported in the MBRRACE-UK report: saving lives, improving mothers' care (2020). Black women in particular had an over four-fold increase in maternal mortality rates compared with white women. The MBRRACE-UK report: perinatal mortality surveillance report (2020) also highlights the higher neonatal mortality rates for babies of black and Asian ethnicity and babies born to mothers living in deprived areas. It is important that clinicians are aware of these inequalities in clinical practice.

This guideline was written with the hope that healthcare professionals can use it to provide consistent and high-quality care, while taking into consideration each family's individual situation and needs, in order to reduce morbidity and mortality and to support families in this new phase.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE topic page on postnatal care.

For full details of the evidence and the guideline committee's discussions, see the evidence reviews. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

Update information

April 2021: This guideline updates and replaces NICE guideline CG37 (published July 2006).

Minor changes since publication

September 2025: Guidance previously produced by Public Health England has been rebadged in line with changes on the gov.uk website.

October 2023: We updated links to the NICE guideline on intrapartum care, which has been updated.

August 2023: We added a link to the Department of Health and Social Care's Healthy Child Programme to recommendation 1.1.15.

November 2022: We changed 'symptoms' to 'signs' in recommendation 1.4.7.

December 2021: We added a link to NICE's guideline on pelvic floor dysfunction in recommendations 1.1.13, 1.2.1 and 1.2.12.

October 2021: We added a link to NICE's shared decision making guideline in recommendation 1.1.5.

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