NICE National Institute for Health and Care Excellence

Postnatal care

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Contents

Recommendations on co-sleeping and sudden infant death syndrome were updated in 2014 and cover the first year of an infant's life. The guideline addendum contains details of the methods and evidence used to develop these updated recommendations.

Introduction

This guideline aims to identify the essential core (routine) care that every woman and her baby should receive in the first 6–8 weeks after birth, based on the best evidence available. The recommendations on co-sleeping and sudden infant death syndrome cover the first year of an infant's life.

Although for most women and babies the postnatal period is uncomplicated, care during this period needs to address any deviation from expected recovery after birth. This guideline gives advice on when additional care may be needed and these recommendations have been given a status level (indicating the degree of urgency needed in dealing with the problem (see table 1).

Table 1 Status levels

Status	Classification
Emergency	Life-threatening or potential life-threatening situation
Urgent	Potentially serious situation, which needs appropriate action
Non-urgent	Continue to monitor and assess

Medicine recommendations

The guideline will assume that prescribers will use a medicine's summary of product characteristics to inform decisions made with individual patients.

Patient-centred care

This guideline offers best practice advice on the care that every woman and her baby should receive in the first 6–8 weeks after birth. The advice on co-sleeping and sudden infant death syndrome covers the first year of an infant's life.

Patients and healthcare professionals have rights and responsibilities as set out in the NHS Constitution for England – all NICE guidance is written to reflect these. Treatment and care should take into account individual needs and preferences. Patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If the patient is under 16, their family or carers should also be given information and support to help the child or young person to make decisions about their treatment. Healthcare professionals should follow the Department of Health's advice on consent. If someone does not have capacity to make decisions, healthcare professionals should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.

NICE has produced guidance on the components of good patient experience in adult NHS services. All healthcare professionals should follow the recommendations in patient experience in adult NHS services.

NICE has also produced guidance on the components of good service user experience. All healthcare professionals and social care practitioners working with people using adult NHS mental health services should follow the recommendations in service user experience in adult mental health.

Key priorities for implementation

The following recommendations were identified as priorities for implementation in the **[2006]** guideline and were not changed in the **[2014]** update.

- A documented, individualised postnatal care plan should be developed with the woman ideally in the antenatal period or as soon as possible after birth. This should include:
  - relevant factors from the antenatal, intrapartum and immediate postnatal period
  - details of the healthcare professionals involved in her care and that of her baby, including roles and contact details
  - plans for the postnatal period.

This should be reviewed at each postnatal contact. **[2006]**

- There should be local protocols about written communication, in particular about the transfer of care between clinical sectors and healthcare professionals. These protocols should be audited. **[2006]**
- Women should be offered relevant and timely information to enable them to promote their own and their babies' health and wellbeing and to recognise and respond to problems. **[2006]**
- At the first postnatal contact, women should be advised of the signs and symptoms of potentially life-threatening conditions (given in table 2) and to contact their healthcare professional immediately or call for emergency help if any signs and symptoms occur. **[2006]**
- All maternity care providers (whether working in hospital or in primary care) should implement an externally evaluated, structured programme that encourages breastfeeding, using the Baby Friendly Initiative as a minimum standard. **[2006]**
- At each postnatal contact, women should be asked about their emotional wellbeing, what family and social support they have and their usual coping strategies for dealing with day-to-day matters. Women and their families/partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of the woman's normal pattern. **[2006]**

- At each postnatal contact, parents should be offered information and advice to enable them to:
  - assess their baby's general condition
  - identify signs and symptoms of common health problems seen in babies
  - contact a healthcare professional or emergency service if required. **[2006]**

1 Recommendations

The following guidance is based on the best available evidence. The full guideline gives details of the methods and the evidence used to develop the **[2006]** recommendations. The guideline addendum gives details of the methods and the evidence used to develop the **[2014]** recommendations on co-sleeping and sudden infant death syndrome.

1.1 Planning the content and delivery of care

Principles of care

1.1.1 Each postnatal contact should be provided in accordance with the principles of individualised care. In order to deliver the core care recommended in this guideline, postnatal services should be planned locally to achieve the most efficient and effective service for women and their babies. **[2006]**

1.1.2 A coordinating healthcare professional should be identified for each woman. Based on the changing needs of the woman and baby, this professional is likely to change over time. **[2006]**

1.1.3 A documented, individualised postnatal care plan should be developed with the woman, ideally in the antenatal period or as soon as possible after birth. This should include:

- relevant factors from the antenatal, intrapartum and immediate postnatal period
- details of the healthcare professionals involved in her care and that of her baby, including roles and contact details
- plans for the postnatal period.

This should be reviewed at each postnatal contact. **[2006]**

1.1.4 Women should be offered an opportunity to talk about their birth experiences and to ask questions about the care they received during labour. **[2006]**

1.1.5 Women should be offered relevant and timely information to enable them to promote their own and their babies' health and wellbeing and to recognise and respond to problems. **[2006]**

1.1.6 At each postnatal contact the healthcare professional should:

- ask the woman about her health and wellbeing and that of her baby. This should include asking women about their experience of common physical health problems. Any symptoms reported by the woman or identified through clinical observations should be assessed.
- offer consistent information and clear explanations to empower the woman to take care of her own health and that of her baby, and to recognise symptoms that may require discussion
- encourage the woman and her family to report any concerns in relation to their physical, social, mental or emotional health, discuss issues and ask questions
- document in the care plan any specific problems and follow-up. **[2006]**

1.1.7 Length of stay in a maternity unit should be discussed between the individual woman and her healthcare professional, taking into account the health and wellbeing of the woman and her baby and the level of support available following discharge. **[2006]**

Professional communication

1.1.8 There should be local protocols about written communication, in particular about the transfer of care between clinical sectors and healthcare professionals. These protocols should be audited. **[2006]**

1.1.9 Healthcare professionals should use hand-held maternity records, the postnatal care plans and personal child health records, to promote communication with women. **[2006]**

Competencies

1.1.10 All healthcare professionals who care for mothers and babies should work within the relevant competencies developed by Skills for Health. Relevant healthcare professionals should also have demonstrated competency and sufficient ongoing clinical experience in:

- undertaking maternal and newborn physical examinations and recognising abnormalities
- supporting breastfeeding women including a sound understanding of the physiology of lactation and neonatal metabolic adaptation and the ability to communicate this to parents
- recognising the risks, signs and symptoms of domestic abuse and whom to contact for advice and management, as recommended by Department of Health guidance[1],[2]
- recognising the risks, signs and symptoms of child abuse and whom to contact for advice and management, as recommended by Department of Health guidance[1]. **[2006]**

1.2 Maternal health

Information giving

1.2.1 At the first postnatal contact, women should be advised of the signs and symptoms of potentially life-threatening conditions (given in table 2) and to contact their healthcare professional immediately or call for emergency help if any signs and symptoms occur. **[2006]**

Table 2 Signs and symptoms of potentially life-threatening conditions

Signs and symptoms	Condition
Sudden and profuse blood loss or persistent increased blood loss Faintness, dizziness or palpitations/tachycardia	Postpartum haemorrhage
Fever, shivering, abdominal pain and/or offensive vaginal loss	Infection

Headaches accompanied by one or more of the following symptoms within the first 72 hours after birth: visual disturbances nausea, vomiting	Pre-eclampsia/ eclampsia
Unilateral calf pain, redness or swelling Shortness of breath or chest pain	Thromboembolism

1.2.2 The Department of Health booklet 'Birth to five'[5], which is a guide to parenthood and the first 5 years of a child's life, should be given to all women within 3 days of birth (if it has not been received antenatally). **[2006]**

1.2.3 The personal child health record should be given to all women as soon as possible (if it has not been received antenatally) and its use explained. **[2006]**

1.2.4 Women should be offered information and reassurance on:

- the physiological process of recovery after birth (within the first 24 hours)
- normal patterns of emotional changes in the postnatal period and that these usually resolve within 10–14 days of giving birth (within 3 days)
- common health concerns as appropriate (weeks 2–8). **[2006]**

Life-threatening conditions: core care and raised concern

Postpartum haemorrhage

1.2.5 In the absence of abnormal vaginal loss, assessment of the uterus by abdominal palpation or measurement as a routine observation is unnecessary. **[2006]**

1.2.6 Assessment of vaginal loss and uterine involution and position should be undertaken in women with excessive or offensive vaginal loss, abdominal tenderness or fever. Any abnormalities in the size, tone and position of the uterus should be evaluated. If no uterine abnormality is found, consider other causes of symptoms (urgent action). **[2006]**

1.2.7 Sudden or profuse blood loss, or blood loss accompanied by any of the signs and symptoms of shock, including tachycardia, hypotension, hypoperfusion and change in consciousness, should be evaluated (emergency action). **[2006]**

Genital tract sepsis

1.2.8 In the absence of any signs and symptoms of infection, routine assessment of temperature is unnecessary. **[2006]**

1.2.9 Temperature should be taken and documented if infection is suspected. If the temperature is above 38°C, repeat measurement in 4–6 hours. **[2006]**

1.2.10 If the temperature remains above 38°C on the second reading or there are other observable symptoms and measurable signs of sepsis, evaluate further (emergency action). **[2006]**

Pre-eclampsia/eclampsia

1.2.11 A minimum of one blood pressure measurement should be carried out and documented within 6 hours of the birth. **[2006]**

1.2.12 Routine assessment of proteinuria is not recommended. **[2006]**

1.2.13 Women with severe or persistent headache should be evaluated and pre-eclampsia considered (emergency action). **[2006]**

1.2.14 If diastolic blood pressure is greater than 90 mmHg, and there are no other signs and symptoms of pre-eclampsia, measurement of blood pressure should be repeated within 4 hours. **[2006]**

1.2.15 If diastolic blood pressure is greater than 90 mmHg and accompanied by another sign or symptom of pre-eclampsia, evaluate further (emergency action). **[2006]**

1.2.16 If diastolic blood pressure is greater than 90 mmHg and does not fall below 90 mmHg within 4 hours, evaluate for pre-eclampsia (emergency action). **[2006]**

Thromboembolism

1.2.17 Women should be encouraged to mobilise as soon as appropriate following the birth. **[2006]**

1.2.18 Women with unilateral calf pain, redness or swelling should be evaluated for deep venous thrombosis (emergency action). **[2006]**

1.2.19 Women experiencing shortness of breath or chest pain should be evaluated for pulmonary thromboembolism (emergency action). **[2006]**

1.2.20 Routine use of Homan's sign as a tool for evaluation of thromboembolism is not recommended. **[2006]**

1.2.21 Obese women are at higher risk of thromboembolism and should receive individualised care. **[2006]**

Mental health and wellbeing

1.2.22 At each postnatal contact, women should be asked about their emotional wellbeing, what family and social support they have and their usual coping strategies for dealing with day-to-day matters. Women and their families/ partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of the woman's normal pattern. **[2006]**

1.2.23 Formal debriefing of the birth experience is not recommended. **[2006]**

1.2.24 All healthcare professionals should be aware of signs and symptoms of maternal mental health problems that may be experienced in the weeks and months after the birth. **[2006]**

1.2.25 At 10–14 days after birth, women should be asked about resolution of symptoms of baby blues (for example, tearfulness, feelings of anxiety and low mood). If symptoms have not resolved, the woman should be assessed for postnatal depression, and if symptoms persist, evaluated further (urgent action)[t]. **[2006]**

1.2.26 Women should be encouraged to help look after their mental health by looking after themselves. This includes taking gentle exercise, taking time to rest, getting help with caring for the baby, talking to someone about their feelings and ensuring they can access social support networks. **[2006]**

Physical health and wellbeing

Perineal care

1.2.27 At each postnatal contact, women should be asked whether they have any concerns about the healing process of any perineal wound; this might include experience of perineal pain, discomfort or stinging, offensive odour or dyspareunia. **[2006]**

1.2.28 The healthcare professional should offer to assess the perineum if the woman has pain or discomfort. **[2006]**

1.2.29 Women should be advised that topical cold therapy, for example crushed ice or gel pads, are effective methods of pain relief for perineal pain. **[2006]**

1.2.30 If oral analgesia is required, paracetamol should be used in the first instance unless contraindicated. **[2006]**

1.2.31 If cold therapy or paracetamol is not effective a prescription for oral or rectal non-steroidal anti-inflammatory (NSAID) medication should be considered in the absence of any contraindications (non-urgent action). **[2006]**

1.2.32 Signs and symptoms of infection, inadequate repair, wound breakdown or non-healing should be evaluated (urgent action). **[2006]**

1.2.33 Women should be advised of importance of perineal hygiene, including frequent changing of sanitary pads, washing hands before and after doing this, and daily bathing or showering to keep their perineum clean. **[2006]**

Dyspareunia

1.2.34 Women should be asked about resumption of sexual intercourse and possible dyspareunia 2–6 weeks after the birth. **[2006]**

1.2.35 If a woman expresses anxiety about resuming intercourse, reasons for this should be explored. **[2006]**

1.2.36 Women with perineal trauma who experience dyspareunia should be offered an assessment of the perineum. (See perineal care above) **[2006]**

1.2.37 A water-based lubricant gel to help ease discomfort during intercourse may be advised, particularly if a woman is breastfeeding. **[2006]**

1.2.38 Women who continue to express anxiety about sexual health problems should be evaluated (non-urgent action). **[2006]**

Headache

For severe headache see section on pre-eclampsia/eclampsia.

1.2.39 Women should be asked about headache symptoms at each postnatal contact. **[2006]**

1.2.40 Women who have had epidural or spinal anaesthesia should be advised to report any severe headache, particularly one which occurs while sitting or standing. **[2006]**

1.2.41 Management of mild postnatal headache should be based on differential diagnosis of headache type and local treatment protocols. **[2006]**

1.2.42 Women with tension or migraine headaches should be offered advice on relaxation and how to avoid factors associated with the onset of headaches. **[2006]**

Fatigue

1.2.43 Women who report persistent fatigue should be asked about their general wellbeing, and offered advice on diet, exercise and planning activities, including spending time with her baby. **[2006]**

1.2.44 If persistent postnatal fatigue impacts on the woman's care of herself or baby, underlying physical, psychological or social causes should be evaluated. **[2006]**

1.2.45 If a woman has sustained a postpartum haemorrhage, or is experiencing persistent fatigue, her haemoglobin level should be evaluated and if low, treated according to local policy. **[2006]**

Backache

1.2.46 Women experiencing backache in the postnatal period should be managed as in the general population. **[2006]**

Constipation

1.2.47 Women should be asked if they have opened their bowels within 3 days of the birth. **[2006]**

1.2.48 Women who are constipated and uncomfortable should have their diet and fluid intake assessed and offered advice on how to improve their diet. **[2006]**

1.2.49 A gentle laxative may be recommended if dietary measures are not effective. **[2006]**

Haemorrhoids

1.2.50 Women with haemorrhoids should be advised to take dietary measures to avoid constipation and should be offered management based on local treatment protocols. **[2006]**

1.2.51 Women with a severe, swollen or prolapsed haemorrhoid or any rectal bleeding should be evaluated (urgent action). **[2006]**

Faecal incontinence

1.2.52 Women with faecal incontinence should be assessed for severity, duration and frequency of symptoms. If symptoms do not resolve, evaluate further (urgent action). **[2006]**

Urinary retention

1.2.53 Urine passed within 6 hours of urination during labour should be documented. **[2006]**

1.2.54 If urine has not been passed within 6 hours after the birth, efforts to assist urination should be advised, such as taking a warm bath or shower. **[2006]**

1.2.55 If urine has not been passed by 6 hours after the birth and measures to encourage micturition are not immediately successful, bladder volume should be assessed and catheterisation considered (urgent action). **[2006]**

Urinary incontinence

1.2.56 Women with involuntary leakage of a small volume of urine should be taught pelvic floor exercises. **[2006]**

1.2.57 Women with involuntary leakage of urine which does not resolve or becomes worse should be evaluated. **[2006]**

Contraception

1.2.58 Methods and timing of resumption of contraception should be discussed within the first week of the birth. **[2006]**

1.2.59 The coordinating healthcare professional should provide proactive assistance to women who may have difficulty accessing contraceptive care. This includes providing contact details for expert contraceptive advice. **[2006]**

Immunisation

1.2.60 Anti-D immunoglobulin should be offered to every non-sensitised Rh-D-negative woman within 72 hours following the delivery of an RhD-positive baby. **[2006]**

1.2.61 Women found to be sero-negative on antenatal screening for rubella should be offered an MMR (measles, mumps, rubella) vaccination following birth and before discharge from the maternity unit if they are in hospital. **[2006]**

1.2.62 See the Public Health England/Department of Health guidance, Immunisation against infectious disease (2013) (the Green Book) for guidance on the timing of MMR vaccination in women who are sero-negative for rubella who also require anti-D immunoglobulin injection. **[new 2015]**

1.2.63 Women should be advised that pregnancy should be avoided for 1 month after receiving MMR, but that breastfeeding may continue. **[2006]**

Safety

Domestic abuse

1.2.64 Healthcare professionals should be aware of the risks, signs and symptoms of domestic abuse and know who to contact for advice and management, following guidance from the Department of Health[1],[2] **[2006]**

6–8-week check

1.2.65 At the end of the postnatal period, the coordinating healthcare professional should ensure that the woman's physical, emotional and social wellbeing is reviewed. Screening and medical history should also be taken into account. **[2006]**

1.3 Infant feeding

A supportive environment for breastfeeding

1.3.1 Breastfeeding support should be made available regardless of the location of care. **[2006]**

1.3.2 All healthcare providers (hospitals and community) should have a written breastfeeding policy that is communicated to all staff and parents. Each provider should identify a lead healthcare professional responsible for implementing this policy. **[2006]**

1.3.3 All maternity care providers (whether working in hospital or in primary care) should implement an externally evaluated, structured programme that encourages breastfeeding, using the Baby Friendly Initiative as a minimum standard. **[2006]**

1.3.4 Healthcare professionals should have sufficient time, as a priority, to give support to a woman and baby during initiation and continuation of breastfeeding. **[2006]**

1.3.5 Where postnatal care is provided in hospital, attention should be paid to facilitating an environment conducive to breastfeeding. This includes making arrangements for:

- 24 hour rooming-in and continuing skin-to-skin contact when possible
- privacy
- adequate rest for women without interruption caused by hospital routine
- access to food and drink on demand. **[2006]**

1.3.6 Formula milk should not be given to breastfed babies unless medically indicated. **[2006]**

1.3.7 Commercial packs, for example those given to women when they are discharged from hospital, containing formula milk or advertisements for formula should not be distributed. **[2006]**

1.3.8 Women who leave hospital soon after birth should be reassured that this should not impact on breastfeeding duration. **[2006]**

1.3.9 Written breastfeeding education materials as a stand-alone intervention are not recommended. **[2006]**

Starting successful breastfeeding

1.3.10 In the first 24 hours after birth, women should be given information on the benefits of breastfeeding, the benefits of colostrum and the timing of the first breastfeed. Support should be culturally appropriate. **[2006]**

1.3.11 Initiation of breastfeeding should be encouraged as soon as possible after the birth, ideally within 1 hour. **[2006]**

1.3.12 Separation of a woman and her baby within the first hour of the birth for routine postnatal procedures, for example weighing, measuring and bathing, should be avoided unless these measurements are requested by the woman, or are necessary for the immediate care of the baby. **[2006]**

1.3.13 Women should be encouraged to have skin-to-skin contact with their babies as soon as possible after the birth. **[2006]**

1.3.14 It is not recommended that women are asked about their proposed method of feeding until after the first skin-to-skin contact. **[2006]**

1.3.15 From the first feed, women should be offered skilled breastfeeding support (from a healthcare professional, mother-to-mother or peer support) to enable comfortable positioning of the mother and baby and to ensure that the baby attaches correctly to the breast to establish effective feeding and prevent concerns such as sore nipples. **[2006]**

1.3.16 Additional support with positioning and attachment should be offered to women who have had:

- a narcotic or a general anaesthetic, as the baby may not initially be responsive to feeding
- a caesarean section, particularly to assist with handling and positioning the baby to protect the woman's abdominal wound
- initial contact with their baby delayed. **[2006]**

Continuing successful breastfeeding

1.3.17 Unrestricted breastfeeding frequency and duration should be encouraged. **[2006]**

1.3.18 Women should be advised that babies generally stop feeding when they are satisfied, which may follow a feed from only one breast. Babies should be offered the second breast if they do not appear to be satisfied following a feed from one breast. **[2006]**

1.3.19 Women should be reassured that brief discomfort at the start of feeds in the first few days is not uncommon, but this should not persist. **[2006]**

1.3.20 Women should be advised that if their baby is not attaching effectively he or she may be encouraged, for example by the woman teasing the baby's lips with the nipple to get him or her to open their mouth. **[2006]**

1.3.21 Women should be advised of the indicators of good attachment, positioning and successful feeding. These are given in box 1. **[2006]**

Box 1. Breastfeeding

Indicators of good attachment and positioning:

- mouth wide open
- less areola visible underneath the chin than above the nipple
- chin touching the breast, lower lip rolled down, and nose free
- no pain.

Indicators of successful feeding in babies:

- audible and visible swallowing
- sustained rhythmic suck
- relaxed arms and hands
- moist mouth
- regular soaked/heavy nappies.

Indicators of successful breastfeeding in women:

- breast softening
- no compression of the nipple at the end of the feed
- woman feels relaxed and sleepy.

1.3.22 Women should be given information about local breastfeeding support groups. **[2006]**

Assessing successful breastfeeding

1.3.23 A woman's experience with breastfeeding should be discussed at each contact to assess if she is on course to breastfeed effectively and identify any need for additional support. Breastfeeding progress should then be assessed and documented in the postnatal care plan at each contact. **[2006]**

1.3.24 If an insufficiency of milk is perceived by the woman, attachment and positioning should be reviewed and her baby's health should be evaluated. Reassurance should be offered to support the woman to gain confidence in her ability to produce enough milk for her baby. **[2006]**

1.3.25 If the baby is not taking sufficient milk directly from the breast and supplementary feeds are necessary, expressed breast milk should be given by a cup or bottle. **[2006]**

1.3.26 Supplementation with fluids other than breast milk is not recommended. **[2006]**

Expression and storage of breast milk

1.3.27 All breastfeeding women should be shown how to hand express their colostrum or breast milk and advised on how to correctly store and freeze it. **[2006]**

1.3.28 Breast pumps should be available in hospital, particularly for women who have been separated from their babies, to establish lactation. All women who use a breast pump should be offered instructions on how to use it. **[2006]**

Preventing, identifying and treating breastfeeding concerns

Nipple pain

1.3.29 Women should be advised that if their nipples are painful or cracked, it is probably due to incorrect attachment. **[2006]**

1.3.30 If nipple pain persists after repositioning and re-attachment, assessment for thrush should be considered. **[2006]**

Engorgement

1.3.31 Women should be advised that their breasts may feel tender, firm and painful when milk 'comes in' at or around 3 days after birth. **[2006]**

1.3.32 A woman should be advised to wear a well-fitting bra that does not restrict her breasts. **[2006]**

1.3.33 Breast engorgement should be treated with:

- frequent unlimited breastfeeding including prolonged feeding from the affected breast
- breast massage and, if necessary, hand expression
- analgesia. **[2006]**

Mastitis

1.3.34 Women should be advised to report any signs and symptoms of mastitis including flu like symptoms, red, tender and painful breasts to their healthcare professional urgently. **[2006]**

1.3.35 Women with signs and symptoms of mastitis should be offered assistance with positioning and attachment and advised to:

- continue breastfeeding and/or hand expression to ensure effective milk removal; if necessary, this should be with gentle massaging of the breast to overcome any blockage
- take analgesia compatible with breastfeeding, for example paracetamol
- increase fluid intake. **[2006]**

1.3.36 If signs and symptoms of mastitis continue for more than a few hours of self management, a woman should be advised to contact her healthcare professional again (urgent action). **[2006]**

1.3.37 If the signs and symptoms of mastitis have not eased, the woman should be evaluated as she may need antibiotic therapy (urgent action). **[2006]**

Inverted nipples

1.3.38 Women with inverted nipples should receive extra support and care to ensure successful breastfeeding. **[2006]**

Ankyloglossia (tongue tie)

1.3.39 Evaluation for ankyloglossia should be made if breastfeeding concerns persist after a review of positioning and attachment by a skilled healthcare professional or peer counsellor. **[2006]**

1.3.40 Babies who appear to have ankyloglossia should be evaluated further (non-urgent action).[6] **[2006]**

Sleepy baby

1.3.41 Women should be advised that skin-to-skin contact or massaging a baby's feet should be used to wake the baby. The baby's general health should be assessed if there is no improvement. **[2006]**

Formula feeding

1.3.42 All parents and carers who are giving their babies formula feed should be offered appropriate and tailored advice on formula feeding to ensure this is undertaken as safely as possible, in order to enhance infant development and health, and fulfil nutritional needs. **[2006]**

1.3.43 A woman who wishes to feed her baby formula milk should be taught how to make feeds using correct, measured quantities of formula, as based on the manufacturer's instructions, and how to clean and sterilise bottles and teats and how to store formula milk[6]. **[2006]**

1.3.44 Parents and family members should be advised that milk, either expressed milk or formula should not be warmed in a microwave. **[2006]**

1.3.45 Breastfeeding women who want information on how to prepare formula feeds should be advised on how to do this. **[2006]**

1.4 Maintaining infant health

The purpose of this section of the guidance is to provide the framework for the healthcare professional, with the parents, to facilitate the health and wellbeing of a baby up to 8 weeks old. It lays out the care given to a healthy baby and support to be offered to the parents. It should be read in conjunction with 'Birth to five'.

1.4.1 Healthy babies should have normal colour for their ethnicity, maintain a stable body temperature, and pass urine and stools at regular intervals. They initiate feeds, suck well on the breast (or bottle) and settle between feeds. They are not excessively irritable, tense, sleepy or floppy. The vital signs of a healthy baby should fall within the following ranges:

- respiratory rate normally 30−60 breaths per minute
- heart rate normally between 100 and 160 beats per minute in a newborn
- temperature in a normal room environment of around 37°C (if measured). **[2006]**

1.4.2 At each postnatal contact, parents should be offered information and advice to enable them to:

- assess their baby's general condition
- identify signs and symptoms of common health problems seen in babies
- contact a healthcare professional or emergency service if required. **[2006]**

1.4.3 Parents, family members and carers should be offered information and reassurance on:

- their baby's social capabilities as this can promote parent–baby attachment (in the first 24 hours)
- the availability, access and aims of all postnatal peer, statutory and voluntary groups and organisations in their local community (within 2–8 weeks). **[2006]**

1.4.4 Both parents should be encouraged to be present during any physical examination of their baby to promote participation of both parents in the care of their baby and enable them to learn more about their baby's needs. **[2006]**

Parenting and emotional attachment

1.4.5 Assessment for emotional attachment should be carried out at each postnatal contact. **[2006]**

1.4.6 Home visits should be used as an opportunity to promote parent- or mother-to-baby emotional attachment. **[2006]**

1.4.7 Women should be encouraged to develop social networks as this promotes positive mother−baby interaction. **[2006]**

1.4.8 Group based parent-training programmes designed to promote emotional attachment and improve parenting skills should be available to parents who wish to access them. **[2006]**

1.4.9 Healthcare providers should offer fathers information and support in adjusting to their new role and responsibilities within the family unit. **[2006]**

Physical examination and screening

1.4.10 The aims of any physical examination should be fully explained and the results shared with the parents and recorded in the postnatal care plan and the personal child health record. **[2006]**

1.4.11 A complete examination of the baby should take place within 72 hours of birth. This examination should incorporate a review of parental concerns and the baby's medical history should also be reviewed including: family, maternal, antenatal and perinatal history; fetal, neonatal and infant history including any previously plotted birth-weight and head circumference; whether the baby has passed meconium and urine (and urine stream in a boy). Appropriate recommendations made by the UK National Screening Committee should also be carried out.

A physical examination should also be carried out. 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. Measure and plot head circumference
- eyes; check opacities and red reflex
- neck and clavicles, limbs, hands, feet and digits; assess proportions and symmetry
- heart; check position, heart rate, rhythm and sounds, murmurs and femoral pulse volume
- lungs; check effort, rate and lung sounds
- abdomen; check shape and palpate to identify any organomegaly; also check condition of umbilical cord
- genitalia and anus; check for completeness and patency and undescended testes in males
- spine; inspect and palpate bony structures and check integrity of the skin
- skin; note colour and texture as well as any birthmarks or rashes
- central nervous system; observe tone, behaviour, movements and posture. Elicit newborn reflexes only if concerned
- hips; check symmetry of the limbs and skin folds (perform Barlow and Ortolani's manoeuvres)
- cry; note sound
- weight; measure and plot. **[2006]**

1.4.12 The newborn blood spot test should be offered to parents when their baby is 5-8 days old. **[2006]**

1.4.13 At 6–8 weeks, an examination, comprising the items listed in 1.4.11, should be carried out. In addition, an assessment of social smiling and visual fixing and following should be carried out. **[2006]**

1.4.14 A hearing screen should be completed before discharge from hospital or by week 4 in the hospital programme or by week 5 in the community programme. **[2006]**

1.4.15 Parents should be offered routine immunisations for their baby according to the schedule recommended by the Department of Health[a]. **[2006]**

Physical health and wellbeing

Jaundice

1.4.16 Parents should be advised to contact their healthcare professional if their baby is jaundiced, their jaundice is worsening, or their baby is passing pale stools. **[2006]**

1.4.17 Babies who develop jaundice within the first 24 hours after birth should be evaluated (emergency action). **[2006]**

1.4.18 If jaundice develops in babies aged 24 hours and older, its intensity should be monitored and systematically recorded along with the baby's overall wellbeing with particular regard to hydration and alertness. **[2006]**

1.4.19 The mother of a breastfed baby who has signs of jaundice should be actively encouraged to breastfeed frequently, and the baby awakened to feed if necessary. **[2006]**

1.4.20 Breastfed babies with jaundice should not be routinely supplemented with formula, water or dextrose water. **[2006]**

1.4.21 If a baby is significantly jaundiced or appears unwell, evaluation of the serum bilirubin level should be carried out. **[2006]**

1.4.22 If jaundice first develops after 7 days or jaundice remains after 14 days in an otherwise healthy baby and a cause has not already been identified, it should be evaluated (urgent action). **[2006]**

Skin

1.4.23 Parents should be advised that cleansing agents should not be added to a baby's bath water nor should lotions or medicated wipes be used. The only cleansing agent suggested, where it is needed, is a mild non-perfumed soap. **[2006]**

1.4.24 Parents should be advised how to keep the umbilical cord clean and dry and that antiseptics should not be used routinely. **[2006]**

Thrush

1.4.25 If thrush is identified in the baby, the breastfeeding woman should be offered information and guidance about relevant hygiene practices. **[2006]**

1.4.26 Thrush should be treated with an appropriate antifungal medication if the symptoms are causing pain to the woman or the baby or feeding concerns to either. **[2006]**

1.4.27 If thrush is non-symptomatic, women should be advised that antifungal treatment is not required. **[2006]**

Nappy rash

1.4.28 For babies with nappy rash the following possible causes should be considered:

- hygiene and skin care
- sensitivity to detergents, fabric softeners or external products that have contact with the skin
- presence of infection. **[2006]**

1.4.29 If painful nappy rash persists it is usually caused by thrush, and treatment with antifungal treatment should be considered. **[2006]**

1.4.30 If after a course of treatment the rash does not resolve, it should be evaluated further (non-urgent action). **[2006]**

Constipation

1.4.31 If a baby has not passed meconium within 24 hours, the baby should be evaluated to determine the cause, which may be related to feeding patterns or underlying pathology (emergency action). **[2006]**

1.4.32 If a baby is constipated and is formula fed the following should be evaluated: (urgent action)

- feed preparation technique
- quantity of fluid taken
- frequency of feeding
- composition of feed. **[2006]**

Diarrhoea

1.4.33 A baby who is experiencing increased frequency and/or looser stools than usual should be evaluated (urgent action). **[2006]**

Colic

1.4.34 A baby who is crying excessively and inconsolably, most often during the evening, either drawing its knees up to its abdomen or arching its back, should be assessed for an underlying cause, including infant colic (urgent action). **[2006]**

1.4.35 Assessment of excessive and inconsolable crying should include:

- general health of the baby

- antenatal and perinatal history
- onset and length of crying
- nature of the stools
- feeding assessment
- woman's diet if breastfeeding
- family history of allergy
- parent's response to the baby's crying
- any factors which lessen or worsen the crying. **[2006]**

1.4.36 Healthcare professionals should reassure parents of babies with colic that the baby is not rejecting them and that colic is usually a phase that will pass. Parents should be advised that holding the baby through the crying episode, and accessing peer support may be helpful. **[2006]**

1.4.37 Use of hypoallergenic formula in bottle-fed babies should be considered for treating colic, but only under medical guidance. **[2006]**

1.4.38 Dicycloverine (dicyclomine) should not be used in the treatment of colic due to side effects such as breathing difficulties and coma. **[2006]**

Fever

1.4.39 The temperature of a baby does not need to be taken, unless there are specific risk factors, for example maternal pyrexia during labour. **[2006]**

1.4.40 When a baby is suspected of being unwell, the temperature should be measured using electronic devices that have been properly calibrated and are used appropriately[f]. **[2006]**

1.4.41 A temperature of 38°C or more is abnormal and the cause should be evaluated (emergency action). A full assessment, including physical examination, should be undertaken. **[2006]**

Vitamin K

1.4.42 All parents should be offered vitamin K prophylaxis for their babies to prevent the rare but serious and sometimes fatal disorder of vitamin K deficiency bleeding. **[2006]**

1.4.43 Vitamin K should be administered as a single dose of 1 mg intramuscularly as this is the most clinically and cost-effective method of administration. **[2006]**

1.4.44 If parents decline intramuscular vitamin K for their baby, oral vitamin K should be offered as a second-line option. Parents should be advised that oral vitamin K must be given according to the manufacturer's instructions for clinical efficacy and will require multiple doses. **[2006]**

Safety

1.4.45 All home visits should be used as an opportunity to assess relevant safety issues for all family members in the home and environment and promote safety education. **[2006]**

1.4.46 The healthcare professional should promote the correct use of basic safety equipment, including, for example, infant seats and smoke alarms and facilitate access to local schemes for provision of safety equipment. **[2006]**

Co-sleeping and sudden infant death syndrome

The cause of sudden infant death syndrome (SIDS) is not known. It is possible that many factors contribute but some factors are known to make SIDS more likely. These include placing a baby on their front or side to sleep. We need clear evidence to say that a factor directly causes SIDS. Evidence was reviewed relating to co-sleeping (parents or carers sleeping on a bed or sofa or chair with an infant) in the first year of an infant's life. Some of the reviewed evidence showed that there is a statistical relationship between SIDS and co-sleeping. This means that, where co-sleeping occurs, there may be an increase in the number of cases of SIDS. However, the evidence does not allow us to say that co-sleeping causes SIDS. Therefore the term 'association' has been used in the recommendations to describe the relationship between co-sleeping and SIDS. The recommendations on co-sleeping and SIDS cover the first year of an infant's life.

1.4.47 Recognise that co-sleeping can be intentional or unintentional. Discuss this with parents and carers and inform them that there is an association between co-sleeping (parents or carers sleeping on a bed or sofa or chair with an infant) and SIDS. **[new 2014]**

1.4.48 Inform parents and carers that the association between co-sleeping (sleeping on a bed or sofa or chair with an infant) and SIDS is likely to be greater when they, or their partner, smoke. **[new 2014]**

1.4.49 Inform parents and carers that the association between co-sleeping (sleeping on a bed or sofa or chair with an infant) and SIDS may be greater with:

- parental or carer recent alcohol consumption, or
- parental or carer drug use, or
- low birth weight or premature infants. **[new 2014]**

Pacifier use

1.4.50 If a baby has become accustomed to using a pacifier (dummy) while sleeping, it should not be stopped suddenly during the first 26 weeks. **[2006]**

Child abuse

1.4.51 Healthcare professionals should be alert to risk factors and signs and symptoms of child abuse. **[2006]**

1.4.52 If there is raised concern, the healthcare professional should follow local child protection policies. **[2006]**

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[1] National Service Framework for Children, Young People and Maternity Services

[2] Department of Health (2005) Responding to domestic abuse: a handbook for health professionals. London: Department of Health

[3] Available from: the Department of Health

[4] Antenatal and postnatal mental health (2007) NICE guideline CG45

[5] Division of ankyloglossia (tongue-tie) for breastfeeding (2005) NICE interventional procedure guidance 149

[6] Department of Health (1996) Immunisation against infectious disease. London: Department of Health

[7] Feverish illness in children (2013) NICE guideline CG160

2 Research recommendations

In 2006, the Guideline Development Group made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline.

2.1 Routine monitoring of the weight of babies

Does routine monitoring of the weight of all low-risk babies during the first 6−8 weeks after birth reduce the incidence of serious morbidities?

Why this is important

Healthy babies normally lose weight in the first week of life. This weight loss is usually transient and of no significance, but may be exaggerated if there is difficulty establishing feeding or if the baby is ill. In the past, all babies were routinely weighed at least twice in the first 10 days after birth. There is debate about the benefits and harms of routine weighing in the first weeks of life.

The existing evidence base relies on findings from population-based surveillance systems and small-scale evaluations. A large-scale randomised controlled trial is therefore required to evaluate whether there is a significant difference in the incidence of important outcomes between routine regular and expectant weighing of babies at low risk of complications in the first 6−8 weeks after birth.

2.2 Evaluation of Baby Friendly Initiative

What is the impact of the use of the Baby Friendly Initiative (BFI) on breastfeeding uptake and duration in English and Welsh hospitals and community settings?

Why this is important

The health and social benefits of breastfeeding to both mother and baby are multidimensional, yet, despite consorted and prolonged policy deigned to improve breastfeeding rates, UK rates are among the lowest in Europe. The BFI sets rigorous standards for healthcare organisations to adopt, with the aim of improving breastfeeding rates. Positive evaluations of the initiative have

been published in Scotland, and other countries outside the UK but cost-effectiveness studies that deal with the Baby Friendly Hospital Initiative have yet to be carried out in England and Wales.

This postnatal care guideline recommends that 'All healthcare providers (hospitals and community) should implement an externally evaluated structured programme that encourages breastfeeding, using the Baby Friendly Initiative (BFI) as a minimum standard.'

Further research to evaluate the cost-effectiveness of BFI compared to another programme, or to standard care, should be carried out. Outcomes should include necessarily initiation, duration and exclusive breastfeeding rates and may also attempt to construct Health Economic measures of outcome, such as the QALY.

2.3 The effect of peer support on severity of postnatal depression

Is the severity of postnatal depression among socially isolated women reduced by the provision of peer social support compared with standard care?

Why this is important

Postnatal depression affects 10−15% of mothers and can lead to cognitive and emotional disturbance in the baby alongside the effects on the mother. Children of depressed mothers are more likely to access Child and Adolescent Mental Health Services (CAMHS) and suffer mental health problems as adolescents and adults. Social isolation is a known risk factor for postnatal depression and reducing this may have a range of clinical and psycho-social benefits.

A randomised controlled trial is proposed to evaluate the effect on the rate of postnatal depression of providing enhanced peer support compared to standard care for women who are at risk of social isolation after childbirth.

Outcomes should include quality of life and clinical measures: maternal and infant/child psychological wellbeing, depression, social wellbeing, physical health

This research would complement research funded by the Health Technology Assessment programme evaluating different models of care in the postnatal period.

3 Other information

3.1 Scope and how this guideline was developed

The scope for the 2006 guideline covers the recommendations labelled **[2006]**. The recommendations labelled **[new 2014]** were developed after reviewing new evidence on co-sleeping and sudden infant death syndrome (SIDS).

The guideline has been developed with the following aims:

- to advise on appropriate objectives, purpose, content and timing of postnatal contact and care for the woman and her baby
- to advise on best practices and competencies for assessment of postnatal health and management of postnatal problems in the woman and/or her infant
- to advise on information, education and support required during the postnatal period
- to advise on postnatal care
- to consider good practice in communication between healthcare providers and women.

It is outside the remit of the guideline to advise on the management of complications arising in the woman or her baby before, during or after the birth, existing pregnancy and/or non-pregnancy-related acute or chronic diseases or conditions, or any aspect of antepartum or intrapartum care, including procedures immediately following the birth. The guideline offers recommendations on the essential core postnatal care that all women and their babies should be offered. It does not offer information on the additional care that a woman or her baby may require, although aspects of the guideline may continue to be relevant to either the woman or her baby, or both. Referral to the guideline may also be appropriate in particular circumstances where elements of core postnatal care may be required, for example women who have had a caesarean section or infants who require special care.

How this guideline was developed

The 2006 guideline was developed by the National Collaborating Centre for Primary Care which is based at the Royal College of General Practitioners. The Collaborating Centre worked with a Guideline Development Group, comprising healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, which reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

NICE's Clinical Guidelines Update Programme updated the recommendations on co-sleeping and SIDS in 2014. The Programme worked with a Standing Committee of healthcare professionals, methodologists and lay members from a range of disciplines and localities.

See the methods and processes for developing NICE clinical guidelines.

3.2 Related NICE guidance

Details are correct at the time of publication of the guideline (December 2014).

Further information is available on the NICE website.

Published

General

- Service user experience in adult mental health (2011) NICE guideline CG136
- Patient experience in adult NHS services (2012) NICE guideline CG138

Condition-specific

- Division of ankyloglossia (tongue-tie) for breastfeeding (2005) NICE interventional procedure guidance 149
- Antenatal and postnatal mental health (2007) NICE guideline CG45
- Antenatal care (2008) NICE guideline CG62
- Induction of labour (2008) NICE guideline CG70

- Maternal and child nutrition (2008) NICE guideline PH11
- Caesarean section (2011) NICE guideline CG132
- Antibiotics for early-onset neonatal infection (2012) NICE guideline CG149
- Feverish illness in children (2013) NICE guideline CG160
- Intrapartum care (2014) NICE guideline CG190

4 Standing Committee B and NICE project team

4.1 Standing Committee B

The Committee members listed are those for the **[2014]** update. For the composition of (the) previous Guideline Development Group(s), see the full guideline.

Susan Bewley, Standing Committee Chair
Professor of Complex Obstetrics, Kings College London

Gita Bhutani
Clinical Psychologist, Lancashire Care NHS Foundation Trust

Jennifer Bostock
Lay member

Simon Corbett
Cardiologist, University Hospital Southampton NHS Trust

John Graham
Consultant Oncologist and Trust Cancer Lead Clinician, Taunton and Somerset Hospital

Peter Hoskin
Consultant in Clinical Oncology, Mount Vernon Hospital

Roberta James
Programme Lead, Scottish Intercollegiate Guidelines Network (SIGN)

Asma Khalil
Obstetrician, St George's Hospital University London

Manoj Mistry
Lay member

Amaka Offiah
Radiologist and Clinical Senior Lecturer, Sheffield University

Mark Rogers
Research Fellow, University of York

Nicholas Steel
Clinical Senior Lecturer in Primary Care, Norwich Medical School

Sietse Wieringa
General Practitioner, Barts and the London School of Medicine and Dentistry

Topic-specific Committee members

Helen Ball
Lay member

Justin Daniels
Paediatrician, North Middlesex Hospital

Valerie Finigan
Midwife, Pennine Acute NHS Trust

Elaine McInnes
Professional Development Officer, Institute of Health Visiting; Health Visitor, Cambridge Community Trust

Gabrielle Osrin
ay member

4.2 Clinical Guidelines Update Team

Philip Alderson
Clinical Adviser

Lynda Ayiku
Information Specialist

Emma Banks
Co-ordinator

Nicole Elliott
Associate Director

Susannah Moon
Programme Manager

Rebecca Parsons
Project Manager

Charlotte Purves
Administrator

Roberta Richey
Technical Analyst

Toni Tan
Technical Adviser

4.3 NICE project team

Christine Carson
Clinical Adviser

Anne-Louise Clayton
Senior Medical Editor

Ben Doak
Guidelines Commissioning Manager

Alexa Forrester
Implementation Lead

Laura Gibson
Communications Lead

Gary Shield
Costing Lead

Sharon Summers-Ma
Guideline Lead

Judith Thornton
Technical Lead

Jennifer Wells
Guideline Coordinator

Erin Whittingham
Public Involvement Programme Lead

4.4 Declarations of interests

The following members of the Committee made declarations of interest. All other members of the Committee stated that they had no interests to declare.

Committee member	Interest declared	Type of interest	Decision taken
Standing Committee Members			
Susan Bewley	Self-employed academic and obstetric expert.	Personal pecuniary interest	Declare and participate
Susan Bewley	100 hour per annum teaching contract with Kings College London.	Personal pecuniary interest	Declare and participate

Susan Bewley	In the last 12 months received income or fees for:	Personal pecuniary interest	Declare and participate
	Research projects as a principal or co-investigator or giving expert advice (presently these include projects on major postpartum haemorrhage, the organisation of maternity care, gestation time for abortion)		
	Academic supervision (PhD on implementation of external cephalic version, chair of 35/39 TSC on the timing of induction)		
	Teaching (BSc law and ethics tutor at KCL, occasional fees for lectures on obstetrics)		
	Medico-legal reports (approx. 2/year) and Medical Defence Union cases committee and council		
	External reviews for NHS organisations related to my obstetric expertise (serious incident and maternal mortality investigations, RCOG review)		
	Chairing NICE GDG		
	Expert advice to NHS Quest (development of a maternity 'safety thermometer')		
	Royalties from edited books		
	Advice to Marie Stopes International about obstetric standards		

Susan Bewley	Expenses paid to attend conferences to lecture on obstetric topics. In the last year this included speaking to a Human Rights conference at the Hague, the Royal Society of Edinburgh, and the International Society of Psychosomatic Obstetrics and Gynaecology, and attending the British Maternal Fetal Medicine Society conference. Received a community grant to attend the British HIV Association conference.	Personal pecuniary interest	Declare and participate
Susan Bewley	Joint intellectual property rights in a new neonatal resuscitation trolley, but these were negotiated to be handed over to Liverpool University and Inditherm. In return, the inventors have negotiated that a fee generated on the sale of each trolley will be given to charity.	Non-personal pecuniary interest	Declare and participate
Susan Bewley	Expressed views in publications about obstetric matters, largely based on evidence.	Personal non-pecuniary interest	Declare and participate
Susan Bewley	A trustee and committee member of Healthwatch (a charity devoted to evidence and "for treatments that work") and a trustee of Sophia (a charity devoted to women with HIV and the UK arm of the Global Coalition for Women and AIDS).	Personal non-pecuniary interest	Declare and participate

Susan Bewley	Member of the following editorial boards: Medical Law Review, International Journal of Childbirth, JASS (Journal Article Summary Service); Member of the London Clinical Senate; Member of the Mayor's Office for Policing and Crime Violence Against Women and Girls Panel; Member All-Parliamentary Party Group on Maternity; Trustee of Maternity Action (a charity which aims to end inequality and improve the health and wellbeing of pregnant women, partners and young children), one of seven members of the Women's Health and Equality Consortium which is a Strategic Partner of the Department of Health.	Personal non-pecuniary interest	Declare and participate
Susan Bewley	Expert advice to Salamander Trust (funded by WHO to perform a global community consultation of women living with HIV to inform Sexual and Reproductive Health and Human Rights guideline update).	Personal pecuniary interest	Declare and participate
Susan Bewley	Expenses paid to attend and present at 'Changing Motherhood' and 'Assisted reproduction that harms' conferences.	Personal pecuniary interest	Declare and participate
Gita Bhutani	Member of British Psychological Society; Division of Clinical Psychology; Faculty of Leadership and Management Committee Member	Personal non-pecuniary interest	Declare and participate
Jennifer Bostock (Dec 13 to Sept 14)	2013 – current, Lay Member/PPI Advisor – CEDAR Institute of Public Health, University of Cambridge	Personal non-pecuniary interest	Declare and participate

	2013 – current, PPI Board Member – NIHR School of Public Health, NIHR – University of Sheffield (host) & 7 others		
	2011 – current, Lay Member – Advisory Group Healthcare Quality Improvement Partnership		
	2011 – current, PPI Advisor, King's College London (MOVE IT & Pembury studies)		
	2010 – current, Lay Member – PPI research group, Healthcare Acquired Infection Research Network		
	2010 – current, PPI Collaborator & Co-Applicant & Trial Steering Committee, Infection RCTrials: Oviva; ARREST & ASSIST + Co-app FAST-GAIN & FACT-MRC; St Thomas' Hospital & University of Oxford & University of Sussex		
	2009 – current, Public Advisor, Dept of Population health University of Oxford		
	2010 – current, Public Involvement Implementation Group – Core Member Quality & Outcomes of person-centred care policy research unit: LSE/Oxford & Kent Universities		
	2010 – current, Lay Reviewer, NIHR & Department of Health (Policy Research Programme)		
	2010 – current, Public Member – H Acquired Infection Research Network University of West London		

	2006 – current, Committee Member – Lead Reviewer & Sub Com member & Proportionate Review analyst, NHS Research Ethics Committee (Institute of Psychiatry REC MCA flagged.)		
	2010 – current, Lay Committee Member, NIHR: RfPB; PgfAR HS&DR & TCC		
	2012 – current, Ethics Consultant – Scabies Study, Public Health England, University of Sussex & British Skin Foundation		
	2010 – current, Visiting Guest Lecturer, Dept of Psychological Medicine: Kings College London		
	2014 – current, Lay Reviewer & Ethics Advisor King's Centre for Military Health		
	2013 – current, Committee Member (Trauma) Royal College of Physicians, National Clinical Guidelines Centre		
	2011 – current, Lay Research Advisor – Very Brief Interventions Project, University of Cambridge		
	2013 – current, Research Design Service – PPI Consultant, Research Design Service – London & South Central		
	2011 – current, Lay Member and Advisor, Guys & St Thomas' Biomedical Research Centre Advisory Group		
	2011 – current, FAST-R Consultant (lay), Mental Health Research Network		

	2014 – current, Lay Reviewer, Dept of Health: Policy Research Programme		
	2011 – current, Lay Advisory Group Member, Health Quality Improvement Partnership		
	2010 – current, Independent Mental Health Act Manager, Oxleas NHS FT		
	2014 – current, Lay Research Advisor, Imperial – Faculty of Medicine		
Simon Corbett	Network Service Adviser for the British Cardiovascular Society. This role incorporates the regional specialty adviser role for the Royal College of Physicians.	Personal non-pecuniary interest	Declare and participate
Simon Corbett	Acting Director for Clinical Effectiveness for employer (University Hospital Southampton NHS Foundation Trust). Part of this role involves the dissemination and implementation of NICE guidance in the Trust.	Personal non-pecuniary interest	Declare and participate
John Graham	Director of National Collaborating Centre for Cancer – this post is funded through a contract with NICE to produce NICE's clinical guidelines.	Non-personal pecuniary interest	Declare and participate
John Graham	Principal investigator for an ongoing clinical trial in prostate cancer with Custirsen funded by OncoGenex Technologies Inc and Teva Pharmaceutical Industries Ltd.	Non-personal pecuniary interest	Declare and participate
John Graham	Principal investigator for 8 ongoing clinical trials in breast and prostate cancer run via the National Cancer Research Network (not pharmaceutical industry funded)	Non-personal pecuniary interest	Declare and participate

John Graham	Member of the trial management groups for 2 prostate cancer trials: RT01 and CHHIP. Both are closed to recruitment but continuing to report trial results.	Personal non-pecuniary interest	Declare and participate
John Graham	Principal investigator for a study of radium-223 in prostate cancer that is funded by Bayer Pharmaceuticals. It is non-personal pecuniary and started on 12th June.	Non-personal pecuniary interest	Declare and participate
John Graham	In May 2014 I did some work for NICE International on a project with the Philippines Department of Health and received a consultancy fee, travel and subsistence payments.	Personal non-pecuniary interest	Declare and participate
Peter Hoskin	Research grant paid to department from Varian Medical (until Dec 2013)	Non-personal pecuniary interest	Declare and participate
Peter Hoskin	Investigator in research studies sponsored by various companies with payment for expenses to NHS Trust and department which fund research staff. Recent studies have been on behalf of Millenium, Astellas, Ipsen and Amgen.	Non-personal pecuniary interest	Declare and participate
Peter Hoskin	Fellow of the Royal College of Radiologists and member of Faculty Board, Specialist Training Board and Chair of Exam Board.	Personal non-pecuniary interest	Declare and participate
Peter Hoskin	Consultant to the IAEA; Undertake by invitation lectures and working group meetings for which expenses may be paid.	Personal pecuniary interest	Declare and participate

Peter Hoskin	Received reimbursement of travelling expenses and conference registration fee for attending the European Society of Radiation and Oncology (ESTRO) in December 2013	Personal pecuniary interest	Declare and participate
Peter Hoskin	Chief investigator for a trial investigating brachytherapy +/- external bean radiotherapy, which received funding from Dept of Health and CRUK. Continues to follow those patients up and publish data from the study.	Non-personal pecuniary interest	Declare and participate
Peter Hoskin	Holds a research grant from Varian which pays the salary for a data manager working of HDR boost, for Brachytherapy in prostate cancer.	Non-personal pecuniary interest	Declare and participate
Peter Hoskin	Department reimbursed for studies on abiraterone by Cougar.	Non-personal pecuniary interest	Declare and participate
Peter Hoskin	Department reimbursed for studies on alpharadin by Astellas.	Non-personal pecuniary interest	Declare and participate
Peter Hoskin	Department reimbursed for studies on MDV 3100 by Medivation.	Non-personal pecuniary interest	Declare and participate
Peter Hoskin	Department reimbursed for studies on Denosumab for prostate cancer. Funded by Amgen.	Non-personal pecuniary interest	Declare and participate
Peter Hoskin	Department receives grants from Astellas for trials in prostate cancer.	Non-personal pecuniary interest	Declare and participate

Peter Hoskin	Department receives grants from Bayer for trails in prostate cancer.	Non-personal pecuniary interest	Declare and participate
Peter Hoskin	Department received grants from Millennium for trials in prostate cancer.	Non-personal pecuniary interest	Declare and participate
Peter Hoskin	Department received grants from Varian for trials in prostate cancer	Non-personal pecuniary interest	Declare and participate
Peter Hoskin	Trustee for funding research within the unit/ department. Funded by Donations/ Legacies. No Non-Hodgkin's lymphoma research has been funded in the last 12 months.	Personal non-pecuniary interest	Declare and participate
Peter Hoskin	Chair Steering Group for National Cancer Intelligence Network (NCIN)	Personal non-pecuniary interest	Declare and participate
Peter Hoskin	Member of the committee of Medical Aspects for Radiation Exposure (COMARE)	Personal non-pecuniary interest	Declare and participate
Peter Hoskin	Chair of the executive committee of GEC ESTRO Brachytherapy Group.	Personal non-pecuniary interest	Declare and participate
Peter Hoskin	Member of the faculty board of the Royal College of Radiologists.	Personal non-pecuniary interest	Declare and participate
Peter Hoskin	Member of the specialist training committee for the Royal college of Radiologists.	Personal non-pecuniary interest	Declare and participate
Peter Hoskin	Member of the specialist training advisory committee (STAC) for the Royal College of Radiologist.	Personal non-pecuniary interest	Declare and participate

Peter Hoskin	Editorial board member for the Journal of Clinical Oncology.	Personal non-pecuniary interest	Declare and participate
Peter Hoskin	Editorial board member for the Journal of Contemporary Brachytherapy.	Personal non-pecuniary interest	Declare and participate
Peter Hoskin	Member of the East of England senate.	Personal non-pecuniary interest	Declare and participate
Peter Hoskin	Member of the NICE standing committee for rapid updates / and non-Hodgkin's lymphoma GDG.	Personal non-pecuniary interest	Declare and participate
Roberta James	Programme Lead at Scottish Intercollegiate Guidelines Network (SIGN)	Personal pecuniary interest	Declare and participate
Roberta James	Validation of systematic review of guideline methodology, Belgian healthcare organisation KCE – one off payment.	Personal pecuniary interest	Declare and participate
Roberta James	Member of Guideline Implementability Research and Application network (GIRAnet).	Personal non-pecuniary interest	Declare and participate
Roberta James	Expert group member of Project on a Framework for Rating Evidence in Public Health (PRECEPT).	Personal non-pecuniary interest	Declare and participate
Asma Khalil	None		No action
Manoj Mistry	Public member of Pennine Care NHS FT as a carer for my sister. Attend monthly meetings	Personal non-pecuniary interest	Declare and participate

Manoj Mistry	PPI representative for the Health Research Authority (HRA). Attended 2 meetings to date	Personal non-pecuniary interest	Declare and participate
Manoj Mistry	PPI representative for the Health Quality Health Improvement Partnership (HQIP) (London). Attended meetings to date	Personal non-pecuniary interest	Declare and participate
Manoj Mistry	PPI representative for the Primary Care Research in Manchester Engagement Resource (PRIMER) group at the University of Manchester. Attended 2 meetings to date	Personal non-pecuniary interest	Declare and participate
Manoj Mistry	Carer representative on NICE Guideline Development Group: 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs.' Attended 4 meetings to date.	Personal non-pecuniary interest	Declare and participate
Manoj Mistry	Appointed Lay representative for the MSc Clinical Science (Clinical Bio informatics) at the University of Manchester.	Personal non-pecuniary interest	Declare and participate
Manoj Mistry	Appointed 'Lay Educational Visitor' with the Health and Care Professions Council. (HCPC London)	Personal non-pecuniary interest	Declare and participate
Amaka Offiah	Provision of expert advice to Her Majesty's Courts in cases of suspected child abuse.	Personal pecuniary interest	Declare and participate
Amaka Offiah	Recipient of honoraria and expenses for lectures and guidelines development from BioMarin.	Personal pecuniary interest	Declare and participate
Amaka Offiah	Chairperson Skeletal Dysplasia Group for Teaching and Research	Personal non-pecuniary interest	Declare and participate

Amaka Offiah	Chairperson Child Abuse Taskforce of the European Society of Pediatric Radiology.	Personal non-pecuniary interest	Declare and participate
Amaka Offiah	Member Joint RCR/RCPCH NAI Working Party for Guideline Update – Imaging in Suspected Non-Accidental Injury.	Personal non-pecuniary interest	Declare and participate
Amaka Offiah	Member of the Royal College of Radiology Academic Committee.	Personal non-pecuniary interest	Declare and participate
Amaka Offiah	Committee member of the International Consortium for Vertebral Anomalies and Scoliosis.	Personal non-pecuniary interest	Declare and participate
Amaka Offiah	Member of South Yorkshire (Sheffield) Research Ethics Committee.	Personal non-pecuniary interest	Declare and participate
Amaka Offiah	Medical Academic Staff Committee Representative of the Yorkshire Regional Council of the BMA.	Personal non-pecuniary interest	Declare and participate
Amaka Offiah	Partner Governor of the Sheffield Children's NHS Foundation Trust (representing the University of Sheffield).	Personal non-pecuniary interest	Declare and participate
Amaka Offiah	Editorial Committee Member of the journal Paediatric Radiology.	Personal non-pecuniary interest	Declare and participate
Amaka Offiah	Recipient of research funding from NIHR, ARUK, The Sheffield Children's Charity, Skeletal Dysplasia Group for Teaching and Research	Non-personal pecuniary interest	Declare and participate
Mark Rodgers	Associate editor of the journal Systematic Reviews that publishes research on health and social care.	Personal non-pecuniary interest	Declare and participate

Mark Rodgers	Research fellow in health services research; has provided independent academic reviews of clinical effectiveness and diagnostic accuracy evidence for funders including NIHR and NICE.	Personal non-pecuniary interest	Declare and participate
Nicholas Steel	Currently finishing work as the principal investigator on a National Institute of Health Research (NIHR) funded project on: 'Are NICE clinical guidelines for primary care based on evidence from primary care?'	Non-personal pecuniary interest	Declare and participate
Nicholas Steel	National Institute for Health Research (NIHR) Health Services & Delivery Research Programme Healthcare Delivery Research Panel member	Personal non-pecuniary interest	Declare and participate
Nicholas Steel	NIHR Regional Advisory Committee for the Research for Patient Benefit Programme East of England region	Personal non-pecuniary interest	Declare and participate
Nicholas Steel	Norfolk & Suffolk Primary & Community Care Research Steering Group	Personal non-pecuniary interest	Declare and participate
Nicholas Steel	Advisory Committee on Clinical Excellence Awards (ACCEA) East of England	Personal non-pecuniary interest	Declare and participate
Nicholas Steel	'Implementation Science' Editorial Board member	Personal non-pecuniary interest	Declare and participate
Nicholas Steel	'Quality in Primary Care' Editorial Board member	Personal non-pecuniary interest	Declare and participate

Nicholas Steel	Faculty of Public Health Part A MFPH Examiner	Personal non-pecuniary interest	Declare and participate
Nicholas Steel	Faculty of Public Health Part A MFPH Development Committee	Personal non-pecuniary interest	Declare and participate
Nicholas Steel	Honorary Public Health Academic Consultant, Public Health England	Personal non-pecuniary interest	Declare and participate
Nicholas Steel	Research grant: 'Are NICE clinical guidelines for primary care based on evidence from primary care?' (Chief Investigator) - National Institute for Health Research, RfPB	Personal non-pecuniary interest	Declare and participate
Nicholas Steel	Publication in press: Steel N, Abdelhamid A, Stokes T, Edwards H, Fleetcroft R, Howe A, Qureshi N. Publications cited in national clinical guidelines for primary care were of uncertain relevance: literature review. In Press Journal of Clinical Epidemiology	Personal non-pecuniary interest	Declare and participate
Sietse Wieringa	At the Centre for Primary care & Public Health at Barts & The London School of Medicine & Dentistry/Queen Mary University I am working on a literature review of 'mindlines' (related to communities of practice) and a qualitative study of a large group of GPs on a virtual social network sharing medical knowledge. I am funded for this via an NIHR In practice fellowship.	Personal pecuniary interest	Declare and participate

Sietse Wieringa	I co-own a small social enterprise called ZorgIdee that develops ideas to help GPs to collaborate. There are no current funders.	Personal pecuniary interest	Declare and participate
Sietse Wieringa	Board member of the Platform of Medical Leadership in the Netherlands, via which I am involved in a mixed methods study for the development of a medical leadership competency framework. The study group receives funds from KNMG (Royal Dutch College of Medicine) and SBOH which receives its funds from the Dutch Ministry of Health.	Non-personal pecuniary interest	Declare and participate
Sietse Wieringa	Member of Generation Next, a think tank and network of young GPs. It's indirectly funded by the Ministry of Health.	Personal non-pecuniary interest	Declare and participate
Sietse Wieringa	Member of NHG (Dutch GP Society), which produces guidelines and I worked for this organisation in the past.	Personal non-pecuniary interest	Declare and participate
Topic-specific Members			
Helen Ball	Research lab has received research grants from SIDS Charities (FSID, Scottish Cot Death Trust, Babes in Arms) to conduct research regarding SIDS and bed sharing. The University has received consultancy funding from NHS Trusts, the Kindred Agency, and TAMBA (Twin and Multiple Birth Association) for infant sleep related projects that my team and I have conducted.	Non-personal pecuniary interest	Declare and participate

Helen Ball	My personal experience of bed-sharing with my infants led to my research interest in why and how UK mothers bed share, the pros and cons of bed sharing under different circumstances, and the cultural variations in bed sharing within the UK. I have published academic articles on this topic and spoken at conferences. I have been invited to contribute to various committees producing SIDS guidance relating to bed sharing (e.g. Dept of Health, Scottish Executive, UNICEF, NHS Trusts, RCM).	Personal non-pecuniary interest	Declare and participate
Justin Daniels	Designated Dr for child deaths in the London Borough of Enfield (part of my job at North Middlesex University Hospital)	Non-personal pecuniary interest	Declare and participate
Justin Daniels	Scientific advisor to Lullaby Trust	Personal non-pecuniary	Declare and participate
Valerie Finigan	Author of Trust's guideline on safe bed sharing and I have worked as a member of the UNICEF designation Committee for the last 3 years (term has ended) where I have contributed comments on the draft of the leaflet 'Caring for babies at night'.	Personal pecuniary interest	Declare and participate
Valerie Finigan	Author of Saggy Boobs: and other breastfeeding myths (receive one third of royalties)	Personal pecuniary interest	Declare and participate
Valerie Finigan	Member Royal College Midwives Editorial Board	Personal non-pecuniary interest	Declare and participate
Valerie Finigan	Member NIFN (National Infant Feeding Leads Group)	Personal non-pecuniary interest	Declare and participate

Valerie Finigan	Member Infant mortality groups (Manchester, Rochdale, Oldham and Bury)	Personal non-pecuniary interest	Declare and participate
Valerie Finigan	Completed 3 years membership UNICEF Designation committee	Personal non-pecuniary interest	Declare and participate
Valerie Finigan	Peer review for MIDIRS, International Review, BJM	Personal non-pecuniary interest	Declare and participate
Valerie Finigan	Written a paper on postnatal ward bed sharing risk assessment tool used within trust. The tool is not industry funded.		
Elaine McInnes	None		No action
Gabrielle Osrin	None		No action

Changes after publication

February 2015: recommendation 1.2.62 has been amended after a surveillance review to update the advice on the timing of MMR vaccination in women who are sero-negative for rubella who also require anti-D immunoglobulin injection.

Update information

December 2014: New recommendations on co-sleeping and sudden infant death syndrome have been added.

Recommendations are marked as **[new 2015], [new 2014] or [2006]**:

- **[new 2015]** indicates a post-publication change to replace a recommendation
- **[new 2014]** indicates that the evidence has been reviewed and the recommendation has been added or updated
- **[2006]** indicates that the evidence has not been reviewed since 2006.

About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions.

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.

The 2006 guideline was developed by the National Collaborating Centre for Primary Care, based at the Royal College of General Practitioners. The Collaborating Centre worked with a Guideline Development Group, comprising healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, which reviewed the evidence and drafted the recommendations.

NICE's Clinical Guidelines Update Programme updated this guideline in 2014. These guidelines are updated using a Standing Committee of healthcare professionals, methodologists and lay members from a range of disciplines and localities. The recommendations were finalised after public consultation.

See the methods and processes for developing NICE clinical guidelines.

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

Strength of recommendations

Some recommendations can be made with more certainty than others. The Guideline Development Group makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the Guideline Development Group is confident that, given the information it has looked at, most patients would choose the intervention. The wording used in the

recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

For all recommendations, NICE expects that there is discussion with the patient about the risks and benefits of the interventions, and their values and preferences. This discussion aims to help them to reach a fully informed decision (see also patient-centred care).

Interventions that must (or must not) be used

We usually use 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally we use 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions that should (or should not) be used – a 'strong' recommendation

We use 'offer' (and similar words such as 'refer' or 'advise') when we are confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective. We use similar forms of words (for example, 'Do not offer…') when we are confident that an intervention will not be of benefit for most patients.

Interventions that could be used

We use 'consider' when we are confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient.

Recommendation wording in guideline updates

NICE began using this approach to denote the strength of recommendations in guidelines that started development after publication of the 2009 version of 'The guidelines manual' (January 2009). This does not apply to any recommendations ending **[2006]** (see 'Update information' above for details about how recommendations are labelled). In particular, for recommendations labelled **[2006]** the word 'consider' may not necessarily be used to denote the strength of the recommendation.

Other versions of this guideline

The full guideline, 'Postnatal care: routine postnatal care of women and their babies' contains details of the methods and evidence used to develop the 2006 guideline. It is published by the National Collaborating Centre for Primary Care.

The recommendations from this guideline have been incorporated into a NICE Pathway.

We have produced information for the public about this guideline.

Implementation

Implementation tools and resources to help you put the guideline into practice are also available.

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summaries of product characteristics of any drugs.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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