Trust Infant Feeding Policy

Document Control:

For Use In:	Any area of the Trust involved in the care of pregnant and breastfeeding mothers and their newborns		
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V1.0	12/2011	Luisa Lyons	To originate document
V5.1	12/2017	Luisa Lyons	To update document
V5.2	01/2021	Luisa Lyons, Susan Harris	Appendix 3 is now a separate document, a hyperlink has been inserted.
V6	12/23	Sophie Harvey, Susan Harris	Update with inclusive language statement and with changes to care standards

Previous Titles for this Document:

Previous Title/Amalgamated Titles	Date Revised
Not applicable	Not applicable

Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

Consultation

The following were consulted during the development of this document:
Infant Feeding Teams for Maternity and Neonatal Services
Maternity Senior Leadership Team
Relevant Ward Managers and Matrons
Practice Development Midwives, Neonatal Nurses and Paediatric Nurses
Service Users via the Maternity and Neonatal Voices Partnerships

Monitoring and Review of Procedural Document

The document owners are responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

Relationship of this document to other procedural documents

This document is a clinical guideline applicable to Norfolk and Norwich University Hospitals NHS Foundation Trust; please refer to local Trust's procedural documents for further guidance, as noted in Section 5.

Contents Page

1. Introduction

1.1. Rationale

The purpose of this policy is to ensure that all staff at Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUHFT) understand their role and responsibilities in supporting expectant and new mothers and their partners to feed and care for their baby in ways which support optimum health and well-being.

The infant feeding policy will cover both breastfeeding and formula feeding. It will commonly refer to breastfeeding and mothers, however we recognise the right of all persons to receive a high standard of personalise care, irrespective of age, disability, gender reassignment, marriage, civil partnership, pregnancy, race, ethnicity, religion, belief, sex, sexual orientation. Language is one of many ways to include and respect people. Through careful attention to the use of language, we can positively contribute to inclusive thought and behaviour and work to support all people to feel represented and to receive care which is culturally sensitive and upholds their dignity and human rights. Please note that we recognise that using inclusive language can help people feel included and respected when receiving infant feeding support; so terms such as chest feeding, parent, primary caregiver, pregnant person and birthing person may be used. Please ask individuals that you are caring about their language preferences and terms.

Breastfeeding can be defined as giving human breast milk to infants to meet their nutritional needs. The nutrients in breastmilk are unique and provide optimal health and immunological benefits for both mother and child.

Infant formula is a food manufactured, usually from modified cow's milk, to support growth of infants under 6 months of age. It is an artificial substitute for breastmilk for feeding infants and does not provide the same health outcomes as breastmilk.

1.2. Objective

This policy aims to ensure that the health benefits of breastfeeding (Ip 2007) and the potential health risks of formula feeding are discussed with all women so that they can make an informed choice about how they will feed their baby.

It aims to enable health-care staff to create an environment and a culture where more women choose to breastfeed their babies and continue for as long as they wish.

The objective of the Infant Feeding Policy is to ensure that the care provided improves outcomes for infants and families, specifically to deliver:

- An increase in breastfeeding initiation and continuation rates in Maternity and Neonatal Services from birth until discharge from care
- An increase in the number of babies on the Neonatal Unit receiving breastmilk
- Amongst mothers who formula feed, an increase in those doing so as safely as possible, in line with nationally agreed guidance
- A reduction in the number of preventable readmissions for feeding issues

- Maintain and achieve standards for UNICEF Baby Friendly Initiative Accreditation in Maternity and Neonatal Services
- An improvement in maternal/parent satisfaction with infant feeding support

1.3. Our Commitment

NNUH is committed to:

- Providing the highest standard of care to support expectant and new mothers and their partners to feed their baby and build strong and loving parent- infant relationships. This service recognises the profound importance of early relationships and parent-infant attachment to future health and well-being, and the significant contribution that breastfeeding makes to good physical and emotional health outcomes for children and mothers.
- Recognising the challenges that the experience of having a sick or premature baby can present to the development of this relationship. Therefore this service is committed to care which actively supports parents to develop a close and loving bond with their baby.
- Ensuring that all care is mother and family centred, non-judgemental and that the mothers' decisions are supported and respected.
- Working together across disciplines and organisations to improve mothers' and parents' experiences of care.

In order to avoid conflicting advice it is mandatory that all staff involved with the care of breastfeeding women adhere to this policy. Any deviation from the policy must be justified and recorded in the maternal and neonatal records.

It is the individual Midwife or Nurse's responsibility to liaise with the baby's medical attendants (Neonatologist, Paediatrician, General Practitioner) should concerns arise about the baby's health. If a problem with feeding is identified the process is to refer to the above guideline/s and manage accordingly.

No advertising of breastmilk substitutes, feeding bottles, teats or dummies is permissible in any part of this Trust. The display of manufacturers' logos on items such as calendars and stationery is also prohibited (UNICEF 2007). No literature provided by infant formula manufacturers is permitted. Educational material for distribution to women and their families must be approved by the Infant Feeding Co-ordinator and relevant Midwifery or Nurse Manager, where indicated.

As part of this commitment the service will ensure that:

- All new staff are familiarised with this policy on commencement of employment.
- All staff will receive training to enable them to implement the policy as appropriate to their role. New staff will receive this training within six months of commencement of employment. Thereafter Maternity staff will complete an annual update. If their knowledge and skills do not meet the standard required, they will be supported to meet the minimum standard as per Appendix 1.

- The International Code of Marketing of Breast-milk Substitutes (WHO, 1981) is implemented throughout the service.
- All documentation fully supports the implementation of these standards.
- Parents' experiences of care will be listened to as per monitoring compliance (Section 7).

1.4. Scope

All staff are expected to comply with this policy. This Policy is based on the UNICEF Baby Friendly Initiative standards which are recognised as the standard for best practice in promoting, supporting and sustaining breastfeeding and early infant relationships.

The Policy is also supported by NICE guidance for Antenatal Care (2021), Postnatal Care (2021), Maternal and Child Nutrition (2014) and Faltering Growth (2020); and sets out the Trust's process for supporting mothers who are both breast and formula feeding. This policy relates specifically to Maternity, Neonatal and Paediatric Services but can be used by other wards supporting breastfeeding mother and baby dyads.

1.5. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
UNICEF BFI	UNICEF Baby Friendly Initiative
BLISS	For babies born premature or sick
BF	Breastfeeding
AF	Artificial Feeding / Formula Feeding
FFT	Friends and Family Test
CQC	Care Quality Commission
MNVP	Maternity and Neonatal Voices Partnership
NICU	Neonatal Intensive Care Unit
PeriPrem	Perinatal Excellence to Reduce Injury in Premature Birth – Care bundle of 11 interventions that demonstrate a significant impact on brain injury and mortality rates against babies born prematurely.
SIDS	Sudden Infant Death Syndome
First Drops	Quality Improvement project run by NNUH NICU to improve early expressing rates
e-lfh	e-learning for health website for health professionals

2. Responsibilities

It is the Infant Feeding Coordinator and Lead Nurse for BFI Standards responsibilities to update and disseminate this document to staff within Maternity and NICU. It is the Paediatric Managers responsibility to disseminate this document to Paediatric staff.

It is the individual Midwife or Nurse's responsibility to liaise with the baby's medical attendants (Neonatologist, Paediatrician, General Practitioner) should concerns arise about the baby's health. If a problem with feeding is identified the process is to refer to the above guideline/s and manage accordingly.

3. Care Standards

This is the care that the Trust is committed to giving each expectant mother and new family. It is based on the UNICEF UK Baby Friendly Initiative standards for both Maternity and Neonatal Services and relevant NICE guidance (2021a, 2021b, 2020, 2014).

3.1. Pregnancy

All pregnant women will have the opportunity to discuss feeding and caring for their baby with a health professional, or other suitably trained designated person (NICE 2021a). This discussion will include the following topics:

- The value of connecting with their growing baby in utero.
- The value of skin-to-skin contact for all mothers and babies.
- The importance of responding to their baby's needs for comfort, closeness and feeding after birth, and the role that keeping their baby close has in supporting this.
- Feeding, including:
    - An exploration of what parents already know about breastfeeding.
    - The value of breastfeeding as protection, comfort and food.
    - Getting breastfeeding off to a good start.

3.2. Birth

- All mothers will be offered the opportunity to have uninterrupted skin contact with their baby at least until after the first feed and for as long as they want, so that the instinctive behaviour of breast seeking (baby) and nurturing (mother) is given an opportunity to emerge.
- All mother and baby dyads will be assessed for risk factors (e.g., hypoglycaemia) at birth and managed appropriately. Babies will be kept warm with effective skin-to-skin contact and their temperature monitored as soon as possible after birth.
- All mothers will be encouraged to offer the first breastfeed in skin-to-skin contact when the baby shows signs of readiness to feed. The aim is not to rush the baby to the breast but to be sensitive to the baby’s instinctive process towards self-attachment.
- When mothers choose to formula feed they will be encouraged to offer the first bottle feed in skin contact, following feeding cues. Subsequent bottle feeds should also be encouraged in skin-to-skin contact.
- Those mothers who are unable (or do not wish) to have skin contact immediately after birth, will be encouraged to commence skin contact as soon

as they are able, or so wish. Separation of mother and baby will normally only occur where the health of either mother or baby prevents care being offered in the postnatal areas.

- Babies should be transferred between ward areas in skin-to-skin contact, wherever possible using wheelchairs and beds for mothers to ensure safety. This is vitally important in keeping babies warm, as well as regulating their heart rate, breathing rate, encouraging calmness and bonding between babies and parents.

3.3. Safety considerations for skin-to-skin contact

Vigilance as to the baby's well-being is a fundamental part of postnatal care in the first few hours after birth. For this reason, normal observations of the baby's temperature, breathing, colour and tone should continue throughout the period of skin-to-skin contact, in the same way as would occur if the baby were in a cot (this includes calculation of Apgar score at 1-, 5- and 10-minutes following birth). Care should be taken to ensure the baby is kept warm and observations should also be made of the mother, with prompt removal of the baby if the health of either gives rise to concern.

Staff should have a conversation with parents about the importance of recognising changes in baby's colour or tone and the need to alert staff immediately if they are concerned.

It is important to ensure that the baby cannot fall on to the floor or become trapped in bedding or by the mother's body. Particular care should be taken with the position of the baby, ensuring the head is supported so the infant's airway does not become obstructed. Please refer to No Co-sleeping policy Trust Docs ID 10415 in related documents.

Many mothers can continue to hold their baby in skin-to-skin contact during perineal suturing. However, adequate pain relief is required, as a mother who is in pain is unlikely to be able to hold her baby comfortably or safely. Mothers should be discouraged from holding their baby when receiving analgesia which impacts their consciousness (e.g. Entonox).

3.4. Babies requiring care on NICU

Parents with a baby on the neonatal unit are supported to have a close and loving relationship with their baby. All parents will:

- Have a discussion with an appropriate member of staff as soon as possible (either before or after their baby's birth) about the importance of touch, comfort and communication for their baby's health and development.
- Be actively encouraged and enabled to provide touch, comfort and emotional support to their baby throughout their baby's stay on the neonatal unit.
- Be enabled to have frequent and prolonged skin-to-skin contact (for at least one hour) with their baby as soon as possible after birth and throughout the baby's stay on the neonatal unit (please refer to developmental care guideline).

This service recognises the importance of breastmilk for babies' survival and health. Therefore, this service will ensure that:

- A mother's own breastmilk is always the first choice of feed for her baby.
- Mothers have a discussion regarding the importance of their breastmilk for their preterm or ill baby as soon as is appropriate.
- Mothers will be enabled to achieve effective breastfeeding according to their needs (including appropriate support with positioning and attachment, hand expression, understanding signs of effective feeding). This will continue until the mother and baby are feeding confidently.
- Mothers will have the opportunity to discuss breastfeeding in the first few hours after birth as appropriate to their own needs and those of their baby. This discussion will include information on responsive feeding and feeding cues.
- A formal feeding assessment will be carried out using the breastfeeding assessment tool, expressing assessment tool or bottle-feeding assessment tool as often as required in the first week, with a minimum of three assessments to ensure effective feeding and the wellbeing of mother and baby. This assessment will include a discussion with the mother to reinforce what is going well and, where necessary, develop an appropriate plan of care to address any issues that have been identified.
- A suitable environment conducive to effective expression is created.
- Mothers have access to effective breast pumps and equipment.
- Mothers are enabled to express breast milk for their baby, including support to:
    - Express as early as possible after birth, ideally within two hours, as recommended by PeriPREM and First Drops.
    - Learn how to express effectively, including by hand and by pump using breast compressions to optimise supply.
    - Learn how to use pump equipment and store milk safely.
    - Express frequently, at least eight times in 24 hours, including overnight with no long gaps, in order to optimise long-term milk supply.
    - Overcome expressing difficulties where necessary, particularly where milk supply is reduced.
    - Stay close to their baby when expressing milk.
    - Offer breastmilk buccally and use for mouth care when their baby is not receiving oral feeds, and later to tempt their baby to feed.

Therefore, this service will ensure that mothers receive care that supports the transition to breastfeeding, including support to:

- Recognise and respond to feeding cues and use skin-to-skin contact to encourage instinctive feeding behaviour.
- Position and attach their baby for breastfeeding.

- Recognise effective feeding and overcome challenges when needed.

Mothers are provided with details of voluntary support for breastfeeding which they can choose to access at any time during their baby's stay.

Mothers are supported through the transition to discharge home from hospital, including having the opportunity to stay overnight, for extended periods (if activity within the unit allows) to support the development of mothers' confidence and modified responsive feeding. For those mothers who require additional support for more complex feeding challenges, a referral to the Speech and Language Therapy Team or Specialist Infant Feeding clinic may be recommended.

3.4.1. Valuing parents as partners in care whilst on NICU

This service recognises that parents are vital to ensuring the best possible short and long term outcomes for babies and therefore, should be considered as the primary partners in care.
The service will ensure that parents:

- Have unrestricted access to their baby unless individual restrictions can be justified in the baby's best interest.
- Are fully involved in their baby's care, with all care possible entrusted to them.
- Are listened to, including their observations, feelings and wishes regarding their baby's care.
- Have full information regarding their baby's condition and treatment to enable informed decision-making.
- Are made comfortable when on the unit, with the aim of enabling them to spend as much time as is possible with their baby.

The Neonatal unit will ensure that parents who formula feed:

- Receive information about how to clean, sterilise equipment and make up a bottle of formula milk as safely as possible to minimise the risks of formula milk.
- Are able to bottle feed their baby using a safe and responsive technique.

It is the joint responsibility of midwifery and neonatal unit staff to ensure that mothers who are separated from their baby receive this information and support.

3.5. Responsive Feeding

The term responsive feeding is used to describe a feeding relationship which is sensitive, reciprocal, and about more than nutrition. Staff should ensure that mothers have the opportunity to discuss this aspect of feeding and reassure mothers that: breastfeeding can be used to feed, comfort and calm babies; breastfeeds can be long or short, breastfed babies cannot be overfed or 'spoiled' by too much feeding and breastfeeding will not, in and of itself, tire mothers any more than caring for a new baby without breastfeeding.

Dummies, soothers and pacifiers can interfere with responsive feeding by masking feeding cues, and this in turn can affect a mother's milk supply. Staff are responsible for informing parents of this, so they can make an informed choice regarding dummy use. Reasons for using a dummy or soother on Neonatal Unit can be different and may be recommended for certain non-nutritive purposes.

3.6. Support for Breastfeeding

- Mothers who breastfeed will be provided with information about why exclusive breastfeeding leads to the best outcomes for their baby and why it is particularly important during the establishment of breastfeeding. Mothers will be supported with recognising feeding cues, positioning and attachment, hand expressing and the signs of effective feeding. If further support is required, such as if a baby is reluctant to feed or at risk of hypoglycaemia, please see related documents.
- When exclusive breastfeeding is not possible, the value of continuing partial breastfeeding will be emphasised and mothers will be supported to maximise the amount of breastmilk their baby receives.
- Mothers who give other feeds in conjunction with breastfeeding will be enabled to do so as safely as possible and with the least possible disruption to breastfeeding. This will include appropriate information and a discussion regarding the potential impact of introducing a teat when a baby is learning to breastfeed.
- A full record will be made of all supplements given, including the rationale for supplementation and the discussion held with parents.
- Supplementation rates will be audited intermittently as part of UNICEF BFI accreditation requirements.
- A formal feeding assessment will be carried out using the breastfeeding assessment tool at least three times in the first week to ensure effective feeding and the wellbeing of mother and baby. This assessment will include a discussion with the mother to reinforce what is going well and where necessary develop an appropriate plan of care to address any issues that have been identified. A final feeding assessment will be done on transfer to the Health Visitor.
- All breastfeeding mothers will be informed about the local support services for breastfeeding and signposted to the support groups list.

3.7. Modified Feeding regimes

There are a number of clinical indications for a short term modified feeding regime in the early days after birth. Examples include: preterm or small for gestational age babies, those who are excessively sleepy after birth, those at risk of hypoglycaemia, those experiencing jaundice and those who have excessive weight loss in the first few days after birth. Frequent feeding, including a minimum number of feeds in 24 hours, should be offered to ensure safety. Please see related documents for relevant guidelines.

3.8. Support for formula feeding

Mothers who formula feed will be enabled to do so as safely as possible through the offer of a demonstration and / or discussion about how to prepare infant formula. This will include discussion regarding holding baby close during feeds, offering the

majority of feeds to their baby themselves to enhance the mother-baby relationship and offering only stage 1 or first infant formula to baby for the first year after birth, before moving onto cow's milk. There is no indication for follow-on milk or specialised formula unless specifically recommended by a trained health professional. Infant formula and expressed breastmilk should not be mixed in the same bottle. Schanler (2007) suggests that mixing breastmilk and formula can affect protein intake, and retentions of calcium, phosphorous, and zinc.

Mothers who formula feed will have a discussion about the importance of responsive feeding and be encouraged to:

- Respond to cues that their baby is hungry
- Hold the baby in a semi-upright position, using eye-contact
- Invite their baby to draw in the teat rather than forcing the teat into their baby's mouth
- Pace the feed so that their baby is not forced to feed more than they want to
- Recognise their baby's cues that they have had enough milk and avoid forcing their baby to take more milk than the baby wants.

For babies who are born prematurely or struggle to breastfeed in a semi-upright position, the elevated side-lying position should be used. See related documents for relevant guideline.

3.9. Supporting close and loving relationships in the early postnatal period

Skin-to-skin contact will be encouraged throughout the postnatal period – please note this is not limited to immediately after birth only.

All parents will be supported to understand a newborn baby's needs (including encouraging frequent touch and sensitive verbal, visual communication, keeping babies close, responsive feeding and safe sleeping practice).

Parents will be given information about local parenting support that is available.

3.10. Recommendations for infant safer sleep practices and discussing bed-sharing with parents

Babies should not co-sleep when in hospital with their mothers. This is because the environment and beds are not conducive to safe co-sleeping, regardless of maternal and infant risk factors. Please see related documents for relevant guideline.

Simplistic messages should be discussed in pregnancy and at every postnatal contact in relation to safer sleep (NICE, 2021b). The current body of evidence overwhelmingly supports the following key messages, which should be conveyed to all parents:

- The safest place for your baby to sleep is in a cot in the same room as you for at least the first 6 months. Your baby should be placed on their back to sleep, with their feet to the bottom of the cot. Use a firm, flat, waterproof mattress in good condition. Don't cover your baby's face or head while sleeping or use loose bedding. Avoid letting your baby get too hot – the optimal room temperature is 16-20 degrees Celsius.

- Sleeping with your baby on a sofa or an armchair puts your baby at greatest risk of SIDS. It should never be done.
- Your baby should not share a bed with anyone who: is a smoker, has consumed alcohol or who has taken drugs (legal or illegal) that make them sleepy. Your baby should not share a bed with you if they were born prematurely or was of low birth weight (less than 2.5kg or 5lbs 7oz).
- Parents should be signposted to further information from the Lullaby Trust and BASIS Online.

3.11. Newborn babies less than 28 days old readmitted to hospital with jaundice or feeding issues

Babies readmitted to hospital for treatment of jaundice or feeding issues should be referred to an Infant Feeding Keyworker or the Infant Feeding Team. Referrals can be made via telephone on ext 2058, Alertive, or via email to infantfeedingco-ordinators@nnuh.nhs.uk if no immediate response if received.

Readmission data is collected by the Infant Feeding Team as part of UNICEF BFI Accreditation. Please see monitoring compliance in section 7 for details.

3.12. Peer Support Volunteers

Peer support volunteers will offer support to mothers where possible, both in Maternity and Neonatal Services. In order to volunteer, peer supporters will:

- Give knowledgeable support, not advice.
- Give no hands-on care.
- Have completed a comprehensive peer support training programme and passed a full practical skills review prior to being permitted to offer support to women.
- Sign a role description and attend supervision sessions quarterly.
- Volunteer for a minimum of 4 hours per month to maintain knowledge and skills.
- Will report any clinical concerns to the midwife or nurse in charge.
- Receive their supervision and ongoing support from the Infant Feeding Co-ordinator and Peer Support Co-ordinator.

3.13. Supporting people who are breastfeeding whilst being cared for at NNUH

- NNUH promote continued breastfeeding in women being cared for and treated within inpatient and outpatient settings.
- Please see related documents for relevant guideline

3.14. Supporting staff who are breastfeeding and/or expressing milk at work

- A parent who has chosen to breastfeed and return to work needs support from employers and colleagues to be able to continue breastfeeding for their

optimum period of time. Parents dedicate a significant amount of time and effort to establish breastfeeding, and this should be valued and respected.
- If a colleague wishes to breastfeed and/or express milk whilst at work, the Trust will aim to enable them to do so by providing appropriate support wherever possible.
- Please see related documents for relevant guideline

4. Training & Competencies

- Please see appendix 1 for training matrix for maternity staff
- Please see appendix 2 for training matrix for neonatal staff
- Paediatric staff will receive infant feeding training as part of mandatory training updates and will be invited to attend the 2-day UNICEF BFI course.
- Paediatric Medical staff will be expected to complete the UNICEF BFI eLearning for paediatricians' package and receive infant feeding training as part of their orientation package.
- E-lfh have an Infant Feeding eLearning package which is available for all health professionals interested in learning more.

5. Related Documents

The policy should be implemented in conjunction with both the Trust's related infant feeding guidelines which can be accessed via the Intranet:

- Trust guideline for the Management of Newborn Babies who are Reluctant to Feed Trustdocs Id: 8334
- Transitional Care Guideline Trustdocs Id: 1510
- Trust Guideline for the Prevention and Management of Excessive Weight Loss in Healthy Breastfed Newborns Trustdocs Id: 8333
- Trust Guideline for the use of Donor Breast Milk on the Neonatal Unit Trustdocs Id: 9994
- Trust guideline for Jaundiced Babies Management Trustdocs Id: 1528
- Trust Guideline for Neonates with a Restrictive Lingual Frenulum (tongue tie) causing feeding difficulty Trustdocs Id: 803
- Management of Neonates at risk of Hypoglycaemia who are equal to / or greater than 37 weeks gestation Trust Docs (nnuh.nhs.uk): 14999
- Trust Guideline for the Management of Hypoglycaemia in Preterm Infants Trustdocs Id: 1196
- Human Resources Maternity Leave Policy Trustdocs Id: 671
- Breastfeeding at work policy Trust Docs (nnuh.nhs.uk): 19051
- Checklist for Managers to discuss breastfeeding and expressing milk at work with employees Trust Docs (nnuh.nhs.uk): 19052
- Guideline to support people who are breastfeeding while under the care of NNUH Trust Docs (nnuh.nhs.uk): 18671

- No Co-sleeping in Hospital Policy for babies up to the age of 6 months Trustdocs Id: 10415
- Trust guideline for the Management of Developmental Care Trustdocs Id: 9174
- Buccal colostrum Awaiting Trustdocs ID
- Elevated side lying Awaiting Trustdocs ID

6. References

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UNICEF UK (2007) Guidelines for compliance with the requirements for advertising in Baby Friendly healthcare facilities London: UNICEF

World Health Organisation (WHO) (2007). Evidence on the long-term effects of breastfeeding. Geneva, Switzerland: WHO

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7. Monitoring Compliance

Compliance with the process will be monitored through the following:

Key elements	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee /dept	Frequency of monitoring
Monitoring breastfeeding initiation, continuation at transfer and at discharge from Maternity care	Infant Feeding Statistics	Infant Feeding Team	Maternity Clinical Governance	Annual
Readmissions rates for infants <28 days old for jaundice and feeding problems	Data collection from Symphony, database for audit results	Infant Feeding Team	Maternity Clinical Governance	Annual
Rates of formula supplementation of breastfed babies within Maternity	UNICEF BFI audit tool	Infant Feeding Team	Maternity Clinical Governance	Annual
BFI Audit results	UNICEF BFI audit tools	Maternity and Neonatal BFI Leads	Maternity and Neonatal Clinical Governance	Annual
Parent satisfaction scores (BFI audit results, FFT, CQC, MNVP)	UNICEF BFI audit tools, FFT, MNVP feedback, FFT results	Infant Feeding Team, Clinical Effectiveness Midwife	Maternity Clinical Governance	Annual

The audit results are to be discussed at Maternity and Neonatal governance meetings to review the results and recommendations for further action. Then sent to Clinical Safety and Effectiveness Sub-Board who will ensure that the actions and recommendations are suitable and sufficient.

8. Appendices

Appendix 1 – Maternity Mandatory Infant Feeding Training Matrix
234 Breastfeeding Management

234 Newborn Infant Feeding Core

- Attend Midwives or MCA's Mandatory Training session annually

234 Hypoglycaemia Update

- Complete relevant elearning package on ESR

Appendix 2 – Neonatal Infant Feeding Training Matrix

9. Equality Impact Assessment (EIA)

Type of function or policy	Existing

Division	3: Women and Children's	**Department**	Maternity, Neonatal and Paediatric
Name of person completing form	Sophie Harvey	**Date**	13/12/2023

Equality Area	Potential Negative Impact	Impact Positive Impact	Which groups are affected	Full Impact Assessment Required YES/NO
Race	N/A			No
Pregnancy & Maternity		Positive (inclusivity)		No
Disability	N/A			No
Religion and beliefs	N/A			No
Sex	N/A			No
Gender reassignment		Positive (inclusivity)		No
Sexual Orientation		Positive (inclusivity)		No
Age	N/A			No
Marriage & Civil Partnership	N/A			No
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?				

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.