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To provide every patient with the care we want for those we love the most

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Trust Infant Feeding Policy

A clinical policy recommended for use

For Use in:	Any area of the Trust involved in the care of pregnant and breastfeeding mothers and their newborns
By:	Registered Midwives, Registered Nurses, Medical Staff, Maternity Care Assistants, Nursery Nurses, Student Midwives, Nurses under the direct supervision of their allocated Mentor, Volunteer Breastfeeding Peer Supporters.
For:	Managing Infant Feeding in Newborn in Maternity and Neonatal Services
Division responsible for document:	Women and Children's Services
Key words:	Infant Feeding, Breastfeeding, Formula feeding, Newborns
Name and job titles of document author:	Luisa Lyons, Infant Feeding Co-ordinator Susan Harris, Senior Sister - Neonatal Intensive Care Unit (Breastfeeding Lead)
Name and job title of document author's Line Manager:	Emma Hardwick, Head of Midwifery
Supported by:	Martin Cameron- Clinical Director for Obstetrics, Consultant Obstetrician, subspecialist in Fetal Medicine, Emma Dolman, Matron Children's Services, Jenny Lind Children's Department. Paula Mellor, Matron NICU, Professor Mark Dyke, Associate Medical Director, Paediatrics, Neonatal Intensive Care Unit
Assessed and approved by the:	Professional Protocols, Policies & Guidelines Committee (PPPG) If approved by committee or Governance Lead Chair's Action; tick here ☐
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If Yes - does the strategy/policy deviate from the recommendations of NICE? If so why?	No

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Version and Document Control:

Version Number	Date of Update	Change Description	Author
5.2	21/01/2021	Appendix 3 is now a separate document, a hyperlink has been inserted.	Luisa Lyons, Susan Harris

This is a Controlled Document

Printed copies of this document may not be up to date. Please check the hospital intranet for the latest version and destroy all previous versions.

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Trust Infant Feeding Policy

Policy Statement and 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.

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 (2014, 2008) and sets out the Trust's process for supporting mothers who are both breast and formula feeding. This policy relates to Maternity, Neonatal and Paediatric Services.

Aims and Objectives

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.

Outcomes

This policy aims to ensure that the care provided improves outcomes for children and families, specifically to deliver:

- An increase in breastfeeding initiation rates in Maternity and Neonatal Services
- An increase in the number of babies on the Neonatal Unit receiving breastmilk
- An increase in breastfeeding and breastmilk feeding rates at Neonatal Unit or Maternity Services discharge
- Amongst mothers who choose to or have to formula feed, an increase in those doing so as safely as possible, in line with nationally agreed guidance
- A reduction in the number of readmissions for preventable feeding problems –see the Procedure for the Specialist Infant Feeding Clinic Trustdocs Id: 14654
- Maintenance of full UNICEF Baby Friendly Hospital Status
- An improvement in Care Quality Commission (CQC) scores and 'Friends and Family test' scores for maternal/parent satisfaction with infant feeding support

Definitions

The infant feeding policy will cover both breastfeeding and formula feeding. 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.

Broad Recommendations

NNUHFT 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.

The policy should also be implemented in conjunction with the Parents' Guide to the Policy (Trustdocs Id: 14619) which all pregnant women will have access to. In addition the Parents' Guide will be displayed in all hospital clinical areas serving pregnant women and new mothers and on the Trust webpage.

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
- Trust Guideline for the Investigation and Management of Neonatal Hypoglycaemia **Trustdocs Id: 1196**
- Human Resources Maternity Leave Policy Trustdocs Id: 671

- 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

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 6.
- 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 through: regular audit, parents' experience surveys (e.g. Care Quality Commission survey of women's experiences of maternity services), BLISS Baby Charter Tool, Friends and Family Test.

Care standards

This is the care that the Trust is committed to giving each and every 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 (2014, 2008a).

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 2010). This discussion will include the following topics:

- The value of connecting with their growing baby in utero.
- The value of 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.

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 contact and their temperature monitored as soon as possible after birth.

All mothers will be encouraged to offer the first breastfeed in 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. Subsequent formula (bottle) feeds should also be encouraged in 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 contact, wherever possible using wheelchairs and beds for mothers to ensure safety.

Babies requiring care in the Neonatal Unit

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 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 breast milk 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.
- 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 six hours).

- 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 once at night) especially in the first two to three weeks following delivery, in order to optimise long-term milk supply.
- Overcome expressing difficulties where necessary, particularly where milk supply is inadequate, or if less than 750ml in 24 hours is expressed by day 10.
- Stay close to their baby when expressing milk.
- Use their milk for mouth care when their baby is not tolerating oral feeds, and later to tempt their baby to feed.

A formal review of expressing is undertaken a minimum of four times in the first two weeks to support optimum expressing and milk supply using the UNICEF expression checklist assessment tool.

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.

Valuing parents as partners in care whilst on the Neonatal Unit

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: see Formula Feeding: Top Tips for Parents Trustdocs ID: 14654.

- 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.

Safety considerations for skin to skin contact in all settings

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 contact, in the same way as would occur if the baby were in a cot. Observations should also be made of the mother, as individually required, with prompt removal of the baby if the health of either gives rise to concern. See Postnatal Care Guideline Trustdocs Id: 8613.

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.

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 causes drowsiness or alters their state of awareness (e.g. entonox).

Where mothers choose to give a first feed of formula milk in skin contact, particular care should be taken to ensure the baby is kept warm.

Support for breastfeeding

Mothers will be enabled to achieve effective breastfeeding according to their needs (including appropriate support with positioning and attachment, hand expression and the signs of effective feeding). This will continue until the mother and baby are feeding confidently. If a baby does not feed spontaneously in the first 4 hours of life, or does not spontaneously feed again within 6 hours of life, the "Care of the baby who is reluctant to feed" guideline will be instigated (Trustdocs Id: 8334).

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 (see Trustdocs Id: 14528) as often as required in the first week with a minimum of three assessments by day 8 to ensure effective feeding and the well-being of mother and baby. This assessment will include a dialogue, 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.

Before discharge home, breastfeeding mothers will be given information both verbally and in writing about recognising effective feeding and where to call for additional help if they have any concerns (Trustdocs Id 14620). All breastfeeding mothers will be informed about the local support services for breastfeeding and given a copy of the support groups list. The Infant Feeding Coordinator will ensure the list is updated every six months.

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

- Need to have undertaken additional training.
- 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 for a minimum of 12 hours per year.
- Volunteer for a minimum of 48 hours per year 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.

For those mothers who require additional support for more complex breastfeeding or bottle feeding challenges, a referral to the infant feeding keyworkers will be made in the first instance. If the keyworker is unable to resolve the infant feeding issue she/he can refer the mother and baby to the Specialist Infant Feeding Clinic Trustdocs Id: 14654.

The infant feeding co-ordinator will only be referred to if the keyworker feels it appropriate. For babies with a Restrictive Lingual Frenulum (tongue tie) causing feeding difficulty please see Neonates with Restrictive Lingual Frenulum (Tongue-Tie) Trustdocs Id: 803. Mothers will be informed of this pathway as required. A parent information leaflet about how and when babies are checked for restrictive lingual frenulum is available on Trustdocs Id: 11904.

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 can interfere with responsive feeding by placating babies who would otherwise be breastfed, and this in turn can affect a mother’s milk supply. Staff are expected to ensure that mothers are aware of this should they choose to use a dummy. A parent information leaflet is available pertaining to healthy term babies Trustdocs Id: 8831, Dummies, Soothers and Pacifiers. Reasons for using a dummy or soother on Neonatal Unit can be different. For parents with a baby on the Neonatal Unit a more pertinent information leaflet is available, see Use of Dummies/Soothers/Pacifiers on the Neonatal Intensive Care Unit Trustdocs Id: 9539.

Exclusive 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.

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 annually supported by regular sampling and reviews of records to ensure compliance with this Policy.

Modified feeding regimes

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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 and those who are excessively sleepy after birth. Frequent feeding, including a minimum number of feeds in 24 hours, should be offered to ensure safety.

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

- Neonates requiring Transitional Care (Management of) Trustdocs Id:1510.
- Healthy Babies over 37 weeks gestation who are Reluctant to Feed (Management of) Trustdocs Id: 8334.
- Trust Guideline for the Prevention and Management of Excessive Weight Loss in healthy breastfed newborns Trustdocs Id: 8333.
- Trust guideline for Jaundiced Babies Management **Trustdocs Id: 1528**.
- Trust Guideline for the Investigation and Management of Neonatal Hypoglycaemia **Trustdocs Id: 1196**.

Formula Feeding

Mothers who formula feed will be enabled to do so as safely as possible through offers of demonstration and/or discussion about how to prepare infant formula.

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.
- 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 by their baby cues that they have had enough milk and avoid forcing their baby to take more than the baby wants.

Early postnatal period: support for parenting and close relationships

Skin-to-skin contact will be encouraged throughout the postnatal period.

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).

Mothers who bottle feed will be encourage to hold their baby close during feeds and offer the majority of feeds to their baby themselves to help enhance the mother-baby relationship.

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

Recommendations for 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 No co-sleeping for babies up until the age of 6 months whilst in Hospital (Policy for) Trustdocs Id: 10415.

Simplistic messages in relation to where a baby sleeps should be avoided; neither blanket prohibitions nor blanket permissions reflect the current research evidence. 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 by your bed for at least the first 6 months.
- Sleeping with your baby on a sofa puts your baby at greatest risk. 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.

The incidence of Sudden Infant Death Syndrome (SIDS) (often called "cot death") is higher in the following groups:

- Parents in low socio-economic groups.
- Parents who currently abuse alcohol or drugs.
- Young mothers with more than one child.
- Premature infants and those with low birth weight (<2500g).

Parents within these groups will need more face to face discussion to ensure that these key messages are explored and understood. They may need some practical help, possibly from other agencies, to enable them to put them into practice.

System for reporting newborns readmitted to hospital with feeding problems during the first 28 days of life

In addition, where a baby is readmitted to hospital with feeding problems, during the first 28 days of life a referral should be made to the Infant Feeding Key Worker Trustdocs ID: 12598

following which, a referral to the Infant Feeding Specialist Clinic may be required. If a keyworker is unavailable and weight loss over 12%, the mother and baby can be referred to the Infant Feeding Co-ordinator or an appropriately trained professional.

An incident form should be completed by the health care professional admitting the baby.

The Infant Feeding Co-ordinator will liaise with Clinical Governance Nurse for paediatrics on a monthly basis to analyse the data on readmissions for excessive weight loss and review each case of weight loss resulting in hypernatraemia on an individual basis.

The Infant Feeding Co-ordinator will meet with the relevant Community Midwifery and NICU Managers on a regular basis to review these cases.

The Infant Feeding Co-ordinator will be responsible for instigating any review process and update the Policy.

Supporting staff who are breastfeeding and, or expressing milk at work

The line manager is required to undertake a risk assessment, see Maternity Leave Policies Trustdocs Id: 671 (before 1st April 2017) and Trustdocs Id:13296 (after 1st April 2017) and make the necessary arrangements to provide breastfeeding women with suitable private rest facilities. The provision of "suitable facilities" for a breast feeding employee is a legal requirement.

Suitable facilities to be provided would include:

- A clean, warm, healthy and safe environment where women can breastfeed or express breast milk.
- This needs to be a private room (not a toilet cubical).
- Use of a secure, clean refrigerator for storing expressed breast milk while at work.
- Facilitates for washing, sterilising and storing receptacles.

Managers must consider requests for flexible working arrangements including extended unpaid breaks during shifts to support breastfeeding, expressing milk at work. Such requests will be based on individual needs and will require discussion with the employee to consider how their needs can be met. Staff are welcome to express their milk or feed their babies in the Hospital Chapel if they prefer a calmer, more peaceful environment.

Monitoring implementation of the standards and their outcomes

See Appendix 2 for Auditable Standards.

Audit results will be reported to the Head of Midwifery and an action plan will be agreed by The BFI Steering Committee which includes all Clinical Managers in Midwifery, NICU and Paediatrics. Any areas of non-compliance will be addressed.

Summary of development and consultation process undertaken before registration and dissemination

Luisa Lyons drafted this Policy on behalf of the Head of Midwifery who has agreed the final content. During its development it was has been circulated for comment to Midwifery

Managers, Neonatal Nurse Manager, Consultant Neonatologists, Community Midwifery Team Leaders, relevant Ward Managers, Practice Development Midwives and Paediatric Managers. Service users, via the Maternity Services Liaison Committee (MSLC) were also consulted. The Policy has been approved by the Midwifery Guidelines Group. This version has been endorsed by the Professional Protocols, Policies and Guidelines Committee.

Distribution list, dissemination method

This Policy will be distributed to the Head of Midwifery, Senior Midwifery Managers, Community Team Leaders, relevant Ward Managers, NICU and Paediatric Managers and Supervisors of Midwives as well as the Maternity Services Liaison Committee (MSLC).

Ward and Departmental managers in Maternity and Neonatal Services will ensure that all staff that come into contact with pregnant women and, or new mothers are aware of the Policy and of new or amended Polices. They will be able to provide evidence of this awareness. The Policy will also be available on the Trust Intranet for all staff to access and download a copy.

References

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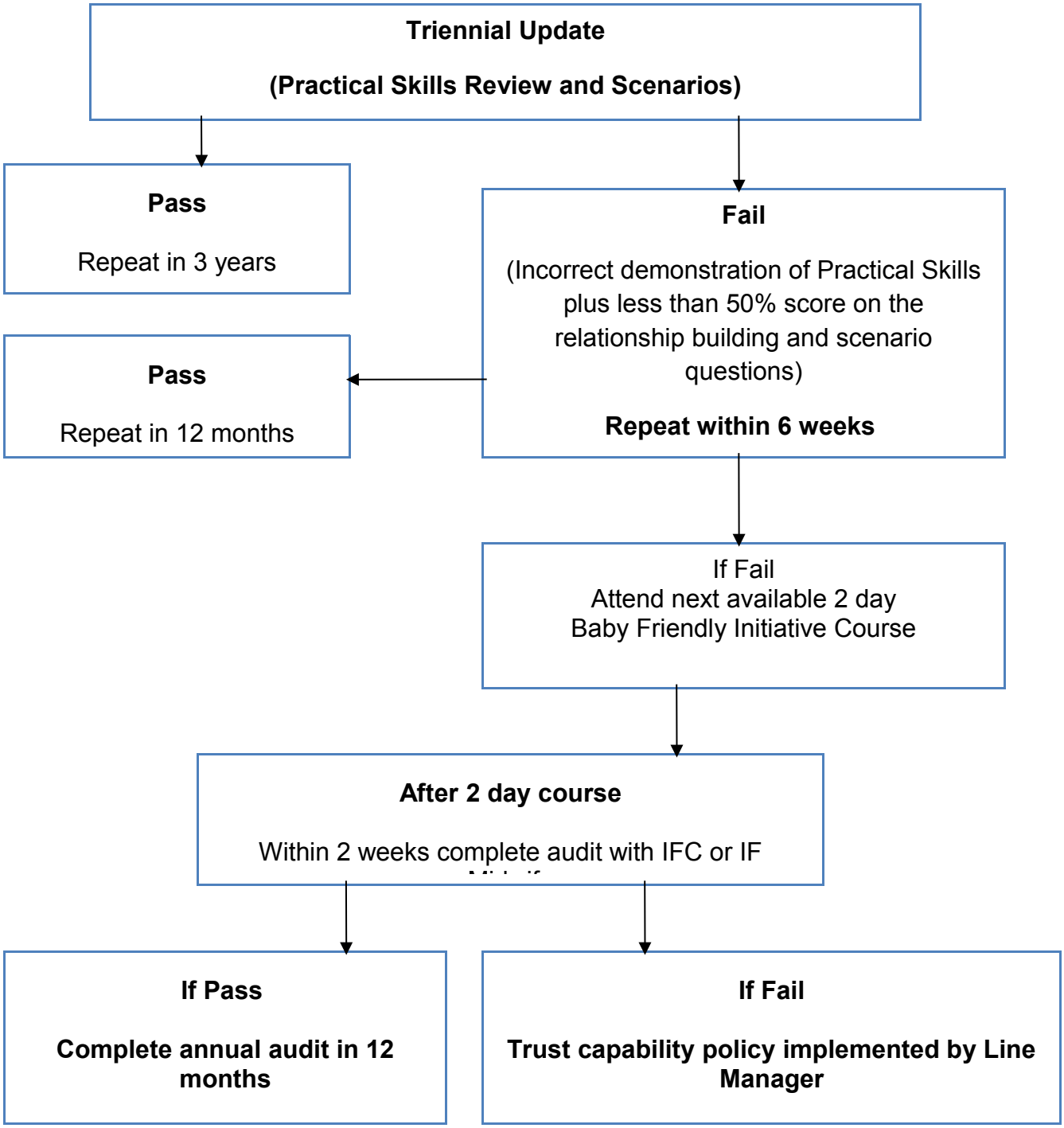
Appendix 1

Process for Completing Infant Feeding Training Update for Maternity staff



Trust Infant Feeding Policy

Monitoring Compliance Table

Appendix 2

Element to be monitored	*Lead Responsible for monitoring*	*Monitoring Tool , Method of monitoring*	*Frequency of monitoring*	*Lead Responsible for developing action plan & acting on recommendations*	*Reporting arrangements*	*Sharing and disseminating lessons learned & recommended changes in practice as a result of monitoring compliance with this document*
Monitoring breastfeeding initiation and 10 day continuation rates	Infant Feeding Co-ordinator	Infant feeding Statistics	At least annually	Infant Feeding Co-ordinators	Department Clinical Governance Meeting	Women and Children's Governance Group.
Readmissions rates for feeding problems	Infant Feeding Co-ordinator	Figures from PAS And a formalised audit tool with reference to CNST requirements	At least annually	Clinical Governance Lead	Department Clinical Governance Meeting	
Rates of formula supplementation of breastfed babies	Infant Feeding Co-ordinator	a) Euroking maternity data collection b) Infant feeding Statistics	At least annually	Infant Feeding Co-ordinators	Department Clinical Governance Meeting	
BFI Audit results	Infant Feeding Co-ordinator	UNICEF Baby Friendly Audit tool 2013	At least annually	Infant Feeding Co-ordinators	Department Clinical Governance Meeting	
Parent satisfaction scores (Care Quality Commission, F&F)	Clinical Governance Lead	CQC audit and Friends and Family Test Numbers of complaints and negative feedback	Ongoing	Infant Feeding Co-ordinators for feeding related outcomes	Department Clinical Governance Meeting	

Appendix 3

Procedure to Follow if the Incorrect Expressed Breastmilk (EBM) Has Been Given To a Baby on the Maternity Wards, NICU or Paediatric Ward (Trustdocs ID: 18293)