NHS
County Durham and Darlington
NHS Foundation Trust

POLICY/PROCEDURE CONTROL SHEET

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Title	Infant Feeding Policy		

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Prepared by (author)	Evidence Based Practice Group
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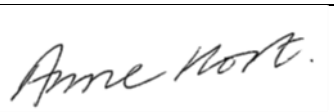
Signature of Chair	
Name of Chair	Anne Holt, Associate Director of Nursing – Family Health

Version Control

Version Number	Date Ratified	Reason for Revision	Brief Description of revisions made
1.0	Dec 2006	Full Review	Superseded
1.1	Dec 2008	Full Review	Superseded
1.2	Aug 2009	Full Review	Superseded
2.0	Dec 2009	Full Review	Superseded
2.1	Apr 2010	Full Review	Superseded

Procedural Document Validity Statement

Users of this document should ensure that they are using the current signed version of this documentation. The guidance will remain valid, including during any period of review, for the duration stated above. The document must be reviewed at least once every three years, or sooner if there is a change to national guidance/practice.

This template should be completed in conjunction with POL/CA/0001 (Policy for Policies)

3.0	June 2010	Full Review	Superseded
4.0	Sep 2010	Full Review	Superseded
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6.4	12.4.17	Full Review	superseded
7.0	8.17	Full Review	superseded
7.1	10/18	Full Review	Superseded
8.0	August 2020	Full Review	Superseded
9.0	September 2021	Full Review	

Contents

1 Introduction

This policy is based on

- UNICEF UK Baby Friendly Initiative Standards for maternity services. and relevant NICE guidance (maternity) (2005).
- UNICEF UK Baby Friendly Initiative Standards for community settings (2005).
- UNICEF UK, How to Implement Baby Friendly Standards – A guide for community settings(2001).
- The Healthy Child Protocol for the promotion of Child and Family Health – (CDDFT -2009).
- Maternal and Child Nutrition- NICE Public Health Guidance 11 (2008).
- Ante natal care: Routine care for the healthy pregnancy woman. NICE clinical guideline 62 (2008).
- The NICE (National Institute for health and Clinical Excellence) Routine Antenatal/Postnatal Care of women and their babies (NICE clinical guidance 37 July 2006).
- Guideline for identifying, prevention and management of poor weight gain in the breastfed baby (NICE Sept 2017).

NICE recommends that women receive breastfeeding support through a service that uses an evaluated structured program (i.e. Unicef Baby Friendly Initiative) and women or main carers' of formula fed babies have the opportunity to discuss information about bottle feeding. (NICE 2006).

The following sets out the Trust policy on all aspects related to Infant feeding both within hospital and community settings.

2 Purpose and Definition

The purpose of this policy is to ensure that all staff at Co Durham and Darlington Foundation Trust (CDDFT) 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 the policy.

2.1 Policy Objectives

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

- An increase in initiation rates.
- An increase in breastfeeding rates at 10 days.
- An increase in breastfeeding rates at 6-8 weeks.

- Amongst mothers who choose to formula feed, an increase in those doing as safely as possible in line with nationally agreed guidelines.
- A reduction in the number of re-admissions for feeding problems.
- An increase in the proportion of parents who introduce solid food to their baby in line with nationally agreed guidance.
- An improvement in the experience of care received by parents.

3 Scope

This policy applies to acute and community Midwifery teams employed by County Durham and Darlington Foundation trust (CDDFT).

The 'CDDFT Group' includes CDDFT and its wholly owned subsidiary; County Durham and Darlington NHS Services (CDD NHS Services). Any reference to the 'Trust' shall be interpreted as a reference to the Trust Group.

4 Duties

- The Midwifery Manager and Infant feeding team are responsible for defining the policy.
- The Ratification Committee will approve the policy document.
- The policy applies to and will be used by all Midwifery staff and compliance will be measured through Unicef Audit tool.

5 Main Content of Policy

(CDDFT) 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 is in recognition of the profound importance of early relationships to future health and well-being and the significant contribution that breastfeeding makes good physical and emotional health outcomes for children and mothers.

- Ensuring that all care is mother and family centred, non-judgemental and that mother's decisions are supported and respected.

- Working together across disciplines and organisations to improve family's experiences of care.

As part of this commitment the service will ensure that:

- All new staff are familiarised with the policy within one week of commencement of employment.
- The International Code of Marketing of breast-milk substitutes is implemented throughout the service.

- All documentation fully supports the implementation of these standards.

- Parent's experiences of care will be listened to, through a varity of areas such as regular audit, parent's experience surveys, Care Quality Commission Survey of women's experiences of maternity services and this list is not exhausative.

- All staff will receive training to enable them to implement the policy as appropriate to their role. New staff receive this training within six months of commencement of employment. Attendance at the Breastfeeding training is recorded by Learning and Development and entered onto the Trust ESR system. Monitoring of non-attendance will be in line with the Training Needs Analysis, monitoring and evaluation will be carried out by Learning and Development and during staff appraisals. (Reference can be made to this policy for detailed information). Please see appendix B

Care standards

This policy is based on:

- UNICEF UK Baby Friendly Initiative Standards for maternity services and relevant NICE guidance (maternity).

Pregnancy

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

1. The value of connecting with their growing baby in utero.
2. The value of skin contact for all mothers and babies.
3. 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.
4. Feeding, including an exploration of what parents already know about breastfeeding, the value of breastfeeding as protection, comfort and food and getting breastfeeding off to a good start.

All women should be offered a discussion around colostrum harvesting in pregnancy including the value and benefits of colostrum harvesting, hand expressing technique and safe storage of breast milk. The leaflet "antenatal colostrum harvesting" can be used it support this discussion.

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 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. There are some situations where early feeds may be appropriate and these will be discussed with the mother and family.

- When mothers choose to formula feed they will be encouraged to offer the first feed 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.

- Mothers with a baby on the neonatal unit are:

    1. Enabled to start expressing milk as soon as possible after birth (ideally within two hours)
    2. Supported to express effectively

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

<u>Safety considerations (Skin to Skin)</u>

Vigilance of the baby's well-being is a fundamental part of postnatal care immediately following and 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 the Apgar score at 1, 5 and 10 minutes following birth). Care should always be taken to ensure that the baby is kept warm. 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 the mother and her companion about the importance of recognising changes in the 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. Mothers should be encouraged to be in a semi-recumbent position to hold and feed their baby. 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.

Notes – Mothers

- Observations of the mother's vital signs and level of consciousness should be continued throughout the period of skin to skin contact. Mothers may be very tired following birth and so may need constant support and supervision to observe changes in their baby's condition or to reposition their baby when needed.

- Many mothers can continue to hold their baby in skin to skin contact during perineal suturing, providing they have adequate pain relief. However, a mother who is in pain may not be able to hold her baby safely. Babies should not be in skin to skin contact with their mothers when they are receiving Entonox or other analgesics that impact consciousness.

Notes – Babies

All babies should be routinely monitored whilst in skin to skin contact with mother or father. Observation to include:

- Checking that the baby's position is such that a clear airway is maintained– observe respiratory rate and chest movement. Listen for unusual breathing sounds or absence of noise from the baby
- Colour - the baby should be assessed by looking at the whole of the baby's body as the limbs can often be discoloured first. Subtle changes to colour indicate changes in the baby's condition
- Tone – the baby should have a good tone and not be limp or unresponsive
- Temperature – ensure the baby is kept warm during skin contact.

Always listen to parents and respond immediately to any concerns raised
G:\Maternity\Shared\Infant Feeding\Policies\HSIB action plan final.docx

Support for breastfeeding – In the early days

- Mothers will be enabled to achieve effective breastfeeding according to their needs (including appropriate support with positioning and attachment, hand expression, and 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 Unicef Breastfeeding assessment as often as required in the first week with a minimum of two assessments to ensure effective feeding and the well-being 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.

- Mothers with a baby on the neonatal unit will be supported to express as effectively as possible and encouraged to express at least 8 times in 24 hours, including once during the night. They will be shown how to express by both hand and pump.

- Before discharge home, breastfeeding mothers will be given information about recognizing effective feeding and where to call for additional help if they have any concerns. This leaflet will also contain informed about the local support services for breastfeeding e.g. Proactive Management of Breastfeeding, BF support leaflet/ baby café, National Breastfeeding helpline number 0300 100 0212
    - This will be done both verbally and in writing (in paper or electronic format) and if needed in different languages.
    - https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/foreign-language-resources/

  For those mothers who require additional support for more complex breastfeeding challenges, a referral to the specialist service should be made.

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 tire mothers any more than caring for a new baby without breastfeeding.

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 which is up to 6 weeks in most cases

- When exclusive breastfeeding is not possible, the value of continuing partial breastfeeding will be emphasized and mothers will be supported to maximize 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 the use of a teat when a baby is learning to breastfeed.

- A full record will be made of all supplements given and recorded in the maternity records including the rationale for supplementation and the discussion held with the parent.

- Supplementation rates will be audited – ongoing (Minimum 10 per month).

Modified feeding regime

- There are a small number of clinical indications for a modified approach to responsive feeding in the short term. 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 as safety.

- This includes babies who have not regained their birth weight by 3 weeks and babies who are gaining weight slowly. Local guidance documents include:

    1. Medical Management of Excessive Weight Loss in BF Newborn Babies (GUID/PAE/Neonatal weight loss).
    2. The management of Breastfeeding in the Sleepy Low Risk Term baby of birth weight greater than 2.500kg (GUID/MAT/1512).
    3. Prevention and management of Hypoglycemia in the post-natal period (GUID/MAT/ 1504).
    4. Guideline for identifying prevention and management of poor weight gain in the breastfed baby (GUID/MAT/1516)

Weighing Babies

- Infants should be weighed 4 times within the first 14 days of life if possible and any weight loss calculated as a percentage. Refer to appendix C for more detail. This will include a weight at birth and 5 and 10 days, as per NICE recommendations. These are usually undertaken by the midwifery team until care is transferred to health visiting service.

- Staff should be vigilant to any infant that, despite breastfeeding well, are losing or continue to lose weight. This is abnormal in any infant and an urgent paediatric review must be expedited, which will include bloods to eliminate metabolic disorders as these infants may appear clinically well. The threshold of 12.5% for urea and electrolytes does NOT apply in cases with this clinical

presentation and must be taken to inform diagnosis. All these mothers and infants require a thorough breast feeding assessment and observation of a feed by a qualified practitioner. This must be communicated in writing to the GP when asked to refer the case to the paediatrician and recorded in the case notes.

- Thereafter, healthy babies should be weighed (naked) at 6-8 weeks, 6-12 months, age 2 years 6 months and 3 years 6 months.

Babies who are gaining weight slowly

A baby's weight may not exactly follow one centile line and may cross a line. This is especially true in the first nine months of life. Changes of less than one centile space (the gap between two centile lines) are quite normal. Weight loss during an illness is also common, but on recovery, the baby's centile usually returns to normal within 2 - 3 weeks. Babies who cross down two or more centile spaces without recovery should be assessed by a GP to exclude illness as a cause of the poor weight gain.

Thresholds for review

A fall across 1 or more weight centile spaces, if birthweight was below the 9th centile.

A fall across 2 or more weight centile spaces, if birthweight was between the 9th and 91st centiles.

A fall across 3 or more weight centile spaces, if birthweight was above the 91st centile.

When current weight is below the 2nd centile for age, whatever the birthweight. (NG75).

- Infants should be weighed using Class III digital scales which must undergo an annual maintenance and accuracy check with re-calibration as required.

- Alongside weight monitoring an assessment of the effectiveness of feeding needs to be undertaken at every postnatal contact by the midwifery teams. This assessment should include the condition of the baby, including his/her output (wet and dirty nappies), frequency of feeding, any problems highlighted by the mother and full observation of a feed if any concerns.

- Weighing earlier than five days should be considered if medically indicated or mother and baby present with a poor feeding history. (Refer to Prevention and management of excessive weight loss in the breast fed neonate guideline).

- The weight will be recorded both in the baby's child health record and maternity notes.

- The percentage weight loss should be calculated using the formula below and recorded in both child health record and maternity notes.

$$\frac{(\text{Birth weight} - \text{Present Weight})}{\text{Birth weight}} \times 100$$

- Any baby losing 8% or more of his or her birth weight requires a detailed assessment by the Midwife and will need further help and support in their chosen method of feeding. For more details please see appendix C

- Any baby with a weight loss of more than 12.5% will need to be reviewed by a Paediatrician and a feeding plan developed that promotes safety but does not discourage breastfeeding.

- An infant's birth weight is usually regained by two weeks, and babies should remain under the care of the community midwife/specialist Infant feeding team until this is achieved.

Use of Artificial Teats, Dummies and Nipple shields

- Health care staff should not recommend the use of artificial teats or dummies during the establishment of breastfeeding. Parents wishing to use them should be advised of the possible detrimental effects such use may have on breastfeeding to enable them to make a fully informed choice.

- The information given and the parents' decision should be recorded in the appropriate health record. It is acknowledged that the use of dummies may interfere with responsive feeding resulting in the mother missing feeding cues. If a mother wishes to commence using a dummy this should be delayed until at least 4 weeks of age or until breastfeeding is well established, as outlined in the UNICEF leaflet *Caring for Your Baby at Night.*

- Nippleshields will not be recommended except in extreme circumstances and then only for as short a time as possible. Any mother considering the use of a nipple shield must have the disadvantages fully explained to her prior to commencing use. She should remain under the care of a skilled practitioner whilst using the shield and should be helped to discontinue its use as soon as possible.

Early postnatal 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 encouraged to do the above and to hold their baby close during feeds and offer the majority of feeds to their baby themselves to help enhance the mother-baby relationship.

- On discharge from maternity care, any further care and support will be given by the health visitor. This will normally include information about local parenting support that is available within Children Centre's services.

Support for formula feeding

- Mothers who formula feed will be offered a demonstration and/or discussion about how to prepare infant formula and types of infant formula.

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

    1. Respond to cues that their baby is hungry
    2. Invite their baby to draw in the teat rather than forcing the teat into the baby's mouth.
    3. Pace the feed so that their baby is not forced to feed more than they want to.
    4. Recognize the baby's cues that they have had enough milk and avoid forcing their baby to take more milk than the baby wants.

Recommendations for health professionals on discussing bed-sharing

Simplistic messages in relation to where a baby sleeps should be avoided; neither blanket prohibitions nor blanket permissions reflect the current research evidence. Discussion with mothers with the use of Caring for your Baby at Night leaflet.

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
- Sleeping with your baby on a sofa puts your baby at greatest risk
- Your baby should not share a bed with anyone who:

    1. is a smoker
    2. has consumed alcohol
    3. has taken drugs (legal or illegal) that make them sleepy

The incidence of SIDS (sudden infant death syndrome) (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

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.

Healthy Start Vitamins

Women should be informed regarding Healthy Start Vitamins. Healthy Start Vitamins are the supplement recommended for pregnant and breastfeeding women, as other supplements may have a different balance of nutrients added.

Vitamin D

Vitamin D supplementation is recommended:

- For Pregnant and breastfeeding mothers
- For breastfed babies from birth up to one year of age

It is essential that health professionals inform all pregnant women and breastfeeding women about the importance of this for their health and the future health of their baby.

The Healthy Start product currently available is licensed as a medicine to be given from four weeks of age. Therefore, any product given to a baby from birth to four weeks, or at a higher dose, should only be given after consultation with a clinician and within the scope of the terms of the licence.

6 Monitoring

6.1 Compliance and Effectiveness Monitoring

Compliance with this policy will be monitored as outlined in the table below.

6.2 Compliance and Effectiveness Monitoring Table

Monitoring Criterion	Response
Who will perform the monitoring?	Maternity Services Specialist Midwife for Infant feeding.
What are you monitoring?	a) Process for supporting mothers who are breastfeeding (Unicef mothers audit). b) Process for supporting mothers who are artificially feeding (Unicef mothers audit). c) Record initiation and continuation rates d) Process to be followed if a problem with feeding is identified. e) Process for weighing newborns. f) Maternity service's expectations in relation to staff training, as identified in the training needs analysis regarding breast and artificial feeding methods. g) System for reporting newborns re-admitted to hospital with feeding

	problems during the first 28 days of life. Process for monitoring compliance with all of the above requirements, review of results and subsequent monitoring of action plans.
When will the monitoring be performed?	Audit of the policy annually. Root cause analysis following re-admissions or in response to incident reporting.
How are you going to monitor?	• Using UNICEF UK Baby Friendly Initiative Audit tool. • Safeguard Report of any readmissions
What will happen if any shortfalls are identified?	Audit results shared with Family Health Governance Assurance Group – Action plan agreed.
Where will the results of the monitoring be reported?	Obstetric and Gynecological SAGE– Quarterly Clinical Audit Meeting. Paediatric SAGE Quaterley clinical audit Meeting.
How will the resulting action plan be progressed and monitored?	Obstetric and Gynecological SAGE– Quarterly Clinical Audit Meeting. Family Health Governence Assurance Group / Infant Feeding Working Group.
How will learning take place?	Mandatory staff training/updates, team meetings, professional forums, bulletins

7 Glossary of Terms

Feeding at Initiation: the milk (breast milk or formula) given as the baby's first feed. (DH England allows initiation to be defined as breastfeeding if, within the first 48 hours after birth, the baby has either been put to the breast or been given any of the mother's breast milk.

Full (or total) breastfeeding: the infant is currently over the last 24 hours receiving only breast milk with no other liquids or solids except vitamin or mineral supplements or medicines (NB the infant may have received infant formula or other foods in the past).

Partial breastfeeding: the infant is currently over the last 24 hours, receiving some feeds of breast milk and some artificial feeds and/or complementary (weaning) foods.

Artificial feeding/ no breastfeeding: The infant is not currently over the last 24 hours receiving any breast milk. The infant is fed on formula with or without complementary (weaning) foods.

(Definitions – Unicef guidance 2014).

8 Associated Documentation & References

This policy links to the following key documents:

Dyson L, McCormick F Renfrew MJ. (2005) **Interventions for Promoting the Initiation of Breastfeeding**. The Cochrane Database of Systematic reviews.

Hoddinott P, Criag L, Maclennan G, Boyers D, Vale L (2012) BMJ, Process evaluation for the Feeding Support team (FEST) randomized controlled feasibility trail of proactive and reactive telephone support for breastfeeding women living in disadvantaged areas.

National Institute for Health and Clinical Excellence (2008) **Improving the nutrition of pregnant and breastfeeding women and children in low income households** NICE London.

Standing Committee on Nutrition of the British Paediatric Association (1994): Is breastfeeding beneficial in the UK? Arch Dis Child, 71:37680.

UNICEF (2012) Guide to the Baby Friendly Initiative standards, UNICEF www.babyfriendly.org.uk

UNICEF (2012) The evidence and rationale for the UNICEF UK Baby Friendly Initiative Standards, www.babyfriendly.org.uk

UNICEF (2012) Renfrew M, **Preventing disease and saving resources:** the potential contribution of increasing breastfeeding rates in the UK, www.babyfriendly.org.uk

UNICEF (2013) A guide for health workers to working within the International Code of marketing of Breastmilk Substitutes, www.babyfriendly.org.uk

UNICEF UK **Baby Friendly Initiative in the Maternity Services**. 2005. www.babyfriendly.org.uk

UNICEF UK **Baby Friendly Initiative in the Community Services**. 2005. www.babyfriendly.org.uk

World Health Organization (1981) International Code of marketing of breast milk substitutes WHO.

World Health Organization (2003) **The Global Strategy for Infant and Young Child Feeding**. WHO. Geneva.

World Health Organization. (2001) **The optimal duration of exclusive Breastfeeding: report of an expert consultation**

HSIB 2021 National Report – Neonatal collapse alongside skin to skin contact

DOH – Off to the best start - Leaflet for parents.

DOH - Bottle feeding - Leaflet for parents.

CDDFT – Management of Breastfeeding in the sleepy low risk term baby weight > 2500g

CDDFT – Expression of Breast milk.

CDDFT (NICE quality standard 57 issued March 2014 neonatal Jaundice).

Lullaby Trust (2013)– Safer sleep for babies a guide for parents.

Unicef - Caring for your Baby at Night.

9 Appendices

Appendix 1 – Breastfeeding Training
Appendix 2 – Weight loss management care plans
Appendix 3 - Equality Impact Assessment
Appendix 4 - Document Approval Request Form

Appendix 1

BREASTFEEDING TRAINING POLICY

The training curriculum will be continually updated and adapted using Unicef Curriculum Guidance.

The training is divided into three levels to meet the needs of different staff members from basic breastfeeding awareness training to two full days of clinical training. All staff who are likely to come into contact with breastfeeding women and their families must have the appropriate training for their role.

- All new staff must attend appropriate training within six months of taking up their post and as part of their induction.
- All appropriate staff must attend an annual 4 hour update thereafter.
- A database of staff and their training requirements should be kept by each employer.
- All staff delivering breastfeeding training should be appropriately trained.

N.B. General Practitioners have their own designated training, designed to fit into time-out slots.

Hospital doctors working within the obstetric and paediatric directorates also have special designated training.

Training Levels and Requirements

Training	Staff to Attend	Delivered By	Content
Level 1 One hour	Administration Staff Ancillary Staff	Midwife who has attended breastfeeding training.	**Breastfeeding Awareness Training** • Benefits of breastfeeding • Barriers of breastfeeding • Overcoming barriers in the specific workplace
Level 3 2 day Workshop One and Two	Midwives Health care assistants Maternity care Assistants	Midwife who has attended breastfeeding training and further training in delivering breastfeeding education	**Breastfeeding Workshops day 1** • Value of breastfeeding • Composition of breastmilk • Barriers to breastfeeding

 Curriculum.docx			• New Unicef standards • The law and BF • UNICEF and standards • Anatomy and physiology • Positioning and attachment • Skin to skin contact • Bed sharing • Hand Expression **Breastfeeding Workshop day 2** • Observing a breast feed • Taking a breastfeeding history • Management of Poor weight gain • Management of pre-term infant / jaundice • Protecting and increasing milk supply • Management of breast/nipple pain • Introducing solid food • Returning to work • Expression and storage of breastmilk

Appendix 2

Weight Loss Management Care Plans

Initial care, the first two weeks

Care Plans in the first week

All breastfed and partially breastfed babies will be routinely weighed by the midwife on day 5. Consider weighing on day three for those babies requiring additional support with feeding and those with feeding difficulties.

A weight loss of 8% or more triggers further action, however up to 10% weight loss is common, and the family should be reassured regarding this. See relevant care plan.

Management Plans

Care Plan 1 8 - 10% weight loss	Care Plan 2 10.1%-12.5% weight loss	Care Plan 3 >12.5% weight loss
Observe a full breastfeed and ensure effective positioning and attachment. **Observe** for effective suckling & swallowing pattern. Complete feeding observation form. Discuss switch nursing & breast compression. **Ensure** minimum 8 feeds in 24 hours. Encourage responsive feeding. Offer both breasts each feed.	**Follow Care Plan 1, plus:** **Liaise** with Infant Feeding Co-ordinator (IFC) and consider GP/Neonatal/Paediatric medical staff, to exclude illness if concerns. **For babies who are sleepy or uninterested in suckling,** consider Switch Feeding and	**Refer to hospital for review by Paediatrician. Careful examination of the baby, to include heart, urine culture, bloods for U&E's Intensive breastfeeding support, liase with IFC**

Frequent Skin Contact to encourage breastfeeding. **Urine:** Observe for change in frequency/amount. 6 wet (heavy) nappies in 24 hours by day 5. **Stools:** Observe for frequency of at least 3-4 in 24 hours by day 4. (Note colour: yellow by day 5) NB Yellow stools are reassuring. If no stools noted for >24 hours encourage hand expression and give EBM* as obtained and inform Infant feeding coordinator. • Consider, Are there any concerns re appearance/presentation of the baby, such as suspected infection? Assess infant for wellness. • Consider: Maternal labour and birth history • Medical condition of mother: anaemia, retained products of conception, endocrine condition, breast surgery, raised BMI **Reweigh** in 48hours. If weight increasing, continue to monitor closely and provide support **If no weight increase, move to Care Plan 2**	Breast Compression. Assess for tongue tie **Express** breast milk after each feed and offer it to baby. **Weigh** again in 48 hours. **If no weight increase or weight increase of <50g in 48 hrs move to Care Plan 3**	**Ensure** 8-12 breastfeeds in 24 hours. **Express** using hospital grade breast pump. Offer breastfeed then up to 20-30mls EBM, If EBM not available offer formula. Alternatively consider 2 full feeds/ day – work closely with IFC for pragmatic family-oriented solution. **Weigh** again in 24 hours looking for at least 25g gain. **If** formula offered, reduce as weight gain improves & breast milk supply increases. **Continue** to monitor weight twice weekly until improvement demonstrated: minimum 120 g/week. Aim for feed-pump-feed cycle max 1 hr total to avoid maternal and infant exhaustion

*EBM- expressed breast milk

Appendix 3 - Equality Analysis/Impact Assessment

Care Group/Speciality	Family Health
Document Type	Policy
Lead Person Responsible	Anne Holt
People involved with completing this document	Evidence Based Practice Group
Type of Policy, procedure, decision, project, function or service	Existing
Date Completed	14/09/2021

Step 1 – Scoping Your Analysis
What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?
To ensure families are given the same information to make their own decisions based on this information.
Who is the policy, procedure, project, decision, function or service going to benefit and how?
All patients and their families
What are you hoping to achieve?
No incidents, Good outcome, Good experience for women and their families, Improve health outcomes of women and children
What barriers are there to achieving these outcomes?
Staff not adhering to guidelines and policies, staff non attendance at training and education
How will you put your policy, procedure, project, decision, function or service into practice?
Monitoring incidents, ensuring lessons are learned, sharing good practice
Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?
None

Step 2 – Collating your information
What existing information/data do you have?
Incident data
Who have you consulted with?
Evidence Based Practice Group, Maternity staff
What are the gaps and how do you plan to collect what is missing?
N/A
Step 3 – What is the Impact?
Using the information from step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?
Ethnicity or Race
No
Sex/Gender
No
Age
No
Disability
No
Religion or Belief
No
Sexual Orientation
No
Marriage and Civil Partnership (applies to workforce issues only)
No
Pregnancy and Maternity
No
Gender Reassignment

No	
Other socially excluded groups or communities e.g. rural community, socially excluded carers, areas of deprivation, low literacy skills etc.	
No	
Step 4 – What are the differences?	
Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?	
No	
Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act 2010?	No
If Yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?	
Step 5 – Make a decision based on steps 2 – 4	
If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided	
Reviewed at Maternity Evidence Based Practice Group and approved at family Health Quality and Governance meeting	
If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:	
N/A	
How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?	
Through incident data and Audit	

Appendix 4. Document Approval Request Form

This form should be completed when creating or reviewing this document. Documents will not be considered for approval until this form has been completed. Should you need any assistance contact Governance Support Team or the Corporate Records Lead on ext 44178.

Document Title	Infant Feeding Policy		
1.	Document Type	Policy	
2.	Is this a new document	No	
3.	If no, provide brief details of amendments made to this version. Full review completed at evidence based practice Group		
4.	Are there any documents (policies or procedures) to be withdrawn following the ratification of this document because they are no longer valid?	No	
	If yes please provide reference number and name of documents to be removed		
5.	Please confirm that consultation has been completed and that there are no outstanding issues. This should be evidenced on CDDFT Quality Insights	Confirmed	
6.	Specific assurance to approving Committee	Abbreviations/Short hand are explained	☒
		Grammar and spelling has been proof checked	☒
		A monitoring table is included	☒
		The correct template has been followed	☒
		Reference number correct	☒
		Paragraph numbering is correct	☒
7.	Are there any financial implications from this document? If so, how will it be funded No		
8.	Dissemination Plan Please detail how you will disseminate this policy/procedure SAGE meeting and Staff intranet page ***All Trustwide procedural documents will be disseminated once ratified in the Trust Bulletin***		