Royal Cornwall Hospitals NHS Trust

Policy Under Review

Please note that this policy is under review. It does, however, remain current Trust policy subject to any recent legislative changes, national policy instruction (NHS or Department of Health), or Trust Board decision. For guidance, please contact the Author/Owner.

Information Category	Detailed Information
Document Title:	Infant Feeding Policy V4.0
This document replaces (exact title of previous version):	Infant Feeding Policy V3.2
Date Issued / Approved:	August 2022
Date Valid From:	September 2022
Date Valid To:	December 2025
Author / Owner:	Infant Feeding Coordinators
Contact details:	rcht.infantfeedingteam@nhs.net
Brief summary of contents:	Guidance to ensure RCHT staff provide the highest standard of care in supporting expectant/ 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 to good physical and emotional health outcomes for children and mothers.
Suggested Keywords:	Infant feeding, breastfeeding, formula feeding, parent-infant relationships, bottle, parents as partners in care, close and loving relationship
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Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Neonatal Audit and Guidelines meeting
Manager confirming approval processes:	Caroline Chappell.
Name of Governance Lead confirming consultation and	Michael Cross

Information Category	Detailed Information
ratification:	
Links to key external standards:	UNICEF Baby Friendly Initiative. CNST 5.5.
Related Documents:	NICE (2006) CG37 Postnatal Care: Routine Postnatal Care of women and their babies. NICE, London. UNICEF (2017)Guide to the Baby Friendly Initiative Standards UNICEF, London. Neonatal Infant Feeding Policy RCHT V1.0. WHO Code & Resolutions and Code Essentials 3; Responsibilities of Health Workers under the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions.
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This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.

Infant Feeding Policy

V4.0

September 2022

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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. Royal Cornwall Hospitals Trust (RCHT) is committed to providing the highest standard of care to support families 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 to good physical and emotional health outcomes for children and mothers.

1.2. RCHT is committed to ensuring that all care is non-judgemental, centred around the mother and family and that the mother decisions are fully informed, supported and respected. The provision of clear and impartial information to all mother at an appropriate time and in an appropriate format is therefore essential.

1.3. This version supersedes any previous versions of this document.

1.4. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals (NEW 2020)

2. Purpose of this Policy

2.1. RCHT is committed to ensuring that the care provided improves outcomes for children and families, specifically to deliver:

- Increase in breastfeeding initiation rates
- Increase in breastfeeding rates at 5 days and at 11-14 days
- Increase in the proportion of mothers/parents who choose to formula feed reporting that they have received proactive support to formula feed as safely as possible in line with Department of Health guidance
- A reduction in the number of readmissions for feeding related problems

2.2. Ensure that all health care staff working in maternity, obstetrics, neonatal and transitional care at RCHT understand their roles and responsibilities in supporting families before and after birth to feed and care for their baby in ways which support optimum health and well-being.

2.3. Create an environment where all families feel supported in their feeding choices.

2.4. Enable all health care staff that have contact with breastfeeding women to train toward full and competent support through identification of training needs in all aspects of breastfeeding management, with both community and maternity services aiming for full Baby Friendly Initiative (BFI) accreditation, as

recommended by the National Institute for Health and Care Excellence (NICE) Guidance on Postnatal Care.

2.5. Encourage liaison with other organisations to ensure delivery of a seamless service, together with the development of a breastfeeding culture throughout the local community, and to improve mothers'/parents' experiences of care.

3. The Scope

All healthcare staff working in maternity, obstetrics, neonatal and transitional care are expected to comply with this guideline.
All staff working at RCHT are expected to comply with the Infant Feeding Policy

4. Definitions / Glossary

World Health Organization (WHO)/United Nations Children's Fund (UNICEF) definitions are:

- Breastfeeding - The infant has received breast milk direct from the breast or expressed.

- Exclusive Breastfeeding – The infant has received only breast milk from the mother or expressed breast milk, and no other liquids or solids with the exception of mineral supplements, or medicines.

5. Ownership and Responsibilities

Health professionals have responsibilities for the development, management and implementation of this policy as detailed below.

5.1. Role of the Managers

The Maternity Matron is responsible for the management of the Infant Feeding Co-ordinators.

5.2. Role of the Infant Feeding Co-Ordinators

The Infant Feeding Co-ordinators are responsible for:

5.2.1. Working closely with those overseeing, updating and writing of any policy or guideline related to infant feeding within maternity, neonatal and transitional care.

5.2.2. Managing Infant Team Members

5.2.3. Ensuring evidenced based and up to date infant feeding training is delivered to all healthcare professionals who work in maternity, obstetrics, neonatal and transitional care.

5.2.4. Ensuring monitoring and compliance standards are met as specified in the policy.

5.2.5. Reporting back to the Infant Feeding Steering Group 4-6 times per annum.

5.3. Role of the Infant Feeding Team Members (NEW 2020)

Where further support is required, it is appropriate to refer the following patients for full assessment and support from the Infant Feeding Team. Referral for these patients should be made via email to the Infant Feeding Team (rcht.infantfeedingteam@nhs.net), or face to face where possible.

Maternal Characteristics	• Maternal critical illness/surgery postnatally affecting feeding management • Ongoing issues with feeding management and establishing feeding (breast, bottle or other feeding methods) • Maternal breast conditions (including but not exclusively breast/nipple anomalies, glandular insufficiency, history of breast surgery.) • Prescribed use of medicine as a galactagogue • Use of nipple shields • Recurring mastitis • Breast abscess • Recurring thrush • Induced lactation
Infant Characteristics	• Infant readmission for jaundice where feeding has not been well established. • Infant readmission for illness where feeding has not been well established. • Weight loss over 12% of birth weight in first ten days of life • Ongoing slow weight gain • Significant feed/breast refusal concerns • Tongue-tie (assessment and division for infants under 12 weeks of age. See Clinical Management of Tongue Tie Guideline for further information.) • Infant involvement with Speech and Language therapy team (including but not exclusively dysphagia, cleft lip and/or palate)

5.4. Role of individual staff

All staff members are responsible for:

- Attending an annual Infant Feeding update if in frontline clinical contact with new babies and their families.
- Practising in accordance with the Infant Feeding Policy at all times while employed in this Trust.
- All health care staff working in maternity, obstetrics, neonatal and transitional care:
- Ensuring attendance at Infant Feeding training relevant to their role within 6 months of taking up a post with RCHT if in frontline clinical contact with new babies and their families

5.5. Role of the Infant Feeding Steering Group

The Infant Feeding Steering Group is responsible for:

- Reviewing the Infant Feeding Policy at least every 3 years, or as often as necessary if new guidance becomes available or new training/updating needs become apparent.
- Overseeing the drive towards achieving and maintaining UNICEF BFI accreditation, as recommended in NICE guidance.
- Monitoring rates of breastfeeding at birth, 5 days, 11-14 days and 6-8 weeks.
- Ensuring that the progress of the UNICEF BFI process, infant feeding rates etc are communicated to all staff members, line managers and the Trust Board as appropriate.

6. Standards and Practice

6.1. Giving information during pregnancy

6.1.1. An up to date copy of 'Essential Guide to Feeding and Caring for your Baby' should be secured into the hand-held notes at booking, in order to give clear, visual, evidence-based and up-to-date information about infant feeding, and to be used as a basis for further discussions.

6.1.2. All pregnant women or persons should be given an opportunity to discuss infant feeding on a one-to-one basis with a suitable health care professional. Such discussion should not solely be attempted during a group parent craft class.

6.1.3. 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, fathers, care givers and babies irrespective of feeding method
- 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
- An exploration of what parents already know about breastfeeding.

6.1.4. The physiological basis of breastfeeding should be clearly and simply explained to all pregnant women or pregnant person during the antenatal booking process, together with good management practices and some of the common experiences they may encounter. The aim of this discussion is to inform feeding choices and understanding of the importance of human milk.

6.1.5. All materials and teaching should reflect the UNICEF Baby Friendly best practice standards

6.2. Care following birth

6.2.1. Careful observation must take place throughout early skin to skin contact, a vital opportunity window for instinctive behaviour of breast seeking (baby) and nurturing (mother) to emerge.

6.2.2. Skin to skin should be encouraged where safe – consider maternal and neonatal condition whilst making every effort to support uninterrupted skin to skin

6.2.3. A baby who is born apparently well, with good Apgar scores, can be safely laid skin-to-skin with the mother or parent for uninterrupted skin contact with their baby for as long as they want, but still requires close observation in the first hours after birth.

6.2.4. Mothers should be encouraged to be in a position to safely hold and feed their babies.

6.2.5. Staff should have a conversation with the mother and her birth partner as soon as is practicably possible after the birth about the importance of recognising changes in the baby’s colour or tone and the need to alert staff immediately if they are concerned.

6.2.6. If skin to skin contact is interrupted, for any reason, then it should be re-instigated safely as soon as possible and continued according to the mother’s wishes and with continued close observation.

6.2.7. 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.

6.2.8. When mothers choose to formula feed they will be encouraged to offer the first feed in skin to skin contact.

6.2.9. Those mothers who are unable (or do not wish) to have skin to skin contact immediately after birth, will be encouraged to commence skin to skin contact as soon as they are able, or so wish.

6.2.10. Mothers with a baby on the neonatal unit will be:

- Enabled to start expressing milk as soon as possible after birth
- Supported to express effectively within 2 hours of birth of baby
- 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.

6.2.11. It is the responsibility of all health care staff to ensure that the baby cannot fall on to the floor or become trapped in bedding or by the mother's body (refer to the Prevention and Management of Falls in Babies under 1 year in Inpatient Healthcare setting Clinical Guideline) (NEW 2020).

6.2.12. Mothers should be discouraged from holding their baby when receiving analgesia which causes drowsiness or alters their state of awareness. Skin to skin with other parent/partner is preferable for the infant over no skin to skin contact

6.3. Support for breastfeeding

6.3.1. 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 feeding is established.

6.3.2. 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.

6.3.3. A pacifier (otherwise known as a dummy) may be offered in set circumstances, but is not recommended in the establishment of breastfeeding, and only ever with explicit parental consent. Please see separate guidance – 'Non-nutritive Sucking Neonatal Clinical Guideline.'

6.3.4. Use of nipple shields may be suggested in set circumstances, but is not recommended in place of initial feeding support. Please ensure the care of these women is overseen by a skilled practitioner.

6.3.5. Before discharge home, breastfeeding mothers/parent 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.

6.3.6. All breastfeeding mothers/parents will be informed about the local support services for breastfeeding.

6.3.7. The term responsive feeding is used to describe a feeding relationship which is sensitive, reciprocal, and about more than nutrition. Staff should ensure that parents have the opportunity to discuss this aspect of feeding and reassure them 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
- Breastfeeding will not tire mothers any more than caring for a new baby without breastfeeding.

6.4. Supporting exclusive breastfeeding

6.4.1. 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.

6.4.2. When exclusive breastfeeding is not possible, the value of continuing partial breastfeeding will be emphasised and the amount of breastmilk the baby received maximised, and given by means least disruptive to breastfeeding.

6.4.3. All supplementation should be with fully informed consent from the parent, and documented rational and volume in the infants documentation.

6.4.4. Supplementation rates will be audited on a continuous basis, with sampling of parent experiences and records at least every 3 months to ensure that supplements are not being given inappropriately or without informed consent.

6.4.5. In the rare circumstances where donor breast milk may be offered, this should be discussed in advance with the neonatal care giving team, or infant feeding co-ordinators. Please refer to South West Neonatal Network Guideline for additional information on the giving of donor breastmilk.
http://swneonatalnetwork.co.uk/media/111960/swnn-guideline-use-of-donor-breastmilk-formatted.pdf

6.5. Modified feeding regimes

6.5.1. The use of the Infant Feeding Chart (Appendix ~~6~~1) is recommended to support parent involvement in establishing feeding.

6.5.2. All babies born healthy at or above 37 weeks gestation should feed **a minimum of 4 times in the first 24hrs**. Most of these babies will feed much more frequently than this.

6.5.3. From 24hrs onwards, all babies should be feeding a minimum of 8x in 24hrs, including at least once at night.

6.5.4. There are a number of clinical indications for a short term modified feeding regime starting immediately after birth.
Babies who may require such a modified approach include:

- Transitional Care babies
- Preterm babies (born prior to 37 weeks gestation)
- Babies with new or pre-existing neurological conditions where feeding may be a concern (NEW 2020)
- Babies small for gestational age
- Babies excessively sleepy after birth

6.5.5. Guidance about the feeding requirements for these babies should be made by a multidisciplinary team who assess for the appropriate feeding care pathway.

6.6. Storage of any expressed breastmilk

Expressed breast milk (EBM) should be consumed by the baby as soon as possible after expression but it is often necessary for EBM to be stored. In order to ensure that the breast milk is kept free from pathogens and is in optimal condition for consumption when it's required, the following storage instructions should be followed:

6.6.1. Fresh EBM can be stored up to 48 hours in a refrigerator at 2 – 4 °C if it is to be used within 48 hours.

6.6.2. Fresh EBM which has not been used before 48 hours should be stored frozen at –20 °C for a maximum of 3 months.

6.6.3. Defrosted EBM whether it is donor or mothers' own should be stored in the fridge for 24 hours and discarded after use (UKAMB, 2001).

6.6.4. EBM when removed from the freezer for use should have a date and time thawed label completed and attached to the container.

6.6.5. EBM should be kept at room temperature for as short a time as possible and refrigerated as soon as possible. Freshly expressed breast milk can be left at room temperature for up to 4 hours.

6.6.6. Each baby should have an allocated area and a labelled storage basket / container for the EBM in the fridge / freezer. This prevents drips of milk contaminating bottles from another mother (UKAMB, 2001). These baskets / containers should be washed in hot soapy water, rinsed and thoroughly dried in between each mothers use, and also wiped daily while in use.

6.6.7. Staff should verify that they are accessing the correct basket / container and bottle and then place newly labelled bottle in refrigerator / freezer in baby's designated container.

6.6.8. All EBM containers should be consistently, correctly and clearly labelled using addressograph labels, with the following information:

- Both the mother and the baby's name and hospital number.
- Date and time expressed

6.6.9. EBM containers with the same or similar names on their labels should not be grouped together.

6.6.10. Labelling must apply equally to EBM expressed in the hospital and to EBM brought from home to Postnatal Ward.

6.6.11. Do not place a patient identification label on donor EBM. Donor EBM can be used by more than one baby.

6.6.12. Store all donor EBM in a separate basket/container in the fridge/freezer. It is the responsibility of every member of staff handling breast milk to check the fridge/freezer for all of the above.

6.7. Storage of supplementary formula milk for inpatients

6.7.1. Ready made infant formula milk is provided for patients when supplementation is indicated. Parents may provide their own if they do not wish to use the stock we offer.

6.7.2. Milk should be decanted in volumes as needed from an opened bottle of formula into the bottle or syringe for feeding baby to reduce risk of overfeeding and waste.

6.7.3. Care must be taken to ensure no cross-contamination takes place.

6.7.4. Once opened, a bottle of formula should be labelled with the date and time opened, and be securely refrigerated between 2-4^{o}C and used within 24 hours.

6.7.5. Any formula which has come into contact with the patient should be used within 1 hour, or discarded (for example in a bottle for a feed).

6.8. Formula feeding

6.8.1. Parents who choose to 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 from powder.

6.8.2. Parents planning to feed their baby with formula should provide their own milk and feeding equipment. Sterilisation equipment is available.

6.8.3. 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 their baby's cues that they have had enough milk and avoid forcing their baby to take more milk than the baby wants

6.9. Early postnatal period – Support for parenting and close relationships

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

6.9.2. All parents should be supported to respond to and understand a newborn baby's needs in support of establishing and maintaining feeding.

6.9.3. Telephone numbers (or other means of contact) of community midwives, health visitors, voluntary breastfeeding counsellors and other sources of parenting support will be issued to all mothers and be routinely displayed in all areas relevant to maternity and child health. Support will mostly be available through the network of Cornwall Family Hubs NEW 2018and details of support available will be kept up to date by each Family Hub NEW 2018 and included in their local 'What's On' guide, updated every 2 months.

6.9.4. Handover of care from Midwife to Health Visitor or Neonatal staff to Midwife/HV will follow established procedure. Full plan to be discussed with the parents and documented in Euroking with a printed copy of the plan given to the parents.

6.9.5. Health professionals will ask about the progress of feeding at each contact with the family. This will enable early identification of any potential complications and allow appropriate information to be given to prevent or remedy them.

6.9.6. Members of the healthcare team should use their influence wherever and whenever possible to support a breastfeeding culture in the local community.

6.9.7. Health professionals should be able to support mothers to continue breastfeeding when returning to work, through provision of information.

6.9.8. Healthcare organisations should be open to working with local breastfeeding support groups to raise society's awareness of the importance of breastfeeding and to encourage the provision of facilities for breastfeeding mothers and infants through liaison with local businesses, authorities, community groups and the media.

6.10. Support for parents in caring for their baby at night

It is the responsibility of all healthcare practitioners working in maternity, neonatal, obstetric and transitional care environments at RCHT to be up to date on the current safe sleeping advice. The Trust follows national guidance, accessible via The Lullaby Trust and Baby Sleep Information Service (BASIS).

6.11. A welcome for breastfeeding families

6.11.1. Breastfeeding should be clearly communicated as the normal way to feed babies and young children. Mothers will be enabled and supported to feed their infants in all public areas of our Health Care Provision

6.11.2. Comfortable facilities should be available and accessible for mothers who prefer privacy.

6.11.3. Signs in all public areas of our facilities need to inform service users of this policy.

6.11.4. All breastfeeding mothers/parents should be supported to develop strategies for breastfeeding outside the home and be provided with information about local places where breastfeeding is known to be welcomed.

6.12. Readmissions of babies with feeding related concerns

6.12.1. The readmission of all babies with a feeding concern, within 28 days of birth, will be recorded monthly on the maternity dashboard. This data will be provided by the information support teams one month in arrears to allow for the capture of all babies.

6.12.2. Any infant readmitted to the acute setting for a feeding related issue: Consider tongue tie. Assess for tongue tie if competent to do so, documenting your assessment as part of the readmission Infant Feeding Assessment, including the TABBY score. If you suspect a tongue tie, refer to Infant Feeding Team for assessment for division via rcht.infantfeedingteam@nhs.net. See Management of Ankyloglossia guideline for assessment forms.

6.13. When a baby is on the Neonatal Unit

6.13.1. Parents will have a discussion with an appropriate member of Neonatal staff as soon as possible after admission about the importance of touch, comfort and communication for their baby's health and development.

6.13.2. Parents will be actively encouraged to provide comfort and emotional support for their baby including frequent and prolonged skin contact, comforting touch and responsiveness to their baby's behavioural cues.

6.13.3. The unit will enable babies to receive breastmilk and to breastfeed when possible. A mother's own breastmilk is always the first choice of feed for her baby. Mothers will have the opportunity to discuss the importance of their breastmilk for their preterm or ill babies as soon as is appropriate.

6.13.4. Mothers will be supported to express breastmilk for their baby including encouragement to:

- express as early as possible after birth (ideally within two hours) NEW 2018

- express at least eight times in 24 hours including once during the night.
- Learn how to express effectively, including hand expression, use of the breast pump equipment and storing milk safely.
- Express frequently, especially in the first two to three weeks following delivery, in order to optimise long term milk supply.
- Stay close to their baby when expressing milk. Mothers are encouraged whenever possible to express at the cotside.
- Access effective breast pump equipment.
- Use their milk as mouth care when their baby is not tolerating oral feeds, and later to tempt their baby to feed.

6.13.5. Staff will ensure that a formal review is undertaken a minimum of four times in the first two weeks to support optimum expressing and milk supply. Appropriate support will be then be offered to overcome expressing difficulties where necessary, particularly where supplies are not meeting the baby's requirements or if the mother is expressing less than 750mls in 24 hours by day 10.

6.13.6. The service will also ensure that in the unit, a suitable environment is provided, which is conducive to effective expressing.

6.13.7. Mothers will receive care that supports the transition to breastfeeding, including:

- Being able to be close to their baby as often as possible so that they can respond to feeding cues.
- Use of skin to skin contact to encourage instinctive feeding behaviour.
- Information about positioning for feeding and how to recognise effective feeding.

6.13.8. Mothers will receive additional help with breastfeeding challenges when needed. This will be provided via the Neonatal staff with support from Infant feeding co-ordinators as necessary.

6.13.9. Parents will be supported through the transition to discharge home from hospital particularly in relation to feeding and caring for their baby and will be offered the opportunity to stay overnight/for extended periods to support development of mothers' confidence and modified responsive feeding. Information will also be provided on how to access support in the community at discharge.

6.13.10. All parents will have unrestricted access to their baby unless individual restrictions can be justified in the baby's best interest.

6.13.11. The unit will ensure parents are as comfortable, informed and involved as possible in their baby's care during their stay.

6.13.12. Every effort will be made to ensure effective communication between parents and the healthcare team including full information on treatment and baby's condition to enable informed decision making.

7. Dissemination and Implementation

7.1. This policy is to be communicated to all health care staff that have any contact with pregnant women or people who are pregnant and mothers. All staff will receive a copy of the policy.

7.2. Midwifery, Neonatal and Child Health Team members have the primary responsibility for supporting all parents to become confident with feeding and caring for their babies and for helping them to overcome related problems.

7.3. Information and training will be given to Paediatricians and offered to Obstetricians (and other medical staff) to enable them to promote breastfeeding and to appropriately support all parents in feeding and caring for their babies.

7.4. Curricula for all staff training provided will be available and will comply with the UNICEF Baby Friendly best practice standards.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	• Compliance of staff with prescribed training • Information giving to pregnant women • Care, information and support given to newly delivered women • Care, information and support given to breastfeeding women • Care, information and support given to formula feeding women • Readmission of babies with a feeding concern within 28 days
Lead	• Infant Feeding Co-Ordinators
Tool	• UNICEF audit tool for maternity services • Staff database of training • Readmission of babies with a feeding related concern tool

Information Category	Detail of process and methodology for monitoring compliance
Frequency	• Staff database reviewed every 6 months to ensure compliance • Audit of 30 midwifery/neonatal/paediatric staff every 12 months • Audit of 40 postnatal women/feeding parent every 12 months • Audit of supplementary feeds to breastfed babies every 3 months New 2018 • Audit of 10 women with a baby on NNU every 12 months • An annual audit of 1% or 10 sets, whichever the greatest, of all health records of mothers and babies where readmission was required within 28 days of birth, with a feeding related concern. • If red flag is activated for 3 consecutive months for readmissions, a full audit of all these readmissions to be undertaken
Reporting arrangements	• Results of audits will be reported to the Infant Feeding Steering Group Meeting every 2 months, with a report on standards achieved made to the Head of Midwifery, Neonatal Unit Matron and Paediatric Consultants. Performance and trends will be fed back to clinical staff in maternity services and Child Health. The standard required is that the maternity services achieve full UNICEF Baby Friendly Initiative accreditation, and maintain this standard. • Any failure to meet required BFI standards (usually 80% pass in all areas) must be discussed by the Infant Feeding Steering Group Meeting. • In addition the readmissions will be reviewed monthly as part of the maternity dashboard review at the maternity risk management and audit forum (MRMF). Any audits undertaken as a result of the review will be received by the MRMF. If deficiencies are identified, an action plan will be developed and monitored by the forum and a report sent to the next infant feeding steering group.
Acting on recommendations and Lead(s)	Infant Feeding Co-ordinators will act on recommendations.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within two months. A lead will be identified to take each change forward where appropriate. Lessons will be shared with all relevant stakeholders.

9. Updating and Review

9.1. The policy and guidelines will be reviewed every three years or earlier in the light of new evidence.

9.2. Revisions can be made ahead of the review date when the procedural document requires updating. Where the revisions are significant and the overall policy is changed, the author will ensure the revised document is taken through the standard consultation, approval and dissemination processes.

9.3. Where the revisions are minor, e.g. amended job titles or changes in the organisational structure, approval can be sought from the Executive Director responsible for signatory approval, and can be re-published accordingly without having gone through the full consultation and ratification process.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Infant Feeding Policy V4.0
This document replaces (exact title of previous version):	Infant Feeding Policy V3.2
Date Issued/Approved:	August 2022
Date Valid From:	September 2022
Date Valid To:	September 2025
Directorate / Department responsible (author/owner):	Infant Feeding Coordinators
Contact details:	rcht.infantfeedingteam@nhs.net
Brief summary of contents:	Guidance to ensure RCHT staff provide the highest standard of care in supporting expectant/ 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 to good physical and emotional health outcomes for children and mothers.
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Target Audience:	RCHT: Yes CFT: No KCCG: No
Executive Director responsible for Policy:	Medical Director
Approval route for consultation and ratification:	Neonatal Audit and Guidelines Meeting
General Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming approval by specialty and care group management meetings:	Caroline Amukusana
Links to key external standards:	UNICEF Baby Friendly Initiative CNST 5.5

Information Category	Detailed Information
Related Documents:	• NICE (2006) CG37 Postnatal Care: Routine Postnatal Care of women and their babies. NICE, London • UNICEF (2017)Guide to the Baby Friendly Initiative Standards UNICEF, London • Neonatal Infant Feeding Policy RCHT V1.0 • WHO Code & Resolutions and Code Essentials 3; Responsibilities of Health Workers under the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions.
Training Need Identified?	Yes
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet
Document Library Folder/Sub Folder:	Clinical/ Newborn Care

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
2005	V1.0	Original policy developed (for WOCPCT) based on Baby Friendly Initiative template.	Stephanie Heard Health Visitor Anna Mankee-Williams, Public Health Project Manager
Feb 2007	V2.0	Full review and consultation, policy made appropriate to cover all Cornwall Health Community.	Stephanie Heard and Helen Shanahan, Infant Feeding Co-ordinators
Oct 2008	V2.1	Review and minor changes, to comply with BFI Stage 1 assessment	Stephanie Heard and Helen Shanahan, Infant Feeding Co-ordinators
July 2010	V2.2	Monitoring & Compliance updated	Stephanie Heard and Helen Shanahan, Infant Feeding Co-ordinators

Date	Version Number	Summary of Changes	Changes Made by
July 2011	V2.3	Review & minor changes following BFI stage 3 assessment. Now called Infant Feeding Policy	Stephanie Heard and Helen Shanahan, Infant Feeding Co-ordinators
April 2012	V2.4	Monitoring & Compliance updated	Stephanie Heard and Helen Shanahan, Infant Feeding Co-ordinators
April 2013	V2.5	Review and minor changes, including monitoring and compliance updating	Stephanie Heard and Helen Shanahan, Infant Feeding Co-ordinators
1st May 2014	V2.6	Review changes to reflect updated UNICEF Baby Friendly standards, including monitoring and compliance updating	Stephanie Heard and Helen Shanahan, Infant Feeding Co-ordinators
28th February 2017	V2.7	Review changes to incorporate UNICEF revised Neonatal standards	Stephanie Heard and Helen Shanahan, Infant Feeding Co-ordinators
6th September 2018	V2.8	Review changes to incorporate UNICEF revised standards and Cornwall Council changes NEW 2018	Stephanie Heard and Helen Shanahan, Infant Feeding Co-ordinators
9th January 2020	V3	Review changes to incorporate inclusive language, transitional care guidance, infant feeding team referral criteria, and alignment with all other feeding policies as part of a broad cohesive review.	Janey Ashton Louise Pickett Helen Shanahan
7th May 2020	V3.1	Inclusion of storage of expressed breast milk and supplementary formula. Inclusion of role of Infant Feeding Team Members Inclusion of Infant Feeding Chart as Appendix 6 Inclusion of Interim Guidance During Covid-19 Pandemic at page 3	Janey Ashton, Infant feeding co-ordinator
September 2020	V3.2	Updated guidance on skin to skin in accordance with HSIB recommendations	Janey Ashton, Infant Feeding Coordinator

Date	Version Number	Summary of Changes	Changes Made by
June 2022	V4.0	Addition of requirement for assessment for tongue tie added (6.12.2) Removal of unnecessary Appendices (to be placed in updated forum on line)	Janey Ashton, Infant Feeding Coordinator Chris Bell, Neonatal Consultant

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document

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Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity & Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Infant Feeding Policy V4.0
Directorate and service area:	Neonatal
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Neonatal Audit and Guidelines Group
Contact details:	01872 252667

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Enable all health care practitioners who have contact with pregnant and newly delivered women to provide full and competent support in infant feeding management.
2. Policy Objectives	To ensure that all women and their families receive information about the health benefits of breastfeeding and the potential health risks of formula feeding, and that all families are supported to be successful in their chosen method of feeding their babies.
3. Policy Intended Outcomes	To enable expectant and new parents to develop confidence in feeding their babies and to develop close and loving parent-infant relationships.
4. How will you measure each outcome?	Compliance Monitoring Tool, data collection and monitoring at the Infant feeding Steering Group Review Meeting.
5. Who is intended to benefit from the policy?	Women, babies and their families, through improved short and long term better health, and the Trust, by lower rates of admission with illnesses related to ineffective breastfeeding or to not breastfeeding.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	Please record specific names of individuals/ groups: Neonatal Audit and Guidelines Group
6c. What was the outcome of the consultation?	Approved- 16 August 2022
6d. Have you used any of the following to assist your assessment?	National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys: No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	All expectant families
Sex (male or female)	No	All expectant families
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	All expectant families
Race	No	Any information provided should be in an accessible format for the parent's needs – i.e. available in different languages if required/access to an interpreter if required
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those parents with any identified additional needs will be referred for additional support as appropriate - i.e to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g. easy read, audio etc

Protected Characteristic	(Yes or No)	Rationale
Religion or belief	No	All staff should be aware of any beliefs that may impact on the decision to treat
Marriage and civil partnership	No	All expectant families
Pregnancy and maternity	No	All expectant families
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	All expectant families

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Neonatal Audit and Guidelines Group

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis