This document represents the collaboration and partnership of, the Hillingdon Hospital NHS Foundation Trust, Central and North West London NHS Foundation Trust and the The London Borough of Hillingdon.
<table>
<thead>
<tr>
<th>Policy Number</th>
<th>223</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version:</td>
<td>6.0</td>
</tr>
<tr>
<td>Category</td>
<td>Clinical Policy</td>
</tr>
<tr>
<td>Ratified by:</td>
<td>The Hillingdon Hospital MGG Clinical Effectiveness and Professional Advisory Group (CEPAG) Central and North West London NHS FT - Hillingdon Community Health (HCH)</td>
</tr>
<tr>
<td>Date Approved</td>
<td>Maternity Governance Group July 2014</td>
</tr>
<tr>
<td>Date ratified:</td>
<td>19\textsuperscript{th} August 2014</td>
</tr>
<tr>
<td>Name of originator/author:</td>
<td>Members of Breast feeding strategy group Kelly Kinsella (Infant Feeding Coordinator, THH) Catherine Cooper (Public Health Project Lead Infant feeding Coordinator) Anne Thysse (Maternity Matron) Annette Patterson (Head of Children’s Services CNWL Hillingdon) Anita Hutchins Head of Midwifery Priscilla Simpson LBH</td>
</tr>
<tr>
<td>Name of responsible committee/individual:</td>
<td>The Breastfeeding Strategy Group (Stakeholder forum)</td>
</tr>
<tr>
<td>Date issued:</td>
<td>22\textsuperscript{nd} August 2014</td>
</tr>
<tr>
<td>Next version date:</td>
<td>19\textsuperscript{th} August 2017</td>
</tr>
<tr>
<td>Review period</td>
<td>3 yearly</td>
</tr>
<tr>
<td>Target audience:</td>
<td>Hillingdon Healthcare Professionals, Local Authority professionals, Third Sector Agencies and Children’s Centre Staff</td>
</tr>
<tr>
<td>This policy has been Equality Impact Assessed</td>
<td></td>
</tr>
<tr>
<td>Document Status</td>
<td>Approved</td>
</tr>
<tr>
<td>Version</td>
<td>Version 6</td>
</tr>
</tbody>
</table>
**Version Control Sheet**

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>March 2013</td>
<td>Kelly Kinsella</td>
<td></td>
<td>Revised Breastfeeding Policy</td>
</tr>
<tr>
<td>1.2</td>
<td>April 2013</td>
<td>KK/ Gillian Pearce</td>
<td>CNST</td>
<td>Requirements</td>
</tr>
<tr>
<td>2.0</td>
<td>May 2013</td>
<td>KK/ GP/ Catherine Cooper</td>
<td></td>
<td>Revision following breastfeeding meeting</td>
</tr>
<tr>
<td>2.1</td>
<td>May 2013</td>
<td>GP/ KK/CC</td>
<td></td>
<td>Revision following comments</td>
</tr>
<tr>
<td>2.2</td>
<td>August 2013</td>
<td>CC</td>
<td></td>
<td>Revision following comments</td>
</tr>
<tr>
<td>2.3</td>
<td>Aug 2013</td>
<td>KK/CC</td>
<td>Draft</td>
<td>Revised due to BFI New Standards</td>
</tr>
<tr>
<td>2.4</td>
<td>Sept 2013</td>
<td>KK/CC</td>
<td>Draft</td>
<td>Re-configuration of clinical pathways and guidance enabling a more user friendly document for all relevant stakeholders within the LBH.</td>
</tr>
<tr>
<td>2.5</td>
<td>Oct 2013</td>
<td>MS/AP/KK/CC</td>
<td>Draft</td>
<td>Corrections and addition of process for weighing Babies (appendix 7.9-7.16) and UK UNICEF stages for BFI (appendix 1). Maternity and professionals roles combine (Appendix 9. KK) Added to Operational summary: Barriers to enable effective communication(CC)</td>
</tr>
<tr>
<td>2.6</td>
<td>Jul 2014</td>
<td>GP/KK</td>
<td>draft</td>
<td>Ratified by public health, adapted to meet needs of the hospital</td>
</tr>
</tbody>
</table>

**Groups or individuals which have been consulted with the production of document**

Maternity Matron, Infant Feeding Advisor Hillingdon Hospital
Electronic draft copies of the policy were sent to all key stakeholders including Head of Children’s Services, Head of Public Health and Deputy Director of Public Health, Head of Midwifery, Maternity Matron, Health Visiting Lead, Clinical Effectiveness and Professional Advisory Group (CEPAG) Hillingdon Community Health (HCH), Children’s Centre Lead, Representative from PCT Sue Nunney.

**Document reference:** Standards for better health: NHSLA Standard 5, Criterion 5

**Review date for approved document** 19th August 2017
Table of Contents

<table>
<thead>
<tr>
<th></th>
<th>Operational summary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Purpose</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>Explanation of terms</td>
<td>6</td>
</tr>
<tr>
<td>4.1</td>
<td>Roles and Responsibilities</td>
<td>7</td>
</tr>
<tr>
<td>4.2</td>
<td>Outcomes</td>
<td>8</td>
</tr>
<tr>
<td>4.3</td>
<td>Our commitment</td>
<td>9</td>
</tr>
<tr>
<td>5</td>
<td>Care Standards</td>
<td>10</td>
</tr>
<tr>
<td>5.1</td>
<td>Pregnancy</td>
<td>10</td>
</tr>
<tr>
<td>5.2</td>
<td>Birth</td>
<td>11</td>
</tr>
<tr>
<td>5.3</td>
<td>Support for breastfeeding</td>
<td>12</td>
</tr>
<tr>
<td>5.4</td>
<td>Exclusive breastfeeding</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Modified feeding regimes</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Formula feeding</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Early postnatal period: support for parenting and close relationships</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Community support for continued feeding</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Introducing solid food</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Support for parenting and close relationships</td>
<td>17</td>
</tr>
<tr>
<td>6</td>
<td>Equality Impact Assessment</td>
<td>18</td>
</tr>
<tr>
<td>7</td>
<td>NHS Constitution</td>
<td>18</td>
</tr>
<tr>
<td>8</td>
<td>Training</td>
<td>18</td>
</tr>
<tr>
<td>9</td>
<td>Monitoring Compliance</td>
<td>18</td>
</tr>
<tr>
<td>10</td>
<td>Dissemination of this policy</td>
<td>20</td>
</tr>
<tr>
<td>12</td>
<td>References</td>
<td>23</td>
</tr>
<tr>
<td>13</td>
<td>Associated documentation</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Appendix 1 UK Baby friendly initiative steps to successful breastfeeding</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Appendix 2 The Hillingdon Hospital Service Guide to Infant Feeding Policy</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Appendix 3 Professional training for all relevant hstakeholders</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Appendix 4 Infant feeding maternity services</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Appendix 4.1 Infant feeding – Antenatal checklist</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Appendix 4.2 Infant feeding – Postnatal checklist (hospital)</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Appendix 4.3 The first feed sticker</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Appendix 4.4 The breastfeeding assessment form</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>Appendix 4.5 Information for breastfeeding mothers on the giving of top up’ formula feeds to their baby</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Appendix 4.6 Use of artificial teats, dummies, nipple shields and cup feeding</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Appendix 5 Inpatient support for mothers who are separated from their babies</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>Appendix 5.1 Storage of breast milk</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Appendix 6 Process to be followed if a maternal problem is identified</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Appendix 6.1 Breast reduction surgery</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Appendix 6.2 Medication and breastfeeding</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Appendix 6.3 Woman who is hIV positive</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Appendix 6.4 Women who are Hepatitis B (HBV) positive</td>
<td>39</td>
</tr>
<tr>
<td>Appendix 6.5</td>
<td>Women who are known to have used illegal or excessive substances while pregnant and in the postnatal period</td>
<td>39</td>
</tr>
<tr>
<td>Appendix 7</td>
<td>Standards of care with bottle feeding</td>
<td>40</td>
</tr>
<tr>
<td>Appendix 7.1</td>
<td>Information for parents who formula feed</td>
<td>41</td>
</tr>
<tr>
<td>Appendix 8</td>
<td>Process to be followed if a neonatal feeding problem is identified</td>
<td>42</td>
</tr>
<tr>
<td>Appendix 8.1</td>
<td>Congenital abnormality</td>
<td>42</td>
</tr>
<tr>
<td>Appendix 8.2</td>
<td>Care of the baby with a naso-gastric tube or pre-term</td>
<td>42</td>
</tr>
<tr>
<td>Appendix 8.3</td>
<td>Babies identified with suspected tongue tie</td>
<td>42</td>
</tr>
<tr>
<td>Appendix 8.4</td>
<td>Dysphagia</td>
<td>44</td>
</tr>
<tr>
<td>Appendix 8.5</td>
<td>Sleepy reluctant feeder (SRF) &amp; flowchart for management</td>
<td>44</td>
</tr>
<tr>
<td>Appendix 8.6</td>
<td>Mothers Guide to sleepy reluctant feeders- feeding chart</td>
<td>46</td>
</tr>
<tr>
<td>Appendix 8.7</td>
<td>Jaundice flow chart</td>
<td>48</td>
</tr>
<tr>
<td>Appendix 8.8</td>
<td>Guidelines for the management of excessive weight loss</td>
<td>49</td>
</tr>
<tr>
<td>Appendix 9</td>
<td>Checklist for the review and approval of procedural document</td>
<td>54</td>
</tr>
<tr>
<td>Appendix 10</td>
<td>Standard equality impact assessment tool</td>
<td>57</td>
</tr>
<tr>
<td>Appendix 11</td>
<td>Plan for the dissemination of procedural documents community setting</td>
<td>59</td>
</tr>
</tbody>
</table>
Operational Summary

Policy Aim
This policy is designed to provide clarity in regards to promoting the health benefits of breastfeeding and the potential risks in formula feeding. The policy has been written in collaboration with the London Borough of Hillingdon, Central North West London NHS Foundation Trust, Hillingdon Community Health and The Hillingdon Hospital Foundation NHS Trust

Policy Summary
It provides guidance on the standards of training required to ensure that health professionals in the hospital and community provide informed choice on infant feeding to pregnant women. Health professionals and other relevant stakeholders will support women to achieve their chosen method of feeding whether it is breastfeeding or formula feeding

What it means for staff
Health professionals in the hospital and community are trained in infant feeding so that they can inform women and their families on the health benefits of breastfeeding and the potential risks of formula feeding

Health professionals are responsible for supporting women in their chosen method of feeding. If barriers to enable effective communication are present, (e.g. language, learning disability, mental or physical impairment) staff are responsible to provide appropriate reasonable adjustments. Example: In the case of language barriers a professional interpreter, in the case of learning disability, mental or physical impairment an advocate or carer) should be present. In all cases written and verbal communication should reflect full understanding of the service and information provided to the mother.

Line managers are responsible for ensuring adequate dissemination and implementation of the Infant Feeding Policy.

All Trust employees are responsible for reading the infant feeding policy and being aware of changes which impact on their roles.
The breastfeeding leads for both community and acute Trust will be responsible for on-going audit and evaluation of the policy implementation and effectiveness.

1) Introduction

Hillingdon believes that breastfeeding is the healthiest way for a woman to feed her baby and recognises the important health and well-being benefits now known to exist for both the mother and the child. (Renfrew 2012, Public Health Outcomes 2013,)

Breastfeeding contributes to the health and well-being of the mother and child in the short and long term. The benefits for mother are as follows: a reduced risk of breast
cancer, ovarian cancer and osteoporosis and improved mother-child bonding. The benefits for the full term baby are: a reduced risk of type 1 & 2 Diabetes, Gastro-enteritis, Otitis Media, hospitalization for respiratory infections, Atopic Dermatitis, Childhood Leukaemia, Allergies, Asthma, Sudden Infant death Syndrome (SIDS). Breast fed babies are also more likely to have improved cognitive ability and a lower risk of childhood obesity (which supports Hillingdon’s Obesity Strategy. In addition to all the benefits listed above, preterm babies have been found to have a reduced risk of necrotising enter-colitis (NEC) as well as improved long term neurodevelopment by age 8 and a much lower risk of childhood and adult obesity, compared to preterm and low weight babies who did not receive breast milk.

Therefore, all professionals who work with expectant and new mothers have the responsibility of raising awareness of the health benefits of breastfeeding and the potential risks of not breastfeeding.

As a joint policy collaboration of local health economy we look forward to, CNWL NHS Foundation Trust: Hillingdon Community Health, Hillingdon Hospital NHS Foundation Trust, the London Borough of Hillingdon and all other relevant community stakeholders working together to make breastfeeding the first choice and a real option for as many as possible.

2. Purpose

The purpose of this policy is to ensure that all health professionals and relevant stakeholders in the London Borough of Hillingdon 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 relevant stakeholders in partnership are expected to comply with this policy.

3. Explanation of Terms

- The Hillingdon Hospital Foundation NHS Trust (THH)
- London Borough of Hillingdon (LBH)
- Central North West London NHS Foundation Trusts,
- Hillingdon Community Health ((CNWL, HCH)
- World Health Organisation (WHO)
- Baby Friendly Initiative (BFI)
- United Nations Institution Children’s Emergency Fund (UNICEF)
- Department of Health (DoH)

4. Roles and Responsibilities

4.1 Roles
Head of Midwifery is responsible for: Ensuring that the maternity unit complies with the policy and implements Baby Friendly Initiatives (appendix 1) and in support of the lead to ensure outcomes and targets are met.

Midwifery Managers/Matrons, Neonatal Managers, Paediatric Managers are responsible for:
- Ensures that the policy is distributed within their Directorate and that staff comply with the policy and in support of the implementation of the Baby Friendly Initiatives.
- Ensures that resources are available to implement the policy.

Specialist Midwife for Infant Feeding is responsible for:
- Ensuring that all relevant staff and new staff are made aware of and are trained in the implementation of this policy.
- Monitor/audit the implementation of the policy and reports outcomes and actions, including the re-admissions rate of neonates with feeding problems to the post natal steering group. Displaying of the Parents Guide to the infant feeding policy that serves mothers and babies.
- Supporting mothers referred to her with specific problems encountered during infant feeding and formulating an appropriate plan of care (appendix 2).

Roles specific for Hillingdon Community
A CNWL Head of Children Young People and Family service is responsible for:
- Supports the Public Health Project lead with the overall implementation, monitoring and effectiveness of this policy
- To allocate resources to provide compliance with this policy

Public Health Project Lead and Infant Feeding Coordinator CNWL is responsible for:
- Breastfeeding Project Management; reporting of data and trends on breastfeeding outcomes Nationally as well as locally
- Promoting breastfeeding as part of the DoH agenda (2011) ‘Healthy Lives, Healthy people: A call to action on obesity in England’ with the aim to implement change and improve breastfeeding outcomes and rates.
- Working in partnership with all services in the Borough of Hillingdon to ensure health care staff create an environment where more women are confident to continue lactating and breastfeeding through evidence based advice and support
- This advice includes supporting and sustaining exclusive breastfeeding for up to around 26 weeks (6 months) and providing advice and support about appropriate complimentary introduction of healthy food up to one year and beyond.

Midwifery and Health Visitor Team responsibilities for infant feeding
- To follow the Hillingdon Infant Feeding Policy in all aspects of their work with children and families.
- To be compliant with mandatory training for infant feeding, attending initially two day breastfeeding management course and an annual update there after
(per training matrix)

- To ensure that the health benefits of breastfeeding and the potential risks of formula feeding are discussed with all pregnant and new mothers. To allow mothers to make an informed choice to promote, support and protect breastfeeding or to make informed choices not to breast feed, discontinue breastfeeding or to begin mix feeding with other infant food. Sign posting to breast feeding support where applicable and support women who wish to formula feed.

- To work with parents and carers to improve and support the continuation of breastfeeding.

- To comply with the UNICEF ‘International Code of Marketing Breast Milk Substitutes’ and refrain from use of and refer any promotional material, company logo etc., offer of education days by formula milk companies or professionals who have a vested interest in formula milk companies to CNWL, Public Health Project Lead infant Feeding Coordinator.

- To seek the support and advice of the Public Health Project Lead and Infant Feeding Coordinator when appropriate.

Responsibilities of committees

- Monitoring of the implementation of infant feeding in the antenatal and postnatal steering groups

- The postnatal steering group reviews the reasons that neonates are readmitted.

- Breastfeeding strategy group monitors the implementation of breastfeeding

4.2. Outcomes

Maternity:

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

- an increase in breastfeeding initiation rates
- an increase in breastfeeding rates at 10 days
- amongst mothers who choose to formula feed,
- an increase in those doing so as safely as possible, in line with nationally agreed guidance
- improvements in parents’ experiences of care
- a reduction in the number of re-admissions for feeding problems
- To meet the key performance indicator for breast feeding rates

Community: (includes Children’s Centres):

- increases in breastfeeding rates at 6-8 weeks
- amongst parents who chose to formula feed, do so as safely as possible in line with nationally agreed guidance
• increases in the proportion of parents who introduce solid food to their baby in line with nationally agreed guidance
• improvements in parents’ experiences of care

4.3. Our commitment
Relevant stake holders, in the hospital, council and community settings are 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 to good physical and emotional health outcomes for children and mothers.
• Ensuring that all care is mother and family centred, non-judgemental and that mothers’ decisions are supported and respected.
• That we will work together across disciplines and organisations to improve mothers’/parents’ experiences of care.

As part of this commitment we will ensure that:

• All relevant new staff that come into contact with mothers and babies are familiarised as appropriate with this policy and their roles on commencement of employment.
• All relevant staff that come into contact with mothers and babies 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. (Appendix 3 Training Matrix)
• The International Code of Marketing of Breast-milk Substitutes 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 and first Health visiting service contact at day 11-14).

5 Care standards
This section of the policy sets out the care that the Trust is committed to giving each and every expectant and new mother. It is based on the UNICEF UK Baby Friendly Initiative standards for maternity services, Health visiting services and Children’s centres and relevant NICE guidance and the Health Child programme.
5.1 Pregnancy

Maternity in partnership with local children centres:

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). This discussion will include the following topics:

- The value of relationship building with their growing baby in utero (appendix 4)
- The value of skin contact for all mothers and babies (appendix 5)
- 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 of getting breastfeeding off to a good start.

Health Visiting service in partnership with Local Children’s Centres:

The service recognises the significance of pregnancy as a time for building the foundations of future health and well-being and the potential role of health visitors to positively influence pregnant women and their families. Staff will therefore make the most of opportunities available to them to support the provision of information about feeding and caring for babies to pregnant women and their families. This will include ensuring that:

- Spontaneous antenatal contacts (such as visits to clinic) are used as an opportunity to discuss breastfeeding and the importance of early relationship building, using a sensitive and flexible approach.
- Members of the health visiting team proactively support and recommend the services provided by other organisations to mothers (e.g. antenatal programmes run by the maternity services, children’s centres or voluntary organisations).
- The service works collaboratively to develop / support any locally operated antenatal interventions delivered with partner organisations.

5.2 Birth

Maternity services:

- 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.(appendix 1)
• 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. (appendix 4)
• 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:

• Enabled to start expressing milk as soon as possible after birth (within six hours)
• 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 this information and support. (Appendix 5 & 6)

Safety considerations

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, with prompt removal of the baby if the health of either gives rise to concern.

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
5.3 Support for breastfeeding:

Mothers will be enabled to achieve effective breastfeeding according to their needs (including appropriate support with positioning and attachment, hand expression, understanding signs of effective feeding). This will continue until the mother and baby are feeding confidently.

Feeding Your Baby folder

This folder can be found by each bedside and is also on the THH website. It is an information and teaching tool designed to support staff and families with implementing the Newborn feeding standards outlined in this policy.

The first feed assessment sticker for breast and formula feeds to be completed (Appendix 4.3). 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.
For mothers who are formula feeding follows the national guidelines (see Appendix 7) and ensure that they are confident to prepare feeds safely. 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.

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 see appendix 5

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.

All breastfeeding mothers will be informed about our local support services for breastfeeding. This includes the health visiting service well baby clinics in collaboration with the children’s centre ‘drop in’ support and advice offered Monday through Saturday across the borough. The breastfeeding peer support volunteers available in the hospital and children’s centres.

Mother’s will also be given information about charities organisations such as: the National childbirth Trust (NCT) (Baby Café’s), La Leche (LLL), Association of breastfeeding mother’s (ABM) and the national 24 hour Breastfeeding Network (BfN telephone support service.

For those mothers who require additional support for more complex breastfeeding challenges, a referral to the specialist service should be made to the GP, Paediatrician specialist service and referral pathway (For example see appendix 8.1) for Congenital Abnormality, Appendix 8.3 for tongue tie). Mothers will be informed of this pathway.

**Responsive feeding**

The term responsive feeding (previously referred to as ‘demand’ or ‘baby-led’ 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.

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 breast milk 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.

Maternity services will complete a full record of all supplements given using the supplementation sticker, including the rationale for supplementation and the discussion held with parents (appendix 4.5).

Supplementation rates will be audited in the hospital during their admission and during the first contact from 11 days for the Health visiting service.

5.5 Modified feeding regimes:

There are a number of clinical indications for a short term modified feeding regime in the early days after birth. Examples include: preterm or small for gestational age babies and those who are excessively sleepy after birth.

Babies who require additional medical support, see ‘Immediate care of the Newborn Guideline’ appendix 8
Examples of babies at risk are:

- Small for gestational weight <2.5kg
- Macrosomia babies > 4.5 Kg
- Pre-term
- Babies of diabetic mothers
- Women with Body Mass index > 40
- Compromised birth Infection/hypoxic
- Babies identified with complex needs / tongue tie (see Appendix)
- Babies with significant weight loss greater than 8% (see appendix)

5.6 Formula feeding:

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

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
- Avoid forcing their baby to take more milk than the baby wants. (appendix 8)

5.7 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 new born baby’s needs (including encouraging frequent touch and sensitive verbal/visual communication, keeping babies close, responsive feeding and safe sleeping practice).

- Breastfeeding will be regarded 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 Trust and LBH premises, whether as a service user or as a visitor. Wherever possible facilities will be made available for mothers who prefer privacy. (Designated area in the Hospital Trust is the PALS room).
- If a breastfeeding mother is admitted to the Hillingdon hospital she will be given a side room wherever possible and her baby will be accommodated with her. If the mother is unable to breastfeed for any period of time, equipment to facilitate breast milk expression will be made available and every effort made to maintain lactation.

Mothers who bottle feed will be encouraged 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 our local parenting support available in all children’s centres in Hillingdon and through the well-baby drop in services. (Health visitor service provides a new parent pack on initial contact.)

Recommendations for health professionals on discussing bed-sharing with parents

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.
Sleeping with your baby on a sofa puts your baby at greatest risk.

Your baby should not share a bed with anyone who:
- is a smoker
- has consumed alcohol
- has taken drugs (legal or illegal) that make them sleepy.

The incidence of 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

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.

5.8 Community Support for continued breastfeeding

A formal breastfeeding assessment, using the local documentation pathway, e.g. RIO for the Health Visitor service will be carried out at the ‘new baby review’ or ‘new birth visit’ at approximately 10–14 days to ensure effective feeding and well-being of the mother and baby. This includes recognition of what is going well and the development, with the mother, of an appropriate plan of care to address any issues identified. (Appendix 4.4)

Mothers will have the opportunity for a discussion about their options for continued breastfeeding (including responsive feeding, expression of breast milk and feeding when out and about or going back to work), according to individual need.

The service will work in collaboration with other local services to make sure that mothers have access to local social support for 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 (It can take up to 6 weeks to establish effortless breastfeeding. This includes: building a mother’s confidence to efficiently attach her baby to the breast, understand effective breast milk transfer, and recognise babies feeding cues and other needs related to the babies need for stimulation and sleep patterns.
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 breast milk 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.

5.9 Community Support for formula feeding

At the birth visit mothers who formula feed will have a discussion about how feeding is going. Recognising that this information will have been discussed with maternity service staff, but may need revisiting or reinforcing; and being sensitive to a mother’s previous experience, staff will check that: Mothers who are formula feeding have the information they need to enable them to do so as safely as possible. Staff may need to offer a demonstration and / or discussion about how to prepare infant formula

Mothers who formula feed understand about the importance of responsive feeding (appendix1) and how 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
- Avoid forcing their baby to take more milk than the baby wants (appendix 8)

5.10 Introducing solid food

All parents will have a timely discussion about when and how to introduce solid food. (See CNWL Health Visitor service Care Pathway for introducing solid foods and vitamins Including:

- Solid food should be started at around six months
- Babies’ signs of developmental readiness for solid food
- How to introduce solid food to babies of all mothers per DoH guidelines of a minimum of 26 weeks.
- The breastfeeding mother will be supported and protected if her intent is to provide breast milk for her baby for up to a year or beyond; enabling the promotion of the important health benefits of longer term breastfeeding/breast milk with complimentary healthy solid foods
- Appropriate foods for babies

6. Equality Impact Assessment

The Trust is committed to promoting an environment that values diversity. The Trust aims to design and implement services, policies and measures that meet the diverse
needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. This document has been equality impact assessed and this can be found in Appendix 1.

7. **NHS Constitution**

The Trust is committed to the principles and values of the NHS constitution and this document takes into account these principles and values.

8. **Training**

The training for health professionals in the maternity unit on infant feeding (breast and formula feeding methods) is described in the Maternity Specific Mandatory Training Policy and states which staff groups require training and the frequency.

All health professional support and children’s centre staff who have contact with pregnant women and mothers will receive training at a level appropriate to their professional group and/or position including volunteers. This is a collaborative training session between THH and HCH, see (Appendix 3). New staff will receive training within 3-6 months of taking up their post.

9. **Monitoring implementation of the standards**

THH, CNWL, HCH and LBH requires that compliance with this policy is audited at least annually using the UNICEF UK Baby Friendly Initiative audit tool (2013 edition).

Staff involved in carrying out this audit require training on the use of this tool. Audit results will be reported to the Breastfeeding Strategy group in collaboration of Head Maternity of services for THH, Head of Children and Families service for HCH, the Children and Families Trust for the LBH and both hospital and community Infant feeding leads. An action plan will be agreed by the Breastfeeding Strategy group which meets on a quarterly basis to address any areas of non-compliance that have been identified in this policy.

Auditable standards

- Patient information on infant feeding audited as part of record keeping
- Annual audit incorporates infant feeding support
- Trends in weight loss above 10% with new-born babies
- Trends in new-born’s readmitted to hospital with feeding problems in the first 28 days of life
- Compliance with infant feeding training to staff is monitored by the practice development team on a monthly basis in the hospital and by the community lead in CNWL and LBH
- Collection of quarterly breastfeeding initiation rated
- Collection of quarterly any and exclusive breastfeeding prevalence at the 6-8 week mother baby contact in the community.
- Service user satisfaction of support given in first 10 days, collected at day 11-14 in the post natal period.
- Service user satisfaction received at the maternal mood assessment visit in the community. Collected between 4-6 weeks in the post natal period.

Outcomes will be monitored by: THH Infant feeding coordinator and HCH Infant feeding coordinator against the Community Quality Care (CQC) standards and pathways and CNST requirements

Outcomes will be reported to: The Head of Midwifery Services, The Head of Children and Family services and the Director of Public Health for Hillingdon. Monitoring compliance

Quarterly and annual collection Reported to Breast Feeding Strategy Group, THH:CNST and CNWL: CCG

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
<th>Tool / Methodology</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
<th>Action Lead(s)</th>
<th>Change in practice and lessons to be shared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient information on infant feeding</td>
<td>Infant feeding midwife</td>
<td>Part of health records audit</td>
<td>Annual</td>
<td>To Postnatal steering group</td>
<td>Matron</td>
<td>Information shared at ward meetings Maternity risk newsletter/ gossip corner</td>
</tr>
<tr>
<td>Weight loss above 10%</td>
<td>Infant feeding midwife</td>
<td>Incident reporting</td>
<td>Trends quarterly</td>
<td>To postnatal steering group Actions and outcomes monitored by Maternity Clinical Governance</td>
<td>Matron</td>
<td>Information shared at ward meetings Maternity risk newsletter/ gossip corner</td>
</tr>
<tr>
<td>New-borns readmitted</td>
<td>Infant feeding</td>
<td>Incident reporting</td>
<td>Trends quarterly</td>
<td>To postnatal steering group</td>
<td>Matron</td>
<td>Information shared at ward meetings Maternity risk newsletter/ gossip corner</td>
</tr>
</tbody>
</table>
10. Dissemination of this Policy

This policy document will be available to all staff via the Trust Policy Information Management System, staff will be alerted to the policy by a standard general email.

11. Acknowledgments and References

We would like to acknowledge UNICEF – Baby Friendly Initiative for the initial 2013 updated ‘sample’ draft of the Breastfeeding policy.

Permission was sought from Derbyshire NHS Trust for the use and adaptation of the ‘Feeding reluctant Healthy Term babies’, Derbyshire Guidelines – as seen in Appendix 4

The following websites will be useful when searching for the latest research findings:

Breastfeeding NHS: http://www.breastfeeding.nhs.uk/
Cochrane Library: http://www2.cochrane.org/reviews/en/ab001141.html
International Lactation Consultant Association: www.ilca.org/
La Leche League: http://www.laleche.org.uk/
NHS Choices: http://www.nhs.uk/conditions/pregnancy-and-baby


### 12. Associated Documentation

**THH Policy Associated Guidelines, Policies and Documents (for THH only)**

- Postnatal Care
- Prevention, detection and management of hypoglycaemia in the newborn
- Immediate care of the newborn
- Raised BMI
- HIV and Pregnancy
- Early onset of Neonatal Infection
- Hep C in pregnancy
- Hep B in pregnancy
- Gestational Diabetes
- Delivery & postnatal Care
- The management of hyper-bilirubinemia in primary and secondary care settings in the term healthy new-born baby
- Caesarean Section
- Antenatal management of hypertension in pregnancy & pre-eclampsia

---

**Appendix 1**

### UK Baby Friendly Initiative Steps to Successful Breastfeeding

**STAGE ONE**

**Building a firm foundation**

1. Have written policies and guidelines to support the standards.
2. Plan an education programme that will allow staff to Implement the standards according to their role.
3. Have processes for implementing, auditing and evaluating the standards.
4. Ensure that there is no promotion of breast milk substitutes, bottles, teats or dummies in any part of the facility or by any of the staff.

**STAGE TWO**
An educated workforce
Educate staff to implement the standards according to their role and the service provided.

STAGE THREE
Parents’ experiences of maternity services
1. Support pregnant women to recognise the importance of breastfeeding and early relationships for the health and well-being of their baby.
2. Support all mothers and babies to initiate a close relationship and feeding soon after birth.
3. Enable mothers to get breastfeeding off to a good start.
4. Support mothers to make informed decisions regarding the introduction of food or fluids other than breast milk.
5. Support parents to have a close and loving relationship with their baby.

Parents’ experiences of neonatal units
1. Support parents to have a close and loving relationship with their baby.
2. Enable babies to receive breast milk and to breastfeed when possible.
3. Value parents as partners in care.

Parents’ experiences of health-visiting
1 Support pregnant women to recognise the importance of breastfeeding and early relationships for the health and well-being of their baby.
2 Enable mothers to continue breastfeeding for as long as they wish.
3 Support mothers to make informed decisions regarding the introduction of food or fluids other than breast milk.
4 Support parents to have a close and loving relationship with their baby.

Parents’ experiences of children’s centres
1. Support pregnant women to recognise the importance of breastfeeding and early relationships for the health and well-being of their baby.
2. Protect and support breastfeeding in all areas of the service.
3. Support parents to have a close and loving relationship with their baby.

Re-accreditation
Demonstrate innovation to achieve excellent outcomes for mothers, babies and their families.
Appendix: 2

The Hillingdon Hospital Service User Guide to the Infant feeding Policy

This Trust supports the right of all parents to make informed choices about how to feed their baby. All Trust staff will support you in your decision. We believe that breastfeeding is the healthiest way to feed your baby and we recognise the important benefits which breastfeeding provides for both you and your child. We therefore encourage you to breastfeed your baby.

Ways in which we help you to give your baby the healthiest start

- All the maternity staff are specially trained to help you breastfeed your baby
- During your pregnancy, you will have the opportunity to discuss infant feeding individually with your midwife or health visitor children's centres staff or peer support worker.
- You will have the opportunity to hold your baby next to your skin as soon as possible after birth. The staff will not interfere or hurry you but will be there to support you and help you with baby's first feed.
- A trained health professional or a member of the infant feeding team will be available to explain how to attach your baby to the breast correctly so that your baby feeds effectively and with no discomfort to yourself.
- You will be shown how to express your breast milk by hand. You will be given a leaflet to refer to for when you get home. Along with staff discussing this with you, we
have placed a folder by your bed called ‘Feeding Your Baby’ which incorporates illustrated diagrams will also assist you in mastering this skill.

- You will be given help with feeding your baby while in hospital and in the early days at home. We will give you information and advice on how to manage night feeds.
- Most babies do not need to be given anything other than breast milk for their first six months. If for some reason your baby does require some other feed, this will be explained to you by the staff and your permission sought.
- Normally, your baby stays with you at all times. If your baby is in the special care unit you have access at all times. We will encourage and support the expressing of your breast milk and breastfeeding in accordance with your baby’s requirements.
- You will be taught baby’s feeding cues and encouraged to feed your baby whenever he or she seems to be hungry.
- We recommend that you avoid using bottles, dummies and nipple shields while your baby is learning to breastfeed. This is because they can change the way that your baby sucks leading to difficulties in achieving successful breastfeeding
- If you have chosen to formula feed your baby we will ensure that you have the knowledge to make up bottles and sterilise feeding equipment safely.
- Before you leave hospital you will be given a flyer on breastfeeding support services within Hillingdon in case you need extra help when you are at home.
- We welcome breastfeeding on our premises. We will arrange for you somewhere private to go to feed your baby if requested.

Professional Training for all Relevant Stakeholders

New starters – Professionals and new staff at THH to access the mandatory (in-house) Breastfeeding Management Course within three - six months of commencing post

(2 - day Course facilitated by Infant Feeding coordinator having completed the UNICEF training the trainer) (Course to be accessed via Learning and Development – Kirk House)

Existing member of staff

If you HAVE attended The UNICEF Breastfeeding Management course?

Access Annual Breastfeeding Training thereafter (2 hours – via Learning and Development) – Bespoke training can be accessed via the Breastfeeding coordinator for teams or individuals on request

If you have NOT attended The UNICEF Breastfeeding Management course?

Access Annual Breastfeeding Training thereafter (2 hours – via Learning and Development) – Bespoke training can be accessed via the Breastfeeding coordinator for teams or individuals on request
Professional to access the (in-house) Breastfeeding Management Course (2-day Course facilitated by breastfeeding lead At the earliest opportunity

The course is non-mandatory and the 2nd day is the midwife's own time

(Course to be accessed via Learning and Development – Kirk House)
Appendix: 4.1

Infant Feeding: Maternity Services

4.1 Infant Feeding – Antenatal Checklist

All of the following topics should be discussed with each pregnant woman by 34 weeks of pregnancy.

<table>
<thead>
<tr>
<th>Conversations in pregnancy: Key points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remember: explore what parents already know → accept → offer relevant information*</td>
</tr>
<tr>
<td>Encouraging parents to connect with their baby</td>
</tr>
<tr>
<td>Taking time out to connect: talking to baby, noticing and responding to movements</td>
</tr>
<tr>
<td>Skin contact</td>
</tr>
<tr>
<td>The value of skin contact</td>
</tr>
<tr>
<td>What this means for mother and baby</td>
</tr>
<tr>
<td>Responding to baby’s needs</td>
</tr>
<tr>
<td>How closeness, comfort and love can help baby’s brain develop</td>
</tr>
<tr>
<td>Responsive feeding</td>
</tr>
<tr>
<td>Feeding</td>
</tr>
<tr>
<td>Value of breastfeeding as protection, comfort and food</td>
</tr>
<tr>
<td>How to get off to a good start</td>
</tr>
</tbody>
</table>

**Confirmation that a conversation has taken place to cover relationship building, responsiveness and feeding, as per mother’s needs**

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*refer to the health professionals’ guide for more information*
### Conversations in the postnatal period: Key points

**Remember: explore what parents already know → accept → offer relevant information**

**After birth**

- All mothers are offered support with
  - Unhurried skin contact
  - Recognising early feeding cues
  - Offering the first feed in skin contact

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Postnatal**

- All mothers are offered support to
  - Appreciate the importance of closeness and responsiveness for mother/baby wellbeing
  - Hold their baby for feeding
  - Understand responsive feeding
- **Breastfeeding mothers** are offered support to
  - Hand express
  - Value exclusive breastfeeding
  - Understand how to know their baby is getting enough milk
  - Access help with feeding when at home
- **Mothers who formula feed** are offered support to
  - Sterilise equipment and make up feeds
  - Feed their baby first milks
  - Limit the number of people who feed their baby

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Breastfeeding Assessments**

Breastfeeding assessments carried out using the breastfeeding assessment form (minimum of two in the first ten days) and an appropriate plan of care made. This may include referral for additional/specialist support.

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Date:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Refer to the health professionals’ guide for more information*
Appendix 4.3

The First Feed Sticker or complete conversations in postnatal

<table>
<thead>
<tr>
<th>Time of first feed:</th>
<th>Worries for next breastfeed/Reluctant Feeder?</th>
</tr>
</thead>
<tbody>
<tr>
<td>How long was skin to skin?</td>
<td></td>
</tr>
</tbody>
</table>

**Did you observe and explain position/attachment?**

**YES/NO**

**P**
- Bring Baby to Breast
- Hold baby close
- Head / body in straight line
- Nose to Nipple

**A**
- Wide open mouth
- Upper areola visible
- Chin to breast
- Full cheeks/bottom lip down

**Was attachment achieved? YES/NO**

**Have you discussed (tick)**
- 2nd feed within 6 hrs.
- Early Feeding cues
- Benefits of Skin to Skin

**Signature:**

**Print/Stamp:**
### Breastfeeding Assessment Form

If any responses in the yellow column are ticked: **Watch a full breastfeed, develop an action plan including revisiting positioning and attachment and/or refer to specialist practitioner. Any additional concerns should be followed up as needed.**

<table>
<thead>
<tr>
<th>What to observe/ask about</th>
<th>Baby’s Age indicating effective feeding</th>
<th>Answer indicating a problem</th>
<th>Baby’s Age indicating a problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine output/number of wet nappies</td>
<td>At least 5-6 wet nappies in 24 hours*</td>
<td>Fewer than 5-6 wet nappies in 24 hours, or nappies that do not feel heavy*</td>
<td></td>
</tr>
<tr>
<td>Appearance &amp; number of stools (record number if &lt;24hrs old)</td>
<td>2 or more in 24 hours; normal appearance 0-4 at least 2 coin size, yellow, soft/fuzzy*</td>
<td>Fewer than 2 in 24 hours or abnormal appearance*</td>
<td></td>
</tr>
<tr>
<td>Colour, alertness and tone</td>
<td>Normal skin colour, alert, good tone</td>
<td>Jaundiced worsening or not improving, baby lethargic, not waking to feed, poor tone</td>
<td></td>
</tr>
<tr>
<td>Weight (following initial post-birth loss)</td>
<td>If re-weighed not lost more than 10% of birth weight – see Weight Guidelines</td>
<td>Weight loss greater than 10%</td>
<td></td>
</tr>
<tr>
<td>Number of feeds in last 24 hrs (or number since birth if &lt;24hrs old)</td>
<td>At least 8 feeds in a 24 hour period*</td>
<td>Fewer than 8 feeds in last 24 hours*</td>
<td></td>
</tr>
<tr>
<td>Baby’s behaviour during feeds</td>
<td>Generally calm and relaxed</td>
<td>Baby comes on &amp; off the breast frequently during the feeds, or refuses to breastfeed</td>
<td></td>
</tr>
<tr>
<td>Sucking pattern during feeds</td>
<td>Initial rapid sucks changing to slower sucks with pauses and soft swallowing*</td>
<td>No change in sucking pattern, or noisy feeding (e.g. clicking)*</td>
<td></td>
</tr>
<tr>
<td>Length of feed</td>
<td>Baby feeds for 5-30 minutes at most feeds</td>
<td>Baby consistently feeds for less than 5 minutes or longer than 40 minutes</td>
<td></td>
</tr>
<tr>
<td>End of the feeds</td>
<td>Baby licks go spontaneously, or does so when breast is gently lifted</td>
<td>Baby does not release the breast spontaneously, mother removes baby</td>
<td></td>
</tr>
<tr>
<td>Offer of second breast?</td>
<td>Second breast offered; Baby feeds from second breast or not, according to appetite</td>
<td>Mother restricts baby to one breast per feed, or insists on two breast per feed</td>
<td></td>
</tr>
<tr>
<td>Baby’s behaviour after feeds</td>
<td>Baby content after most feeds</td>
<td>Baby unsatisfied after feeding</td>
<td></td>
</tr>
<tr>
<td>Shape of either nipple at end of feed</td>
<td>Same shape as when feed began, or slightly elongated</td>
<td>Misshapen or pinched at the end of feeds</td>
<td></td>
</tr>
<tr>
<td>Mother’s report on her breasts &amp; nipples</td>
<td>Breasts and nipples comfortable</td>
<td>Nipples sore or damaged, engorgement or mastitis</td>
<td></td>
</tr>
<tr>
<td>Use of dummy/nuisance shield/formula?</td>
<td>None used</td>
<td>Yes (state which) Ask why: Difficulty with attachment? Baby not growing? Baby unsettled?</td>
<td></td>
</tr>
</tbody>
</table>

*This assessment tool was developed for use on or around day 5. Please put N/A if any part is not yet applicable. If the tool is used before or after 5 days:

<table>
<thead>
<tr>
<th>Wet nappies:</th>
<th>Day 1-2 = 1-2 or more</th>
<th>Day 3-4 = 3 or more, heavier</th>
<th>Day 7+ = 6 or more, heavy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stools:</td>
<td>Day 1-2 = 1 or more, macaroni</td>
<td>Day 3-4 = 2 or more changing stools</td>
<td>Feed frequency:</td>
</tr>
<tr>
<td></td>
<td>Day 1 at least 3-4 feeds</td>
<td>SUCKING pattern: Swallows may be less audible until milk comes in day 3-4</td>
<td></td>
</tr>
</tbody>
</table>

UNICEF UK Baby Friendly Initiative 2016. Adapted from checklists used in the Oxford Radcliffe NHS Trust and East Lancashire Hospitals NHS Trust

The Hillingdon Infant Feeding Policy

Version 6.0 Policy Author Kelly Kinsella (Created 08/2014 – disposal date 07/2039)
Appendix: 4.5

INFORMATION FOR BREASTFEEDING MOTHERS ON THE GIVING OF ‘TOP UP’ FORMULA FEEDS TO THEIR BABY

Guidance for Staff on Completion of INFANT FEEDING SUPPLEMENTATION STICKER

This Sticker to be completed and placed in the baby’s handheld notes for all:

1. Breastfeeding babies who are given artificial milk for any reason
2. Babies who are being breast and bottle fed (mixed feeding)
3. Babies who start breastfeeding and are then changed to bottle feeding

Instructions

- Please fill in all requested information on the sticker. (Please see overleaf)
- Artificial milk should not be given if sufficient Expressed breast milk (EBM) is available, and mothers should always be given the opportunity to express milk first (8-10 times in a 24 hour period in the absence of effective feeding).
- No supplements to be given unless discussed with the midwife in charge
- Staff should discuss with the mother why we do not usually recommend giving supplements to breastfed babies unless clinically needed
- Staff should not recommend the make of artificial milk to be given to a baby, ward stock to be used. (To comply with the International code of marketing of Breastmilk substitutes).
- Ensure discussion with parents to enable an informed decision, document.
- If a Paediatrician has recommended a supplement for a medical reason, please ensure a feeding management plan is initiated, with a review date.
- If you are the Health Professional that is looking after a woman that is breast feeding and a supplement has been given and a sticker is not in place, please complete.

This ongoing audit will help us to monitor our practice and protecting lactation / breastfeeding.

Mothers should always be given the opportunity to express milk first, as well as Skin to Skin.

The Infant feeding support worker will use these stickers to audit the notes monthly. Feedback will be given in the form of a graph that will be kept at the back of a supplementation folder.

Any concerns please do not hesitate to speak to the ward manager or the Infant feeding Coordinator.

Contact number: Kelly Kinsella x 3723
By breastfeeding you are giving your baby the best possible start in life. The midwives and staff will help, advice and support you. This leaflet is for your information on the possible consequences of giving a top up formula feed to your baby where there is no clinical indication.

The first milk, known as colostrum, gives your baby all the fluid and nutrition that is required. Most breastfed babies do not require anything else. Colostrum lines the baby’s stomach and intestines and acts as a barrier against infection. By only giving breast milk you will ensure this protection is maintained.

### Reasons to avoid giving formula to breastfed babies

- Formula feed is more slowly digested than breast milk, increasing the time between feeds. This gives you less stimulation often leading to a reduced milk supply. New-born babies should be fed frequently.

- Formula feeds give babies much larger quantities of milk than the mother can produce in the first few days so the baby may not be satisfied with breastfeeds in the future. The average volume of breast milk is about one and half teaspoons (7mls) per feed in the first 24 hours, 3 teaspoons (14mls) on day 2 and increasing steadily to about 70mls (two and half ounces) by the 5th day.

- Frequent full drainage of the breast prevents engorgement. Giving formula can interfere with breast drainage and engorgement is more likely.

- Research has shown that mothers who introduce formula feeds are more likely to give up breastfeeding early.
If there is a medical reason to give your baby formula, then the midwife or doctor will fully explain this to you. It should be possible to give the formula in a cup as this is less likely to interfere with the sucking action.

If you are concerned that your baby has not breastfed, discuss this with a member of staff. We can teach you how to hand express your colostrum to give to your baby in conjunction with the breastfeeding assessment tool.

Signature: (mother)  

Signature: (Health Professional)
feeding has not been established and mothers will be informed of this to enable them to make fully informed choice about their use. The information given should be recorded in the mother’s care plan. Where supplementation has been medically recommended it should be preferably given by cup, which are less disruptive to breast feeding than feeds given via a bottle and teat.

Guidance for staff: term well babies: bottles and teats should only be used in support of breast feeding continuation with the least disruption:

- If parents make a fully informed choice to use them
- Parents are unable to master the cup feeding method safely
- The baby is spilling large volumes and the EBM is in short supply
- The baby has been cup feeding for some time and shows no attachment to the breast, the baby may become cup dependent and so there comes a point usually after the first week, when bottle feeding and sucking practice seem sensible

Syringe and Spoons: These methods do not have an underpinning evidence base but they are commonly used and do have a place in current practice. The concern about these methods is safety. Syringes should only be used to give tiny amounts of colostrum only (<0.5mls).

Cup feeding can provide a positive feeding experience for the baby. If the mother is unable to feed directly from the breast, cup feeding is a safe alternative method of feeding as long as the mother has been instructed by an appropriately trained health professional how to cup feed safely. Health professionals will observe a mother cup feed and provide her with the information sheet 13.3 Nipple shields will not be routinely recommended unless indicated after an assessment by a health professional and used only for as short a time as possible. The potential consequences of their use will be explained and the mother will receive support from an appropriately trained professional.

Cup Feeding Method
Cup feeding helps a mother work towards breast feeding as it encourages a baby to use their tongue and lower jaw to take the milk in a similar way to when a baby is breast feeding. Cup feeding can be used as a temporary feeding method until breastfeeding is established. It is important that continued encouragement is given for a baby to breast feed by using skin to skin contact and offering the breast frequently. Appropriately trained Midwives, Child Branch Nurses and, if relevant specially trained Health Visiting staff, can teach mothers how to cup feed her baby and offer continued support as needed.

Getting ready to cup feed; the mother or health professional should wash their hands before you start. They should use an appropriate cup that has been washed thoroughly as per the expressing and storing breast milk guideline. They should pour the breast milk into the cup, wrap baby securely
to keep their hands out of the way to avoiding any spillages and place a bib or towel under the baby’s chin.

**How to position a baby for cup feeding;** The baby should be sat upright, supporting its neck and shoulders; The baby’s back should be straight and **head tilted back** with their chin pointing upwards. Gently rest the edge of the cup against baby’s bottom lip and tilt the cup slightly so that the milk touches the baby’s lip.

**How a baby feeds from a cup;** a baby will often sniff the milk and make movements with their tongue, exploring the milk. The baby brings his lips together with top lip above rim, bottom lip and tongue below rim. A baby feeds by either lapping or sipping milk from the edge of the cup. Let the baby feed at its own pace, remembering to keep baby upright and the cup still. A baby will drink at its own speed and pause when they need to. The baby may need winded several times during a feed depending on amount being given. When cup feeding session is finished, wash cup in soapy water and dry store for the next feed.

**Tips & Warnings:** *Only* cup feed when the baby is awake and alert. Follow the baby’s cues. He or she will set a pace for him or herself that is comfortable. Allow breaks for burping if the baby is sipping over a longer period of time.

**Don’t pour the milk into the baby’s mouth as the baby can choke.**
Don’t pull the cup away just because the baby pauses. It is okay to pull the cup away if the baby stops and turns away from the cup.
Appendix 5

Inpatient Support for Mothers who are separated from their Babies

(a) Mothers who are separated from their babies will be encouraged to hand express her milk as soon as possible, ideally eight times in a 24 hour. Expressing will be initiated as soon as possible after birth, but within 6 hours if physically possible. It is advisable to express at least once at night to maintain the milk supply.

(b) Once mothers have become confident with hand expressing or produce >5mls colostrum, an electric pump can be encouraged. Electric pumps are available on the Maternity unit and the Neonatal unit.

(c) Women returning to work need particular support. Intentions, regarding return to work, should be explored as early as possible to enable formulation of a plan and assist the mother to maximise her breast milk production and continue breastfeeding (or providing breast milk) for as long as she wishes. Refer to leaflet ‘Breastfeeding at study or work’.

http://www.nhs.uk/start4life/Documents/PDFs/407349_C4L_BackToWork_acc.pdf

(d) Antenatal women who are in the at risk groups (diabetes, BMI 40+) should have a discussion on colostrum harvesting and storage of expressed colostrum.

5.1 Storage of Breast milk

<table>
<thead>
<tr>
<th>Place</th>
<th>Maximum Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresh breast milk</td>
<td></td>
</tr>
<tr>
<td>Room</td>
<td>6 Hours</td>
</tr>
<tr>
<td>Fridge 5 - 10°C</td>
<td>3 Days</td>
</tr>
<tr>
<td>Fridge 0 - 4 °C</td>
<td>8 Days</td>
</tr>
<tr>
<td>If the temperature rises above 4°C after 3 days, use within 6 hours or throw away)</td>
<td></td>
</tr>
<tr>
<td>Freezer - 18°C or lower</td>
<td>6 months</td>
</tr>
<tr>
<td>Previously frozen breast milk</td>
<td></td>
</tr>
<tr>
<td>Defrosted in fridge</td>
<td>12 hours</td>
</tr>
<tr>
<td>Defrosted outside fridge</td>
<td>Use immediately</td>
</tr>
</tbody>
</table>

If breast milk is not used immediately it needs to be put into the fridge. All breast milk syringe or bottle must be labelled as follows:

NAME: 
DATE: 
TIME: 
BABYS HOSPITAL NUMBER/MOTHERS HOSPITAL NUMBER:
Appendix 6

Process to be Followed if a Maternal complex needs is Identified

Please Note: Painful nipples or breasts are often a sign that baby’s attachment to the breast is incorrect. Nipple sensitivity is normal in the first few days of feeding. Nipple soreness is not normal nor is it related to the mother’s skin type or colouring.

(a) **A full breastfeeding history needs to be taken**: Position and attachment observed. Information and advice regarding positioning and attachment should be offered. If required, further support and help should be sought from the infant feeding advisor.

(b) **Early engorgement**: Can occur if the baby isn’t given time or opportunity to drain the breasts effectively. Warm compresses and gentle hand expression can provide relief and reduce the build-up of Feedback Inhibitor of Lactation (FIL). Please note: Expressing large amounts may perpetuate the problem.

(c) **Mastitis**: Caused by localised milk obstruction or prolonged engorgement and attachment issues. *(See Health Visiting Care Pathway Standard for management of mastitis in mother)*
   - Continue to breastfeed frequently
   - Express milk by hand or pump to relieve stasis.
   - Consider changing feeding position to allow gravity to help drain the breast and aligning baby’s tongue under the affected area of the breast.
   - If symptoms persist referral to a medical practitioner for review and antibiotics is appropriate.
   - The infant feeding team should also be involved in the continuing plan of care

(d) **Candida Albicans (Thrush)**: Both mother and baby can suffer from infection by Candida Albicans. For effective treatment it is imperative and beneficial to treat both mother and baby though only one may display symptoms
   - **In babies** ‘Thrush’; may manifest any or all of the following:
     - white patches in the mouth
     - aggressive nappy rash that does not resolve with over the counter barrier creams
     - May or not be to fretful
     - May cry at the breast or refuse the breast.
   
   - **In mothers**: ‘Thrush’ can manifest as follows:
     - can be superficial and manifest as itchy, shiny, paler areola than normal
     - can be present within the milk ducts which can cause an acute stabbing like deep breast pain and often persists after the feed.

 *(See Health visiting Care Pathway Standard for management of Thrush in mother and baby)*

Refer to breastfeeding network for fact sheets on the treatment of thrush.
www.breastfeedingnetwork.org.uk

More Complex needs

6.1 **Breast reduction surgery**: Lactation can be compromised after breast reduction surgery but depends on the nature of the surgery and the length of time since the surgery. The mother needs to be aware of the possible limitations past surgery can have on her lactation. The Infant feeding team should always be involved in this discussion with the mother.
6.2 Medication and Breastfeeding: Women who are on medication during pregnancy will have a risk assessment completed during a one to one discussion so as to establish the possible effects of the medication when breastfeeding.

Breastfeeding mothers who are taking medication would require a risk assessment, and if required a referral to the Hospital Infant Feeding Co-ordinator, Community Infant feeding Co-ordinator, Consultant Obstetrician or General Practitioner along with advice from the pharmacist who can help inform a plan of care in regards to safe and sustainable breastfeeding. These decisions may include a change in medication or dosage in pregnancy or in the postnatal period. In rare situations a medication may be an absolute contra-indication to breastfeeding. (Jones 2013, Hale 2012)

6.3 Woman who HIV positive: Will be strongly advised to artificially feed due to the risk of possible vertical transmission. (Not enough evidence has been collated or researched regarding the exclusively breastfed baby at the writing of this policy therefore artificial feeding is the safest option at this present time per NICE guidelines). Please note: It is unsafe for the mother to mix feed her baby under 26 weeks as this has been well documented in doubling the risk of vertical transmission of HIV infection for the infant

6.4 Women who are Hepatitis B (HBV) positive: Will be advised to breastfeed as current studies do not indicate an increased risk of vertical transmission.

6.5 Women who are known to have used illegal or excessive substances while pregnant and in the postnatal period

Will be encouraged to breastfeed unless there is risk of significant harm to the baby from the continued abuse of the substance to the infant via breast milk and following a safeguarding risk assessment. Potential risks associated with various substances should be discussed and weighed against the benefits of breastfeeding. (See care standard pathway for specialist referral)

Appendix 7 Standards of care with bottle feeding
It is essential that all Health professionals should update their advice to families, in particular knowing the difference between the recommended whey based formula (standard formula) and casein based formula (follow-on), as the recommendations suggest that parents choose a whey based infant formula and stay on this for the first year. The following leaflet should be read by all staff involved in management of formula feeding:

‘Health professionals guide to: A guide to infant formula for parents who are bottle feeding’. It is also important for all health professionals to refer to the International Code of Marketing of breast milk substitutes


This is a useful guide for parents and explains appropriate standards of care for preparing and making up formula feeds.


Standards Agency issued revised guidance for health professionals on the preparation and storage of powdered infant formula milk.
Health professionals should re-emphasise to parents and carers:

- that powdered infant formula is not sterile and good hygiene practices are essential in preparing and storing feeds made from powdered formula
- failure to follow the manufacturer’s guidelines may increase the chances of a baby becoming ill.

### 7.1 Information for Parents who formula feed

- How to formula feed. They should be offered help and teaching with the first feeds.
- How to choose appropriate whey based formula.
- How to make up a feed correctly.
- How to use prepared feeds safely.
- How to sterilise equipment.

Parents whom choose to formula feed on admission to the post-natal ward should be made aware of the bedside guide 'Feeding Your Baby' highlighting the formula feeding section.

All parents whom choose to formula feed will be offered to attend a daily session to watch a DVD 'Infant Formula Explained' by Baby Milk Action. This is a 10-minute film on how to make up powdered formula in line with government recommendations.

Prior to discharge home Health Professionals will confirm with parents they understand the key principals with sterilizing /making up feeds safely.

Appendix 8

Baby with complex needs:

(Please note: The benefits of breast milk will be discussed with the mother and she will be supported to provide her baby with EBM if feeding at the breast is not possible)

8.1 Congenital abnormality
Where a congenital abnormality is identified which interferes with feeding mechanisms, the baby will be referred to the neonatologist as soon as possible after delivery (for example cleft palate). Further specialist referral to the Speech and Language team may then be appropriate.

8.2 Care of a baby with Naso-Gastric Tube or a pre-term in the community
After a feeding assessment has been completed by a HCP trained in the principles of this policy and a swallowing concern is identified, a discussion with the Speech and Language Team (SLT) should take place. Following this discussion, and if appropriate a referral for ‘Swallowing Difficulties’ should be made to the SLT. (THH staff should also follow additional THH policies and guidelines and care).

8.3 Babies identified with suspected tongue tie
Referral to the local Infant feeding advisor for review. Mother’s contact details will be placed in the infant feeding diary. The infant feeding advisor reviews/assesses feeding and a referral is made to oral surgery if necessary, for a ‘Frenulectomy’.

Care Pathway: Tongue Tie in the Breastfeeding Infant
Definition: Tongue-tie (ankyloglossia) occurs when the frenulum, or piece of tissue which bridges the gap between the underside of the tongue and the floor of the mouth is abnormally short, stopping the tip of the tongue from protruding beyond the lower gum. It varies in degree, from a mild form in which the tongue is bound only by a thin mucous membrane to a severe form in which the tongue is completely fused to the floor of the mouth. Breastfeeding difficulties may arise as a result of the inability to move the tongue in a normal way and therefore attach and suck effectively, causing sore nipples and poor infant weight gain.

Suspected tongue tie
- visually observed by professional or parent

Mother presents with sore nipples, compressed following feeds, pain during feeding when attachment appears satisfactory to professional, noisy feeding (clacking), the infant may not be gaining weight, may feed more frequently than expected

Check for tongue tie (observation/ parental observation/ discussion) –
Assessment whilst crying can enable visualisation of the frenulum or placing mild pressure with finger to the chin to open the mouth. Observe:
- Inability to extend tongue
- Frenulum may be seen to attach close to the tip of the tongue or to restrict movement of the tongue (mild to moderate mid tongue)
- Heart shaped tip to the tongue on extension

Breastfeeding assessment to inform if the tongue tie is causing pain on feeding/ difficulty latching (often external signs will indicate good attachment, be led by maternal comfort and appearance of breast following feed)
Exclude position and attachment difficulties

Tongue Tie but no problems feeding –
- Gaining weight
- Comfortable feeds.

No – intends to formula feed
- No action

Parents do not wish to proceed with tongue tie division
Support parent with evidenced based knowledge in continued breastfeeding

Discuss with Infant Feeding Co-ordinator KKinsella/CCooper
Fax referral letter to prefer lead) including:
- Name, date of birth, address and contact telephone number of the child
- Name of parent
- GP details
- Details of feeding assessment and description of findings/ degree of tongue tie/ any family history
- Check child had vitamin K
- Your contact details
- Confirm receipt of fax

Tongue Tie with difficulty feeding
(may or may not include poor weight gain)

Yes –
Discuss division of tongue tie - parent information available at www.live.unicef.org.uk/babyfriendly

Parents wish to proceed with tongue tie division

Follow-up post procedure - Effective attachment may take up to two weeks to resolve. Nipple shields can be helpful
Not related to routine feeding difficulties. (Follow guidelines in the Paediatric Eating and Drinking and Swallowing Policy as in 7.1).

**8.5 Sleepy Reluctant feeder (SRF) & Flowchart for management**

Babies who have not fed at birth and/or at six hours despite implementing good breastfeeding management are to undergo Sleepy Reluctant Feeder (SRF), management. See flowchart

---

Breastfeeding Flow Chart For Sleepy Reluctant Feeders
Within 1 hour, baby has not attached to the breast

Over the next 6 hours, maintain skin/skin contact

6hrs old, not feeding
stimulate baby to feed,
discuss hand expressing, give mothers guide

12hrs, give colostrum
Stimulate baby to feed

Observe in skin contact - muscle tone, behaviour
Monitor

Dry baby
Initiate skin to skin
Feeding preferences established
Discuss A&P
Feeding cues
Baby Led Feeding

Baby effectively attaches to the breast

6 hrs old - Breastfeeds again

B/F 2/3 times in last 12

Baby Led Feeding

Are your observations satisfactory and baby is taking feeds within 18 hours?

Yes and feeding

Yes and NOT feeding

No

*Hand express, offer drops of colostrum review in 3 hours. Keep skin/skin /change position

Temp <36.5C offer skin/skin, hat on head

Re-check in 1 hour

Temp still <36.5C

INFORM PAEDIATRICIAN

If baby is still not feeding at 24 hours and appears clinically well refer to IFC
Perform set of observations: If
Temp: 37C
Pulse: 150 or >90 BPM
Respirations: >60 BPM or grunting
Skin colour: Dusky or jaundiced
Muscle tone: poor or jittery

INFORM PAEDIATRICIAN

If BM <2.6mmol refer to hypoglycaemia guidelines - inform paeds
Keep skin /skin, give EBM

If BM >2.6 and observations normal, well baby, skin/skin and hand express. Continue with EBM syringe, attaching/positioning. Seek advice Infant feeding coordinator

The Hillingdon Infant Feeding Policy
Version 6.0 Policy Author Kelly Kinsella (Created 08/2014 – disposal date 07/2039)
**Mothers Guide to sleepy reluctant feeders- feeding chart**

Extra support will be given along with health professional monitoring until breastfeeding is sustainable.

(a) If after birth a baby has not taken an adequate feed despite implementing ‘the Golden Hour’ and SRF guidelines within 24hr a referral will be made to the infant feeding advisor or neonatologist. A full examination of the baby will be expected to be completed at twelve hours old. This will eliminate illness or abnormality. A plan of care is to be agreed and documented in the baby’s notes.

(b) Babies of 37 weeks gestation can take longer to mature their suckling patterns. Mothers who have infant’s under 37 weeks gestation will stay on the postnatal ward for 48-72 hours to ensure feeding is progressing normally.

(c) The baby may be sleepy and uninterested in feeding for 24 hours if affected by labour analgesia. Continued Skin to Skin contact is important during this time.

(d) If despite review of attachment and positioning the baby continues to have difficulty feeding consider tongue tie and if present refer to infant feeding advisor.

---

**‘Mothers Guide to Breastfeeding Success if baby is reluctant to feed- Care Plan & Feeding Record’**

<table>
<thead>
<tr>
<th>Date &amp; time of feed</th>
<th>Help given with positioning and attachment (who by)</th>
<th>Help given with hand expressing (who by)</th>
<th>How well did baby feed? (see score guide below)</th>
<th>How long did baby feed for?</th>
<th>Wet (tick)</th>
<th>Bowel (colour)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please feel free to add your own comments**

1 = licked around nipple but not interested in sucking  
2 = rooting at the breast and attempting to attach.  
3 = rooting, attaching with a weak suck with no swallow or falls asleep  
4 = rooting, attaching with strong suck with swallows (heard or seen)
This chart is offered as a guide, so that together we can make sure that your breastfeeding gets off to a good start. Although breastfeeding is natural, sometimes it may take a while for you and your baby to get the hang of it. Don't worry, we are here to help, so please don't hesitate to ask if you would like the staff to assist you. Once breastfeeding is established there is no need to keep a record, simply allow your baby to decide when he/she is hungry.

You will find some helpful tips to getting breastfeeding off to a good start over the page

Don't feel tempted to give formula feeds, as this is likely to interfere with breastfeeding. Facts about formula:

1) Families with strong history of allergies, formula can make it more likely the baby can develop an allergy
2) Bottle feeding may confuse your baby as a plastic teat is different to your nipple
3) Your breasts will not be as stimulated and therefore your milk supply may be reduced
4) Research has shown that mothers who introduce formula feeds are more likely to give up breastfeeding early.

IT'S OK TO ASK FOR HELP
Lactation Support for

CONSISTENT ADVICE
PROVIDE EXTRA SUPPORT
BUILD ON CONFIDENCE
CHECK ATTACHMENT AND POSITIONING

**TCB < 250**
- Assess Attachment
- Baby led feeding
- Monitor stools and urine
- Educate Mother
  - Recognise effective milk transfer
  - Frequency of feeds
  - Observe for feeding cues
  - Check Nappies
  - Recognise change in baby’s behaviour – sleepy.

**TCB 250-340**
- Discuss Feeding Plan with mother
  - Increase milk supply
  - Increase frequency of feeds
- Wake baby every 3 hours
- Check nappies Wet/D Dirty
- Assess Attachment
- Assess breastfeeds. If baby does not feed well (well attached with a good suck: swallow ratio and lots of gulping) then express after feeds and cup feed any EBM. If baby is too sleepy to take enough feeds or sustain feeds then cup feed EBM.
- Weight as per protocol. If weight loss is> 10% and EBM volume is low refer to Paediatrician and Infant Feeding advisor

**TSB >340**
- Phototherapy
- NG Tube
- Reassurance/explanation on light therapy
- Maintenance of breastfeeding during light therapy
- Optimise Milk Supply
- Express (double) 8/24

Breastfeeding Assessment Tool will help with feeding Assessments and discussing mother’s expectations
Appendix 8.8

8.8 Guidelines relating to the Prevention and Management of Excessive Weight Loss

8.8.1 Process for weighing babies THH

- Weighing scales are calibrated to zero prior to putting the baby on the scales. The equipment is checked annually by the bio-engineering department.
- All children up to 2 years must be weighed undressed and without a nappy. Fewer than 5% of babies lose more than 10% of their weight at any stage, and only 1 in 50 are 10% or lighter than birth weight at 2 weeks. Recovery of birth weight by 2 weeks indicates that feeding is effective and that the child is well.

8.8.2 Assessing Weight Loss after birth

Guidelines relating to the Prevention and Management of Excessive Weight Loss Assessment of breastfeeding at each postnatal check. Any abnormal finding triggers further action.

<table>
<thead>
<tr>
<th>Baby warning triggers</th>
<th>Breast warning triggers</th>
<th>Breastfeeding warning triggers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jaundiced and sleepy or difficult to rouse for feeding</td>
<td>Engorgement or mastitis</td>
<td>Difficulty with attachment</td>
</tr>
<tr>
<td>Demanding to be fed fewer than 6x in 24 hours and/or not</td>
<td>Trauma to nipples; nipples</td>
<td>No change in sucking pattern i.e. from</td>
</tr>
<tr>
<td>sustaining an effective sucking pattern</td>
<td>missshapen or ‘pinched’ at end of</td>
<td>initial rapid sucks to slower</td>
</tr>
<tr>
<td>Feeding very frequently i.e. more than 12x in 24</td>
<td>feed</td>
<td>sucks with pauses and audible swallows</td>
</tr>
<tr>
<td>hours.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consistently feeding for longer than 45 minutes</td>
<td></td>
<td>Baby ‘fussy’ at the breast – on and off the</td>
</tr>
<tr>
<td>Unsettled after feeding</td>
<td></td>
<td>breast frequently during the feed or refuses to</td>
</tr>
</tbody>
</table>

Assessment of output (baby) at each postnatal check together with monitoring the mother.

Inadequate output i.e. less than specified in the table, triggers weight assessment and implementation of appropriate Management plan.

<table>
<thead>
<tr>
<th>Age</th>
<th>Day 1-2</th>
<th>Day 3-4</th>
<th>Day 5-6</th>
<th>Day 7-28</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine</td>
<td>Number of wet nappies per day</td>
<td>1-2 or more; urates may be present *</td>
<td>3 or more; nappies feel heavier</td>
<td>5 or more; heavy</td>
</tr>
<tr>
<td>Stools</td>
<td>Number per day, colour &amp; consistency</td>
<td>1 or more, dark green/black. Meconium</td>
<td>2 or more, changing in colour and consistency-brown/green/yellow . Changing stool</td>
<td>2 or more, yellow may be watery</td>
</tr>
</tbody>
</table>

*Urates are normal bladder discharges in the first few days but persistent urates may indicate insufficient milk intake.

Weigh at 4-5 days and again at least once prior to transfer to Health
Visitor. Weight loss of 8% or more triggers further action

<table>
<thead>
<tr>
<th>Amount of weight loss</th>
<th>Management plan indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-10% of birth weight</td>
<td>1</td>
</tr>
<tr>
<td>10-12% of birth weight</td>
<td>1 + 2</td>
</tr>
<tr>
<td>More than 12% of birth weight</td>
<td>1 + 2 + 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan</th>
<th>Weight loss</th>
<th>Management details</th>
</tr>
</thead>
</table>
| 1    | 8-10%       | Observe a full breastfeed - ensure effective A&P  
|      |             | Observe for effective sucking pattern  
|      |             | Ensure minimum of 8 feeds in 24hrs  
|      |             | Skin contact to encourage breastfeeding  
|      |             | Observe for change in amount/frequency of urine and stools  
|      |             | Re-weight on day 7. If weight increasing continue to monitor and support .  
|      |             | If no or minimum weight gain move to Management Plan 2 |
| 2    | 10 - 12%    | Follow management plan  
|      |             | Discuss with Infant Feeding team  
|      |             | Express breast milk after each feed and offer to baby preferably by cup otherwise bottle  
|      |             | Check for any signs of infection or suspected illness. If yes, telephone paediatrician  
|      |             | Weigh again in 24-48 hours. If no or minimal weight gain, move to Management Plan 3 |
| 3    | 12%>        | Refer to A&E for review by paediatrician and Infant Feeding team.  
|      |             | Follow Management Plan 2 plus:  
|      |             | Frequent breastfeeds and expressing using a hospital grade pump  
|      |             | Paediatric team to carry out investigations to determine on going care.  
|      |             | This may include formula feeds by cup or intravenous fluids if breastfeeding ineffective or EBM not available  
|      |             | Reduce formula feeds as breast milk supply increases.  
|      |             | Weigh again after 24 hours. Continue to monitor weight as appropriate. |
8.8.3 Guidance for Health Professionals to consider when to weighing babies,

Weight loss or failure to gain weight adequately may be an indication of a problem with feeding or an underlying illness. Most breastfeeding women produce plenty of milk but for some lactogenesis (“the milk coming in”) takes longer or needs extra stimulation. True milk insufficiency is uncommon. It is much more likely that adequate milk is able to be produced but the baby has difficulty removing it from the breast. It is important to identify these difficulties and manage them effectively.

- Common causes of/ poor milk removal that lead to insufficient milk supply are:
  - Ineffective attachment at the breast due to poor technique or sucking difficulties.
  - The use of nipple shields resulting in poor stimulation and incomplete emptying of the breast
  - Insufficient stimulation to the breast due to a delay initiating breastfeeding, infrequent or restricted feeding, and the use of dummies and/or supplementary feeds.
  - Breast engorgement, mastitis or breast abscess
  - Maternal health problems (e.g. large haemorrhage, hypotension, severe malnutrition, dehydration, breast surgery, pituitary disorders, hypothyroidism, the combined pill, polycystic ovary disease and unexplained infertility.
  - Psychological factors (e.g. lack of confidence, embarrassment, fear, rejection of baby and severe tiredness)

7.12

8.8.4 Assessment and management of excessive weight loss

- It is important to establish the reason for excessive weight loss so that the correct management can be implemented. (Appendix 6) This involves:
  - Full clinical assessment to exclude underlying illness. If there is concern regarding the health of the baby a referral to the paediatrician should be made immediately.
  - All admissions within 28 days should trigger a risk form and investigation
  - Assessment of breastfeeding/ formula feed (including a feeding history
and observation of a full feed) by an appropriately-trained member of staff. Monitoring of urine output and frequency and consistency of stools.

8.8.5 Management of the healthy term breastfed baby, with a weight loss of 8-10% in the first week. (See Care plan 1, appendix ??)

This degree of weight loss is above average and still fairly common but it does merit additional attention. Complete breastfeeding assessment tool. A breastfeed should be observed with urine/stools monitored. Additional actions may be necessary if the baby is sleepy, has poor ineffective suck or stools and urine are not progressing normally.

8.8.6 Management of the healthy term breastfed baby, with a weight loss in excess of 10-12.5% in the first week. (See Care Plan 2 & 3, appendix of what?)

- Observation of a full feed by an appropriately trained member of staff, this must be recorded in baby postnatal notes. A management plan of care agreed and documented if indicated. A review date should be set.
- Advice regarding positioning and attachment as needed
- Avoid separation of mother and baby
- Advise to feed the baby frequently. Teach the mother to recognise baby feeding cues but feed at least 3 hourly. Encourage skin to skin
- Expressed breast milk to be given after feeds by cup.
- Close monitoring of urine output and stool passage to assess milk transfer
- Advice on location and provision of support for breastfeeding e.g. Peer support Children Centres, baby Cafes.
- Café
- Review above daily and reweigh in 48 hours.

Supplementation with formula will further compromise the mother’s milk supply and increase the risk of infection for the baby. This should be considered only if the baby’s health is at risk.

8.8.7 Management of a healthy term formula fed baby with weight loss ≥10%

- Observation of a full feed by an appropriately trained member of staff, this must be recorded in baby postnatal/ health record. A management plan of care agreed and discussed with a paediatrician and documented if indicated. A review date should be set
- Advise the mother to feed the baby frequently. Teach the mother to recognise feeding cues but feed at least 3 hourly.
- Close monitoring of urine output and stool passage to assess milk transfer
- Review above daily and reweigh in 48 hours.
8.8.8 Babies referred or readmitted with a weight loss of ≥10% and or feeding related problems.

All babies readmitted to hospital within 28 days of birth with excessive weight loss and or feeding related problems will require an Incident form to be completed via the on-line DATIX report. This will be reviewed initially by the Risk Midwife who will notify the Infant Feeding Lead of feeding related neonatal admissions via Datix. The incidents are reviewed by the risk management team on quarterly basis. The Infant Feeding Lead will review the maternity and baby’s health record, with regard to how the mother was supported in her choice of feeding, based on the Breastfeeding Care Plan. Actions and recommendations for any practice or learning issues identified will be fed back to the Practice Development Group, Risk Management Team, P/N Steering Group and Head of Midwifery.

This will be in the form of a quarterly Root Cause Analysis written report. The Infant Feeding Specialist Midwife will lead on any practice changes required.
### Checklist for the Review and Approval of Procedural Document

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th>Title of document being reviewed: New born Feeding</th>
<th>Yes/No/Unsure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Title</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the title clear and unambiguous?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Is it clear whether the document is a guideline, policy, protocol or standard?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>2. Rationale</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are reasons for development of the document stated?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>3. Development Process</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the method described in brief?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are people involved in the development identified?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Is there evidence of consultation with stakeholders and users?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>4. Content</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the objective of the document clear?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Is the target population clear and unambiguous?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are the intended outcomes described?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are the statements clear and unambiguous?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>5. Evidence Base</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the type of evidence to support the document identified explicitly?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are key references cited?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Are the references cited in full?</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Title of document being reviewed: New born Feeding</td>
<td>Yes/No/Unsure</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------------</td>
<td>----------</td>
</tr>
<tr>
<td>Are supporting documents referenced?</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

6. Approval

| Does the document identify which committee/group will approve it? | Yes |
| If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document? | No |

7. Dissemination and Implementation

| Has the consultation record been completed? | Yes |
| Is there an outline/plan to identify how this will be done? | Yes |
| Does the plan include the necessary training/support to ensure compliance? | Yes |

8. Document Control

| Does the document identify where it will be held? | Yes |
| Have archiving arrangements for superseded documents been addressed? | Yes |

9. Process to Monitor Compliance and Effectiveness

| Are there measurable standards or KPIs to support monitoring compliance of the document? | Yes | CNST Criterion 5.5 |
| Is there a plan to review or audit compliance with the document? | Yes |

10. Review Date

| Is the review date identified? | Yes |
| Is the frequency of review identified? If so is it acceptable? | Yes |

11. Overall Responsibility for the Document
Title of document being reviewed: New born Feeding

| Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation? | Yes | 

Minor Amendments Ratification Chair Approval

If as ratification committee/group chair you are happy to acknowledge and approve this document, please confirm this by email to the document author. Please enter your name and date of your approval in the box below.
NB: A copy of the confirmation email must be sent to the Information Governance Team as evidence of approval before the document can be placed on to the intranet

| Name | Date |

Ratification Committee/Group Approval

If the committee is happy to approve this document, please sign and date it and forward copies to the document author with responsibility for disseminating and implementing the document and the Governance Information Team who are responsible for maintaining the organisation’s database of approved documents.
A copy of the minutes demonstrating ratification has been agreed must also be sent as evidence of completing the process.

| Name | Clinical Governance Committee | Date |

Acknowledgement: NHSLA Policy Template/Cambridgeshire and Peterborough Mental Health Partnership NHS Trust
# Standard Equality Impact Assessment Tool

<table>
<thead>
<tr>
<th>Name of Policy or Document</th>
<th>Hillingdon Infant Feeding Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Author</td>
<td>Kelly Kinsella (Infant Feeding Coordinator, THH) and Catherine Cooper (Public Health Project Lead and HCH Infant feeding Coordinator) Anne Thysse (Maternity Matron)</td>
</tr>
<tr>
<td>Who is this policy or service aimed at:</td>
<td>This is a joint policy collaboration and partnership with relevant stakeholders in health and wellbeing. We look forward to CNWL NHS Foundation Trust Hillingdon Community Health, Hillingdon Hospital NHS Foundation Trust, Hillingdon, the Local Authority and Third Sector Agencies, working together to make breastfeeding the first choice and a real option for as many as possible in the London Borough of Hillingdon</td>
</tr>
<tr>
<td>Description and aims of the policy/service change</td>
<td>Inform and educate health professionals and relevant stakeholders about supporting mothers who intend to breastfeed or who make a full informed choice to formula feed</td>
</tr>
<tr>
<td>Date EIA Completed</td>
<td>22/05/13</td>
</tr>
<tr>
<td>Nature of the Change</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Details of adverse impact identified</td>
<td>If yes to any of the following a full EIA must be completed</td>
</tr>
<tr>
<td>Does the policy/Service change affect one group less or more favourably than another on the basis of:</td>
<td></td>
</tr>
<tr>
<td>Race or Ethnicity</td>
<td>No</td>
</tr>
<tr>
<td>Nationality</td>
<td>No</td>
</tr>
<tr>
<td>Gender, Marital Status, Pregnancy and maternity</td>
<td>No</td>
</tr>
<tr>
<td>Culture or Heritage</td>
<td>Yes  The policy reflects current government agenda ‘Healthy Lives, Healthy people: A call to action on obesity in England’ with the aim to implement change and improve breastfeeding outcomes and rates.</td>
</tr>
<tr>
<td>Religion, Faith or belief</td>
<td>No</td>
</tr>
<tr>
<td>Sexual orientation, transgender Gender Reassignment</td>
<td>No</td>
</tr>
<tr>
<td>Age</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health</td>
<td>No</td>
</tr>
<tr>
<td>Physical, sensory or Learning</td>
<td>No</td>
</tr>
<tr>
<td>Disabilities</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>--</td>
</tr>
<tr>
<td>Homelessness, Gypsy/Travellers, Refugees/Asylum Seekers</td>
<td>No</td>
</tr>
</tbody>
</table>

I declare that in assessing the proposed documentation/change I have identified that there is a positive discrimination towards breastfeeding but this is reflected by government policy and therefore no further assessment has been done.

Name: Gillian Pearce
Post: CNST Midwife
Signature
Date: 12/08/14
Contact Number: 3555
# Appendix 11

## Plan for Dissemination of Procedural Documents within community setting

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Acknowledgement: University Hospitals of Leicester NHS Trust

<table>
<thead>
<tr>
<th>Title of document:</th>
<th>New-born Feeding Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date finalised:</td>
<td></td>
</tr>
<tr>
<td>Previous document already being used? (Yes (Please delete as appropriate))</td>
<td>Catherine Cooper Kelly Kinsella</td>
</tr>
<tr>
<td>Dissemination lead: Print name and contact details</td>
<td></td>
</tr>
<tr>
<td>If yes, in what format and where?</td>
<td>The Hillingdon Infant feeding Policy - Due for review in January 2017</td>
</tr>
<tr>
<td>Proposed action to retrieve out-of-date copies of the document:</td>
<td>Catherine Cooper to lead retrieval of community based policies by reaching each community base lead. This can be done electronically. Kelly Kinsella to lead implementation of policy at THH, communicate to professionals, retrieve and replace Breastfeeding Policy</td>
</tr>
<tr>
<td>To be disseminated to:</td>
<td>How will it be disseminated, who will do it and when? Paper or Electronic Comments</td>
</tr>
<tr>
<td>Hillingdon Hospital</td>
<td>Kelly Kinsella to ensure all Clinical areas in contact with pregnant women and babies have a copy and are of the changes to the document How : Verbal, email, teaching and hand delivering copies of the policy to individuals</td>
</tr>
<tr>
<td>Hillingdon community Health (Health visiting teams, community paediatric nurses), GP practices, Children Centres, Libraries, Specialist Health Promotion Team (LBH) (former Healthy Hillingdon)</td>
<td>Catherine Cooper to ensure areas in contact with pregnant women and babies have a copy and are aware of the changes to the document. How : Verbal, email, teaching and hand delivering copies of the policy to individuals – replacing policies</td>
</tr>
</tbody>
</table>
Dissemination Record - to be used once document is approved

<table>
<thead>
<tr>
<th>Date put on register / library of procedural documents</th>
<th>Date due to be reviewed</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Disseminated to: (either directly or via meetings, etc.)</th>
<th>Format (i.e. paper or electronic)</th>
<th>Date Disseminated</th>
<th>No. of Copies Sent</th>
<th>Contact Details / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Equality Impact Assessment Tool

Screening to Full Impact Templates:

- Equality Impact Assessment Report Outline
- Screening Grid
- Full Impact Assessment Grid

Remember that your EIA report should demonstrate what you do (or will do) to make sure that your service/policy is accessible to different people and communities, not just that it can, in theory, be used by anyone.

1. **Name of Policy or Service:**

   London Borough Hillingdon Infant Feeding Policy

2. **Responsible Manager:**

   Kelly Kinsella and Catherine Cooper

3. **Date EIA Completed**

   TBA
4. Description and Aims of Policy/Service (including relevance to equalities)

The benefits of breastfeeding are widely recognised. Evidence demonstrates that breastfeeding has an important contribution to make towards reducing infant mortality and the reduction of health inequalities (WHO, 2007; DOH, 2008).

NHS Hillingdon and other relevant stakeholders believe that breastfeeding is the healthiest way for a woman to feed her baby and recognises the important health benefits known to exist for both the mother and her child. All mothers have the right to receive clear up to date evidence based impartial information to enable them to make a fully informed choice as to how to provide optimal nutrition while nurturing a close bond with their babies.

5. Brief Summary of Research and Relevant Data

Please refer to page 17 – where a full list of references and research can be seen

6. Methods and Outcome of Consultation

Electronic draft copies of the policy were sent to all key stakeholders including Head of children’s services, MD of Hillingdon Community Health, Head of Midwifery, Maternity Matron, Health Visiting services, CEPAG, The Director of Public Health Hillingdon

7. Results of Initial Screening

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Assessment of Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Nil</td>
</tr>
<tr>
<td>Gender</td>
<td>Appendix 7 pays reference to the rights of women (Sex Discrimination Act 1975) in supporting women to breastfeed comfortably and freely in public places</td>
</tr>
<tr>
<td>Race</td>
<td>Nil</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>Nil</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>Nil</td>
</tr>
<tr>
<td>Disability</td>
<td>Nil</td>
</tr>
<tr>
<td>Deprivation</td>
<td>Nil</td>
</tr>
<tr>
<td>Dignity and Human Rights</td>
<td>With reference to the human rights of a new-born child, breastfeeding reduces health inequalities from the onset, promotion of breastfeeding places the interest and protection of the child foremost</td>
</tr>
</tbody>
</table>

8. Decisions and/or Recommendations (including supporting rationale)

A Full Equality Impact Assessment is not required as this policy does not discriminate against any equality group.

9. Monitoring and Review Arrangements (including date of next full review)
Not required

*The sections in **bold** must be included within every EIA Report; a full impact assessment will also contain the remaining sections. **Screening Grid** (i.e. is it discriminatory under anti-discriminatory legislation)

<table>
<thead>
<tr>
<th>Equality Area</th>
<th>Key Equalities Legislation / Policy (See summary sheet)</th>
<th>Is this policy or service RELEVANT to this equality area? YES / NO</th>
<th>Assessment of Potential Impact: HIGH MEDIUM LOW NOT KNOWN</th>
<th>Reasons for Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td>Race Relations Act 1976 Race Relations (Amendment) Act 2000</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>Disability Discrimination Act 1995 and 2005</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Age Regulations 2006</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>Equalities Act 2006 Relevant employment legislation</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion and beliefs</td>
<td>Equalities Act 2006 Relevant employment legislation</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deprivation</td>
<td>Tackling Health Inequalities</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dignity and Human Rights</td>
<td>Yes</td>
<td>+</td>
<td>With reference to the</td>
<td></td>
</tr>
</tbody>
</table>
10. Decision whether to proceed to full assessment:

**Yes:** We have decided we should proceed with a full assessment.

**No:** We have decided it is not necessary to undertake full assessment.

**Statement explaining this decision:**

This policy does not discriminate against any equality group but seeks to promote the health and wellbeing of all women and babies.

**Signature of Director:**
**Date:**