‘Breastfeeding should just be how we naturally feed our babies. Our society should be set up for that. Breastfeeding should be what every mum who wants to can do. And it should be a straightforward choice for most. Not a battle. No guilt. Not something that gets criticized. Just feeding a baby in the way nature intended.’

Dr Amy Brown, 2016 ‘Breastfeeding Uncovered’
**The Hillingdon Infant Feeding Policy**

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### Version Control Sheet

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

- Infant Feeding coordinators - Hillingdon Hospital & CNWL
- 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,

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**Review date for approved document**: 19th August 2017
# The Hillingdon Infant Feeding Policy

## Version 7.0

Policy Authors: Sally Crowther & Julia Masdin (Created 07/2017, disposal date 07/2042)

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Operational Summary

Policy Aim
The purpose of this policy is to ensure that all staff at The Hillingdon Hospital NHS Foundation Trust (THH), Central and North West London NHS Foundation Trust (CNWL) and London Borough of Hillingdon Children’s Centres understand their roles and responsibilities in supporting expectant and new mothers and their partners to feed and care for their babies in ways which support optimum health and wellbeing. All staff are expected to comply with this policy.

Policy Summary
This policy provides the basis for the implementation and maintenance of best practice standards for breastfeeding. These are based on the UNICEF Baby Friendly Standards (appendix 1). It acknowledges the importance and clear health benefits that breastfeeding offers for both mothers and babies.

The policy will ensure that all mothers receive impartial evidence based information to help them to decide how to feed and care for their baby. No woman will be discriminated against whatever her chosen feeding method.

What it means for staff
All staff are trained to an appropriate level in infant feeding so that they can enable women and their families to make an informed choice about infant feeding. They will provide ongoing support in order for parents to safely and responsively feed and care for their babies.

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 recognises breastfeeding as the normal way for a woman to feed her baby and there is increasing evidence that it offers health benefits as well as social benefits to both mother and child. Exclusive breastfeeding provides protection from the precursors of morbidity in adult life, such as high blood pressure and obesity and breast milk provides all the nutrients a baby requires in the first 6 months of life.

This Policy is informed by the UNICEF Baby Friendly Initiative (BFI) Standards, the Department of Health (DH) Infant Feeding Recommendation, as well as the National Institute for Health and Clinical Excellence (NICE) guidelines, “Routine postnatal care for women and their babies” and “Maternal and Child Nutrition”. The Department of Health recommends that babies are breastfed exclusively for the first 6 months (26 weeks) of life after which breastfeeding should continue beyond the first year along with appropriate types and amounts of solid foods.

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, The 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 Trust (CNWL)
- 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

Roles specific for The Hillingdon Hospital

**Head of Midwifery is responsible for:**
- Ensuring that the maternity unit complies with the policy and implements Baby Friendly Initiative Standards (appendix 1)
- Supports the Infant Feeding Coordinator to ensure outcomes and targets are met.

**Midwifery Managers/Matrons, Neonatal Managers, Paediatric Managers are responsible for:**
- Ensuring that the policy is distributed within their Directorate and that staff comply.
- Ensuring that resources are available to implement the policy.

**Infant Feeding Coordinator 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 report outcomes and actions, including the re-admission rate of neonates with feeding problems to the postnatal steering group.
- Supporting mothers referred to her with specific problems encountered during infant feeding and formulating an appropriate plan of care.

Roles specific for CNWL

**Head of Children and Young Peoples Services and Operations, Hillingdon:**
- Supports the Infant Feeding Coordinator with the overall implementation, monitoring and effectiveness of this policy
- To allocate resources to provide compliance with this policy

**Infant Feeding Coordinator is responsible for:**
- Breastfeeding Project Management; reporting of data and trends on breastfeeding outcomes.
- 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 promote and support safe and responsive infant feeding practice.
- 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.

**Maternity Staff 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 and relationship building course and an annual update
thereafter.

- To comply with the UNICEF ‘International Code of Marketing of Breast Milk Substitutes’
- To seek the support and advice of the Infant Feeding Coordinator when appropriate.

**Responsibilities of committees**

- Monitoring of the implementation of infant feeding policy 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.
- 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 and parents’ experience surveys.

5 Care Standards

This section of the policy sets out the care that the Trusts are committed to giving each 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, relevant NICE guidance, and the Healthy Child programme.

5.1 Pregnancy

Maternity in partnership with local Children’s 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,
  - How to get breastfeeding off to a good start.

A record of these conversations should be documented on the ‘Conversations in Pregnancy’ sheet.

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.
- This must be documented on the ‘Conversations in the Postnatal Period’ sheet.

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)
Skin to Skin - 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 analgesia which causes drowsiness or alters their state of awareness (e.g. entonox).

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

‘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.

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.

The ‘Conversations in the Postnatal Period’ sheet must be completed to reflect this. 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, follow the national guidelines (Appendix 6) 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 (Appendix 4)

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. A breastfeeding assessment must be carried out using the breastfeeding assessment tool (available from Intranet) prior to discharge home and at least one other time before discharge to the Health Visiting Team. It should also be used if any problems are developing alongside a plan of care.

All breastfeeding mothers will be informed about our local support services for breastfeeding. This includes the health visiting service well baby clinics and telephone help line, the Children’s Centres support and advice across the borough, and the breastfeeding peer support volunteers available in the hospital, Children’s Centres and social media. Mothers will also be given information about voluntary organisations.

For those mothers who require additional support for more complex breastfeeding challenges, a referral to a specialist service should be made (Appendix 7).

**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 or to ease maternal discomfort e.g. engorgement, 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.

**5.4 Exclusive Breastfeeding:**

- Mothers who breastfeed will be provided with information about why exclusive breastfeeding leads to the best outcomes for their baby; and why it is particularly important during the establishment of breastfeeding.
- When exclusive breastfeeding is not possible, the value of continuing partial breastfeeding will be emphasised and mothers will be supported to maximise the amount of 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 3.1)
- 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’

Examples of babies at risk are:
- Small for gestational age
- Pre-term
- Babies of diabetic mothers
- Babies with jaundice
- Women with Body Mass index > 40
- Compromised at birth: infection/hypoxic
- Babies identified with complex needs / tongue tie (see Appendix 7)
- Babies with significant weight loss greater than 8% (see Appendix 7)

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 others apart from the main caregiver(s) feeding their baby.

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 breastfeeding assessment tool will be carried out at the 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.

For those mothers who require additional support for more complex breastfeeding challenges, a referral to a specialist service should be made (Appendix 7).

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 new 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 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 (appendix 6)

### 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 9.

### 7. NHS Constitution

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

### 8. Training

All health professionals support workers 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 CNWL, see (Appendix 3). New staff will receive training within 3-6 months of taking up their post. All staff will be required to attend annual update training.

### 9. Monitoring Implementation of the Standards

THH, CNWL and LBH requires that compliance with this policy is audited at least annually using the UNICEF UK Baby Friendly Initiative audit tool.
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. An action plan will be agreed by this 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 4-6 week mother baby contact in the community.
- Service user satisfaction data will be collected by both THH and CNWL

Outcomes will be monitored by: THH and CNWL Infant Feeding Coordinators and reported to: The Head of Midwifery Services, The Head of Children and Family services and the Director of Public Health for Hillingdon.

Quarterly and data annual collection will be reported to Breast Feeding Strategy Group.

<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>Weight loss above 10%</td>
<td>Infant feeding midwife</td>
<td>Incident reporting</td>
<td>Trends</td>
<td>quarterly</td>
<td>To postnatal steering group; Actions and outcomes monitored by Maternity Clinical Governance</td>
<td>Matron; Head of Midwifery Consultant Paediatrician</td>
</tr>
<tr>
<td>New-borns readmitted to hospital with feeding</td>
<td>Infant feeding midwife</td>
<td>Incident reporting</td>
<td>Trends</td>
<td>quarterly</td>
<td>To postnatal steering group; Actions and outcomes monitored by Maternity Clinical Governance</td>
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The Hillingdon Infant Feeding Policy
Version 7.0. Policy Authors Sally Crowther & Julia Masdin (Created 07/2017 – disposal date 07/2042) 17
<table>
<thead>
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<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>Infant feeding training to staff</td>
<td>Practice development team</td>
<td>Training needs analysis</td>
<td>Trends 6 monthly</td>
<td>Maternity Clinical Governance</td>
<td>Infant feeding lead Paediatric Consultant PDT</td>
<td>To assess if training meets required standard</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 2015 updated ‘sample’ draft of the Infant Feeding Policy.

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

- Cochrane Library: [http://www2.cochrane.org/reviews/en/ab001141.html](http://www2.cochrane.org/reviews/en/ab001141.html)
- International Breastfeeding Journal: [https://internationalbreastfeedingjournal.biomedcentral.com/](https://internationalbreastfeedingjournal.biomedcentral.com/)


12. Associated Documentation

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

- Postnatal Care
- Hypoglycaemia: Management of At-Risk Babies Outside the Neonatal Unit
- Immediate Care of the Newborn
- Raised Body Mass Index (BMI) in Pregnancy
- HIV Infection in Pregnancy
- Early Onset Neonatal Infection
- Hepatitis C in Pregnancy
- Hepatitis B in Pregnancy
- Gestational Diabetes: Diagnosis, Antenatal Care, Delivery and Postnatal Care
- Management of Hyperbilirubinaemia in Primary and Secondary Care Settings in the Term Healthy Newborn Baby
- Caesarean Section
- Antenatal Management of Hypertension in Pregnancy & Pre-Eclampsia
## 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. Evidence of improving outcomes and more advanced staff education can all contribute towards a services application for Advanced or Beacon Baby Friendly status.
Appendix 2

Professional Training for all Relevant Stakeholders

New starters – access the mandatory (in-house) 2-day Breastfeeding & Relationship Building Course within three-six months of commencing post. If the individual can provide evidence of having completed the course at another facility, they will not be required to repeat it.

Attend annual Breastfeeding update thereafter. Bespoke training can be accessed via the Infant Feeding coordinator for teams or individuals on request.

Existing member of staff

If you HAVE attended The Breastfeeding & Relationship Building course?

Attend annual Breastfeeding update Bespoke training can be accessed via the Infant Feeding coordinator for teams or individuals on request.

If you have NOT attended The Breastfeeding & Relationship Building course?

Professional to access the mandatory (in-house) 2-day Breastfeeding & Relationship Building Course at the earliest opportunity.

Attend annual Breastfeeding update Bespoke training can be accessed via the Infant Feeding coordinator for teams or individuals on request.
Appendix 3: Infant Feeding: Maternity Services
Appendix 3.1

Guidance for Staff on Completion of INFANT FEEDING SUPPLEMENTATION STICKER

This Sticker to be completed and placed in the mother’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.

There is an ongoing audit to help us to monitor our practice and protect lactation / breastfeeding.

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

The Infant feeding co-ordinator will use these stickers to audit the notes monthly.

Please direct the parents to the information on supplements in the 'Feeding Your Baby' folder

Any concerns please do not hesitate to speak to the ward manager or the Infant feeding Co-ordinator.

Contact number:   x 3723
<table>
<thead>
<tr>
<th>Artificial Milk Supplement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date…………………………Time………….</td>
</tr>
<tr>
<td>Requested by:</td>
</tr>
<tr>
<td>Mother□ Midwife□ Neonatologist□</td>
</tr>
<tr>
<td>Reason:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Steps taken to protect breastfeeding</td>
</tr>
<tr>
<td>□ Positioning and attachment support</td>
</tr>
<tr>
<td>□ Skin to skin</td>
</tr>
<tr>
<td>□ Hand expression</td>
</tr>
<tr>
<td>□ None of the above (document why not)</td>
</tr>
<tr>
<td>Discussed with mother:-</td>
</tr>
<tr>
<td>□ concerns explored</td>
</tr>
<tr>
<td>□ impact on milk supply</td>
</tr>
<tr>
<td>□ plan for next feed (document in notes)</td>
</tr>
<tr>
<td>Volume…………Method..........</td>
</tr>
</tbody>
</table>

Sign & Print:
Appendix 3.2

Use of Artificial Teats, Dummies, Nipple Shields and Cup Feeding

Dummies and teats have been shown to have a detrimental effect on breastfeeding, especially when 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 notes. Where supplementation has been medically recommended it should be preferably given by cup, which is less disruptive to breastfeeding than feeds given via a bottle and teat.

Guidance for staff - term well babies: bottles and teats should only be used in support of breastfeeding 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. 1ml Oral syringes should only be used to give tiny amounts of colostrum only (<0.5mls).

Nipple shields will not be routinely recommended. They occasionally have a place particularly for babies who have become used to a teat. They must never be used until there is evidence that the mother is lactating (i.e Day 3 / milk has come in). The potential consequences of their use will be explained – inadequate milk transfer / milk production, nipple confusion - and the mother will require ongoing support from an appropriately trained health professional and a plan to return to direct breastfeeding.

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 member of staff how to cup feed safely. They will first demonstrate and then observe a mother cup feed until she is competent. Her competence needs to be recorded in the maternal notes. (See https://globalhealthmedia.org/portfolio-items/cup-feeding/?portfolioID=5623)

Cup Feeding Method

*Only* cup feed when the baby is awake and alert.

Cup feeding helps a mother work towards breastfeeding 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...
breastfeeding. 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 breastfeed by using skin to skin contact and offering the breast frequently. Appropriately trained 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 starting. 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. Leave the cup gently resting in this position for the duration of the feed. **Never** pour the milk into the baby’s mouth.

**How a baby feeds from a cup;** 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. When cup feeding session is finished, wash cup in soapy water and dry store for the next feed.
Appendix 4

Inpatient Support for Mothers who are Separated from their Babies

(a) Antenatal women who are in the at risk groups (diabetes, BMI 40+, previous breast surgery), or any woman who wishes to, should have a discussion on colostrum harvesting and storage of expressed colostrum.

(b) Mothers who are separated from their babies will be encouraged to hand express their milk as soon as possible, ideally eight times in 24 hours. 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.

(c) Once mothers are producing >5mls colostrum or are lactating, an electric pump can be used. Electric pumps are available on the Maternity unit and the Neonatal unit.

(d) 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.

## 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 syringes or bottles must be labelled as follows:

- **NAME:**
- **DATE:**
- **TIME:**
- **BABYS HOSPITAL NUMBER/MOTHERS HOSPITAL NUMBER:**
Please Note: Painful nipples or breasts are often a sign that baby’s attachment to the breast is incorrect.

Observe a full breastfeeding and complete the Breastfeeding Assessment Tool. Information and guidance regarding positioning and attachment should be offered. If required, further support and help should be sought from the Infant Feeding Coordinator.

5.1 Engorgement can occur if the baby is not allowed unrestricted access to the breast or is not attaching effectively. When the breast is engorged, oedematous and the milk is not flowing freely, it is important NOT to use heat as this will exacerbate the condition. Cold compresses, reverse pressure softening to enable gentle hand expression can enable milk to flow and reduce the build-up of Feedback Inhibitor of Lactation (FIL). For full breasts where the milk is flowing easily, warm compresses can be used and unrestricted breastfeeding or expression encouraged. If in doubt, use cold compresses rather than heat.

5.2 Mastitis: Caused by localised milk obstruction or prolonged engorgement and attachment issues.
- Assess for effective positioning and attachment and correct as necessary
- Continue to breastfeed frequently, particularly on the affected side
- Express milk by hand or pump to relieve stasis
- Consider changing feeding position to align 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

5.3 Thrush: Both mother and baby can suffer from thrush infections. 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 as 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 cry at the breast or refuse the breast or bottle.

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 which often persists after the feed.

If thrush is suspected, it must be confirmed by a swab prior to treating.
See Breastfeeding Network website for up to date advice on diagnosing and prescribing. [https://breastfeedingnetwork.org.uk/wp-](https://breastfeedingnetwork.org.uk/wp-
5.4 **Breast Reduction Surgery:** Lactation can be compromised after breast reduction surgery. The mother needs to be aware of the possible limitations post surgery can have on her lactation. There is evidence that antenatal colostrum harvesting can be helpful. The baby needs to be carefully monitored in the early days for effective milk transfer. The Infant Feeding Coordinator should always be involved in this discussion with the mother.

5.5 **Medication and Breastfeeding:** Women who are on medication during pregnancy should have a discussion with her consultant obstetrician to ensure the medication is not contraindicated when breastfeeding. If so, alternatives should be explored.

Mothers who are required to take medication that is contraindicated in breastfeeding should have an opportunity to explore this further with the relevant consultant, consultant Neonatologist and the Infant Feeding Co-ordinator should be involved 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.

5.6 **Woman who are HIV positive:** should not breastfeed where safe, affordable infant food alternatives are available to reduce the risk of possible vertical transmission.

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

5.8 **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 a 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.
Standards of Care with Bottle Feeding

It is essential that all Health Professionals should update their advice to families. In particular knowing that the recommendations suggest that parents choose a first formula and stay on this for the first year. The following leaflet should be read by all staff involved in management of formula feeding:


It is also important for all health professionals to refer to the International Code of Marketing of Breastmilk Substitutes


Parents can find information at:-
http://www.firststepsnutrition.org/

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

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.
6.1 Information for Parents who formula feed

➢ How to formula feed. They should be offered help and teaching with the first feeds.
➢ How to choose an appropriate first/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.

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

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

7.1 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.

7.2 Babies identified with suspected tongue tie
The Midwife or Health Visitor who identifies a tongue tie can refer the baby directly for frenulotomy after a full breastfeeding assessment. If unsure, please refer to the Infant Feeding Coordinator using the Specialist Infant Feeding Clinic referral pathway. It is not normal for babies to be unable to attach to the breast. Where breastfeeding difficulties persist beyond the first 10 days of life, despite appropriate skilled help and support, tongue tie should be suspected and referral made to the Specialist Infant Feeding Clinic.
Care Pathway: Tongue Tie in the Breastfeeding Infant

**Definition:** Tongue-tie (ankyloglossia) occurs when the lingual frenulum is abnormally short or restricting. Normally it is elastic allowing free movement of the tongue. When it is short, thick, tight or broad, or extends across the floor of the mouth to finish at the base of the teeth it restricts the mobility of the tongue.

**Suspected tongue tie**

Visually observed by professional or parent

**Mother:** may present with **any** of the following:
- Sore / damaged nipples, pain during feeding
- Misshapen nipples following feeds
- Baby:
  - Excessive early weight loss
  - Slow weight gain
  - Frequent/long feeds
  - Unsettled baby
  - Noisy feeding (clicking)
  - Colic/reflux.

**Check for tongue tie**

Assessment whilst crying can enable visualisation of the frenulum or placing mild pressure with finger to the chin to open the mouth. Observe:
- Frenulum may be seen to attach close to the tip of the tongue or to restrict movement of the tongue
- Heart shaped tip to the tongue on extension
- NB – not all tongue ties are visible to the naked eye – see further signs and symptoms.

**Complete Breastfeeding assessment**

- NB often external signs will indicate good attachment, be led by maternal comfort and appearance of nipple following feed
- Exclude position and attachment difficulties
- A ‘good’ latch can usually be improved!

**Tongue Tie with difficulty feeding**

(may or may not include poor weight gain)


Parents wish to proceed with tongue tie division

Parents do not wish to proceed with tongue tie division or wish to explore further

Support parent with evidenced based knowledge in continuing breastfeeding and how to access ongoing support.

**Refer**

- Complete and email appropriate referral form (available on shared drive)
- If unsure, discuss with Infant Feeding Coordinator.

Plan for follow-up post procedure with named Health Professional.

NB Improvement may not be immediate.
7.3 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.

- **6-8 hours following birth**
  - Second feed completed?
  - Fed effectively?

  **NO**
  - Initiate active feeding plan**

- **Birth**
  - Dry baby/ keep warm
  - Initiate and maintain skin to skin for at least 1 hour or until after first feed.
  - Encourage responsiveness with mother.
  - Discuss signs of readiness to feed
  - First feed in skin to skin contact preferably within 1 hour
  - For babies being fed formula follow the chart but give formula milk instead of colostrum
  - Fed effectively?

  **NO**

  **YES**

- **1-2 hours following birth.**
  - Maintain skin-to-skin contact
  - Review in 1-2 hours
  - Assess well-being of the baby and record observations on NEWS chart.
  - If breastfeeding encourage mother to hand express and give small amounts of colostrum to baby

  **NO**

  **YES**

- **Complete Initial Breastfeeding Assessment:**
  - Within 6 hours of birth or once feeding initiated.
  - Assess:
    - Signs of effective feeding
    - Pain free
    - Maternal concerns
    - Breast/nipple damage
    - Baby readiness to feed
    - Monitor wellbeing*

  **NO**

  **YES**

- Once the baby is feeding successfully, perform full breastfeeding assessment prior to discharge

- **Active Feeding Plan** **
  - Maintain skin contact
  - Commence feed chart
  - Review every 2 to 4 hours & document findings
  - Actively encourage breastfeeding
  - Offer feeds according to feeding cues at least 8-10 times in 24 hours when feeding is established.
  - If breastfeeding: hand express at least 8-10 times in 24 hours (commence pumping when milk comes in if mother chooses to do so)
  - Continue to give expressed breast milk and actively support until successfully breastfeeding
  - Avoid teats, dummies and nipple shields
  - Support mother and listen/action any concerns voiced regarding ill-health
  - Refer to neonatal team if any concerns
  - Monitor well-being of baby at least 4 hourly*
  - Continue until feeding issue resolves

---

*Monitor well-being of baby at least 4 hourly*

Check & document:
- Any maternal concerns
- Colour
- Tone
- Respiratory well-being
- Temperature
- Alertness/level of consciousness
- Number and consistency of wet and dirty nappies
- Risk for sepsis

If any signs of illness refer to neonatal team.

Any concerns about possible hypoglycaemia or ill-health, refer to relevant guideline.
7.4 Guidelines relating to the Prevention and Management of Excessive Weight Loss

7.4.1 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.
- Babies are to be weighed at birth, on day 5 (approx.120hrs old) and day 10. If there are signs that feeding is not going well and indications of inadequate intake (see 8.8.3) perform a breastfeeding assessment and consider weighing at 72 hrs.
- 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.

7.4.2 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 reduction surgery, pituitary disorders, hypothyroidism, the combined pill, polycystic ovary disease and unexplained infertility).
7.4.3 Preventing Excessive 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>Maternal 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>• After 24 hrs of age, feeding &lt; 8 times in 24 hours</td>
<td>• Sore or damaged nipples; nipples misshapen or ‘pinched’ at end of feed</td>
<td>• Baby ‘fussy’ at the breast – on and off the breast frequently during the feed or refuses to breastfeed</td>
</tr>
<tr>
<td>• Not sustaining an effective sucking/swallowing pattern.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Feeding very frequently i.e. more than 12x in 24 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consistently feeding for &lt; 10 minutes or &gt; 45 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Unsettled after feeding.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inadequate output (see chart below)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Assessment of output (baby) at each postnatal check.
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><strong>Urine</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of wet</td>
<td>1-2 or more; urates may be</td>
<td>3 or more; nappies feel heavier</td>
<td>5 or more; heavy</td>
<td>6 or more; heavy</td>
</tr>
<tr>
<td>nappies per day</td>
<td>present *</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Stools</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number per day,</td>
<td>1 or more, dark green/black.</td>
<td>2 or more, changing in colour and</td>
<td>2 or more, yellow may be watery</td>
<td>2 or more at least the size of a</td>
</tr>
<tr>
<td>colour &amp;</td>
<td>Meconium</td>
<td>consistency-brown/green/yellow</td>
<td></td>
<td>£2 coin, yellow, watery, seedy</td>
</tr>
<tr>
<td>consistency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*NB 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
### 7.4.4 Management of weight loss >8%

<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>
<tbody>
<tr>
<td>1</td>
<td>8-10%</td>
<td>Observe a full breastfeeding - ensure effective attachment &amp; positioning. Complete breastfeeding assessment tool. Ensure baby is alert with good tone. Observe for effective sucking pattern. Advise breast compressions during feed. Ensure minimum of 8 feeds in 24hrs – support mother to recognise and respond to feeding cues. Skin contact to encourage breastfeeding. Observe for change in amount/frequency of urine and stools. Re-weigh on day 7. Document findings and plan in notes. If weight increasing continue to monitor and support. If no or minimal weight gain move to <strong>Management Plan 2</strong></td>
</tr>
<tr>
<td>2</td>
<td>10-12%</td>
<td><strong>Follow Management Plan 1</strong> Where possible discuss with Infant Feeding Coordinator. Express breast milk after each feed and offer to baby preferably by cup or otherwise paced bottle feeding. Check for any signs of infection or suspected illness. If yes, discuss with neonatal registrar. Weigh again in 24-48 hours. If no or minimal weight gain, move to <strong>Management Plan 3</strong></td>
</tr>
<tr>
<td>3</td>
<td>12%&gt;</td>
<td>Refer to A&amp;E for review by paediatrician and Infant Feeding team. All neonatal admissions less than 28 days should trigger a Datix. <strong>Follow Management Plan 2 plus:</strong> Frequent breastfeeds and expressing using a hospital grade pump. Paediatric team to carry out investigations to determine on going care. If breastfeeding ineffective or EBM not available, supplements may be required, counsel re: option of NGT to reduce risk of nipple confusion. Reduce formula feeds as breast milk supply increases. Weigh again after 24 hours. Continue to monitor weight as appropriate.</td>
</tr>
</tbody>
</table>
7.4.5 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 neonatal registrar 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.
- Consider tongue tie.
**Appendix 8**

**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 Baby Friendly standards
- 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
<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>Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation?</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Clinical Governance Committee</th>
<th>Date</th>
<th>August 2014</th>
</tr>
</thead>
</table>

Acknowledgement: NHSLA Policy Template/Cambridgeshire and Peterborough Mental Health Partnership NHS Trust
Appendix 9

EQUALITY IMPACT ASSESSMENT (EIA) INITIAL SCREENING TOOL

<table>
<thead>
<tr>
<th>Name of Policy or Service:</th>
<th>Hillingdon Infant Feeding Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Author:</td>
<td>Julia Masdin (Infant Feeding Coordinator, THH) and Sally Crowther (Infant Feeding Coordinator, CNWL)</td>
</tr>
<tr>
<td>Who is the policy or service aimed at? (Staff, Patients/Carers, Visitors/Public)</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</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>What outcomes are wanted from this policy/service?</td>
<td>To ensure that all mothers receive impartial evidence based information to help them to decide how to feed and care for their baby. No woman will be discriminated against whatever her chosen feeding method.</td>
</tr>
<tr>
<td>Are there any factors that might prevent outcomes being achieved?</td>
<td>Policy non-compliance</td>
</tr>
</tbody>
</table>

You must assess each of the 9 areas separately and consider:

1. Where you think that the policy/service could have a **NEGATIVE** impact on any of the equality groups, i.e. it could disadvantage them
2. Where you think that the policy/service could have a **POSITIVE** impact on any of the equality groups like promoting equality and equal opportunities or improving relations within equality groups
3. Where you think that this policy/service has a **NEUTRAL** effect on any of the equality groups listed below i.e. it has no effect currently on equality groups.

<table>
<thead>
<tr>
<th>Equality Groups</th>
<th>Positive impact</th>
<th>Negative impact</th>
<th>Neutral effect</th>
<th>If negative, please state why and the evidence used in your assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age?</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Sex (Male and Female)?</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
Disability (Learning Difficulties / Physical or Sensory disability)? | X |
Race or Ethnicity? | X |
Religion, Faith or Belief? | X |
Sexual Orientation (gay, lesbian or heterosexual)? | X |
Pregnancy and Maternity? | X |
Gender Reassignment (the process of transitioning from one gender to another)? | X |
Marriage and Civil Partnership | X |
Mental Health | X |
Homelessness, Gypsy/Travellers, Refugees/Asylum seekers | X |

➢ 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.

If you have identified a negative impact to any of the above, you must complete a full Equality Impact Assessment (See Appendix B)

Summary

I declare that I have paid due regard to equality (i.e. promote equality of opportunity between communities/staff, eliminate discrimination that is unlawful, promote positive attitudes towards communities/staff) for this policy / service.

I declare that in assessing the proposed policy / service I have identified that there is unlikely to be an adverse impact on different minority groups

| Name: Gillian Pearce | Date: 12/12/2017 |
| Post: Midwife | Contact Number: 3555 |
Appendix 10

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?</td>
<td>Yes</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>
</tbody>
</table>

Proposed action to retrieve out-of-date copies of the document:

- 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

To be disseminated to:

- **Hillingdon Hospital**
  - 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
  - To be uploaded on the hospital intranet

- **Hillingdon community Health (Health visiting teams, community paediatric nurses), GP practices, Children Centres, Libraries, Specialist Health Promotion Team (LBH) (former Healthy Hillingdon)**
  - 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
  - To be uploaded on the HCH and community intranet, Copy to be available on the LBH website
**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 positive (+) negative (-)</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>Human Rights Act 1998 (relevant articles)</td>
<td>Yes</td>
<td>+</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</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: