University Hospitals of North Midlands NHS
NHS Trust

Policy No. C45
Trust Policy and Guidelines for Infant Feeding

The following personnel have direct roles and responsibilities in the implementation of this policy:

- **All Trust Staff**

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Trust Contact:	**Lead Infant Feeding Co-Ordinator**
Executive Lead:	**Chief Nurse**

Version Control Schedule

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7	August 2015	

University Hospitals of North Midlands NHS
NHS Trust

Statement on Trust Policies to be included in all policies

Staff Side and Trade Unions
The University Hospitals of North Midlands NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way in which we provide services to the public and the way in which we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

Equality and Diversity
The University Hospitals of North Midlands aims to promote equality and diversity and value the benefits this brings. It is our aim to ensure that all staff feel valued and have a fair and equitable quality of working life.

Equality Impact Assessment
The organisation 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. The Equality Impact Assessment tool is designed to help you consider the needs and assess the impact of your policy.

Information Governance
Any Trust policy which impacts on or involves the use and disclosure of personal information (patient or employee) must make reference to and ensure that the content of the policy is comparable with the relevant statutory or legal requirement and ethical standards

Data Protection Bill, General Data Protection Regulations (GDPR) and the NHS Code of Confidentiality
GDPR replaces the EU Data Protection Directive of 1995 and supersedes the law of member states that were developed in compliance with the Data Protection Directive 95/45/EC. Its purpose is to protect the "right and freedom" of natural persons (i.e. livening individuals) and to ensure that personal data is not processed without their knowledge, and, wherever possible, that it is processed with their consent.

Processing includes holding, obtaining, recording, using and disclosing of information and applies to all forms of media, including paper and images. It applies to confidential patient information but is far wider in its scope, e.g. it also covers personal records

Whiles GDPR applies to both patient and employee information, the Confidentiality Code of Practice (COP) applies only to patient information. The COP incorporates, the requirements of GDPR and other relevant legislations together with the recommendations of the Caldicott report and medical ethics considerations, in some cases extending statutory requirements and provides detailed specific guidance.

Freedom of Information Act 2000
The Freedom of Information Act 2000 (FOIA) is an Act which makes legal provision and creates a legal gateway and timetable for the disclosure, to the public, of the **majority** of corporate information held (but not necessarily created) by this Trust. The Trust has a legal responsibility to proactively provide a large amount of information to the public and to pro-actively respond to specific requests for information. Information will not be disclosed when the Trust can claim legal exemption. Any non-disclosure must be conveyed in writing; quoting the relevant exemption together with signposting to internal and external methods of compliant. Locally, guidance on the DPA, FOIA and COP can be obtained from the Information Governance Manager or the Caldicott Guardian.

Mental Capacity Act

Any Trust policy which may affect a person who may lack capacity should comply with the requirements of the Mental Capacity Act 2005 (MCA)

The MCA and its associated Code of Practice provides the framework for making decisions on behalf of individuals who lack the mental capacity to do these acts or make these decisions for themselves. Everyone working with and/or

caring for adults who lack capacity, whether they are dealing with everyday matters or life-changing events in the lives of people who lack capacity must comply with the Act.

In a day to day context mental capacity includes making decisions or taking actions affecting daily life – when to get up, what to wear, what to eat etc. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person lacking capacity, or for other people.

The Code provides guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do this for themselves. In particular, it focuses on those who will have a duty of care to a person lacking capacity and explains how the legal rules set out in the Act will work in practice.

The Health Act: Code of Practice for the Prevention and Control of Health Care Associated Infections
The purpose of the Code is to help NHS bodies plan and implement how they can prevent and control HCAI. It sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean, safe environment, where the risk of HCAI is kept as low as possible. Failure to observe the Code may either result in an Improvement Notice being issued by the Care Quality Commission, or in the Trust being reported for significant failings and placed on 'Special Measures'.

The Code relates to healthcare provided by all NHS bodies. Each NHS body is expected to have systems in place sufficient to comply with the relevant provisions of the Code, so as to minimise the risk of HCAI to patients, staff and visitors.
The Trust Board must have an agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks.

Effective prevention and control of HCAI must be embedded into everyday practice and applied consistently by all staff.

Human Rights
The Trust is committed to the principles contained in the Human Rights Act. We aim to ensure that our employment policies protect the rights and interests of our staff and ensure that they are treated in a fair, dignified and equitable way when employed at the Trust.

Sustainable Development
The University Hospitals of North Midlands NHS Trust (UHNM) is committed to demonstrating leadership in sustainability and has a Trust Board approved Sustainable Development Management Plan (SDMP): Our 2020 Vision: Our Sustainable Future which sets out the route to developing a world-class healthcare system that is financially, socially and environmentally sustainable.

There are three 'Key Priorities' to aim for by 2020. With the help of employees, key partners and other stakeholders the trust will embed opportunities to:

1. Reduce our environmental impact, associated carbon emissions and benefit from a healthier environment;
2. Improve the resilience of our services and built environment as a result of severe environmental and climatic changes;
3. Embed sustainable models of care and support our local community to be well-connected, healthy, resilient, independent and managing their lives in a positive way.

The SWITCH campaign is designed to achieve these priorities. It is relevant to all departments and all members of staff. The focus is on using resources sustainably in order to provide better patient care, improve health and our working environment.

Contents

This document should be read in conjunction with the Maternity Services Risk Management and Skills Drills Training Needs Analysis.

1. INTRODUCTION

Evidence regarding the key contribution that breastfeeding makes to health and development continues to increase. The substantiated effects on health are well documented. If a mother chooses not to breastfeed, this can pose significant risks for both mother and child. In the short term, there is an increased risk to the infant of admission to hospital for gastroenteritis and respiratory disease. Recently published Infant Feeding profiles (DH, 2013a) show a correlation at Primary Care Trust level between higher rates of breastfeeding prevalence and lower rates of inpatient admissions among infants under one year old for 10 conditions: lower respiratory tract infections, infant feeding difficulties, wheezing, gastroenteritis, non-infective gastroenteritis, eczema, otitis media, infant feed intolerance, lactose intolerance and asthma. In the longer term, infants who are not breastfed tend to have higher blood pressure and are at greater risk of type 2 diabetes and obesity .Breastfeeding provides a unique opportunity for attachment between mother and baby and can protect the child from maternal neglect. For mothers, breastfeeding is associated with a reduction in breast and ovarian cancers. No other health behavior has such a broad-spectrum and long-lasting impact on public health. The child's road to success and subsequent life chances begin in pregnancy and strong emotional bonds between a parent and their baby are built on good foundations in the early postnatal period and through breastfeeding. (Entwistle 2013)

For generations in the UK, formula feeding and routinized care has been the cultural norm. As a consequence, the physiological norm of breastfeeding, and subsequently emotional attachment and parenting skills, has been interrupted. In addition, continuous media attention and social trends undermine women's confidence in their ability to breastfeed. For some women living in this environment, breastfeeding can be very challenging. Women make decisions about their infant feeding choices for a variety of reasons, including their own cultural expectations and personal circumstances they then choose not to breastfeed, they need the best possible evidence-based information to help them to minimize the risks of formula feeding (UNICEF 2013).

This policy should be read in conjunction with:

- Entwistle FM (2013) The evidence and rationale for the UNICEF UK Baby Friendly Initiative standards.
- UNICEF UK Baby Friendly initiative standards.(2012)
- Trust Policy HS12 (Ionising Radiation Protection) paragraphs 5.11.1, 6.3.6 and 6.5.1
- UHNM (2014) Guidelines for the assessment of breastfeeding, prevention of excessive weight loss, and the process to be followed for weighing all neonates.
- UNICEF 2012. Preventing disease and saving resources.
- Department of Health (DH) A public Health Outcomes Framework for England.(2012)
- NICE(2006) Routine postnatal care of women and their babies.
- NICE(2013) Postnatal care quality Standards 37.
- RCM(2012) Maternal and emotional wellbeing and infant development: A good Practice Guide for Midwives.
- UNICEF (2010) The health professionals guide to "A guide to infant formula for parents who are bottle feeding"
- An "Equality Impact Assessment has been made and no actual or potential discriminatory impact has been identified.
- DoH 2010 Midwifery 2020 : Delivering Expectations

2. POLICY STATEMENT

The purpose of this policy is to ensure that all staff at the University Hospitals of North Midlands NHS Trust (UHNM) 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. In recognition of this mothers and babies who are breastfeeding will be supported to do so within all departments of the University Hospitals of North Midlands NHS Trust.

Staff will create an environment where more mothers are able to choose to breastfeed their babies and where more mothers are given sufficient information to enable them to breastfeed exclusively for six months and then continue as part of their infant's diet as long as they both wish. (DOH 2003).

Employees of the University Hospitals of North Midlands NHS Trust returning to work following maternity leave and who wish to continue breastfeeding are supported to do so. Considerations regarding how they are best supported to do this should be on an individual basis with discussions between the member of staff and her manager. (ACAS 2014)

This policy has mandatory status and any deviation should be recorded in the West Midlands Perinatal Institute Hand Held Records.

All staff are expected to comply with this policy.

Outcomes

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

a) Maintenance of UNICEF Baby Friendly accreditation for the maternity units and neonatal unit.
b) An increase in breastfeeding initiation rates.
c) amongst mothers who choose to formula feed, an increase in those doing so as safely as possible, in line with nationally agreed guidance
d) improvements in parents' experiences of care
e) a reduction in the number of re-admissions for feeding problems

3. OUR COMMITMENT

UHNM is committed to:

Providing the highest standard of care to support expectant and new mothers and their partners to feed their baby and build strong and loving parent- infant relationships. This is in recognition of the profound importance of early relationships to future health and well-being, and the significant contribution that breastfeeding makes to good physical and emotional health outcomes for children and mothers.

Ensuring that all care is mother and family centered, non-judgmental and those mothers' decisions are supported and respected.

Working together across disciplines and organizations to improve mothers' / parents' experiences of care.

As part of this commitment the service will ensure that:

All new staff within the Maternity and Neonatal unit is familiarized with this policy on commencement of employment within their first week. (Appendix 1)

All staff 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 .This prohibits the display or distribution of materials which promote breast milk substitutes, feeding bottles, teats or dummies. The display of manufactures logos on items such as calendars and stationary is also prohibited under this code.

All documentation fully supports the implementation of these standards.

Parents' experiences of care will be listened to through: regular audit, maternity questionnaire and maternity services liaison committee.

4. SCOPE

This policy will mainly affect the maternity and neonatal unit but contains information for practice in all areas where mothers and their babies may be cared for. Thus fostering good practice throughout the Trust and providing training that is appropriate to the level of contact with mothers and their babies.

5. ROLE AND RESPONSIBILITIES

It is important that all trust staff adhere to this policy to avoid conflicting advice and to improve practice and maintain UNICEF baby friendly accreditation within the Maternity and neonatal unit.

Lead Infant feeding co-ordinator – To ensure that UNICEF Baby friendly standards are implemented and updated as per policy and guidance.

Infant feeding team- To ensure that the policy and guidance are implemented and provide clinical support to ward staff.

Head of Midwifery Divisional Nurse Surgical Division – Supports Infant feeding team with implementation of UNICEF Baby Friendly Standards and involved in the audit process to ensure compliance

Deputy Head of midwifery - Supports Infant feeding team with implementation of UNICEF Baby Friendly Standards and involved in the audit process to ensure compliance

NNU Breast feeding co-ordinator - To ensure that UNICEF Baby friendly standards are implemented and updated as per policy and guidance.

NNU Manager – Supporting the Infant feeding co-ordinator in implementing the UNICEF Baby friendly standards and audit process

Band 8 Clinical Managers - Supporting the Infant feeding co-ordinator in implementing the UNICEF Baby friendly standards and audit process relevant to their area (community, delivery suite, antenatal clinic, MAU)

Band 7 Clinical Managers - Supporting the breast feeding coordinator in implementing the UNICEF Baby friendly standards and audit process relevant to their area

All staff within the maternity, neonatal unit and community has a responsibility to provide high level of care and support to maintain the UNICEF Baby Friendly Standards

6. PRINCIPLES

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 and relevant NICE guidance.

Pregnancy

All pregnant women will have the opportunity to have a meaningful discussion regarding feeding and caring for their baby with a health professional (or other suitably trained designated person). The discussion should take into account their own individual circumstances and needs.This discussion will include the following topics.

- The value of connecting with their growing baby in utero
- The value of skin contact for all mothers and babies
- The importance of responding to their baby's needs for comfort, closeness and feeding after birth, and the role that keeping their baby close has in supporting this
- Feeding, including: an exploration of what parents already know about breastfeeding
- The value of breastfeeding as protection, comfort and food
- Getting breastfeeding off to a good start
- **Ideally the discussion should happen in any care setting and could be part of routine antenatal care or as part of a class. The Midwife has the responsibility to check that this discussion has taken place prior to the 36 week appointment whether this is in the community or in the maternity unit and appropriate action taken to facilitate this if it has not happened. This should be recorded in the maternity hand held records.**

Where Antenatal classes are provided the information should be evidenced based and based on the UNICEF baby friendly initiative standards. Further information about effective programmes of Antenatal classes should be taken from the Department of Health (DoH 2011) Pregnancy, birth and beyond programme. All education programmes delivered by maternity staff should be discussed with the Lead Infant feeding co-ordinator and audited against the UNICEF standards.

No group instruction on the preparation of formula feeds should be included in Antenatal classes. This should be given according to need in the postnatal period. (Dyson et al 2008)

7. BIRTH

- All mothers will be encouraged 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 behavior of breast seeking (baby) and nurturing (mother) is given an opportunity to emerge. This usually takes a minimum of one hour. (Cadwell 2007, Colsonet et al 2008)
- 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. (Widstrom et al 2011)
- For mothers who intend to formula feed staff are expected to be sensitive to the fact that when a new mother is holding her baby in skin contact and the baby starts to show interest to feed the mother may decide to try to breastfeed and staff should be open to this possibility and provide encouragement if the mother so wishes.
- When mothers choose to formula feed they will be encouraged to offer the first feed in skin contact to encourage the bonding process. Extra precautions may be required to ensure the baby remains warm when bottle feeding in skin contact as there may be less of the baby's body in close contact with their mother.
- 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 will be sensitively encouraged by staff to enable them to do so.

- Mothers with a baby on the neonatal unit are: enabled to start expressing milk as soon as possible after birth within 4-6 hours and encouraged to express frequently and effectively a minimum of 8 to 10 times within 24 hours including once during the night (Jones 2008). They will be shown how to express by both hand and pump.

- 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.

8. 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)

9. 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 and attachment). This will continue until the mother and baby are feeding confidently.

Mothers will have the opportunity to discuss breastfeeding in the first few hours after birth as appropriate to their own needs and those of their baby. This discussion will include information on responsive feeding, normal feeding frequency and feeding cues. Feeding "for comfort" should be encouraged as it is both beneficial for the baby and in the establishment of a good milk supply, and the normality of this discussed with the parents.

A formal feeding assessment will be carried out using the UHNM breast feeding assessment tool. It should be completed in addition to the routine baby check for breast fed babies aiming at supporting mothers to gain confidence and to ensure safety. During in patient stay it should be completed on a daily basis and repeated by the community midwife on the first visit and again on day 5. When there are feeding concerns the assessment should be used and an appropriate management plan implemented. 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 early within the first 4-6 hours and as effectively as possible. They will be encouraged to express at least 8-10 times in 24 hours including once during the night. Timing should be encouraged around her lifestyle with no gaps of longer than 4 hours (daytime) and 6 hours (night time). They will be shown how to express by both hand and electric pump. At a minimum a formal review of expressing will take place 4 times within the first 2 weeks with the first formal assessment taking place within the first 12 hours. This is to support early and frequent milk expressing in order to maximize milk production. It is expected that the majority of the reviews will be undertaken by the staff on NNU but when a mother is being cared for in the maternity unit then the responsibility will be with the maternity staff. Good communication between neonatal staff and maternity staff is essential to ensure early, frequent and effective expressing to enable good lactation.

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. This will help to reduce anxiety and the use of unnecessary formula supplements.

All breastfeeding mothers will be informed about the local and national, professional and voluntary support services for breastfeeding, these will be available in written form as well as via the internet and updated as required.

For those mothers who require additional support for more complex breastfeeding challenges, a referral to the specialist service should be made. It is expected that common breastfeeding issues should be managed by the midwife. During inpatient stay referral is made to the hospital Infant Feeding Team. Mothers will be informed of how to access local specialist support (see Appendix 2, 3 and 4) via written information and via the Trust intranet. It is expected that a referral will be made once staff have followed relevant clinical guidance and further support is needed from the specialist service.

10. 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 (Entwistle 2013). 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, breastfeeding can be used not just when babies show feeding cues but also when they are distressed, when they feel lonely, when the mothers breasts feel full or when the mother needs to sit down and rest, breastfed babies cannot be overfed or 'spoiled' by too much feeding and breastfeeding will not, in and of itself, tire mothers any more than caring for a new baby without breastfeeding.

Dummies can interfere with responsive feeding by placating babies who would otherwise want to breastfeed, this can then affect the mother's milk supply. Staff are expected to ensure mothers are aware of this if they are considering the use of a dummy.

11. 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.

Formula supplements should only be given to breastfed babies where there is a clear medical indication or fully informed maternal choice and this has been fully discussed with the mother. (Appendix 5).The need for supplementation should be clearly documented in the WMPI notes and a continuous audit form completed. Disruption to breastfeeding should be kept to a minimum and the mother supported to continue breastfeeding.

When exclusive breastfeeding is not possible, or a mother chooses not to exclusively breastfeed the value of continuing partial breastfeeding will be emphasised and mothers will be supported to maximise the amount of breast milk their baby receives. Staff should encourage mothers to express their milk, breastfeed at night, limit the amount of formula, and separate formula feeds from breastfeeds. These suggestions will help to maximize a mother's milk supply and help to continue to breastfeed and or give breast milk.

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 formula on their breast milk supply and the risks of using a teat when a baby is learning to breastfeed. Staff are expected to fully document this discussion in the WMPI notes and to complete a continuous formula audit form.

When a mother makes an informed decision to continue with mixed feeding at home staff are expected to ensure that the mother is able to make up formula feeds as safely as possible.

Supplementation rates will be continuously audited and supported by regular sampling and reviews of records.

12. ALTERNATIVE FEEDING METHODS

Syringe feeding and cup feeding is often considered the preferred way of breast milk supplementation as they are less disruptive to breastfeeding. However because there is a risk of aspiration if they are not done safely both methods should not be used without professional guidance.

13. SYRINGE FEEDING

Syringe feeding can be useful for giving small amounts of colostrum to babies (less then 5 mls) when a baby may be slow or reluctant to feed.

- An oral feeding syringe should be used.
- The baby should ideally be syringe fed at the breast to encourage breastfeeding.
- The baby should be held upright in a semi reclining position – never flat.
- The syringe tip is gently placed in between the baby's gum and cheek.
- Gently syringe very small amounts of colostrum [no more than 0.2mls] into the baby's mouth always directing the flow to the inside of the cheek.
- Allow the baby time to suck and swallow before dripping in more.
- Carry on as described until the feed is completed.

When more than 5mls is to be given the baby should be cup fed.

14. CUP FEEDING

Babies who require additional fluids should be offered these by cup rather than by bottle. This will help avoid nipple teat confusion and encourage the baby to develop the correct tongue technique. (Jones E 1994)

1. Sit baby upright on your lap with baby's head supported while you have one hand behind his shoulders and neck.

2. Place the edge of the cup gently on baby's lower lip.

3. Bring the liquid to baby's lower lip so baby can lap. **Do not pour the liquid in baby's mouth.**

4. It is important to maintain the level of the liquid as best as possible so baby can continually lap it up.

5. Babies should be allowed to pace the feed themselves. This will avoid overfeeding.

6. When parents are cup feeding their baby, they should be shown how to do this as above, a member of staff observes them cup feeding, below they are allowed to do this independently. This should be fully documented in the WMPI notes.

7. **It is preferable that babies are not discharged home cup feeding as baby's can become addicted to cup feeding and this potentially makes breastfeeding more difficult. If a baby needs to be transferred home cup feeding then a robust plan of care must be in place to support the mother to breastfeed with further specialized feeding support.**

15. USE OF DUMMIES AND NIPPLE SHIELDS

Dummies have been shown to reduce breastfeeding success and should not be recommended apart from when clinically indicated for non-nutritive sucking. (Unicef 2008)

Nipple shields should not be recommended except in extreme circumstances and then only for as short a time as possible. Mothers should be made aware of the increased risk of mastitis, breast abscess and lower milk volume and help given with reducing this risk. A plan should be made with the mother to help her to continue to breastfeed. (UNICEF 2004)

16. 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. Frequent feeding, including a minimum number of feeds in 24 hours, should be offered to ensure safety. However staff need to ensure that mothers do not get the impression that feeding a baby every two, three or four hours is normal and any other feeding pattern a cause of concern even when their baby is no longer "at risk".(refer to the prevention of hypoglycaemia guidelines and babies who are slow to feed).

Indications include:

- Preterm <37 weeks
- Small for gestational age
- Babies weighing 2.5 kilos or less
- Severe intrapartum asphyxia
- Ill Babies
- Hypothermia
- Obvious syndromes
- Maternal Diabetes
- Maternal Beta-blockers
- Family history of MCADD.

17. 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 are encouraged to bring in their own feeding equipment and ready to feed formula that is suitable for a new-born baby. Sterilisation equipment will be provided.This will give parents the opportunity to learn to sterilise their own equipment and to practice using their own bottles and teats prior to returning home.

- 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, to hold their baby close for feeding and to make eye contact during feeds. Limiting the numbers of feeders is also important to help babies feel secure and to avoid different techniques being used.

- 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. Recognize their baby's cues that they have had enough milk and avoid forcing their baby to take more milk than the baby wants as this can lead to over feeding and should be discouraged.

18. EARLY POSTNATAL PERIOD: SUPPORT FOR PARENTING AND CLOSE RELATIONSHIPS

- Skin-to-skin contact will be encouraged throughout the postnatal period regardless of feeding method. Fathers or partners should be encouraged to have skin contact in addition to the mother. Kangaroo care should be offered as per guideline. All parents will be supported to understand a new-born baby's needs

and staff are expected to discuss the importance of encouraging frequent touch and sensitive verbal/visual communication, keeping babies close, responsive feeding and safe sleeping practice.

- Mothers who bottle feed will be encouraged to hold their baby close during feeds and offer the majority of feeds to their baby themselves to help enhance the mother-baby relationship. Where possible close family members should be included in this discussion to help support the parents to be able to do this.

- Parents will be given information about local parenting support that is available via the health visitors and local children's centres.

- Mothers and babies should remain together 24 hours a day. Separation of a mother and baby should only occur as a result of fully informed maternal choice and for the shortest period of time possible.

19. RECOMMENDATIONS FOR HEALTH PROFESSIONALS ON DISCUSSING BED-SHARING WITH PARENTS

To minimise the risk of accidents in hospital, the safest place for a baby to sleep is in a cot in the same room as its mother by the mother's bed (UNICEF UK 2003). However some mothers will take their babies into bed so that they can breastfeed or to comfort their baby. Mothers should be advised to inform staff if they do this to reduce the risks of accidents and to discuss safe sleeping practices.

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 and documented in the WMPI notes.

- 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.

20. TRAINING

The Trust is committed to providing training to staff appropriate to their role with Maternity and neonatal staff having primary responsibility

All staff who have contact with expectant and new mothers and their families will be orientated to the policy within one week of employment.This is to ensure staff are aware of the significance of this policy and do not inadvertently undermine the work of the rest of the team

Within six months of commencement of employment all grades of staff who have contact with expectant and new mothers will receive essential training to enable them to give unbiased and non-conflicting information and support regarding feeding. This will ensure that the standards are consistently maintained.Training will be given at a level appropriate to their role. Attendance will be mandatory and recorded in the maternity and neonatal units infant feeding training database (for maternity and neonatal staff only).

Joint training of Maternity and neonatal staff will be undertaken by means of the foundation course. Additional training to meet the UNICEF neonatal standards will be undertaken by neonatal staff, provided by the Neonatal Unit Infant Feeding Co-ordinator. This will include Neonatal nurses and paediatric medical staff. Recording of the above training will be the responsibility of the Neonatal Infant Feeding Co-ordinator.

Arrangements will be made between the Lead Infant feeding co-ordinator and the Lead midwife for Education at Keele University to ensure that all student midwives are informed of the infant feeding policy prior to their clinical placement.

The responsibility for co-ordinating maternity infant feeding education lies with the Lead infant feeding co-ordinator who will audit the uptake and efficacy of the education programme. Co-ordination of the Neonatal education lies with the Neonatal Infant Feeding Co-ordinator.

The above levels of training will be incorporated in the Training needs analysis of the Women and Children's and Clinical Support Services Division.

A written training curriculum is available.

21. READMISSION TO HOSPITAL WITH FEEDING PROBLEMS WITHIN FIRST 28 DAYS

The Infant feeding team will check on a daily basis for readmissions to the Paediatric wards. A readmission form and Datix will be completed by the Infant Feeding Co-ordinators.

Mothers who are hospitalised with their babies will be provided with appropriate equipment for safe expression and storage of breast milk and supported to continue to breastfeed their babies. Further information and support will be available from the Infant Feeding Team.

22. MEDICINES AND BREASTFEEDING

Many mothers can continue to breastfeed their baby and take medication without risk. Specialist advice and information is available from Pharmacy Medicines Information and a quick reference guide for the most common medicines taken by breastfeeding mothers is available from http://www.midlandsmedicines.nhs.uk/ or http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm. Where possible, advice should be sought during the antenatal period and the information found/recommendations documented in the patients WMPI Pregnancy Notes. Discontinuing breastfeeding for some hours/days may be required following stat doses or during short courses of a medicine for which the available information suggests that the risk continuing breastfeeding whilst receiving

the medicine clearly outweighs any possible benefit. Mothers should be encouraged to express and discard their breast milk to maintain lactation until it is safe to resume breastfeeding. In addition breastfeeding mothers should be advised to check with a pharmacist before buying or taking any medicines to establish if safe in breastfeeding.

Breastfeeding and nuclear medicine

If a nuclear medicine procedure is required by a breastfeeding mother, then specific instructions to minimise the radiation dose to the baby will be issued by the Nuclear Medicine Department to the mother, ward staff and referring clinician. If breastfeeding is affected the mother will be encouraged to express her breast milk and discard this until she is able to breastfeed again so that there is minimum disruption to lactation and breastfeeding.

23. BREASTFEEDING FAMILIES

A welcome for breastfeeding families.

Breastfeeding will be regarded as the normal way to feed babies and children. Mothers will be welcomed and supported to feed their infants in all public areas of Trust premises.

Comfortable facilities will be made available for mothers who prefer privacy.

24. COMMUNITY SUPPORT

Encouraging community support for breastfeeding

Handover of care from midwife to specialist public health practitioner will be in writing with sufficient information about the breastfeeding progress to date to enable a seamless transfer of care. This will be documented in the Child Health Record (Red Book).

All health professionals educate and support mothers to breastfeed and whenever possible encourage a breastfeeding culture within the local community.

25. MONITORING IMPLEMENTATION OF THE STANDARDS

The UHNM requires that compliance with this policy is audited at least annually using the UNICEF UK Baby Friendly Initiative audit tool (2013 edition).The Infant feeding team will be responsible for auditing and monitoring, involving ward managers as required. Staff involved in carrying out this audit require training on the use of this tool. Audit results will be reported to the Head of Midwifery and the Division lead. Action plans will be agreed by the Lead Infant feeding Co-ordinator, Head of Midwifery and the Senior Midwifery team to address any areas of non-compliance that have been identified.

26. MONITORING OUTCOMES

The Infant feeding team will monitor outcomes by

- Maintenance of UNICEF Baby friendly standards through audit.
- Monthly statistics collection of number of mothers initiating breastfeeding and breastfeeding and be categorized as full/total breastfeeding, partial breastfeeding, or artificial feeding.
- Maternity questionnaire
- DATIX reporting of babies re-admitted under the age of 28 days with feeding problems.

Outcomes will be reported to:

The Head of Midwifery and Directorate Manager.

27. REVIEW

Policy review date will be set 3 years from ratification by the Lead Infant Feeding Co-ordinator, or following change in guidance from any National Organisations including UNICEF Baby Friendly.

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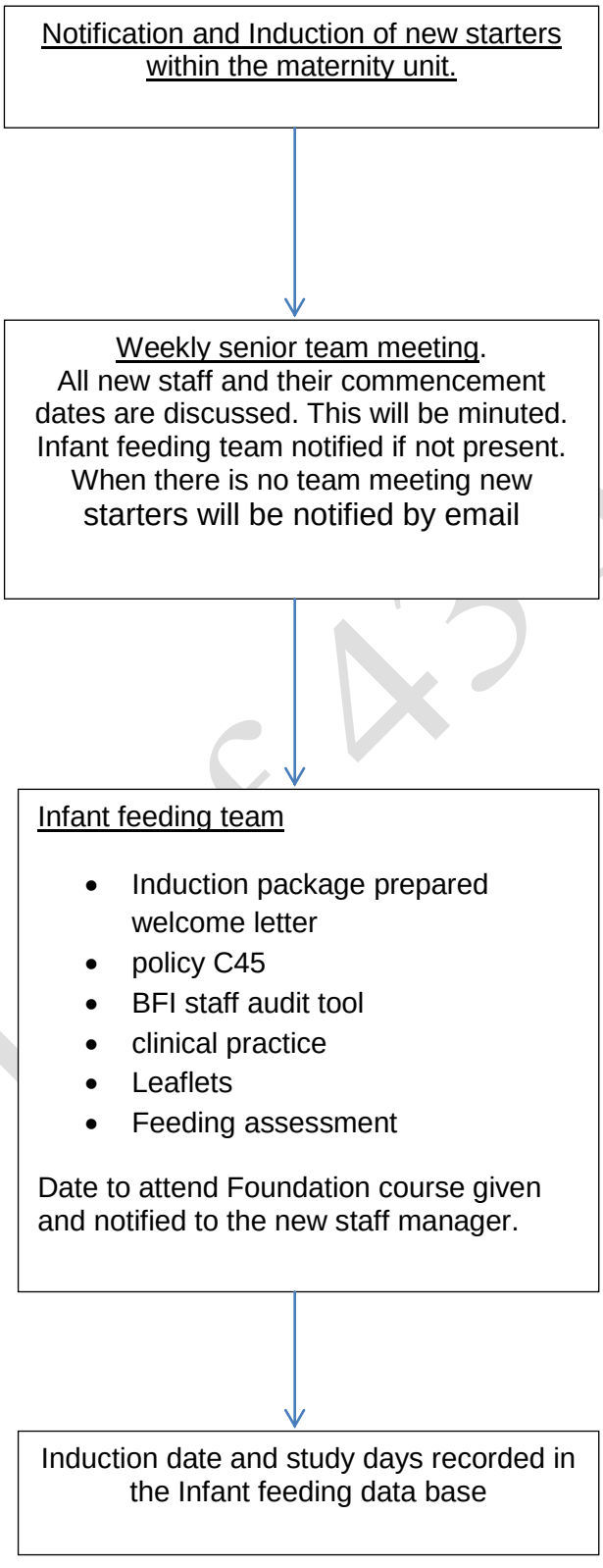
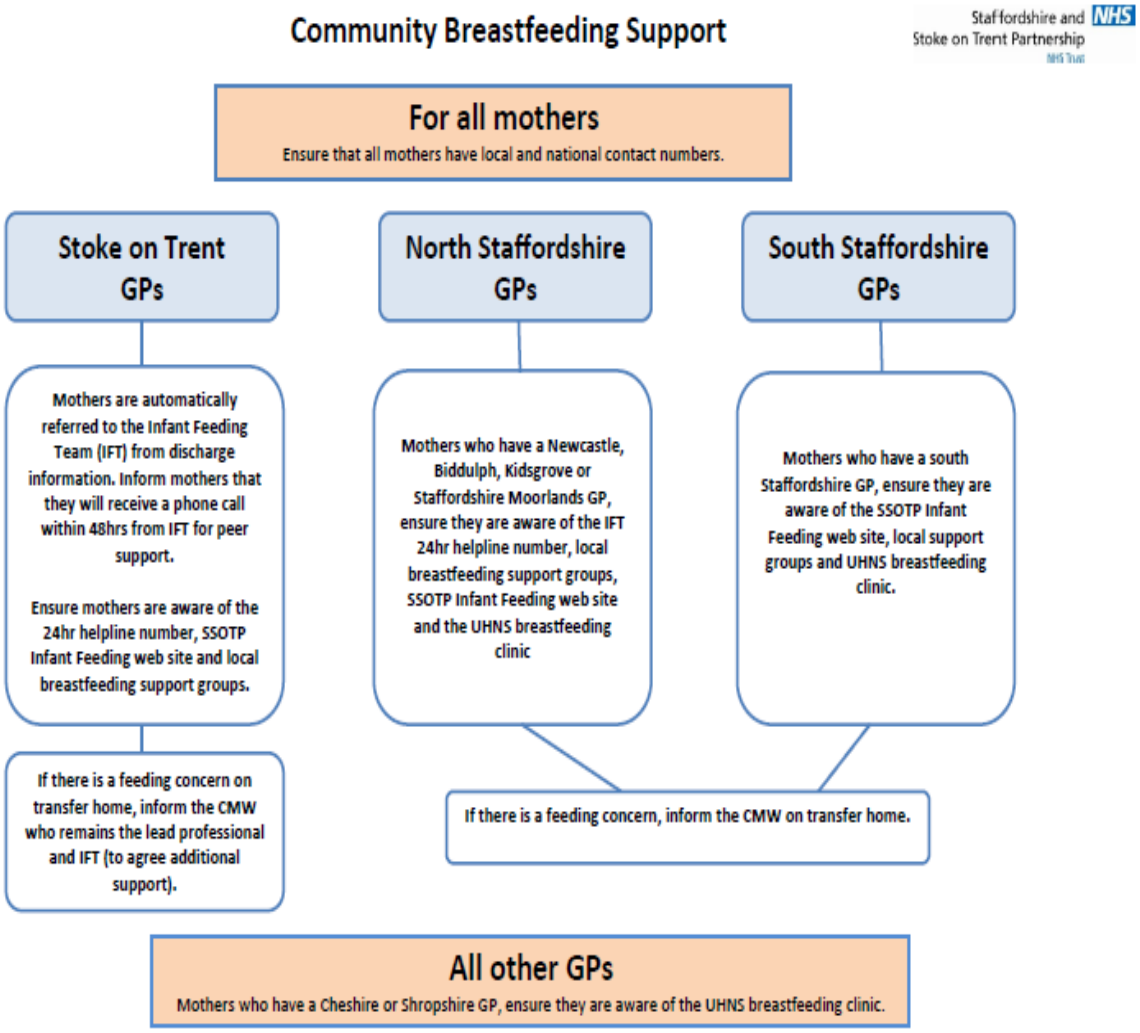
APPENDIX 1

ARRANGEMENT FOR THE NOTIFICATION AND THE INDUCTION OF NEW STARTERS IN MATERNITY

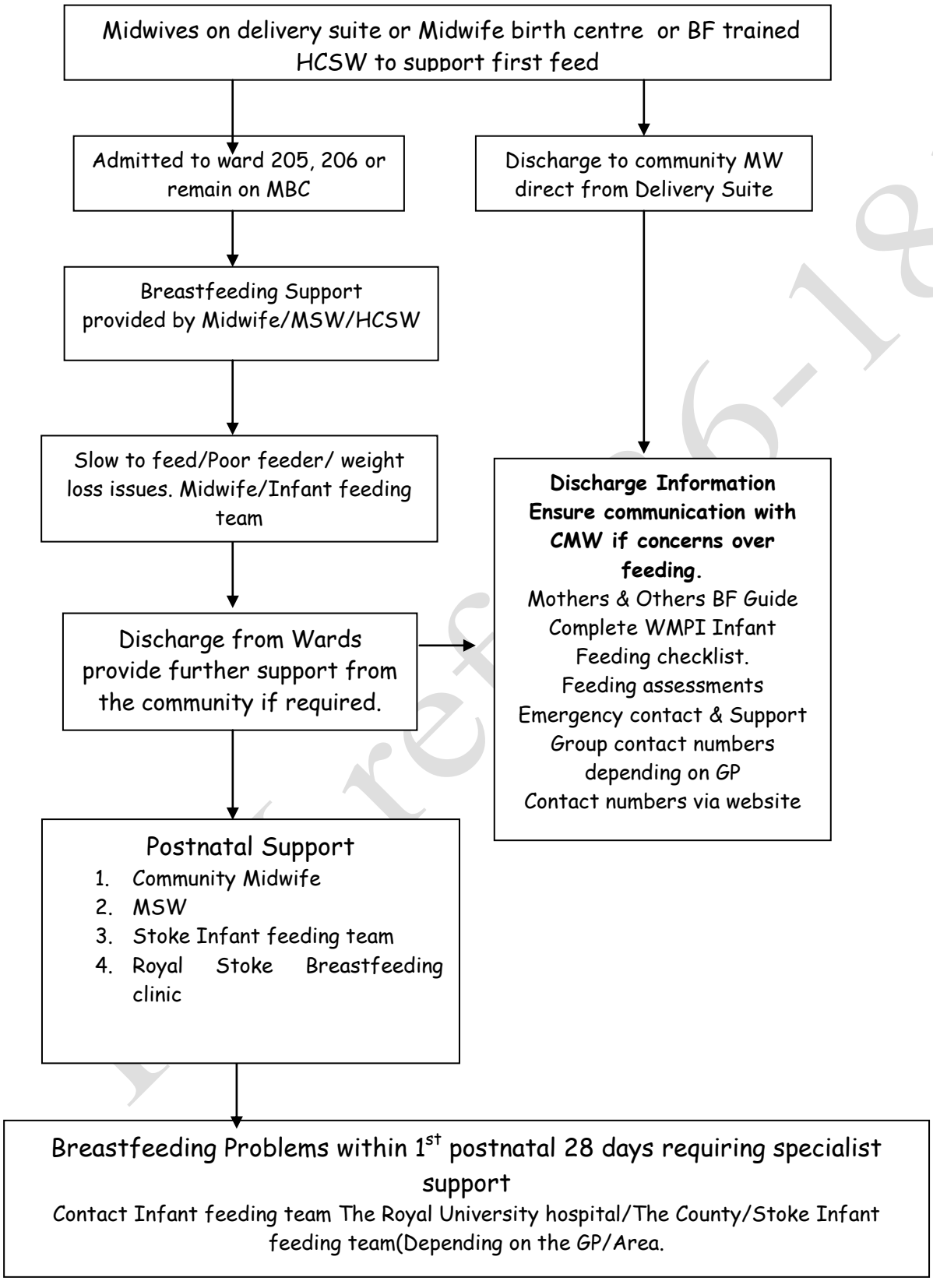


APPENDIX 2


Community Breastfeeding Support
Staffordshire and Stoke on Trent Partnership NHS Trust
For all mothers
Ensure that all mothers have local and national contact numbers.
Stoke on Trent GPs
North Staffordshire GPs
South Staffordshire GPs
Mothers are automatically referred to the Infant Feeding Team (IFT) from discharge information. Inform mothers that they will receive a phone call within 48hrs from IFT for peer support.
Ensure mothers are aware of the 24hr helpline number, SSOTP Infant Feeding web site and local breastfeeding support groups.
Mothers who have a Newcastle, Biddulph, Kidsgrove or Staffordshire Moorlands GP, ensure they are aware of the IFT 24hr helpline number, local breastfeeding support groups, SSOTP Infant Feeding web site and the UHNS breastfeeding clinic
Mothers who have a south Staffordshire GP, ensure they are aware of the SSOTP Infant Feeding web site, local support groups and UHNS breastfeeding clinic.
If there is a feeding concern on transfer home, inform the CMW who remains the lead professional and IFT (to agree additional support).
If there is a feeding concern, inform the CMW on transfer home.
All other GPs
Mothers who have a Cheshire or Shropshire GP, ensure they are aware of the UHNS breastfeeding clinic.

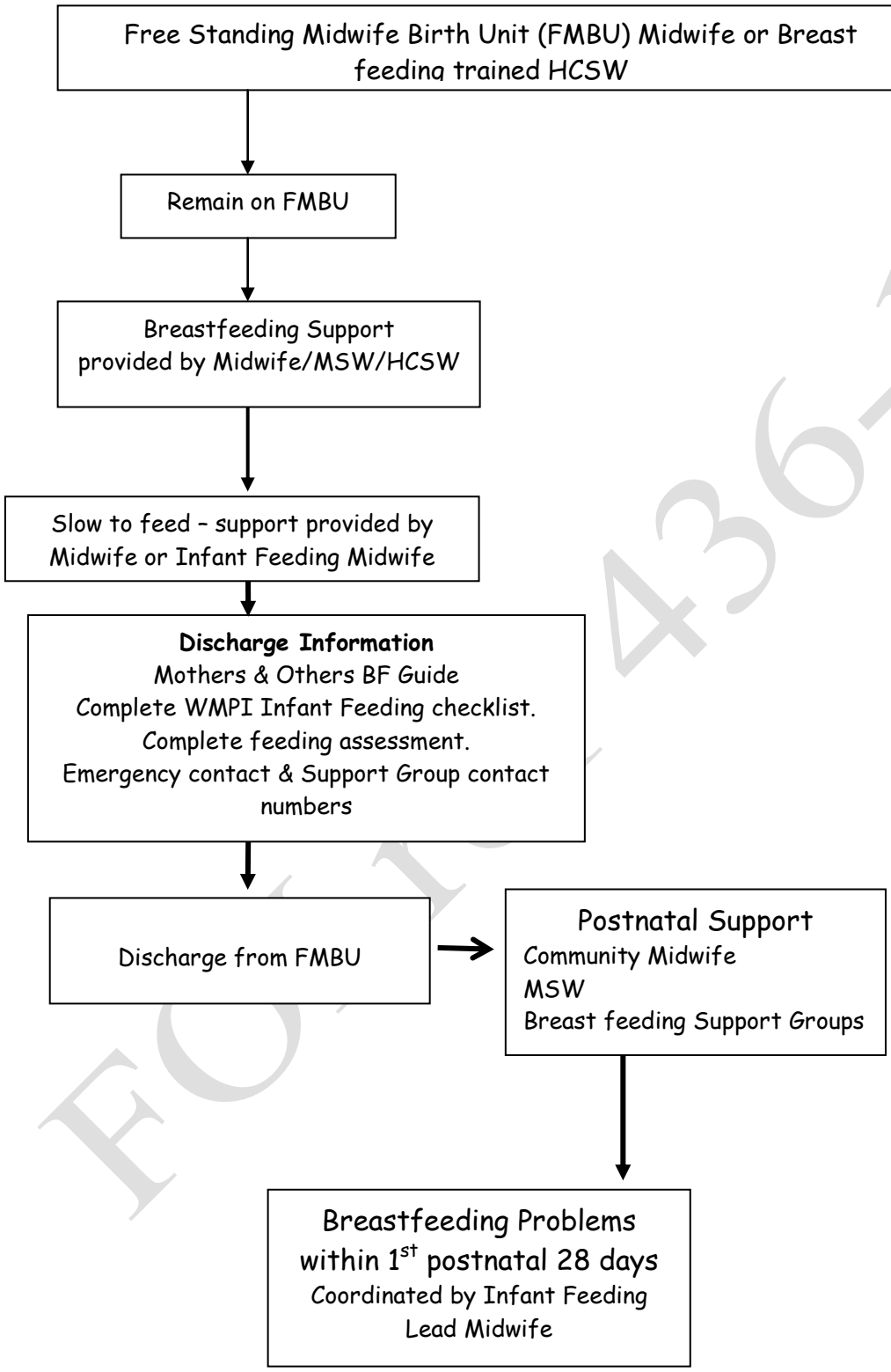
APPENDIX 3

Breastfeeding Support
Royal Stoke University Hospital



APPENDIX 4

Breastfeeding Support
County Hospital



APPENDIX 5

MEDICAL INDICATIONS FOR SUPPLEMENTATION

1. Pre-term infants of 34 weeks gestation and below have a very high nutritional requirement which may not be satisfied by demand breastfeeding resulting in hypothermia and sub-optimal weight gain. Colostrum may be insufficient to provide adequate calorific intake for these vulnerable infants. Supplementation with infant formula may need to continue until lactation is established and the baby able to breastfeed effectively.

2. Babies who are increased risk of developing hypoglycaemia such as those with severe dysmaturity and babies of diabetic mothers may require supplementation with formula milk to ensure adequate maintenance of nutritional requirements. (See Guidelines for management of the baby at risk of developing hypoglycaemia).

3. Babies who are unwell, although mothers own expressed breast milk would always be the feed of choice.

4. Babies who have conditions involving inborn errors of metabolism such as Phenyloketonuria may require dietician referral to ensure an appropriate diet allows for adequate growth and development.

5. Babies with acute water loss, for example during phototherapy when breastfeeding may not provide adequate hydration. Mother's own expressed breast milk given by cup would be the feed of choice. Water is never offered.

6. In situations where the mother is too unwell to breastfeed and to express breast milk e.g. eclampsia, severe shock, psychosis cup feeds of formula milk will be required until the mother's condition improves.

7. When mothers are taking medication which is contra-indicated in breastfeeding e.g. cytotoxic and radioactive drugs. Very few drugs are in fact contra-indicated, however where there is any doubt regarding maternal medication, medicines information should be contacted to clarify the situation.