University Hospitals of Leicester NHS
NHS Trust

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Joint Infant Feeding Policy

This policy sets out the roles and responsibilities of staff across Leicester, Leicestershire, and Rutland (LLR) in collaboration to support expectant and new mothers and their partners to feed and care for their baby in ways which optimise health and well-being.

Key words: Infant Feeding, Breastfeeding, UNICEF, Pregnant Mothers, birthing parents, Parents, Babies.

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Approved by: Nutrition and Hydration Steering Group

UHL Women's Board, UHL Trust Board, UHL Childrens Hospital Practice Meeting.

Ratified By: Safety Forum

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Type of Policy: clinical and non-clinical / public.

Contents

Summary & Aim

The purpose of this policy is to ensure that all staff understand their role and responsibilities in supporting expectant, new mothers/parents, and their partners to feed and care for their baby in ways which support optimum health and well-being. This includes staff working in the below areas:-

- University Hospitals Leicester (UHL)
  Maternity (M), Neonatal (N) and paediatric services (Paeds),
- Leicestershire Partnership Trust (LPT)
  Healthy Together Public Health Nursing Teams (PHNT), Mammas and Peer supporters (PS).
- Family Hubs (FH) across Leicester Leicestershire and Rutland (LLR)

Aim

- To increase breastfeeding initiation and continuation rates by implementing UNICEF Baby Friendly standards. The World Health Organisation recommends exclusive breastfeeding for the first six months of baby's life, with introduction of complementary foods with continued breastfeeding for two years and beyond.
- To ensure that staff receive consistent and evidence-based information through training.
- To ensure that staff provide parents with consistent and evidence-based information throughout pregnancy and postnatally through provision of the warm chain of support for breastfeeding. Placing parent-baby dyad at the centre of care.

KEY REQUIREMENTS

UNICEF Baby Friendly Initiative Standards

NICE Guidance Post natal care

NICE Clinical Promotion of Breastfeeding Initiation and Duration.

Healthy Child Programme.

DH Introduction of Solids.

The International Code of Marketing of Breastmilk Substitutes.

TARGET AUDIENCE:

UHL Clinical Staffing Midwifery

UHL Clinical Staffing Paediatrics

UHL Clinical Staffing Neonatology

LPT Clinical Staffing Healthy Together

Family Hubs Staff

Peer support Volunteers

Perinatal Mental Health Nurse

TRAINING

LPT Healthy Together 0-5 service – 2-day Infant feeding management training.

LPT Healthy Together 0-5 service – ½ day Annual Update

LPT Healthy Together Management – ½ day 3 yearly.

LPT Healthy Together 5-19 service – ½ day 3 yearly update.

LPT Peer Supporters - Infant feeding management training.

LPT Peer Supporters- Annual Update

UHL Midwifery, Paediatrics and Neonatal service – Mandatory Infant feeding training of up to 18 hours.

UHL Midwifery, Paediatrics and Neonatal service – Annual Update and rolling Practical Skills reviews every 3 years.

UHL Neonatologists/ Paediatricians BFI eLearning; Obstetricians information on orientation days

Family Hubs Family Support workers – 2-day infant feeding management training.

Family Hubs staff- 2hr Infant feeding awareness

Perinatal Mental Health - 2-day infant feeding management training

Perinatal Mental Health - ½ day Annual Update

1.0 Quick look summary

Reference guide to be added after comments from shared services.

1.1 Version control and summary of changes

Version number	Date	Comments (description change and amendments)
8	Sept 2024	Updating relevant information, removing references from body of text, links to websites/documents and irrelevant wording.

For Further Information Contact:

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Claire Hubbard – Infant Feeding Lead, Clinical Team Lead.

Ann Raja – Lead Infant feeding Midwife UHL

1.2 Key individuals involved in developing and consulting on the document.

- Claire Hubbard - Infant Feeding Lead, Clinical Team Leader
- Lyn Quinnell Public Health Nursing Lead 0-19 LLR
- Louise Martin – Family Service Manager
- Sarah Ward – Service Group Manager
- Trust Policy experts – see checklist for list of current contact details.
- Ann Raja - Lead Infant feeding Midwife UHL

1.3 Governance

Level 2 or 3 approving delivery group – DMT?

Level 1 Committee to ratify policy – Nutrition and Hydration Steering Group.

1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity.

The policy provides guidance on both breastfeeding and formula feeding, with a primary reference to breastfeeding and mothers. However, it acknowledges and respects the rights of all individuals to access high-quality, personalised care, regardless of their age, disability, gender identity, marital or civil partnership status, pregnancy, race, ethnicity, religion, belief, sex, or sexual orientation.

Recognising the power of language to foster inclusivity, the policy emphasises the importance of using respectful and culturally sensitive terminology. It supports the use of inclusive language—such as *chest feeding*, *parent*, *primary caregiver*, *pregnant person*, and *birthing person*—to ensure all individuals feel represented and respected when receiving infant feeding support.

Healthcare providers are encouraged to ask individuals about their language preferences and terms to deliver care that aligns with their identity and needs. This approach underscores the commitment to promoting inclusive practices that uphold dignity and human rights for everyone.

If you would like a copy of this document in any other format, please contact lpt.corporateaffairs@nhs.net

1.6 Due Regard

LPT and UHL will ensure that due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT and UHL complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

1.6 Definitions that apply to this policy.

Consent: A patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

- be competent to take the particular decision.
- have received sufficient information to take it and not be acting under duress.

Due Regard: Having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Abbreviations

LLR – Leicester, Leicestershire & Rutland

UHL - University Hospitals Leicester

LPT - Leicestershire Partnership Trust

M - Maternity

N - Neonatal

Paeds- Paediatric services

PHNT - Healthy Together Public Health Nursing Teams

PS - Mammas and Peer supporters (PS).

FH - Family Hubs

PCHR - Personal Child Health Record

2.0 Purpose and Why we need this policy .

This policy is designed to ensure that staff working within University Hospitals Leicester, Maternity, Neonatal, Paediatric units, LPT Healthy Together 0-19 service, peer supporters and LLR Family Hubs provide accurate, consistent, evidence-based information care and support for parents around infant feeding, facilitating the warm chain of breastfeeding support.

2.1 Following recommendation and evidence by the LLR Infant feeding strategy board; a collaborative Infant feeding policy sharing principles for UHL maternity, neonatal and Paediatric services, LPT Healthy Together and Family Hubs has been updated to ensure that breastfeeding is promoted, protected, and supported as the healthiest way to feed a baby.

2.2 The purpose of this policy is to ensure that all staff employed within UHL, LPT and LLR Family Hubs our understand their role and responsibilities in supporting expectant and new mothers/ birthing parents/carers and their partners to feed and care for their baby in ways which support optimum health, well-being and reduce health inequalities.

2.3 The UNICEF UK Baby Friendly Initiative (BFI) have developed evidence-based standards for Maternity, Neonatal, Public Health Nursing (Health Visiting), Family Hubs and implementing standards in the Childrens Hospital. These are now recommended as the UK minimum Best Practice standards, as documented in the NHS National Institute for Clinical Promotion of Breastfeeding Initiation and Duration:

2.4 The policy aim is to improve the following outcomes:

- Evidence based practice showing increased breastfeeding initiation rates.
- An increase in breastfeeding rates at 10 days
- Amongst mothers/parents who choose to formula feed, an increase in those doing so as safely and responsively as possible, in line with nationally agreed guidance.
- A reduction in the number of hospital re-admissions for feeding problems.
- Increases in breastfeeding rates at 6-8 weeks.
- Amongst parents/primary caregivers who formula feed, increases in those doing so to feed as responsively and as safely as possible in line with nationally agreed guidance.

- An Increase in the proportion of parents/primary caregivers who introduce solid food to their baby in line with nationally agreed guidance.
- An increase in the proportion of parents /primary caregivers who are supported to develop a close and loving relationship with their baby.
- Improvements in parents'/primary caregivers' experience's of infant feeding support and health care.

2.5 BFI is at the heart of Public Health England's guidance on the Healthy Child Programme. The Early Years High Impact Area 3: Supporting Breastfeeding (updated 27.6.23)

Public Health England describes the UNICEF UK Baby Friendly Initiative as a:

"Nationally recognized mark of quality care for babies and mothers. The programme helps to ensure that professionals can provide sensitive and effective care and support for mothers, enabling them to make an informed choice about feeding, get breastfeeding off to a good start and overcome any challenges they may face. The staged accreditation programme trains health professionals to support mothers to breastfeed and helps all parents to build a close and loving relationship with their baby irrespective of feeding method."

2.6 Updated National Institute of Clinical Excellence (NICE) guidelines Postnatal Care (April 2021) outlines routine postnatal care that women should receive in the first eight weeks after birth. Infant feeding is covered under section 1.5: Planning and Supporting Babies' Feeding. This is an in-depth look at how to not only support, promote and protect breastfeeding but also manage safe and effective formula feeding. The importance of helping parents form strong relationships with their babies is stressed and responsive feeding is advocated for all babies.

2.7 Discussions to be documented contemporaneously in the patient record according to record keeping policy.

3.0 Policy Requirements

Baby Friendly is a staged accreditation programme that supports services to improve care by:

Table 1: Overview of the Revised Baby Friendly Initiative Standards

STAGE 1; 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 breastmilk substitutes, bottles, teats, or dummies in any part of the facility or by any of the staff.

Stage 2: An educated workforce Educate staff to implement the standards according to their role and the service provided.

STAGE 3; Parents' experience of…

Maternity services.

1. Support those who are pregnant to recognise the importance of breastfeeding and early relationships for the health and wellbeing 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 breastmilk.
5. Support parents to have a close and loving relationship with their baby.

Community services

1. Support those who are pregnant to understand the evidence for breastfeeding and early relationships and their influence on the health and wellbeing of them and their baby.
2. Protect and support breastfeeding in all aspects of the service and enable mothers to continue to breast for as long as they wish.
3. Support mothers to make informed decisions regarding the introduction of food or fluids other than breastmilk.
4. Support parents to have a close and loving relationship with their baby.

Neonatal units

1. Support parents to have a close and loving relationship with their baby.
2. Enable babies to receive breastmilk and to breastfeed when possible.
3. Value parents as partners in care

Hospital-based children's services

1. Enable babies to continue to breastfeed and/or receive breastmilk when possible.
2. Implement evidence-based practices related to giving foods or fluids other than breastmilk.
3. Support close and loving relationships and value parents as partners in care.

Re-accreditation Embed all of the standards to support excellent practice for babies, mothers, parents, and families.

Achieving Sustainability (Gold) Provide the leadership, culture and monitoring required to maintain/progress the standards over time.

- Providing the highest standard of care to support expectant and new mothers / birthing parents 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 on future health and wellbeing, and the significant contribution that breastfeeding makes to good physical and emotional health outcomes for children and mothers/ birthing parents.
- Ensuring that all care is mother/ birth parent and family-centred, non-judgemental and that mothers'/ birth parents' decisions are supported and respected.
- Working together across disciplines and organisations to improve mothers'/ birthing parents' experiences of care.
- Working together to ensure that all resources including digital adhere to the International Code of Marketing of Breastmilk Substitutes.

3.1 Care Standards

This section of the policy sets out the care which our organisations are committed to providing for every expectant and new parent.

Pregnancy: Maternity, Neonatal, Public Health Nursing Teams, Family Hubs, Peer Supporters

All pregnant women/birthing parents will have evidence-based information in a digital or written format alongside the opportunity to discuss feeding and caring for their baby with a member of the Maternity and Public Health Nursing team or other suitably trained individual. This discussion can either be face to face, virtually, or in a group setting. This discussion will include the following topics.

- The value of connecting with their growing baby in utero including the positive impact on the baby's brain development.
- The value of skin contacts for all mothers/ birthing parents and babies
- The importance of responding to their baby's need for love, comfort, closeness to support emotional and social development. Feeding after birth, and the role that keeping baby close has in supporting this.
- Feeding,
    - An exploration of what parents/ primary caregivers already know and feel about infant feeding, including previous experiences and if appropriate additional support for mothers/birthing parents' emotional wellbeing.

- The value of breastfeeding as nutrition, protection, and comfort,
- Getting to breastfeed off to a good start.
- Support available for breastfeeding.

- Mothers/ birthing parents have a conversation regarding the importance of their breastmilk for their preterm or ill baby as soon as is appropriate.

- All those who are pregnant can access services which may include 1-2-1 conversations, classes, written/online information, peer support/volunteer support, phone contact.

- Any preparation for parenthood sessions referring to Infant Feeding will reflect the Baby Friendly standards and comply with the International Code for the Marketing of Breastmilk Substitutes.

3.2 Birth: Maternity, Neonatal, Peer Supporters

- All mothers/birthing parents will be offered the opportunity to have uninterrupted skin contact with their baby at least until after the first feed for at least one hour, or for as long as they wish.
- All mothers/birthing parents will be encouraged to offer the first breastfeed in skin contact when the baby shows signs of readiness to feed.
- When mothers/birthing parents choose to formula feed they will be encouraged to offer the first feed in skin contact.
- Birthing parents may face unique challenges with infant feeding. Early recognition will ensure timely referral to IFT at UHL & LPT for specialist personalised care promoting successful feeding journeys and positive feeding experiences for all parents.
- Those mothers/birthing parents who are unable for medical reasons (or do not wish) to have skin contact immediately after birth, will be encouraged to commence skin contact as soon as they are able to, or so wish.
- Mothers/birthing parents and partners are given information about keeping their baby safe during skin-to-skin contact (see safety statement below).
- Mothers/ birthing parents with a baby on the neonatal unit see Care Standards Neonatal section below.

It is the joint responsibility of maternity and neonatal staff to ensure that mothers/parents who are separated from their baby receive this information and support.

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/birthing parent, 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/birthing parent'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/ birthing parents can continue to hold their baby in skin-to-skin contact during perineal suturing. However, adequate pain relief is required, as a mother /birthing parent who is in pain is unlikely to be able to hold her baby comfortably or safely. Mothers/birthing parents should be discouraged from holding their baby when receiving analgesia which causes drowsiness or alters their state of awareness (e.g., Entonox).
Where mothers/birthing parents choose to give a first feed of formula milk in skin contact, particular care should be taken to ensure the baby is kept warm.

3.3 Protect and Support for Breastfeeding

- Mothers/ birth parents are welcome and encouraged to breastfeed in all areas of UHL, LPT and LLR Family Hubs and in facilities that are comfortable.
- Mothers/birthing parents 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/parent and baby are feeding confidently. (M, NNU, Paed's and PHNT, PS, FH).
- Mothers/birthing parents and partners 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. (M).
- Midwives will undertake formal feeding assessments using the Breastfeeding Assessment Tool, with a minimum of two assessments in the first week to ensure effective feeding. Feeding should be discussed at every contact with the mother/ birthing parent and documented in the

postnatal record. The breastfeeding assessment in the Personal Child Health Record (PCHR) should be completed when transferring from the maternity to the PHNT. Public Health Nurse (PHN) will complete feeding assessment within the PCHR at the Healthy Child Programme new birth contact. Further feeding assessments to be completed at contacts where feeding concerns are identified by parents or health professionals. (Breast Feeding Support of healthy term infants who are slow to feed C120/2008 UHL Obstetric Guideline, UHL Weighing of well term babies C21/2011, LPT Healthy growth guidelines).

- Mothers/ birthing parent with a baby on the neonatal unit will be supported to express as effectively as possible and encouraged to express at least eight times in 24 hours, including once at night. They will be shown how to express by both hand and pump including safe cleaning of equipment. A formal expressing review is undertaken a minimum of four times in the first 2 weeks to support optimum expressing and milk supply. Appropriate interventions are implemented to overcome breastfeeding/expressing difficulties where necessary. (M, N, PS).

- Breastfeeding mothers/ parents with a sick baby/child in the Children's Hospital are enabled to continue breastfeeding when possible and are supported to maximise breastmilk use. (M, Paed's, PS)

- Before transfer home and at the midwifery primary visit, all breastfeeding mothers/ parents will be given information, both verbally and in writing about how to recognise effective feeding.

- Mothers are actively contacted and offered infant feeding support in advance of the New Birth visit, from Maternity, peer supporters.

- All breastfeeding mothers'/parents/ will have access to social support and basic breastfeeding problem solving at local peer support services accessible via websites https://healthforunder5s.co.uk (M, NNU, Pead's, PHNT, FH, PS).

- For mothers/birthing parents who require additional support for more complex feeding challenges, a referral to the Specialist Infant feeding Support services should be made. This will include the availability of a frenotomy service and breast pump loan scheme as part of the specialist service, with appropriate referral pathways and evaluation of the service. This service is provided by the infant feeding teams within LPT and UHL. Mothers/parents will be informed of the referral pathway. (M, PHNT, FH, PS).

- Mothers/parents will have the opportunity for discussion about their options for continued breastfeeding (including responsive feeding, expression of breastmilk, and feeding when out, or going back to work) according to individual need (PHNT, FH, PS).

- Breastfeeding is valued by staff; and mothers/ parents are encouraged and commended for providing any breastmilk.

- No advertising of breastmilk substitutes, bottles, teats, or dummies is permitted within UHL, LPT buildings, LLR Family Hubs.

Responsive breastfeeding

Responsive breastfeeding embraces the many and varied reasons a mother/ birthing parent may offer the breast aside from meeting the nutritional requirements of the infant and describes a sensitive, reciprocal relationship whereby the physical, social, and emotional needs of the mother and baby can be met.

Staff should ensure that mothers/parents/primary caregivers have the opportunity to discuss this aspect of feeding and reassure them that: ·

- breastfeeding can be used to feed, comfort and calm babies
- breastfeeds can be long or short.
- breastfed babies cannot be overfed or 'spoiled' by too much feeding. breastfeeding gives mothers an opportunity to relax with their baby, supports hormonal responses associated with breastfeeding to enhance their mood, and to help them fit breastfeeding into a busy day.

There are a small number of situations where relying on the baby to responsively breastfeed may not be appropriate, for example if weight gain is a cause for concern. These babies may need to be fed proactively until the issue is resolved. Care should be taken to ensure parents/primary caregivers understand the temporary nature of proactive feeding plans and resumption of responsive feeding should be supported as soon as is safely possible please refer to Weighing well term babies, Healthy Growth Guidelines

3.4 Support for mothers/ parents to make informed decisions regarding the introduction of food and fluids other than breastmilk.

- Mothers/parents who breastfeed will be provided with information about why exclusive breastfeeding for the first 6 months leads to the best outcomes for their baby, and why it is particularly important during the establishment of breastfeeding, which may take several weeks (M, NNU, Pead's, PHNT, PS & FH).

- When exclusive breastfeeding is not possible, the value of continuing partial breastfeeding will be emphasised, and mothers/parents will be supported to maximise the amount of breastmilk their baby receives (M, NNU, Pead's, PHNT, PS & FH).

- Mothers/parents who give other feeds in conjunction with breastfeeding will be supported to do so as safely as possible and with the least possible disruption to breastfeeding to protect their milk supply. This will include information about the potential impact of the use of a dummy on milk supply when a baby is learning to breastfeed. (M, NNU, Pead's, PHNT, PS, & FH).

- Where breastmilk is supplemented, a full record will be documented, including the rationale for supplementation and the discussion held with parents (M, NNU, Pead's, PHNT).

- The rates of breastmilk supplementation will be audited regularly (M).

3.5 Modified Feeding Regimes

There are several clinical indications for a short-term modified feeding regime in the early days after birth. Examples include preterm or those who are having Newborn Early Warning Trigger and Track (NEWTT) two observations and those who are slow to feed after birth. Frequent feeding, i.e., at least eight feeds in 24 hours should be offered to ensure safety with reference to the Guideline for the Prevention and Management of Symptomatic or significant Hypoglycemia in Neonates and the Breastfeeding: Guideline to Support Successful Feeding of Healthy Term Baby who are slow to feed. Neonatal Transitional Care SOP, Faltering Growth: Recognition and Management of Faltering Growth in Children C43/2019
(M, NNU, Paed's).

- There are other indications for a modified approach to responsive feeding after this period i.e., those babies who have lost an excessive amount of weight, who have not regained their birth weight by 3 weeks of age, have static weight or who are gaining weight very slowly with reference to the guideline: Weighing of

Well Term Babies (C21/2011), LPT Healthy growth guidelines. A small number of these babies may require referral to the Specialist Infant feeding Support services. (M & PHNT, Pead's, NNU).

3.6 Support for Formula Feeding

- Postnatal parents/carers who are formula feeding their baby, will be enabled to do so as safely as possible, in line with the Department of Health (DH) guidance and reference to: Bottle Feeding: Bottle Feeding UHL Obstetric Guideline This will be achieved by the offer of a demonstration and/or a discussion about how to sterilise equipment and how to prepare infant formula safely. Explanation will be given to parent/carers regarding the use of first formula and bottle feeding responsively. This should take place before transfer home from hospital and documented in the postnatal record and should be reinforced at further contacts (M).

- Postnatal parents/carers who formula feed will have a discussion about the importance of responsive feeding and be encouraged to:
    - Encourage feeding in skin-to-skin contact.
    - respond to cues that their baby is hungry.
    - invite their baby to draw in the teat rather than pushing the teat into the the baby's mouth.
    - Pace the feed so that the baby is not made to feed more than they want to.
    - Limit the number of people feeding the baby to the mother/parent and partner in the early weeks postpartum.
    - Recognise their baby's cues that they have had enough milk and avoid making their baby take more milk than needed. (M & HV).
    - Never leave the baby alone to feed with a propped-up bottle due to associated risks.
        - Choking
        - Suffocation
        - Aspiration
        - Ear infections
        - Tooth decay
        - Decreased interaction with parents/ primary caregivers

- A bottle-feeding C-checklist should be completed before leaving the ward and by the community midwifery service before transferring to the Health Visiting Service. This is available in the PHCR. A discharge/primary visit conversation will also take place as outlined in the Weighing Term Babies Guideline.

  A bottle-feeding assessment checklist will be completed at the new birth and subsequent relevant contacts in line with the Healthy Child Programme with

mothers who bottle feed (expressed breast milk or infant formula) including provision of appropriate support if needed. (PHNT)

Bottle feeding responsively and as safely as possible

Ensuring parents/primary caregivers are able to cleanse and sterilise equipment and make up feeds as safely as possible is crucial in order to reduce the risk of infection in the baby, who does not have the benefit of the protective factors of breastmilk, as well as to ensure correct concentration of ingredients.

Powdered infant formula is not sterile and needs to be made up at a temperature which will kill any potential bacteria present, with water above 70°C. Commercial preparation machines may not heat the water to > 70°C and therefore are not recommended.

Parents/primary caregivers should be encouraged to use a first infant formula until their baby is 12 months old. There is no evidence that milks which claim to help hungry babies, prevent colic, wind, reflux, or allergies are helpful and they may not be safe.

There is little meaningful variation in the nutrient content of different brands of infant formula because they must all conform to the same compositional requirements. Parents/primary caregivers can be reassured that they do not need to buy the most expensive product; a higher price generally reflects the addition of non-essential ingredients and a higher spend on brand promotion.

Responsive bottle feeding enables parents/primary caregivers to monitor their baby's intake by observing for cues to indicate fullness and can therefore help avoid overfeeding which may lead to obesity. Babies who ingest excess infant formula may exhibit symptoms such as vomiting, colic, fussiness and this has the potential to lead to overdiagnosis of reflux and CMPA.

There may be a small number of occasions whereby the volume of milk needed by the baby is not being met by responsive feeding and a proactive feeding plan is indicated.

This should be overseen by a health professional with the goal of returning to feeding the baby responsively once the issue is resolved. Please refer to Faltering Growth UHL Childrens Hospital Guidance, LPT Healthy Growth Guidance.

- All parents/carers will be supported to understand their baby's social and emotional needs including the importance of love and nurture for infant brain development. (Encouraging frequent touch and sensitive verbal/visual communication, keeping babies close, responsive feeding, night-time feeding, and safer sleeping practice) (M, NNU, Paeds, PHNT, PS & FH).

- Parents/carers 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/parent baby relationship (M, NNU, Paeds, PHNT, PS & FH).
- Parents/carers are encouraged to recognise the positive impact of being responsive and close to their baby on their own emotional wellbeing. (M,NNU, Paeds, PHNT, PS & FH).
- Parents/carers will be given information about local parenting support that is available (M, NNU, Paeds, PHNT, PS & FH)

    - Peer Support
    - Support Groups
    - Breast pump hire
    - Family Hub Pathways
    - Mammas Pathway

Mothers are enabled to discuss the impact of feeding challenges (previous, current, or perceived) on the emotional wellbeing of themselves and their family with options for signposting or referral if indicated.

Recommendations for staff on discussing bed-sharing with parents/carers.

All parents/ carers should have a conversation to support them to understand how to keep their baby safe when they are asleep with the following key messages conveyed:

Individualised safe sleep conversations should be undertaken using the Safe Sleep Risk Assessment

Babies should be:

- Put on their back for every sleep.
- The baby should have a clear, safe sleep space, in the same room as the parent/carers for the first 6 months.
- Sleeping with a baby on a sofa or chair puts the baby at greatest risk of harm and should be avoided.

Parents/primary care caregivers should not bedshare if:

- The baby was born prematurely (before 37 weeks pregnancy) or weighed under 2.5kg or 5.5lbs when born.
- Anyone in the bed has recently drunk alcohol
- Anyone in the bed smokes
- Anyone in the bed has taken drugs (legal or illegal) that make them sleepy.

For further information please see:

Safer Sleeping and Reducing the Risk of Sudden Infant Death Syndrome Guidelines (LPT guideline updated March 2022)

3.7 Introducing Solid Food (PHNT, PS & FH)

All parents will have a discussion at the 6-8wk contact about when and how to introduce solid food including

- That solid food should be started at around six months in line with DH guidelines.
- Babies' signs of developmental readiness for solid food.
- How to introduce solid food, signpost to H4U5's Babies Next Steps.
- The value of continued breastfeeding alongside appropriate complementary foods for 2yrs and beyond.

- When a baby demonstrated difficulty with suck, swallow and breathing co-ordination, then a referral to Speech and Language Dysphagia team will be made.

At around 16 week all parents/ carers will receive a text signposting them to Babies next step's video on the Health for Under 5's website.

3.8 Care Standards for Neonatal Unit

Supporting parents to have a close and loving relationship with their baby.

- The neonatal service recognises the profound importance of secure parent-infant attachment for the future health and well-being of the infant and the huge challenges that the experience of having a sick or premature baby can present to the development of this vital relationship. Therefore, this service is committed to care which actively supports parents to develop a close and loving bond with their baby.

- All parents will:

    - have a discussion with an appropriate member of staff as soon as possible (either before or after their baby's birth) about the importance of touch, comfort and communication for their baby's health and development.
    - be actively encouraged and enabled to provide touch, comfort, and emotional support to their baby throughout their baby's stay on the neonatal unit.
    - be enabled to have frequent and prolonged skin contact with their baby as soon as possible after birth and throughout the baby's stay on the neonatal unit.

3.9 Enabling babies to receive breastmilk and to breastfeed.

UHL Neonatal service recognise the importance of breastmilk for babies' survival and health.
Therefore, will ensure that:

- A mother's/parent's own breast milk is always the first choice of feed for the baby unless there are clinical contra-indications to this.

- Parents have a discussion regarding the importance of their breastmilk for their preterm or ill baby as soon as is appropriate.

- A suitable environment conducive to effective expression is created.

- Mothers/parents have access to effective breast pumps and equipment and are shown how to use them effectively.

3.10 Mothers/parents are enabled to express breastmilk for their baby, including support to:

- express as early as possible after birth (ideally within two hours).
- learn how to express effectively, including by hand and by pump.
- learn how to use pump equipment and store milk safely with reference to:

3.12 Breastfeeding: Guideline to Support Successful Feeding of Healthy Term
Babies who are slow to feed and guideline Decontamination of breast pump equipment.

- express frequently (at least eight times in 24 hours, including once at night) especially in the first two to three weeks following delivery, to optimise long-term milk supply.
- overcome expressing difficulties where necessary, particularly where milk supply is inadequate, or if less than 750ml in 24 hours is expressed by day ten.
- stay close to their baby when expressing milk.
- use their milk for mouth care when their baby is not tolerating oral feeds, and later to tempt their baby to feed.
- A formal review of expressing is undertaken a minimum of four times in the first two weeks to support optimum expressing and milk supply.
- Mothers/parents receive care that supports the transition to breastfeeding, including support to:
    - recognise and respond to feeding cues.
    - use skin-to-skin contact to encourage instinctive feeding behavior.
    - position and attach their baby for breastfeeding.
    - recognise effective feeding.
    - overcome challenges when needed.
- Mothers/parents are provided with details of voluntary support for breastfeeding which they can choose to access at any time during their baby's stay.
- Mothers/parents are supported through the transition to discharge home from hospital, including having the opportunity to stay overnight/for extended periods to support the development of their confidence and

modified responsive feeding.

3.13 Valuing parents as partners in care

The neonatal service recognises that parents are vital to ensuring the best possible short- and long-term outcomes for babies and therefore, should be considered as the primary partners in care.

Staff will ensure that parents:

- have unrestricted access to their baby unless individual restrictions can be justified in the baby's best interest.
- are fully involved in their baby's care, with all care possible entrusted to them.
- are listened to, including their observations, feelings and wishes regarding their baby's care.
- have full information regarding their baby's condition and treatment to enable informed decision-making.
- are made comfortable when on the unit, with the aim of enabling them to spend as much time as is possible with their baby.

Staff will ensure that parents who formula feed:

- receive information about how to clean/sterilise equipment and prepare formula safely.
- can bottle feed their baby using a safe and responsive technique. This may include paced feeding and elevated side lying (Elevated side lying positioning for bottle feeding: UHL Guidelines.
-

4.0 Duties within the Organisation

4.1 This policy applies to all staff/volunteers involved in the care of expectant and new mothers/parents and their partners.

4.2 All above staff/volunteers working for our organisations that have contact with pregnant or new mothers/parents and their partners are required to adhere to this policy. Managers of staff at all levels are responsible for ensuring that the staff, for which they are responsible, are familiarised with and adhere to this policy.

4.3 The organisations will provide the highest standards of care to support expectant and new parents with feeding their baby and building 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/parents.

4.4 The International Code for the Marketing of Breastmilk Substitutes will be implemented throughout the service within LPT, UHL and Leicester, Leicestershire, and Rutland Family Hubs.

4.5 The Infant Feeding Policy in the format of a “Guide for Parents” will be clearly displayed in all public areas of LPT, UHL and LLR Family Hub facilities where care is provided for pregnant and new mothers/parents and babies. (See appendix 5)

4.6 The Joint Infant Feeding Policy is available within the public domain via Trust websites.

Policy, Guideline or Procedure / Protocol Author

Lead Director

Directors, Heads of Service

Senior Managers, Matrons and Team Leads

Staff

Corporate Affairs Team

Responsibility of Clinical Staff (To be added to all clinical policies

5.0 Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent if they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.

If the patient’s capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or

a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- Understand information about the decision.
- Remember that information.
- Use the information to make the decision.
- Communicate the decision.

6.0 Monitoring Compliance and Effectiveness

6.1 Compliance with this policy will be audited in line with Baby Friendly Guidelines by the Infant Feeding Team using the Baby Friendly audit tool © to assess progress against the UNICEF UK Baby Friendly Initiative Standards. The results of audit will be communicated to clinical staff and the organisations' audit department.

6.2 The policy must be reviewed every three years.

6.3 Midwives, Neonatal Nurses, Public Health Nurses, and local authority staff are responsible for collecting the required infant data at the ages specified by the organisation and Department of Health to facilitate monitoring of breastfeeding rates. Figures for breastfeeding rates will be collected for all infants at birth, at 10 days, and 6 weeks. LPT will collect and analyse data for continuation of breastfeeding, at 6 months and 10 months.

6.4 Parents' experience of care will be listened to through: regular audit, parents' experience surveys, friends and Family feedback, Care Quality Commission, the Maternity and Neonatal Voices partnership, National Health Service Litigation Authority and through OFSTED.

Monitoring tools must be built into all procedural documents in order that compliance and effectiveness can be demonstrated.

Be realistic with the amount of monitoring you need to do and time scales.

Minimum requirements	Self-assessment evidence	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
Ensure that staff attend training to deliver the BFI care standards relevant to role	Sections 4.6,5.1,7.1,7.2,7.3,7.4,7.5	Review by Infant feeding lead of records of training that is recorded on training data base	Infant feeding Team, Clinical team leaders, Locality managers, Leads	quarterly
Ensure that staff are competent to deliver effective support around infant feeding relevant to role	Sections 5.1	Audit of staff training using UNICEF BFI audit tool. Completion of a practical skills review after completion of initial 2 day course	Infant feeding Team. Key people within Healthy together	Annual audit
Feedback from mothers about infant feeding support received by the health visiting service	Sections 5.1	Audit of breastfeeding and formula feeding mothers using UNICEF BFI audit tool	Infant feeding Team. Key people within Healthy together	Annual audit
Audit of premises to ensure they are compliant with International code of marketing of Breast milk substitutes	Sections 6.1,6.2 and 6.4	Spot checks by key people and Infant feeding team.	Infant feeding Team. Key people within Healthy together workforce	Annual
Collection of breastfeeding data at initiation,10 days and 6 weeks	Sections 3.1,5.3	Figures reviewed every quarter – monthly missing data reports cascaded to staff.	Information analysts Managers, frontline staff	quarterly

7.0 References and Bibliography

Include a list of all documents referred to in the Policy including those from other Trust's policies. The date of the document should be included. Do not include electronic links or embedded documents to other policies/guidelines and are in a standard format.

Baby Friendly Initiative. (n.d.). *Audit tools*. [online] Available at: https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/implementing-standards-resources/audit/.

https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/early-years-high-impact-area-3-supporting-breastfeeding

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HSSIB. (2021). *Neonatal collapse alongside skin-to-skin contact*. [online] Available at: https://www.hssib.org.uk/patient-safety-investigations/neonatal-collapse-alongside-skin-to-skin-contact/.

Leicester, Leicestershire, Rutland Infant feeding Strategy 2016/7 –

Leicester Royal Infirmary Children's Hospital : Guidelines for weight measurement (Baby and Children). May 2023

LPT Healthy Growth Guidelines

National Institute for Health and Care Excellence (NICE) (2021). *Postnatal care NICE guideline*. [online] Available at: https://www.nice.org.uk/guidance/ng194/resources/postnatal-care-pdf-66142082148037.

NICE (2014). *Overview | Maternal and child nutrition | Guidance | NICE*. [online] Nice.org.uk. Available at: https://www.nice.org.uk/Guidance/PH11

UHL Weighing of Well Term Babies. C21/2011 August 2022

UHL Breast feeding support of healthy term infant who are slow to feed. Oct 2023

UNICEF (2016). *The International Code of Marketing of Breastmilk Substitutes - Baby Friendly Initiative*. [online] Baby Friendly Initiative. Available at: https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/international-code-marketing-breastmilk-substitutes-resources/the-code/.

UNICEF (2016). *Baby Friendly Standards - Baby Friendly Initiative*. [online] Baby Friendly Initiative. Available at: https://www.unicef.org.uk/babyfriendly/about/standards/.

UNICEF (2016). *Breastfeeding Assessment Tools - Baby Friendly Initiative*. [online] Baby Friendly Initiative. Available at: https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/implementing-standards-resources/breastfeeding-assessment-tools/.

UNICEF (2023). *Skin-to-skin Contact*. [online] Baby Friendly Initiative. Available at: https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/implementing-standards-resources/skin-to-skin-contact/.

https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/implementing-standards-resources/guide-to-the-standards/.

8.0 Fraud, Bribery and Corruption consideration

The Trust has a zero-tolerance approach to fraud, bribery, and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

Appendix 1 Training Needs Analysis

Training topic:	Delete answers that are not applicable *	
Type of training: (See study leave policy)	Mandatory (must be on mandatory training register) * Role Essential (must be on the role essential training register) *	
Directorate to which the training is applicable:	Families Young People Children / Learning Disability/ * MH	
Staff groups who require the training:	Healthy Together Public Health Nursing teams Healthy Together Infant Feeding peer supporters Leicester Family Hubs workforce	
Regularity of Update requirement:	Annual for clinical staff Three yearly for managers	
Who is responsible for delivery of this training?	Infant feeding team	
Have resources been identified?	Yes	
Has a training plan been agreed?	Yes	
Where will completion of this training be recorded?	ULearn	
How is this training going to be monitored?	Ulearn and audits	
Signed by Learning and Development Approval name and date		Date:

Appendix 2 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

Shape its services around the needs and preferences of individual patients, their families and their carers Answer yes/no to all.

Respond to different needs of different sectors of the population yes/no

Work continuously to improve quality services and to minimise errors yes/no

Support and value its staff yes/no

Work together with others to ensure a seamless service for patients yes/no

Help keep people healthy and work to reduce health inequalities yes/no

Respect the confidentiality of individual patients and provide open access to information about services, treatment, and performance yes/no

Appendix 3 Due Regard Screening Template

Section 1	
Name of activity/proposal	
Date Screening commenced	
Directorate / Service carrying out the assessment	
Name and role of person undertaking. this Due Regard (Equality Analysis)	
Give an overview of the aims, objectives, and purpose of the proposal:	
AIMS:	
OBJECTIVES:	

Section 2	
Protected Characteristic	If the proposal/s have a positive or negative impact, please give brief details
Age	
Disability	
Gender reassignment	
Marriage & Civil Partnership	
Pregnancy & Maternity	
Race	
Religion and Belief	
Sex	
Sexual Orientation	
Other equality groups?	

Section 3	
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.	
Yes	No
High risk: Complete a full EIA starting click here to proceed to Part B	Low risk: Go to Section 4.

Section 4			
If this proposal is low risk, please give evidence or justification for how you. reached this decision:			
Signed by reviewer/assessor		Date	

Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		Date	

Appendix 4 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) is a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.			
Name of Document:			
Completed by:			
Job title			**Date**
Screening Questions		**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.			
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.			
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?			
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?			
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.			
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?			

7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records, or other information that people would consider to be particularly private.		
8. Will the process require you to contact individuals in ways which they may find intrusive?		
If the answer to any of these questions is 'Yes', please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.		
Data Privacy approval name:		
Date of approval		

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust