NHS
University Hospitals Sussex
NHS Foundation Trust
St Richards, Worthing & Southlands Hospitals

Newborn Feeding Guideline

Summary statement: How does the document support patient care?	By providing evidence based guidance to support and assist women/people in newborn feeding in accordance with UNICEF Baby Friendly Initiation standards.
Staff/stakeholders involved in development:	Midwives, Maternity Support Workers, Neonatal Nurses, Consultant Paediatricians, Consultant Obstetricians
Division:	Women and Children's
Department:	Maternity & Paediatrics
Responsible Person:	Chief of Service
Author:	Public Health Midwife
For use by:	All medical, midwifery, nursing & support staff involved in supporting mothers/birthing parents with newborn feeding.
Purpose:	To provide clear guidance on supporting mothers/birthing parents with feeding their babies.
This document supports:	Baby Friendly Initiative (WHO/UNICEF)
Key related documents:	Maternity Guidelines: Tongue Tie (Ankyloglossia) Division Guideline; Safe Sleeping of Babies and Reducing the Risk of Sudden Infant Death; Neonatal Hypoglycaemia Guideline
Approved by:	Joint Obstetric Guideline Group
Approval date:	16th March 2022 Date uploaded: 22/03/22
Ratified by Board of Directors/ Committee of the Board of Directors	N/A
Ratification Date:	N/A
Expiry Date:	March 2025
Review date:	September 2024
If you require this document in another format such as Braille, large print, audio or another language please contact the Trusts Communications Team	
Reference Number:	CG1129

Version	Date	Author	Status	Comment
1.0	November 2010	Infant Feeding Specialists	Archived	New Trust wide guideline
2.0	February 2011	CNST Midwife	Archived	Admin. additions
3.0	January 2012	Infant Feeding Specialists	Archived	BFI additions added
4.0	January 2013	CNST Midwife	Archived	Minor amendment
5.0	November 2013	Infant Feeding Specialists	Archived	BFI information updated and 3 year update
6.0	May 2017	Public Health Midwife	Archived	BFI information updated to include new standards and Neonatal standards
7.0	October 2019	Public Health Midwife	Archived	Additional information re formula; finger feeding; volumes
8.0	February 2022	F. Humberstone Infant-Feeding Lead	LIVE	• Aim added -An increase in the number of babies receiving breastmilk on the neonatal unit. • Staff responsibilities to the BFI code reworded. • 8.0 Supplementation section amended. • 9.1 Inpatient formula milk provision amended. • Parent information on supplementation added. (see appendix 4)

The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician.
If in doubt contact a senior colleague or expert.

Index

Newborn Feeding Guideline

1.0 Aim

The purpose of this guideline is to ensure that all staff understands their role and responsibilities in supporting expectant and new mothers/birthing parents and their partners to feed and care for their baby in ways which support optimum health and well-being.

The Baby Friendly Initiative is a worldwide programme of the World Health Organisation and UNICEF. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care. It is the first ever national intervention to have a positive effect on breastfeeding rates in the UK and to practise in accordance with the International Code of Marketing of Breast Milk Substitutes (See Appendix 1).

This guideline aims to create an environment where more women/people choose to breastfeed their babies by giving them information, advice and support to enable them to breastfeed according to the World Health Organisation recommendations of exclusive breastfeeding for 6 months and then as part of their infant's diet to the end of the first year and beyond. However following this information, if a woman/person chooses to formula feed their baby, Trust staff will not discriminate against their chosen method of feeding and will fully support them when they have made a choice.

1.1 Outcomes

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

- An increase in breastfeeding initiation rates.
- An increase in breastfeeding rates at 10 days.
- Amongst mothers/birthing parents who choose to formula feed, an increase in those doing so as safely as possible, in line with nationally agreed guidance.
- Improvements in parents' experiences of care.
- A reduction in the number of re-admissions for feeding problems.
- An increase in the number of babies receiving breastmilk on the neonatal unit.

2.0 Scope

This guideline applies to:

- All members of staff involved in the immediate care of newborn babies.
- All newborn babies and their mothers/birthing parents.

It is crucial that staff adhere to the guideline to avoid conflicting advice. Any deviation must be justified and recorded in the mother/birthing parent's Postnatal Care Record and baby record.

3.0 Abbreviations used within this guideline

NEC - Necrotising Enterocolitis	**EBM -** Expressed Breast Milk
NNU - Neonatal Unit	**BFI -** Baby Friendly Initiative

4.0 Responsibilities

Midwives, Health Care Assistants, Maternity Care Assistants, Maternity Support Workers, Obstetricians, Paediatricians, Neonatal Nurses and Nursery Nurses:

- To access, read, understand and follow this guidance.
- To use their professional judgement in application of this guidance.
- This guidance is for staff employed by Western Sussex Hospitals Trust. The guidance is not rigid and should be tailored to the individual circumstances of each woman. If the guidance is not being followed, documentation of the reasoning and/or justification is essential, with clear documentation of alternative plans and discussions.

4.1 Commitment

The Women & Children's Division is committed to:

- 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 to future health and well-being, 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/birthing parent and family centred, non-judgemental and those mothers'/birthing parents' decisions are supported and respected.
- Working together across disciplines and organisations to improve mothers'/ /birthing parents'/parents' experiences of care.

As part of this commitment the service will ensure that:

- All new staff are familiarised with this policy on commencement of employment.
- All staff receives training to enable them to implement the policy as appropriate to their role. New staff receives this training within six months of commencement of employment.
- All documentation fully supports the implementation of these standards.
- Parents' experiences of care will be listened to through: regular audit, parents'

experience surveys (e.g. Care Quality Commission survey of women's/birthing parent's experiences of maternity services, Friends & Family, COOS Cards, Feedback via social network forums administrated by the Trust and the Maternity Voices Partnership).
- This guidance is to be communicated to all health care staff having any contact with pregnant women/people and mothers/birthing parents.
- The International Code of Marketing of Breast-milk Substitutes is implemented throughout the service.

5.0 In support of the guidance

The International Code of Marketing of Breast-milk Substitutes

The International Code of Marketing of Breast-milk Substitutes (the Code) was adopted by a resolution of the World Health Assembly in 1981. Any facility seeking Baby Friendly accreditation must adhere to the requirements of the Code and any subsequent World Health Assembly resolutions relating to the Code. Click here for the full Code.

The Code prohibits all promotion of milks and equipment related to bottle feeding and sets out requirements for labelling and information on infant feeding. Any activity that undermines breastfeeding also violates the aim and spirit of the Code. The Code and its subsequent resolutions are intended as a minimum requirement in all countries, and are written into the United Nations Convention on the Rights of the Child, to which the UK is a signatory.

All breastmilk substitutes are covered by the Code. This means products that can be marketed in a way which suggests they could replace breastfeeding, even if the product is not suitable for that purpose. They may include:

- Infant formula
- Follow-on formula
- Baby foods
- Bottles/teats and related equipment.

The companies may not:

- Promote their products in hospitals, shops or to the general public.
- Give free samples to mothers/birthing parents or free or subsidised supplies to hospitals or maternity wards.
- Give gifts to health workers or mothers.
- Promote their products to health workers: any information provided by companies must contain only scientific and factual information.
- Promote foods or drinks for babies.
- Give misleading information.
- Have direct contact with mothers/birthing parents.

Staff responsibilities in relation to the code:

Appropriate and factual information on infant formula will be provided.

- This should include that first milk formulas should be used for the first year and that they adhere to the same standards, despite huge variety in cost.
- Parents will be directed towards 'first steps nutrition' Family assist and the baby postnatal notes for further information.
- No antenatal group instruction will be given around artificial feeding.
- Employees will *never* promote a particular brand of formula.

6.0 Baby Friendly Initiative Care Standard

This section of the guidance sets out the care that the Trust is committed to giving each and every expectant and new mother/birthing parent. It is based on the UNICEF UK Baby Friendly Initiative standards for maternity services and relevant NICE guidance.

6.1 Pregnancy

All pregnant women/people will have the opportunity to discuss feeding and caring for their baby with a health professional. The value of connecting with their growing baby in utero will be discussed. Also the importance of skin to skin contact as well as the importance of responding to their babies needs for comfort, closeness and feeding after the birth.

This discussion will involve an exploration of what parents already know about breastfeeding. The value of breastfeeding as protection, comfort and food and getting breastfeeding off to a good start will be discussed. All women/people will be invited to the Baby Matters parent education session run by the Trust.

6.2 Hand expressing / colostrum harvesting in pregnancy

Research has shown that women/people who hand express in pregnancy are more confident and better prepared to breastfeed their babies. This is a useful skill to learn and it will take practice so encourage women to learn this from 36 weeks gestation onwards.

Women/people should be given a colostrum harvesting pack with sterile syringes, labels and patient information. They can obtain this via their community midwife or via antenatal clinic.

If colostrum is obtained during hand expressing then this can be stored, saved and frozen in the sterile syringes ready to use if required after the baby is born. Using the harvested colostrum will support breastfeeding for those occasions where mothers/birthing parents and their babies have a difficult start with birth and breastfeeding whilst they are supported with feeding in the early days.

Women/people should be encouraged, whatever their feeding intention in pregnancy, to consider expressing their colostrum in pregnancy, to enable them to learn this skill in

pregnancy, and for freezing for use if needed once the baby is born, especially if they are spontaneously producing breastmilk in their pregnancy. Why colostrum is important in the early days should be discussed.

- Colostrum coming in naturally small volumes so as not to overload the baby's system with additional water, which both mature breastmilk and formula milk contain.
- Colostrum, like mature breastmilk, is tailored specifically for their baby. It will contain antibodies of viruses the mother/birthing parent has had in the past.
- Colostrum is high in anti-infective and anti-viral properties and is important for priming and protecting a baby's delicate gut. It will help protect a premature or sick baby's delicate gut from developing necrotising enterocolitis (NEC).
- Colostrum contains the perfect balance of proteins, fats and micronutrients needed for babies as well as acting as a laxative to help the passing of the first meconium stools.

6.3 Birth

- All mothers/birthing parents will be offered the opportunity to have uninterrupted skin contact with their baby as close to birth as possible and at least until after the first feed and for as long as they want, so that the instinctive behaviour of breast seeking (baby) and nurturing (mother) is given an opportunity to emerge.
- Skin-to-skin contact should never be interrupted at staff's instigation to carry out routine procedures (such as weighing baby). This is because the baby's innate reflexes during skin-to-skin will not recommence where left and the process will be started again. This increases the baby's risk of becoming sleepy and reluctant to feed. If skin-to-skin contact is interrupted for clinical indication or maternal choice it should be re-instigated as soon as mother/birthing parent and baby are able. Evidence supports that early skin to skin contact should be normal practice for healthy newborns including those born by caesarean and babies born early at 35 weeks or more. Consider transferring to the postnatal ward in skin to skin ensuring the baby is secure in the mother's//birthing parent's arms.
- All mothers/birthing parents 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.
- When mothers/birthing parents choose to formula feed they will be encouraged to offer the first feed in skin contact.
- Those mothers/birthing parents 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.

6.4 Mothers/birthing parents separated from their baby on the neonatal unit are:

- Supported to start expressing milk as soon as possible after birth (ideally to start within the first hour but definitely within six hours). Expressing will be dependent on maternal//birthing parent condition. If mother/birthing parent and baby have been separated due to maternal/birthing parent condition this may not be immediately possible. However regular communication should take place between the staff caring for the mother/birthing parent and those caring for the baby to ensure expressing can be commenced as soon as possible.
- Supported to express effectively in the environment the mother/birthing parent is being cared for. An expressing pack should be given to the mother/birthing parent including sterile syringes, patient information and an expressing log.
- Given resources to enable effective hormone release. These can include a comforter from baby or photos, videos etc.
- Mothers/birthing parents with a baby on the neonatal unit will be supported to express as effectively as possible and encouraged to express at least 8 times in 24 hours including once during the night. They will be shown how to express by both hand and pump.

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

6.5 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 mothers/birthing parents are aware of the need to keep their baby safe and should be aware of the protecting the baby so it 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, but adequate pain relief must be provided. However, 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.

7.0 Support for breastfeeding / feeding assessments

- Mothers/birthing parents should be supported to enable them to achieve effective breastfeeding according to their needs (including appropriate support with positioning and attachment, hand expression, understanding signs of effective feeding). This will continue until the mother and baby are feeding confidently.
- Mothers/birthing parents will have an opportunity to discuss breastfeeding in the first few hours after birth as appropriate to their own needs and those of their baby. This will include information on responsive feeding and feeding cues. Watch how the baby is attaching to the breast.
- A formal feeding assessment will be carried out as often as required in the first week with a minimum of two assessments to ensure effective feeding and the well-being of mother/birthing parent and baby (found in the postnatal baby record). This will include a dialogue with the mother/birthing parent to reinforce what is going well and where necessary, develop an appropriate plan of care to address any issues identified.
- Prior to transfer home, all breastfeeding mothers/birthing parents will receive information, both verbally and in writing (postnatal baby record), about how to recognise effective feeding and where to call for additional help if they have any concerns. This will include the locally run MILK breastfeeding drop-ins situated in the West Sussex community. All breastfeeding mothers/birthing parents will have a feeding assessment prior to discharge.
- For those mothers/birthing parents who require additional support for more complex breastfeeding challenges please signpost to the community MILK breastfeeding drop-ins, or other locally run breastfeeding support groups. If they are still an inpatient, discussion of the issue should take place between the midwife and maternity support worker and possibly the paediatrician dependant on the concern. Please also see NICE Guidance on Postnatal care up to 8 weeks after birth (CG37) and NICE Clinical Knowledge Summaries on Breastfeeding Problems. Alternatively, section 13 of this guidance may offer some solutions to more commonly occurring issues.
- Where there is a suspected tongue tie, a referral to the Infant Feeding Clinic (situated at both St Richard's & Worthing Hospital on a weekly basis) should be made. A referral of babies with a tongue tie should be made where there are concerns about feeding and where a feeding assessment has taken place. Mothers will be informed of this pathway and referral by the health care professional assessing the feeding. For more information please refer to the WSHT Division of Tongue Tie Guideline.

7.1 Responsive feeding

The term responsive feeding is used to describe a feeding relationship which is sensitive, reciprocal, and about more than nutrition. Staff should ensure that mothers/birthing parents have the opportunity to discuss this aspect of feeding and reassure mothers that: breastfeeding can be used to feed, comfort and calm babies; breastfed babies cannot be

overfed or 'spoiled' by too much feeding and breastfeeding will not, tire mothers/birthing parents any more than caring for a new baby without breastfeeding.

Find out more in Unicef UK's responsive feeding infosheet: http://unicef.uk/responsivefeeding

7.2 Exclusive breastfeeding

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

7.3 Modified feeding regimes

There are a number of clinical indications for a short term modified/managed 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. Please see CG1104 Guideline for neonatal hypoglycaemia including the reluctant feeder for those babies at risk of hyperglycaemia and the assessment and treatment required for this group of babies. Frequent feeding, including a minimum number of feeds in 24 hours, should be offered to ensure safety. This guidance also offers a guide to reluctant feeders/ sleepy babies also.

8.0 Supplementation

Artificial feeds should not be given to a breastfed baby except in cases of clinical indication or fully informed parental choice. A single supplementation can have a significant effect on milk supply as well as undermine the mother's/birthing parent's confidence in their ability to breastfeed their baby.

The supplementation information sheet will be provided and discussed with the mother/birthing parent, prior to the supplement being given.

A record of all supplements given will be made using the supplementation stickers provided on the ward, including the rationale for supplementation and that a discussion has taken place with the parent.

- Mothers/birthing parents who give other feeds in conjunction with breastfeeding will be enabled to do so as safely as possible with the least disruption to breastfeeding. This will include appropriate information and a discussion regarding the potential impact of introducing a teat when a baby is learning to breastfeed (see these methods below).
- The supplementation amount does not need to be calculated in a term, healthy baby. The supplement should be offered responsively, taking care to ensure the baby takes what it wants, rather than a specific amount.

- Supplementation rates will be audited continuously, supported by monthly sampling and reviews of records.

A breastfeed should always be the first method of feeding prior to supplementation to encourage direct breastfeeding and with the aim of increasing breastmilk supply.

The following should be encouraged to support continued breastfeeding:

- Maintain prolonged skin-to-skin contact whenever possible.
- Look out for and be ready to respond to baby's early feeding cues, such as poking out their tongue, rooting, making seeking movements, fidgeting and more alert behaviour. Prior to supplementation help the mother/birthing parents position and attach the baby at the breast.
- Express frequently (at least 8 times in 24 hours including once at night) by hand initially, and then in combination with a pump. This is essential to secure milk supply at this time.

8.1 Finger feeding using a syringe

No more than 2mls per feed should be given directly to the baby by syringe using this method. This is because of the increased risk of aspiration of milk into the lungs. If a larger volume is required then please consider one of the other options below. Less than 2mls can be given via sterile syringe or spoon. It is usually used as a short term measure.

Advantages:

- Finger feeding with a syringe is useful for giving small amounts of colostrum which is usually of a thicker consistency.
- Protects breastfeeding by offering a small volume of supplementation (expressed breastmilk or formula) without the use of a teat.
- Can encourage the baby to feed from breast if sleepy and not wanting to latch. The supplementation, especially if it is colostrum, will be highly calorific and will stimulate a sleepy baby and encourage it to feed from the breast.
- Using a finger will stimulate the suckle reflex if baby is unable to latch and breastfeed.
- It's a suitable option for very young babies as the baby can pace the feed.

Disadvantages:

- The potential for some spillages which can cause waste. Mothers/birthing parents can feel particularly frustrated, especially if expressed breastmilk was obtained.
- Risk of the milk being aspirated into baby's lungs, if used when a baby is too sleepy and with poor technique
- It can be a slower way to feed so will take patience.

How to finger feed using syringe:

- If the mother/birthing parent's wishes to use her finger, ensure that they wash and dries their hands before the start, making sure nails are not too long, and use a sterile syringe each time. If a staff member is using their finger please ensure gloves are worn.
- Hold the baby in an upright position.
- Gently stroke down over baby's top lip to encourage rooting and mouth opening.
- Once baby opens their mouth place the pad of your finger to the roof of baby's mouth, taking care not to make the baby gag. If this happens pull back your finger so it's more comfortable for the baby.
- Place the top part of the syringe into the baby's cheek between your finger and baby's gum.
- Push the plunger gently so that the baby suckles your finger while drinking in the milk a little at a time (0.1-2ml).
- Continue until all the milk has gone.
- Continue to give the milk in this way until the baby feeds reliably at the breast, and consider cup feeding, or finger feeding with a tube, as milk volumes increase. Please note that this method should not be used in the community.

Larger volumes of expressed breastmilk or formula can be administered using this method.

Advantages:

- Finger feeding with a tube is used for larger amounts when the milk is more liquid.
- Protects breastfeeding by offering a larger volume of supplementation (expressed breastmilk or formula) without the use of a teat.
- Using a finger will stimulate the suckle reflex if baby is unable to latch and breastfeed.
- Taping the tube close to the breast will enable a baby to help increase maternal breastmilk supply whilst receiving the supplementation for those babies able to latch.
- The baby will be actively pacing the feed.
- Supplementation can be delivered in skin to skin with the mother/birthing parents even when using the tube & finger method.

Disadvantages:

- Potential for milk waste in the tube, however this is estimated to be approximately 0.2-0.3mls. Therefore volumes 2mls and under should be given via finger and syringe.
- If using the finger method a staff member should do this. This is because the practice is new to the department.

How to finger feed with tube:

- Wash and dry your hands before beginning, using a fresh sterile tube and syringe each time.
- Hold baby in a position ensuring the baby can have eye contact with mother and feeder.
- Draw up the required volume into a 10ml or 20ml syringe (this isn't the volume of feed but using this size barrel is most effective).
- Attach syringe to tube (size 5.0) and ensure milk is pushed to end of the tube.
- Place the tip of tube near the tip of your gloved finger, and secure with tape.
    - If taping to breast, support the mother to attach baby in the normal way. However you may need to hold the tube as baby latches to ensure it is taken in by the baby with the breast.
- The syringe can be placed next to the baby/mother/birthing parent in a clean environment (always ensure the plunger is in place)
- Gently stroke down over baby's top lip to encourage rooting and mouth opening.
- Once baby opens their mouth place the pad of your finger to the roof of baby's mouth, taking care not to make the baby gag. If this happens pull back your finger towards the front of the mouth so it's more comfortable for the baby.
- Allow baby to suck your finger and the milk will gradually be drawn along the tube.
- Allow the baby to pause so they can pace the feed at a rate that's comfortable for them.
- Please note that this method should not be used in the community.

8.3 Cup feeding

Larger volumes of expressed breastmilk or formula can be administered using this method. The baby will lap/ slurp the milk. A suitable soft curved cup should be used to avoid damage to lips. It is usually used as a short term measure.

Please note: this method should never be used in a sleepy/lethargic baby due to risk of aspiration.

Advantages:

- Protects breastfeeding by offering a larger volume of supplementation (expressed breastmilk or formula) without the use of a teat.
- It's a suitable option for very young babies as the baby can pace the feed.

Disadvantages:

- The potential for some spillages which can cause waste.
- Risk of the milk being aspirated into baby's lungs.
- It can be a slower way to feed.

How to cup feed:

- Support the baby in an upright position on your lap so that you are both comfortable.
- Fill cup with required volume (bear in mind that the milk can only be out in the cup for 1 hour).
- Stroke your finger over baby's top lip to encourage mouth opening.
- Place the cup towards the corners of their mouth, with the cup resting gently on the lower lip.
- Angle the cup just enough so the milk is just touching the lower lip.
- Wait for the baby to lap the milk, they might smell it first.
- It should not be poured into the baby's mouth.
- Gently increase the angle of the cup as the milk is swallowed, so that milk is always at the rim.
- Allow baby to have short breaks as that way baby will pace the feed and take what is needed at each feed, but keep the cup in place during the breaks.
- The baby will stop when enough milk is taken by closing their mouth.
- The cup can be washed and re-sterilised for future use for the same baby.

9.0 Artificial feeding

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

- Mothers/birthing parents who formula feed will have a discussion about the importance of responsive feeding and be encouraged to:

    - Offer the first feed in skin-to skin contact.
    - Respond to cues that their baby is hungry.
    - Invite their baby to draw in the teat rather than forcing the teat into their baby's mouth by encouraging rooting response.
    - Pace the feed so that their baby is not forced to feed more than they want to. Keep the bottle horizontal.
    - Recognise cues that the baby has had enough milk. Such as splaying of their hands and feet, dribbling milk from the mouth or pushing the the teat from their mouth using the tongue.
    - Be encouraged to swap sides when bottle feeding to ensure equal strengthening of the orbital muscles.
    - Limit who feeds the baby to 2 people at most with the ideally the mother or main carer for at least the first few weeks.
    - Give eye contact and hold baby close.

- Ensure that mothers/birthing parents are aware that all UK brought 'First Milk' formula is made to the same standard across all brands. The only variation is cost.

9.1 Inpatient formula milk provision

- Mothers/birthing parents who have decided in pregnancy to formula feed are to bring ready-made formula with them to the hospital. This must be kept in their side cupboard and each bottle when in use, to be stored in our fridge.
- All feeds to be decanted into our clear plastic bottles, in line with the international code for marketing of breastmilk substitutes.
- We will always provide formula milk for babies with a medical indication for supplementation and where the mother is unable to express sufficient breast milk for the baby's needs.
- We recommend that if midwives are asked which formula we are stocking that they advise women that the milk is infant first milk formula, suitable for newborn babies, and that there is no evidence of difference between the brands.
- See Appendix 2 for separate guides for each of the following groups:
  A) Parents who have chosen in pregnancy to formula feed or mix feed from birth.
  B) Parents who have not planned to formula feed but choose to supplement their babies whilst inpatients.
  C) Parents whose babies have a medical indication for supplementation with formula milk.

10.0 Early postnatal period: support for parenting and close relationships

- Skin-to-skin contact will be encouraged throughout the postnatal period.
- All parents will be supported to understand a newborn baby's needs (including encouraging frequent touch and sensitive verbal/visual communication, keeping babies close, responsive feeding and safe sleeping practice). The Baby Postnatal Record contains within it some parent information regarding the local 'Five to Thrive' scheme.
- Mothers/birthing parents 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/birthing parents-baby relationship.
- Parents will be given information about local parenting support that is available. This includes the locally run MILK breastfeeding drop-ins situated in the West Sussex community.

11.0 Recommendations for health professionals on discussing bed-sharing with parents

Simplistic messages in relation to where a baby sleeps should be avoided; neither blanket prohibitions nor blanket permissions reflect the current research evidence.

The current body of evidence overwhelmingly supports the following key messages, which should be conveyed to all parents:

- The safest place for your baby to sleep is in a cot by your bed.

- Sleeping with your baby on a sofa puts your baby at greatest risk.
- Your baby should not share a bed with anyone who:
  - Is a smoker
  - Has consumed alcohol
  - Has taken drugs (legal or illegal) that make them sleepy.

The incidence of SIDS (often called “cot death”) is higher in the following groups:

- Parents in low socio-economic groups.
- Parents who currently abuse alcohol or drugs.
- Young mothers/birthing parents with more than one child.
- Premature infants and those with low birthweight.

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.

The infographic and guidance is designed to support health professionals when discussing co-sleeping and SIDS with parents (see Appendix 3). Giving them all the facts and figures, this accessible guide assists health professionals to take a sensible, proportionate parent-centred approach in order to find practical solutions to this complex issue.

12.0 Care Standards for babies in the Neonatal Unit

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

This service recognises the profound importance of secure parent-infant attachment for the future health and well-being of the infant and the challenges that the experience of having a sick or premature baby can present to the development of this 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. Local guidance from South Central Neonatal Network Quality Care Group for skin-to-skin on the NNU (Guideline framework for kangaroo care) can be found here. Additional information can also be found on the Bliss website.

12.2 Enabling babies to receive breastmilk and to breastfeed

This service recognises the importance of breastmilk for babies' survival and health. Therefore, this service will ensure that:

- A mother's/birthing parent's own breastmilk is always the first choice of feed for their baby.
- Mothers/birthing parents have a discussion regarding the importance of their breastmilk for their preterm or ill baby as soon as is appropriate (women/birthing parents will have received discussion regarding importance of breastmilk in the pregnancy but this should be reiterated in relation to their preterm or ill baby).
- When a baby is admitted to NNU it is the shared responsibility of the neonatal nurse and mother's/birthing parent's midwife to ensure the mother/birthing parent is given sufficient help to express their milk by hand and by pump in order to establish and maintain lactation. This should ideally be commenced within 6 hours of birth but preferably within the first hour where possible.
- A suitable environment conducive to effective expression is created ideally near to their baby to optimise hormonal response.
- Mothers/birthing parents have access to effective breast pumps and equipment.
- Mothers/birthing parents are enabled to express breastmilk for their baby, including support to:
    - Express as early as possible after birth (ideally within six hours).
    - Learn how to express effectively, including by hand and by pump.
    - Learn how to use pump equipment and store milk safely (BfN leaflet).
    - Express frequently (at least eight times in 24 hours, including at least once at night) especially in the first two to three weeks following delivery, in order 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 10.
    - Stay close to their baby when expressing milk.
    - Use their milk for mouth care, 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 (and carried out at least once within the first 12 hours following birth) to support early expressing to support optimum expressing and milk supply. Please use the local expressing assessment tool and log.
- Mothers/birthing 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 behaviour.
    - Position and attach their baby for breastfeeding.
    - Recognise effective feeding.
    - Overcome challenges when needed.
- Mothers//birthing 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/birthing 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 mothers'/birthing parents' confidence and modified responsive4 feeding.

12.3 Valuing parents as partners in care

This 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.

The service 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.

The service will ensure that parents who formula feed:

- Receive information about how to clean/sterilise equipment and make up a bottle of formula milk.
- Are able to feed this to their baby using a safe technique.

13.0 Rooming in

Mothers/birthing parents will normally assume primary responsibility for the care of the babies but will be supported with any questions or concerns they may have.

Babies will not be routinely separated from their mothers/birthing parents at night. Mothers/birthing parents who are unable to care for their baby due to illness or temporary problem will be given appropriate care and staff will support the mother/birthing parent and/or partner to continue routine care of their babies.

14.0 Weighing newborns

Birth weight, correctly taken and recorded, and related to gestational age, is an essential first step in growth monitoring. Weight gain in the first few weeks of life is occasionally a cause for concern but there is little evidence on optimal frequency of weighing in the neonate.

Re-weighing a baby who has remained on the postnatal ward beyond 3 days for a feeding concern is recommended to minimise the potential for readmission for abnormal weight loss on day 5.

Babies should be weighed at birth, on day 5 and day 10 or prior to discharge to the health visitor. This must be documented in the baby postnatal record and in the Personal Child Health Record aka 'red book' where this is available.

Baby scales within the Trust are calibrated annually.

15.0 Feeding problems

The mothers/birthing parents must be given details of local support groups and telephone numbers of feeding advisors. Please signpost breastfeeding mothers to their local MILK! Group.

If a feeding problem is suspected a feeding assessment should take place (found in the postnatal baby record) and a plan put in place to support the mother/birthing parents. If the feeding assessment highlights any concerns then a Midwife or Maternity Support Worker must watch a full breastfeed, develop a care plan including revisiting positioning and attachment. Where weight loss is between 8 and 10% at day 5 and there have been feeding problems identified, extra feeding support should be considered.

For babies who lose over 10% of their birth weight on day 5, the advice of a paediatrician must be sought. This can be done via the neonatal unit or by bleeping the on-call paediatrician directly.

For those mothers/birthing parents who require additional support for more complex breastfeeding challenges please highlight to an advanced trained maternity support worker or midwife or to the community MILK breastfeeding drop-ins. Please also see NICE Guidance on Postnatal care up to 8 weeks after birth (CG37) and NICE Clinical Knowledge Summaries on Breastfeeding Problems

Where there is a suspected tongue tie, a referral to the Infant Feeding Clinic (situated at both St Richard's & Worthing Hospital) should be made. A referral of babies with a tongue tie should be made where there are concerns about feeding and where a feeding assessment has taken place. Mothers/birthing parents will be informed of this pathway and referral by the health care professional assessing the feeding. For more information please refer to CG12033 Tongue-tie guideline.

The system for reporting newborns who are re-admitted with feeding problems during the first 28 days of life is for the health professional involved to complete the Trust web-based Clinical Incident Form (Datix). The incident will be allocated to the most appropriate senior midwife for review and feedback any lessons identified on review.

16.0 Training

Midwives have the primary responsibility for protecting and promoting breastfeeding and helping women/birthing parents overcome related problems. Professional and support staff who have contact with pregnant women/people and mothers/birthing parents will receive training in breastfeeding support at a level appropriate to their professional group.

Staff will have a mandatory infant feeding update annually.

Clerical and ancillary staff will be made aware of the breast feeding policy and receive advice to enable them to refer breast feeding queries appropriately

The responsibility for providing training lies with the Trust and details are contained within the Maternity Training Needs Analysis document.

17.0 Monitoring / Audit

The process for audit and monitoring of this guideline is completed in the following ways:

a) Compliance with this guidance is audited at least annually using the UNICEF UK Baby Friendly Initiative audit. Audit results will be reported to the head of service and head of division and an action plan will be agreed by Infant Feeding Group to address any areas of non-compliance that have been identified.
b) Outcomes will be monitored by:
    - Guideline is monitored through Baby Friendly Initiative (BFI) audit cycles specifically the continuous supplementation audit, as supplementation rates are indicative of the level of individualised care and promotion of breastfeeding. BFI also request staff knowledge and maternal/birthing parent satisfaction audits which help target training requirements for midwives and support workers
    - Monitor attendance of women/people & their partners to the Baby Matters antenatal session
    - Staff Training in relation to infant feeding - Training Needs Analysis audit
    - Monitoring breastfeeding initiation rates & retention rates at 10 days
c) Outcomes will be reported to:
    - Infant Feeding Group
    - Public Health Meeting

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NICE guidance on maternal and child nutrition: http://www.nice.org.uk/ph11

The international Code of Marketing of Breastmilk Substitutes
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Appendix 1: Baby Friendly Initiative Stages

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

1. Educate staff to implement the standards according to their role and the service provided.

Stage 3
Parents' experiences of maternity services-

1. Support pregnant women/people to recognise the importance of breastfeeding and early relationships for the health and well-being of their baby.
2. Support all mothers/birthing parents and babies to initiate a close relationship and feeding soon after birth.
3. Enable mothers/birthing parents to get breastfeeding off to a good start.
4. Support mothers/birthing parents 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.

Parents' experiences of 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.

Re-accreditation-

1. Demonstrate innovation to achieve excellent outcomes for mothers/birthing parents, babies and their families.

Click here for a flowchart overview of BFI accreditation. For more information and guidance around the BFI stages please visit the UNICEF BFI website here

Appendix 2: Staff information sheet

A. For parents who have chosen in pregnancy to formula feed or mix feed from the outset, they will be asked to provide formula milk for their babies whilst inpatients.

They will be asked to bring in a 'Starter Pack' of 'Ready to Feed' first infant formula, which are available from most supermarkets and pharmacies. Healthy Start vouchers can be used to purchase these packs. We are advising that women/people should expect their babies to need around 8 teats and bottles per day, although the number of bottles may be reduced if we can decant and minimise wastage.

For these women/people, midwives are asked to:

- Check with the parents that the Starter Pack formula milk they have brought is a first milk for newborn babies and the expiry date. An open bottle should be discarded within 1 hour from opening if the baby drinks directly from it. However if decanting this can be refrigerated at kept at the back of the fridge for 24 hours.

- Discuss colostrum and collecting and offer an antenatal expressing pack.

- Demonstrate responsive bottle feeding and discuss feeding cues.

- Demonstrate how to make up formula from powder safely and understand the importance of washing and sterilising the necessary equipment before discharge. Reiterate the importance of using boiling water as there is a misconception that using cooled boiled water is ok. Boiling water is essential for killing the bacteria in the powder, not to sterilise the water alone.

- Ensuring that they position themselves and their baby safely, in order to look into baby's eyes, and to pace the feeds so as not to overload the baby.

- The 'Perfect Prep Machine' and other mechanical bottle preparation technology is currently not recommended.

- Use the Guide to Bottle feeding booklet found here: https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2008/02/start4life_guide_to_bottle_-feeding.pdf

- For a simple guide on which type of formula and how to feed responsively please see the information contained within the Baby Postnatal Record.

B. Parents who have not planned to formula feed but choose to supplement their babies whilst inpatients

For these women/people, midwives are asked to:

- Continue to maximise support and encouragement for breastfeeding and expression of breast milk, seeking additional support where necessary. Ensure women/people are fully informed about the impact on breastmilk supply when supplementing with formula and the risk of nipple confusion when using a bottle teat.

- Give to the baby in the least disruptive way to breastfeeding (cup/ finger feeding), especially if this is the eventual feeding intention. See Section 8.0 for other methods of feeding.

- In the circumstance where parents decide that they wish to give their baby formula, we will provide them with formula milk for the next time their baby needs to feed, until their partner or family member is able to bring in formula milk for the baby. Formula milk 'starter packs' are available at a range of supermarkets and pharmacies close to the Trust hospitals.

- If formula milk is requested before any 'Ready Made' formula can be brought in for the baby, please decant any formula milk provided by the ward in a non-branded bottle. Decant the amount required into a neutral sterile container and place the rest into the fridge indicating date and time of opening (use the refrigerated milk within 24 hours). The remaining milk can be used for this or other babies within 24 hours of opening so long as it remains refrigerated.

- Inform the parents that the decanted formula should be used within 1 hour

- If using a bottle demonstrate responsive bottle feeding technique

- Ensuring that they position themselves and their baby safely, in order to look into baby's eyes, and to pace the feeds so as not to overload the baby.

- The 'Perfect Prep Machine' and other mechanical bottle preparation technology is currently not recommended.

- Use the Guide to Bottle feeding booklet found here:https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2008/02/start4life_guide_to_bottle_-feeding.pdf

- For a simple guide on which type of formula and how to feed responsively please see the information contained within the Baby Postnatal Record.

- If parents will continue to give infant formula on discharge from hospital, they should be shown how to make up infant formula from powder safely, and understand the importance of washing and sterilising the necessary equipment prior to discharge. Reiterate the importance of using boiling water as there is a misconception that using cooled boiled water is ok. Boiling water is essential for killing the bacteria in the powder, not to sterilise the water alone.

C. For parents whose baby needs formula milk as a supplementation for a medical reason

We will always provide formula milk for babies with a medical indication for supplementation and where the mother/birthing parent is unable to express sufficient breast milk for the baby's needs.

For these women/people midwives are asked to:

- Discuss the medical reason for supplementing, on the basis of a documented paediatric recommendation.
- Support mother/birthing parents to keep on breastfeeding and/or expressing. Where possible babies should breastfeed or receive expressed breast milk prior to a formula supplementation. This will help the mother/birthing parents maintain or increase milk supply.
- Each ward will have a supply of a single brand of formula milk. Check the expiry date on the individual bottle.
- Decant the amount required into a non-branded sterile container and place the rest into the fridge indicating date and time of opening (use the refrigerated milk within 24 hours). The remaining milk can be used for this or other babies within 24 hours of opening so long as it remains refrigerated.
- Inform the parents that the decanted formula should be used within 1 hour
- Give to the baby in the least disruptive way to breastfeeding (cup/ finger feeding). See Section 8.0 for other methods of feeding.
- If using a bottle demonstrate responsive bottle feeding technique
- Ensuring that they position themselves and their baby safely, in order to look into baby's eyes, and to pace the feeds so as not to overload the baby.
- Use the Guide to Bottle feeding booklet found here:https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2008/02/start4life_guide_to_bottle_-feeding.pdf
- For a simple guide on which type of formula and how to feed responsively please see the information contained within the Baby Postnatal Record.
- If parents decide to switch to formula but no longer with a medical indication, then ask them to bring a Starter Pack of 'Ready to Use' formula into hospital. These are available from supermarkets and pharmacies.

- If parents will continue to give infant formula on discharge from hospital, they should be shown how to make up infant formula from powder safely, and understand the importance of washing and sterilising the necessary equipment prior to discharge.

Appendix 3: A guide for health professionals: Safe Sleeping

A guide for health professionals

~680,000
babies are born each year in England and Wales[1]

~340,000
babies will have slept together in an adult bed with one or both parents by three months, whether intended or not[2]

Sleeping in close contact helps babies to settle and supports breastfeeding,[3,4,5] which in turn protects babies from **Sudden Infant Death Syndrome (SIDS)**.[6]

On any night, 22% of babies will bed-share[◊] – so 149,000 babies will be in bed with their parent tonight.[2]

IN 2017, 183 BABIES DIED OF SIDS IN THE UK: 0.03% OF ALL BIRTHS[7]

Previous UK data suggests:

- around half of SIDS babies die while sleeping in a cot or Moses basket.
- around half of SIDS babies die while co-sleeping. **However, 90% of these babies died in hazardous situations which are largely preventable.[#,8]**

1 IN 3,710	The risk of SIDS for all babies in England & Wales[1]
1 IN 203	The risk of SIDS while co-sleeping on a sofa[1,9]
1 IN 203	The risk of SIDS while co-sleeping after consuming alcohol or drugs[1,9]
1 IN 919	The risk of SIDS while co-sleeping with a regular smoker[1,9]

IF NO BABY CO-SLEPT IN HAZARDOUS SITUATIONS, WE COULD POTENTIALLY REDUCE CO-SLEEPING SIDS DEATHS BY NEARLY 90%[8]

unicef.uk/safesleeping

*Co-sleeping: an adult and a baby sleeping together on any surface (such as a bed, chair or sofa).
◊ Bed-sharing: sharing a bed with one or both parents while baby and parent(s) are asleep.
Using SIDS by sleeping environment from the latest case-control study conducted in England.

Basis Baby sleep info source

the lullaby trust – safer sleep for babies – support for families

unicef UNITED KINGDOM

THE BABY FRIENDLY INITIATIVE

CO-SLEEPING AND SIDS:
A guide for health professionals

As a health professional tasked with discussing co-sleeping and Sudden Infant Death Syndrome (SIDS) with parents (as recommended by NICE (2014) CG37),[10] it is easy to feel overwhelmed.

The messages can seem complex, controversial and at odds with the reality of parents' lives. You may also fear getting it wrong, as this could result in the loss of a baby's life and/or serious consequences for your career. It can, therefore, feel safest to either simply tell all parents to never co-sleep or just to say nothing at all.

Unfortunately, this approach is not safe. It can increase the risks to babies because:

- Young babies wake frequently at night and need to be fed and cared for somewhere. In most homes this will be in bed or on a sofa or armchair, simply because there is no other comfortable place. Parents can easily choose the more dangerous sofa over the less dangerous bed because they are trying to follow advice to never bed-share.
- Mothers can try and sit up rather than lay in bed to breastfeed in order to stop themselves falling asleep. As most babies breastfeed frequently, mothers risk falling asleep in a more dangerous position than if they had been lying down. Many abandon breastfeeding altogether as they are so exhausted, thereby depriving themselves and their baby of all the benefits that breastfeeding brings.
- Babies thrive on closeness and comfort. Many parents end up co-sleeping, whether they intended to or not, as it settles their baby and so enables everyone to sleep.
- While some young babies settle easily in a cot or Moses basket between feeds, others do not. Some parents who choose not to co-sleep may decide to encourage their baby to learn to sleep independently using the controlled crying method, which is not recommended. This approach can be distressing for the parents and their baby, be detrimental to the baby's growth and development and can undermine breastfeeding.

So what to do?

SIDS is very rare (0.03% of all births) and it will never be possible to eliminate all risk. However, with sensible, parent-centred communication, we could potentially reduce co-sleeping SIDS deaths by nearly 90%.

Remember that it isn't helpful to tell parents what they must or mustn't do; instead, listen carefully and offer information appropriate to their needs. You may find the Unicef UK 'Having meaningful conversations with mothers' guide helpful (available at unicef.uk/safesleeping).

Acknowledge that young babies wake and feed frequently in the night and that this is normal and not modifiable, as young babies are not capable of 'learning' to defer their needs. Accepting this reality can be helpful, as parents are reassured that their baby is normal and they aren't doing anything wrong. It can also relieve the pressure to find 'solutions'.

CO-SLEEPING AND SIDS:
A guide for health professionals

Give parents (or talk through with parents) the Unicef UK leaflet 'Caring for your baby at night', which covers all the safety issues and offers practical tips (available at unicef.uk/safesleeping). Durham University's Baby Sleep Information Source website can also be suggested. It is most important to **explain** that around half of all parents will sleep with their baby at some point, be this planned or unplanned, and, although SIDS is very rare, it is much more likely to happen in certain circumstances.

Therefore:

- Sleeping on a sofa or chair with a baby is very dangerous[9] and should always be avoided. If parents fall asleep with their baby they are much safer in a bed than on a sofa or chair.*
- SIDS is more likely if parents co-sleep after drinking or taking drugs;[9] having an open conversation can help them to understand why they should be very careful not to fall asleep with their baby after drinking or taking drugs. Drink and drugs also affect normal functioning and decision-making. Discuss the importance of planning care for their baby at such times, for example by asking a sober adult to help.
- Co-sleeping is much more dangerous when parents smoke or have smoked during pregnancy;[9] help parents understand this and offer every support for them to cut down or stop, especially in pregnancy.
- SIDS is more common in babies who were born low birthweight or premature; therefore parents of these babies should avoid co-sleeping especially in early infancy.[9]

Try and take time to discuss the issues with these parents and to help them look for practical solutions to issues that are affecting them such as lack of a cot, bed or space for sleeping. Breaks in routine, such as visiting friends and family overnight or going on holiday can also present an extra risk to babies. Suggesting that parents think about what they are going to do at such times can therefore be helpful.

Remember, shocking messages that imply that all/any co-sleeping leads to death are not helpful. They do not reflect the evidence, and they frighten parents and staff, induce guilt and close down honest conversations.

*Adult beds are not designed to keep babies safe – parents must keep babies safe. Please refer to Unicef UK's 'Caring for your baby at night' booklet and health professionals' guide for more information.

Please turn over for references.

UNICEF.UK/SAFESLEEPING

CO-SLEEPING AND SIDS:
A guide for health professionals

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Appendix 4: Parent information - Supplementation

Possible effects of offering a formula supplementation to a breastfeeding baby

If you are thinking of giving your breastfed baby formula milk, here is some important information to consider to help you make an informed decision.

Breastfeeding is generally recognised to be the most beneficial feeding method for both mother and baby in terms of health outcomes (NICE 2006). Breastfeeding provides a complete food, and is actively protective for both mother and baby, whilst formula, although meeting with European nutritional standards (Commission Directive 2006), does not provide immunity or contain any of the other ingredients that breastmilk does.

Some mothers worry that their colostrum is not enough for their baby. This milk is very special and full of factors that protect your baby and colostrum is naturally produced in smaller quantities in the first two days after birth.

New babies can be unsettled, fussy or sleepy and sometimes mothers ask for formula supplements without realising the possible problems of giving formula to their breastfed newborn. Staff can suggest ways of soothing your baby, support you to recognise effective feeding, and help you hand express your breastmilk in the first instance.

Helpful Hints…

⇒ Skin to skin is wonderful at calming your baby; encourages their instinctive response to breastfeed and will increase your breastmilk supply. They are happiest being held.

⇒ Breastfed babies will normally feed 8-12 times in twenty four hours. Feed your baby at the earliest feeding cues. Ring your call-bell so we can help guide you with optimal positioning and attachment of your baby to your breast to get the most out of the breastfeed.

⇒ Try a laid back (baby driven) position which will encourage your baby's instinctive behaviour to self-attach.

⇒ If your baby seems to be sleepy whilst breastfeeding, compress the breast your baby is feeding from, with your hand, which will increase milk flow and encourage your baby to actively feed. Alongside this switch your baby to the other breast when they are no longer actively feeding which will bring a new 'let down' of milk and will encourage baby to actively feed. Switch over 3-4 times until your baby is done.

⇒ Express small but frequent amounts and give this to your baby regularly on a finger or syringe which will stimulate a sleepy baby.

Some things to consider…

◊ **Effects on breastmilk supply:** Offering formula milk may affect your breastmilk supply as breastfeeding works best if you repeatedly put your baby to your breast again and again. This extra stimulation will improve your supply and help settle your baby. By replacing a breastfeed with formula, your breasts can become over-full (engorged), which can be painful and can cause some difficulty in attaching your baby to the breast. If this is not resolved quickly (by getting your baby to feed from your breasts or by expressing your breastmilk) it can lead to reduced milk supply. It could also lead to mastitis.

◊ **Increased chance of gut infections:** breastfed babies have a lower gut pH level (this means that their gut is more acidic) during the first six weeks of life. This is beneficial as it reduces harmful germs in the gut. If formula supplements are given in the first seven days, the development of the lower pH in the gut is slowed.

◊ **Increased chance of cow's milk allergy:** Giving formula milk to a breastfed baby can increase their chance of developing Cow's Milk Protein Allergy (CMPA).

◊ **Nipple confusion:** Sucking on a bottle teat may make it more difficult for the baby to latch to the breast effectively as the action the baby makes with its mouth when feeding from a teat is very different.

◊ **Over-feed:** Babies given larger volumes of formula milk can take more than required during a feed and can be less satisfied on subsequent breastfeeds. Breastfeeds are naturally smaller in volume while delivering the exact nutritional needs to your baby.

Medical reasons: Occasionally, there are medical reasons to offer a breastfed baby supplements of formula milk. The health professionals working with you will advise you if your baby has a medical need for supplemental milk. The healthiest supplement is the mother's expressed breast milk followed by formula milk.

Decisions…

If you do decide to give formula milk after reading this information and considering your options, staff will be sensitive to your informed decision, and will support you to keep your options open to continue breastfeeding.

Supporting breastfeeding while giving a formula supplement...

⇒ Offer the formula milk in small amounts to mimic how breastfeeding works.

⇒ Staff will help you to use a cup or tube (supplementary nursing system) to avoid possible teat confusion.

⇒ Express your breastmilk so that your supply is maintained. As babies grow, latching issues can improve and you may wish to remove the added formula supplement.