East of England Neonatal ODN
(Hosted by Cambridge University Hospitals)

**Clinical Guideline: Neonatal Feeding Policy**

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**For use in:** EoE Neonatal Units
Guidance specific to the care of neonatal patients

**Used by:** All staff caring for babies and supporting within neonatal services

**Key Words:** baby feeding, breastfeeding, Baby Friendly Initiative

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**Approved by:**

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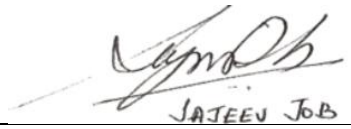
| Neonatal Clinical Oversight Group |  |
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**Ratified by ODN Board:**

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**Audit Standards:**

**Monitoring implementation of the standards**
The East of England Neonatal ODN requires that compliance with this policy, or the used unit specific policy, is audited at least annually using the UNICEF UK Baby Friendly Initiative neonatal audit tool (unicef.uk/audit), although more frequent audit is strongly recommended. Staff involved in carrying out this audit require training on the use of this tool. Audit via the Baby Friendly Dashboard within BadgerNet will support collation of data. Other methods may include, but are not limited to, questionnaires, clinical supervision of staff, and examination of appropriate records. Audit results will be reported to the individual unit's head of service and head of division, and an action plan will be agreed by each unit's BFI Implementation/Management Team to address any areas of non-compliance that have been identified.

**Monitoring outcomes**
Policy implementation aims to improve outcomes in care for babies and their families by:

- increasing rates of mothers expressing breastmilk on admission, using the BadgerNet UNICEF Baby Friendly Report to assess
- increasing rates of breastmilk feeding initiation on admission, using the BadgerNet UNICEF Baby Friendly Report to assess
- increase rates of mothers expressing breastmilk during the first 24 hours following their baby's admission to the neonatal unit using the Badger Net UNICEF Baby Friendly Report to assess
- increase rates of babies who receive human milk in the first 24 hours following admission to the neonatal unit using the Badger Net UNICEF Baby Friendly Report to assess
- increasing rates of babies who receive their mother's breastmilk (suckling at the breast, fresh/frozen expressed breastmilk, mouthcare) in the first 48 hours (NNAP data)
- Increasing rates of babies having their own mother's milk at day 14 (NNAP data)
- increasing of breastfeeding initiation rates, which may be assessed with the BadgerNet Unit Feeding Report and the Baby Friendly Initiative neonatal audit tool to assess
- Increasing rate of breastmilk feeding / breastfeeding rates at discharge/transfer, using the BadgerNet UNICEF Baby Friendly Report to assess
- increase rate of babies receiving human milk when they leave the unit, using the Badger Net UNICEF Baby Friendly Report to assess
- increase rate of mothers expressing breastmilk when their baby leaves the unit, using the Badger Net UNICEF Baby Friendly Report to assess
- monitoring, amongst families who have chosen to bottle feed or do so out of necessity, embedding of bottle-feeding techniques that are as safe and responsive as possible, using the Baby Friendly Initiative neonatal audit tool to assess
- improving parents' experience of neonatal care, using the Baby Friendly Initiative neonatal audit tool to assess

**Outcomes will be reported to**:
Each neonatal unit's appropriate head of service / head of division, Neonatal Baby Friendly Guardian, committee / board or working party, and the East of England Neonatal ODN Care Coordinators. As a minimum, this should be reported quarterly, i.e., 30th June, 30th September, 31st December, and 31st March.

**Equality, Diversity & Inclusivity Statement**

This policy document aims to meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It considers the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document ensures that no one receives less favourable treatment on the protected characteristics of their age, disability, sex, gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. The East of England Neonatal ODN advocates due regard to the various needs of different protected equality groups in our network.

The East of England Neonatal ODN acknowledges the additional challenges that gender identity can have, specifically around the perinatal period and in regard to infant feeding. We are aware that there is not yet universal language that addresses all families accessing maternity and neonatal care. We refer to breastfeeding and breastmilk but recognise terms such as chest feeding, body feeding, nursing, lactation, or providing human milk may be more preferable for and accurate to some of the families we support. We support mothers to express their breastmilk and to breastfeed their babies, but we also understand that not all birthing parents will identify as women or as mothers. We will always use the individual's preferred language, name, pronouns or terminology that they most comfortable with, as we recognise the importance of providing inclusive and respectful perinatal information and support to all pregnant women, pregnant people, mothers, parents and families.

**Purpose**

This collaborative policy shares its principles with the East of England Neonatal Operational Delivery Network (ODN) and all neonatal units therein. The purpose of this policy is to ensure that all staff caring for pregnant women, new parents, and babies (in the immediate postnatal period and throughout all levels of neonatal care) within the East of England Neonatal ODN need to understand their role and responsibilities in supporting parents to feed and care for their baby[1] in ways which support optimum health and wellbeing.

This policy adheres to the current UNICEF Baby Friendly Initiative (BFI) Neonatal Standards (1), Bliss Baby Charter Principles (2), and the World Health Organisation's (WHO) International Code of Marketing of Breastmilk Substitutes (3, 4, 5) (often referred to as "The Code") in order to promote that all babies are safely and optimally fed. This policy adheres to the recommendations of the NCCR (Neonatal Critical Care Review) (6) and NHSE (NHS England) to implement BFI neonatal standards within all neonatal units. All staff within the East of England Neonatal ODN are expected to comply with this policy, reading it upon commencement of their relevant role, as well as remain current with updates. Any deviation from this policy must be addressed by additional training from the infant feeding teams within the neonatal unit and supported by the Care Coordinator team within the neonatal ODN. All staff working within the neonatal units (clinical and non-clinical, medical, nursing, allied healthcare professionals, administration, support staff, etc.) will attend baby feeding education relevant to their role upon commencement and within six months, as well as regular updates, learning opportunities, and participation in audit to promote sustainability and current best practice. All curricula should adhere to Baby Friendly Initiative Neonatal Standards (1).

**Outcomes**

This policy aims to ensure that the care provided improves short- and long-term outcomes for children and families, specifically to deliver:[2]

- increase rates of mothers expressing breastmilk during the first 24 hours following their baby's admission to the neonatal (BadgerNet data)
- increasing rates of babies who receive human milk in the first 24 hours after admission (BadgerNet data)
- increasing rates of babies who receive their mother's breastmilk (suckling at the breast, fresh/frozen expressed breastmilk, mouthcare) in the first 48 hours (NNAP data)

[1] We refer to a singleton "baby" throughout this document but accept that parents/carers may have multiple babies.

[2] List the appropriate outcome indicators in alignment with national policy and local agreements

- Increasing rates of babies having their own mother's milk at day 14 (NNAP data)
- increasing rates of babies receiving human milk when they leave the unit (BadgerNet data/ NNAP data)
- increasing rates of mothers expressing breastmilk when their baby leaves the unit (BadgerNet data)
- increasing rates of babies being breastfed at discharge/ transfer (BadgerNet data)
- families who have chosen to bottle feed or do so out of necessity, embedding of bottle-feeding techniques that are as safe and responsive as possible of the mothers who chose to formula feed, an increase in reporting that they have received proactive support to do so as safely and responsively as possible in line with Department of Health guidance (7)
- Improvements in parents' experiences of care and promote close and loving relationships
- improving parents' experience of neonatal care, using the Baby Friendly Initiative neonatal audit tool to assess

**Our commitment**

All neonatal units within the East of England Neonatal ODN are committed to:

- Providing the highest standard of care to support parents with a baby on the neonatal unit to feed their baby and build strong and loving parent-baby relationships. This is in recognition of the profound importance of early relationships to acute and future health and wellbeing, and the significant contribution that breastfeeding makes to good physical and emotional health outcomes for children and mothers.
- Ensuring that all care integrates the mother and family as valued and essential members of their baby's care team, is non-judgmental and that parents' decisions are informed, supported and respected.
- Working together across disciplines and organisations to improve parents' experiences of care.

**As part of this commitment, neonatal units within the East of England Neonatal ODN will ensure that:**

- All new staff are familiarised with the policy on commencement of employment so that they understand what is required of their practice. This includes all staff routinely involved in the care of pregnant women, mothers, their babies, and their families, such as neonatal nurses, children's nurses, midwives, nursery nurses, healthcare assistants, midwifery care assistants, Allied Healthcare Professionals, the medical team involved in the care of the family not exclusively neonatologists and obstetricians.
- All staff receive training to enable them to implement the policy as appropriate to their role. New staff receive this training within six months of commencement of employment, and all staff receive regular updates (at least annually) specific to their role and the current needs of the local neonatal unit and neonatal ODN, to promote consistent adherence to the standards. Neonatal unit feeding leads/link role will be supported to develop and/or update staff training curricula that incorporate the Baby Friendly Initiative Neonatal Standards (1). In order to improve outcomes for families, where the neonatal unit feeding leads roles are not yet in place, the East of England Neonatal ODN recommends their development.
- Collaborative working should exist across professions and all sectors so that resources and workstreams can be streamlined to improve outcomes for mothers and babies. Some may exist locally or across the ODN, whilst others will be established. This will include:
    - Neonatal units working with their maternity units to provide consistent and complementary care
    - Services working closely with local voluntary groups and peer supporters to improve support for mothers and parents on the neonatal units
    - Liaising with local children's centres and or third sector organisations
    - Health visitors
- The International Code of Marketing of Breastmilk Substitutes (The Code) (3,4,5) is adopted throughout the East of England Neonatal ODN. This includes: no advertising, displays or distributions of materials that are direct or indirection promotions or sales aimed at parents or staff

of any part of the breastmilk substitute (BMS) industry, feeding bottles, teats or dummies[3]. Therefore, to ensure compliance with The Code, any contact or approach from representatives relating to breastmilk substitutes or associated feeding equipment must be managed in a controlled and transparent manner (see Appendix I).

- Conflict of interest will be avoided between staff and representatives of the manufacturers of breastmilk substitutes or additives, which may include: study days, education opportunities, and meetings offered to staff and/or parents; staff engagement by speaking at events or writing for the BMS industry, gifts or awards made to staff or services by the BMS industry or other organisations themselves sponsored by the BMS industry.
- Procurement contracts of breastmilk substitutes and associated feeding equipment should be reviewed and agreed at the initial stage of contract and prior to renewal. This will ensure that Trusts regularly monitor compliance with The Code within the procurement process. Agreement should be sought by Infant Feeding Leads, Dietitian, Speech and Language Therapist, and Neonatal Unit Ward Manager/Budget holder, as appropriate.
- Feeding Leads and Ward Managers should seek quarterly reports from stores/procurement departments to ascertain fair pricing of breastmilk substitutes and feeding accessories. In the case that costing may be agreed at a consortium level outside the Trust, Feeding Leads or Ward Managers should advocate for fair pricing and have evidence of this request.
- An Escalation pathway is in place related with suspected breech of the International Code of Marketing of Breastmilk substitutes are in place (please see template for escalation pathway in Appendix II).
- An Environmental audit is performed twice a year (please see suggested audit tool in Appendix III).
- Parents' experiences of care will be listened to through:
    - regular audit using the Baby Friendly Initiative audit tool:
        - a minimum of 12-15 audits 6 monthly whilst working towards Stage 2.
        - a minimum 12-15 audits quarterly, when working towards Stage 3.
    - parents' experience surveys (e.g. Care Quality Commission, Bliss Baby Charter audit tool etc.).
    - the East of England Neonatal ODN Parent Advisory Group, national, regional, and local Maternity and Neonatal Voices Partnerships (8).
    - Results of audit and feedback will be communicated to clinical staff, audit departments, and stakeholders, as appropriate.
- Staff is audited using the Baby Friendly Initiative audit tool regularly:
    - A minimum of 12-15 audits is performed quarterly when working towards Stage 2.
    - A minimum of 12-15 audits is performed twice a year when working towards Stage 3.
- An ODN and/or unit leaflet for new mothers and parents that reflects this policy will be displayed or otherwise made available to all parents of babies admitted to neonatal care.
- This policy will be publicly available on the East of England Neonatal ODN's website.

## Care standards

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

The neonatal units within the East of England Neonatal ODN recognise the profound importance of secure parent-baby attachment for the future health and wellbeing of the baby and the challenges that the experience of having a sick or premature baby can present to the development of this relationship. Therefore, each neonatal unit is committed to care that 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, which will be recorded in the baby's neonatal clinical notes

[3] We recognise that use of a dummy for non-nutritive sucking (always with parental informed consent), when the baby is not able to suckle at their mother's breast for the same purposes, is a developmental care intervention that can facilitate transition from enteral to oral feeding and serve as a comfort measure (9, 13).

- Be actively encouraged and enabled to provide touch, comfort and emotional support to their baby throughout their baby's stay on the neonatal unit (9)
- Be actively encouraged to be responsive to their baby's behavioural cues (9, 10, 11)
- 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 (9, 12) aiming for 60 minutes or more.
    - Whilst facilitating skin to skin contact / kangaroo care, the staff member caring for the family will ensure that the baby cannot fall to the floor, that the baby is routinely monitored, and that they respond immediately to any parental concern expressed, acknowledging that the parents are their baby's experts. They will also ensure the following safety considerations are considered:
        - Responsiveness – while a relaxed and calm environment is promoted, parents should not be distracted or overly sleepy, e.g. due to immediate postpartum tiredness, effects of pain or analgesia, etc., as they will be encouraged to respond to their baby and alert staff with any concerns.
        - Airway and breathing – positioning of the baby is carefully considered and demonstrated to parents to avoid obstruction of the airway by observing respiratory rate, work of breathing, unusual breath sounds or absence of breath sounds / chest rise. If continuous monitoring is required, this continues to work appropriately.
        - Colour – as subtle changes can indicate concerns with oxygenation, the colour of the baby's body and limbs should be observed before, throughout and after skin to skin, avoiding the baby becoming trapped by pillows, blankets, or the mother's/parent's body.
        - Tone – tone should be observed prior to, throughout, and after skin to skin, ensuring that the baby's tone has not deteriorated during repositioning and that the baby remains responsive.
        - Temperature – the baby's temperature should be maintained during skin to skin, ensuring that thermoregulation is maintained, 36.5-37.5ºC (14)

    - The ODN suggests documenting the skin-to-skin period on baby's notes or/and on record sheets, such as the one developed by Bliss and Best Beginnings (15). Units may wish to provide parents with a personal log / diary to record their own daily observations and interactions, which can include touch, comfort holding, and skin to skin / kangaroo care.

**Enabling babies to receive breastmilk and to breastfeed**

The neonatal units in this ODN recognise the importance of breastmilk for babies' survival and health, particularly when they are sick, small, and premature. Breastmilk is clean, safe, contains antibodies, anti-inflammatory factors, and growth hormones; it improves enteral feeding tolerance, protects babies from necrotising enterocolitis (NEC) and other infections, and can be used for analgesia (9,16, 17) and mouth care (18, 19, 20).

Therefore, East of England neonatal units will ensure that:

- A mother's own breastmilk is promoted as the first choice of feed for her baby; if there are any contraindications, babies should be safely fed the best available nutritional alternative, according to WHO guidance.
- Mothers have a discussion regarding the vital importance of their breastmilk for their preterm or ill baby – this may be done antenatally if a neonatal unit admission is anticipated at birth or in the immediate perinatal period, as soon as appropriate, to ensure that they are able to make informed decisions in the health of their baby.
- Mothers expressing next to their baby is advocated, and practical measures will be employed to achieve this, e.g. comfortable chairs, sufficient expressing equipment, privacy screens if requested, etc. In rare instances when this is not possible, another suitable and pleasant environment is created that is conducive to effective expression.
- Mothers have access to effective breast pumps and equipment, including various funnel sizes (this can change throughout the neonatal journey), on the neonatal unit and that there are arrangements in place so that mothers can also access equipment once home, with support provided in practical use and troubleshooting.
- Mothers are enabled to express breastmilk for their baby, including support to:
    - Express as early as possible after birth (ideally within 2 hours after birth, maximum within 6 hours after birth)[28], whether this is on the neonatal unit or a maternity ward.

  - Learn the importance to express early, frequently, and effectively, and also be shown how to use an electric pump, with staff adapting support to the mother's individual learning needs.
  - Learn how to use pump equipment and store milk safely on the neonatal units (individual units will have pump equipment and milk storage guidance and/or information, as specific to the pumps used and milk storage facilities) and once home.
  - Express eight to ten times in 24 hours, including at least once overnight, and avoiding long gaps. Gaps for expressing do not need to be evenly spaced within 24 hours. Cluster expressing produces a higher fat content milk (avoid routine expressing and long gaps). Following this plan, especially in the first two to three weeks following delivery will optimise long-term milk supply potential.
  - Overcome expressing difficulties where necessary, e.g. if <750ml in 24 hours is expressed by day 10 or the pump kit is no longer effective, etc. This may be resolved by support given around technique, frequency, general support, or reassurance, which all neonatal staff are trained to provide. If a referral is indicated for more complex difficulties or queries, staff will liaise with a member of the neonatal baby feeding team (unit dependent, this may be a Lactation Consultant (IBCLC), baby feeding coordinator, baby feeding lead/ link nurse, etc.)
  - Stay close to their baby (when possible) when expressing milk
  - Use their milk for mouth care when their baby is not tolerating enteral feeds or not yet orally feeding and later to encourage their baby to feed
- A documented formal review of expressing is undertaken a *minimum* of four times in the first two weeks to support optimum expressing and milk supply, with staff from maternity and neonatal units working together to ensure consistent support. The reviews should be carried out collaboratively between the staff allocated to care for the baby and the neonatal infant feeding team. East of England Neonatal ODN recommend this is done around: Day 1, Day 3, Day 5, Day 7, and Day 9 (21), and staff could choose to record these reviews on the Nutrition Care Pathway. Staff will understand the typical timing of transition from colostrum to copious milk production, what can prolong or inhibit this, and reassure mothers appropriately. If issues are identified, an action plan should be put in place to support resolution. Please follow guidance found here: Assessment-of-breastmilk-expression-staff-guidance.pdf and Assessment-of-breastmilk-expression-checklist-2023.pdf.
- Mothers are provided with an individual expressing log so that they can record the frequency and volumes expressed, enabling them to monitor efficacy and when to request further support.
- Mothers receive care that supports the transition to breastfeeding, including support to:
  - Recognise and respond to early feeding cues
  - Use skin-to-skin contact to encourage instinctive feeding behaviour
  - Hand expressing some milk for the baby to taste and/or to soften a full breast in order to ease latching
  - Position their baby for effective attachment for breastfeeding
  - Recognise effective attachment, watching for sucking/swallowing patterns, evolving hand expressing skills in order to use breast compressions, where indicated, to maintain a high flow after initial "letdown/milk ejection reflex" to promote effective milk transfer and continued feeding
  - Discuss when their baby requires naso/orogastric tube top-ups (or parent requested method) by using assessment tools (an example can be found here)
  - Continuing to express her breastmilk in order to maintain a high milk supply as her baby becomes more mature and efficient, gradually reducing expressing when top-up feeds are not indicated
  - Overcome challenges when needed, with access to 1:1 support from the neonatal baby feeding team when indicated
- Mothers are provided with details of local and national voluntary breastfeeding peer support they can choose to access at any time during their baby's stay and during any neonatal outreach package of care and beyond
- Mothers 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' confidence and modified responsive feeding.

- Parents and carers are again, provided with information about all available NHS and voluntary sources of support before they are transferred home.

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 have the opportunity to discuss this aspect of feeding and reassure mothers that breastfeeding can be used to feed, comfort and calm babies. Breastfeeds can be long or short, breastfed babies cannot be overfed or 'spoiled' by too much feeding and breastfeeding will not, tire mothers in addition to caring for a new baby, which is not breastfeeding (22).

**Valuing parents as partners in care**

The East of England Neonatal ODN recognises that a positive parent/baby relationship is critical to ensuring the best possible short and long-term outcomes for babies and therefore, parents should be considered as the primary partners in care. All staff will enable parents to be fully involved in the care of their babies, valuing their much-needed contribution.

The service will ensure that parents:

- Have unrestricted access to their baby, unless individual restrictions can be justified in the baby's best interest (23).
- Are fully involved in their baby's care, with all care possible entrusted to them (23)
- Are fully engaged with their baby's progress and listened to, including their observations, feelings and wishes regarding their baby's care (11). This necessitates clear and regular updates with full information on their baby's condition, treatment, and care plans to promote parents' informed decision-making.
- Have full information regarding their baby's condition and treatment to enable informed decision-making (11, 23)
- Are made comfortable and welcome when on the unit, with the aim of enabling them to spend as much time as is possible with their baby (11, 23).

The neonatal units will ensure that parents whose babies transition to bottle feeding (1, 7):

- Receive information about how to clean and sterilise equipment and make up a bottle of expressed breastmilk or formula milk.
- Are able to feed this to their baby using a safe and responsive technique.
- Understand that giving bottles of formula will reduce breastmilk supply and are given support if they wish to return to breastfeeding or to expressing more breastmilk.

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

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**APPENDIX I – Pathway for approaches from industry representatives for breastmilk substitutes or associated with feeding equipment**

All approached from industry representatives must be escalated via the appropriate pathway, outlined below:

1. **Infant Formula and Breastmilk Fortifier (BMF)**
    a. Any contact from representatives regarding infant formula or BMF must be declined and referred to:
        i. Dietitian for neonatal services
        ii. Infant Feeding Lead
        iii. Ward Manager
    b. No changes to prescribed products or introduction of new products should occur without review and approval through these professional leads.
2. **Bottles, Teats and Dummies**
    a. Approaches regarding bottles, teats and dummies, or related feeding equipment must be redirected to:
        i. Infant Feeding Lead
        ii. Speech and Language Therapist for Neonatal Services
        iii. Ward Manager
    b. Selection and use of feeding equipment must be clinically justified and aligned with infant feeding assessments.
3. **Nipple shields, Breast Pumps, and accessories (including nipple creams)**
    a. Any discussion or offers relating to nipple shields, breast pumps, or associated accessories must be referred to:
        i. Infant Feeding Lead
        ii. Ward Manager
    b. Assessment of suitability and procurement decisions must be coordinated through the feeding lead to ensure safe and evidence-based practice.

**General principles**

- Staff must not engage in direct procurement discussions or accept product trials.
- All interactions with representatives should be documented and reported in line with organisational governance processes.
- This approach ensures unbiased, safe, and clinically appropriate infant feeding practices, protecting families from commercial influence.

**APPENDIX II – Escalation pathway: WHO Code Breaches (External representatives & staff member)**

1. Identification of a breach

   A breach involve:

   A. Commercial representative
      - Direct or indirect promotion of formula/breastmilk substitutes
      - Providing samples, gifts, or branded materials to staff members
      - Contacting staff or service users inappropriately

   B. Staff member
      - Accepting gifts, sponsorship, or samples
      - Sharing promotional materials with families
      - Engaging with representatives outside approved processes
      - Providing advice influenced by promotional materials
      - Failing to challenge or report inappropriate contact

2. Immediate action (staff witness or involved)
   a. Stop interaction (if ongoing and safe to do so)
   b. Do not distribute or use any materials
   c. Preserve evidence (emails, items, screenshots)

   If the breach involves self, the staff member should:
      - Declare it immediately to Infant Feeding Lead, Nurse in charge or Ward Manager
      - Cooperate fully with the review.

3. Reporting (within 24 hours)
   Report all suspected breaches via:
      - Infant Feeding Lead
      - Nurse in charge
      - Ward Manager
      - Incident Reporting System (e.g. InPhase, Datix, etc.)

   Include:
   a. Who was involved (staff and/or company)
   b. Description of the incident
   c. Where and when
   d. Any supporting evidence

4. Ward Manager responsibilities
   a. Acknowledge report within 24 hours
   b. Ensure immediate containment (e.g. removal of materials)
   c. Escalate to:
      i. Infant Feeding Lead
      ii. Governance/Risk team

5. Review and investigation
   Led by: Infant Feeding Lead + Governance Team + HR (if staff involved)

   Assess:
   a. Nature and severity of breach
   b. Whether staff actions were:
      i. Unintentional (training gap)
      ii. Negligent
      iii. Deliberate misconduct

6. Response actions
    a. Commercial representative breach
        i. Record and log
        ii. Issue formal warning or complaint to company
        iii. Escalate to UNICEF Baby Friendly UK
        iv. Consider restrict or ban site access
    b. Staff member breach
        i. Actions will depend on severity
            1. Low-level (e.g. lack of awareness): education and supervision, reflection and documented discussion, and reinforcement of the WHO Code training.
            2. Moderate: formal management investigation, written warning, and mandatory re-training.
            3. Serious/ repeated breach: escalation to HR, potential referral to professional body, impact on appraisal/revalidation, possible restriction of duties.

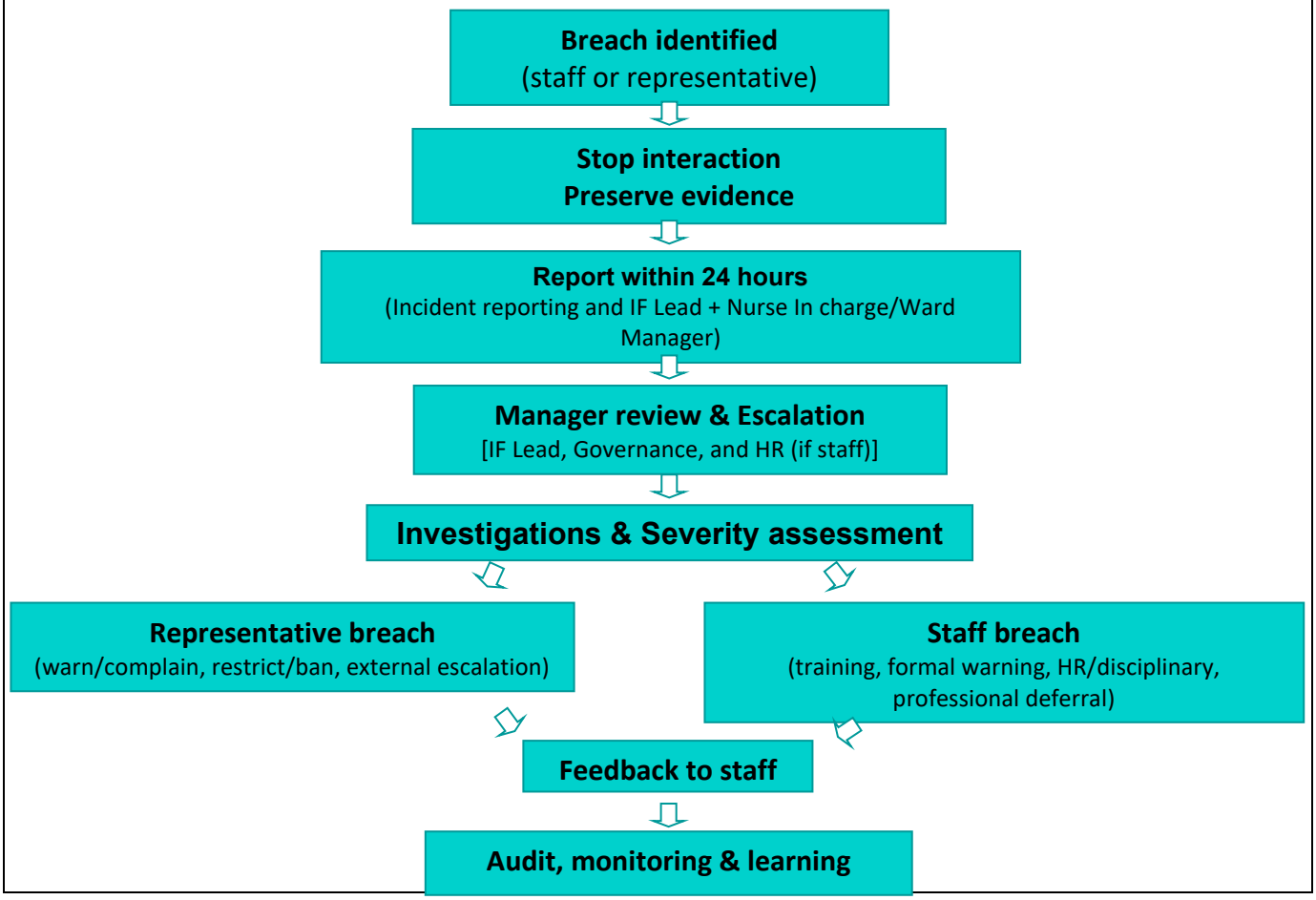
7. Organisational escalation
   For significant and repeated issues:
    a. Report to:
        i. Trust governance committee
        ii. Baby Friendly Initiative Leads
    b. External reporting where required:
        i. UNICEF BFI UK

8. Feedback and learning
    a. Provide feedback to reporting staff
    b. Shared anonymised learning:
        i. Staff briefings
        ii. Team meetings
    c. Reinforce zero-tolerance approach to Code breaches

9. Monitoring and audit
    a. Maintain log of:
        i. Representative breaches
        ii. Staff breaches
    b. Regular review of trends
    c. Include in BFI audits and governance reports

10. Prevention
    a. Mandatory WHO Code of Conduct training for all staff
    b. Clear policy on:
        i. Gifts and sponsorship
        ii. Industry contact
        iii. Controlled access for external representatives (only through Infant Feeding teams and Dietitian Leads)

**Flowchart: Escalation Pathway – WHO Code of Conduct Breaches**



## APPENDIX III – EoE TEMPLATE FOR ENVIRONMENTAL AUDIT

Recommended to be performed, twice yearly, in any area that is service user facing (e.g toilets, parents' room, clinical rooms, corridors, rooming in areas, etc.), by at least by:

- Neonatal Infant Feeding Lead, dietitian, senior nursing team or ward manager.
- An external to the unit counterpart (such as, Maternity Infant Feeding Lead, another department dietitian, etc)

| | Y | N | If not, action required (please specify) |
|---|---|---|---|
| Breastmilk substitutes (BMS) are not on display to parents (e.g. formula milk, follow on milk, pacifiers, teats, feeding bottles, nipple shields**, nipple creams**) **in all service users facing areas** | | | |
| No generic "company level" advertisement (paper form, mail or digital) from:<br>• Cow & Gate • Aptamil • Mead Johnson • Hipp<br>• SMA • Nestle • Abbott • or any other company that markets infant milks in the UK<br>• Nutricia • Danone • Nannycare | | | |
| Boots and similar companies – anything from this companies must not be related with feeding | | | |
| Complementary/weaning foods – no samples are acceptable | | | |
| Any information about weaning foods for infants should clearly state from 6 months onwards | | | |
| **D**iscounts **or promotions aimed at service users for** breast pump purchases**/**rentals are not acceptable | | | |
| No samples for nipple creams or sprays should be available | | | |
| Monitor websites **shared with services users** on NICU for Code compliance | | | |
| No leaflets/posters available that promote**/ normalise** formula feeding | | | |
| No presence of free or subsidised supplies from BMS companies on NICU | | | |
| Policy of not accepting gifts, favours or hospitality from **BMS** companies to healthcare workers or families | | | |
| Policy for staff to not attend study days sponsored by BMS companies or companies not compliant with the Code | | | |
| Policy that BMS representatives have no direct contact with families and staff (only Feeding Team**/ Dietitians**) | | | |
| Promotion on unbiased information for infant feeding is recommended from websites such as:<br>• Baby Friendly Initiative • Bliss • Ready, Steady Baby<br>• First Steps Nutrition Trust • Start4life • Best Beginnings<br>• UNICEF UK formula guidance • Bump, baby and beyond • Publications from Public Health Agency from Northern Ireland | | | |
| No BMS surveys available to staff and families | | | |
| Cupboards that have BMS should **say "feeding equipment" rather than anything** related **to** formula**/bottle** feeding | | | |

Note: Breastmilk substitutes include anything that could benefit formula feeding instead of direct breastfeeding (e.g. bottles, teats, nipple shields, formula milk, breastmilk fortifier, breast pump companies that sell bottles for suck feeding purposes, dummies, formula preparation machines, etc.)

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Exceptional Circumstances Form

Form to be completed in the **exceptional** circumstances that the Trust is not able to follow ODN approved guidelines.

| Details of person completing the form: | |
|---|---|
| Title: | Organisation: |
| First name: | Email contact address: |
| Surname: | Telephone contact number: |
| Title of document to be excepted from: | |
| Rationale why Trust is unable to adhere to the document: | |
| Signature of speciality Clinical Lead:<br><br>Date: | Signature of Trust Nursing / Medical Director:<br><br>Date: |
| Hard Copy Received by ODN (date and sign): | Date acknowledgement receipt sent out: |

Please email form to: Kelly.hart5@nhs.net requesting receipt.

Send hard signed copy to: Kelly Hart
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Robinson Way
Cambridge CB2 0SW