# Supporting Breastfeeding

## Looked After Children
Regional Guidance

HSC Public Health Agency

HSC Health and Social Care

# Contents

# 1. SUMMARY OF GUIDANCE

**1.1** The Public Health Agency (PHA) and the Health and Social Care (HSC) Trusts promote breastfeeding as the healthiest way a mother can feed her baby. We are committed to ensuring all mothers are provided with the best evidence and support to make informed decisions about feeding their babies.

**1.2** This document has been developed in consultation with key stakeholders across the 5 HSC Trusts and will provide staff with regionally consistent guidance for supporting a mother and baby to maintain breastfeeding when a baby is being cared for in a Looked After Child (LAC) placement.

**1.3** "Children looked after" are those in the care of a Trust or who are provided with accommodation by a Trust. They may be living, with foster carers, or with a family relative or friend. Or they may be living in residential homes or schools. In some cases, they may still live with their birth parents whilst being in care of the Trust.

**1.4** Parents continue to have or share parental responsibility when a child is Looked After. Parental Responsibility is defined in the Children (NI) Order as "all rights, duties, powers and responsibilities and authority which by law a parent has in relation to the child and his/her property".

## 2. RESPONSIBILITIES

**2.1** The Chief Executive of the HSC Trust accepts responsibility and accountability for quality service provision at Trust Board level.

**2.2** Operational Directors/Senior Managers are responsible for ensuring this guidance is implemented within their Division/sphere of responsibility.

**2.3** Line Managers are responsible for ensuring that practitioners are aware of, and adhere to, the guidance.

**2.4** Professional practitioners are responsible for ensuring that they have a working knowledge of, and adhere to, the guidance.

## 3. INTRODUCTION

**3.1** The PHA and the five HSC Trusts promote breastfeeding as the best way for a mother to feed her baby and recognise the health benefits that exist for both mother and child. HSC Trust Infant Feeding Policies and involvement in UNICEF Baby Friendly Initiative underpins a commitment to support breastfeeding by the Trusts. Breastmilk is a whole food. The World Health Organisation recommends that breastmilk should be the only food a baby receives until six months and breastfeeding continued as part of a weaning diet until two years and beyond.

**3.2** If a mother is unable to breastfeed consideration should be given to supporting her to provide expressed breastmilk to her baby.

**3.3** The preference would be for all babies in Looked After Child (LAC) placements to be breastfed or to be fed breastmilk by bottle to ensure optimal health for both baby and mother. However, there will be situations when breastfeeding will not be possible This may be because of unacceptable risks posed to the baby or because a mother has made an informed decision that she does not wish to breastfeed. Each circumstance should be considered on an individual basis and professionals should seek advice from safeguarding leads as required.

## 4. WHEN A BABY IS BEING DISCHARGED TO A FOSTER PLACEMENT FOLLOWING BIRTH AND A UNOCINI PATHWAY HAS BEEN FOLLOWED

**4.1** A multidisciplinary plan to support breastfeeding and/or expressing will be developed as part of the relevant UNOCINI pathway processes. This is most likely to be Pre-Birth Risk Assessment process. All relevant professionals will contribute to these processes and planning should commence early in the antenatal period where possible.

**4.2** Planning for breastfeeding or expressing when a baby is in a foster placement should consider the practical challenges which may occur and how the impact of these can be minimised for a baby. Challenges may include the impact of travel time or contact with multiple adults for a baby when supporting breastfeeding. Refer to *Expression, storage and transportation of breastmilk* information leaflet (Appendix 1) and *Additional Information for the caregiver of a Breastmilk Fed Baby* (Appendix 3). The plan should also recognise that separation of a mother and baby can impact upon milk supply. See the *Expressing Breastmilk Assessment Tool* (Appendix 2). A further action plan must be put in place if it is evident that poor milk supply is impacting upon the wellbeing of the baby.

# 5. ROLES AND RESPONSIBILITIES

## Community Midwives

**5.1** The mother's community midwife will lead when planning to support breastfeeding during the Pre-Birth Risk Assessment process. The community midwife will retain this role until discharge to health visitor or family nurse and will liaise with other professionals involved with the family. This will include, at the earliest opportunity, discussion with the infant feeding leads and liaison with the community midwife for the baby where they are different.

**5.2** The community midwife will carry out an antenatal home visit and discuss infant feeding with the mother. If the mother indicates at this stage that she plans to breastmilk feed or breastfeed the following resources will be provided:

- *Off to a Good Start* PHA
- Link to 'Feeding your baby page' on HSC Trust website. (if available)
- *Storage and Transportation of Breastmilk* (Appendix 1) HSC version

**5.3** The community midwife will use the Expressing Breastmilk Assessment Tool (Appendix 2).

**5.4** During the antenatal home visit the community midwife will discuss the need for an electric breast pump with the mother. The community midwife will send a referral to the acute infant feeding lead (IFL) to request loan of a breast pump for the mother. Pump loan is usually for short term use (4-6 weeks). Mothers requiring longer term use will need to purchase their own pump. This should be discussed with the family social worker. A family nurse will ensure a breast pump is available for young mothers availing of the family nurse Partnership programme.

**5.5** The social worker will give the foster carer the *Off to a Good Start* book and *Additional information for the caregiver of a breastmilk fed baby* (Appendix 3). The community midwife caring for the baby will provide breastfeeding advice support for the foster carer if required.

**5.6** The community midwife will continue to support the breastfeeding mother in the early postnatal period.

**5.7** If breastfeeding issues arise which would benefit from a period of more frequent contact between mother and baby, e.g. reduced supply/engorgement/mastitis, the community midwife will discuss and review the plan of care with the relevant social worker to reach agreement regarding a period of increased contact if required.

**5.8** Due to the geographical locations of maternity hospitals and community maternity services it is possible a mother and her baby will not have the same community midwife on discharge from hospital. If possible, continuity should be facilitated and any change in community midwife should be discussed by practitioners with their line manager before making a decision.

**5.9** The community midwife caring for the baby should communicate with the baby's parents and the mother's midwife after the first visit and thereafter if there are any significant changes. Details regarding the location of the baby's placement or foster carer should not be discussed with the mother unless agreed by the social worker.

**5.10** The community midwife will ensure the records for mother and baby (including Repository Files) are amalgamated at the end of the episode of midwifery care.

**5.11** Community midwifery or family nurse will transfer care for both mother and baby to the health visitor, as per local arrangements and pathways.

## 6. HOSPITAL MIDWIFE

**6.1** The hospital midwife must contact the social worker when the mother goes into labour and when the baby has been born. Following the birth, the Child Protection or Looked After Child Plan will be instigated.

**6.2** A Regional Observations/Interactions Recording Sheet should be commenced and completed as per Regional Guidance "Recording of Nursing/midwifery/AHP Observations/ Interactions between parent/care giver and children considered "at risk" or where there are safeguarding concerns (Acute Hospital Settings)" PHA, 2018 (Appendix 4).

**6.3** The hospital midwife will ensure expression of milk, breast pump, storage and transfer of milk to placement has been discussed with the mother prior to discharge. In some HSC Trusts a breast pump loan agreement is also completed prior to discharge.

**6.4** The hospital midwife will liaise with the acute infant feeding lead via referral form/phone call, to book a breast pump and agree a plan for discharge of mother and baby.

**6.5** If issues arise in breastfeeding/expressing (e.g. engorgement/mastitis/reduced supply) that would be resolved through a period of more frequent contact between mother and baby, the hospital midwife will discuss and review the plan of care with the social worker to reach agreement regarding a period of increased contact if required.

**6.6** The hospital midwife will ensure all relevant professionals are aware of the plans for discharge and will be mindful of the possibility that a mother and her baby are being cared for by different health professionals i.e. need to liaise with community midwife and health visitor for both mother and baby which may be in different health trusts.

**6.7** On discharge of the baby from the maternity ward the hospital midwife will provide the mother with a Discharge letter outlining the wellbeing of the infant and any health needs identified. The Discharge letter will provide the contact details of the community midwife and health visitor caring for her baby. Details regarding the location of the baby's placement or foster carer should not be discussed with the mother unless agreed by the social worker.

**6.8** A baby may be transferred to the neonatal unit following birth. The Child Protection Plan or Looked After Child Plan must be transferred with the baby to the unit by the midwife. The hospital midwife will also provide a verbal handover of safeguarding information to the neonatal nurse and will make the social worker aware of the transfer of the baby to the neonatal unit.

## 7. NEONATAL UNIT NURSE

**7.1** On transfer of a baby to the neonatal unit the neonatal nurse will receive a copy of the Child Protection or Looked After Child Plan and a verbal handover of safeguarding concerns from the hospital midwife.

**7.2** The neonatal nurse will contact the infant feeding lead to make them aware of plans for discharge of the baby. If issues arise in breastfeeding that would be resolved through a period of more frequent contact between mother and baby, the neonatal nurse will discuss and review the plan of care with the social worker to reach agreement regarding a period of increased contact if required.

**7.3** The neonatal nurse will ensure expression of milk, breast pump, storage and transfer of milk to placement has been discussed with the mother prior to discharge.

**7.4** The neonatal nurse will ensure all relevant professionals are aware of the plans for discharge and will be mindful of the possibility that a woman and her baby are being cared for by different health professionals, i.e. need to liaise with community midwife and health visitor or family nurse for both mother and baby.

**7.5** On discharge of the baby from the neonatal unit the nurse will provide the mother with a discharge letter outlining wellbeing of the baby and any health needs or further treatment required. The discharge letter will give the contact details of the community midwife (if appropriate) and health visitor caring for her baby. Details regarding the location of the baby's placement or foster carer should not be discussed with the mother unless agreed by the social worker.

## 8. SOCIAL WORKER

**8.1** A Discharge Planning Meeting involving all relevant professionals and parents will be arranged by the social worker to review and agree plans to support breastfeeding prior to discharge.

**8.2** The social worker will update the maternal and baby records when there has been contact with a mother/baby on the ward.

**8.3** Contact between a mother and her baby will be arranged by the social worker to occur within 24 hours of discharge from hospital to support the maintenance of breastfeeding.

**8.4** Contact arrangements will be agreed as part of the multidisciplinary Pre-Birth Risk Assessment process or relevant UNOCINI pathway plan.

**8.5** Where possible the social worker will arrange for parents to meet the foster carer before birth to provide an opportunity for them to discuss the maintenance of breastfeeding.

**8.6** The social worker will be responsible for liaison with the foster carer and updating the mother regarding the baby's feeding pattern.

**8.7** Where possible the social worker will provide the foster carer with a copy of the *"Off to a Good Start"* booklet and Expressing, storage and transportation of breastmilk leaflet (Appendix 1) prior to placement of the baby.

**8.8** The social worker will discuss with the foster carer the possibility that a baby who has been breastfeeding may be unsettled due to separation from mother. The social worker will provide the foster carer with literature about managing an unsettled baby prior to placement of the baby (Appendix 3).

**8.9** If a mother is unable to access an electric breast pump through HSCT, then the social worker will assess if financial assistance is required to ensure a quality double breast pump is available prior to discharge from hospital. If there are concerns around expressing or infant feeding related problems the social worker should liaise with the community midwife/health visitor/ family nurse for advice. if the issue cannot be resolved then the community infant feeding lead should be contacted.

**8.10** There may be situations when a baby will have to be given formula milk, i.e. if a mother does not attend for contact. If possible, the mother will be asked if she has a formula preference. If this is not possible, the foster carer will be advised that any first stage formula milk should be given to the baby.

**8.11** The foster carer should be provided with information regarding formula feeding and paced bottle-feeding as per the PHA bottle-feeding leaflet.

## 9. HEALTH VISITOR/FAMILY NURSE

**9.1** The health visitor/family nurse will provide breastfeeding support in the antenatal and postnatal period in accordance with the HSCT Infant Feeding Policy.

**9.2** Following discharge from community midwifery services the health visitor/family nurse will continue to provide breastfeeding support for the mother and foster carer if required.

**9.3** The health visitor/family nurse will discuss the plan with the community infant feeding lead if required to support breastfeeding for a baby in a foster placement and will refer to the Trust Pathway to Specialist Breastfeeding Support if indicated.

**9.4** Due to the geographical area of HSCTs it is possible the mother and her baby will not have the same health visitor on discharge from hospital. If possible, continuity should be facilitated and any change should be discussed by practitioners with their line manager before making a decision.

**9.5** If issues arise in breastfeeding that would be resolved through a period of more frequent contact between mother and baby, the health visitor/family nurse will discuss and review the plan of care with the social worker to reach agreement regarding a period of increased contact if required.

**9.6** The health visitor/family nurse caring for the mother will provide her with a letter detailing the contact details of the health visitor caring for her baby if required.

## 10. RE-ESTABLISHING BREASTFEEDING AFTER A PERIOD OF SUSPENDED CONTACT

**10.1** Contact Community infant feeding lead for guidance for both mother and professionals involved in re-establishing contact and potential direct breastfeeding.

**10.2** The mother should be supported to stimulate her milk supply as much as possible in the period leading up to contact being re-established. Ideally the mother will have been supported to maintain her breastmilk supply during the period of separation as detailed above with provision of a double electric breast pump.

**10.3** Consider appropriateness of the environment for contact. The environment should, where possible, allow for mother and baby to have uninterrupted skin to skin contact in a safe and appropriately supervised manner.

**10.4** Length of contacts should be of sufficient duration to allow the baby the opportunity to be exposed to the breast in an unhurried and unpressured manner.

**10.5** Where possible, contacts should take place frequently enough to allow both the mother and baby the opportunity to continue to re-learn to breastfeed.

**10.6** The baby should not be forced onto the breast. Mother should be supported to allow the baby to have periods of ongoing time in skin to skin contact.

**10.7** If baby is reluctant to attach to the breast, the infant feeding lead/health visitor/family nurse may suggest a nipple shield. The baby may have become more reliant on a silicone teat to stimulate the suck reflex during the period of suspended direct breastfeeding. Clear and realistic expectations should be discussed.

**10.8** Foster carer and mother should be informed about the importance of using a paced bottle-feeding approach. If baby is reluctant to attach to the breast then mother may find it beneficial to give a bottle feed whilst the baby is in skin to skin at the breast.

**10.9** If baby remains reluctant to maintain feeds at the breast then the use of a supplemental nursing system may be considered under support from midwife/health visitor/family nurse/ infant feeding lead.

**10.10** If issues arise during the period of re-establishing breastfeeding that may benefit from a review of the contact plan then the infant feeding lead/midwife/health visitor/family nurse will discuss the potential need for a review of the current plan with the allocated social worker to reach agreement regarding any suggested changes.

## 11. MONITORING (INCLUDING AUDIT)

**11.1** This policy will be monitored and reviewed via the HSCTs local Child Protection subgroups and the Regional Health and Wellbeing LAC committee led by PHA.

## 12. EVIDENCE BASED/REFERENCES


- Safeguarding Board for Northern Ireland revised Core Child Protection Policies and Procedures – November 2017. https://www.proceduresonline.com/sbni/
- Co-operating to Safeguard Children (DHSSPSNI, 2016).https://www.health-ni.gov.uk/publications/co-operating-safeguard-children-and-young-people-northern-ireland
- Baby on Board, Report of the Infants in Care and Family Contact, Research Project 2009.
- Baby on Board: Report of the Infants in Care and Family Contact Research Project
- HSCT Infant Feeding Policies
- UNICEF Baby Friendly Initiative. Baby Friendly Standards - Baby Friendly Initiative
- UNOCINI Guidance; Understanding the Needs of Children in Northern Ireland (2011)UNOCINI Guidance; Understanding the Needs of Children in Northern Ireland (2011). - Bing
- United Nations Convention on the Rights of the Child, 1990. Convention on the Rights of the Child | UNICEF
- The Children (Northern Ireland) Order 1995 https://www.legislation.gov.uk/nisi/1995/755/contents/m

## 13. PERSONAL & PUBLIC INVOLVEMENT (PPI)/ CONSULTATION PROCESS

**13.1** Circulated for comment to HSCTs acute and community infant feeding leads, health visitor leads, FNP leads, neonatal infant feeding lead, LAC nurse specialist, acute and community lead midwives and social work leads.

## 14. EQUALITY, HUMAN RIGHTS & DDA

**14.1** This guidance has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the Trust to have due regard to the need to promote equality of opportunity. It has been screened to identify any adverse impact on the nine equality categories.

**14.2** The policy has been 'screened out' without mitigation or an alternative policy proposed to be adopted.

## 15. ALTERNATIVE FORMATS

**15.1** This document can be made available on request on compact disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.

## 16. SOURCES OF ADVICE IN RELATION TO THIS DOCUMENT

**16.1** The chair of the working group responsible for developing this guidance should be contacted with regard to any queries on the content: emily.roberts@hscni.net

## EQUALITY STATEMENT

This guidance has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the Trusts to have due regard to the need to promote Equality of Opportunity.

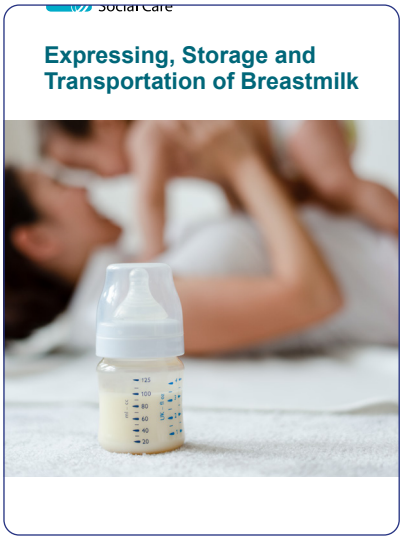
In line with the duty of equality this policy has been screened against particular criteria and as a result no major issues requiring further impact assessment have been identified.

This policy has also been considered and prepared with regard to the Trust's obligation under the Human Rights Act 1998. The Trust is satisfied that the policy complies with its obligations under the Act.

If at any stage of the life of the policy there are any issues within the policy which are perceived by any party as conflicting with his/her rights, that party should bring these to the attention of the Director of Human Resources & Corporate Affairs or raise a complaint through the published complaints procedure.

# 17. APPENDICES

## Appendix 1
Storage and transportation of breastmilk leaflet for expressing mothers




## Appendix 2
Expressing Breastmilk Assessment tool

**ASSESSMENT OF BREASTMILK EXPRESSION: STAFF INFORMATION**

For sick and preterm babies the importance of breastmilk cannot be overestimated, supporting growth and providing protection from infection. In particular, evidence suggests that the use of breastmilk decreases the incidence and severity of the life threatening disease necrotising enterocolitis. By providing her breastmilk a mother can be assured that she is uniquely contributing to the wellbeing and development of her baby. However, expressing breastmilk over a long period of time is extremely demanding and if a mother is to succeed, effective support is needed from those involved with caring for her and her baby.

The Baby Friendly Initiative recommends that a formal review is carried out at least once within the first 12 hours following delivery to support early expressing and **at least four times within the first two weeks**. This will ensure that mothers are expressing effectively and will provide an opportunity to address any issues or concerns they may have. Early (within the first 2 hours), frequent (at least 8 to 10 times in 24 hours including once at night) and effective expressing (combining hand and pump expression) is crucial to ensuring a mother is able to maximise her individual milk production so that she can maintain her supply for as long as she wishes. Many women will be able to express between 700 and 900 mls per day when provided with the support to express effectively. There are many factors, however, that may impact on the amount of milk an individual woman may produce, so the focus should primarily be on enabling the woman to achieve her potential rather than on specific amounts.

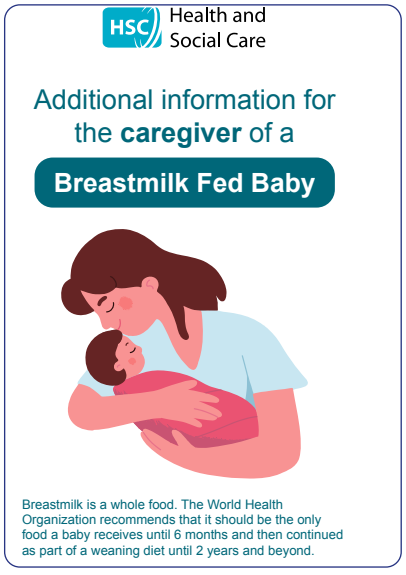
Delays in starting to express or any reduction in the frequency or effectiveness of expression will compromise her long term supply. Early detection and correction of problems will help her maintain confidence in her ability to produce milk for her baby.

**Tips to help mothers succeed**

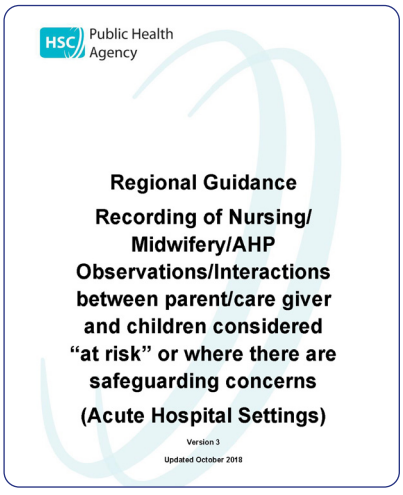
- Hand expressing is a good technique for obtaining small volumes of colostrum.
- Breast massage and relaxation techniques support a mother's milk flow by increasing oxytocin.
- Expressing close to her baby or having a photo or piece of baby's clothing can also help a mother's milk production and flow.
- Encouraging frequent and prolonged skin-to-skin contact or, where this is not possible, interacting with and undertaking cares for the baby will further support an emotional connection and increase milk making hormones.
- When using a pump mothers should be taught how to use this correctly and staff should ensure that the equipment fits effectively.
- Double pumping should be encouraged as this can save time and may contribute to being able to express long term. Larger volumes can often be achieved when mothers double pump.
- Support mothers to develop a plan for expressing and consider using an expressing log to help. Flexibility around when a mother expresses often helps mothers sustain expressing for prolonged periods. Emphasis on the frequency of 8-10 times (including once at night), will enable a mother to express for as long as she wishes. She does not have to stick to a strict 3-4 hourly routine (she can cluster express if she wishes i.e. expressing 2-3 times in a 4 hourly period), but should avoid long gaps (4 hours in the day and 6 hours at night) between expressions.
- The importance of the night-time expression should be emphasised to replicate normal physiology and support long term milk production.
- It is expected that milk volumes will increase in the first two weeks. Frequent evaluation of how the mother is expressing will enable staff to support the mother in increasing the effectiveness of her expressing. Referral to specialist support should be considered if, despite effective expressing, the amount the mother is able to express is not increasing as hoped.
- Emotional support is important throughout the mother's journey. This may include enabling the mother to stay with her baby as often and for as long as she wishes, frequent updates on the condition of her baby and participation in as much care as she feels comfortable with.

1 ©Unicef UK Baby Friendly Initiative November 2017

## Appendix 3
Information for carers leaflet




## Appendix 4
Recording of Nursing/midwifery/AHP Observations/ Interactions between parent/care giver and children considered "at risk" or where there are safeguarding concerns (Acute Hospital Settings)




**Documents are available to download from the PHA website:**
Safeguarding Children and Young People | HSC Public Health Agency (hscni.net)

**Version 1**
Issue Date: December 2023
Review Date: December 2024

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