

Management of Faltering Growth in Human Milk Fed Babies Guideline

Category:	Guideline
Summary:	Guidance on the clinical management of faltering growth in breastfed/chest fed babies from 3 weeks to 6 months of age
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Related documents:	<ul style="list-style-type: none"> • Oxfordshire Paediatric Faltering Growth Guideline • Faltering growth: recognition and management of faltering growth in children • Oxfordshire Infant Feeding Guidelines and the Appropriate Prescribing of Formula
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Clinical lead:	Infant Feeding Lead
Further information:	NICE Faltering Growth Guideline
This document replaces:	Oxfordshire Management of Faltering Growth Guideline 2021

This document is uncontrolled once printed.

It is the responsibility of all users to this document to ensure that the correct and most current version is being used.

This document contains many hyperlinks to other related documents.

Document History

Version valid from	Version number	Reason for review/update
12/02/2025	3.0	<p>Information on Domperidone has been amended to reflect GP formulary changes.</p> <p>Language used throughout document has been updated to be more inclusive.</p> <p>Age range of pathway amended to reflect NICE definitions.</p> <p>Additional information regarding Oxford Health Staff and processes added to reflect shared nature of the pathway.</p>
20/12/2021	2.0	This Oxfordshire guideline will replace Oxfordshire Management of Faltering Growth Guideline (2021)

Consultation Schedule

Who? Individuals or Committees	Rationale and/or Method of Involvement
La Leche League Oxfordshire (IBCLC)	Update/Review
Project Lead, Oxfordshire Breastfeeding Support (IBCLC)	Update/Review
Infant Feeding Specialist midwife (IBCLC)	Update/Review
Infant Feeding Lead, Oxford Health	Update/review

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Who should read this document?

1. All staff involved in breastfeeding/chest feeding support during the postnatal period. This will include: Community Midwives, Maternity Support Workers, Paediatricians, Health Visitors, Community Public Health Nurses, Community Public Health Associates, Family Nurses and GPs.

Key Standards/Messages

2. Medical assessment by the baby's GP is essential for all babies identified as having faltering growth. This is to rule out a medical reason for the baby not gaining weight such as an undiagnosed heart problem, infection or metabolic disorder. If the GP is unable to confirm that the baby is well, the baby must be seen by a paediatrician in the Clinical Decision Unit.

3. Intervene immediately when a baby is identified as having faltering growth - milk supply is time sensitive and will reduce if milk is not being effectively removed from the breasts/chest. A mother/parent may need to start expressing alongside breastfeeding/chest feeding to protect and promote their milk supply.
4. The importance of good attachment at the breast/chest should not be overlooked and needs to be assessed by a suitably qualified practitioner with the appropriate skills, such as a midwife, maternity support worker or Health Visitor/Family Nurse.
5. Open, honest and realistic communication with parents about the importance of appropriate weight gain and the implication of faltering growth is essential to achieve effective implementation of plans and to avoid false reassurances.
6. Breastfeeding/chest feeding provides more than nutrition. Mothers/parents and babies can be supported to enjoy a successful breastfeeding relationship even if additional interventions such as supplementation are necessary.
7. Exclusive breast/chest feeding should be protected unless there is no alternative. A slow growing medically well baby may not need immediate supplementation, and this decision should be discussed with a feeding specialist such a member of the Infant Feeding Team or 0-19 Enhanced Breastfeeding Practitioner .
8. Where available donated human milk should be offered in preference to formula milk.

Background/Scope

9. The first two years of life provide a critical window of opportunity for ensuring children's appropriate growth and development through optimal feeding.
10. The World Health Organisation (WHO) has proposed growth standards, based on healthy, relatively affluent, human milk fed infants from six countries. These standards, along with UK birth and preterm growth data, have been incorporated into the UK-WHO growth charts:
[RCPCH-WHO baby growth charts for 0-4 years](#)
11. Adequate nutrition during infancy and early childhood is essential to ensure the growth, health, and development of children to achieve their full potential. Early nutritional deficits are linked with long-term impairment of growth and poorer health outcomes.
Faltering growth happens across all socio-economic groups and family structures.

12. Faltering growth is not a 'syndrome' or a specific disease. It is an observation that a child's growth is slower than expected. This most commonly occurs because children are not consuming adequate calories. Only approximately 5% of young children whose growth falters have an underlying medical condition or illness. Only a very small minority of children fail to grow because of neglect or abuse. Be curious with regards to factors that may indicate broader safeguarding concerns and take action as appropriate.
13. This guideline is applicable to all babies aged from 3 weeks to 6 months receiving healthcare in Oxfordshire and receiving any amount of human milk.
14. The purpose of this document is to guide and inform the practice of clinicians including 0-19 Service staff (HVs, FNs CPHNs, CPHAs), maternity staff, General Practitioners (GPs), paediatricians, hospital medical staff, (IBCLCs), Oxfordshire Breastfeeding Support facilitators and other infant feeding specific community supporters.

Aim(s)

- Manage faltering growth safely and effectively using best available evidence.
 - Formulate sustainable plans in partnership with parents.
 - Protect breastfeeding/chest feeding and maximise human milk production.
15. When supplementation is necessary, educate and support parents to use donor human milk (as available) and/or formula milk safely, and feed responsively in such a way as to minimise negative impact on breast/chest feeding or milk supply.
 16. For guidance on choosing formula milk and responsive formula feeding visit:
 - <https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/bottle-feeding-resources/infant-formula-responsive-bottle-feeding-guide-for-parents/>
 - [Infant milks for health workers — First Steps Nutrition Trust](#)
 17. For guidance on safe preparation of formula milk visit:
 - [Bottle feeding leaflet \(unicef.org.uk\)](#)

Full Guideline

Identifying Faltering Growth

- Baby whose weight is below birth weight at 3 weeks.
- Baby under 6 weeks who produces fewer than 6 wet nappies and 2 yellow/orange stools per 24 hours.
- Baby aged <4 months whose average weight gain is consistently less than 20g/day [WHO growth chart 50th centile gain is 34g for a girl, 40g for a boy]. If a baby consistently gains less than 20g/day, they will fall below their growth centiles on their growth chart.
- Baby aged 4 to 6 months whose average weight gain is consistently less than 90g/week.
- If birthweight was below the 9th centile; A fall across 1 or more weight centile spaces
- If birthweight was between the 9th and 91st centiles; A fall across 2 or more weight centile spaces
- If birthweight was above the 91st centile: A fall across 3 or more weight centile spaces
- When current weight is below the 2nd centile for age, whatever the birthweight.

18. For additional information please access:

- <https://www.nice.org.uk/guidance/ng75/chapter/Recommendations>

Accessing specialist feeding support

- Babies under Midwifery care (up to 4 weeks) should be referred to the Maternity Infant Feeding Team (tel 01865 572950 e-mail infantfeeding.team@ouh.nhs.uk bleep 1151 Monday to Saturday)
- Babies under 0-19 (HV) care should be referred to the Enhanced Infant Feeding Service within the 0-19 service (accessed via the referral form included in appendix 4)
- Babies where a medical cause for faltering growth is identified by medical practitioner assessment, should be referred to paediatrics (urgency as determined by clinical assessment e.g. acute paediatrics/Clinical Decision Unit

(CDU) or urgent outpatient referral, unless still under the care of the neonatal team)

Review

19. This guideline will be reviewed every 3 years, as set out in the *Policy for the Development and Implementation of Procedural Documents*.

Documentation

20. Feeding plans should be documented on the electronic record system of the Service managing care, as a clinical note for both Mother/feeding parent and baby.

References

<https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2019/04/Infanthttps://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2019/04/Infant-formula-and-responsive-bottle-feeding.pdfformula-and-responsive-bottle-feeding.pdf> (accessed 05/09/2024)

[Bottle feeding leaflet \(unicef.org.uk\)](#) (accessed 05/09/2024)

<https://www.nice.org.uk/guidance/ng75/chapter/Recommendations> (accessed 05/09/2024)

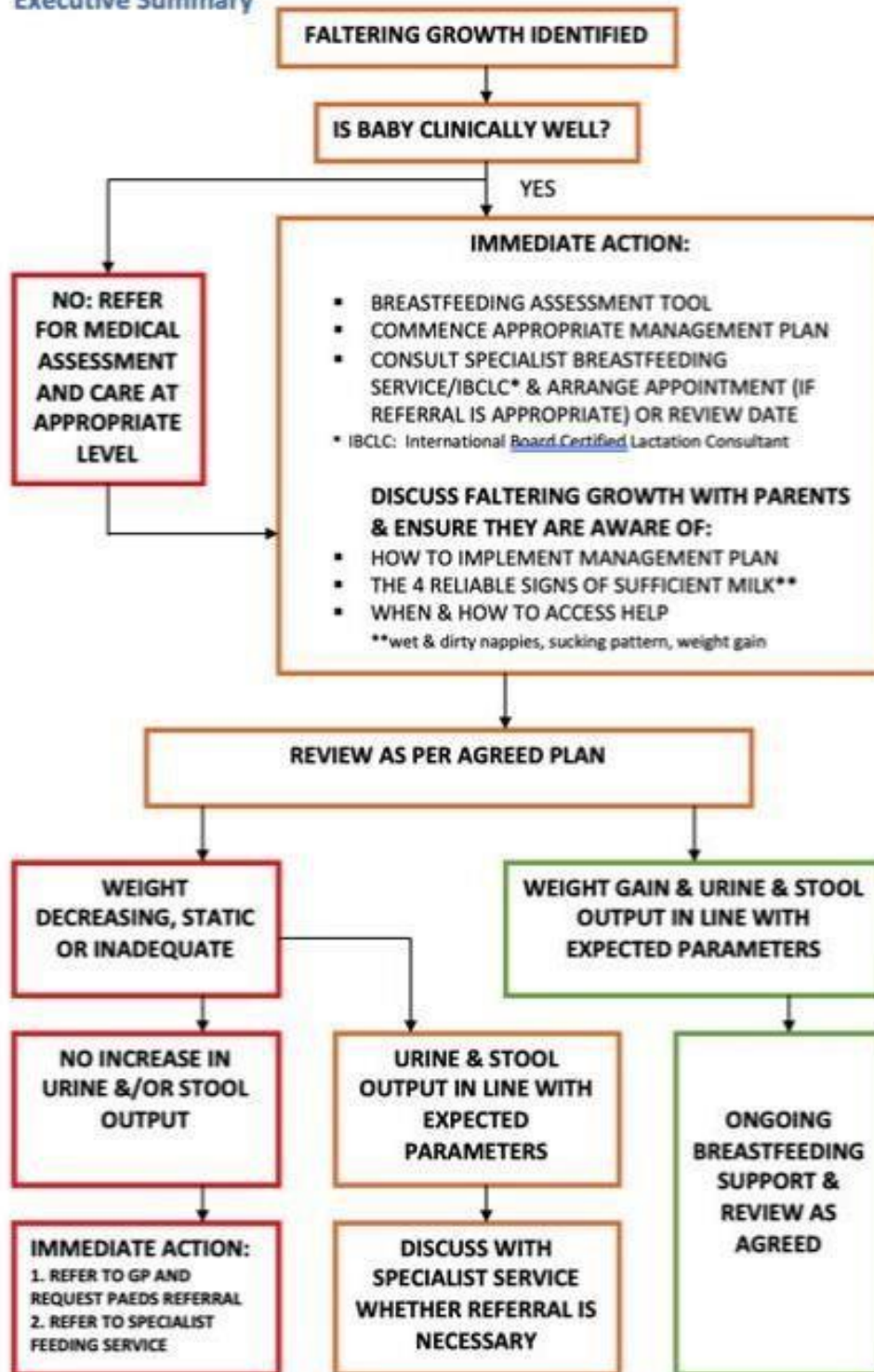
www.nice.org.uk. (2020). *Quality statement 1: Measurement of growth | Faltering growth | Quality standards* | NICE. [online] Available at: <https://www.nice.org.uk/guidance/qs197/chapter/Quality-statement-1-Measurement-of-growth> (accessed 07/10/2024)

Management plans for exclusively breastfed/chest fed babies aged 3 weeks – 6 months with faltering growth

Every baby must be seen by a medical practitioner

<p align="center">Management Plan 1</p> <p align="center">Well baby, but not regained birth weight by day 21 and/or is consistently gaining $\leq 20\text{g/day}$.</p> <p align="center"><i>If there is any concern about milk production, move straight to Plan 2 or Plan 3.</i></p> <p align="center"><i>Peak milk volume usually reached 2-4 weeks after birth. It is essential to avoid delay, if milk production needs to be increased.</i></p>	<p align="center">Management Plan 2</p> <p align="center">Faltering growth has been identified after 21 days OR no/minimal improvement using management Plan 1</p>	<p align="center">Management Plan 3</p> <p align="center">Baby with observable signs of severely inadequate calorie intake: thin, hypervigilant, visible suture lines. <i>To be supervised by a feeding specialist</i></p>
<ul style="list-style-type: none"> • Screen for maternal risk factors for low milk production and refer for specialist assessment if necessary (<i>see Appendix 1</i>) • Screen for tongue-tie or other physical anomalies and refer for specialist assessment if necessary (<i>see Appendices 2 & 3</i>) • Optimise attachment, ensuring an asymmetrical attachment with 'nose to nipple' positioning • Maximise skin to skin contact • Offer the breast at every sign of interest; $\geq 8\text{-}12/24\text{h}$, waking baby if necessary • Discontinue swaddling/dummy/swing, and water or other low-calorie supplements, if used • Offer the other side as soon as the baby comes off or stops actively suckling and switch between breasts until baby is no longer actively suckling • Use breast/chest compressions to increase milk flow and transfer * • Record number of feeds • Record wet and dirty nappies • Review & weigh at appropriate frequency taking account of factors such as age and the level of concern, but usually no more often than: daily if less than 1 month old weekly between 1–6 months old (NICE, 2020) <p>*https://ibconline.ca/information-sheets/breast-compression/</p>	<p align="center">Follow Management Plan 1 plus</p> <ul style="list-style-type: none"> • Express milk using a combination of "hands on pumping"*** and hand expressing as many times a day as achievable. [For marginal weight gain, 1-3/24h may be enough; to maximise milk production and intake when growth is very slow, $\geq 8/24\text{h}$]. <i>This may mean that baby temporarily feeds less from the breast/chest</i> • Feed as much EBM as the baby will drink, by cup, finger feeding, lactation aid/supplementer or paced bottle-feeding • Feed EBM between or during breast/chestfeeds. Aim to finish feeds at the breast/chest, whenever possible. (If a lactation aid/supplementer is used, EBM can be fed while baby breastfeeds) • Record volumes of milk expressed and fed to the baby • Review and weigh at appropriate frequency for age • If no/minimal improvement, increase number of expressions and/or discuss with parents supplementation with donor breastmilk or infant formula milk <p>**https://med.stanford.edu/newborns/professionaleducation/br-eastfeeding/maximizing-milk-production.html</p>	<p align="center">Follow Management Plans 1 & 2 plus</p> <ul style="list-style-type: none"> • If EBM is not available in sufficient quantities, use donor human milk or infant formula milk • Expect the baby to take small quantities ($\leq 100\text{ml/kg/day}$) initially, rapidly increasing (to $\geq 200\text{ml/kg/day}$) as stomach capacity and appetite increase. • If the baby cannot tolerate adequate volumes, consider use of a high-calorie formula. • Review and weigh at appropriate frequency for age. • The baby should be under the care of a feeding specialist (see above section for details)

Executive Summary



Appendix 1: Maternal/feeding parent risk factors for faltering infant growth

Indicate by ticking the first column below whether the mother/parent has any of the following risk factors. If one or more factors are present, discuss with the appropriate service Infant Feeding Team

✓	Risk factor	Notes
	Breast or chest procedures/surgery	Including reduction, augmentation, nipple piercings, radiation
	Polycystic ovaries (PCOS)	
	Retained placental fragments	May be indicated if bleeding continues beyond 6 weeks
	Any chronic illness	Including diabetes & autoimmune disease
	Thyroid conditions	Hypo- or hyper-thyroid
	Assisted conception	For hormonal reasons
	Large blood loss	More than 500ml at or after birth
	Anaemia	Haemoglobin <10g/dL
	Sheehan's syndrome	Hypopituitarism
	Ovarian theca lutein cysts in pregnancy	
	Obesity	BMI ≥30
	Vegan mother/feeding parent not taking vitamin B12 supplements	This may affect nutritional completeness of human milk but not volumes
	Previous gastric bypass surgery	This may affect nutritional completeness of human milk but not volumes
	Eating disorder	This may affect nutritional completeness of human milk but not volumes
	Inverted nipples	May make effective attachment more difficult
	No breast/chest changes in pregnancy or since giving birth	Increase in size, tenderness, prominence of veins
	Markers for hypoplasia/insufficient glandular tissue (IGT)	Very small, asymmetric, widely spaced breasts (>4cm apart); may be tube-shaped, with puffy, cone-shaped areolae

Appendix 2: Indicators for specialist oral assessment

Indicate by ticking the first column below whether the infant has any of the following risk factors. If one or more factors are present, discuss with appropriate Infant Feeding service

✓	Indicator	Notes
	Baby's frenulum is thick or lacks elasticity, attaches to tip or near tip of tongue OR	"Heart-shaped" tongue tip
	Tongue does not elevate to at least half-way to roof of mouth when baby cries, or only the front/sides of the tongue lift	Front of tongue may have a flat or spade-like appearance. The middle of the tongue may depress ("spoon-like" tongue) while the edges lift
	PLUS at least one of the following:	<i>The appearance of the tongue is less important than its function – some babies with apparent tongue-tie can breastfeed without difficulty while others, with tongue-ties that are not easily visible, may be unable to breastfeed adequately or at all</i>
	Baby cannot attach and/or stay attached to the breast	Multiple, frustrating attempts to attach, keeps falling off breast or will not attempt to attach
	Nipple damage is getting worse or not improving despite skilled support with positioning and attachment	Nipple always looks compressed/squashed when baby comes off. (Occasionally a mother does not experience pain or damage)
	Baby typically feeds for longer than 40 minutes per breast	Baby may: <ul style="list-style-type: none"> • Have a non-nutritive suckling pattern i.e. long pauses or no pauses • Feed "all the time" • Never release the breast spontaneously • Make a "clicking" noise at the breast, as suction is repeatedly lost

Appendix 3: Risk factors for poor milk transfer (infant)

Indicate by ticking the first column below whether the infant has any of the following risk factors. If one or more factors are present, discuss with appropriate Infant Feeding Team

✓	Risk factor	Notes
	Prematurity	Birth ≤ 37 weeks gestation
	Intrauterine Growth Retardation (IUGR)	
	Cleft lip or palate	Occasionally missed at routine screening
	Ankyloglossia (tongue-tie)	See Appendix 2
	Cardiac anomaly	
	Micrognathia	Unusually small/receding chin
	Chromosomal abnormality e.g. trisomy 21	
	Abnormally shaped hard palate	
	Respiratory condition or illness	Unable to coordinate or sustain suck/swallow/breathe cycle

✓	Clinical features suggestive of infant transfer issues	Notes
	Inability to attach to the breast/chest	
	Inability to maintain attachment at the breast/chest	
	Inability to maintain seal on breast/chest	Clicking sound throughout most feeds post 14 days
	Inability to feed effectively from a bottle	Cannot form adequate seal on teat; may spill excessively
	Poor/ abnormal tongue function	See Appendix 2
	Mother/feeding parent has nipple pain and/or trauma that is getting worse or not improving despite skilled support with positioning and attachment	

Appendix 4: Oxford Health Enhanced Infant Feeding Service Referral Form

0-19 Enhanced Infant Feeding Service Referral Form

Date of referral			
Name and email address of referrer		Referring organisation and team	

Baby's Name		Baby's NHS number (if known)	
Parent's Name & Tel no Mobile:		Parent's email address:	

Reason for referral (please tick)						
Suspected Tongue Tie	Ongoing issues despite Positioning and attachment support	Frequent feeds	Cardiac condition	Downs Syndrome /Atonia	Other Medical condition	Breastfed baby with faltering growth
Noisy/clicky feeds	Growing but unsettled	Prolonged feeds	Unable to attach	Not coming off the breast spontaneously	Digestive symptoms (provide details, but support CMPA locally)	
Other (please specify):						

Please confirm the following advice has been given	Other services involved	
Demonstration of effective positioning and attachment: <input type="checkbox"/>	OUH Infant Feeding Team <input type="checkbox"/>	
Shown how to recognise effective transfer of breastmilk: <input type="checkbox"/>	GP/Paediatrician <input type="checkbox"/> (provide name and contact details)	
Encouraged to increase skin-to-skin contact	OBS <input type="checkbox"/>	
Pumping to increase supply (if necessary) <input type="checkbox"/>	Abingdon Breastfeeding Cafe <input type="checkbox"/>	
Encouraged to breastfeed at least 8 but better 10-12 times in 24 hours: <input type="checkbox"/>	Wallingford Baby Bar <input type="checkbox"/>	Private Lactation Consultant <input type="checkbox"/>
	Dieticians <input type="checkbox"/>	SALT <input type="checkbox"/>

Additional information:

Send forms to: EnhancedInfantFeedingService@oxfordhealth.nhs.uk

Appendix 5: Responsibilities

No	Recommendation for Implementation	Action to be taken	Evidence of Action	Responsible Person	Date Action to be completed by	R.A.G. Action completion status ^[2]
1	Raise awareness of changes to new guideline	Training to be included in OXMUD Study day and OH 0-19 Infant Feeding Update	Certificate of attendance/ completion of study day	Guideline Authors	As part of Mandatory study day OXMUD training As part of OH Infant Feeding Update	
2	Raise awareness of changes to new guideline	Promote in Maternity Bulletin Include in the Monthly Guidelines Updated Table Communicate in Oxford Health 0-19 SWAY Link HVs to forward to GP surgeries Update GP Infant Feeding Resource Pack Provide document to OOH and MIU Forward to dietetics, CCNs, and SALT	Email Circulating Maternity Bulletin And Breathe Recorded in the OH 0-10 SWAY Link HVs email data Email to head of MIU and OOH Email data Email data	Guideline Author for text to be included Quality Team for inclusion in Bulletin and Monthly Guideline Updates Table GP link HVs OH IF Lead and Champions OH IF Lead OH IF Lead		

Appendix 6: Definitions

CCNs	Community Children’s Nurses
CDU	This unit is an arm of Paediatrics A&E, based in the Childrens’ Hospital in Belhouse Drayson Ward
CPHA	Community Public Health Associate
CPHN	Community Public Health Nurse
g	gram
GP	General Practitioner
HV	Health Visitor
IBCLC	International Board Certified Lactation Consultants
MIU	Minor Injuries Unit
OH	Oxford Health NHS Foundation Trust
OOH	Out of Hours service
OXMUD	Mandatory yearly Midwifery Update Day
OUH	Oxford University Hospitals
SALT	Speech and Language Therapy
WHO	World Health Organisation

Appendix 7: Education and Training

- Individual staff members are responsible for attending the relevant Trust's training event to update to this guidance (see Implementation plan).

Appendix 8: Monitoring Compliance

Compliance Standard	Monitoring method	Frequency of monitoring	Review Group/Committee
Appropriate advice documented /action Plans formulated in the event of faltering growth in accordance with guideline	Audit (10 sets of notes)	3 yearly	MCGC
Evidence of appropriate referral to MDT /relevant specialist Infant Feeding service	Audit (10 sets of notes)	3 yearly	MCGC

Appendix 9: Equality Impact Assessment

1. Information about the policy, service or function

What is being assessed?			
New Policy/Procedure	<input type="checkbox"/>	New Service/Function	<input type="checkbox"/>
Existing Policy/Procedure	<input checked="" type="checkbox"/>	Existing Service/Function	<input type="checkbox"/>
Staff member completing assessment: Ilana Levene			
Name of policy/service/function: Management of faltering growth guideline			
Details about the policy/service/function: Guidance on the management of faltering growth for breastfed babies from 2 weeks to 6 months of age			

Review Date: 13/01/2025	Date assessment completed:
Signature of staff member completing assessment:	Signature of staff member approving assessment:

2. Screening Stage

Who benefits from this policy, service or function? Who is the target audience? (tick all that apply)			
Patients	<input checked="" type="checkbox"/>	Family/Carers	<input type="checkbox"/>
Staff	<input type="checkbox"/>	Other (specify):	
		Not applicable	<input type="checkbox"/>
Does the policy, service or function involve direct engagement with the target audience?			
Yes	<input checked="" type="checkbox"/>	Continue with full equality impact assessment	
No	<input type="checkbox"/>	Full equality impact assessment not required	

3. Research Stage

notes: If there is no impact for a particular group or characteristic, mention this in the Reasoning column and refer to evidence where applicable.

¹Race categories follow those used in the National Census by the Office for National Statistics. Consideration should be given to the specific communities within broad categories such as Bangladeshi people.

²Please select age groups which may be impacted by the policy, service or function and complete as appropriate.

³Religion or Belief covers a wide range of groupings, the most common of which are Muslims, Buddhists, Jews, Christians, Sikhs and Hindus; it also covers people who do not have a faith. Consider these individually and collectively when determining impacts.

		Positive Impact	Negative Impact	Neutral Impact	Not Enough Information	Reasoning
Sex and Gender Reassignment	Men (incl. trans men)			x		All genders of postnatal parents will have equal access to care following diagnosis of faltering growth of a breast/chest fed infant from 3 weeks to 6 months of age.
	Women (incl. trans women)			x		
	Non-binary people			x		
Race ¹	Asian or Asian British			x		All parents with a breast/chest fed baby with faltering growth from 3 weeks to 6 months of age will benefit from this guideline.
	Black or Black British			x		
	Mixed Race			x		Consideration should be taken if the parent(s) is not able to read written English. Pictorial explanations may need to be used. If the parent(s) is not able to communicate using English, then language line should be used for consultations.
	White British			x		
	White Other			x		
	Other:			x		

Disability	Disabled people			x		If the parent(s) has a learning disability an advocate should be in attendance.
	Carers			x		If the parent(s) has a hearing loss she should be asked if she wishes to have a British Sign Language interpreter in attendance
Age ²	<18 years of age			x		This guidelines is relevant to parent(s) of all ages who are breast/chest feeding a baby diagnosed with faltering growth from 3 weeks to 6 months of age.
	>18 years of age			x		
Sexual Orientation				x		This guideline does not discriminate with regards to sexual orientation, as all people will have equal access to the care pathway described above.
Religion or Belief ³				x		This guideline does not discriminate with regards to belief or religion, as all people will have equal access to the care pathway described above.
Pregnancy and Maternity				N/A		
Marriage or Civil Partnership				x		This guideline does not discriminate with regards to marriage or civil partnership, as all people will have equal access to the care pathway described above.
Other Groups /Characteristics	For example: homeless people, sex workers, rural isolation.			x		This guideline does not discriminate with regards to social situations, as all people will have equal access to the care pathway described above.

List the sources of information used in the table below

OUH trust Equality impact assessment procedure guideline – available via trust intranet

Annual Equality and Diversity Report, Workforce Race Equality Standard Data or the Equality Delivery System 2 report

Using the table below, list any protected groups you will target during the consultation process, and give a summary of those consultations.

Group	Summary of consultation

List any other individuals/groups that have been or will be consulted on this policy, service or function.

This guideline will be reviewed prior to publication by relevant Midwives, Health Visitors, Infant Feeding Specialists, Obstetricians and Paediatricians and Voluntary Agencies.

4. Summary Stage

Outcome Measures

List the key benefits that are intended to be achieved through implementation of this policy, service or function and state whether or not you are assured that these will be equitably and fairly achieved for all protected groups. If not, state actions that will be taken to ensure this.

The benefits of this guideline will be to improve the care of breast/chest fed babies diagnosed with faltering growth from 32 weeks to 6 months of age. This will be evidenced by no more than a 1 day period between identification of faltering growth, and instigation of appropriate management measures, including prompt referral to appropriate services.

Consideration will be taken of those parents who may not be able to read written English. Pictorial explanations may need to be used.

If the parent(s) is not able to communicate using English then translation services will be used for consultations.

If the parent(s) has any learning difficulties an advocate will be in attendance.

If they have a hearing loss – a British Sign Language Interpreter will be offered which can be done via language line.

Positive Impact

List any positive impacts that this policy, service or function may have on protected groups as well as any actions to be taken that would increase positive impact.

This guideline has been written specifically to support the management of breast/chest fed babies diagnosed with faltering growth from 3 weeks to 6 months of age, therefore this is a positive impact for those people.

Unjustifiable Adverse Effects

List any identified unjustifiable adverse effects on protected groups along with actions that will be taken to rectify or mitigate them.

No adverse effects predicted on any group.

<p>Justifiable Adverse Effects</p> <p>List any identified unjustifiable adverse effects on protected groups along with justifications and any actions that will be taken to mitigate them.</p>
<p>No adverse effects predicted on any group.</p>

Equality Impact Assessment Action Plan

Complete this action plan template with actions identified during the Research and Summary Stages

Identified Risk	Recommended Actions	Lead	Resource Implications	Review Date	Completion Date



Oxford Health
NHS Foundation Trust