London InFed

Scoping Infant Feeding Support

Phase 1 Report
Neonatal Services

Mar 2025

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Executive Summary

Background

Infant feeding support (IFS) is a critical component of neonatal and maternity care, influencing both short- and long-term health outcomes. Despite frameworks such as the UNICEF Baby Friendly Initiative (BFI), variations in training, role allocation, and resource availability persist across the NHS. The London InFed project was established to assess current IFS provision within neonatal services across the London network. Phase 1 of this project aimed to:

- Identify staff involved in IFS in neonatal settings.
- Assess funded and protected time for IFS.
- Determine how the ODN could support service improvements.

Methodology

A mixed-methods approach was used; including an online survey (n = 108) of neonatal staff and maternity staff that in-reach to neonatal services (February 2024) and structured interviews (n = 7) for in-depth qualitative insights (October–December 2024). Survey data were analysed using Microsoft Excel, while interview transcripts underwent thematic analysis to identify key challenges and opportunities.

Key Findings

IFS roles and time allocation: 915 hours per week were dedicated to IFS, but only 54% were funded; many staff reported that IFS was an “add-on" to their primary role, lacking protected time.

Workforce composition and representation: The majority of respondents were nurses (37%) and based in Local Neonatal Units (43%); only 11% identified as Black or from another minority ethnic group, compared to 52.1% of NHS staff in London, highlighting limited workforce diversity.

BFI training and accreditation: 63% of respondents aligned with Breastfeeding Alliance role descriptors, with 59% identifying as a ‘Healthcare Professional’; BFI accreditation knowledge varied, with only 43% correctly identifying their unit’s status; Protected time for BFI work was limited, with only 22% of staff funded for these activities.

Challenges identified in structured interviews: High workload pressures and insufficient dedicated time were recurring themes; inconsistent peer supervision and training limited staff confidence; parental misinformation and social media influence complicated IFS delivery.

Role of the ODN in IFS: Participants called for structured training, mentorship, and financial support for CPD.

Discussion & Conclusions

These findings, though limited in scope, align with previous research, which highlight the necessity of dedicated time, structured training, and clear role definitions for effective IFS. This also stresses the importance of culturally sensitive approaches and equitable resource distribution.

The next phase of the London InFed project should focus on the experiences of service users and families in neonatal settings. This will provide valuable insights into how IFS is perceived and accessed by parents, helping to shape future service improvements and ensure family-centred, equitable care. By addressing both workforce challenges and service user experiences, neonatal services can move towards a more structured, equitable, and sustainable approach to infant feeding support.

Background

Infant feeding support (IFS) in the UK has evolved significantly since the NHS was established in 1948. Initially, support was informal, provided by midwives, health visitors, and voluntary organisations. During the mid-20th century, formula feeding became increasingly popular due to cultural shifts and aggressive marketing by commercial infant formula companies. By the 1980s, concerns over declining breastfeeding rates led to growing advocacy for breastfeeding promotion and regulation of commercial infant formula advertising.

A major turning point came in 1981 when the UK began supporting elements of the World Health Organisation's International Code of Marketing of Breast-milk Substitutes, restricting formula promotion (1). The Baby Friendly Initiative (BFI), launched by UNICEF and WHO in 1991, further shaped NHS policy by supporting maternity services to adopt breastfeeding-friendly practices (2). The standards were extended further to encompass neonatal services in 2012 (3). Many NHS trusts have since worked towards BFI accreditation, embedding evidence-based IFS into maternity, postnatal and neonatal care.

IFS is the responsibility of all healthcare professionals, however within the NHS it is more often delivered by midwives, nurses, health visitors, and specialist infant feeding leads, with growing input from dietitians and other allied health professionals (AHPs). Midwives provide early breastfeeding support in maternity units and at home, and neonatal nurses and other healthcare professionals such as AHPs support families in the neonatal unit, while health visitors continue this in the community. Specialist infant feeding teams and neonatal outreach teams offer targeted support, particularly for complex feeding issues, including tongue-tie, preterm infant feeding, and maternal health conditions affecting lactation. Voluntary and peer support groups also play a crucial role in providing accessible, ongoing support.

Despite progress, significant challenges remain in providing equitable and effective IFS. Workforce shortages and inconsistent funding mean access to specialist support varies across neonatal units. Healthcare professionals may lack sufficient training in IFS, leading to inconsistent advice and support for families. Health inequalities also play a pivotal role, with breastfeeding rates lower in disadvantaged areas due to factors such as lack of support, cultural influences, and returning to work early (4,5).

Another challenge is ensuring that IFS is inclusive of all feeding choices, including those who formula feed or require specialist interventions. While breastfeeding promotion remains a priority, there is increasing recognition that families need non-judgmental, evidence-based support for all feeding methods.

The London InFed project was identified by members of the London Neonatal Nutrition Group and implemented by the London Neonatal ODN team as a possible scoping project to try and capture the intricate landscape of IFS within neonatal units in the London Network.

Phase 1 Project Aim & Objectives

To explore and map out current IFS provision across the London network by:

- Identifying unit staff members involved in IFS in neonatal settings.
- Measure IFS provision (funded and unfunded).
- Identify how the ODN could support units with their IFS services.

Methodology

A Data Protection Impact Assessment was completed, and this project received retrospective approval from the GSTT Information Governance Department in May 2024.

A mixed-methods approached was used; firstly, an online survey was developed and distributed via email to neonatal staff within the network using the ODN email distribution list for unit contacts (recipients were encouraged to disseminate the survey to neonatal staff and maternity colleagues that in-reach to neonatal care) to collect baseline information, including profession, place of work, and diversity data, as well as their role in IFS and BFI accreditation. The survey also aimed to recruit volunteers willing to participate in follow-up discussions on IFS practices within their units (see Appendix 1). This included the use of IFS role descriptors developed by the Breastfeeding Alliance (6). The survey was hosted on SurveyMonkey and circulated across the network for staff completion during February 2024. The data collected was analysed quantitatively using Microsoft Excel.

Survey participants who consented to follow-up discussions were invited to schedule virtual structured interviews between October and December 2024. These interviews explored participants' roles, involvement in infant feeding support, training and professional development, challenges, and perceptions of the ODN's role (see Appendix 2). The interviews were conducted via Microsoft Teams, enabling the generation of transcripts. The transcripts were manually reviewed and analysed to identify common themes and key phrases.

Results

Online survey – quantitative analysis

A total of 108 neonatal and maternity staff from across the London network completed the online survey. A detailed breakdown of respondents' diversity data can be found in Appendix 3, which was optional, and completed by 52 (48%) respondents. Of note, there was a significant disparity in reported ethnic backgrounds, with only 11% of respondents identifying as Black or from another minority ethnic group, compared to 52.1% of NHS staff in London surveyed in 2023 (7).

The distribution of respondents by sector is shown in figure 1, with the majority working in the North Central London sector. Most respondents were nurses, as illustrated in figure 2. Further details regarding respondents' neonatal unit designation, service of employment, and Agenda for Change (AfC) banding (where applicable) are provided in Table 1. The majority worked in neonatal services (79%), within Local Neonatal Units (LNUs – 43%).

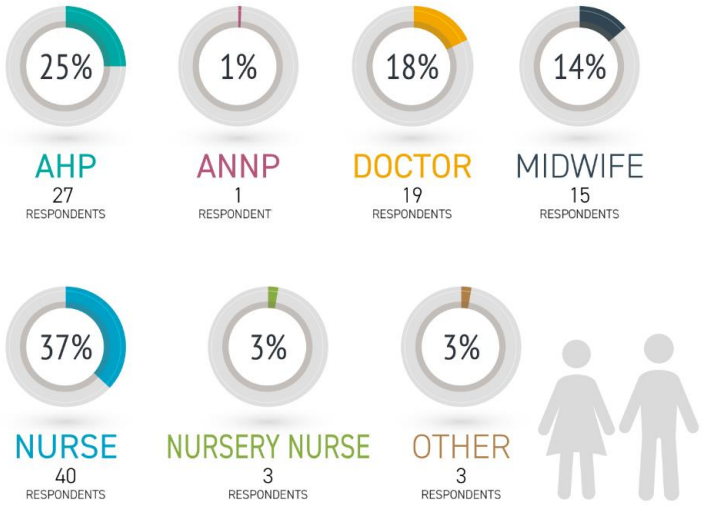
Figure 1: Breakdown of respondents by sector (n = 108)

Table 1: Breakdown of respondents by unit designation, service and AfC banding

Unit Designation	Number* (%)	Service	Number (%)	AfC Banding	Number (%)
SCU	4 (3%)	Neonates	85 (79%)	5	8 (8%)
LNU	50 (43%)	Maternity	15 (14%)	6	23 (23%)
NICU	26 (22%)	Dietetics	1(1%)	7	30 (30%)
Surgical NICU	36 (31%)	Therapies	5 (5%)	8a	18 (18%)
		Health Visiting	1(1%)	8b	5 (5%)
		Other	1(1%)	N/A	16 (16%)

*Total >108 as some respondents work in more than one unit

Figure 2: Breakdown of respondents by profession (n = 108)



All respondents were given the opportunity to define and quantify their role within Infant Feeding Support (IFS), with 68 out of 108 (63%) providing this information. Using IFS role descriptors defined by the Breastfeeding Alliance (6), the majority (59%) identified as a 'Health Care Professional', while a substantial proportion (28%) classified themselves as a 'Health Care Professional educated to BFI Standards' (figure 3).

Respondents also reported the presence of various IFS team members, with Infant Feeding Leads (59%) and Infant Feeding Specialists (57%) being the most common (figure 4). Additional professions listed under 'Other' included Speech and Language Therapists (8%), Dietitians (5%), Midwives (2%), and Volunteers (2%).

There was significant variation in respondents' experience in IFS roles, with a slight majority (24%) having over 15 years of clinical experience (figure 5).

In total, respondents reported 915 hours per week dedicated to IFS, of which 497 hours (54%) were funded. A breakdown of funded vs. unfunded hours by sector is provided in Table 2.

Table 2: Reported hours per week spent on IFS (funded vs. unfunded) by sector

Sector	Number of respondents	Total IFS hours per week	Funded hours per week (%)	Unfunded hours per week (%)
NCL	21	290	66 (23%)	224 (77%)
NEL	11	154	97 (63%)	57 (37%)
NWL	13	175	153 (87%)	22 (13%)
SEL	16	212	100 (47%)	112 (53%)
SWL	7	84	81 (96%)	3 (4%)
Total	**68**	**915**	**497 (54%)**	**418 (46%)**

Figure 3:Breakdown of respondents by IFS role description (n = 68)

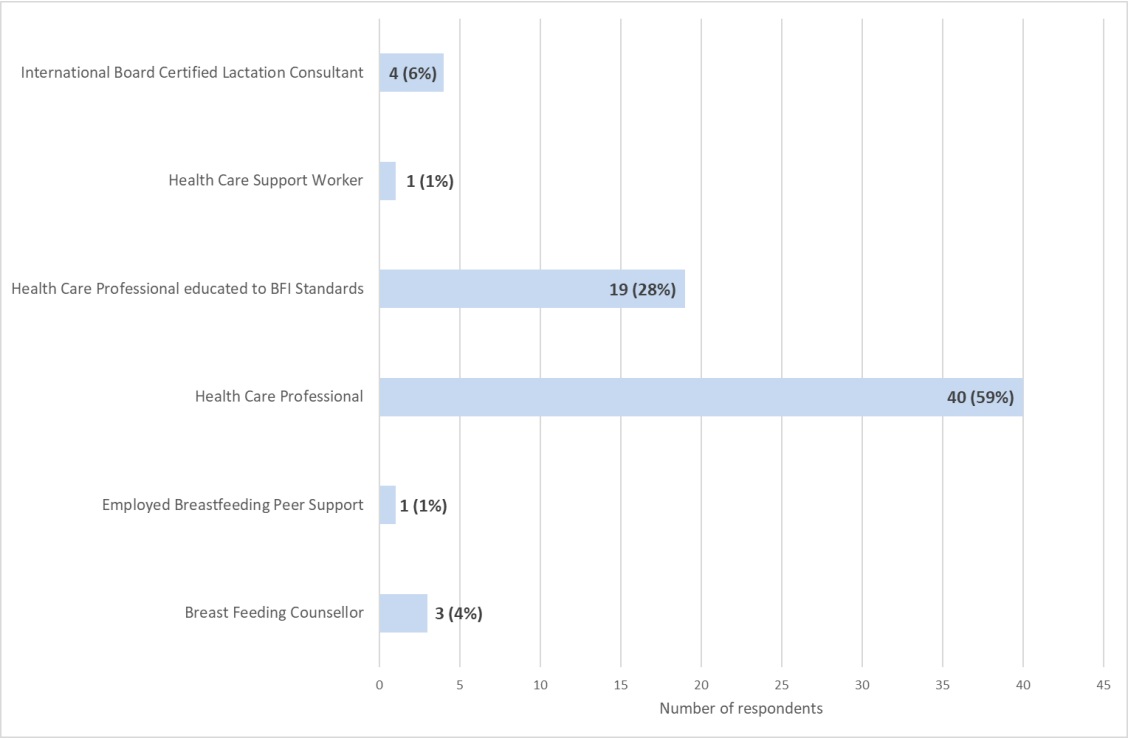


Figure 4: Reported additional IFS team members (n = 68)

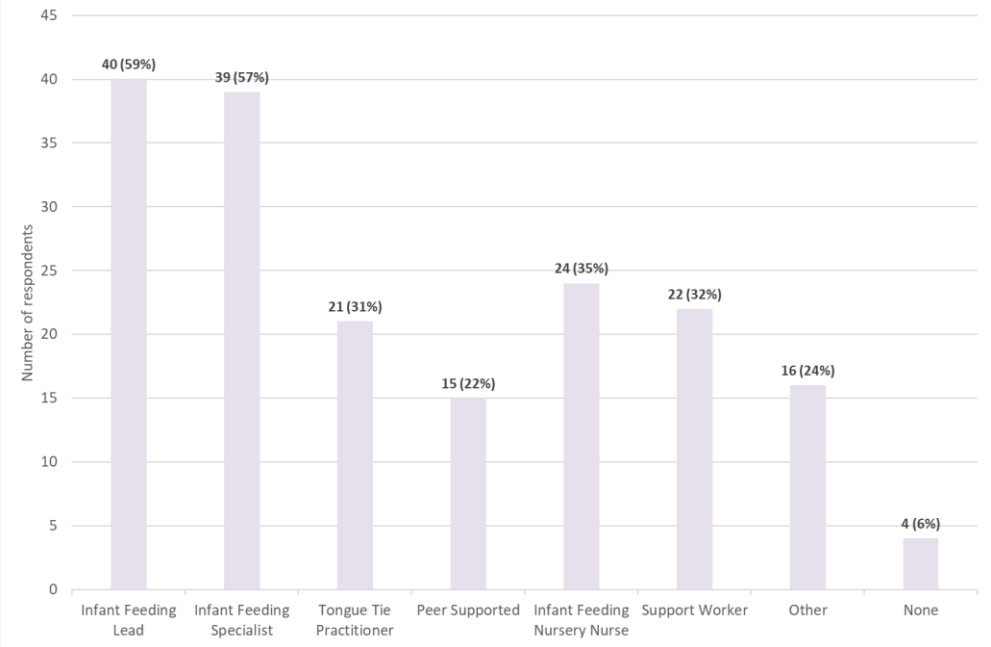
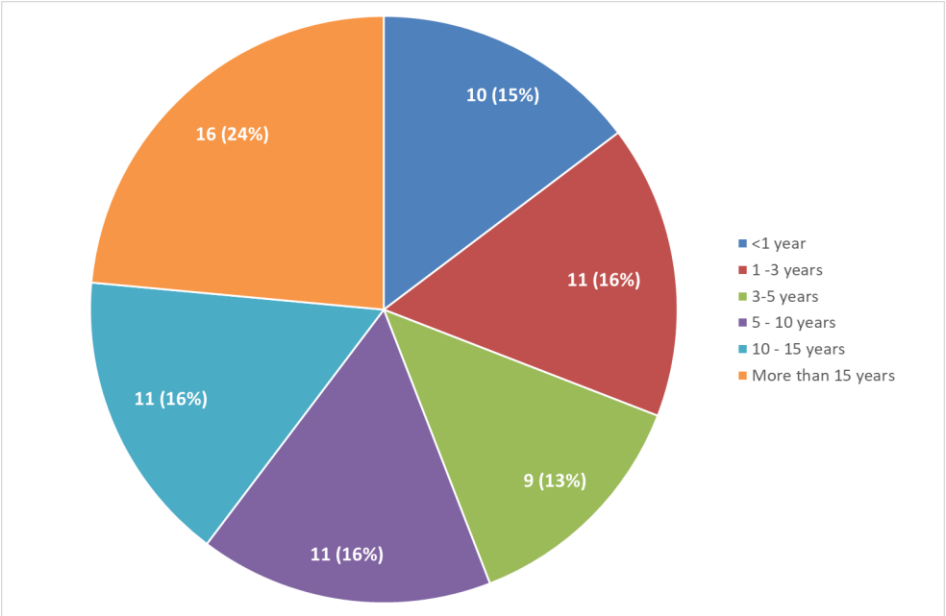


Figure 5: Reported number of years in IFS role (n = 68)



Some respondents provided information on their unit's BFI accreditation status and their involvement in BFI-related work. The reported BFI accreditation status was cross-checked against UNICEF's BFI accreditation statistics and awards table (8).

Table 3 presents the percentage of respondents who correctly identified their unit's BFI accreditation status, alongside their reported involvement in BFI accreditation work and the funded time allocated for these activities.

A total of 20 respondents (19%) described their role in BFI accreditation, with most (n = 9) identifying as the 'Lead' for BFI, followed by staff education roles (n = 3).

Table 3: BFI accreditation status, involvement, and funded time by sector

Sector	Number of respondents	N (%) identified correct unit BFI status	N (%) involved in unit BFI work	N (%) funded for unit BFI work	Total funded BFI hours per week
NCL	12	4 (33%)	6 (50%)	1 (8%)	0
NEL	11	2 (18%)	4 (36%)	1 (9%)	0
NWL	13	7 (54%)	11 (85%)	3 (23%)	37
SEL	11	4 (36%)	7 (64%)	4 (36%)	18
SWL	7	6 (86%)	5 (71%)	3 (43%)	59
Total	**54**	**23 (43%)**	**33 (61%)**	**12 (22%)**	**114**

Structured interviews – qualitative analysis

A total of 55 (51%) survey respondents provided contact details for follow-up interviews, with seven (6%) proceeding to participate. Interviewees included three neonatal nurses, three speech and language therapists, and one health visitor.

Key themes extracted from the interviews are summarised in Table 4, categorised by interview question, with notable key phrases highlighted in bold.

Table 4: Thematic analysis of seven structured interviews with neonatal staff

Q1: Tell me about yourself and your role on the unit	• Participants have **specialised roles** in BFI accreditation and infant feeding support. • Several participants highlight a **lack of formally defined roles**, with infant feeding responsibilities often being an "add-on" to their primary role. • **Workload** is a common concern, with some feeling that allocated time is insufficient to fulfil responsibilities effectively.
Q2: How is your role involved in Infant Feeding Support?	• Most participants contribute indirectly through **staff training, guideline development, and quality improvement projects.** • Some provide **direct parental support**, particularly in areas such as expressing breast milk, colostrum harvesting, and feeding techniques. • Education efforts include **teaching staff about bottle flow rates, pacing, and best practices in breastfeeding.** • Several units have introduced **regular training topics** (e.g., side-lying feeding) to improve consistency in practice.
Q3: What education and training support do you receive for Infant Feeding?	• Participants have received training through **UNICEF BFI courses, lactation consultant certifications, and national conferences**. • Some rely on **self-directed learning** due to limited structured CPD opportunities. • A **gap in formal clinical supervision** is noted, with calls for more peer support and structured competency assessments. • Some participants have benefited from **mentorship networks and specialised training funds** but feel more structured access to training is needed.
Q4: How confident do you feel talking to parents about Infant Feeding?	• Most participants report **high confidence** in supporting parents with feeding challenges.

	• Challenges include staying updated with **new feeding techniques and social media-driven trends**. • Some emphasised the need to **balance clinical guidelines with individualised parent-led care**.
Q5: What does your unit do to support families with Infant Feeding?	• Some units offer **drop-in clinics, peer support groups, and ward rounds** to assist families with feeding. • Challenges include **limited resources and time constraints** that affect the ability to provide hands-on support. • Some participants report **good leadership buy-in**, while others struggle with unit/trust **prioritisation** of infant feeding.
Q6: How does your unit support you with Infant Feeding?	• Some participants feel well-supported, citing **training opportunities and leadership investment** in infant feeding initiatives. • Others report challenges in securing **dedicated time** for feeding support and difficulties in getting staff on board with changes. • The presence of **peer networks and mentorship programs** helps in some settings, but others feel isolated in their roles.
Q7: What do you think is the ODN's role in Infant Feeding?	• Participants acknowledge ODN's efforts in **consistency, policy development, and peer networking**. • Some feel unclear about how the ODN could further support their work beyond policy guidance. • Calls for more **structured training packages, mentorship, and financial support for courses** were common.
Q8: How could the ODN better support you with Infant Feeding?	• Participants suggest more **structured, ready-made training packages** to reduce workload. • Increased **peer supervision and mentorship opportunities** would be beneficial. • Financial support for **training courses and networking events** is frequently mentioned as a need.
Q9: So now I would like to ask you about BFI; can you tell me what you understand about the Baby Friendly Initiative?	• Participants describe BFI as a **framework promoting breastfeeding and parent-infant relationships**. • Many associate it with **UNICEF accreditation** and structured guidance on infant feeding best practices. • Some view it as a method to improve staff training and parental support. • Challenges include **varying levels of engagement and understanding** across units.
Q10: Before we finish, is there anything else you would like to tell me that you haven't shared already?	• Some participants emphasised the need for stronger **collaboration** across units. • **Limited time and resources** are a significant barrier, with some participants balancing multiple roles. • **Staff engagement and training gaps** make it difficult to implement best practices consistently. • **Interdisciplinary collaboration difficulties**, with some staff not prioritising infant feeding support as highly as others.

	• **Parental misinformation and social media influence** create additional challenges in guiding families effectively. • Additional support for **parental education** and long-term feeding guidance is suggested. • A few mention concerns about **sustainability** and maintaining momentum in feeding initiatives. • Others highlight the importance of **ongoing research and innovation** in neonatal nutrition. • Better **integration with community and post-discharge support** to help families continue successful feeding practices at home. • Stronger **leadership and policy enforcement** to ensure infant feeding is a priority within healthcare settings.

Discussion

The findings from Phase 1 of this project provide a very limited, yet fascinating snapshot of staff perceptions and experience with IFS services across neonatal services within the London network. The combined quantitative and qualitative data reveal considerable variation in IFS roles, resources, and training, which reflect broader systemic challenges within neonatal care.

The survey results indicated that respondents dedicated a total of 915 hours per week to IFS, with only 54% of these hours being funded. Further variation in funded and unfunded time could be seen between regional sectors. This imbalance highlights ongoing resource constraints within neonatal care, and emphasises the risks associated with relying on unfunded 'goodwill' time. Investment from service providers would be needed to address these under resourced essential services.

In recent years there has been extensive investment from the NHS and UK government in maternity services to improve IFS services (9–11), however, this has not been matched in neonatal services. While neonatal services are dwarfed by maternity in terms of population size, IFS in the neonatal community requires enhanced and specialised skills given the complexity of infant feeding difficulties seen in the preterm and sick infant population. If the right support is not provided in the right place and time, this is likely to prolong and compound the infant feeding difficulties. This investment in maternity IFS services also shows how important and essential these roles are for infants and their families. However, the absence of national standards for IFS workforce requirements makes benchmarking a challenge for units and service providers, and likely contributes to the significant amount of 'goodwill' care given.

Many staff members also reported that IFS responsibilities are appended to their primary roles rather than being clearly defined as dedicated positions. Such role ambiguity, along with reported shortfalls in formal training and clinical supervision, mirrors the findings of a systematic review by Gavine et al. (12), which concluded that effective breastfeeding support requires dedicated resources, comprehensive training, and clearly defined roles. This finding further highlights the importance for providers to prioritise investment in these essential quality roles.

Another noteworthy observation from the survey data is the low proportion of respondents (11%) identifying as Black or from another minority ethnic group compared to the 52.1% representation reported in the NHS London workforce (7). However, it is important to interpret this finding with caution given that 56% of survey respondents did not provide information on their ethnicity. This considerable non-response may limit the extent to which the observed disparity reflects the true engagement of different ethnic groups in IFS practices. Nevertheless, the data that are available potentially highlights gaps in engagement and representation, suggesting that current the IFS workforce may not fully address the needs of London's rich ethnically diverse population. Research by Hunt et al. (4) further underscores how health inequalities and socioeconomic factors can adversely affect breastfeeding rates, reinforcing the need for culturally sensitive and equitable support across services.

Qualitative insights from structured interviews further illustrate the challenges faced by staff. Workload pressures, insufficient dedicated time, and variable support in terms of training and supervision were recurring themes. Although some units have implemented positive measures, such as the appointment of dedicated Infant Feeding Leads, overall, the study highlights the need for clearer role definitions and enhanced, standardised training programmes. Moreover, the inconsistencies in knowledge and involvement regarding BFI accreditation indicate that communication and support for best practices require further reinforcement, however it is unclear if respondents were quoting the BFI status of their maternity services rather than neonatal services, and if the online BFI accreditation table is kept up-to-date in real-time.

Several participants also noted the potential for the ODN to provide more structured support. The call for ready-made training packages, increased peer supervision, and improved financial backing for professional development aligns with the recommendations of the Becoming Breastfeeding Friendly (BBF) initiative (5). This external evidence suggests that standardised, well-funded initiatives can improve service delivery and breastfeeding outcomes, supporting the participant-driven recommendations from this study – again emphasising the critical need for investment from service providers. To support units, the London Neonatal ODN hosted a BFI stakeholder event in September 2024, and feedback from participants has resulted in the initiation of quarterly BFI and Infant feeding Peer support group meetings.

While this project offers valuable insights into current IFS provision, several limitations must be acknowledged when interpreting the findings. First, the self-selecting nature of the survey may have introduced response bias. It is possible that those with a particular interest or involvement in IFS were more likely to participate, potentially skewing the results. Also, the survey's reliance on voluntary self-reported data introduces the possibility of recall bias or social desirability bias, which could influence the accuracy of responses regarding roles, hours dedicated to IFS, and perceptions of support. And furthermore, we cannot guarantee that all neonatal and maternity staff involved in IFS in neonatal settings were able to participate in the online survey, depending on how well the invitation email was circulated and its uptake. This is most likely reflected in the small number of maternity staff that completed the survey (14%).

A notable limitation concerns the incomplete diversity data, of which 56% of respondents did not complete. This high non-response rate for elements like ethnic background limits our ability to draw definitive conclusions about the representativeness of the sample in relation to the broader London workforce. The lack of complete demographic information makes it challenging to fully understand how engagement with IFS might differ across diverse cultural groups. Finally, the relatively small number of participants in the qualitative interviews restricts the generalisability of the in-depth insights gathered, and future work should aim to include a broader range of voices to corroborate and extend these findings. Nonetheless, the mixed-methods approach has provided a good initial basis for understanding current practice and identifying priorities for future improvement.

Conclusions

This phase 1 project has highlighted several key areas for improvement in the provision of IFS within the London network. There is significant variation in how IFS is delivered, with many staff members managing these responsibilities as an 'add-on' to their primary roles. The imbalance between funded and unfunded hours and the lack of formalised training and clear role definitions indicate systemic challenges that could undermine the quality of support available to families.

The marked disparity in ethnic representation among survey respondents further raises questions about the inclusivity of current IFS practices and suggests that additional efforts are needed to ensure culturally sensitive and equitable support. Participants' recommendations for more structured training programmes, enhanced peer support, and improved financial backing for professional development underscore the potential for the ODN to standardise and elevate IFS across the network.

Moving forward, it is essential for service providers to work closely with their relevant stakeholders to address these identified gaps through targeted interventions, and investment in the IFS workforce. More in-depth scoping of neonatal services as well as maternity services (to potentially serve as a comparator) may be warranted. The next phase of the London InFed project should focus on exploring the experiences of service users and families in neonatal and maternity settings. This will provide critical insight into the accessibility, quality, and impact of IFS from the perspective of those directly affected. Understanding the challenges,

preferences, and needs of families will help shape more effective, equitable, and family-centred support strategies across the network.

Strengthening the framework for IFS is crucial not only for improving immediate support for parents and infants but also for reducing health inequalities and ensuring that all families receive evidence-based, non-judgemental care. The insights gained from this study provide a strong foundation for further research, policy development, and service improvement across neonatal care settings.

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Appendix 1 – Online survey questions

About you

1. If you are happy to be contacted for a follow-up discussion, please provide your name and email address:

2. Please select your hospital of employment: [tick all that apply]

3. Which service are you employed by?
    a. Maternity
    b. Neonates
    c. Other (please specify)

4. What is your NHS AfC band?

5. What is your job title?

6. What is your professional background?
    a. AHP (SLT/DT/OT)
    b. ANNP
    c. Doctor
    d. Midwife
    e. Nurse
    f. Nursery nurse
    g. Other

Your role in IFS

7. Show "Infant Feeding Support Competencies – Role Comparison" and ask: which of these role descriptors best describes your role in Infant Feeding?
    a. IBCLC
    b. Breastfeeding Counsellor
    c. Volunteer Breastfeeding Peer Supporter
    d. Employed Breastfeeding Peer Supporter
    e. Healthcare Professional
    f. Healthcare Support Worker
    g. BFI Framework Practitioner

8. In relation to question 7, how long have you been in this role? (do we add ranges e.g. <1yr, 1-4 yrs)

9. How many hours per week do you provide IFS?

10. In relation to question 9, how many of these hours are funded/protected for IFS?

11. Are you aware of any of the following roles in your IF team?
    a. IF Specialist
    b. Tongue tie practitioner
    c. Peer supporters

d. IF Nursery Nurse
e. Support Workers
f. Other (please specify)

BFI accreditation

12. Please select the BFI status of your neonatal unit:
    a. Intent Registered
    b. Certificate of Commitment
    c. Stage 1
    d. Stage 2
    e. Stage 3/Full accreditation
    f. Gold

13. Are you involved in BFI accreditation work? Yes/no

14. If "yes" please describe your role:

15. Are you funded to do our BFI accreditation work?

16. If so, how many of these hours are protected for BFI accreditation?

Diversity Monitoring (all optional)

1. Your age (in years)

2. Which of the following best describes your gender?
    - Female
    - Male
    - Non-binary
    - Prefer to self-describe (please specify)
    - Prefer not to say

3. Is your gender identity the same as the sex you were registered with at birth?
    - Yes
    - No
    - Prefer not to say

4. Your ethnic background:
    - Asian, Asian British, Asian Welsh:
        - Bangladeshi
        - Chinese
        - Indian
        - Pakistani
        - Any other Asian background
    - Black, Black British, African, Caribbean:
        - African
        - Caribbean
        - Any other Black/African/Caribbean background

- Mixed or multiple:
  - Asian & white
  - Black African & white
  - Black Caribbean & white
  - Any other mixed background/multiple ethnic groups
- Other ethnic group:
  - Arab
  - Any other ethnic group
- White:
  - English/Welsh/Scottish/Northern Irish/British
  - Irish
  - Gypsy or Irish traveller
  - Any other white background

5. Your religious beliefs:
   - Buddhist
   - Christian
   - Hindu
   - Jewish
   - Muslim
   - No religion
   - Sikh
   - Other (please comment)
   - Prefer not to say

6. Which of the following best describes your current sexual orientation?
   - Straight or heterosexual
   - Gay or lesbian
   - Bisexual
   - Other sexual orientation (please comment)
   - Prefer not to say

7. Do you consider yourself to have a disability?
   - Yes
   - No
   - Prefer not to say

8. If 'yes', please state the type of disability which applies to you. People may experience more than one type of disability; in which case you may indicate more than one. If none of the categories apply, please mark 'other':
   - Physical impairment
   - Learning disability/difficulty
   - Sensory impairment
   - Long-standing illness
   - Mental health condition
   - Other (please specify)
   - Prefer not to say

Appendix 2 – Structured interview questions

ABOUT YOU

1. Firstly, I will ask you a few questions about your role on the unit; so, tell me about yourself and, what is your role on the unit.

2. How is your role involved in Infant Feeding Support?

3. In relation to education and training; can you tell me about the support that you get to provide infant feeding support in your role.
    - *Further prompting if unable to answer initially: for example; training, supervision, other Infant Feeding specialists etc.*

4. How confident do you feel talking to parents about their Infant Feeding?

YOUR UNIT

5. Is there something else that your unit does or provides to support families with Infant Feeding? *[e.g. family feedback, group sessions etc].*

6. How do you feel your unit supports you with Infant Feeding? *[tell me about any challenges]*

THE ODN

7. What do you think is the ODN's role with Infant Feeding?

8. How do you think the ODN could support you with your infant feeding support work?

9. So now I would like to ask you about BFI; can you tell me what you understand about the Baby Friendly Initiative?

10. Before we finish, is there anything else you would like to tell me that you haven't shared already?

Appendix 3 – Diversity data from online survey responses

NB: n = 108. Responses to the diversity questions were optional. NHSE workforce staffing data is also provided where applicable.

Ethnic Background	**Number (%)**	**NHSE WRES 2023 data for London (%)**(7)
Asian, Asian British, Asian Welsh: Any other Asian background	2 (2%)	Black & Minority Ethnic groups 52.1%
Asian, Asian British, Asian Welsh: Indian	1 (1%)	
Asian, Asian British, Asian Welsh: Pakistani	1 (1%)	
Black, Black British: African	3 (3%)	
Black, Black British: Caribbean	2 (2%)	
Mixed or multiple: Asian & white	1 (1%)	
Other ethnic group: Any other ethnic group	1 (1%)	
White: Any other white background	9 (8%)	White 43%
White: English/Welsh/Scottish/Northern Irish/British	30 (28%)	
White: Irish	2 (2%)	
No response	56 (52%)	Unknown 4.9%

Declared disability	**Number (%)**	**NHSE WDES 2022 data for England (%)**(13)
Yes	2 (2%)	4.3%
No	48 (44%)	77.6%
Prefer not to say	4 (4%)	Unknown 18.1%
No response	54 (50%)	

Age Category	**Number (%)**
Under 18	1 (1%)
18-24	1 (1%)
25-34	10 (9%)
35-44	21 (19%)
45-54	12 (11%)
55-64	10 (9%)
No response	53 (49%)

Gender	**Number (%)**
Female	50 (46%)
Male	3 (3%)
Prefer not to say	2 (2%)
No response	53 (49%)

Religion	**Number (%)**
Christian	27 (25%)
Hindu	2 (2%)
Jewish	1 (1%)
Muslim	1 (1%)
Pagan	1 (1%)
Sikh	1 (1%)
No religion	18 (17%)
Prefer not to say	3 (3%)
No response	54 (50%)

Sexual Orientation	**Number (%)**
Bisexual	3 (3%)
Straight or heterosexual	49 (45%)
Prefer not to say	3 (3%)
No response	53 (49%)

Appendix 4 – London InFed Working Group

- Moriam Mustapha – Lead Dietitian, London Neonatal ODN (lead)
- Laura Kelly – Lead Care Coordinator, London Neonatal ODN
- Louise Wells – Care Coordinator, London Neonatal ODN
- Ines DaSilva – Care Coordinator, London Neonatal ODN
- Brenda Carty – Joint Lead Speech & Language Therapist, London ODN
- Ellie Atkins – Lead Psychologist, London Neonatal ODN
- Adedoyin Yissau – Education & Workforce Lead, London Neonatal ODN
- Kirsty Gallagher – Academic Neonatal Nurse, University College Hospitals
- Jenni Jagodzinski – Lead Nurse, London Neonatal ODN