EtD 21. Should slower feed advancement vs. faster feed advancement be used for preterm infants who require enteral feeding?

POPULATION:	Preterm infants who require enteral feeding
INTERVENTION:	Slower feed advancement
COMPARISON:	Faster feed advancement
MAIN OUTCOMES:	**Critical outcomes** Mortality Necrotising enterocolitis Time to full enteral feeds Duration of initial hospital stay Fully breastfed or breastmilk feeding at hospital discharge Adverse effects – feed intolerance **Important but not critical** Neurodevelopmental impairment Faltering growth/body composition – especially length growth Sepsis: proven or suspected Bronchopulmonary dysplasia Retinopathy of prematurity Anaemia of prematurity Cost: cost of intervention, cost of neonatal care and life-long cost **Less important for decision making** Time to full sucking feeds
SETTING:	Neonatal care
PERSPECTIVE:	Clinical recommendation
BACKGROUND:	Enteral feeding is essential to provide the necessary nutrients for growth and development. However, determining the optimal rate of feed advancement for preterm infants remains a significant clinical challenge. The speed of advancing feeds must balance the risk of gastrointestinal complications, such as feed intolerance and necrotising enterocolitis, with the benefits of earlier nutritional adequacy, reduced parenteral nutrition exposure and a shorter hospital stay. Faster feed advancement can reduce the time to achieve full enteral feeds and minimise reliance on parenteral nutrition, which is associated with risks such as infection and liver dysfunction. However, rapid progression may overwhelm the immature gastrointestinal system, increasing the risk of necrotising enterocolitis—a life-threatening condition that remains a leading cause of morbidity and mortality in preterm infants. Slower feed advancement is thought to reduce the risk of gastrointestinal complications by allowing the gut more time to adapt to enteral feeding. However, prolonged reliance on parenteral nutrition and increased risk of sepsis, and delayed achievement of full enteral feeds can all result in nutritional deficits, growth faltering and extended neonatal intensive care stays. While each infant needs individualised prescription of advances in enteral feeding based on the infant's clinical condition, gestational age, and tolerance to feeds, standardised feeding protocols on which to base these decisions are helpful and when used, have been shown to reduce necrotising

	enterocolitis rates.
CONFLICT OF INTERESTS:	None

Assessment

Desirable Effects

How substantial are the desirable anticipated effects?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
● Trivial ○ Small ○ Moderate ○ Large ○ Varies ○ Don't know	Evidence based on a Cochrane systematic review [1], another systematic review [2], an additional RCT report from the SIFT trial [3] and an economic evaluation of the SIFT trial [4]. **Note that the data as slow advancement being the intervention versus faster advancement as the comparator.** Mortality: RCT: No difference in all-cause mortality in the slow-rate-of-advancement group (7 more per 1000; from 8 fewer to 27 more) [Critical]. Necrotising enterocolitis: RCT: Little or no effect on risk of NEC (3 more per 1000, 9 fewer to 20 more). Sensitivity analysis did not show any effect in extremely preterm or ELBW infants [Critical]. Time to full enteral feeds: RCT: Eleven trials reported that it took longer to establish full enteral feeds in infants in the slow-rate-of-advancement group (meta-analysis not possible) [Critical]. Neurodevelopmental impairment: RCT: No significant effect on moderate to severe disability (31 per 1,000 fewer; 64 fewer to 6 more). No significant reduction in neurodevelopmental impairment (slow advancement of enteral feed volumes) for cognitive impairment (19 per 1,000 fewer; 50 fewer to 19 more), in hearing impairment (16 per 1,000 fewer; 27 fewer to 1 more), or in visual impairment (5 per 1,000 fewer; 11 fewer to 8 more). No significant reduction in survival without moderate or severe neurodevelopmental disability at 24 months (26 fewer per 1,000; 59 fewer to 13 more) [Important]. Large reduction in risk of cerebral palsy (21 per 1,000 fewer; 33 fewer to 5 fewer). No faltering growth/body composition: RCT: Little or no effect on weight z-scores at hospital discharge (MD 0.00 points; 0.08 lower to 0.08 higher) or head circumference z-scores at hospital discharge (MD 0.00 points; 0.13 lower to 0.13 higher). Slow-rate-of-advancement group took a longer time to regain birthweight (meta-analysis not possible) [Important]. **Desirable effects for Māori**	**Population information for included evidence** The Cochrane review [1] included 14 RCTs that assessed effects of slow (up to 24 mL/kg/day) versus faster rates of advancement of enteral feed volumes in very preterm or VLBW infants. Trials typically defined slow advancement as daily increments of 15 to 24 mL/kg/day, and faster advancement as daily increments of 30 to 40 mL/kg/day. The other systematic review [2] included 12 RCTs. Slow feed advancement was defined as <30 mL/kg per day and compared with fast feed advancement ≥30 mL/kg per day. No additional studies identified. UK [3]: RCT: included very preterm or very-low-birth-weight infants.

	No additional data	

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects* (95% CI)	
				Risk with faster feed advancement	Risk difference with slower feed advancement
Mortality: RCT assessed with: All-cause mortality prior to hospital discharge	3860 (13 RCTs)	⨁⨁⨁◯ Moderate[a]	**RR 1.10** (0.88 to 1.38)	Study population	
				71 per 1,000	**7 more per 1,000** (8 fewer to 27 more)
Necrotising enterocolitis: RCT	4026 (14 RCTs)	⨁⨁⨁◯ Moderate[a]	**RR 1.06** (0.83 to 1.37)	Study population	
				54 per 1,000	**3 more per 1,000** (9 fewer to 20 more)
Time to full enteral feeds: RCT	n not reported (11 RCTs)	⨁⨁◯◯ Low[a,]	-	Eleven trials reported that it took longer to establish full enteral feeds in infants in the slow-rate-of-advancement group (meta-analysis not possible)	
Duration of initial hospital stay (RCT)	n not reported (10 RCTs)	⨁◯◯◯ Very low[a,b,]	-	Six trials reported no difference in duration of hospital stay between groups. Four trials reported that duration of hospital stay was longer amongst infants in the slow-rate-of-advancement group (meta-analysis not possible).	
Fully breastfed or breastmilk feeding at hospital discharge - not measured	-	-	-	-	-
Adverse effects (feed intolerance): RCT assessed with: Feed intolerance (causing interruption of enteral feeding)	719 (8 RCTs)	⨁⨁◯◯ Low[a,c]	**RR 1.18** (0.95 to 1.46)	Study population	
				282 per 1,000	**51 more per 1,000** (14 fewer to 130 more)
Survival without severe neurodevelopmental disability: RCT follow-up: 24 months	2470 (1 RCT)	⨁⨁◯◯ Low[a,d]	**RR 0.96** (0.91 to 1.02)	Study population	
				655 per 1,000	**26 fewer per 1,000** (59 fewer to 13 more)
Neurodevelopmental impairment: RCT assessed with: Cognitive impairment	2326 (1 RCT)	⨁◯◯◯ Very low[a,c,d,]	**RR 0.93** (0.81 to 1.07)	Study population	
				266 per 1,000	**19 fewer per 1,000** (50 fewer to 19 more)
Neurodevelopmental impairment: RCT assessed with: Hearing impairment	2315 (1 RCT)	⨁⨁◯◯ Low[a,d]	**RR 0.69** (0.47 to 1.02)	Study population	
				51 per 1,000	**16 fewer per 1,000** (27 fewer to 1 more)
Neurodevelopmental impairment: RCT assessed with: Visual impairment	2327 (1 RCT)	⨁◯◯◯ Very low[a,c,d]	**RR 0.75** (0.39 to 1.43)	Study population	
				18 per 1,000	**5 fewer per 1,000** (11 fewer to 8 more)

Neurodevelopmental impairment: RCT assessed with: cerebral palsy	2183 (1 RCT)	⨁⨁◯◯ Low[a,d]	**RR 0.60** (0.39 to 0.90)	Study population	
				54 per 1,000	**21 fewer per 1,000** (33 fewer to 5 fewer)
Neurodevelopmental impairment: RCT assessed with: moderate or severe disability	2325 (1 RCT)	⨁⨁◯◯ Low[a,d]	**RR 0.90** (0.79 to 1.02)	Study population	
				306 per 1,000	**31 fewer per 1,000** (64 fewer to 6 more)
Faltering growth/body composition: RCT assessed with: Weight z score at hospital discharge	2602 (1 RCT)	⨁⨁◯◯ Low[a,d]	-	The mean faltering growth/body composition: RCT was **-1.5 points**	MD **0** (0.08 lower to 0.08 higher)
Faltering growth/body composition: RCT assessed with: Head circumference z score at hospital discharge	2286 (1 RCT)	⨁◯◯◯ Very low[a,c,d,]	-	The mean faltering growth/body composition: RCT was **-0.8 points**	MD **0** (0.13 lower to 0.13 higher)
Faltering growth/body composition: RCT assessed with: Time to regain birthweight	n not reported (10 RCTs)	⨁⨁◯◯ Low[a]	-	Ten trials reported that infants in the slow-rate-of-advancement group took a longer time to regain birthweight (meta-analysis not possible).	
Sepsis - not measured	-	-	-	-	-
Bronchopulmonary dysplasia - not measured	-	-	-	-	-
Retinopathy of prematurity - not measured	-	-	-	-	-
Anaemia of prematurity - not measured	-	-	-	-	-
Cost: cost of intervention, cost of neonatal care and life-long cost: RCT assessed with: Total costs (£) of health service use after initial discharge from hospital and up to 24 months corrected age	2470 (1 RCT)	⨁◯◯◯ Very low[a,c]	-	The mean cost: cost of intervention, cost of neonatal care and life-long cost: RCT was **GBP 109,783 (total cost divided by sample size of arm)**	MD **267 lower** (6928 lower to 8117 higher)
Cost: cost of intervention, cost of neonatal care and life-long cost: RCT assessed with: Costs (£) of initial hospital care	2470 (1 RCT)	⨁◯◯◯ Very low[a,d]	-	The mean cost: cost of intervention, cost of neonatal care and life-long cost: RCT was GBP **101,744 (total cost divided by sample size of arm)**	MD **242 higher** (6307 lower to 6251 higher)
Time to full sucking feeds (<0.5 days) - not measured	-	-	-	-	-

a. Downgraded one level for methodological concerns/risk of bias.
b. Downgraded one level for indirectness as studies had inconsistent reporting of no effect or increased duration of hospital stay.
c. Downgraded one level for imprecision with confidence intervals crossing the line of no effect
d. Downgraded one level for indirectness. Although this is a large study it is only based in the UK and results may not be generalisable to other settings

Undesirable Effects

How substantial are the undesirable anticipated effects?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS

○ Trivial ● Small ○ Moderate ○ Large ○ Varies ○ Don't know	Duration of hospital stay: RCT: Six trials reported no difference in duration of hospital stay between groups. Four trials reported that duration of hospital stay was longer amongst infants in the slow-rate-of-advancement group (meta-analysis not possible) [Critical]. Adverse effects (Feed intolerance): RCT: No significant increase in feed intolerance for slow advancement of enteral feed volumes (51 per 1,000 more; 14 fewer to 130 more) [Critical]. Cost: RCT: No significant increase in costs for slow advancement feeds compared with faster feeds (mean difference £247 higher; 6307 lower to 6251 higher) for costs of initial hospital care. No significant reduction in costs for slow advancement feeds compared with faster feeds (mean difference £267 lower; 6928 lower to 8117 higher) for total costs of health service use after initial discharge from hospital and up to 24 months corrected age [Important]. **Undesirable effects for Māori**	

Certainty of evidence

What is the overall certainty of the evidence of effects?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Very low ● Low ○ Moderate ○ High ○ No included studies	We have some concerns about the economic evaluation that was based on UK cost data only so may not be generalisable to Aotearoa New Zealand context. Some resource uses were self-reported by parents/caregivers but the proportion of responders was 69.5% which may have influenced the data. The use of self-reported parental data may also influence the findings. The confidence intervals associated with the costs are extremely wide and no statistical analysis of the data were conducted. The available trial data indicate that advancing enteral feed volumes slowly (daily increments up to 24 mL/kg/day) compared with faster rates probably does not reduce the risk of NEC, death, or feed intolerance in very preterm or VLBW infants. Advancing the volume of enteral feeds at faster rates (typically 30 to 40 mL/kg/day) shortens by several days the time taken to regain birthweight and establish full enteral feeds, and may slightly reduce the risk of late-onset invasive infection (low-certainty evidence) Moderate to very low certainty of evidence overall. **Certainty of evidence for Māori**	

Outcomes	Importance	Certainty of the evidence (GRADE)
Mortality: RCT assessed with: All-cause mortality prior to hospital discharge	CRITICAL	⨁⨁⨁◯ Moderate[a]
Mortality: RCT assessed with: Survival without moderate or severe neurodevelopmental disability at 24 months	CRITICAL	⨁⨁◯◯ Low[a,b]
Necrotising enterocolitis: RCT	CRITICAL	⨁⨁⨁◯ Moderate[a]
Time to full enteral feeds: RCT	CRITICAL	⨁⨁◯◯ Low[a,c]
Duration of initial hospital stay (RCT)	CRITICAL	⨁◯◯◯ Very low[a,c,d]
Fully breastfed or breastmilk feeding at hospital discharge - not measured	CRITICAL	-
Adverse effects (feed intolerance): RCT assessed with: Feed intolerance (causing interruption of enteral feeding)	CRITICAL	⨁⨁◯◯ Low[a,e]
Survival without severe neurodevelopmental disability: RCT follow-up: 24 months	IMPORTANT	⨁⨁◯◯ Low[a,b]
Neurodevelopmental impairment: RCT assessed with: Cognitive impairment	IMPORTANT	⨁◯◯◯ Very low[a,b,e]
Neurodevelopmental impairment: RCT assessed with: Hearing impairment	IMPORTANT	⨁⨁◯◯ Low[a,b]
Neurodevelopmental impairment: RCT assessed with: Visual impairment	IMPORTANT	⨁◯◯◯ Very low[a,b,e]
Neurodevelopmental impairment: RCT assessed with: cerebral palsy	IMPORTANT	⨁⨁◯◯ Low[a,b]
Neurodevelopmental impairment: RCT assessed with: moderate or severe disability	IMPORTANT	⨁⨁◯◯ Low[a,b]
Faltering growth/body composition: RCT assessed with: Weight z score at hospital discharge	IMPORTANT	⨁⨁◯◯ Low[a,b]
Faltering growth/body composition: RCT assessed with: Head circumference z score at hospital discharge	IMPORTANT	⨁◯◯◯ Very low[a,b,e]
Faltering growth/body composition: RCT	IMPORTANT	⨁⨁◯◯

assessed with: Time to regain birthweight		Low[a,c]
Sepsis - not measured	IMPORTANT	-
Bronchopulmonary dysplasia - not measured	IMPORTANT	-
Retinopathy of prematurity - not measured	IMPORTANT	-
Anaemia of prematurity - not measured	IMPORTANT	-
Cost: cost of intervention, cost of neonatal care and life-long cost: RCT assessed with: Total costs of health service use after initial discharge from hospital and up to 24 months corrected age	IMPORTANT	⨁◯◯◯ Very low[a,e]
Time to full sucking feeds (<0.5 days) - not measured	NOT IMPORTANT	-
Cost: cost of intervention, cost of neonatal care and life-long cost: RCT assessed with: Costs of initial hospital care		⨁◯◯◯ Very low[a,b]

a. Downgraded one level for methodological concerns/risk of bias.
b. Downgraded one level for imprecision. Although this is a large study it is only based in the UK and results may not be generalisable to other settings
c. Downgraded as unable to judge as meta-analysis not possible.
d. Downgraded one level as studies had inconsistent reporting of no effect or increased duration of hospital stay.
e. Downgraded one level for imprecision with confidence intervals crossing the line of no effect

Values

Is there important uncertainty about or variability in how much people value the main outcomes?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Important uncertainty or variability ● Possibly important uncertainty or variability ○ Probably no important uncertainty or variability ○ No important uncertainty or variability	Possibly important uncertainty or variability. **Values for Māori** No data available	

Balance of effects

Does the balance between desirable and undesirable effects favour the intervention or the comparison?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Favours the comparison ○ Probably favours the comparison ● Does not favour either the intervention or the comparison ○ Probably favours the intervention ○ Favours the intervention ○ Varies ○ Don't know	**Slow advancement of enteral feed volumes - moderate certainty of evidence** Uncertain effect for all-cause mortality Probably has little or no effect on NEC **Slow advancement of enteral feed volumes - low certainty of evidence** Reduction in cerebral palsy Longer time to full enteral feeds, longer time to regain birthweight Uncertain effect on adverse effects (feeding intolerance); neurodevelopmental impairment (hearing impairment); survival without severe neurodevelopmental disability at 24 months No effect on faltering growth/body composition (weight z score at discharge **Slow advancement of enteral feed volumes - very low certainty of evidence** Uncertain effect on duration of initial hospital stay, neurodevelopmental impairment (cognitive impairment, visual impairment), No effect on faltering growth/body composition (head circumference z score discharge) **Balance of effects for Māori** No additional data	Low certainty evidence of an increased risk of neurodevelopmental impairment at 24 months in the 1 trial (the SIFT trial) that reported this outcome. Additionally, the SIFT trial found an increased risk of moderate to severe motor impairment in the faster feed advancement group. These findings need to be interpreted with extra caution for three reasons. Both fast and slow groups in the SIFT trial had about 200 participants that were lost to follow-up and did not complete the neurodevelopment assessment. As the neurodevelopment status of this substantial portion of participants was unavailable, we should be careful in interpreting the finding and drawing conclusions. There was no significant difference in the primary outcome of survival without moderate or severe neurodevelopmental disability at 24 months in the SIFT trial. These findings are from a single trial and may have occurred by chance as it was 1 of many secondary outcomes assessed and was not a prespecified trial outcome.

Resources required

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Large costs ○ Moderate costs ● Negligible costs and savings ○ Moderate savings ○ Large savings ○ Varies ○ Don't know	**Parenteral nutrition costs** $55 to $105 per day, depending on region and policies for hang time. **Enteral nutrition costs at 180 mL/kg/day $2 to $62 per day, depending on feed type** Term infant formula $2 to $5 per day Preterm infant formula $6 to $15 per day Fortified mother's own milk (fortifier $3.75 per 100 mL) $5.80 to $9 per day Pasteurised donor milk from a Milk Bank ($16 per 100 mL) $29 to $43 per day Fortified donor milk from a Milk Bank ($23 per 100 mL) $42 to $62 per day **Slower feed advancement costs $10 to $103 per extra day on parenteral nutrition, depending on feed type** **Resources required for Māori**	

	No additional data	

Certainty of evidence of required resources

What is the certainty of the evidence of resource requirements (costs)?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Very low ○ Low ● Moderate ○ High ○ No included studies	A formal assessment of the certainty of evidence of the cost was not undertaken. **Certainty of evidence of required resources for Māori** No additional data	

Cost effectiveness

Does the cost-effectiveness of the intervention favour the intervention or the comparison?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Favours the comparison ○ Probably favours the comparison ○ Does not favour either the intervention or the comparison ○ Probably favours the intervention ○ Favours the intervention ○ Varies ● No included studies	There are no studies that assess the specific cost-effectiveness of slower compared with faster feed advancement, particularly in the context of preterm infants. **Cost effectiveness for Māori** No additional data	

Equity

What would be the impact on health equity?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ Reduced ● Probably reduced ○ Probably no impact	**Equity for Māori** Whānau Māori want the very best health outcomes for their pēpi. Whānau Māori experience racism within the health system. When healthcare professionals need to	

○ Probably increased ○ Increased ○ Varies ○ Don't know	provide observations, it is important to ensure that this is communicated with whānau Māori in a mana-enhancing way. **Equity for Pacific families** Pacific infants may experience inconsistent feeding approaches across hospitals, particularly where clinical staffing or guidelines vary. Pacific families may not receive clear explanations about the reasons for feed advancement decisions. Equity requires consistent protocols and culturally inclusive communication that empowers Pacific families to understand and support feeding progression. **Equity for underrepresented groups** Families from migrant or rural communities may be unfamiliar with the concept of feed advancement and its risks or benefits. Without accessible information or consistent care, they may feel anxious or excluded. Standardised guidelines and inclusive education are essential to ensure all infants benefit equally from safe and timely feeding practices.	

Acceptability

Is the intervention acceptable to key interest-holders?

JUDGEMENT	RESEARCH EVIDENCE	ADDITIONAL CONSIDERATIONS
○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	Some parents are concerned when feeds increase at a rate that they perceive as too slow or fast. **Acceptability for Māori** No additional data	

Feasibility

Is the intervention feasible to implement?

Judgement	Research evidence	Additional considerations
○ No ○ Probably no ● Probably yes ○ Yes ○ Varies ○ Don't know	Faster advancement of enteral feeds requires the production of sufficient expressed breastmilk. **Feasibility for Māori** No additional data	

Summary of judgements

	JUDGEMENT						
DESIRABLE EFFECTS	**Trivial**	Small	Moderate	Large		Varies	Don't know
UNDESIRABLE EFFECTS	Trivial	**Small**	Moderate	Large		Varies	Don't know
CERTAINTY OF EVIDENCE	Very low	**Low**	Moderate	High			No included studies
VALUES	Important uncertainty or variability	**Possibly important uncertainty or variability**	Probably no important uncertainty or variability	No important uncertainty or variability			
BALANCE OF EFFECTS	Favours the comparison	Probably favours the comparison	**Does not favour either the intervention or the comparison**	Probably favours the intervention	Favours the intervention	Varies	Don't know
RESOURCES REQUIRED	Large costs	Moderate costs	**Negligible costs and savings**	Moderate savings	Large savings	Varies	Don't know
CERTAINTY OF EVIDENCE OF REQUIRED RESOURCES	Very low	Low	**Moderate**	High			No included studies
COST EFFECTIVENESS	Favours the comparison	Probably favours the comparison	Does not favour either the intervention or the comparison	Probably favours the intervention	Favours the intervention	Varies	**No included studies**
EQUITY	Reduced	**Probably reduced**	Probably no impact	Probably increased	Increased	Varies	Don't know
ACCEPTABILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know
FEASIBILITY	No	Probably no	**Probably yes**	Yes		Varies	Don't know

Type of recommendation

Strong recommendation against the intervention	**Conditional recommendation against the intervention**	Conditional recommendation for either the intervention or the comparison	Conditional recommendation for the intervention	Strong recommendation for the intervention
○	●	○	○	○

References

1. Oddie, S.J.; Young, L.; McGuire, W. Slow advancement of enteral feed volumes to prevent necrotising enterocolitis in very low birth weight infants. *Cochrane Database Syst. Rev.* **2021**, *8*, Cd001241, doi:10.1002/14651858.CD001241.pub8.
2. Yang, W.C.; Fogel, A.; Lauria, M.E.; Ferguson, K.; Smith, E.R. Fast feed advancement for preterm and low birth weight infants: A systematic review and meta-analysis. *Pediatrics* **2022**, *150*, doi:10.1542/peds.2022-057092G.
3. Dorling, J.; Abbott, J.; Berrington, J.; Bosiak, B.; Bowler, U.; Boyle, E.; Embleton, N.; Hewer, O.; Johnson, S.; Juszczak, E., et al. Controlled trial of two incremental milk-feeding rates in preterm infants. *N Engl J Med* **2019**, *381*, 1434-1443, doi:10.1056/NEJMoa1816654.
4. Tahir, W.; Monahan, M.; Dorling, J.; Hewer, O.; Bowler, U.; Linsell, L.; Partlett, C.; Berrington, J.E.; Boyle, E.; Embleton, N., et al. Economic evaluation alongside the Speed of Increasing milk Feeds Trial (SIFT). *Arch Dis Child Fetal Neonatal Ed* **2020**, *105*, 587-592, doi:10.1136/archdischild-2019-318346.

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