



*The Infant Feeding Strategy
& Action Plans
Greater Glasgow and Clyde
NHS Board
October 2007 – October 2009*

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1. The Introduction and Overview

1.1 The Aim of the Infant Feeding Strategy is to Promote and Support Optimal Nutrition for Babies and Infants in the 0-2 Year Range.

- *To increase breastfeeding initiation and maintenance rates at all time points.*
- *To increase the incidence of exclusive breastfeeding until around 6 months.*
- *To improve practices associated with formula feeding and use of suitable milks.*
- *To increase the incidence of mothers introducing solids later at around 6 months.*
- *To increase the incidence of appropriate vitamin supplementation.*

Good nutrition has a major role to play in promoting public health and reducing inequalities. Breastfeeding can make a major contribution to an infant's health and development and it is associated with better health outcomes for the mother; reducing her incidence of breast and ovarian cancer, osteoporosis and obesity and its associated diseases (diabetes, hypertension and heart disease). It has long term health benefits for the child including; reduced incidence of gastroenteritis, otitis media, urinary tract infections, obesity, eczema, asthma and diabetes¹³³.

Some of the Board's priority health improvement areas could be partially met by increasing breastfeeding rates. *It has been clearly demonstrated that even children from the most affluent families who are formula fed are less healthy as teenagers and show worrying markers of poor, long term health than children from the poorest families who are breastfed.* There remains a great deal of work to do towards reducing the gap in health inequalities but improving child nutrition would be a huge step in the right direction. Over the last decade Glasgow and Clyde has been proactive in implementing successful Breastfeeding Strategies. This new strategy will continue much of this work but also expand the remit to all nutrition for children in the 0-2 year range.

1.2 The Responsibility and accountability for implementing the Infant Feeding Strategy is clearly identified below:-

- Directors of CHP's, Director of Mental Health Partnership, Director of Women & Children's Directorate and Board Nurse Director
- A variety of health care staff and managers across the Board area e.g. midwives, health visitors, dieticians, pharmacists, GP's, paediatricians, neonatologists, nurses, support staff, social workers, mental health and addictions staff.
- Leads for pre registration and under graduate Health Professional Education

1.3 The Role of Glasgow and Clyde NHS Board

The Board has appointed an Infant Feeding Coordinator and team of Advisors to assist with the delivery of this Strategy and enable its partners to implement the objectives. The team of Advisors will use their expertise to assist local teams to implement the action plans and set local targets. Each service will have a named link Advisor. This team will work towards increasing staff capacity and capability and improving processes and communication. There are core services that require expertise which this team will provide i.e. staff training, audit, policy and guideline development and expert support at breastfeeding clinics. The team will carry out much of the project work of the strategy sub groups and disseminate good practice. ***However the ultimate responsibility for achieving these objectives lies with the directors and clinical leads within each service.***

1.4 The Objectives of the Strategy;

1. **To Increase the Capacity and Capability of Health Professionals**
2. **To Develop a Centrally Coordinated, Standardised System of Collecting and Disseminating Infant Feeding Data, Quality Outcomes and Practice Audit**
3. **To Promote and Enhance Public Acceptability of Breastfeeding**
4. **To Promote Optimal Nutrition for Formula feeding babies and all infants when Introducing Solid Foods and Establishing Lifelong Healthy Eating Habits**

1. To Increase the Capacity and Capability of Health Professionals;

- By educating professionals and designing processes that deliver a service that can promote optimal nutrition for infants and improve the patient journey to that end.
- By implementing, achieving accreditation and maintaining the UNICEF UK Baby Friendly Initiative³ standards for maternity Units⁴, Community⁵ Health Partnerships Education⁶ providers and Neonatal Units⁷.
- By continuing to develop and review service policies and procedures to ensure that they actively support breastfeeding and optimal nutrition.
- By providing breastfeeding training for all staff that have contact with pregnant women and or breastfeeding mothers at an appropriate level for each staff group. There will be a consistent approach and standard across the board, and this will be regularly evaluated, reviewed and updated.
- By developing and supporting staff to be able to provide evidence based information, skilled clinical and positive emotional support for parents whilst establishing and maintaining breastfeeding and throughout the establishment of good eating habits.

2. To Develop a Centrally Coordinated, Standardised System of Collecting and Disseminating Infant Feeding Data, Quality Outcomes and Practice Audit;

- By collecting data about breastfeeding initiation and maintenance, formula feeding and weaning practices through a centrally coordinated system.
- By collecting information on the quality of the patient experience using measurable quality indicators and identifying risk.
- By providing comprehensive information throughout the board area to inform and direct future action plans and resources.

2. To Promote and Enhance Public Acceptability of Breastfeeding;

- By developing and implementing a multi-agency approach to all services; working together to promote and support breastfeeding.
- By developing and implementing educational tools for schools and nurseries to promote the benefits of breastfeeding and public acceptability of breastfeeding as the norm.
- By implementing programs which raise public awareness of the benefits and public acceptability of breastfeeding.
- By further developing and implementing human resources policies and suitable facilities for staff who return to work whilst breastfeeding within the public and private sector.
- By targeting resources into areas with low breastfeeding rates with a view to facilitating peer volunteer support networks and peer support groups.

4. To Promote Optimal Nutrition;

- *for infants when parents cannot or choose not to breast feed*
- *throughout the period of weaning and whilst establishing lifelong eating habits*
- By providing nutrition training for appropriate staff. There will be a consistent approach and standard across the Board, and this will be regularly evaluated, reviewed and updated.
- By developing and supporting staff to be able to provide evidence based information, skilled clinical support and positive emotional support for parents whilst establishing and maintaining formula feeding and throughout the establishment of good eating habits⁸.

1.5 Breastfeeding - How are we doing so far?

Glasgow and Clyde has breastfeeding rates at 6 weeks of 34.1% (2006) below the national average of 36.3%. This reduced initiation and maintenance of breastfeeding is of growing concern especially in disadvantaged groups and is a prime example of the gap in health inequalities.

Best Practice; It is recommended that mothers exclusively breastfeed for around 6 months and then continue for two years and beyond.

Exclusive Breastfeeding at 7 days (Guthrie card data by Maternity Unit (%))	2000	2001	2002	2003	2004	2005	2006
Inverclyde Royal Hospital, Greenock	34.4	38.6	37.3	31.9	29.6	*	*
Princess Royal Maternity	30.4	29.0	35.1	34.6	34.0	34.5	33.9
Queen Mother's Hospital,	49.6	48.6	51.0	49.4	50.2	49.1	45.9
Royal Alexandra Hospital, Paisley	39.2	41.4	44.7	44.4	41.3	39.2	38.0
Southern General Hospital,	43.7	43.1	46.7	48.4	45.2	47.2	44.0
Vale of Leven, Dumbarton	45.6	41.8	39.7	*	65.6	*	*
SCOTLAND	44.3	43.2	45.5	45.1	45.0	45.4	43.9

* Data is not available

Breastfeeding Rates (exclusive & mixed)at 6 weeks by CHP ⁹	2001	2002	2003	2004	2005	2006
East Dunbartonshire CHP	44.4	46.9	45.3	47.9	46.6	45.7
East Glasgow CH&CP	16.2	19.3	17.0	19.0	21.4	21.7
East Renfrewshire CH&CP	47.2	49.3	49.7	47.0	51.3	47.5
Inverclyde CHP	26.4	26.8	22.7	25.8	25.4	23.8
North Glasgow CH&CP	28.0	28.9	29.9	31.6	36.6	31.7
Renfrewshire CHP	31.4	32.5	32.2	32.2	29.6	32.1
South West Glasgow CH&CP	30.3	28.3	31.7	29.4	30.8	31.0
South East Glasgow CH&CP	38.9	42.5	39.9	43.4	46.4	46.9
South Lanarkshire CHP	28.9	30.4	31.1	30.5	29.4	29.1
West Dunbartonshire CHP	26.4	25.9	25.3	24.9	24.7	20.0
West Glasgow CH&CP	40.9	44.0	46.5	44.1	44.1	45.9
NHS Greater Glasgow & Clyde	32.7	34.4	33.8	34.2	35.0	34.1
All participating NHS Boards in Scotland	35.2	36.4	36.1	35.7	37.2	36.3

Why are breastfeeding rates so low?

The reasons for not initiating breastfeeding are multifaceted and include the influence of society and cultural norms. Mothers do not maintain it for the same reasons but also because of clinical problems¹⁰. The organisation of health services and the lack of consistent and effective support for breastfeeding can cause or exacerbate these issues. To improve breastfeeding rates a

sustainable, coordinated approach is needed requiring effective partnerships between statutory, voluntary and community services¹¹. This strategy highlights a vision of the multi-agency action that is required to promote and protect breastfeeding in Glasgow and Clyde. It is based on the best available current evidence.

1.6 Formula feeding -how are we doing so far¹⁰?

Best Practice; Where parents choose not to breastfeed or it is not possible then exclusive whey based formula milk is recommended for the first year.

We do not have precise data for local formula feeding practices, however the Infant Feeding Survey 2005¹² said;

- Three-quarters of all mothers had given their baby milk other than breast milk by the age of six weeks, this proportion rising to 92% by six months.
- About half of all mothers had given their baby casein based follow-on milks.
- Just under half of all mothers who had prepared powdered infant formula in the last seven days had not followed the key recommendations for preparing formula.
- Anecdotally, local health professionals are reporting common use of casein based milks and increasingly associated referrals to dietetic services and “constipation” clinics. Over feeding and obesity are common.

1.7 Introduction and Establishment of Complementary foods (weaning) how are we doing so far¹⁰?

Best Practice; Weaning foods should be introduced at around 6 months. Additional vitamin supplements should be given according to current recommendations. Healthy eating patterns and appropriate food and drinks should be established during the weaning process and continued into childhood to meet changing nutritional and developmental needs.

The Infant Feeding Survey 2005¹² said; that there has been a marked trend towards mothers introducing solid foods later. In 2000 85% of mothers had introduced solid foods too early (by four months) but by 2005 this figure had fallen to 51%. Only a negligible proportion of mothers (2%) were delaying weaning onto solids until six months.

- Later introduction of solids tended to be guided by professional advice such as the health visitor and written sources. The decision for earlier weaning was likely to be based on informal advice from friends, family and subjective criteria such as whether the baby seems satisfied with milk feeds and the mother’s previous experience.
- There is some local data but no Infant Feeding Survey results for vitamin Supplements; Each year a significant number of children show evidence of rickets in Glasgow and Clyde. Work is currently under way to identify the causes. Although some of the children had major underlying illnesses, some were healthy term infants. The guideline around vitamin supplements requires to be more closely complied with and the mechanisms for distribution clarified.

1.8 Strategy Objectives and Prioritisation Overview

Short-term actions / priorities Nov 2007 – May 2008	Medium-term actions / priorities Nov 2007 – Nov 2009	Long-term actions / priorities Nov 2007 – Nov 20 12
<ul style="list-style-type: none"> • Set up a new Infant Feeding Strategy Group, Implementation and Monitoring Group and Sub Groups to oversee and develop the implementation of the Strategy (with appropriate membership, chairpersons, remit, communication mechanisms, objectives, time scales and reporting frameworks). • Roll out Strategy & align health services to the aims and objectives. • Link members of the Infant Feeding advisor team to support services. • Roll out action plans to services and clinical teams / CHP's etc to carry out self assessment of progress within action plans. • Health services to plan actions for prioritised objectives of action plan. • Advisors to assist the implementation of these objectives, including the UNICEF UK Baby Friendly Standards and WHO International Code compliance (includes the cessation of artificial milk promotion within the health service). • Complete the roll out of the board wide Infant Feeding Policy & Guidelines • Update, coordinate and deliver training for staff with clinical responsibility for Infant feeding • Evaluate the models of peer support available and promote the appropriate model(s) (effective, acceptable and sustainable) to individual CHP's. • Service providers to agree uniform data and quality indicator collection, risk management tools and standardised audit tools. 	<ul style="list-style-type: none"> • Action plans within services and clinical teams /CHP's etc to be progressing with objectives within the action plans and achieving prioritised objectives. • Local rates and quality targets to be set and audit of action plans underway. • Strategy sub groups to be developing from implementers of best practice standards to a research and development phase where new evidence is created. • Roll out and align non health sector partners to the Infant Feeding Strategy. • Roll out new action plans to non NHS partners and link members of the Infant Feeding advisor team to services to support services. i.e. develop partnership working with nurseries, schools, universities and the public sector to develop appropriate action plans, implementing standards and teaching tools for these groups. • Review Strategy Action Plans in line with the National Infant Feeding Strategy (when available). • Completion of training for staff who have primary clinical responsibility for feeding • Provision of training for staff that provide secondary clinical responsibility for feeding underway. • Data, quality indicators and action plans to be formed into Clinical Effectiveness Reports, to inform providers and strategy group of progress and reported annually to the Strategy Group and the Health Board. 	<ul style="list-style-type: none"> • Review of membership, structure, workload and effectiveness of groups • Groups to contribute to further setting of local and Board targets and future structure of the Clinical Effectiveness Reports. • Review partners involved in groups; in and outputs • Review of outcomes, effectiveness and evidence for actions and re-write of Strategy Action Plans. • Review achievements in light of the 2010 Infant Feeding Survey (DOH) • Health services and non NHS partners to complete action plans and achieve all objectives. • Health services to all have achieved and be maintaining UNICEF UK accreditation. • Research projects ongoing including searching for further means of promoting optimal feeding within the Board area.

1.9 How will things get better for mothers and babies ?

All mothers will have access;

- to a suitable professional who will offer a one to one discussion on the benefits and management of breastfeeding.
- to effective antenatal classes which prepare them for breastfeeding.
- to antenatal input that is adapted to best suit individual needs
- to breastfeeding promotion in a number of areas, particularly within schools.

All health professionals who advise parents will;

- promote optimal nutrition and be informed, knowledgeable, skilled and appropriately trained
- provide standards based on the UNICEF UK Baby Friendly Initiative
- adhere to the Health Board policy and guidelines which will be evidence based, support optimal nutrition and effective care.
- provide formula feeding mothers with care based on the Boards standards
- participate in the local audit of standards and act on discrepancies.

Parents who encounter feeding difficulties and challenging situations

- will be fully supported by the board staff and given consistent information.
- will be appropriately referred to the most appropriate service
- access to relevant expertise will be provided
- parents views and insight into their experiences will be actively sought

Parents will have access to community based nutritional support;

- from trained health professionals and specialist services
- at breastfeeding workshops
- at breastfeeding support groups
- from peer support volunteers (target groups)
- at weaning fares

How will we know things are better?

Breastfeeding rates will increase at all time points and be measured;

- at birth
- on discharge from hospital
- at two weeks
- at 6 weeks
- at 6 months

There will be improved rates of exclusive breastfeeding at all stages

More Formula feeding mothers will report;

- that they are following recommendations for preparing formula and are choosing more appropriate milks.
- a reduced incidence of vomiting, colic and constipation

Whilst introducing solids more mothers will report;

- that they are waiting until nearer 6 months to introduce solids
- that the incidence of vitamin use is increasing and the incidence of rickets decreasing, particularly in healthy term infants.

Mothers' comments and audits will report improved standards of care;

- more UNICEF Baby Friendly accreditations
- improved audit results
- reduced incidence of breastfeeding problems
- higher satisfaction levels and less complaints
- improved rates of exclusive breastfeeding at all stages
- reduced incidence of high risk events

1.10 Staff Training Plan			
Target Group	Content	How Often	Delivered by
Midwives Health Visitors /Public health nurses Paediatric / Special Care Baby / Child branch nurses Nursery nurses Health visiting staff nurses	2 day revised Mandatory Infant Feeding training and Supervised Clinical Practices Ongoing seminar/updates as identified in audit/ training needs assessment. Mandatory 1 day 3 yearly	10 times a year Within 6 months of employment As identified in training needs assessment	Infant Feeding Advisors and partners Mentors Advisors, partners, key workers and mentors
<u>Medical Staff</u> Obstetrics Paediatrics	1 ½ hrs Board infant feeding policy and guidelines UNICEF 10 step plan/ Neonatal Standards Management of problems	Induction (February-August)	Local trainer
<u>Medical Staff</u> GP's and GP trainees	2 hrs Board infant feeding policy and guidelines UNICEF 7 step plan Potential e-learning tool	Localised arrangements	Infant Feeding Advisors to liaise with local GP trainer
CHCP's, maternity and paediatric facilities Nursing and non nursing staff who have contact with pregnant /breastfeeding mothers School nurses Auxiliaries GP receptionists Practice nurses	2 hrs Board infant feeding policy and guidelines UNICEF 7/10 step Welcome for breastfeeding mothers	To be locally agreed to enable staff to complete training Within 6 months of employment	Infant Feeding Advisors to liaise with local GP trainer
Student Midwives, Health Visitors /Public Health Nursing and Child Branch Nursing	2 day revised Mandatory Infant Feeding training and Supervised Clinical Practices to meet UNICEF Education Standards Updates as identified in training needs assessment	6 times a year To be completed By the end of training	Infant Feeding Advisors and partners (Educators) & Mentors
Medical Students Dieticians and students Pharmacists and students	Still to be determined 2 day revised Mandatory Infant Feeding training and Supervised Clinical Practices to meet UNICEF Education Standards Health Scotland e-learning tool	To be determined by clinical practice sub group	To be determined clinical practice sub group
School teachers Nursery staff	Still to be determined by public acceptability sub group	Still to be determined	Still to be determined

2.0 The Evidence for the Action Plans

- 2.1. Antenatal Care: – Information for Pregnant Women
- 2.2 Information and Support for New Mothers in Hospital
- 2.3 Information and Support for Mothers in the Community
- 2.4 Information and Support for mothers and babies in Paediatric and Neonatal Units
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- 2.6 Introduction and Establishment of Complementary foods (weaning)



Breastfeeding

2.1 Antenatal Care: – Information for Pregnant Women

The Evidence - Effective action recommendations to increase breastfeeding initiation rates (N.I.C.E 2006¹⁰)

- One-to-one needs-based breastfeeding education and peer support programmes should provide information and counseling support in the antenatal period combined with postnatal support to low income women.
- Informal, practical breastfeeding education in the antenatal period should be delivered in combination with peer support programmes to all women.
- A single session of informal, small group and discursive breastfeeding education should include topics like avoiding and resolving nipple pain and trauma, particularly targeting women from minority ethnic groups.
- Breastfeeding education and support from one professional should be targeted to women on low incomes.

What do the mothers say? Infant Feeding Survey (2005¹²)

- First-time mothers, second-time mothers who had breastfed their previous child for six weeks or more, mothers who had been breastfed themselves as infants, and mothers who had friends who breastfed were the most likely to intend to breastfeed. Mothers who intended to breastfeed exclusively fed for longer than mothers who intended to mix breast and formula feeding.
- 80% of mothers had received some advice during their pregnancy about the health benefits of breastfeeding, with midwives being the most common source of such advice. Mothers who had information were more likely than mothers who had not to initiate breastfeeding.
- About a third of mothers had attended antenatal classes and first-time mothers and mothers from managerial and professional occupations were the most likely to attend. Mothers who had attended antenatal classes where feeding was discussed or where they were taught how to position the baby were more likely to intend to breastfeed.

Where are the gaps at present?

- Health Education classes and breastfeeding workshops are generally provided in hospitals and in the community by midwives and a few health visitors. Few are needs based, attendance is low and often not reaching target groups.
- Peer volunteer intervention, on a one to one basis, in pregnancy is available in some areas but it is not provided equitably for all women for whom it may benefit. Mothers in areas where it is available are recruited from deprivation category 5, 6 and 7 and offered input from peer volunteers. The recruitment process is resource intensive but could be refined to more accurately target the appropriate mothers. Other staff groups could assist by referring appropriate mothers.
- There is no input from peer volunteers into local or hospital antenatal groups.
- One to one additional professional input for target mothers is variable.

2.2 Information and Support for New Mothers in Hospital

Evidence; -Effective action recommendations to increase *breastfeeding maintenance* in hospital (N.I.C.E 2006¹⁰)

Most of the recommendations could be achieved by implementing the UNICEF UK Baby Friendly Standards⁴

Hospital practices – to be adopted (these practices have the greatest evidence that they support successful breastfeeding)

- Unrestricted breastfeeding from birth onwards and unrestricted mother-baby contact during the postnatal stay, for all women. Encouraging rooming in and early initiation of breastfeeding.
- Provision of additional, breastfeeding-specific, practical and problem solving support from a health professional should be delivered in the early postnatal period *for all women*.
- Changes in hospital policies to ensure that discharge packs are free from promotion for artificial feeding.
- A review of educational materials and approaches
- Professional training should be undertaken for hospital staff to teach positioning and attachment using a predominantly “hands off” approach in the early postpartum period.
- One-to-one needs-based breastfeeding education in the antenatal period combined with postnatal support through the first year should be available to low income women

Hospital practices – to be abandoned (these practices have the strongest evidence that they are harmful to the establishment of successful breastfeeding).

- Routine supplemental feeds given in addition to breast feeds
- Restriction of the timing and/or frequency of breastfeeds
- Restriction of mother-baby contact from birth onwards during immediate postnatal care.
- The provision of hospital discharge packs containing formula
- Separating healthy babies from their mothers for the treatment of jaundice

What do the mothers say? Infant Feeding Survey (2005¹²) – Key findings

The most common time for mothers to stop breastfeeding is in the first 72 hours (14%). In Scotland an increase in prevalence was seen at birth but the proportion still breastfeeding at six weeks and six months fell in 2005. 38% of mothers who breastfed initially had stopped breastfeeding at six weeks.

Breastfeeding and the birth/experience in hospital; the type of delivery did not have a significant effect on breastfeeding duration. Initiation of breastfeeding was higher for mothers who had early skin-to-skin contact than those who had no such contact after the birth. Babies spending a few days in special care after the birth were less likely than average to be successfully breastfed. Long-term admissions did better.

A third of breastfed babies had received additional feeds in the form of formula, water or glucose while in hospital – this practice was particularly associated with low birth weight babies and those starting life in special care. In about a third of cases, additional feeds had been given because the mother wanted this rather than because this had been advised.

Help in hospital; only 70% of mothers’ breastfeeding in hospital had been shown how to put their baby to the breast in the first few days. Mothers who had received help or advice found this most useful if the helper stayed until the baby had fed.

The problems experienced in hospital; Problems encountered in the very early days by breastfeeding mothers were mainly centered on problems with attachment or failure to feed followed by breast or nipple discomfort. These still featured as problems for mothers after leaving hospital. Mothers introducing or switching to formula milk commented that the babies were not satisfied (24%) or had a medical need for top-ups of formula (18%).

Most Common reasons mothers give up breastfeeding in hospital¹²;

1. Reluctant Feeders
2. Difficult attachment
3. Formula supplement given
4. Skin Contact, none or <30 minutes
5. Roomed out
6. Admission to PD > 2 days
7. Sore Nipples
8. Wt loss > 10%

Where are the gaps at present?

The breastfeeding cessation and incidence of mixed feeding occurs most often in the first 72 hours (14%). Many of the interventions need to be preventative. More effective support needs to be targeted into this period e.g. more intensive input from midwives, Infant Feeding Advisors, peer support volunteers and lay counselors.

5 of the 6 local maternity units are accredited as UNICEF UK Baby Friendly and many of the core principles should be in place. It is clear that these standards are not being met all of the time. The additional support for auditing, maintaining and improving the standards is inequitable across the services.

The likely hood of success is increased by avoiding problems⁴;

- Skin Contact at birth and an early feed
- Teaching positioning and attachment and particularly observing a full breastfeed
- Rooming in
- Demand feeding
- Avoiding Supplements
- Previous successful breastfeeding, > 6 weeks is predictive of future success– so ensure prim gravid have an optimal experience



2.3 Information and Support for Mothers in the Community

Evidence; -Effective action recommendations to increase *breastfeeding maintenance* in the community (N.I.C.E 2006¹⁰) (these practices have the greatest evidence that they support successful breastfeeding)

- Peer support or volunteer counsellor support should be delivered by telephone to complement face-to-face support in the early postnatal period to women who want to breastfeed.
- Additional health professional, breastfeeding-specific, practical and problem solving support should be delivered in the early postnatal period for all women.
- Regular breast drainage and continued breastfeeding should be implemented as routine practice for breastfeeding women experiencing mastitis.
- The combination of supportive care, teaching breastfeeding technique, rest and reassurance should be routine practice for breastfeeding women with '**insufficient milk**'.

What do the mothers say? Infant Feeding Survey (2005¹²) – Key findings

Problems feeding the baby in the early weeks; A third of breastfeeding mothers had experienced some kind of feeding problem either in hospital or in the early weeks after leaving. The highest levels of problems were experienced by mothers who used a combination of breast and formula (around half of all mixed feeding mothers experienced problems). Mothers who did not receive help for these problems were more likely to have stopped breastfeeding within two weeks than those who did.

Prevalence and duration of exclusive breastfeeding; At six months the prevalence of exclusive breastfeeding was negligible (<1%). The prevalence and duration of exclusive breastfeeding was higher at all ages up to four months among mothers from managerial & professional occupations, aged 30 or over and highest education level.

Most common reasons mothers stop breastfeeding in the community¹²;

1. Wouldn't suck/latch on/poor attachment
2. Baby still hungry/not satisfied
3. Needed (top-ups of) formula
4. Baby fed too slowly/ falling asleep/ distracted / Baby not feeding properly/ enough/ not interested
5. Baby vomiting/reflux / Colic/wind
6. Breast milk dried up/not enough / not gaining enough/ lost weight
7. Breastfeeding painful (incl. sore breasts/nipples/ mastitis)

Where are the gaps at present?

Many of the interventions need to be preventative but more effective support needs to be targeted into the early period of establishing breastfeeding e.g. more intensive input from midwives, Infant Feeding Advisors, Health Visitors, peer support volunteers and lay counselors.

There are 3 UNICEF Baby Friendly accreditations in the community⁵ areas of Glasgow and Clyde. These standards need to be achieved for all areas. The additional support for auditing, maintaining and improving the standards is inequitable across the services. This needs to be addressed locally by the CHP's and within the Boards Infant Feeding Team.

The likely hood of success is increased by avoiding problems⁵;

- Skin to skin contact in hospital and home.
- All staff able to **effectively teach** positioning and attachment
- All staff able to **effectively teach** parents how to understand feeding cues, demand feeding, offer both breasts and rooming in.
- Strict guidelines and monitoring of supplements, Staff skilled around issues which avoid parental choice to supplement
- Targeting high risk groups e.g. by providing peer support input and or additional professional led groups and interventions.



2.4 Information and Support for Mothers and Babies in Neonatal Units and Paediatric Hospitals

Evidence; Recommendations to increase breastfeeding initiation and maintenance amongst sick and premature babies. *Effective action recommendations; Breastfeeding in Neonatal Units: A review of publications McInnes R & Chambers J³ (2005)*

Breastfeeding is associated with significant health advantages for the low birth weight infant and the mother; however, they are less likely to be breastfed than their term counterparts. The evidence base for practices that support breastfeeding in the neonatal unit is more limited than the term evidence base and as preterm or sick babies experience different feeding challenges it may not be helpful to extrapolate findings to them. The above report is a systematic review of interventions that affect breastfeeding in neonatal units.

- **Skin to Skin Contact and Kangaroo Mother Care;** the largest evidence base was for Kangaroo Mother Care where studies consistently demonstrated advantages for the infant in terms of physiological stability, reduced morbidity and improved breastfeeding. This may have the greatest potential to impact neonatal stability, parental attachment and breastfeeding and therefore it should take priority for development. It promotes increases in breastfeeding amongst low birth weight infants especially in countries where breastfeeding is less prevalent.
- **Teats, Dummies and Cups;** Cup feeding was found to have no significant risks and may offer advantages in terms of physiological stability. There is some evidence of a positive impact on breastfeeding. Infants who received supplements by bottle appeared to have the poorest breastfeeding outcomes. The use of dummies for Non Nutritive Sucking has little evidence base for their use for preterm infants, in terms of feeding ability but not currently there is no evidence that they are associated with any adverse effects in terms of breastfeeding duration.
- **Expressing Breast Milk;** hand expressing is recommended, starting as soon after the birth as possible, expressing *at least* 6-8 times in 24 hours including *at least* once at night. When the breasts begin to fill, at around 3-5 days after delivery the mother can continue to hand express and or use an electric or hand breast pump. She should continue to use a massage technique prior to and during expressing to increase hormone release. Double pumping is preferred to sequential pumping (electric pumps). Even though hand pumps are preferred by some mothers the purchase or hire requires motivation and has cost implications and it may not convey a sense of necessity or medical support to express amongst some parents. Therefore units should be cautious about a move to recommending hand pump for all parents.
- **Fortifiers v Preterm Formulae;** parents preferred powder additives and infants who had powder additives tended to be breastfed for longer. Parents were more satisfied with the growth with liquid supplements (although weights were not statistically significant and may be driven by professional attitudes). Current fortification practice is generally driven by individual paediatricians or units preferences. A balance needs to be struck between the many benefits of breastmilk use and the likelihood of increasing breastfeeding duration without compromising long term growth.

Food, Fluid and Nutritional Care in Hospitals¹⁴

The effective delivery of food and fluid, and the provision of high quality nutritional care, are crucial for the wellbeing of patients in all hospitals. The NHS Quality Improvement Scotland (NHS QIS) Food, Fluid and Nutritional Care in Hospitals Project Group developed six standards which bring together the patient at all stages in the journey of care, with the processes of planning, preparing and delivering food and fluid. The overall performance assessment statements are underpinned by criteria that are mapped directly from each standard.

- **Standard 1 - Policy and Strategy;** Each NHS Board has a policy, and a strategic and co-ordinated approach, to ensure that all patients in hospitals have food and fluid delivered effectively and receive a high quality of nutritional care.
- **Standard 2 - Assessment, Screening and Care Planning;** Processes and procedures for assessment, screening and care planning are being implemented and monitored fully, and there is a cycle of continuous monitoring of implementation and impact on patient care throughout the Board area. When a person is admitted to hospital, an assessment is carried out. Screening for risk of under nutrition is undertaken, both on admission and on an ongoing basis. A care plan is developed, implemented and evaluated.
- **Standard 3 - Planning and Delivery of Food and Fluid;** There are formalised structures and processes in place to plan the provision and delivery of food and fluid. There are formalised structures and processes in place to plan the provision and delivery of food and fluid.
- **Standard 4 - Provision of Food and Fluid to Patients;** Food and fluid are provided in a way that is acceptable to patients.
- **Standard 5 - Patient Information and Communication;** Patients have the opportunity to discuss, and are given information about, their nutritional care, food and fluid. Patient views are sought and inform decisions made about the nutritional care, food and fluid provided.
- **Standard 6 - Education and Training for Staff;** A Board nutrition awareness, education and training programme is being implemented and monitored fully, and there is a cycle of continuous monitoring of implementation and impact on patient care throughout the Board area.

Where are the gaps in Neonatal Services at present?

- The UNICEF UK Neonatal Standards are available; however they cannot be externally assessed and accredited as yet. There has been less awareness raising amongst staff although the neonatal units have many of these standards in place because of the similar maternity standards. The Paediatric sites are the acute area that needs most attention. The additional support for auditing, maintaining and improving the standards has not been available consistently. This needs to be addressed by the individual services.
- Many of the interventions need to be proactive and more effective support needs to be targeted into the early period of establishing lactation then breastfeeding e.g. more intensive input from midwives, Infant Feeding Advisors, Health Visitors, peer support volunteers and lay counselors.
- The Food, fluid and nutrition standards are being implemented but much work is still required for all of the standards to be met.

Formula Feeding

2.5 Supporting Mothers who choose to formula feed or who cannot breastfeed.

What do the mothers say? Infant Feeding Survey (2005¹²) – Key findings

- **Formula milk use;** Three-quarters of all mothers had given their baby milk other than breast milk by the age of six weeks, this proportion rising to 92% by six months. Mothers from managerial and professional occupations and older mothers were the most likely to introduce milk other than breast milk at a later age, which reflects the higher levels of breastfeeding amongst these babies. About half of all mothers had given their baby follow-on milk. Mothers from routine and manual occupations, mothers who had never worked, and mothers with the lowest education level were more likely than average to say they had given their baby follow-on at an earlier age.
- **Preparation of feeds;** Just under half of all mothers who had prepared powdered infant formula in the last seven days had not followed the key recommendations for preparing formula: either by not always using boiled water that had cooled for less than 30 minutes or not always adding the water to the bottle before the powder. About a third of mothers did not follow the recommendations for preparing formula when away from the home, either by not keeping pre-prepared formula chilled or by using cold or cooled water when making up feeds.
- **Formula-feeding mothers with problems;** These mothers were particularly likely to mention that the baby fed too slowly (30% compared with around one in ten mothers breast or mixed feeding) or that the baby suffered from vomiting/reflux (15% compared with 1% breastfeeding and 2% mixed feeding).
- **After leaving hospital, the main problems** experienced by mothers formula-feeding were related to the health of the baby: vomiting (27% compared with 4% of breastfeeding babies and 6% for mixed feeding) and colic/wind (27% compared with 8% breastfeeding & 6% mixed feeding).

Preventing Formula Feeding Problems

- Many of the interventions need to be preventative and support needs to be most available in the early days and weeks.
- Promoting breastfeeding in the antenatal period
- Recommending skin contact and an early feed
- Teaching how to bottle feed, choosing appropriate teats and bottles and winding the baby effectively. Explaining demand feeding and avoiding overfeeding
- Demonstrating how to sterilise equipment, make up feeds correctly and discussion on appropriate milk choices.

Where are the gaps at present?

- Without precise local data and practice audit it is difficult to determine where we are. From reports in a variety of areas, there are comments that professionals remain very unclear about giving correct information to parents. Many feel that access to formula milk companies has reduced this. The Infant Feeding Policy and Guidelines¹⁵ have a nutrition sub group which has been providing accurate information since 2003 but staff awareness of this is limited. A more proactive approach to information dissemination, awareness raising and staff training is required.

Weaning

2.6 Introduction and Establishment of Complementary foods (weaning)

Introducing solids -What do the mothers say? Infant Feeding Survey (2005¹²) – Key findings

- **Age of introducing solid foods;** There has been a marked trend towards mothers introducing solid foods later in 2005. For example, in 2000 85% of mothers had introduced solid foods by four months, but by 2005 this figure had fallen to 51%. Only a negligible proportion of mothers (2%) were following Department of Health guidelines in accordance with their precise interpretation - that is to delay weaning onto solids until six months. *Later introduction of solids tended to be guided by professional advice such as the health visitor and written sources*, whilst the decision for earlier weaning was likely to be based on informal advice from friends, family and subjective criteria such as whether the baby seems satisfied with milk feeds and the mother's experience.
- **Solid foods given and avoided;** When babies were four to six months, mothers giving solids were much more likely to provide commercially-prepared foods than home-prepared foods in their babies' daily diets. Compared with 2000, higher proportions of mothers in 2005 said they avoided the use of salt, nuts and honey in their babies' diets. A greater awareness of food allergies in 2005 was one of the key reasons behind these shifts
- **Local guidance on establishing healthy eating habits for life** (See Glasgow and Clyde Infant Feeding Policy and Guidelines¹⁵). There is no clear evidence on local progress towards the objectives. By 12 months the diet of infants should have a variety of foods with appropriate textures, quantity, frequency and variety to meet changing nutritional and developmental needs. In the second year of life self feeding should be established in a family mealtime setting offering home prepared, nutritious foods, limiting high fat, high sugar and convenience foods and drinks.
- **Preventing ongoing feeding problems requires** interventions which are support good practice. Support needs to be available prior to the period of likely introduction of solids and again proactively to chart progress towards family foods and lifetime eating habits; By promoting 6 months exclusive milk feeding in the antenatal and postnatal period and by teaching how to make and offer nutritious and appropriate foods at different stages. Parents need education on the basic nutritional principles and how to avoid overfeeding, faddy diets and unhealthy eating habits.
- **Vitamin Supplements;** There is some local data but no Infant Feeding Survey results for vitamin Supplements; Each year a significant number of children show evidence of rickets in Glasgow and Clyde. Work is currently under way to identify the causes. Although some of the children had major underlying illnesses, some were healthy term infants. The guideline around vitamin supplements requires to be more closely complied with and the mechanisms for distribution clarified.

Where are the gaps at present?

- Without precise local data and practice audit it is difficult to determine where we are. From professionals in a variety of areas, there are reports that staff remains unclear about giving correct information to parents. The Infant Feeding Policy and Guidelines have nutrition sub group have been providing accurate information since 2003 but staff awareness of this is limited. A more proactive approach to information dissemination, awareness raising and staff training is required.

Section 3. The Action Plans

- 3.1 Policy and Guideline Implementation and Staff training – for all areas
- 3.2 Audit and data collection –for all areas
- 3.3 Antenatal Care: – Information for Pregnant Women – for all areas
- 3.4 Postnatal Care in Hospital and by Community Midwives at Home –for Maternity Units
- 3.5 Information and Support for Mothers in the Community- for Community Health Partnerships
- 3.6 Information and Support For infants in Neonatal Units and Paediatric Hospitals

Each action plan relates to a particular aspect of the parents journey. It is recommended that individual services work with the appropriate action plan or plans relating to the care they provide

- The plans require to be localised according to local needs and are designed to be dynamic, to be developed and to evolve with time.
- Action plans include all of the elements which will lead to readiness for UNICEF Baby Friendly assessment and accreditation. **This is the Board's priority recommendation.**
- The Board Infant Feeding Advisors are available to assist services to complete self assessments, develop the action plans and assist with the implementation. UNICEF requires an action plan to be completed as part of the staged approach to accreditation. As a board we can apply for some of these stages as a whole board or in groups (much more likely as many areas are at different stages). UNICEF can provide an action planning visit or your local attached advisor can work with your team to complete this. The UNICEF action plan will only cover the points in the action plan which relate to their standards.
- There are a number of core services provided by the Board team to enable a simpler, more coordinated and effective implementation of the action plans objectives including;
 - Staff training packages and delivery of training.
 - A Board wide Infant Feeding Policy and Guidelines
 - Audit tools and audit training for local staff
 - Standardised implementation tools, data collection and analysis



Action Plan 1. – For all areas

- Actions designed to Increase Capacity and Capability of Health Professionals across the Board area

3.1 Policy and Guideline Implementation and Staff training			
Standards and Criteria	Actions to be undertaken	By Whom and timescales	Criteria met / not met /date
<p>Implement the UNICEF UK Baby Friendly Standards (see appendix 1,2 & 3)</p> <p>3.1.1 Policy (Step 1 /point 1.)</p> <ul style="list-style-type: none"> a. <i>Display parents' guide to the policy and provide full policy copies for users on request</i> b. <i>Develop a written curriculum for orientation of for new staff (including new medical staff) to the G & C Infant Feeding Policy and Guidelines.</i> c. <i>All staff to be orientated to the policy based on this curriculum.</i> <p>3.1.2. Staff Training (Step 2 /point 2.) (See the Training Plan)</p> <ul style="list-style-type: none"> a. <i>Key Workers to be educated to facilitate Supervised Clinical Practice (SCP), policy orientation and short education sessions.</i> b. <i>Key workers to be available in each clinical area.</i> c. <i>Key workers to carry out clinical practices with staff in their allocated areas. Key workers to have an ongoing, updating programme.</i> d. <i>Staff to be booked to have the appropriate mandatory Infant Feeding Training and appropriate clinical staff to have mentored Supervised Clinical Practice (SCP) within 6 months of starting a new post. Workbook should be completed within this 6 month period.</i> e. <i>Training programme will be provided as a core board service and will be updated according to recommendations and evidence.</i> f. <i>Standard programme will be available to all staff and the public for comment. Training will be evaluated at least annually.</i> g. <i>A schedule for staff who has already received training will be completed to ensure they are updated at least every 3 years and complete SCP in workbook again. Staff updates to be locally based on audit discrepancies.</i> 			

<p>b. <i>Provision of skills training for all midwives, neonatal nurses, health visitors and support staff in skills necessary to support mothers with positioning and attachment and hand expression of breastmilk.</i></p> <p>i. <i>Professional training should be undertaken for hospital staff to teach positioning and attachment using a predominantly “hands off” approach with women in the early postpartum period with all women.</i></p> <p>j. <i>All staff orientation, training and SCP should be recorded in central record / database.</i></p>			
<p>3.1.3 International Code Compliance (no promotion of breastmilk substitutes, bottles, teats or dummies)</p> <p>a. <i>Check all areas and written materials including Bounty packs 4-6 weekly to ensure that they are WHO International Code compliant.</i></p> <p>b. <i>Ensure only appropriate formula feeding information is disseminated</i></p>			
<p>3.1.4. Mandatory staff training to support;</p> <ul style="list-style-type: none"> • formula feeding for babies and children with whose mothers cannot or choose not to or who stop breastfeeding • for community and children’s hospital based staff to support weaning and establishment of healthy eating habits. • for children’s hospital based staff to support the Food, fluid and Nutrition standards <p>a. <i>Staff to be booked to have the appropriate mandatory Infant Feeding Training within 6 months of starting a new post.</i></p> <p>b. <i>Training will support exclusive milk feeding for around 6 months.</i></p> <p>c. <i>Training programme will be provided as a core board service but will be updated according to recommendations and evidence.</i></p> <p>d. <i>Standard programme will be available to all staff and the public for comment.</i></p> <p>e. <i>Training will be evaluated at least annually.</i></p> <p>f. <i>Complete a schedule for staff who has already received training to ensure they are updated at least every 3 years. Staff updates to be locally based on audit discrepancies.</i></p>			

Action Plan 2. – For all areas

- Actions designed to provide Evidence of Improved Outcomes and Standards of Care

3.2 Audit and data collection			
Standards and Criteria	Actions to be undertaken	By Whom and timescales	Criteria met / not met /date
<p>Total Quality Improvement Audit</p> <p>3.2.1 Maintenance of standardised feeding statistics</p> <ul style="list-style-type: none"> ○ <i>Antenatal checklist completion</i> ○ <i>Feeding at birth</i> ○ <i>Feeding at discharge from hospital</i> ○ <i>Feeding at 2, 6, 12 and 26 weeks</i> ○ <i>Breastfeeding - supplementation rates</i> <ul style="list-style-type: none"> a. Staff to complete statistical tools b. Compliance to be monitored locally c. Results to influence local feeding targets <p>3.2.2 Audit to contribute to staff development;</p> <ul style="list-style-type: none"> a. Development of a peer review system for staff to examine poor feeding outcomes b. Provide clinical effectiveness reports annually (results from audits, risk assessment, quality monitoring and incident monitoring). c. Staff development to be influenced by Clinical Effectiveness reports d. Improve feedback for parents <p>3.2.3 Quality Indicators</p> <ul style="list-style-type: none"> a. <i>Implement routine face to face / telephone audit tool to measure standard implementation.</i> b. <i>Audit tool should cover all of the UNICEF UK BFI standards at least annually.</i> c. <i>Develop strategies to identify and monitor problems and risk e.g. feed charts & audit tools – continual audit</i> d. <i>Feeding Advisors & local teams to complete annual face to face audit, feedback to local staff on standards of antenatal information giving, staff skills & postnatal support.</i> e. <i>Monitor quality indicators and re-train staff to improve clinical outcomes. Staff updates to be designed to meet deficiencies.</i> f. <i>Quality Indicators to be based on the Infant Feeding Survey Findings;</i> <p>3.2.4 Risk management</p> <ul style="list-style-type: none"> a. Implement an incident monitoring system b. Provision of debriefing for parents who have difficult feeding experiences. 			

Action Plan 3. – For all areas

- Actions designed to increase the initiation of and prepare parents for the reality of breastfeeding

3.3 Antenatal Care: – Information for Pregnant Women			
Standards and Criteria	Actions to be undertaken	By Whom and timescales	Criteria met / not met /date
<p>Implement the UNICEF UK Baby Friendly Standards; Step 3/ point 3</p> <p>3.3.1 Provision of information on health benefits and management of breastfeeding to all pregnant women</p> <ul style="list-style-type: none"> a. <i>Health professionals to have a discussion on a 1:1 basis with all mothers on the benefits and management of breastfeeding prior to 32 weeks.</i> b. <i>Agreed written information should be given.</i> c. <i>An antenatal checklist should be completed for all mothers</i> d. <i>Professionals to further target those mothers greatest need.</i> e. <i>Peer support volunteers to target appropriate groups</i> 			
<p>3.3.2 Ensure all professionals who provide this antenatal care; midwives, health visitors, GP's, obstetricians, students & support staff have had specific training to enable them to deliver this effectively.</p> <ul style="list-style-type: none"> a. <i>Ensure the appropriate teaching is within the standard Infant Feeding Curriculum for all staff that has responsibility for provision of this information.</i> b. <i>Design updates for staff who deliver antenatal care.</i> c. <i>Integrate training into pre registration training</i> 			
<p>3.3.3 Develop a coordinated approach between health professionals to ensure all mothers receive this information</p> <ul style="list-style-type: none"> a. <i>At action planning stage discuss and decide who will take the lead in providing / or ensuring this information is provided, proactively.</i> b. <i>Review situations where this information could be opportunistically given.</i> 			
<p>3.3.4 Provide a written description of the minimum information provided for pregnant women at antenatal visits, classes & workshops</p> <ul style="list-style-type: none"> a. <i>Design standards for information giving sessions.</i> b. <i>Implement written standards for antenatal information giving</i> 			

<p>3.3.5 Review provision of antenatal breastfeeding workshops</p> <ul style="list-style-type: none"> a. <i>Infant Feeding Advisors to carry out a city wide review of provision</i> b. <i>CHCP planning group to review local needs</i> c. <i>Review equity and accessibility of service provision and uptake i.e. consider combining midwifery, health visiting and peer volunteers to provide workshops in each CHP.</i> 			
<p>3.3.6 Review provision of antenatal education needs of specific target groups;</p> <ul style="list-style-type: none"> a. <i>Consider specific additional needs based provision for target groups, i.e. young pregnant mothers, ethnic groups, partners, families and supporters, pregnant diabetics, multiple pregnancy & fetal abnormality,</i> b. <i>Develop needs based provision for these groups. Consider developing programs in conjunction with other agencies which may be more acceptable to particular groups.</i> c. <i>Develop informal, practical breastfeeding education in the antenatal period to be delivered in combination with peer support volunteer programs</i> d. <i>Extend invitations to pregnant mothers to attend postnatal breastfeeding support groups</i> 			
<p>3.3.7 Ensure Effectiveness and accuracy of written materials and WHO International Code Compliance</p> <ul style="list-style-type: none"> a. <i>Review resources locally and at Board level</i> 			
<p>Evidence from the NICE¹⁰ Review (2006)</p> <p>3.3.8 Preparation for Birth</p> <ul style="list-style-type: none"> a. <i>Type of analgesia used in labour and at delivery and it's potential effect on breastfeeding outcome should be discussed with parents</i> 			



Action Plan 4. – For Maternity Units

- f. Actions designed to increase the initiation and maintenance of breastfeeding rates within maternity units
- g. Actions designed to improve the care provided for formula feeding families within maternity units

3.4 Postnatal Care in Hospital and by Community Midwives at Home			
Standards and Criteria	Actions to be undertaken	By Whom and timescales	Criteria met / not met /date
Evidence from the NICE ¹⁰ Review (2006) Preparation for Birth 3.4.1 Type of analgesia used in labour and at delivery <i>a. Discuss potential effect on breastfeeding outcome with parents</i>			
Implement the UNICEF UK Baby Friendly Standards: (appendix 1.); Step 4. & 7 3.4.2 Mother and baby contact <i>a. Opportunity for all mothers to have skin-to-skin contact with their babies in an unburied environment after delivery</i> <i>b. Keep mothers and babies together at all times including at night time</i> <i>c. Offer of help with a first breastfeed for all mothers</i>			
3.4.3 Help given to breastfeeding mothers Information and support to breastfeed effectively a. Offer of further assistance for mothers within six hours of delivery b. Effective teaching for all breastfeeding mothers on how to position and attach their babies for breastfeeding (hands off technique) c. Demonstration/teaching for all breastfeeding mothers on how to hand express breastmilk d. Encouraging baby-led feeding e. Keep mothers and babies together at all times including at night time f. Avoiding the use of teats and dummies for breastfed babies g. Ensure mothers can contact a professional for breastfeeding support prior to going home. h. Refer mothers to local support groups and lay organisations. i. Ensure effectiveness of information giving including accuracy of written materials			
j. Discharge packs are free from promotion for artificial feeding and to encourage rooming in and early initiation of breastfeeding.			

<p>3.4.4 Peer Support</p> <ol style="list-style-type: none"> a. One-to-one needs-based peer support should be available to women in hospital who have been identified as target groups. b. Include mothers and peer supporters views and ideas in the development of services within maternity units. 			
<p>3.4.5 Supplementation of breastfed babies (step 6)</p> <ol style="list-style-type: none"> a. <i>Ensuring appropriate supplementation of breastfed babies for clinical indication only.</i> b. <i>Clinical indications should be evidence and needs based and recommended by appropriately trained staff.</i> c. <i>Address supplementation of babies for non-clinical reasons and ensure this choice is fully informed.</i> d. <i>Policies and Guidelines to support exclusive and continued breastfeeding and balance the need for safety.</i> 			
<p>3.4.6 Support for breastfeeding in difficult circumstances and when complications occur</p> <ol style="list-style-type: none"> a. <i>Provide support to continue breastfeeding /expressing breastmilk and maintain contact with the baby when mothers and babies are separated if the baby is unwell or premature (see neonatal and paediatric action plan).</i> b. <i>Provide support to continue breastfeeding /expressing breastmilk and maintain contact with the baby when the mother is sick.</i> c. <i>Provide additional, breastfeeding-specific, practical and problem solving support from a trained professional in the early postnatal period for women who are identified “at risk.” and provide specialist intervention if needed.</i> d. <i>Provide contact number(s) for professional specialist support for feeding problems and refer to breastfeeding clinics.</i> 			
<p>3.4.7 Encourage appropriate formula feeding for babies and children with whose mothers cannot or choose not to or who stop breastfeeding</p> <ol style="list-style-type: none"> a. <i>Ensure mothers receive all necessary information and support to formula feeding as safely as possible.</i> b. <i>Recommending skin contact and an early feed and continued closeness</i> c. <i>Teaching how to bottle feed, choosing appropriate teats and bottles and winding the baby effectively.</i> d. <i>Explaining demand feeding –avoiding overfeeding</i> e. <i>Demonstrating how to sterilise equipment and make up feeds</i> f. <i>Provision of information for all mothers on the following issues:</i> g. <i>Exclusive milk feeding until around 6 months</i> k. <i>Appropriate whey based formula milk feeding for at least a year</i> h. <i>Ensure adequate provision of, effectiveness and accuracy of written materials</i> 	<ul style="list-style-type: none"> • 		

Action Plan 5. – For Community Health Partnerships

- Actions designed to increase the maintenance of breastfeeding rates within the community
- Actions designed to improve the care provided for formula feeding families within the community
- Actions designed to improve the care families who are establishing a healthy eating life style for their infants

3.5 Information and Support for Mothers n the Community			
Standards and Criteria	Actions to be undertaken	By Whom and timescales	Criteria met / not met /date
<p>Implement the UNICEF UK Baby Friendly Standards (appendix 2.);</p> <p>3.5.1 Mechanism for ensuring that mothers receive all necessary information and support to breastfeed effectively</p> <ol style="list-style-type: none"> Ensure all breastfeeding mothers receive a demonstration/teaching on how to position and attach their babies for breastfeeding Ensure all breastfeeding mothers receive a demonstration/teaching on how to hand express their breastmilk 			
<p>3.5.2 Provision of information for all breastfeeding mothers and increase staff capacity and capability to be able to give information on;</p> <ol style="list-style-type: none"> Maintaining closeness of mother and baby and rooming-in Baby-led feeding Avoiding the use of teats and dummies for breastfed babies Promote exclusive breastfeeding until around 6 months* Promote continued breastfeeding for at least a year Provide information for all mothers of the benefits of and contra-indications to bed sharing Provision of contact number(s) for health visitor/professional support and local/national breastfeeding support groups Ensure effectiveness and accuracy of written materials 			
<p>3.5.3 Support when mothers and babies are separated</p> <ol style="list-style-type: none"> <i>Support for mothers to continue breastfeeding on return to work</i> <i>Support for mothers whose babies are unwell</i> 			

<p>3.5.4 Supplementation of breastfed babies</p> <ol style="list-style-type: none"> a. Ensuring appropriate supplementation of breastfed babies for clinical indication b. Addressing supplementation of breastfed babies for non-clinical reasons 			
<p>3.5.5 Ongoing Support for Breastfeeding Mothers</p> <ol style="list-style-type: none"> a. <i>Ensure adequate provision of suitable, accessible, acceptable support groups within each locality.</i> b. <i>Ensure such groups are based on effective, evidence bases (BIG trial) models that best suit local needs –board advisors will enable localities to investigate such models i.e. professional supported groups, ‘The Baby Café; model and or peer volunteer of counsellor supported (NCT, La Leche League, BFN or ABM).</i> c. <i>Group facilitators should be suitably trained in breastfeeding support skills and group facilitation skills and be able to refer appropriately when difficulties occur.</i> 			
<p>3.5.6 Support for breastfeeding in difficult circumstances and when complications occur</p> <ol style="list-style-type: none"> a. <i>Provide support to maintain lactation when mothers and babies are separated</i> b. <i>Implement policies and guidelines for infants requiring special feeds</i> c. <i>Provide contact number(s) for health visitor/ professional support for feeding problems</i> d. <i>Provide mothers with referral to additional, breastfeeding-specific, practical and problem solving support at breastfeeding clinics.</i> e. <i>Board Infant Feeding Advisors to develop an accessible clinic service equitably across the board area.</i> 			
<p>3.5.7 Peer Support</p> <ol style="list-style-type: none"> a. <i>Target appropriate women for peer volunteer support</i> b. <i>Volunteer support should be based on a model that is effective, safe, acceptable, affordable, and sustainable.</i> c. <i>Peer models should enable volunteers to engage with the general public, mothers in the antenatal and postnatal period to provide information and give basic clinical and emotional support.</i> d. <i>Peer support models should be localised to suit the needs of their local peers and have a core function of focusing on community involvement and development e.g. at breastfeeding support groups, community events with a local health focus including breastfeeding awareness week.</i> e. <i>Models should be equitably available across each CHP and for all CHP’s</i> 			

<p>3.5.8 Encourage appropriate formula feeding for babies and children with whose mothers cannot or choose not to or who stop breastfeeding</p> <ul style="list-style-type: none"> a. <i>Mechanism for ensuring that mothers receive all necessary information and support to formula feeding as safely as possible.</i> b. <i>Recommending skin contact and continued closeness</i> c. <i>Teaching how to bottle feed, choosing appropriate teats and bottles and winding the baby effectively.</i> d. <i>Explaining demand feeding – avoiding overfeeding</i> e. <i>Demonstrating how to sterilise equipment and make up feeds</i> f. <i>Provision of information for all mothers on the following issues:</i> g. <i>Exclusive milk feeding until around 6 months</i> h. <i>Appropriate whey based formula milk feeding for at least a year</i> i. <i>Ensure adequate provision of, effectiveness and accuracy of written materials</i> 			
<p>3.5.8 Encourage appropriate introduction of complimentary food and vitamins for babies and children</p> <ul style="list-style-type: none"> a. <i>Develop a mechanism for ensuring that mothers receive all necessary information and support to enable mothers to introduce solid foods appropriately and confidently.</i> b. <i>Provide demonstration/teaching for all mothers on how to effectively introduce solids and on how to make nutritious foods</i> c. <i>Board wide evaluation of weaning fares and development of a standard curriculum.</i> d. <i>Provide ongoing professional support towards the establishment of healthy eating habits</i> e. <i>Ensure effectiveness and accuracy of written materials</i> 			
<p>3.5.9 Infants requiring special foods</p> <ul style="list-style-type: none"> a. <i>Implement policies and guidelines for infants requiring special foods (to be developed by dieticians).</i> b. <i>Provision of contact number(s) for health visitor/professional support for feeding problems, e.g. allergies, vegan / vegetarian, premature and unwell babies and fussy eaters.</i> 			

Action Plan 6. – For Sick and Premature Babies and Infants in Hospital

- Actions designed to increase the maintenance of breastfeeding rates
- Actions designed to improve the care provided for formula feeding families within hospital
- Actions designed to improve the care of infants (0-2 years) who are establishing a healthy eating life styles
- Actions designed to ensure the effective delivery of food and fluid, and the provision of high quality nutritional care in all Neonatal and Paediatric hospitals (NHS QIS).

3.6 Information and Support For infants in Neonatal Units and Paediatric Hospitals			
Standards and Criteria	Actions to be undertaken	By Whom and timescales	Criteria met / not met /date
<p>Implement the UNICEF UK Baby Friendly Neonatal Standards (appendix 3);</p> <p>3.6.1 Mechanism for ensuring that mothers receive all necessary information and support to breastfeed effectively</p> <p>a. <i>Inform all parents of the benefits of breastmilk and breastfeeding for babies in the neonatal unit</i></p> <p>b. <i>All parents whose baby is admitted, or is likely to be admitted, to the neonatal unit should have a one to one discussion with a suitably qualified health professional about the crucial importance of breastmilk to the preterm and ill infant. This discussion along with the parents' decision should be documented in the baby's records</i></p>			
<p>3.6.2 Support mothers to initiate and maintain lactation through expression of breastmilk</p> <p>a. <i>All mothers with a baby on the neonatal unit should be encouraged to initiate lactation as soon as possible after delivery.</i></p> <p>b. <i>All mothers whose babies cannot breastfeed or take full feeds from the breast should be taught how to express their milk by hand and by pump</i></p> <p>c. <i>Frequent expression of breastmilk should be encouraged at least 6-8 times in 24 hours including at night. Emphasis should be on frequent expressing rather than regular intervals between expressing.</i></p> <p>d. <i>Well maintained and sterile equipment for the safe expression of breastmilk should be available at all times.</i></p> <p>e. <i>Facilities should be available to allow mothers to express breastmilk in comfort either near their baby or in private if preferred</i></p> <p>f. <i>Instruction should be provided on the safe handling and storage of breastmilk in line with nationally agreed guidelines</i></p> <p>g. <i>A system for the provision of breast pumps for home use should also be in place.</i></p> <p>h. <i>She should continue to use a massage technique prior to and during expressing to increase hormone release.</i></p> <p>i. <i>Double pumping is preferred to sequential pumping (electric pumps).</i></p> <p>j. <i>Even though hand pumps are preferred by some mothers the purchase or hire requires motivation and has cost implications and it may not convey a sense of necessity or medical support to express amongst some parents.</i></p>			

<p>3.6.3 Encourage skin to skin contact and Kangaroo Mother Care between mother and baby</p> <ul style="list-style-type: none"> a. <i>The benefits of skin to skin contact should be discussed with all parents at an appropriate time to allow informed decision making</i> b. <i>Skin to skin contact between mother and baby should be initiated in an unhurried environment as soon as the baby's condition allows</i> c. <i>Skin to skin contact should continue to be offered at least on a daily basis or whenever the mother is available and the baby's condition allows.</i> 			
<p>3.6.4 Support mothers to establish and maintain breastfeeding</p> <p>Demonstration/teaching for all breastfeeding mothers on how to position and attach their babies for breastfeeding</p> <ul style="list-style-type: none"> a. <i>All breastfeeding mothers should be offered help with a first breastfeed as soon their baby's condition permits. Breastfeeding mothers should receive information, help and support to achieve correct positioning and attachment</i> b. <i>When the baby is not yet able to take a full feed from the breast, mothers should be encouraged to practice positioning techniques</i> c. <i>Parents should be given information on the importance of baby-led feeding (as soon as appropriate) for the continuation of breastfeeding.</i> d. <i>They should be taught to recognise feeding cues and be encouraged to use all available opportunities to initiate breastfeeds</i> e. <i>The unit should have a policy of open visiting for parents.</i> f. <i>Facilities for rooming-in should be available and where possible parents and babies should be enabled to room-in together when the baby is well enough. It is recognised that rooming-in may not be available for all breastfeeding mothers. Priority should be given to mothers establishing breastfeeding prior to the baby's discharge home.</i> g. <i>All written materials on infant feeding provided for parents should be accurate and effective.</i> h. <i>It is recognised that some mothers may not wish to breastfeed, but may decide to continue expressing breastmilk. In this circumstance the mothers should be supported to continue providing breastmilk and given an informed choice regarding the short and long term benefits to baby of feeding directly from the breast.</i> 			
<p>3.6.5 Provision of information for all breastfeeding mothers on the following issues:</p> <ul style="list-style-type: none"> a. <i>exclusive breastfeeding until around 6 months (may vary for some premature or sick babies) and continued breastfeeding for the first year and beyond.</i> b. <i>Staff should provide contact number(s) for health visitor/professional support and local/national breastfeeding support groups</i> c. <i>Ensure the effectiveness and accuracy of written materials Staff should recommend</i> 			

<p>3.6.6 Avoid the use of teats or dummies for breastfed babies unless clinically indicated</p> <ul style="list-style-type: none"> a. <i>Breastfed babies should be fed breastmilk by tube, syringe or cup as appropriate to the baby's ability.</i> b. <i>Parents wishing to breastfeed who request that their baby be fed by teat must have the potential risks discussed and alternatives offered. Cup feeding has no significant risks and may offer advantages in terms of physiological stability</i> c. <i>Dummy use should be limited to when there is a clear clinical indication. Indiscriminate dummy use should be discouraged for breastfed babies.</i> d. <i>The use of dummies for Non Nutritive Sucking -little evidence base for their use for preterm infants but not currently associated with any adverse effects in terms of breastfeeding duration.</i> e. <i>Parents should have a discussion and receive written information on any benefits and known potential risks of dummies / non nutritive sucking devices.</i> f. <i>Skin to skin contact and breastfeeding should be promoted for comforting babies and relieving pain during minor procedures such as heel pricks.</i> g. <i>Feeding and comforting methods appropriate to the baby's condition, and with reference to the presence or absence of the parents at any given time, should be discussed with the parents.</i> h. <i>Discussion should be evidence based and include all potential benefits, risks and alternatives to allow informed decision making. The discussion and the parent's choice should be recorded in the baby's notes or care plan.</i> i. <i>The impact nipple shields on preterm breastfeeding have not been adequately determined and therefore should not be advised.</i> 			
<p>3.6.7 Support when mothers and babies are separated</p> <p>Promote breastfeeding support through local and national networks.</p> <ul style="list-style-type: none"> a. <i>All mothers should be provided with the contact details of midwives, health visitors, community neonatal nurses (where these exist), breastfeeding support networks and organisations which support parents of ill and premature babies for help with breastfeeding on admission to a neonatal unit and on discharge of the baby from the hospital.</i> b. <i>A formal mechanism should exist to ensure that information on breastfeeding progress is passed on during handover of care from the neonatal unit to the community health care team.</i> c. <i>Counselling and support service for both parents did not affect breastfeeding duration or exclusivity in an advantaged and motivated population but provision of clinical support may increase the number of mothers willing to express their own milk for their infants.</i> 			

<p>3.6.8 Encourage exclusive breastmilk feeding</p> <ul style="list-style-type: none"> a. <i>No food or drink other than breastmilk should be given to babies who are being breastfed or receiving breastmilk unless this is medically indicated or the result of a fully informed parental decision.</i> b. <i>Mother's own breastmilk is the first choice for infant feeding. Where mother's own milk is not available the use of donor milk should be considered and where possible obtained.</i> c. <i>When mothers are separated from their babies, mechanisms should exist to enable the regular transportation of the mother's milk to the facility caring for the baby.</i> d. <i>No promotion for breastmilk substitutes, feeding bottles, teats or dummies, should be displayed or distributed to parents or staff in the facility</i> 			
<p>3.6.9 Policies and guidelines</p> <ul style="list-style-type: none"> a. <i>Protocols which protect exclusive breastfeeding should be developed where there is hypoglycaemia, jaundice requiring phototherapy or slow weight gain. Breastmilk should only be fortified where there is a clear medical indication, for example for very low birth weight (less than 1500g) babies when a biochemical assessment indicates a need.</i> b. <i>Implement guidelines for;</i> c. <i>Cup feeding,</i> d. <i>Dummies and teats</i> e. <i>Hypoglycaemia</i> f. <i>Supplements (Fortifiers v Preterm Formulae)</i> g. <i>Sucrose analgesia</i> 			
<p>3.6.10 Donor milk banking</p> <ul style="list-style-type: none"> a. <i>Implement all UKAMB regulations</i> b. <i>Ensure equity of provision across the Board areas.</i> 			
<p>3.6.11 Support for breastfeeding in difficult circumstances and when complications occur</p> <ul style="list-style-type: none"> a. <i>Provide support to maintain lactation when mothers and babies are separated</i> b. <i>Implement policies and guidelines for infants requiring special feeds</i> c. <i>Provide contact number(s) for health visitor/professional support for feeding problems</i> d. <i>Provide mothers with referral to additional, breastfeeding-specific, practical and problem solving support at breastfeeding clinics.</i> e. <i>Board Infant Feeding Advisors to develop an accessible clinic service equitably across the board area.</i> 			
<p>3.6.12 Peer Support</p> <ul style="list-style-type: none"> a. <i>Target appropriate women for volunteer support</i> b. <i>Provide volunteer support based on a model that is effective, safe, acceptable, affordable, and sustainable.</i> c. <i>Peer models should enable volunteers to engage with the general public, mothers in neonatal units and at home to provide information and give basic clinical and emotional support.</i> d. <i>Peer support models should be localised to suit the needs of their local peers and have a core function of focusing on community involvement and development in appropriate settings (i.e. cleft lip and palate association)</i> e. <i>Models should be equitably available across neonatal and paediatric services.</i> 			

<p>3.6.13 Encourage appropriate formula feeding for babies and children with whose mothers cannot or choose not to or who stop breastfeeding</p> <ul style="list-style-type: none"> a. <i>Mechanism for ensuring that mothers receive all necessary information and support to formula feeding as safely as possible.</i> b. <i>Discussing previous experience</i> c. <i>Recommending skin contact and continued closeness</i> d. <i>Teaching how to bottle feed, choosing appropriate teats and bottles and winding the baby effectively.</i> e. <i>Explaining demand feeding –avoiding overfeeding</i> f. <i>Demonstrating how to sterilise equipment and make up feeds</i> g. <i>Provision of information for all mothers on the following issues:</i> <ul style="list-style-type: none"> h. <i>Exclusive milk feeding until around 6 months</i> i. <i>Appropriate whey based formula milk feeding for at least a year</i> j. <i>Ensure adequate provision of, effectiveness and accuracy of written materials</i> 			
<p>3.6.14 Encourage appropriate introduction of complimentary food and vitamins for babies and children</p> <ul style="list-style-type: none"> a. <i>Mechanism for ensuring that mothers receive all necessary information and support to enable mothers to introduce foods appropriately.</i> b. <i>Provide demonstration/ teaching for all mothers on how to effectively introduce solids and on how to make nutritious foods.</i> c. <i>Evaluate the provision of weaning information and development of a standard curriculum.</i> d. <i>Ensure effectiveness and accuracy of written materials</i> 			
<p>.6. 15 Implement the Food, Fluid and Nutritional Care in Hospitals¹⁴ (NHS QIS) Standards</p> <p>Standard 1 – Policy and Strategy</p> <p>Each NHS Board has a policy, and a strategic and co-ordinated approach, to ensure that all patients in hospitals have food and fluid delivered effectively and receive a high quality of nutritional care.</p> <p>Essential</p> <p>1.1 Each NHS Board has a policy on nutritional care and a strategic plan to improve the provision of nutritional care, food and fluid.</p> <p>These :</p> <ul style="list-style-type: none"> i) <i>are patient-focused, follow the patient journey of care and ensure that a comprehensive and co-ordinated nutritional care service is provided;</i> ii) <i>are based on a health population needs assessment, which considers local ethnic, religious and cultural patterns and which recognises the need for equity of access;</i> iii) <i>recognise patient groups with particular needs, e.g. children;</i> iv) <i>are risk-assessed and managed;</i> v) <i>are discussed annually at NHS Board level to evaluate progress and produce a plan for further action, based on:</i> <ul style="list-style-type: none"> – <i>reports from operational nutritional care group(s);</i> – <i>any need for re-design; and</i> – <i>the need for managing change of attitude and behaviour;</i> vi) <i>include a financial framework to underpin the implementation of the action plan; and</i> vii) <i>are published in a format easily understood by and accessible to the public.</i> 			

<p>1.2 Each NHS Board area has at least one operational nutritional care group responsible to the NHS Board for overseeing the implementation of:</p> <ul style="list-style-type: none"> • <i>NHS Quality Improvement Scotland standards for food, fluid and nutritional care in hospitals; and</i> • <i>the NHS Board's strategic plan.</i> <p><i>The nutritional care group produces an annual written report, detailing progress made and action taken/required. The core membership of this group includes a senior manager reporting to the chief executive, a senior dietitian or dietetic manager, a lead doctor appointed by the medical director, a senior nurse appointed by the nursing director, a catering manager, a dentist, lay representation and co-opted specialist expertise appropriate for the population.</i></p> <p>1.3 Where complex nutritional techniques are employed, the patient has access to the services of a clinical nutritional support team responsible for the clinical aspects of intravenous and enteral tube feeding. The core membership of this team includes a doctor, a dietitian, a specialist nutrition nurse and a pharmacist. Clinicians should be part of the Scottish Managed Clinical Network for Home Parenteral Nutrition</p>			
<p>Standard 2 – Assessment, Screening and Care Planning Processes and procedures for assessment, screening and care planning are being implemented and monitored fully, and there is a cycle of continuous monitoring of implementation and impact on patient care throughout the Board area.</p> <p>Essential</p> <p>2.1 When a person is admitted to hospital as an in-patient, the following are identified and recorded within 1 day as part of the medical/nursing assessment :</p> <ul style="list-style-type: none"> • <i>height and weight;</i> • <i>eating and drinking likes/dislikes;</i> • <i>food allergies and need for a therapeutic diet;</i> • <i>cultural/ethnic/religious requirements;</i> • <i>social/environmental mealtime requirements;</i> • <i>physical difficulties with eating and drinking; and</i> • <i>the need for equipment to help with eating and drinking.</i> <p>2.2 The initial assessment includes screening for risk of under nutrition. This screening is carried out using a validated tool appropriate to the patient population, and which includes criteria and scores that indicate action to be taken.</p> <p>2.3 Repeat screenings are undertaken in accordance with clinical need and at a frequency determined by the outcome of the initial and subsequent screenings.</p> <p>2.4 The outcome of screening is recorded in the medical notes.</p> <p>2.5 The assessment process identifies the need for referral to specialist services, e.g. dietetic, dental.</p> <p>2.6 Patients have access to specialist services :</p> <ul style="list-style-type: none"> • within agreed timescales; and • 7 days a week for urgent cases. 			

<p>When a person is admitted to hospital, an assessment is carried out. Screening for risk of under nutrition is undertaken, both on admission and on an ongoing basis. A care plan is developed, implemented and Evaluated.</p> <p>Essential 2.7 A multidisciplinary care plan is followed, reviewed and refined, and includes the : i) outcomes of the initial assessment; ii) outcomes of the screening for risk of under nutrition; iii) frequency/dates for repeat screenings; and iv) actions taken as a consequence of repeat screenings. 2.8 The discharge plan is developed with the patient and, where appropriate, carer, and includes information about : i) <i>the patient's nutritional status;</i> ii) <i>special dietary requirements; and</i> iii) <i>the arrangements made for any follow-up required on nutritional issues.</i></p> <p>Desirable 2.9 Patients referred to the dietetic service are seen within 2 days.</p>			
<p>STANDARD 3 ~ Planning and Delivery of Food and Fluid</p> <p>There are formalised structures and processes in place to plan the provision and delivery of food and fluid.</p> <p>Essential 3.1 There is a planning group responsible for the implementation of a local protocol or protocols for the provision of food and fluid for patients. The core membership of this group includes a senior member of catering staff, a senior nurse, a doctor, a senior dietitian and allied health professionals and patient representation. The group will also have others appropriate to patient groups (as identified in the population assessment) and to the food delivery system. 3.2 The planning group is responsible for: i) <i>overseeing a local assessment of need;</i> ii) <i>producing a local 'food chain' protocol/protocols;</i> iii) <i>menu planning, including the use of standard recipes;</i> iv) <i>ensuring the food and fluid provided meets the requirements of the individual, the catering specification is appetising, and is presented with consideration;</i> v) <i>setting main mealtimes appropriate for patient groups;</i> vi) <i>setting mealtimes such that if the evening meal and breakfast are more than 14 hours apart, a substantial snack is available;</i> vii) <i>ensuring there is appropriate food and fluid available out with main mealtimes;</i> viii) <i>ongoing monitoring and review of the food and fluid provided for patients; and</i> ix) <i>reporting to, and implementing issues devolved from, the Nutritional Care Group.</i> 3.3 All dishes and menus are analysed for nutritional content by a state-registered dietitian at the planning stage. 3.4 Patient groups are consulted about new menus/dishes before they are introduced. 3.5 There is a procedure : • for the delivery of the correct meals/dishes to the ward; • for responding when an incorrect meal/dish is provided; and • to ensure that when a patient misses a meal he/she is then provided with a meal that meets his/her needs</p>			

<p>There are formalised structures and processes in place to plan the provision and delivery of food and fluid.</p> <p>Essential</p> <p>3.6 The nurse with responsibility for the ward is responsible for having in place a protocol which ensures that :</p> <ul style="list-style-type: none"> • correct meals/dishes are received on the ward; • meals are delivered to the correct patients at the correct temperature; • there is adequate time for patients to eat or drink; • staff assist and support patients as required; and • patients’ intake of food and fluid is monitored, and the necessary action is taken if this intake is inadequate.. <p>3.7 All non-essential staff activity (clinical and non-clinical) is stopped during patient mealtimes.</p> <p>3.8 There is an adequate number of staff available at mealtimes to provide food and fluid to patients and, where necessary, to provide individual assistance with eating and drinking.</p> <p>3.9 There is a protocol for the provision of all therapeutic diets, including oral nutritional supplements, and for high-energy and high- protein food and fluid.</p> <p>3.10 There is a protocol for the provision of any requirement out with the planned menu, e.g. vegan meals</p>			
<p>STANDARD 4 ~ Provision of Food and Fluid to Patients</p> <p>Food and fluid are provided in a way that is acceptable to patients.</p> <p>.Essential</p> <p>4.1 Patients are given a choice for all food and fluid options provided, including therapeutic and texture-modified diets. There is a choice of portion size for all main courses.</p> <p>4.2 Patients are given the opportunity to choose their own food and fluid. Where required, they are given help in doing so from a member of staff who is aware of their nutritional needs and preferences.</p> <p>4.3 Patients select their menu choice as close to the serving of the meal as possible, and no more than two meals in advance.</p> <p>4.4 Food and fluid are provided to patients at the correct temperature and texture. Where required, patients are given assistance with eating/drinking while the food/fluid is at the correct temperature.</p> <p>4.5 Meals/dishes provided for patients are appetising. Consideration is given to presentation, including the colour balance of dishes and when different courses are provided.</p> <p>4.6 Patients are provided with the equipment/utensils for eating/drinking that meet their individual needs.</p> <p>4.7 Accompaniments/condiments are available for patient use.</p> <p>4.8 Where clinically appropriate, patients have access to fresh drinking water at all times.</p> <p>Desirable</p> <p>4.9 Where clinically appropriate, patients are given the opportunity to choose whether to eat/drink at or away from their bed.</p>			

<p>Standard 5 ~ Patient Information and Communication Patients have the opportunity to discuss, and are given information about, their nutritional care, food and fluid. Patient views are sought and inform decisions made about the nutritional care, food and fluid provided.</p> <p>Essential 5.1 On, or prior to, admission to hospital, patients are provided with information on : i) how to order their meals; ii) <i>mealtimes;</i> iii) <i>the content of meals and choices available;</i> iv) <i>facilities available for eating meals, and where meals are served;</i> v) <i>the opportunities available for preparing/ consuming food and fluid;</i> vi) <i>assistance with eating and drinking if required;</i> vii) <i>special equipment/ utensils for eating and drinking if required;</i> viii) <i>the procedure for obtaining a meal if one is missed; and</i> ix) <i>how to make a comment or compliment about the nutritional care, food and fluid provided.</i></p> <p>5.2 Patients and, where appropriate, carers, are given information about the : i) <i>food and fluid that relatives and carers can provide for them; and</i> ii) <i>patient's nutritional needs, including any food/ fluid to avoid.</i></p> <p>5.3 Patients are encouraged to give their views on the food and fluid provided. These views are collected and trends are reported regularly to the relevant planning group.</p>			
<p>Standard 6 – Education and Training for Staff A Board nutrition awareness, education and training programme is being implemented and monitored fully, and there is a cycle of continuous monitoring of implementation and impact on patient care throughout the Board area.</p> <p>Essential 6.1 All staff should be aware of the importance of nutritional care for the patients' health and quality of life. Staff in contact with patients at any point in the 'food chain' are aware of : i) <i>the local protocol/ s or processes for ordering and delivering food/ fluid;</i> ii) <i>meal and snack times; and</i> iii) <i>procedures for ordering missed meals.</i></p> <p>6.2 All staff in contact with patients and their food and fluid receive training in health and safety issues and food hygiene commensurate with their duties.</p> <p>6.3 There is a programme of nutrition education for staff, commensurate with their duties, which ensures that all staff with a specific responsibility at any point in the 'food chain' are given appropriate guidance and training, e.g. in the preparation of texture-modified diets, in the use of the screening tool and appropriate alternative measures, and in the recognition of physical difficulties with eating and drinking</p>			

Section 4. The Role of the Infant Feeding Team and Team Work plan

- 4.1 Team commitment to Services
- 4.2 Team objectives and priorities
- 4.3 Appendices
- 4.4 References



4.1 Team commitment to Services

To deliver this Strategy, the Board has appointed an Infant Feeding Coordinator and team of Advisors to enable its partners to implement the objectives. The team of Advisors will use their expertise to assist local teams to develop and implement their action plans and set local targets. Each service will have a named link Advisor. The team will work towards increasing staff capacity and capability, improving processes and flow.

Where will the Strategy Budget Go?

These tables **do not include** any extra work provided by service level agreements. This is the planned minimum service provided by the Board Team of Infant Feeding Advisors based on current budget.

Calendar Monthly Time Input

Staff	Hours per week	Per Calendar Month	Distribution of Staff to Services
coordinator	37.5	126	Maternity 182 hours
A	37.5	126	Out patients 48 hours
B	30	100.8	CHCP's 173 hours
C	30	100.8	Peer Support 80 hours
D	22.5	75.6	Meetings, Projects 95.6 hours
E	14	47	
Totals		575.6	575.6 hours

Acute Services –Staff Deployment

Unit	Inpatient Services	Out patient Services	Action Planning and process development	Training and Audit	Totals
The PRMH					
The SGH					
The QMH					
The RHSC					
The RAH					
The VOL					
Inverclyde					
	78	48	68	72	230

Community Health Partnership – Staff Deployment

Area	Action Planning and process development	Training and Audit	The Breastfeeding Initiative Peer Support (does not include recruitment by staff)	Totals
1. East Dunbartonshire	7.5	7.5		
2. East Glasgow	7.5	7.5		
3. East Renfrewshire	7.5	7.5		
4. Inverclyde	7.5	7.5		
5. North Glasgow	7.5	7.5		
6. Renfrewshire	7.5	7.5		
7. South East Glasgow	7.5	7.5		
8. South West Glasgow	7.5	7.5		
9. West Dunbartonshire	7.5	7.5		
10. West Glasgow	7.5	7.5		
11. South Lanarkshire	7.5	7.5		
	82.5	82.5	80 hours to be divided according to local needs assessment	253

4.2 Infant Feeding Team objectives and priorities

Standards and Criteria	Actions to be undertaken	By Whom and timescales	Criteria met / not met / date
<p>1. Strategic</p> <p>To develop a comprehensive Strategy and Action Plans and integrate them into overall health policies and strategies</p>	<p>Planning</p> <ul style="list-style-type: none"> To set priorities, objectives and targets based on comprehensive local needs. Use evidence, audit, Health Impact Assessment to Prioritise action plans, objectives and to set targets. <p>Management</p> <ul style="list-style-type: none"> To ensure continuity of the coordinator's and committee's activities To establish an Implementation and monitoring group with sub groups to progress the aims and objectives of the Strategy, regularly monitor progress and evaluate results of the local and Board plans. <p>Financing</p> <ul style="list-style-type: none"> To find /assign adequate human and financial resources for the implementation and monitoring of the Strategy. Actions need to be prioritised within budget constraints and finance allocated to achieve "best value" and greatest positive "Health Impact". To ensure that planning, implementation, monitoring and evaluation of activities are carried out 		
<p>2. Best Practice Standards</p>	<p>Policy and BFI Accreditation</p> <ul style="list-style-type: none"> Policies should reflect the requirements of the WHO /UNICEF standards and partners should achieve and maintain accreditation. The Maternity "Ten Steps to Successful Breastfeeding". The Community "Seven Point Plan". The UNICEF UK Neonatal Standards The Pre Registration Education Standards Adopt and monitor adherence to the WHO Code on Marketing of Breast milk substitutes & WHA resolutions <p>Infant Feeding policy and guidelines (2006)</p> <ul style="list-style-type: none"> To ensure professional groups implement policy recommendations and practice guidelines and require their members to follow them. The Infant feeding policy and guidelines will be updated every 3 years to ensure it covers best practice standards The "Parents Guide to the Policy" will be on display in all Board areas which serve mothers and babies 		
<p>3. Increasing capacity and capability</p> <p><i>See Training Plan</i></p> <p>Ensure appropriate</p>	<ul style="list-style-type: none"> All new staff in all Board areas which serve mothers and babies including medical staff will be orientated to the policy on commencement of employment. There will be orientation of other staff (e.g. Receptionists, Practice Nurses) 		

<p>training of NHS staff to enable them to implementation objectives of Strategy and Action Plans</p>	<p>to the policy</p> <ul style="list-style-type: none"> • To develop, or review if existing, a minimum (contents, methods, time) standard for pre- and post-graduate curricula and competency on infant feeding and lactation management for relevant health workers • To develop, or review if existing, course textbooks and training materials in line with the updated standard curricula and recommended policies and practices • Education for all staff in skills necessary to support mothers with positioning and attachment and hand expression of breastmilk • Record keeping of student’s education in infant feeding. • Development of an education programme for trained and support staff including written curriculum • To offer continuing interdisciplinary education based on WHO/UNICEF or other evidence-based courses on infant feeding and lactation management, as part of induction and in-service education for all relevant health care staff, with particular emphasis on staff in frontline maternity and child care areas • To develop, or review if existing, training materials to be used for such interdisciplinary continuing education, ensuring that materials and courses are not influenced by manufacturers and distributors of products under the scope of the International Code • To encourage relevant health care workers to attend accredited advanced lactation management courses and to acquire certification shown to meet best practice criteria for competence. • To encourage Infant Feeding Advisors to attend accredited advanced lactation management, nutrition and practice educator courses and to acquire certification shown to meet best practice criteria for competence. • To encourage e-networking amongst professionals in order to increase knowledge and skills • Record keeping of mandatory staff education • Develop / Implement training for Pharmacists, Dieticians, Oral Health Action Teams 		
<p>4. Provide a Specialist Service for mothers experiencing breastfeeding problems or challenging situations</p>	<ul style="list-style-type: none"> • Ensure an equitable, accessible, effective provision of specialist services for mothers experiencing feeding problems within the maternity, paediatric services and at home. • Increase capacity and capability across the service for the management of feeding problems. • Ensure breastfeeding clinics effectiveness and acceptability are evaluated, lessons learned are shared. • Ensure services are integrated and can make appropriate direct referrals. 		

<p>5. Develop public acceptability and promotion of breastfeeding</p>	<ul style="list-style-type: none"> • Peer Support; Evaluate current provision and models and secure funding to proliferate suitable model(s) across the acute and maternity/paediatric services. • Work with CHP's to establish / maintain / fund peer supporters. Review volunteer activity and develop their capability and capacity. Safe, secure support for volunteers. • Support Groups; Evaluate provision and effectiveness of existing groups, identifying gaps in accessibility, acceptability, suitability and effectiveness. • Lay Support Organisations; Make links with local networks and involve and integrate in development of services. • Breastfeeding in Public Award; • Nurseries Award, Child minding, Education Curriculum • Support breastfeeding in the workplace policies for NHS and public sector 		
<p>6. Develop ways of measuring the patient journey</p>	<ul style="list-style-type: none"> • Improve the patient journey to achieve improved outcomes • Collection of breastfeeding statistics • Development and monitoring of Quality Indicators • Risk Management • Improved systems 		
<p>7. Support the further development of the programmes which reach target families</p>	<ul style="list-style-type: none"> • Use appropriate methods and organisations (professional, peer or other partners) • Develop / maintain / evaluate appropriate models of education and support. • Target groups; areas of deprivation, young mothers below 25, smokers, low educational attainment groups, mothers who did not breastfed previous children or fed for less than 6 weeks. • Mothers with medical problems, e.g. diabetes • High risk (ill, premature) neonates • Ethnic groups with specific issues 		
<p>8. Innovation and Development</p>	<ul style="list-style-type: none"> • Work with researchers • Commission / carry out new research, evaluation & audit • Encourage innovation and creative thinking. 		

4.3 Appendices

Appendix 1.

UNICEF/UK Baby Friendly initiative The Ten Steps to Successful Breastfeeding in the Maternity Services

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all healthcare staff in the skills necessary to implement the breastfeeding policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding soon after birth.
5. Show mothers how to breastfeed and how to maintain lactation even if they are separated from their babies.
6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.
7. Practice rooming-in, allowing mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or dummies to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Appendix 2.

UNICEF/UK Baby Friendly initiative The Seven Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Care Settings

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all staff involved in the care of mothers and babies in the skills necessary to implement the policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Support mothers to initiate and maintain breastfeeding
5. Encourage exclusive and continued breastfeeding, with appropriately-timed introduction of complementary foods
6. Provide a welcoming atmosphere for breastfeeding families.
7. Promote co-operation between healthcare staff, breastfeeding support groups and the local community.

Appendix 3.

UNICEF/UK Baby Friendly initiative Best practice standards for neonatal units

1. Have a written neonatal unit breastfeeding policy, which is routinely communicated to all staff.
2. Educate all health care staff in the skills necessary to implement the policy
3. Inform all parents of the benefits of breastmilk and breastfeeding for babies in the neonatal unit
4. Encourage skin to skin contact (Kangaroo care) between mother and baby
5. Support mothers to initiate and maintain lactation through expression of breastmilk
6. Support mothers to establish and maintain breastfeeding
7. Encourage exclusive breastmilk feeding
8. Avoid the use of teats or dummies for breastfed babies unless clinically indicated.
9. Promote breastfeeding support through local and national networks.



4.4 References

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