

***National Institute for
Health and Clinical Excellence***

Maternal and Child Nutrition Programme Guidance

Fieldwork report

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Produced by SHM

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Executive summary

This document collates the findings from SHM's fieldwork with practitioners and commissioners to test the draft Maternal and Child Nutrition Programme Guidance with those involved locally in the commissioning and delivery of services to improve the nutrition of pregnant and breastfeeding mothers and children and infants in low income households.

SHM's fieldwork was structured into three stages: impact and implementation workshops with practitioners to interrogate the draft recommendations' *relevance, utility and feasibility* using a structured approach; telephone interviews with specialist practitioners representing the kinds of professional roles that it had proved difficult to engage in the workshop phase; and telephone interviews with commissioners to consider how implementation of the guidance could be supported from a commissioning perspective.

In general, practitioners were extremely positive about the draft Maternal and Child Nutrition programme guidance draft recommendations.

- Many saw the draft recommendations as an endorsement of things that they are doing already, and as providing a welcome common standard.
- Practitioners welcome the fact that the guidance has the potential to create the conditions for consistent, standardised approaches to delivery
- Practitioners also welcome having visibility of what other professionals are being asked to do. This enhances inter-professional understanding and has the potential to support 'whole systems' approaches

However, practitioners and commissioners did express some reservations about aspects of the draft recommendations:

- Practitioners of all kinds felt that the draft recommendations appear to give insufficient consideration to the broader factors that influence clients' behaviour and health outcomes. These factors are especially pronounced in the lives of women from low income families, and it is therefore essential that they are addressed.
- Many were surprised that more of the draft recommendations did not emphasise the importance of schools, youth services, and Connexions, which practitioners felt had a critical role to play in targeting younger women and teenage mothers.
- Practitioners and commissioners were surprised that the draft recommendations do not acknowledge explicitly the emerging institutional and strategic landscape – for example, of *Every child matters*, joint commissioning, and Local Area Agreements – that have the potential to support delivery of the draft recommendations.
- Practitioners suggested that the draft recommendations do not adequately reflect the fact that professionals need increasingly to be creative to respond to the broader factors that influence behaviour
 - Being in the right role to deliver the draft recommendation is less important than being having the right kind of relationship with a client to deliver a recommendation

- Practitioners welcome the fact that the draft recommendations provide a standard (the ‘what’); but some are uncomfortable about the draft recommendations over-specifying the means of reaching that standard (the ‘how’), as this has the potential to inhibit innovative practice.

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For a complete list of all of the practitioners consulted in the process, please see Appendix 1.

1. Introduction

In October 2006, the Centre for Public Health Excellence at the National Institute for Health and Clinical Excellence (NICE) commissioned SHM to undertake fieldwork to test the Maternal and Child Nutrition Programme Guidance draft recommendations with those involved locally in the commissioning and delivery of services to improve the nutrition of pregnant and breastfeeding mothers and children and infants in low income households.

The aim of the fieldwork was to engage Maternal and Child Nutrition practitioners to examine the **relevance, utility** and **implementability** of the Programme Guidance. This is in order to help NICE understand:

- The **relevance and usefulness** of the guidance to practice
- The **factors that could help or hinder effective implementation and delivery** of the guidance
- The **potential impact** of the guidance draft recommendations, and the extent to which the draft recommendations are both feasible and likely to make a difference to practice
- The **relative priority** of each of the draft recommendations for the different practitioner groups involved.

Following some delays with the initiation of the fieldwork due to an extension to the process by which the draft recommendations were refined and finalised, the fieldwork took place in July and August 2007. SHM conducted fieldwork with 107 practitioners in total (81 participated in the workshop process; 15 in the specialist practitioner interviews; 11 in the commissioner interviews). Although the fieldwork sought to interrogate the draft recommendations' relevance, utility, feasibility and implementability from the practitioner perspective, care was taken within this approach to ensure that the impacts of the guidance in terms of real outcomes for real clients was considered.

The findings from the fieldwork suggest a broad base of support for the draft recommendations. It emerged that many practitioners are already doing many of the things specified. However, the fieldwork workshops drew attention to aspects of the draft recommendations that need to be clarified further to ensure that professionals are clear about the implications for them and their practice. The workshops also identified issues related to feasibility that need to be considered if the draft recommendations are to be put into practice effectively.

1.1 About this document

This document collates the findings from SHM's fieldwork with practitioners and commissioners to test the draft Maternal and Child Nutrition Programme Guidance with those involved locally in the commissioning and delivery of services to improve the nutrition of pregnant and breastfeeding mothers and children and infants in low income households.

The document is structured as follows:

- Section 2** Provides details of the fieldwork method that was undertaken and provides reflections on the strengths and weaknesses of the approach as a means of engaging practitioners and generating meaningful insights on the draft recommendations.
- Section 3** Outlines the overarching themes emerging from the fieldwork process (both the workshops and telephone interviews).
- Section 4** Provides findings from the practitioner workshops, and discusses practitioners' suggestions for *clarifications* to each draft recommendation their reflections on the draft recommendations' *impact and feasibility* in practice, and their thoughts on *gaps, missed opportunities and suggestions for improvements*.
- Section 5** Provides findings from the telephone interview phase, which followed the fieldwork phase, and which involved specific specialist practitioners who we were unable to engage in the fieldwork workshops, and commissioners.
- Section 6** Provides summary of the findings from the impact/feasibility chart exercise.
- Appendix 1** Lists all of the practitioners who were involved at all three stages of the fieldwork process: the fieldwork workshops, the specialist practitioner interviews, and the commissioner interviews.
- Appendix 2** Contains the key research instruments that were used at each stage of the fieldwork: the workshop facilitation guide and impact/feasibility chart, and the interview discussion guides for the conversations with specialist practitioners and commissioners.

This document has been submitted to NICE to enable it to progress its discussions with the Maternal and Child Nutrition Programme Development Group (PDG). SHM will present a digest of the key findings from the fieldwork at the PDG meeting on 10th – 11th September 2007 at the Royal College of Physicians, London.

2. Fieldwork methodology

Fieldwork represents a key stage in the development of NICE guidance, providing crucial evidence on the feasibility of the draft recommendations and the conditions required for effective implementation and delivery in practice. In this instance, the fieldwork sought to field test the draft Maternal and Child Nutrition Programme Guidance with those involved locally in the commissioning and delivery of services to improve the nutrition of pregnant and breastfeeding mothers and children in low income households.

SHM's fieldwork was structured into three stages as follows:

- (i) The **impact and implementation workshops** were designed to enable maternal and child nutrition practitioners to interrogate the draft recommendations in a structured way based on our brief to explore the draft recommendations' *relevance, utility, feasibility, and implementability*. Practitioners participated in facilitated small group creative exercises to explore the draft recommendations' potential impact on practice, potential impact on clients, and potential feasibility in practice. The small group exercise involved participants rotating around three 'stations'. Each station focused on a subset of the draft recommendations that relate to a particular 'life stage': Station 1: Nutrition at pre-conception and during pregnancy; Station 2: Infant feeding; and Station 3: Child nutrition. The session was designed in this way to enable us to cover such a large number of draft recommendations (24) in a three-hour workshop. Even though there was not time for each participant to explore every draft recommendation (from the point of view of every topic), we were satisfied that such a 'rotating' process enabled the group as a whole to cover all of the draft recommendations sufficiently. Finally, we provided pre-prepared charts to encourage participants to think critically about each recommendation's *impact and feasibility* (see Appendix 2).
- (ii) We then **interviewed practitioners** representing the kinds of professional roles that it had proved difficult to engage in the workshop phase. The interviews were designed along much the same lines as the workshop in that we sought to encourage practitioners to reflect on the draft recommendations' potential impact on practice, potential impact on clients, and potential feasibility in practice. To support discussion in the interview, we circulated to respondents beforehand the draft recommendations as well as the impact/feasibility chart described above. Respondents were encouraged to plot the draft recommendations on the chart before the telephone interview so that the chart could be discussed as part of the telephone call.
- (iii) Insights gleaned from practitioners in the workshops and interviews were then explored in **interviews with commissioners**. Commissioners were asked to consider the feasibility of practitioners' ideas for how the guidance could be made to work in practice, and to think about how implementation of the guidance could be supported from a commissioning perspective.

The research instruments used in the course of the fieldwork can be found in Appendix 2.

3. Discussion of overarching themes emerging from the fieldwork

3.1 General reflections

- In general, practitioners were extremely positive about the draft Maternal and Child Nutrition Programme Guidance draft recommendations.
- Many saw the draft recommendations as an endorsement of things that they are doing already, and as providing a welcome common standard. Practitioners felt that having such a standard in place will enable consistency in service delivery.
- Practitioners also welcome having visibility of what other professionals are being asked to do. This enhances inter-professional understanding and has the potential to support ‘whole systems’ approaches, which will make exchanges between organisations more informed and seamless, and enable a more coherent “service journey” for the client.

3.2 Draft recommendation language and structure

- Practitioners identified many instances within the draft recommendations in which they felt that the language needed clarification. Practitioners and commissioners felt that only by defining precisely what certain activities involve can they understand what training and implementation resources are required to support delivery.
- Practitioners tend to assume that where a professional role(s) is stated explicitly under ‘Who should take action’, this professional role is **responsible for *delivery*** of that recommendation. It is unclear to practitioners that professionals mentioned under ‘Who should take action’ can ***delegate delivery*** to colleagues. Furthermore, practitioners did not always realise that, very often, the body text of the draft recommendation goes on to identify specific professionals to deliver particular aspects of the recommendation. Had practitioners understood this properly, it may have changed their views about the extent to which some of the draft recommendations are feasible. Many practitioners assumed that if their role is listed under ‘Who should take action’, they are **responsible for delivering the *whole* recommendation.**

3.3 The importance of understanding *influence* to maximise *impact*

- Practitioners of all kinds felt that in general the draft recommendations appear to give **insufficient consideration to the broader factors that influence** clients’ behaviour and health outcomes, and that in many draft recommendations the target audience should be broadened to address this.
- Practitioners felt that these influencers are **especially pronounced – and particularly powerful – in the lives of women from low income families.** It is therefore essential that they are addressed in these draft recommendations.
- Many practitioners were surprised that more of the draft recommendations did not include schools (e.g. via PSHE curriculum, Healthy Schools programme), youth services (including Connexions), and Family Welfare services under ‘Who should take action’.

They felt that such organisations and agencies had a critical role to play in **targeting younger women and teenage mothers**.¹

- Practitioners occasionally described the draft recommendations as being “a bit middle class”. In some cases they were suggesting that the draft recommendations place too great an emphasis on women’s ability to afford certain things.² However, more often they were alluding to the fact that the draft recommendations assume a **degree of autonomy and agency, and a positive attitude towards behaviour change, on the part of mothers and women** that is simply not accurate in their experience of women from low income households.
- Practitioners recognise that to tackle these broader influencing factors requires them to **deliver services in more integrated ways**. Practitioners and commissioners feel that the drive towards joint commissioning, Local Area Agreements, Children’s Trusts, and broader service reconfiguration has the potential to support work in this area.
- However, practitioners’ and commissioners’ main concern is that the **draft recommendations appear not to acknowledge explicitly this emerging institutional landscape** and its significant potential for improving health outcomes.

“It’s about health education, it’s about health promotion and the broader public health role, it’s much wider than waiting till somebody’s pregnant, it’s about getting into schools, it’s about the general messages out there, it’s about healthy eating programmes and all that stuff, and all of that builds in to whether you are going to get them to breastfeed when they get to that point. So I would say that it’s about having the resource to do that real public health work, which is what health visitors are so well placed to do, but which also involves a whole raft of other professionals working in harmony.” Commissioner, North East

“I think we do need to start looking more creatively at how we tackle some of these public health issues. I think there has been an overemphasis on sometimes one-to-one but what we might need to do is work in the communities. Promoting healthy eating is about helping [clients] be like everybody else. So if you’re having a one-to-one session on how to make mashed carrots, it’s not as powerful as sitting around with a load of mums that you know and all of you agree mashed carrots is a good idea!” Commissioner, South West

3.2 Understanding the shift from ‘role’ to ‘relationship’

- Currently, the draft recommendations tend to focus the ‘Who should take action’ category on the professionals who (traditionally) are in the right *role* to deliver the recommendation.
- However, practitioners suggested that in a world in which they need increasingly to work creatively to respond to the broader factors that influence behaviour, they feel that **being in the right role to deliver the draft recommendation is less important than being having the right kind of relationship with a client to deliver a recommendation**.

¹ Practitioners suggested that teenage mothers tend to access services later, and many teenage pregnancies are unplanned. As a result of both of these factors, it is difficult to engage teenage women pre-pregnancy. This has particular implications where Recommendations such as 2 (timely diet supplementation with folic acid) and 6 (timely cessation of alcohol consumption) are concerned.

² e.g. vitamin supplements (draft recommendations 1 and 2), electric breast pumps and fridge thermometers (draft recommendation 13).

- Practitioners were keen to emphasise the importance of peer supporters and peer trainers, and also schools—individuals and organisations that may not traditionally provide advice on matters relating to maternal and child nutrition, but who nevertheless have the right kinds of trusted and enduring relationship with clients to initiate a conversation on these issues.
- Practitioners feel that if services want to have an impact, they need to think about how they can build the kinds of relationships with clients that have the potential to change behaviour.

“In our service, obviously the team leader is the health visitor, and they do the needs assessment and they work out what needs to be done, some of that work with the family, getting in there under the skin is often done by the nursery nurse. And once you’ve got that relationship then you’re going to be in a position to be able to put in all sorts of other stuff—healthy eating is a very good example. If you’ve sent a nursery nurse into do a piece of work around behaviour management with the family and actually you get there and find that the diet’s appalling, if they’re going in once a week for six weeks, they might build up a relationship with the mother to be in a position to then discuss that and then lead on it.” Commissioner, South East

3.5 Resources: the importance of being proactive and sustaining engagement

- Practitioners are aware of the **staffing resource implications** of a shift towards professionals working in new ways to tackle broader influencing factors or to develop trusted relationships with clients.
- Staffing resources are felt to be critical because practitioners recognise that to do these things, they need to:
 - Be **proactive** and reach out to clients in a timely way. This is particularly important in instances in the draft recommendations in which an early or time-critical intervention is necessary.³
 - **Sustain engagement** and deliver information and services to clients over time. This is particularly important in the context of building the trusted relationships described above.
- Practitioners and commissioners recognise that within the current financial climate it is unlikely that additional resource will be made available to support workforce expansion in key areas of delivery. Recognising this, many commissioners are keen to explore creative ways of delivering services with existing levels of resource.

3.6 ‘How’ as well as ‘what’? The potential for flexibility within the draft recommendations

- Practitioners welcome the fact that the draft recommendations provide a standard that has the potential to reduce variation and inconsistency in practice. But whilst no-one disputes the importance of the draft recommendations specifying the standard (the ‘what’); some **practitioners were uncomfortable about the draft recommendations over-specifying the means of reaching that standard (the ‘how’)**.

³ e.g. When advising about folic acid and folate in the diet, or cessation of alcohol consumption, or initiation of breastfeeding and initiation of weaning.

- Practitioners suggest that over-specifying the ‘how’ has the **potential to inhibit potentially valuable innovative practice.**⁴

⁴ An example of this is draft recommendation 12, which practitioners feel is currently unfeasible. However, if the recommendation allowed practitioners some flexibility in terms of how they ‘ensure that mothers know how to breastfeed...’ (i.e. practitioners may decide that their intervention may be more effectively delivered antenatally in the community rather than before the mother leaves the hospital or birth centre), this may improve the feasibility of the recommendation.

4. Findings from the fieldwork workshop phase

The following sections gather together insights gleaned from practitioners engaged in the fieldwork workshop process. For more information about the workshops, where they were held, and which kinds of practitioner attended, please see Appendix 1.

4.2 Detailed findings from practitioners recommendation-by-recommendation

Draft recommendation 1

Who is the target population?

Women of childbearing age

Who should take action?

Planners and organisers of public health campaigns at a national and local level, strategic health authorities (SHAs) and Primary Care Trusts (PCTs), manufacturers of goods for women of childbearing age.

What action should they take?

- Promote and increase the uptake of folic acid supplements and the intake of dietary folic acid and folate (for example, fortified breakfast cereals and green vegetables). This should be supported by local initiatives that include education of health professionals and the provision of Healthy Start vitamin supplements for women.
- Manufacturers of goods specifically for women of childbearing age, for example, pregnancy tests, sanitary products and oral contraceptives, should consider including information on the importance of folic acid supplements before and during pregnancy.

Clarifications

- 1.1 Some health visitors were unclear about whether folic acid supplements should be taken in addition to vitamin supplements that contain folic acid. Many were unclear about whether Healthy Start vitamins contain folic acid. Dietitians and nutritionists suggested that the women they work with are certainly unclear on these issues

Impact and feasibility

- 1.2 All practitioners felt that the impact of this recommendation would be enhanced if it were more explicit in its guidance to practitioners about the need to pay particular attention to women from low income households in the promotion of folic acid and folate intake.
- 1.3 Many practitioners, especially midwives, thought that information on product packaging about folic acid should not be limited to oral contraceptives; rather, such information should be included on *all* contraceptives.

- 1.4 Many practitioners suggested that a television campaign might help to get the information across to women from disadvantaged groups.

Gaps, missed opportunities and suggestions for improvements

- 1.5 Practitioners felt that the impact of this recommendation would be enhanced if it were more explicit in its guidance to practitioners about the need to pay particular attention to women from low income households in the promotion of folic acid and folate intake.
- 1.6 Practitioners across the board agreed that the ‘Who should take action’ category should include family planning clinics, sexual health clinics, schools, pharmacists and drug centres (treatment centres and methadone clinics). This is in recognition of the fact that they feel the recommendation is likely to have greater impact if a wider range of the services with which women have contact are involved in the promotion of dietary and supplementary folic acid and folate.

Practitioner quotes

“Excellent idea. Manufactured goods become the messenger, but you should also include condoms and other toiletries—not just oral contraceptives.” (Midwife, 2½ years, Manchester)

“School nurses should play a major role in educating young people in school.” (Health Manager, 3 years, Manchester)

“This must include the wider community! i.e. supermarkets, the media, schools, etc. But supermarkets need a better understanding of the Healthy start scheme.” (Midwife, 20 years, Lowestoft)

“It will be difficult to get manufacturers on board and they will need to be given incentives to join the campaign.” (Health Visitor, 33 years and Senior Children’s Centre Dietitian, 5½ years, London)

“The groups you need to target most are the ones that are hardest to reach, so PCTs need to recruit the right people to reach them.” (Dietitian, 1 month, Birmingham)

Draft recommendation 2

Who is the target population?

Women of childbearing age.

Who should take action?

GPs, hospital doctors and nurses, particularly those working in gynaecology, sexual health, contraceptive services, fertility clinics and school health services, pharmacists.

What action should they take?

Advise all women who may become pregnant that they can reduce the risk of having a baby with a neural tube defect (for example, anencephaly and spina bifida) by taking folic acid supplements. Advise them to take 400 micrograms (µg) daily before pregnancy and

throughout the first 12 weeks, even if they are already eating foods fortified with folic acid and/or rich in folate.

GPs should prescribe 5 milligrams of folic acid a day for women who may become pregnant if they:

- (or their partner) have a neural tube defect
- have had a previous baby with a neural tube defect
- (or their partner) have a family history of neural tube defect
- have diabetes mellitus.

Clarifications

- 2.1 Some practitioners felt that the link between draft recommendation 1 and draft recommendation 2 needs to be clarified.
- 2.2 Whilst public health nutritionists and GPs tended to be clear on this issue, other practitioners suggested that the recommendation ought to:
 - Clarify the distinction between folic acid and folate
 - Be more precise about how long before pregnancy women should take folic acid supplements
 - Suggest where folic acid supplements can be bought, how much they cost, and what brands are suitable—although it is worth noting that most practitioners recognised that it was probably not appropriate for NICE draft recommendations to be seen to endorse particular brands of folic acid supplements.

Gaps, missed opportunities and suggestions for improvements

- 2.3 Practitioners felt that the ‘Who should take action’ category should include anyone who deals with young women (e.g. youth services). This is to ensure that advice about folic acid supplements can be delivered in a timely way—and especially before they become pregnant.
- 2.4 Some practitioners thought that the recommendation ought to emphasise more strongly the fact that women who are eating fortified foods should still take folic acid supplements.
- 2.5 Practitioners thought that the first point should be ‘Advise all women *and all health professionals...*’ as it was felt that health professionals are not aware of this information. However, the very publication of this recommendation will surely make health professionals aware of this issue; this does not need to be stated explicitly in the recommendation itself.
- 2.6 Practitioners thought that the recommendation ought to suggest that the professionals use accessible language when advising women about preventative measures related to neural tube defects. Practitioners felt that some women (with limited educational ability from low income families) may not understand terms such as ‘neural tube defect’, ‘anencephaly’ and ‘spina bifida’.

Practitioner quotes

“It’s all very well saying to low-income mothers-to-be that they should have folic acid, but not if they end up having to go and pay for it themselves, they won’t take it.” (Health Promotion Midwife, 7 years, Lowestoft)

“Will folic acid be available free? And from where? This needs to be sorted out and clarified to enable low-income and less educated women to access it. And not just those women on benefits either.” (Health Visitor, 26 years, London)

“It would be ideal if midwives could have earlier intervention with women; extend their roles and get more involved at the pre-conception stage.” (Clinical Manager Maternity, 8 years, Lowestoft)

“You’re recommending 5mg of folic acid for women if they’ve had a previous defect, or if they’re diabetic. I would suggest that we also give it to women who are on anti-epileptic medication because this is an anti-folate, women with coeliac disease, women who have had a child with a cleft lip or cleft palate and also women who are significantly obese.” (Obstetrician)

Draft recommendation 3

Who is the target population?

Pregnant women

Who should take action?

Midwives, obstetricians, GPs and health visitors.

What action should they take?

- Discuss with pregnant women, at the first opportunity, their diet and eating habits. Help them to voice any concerns they may have about their diet. Provide information and advice on healthy eating that is tailored to their needs.
- Offer information and advice on the benefits of eating a varied diet during pregnancy, including five portions of fruit and vegetables a day.
- Encourage pregnant women to eat one portion of oily fish (for example, mackerel, sardines, pilchards, herring, trout or salmon) per week.

Clarifications

- 3.1 Practitioners felt that the second point could be clarified to read ‘...practical advice on the benefits to mother and child of eating a varied diet...’. Some practitioners thought that the recommendation should provide more detail about precisely what information and advice should be given on healthy eating (besides the advice related to eating five portions of fruit and vegetables), and about where practitioners can get this information.
- 3.2 Some practitioners were unclear about whether the five portions of fruit and vegetables a day includes frozen or tinned fruit and vegetables.
- 3.3 Practitioners also felt that the point about oily fish needs to:

- Clarify whether ‘one portion of oily fish’ includes tinned fish and fish oil supplements
- Be more explicit about how much oily fish constitutes one portion
- Include non-fish alternatives for vegetarians and vegans
- Contain a longer list of oily fish—especially fish that might form part of the diets of members of Black and minority ethnic groups.

Gaps, missed opportunities and suggestions for improvements

- 3.4 Practitioners felt that the ‘Who should take action’ category should also include supermarkets, schools, dietitians, general support staff through children’s centres, local authorities and members of mothers’ extended family. Practitioners felt that this category should be broader but the new additions will need to be provided with training.
- 3.5 Practitioners felt that the last point should be strengthened to read ‘Encourage *and support* women to eat...’. This was in recognition of the fact that they felt that simply telling women to eat oily fish (or even describing the benefits of eating oily fish) is unlikely alone to change people’s behaviour. Encouragement needs to be accompanied by support, including advice on how to prepare and cook oily fish.

Practitioner quotes

“Everyone wants this to happen, but there’s no time or money to make it happen. And there’s currently no genuinely consolidated approach—which is what it would take.” (Health Visitor, 8 years, Lowestoft)

“Consider cultural differences, vegetarians, vegans, people who don’t eat UK food but who buy from ethnic shops. Community workers for instance can give lists of ‘Bangladeshi fish rich in oil’ or ‘vegetables rich in folic acid’.” (Breastfeeding Peer Support Worker, 4 years, London)

“Give more practical advice on how to change their life style rather than just giving advice.” (Health Visitor, 26 years, London)

“We try to encourage healthy eating, but do the families we work with really understand the benefits? More education on the benefits of healthy eating would be useful.” (Community Nursery Nurse, 5 years, Lowestoft)

“My experience is that pregnant women take this advice more seriously when it is delivered by a dietician; for example, as part of a session about parent craft or at an ante-natal drop-in session.” (Health Coordinator, 2½ years, Manchester)

Draft recommendation 4

Who is the target population?

Pregnant women and parents of infants and children under 4 years who may be eligible for Healthy Start benefit

Who should take action?

Commissioners in SHAs and PCTs. GPs, obstetricians, paediatricians, midwives and health visitors.

What action should they take?

- PCTs should ensure Healthy Start vitamin supplements are readily available for GPs and health visitors to give to all eligible women and young children.
- At the first contact, health professionals should encourage pregnant women who may be eligible for the Healthy Start scheme to register.
- Health professionals should, at every opportunity, offer those parents who are (or who may be) eligible for the Healthy Start scheme practical and personalised information, support and advice on:
 - how to maximise the use of Healthy Start vouchers and increase their fruit and vegetable intake
 - how to initiate and maintain breastfeeding
 - how to introduce foods other than milk as part of a progressively varied diet when infants are 6 months old.
- GPs, midwives and health visitors should offer Healthy Start vitamin supplements (folic acid, vitamins C and D) to women who are planning a pregnancy and who receive Healthy Start benefit for a child under 4 years.
- GPs, midwives and health visitors should offer Healthy Start vitamin supplements (Vitamins A, C and D) to all eligible children.

Clarifications

- 4.1 A number of practitioners questioned what ‘support’ (third bullet point) means in this context.

Impact and feasibility

- 4.2 Practitioners across the board felt that if the recommendation were to explain where Healthy Start vitamins are given to those who are eligible beneficiaries and where they are sold to others, this would help to increase the uptake of the voucher scheme.
- 4.3 A number of practitioners described the challenges they had experienced in accessing sufficient supplies of Healthy Start vitamin supplements. They suggested that poor availability of Healthy Start vitamins would inhibit significantly the implementation of this recommendation. One practitioner in East London went on to express practical concerns over the packaging of the Healthy Start vitamins: apparently the batch she had received had leaked in transit.

Gaps, missed opportunities and suggestions for improvements

- 4.4 Practitioners felt that the ‘Who should take action’ category should also include community staff nurses, children’s centres, peer supporters, pharmacists, sure start workers, midwives and drug centres (treatment clinics and methadone clinics).
- 4.5 Practitioners thought that the recommendation overall needs to emphasise that the Healthy Start supplements are only supplements and are therefore not a replacement for a healthy diet.
- 4.6 Practitioners felt that information needs to be provided to health professionals (and women) about the eligibility criteria for the Healthy Start programme since this was an area in which they recognised there was confusion and limited awareness among professionals—particularly GPs and midwives,⁵ Practitioners also felt that clarification should be offered about the documents that women need to prove that they are eligible, and about the Healthy Start programme application process overall.

Practitioner quotes

“They need to ensure the sources from which people can obtain Healthy Start vitamins have access to supplies of these vitamins. The DoH has been advertising them, but we can’t actually get hold of them. We don’t have them.” (Health Visitor, 7 years, Lowestoft)

“What about low income women who are not entitled to Healthy Start vouchers and vitamins e.g. Asylum seekers. Is there something else available for them?” (Midwife, 1 year, Manchester)

“You need to educate health professionals about Healthy Start. The biggest barrier to this recommendation working is that people like obstetricians don’t know enough about the Healthy Start programme.” (Audit Midwife, 8 years, Lowestoft)

“I have never heard of Healthy Start benefit...and I suspect most GPs are completely ignorant as to what is Healthy Start is.” (GP, Surrey)

⁵ However, some practitioners challenged that although this information is important to support delivery of the programme – and implementation of the recommendation – it is probably not the role of a NICE recommendation to communicate this information; some other, more appropriate channel of communication should address the fact that there is limited awareness among some groups of professionals of the eligibility criteria for Healthy Start.

Draft recommendation 5

Who is the target population?

Pregnant women, particularly those at greater risk of vitamin D deficiency (those who have limited exposure to sunlight and/or have dark skin).

Who should take action?

Midwives, obstetricians and GPs.

What action should they take?

- At the woman's first appointment, offer information and advice on the benefits of taking a vitamin D supplement (10 micrograms [μg] per day) during pregnancy. Ensure she is aware of the longer term benefits for herself and her baby.
- Advise all women who have limited exposure to sunlight and/or have dark skin to take a vitamin D supplement during their pregnancy. The aim is to increase their body's vitamin D stores and reduce the risk of their baby developing rickets.
- Encourage women who are not eligible for Healthy Start benefit to take a suitable vitamin D supplement

Clarifications

- 5.1 Many practitioners felt that the recommendation was unclear about the women it is targeting—is it targeting (all) 'pregnant women' or simply those 'women with limited exposure to sunlight'? When pushed, most practitioners indicated that they felt the recommendation was probably targeted at the latter. They suggested that one way of clarifying this would be to put the second bullet point first—thus foregrounding the group to be targeted. Practitioners also felt that explanation is needed about what 'dark skin' means (i.e. does this relate to tanned Caucasian skin as well as, say, African-Caribbean or Asian skin?) and about what counts as 'limited exposure to sunlight'. Practitioners recognised that given recent stories about incidences of rickets this recommendation has an important potential impact.
- 5.2 Many practitioners – especially health visitors – felt that clarification needs to be provided about the different types of Vitamin D supplement available. Questions were asked about whether breastfeeding mothers, pregnant women and babies need a Vitamin D supplement, and, if so, whether they need different types of Vitamin D supplement. Practitioners across the board, especially nutritionists, midwives and health visitors, tended to be quite open about the fact that there was very poor awareness of issues relating to Vitamin D deficiency and the preventative measures needed to address it, and they recognised that health professionals need more information on this topic—whether this comes from the NICE draft recommendations or from another source of communication.
- 5.3 A few health visitors asked about the fat solubility of Vitamin D, and the implications of this for the advice they should give, e.g., to women with different BMI scores; in relation to other dietary advice.

Gaps, missed opportunities and suggestions for improvements

- 5.4 Practitioners in general felt that the target population for this recommendation should also include breastfeeding mothers and the wider community. Practitioners tended to be unclear about why pregnant women specifically are featured in the target population. This unclarity stems from a wider confusion evident in many of the fieldwork workshops about whether the recommendation is for *all* women or only a subset of pregnant women.
- 5.5 Practitioners across the board also felt that the ‘Who should take action’ category should also include health visitors, link workers, health promotion practitioners, pharmacists, children’s centres, family members, churches and mosques and other religious/community centres, and the wider community. This is in recognition of the fact that practitioners feel the recommendation is likely to have greater impact if a wider range of professionals and other people with whom women have contact are included.

Practitioner quotes

“This is new information to me, I didn’t know about this. We need training in this area in the first place.”
(Health Visitor, 11 years, Lowestoft)

“Vitamin D supplementation? I have to tell you, and I don’t think I’m alone, I have never offered Vitamin D supplementation to anyone. I think that’s a new thing.” (GP, Surrey)

“We need more info about Vitamin D, what is limited exposure to sunlight, what is the right amount.”
(Audit Midwife, 27 years, Manchester)

“Lack of supplies is a problem. You get a GP to prescribe and they don’t know what to prescribe and then they want a blood test to check how low the levels are and eventually it just doesn’t get done.” (Health Visitor, 4 years, London)

“Add health visitors to ‘Who should take action’ as they have more dedicated time than midwives to do this sort of thing.” (Midwife, 12 years, Faye)

Draft recommendation 6

Who is the target population?

Women who may become – or who are – pregnant.

Who should take action?

Midwives, obstetricians and GPs.

What action should they take?

- At the earliest opportunity, encourage women not to drink alcohol while trying to conceive or when pregnant and advise them about the risks to their baby.
- At the earliest opportunity and, as appropriate throughout their pregnancy, advise women who choose to drink alcohol not to drink more than one or two units once or twice a week. (Examples of one unit include one half pint of lager or cider or a small glass of wine. One alcohol equals two units).

Clarifications

- 6.1 Some practitioners felt that the relationship between the first and second bullet point is contradictory and confusing, i.e. “is NICE saying that women can drink one or two units once a week, or that women shouldn’t drink any alcohol at all?!”. To clarify this, practitioners suggested that the second bullet point should emphasise that it relates to women who choose to continue drinking despite being told about the risks of drinking whilst trying to conceive and during pregnancy. (e.g. *‘For women who choose not to follow the above advice, at the earliest opportunity...’*). Some practitioners felt that the list of alcoholic drinks with their associated units could be made more comprehensive.
- 6.2 One obstetrician said she felt that the recommendation contradicted existing DoH advice on alcohol consumption.

Gaps, missed opportunities and suggestions for improvements

- 6.3 Practitioners felt that, although teenage girls are implicit in the definition of the target group as ‘women who may become ... pregnant’, this needs to be made much more explicit. This is in recognition of the fact that this information needs to be available to girls who may be drinking and sexually active in adolescence as early as possible to minimise the risk of harm to the foetus if they are pregnant. Practitioners also suggested that the target group should include women who are pregnant, their child’s father/the mother’s partner, and members of their extended family.
- 6.4 Practitioners felt that the ‘Who should take action’ category should include schools, pubs, teachers, youth programmes, youth centres, health visitors and school nurses—all of the services that women – especially younger women – use. This was in recognition of the need to engage wider influencers to reinforce key health promotion messages.

- 6.5 Practitioners were keen for the recommendation to emphasise the risks of drinking (excessive) alcohol not only to the unborn baby but also to the woman herself.
- 6.6 Some practitioners felt that the recommendation misses an opportunity to advise practitioners on what to do in relation to women who are alcoholic and who are pregnant or trying to conceive.
- 6.7 Some practitioners expressed surprise that there is not an equivalent recommendation focused on smoking cessation, since smoking is prevalent in many cultures in which drinking is not. Practitioners satisfied themselves that rather than being an oversight this ‘omission’ was simply because smoking is neither a food nor a drink and therefore was not in the scope of the Maternal and Child Nutrition guidance; and is likely to be covered in separate programme or intervention guidance focused on smoking cessation.

Practitioner quotes

“We need to change cultural attitudes to alcohol and uncover the reasons for people’s high alcohol abuse. Also we should involve the media in indirect promotion of healthy alcohol intake, through soap storylines and things like that.” (Health Visitor, 4 years, London)

“Who should take action should include the wider community. And alcopops should include visible warnings about the dangers of foetal alcohol syndrome and an easier explanation of alcohol units. Above all, all professionals should advise no alcohol during pregnancy.” (Health Promotion Midwife, 2 years, Lowestoft)

Draft recommendation 7

Who is the target population?

Women who have a body mass index (BMI) over 30, particularly those who may become pregnant and those who have had a baby.

Who should take action?

Obstetricians, gynaecologists, GPs, midwives, health visitors, nurses, dietitians and those working in family planning.

What action should they take?

- Encourage women to reduce their BMI to below 30 before becoming pregnant and/or after pregnancy, by informing them (as appropriate) about the risks and providing a structured programme of support. This programme should:
 - be tailored to the needs of an individual or group
 - combine advice on healthy eating with regular, moderate physical activity (for example, brisk walking)
 - identify and address barriers to change
 - provide ongoing support over a sufficient period of time to allow for sustained lifestyle changes.
- Advise breastfeeding women that losing weight through a combination of healthy eating and regular exercise will not affect the quantity or quality of their milk.

Clarifications

7.1 Practitioners across the board suggested that clarification is needed on various aspects of this recommendation:

- Explanation is needed about what a ‘structured programme of support’ entails, and about how to provide the support, e.g. use/modify an existing form of support or create a new support package from scratch?
- Many practitioners were unclear about how precisely they should ‘identify and address barriers to change’.
- Practitioners felt that greater precision is needed in the recommendation about what ‘regular, moderate physical activity’ can involve. Some practitioners were concerned about the risk of rapid weight loss causing the release of dioxides.⁶
- There was uncertainty about exactly how long the ‘sufficient period of time to allow for sustained lifestyle changes’ is. Practitioners understood that this timeframe is likely to

⁶ There is a misconception that doing physical activity whilst breastfeeding can cause breast milk to sour. There is no evidence to support this, but it is nevertheless important to address this view where it is held.

differ for different people, but they were unclear about how they would identify an appropriate likely timeframe for a given individual.

Impact and feasibility

- 7.2 Different practitioners responded in different ways to this recommendation. Midwives felt that the onset of pregnancy was an appropriate time to talk to women about their weight and therefore something that they could address in a professional conversation; other practitioners felt that it was not their place to discuss weight loss with women, and that women would simply not listen to them. Overall, practitioners, in particular health visitors, agreed that this recommendation needs to be more specific about how much exercise should be taken during pregnancy.
- 7.3 Conversations with practitioners suggested that there were gaps in their awareness about some details of BMI measurement—something that certain practitioners, including dietitians, acknowledged. Some practitioners felt that the recommendation should provide more information about BMI measurement, including how to calculate a woman's BMI, and what to do for women with low BMI scores. However, once again, many practitioners felt that awareness-raising about BMI is a matter best addressed by another form of communication rather than a NICE guidance recommendation. Nevertheless, they emphasised that addressing this lack of knowledge and skill is an important precondition for the effective implementation of this recommendation.
- 7.4 Some practitioners felt that this recommendation offers an opportunity to help practitioners communicate a 'bigger picture' to mothers about the relationship between topics such as excessive weight and infant death and child obesity.

Gaps, missed opportunities and suggestions for improvements

- 7.5 Practitioners felt that the 'Who should take action' category should include schools, mental health workers, drug centres, health trainers and peer supporters. Given the diversity of professionals who are potentially involved in taking action, some participants felt it might be helpful in this instance to identify a particular type of professional who should be accountable overall for spearheading and driving the action—and to whom the other professional constituencies should be accountable.⁷
- 7.6 Some practitioners felt that for the sake of clarity and focus it may be beneficial to separate this recommendation into two separate draft recommendations: one dealing with exercise and one dealing with weight loss through healthy eating.
- 7.7 Many practitioners felt that the recommendation misses an opportunity in that it does not mention crash dieting and eating disorders—both of which practitioners felt are increasingly prevalent, and especially relevant to teenage mothers.

⁷ This suggestion – to identify a single accountable organisation to spearhead the action – was touched on by practitioners in different workshops, and forms the basis for one of the guiding principles featured in the introductory section of this Fieldwork Report.

Practitioner quotes

“What about low BMIs and eating disorders? These also pose huge health risks to pregnant women. The recommendation should target popular eating disorders overall.” (Clinical Manager Maternity, 7 years, Lowestoft)

“Cultural factors have to be identified and tackled. Healthy eating and exercise rather than dieting.” (Infant Feeding Co-ordinator, 4 weeks, London)

“The problem with implementing this recommendation is the time barrier as this is not a quick fix but the women will need time and support.” (Health Visitor, 6 years, London)

Draft recommendation 8

Who is the target population?

Pregnant women and breastfeeding mothers.

Who should take action?

Managers responsible for providing maternity and children’s services in primary and secondary care.

What action should they take?

- Adopt a multifaceted approach and/or a coordinated programme of interventions across settings to increase breastfeeding rates. This approach or programme may include:
 - raising awareness of the benefits and barriers to breastfeeding
 - training for health professionals
 - breastfeeding peer support programmes
 - joint working between health professionals and peer supporters
 - education during pregnancy about how to breastfeed combined with information and proactive voluntary support during the postnatal period.
- Implement an externally evaluated, structured programme that encourages breastfeeding, using the Baby Friendly Initiative (BFI) as a minimum standard. (www.babyfriendly.org.uk)
- Ensure there is a written breastfeeding policy that includes provision for staff who may be breastfeeding. This should be communicated to all staff and parents. Each provider should identify a lead health professional responsible for implementing this policy.
- Provide effective breastfeeding peer support programmes in areas where breastfeeding initiation and duration rates are low.

Clarifications

- 8.1 Overall, practitioners felt that this recommendation is insufficiently clear about whether it is referring to exclusive breastfeeding or partial breastfeeding. Practitioners

felt that this should be clarified and breastfeeding in the recommendation using the Baby Friendly Initiative (BFI) definition.

8.2 Some health visitors and infant feeding specialists felt that the recommendation was unclear in the way that it referred to breastfeeding rates. In particular, they were unclear about:

- How to measure breastfeeding rates and precisely how to undertake an effective comparison of rates
- Whether breastfeeding rates relate to exclusive breastfeeding solely or whether they should include partial breastfeeding.

Midwives were also concerned that this recommendation apparently aims to raise rates of *initiation* of breastfeeding; they felt that the focus of the recommendation should shift to raise rates of *duration* of breastfeeding.

8.3 Health visitors felt that the recommendation needs to offer clarification on exactly what they should communicate as far as the ‘benefits and barriers of breastfeeding’ are concerned. Some practitioners thought that the health effects need to be clarified (e.g. breastfeeding is not a contraceptive). They also felt that not only should the benefits of breastfeeding be promoted but also that the risks of not breastfeeding should be publicised. They felt that this would help to “re-normalise” breastfeeding.

8.4 Many practitioners suggested that the last bullet of this recommendation should read ‘provide effective and sustainable peer support programmes...’ since the sustainability of any such programme will be a significant factor in maximising its impact. Practitioners felt that clarification was needed about exactly what a ‘breastfeeding peer support programme’ should entail.

Impact and feasibility

8.5 Many practitioners felt that there needs to be greater awareness about the cultural issues and sensitivities surrounding breastfeeding. They felt that the introduction of breastfeeding managers could be beneficial in this regard

8.6 Practitioners suggested that the breastfeeding policy should be a national policy. They were keen to emphasise that the ‘lead health professional’ responsible for implementing this policy within an organisation should have breastfeeding expertise.

8.7 Many practitioners were concerned about an over-emphasis in the recommendation of delivering such programmes in areas where breastfeeding initiation and duration rates are low. Practitioners felt that such programmes should also be delivered in areas in which rates are high since they may reduce if areas do not receive the support they need to maintain breastfeeding. Some practitioners also felt that some explanation is necessary about what constitutes a low rate. However, other practitioners felt that this would be something that would be determined locally and therefore it is inappropriate to specify ‘low’ or ‘high’ rates in a guidance recommendation.

Gaps, missed opportunities and suggestions for improvements

8.8 Practitioners thought that the ‘Who should take action’ category should include the mother’s partner/child’s father, parents, grandparents, Sure Start centres, schools, local councils, peer supporters, midwives, health visitors and GPs. In other words, a wide

range of professionals, organisations and other individuals linked to the mother who practitioners felt would participate in the ‘co-ordinated programme’.

- 8.9 Practitioners felt that the target population should include men and the wider community (e.g. shops, organisations, services) as these constituencies will presumably be key audiences impacted by the ‘co-ordinated programme of interventions across settings’ described in the recommendation. Practitioners were also keen that teenage girls be mentioned explicitly to draw professionals’ attention to their needs specifically.
- 8.10 Practitioners felt that a minimum standard should be specified in the recommendation for training health professionals, and that this training should be mandatory and updated regularly. Community dentists and GPs suggested that making the training mandatory would be essential if professionals in their roles were to undertake it.
- 8.11 Practitioners felt that the recommendation should provide more detailed guidance on how peer supporters should work with mothers within peer support programs (though they recognised that this was, to an extent, addressed in draft recommendation 15).
- 8.12 Many practitioners also felt that this recommendation could suggest solutions to the problem of women feeling discomfort when breastfeeding outside the home, since this is currently a major barrier to their maintaining breastfeeding. Practitioners felt, for example, that local councils could be encouraged to take action ensuring there are places where women can breastfeed in public.

Practitioner quotes

“Include fathers and grandparents. Grandmas have a great deal of influence.” (Midwife, 7 years, Manchester)

“This whole area needs to be clarified as when are the rates going to be collected? How long are they to be measured?” (Health Visitor, 33 years, London)

“Need a breastfeeding support person. If it’s just left to managers it won’t happen. Need a breastfeeding manager for an area.” (Midwife, 2½ years, Birmingham)

“Need different training for the different groups. They should all have the same agenda, just different training is needed.” (Health Visitor, 22 years, Plymouth)

Draft recommendation 9

Who is the target population?

Pregnant women and breastfeeding mothers.

Who should take action?

Managers responsible for providing maternity and children's services in primary and secondary care.

What action should they take?

- Ensure health professionals who provide information and advice to breastfeeding mothers have the required knowledge and skills.
- Ensure support workers receive training in breastfeeding management from a skilled knowledgeable person before they support mothers who are breastfeeding.
- Ensure all those who work in maternity services, including receptionists, volunteers and ancillary staff, are informed of the importance of breastfeeding and help to promote a supportive environment for breastfeeding.

Clarifications

- 9.1 Many practitioners felt that the statement 'required knowledge and skills' (first bullet point) is too vague, and that the specific skills and capabilities should be specified (e.g. 'training in...').

Impact and feasibility

- 9.2 Practitioners felt that the first bullet point should emphasise the need for training programmes to be consistent and based on current information about what works. There was concern generally among practitioners about the lack of standards for peer support workers. Practitioners suggested that the 'training in breastfeeding management' (second bullet point) should be mandatory, and also that it should be multi-disciplinary, and evaluated and updated regularly, and then the knowledge imparted by the training shared with every professional who comes into contact with young women. Practitioners suggested that the last bullet point should be strengthened to read '...and help to promote *a positive culture and* a supportive environment for breastfeeding.'

Gaps, missed opportunities and suggestions for improvements

- 9.3 Practitioners felt that the target population should include the entire community.
- 9.4 Practitioners felt that the 'Who should take action' category should include pharmacists, health visitors, voluntary organisations, community groups, dietitians, Sure Start workers, GPs, children's centres, paediatricians, and general medical staff.

Practitioner quotes

“Nine and 10 are both very good [draft] recommendations but there are resource issues: staff, money, training, and updating of training.” (Health Visitor, 2 years and Senior Midwife, 2 years and Infant Feeding Co-ordinator, 22 years, Plymouth)

“Managers need to accept that training is needed across the whole skill mix within the professional team.” (Senior Midwife, 30 years, Lowestoft)

Draft recommendation 10

Who is the target population?

GPs, paediatricians, obstetricians, surgeons and physicians, midwives, midwifery support workers, health visitors, community nurses, nursery nurses, pharmacists and dentists.

Who should take action?

Professional bodies and those responsible for setting competencies and continuing professional development (CPD) programmes for health professionals, nursery nurses and support workers.

What action should they take?

- Ensure health professionals have knowledge, skills and competencies in:
 - the nutritional needs of women before and during pregnancy
 - the health benefits of providing pregnant women with folic acid and vitamin D supplements
 - the nutritional needs of infants and young children
 - breastfeeding management (using BFI training as a minimum standard) strategies for behaviour change.
- Train all midwives, health visitors and support workers in breastfeeding management, using BFI training as a minimum standard, as part of their continuing professional development (www.babyfriendly.org.uk).
- Train doctors, dietitians and pharmacists, as part of their continuing professional development, to take every opportunity to promote and support breastfeeding, using the principles of BFI training as a minimum standard (www.babyfriendly.org.uk).

Impact and feasibility

10.1 As with draft recommendation 9, practitioners felt that the training should be mandatory, and also that it should be multi-disciplinary, evaluated and updated regularly.

10.2 Many practitioners agreed that if draft recommendations 9 and 10 are implemented effectively, then draft recommendations 1-7 will follow naturally. Essentially, draft

recommendations 9 and 10 are an important pre-condition for the impact and feasibility of the other draft recommendations.

Gaps, missed opportunities and suggestions for improvements

- 10.3 Practitioners felt that the ‘Who should take action’ category should include pharmacists, health visitors, voluntary organisations, community groups, dietitians, Sure Start workers, GPs, children’s centres, paediatricians, general medical staff, and the community.
- 10.4 Practitioners felt that the recommendation should be more specific about which ‘health professionals’ it is referring to. Not every health professional needs the knowledge, skills and competencies listed in the recommendation, and certainly not to the same degree.

Practitioner quotes

“This is great! We need evidence-based guidelines like these, and resources. Training may need to be mandatory, not optional, and it needs to cover complementary feeding and weaning.” (Infant Feeding Co-ordinator, 4 weeks, London)

“All PCTs need a breastfeeding guru-type person who can co-ordinate training.” (Health Visitor, 11 years, Lowestoft)

“There are big training issues to make sure everyone is given the same advice, so there needs to be clear advice on this.” (Health Visitor, 33 years and Dietitian, 5 years, London)

Draft recommendation 11

Who is the target population?

Pregnant women.

Who should take action?

NHS trusts responsible for maternity care. Midwives, obstetricians, GPs and health visitors.

What action should they take?

Provide pregnant women and their partners with individual or group antenatal support. This should be led by someone trained in breastfeeding management and delivered in a setting and style that best meets the women's needs.

- Encourage breastfeeding, as appropriate and whenever possible, during individual antenatal consultations. Pay particular attention to women who are least likely to breastfeed (for example, young single women from disadvantaged groups).
- Provide an informal group session in the last trimester of pregnancy to focus on breastfeeding: this should cover positioning for mother and baby and how to attach the baby to the breast to ensure effective breastfeeding.

Impact and feasibility

- 11.1 Practitioners welcomed the fact that the recommendation suggests that guidance on breastfeeding be provided earlier (i.e. in the last trimester) than is often the case (i.e. in the days following birth). However, many practitioners were concerned that even the third trimester is too late to begin focusing on breastfeeding, and they suggested that the recommendation would have much greater impact with pregnant women if the 'informal group session' were introduced even earlier.
- 11.2 Practitioners who had experience of working with teenage mothers suggested that it can be difficult to encourage young women who are pregnant to attend ante-natal groups. When they do attend, young women tend to prefer to meet with other young women like them (ideally women who they already know) in dedicated ante-natal groups rather than join more general ante-natal groups. Practitioners felt that sensitivity to young women's needs was implied by the statement 'delivered in a setting and style that best meets the women's needs', but that issues related to teenage mothers could perhaps be emphasised more strongly in the recommendation to enable practitioners to engage them more effectively.

Gaps, missed opportunities and suggestions for improvements

- 11.3 Practitioners felt that the 'Who should take action' category should include breastfeeding supporters, peer supporters, schools, children's centre staff, and managers of children and young people's services.

11.4 Practitioners felt that it is necessary to provide some other examples of ‘women who are least likely to breastfeed’ since some practitioners are unsure how to determine who would be in this category. Many practitioners thought that the recommendation should use the term ‘teenage mothers’ rather than ‘young single women’ as they felt that this latter term is too broad.

Practitioner quotes

“This does not always need to come from health professionals, although they should be the instigators of care plan. Sure Start, Connexions, peer supporters etc can all play a big part.” (Health Promotion Midwife, 2 years, Lowestoft)

“The danger is that only clients who are interested in breastfeeding attend; therefore you are missing the target group. Some young mothers think they know best.... and in my experience, if you pressurise someone to do something, they will rebel.” (Health Visitor, 11 years and Student Nurse, Lowestoft)

“This will mean a big change in practice for midwives as to reach the client group they will have to pay visits to the clients rather than clients coming to see them.” (Health Visitor, 26 years, London)

Draft recommendation 12

Who is the target population?

Breastfeeding mothers.

Who should take action?

Midwives.

What action should they take?

- Ensure that mothers know how to breastfeed before leaving the hospital or birth centre (or before they leave the mother after a home birth). The mother should be able to position and attach her baby to the breast and identify signs that the baby is feeding well.
- Advise mothers that a healthy diet is important for everyone and reassure them that they do not need to eat a special diet to breastfeed.
- Do not provide written materials in isolation, rather, use them to reinforce verbal advice about breastfeeding.

Impact and feasibility

12.1 Practitioners endorsed the second bullet point, saying that it is important in their experience to let mothers know they do not need to change their diet to breastfeed. Many also felt that the recommendation should clarify that mothers and babies do not need extra water when breastfeeding. Some practitioners felt that such a conversation would be a good opportunity to talk to mothers about nutrition and healthy eating more generally—since many practitioners’ confirmed that in their experience, women

who are pregnant are likely to be more receptive to advice about changing their health behaviour.

- 12.2 Practitioners in all of the workshops had concerns over the feasibility of this recommendation. They felt that it is simply unfeasible to offer guidance to mothers on breastfeeding before they leave the hospital or birth centre. This is because many mothers are discharged within six hours of giving birth, and in many services there is simply not enough staff available to offer breastfeeding instruction to the degree specified in the recommendation within this timeframe. Some practitioners felt that if the recommendation were interpreted as suggesting that women should remain in hospital until they have received instruction on breastfeeding, this could create a situation in which women decide to ‘opt out’, leaving hospital without receiving instruction and not breastfeeding subsequently—in order that they are able to return home more quickly after giving birth. Some practitioners also explained that a woman’s breast milk may not arrive until several hours or even days after she has left hospital, and it makes little sense to offer breastfeeding instruction if the milk is unavailable. Practitioners felt that any advice to mothers should include information on how to maintain their milk supply, and what to do if their milk does not come through promptly after giving birth.

Gaps, missed opportunities and suggestions for improvements

- 12.3 Practitioners felt that the ‘Who should take action’ category should include health professionals, maternity nurses and health visitors.
- 12.4 Some midwives were surprised that the recommendation did not make reference to ‘baby-led feeding’.
- 12.5 Many practitioners felt that the recommendation misses an opportunity to emphasise the importance of ongoing professional support. They felt this was an important point because it recognised that continuation of breastfeeding is as important as initiation. Practitioners explained that many women give up breastfeeding in the first week post-partum, and that sustained intervention from professionals in this early stage can promote maintenance of breastfeeding.

Practitioner quotes

“It can sometimes take weeks to establish feeding so the first point in this recommendation is not really possible.” (Infant Feeding Specialist, 2 years, Manchester)

“The wording of this recommendation needs to reflect that mums and babies do not establish feeding possibly for days but mum should be aware of positioning, also they should have the relevant contact details for advice.” (Midwife, 7 years, Manchester)

“You are not leaving hospital until I can see you can breastfeed!” That’s what point one sounds like. Point one is impossible!” (Heath Promotion Midwife, 2 years, Lowestoft)

“Continuation of breastfeeding is as important as initiation. Information should be given on where to find ongoing support in breastfeeding while mums are leaving hospital.” (Infant Feeding Coordinator, 8 months, London)

Draft recommendation 13

Who is the target population?

Breastfeeding mothers.

Who should take action?

Managers of maternity services in primary and secondary care. Midwives, health visitors, paediatric nurses, nurses working in special-care baby and neonatal units, and nursery nurses.

What action should they take?

- Offer information on how to hand-express breast milk. Advise women who are expressing in place of breastfeeding that expressing both breasts simultaneously with an electric pump produces more milk in less time.
- Advise mothers who wish to store expressed breast milk to obtain a fridge thermometer.
- Advise mothers who wish to store expressed breast milk for less than 5 days that storing breast milk in the fridge preserves its properties more effectively than freezing.
- Advise mothers that expressed milk should be stored for:
 - up to 5 days in the main part of a fridge, at 4°C or lower
 - up to 2 weeks in the freezer compartment of a fridge
 - up to 6 months in a domestic freezer, at minus 18°C or lower.
- Advise mothers who freeze their expressed breast milk to defrost it in the fridge and not to re-freeze it once thawed. Advise them never to use a microwave oven to warm or defrost breast milk.

Impact and feasibility

- 13.1 Practitioners expressed concern at the fact that the recommendation suggests the use of electric breast pumps. Many felt that this was inappropriate given (a) that women from low-income families may not be able to afford one pump let alone two; and (b) there is some evidence⁸ to suggest that electronic pumps can damage breast tissue. One practitioner thought that the recommendation should specify what kind of container (of what material) professionals should advise mothers to express their breast milk into. Some practitioners felt that the recommendation should be clearer about the fact that expressing milk is suitable only for certain circumstances and should not be carried out routinely in place of 'direct' breastfeeding.
- 13.2 Whilst all practitioners welcomed clear advice on the storage of expressed milk, many had concerns about the widespread use of fridge thermometers – and, similar to the concerns expressed above – particularly their availability to families in low-income households. To address this issue, practitioners suggested that the recommendation could be less specific and take into account variances in the temperature of fridges.

⁸ When pressed on this topic, practitioners were unable to provide referencing information for this evidence; suggesting instead that it was anecdotal or experiential evidence.

- 13.3 Some practitioners admitted that it may be challenging for them or their colleagues to communicate the advice in this recommendation – specifically the advice relating to storage of expressed milk, given that it seems quite numerically complicated and potentially confusing – effectively to some women who have limited education. Some practitioners also suggested that the numbers given in this recommendation do not align with the storage advice given by formula manufacturers. Practitioners felt that, as a result, they may need to provide some women with the evidence behind this recommendation to persuade them to follow this advice.

Gaps, missed opportunities and suggestions for improvements

- 13.4 Practitioners felt that the target population should include pregnant women.
- 13.5 Practitioners thought that the ‘Who should take action’ category should include anyone involved in childcare, play groups, assistant teachers, peer supporters and pharmacists.
- 13.6 Practitioners felt that there is an opportunity for this recommendation to provide valuable advice for mothers with ill or premature babies, or for mothers who are diabetic.
- 13.7 Practitioners felt that the recommendation could be strengthened by recommending that a specific health professional be responsible for showing women how to hand express breast milk after birth. This is to avoid a situation in which this responsibility is unclear and therefore it ‘falls between roles’ and does not get done.

Practitioner quotes

“Take the bit out about the electric pump. It has no bearing on low income families, and would be off putting. Besides, even in a family who might have one breast pump; who has two?!” (Health Visitor, 17 years, Lowestoft)

“‘Hard to reach’ groups are just that: hard to reach. Engaging with disadvantaged groups requires community development approaches. Lots of time and resources to engage with, and understand, the individual. This recommendation is simply impractical and too expensive to implement.” (Public Health Improvement Manager, 5 years, Lowestoft)

“There needs to be more emphasis on breastfeeding than on expressing.” (Senior Community Nursery Nurse, 7 years, London)

“Need to tackle cultural barriers to expressing even within communities that traditionally breastfeed. Consistency in information is needed. The DoH leaflet has a different suggestion.” (Infant Feeding Co-ordinator, 4 weeks, London)

Draft recommendation 14

Who is the target population?

Pregnant women and mothers.

Who should take action?

NHS trusts, health centres, GP surgeries, children's trusts and centres. GPs, midwives, health visitors and pharmacists.

What action should they take?

- Avoid promoting or advertising infant formula. Do not display, distribute or use leaflets, posters, charts, educational materials or any other materials and equipment produced by infant formula manufacturers.
- Ensure all mothers have access to independent advice on the use of infant formula, including any associated risks.
- Ensure mothers who choose to use infant formula are shown how to make up a feed before leaving hospital or the birth centre (or before the mother is left after a home birth). This advice should follow the most recent guidance from the DH and the Food Standards Agency.
- Ensure mothers who choose to use infant formula know how to obtain ongoing independent information and advice from a qualified health professional.

Clarifications

14.1 Practitioners felt that further clarification is necessary in the recommendation about the 'independent advice' (second bullet point), e.g. where can such independent advice be found? Who can provide this independent advice, and how can they be contacted?

Impact and feasibility

14.2 Practitioners were concerned about the feasibility of implementing the guidance outlined in the third bullet point for the same reasons they offered in relation to draft recommendation 12. To improve the feasibility of the recommendation, practitioners suggested shifting the emphasis of the third bullet point so that health professionals provide instruction only to 'mothers who choose to use infant formula *and need to be shown how to make up feed...*' Practitioners felt that this would serve to reduce the number of people being instructed, and therefore delivery would be more manageable within current workforce levels.

Gaps, missed opportunities and suggestions for improvements

14.3 Practitioners thought that the 'Who should take action' category should include retail outlets, supermarkets and schools.

- 14.4 Many practitioners were concerned that this recommendation gives insufficient consideration to the fact that, for some women, breastfeeding is not an option, and therefore formula feeding has an important role to play. However, they recognised at the same time that mothers who are going to use formula need to know how to make up feeds safely. In general they felt that the recommendation struck an appropriate balance discouraging the promotion of formula whilst at the same time ensuring that information is available for those professionals who need it to support women to use formula safely.

Practitioner quotes

“Although every mum knows that breast is best some mothers are unable to breast feed. This recommendation will make these mums feel like their child is not receiving ‘the best’ leaving the mum feeling demoralised or post-natally depressed. I feel a less aggressive approach to breastfeeding is needed.” (Midwife, 8 years, Lowestoft)

“This may have a problem in implementation as nurses cannot show mothers how to make up a bottle feed in hospital for various reasons. Hospitals do not have kettles, they do not have formula and there are not enough members of staff to show every mother individually.” (Senior Midwife, 2½ years and Clinical and Professional Lead Health Visitor, 2 years, Plymouth)

“Who is the independent advice – is it us, would we be trained to be independent advice, is it going to be another body that people refer or is it going to be a dietitian or what will NICE consider to be a qualified person to do that?” (Paediatric Pharmacist, Liverpool)

“Really we should know what are the associated risks that NICE are considering to be associated with formulas? I don’t know definitely what they mean. We need to know more about that.” (Paediatric Pharmacist, Manchester)

Draft recommendation 15

Who is the target population?

Pregnant women and new mothers, particularly those who are least likely to start and continue to breastfeed – for example, the young, less well-educated women and those from disadvantaged groups.

Who should take action?

NHS trusts responsible for maternity care.

What action should they take?

- Provide local, easily accessible breastfeeding peer support programmes.
- Ensure peer supporters:
 - are trained to give breastfeeding support
 - contact new mothers directly within 48 hours of their transfer home (or within 48 hours of a home birth)
 - offer mothers ongoing, flexible support at home via telephone and/or through local groups
 - are part of a multidisciplinary team, are able to consult a health professional, and are provided with ongoing support
 - gain appropriate child protection clearance.
- Consider training peer supporters and link workers to provide mothers, parents and carers with support to help them follow professional advice on feeding infants aged 6 months and over. They should promote an increasingly varied diet using different textures of food in appropriate amounts.

Clarifications

- 15.1 Some practitioners felt that it was unclear how much responsibility NHS Trusts are expected to have for peer supporters. In particular, practitioners raised questions about the extent to which NHS Trusts will be responsible for the confidentiality and data protection issues associated with peer supporters initiating unsolicited contact with new mothers within 48 hours of their having given birth (see below). Peer supporters contacting mothers was felt by practitioners to be an issue not only of feasibility but also of *appropriateness*.
- 15.2 Many practitioners felt unclear about whether the recommendation is suggesting that *all* new mothers should be called or simply those mothers who are breastfeeding.

Impact and feasibility

- 15.3 Practitioner responses around the country indicated that training of peer supporters is inconsistent: in some areas, training is provided; in other areas different training is

provided, or no training is provided at all. Practitioners felt that in order for this recommendation to be feasible, peer supporters will need to be trained properly – with some consistency between one area and the next – within a clear framework of governance and accountability. Some practitioners suggested that peer support programmes could be overseen by midwives or health visitors; however other practitioners expressed major reservations about the feasibility of such proposals given the workload of professionals in these roles. In line with the variations in approach described above and the different levels of progress made around the country in establishing peer support programmes, some practitioners said that they felt they had sufficient peer support resource in their locality to carry this out; other practitioners said that they felt that they did not have sufficient peer support resource. In one case – in Manchester – practitioners *from the same area* had different views about whether their existing peer support programme capacity was sufficient.

- 15.4 Practitioners felt that the greatest feasibility barrier to this recommendation being implemented is the cost associated with training peer supporters. Where training is available – e.g. the La Leche League – this is felt to be expensive and therefore unsustainable.
- 15.5 Many practitioners felt uncomfortable about the issue of confidentiality and data protection in relation to peer supporters telephoning new mothers at home 48 hours after they leave hospital—without the mother having given permission explicitly for this contact to take place. Some suggested that reliance on using the telephone to contact mothers from low-income families may not be practical as they may not have a landline telephone at home, and they may not attend organised local groups. In these circumstances, practitioners felt that the recommendation should promote flexibility in terms of how practitioners engage mothers, encouraging them to use means that are appropriate to the women’s needs. Some practitioners felt that the 48 hour contact timeframe is too prescriptive, and that it would be more appropriate for the recommendation to promote follow-on contact with mothers ante-natally.
- 15.6 Many practitioners felt that if peer supporters are to be asked to take on the responsibility of this recommendation, then they should be paid.

Practitioner quotes

“Needs funding that is continuous and consistent. Peer supporters may need incentives – if we want to cover every mother.” (Infant Feeding Co-ordinator, 22 years, Plymouth)

“Increase early support for breastfeeding mothers to reduce fall out in early days following birth.” (Health Visitor, 7 years, Lowestoft)

“On the “visit within 48 hours” point – do we have the staff to do this? Is it actually practical?” (Pregnancy Outreach Worker, 4 years, Birmingham)

“In order to contact mothers within 48 hours of their transfer home, permission from each mother to give out her phone number will be needed; otherwise there is a breach of confidentiality. There are currently not enough resources to ensure each mother is happy to be contacted within 48 hours.” (Infant Feeding Coordinator, 22 years, Plymouth)

“There is a big question surrounding the issue of the accountability of peer supporters, who is accountable for them, their training, etc.” (Health Visitor, 33 years, London)

Draft recommendation 16

Who is the target population?

Pregnant women and mothers whose first language is not English, their partners and extended family

Who should take action?

NHS trusts responsible for maternity care, GP surgeries and community health centres.

What action should they take?

- Where possible, train link workers to provide information and support on breastfeeding, weaning and healthy eating in the mother’s first language.
- Where link workers are not available, ensure women whose first language is not English have access to interpreting services and information in a format and language they can understand.
- Encourage women from minority ethnic communities who speak English as a second language to train as peer supporters.

Impact and feasibility

16.1 Practitioners felt that in order for the recommendation to have the right kind of impact, if link workers are to be responsible for translating for women who do not speak English as their first language, they will need to be subject to framework of governance and accountability.

16.2 Some practitioners expressed concern that it is not feasible to provide access to link workers or translation services because the cost of such provision is prohibitive. This was a few echoed by some commissioners.

16.3 Some practitioners reported that they had had issues in the past with the accuracy of translation services. They also pointed to potential limitations with translation services with regard to this recommendation in that whilst such services may be able to translate languages, they do not always understand *cultures*—and this cultural understanding is critical to maximising the impact of the recommendation. Many practitioners also felt that the recommendation is not feasible in practice as even relatively small communities may have 50-100 languages—so finding translators for all of the languages may be a major problem.

Gaps, missed opportunities and suggestions for improvements

16.4 Practitioners felt that the ‘Who should take action’ category should include children’s centres.

Practitioner quotes

“Use a variety of methods to relay information e.g. pictures/DVD.” (Health Manager, 2½ years, Manchester)

“Language is a barrier, in some areas there are so many languages spoken that it’s simply not practical. For example in some places there are over 50 different languages used.” (Specialist Dietitian, 1 month, Birmingham)

“There will be a problem with accountability of link workers/peer supporters and on a large scale how is it going to be supervised?” (Health Visitor, 26 years, London)

“It isn’t possible to cover all languages in an area. It might be a good idea to do something with pictures and DVDs.” (Community Midwife, 35 years, Birmingham)

“Even if you use a family member or something similar as a translator there’s no way to be sure that what you mean is getting across.” (Paediatric Dietitian, 44 years, Birmingham)

Draft recommendation 17

Who is the target population?

Hospital doctors, GPs, obstetricians, pharmacists, specialist nurses and dentists.

Who should take action?

NHS trusts responsible for maternity care, GP surgeries, community health centres and pharmacies.

What action should they take?

Ensure those who prescribe or dispense drugs to a breastfeeding mother consult supplementary sources and only use the 'British national formulary' as a guide. They should discuss the benefits and risks associated with the prescribed medication and encourage the mother to continue breastfeeding for as long as she chooses.

Clarifications

- 17.1 Some practitioners felt that the recommendation should clarify what appropriate 'supplementary sources' of information are, since they felt that few health professionals know of reliable sources other than the *British National Formulary* (BNF). One community dentist suggested that the guide *Drugs in pregnancy and lactation* would be a credible supplementary source.
- 17.2 Some Practitioners felt that the sentence 'only use the BNF as a guide' could be misinterpreted due to the ambiguous placement of the word 'only'. Rather than grasp its intended meaning – use *only* the BNF as a guide (i.e. don't use other sources) – practitioners could understand it to mean 'only use the BNF *as a guide*' (i.e. ultimately you'll need to make a final decision yourself).

Impact and feasibility

- 17.3 Community dentists expressed concern at the suggestion that mothers should be encouraged 'to continue breastfeeding for as long as she chooses'. Community dentists felt that the recommendation did not make sufficiently clear the risks to infants of prolonged breastfeeding if their teeth are susceptible to decay.

Gaps, missed opportunities and suggestions for improvements

- 17.4 Practitioners thought that the 'Who should take action' category should include link workers. Some practitioners felt that some pharmacists may need training in discussing the risks associated with certain prescribed medications/and in encouraging breastfeeding.

Practitioner quotes

"If I just read the sentence, 'ensure those prescribe or dispense drugs to a breast-feeding mother consult supplementary sources and only use the British National Formulary as a guide' I read that first time round as, the only thing you should use as a guide is the British National Formulary." (Paediatric Pharmacist, Manchester)

"We have got to make sure that the British National Formulary people subscribe to the 'breast is best' philosophy." (Paediatric Pharmacist, Manchester)

"We wouldn't necessarily use the BNF because we would use Drugs in pregnancy and lactation. It's got more detail and it gives you a lot more advice." (Paediatric Pharmacist, Liverpool)

Draft recommendation 18

Who is the target population?

Parents and carers of infants and pre-school children.

Who should take action?

Health visitors, managers and community nursery nurses.

What action should they take?

- Health visitors should assess the needs of all mothers, parents, and carers with young children. They should provide intensive and early support at home for those parents and children who have the greatest needs.
- Health visitors should:
 - support mothers to continue breastfeeding for as long as they choose.
 - provide mothers and other family members with support to introduce a variety of nutritious foods (other than milk) to ensure the child has a progressively varied diet from 6 months of age.
 - encourage and support parents and carers in making home-prepared foods for infants and young children, without adding salt or sugar.
 - encourage families to eat together when children are ready to join in family meals.
 - advise parents and carers not to leave infants alone when they are drinking from a feeding bottle.

Changes and clarifications

18.1 Some practitioners felt that it was not obvious that the 'needs' described in the first point relate to nutrition. They felt that this should be clarified in the recommendation.

18.2 Practitioners felt that the phrase 'home cooked foods' needs to be clarified. What constitutes 'home cooked'? Does this include frozen ready meals reheated at home as well foods that are prepared in the home?

Impact and feasibility

- 18.3 As described in draft recommendation 17 above, community dentists expressed concern at the suggestion that mothers should be encouraged ‘to continue breastfeeding for as long as she chooses’. Community dentists felt that the recommendation did not make sufficiently clear the risks to infants of prolonged breastfeeding if their teeth are susceptible to decay.
- 18.4 Nursery nurses felt that they could also ‘assess the needs of mothers, parents, and carers...’, since implying that this responsibility should rest solely with health visitors – who are already very busy – could make it very hard to implement. In general, practitioners felt that sharing this responsibility would help to alleviate delivery problems related to staff shortage, which the recommendation might otherwise create.
- 18.5 Practitioners felt that the guidelines in the recommendation that encourage professionals to advise mothers on weaning need to be clarified and more detail provided. Practitioners felt that the recommendation should go into detail about what types of food should be introduced from what age, and should be consistent with other general guidelines on weaning.
- 18.6 Many practitioners felt that the idea of encouraging ‘*families* to eat together’ was too limiting since not all family members are always present at mealtimes. Some practitioners suggested that that ‘social eating’ (fourth sub-bullet point) might be a more appropriate phrase. Some practitioners also felt that the phrase ‘when the child is ready’ (fourth sub-bullet) should be removed. This is because they felt that low-income families may not be used to eating together (or indeed the extent of families eating together may vary culturally). A child may be used to watching television at mealtimes and therefore may never show that they are ‘ready’ to eat with others. Practitioners felt strongly that infants should eat with their parent/s from the start, or from whenever is practical.

Gaps, missed opportunities and suggestions for improvements

- 18.7 Practitioners thought that the ‘Who should take action’ category should include childcare workers / early years workers, dietitians and commissioners.
- 18.8 Some practitioners felt that the recommendation should advise ‘not to leave infants alone when they are drinking from a feeding bottle *or eating*’. Some were also unclear about whether this applies to the child at a particular age (i.e. when the child is six months old and beginning weaning, or throughout childhood?) Practitioners also felt that the recommendation as it is presently worded misses an opportunity to reinforce the importance of parents using cups from a young age in recognition of the risks that can be caused by prolonged bottle feeding.

Practitioner quotes

“Health visitors are stretched in our area – more input from nursery nurses.” (Community dietitian, 5 years, London)

“The availability of a community kitchen and a local nutritionist would be good practice and would have an impact on the disadvantaged and their healthy eating habits.” (Health visitor, 11 years, Lowestoft)

“To expect health visitors to do all the outlined work seems unfair and the language is very strong, so maybe it should be changed from ‘health workers should...’ to something lighter.” (Health coordinator, 2½ years, Manchester)

Draft recommendation 19

Who is the target population?

Infants and pre-school children.

Who should take action?

SHAs, PCTs and NHS trusts. GPs, paediatricians, midwives, health visitors and community nursery nurses.

What action should they take?

- Ensure health professionals receive training on weighing and measuring infants. This training should include: how to use equipment, how to document and interpret the data and how to communicate the results and give dietary advice to parents and carers.
- Ensure support staff are trained to a demonstrable level of competency in weighing infants and young children.
- Ensure infants are weighed using digital scales which are maintained and calibrated annually, in line with the medical devices standards (spring scales should not be used as they are inaccurate).
- As a minimum, ensure babies are weighed (naked) at birth and at 5 and 10 days, as part of an overall assessment of feeding. Thereafter, babies who are growing normally should be weighed (naked) at 2, 3, 4 and 8 months in their first year – and no more than fortnightly.

Impact and feasibility

19.1 Practitioners welcomed the fact that the recommendation specified the focus of the training to be offered on weighing babies. They felt strongly that training is needed especially in the following areas:

- How to weigh babies correctly
- How to understand, interpret, and plot the results

- How to communicate these results appropriately to the client, and how to advise the client on an action plan
 - General cultural change to practice to promote the empowerment of parents in monitoring health in a holistic way.
- 19.2 Midwives and health visitors had concerns over the specification of ‘digital scales’. Some had found previously that not all clinics have digital scales and that such scales are occasionally prone to breaking. Participants suggested that a barrier to implementation of the recommendation would be the availability of funding to buy the correct digital weighing scales. These units are expensive, and so funding would be necessary to enable services to procure them.
- 19.3 Generally, practitioners felt that the specification of the timing and frequency of weighing (‘at birth and at five and 10 days’) offers potential efficiencies to practitioners as there may be an opportunity to combine weighing and other activities (e.g. neo-natal screening) in the same visit to the mother. However, some practitioners felt that weighing at five days was too early for the first weighing and the baby may not have gained weight yet; something that could cause already anxious new mothers to worry unduly.
- 19.4 Practitioners felt that the recommendation is too strict in terms of the way in which it over-specifies how often professionals should weigh babies. Practitioners felt that the recommendation should be more flexible, specifically in terms of the dates for weighing. This is because they felt it would be very difficult to turn mothers away from the clinic if they come every week, and this could easily unsettle new mothers who tend to visit the clinic every week for reassurance that they are doing a good job with their new baby. Practitioners acknowledged that baby weighing sessions are also often an important opportunity for mothers to meet (especially those in low-income families), and exchange experiences and develop friendships with other mothers, gather information, and talk to health professionals about a range of issues. The group recognised the risks to this social and information giving activity associated with discouraging mothers from attending weighing sessions too frequently. Participants felt that children’s centres could potentially provide an opportunity for women to meet and get information, and also emphasised the importance of baby massage and other post-natal activities that provide a social opportunity for mothers.

Gaps, missed opportunities and suggestions for improvements

- 19.1 Practitioners thought that the ‘Who should take action’ category should include children’s centres, commissioners and practice nurses.

Practitioner quotes

“A lot of parents who come to our post-natal drop in like to have their babies weighed every week. Some are anxious first-time mums. Surely we would be adding to their anxiety if we said they could only weigh fortnightly or monthly.” (Community nursery nurse, 5 years, Lowestoft)

“As GPs we don’t tend to weigh and measure babies; we don’t have the scales – or the time – so health visitors and midwives tend to do that early on.” (GP, Surrey)

“There needs to be clarification about which weight charts are to be used. If we’re not clear on that point, what’s the point of having a recommendation at all?!” (Health visitor, 33 years, London)

Draft recommendation 20

Who is the target population?

Pregnant women, mothers and their partners who have a family history of allergy (including eczema, asthma and hay fever).

Who should take action?

Midwives, health visitors, GPs, paediatricians, community dietitians and pharmacists.

What action should they take?

Provide pregnant women, mothers and their partners with information and advice on how to reduce their baby’s risk of developing allergies. This advice should include: feed the baby only on breast milk until he or she is 6 months old and introduce solid foods, one at a time when the infant is 6 months old.

Clarifications

- 20.1 Practitioners felt that this recommendation should be clearer about the fact that it is about allergies specifically. Practitioners indicate that the unclarity stems from the fact that the target population states ‘pregnant women’ first of all—implying that the guidance should be applied to *all* mothers. Some practitioners also felt that the description ‘...who have a family history of allergy’ is too general. Practitioners felt that, as far as family history of allergy is concerned, they would need to know how many people and generations were affected, what allergies were involved—and this should be reflected in the recommendation. One practitioner felt that because this recommendation is so general it could have negative effects on weaning (in that, if mothers are overly – and unnecessarily – worried about allergies, they may wean their baby late, thus affecting their baby’s speech development and creating the conditions for them to have a problematic diet).
- 20.2 Practitioners thought that the ‘information and advice’ described in the recommendation needs to be more specific in explaining what professionals should actually say to mothers. Many practitioners recognised the risks of inadvertently panicking mothers into offering their baby too few solid foods. Some practitioners felt

that the recommendation should explain that starting weaning too early can be linked to the development of allergies.

- 20.3 Practitioners thought that the statement ‘introduce solid foods one at a time’ needs clarification. They felt that further explanation is necessary in relation to how long each individual food is to be introduced for, the extent to which foods can be mixed once introduced.

Gaps, missed opportunities and suggestions for improvements

- 20.4 Practitioners thought that an alternative (e.g. hypoallergenic formula feed) to breast milk should be specified as an option in the recommendation to account for instances in which a mother cannot breastfeed, or in which the mother is anaemic. Practitioners also felt that the recommendation misses an opportunity to make it clear that breastfeeding can and should continue whilst solid foods are being introduced.

Practitioner quotes

“I do know that they are developing a number of infant formula feeds that are hypo-allergenic and may be beneficial to children who have a history of allergy, and where the parents can’t breast feed. Where’s the information about those?” (Paediatric pharmacist, Liverpool)

“We’ll need enough manpower, e.g. enough peer supporters, so that mothers can be supported—even after the first few days.” (Infant feeding co-ordinator, 1 month, London)

Draft recommendation 21

Who is the target population?

Parents and carers of infants and pre-school children.

Who should take action?

Health visitors, GPs, dentists, dental hygienists/assistants, community and day care nursery nurses, home-based child carers and others who work with young children.

What action should they take?

- Encourage parents and carers to:
 - use a feeding bottle only for breast milk, infant formula and cooled boiled water
 - offer infants aged 6 months and over drinks in a non-valved, free-flowing cup
 - limit foods with a high sugar content to mealtimes
 - offer only low-sugar snacks between meals (such as fruit and vegetables)
 - provide milk and water to drink between meals (diluted fruit juice can be provided with meals).

Clarifications

- 21.1 Practitioners felt that the guidance about appropriate feeding bottles for breast milk is ambiguous (first sub-bullet point). Is the recommendation stating that you should use *only* a feeding bottle for breast milk, etc. (i.e. you shouldn't use other types of drinking vessel for drinking those liquids; however, your baby can use a feeding bottle for drinking other things); or that you should use a feeding bottle *only* for breast milk, etc. (i.e. the feeding bottle should be used exclusively for the purpose of giving your baby breast milk, etc.) Some practitioners also felt that this bullet point also offered an opportunity to say that solid food should not be given to babies via bottles.
- 21.2 Practitioners thought that the third sub-bullet point should say 'limit food with a high sugar *and salt* content...' Many felt that the recommendation should offer a wider range of foods as examples of low-sugar snacks. Some practitioners pointed out that dentists recommend that fruit is consumed only at mealtimes as it is high in sugar—apparently in contradiction to the recommendation.

Gaps, missed opportunities and suggestions for improvements

- 21.3 Practitioners thought that the 'Who should take action' category should include schools, dietitians—in fact anyone who comes into contact with and/or influences mothers.

Practitioner quotes

"Some parents may offer a feeding bottle with formula milk all day long. A clearer message would be to only offer a cup after 6 months." (Health coordinator, 2½ years, Manchester)

Draft recommendation 22

Who is the target population?

Parents and carers of infants and pre-school children.

Who should take action?

Nursery nurses, home-based child carers and others working in pre-school day care settings such as nurseries, crèches and playgroups.

What action should they take?

- Support breastfeeding mothers by:
 - offering the opportunity to breastfeed if they need to
 - encouraging them to bring expressed breast milk in a cool bag
 - ensuring expressed breast milk is labelled with the date and name of the infant and stored in the main body of the fridge.
- Reduce the risk of infection to infants in care settings by implementing the FSA's guidance on the preparation and use of powdered infant formula feeds.

Impact and feasibility

- 22.1 Many practitioners were keen for the recommendation to be more prescriptive about the management of expressed milk supplies. They felt that the third sub-bullet point should also say 'ensure that the correct milk is given to the correct child' since this can have very big implications as far as limiting the risk of prevention of HIV is concerned. Practitioners also felt that this recommendation should provide information on how long expressed breast milk can stay out of the fridge, and within what timeframe can it be returned to the fridge for storage (link to recommendation 13).
- 22.2 Practitioners felt that the recommendation misses an opportunity to explain the kinds of things that employers can do for breastfeeding mothers.

Gaps, missed opportunities and suggestions for improvements

- 22.3 Practitioners thought that the target population should include local authorities.
- 22.4 Practitioners thought that the 'Who should take action' category should include any employer with a breastfeeding employee, all workplaces, schools and children's centres.
- 22.5 Some practitioners thought that this recommendation needs to be made more 'mother-friendly'. They suggested that the recommendation should say '*promote* the opportunity to breastfeed...' rather than merely 'offer...', since simply offering is not enough and organisations need to be more proactive. In the same spirit, practitioners also felt that the recommendation should say 'breastfeed *if they wish...*' rather than 'breastfeed if they need to', since this language was not felt to be very sympathetic towards mothers.

Practitioner quotes

“You must ensure the correct child gets the correct milk. This has huge HIV implications.” (Health Co-ordinator, 2½ years, Manchester)

Draft recommendation 23

Who is the target population?

Infants and pre-school children up to the age of 5 years.

Who should take action?

Teachers, teaching assistants, nursery nurses, home-based child carers and those working in pre-school day care settings such as nurseries, crèches and playgroups.

What action should they take?

- Implement a food policy which takes a ‘whole settings’ approach to healthy eating, so that foods and drinks made available during the day reinforce teaching about healthy eating.
- Take every opportunity to encourage children to handle and taste a wide range of fruit and vegetables by:
 - providing classroom-based activities
 - ensuring healthy choices (for example, fruit and vegetables) are offered at meal and snack times
 - ensuring carers eat with children wherever possible
 - encouraging similar activities with parents at home.

Clarifications

- 23.1 Some practitioners were unclear about what a ‘whole settings’ approach might involve. Other practitioners wanted to go further than this, calling for a ‘whole *community*’ approach.
- 23.2 Practitioners thought that there should be a longer list of healthy foods with alternatives to fruit and vegetables. They also felt that the recommendation should advise professionals on how to communicate to mothers the issue of *why* they should be doing this.

Impact and feasibility

- 23.3 Practitioners felt that this recommendation is unlikely to have much impact on families who are highly mobile (e.g. traveller families, refugees, asylum seekers).

Gaps, missed opportunities and suggestions for improvements

23.4 Practitioners thought that the target population should be the whole family.

23.5 Practitioners thought that the ‘Who should take action’ category should include dietitians and children’s centres.

Practitioner quotes

“This would work as long as child care settings were given training on developing and implementing a food policy.” (Nutritionist, 3 years, London)

“There would need to be clarity about exactly what healthy eating is because healthy eating, well, there isn’t actually a definition, but, you know, it’s a sort of term that’s used and people have different views on what it actually means.” (Public health nutritionist, Nottingham)

“It’s about support and practical hands on activities and we do work in schools as well as in improved children’s centres with younger families.” (Public health nutritionist, Nottingham)

Draft recommendation 24

Who is the target population?

Low-income families.

Who should take action?

Commissioning agencies, local authorities and local strategic partnerships that fund or provide community projects. Public health nutritionists.

What action should they take?

- Introduce and maintain healthy eating and lifestyle programmes to help parents on a low income develop their skills in planning meals, cooking, shopping and budgeting.
- Work with local retailers to improve the way that fresh fruit and vegetables are displayed and promoted.
- Provide support (both practical and financial) to develop and maintain community-based initiatives which aim to make a balanced diet more accessible to people on a low income. Examples include food cooperatives and ‘cook and eat’ clubs.

Clarifications

24.1 Some practitioners thought that the phrase ‘lifestyle programme’ sounds too much like jargon (which many are averse to and are inclined to mistrust), and they were unclear about what it meant.

24.2 Practitioners felt that in the second point too much emphasis is being placed on the displaying and promotion of food. They felt that the emphasis should instead be placed on the quality of the food, as well as on mothers who can be encouraged and enabled to buy the food.

Impact and feasibility

24.3 Practitioners thought that this recommendation should address how professionals should discourage women from buying and eating fast food.

Gaps, missed opportunities and suggestions for improvements

24.4 Practitioners felt that the government and schools should be added to the ‘Who should take action’ category.

Practitioner quotes

“Need to make it alternative to the low-income families. Excellent idea but very expensive to implement.”

(Health Visitor, 17 years, Lowestoft)

“Funding is needed to make healthy eating happen – many mothers think food in a jar is proper food.”

(Community Midwife Manager, 25 years, Manchester)

“Need ongoing support at home to do this.” (Children’s Centre Programme Manager, 4 years,

Lowestoft)

5. Findings from the telephone interview phase

5.1 Insights gleaned from specialist practitioners

In recruiting for the fieldwork workshops, we acknowledged that there would be some practitioners who we would be unable to engage, simply because they would be unable to commit to any significant length of time away from their professional role. To address this, and to ensure we gathered their valuable input into the process, we engaged specialist practitioners in telephone interviews. The main findings from the telephone interviews with commissioners were as follows:

- The findings from the telephone interviews support many of the insights gleaned from discussion with practitioners in the workshops.
- Specialist practitioners agree that the fact that the draft recommendations involve such a breadth of professionals will mean that important health messages are reinforced by different people—which is felt unequivocally to be a good thing.

“So if the pharmacist tells them something, and then the midwife tells them something, and then their GP says, ‘Are you taking folic acid?’, I think you’re reinforcing the same message. So if we can all be singing from the same hymn sheet, I think it would have a bigger impact on the patients. If they just hear something from a midwife they may not think it’s as important as hearing it from three different health professionals.”
(Community pharmacist)

- Most specialist practitioners feel that implementing the draft recommendations will lead to a general improvement in terms of prevention of nutritional problems.
- However, specialist practitioners are realistic about what they feel can be achieved given the influence of advertising and the media more generally, and entrenched unhealthy behaviours among the population.

“There’s a big problem around promoting or advertising infant formula, because the laws are in place but nobody’s enforcing them. If you want this recommendation to happen, then in your Who should take action, it should be the Trading Standards people!”

“I don’t see how something like this can work, when we’re still advertising foods that are bad for us on the TV and in the popular press. I can’t see that we’re going to suddenly turn our population from the way they are now, to a population of normal body mass index, or exercising regularly and eating healthy food. That’s not realistic, but if you accept that you might get the odd person that changes their behaviour – takes folic acid, or breastfeeds – as a consequence, at least you get one of your targets reached.”

- A number of practitioners – particularly community dentists, obstetricians and paediatric dietitians – suggested that the real paradigm shift in terms of the feasibility of the draft recommendations would come when clients become enabled to take greater responsibility for their own health. However, these practitioners felt that the draft recommendations tend to assume that information – particularly nutritional information – has to come from health workers.

- They also support some of the views expressed by commissioners—especially commissioners’ points about the limited extent to which the draft recommendations support explicitly other strategies and provision such as *Every child matters*, the Healthy Schools programme and Children’s Trusts.
- Whilst GPs suggested that they were already doing many of the things outlined in the draft recommendations, they were concerned about the feasibility of carrying out some of the activities specified given the other things they have to do in a short consultation. They suggested that they would delegate to midwives many of the activities specified in the draft recommendations so that midwives could dispense advice at the point at which they give women the *NHS pregnancy book*. The GPs we spoke to had not heard of the Healthy Start programme.
- School nurses indicated that they felt they should be included in draft recommendations 6 and 23, in which they have an important potential role to play. Schools nurses endorsed the points made by practitioners in the workshops about the need to engage women earlier to have impact. As one school nurse put it, “This document gives the idea that this is about women who are thinking and choosing to become pregnant; but of course school nurses deal with all the ones who *weren’t* thinking and *didn’t* choose.”. School nurses shared the views held by other practitioners that the best way to ensure the draft recommendations have impact is to:
 - Incorporate them into the school curriculum, for example as part of the Healthy Schools programme. However, the practitioners recognised that the curriculum is very full, and also that young people from the target groups may not access the curriculum.
 - Make use of the relationship dynamics between teenage girls and teenage boys, and target the latter. “If you don’t include the boys, I can assure you this [impact] won’t happen. If you can get boys to think that girls should eat a healthy meal – and get them to say so – girls will eat one!” “In London, the only people who can influence the ‘rude gyals’ are the ‘rude boys’”

“One of the most important things in this constant battle with regard to nutrition in our country is to target the school population, and I know that later [draft] recommendations give a nod to that, but also to get across to patients how important preconception care is, because a lot of this is taking action after the horse has bolted, really.” Obstetrician

- Practitioners in the telephone interviews echoed workshop participants’ points about the implications on resourcing of implementing the draft recommendations.

“It says in recommendation 11 that the NHS Trust should provide people for group antenatal support who should be trained in breastfeeding management. This used to happen, and we know that lots of health visitors and midwives are trained, but in lots of places now these antenatal support groups have faded away, because there aren’t the staff to deliver them, or the places to deliver them. The actual facilities – the large rooms where you can deliver group support – are very few, because in many places people are charging for the use of these rooms, so Trusts don’t take them.”

- Practitioners were supportive of the role of peer supporters and peer trainers. However, they recognised the importance of appropriate leadership and supervision to ensure that such a system works effectively.

“You can train peer workers up about breastfeeding or nutrition. Six months down the line, they’ll have adapted what they know to suit the environment where they’re working. Unless you’ve got very good line management and clinical governance within that, you’ll just get a lot of myths and grandmother’s tales going on.”

“Say the PCT decides to train up hairdressers, because they spend a while with people. You’re not employing them; you’re commissioning the work, and the commissioners have got to have, within that contract, a way of checking the validity of what the people they’re commissioning have said. And at the moment, there’s no system going on to do that. So, you could be commissioning people, training them, and off they go and do their own thing. And what’s more, you’re paying for it.”

Almost all practitioners felt that recommendation 12 is very limited in its feasibility and that successful delivery of the recommendation will require more midwife resource.

“The recommendation that mothers should know how to breastfeed before leaving hospital is out of the question[...] They go home within six hours, they’ve barely got over the gas and air, and there’s no way they know how to breastfeed before they leave hospital—and then when you’re talking about weekends, early mornings, late at night; there’s just no way that’s going to happen.” (School nurse)

“I think I can speak for myself and all my colleagues, that if there were more midwives and better training of midwives, then we could really make a difference to the amount of women who leave hospitals successfully breastfeeding, because women who stop will say they didn’t get the support. That’s the most common reason for giving up and the reason they don’t get the support is that we can’t give it, because we are absolutely run off our feet.” (Community midwife)

“I think this is a joke, number 12. I know it’s not for GPs, but ‘Ensure that mothers know how to breast-feed before leaving the hospital?’ That’s a complete joke because women come in and go, and, to be honest, breast feeding takes much longer to learn than by the time you leave hospital. What’s more, it’s as important to know how to condition and touch your baby before you leave. Women actually need a lot more support at home for breast feeding, because that’s when you run into the problems.” (GP)

- Community dentists support the “heavy emphasis” in the draft recommendations on breastfeeding. However, they indicate that whilst breastfeeding should be encouraged as a result of its health benefits, we should be aware of the potential disbenefits. As one dentist put it, “The recommendation encourages ‘the mother to continue breastfeeding for as long as she chooses’. This is potentially problematic as there is a risk of prolonged breastfeeding for decay-susceptible children. Extended breastfeeding is not always good from a dental point of view. Babies can be susceptible to rampant decay beyond 12 months—particularly those who demand feed.” This view was challenged by another

community dentist, who suggested that such a view was “incorrect and not evidence-based.”⁹

- Community dentists feel that recommendation 21 is extremely important. They indicate that the recommendation has a huge potential impact “as it will get children off flavoured and coloured drinks, and get them off drinking out of bottles.” Community dentists feel that this could impact on levels of dental decay and referral to dentist services.
- All specialist practitioners supported recommendation 14 on the avoidance of promotion of infant formula. However, they felt that this is an area in which there is contradictory advice. As one public health nutritionist put it, “Although they’re saying that feeding should start at six months, most of the baby foods still say ‘from four months’. Why hasn’t six months been taken on board commercially? Why isn’t there pressure to say six rather than four months on all packets and jars and drinks?”

5.2 Insights gleaned from commissioners

Following the practitioner workshop and specialist practitioner interview phases, we spoke to commissioners working in Trusts around the country to gather their views on the draft recommendations. Whilst a few commissioners had views on specific draft recommendations, most of them tended to offer more general reflections on the draft recommendations, and on how commissioning arrangements could support implementation and delivery. The main findings from the telephone interviews with commissioners were as follows:

- Commissioners tended to agree with practitioners in the sense that they felt that many of the draft recommendations were things that they were doing already within their services.
- Many commissioners felt that institutional and strategic conditions are currently largely favourable for implementation of the draft recommendations:
 - The provision for partnership working and integrated service delivery established by joint commissioning arrangements—and supported by *Every child matters*,¹⁰ *Commissioning framework for health and wellbeing*,¹¹ the *National Service Framework (NSF) for Children, young people and maternity services*,¹² and the statutory arrangements of The Childcare Act 2006 and The Children’s Act 2004. Many commissioners also welcome the potential of the DFES guidance, *Raising standards, improving outcomes*¹³ to support further partnership working between the health sector and local authorities to improve

⁹ This interview respondent provided details on the Scottish Intercollegiate Network’s guidelines on the prevention of decay, which provides supporting evidence for the frequency of sugar intake and avoidance of night feeding (<http://www.scottishdental.org/pbrn/education/sign83.htm>). The respondent also supplied the Royal College of Surgeons dental guidelines (<http://www.rcseng.ac.uk/fds/docs/pd2.pdf>), drawing our attention to sections 2.1.4 to 2.1.9 that discourage prolonged breastfeeding. The respondent was keen that we understood that the recommendations were published some time ago.

¹⁰ HM Government, *Every child matters: Change for children*, London: Crown copyright, 2003.

¹¹ Department of Health, *Commissioning framework for health and wellbeing: Health and social care working together in partnership*, London: Crown Copyright, 6th March 2007.

¹² Department of Health, *National service framework for children, young people and maternity services*, London: Crown Copyright, 14th September 2004.

¹³ DFES, *Raising standards, improving outcomes: Draft statutory guidance on the early years outcomes duty: Consultation document*, London: Crown copyright, 23rd May 2007 (Consultation closes on 3rd September 2007).

outcomes for young children and reduce inequalities through the provision of accessible and integrated early childhood services.

- The ongoing service re-design agenda offers opportunities for commissioners and providers to think critically about how best to meet clients' needs and therefore to make changes in line with the draft recommendations.

“The major opportunity ... is where there are elements of redesign of service: where we're looking at a more 'whole-system' approach rather than just purely, say, midwifery, or traditional health services; where we're looking more at bringing on board our local authority partners, children's centres, voluntary community sector, even extended schools, etc.” Commissioner, North East

- Opportunities afforded by current thinking on redefining key professional roles and ways of working—especially that focused on changes to health visiting and midwifery services.^{14 15}
- The ongoing programme of PCT reorganisation has created a momentum for organisational change that it may be possible to harness to make further institutional changes to support delivery of the draft recommendations.
- The coverage of key aspects of the draft recommendations within existing Local Area Agreements and Public Service Agreement targets. Commissioners echoed the comments made by practitioners about the importance of tackling the broader factors that influence clients' behaviour. Some commissioners cited the fact that breastfeeding is covered within Local Area Agreements as an example of effective joined thinking to tackle these broader influencing factors.

“Breastfeeding is not the norm anymore for a lot of communities, so the influencing factors are often the family structures and the peers. So as health services, we can't just do that on our own. When somebody becomes pregnant, it's a much bigger picture than that. So actually having breastfeeding in the local area agreement, to me, is a very positive step.” Commissioner, South East

“The other aspect that I feel has been a major driver in this area is having breastfeeding as part of the local area agreement target.” Commissioner, North West

- Some commissioners expressed surprise, and, in some cases, disappointment and frustration, that the role of provision such as schools – or, more commonly, Children's Trusts – was not emphasised in the draft recommendations.

¹⁴ Department of Health, *Facing the future: A review of the role of health visitors – Report of the findings of the Health Visitors Review Group*, London: Crown copyright, June 2007.

¹⁵ Department of Health, *Maternity Matters: Choice, access and continuity of care in a safe service*, London: Crown copyright, April 2007.

“I was really quite disappointed that there wasn’t more around the children’s centres; the work we do in children’s centres, the work we’re doing around schools, more around Children’s Trusts. Children’s Trusts aren’t mentioned at all, so it was a bit of a disappointment for me really that all of that was left out when we are in this age of integration, working in partnership, joint ownership and shared budgets. It just seems like a missed opportunity...” Commissioner, South East

“Where are school children in all this? Where is the link to the PSHE programme? Where is all the work we’re doing around activity and healthy eating? If you talk to the majority of eleven, twelve, thirteen year olds, they are really interested in food. They really want to eat healthily and want to influence their mums, and we know from local work that if you get in and start to do that with children very, very early on, and you start to look at their lunch boxes and what they take to school, you actually influence their parents on what the parents eat.” Commissioner, South East

- Commissioners recognised the challenges associated with engaging hard-to-reach groups, and many described provision that had been developed in their local area to respond to these challenges. Many cited targeted, joined-up local activity that had been effective in reaching disadvantaged groups—precisely not by targeting services at them, but by reaching out to them and encouraging and enabling them to access *mainstream* services.

“If [these communities] are not normally going to come forward for this sort of healthcare, they’re not normally going to come forward for many things—and that includes benefits like further education, and a lot of other things, so I think if you’re cunning about this and you look around you’ll find that actually there are other types of agencies trying to reach and identify exactly the same sorts of groups. We need to put these [draft] recommendations somewhere near the heart of what these agencies are out there doing...” Commissioner, West Midlands

“Rather than developing a parallel set of services specifically for people in socio-economically deprived or vulnerable groups, there’s something about actually just reaching out to them with a ‘hit squad’ and saying, ‘look, you are able to access these services as well’, and then getting them into the mainstream services, which then has a knock-on effect on sustainability because then we’re talking about driving uptake of mainstream services. And once you’ve hit one area you can roll-on into the next area and so it works that way. It gets some of the proactivity, but it also produces something that’s sustainable.” Commissioner, West Midlands

- Whilst commissioners tended to share the view the draft recommendations have the potential to have a positive impact on client behaviour and health outcomes, generally they shared concerns about the extent to which the draft recommendations will be taken seriously by Trusts when viewed among their other priorities. This was felt to be as a result of the fact, first, that Trusts tend currently to be focused on acute areas such as coronary heart disease and Type 2 Diabetes, for which there are hard targets and performance criteria; and second, that – perhaps as a result of the above, there is a general emphasis on treatment (rates of which can be measured) rather than prevention (rates of which are very difficult to measure in a reliable and meaningful way).

“I don’t think the government’s put a lot of emphasis on prevention. They keep talking prevention, but they don’t actually make it viable to commission [preventative provision] in a way that is meaningful...Because the other elements of this, of course, is that there isn’t an incentive for local Trusts or anybody else to focus on prevention, because taking mothers or others into hospital is where Trusts get their money from. From a Trust point of view, as things stand, there is no money in doing it in any other way.” Commissioner, South West

- There was a difference of opinion among commissioners about how to ensure that the draft recommendations were accorded the necessary importance and level of priority within Trusts. Some commissioners felt that it was simply a case of ensuring the draft recommendations are incorporated into Trusts’ delivery planning and prioritisation processes. Others felt that this could only be achieved by establishing targets and performance management criteria.

“I know this isn’t the Government’s drift on things at the moment, but if you want services prioritised within a PCT, it’s actually quite difficult to do that if there isn’t any national ‘must-do’ about these things. I know that the way that the government is moving is not necessarily to send down measurable targets about everything ... but if you think about when the PCT is commissioning services, and if they are also commissioning acute services – such as intensive care, heart care, something like that, life threatening things – and the PCT’s finances are restricted, then you can imagine that prioritisation may not always be given to what I call the softer targets. And in a Trust board’s mind, nutrition is probably a softer target...” Commissioner, South East

“That’s part of the problem that the whole NSF for Children and Maternity Services: it has no hard targets in it. And having had a whole series of NSFs with hard targets – like the older people’s one, the mental health one, etc. – meant they got the attention required because they pointed to hard and fast stuff that could be measured.” Commissioner, South West

“How could the annual health check and the Healthcare Commission review of services support the implementation? Because if a Trust’s being measured on whether they deliver these things or not, if it’s incorporated within that assessment, it’s more likely to be done.” Commissioner, South East

“I don’t see anything in here that says to me that I need to target in order to do this. Most of what you are talking about is good practice for community workers—and that alone should be compelling for commissioners and for Trust boards as far as implementation is concerned. This guidance is not something that I would necessarily say needs a target.” Commissioner, North West

- A small number of commissioners drew attention to Draft recommendations 8 and 10 and the naming of the Baby Friendly Initiative [BFI] explicitly as the standard to be reached in implementing breastfeeding programmes (draft recommendation 8) and in training in breastfeeding management (draft recommendation 10). Commissioners welcomed the idea of a standard, but were concerned that the recommendation should

mention BFI specifically, since this training is expensive and time-consuming to attain. Moreover, they felt that the recommendation was unclear about whether an organisation would have to be fully BFI-accredited in order to meet the standard.

On recommendation 8: *“It’s very tough to get it, and there are hefty cost implications. I think we would all aspire to the standards, but I’m not sure that actually we would have any grand plans to get the actual BFI title. What the BFI says is fantastic, but you have to jump through some hoops to get there.”*

Commissioner, South East

On recommendation 10: *“It says ‘using the principles of BFI training as a minimum standard’, and I suppose that’s correct and that’s what we’re doing, but it doesn’t actually say that we need to become BFI-registered. To make it clearer I just wonder whether the recommendation ought to say that it’s a Baby Friendly standard, or whether it ought to be calling it a minimum standard. After all, ‘Baby Friendly’ is a well identified, patented product, and there are plenty of other ways of doing breastfeeding just as well that one wouldn’t be allowed to call Baby Friendly because you haven’t paid the money and got the licence.”*

Commissioner, South East

- Some commissioners highlighted other practical issues that they felt could impede delivery:

“There are a few practical issues about things like how do you provide every woman with a breast-pump, for example. When you’ve got 3,900 or 4,000 births – do you have 4,000 breast-pumps available?”

Commissioner, South West

“At the moment, not every baby is being routinely seen at five and 10 days, so what the recommendation says suggests a big implication for services in terms of resources. There are also big implications for babies who are growing normally who you are saying should be weighed naked at two, three, four and eight months. But we’re moving away from universal provision and moving towards provision being much more targeted and towards parents choosing how often they weigh their babies and what they do. There has always been some concern that some babies who are malnourished, who are underweight or overweight, would be missed. But actually, the reality of having an enhanced Health Visiting Service as opposed to universal is that it’s not happening. So this recommendation is a bit of a backward step for us, really, to go back to weighing babies at particular times.” Commissioner, South East

- Commissioners had mixed views on the issues raised by practitioners about the need for more staff resource to deliver certain aspects of the draft recommendations (see section 3.1 and 3.2). Commissioners were quick to point out that in light of cash constraints, other local priorities, and changes to professional roles and ways of working in this arena¹⁶ it is unrealistic and unfeasible to expect Trusts to make additional funding available to expand the workforce significantly. Commissioners felt that it was the

¹⁶ For example, changes to the health visitor role, as outlined in Department of Health, *Facing the future: A review of the role of health visitors – Report of the findings of the Health Visitors Review Group*, London: Crown copyright, June 2007.

responsibility of the workforce planning process to explore intelligent ways of getting value from the existing workforce. In some instances this could involve sourcing capacity in the voluntary and community sector. Many commissioners are enthusiastic about this, since in line with the points earlier about effective engagement and relationship-development, they see the voluntary and community sector not just as an untapped resource, but also as a means of reaching communities that mainstream health services have often struggled to reach. For such arrangements to be feasible, many commissioners feel that appropriate and proportionate (and therefore not overly-bureaucratic) accountability and clinical and frameworks are put in place.

“Do we need more health visitors because actually they’re going to spend longer with families actually talking through some of these wider issues such as the extended family and the other issues that affect women and children? Do we think we need the same amount of them because, actually, we can get them to skill-mix with, say, social work teams and there can be a sharing of responsibilities? Or do we think we need less of them because we can skill-mix with other special groups?”

“I think we could do a lot more with more support staff supervised by trained staff. That could develop those kinds of community links but also provide some more intensive home support where it is needed. And that model applies not just to nutrition but to the whole agenda around supporting families that need just that bit extra.”

“[On the importance of peer support] You don’t want to make people work for free – undervalue people’s time – but sometimes the people are sitting there, waiting for the opportunity to do something. Or you’ve got a mothers and toddlers group where the women just sit there staring at the wall while the children play with toys on the floor. Well, with a little bit of input, that group could function to support better nutrition for the mother and for the child. Basically, and I’m talking as a public health servant here, it’s about building public health capacity out in the community.”

“If there is a requirement for additional staff, I would want to be clear why that was there. From a commissioning perspective I would want to see a very clear needs analysis, identifying what the needs of these families were and what the skills required to support them were. And that is what I would want to see taken as a baseline before making any changes to services.”

“There is a lot of hostility and protectionism around what I call traditional roles. So for example, midwives have a lot of very good skills, they are also a very expensive specialised resource. Should we be using them, for example, to act as breastfeeding supporters? No, we probably shouldn’t; we should be bringing in peer support people, which the [draft] recommendations have identified, and which I think is really good.”

“Very often where staff have been saying what they want is more staff, what I say to them is, well, it may be that you need staff, but do you need more of the same? Do we need less of the top skills people and more support staff? Do we need people with some special training, but in particular areas? And if there’s some change of practice in your own working now that we’re moving forward, is there an opportunity to approach things in different ways. I don’t think any of those in isolation is the right answer; I think getting the [draft] recommendations into practice is a matter of these different options working together.”

“How are we going to influence the fact that more than one person needs to be giving the same advice whenever they are in contact with the individual? From a commissioning perspective I would say it’s not necessarily new people; it’s about existing people giving the same message. Which is much the same thing as we’ve done with regards to substance misuse, or domestic violence, or drug and alcohol, or mental health; we’ve got joint shared ownership of those issues. So the resources issue – i.e. more people giving the message – I think, is actually an ‘ownership of the recommendations’ issue.”

- Particularly where midwives are concerned, commissioners recognised the changes to maternity services may impact significantly on midwives ability to deliver the many draft recommendations in which they are asked to take action.

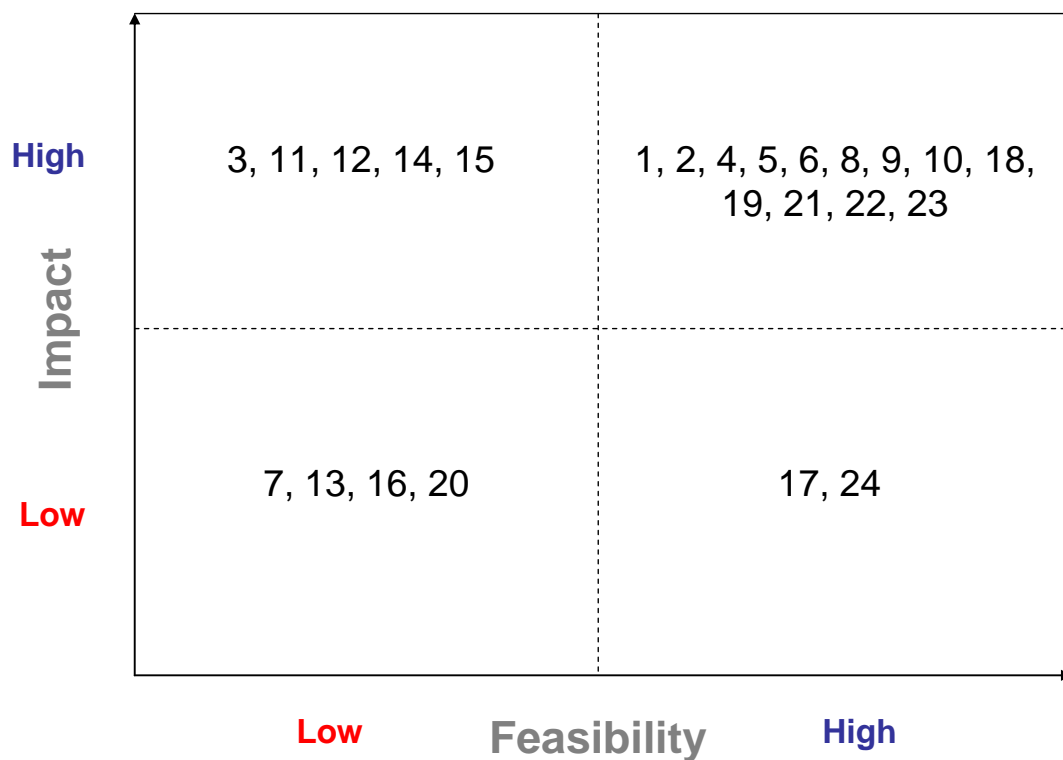
“Where are maternity services heading in future? The answer to this question will influence our ability to deliver local community midwifery services. So [delivering the draft recommendations] is going to be a bit of a challenge for us because at the same time as we’re potentially reducing midwifery input, for example, to the pre-natal education programme, the [draft] recommendations are telling us to do more in the last trimester of pregnancy, for example, and focus on breastfeeding. We may have to think about who does it other than midwives because it may not be possible for midwives to continue to do the work that they are currently doing, let alone any additional work.”

6. Findings from the impact/feasibility chart exercise

Fig. 1 below summarises the findings from the impact/feasibility chart exercise, in which practitioners plotted onto the chart where they felt each draft recommendation sits in terms of whether it is:

- High impact, high feasibility (top-right)
- High impact, low feasibility (top-left)
- Low impact, low feasibility (bottom-left)
- Low impact, high feasibility (bottom-right)

Fig. 1 Summary of impact/feasibility chart exercise



Whilst there were some minor differences of opinion between – and occasionally within – workshops, the picture was overwhelmingly consistent overall. We provide analysis of the findings from this exercise, and, where they were provided by practitioners, details of how the feasibility of a draft recommendation could be improved, in the following section.

Draft recommendation 1

Practitioners were concerned that the availability of resources could be a barrier to successful implementation. Time constraints, staff numbers and training, as well as material resources were all seen as potentially problematic. Practitioners pointed out that those most in need are those who are hardest to engage. As a result, they felt that guidance and support is needed for PCTs to enable them to recruit practitioners carefully in order to reach these women. Some midwives and health visitors suggested that one solution might be to establish specialised BFI ‘trainers’ for mothers.

Draft recommendation 2

Practitioners felt that the major barrier in terms of the feasibility of this recommendation is the cost of Folic Acid supplements.

Draft recommendation 3

There was considerable concern among all practitioners that the lack of cooking skills and cooking facilities among low income groups would make this recommendation unfeasible. Practitioners also felt that health professionals lacked the time and money to implement this. They felt that extra funding would be required to update the skills and knowledge of staff, and more resources to enable the recruitment of more midwives. Some suggested that a wider educational approach should be adopted, teaching women how to buy and prepare healthy food.

Draft recommendation 4

Practitioners were concerned about the difficulty in obtaining Healthy Start application forms (and the supplements themselves), as well as inadequate packaging (lack of child proof tops, leaky packages, etc.). The amount, and complexity, of the form filling involved was seen as a barrier for low income women, as well as being a drain on the time of staff that would need to help mothers complete them. Practitioners suggested that extra support for health professionals in conveying healthy eating message to low income mothers would be necessary for successful implementation—for example, Community Food Skills Teams.

Draft recommendation 5

Practitioners felt that training for relevant health professionals will be necessary to ensure that practice is standardised and the issue was properly understood. This training would need to be multi-disciplinary so that professionals better understand each other’s roles and responsibilities, and how to work together.

Draft recommendation 6

No specific comments,

Draft recommendation 7

Practitioners suggested that funding for community weight management programmes will be necessary to support delivery of this recommendation. Some identified support for data collection at a national and local level as an area requiring strengthening.

Draft recommendation 8

Practitioners suggested that funding could be a problem in providing the necessary training to the health professionals specified. Practitioners felt strongly that a more co-ordinated approach would be needed from management downwards. Health visitors and practitioners working in breastfeeding support suggested that the involvement of breastfeeding managers might help to make delivery of this recommendation more feasible.

Draft recommendation 9

The cost of providing training to such a wide range of staff and keeping it up to date was generally seen as being an issue.

Draft recommendation 10

Practitioners felt that the cost of training staff, as well as the practical issues of providing training to large numbers of part-time workers, were significant barriers to implementation.

Draft recommendation 11

Midwives cited their lack of availability as making delivery of this recommendation problematic. They reiterated the point made previously that further resource and support for midwives and midwifery supervisors is crucial—time would somehow need to be freed up, or new staff put in place, for individual support to be given in line with the recommendation. The difficulty of engaging those most in need was again raised as a concern, and participants felt that this may lead to a further drain on resources (either as a result of the need to visit clients or provide transport for clients least likely to engage proactively). Practitioners suggested that clearer guidance is needed to provide clarity on the arrangements and cost implications of individual visits to low income families.

Draft recommendation 12

There was almost complete agreement that this recommendation would be highly impractical to implement. Midwives feel that they simply do not have the time in their schedule to undertake this activity, and, in addition, they highlighted the fact that hospitals operate a six hour discharge policy for new mothers due to the shortage of available beds. Some practitioners pointed out that material resources (such as dolls and pumps to use as props in demonstrations) would also be an additional, but necessary, cost. It was suggested that NICE recommend women be allowed to stay longer in hospital after giving birth so that this recommendation could be implemented.

Draft recommendation 13

This recommendation caused considerable concern amongst delegates who felt that the cost of equipment such as fridge thermometers and electric breast pumps would be prohibitive for low income families. They also pointed out that introducing technology in this way raises the risk of infection, especially for those with poor levels of education. Training resources (in terms both of materials [e.g. breast pumps] and time) were again raised as an issue, and some practitioners suggested that lead midwife positions would have to be created to oversee implementation.

Draft recommendation 14

Practitioners generally agreed that a lack of facilities in hospitals such as kettles, infant formula, and sterile bottles, as well as the space to demonstrate, would make it very difficult to implement this recommendation. In addition to this there are not enough staff to be able to show each mother individually.

Draft recommendation 15

Practitioners on the whole agreed that the recommendation to ‘contact new mothers directly within 48 hours of their transfer home...’ was unrealistic for a number of reasons. These included a lack of available peer supporters (and the cost of training new ones), unwillingness to put too much pressure on voluntary workers, and lack of a proper communication process to pass the details of discharged mothers on to the relevant health workers within the designated time limit. Potential risks around data protection and confidentiality were also raised with regard to passing mothers’ details from one health professional to another, with ante-natal contact between mothers and peer supporters being suggested as a possible solution. This would allow a relationship to be established early, and an opportunity for consent to be given for postnatal contact.

Draft recommendation 16

The large number of languages spoken in certain areas was identified as a major barrier to implementing this recommendation. The use of translators would also put a strain on resources, both from the cost of hiring them and the added time needed for visits. Practitioners also expressed concern that there was no way to be certain that what they said was being translated accurately and that the message was getting through.

Draft recommendation 17

No specific comments,

Draft recommendation 18

Practitioners – particularly health visitors – felt that more staffing resources will be needed to implement this recommendation effectively—specifically, health visitors. Health visitors and breastfeeding co-ordinators also felt that ante-natal weaning classes could be very helpful and that the NICE guidance should reflect this. Health visitors expressed concern that this recommendation would create a significant burden of work for them due to the

strong wording of the recommendation. They felt that funding would need to be made available to ensure that health workers' training is kept up to date.

Draft recommendation 19

Whilst some participants felt the recommendation was too strict with regard to timing of weighing, most welcomed the standardisation in practice it enables. Practitioners felt that greater integration between different individuals working with families would be a key factor in effective delivery. Health visitors were concerned generally about their capacity to implement this.

Draft recommendation 20

Practitioners across the board felt that there is currently not enough resource – particularly peer supporters – to put this into practice. Several individuals suggested that more paid staff would be needed due to the demanding nature of the work and long hours, as well as training, supervision and proportionate mechanisms for accountability and clinical governance.

Draft recommendation 21

No specific comments.

Draft recommendation 22

No specific comments.

Draft recommendation 23

No specific comments.

Draft recommendation 24

Practitioners felt that more funding will be needed to enable practitioners to promote the message of healthy eating and to support low income mothers in continuing with healthy practice.

Appendices

Appendix 1: Workshop and interview participants

Workshops

Birmingham

Jessica Williams	Paediatric Dietitian, Halton General Hospital
Susan Weaver	Health Improvement Specialist, South Birmingham PCT
Shirley Phillips	Paediatric Dietitian, St Patrick's Centre for Community Health
Jewant Singh	Infant Feeding Coordinator, Birmingham East & North PCT
Lorraine Smith	Practice Development Midwife, New Cross Hospital Maternity Unit
Rose Barklam	Community Midwife, New Cross Hospital Maternity Unit
Harkesh Verdi	Specialist Dietician for under 5's, St Patrick's Centre for Community Health
Ann Hunt	Children's Centre Midwife, Anthony Road Children's Centre
Zabima Qousar	Community Family Worker, Anthony Road Children's Centre
Doreen Harris	Pregnancy Outreach Worker, Anthony Road Children's Centre
Amanda Costello	Infant feeding Specialist Midwife – New Cross Hospital
Chris Clewlow	Nursery Nurse – New Cross Hospital
Jane Fleming	Professional Development Facilitator – Birmingham East & North PCT
Jackie Macdonald	Clinic Assistant, Murdishaw Health Centre
Jean Davies	Nursery Nurse, Murdishaw Health Centre

Brighton

Angelique Ramsbottom	Health Visitor, Prince's Park Health Centre
Karen Farrow	Additional Support Midwife, Conquest Hospital
Valerie King	Health Visitor, East Sussex Downs and Weald PCT

Derby

Angela Sherridan	Community Breastfeeding Coordinator, Barnsley PCT; Practicing Midwife; NCT Breastfeeding Counsellor; La Leche League Peer Administrator Trainer; and Trent Breastfeeding Regional Group Joint Chairperson
Angela Beaumont	Breastfeeding Link Worker; and Peer Support, Barnsley PCT
Jane Burren	Peer Support, BIBS Coordinator, Barnsley PCT
Emma Barlow	Volunteer Coordinator, Barnsley Children's Centre

Helen Dean	Infant Feeding Coordinator, Derby City PCT
Anne Jobling	La Leche League Leader Derbyshire; LLLGB PCP Training Coordinator; and IBCLC
Marion Jones	La Leche League Leader Derbyshire; LLLGB PCP Training Coordinator; and IBCLC
Frances Lane	Community Nutritionist, Derby City PCT

East London

Lynda Rowlinson	Senior Practitioner/Health Visitor, River Place Health Centre
Shelley Walker	Nutritionist, Early Start Little Ilford
Anne Butler	Health Visitor, Finsbury Health Centre
Mary Chatrath	Health Visitor, Hanley Primary Care Centre
Faizun Nahar	Coordinator, Breastfeeding Peer Support Programme, River Place Health Centre
Marjorie Kelly	Health Visitor, Ealing PCT
Theresa Taylor	Senior Community Nursery Nurse, Ealing PCT
Sarah Jean-Marie	Senior Children's Centre Dietitian, Stamford Hill Community Centre
Rosemary Brown	Infant Feeding Coordinator, River Place Health Centre

Leeds

Dylis Hart	Cook, Copper Beech Day Nursery
Liz Strangeway	Day Nursery Manager, New Beginnings At Park Spring
Angela Jackson	Cook, Jumping Jacks Day Nursery
Helin Smith	Owner/Manager, Acorn-In-Adel Nursery

Lowestoft

Amanda Williamson	Neonatal Midwifery Lecturer, School of Nursing and Midwifery, University of East Anglia and Clinical Standards Lead NICU
Kim Joyce	Health Visitor, Waveney PCT
Stacey Mickleburgh	Student Nurse formerly Nursery Nurse, Waveney PCT
Elaine Speirs	Health Promotion Midwife, Suffolk Health Partnership/Sure Start
Julie Collins	Health Visitor, Beccles PCT
Fiona Miles	Clinical Manager Maternity, James Paget Hospital Trust
Sarah Barnes	Health Improvement Practitioner, Great Yarmouth & Waveney PCT
Sharon Smith	Community Nursery Nurse, The Ark Children's Centre
Jan Parker	Community Nursery Nurse, The Ark Children's Centre, Sure Start North Lowestoft
Sheila Keenan	Programme Manager, The Ark Children's Centre

Richard Mills	Centre Manager, Seagulls Children's Centre
Sally Crane	Health Visitor, Seagulls Children's Centre
Sue Cummings	Team Leader Health Visitor, Seagulls Children's Centre
Elaine Aylott	Public Health Improvement Manager, Ipswich Borough Council
Elsbeth Lickert	Paediatric Dietician, Ipswich Hospital
Lorna Riseborough	Community Nutritionist, Community Nutrition Team, Priory Centre
Nicki Young	Midwife/ Midwifery Lecturer, University of East Anglia, Institute of Health
Frances Slemmings	Health Visitor, Waveney PCT
Caroline Seaman	Public Health Food, Nutrition and 5-a-day Coordinator Norfolk NHS

Manchester

Gerri Ross	Head, Old Moat Children's Centre
Maureen Waddicor	Health Manager, Sure Start South West Burnley
Anne Evans	Health Visitor, Murdishaw Health Centre
Therese Woods	Health Visitor, Murdishaw Health Centre
Fay Beresford	Specialist Health Visitor Drug/Alcohol, Zion Centre
Madeleine Giggs	Student Midwife, Murdishaw Health Centre
Sue McCauliffe	Community Midwife, Murdishaw Health Centre
Judith Mace	Health Coordinator, The Maden Community and Children's Centre
Hazel Andrews	Team Leader, Central Manchester Community Nutrition Service
Sue Blantern	Midwife Manager, Lythenshaw Maternity Hospital
Jocelyn Ellis	Community Midwife, Sure Start Merseyside
Alice Edgerton	Supervisor of Midwives Research/Audit Midwife, Whiston Maternity Unit
Julie Pilkington	Midwife Supervisor, Sure Start Merseyside

Plymouth

Hilary Peake	Public Health Nutritionist, Devon PCT
Nicola MacPhail	Senior Midwife, Public Health
Sue Cheney	Breastfeeding Coordinator, Plymouth PCT
Denise Edgecombe	Clinical and Professional Lead Health Visitor, Cumberland Centre
Julie Bartlett	Health Visitor Assistant, The Surgery, Adelaide St Plymouth
Jane Hamlyn	Health Visitor Assistant, Plymbridge Children's Centre
Helen Shanahan	Infant Feeding Coordinator and Midwife, Royal Cornwall Hospitals
Janice Potter	Community Public Health Practitioner, Tamar View Resource Centre
Charlotte Thomas	Inclusion Worker, Lark Children's Centre

Lesley Ronayne	Project Lead and Health Visitor, Tamar Folk Children's Centre
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Interviews

Specialist practitioners

Professor Mary Rudolf	Consultant Paediatrician and Professor of Child Health, Leeds PCT and University of Leeds
Ilona Walker	Community Dentist, Dorset County Hospital
Anne Williams	Community Dentist, Poole Clinic
Jenny Grogan	Child Minder, Maden Centre, Lancashire
Susannah Riley	GP
Rosalind Godson	School Nurse
Tony Nunn	Paediatric Pharmacist, Alderhay Children's Hospital
Michelle Lee	Paediatric Pharmacist, Booth Hall Hospital
Jane Birch-Tomlinson	Community Pharmacist
Virginia Beckett	Obstetrician, Bradford Hospital
Pam Harvey	Public Health Nutritionist, Devon PCT
Rachel Rundle	Public Health Nutritionist, Nottingham City PCT
Janet Mountford	Children's Services Manager, Early Years
Chris Robinson	Teenage Pregnancy Midwife, Whiston Hospital, Merseyside
Eve Bish	Alliance Pharmacy

Commissioners

Maria Cody	Lead Health & Social Care Central, Central Liverpool PCT
Robert Jones	Commissioner Children's Services, Norfolk PCT
Waheed Saleem	Head of Children's Commissioning, Birmingham East and North PCT
Aileen Fitzgerald	Head of Children and Families Commissioning, Newcastle PCT
Helen McLindon	Children's Commissioning Manager, Plymouth PCT
Kathy Wocial	Assistant Director Children's and Family Service, Sutton and Merton PCT
Alison Smith	Child Services Commissioner and Strategic Development Lead, Hastings and Rotherham PCT
Ann Corkery	Assistant Commissioner Children's Services Public Health, West Sussex PCT
Diane Gray	Head of Children's Commissioner, Milton Keynes PCT

Appendix 2: Workshop facilitation guide and telephone interview guides

NICE MCN Fieldwork – draft facilitation guide for workshops

0	Welcome and introductions	30mins	
0.1	Aims and context Thank people for coming. High-level aim of fieldwork workshops. Day is structured to be useful, but is <i>not</i> a training day. Reassure people that, whatever their level of experience, as a practitioner their input is highly valuable.	5	Title slide
0.2	Participant introductions Also introduce NICE observers, SHM personnel, etc.	5	
0.3	Process The guidance process and the position of fieldwork Clarity about focus of today Agenda for today Explain allocation of groups to clusters of draft recommendations; organise groups	10	Slides on process
0.4	Questions	10	
1	Impact on practice	30mins	
1.1	Brief We'd like you to suspend your disbelief for a moment. Imagine the draft recommendations landed on your desk, without any further changes or clarifications, and you (and everyone else) were required to implement them as they stand. Imagine that any practical issues (training, resources etc) are dealt with. Introduce questions for this working session. Identify spokesperson for each group, and explain what will be fed back to plenary (highlights only).	5	Briefing slide, also provided as handout 'Posters' for recommendation clusters Note-taking templates
1.2	Groupwork Note-taker allocated to each group	20	
1.3	Plenary feedback	5	
2	Impact on clients	30mins	
2.1	Brief We'd like you to continue the suspension of disbelief for a little longer. Imagine everyone is implementing these draft recommendations in full, and that any practical issues (training, resources etc) have been dealt with Introduce questions for this working session. Identify new spokesperson for each group, and explain what will be fed back to plenary (highlights only).	5	Briefing slide, also provided as handout 'Posters' for recommendation clusters Note-taking templates

2.2	Groupwork Note-taker allocated to each group	20	
2.3	Plenary feedback	5	
3	Feasibility in practice	30mins	
3.1	Brief Now that we've looked at the potential impact, we'd like to go back to some of the practical issues that you or others might face actually implementing these draft recommendations if they were to stand in their current form. Introduce questions for this working session. Identify new spokesperson for each group, and explain what will be fed back to plenary (highlights only).	5	Briefing slide, also provided as handout 'Posters' for recommendation clusters Note-taking templates
2.2	Groupwork Note-taker allocated to each group	20	
2.3	Plenary feedback	5	
4	Prioritisation exercise	30mins	
4.1	Brief Reviewing all of the discussion so far, we'd like you to think about all the draft recommendations and sort them – entirely from <i>your own perspective</i> – in terms of impact and feasibility.	5	Briefing slide Handout for completion by participants
	Individuals complete sheet	10	
	Plenary discussion Any surprises? Comments?	15	
5	Concluding remarks	10mins	
	Thanks to participants Travel expense forms Next steps (including circulation of record of day)	10	

NICE Maternal and Child Nutrition programme guidance

Interview guide for telephone conversations with COMMISSIONERS

Introduction and background

Hello. Thank you very much for sparing the time to talk to us.

SHM has been commissioned by NICE to run the fieldwork process for the draft public health programme guidance on Maternal and Child Nutrition. This guidance is designed to **improve the nutrition of pregnant and breastfeeding mothers and children in low-income households.**

Following reviews of the evidence and consultation with stakeholders, NICE has produced recommendations in draft form and a programme of consultation including this fieldwork is now under way to invite comment and feedback from a range of practitioners on the relevance, usefulness, impact and feasibility of these draft recommendations in different contexts of practice. Over the past 2 weeks SHM has facilitated six workshops with diverse groups of practitioners working in the field of maternal and child nutrition around the country.

The current stage of our work involves talking to commissioners of Maternal and Child services. The purpose of this telephone interview is to build on the insights we gleaned in the practitioner workshops. We also aim to understand the implications this draft guidance would have for you in your role as a commissioner.

Please feel free to speak freely in your answers to the questions. Your responses will be made anonymous so that specific statements will not be attributable to you directly.

1. Which of the draft recommendations do you think would have implications for commissioning? What might the challenges be in implementing the draft recommendations, and how might these be overcome?

(Note to interviewers: NICE feels that all of the draft recommendations may relate directly to commissioners and that commissioners will know which draft recommendations don't have implications for them. Interviewers should probe this where appropriate.)

2. Practitioners suggest that broadening delivery to engage wider audiences could require changes to ways of working and, in particular, more joined-up delivery between organisations. What provision could be made in the draft recommendations to support these kinds of changes?

3. When we spoke to practitioners working in this field about the things that would enable them to implement the draft recommendations (or the things that would need to *change* in order for them to do so), they tend to point to the need for additional **staffing resource**. This is particularly because they recognise the need

to be more **proactive** in reaching out to this client group, and the need to **sustain engagement over time** to deliver information to clients in a more strategic way. What is your view as a commissioner on this? And what, from your perspective, would improve the feasibility of this?

4. Thinking more generally now, given the changes in commissioning that are currently taking place, what do you think the main challenges and opportunities are for implementing the draft recommendations for Maternal and Child Nutrition? Are there any other challenges that you can foresee?

5. Do you have any final comments about the draft recommendations that you would like to share with us?

Closing remarks

Thank you very much indeed for your time. As I indicated before, your responses to these questions will be made anonymous so that specific statements will not be attributable to you directly.

However, we will be sure to acknowledge your contribution in our final Fieldwork report.

NICE Maternal and Child Nutrition programme guidance

Interview guide for telephone conversations with SPECIALIST PRACTITIONERS

Introduction and background

Hello. Thank you very much for sparing the time to talk to us.

SHM has been commissioned by NICE to run the fieldwork process for the draft public health programme guidance on Maternal and Child Nutrition. This guidance is designed to **improve the nutrition of pregnant and breastfeeding mothers and children in low-income households.**

Following reviews of the evidence and consultation with stakeholders, NICE has produced recommendations in draft form and a programme of consultation including this fieldwork is now under way to invite comment and feedback from a range of practitioners on the relevance, usefulness, impact and feasibility of these draft recommendations in different contexts of practice. Over the past 2 weeks SHM has facilitated six workshops with diverse groups of practitioners working in the field of maternal and child nutrition around the country.

The current stage of our work involves talking to commissioners of Maternal and Child services. The purpose of this telephone interview is to build on the insights we gleaned in the practitioner workshops. We also aim to understand the implications this draft guidance would have for you in your role as a commissioner.

Please feel free to speak freely in your answers to the questions. Your responses will be made anonymous so that specific statements will not be attributable to you directly.

A) General reflections

1. To what extent do the draft recommendations in which your professional role is specified in 'who should take action' feel relevant to you? Are there any other draft recommendations in which your role is not specified that you feel are relevant to you? If so, how are they relevant?

B) Impact on *practice*

2a) Would you need any clarifications before you could put the draft recommendations into practice? If so, what are they?
2b) What impact would each of the draft recommendations that you feel are relevant to you have for your practice? What would actually change as a result—in what you do? In what colleagues in your field of practice do? In what you see in other fields of practice?)

C) Impact on *clients*

3. What would the impact be on the behaviour and health of the kinds of client you are familiar with—and why? Would any groups of clients be affected more/differently? Why? What opportunities would have been missed?

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D) *Feasibility in practice*

4. I'd like now to turn our attention to the diagram that you have completed, which plots the draft recommendations according to their impact and feasibility. I'd like us to look at your placement of each of the draft recommendations on the diagram. I'd then like to discuss with you the draft recommendations for which you think there is an opportunity to do something differently to maximise their impact or make them more feasible. In particular, I'd like to focus on what needs to happen to make a given recommendation more feasible in terms of **support** (in which case, from whom), **resources**, and **training**. I'd also like to find out what barriers might need to be overcome.

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E) Final comments

5. Do you have any final comments about the draft recommendations that you would like to share with us?

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Closing remarks

Thank you very much indeed for your time. As I indicated before, your responses to these questions will be made anonymous so that specific statements will not be attributable to you directly.

However, we will be sure to acknowledge your contribution in our final Fieldwork report.