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Quality standards and indicators

Briefing paper

Quality standard topic: Maternal and child nutrition: improving nutritional status

Output: Prioritised quality improvement areas for development.

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1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for maternal and child nutrition: improving nutritional status. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development sources referenced in this briefing paper are:

- Maternal and child nutrition (2008) NICE guideline PH11
- Vitamin D deficiency prevention (2014) NICE guideline PH56
- Weight management before, during and after pregnancy (2010) NICE guideline PH27.
- Antenatal care (2008) NICE guideline CG62.
- Postnatal care: routine postnatal care of women and their babies (2006) NICE guideline CG37.

Review decision made in 2014 to fully update guideline PH11 following publication of the following:

- NICE Public Health Guideline on Vitamin D - implementation of existing guidance to prevent deficiency (PH56)
- Scientific Advisory Committee on Nutrition (SACN) working group review of the Dietary Reference Values for vitamin D intake
- SACN sub group on Maternal and Child Nutrition (SMCN) review on complementary feeding
- The Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment (COT) systematic review of antigenic tolerance and risk of allergic disease.

PH56 was published in November 2014 and will be reviewed after 3 years.

PH27 was reviewed in 2013 and was not updated as it remained current. It will be reviewed in 2016.

CG62 was reviewed in 2014 and placed on the static list.

CG37 was updated in 2014 and will be reviewed again in 2015.

2 Overview

2.1 Focus of quality standard

This quality standard will cover improving nutrition for women of childbearing age pre-conception, during pregnancy and post-pregnancy (up to a year after birth) and for babies and pre-school children particularly focusing on low-income and other disadvantaged households.

It does not cover population-based screening programmes or national maternal and child nutrition policies. It does not cover the nutritional status and care of women and children with clinical conditions that require specialist advice, secondary dietary management, or clinical therapeutic advice, for whom normal care would be inappropriate. For example, it does not cover women and children with diabetes, epilepsy or HIV, or the care of low birth weight babies.

2.2 Definition

Nutritional status describes an individual's nutritional wellbeing. It is a more comprehensive measure than dietary intake alone as it takes account of body shape and size together with measures of body function.

The importance of ensuring mothers and their babies are well-nourished is widely recognised. A pregnant woman's nutritional status influences the growth and development of her fetus and forms the foundations for the child's later health. The mother's own health, both in the short and long term, also depends on how well-nourished she is before, during and after pregnancy.

A child's diet during the early years impacts on their growth and development. It is linked to the incidence of many common childhood conditions such as diarrhoeal disease, dental caries and iron and vitamin D deficiencies. It may also influence the risk in adult life of conditions such as coronary heart disease, diabetes and obesity.

Up to 50% of pregnancies are likely to be unplanned, so all women of childbearing age need to be aware of the importance of a healthy diet. Nutritional interventions for women who are, or who plan to become, pregnant are likely to have the greatest effect if delivered before conception and during the first 12 weeks.

2.3 Incidence and prevalence

Acheson's independent inquiry (1998) recognised the impact of poverty on the health and nutritional status of women and children. In particular, the inquiry highlighted that mothers from disadvantaged groups are more likely than others to give birth to babies with a low birth weight. It also pointed out that breastfeeding is a strong indicator of social inequalities (that is, women who are most disadvantaged are least likely to breastfeed).

A healthy diet is important for both the baby and mother throughout pregnancy and after the birth. However, 39% of people from low income groups report that they worry about having enough food to eat before they receive money to buy more. Similarly, about a third (36%) report that they cannot afford to eat balanced meals. Overall, one fifth of adults in low income groups report reducing the size of, or skipping, meals. Five per cent report that, on occasion, they have not eaten for a whole day because they did not have enough money to buy food. Women from disadvantaged groups have a poorer diet and are more likely either to be obese or to show low weight gain during pregnancy.

The infant feeding survey 2010 confirmed that low maternal age, low educational attainment and low socioeconomic position continue to have a strong impact on patterns of infant feeding. For example, 70% of UK women from managerial and professional occupations were breastfeeding at 6 weeks compared to only 42% of those from routine and manual groups.

Babies who were exclusively breastfed for a minimum of four months were considerably less likely than babies who were never breastfed to suffer from diarrhoea (25% compared with 45% of those who were never breastfed), constipation (32% compared with 48%) and sickness or vomiting (29% compared with 41%).

Less privileged mothers are also more likely to introduce solid foods earlier than recommended and their children are at a greater risk of both 'growth faltering' (gaining weight too slowly) in infancy and obesity in later childhood. In addition, average daily intakes of iron and calcium are significantly lower, and rates of dental caries are significantly higher among children from manual groups compared with those from non-manual groups.

2.4 Management

Healthy Start

In 2000, the Committee on Medical Aspects of Food and Nutrition Policy (COMA) (now disbanded and replaced by The Scientific Advisory Committee on Nutrition (SACN)) undertook a scientific review of the Welfare Food Scheme (WFS) which had been in existence in various forms since 1940. WFS provided eligible pregnant women, mothers and children with vouchers for milk or infant formula.

COMA recommended giving pregnant women and those with young children vouchers for a broader range of foods (that is, not just milk or infant formula). Healthy Start, which replaced WFS in 2006, implemented this and a range of other measures. An important innovation was its emphasis on the need for health professionals to give participating mothers health and lifestyle advice. This advice has to cover diet during pregnancy, breastfeeding and the importance of fresh fruit, vegetables and vitamins.

The Healthy Start scheme provides food vouchers and Healthy Start-branded vitamins to pregnant mothers, new mothers and young children (under 4 years) living on low incomes across the UK and aims to improve access to a healthy diet for these vulnerable families.

Folic acid

Folic acid supplements reduce the risk to the fetus of neural tube defects (NTDs) such as anencephaly and spina bifida.

Vitamin D

Dietary sources of vitamin D are limited and the main source is skin synthesis on exposure of the skin to sunlight. However, at UK latitudes, there is limited sunlight of the appropriate wavelength, particularly during winter. Thus maternal skin exposure alone may not always be enough to achieve the optimal vitamin D status needed for pregnancy. During pregnancy, lack of vitamin D may adversely affect fetal bone mineralisation and accumulation of infant vitamin D stores for their early months of life.

Breastfeeding

Current UK policy is to promote exclusive breastfeeding (feeding only breast milk) for the first 6 months. Thereafter, it recommends that breastfeeding should continue for as long as the mother and baby wish, while gradually introducing a more varied diet.

Breastfeeding contributes to the health of both mother and child, in the short and long term. For example, babies who are not breastfed are more likely to acquire infections such as gastroenteritis in their first year. It is estimated that if all UK infants were exclusively breastfed, the number hospitalised each month with diarrhoea would be halved, and the number hospitalised with a respiratory infection would be cut by a quarter.

Exclusive breastfeeding in the early months may reduce the risk of atopic dermatitis. In addition, there is some evidence that babies who are not breastfed are more likely to become obese in later childhood. Mothers who do not breastfeed have an increased risk of breast and ovarian cancers and may find it more difficult to return to their pre-pregnancy weight.

The Infant Feeding Survey 2010 found that the initial breastfeeding rate increased from 76% in 2005 to 81% in 2010 in the UK. Initial breastfeeding rates in 2010 were 83% (78% in 2005) in England, 74% (70% in 2005) in Scotland, 71% (67% in 2005)

in Wales, and 64% (no change from 2005) in Northern Ireland. However, the proportion of mothers following current UK government guidelines on exclusive breastfeeding remained unchanged between 2005 and 2010 – with only one in every hundred breastfeeding exclusively for the first six months of their baby's life.

Infant feeding

UK dietary recommendations for children aged 6–24 months involves a gradual transition from an exclusively milk-based diet to one based, for the most part, on foods other than milk.

Health departments in England, Wales and Northern Ireland recommend that babies should be offered a gradually increasing amount and variety of solid foods, in addition to milk, from 6 months. This should include meat, fish, pulses, vegetables and fruit without added salt or sugar. National infant feeding surveys have consistently shown that early introduction of solid foods is associated with lower socioeconomic position and educational attainment.

Pre-school children

The pre-school years are an ideal time to establish the foundation for a healthy lifestyle. Parents are primarily responsible for their child's nutrition during these years, but child care providers also play an important role.

Generally, children aged 1.5 to 6 years do not eat enough fruit and vegetables (particularly those from lower income and one parent families). However, they do eat a lot of added sugars.

Since 1998, children's centres and initiatives such as Sure Start have created more opportunities for multidisciplinary involvement outside traditional healthcare settings. This has led to more local opportunities to offer nutritional advice to mothers and those who care for young children.

Maternal diet

Up to 50% of pregnancies are likely to be unplanned, so all women of childbearing age need to be aware of the importance of a healthy diet. Nutritional interventions for

women who are, or who plan to become, pregnant are likely to have the greatest effect if delivered before conception and during the first 12 weeks.

Women who are overweight or obese before they conceive have an increased risk of complications during pregnancy and birth. This poses health risks for both mother and baby in the longer term. There is also evidence that maternal obesity is related to health inequalities, particularly socioeconomic deprivation, inequalities within ethnic groups and poor access to maternity services.

Infant formula

Powdered infant formula is not a sterile product and can be contaminated with micro-organisms such as enterobacter sakazakii and salmonella, which can cause serious illness. The correct preparation and handling of powdered formula is important and the Food Standards Agency and all the UK health departments have issued guidance about the safe preparation, storage and handling of powdered infant formula. (The Infant Feeding Survey 2010)

Training

Women who are preparing for pregnancy need help to understand the long-term consequences on their child's health of poor nutrition during pregnancy. Cultural beliefs may prevent people from accepting professional advice. In addition, mothers may be subjected to conflicting and inconsistent advice from health professionals, literature, media sources and product labelling.

2.5 National Outcome Frameworks

Tables 1and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2014–15

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicator*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults ii Children and young people ***Improvement areas*** **Reducing deaths in babies and young children** 1.6 i Infant mortality (PHOF 4.1*) ii Neonatal mortality and stillbirths
4 Ensuring that people have a positive experience of care	***Overarching indicator*** 4b Patient experience of hospital care ***Improvement areas*** **Improving women and their families' experience of maternity services** 4.5 Women's experience of maternity services
Alignment across the health and social care system * Indicator shared with Public Health Outcomes Framework (PHOF)	

Table 2 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.1 Low birth weight of term babies 2.2 Breastfeeding 2.6 Excess weight in 4-5 and 10-11 year olds 2.11 Diet 2.12 Excess weight in adults
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.2 Tooth decay in children aged 5

3 Summary of suggestions

3.1 Responses

In total 7 stakeholders responded to the 2-week engagement exercise 27/10/14 – 10/11/14.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 1 for further consideration by the Committee.

NHS England's patient safety division did not submit any data for this topic.

Full details of all the suggestions provided are given in appendix 3 for information.

Table 3 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Healthy Start • Food poverty • Use of food vouchers • Signposting to local classes/groups • Healthy Start vitamin scheme • Folic acid	RCPCH, SCMs, PHE
Breast feeding • Initiation and duration/continuation • Training of health care professionals • Peer support	UNICEF, SCMs, BFN, PHE
Weaning	SCM
Nutrition in pre-school settings	SCMs
Food education	SCM
Infant formula	SCM
Maternal diet pre/during pregnancy	SCM, PHE

Additional areas Ankyloglossia (tongue-tie) • Include an assessment of Tongue Tie(TT) within the New-born Infant and Physical Examination • Include TT examination in the Management of Breastfeeding Training curriculum for Midwives and Health Visitors • Extend the provision of TT clinics Inequalities and regional/ inter-regional variations in infant feeding Breastfeeding alongside taking medications for mental health needs Medicinal Preparations list of Nurse Prescribers' Formulary for community practitioners Food Labelling Advertise breastfeeding through "change for Life" Change to NICE pathways/guidance Change the DH definition of Prevalence of Breastfeeding at 6-8 weeks	SCMs, BFN
BFN, Breastfeeding Network NHSE, NHS England PHE, Public Health England RCN, Royal College of Nursing RCPCH, Royal College of Paediatrics and Child Health SCM, Specialist Committee Member UNICEF, UNICEF UK Baby Friendly	

4 Suggested improvement areas

4.1 Healthy Start

4.1.1 Summary of suggestions

Food poverty

A stakeholder raised this as a key improvement area and queried what interventions have worked to reduce inequalities in food adequacy in this age group. Healthy Start was highlighted as a core initiative to impact health inequalities. As a national government scheme it aims to improve the health of low-income pregnant women and families on benefits and tax credits.

Use of food vouchers

Stakeholders commented that people eligible for Healthy Start should be given specific guidance and advice on how to maximize their food vouchers.

Signposting to local classes/groups

Stakeholders commented that people eligible for Healthy Start should be sign posted to local cooking classes, group support at children's centres etc.

A stakeholder highlighted that the opportunity to engage with women who may otherwise be 'hard to reach' is often given by the need for a health professional to sign the Health Start eligibility form, and this contact should be used to its best advantage by relevant health professionals to discuss eating in pregnancy, vitamin use, family food choices and breastfeeding and how families can access support for this.

Healthy Start vitamin scheme

A stakeholder commented that families ineligible for the Healthy Start scheme should be able to buy the vitamins as buying a commercial vitamin supplement is expensive and often contains more vitamins than is recommended. The stakeholder considered this would increase the awareness of need for supplementation in this population group.

A stakeholder suggested that commissioners could provide free universal vitamin supplements for pregnant and breastfeeding mothers and infants.

Please note: NICE is working on a separate report on the cost effectiveness of extending the Healthy Start vitamin programme from the current targeted offering to a universal offering. This will be forwarded to the Chief Medical Officer in 2015

A stakeholder suggested the extension of the Healthy Start vitamin scheme entitlement to include children up to their 5th birthday. They commented that currently the recommendation is for all children to receive vitamins A, D and C supplementation up until age 5 but Healthy Start vouchers cease at the age of 4 years which includes vouchers for vitamins.

A stakeholder commented that vitamin D deficiency impairs the absorption of dietary calcium and phosphorous which can cause bone problems. All pregnant and breastfeeding women, in particular teenagers and young women, and infants are at risk of vitamin D deficiency and are recommended to take a supplement. Those eligible for Healthy Start can receive free vitamin supplements which contain vitamin D.

Folic acid

A stakeholder commented that folic acid is very important for the development of a healthy fetus, as it can significantly reduce the risk of neural tube defects (NTDs) therefore pregnant women and women who may become pregnant are advised to take a daily supplement of 400 µg folic acid prior to conception and until the 12th week of pregnancy, to reduce the risk of NTDs.

4.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 4 to help inform the Committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Food poverty	NICE PH11 Recommendations 4 (KPI) and 22 NICE PH27 Recommendation 2 NICE CG62 Recommendation 1.1.1.1
Use of food vouchers	NICE PH11 Recommendations 4 (KPI) and 22 NICE PH27 Recommendation 2
Signposting to local classes/groups	NICE PH11 Recommendation 22
Healthy Start vitamin scheme	NICE PH11 Recommendations 2 and 4 (both KPI) NICE PH56 Recommendations 5 and 6
Folic acid	NICE PH11 Recommendations 2 (KPI)

Food poverty

<u>NICE PH11 - Recommendation 4 (KPI)</u>

- PCTs should promote the Healthy Start scheme.
- PCTs should ensure an adequate supply of both types of Healthy Start vitamin supplements (for women and for children from 6 months to 4 years) is available for distribution by health professionals when they see pregnant women and parents of children under 4 years.
- PCTs should ensure an adequate supply of Healthy Start application forms is available and that the uptake of Healthy Start benefits is regularly audited.
- Health professionals should advise pregnant women and parents of children under 4 years about the Healthy Start scheme. They should ensure all women who may be eligible receive an application form as early as possible in pregnancy.
- Health professionals should use every opportunity they have to offer those parents who are eligible for the Healthy Start scheme practical, tailored information, support and advice on:
    - how to use Healthy Start vouchers to increase their fruit and vegetable intake
    - how to initiate and maintain breastfeeding
    - how to introduce foods in addition to milk as part of a progressively varied diet when infants are 6 months old.
- Health professionals should offer the maternal Healthy Start vitamin supplement (folic acid, vitamins C and D) to pregnant women who are (or who may be) eligible.
- GPs and health visitors should offer children's Healthy Start vitamin supplements (vitamins A, C and D) to all children aged from 6 months to 4 years in families receiving the Healthy Start benefit.
- Commissioners should consider distributing the maternal Healthy Start vitamin supplement (folic acid, vitamins C and D) to all women who receive Healthy Start benefit for children aged 1– 4 years, particularly those who may become pregnant.

- Community pharmacists should ensure the Healthy Start maternal vitamin supplements are available for purchase by women who are not eligible to receive them free of charge.

NICE PH11 - Recommendation 22

- Public health nutritionists and dietitians should offer parents in receipt of Healthy Start benefit practical support and advice on how to use the Healthy Start vouchers to increase their intake of fruit and vegetables.

- 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, 'cook and eat' clubs, 'weaning parties' and 'baby cafes'.

- Work with local retailers to improve the way fresh fruit and vegetables are displayed and promoted.

NICE PH27 - Recommendation 2

- Offer practical and tailored information. This includes advice on how to use Healthy Start vouchers to increase the fruit and vegetable intake of those eligible for the Healthy Start scheme (women under 18 years and those who are receiving benefit payments).

NICE CG62 - Recommendation 1.1.1.1

New Antenatal information should be given to pregnant women according to the following schedule.

- At booking (ideally by 10 weeks):
    - nutrition and diet, including vitamin D supplementation for women at risk of vitamin D deficiency, and details of the 'Healthy Start' programme

Use of food vouchers

NICE PH11 – Recommendations 4 (KPI) and 22

Please see full wording of recommendations under ‘Food poverty’.

NICE PH27 - Recommendation 2

Please see relevant section of the recommendation under ‘Food poverty’.

Signposting to local classes/groups

NICE PH11 - Recommendation 22

Please see full wording of recommendation under 'Food poverty'.

Healthy Start vitamin scheme

NICE PH11 - Recommendation 2 (KPI)

- PCTs should ensure local education initiatives aimed at health professionals include information on the importance of folic acid supplements. They should provide the maternal Healthy Start vitamin supplements (folic acid, vitamins C and D) for eligible women. They should also ensure women who are not eligible for Healthy Start can obtain the supplements from their local pharmacy.

NICE PH11 – Recommendation 4 (KPI)

Please see full wording of recommendation under 'Food poverty'.

NICE PH56 – Recommendation 5

Local authorities should ensure vitamin D supplements containing the recommended reference nutrient intake are widely available for all at-risk groups by:

- Establishing arrangements with a range of settings to promote and distribute them. This could include local pharmacies, children's centres, midwifery and health visiting services and GP reception areas.
- Considering providing free supplements for at-risk groups.
- Encouraging pharmacies and other outlets selling food supplements (such as supermarkets) to stock the lowest cost vitamin D supplements and promote them to at-risk groups.
- Ensure improvements in the availability of vitamin D supplements are supported by local awareness-raising activities (see recommendations 9 and 10).

NICE PH56 – Recommendation 6

Local authorities should:

- Consider how accessibility, availability and uptake could be improved. For example:
  - Encourage a range of outlets where pregnant and breastfeeding women and families and carers of under-5s may go to stock and promote Healthy Start supplements. This includes high street and supermarket pharmacies,

children's centres, schools and clinics with a range of opening times. Many of them should also be accessible by public transport.

– Consider offering free Healthy Start supplements to all pregnant and breastfeeding women and children aged under 5 years.

– Encourage pharmacies to sell the Healthy Start supplement to:

- pregnant and breastfeeding women and children under 4 years not eligible for the benefit
- parents or carers of children aged 4 to 5 years and older children in 1 of the other at-risk groups
- women planning a pregnancy and women of child bearing age (see recommendation 1).

Folic acid

NICE PH11 - Recommendation 2 (KPI)

Health professionals should:

– use any appropriate opportunity to advise women who may become pregnant that they can most easily 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 or rich in folate

– advise all women who may become pregnant about a suitable folic acid supplement, such as the maternal Healthy Start vitamin supplements

– encourage women to take folic acid supplements and to eat foods rich in folic acid (for example, fortified breakfast cereals and yeast extract) and to consume foods and drinks rich in folate (for example, peas and beans and orange juice).

- PCTs should ensure local education initiatives aimed at health professionals include information on the importance of folic acid supplements. They should provide the maternal Healthy Start vitamin supplements (folic acid, vitamins C and D) for eligible women. They should also ensure women who are not eligible for Healthy Start can obtain the supplements from their local pharmacy.

- GPs should prescribe 5 milligrams of folic acid a day for women who are planning a pregnancy, or are in the early stages of pregnancy, 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 defects
  - have diabetes.

4.1.3 Current UK practice

Food poverty

Healthy Start Vouchers Study: The Views and Experiences of Parents, Professionals and Small Retailers in England

The Healthy Start scheme provides food vouchers and Healthy Start-branded vitamins to pregnant mothers, new mothers and young children (under 4 years) living on low incomes across the UK and aims to improve access to a healthy diet for these vulnerable families. A study was carried out in 13 Primary Care Trusts (PCTs) across all regions of England only looking at the uptake and use of Healthy Start vouchers.

Many frontline professionals perceived the food vouchers scheme to be a 'drop in the ocean' and, at best, a financial safety net for families (albeit one that was needed). Professionals were positive about the inclusion fruit and vegetables since the change from Welfare Foods, but were sceptical that the scheme had moved beyond 'milk tokens' and judged that families struggling to cope with stringent budgets would usually buy cow's or formula milk. Many parents reported that the Healthy Start vouchers were an essential part of their food budget, particularly when buying infant formula. A sizeable proportion also spent the vouchers on fruit and vegetables that would otherwise be unaffordable suggesting the scheme is moving further beyond 'milk tokens' than professionals realise, particularly for those families who breastfeed or have older children. Many parents in the sample prided themselves on providing a good and healthy diet for their children that included fresh fruit and vegetables.

The study demonstrated the financial safety net the Healthy Start vouchers can provide for low income families struggling to make ends meet. However, it was felt that some very needy families are probably missing out and others just above the eligibility criteria are likely to also benefit from food vouchers and access to vitamins.

Use of food vouchers

Healthy Start Vouchers Study: The Views and Experiences of Parents, Professionals and Small Retailers in England showed that pregnant women tended to use the vouchers for extra milk, fruit and vegetables; formula-feeding mothers to offset the cost of infant formula; and breastfeeding mothers and those with older children for additional fruit and cow's milk.

PCTs were not required to monitor the impact of Healthy Start vouchers on local beneficiaries, nor were they provided with any data from other sources on how families use the vouchers and the impact on parents and children. This contributed to the lack of focus locally in encouraging and supporting health professionals to make explicit the links between the scheme and wider health promotion initiatives.

Most parents reported receiving minimal information from health professionals about how they could use their food vouchers to improve their family's health. Some parents found the Healthy Start website and leaflet information useful for recipes and nutritional advice.

Signposting to local classes/groups

Healthy Start Vouchers Study: The Views and Experiences of Parents, Professionals and Small Retailers in England found that professionals had good knowledge of the aims of the Healthy Start scheme, and viewed it as a financial and nutritional safety net; ensuring low income families always had access to healthy food.

While both midwives and health visitors offered nutrition advice as part of their usual role, most were not connecting this to the potential of Healthy Start vouchers to increase the amount of fruit and vegetables families buy. In most of the sites there were limited other nutrition services (such as cookery classes, or diet advice) available, and links were not made to the Healthy Start scheme.

Healthy Start vitamin scheme

Healthy Start Vouchers Study: The Views and Experiences of Parents, Professionals and Small Retailers in England found that vitamin take-up was below 10% of eligible beneficiaries for free vitamins. It found that Healthy Start vitamin take-up, even in those sites where provision was universal for pregnant women and/or infant children, was very low, often below 10%.

The Healthy Start tablets for women provide a daily dose of vitamin C, vitamin D and folic acid. Healthy Start vitamin drops for children provide a daily dose of vitamin A, vitamin C, and vitamin D3.

Currently NICE guidelines state that consideration should be given to vitamin D supplements during pregnancy and breastfeeding. The Healthy Start vouchers study

stated that in 2010 6% of women in England took supplements containing vitamin D during early pregnancy. However, these high rates are not sustained after birth with just 23% of mothers and 7% of babies taking supplements at 8-10 months. Current UK government recommendations are that babies children over 6 months of age should be given supplements containing vitamins A, C and D (unless they are being fed more than 500ml a day of formula milk which will already be fortified with these). However, only 15% of 8-10 month old babies in England are currently given vitamin drops, and this figure was lower among those who had bottle fed and among white British families.

University Hospitals of Leicester carried out a survey of pregnant women attending ante-natal appointments October – December 2013. (Are all pregnant women being advised and taking vitamin D supplements during pregnancy?) Of 228 responses, 24% of women had been recommended to supplement vitamin D during pregnancy. 38% were taking a supplement containing vitamin D however the dose was less than the Department of Health recommended dose of 400micrograms.

In a survey of health visitors, GPs, and midwives within a South London borough from June to July 2010 pregnant women were routinely advised about vitamin D supplementation by 8/34 (24%) midwives and 2/21 (10%) GPs. Supplementation advice for breastfeeding women and breast-fed babies was given by 10/22 (45%) health visitors and 3/21 (14%) GPs. Of those healthcare professionals who do not routinely advise on supplementation, 8/12 (67%) health visitors and 17/26 (65%) midwives targeted one or more high-risk groups, compared to 2/19 (11%) GPs. One or more occasions when formula fed children would need supplementation was recognised by 13% of GPs and 68% of health visitors. Knowledge of vitamin D deficient rickets was evident in 96% of health visitors and fewer midwives (53%). No GPs, 65% of midwives and 95% of health visitors were aware of 'Healthy Start'. All groups requested further clarity on vitamin D supplementation (95% of GPs, 74% of midwives and 50% of health visitors).

The national diet and nutrition survey findings 2012 stated that for vitamin D, reference nutrient intakes (RNIs) are set only for those aged up to four years and those aged 65 years and over. Mean intakes from food sources were well below the RNI for children aged 1 and a half to 3 at 27%. 'Milk and milk products' was the major contributor to vitamin D intake for children aged 1.5 to three years, providing 24%.

No current practice on extending the eligibility to age 5 or the sale of vitamins to those not eligible for the Healthy Start scheme has been identified.

Folic acid

Currently NICE guidelines state that all women who are or plan to become pregnant take folic acid.

The extent of folic acid supplementation among women who had antenatal screening for Down's syndrome and neural tube defects (NTDs) at the Wolfson Institute of Preventive Medicine, London between 1999 and 2012 was assessed. 466,860 women who were screened provided details on folic acid supplementation. The proportion of women who took folic acid supplements before pregnancy was determined according to year and characteristics of the women. The proportion of women taking folic acid supplements before pregnancy declined from 35% in 1999–2001 to 31% in 2011–2012. 6% of women aged under 20 took folic acid supplements before pregnancy compared with 40% of women aged between 35 and 39. 51% of women who previously had an NTD pregnancy took folic acid supplements before the current pregnancy.

The Healthy Start Vouchers study stated that in 2010 69% of women in England took folic acid during early pregnancy.

4.2 Breast feeding

4.2.1 Summary of suggestions

Initiation and duration/continuation

Stakeholders highlighted there is strong evidence to support the promotion, protection and support of breastfeeding to improve the health and wellbeing outcomes for both mothers and babies. Stakeholders commented that improvement in the uptake of breastfeeding and continuation rates reduces the likelihood of infant allergies, obesity and morbidities and would bring about important financial benefits in the long term through improving the health outcomes of mothers. They highlighted that there should be consistent implementation of evidence-based actions to promote the initiation and duration of breastfeeding.

There is an overlap here with statement 5 of the postnatal care quality standard (QS37) which contains a statement on breastfeeding (see appendix 1).

Training of health care professionals

Stakeholders highlighted that health care professionals being trained to support the development of early mother-infant relationships and early and continued breastfeeding reduces likelihood of infant allergies, obesity and morbidities and protects mothers' health and wellbeing.

Peer support

A stakeholder stated that peer support services are important at increasing breastfeeding prevalence rates, developing community support for breastfeeding and challenging a hostile culture. However they raised concerns about the level of detail within the recommendations and felt more guidance was needed on managing a peer support service and the description of what a peer support service does.

4.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Initiation and duration/ continuation	NICE PH11 Recommendations 4 (KPI), 7 (KPI), 8, 9, 10, 16 and 20 NICE PH27 Recommendation 3 NICE CG37 Recommendations 1.3.1 –

	1.3.5 (1.3.3 KPI), 1.3.8 – 1.3.11 and 1.3.15 – 1.3.22 NICE CG62 Recommendation 1.1.1.1
Training of health care professionals	NICE PH11 Recommendations 1 (KPI), 7 (KPI), 8 and 9 NICE CG37 Recommendations 1.1.10
Peer support	NICE PH11 Recommendations 7, 11 (both KPI) and 13 NICE CG37 Recommendation 1.3.22

Initiation and duration/ continuation

<u>NICE PH11 - Recommendation 4 (KPI)</u>

Health professionals should use every opportunity they have to offer those parents who are eligible for the Healthy Start scheme practical, tailored information, support and advice on:

- how to initiate and maintain breastfeeding

<u>NICE PH11 - Recommendation 7 (KPI)</u>

- Adopt a multifaceted approach or a coordinated programme of interventions across different settings to increase breastfeeding rates. It should include:
  - activities to raise awareness of the benefits of – and how to overcome the barriers to - breastfeeding
  - training for health professionals
  - breastfeeding peer-support programmes
  - joint working between health professionals and peer supporters
  - education and information for pregnant women on how to breastfeed, followed by proactive support during the postnatal period (the support may be provided by a volunteer).
- Implement a structured programme that encourages breastfeeding, using BFI as a minimum standard. The programme should be subject to external evaluation.

(See also NICE clinical guideline 37 on postnatal care)

<u>NICE PH11 - Recommendation 8</u>

- Ensure health professionals who provide information and advice to breastfeeding mothers have the required knowledge and skills.

- Ensure all those who work in maternity and children's services, including receptionists, volunteers and ancillary staff, are made fully aware of the importance of breastfeeding and help to promote a supportive environment.

NICE PH11 - Recommendation 9

- Midwives and health visitors should ensure pregnant women and their partners are offered breastfeeding information, education and support on an individual or group basis. This should be provided by someone trained in breastfeeding management and should be delivered in a setting and style that best meets the woman's needs.

- During individual antenatal consultations GPs, obstetricians and midwives should encourage breastfeeding. They should pay particular attention to the needs of women who are least likely to breastfeed (for example, young women, those who have low educational achievement and those from disadvantaged groups).

- A midwife or health visitor trained in breastfeeding management should provide an informal group session in the last trimester of pregnancy. This should focus on how to breastfeed effectively by covering feeding position and how to attach the baby correctly.

NICE PH11 - Recommendation 10

- Ensure a mother can demonstrate how to position and attach the baby to the breast and can identify signs that the baby is feeding well. This should be achieved (and be documented) before she leaves hospital or the birth centre (or before the midwife leaves the mother after a home birth).

- Provide continuing and proactive breastfeeding support at home, recording all advice in the mother's hand-held records.

- Provide contact details for local voluntary organisations that can offer ongoing support to complement NHS breastfeeding services.

- Do not provide written materials in isolation but use them to reinforce face-to-face advice about breastfeeding.

NICE PH11 - Recommendation 16

- Commissioners and managers should work with local partners to ensure mothers can feed their babies in public areas without fear of interruption or criticism.

- Health visitors should assess the needs of all mothers, parents and carers with young children. They should provide relevant, early and ongoing support at home

for those with the greatest needs, including any that may be the result of a physical or learning disability or communication difficulties.

- Health visitors and the child health promotion programme (CHPP) team should:
    - support mothers to continue breastfeeding for as long as they choose

NICE PH11 - Recommendation 20

- Support breastfeeding mothers by:
    – offering them the opportunity to breastfeed when they wish
    – 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.

NICE PH27 – Recommendation 3

- Midwives and other health professionals should encourage women to breastfeed. They should reassure them that a healthy diet and regular, moderate-intensity physical activity and gradual weight loss will not adversely affect the ability to breastfeed or the quantity or quality of breast milk.

NICE CG37 – Recommendations 1.3.1 – 1.3.5 (1.3.3 KPI), 1.3.8 – 1.3.11 and 1.3.15 – 1.3.22

1.3.1 Breastfeeding support should be made available regardless of the location of care.

1.3.2 All healthcare providers (hospitals and community) should have a written breastfeeding policy that is communicated to all staff and parents. Each provider should identify a lead healthcare professional responsible for implementing this policy.

1.3.3 All maternity care providers (whether working in hospital or in primary care) should implement an externally evaluated, structured programme that encourages breastfeeding, using the Baby Friendly Initiative (www.babyfriendly.org.uk) as a minimum standard. (KPI)

1.3.4 Healthcare professionals should have sufficient time, as a priority, to give support to a woman and baby during initiation and continuation of breastfeeding.

1.3.5 Where postnatal care is provided in hospital, attention should be paid to facilitating an environment conducive to breastfeeding. This includes making arrangements for:

- 24 hour rooming-in and continuing skin-to-skin contact when possible
- privacy
- adequate rest for women without interruption caused by hospital routine
- access to food and drink on demand.

1.3.8 Women who leave hospital soon after birth should be reassured that this should not impact on breastfeeding duration.

1.3.9 Written breastfeeding education materials as a stand-alone intervention are not recommended.

1.3.10 In the first 24 hours after birth, women should be given information on the benefits of breastfeeding, the benefits of colostrum and the timing of the first breastfeed. Support should be culturally appropriate.

1.3.11 Initiation of breastfeeding should be encouraged as soon as possible after the birth, ideally within 1 hour.

1.3.15 From the first feed, women should be offered skilled breastfeeding support (from a healthcare professional, mother-to-mother or peer support) to enable comfortable positioning of the mother and baby and to ensure that the baby attaches correctly to the breast to establish effective feeding and prevent concerns such as sore nipples.

1.3.16 Additional support with positioning and attachment should be offered to women who have had:

- a narcotic or a general anaesthetic, as the baby may not initially be responsive to feeding
- a caesarean section, particularly to assist with handling and positioning the baby to protect the woman's abdominal wound
- initial contact with their baby delayed.

1.3.17 Unrestricted breastfeeding frequency and duration should be encouraged.

1.3.18 Women should be advised that babies generally stop feeding when they are satisfied, which may follow a feed from only one breast. Babies should be offered the second breast if they do not appear to be satisfied following a feed from one breast.

1.3.19 Women should be reassured that brief discomfort at the start of feeds in the first few days is not uncommon, but this should not persist.

1.3.20 Women should be advised that if their baby is not attaching effectively he or she may be encouraged, for example by the woman teasing the baby's lips with the nipple to get him or her to open their mouth.

1.3.21 Women should be advised of the indicators of good attachment, positioning and successful feeding.

1.3.22 Women should be given information about local breastfeeding support groups.

NICE CG62 – Recommendation 1.1.1.1

New Antenatal information should be given to pregnant women according to the following schedule.

- At booking (ideally by 10 weeks):
    - breastfeeding, including workshops
- Before or at 36 weeks:
    - breastfeeding information, including technique and good management practices that would help a woman succeed, such as detailed in the UNICEF 'Baby Friendly Initiative'

This can be supported by information such as 'The pregnancy book' (Department of Health 2007) and the use of other relevant resources such as UK National Screening Committee publications and the Midwives Information and Resource Service (MIDIRS) information leaflets.

Training of healthcare professionals

NICE PH11 - Recommendation 1 (KPI)

- Professional bodies should ensure health professionals have the appropriate knowledge and skills to give advice on the following:
    - breastfeeding management, using the Baby Friendly Initiative (BFI) training as a minimum standard (www.babyfriendly.org.uk)
- As part of their continuing professional development, train midwives, health visitors and support workers in breastfeeding management, using BFI training as a minimum standard.
- As part of their continuing professional development, train health professionals, including doctors, dietitians and pharmacists, to promote and support breastfeeding, using BFI training as a minimum

NICE PH11 - Recommendation 7 (KPI)

- Adopt a multifaceted approach or a coordinated programme of interventions across different settings to increase breastfeeding rates. It should include:
    - training for health professionals
- Ensure there is a written, audited and well-publicised breastfeeding policy that includes training for staff and support for those staff who may be breastfeeding. Identify a health professional responsible for implementing this policy.

NICE PH11 - Recommendation 8

- Ensure support workers receive training in breastfeeding management from someone with the relevant skills and experience before they start working with breastfeeding mothers.

NICE PH11 - Recommendation 9

- Midwives and health visitors should ensure pregnant women and their partners are offered breastfeeding information, education and support on an individual or group basis. This should be provided by someone trained in breastfeeding management and should be delivered in a setting and style that best meets the woman's needs.

NICE CG37 - Recommendation 1.1.10

All healthcare professionals who care for mothers and babies should work within the relevant competencies developed by Skills for Health (www.skillsforhealth.org.uk). Relevant healthcare professionals should also have demonstrated competency and sufficient ongoing clinical experience in:

- supporting breastfeeding women including a sound understanding of the physiology of lactation and neonatal metabolic adaptation and the ability to communicate this to parents

Peer support

NICE PH11 - Recommendations 7 (KPI)

Please see relevant section of the recommendation under ‘initiation and duration/ continuation’.

NICE PH11 - Recommendation 11 (KPI)

- Provide local, easily accessible breastfeeding peer support programmes and ensure peer supporters are part of a multidisciplinary team.

- Ensure peer supporters:
    - attend a recognised, externally accredited training course in breastfeeding peer support
    - contact new mothers directly within 48 hours of their transfer home (or within 48 hours of a home birth)
    - offer mothers ongoing support according to their individual needs. This could be delivered face-to-face, via telephone or through local groups
    - can consult a health professional and are provided with ongoing support
    - gain appropriate child protection clearance.
- Consider training peer supporters and link workers to help mothers, parents and carers follow professional advice on feeding infants aged 6 months and over. The advice should promote an increasingly varied diet using food of different textures in appropriate amounts (in addition to milk), in response to the baby's needs.

NICE PH11 - Recommendation 13

- NHS trusts should encourage women from minority ethnic communities whose first language is not English to train as breastfeeding peer supporters.

NICE CG37 - Recommendation 1.3.22

Women should be given information about local breastfeeding support groups.

4.2.3 Current UK practice

Initiation and duration/ continuation

The Infant Feeding Survey 2010 found that the initial breastfeeding rate increased from 76% in 2005 to 81% in 2010 in the UK. Initial breastfeeding rates in 2010 were 83% (78% in 2005) in England, 74% (70% in 2005) in Scotland, 71% (67% in 2005) in Wales, and 64% (no change from 2005) in Northern Ireland.

Across the UK, the prevalence of breastfeeding fell from 81% at birth to 69% at one week, and to 55% at six weeks. At six months, just over a third of mothers (34%) were still breastfeeding.

Mothers continued to breastfeed for longer in 2010 than in 2005. By 6 months 34% of mothers were breastfeeding in 2010 compared with 25% in 2005.

There has been an increase in breast feeding since 1995. At six weeks, the respective prevalence levels of mothers breastfeeding (either exclusively or also

using infant formula) were 42% in 1995 and 2000, 48% in 2005 and 55% in 2010, while at 6 months they were 21% in 1995 and 2000, 25% in 2005 and 34% in 2010.

Across the UK, 69% of mothers were exclusively breastfeeding at birth in 2010. At one week, less than half of all mothers (46%) were exclusively breastfeeding, while this had fallen to around a quarter (23%) by six weeks. By six months, levels of exclusive breastfeeding had decreased to one per cent, indicating that very few mothers were following the UK health departments' recommendation that babies should be exclusively breastfed until around the age of six months.

Training of healthcare professionals

No current practice was identified.

Peer support

The Infant Feeding Survey 2010 found that in the UK, mothers of full term babies who initiated breastfeeding were more likely to be breastfeeding still at two weeks if they:

- were breastfeeding exclusively at one week;
- were from a non-White background;
- had breastfed a previous child for six weeks or more;
- had received help or information on breastfeeding from a breastfeeding support group, peer supporter, voluntary organisation or community group.

Mothers were asked about use or awareness of help or information on breastfeeding from a peer supporter, breastfeeding support group, voluntary organisation or community group. Mothers who had received help or information from one or more of these sources (90%) or were aware of this help even though they had not used it (85%) were more likely to be breastfeeding still at two weeks than other mothers (70%).

4.3 Weaning

4.3.1 Summary of suggestions

A stakeholder commented that appropriate and timely introduction of weaning foods is protective of infant gut and kidneys and helps to prevent obesity.

4.3.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Weaning	NICE PH11 Recommendations 1 (KPI), 4 (KPI), 11 (KPI), 13 and 16

NICE PH11, Recommendation 1 (KPI)

- Professional bodies should ensure health professionals have the appropriate knowledge and skills to give advice on the following:
    - the nutritional needs of infants and young children

NICE PH11 - Recommendation 4 (KPI)

- Health professionals should use every opportunity they have to offer those parents who are eligible for the Healthy Start scheme practical, tailored information, support and advice on:
    - how to introduce foods in addition to milk as part of a progressively varied diet when infants are 6 months old.

NICE PH11 - Recommendation 11 (KPI)

- Consider training peer supporters and link workers to help mothers, parents and carers follow professional advice on feeding infants aged 6 months and over. The advice should promote an increasingly varied diet using food of different textures in appropriate amounts (in addition to milk), in response to the baby's needs.

NICE PH11 - Recommendation 13

- NHS trusts should train link workers who speak the mother's first language to provide information and support on breastfeeding, use of infant formula , weaning and healthy eating.

NICE PH11 - Recommendation 16

- Health visitors and the child health promotion programme (CHPP) team should:
    - provide mothers and other family members with support to introduce a variety of nutritious foods (in addition to milk) to ensure the child is offered a progressively varied diet from 6 months
    - encourage and support parents and carers to make home-prepared foods for infants and young children, without adding salt, sugar or honey
    - encourage families to eat together and encourage parents and carers to set a good example by the food choices they make for themselves

4.3.3 Current UK practice

The Infant Feeding Survey 2010 found that in the UK in 2010, 25% (41% in 2005) of mothers introduced solids between three and four months and there was a corresponding increase in the proportion of mothers doing so between four and five months (45% in 2010 compared with 31% in 2005). This meant that by five months, there were still fewer mothers who had introduced solids by this point in 2010 than in 2005 (75% and 82% respectively). 94% of mothers had introduced solids by six months in 2010 compared with 98% in 2005. Only 5% of mothers introduced solids after six months in 2010 (2% in 2005).

4.4 Nutrition in pre-school settings

4.4.1 Summary of suggestions

A stakeholder commented that all early years settings should follow national guidance on food provision. Where children from low income families receive free nursery education this opportunity should be used to practically engage with families about food choices and the nutritional health of their child.

4.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Nutrition in pre-school settings	NICE PH11 Recommendation 21

NICE PH11 - Recommendation 21

- 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 foods that make up a healthy diet by:

  - providing practical classroom-based activities

  - ensuring a variety of healthier choices are offered at mealtimes, and snacks offered between meals are low in added sugar and salt (for example, vegetables, fruit, milk, bread and sandwiches with savoury fillings)

  - ensuring carers eat with children whenever possible.

4.4.3 Current UK practice

No current practice was identified.

4.5 Food education

4.5.1 Summary of suggestions

A stakeholder highlighted that food education and cooking skills are important to allow individuals to exercise choice and control over their diet. This can be either by cooking their own meals or by understanding the processes that are used in pre-prepared food. They commented that community cooking programmes such as those analysed by Community Food and Health (Scotland) can improve cooking skills and confidence around healthy eating and, in turn, impact on nutrition across families.

4.5.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Food education	NICE PH11 Recommendations 19 and 22

NICE PH11 – Recommendation 19

- Encourage parents and carers to:
    - use a bottle for expressed breast milk, infant formula or cooled boiled water only
    - offer drinks in a non-valved, free-flowing cup from age 6 months to 1 year
    - discourage feeding from a bottle from 1 year onwards
    - limit sugary foods to mealtimes only
    - avoid giving biscuits or sweets as treats
    - encourage snacks free of salt and added sugar (such as vegetables and fruit) between meals

    - provide milk and water to drink between meals (diluted fruit juice can be provided with meals – 1 part juice to 10 parts water).

- Discourage parents and carers from:

    - adding sugar or any solid food to bottle feeds

    - adding sugar or honey to weaning (solid) foods

<u>NICE PH11 - Recommendation 22</u>

- 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, 'cook and eat' clubs, 'weaning parties' and 'baby cafes'.

4.5.3 Current UK practice

No current practice was identified.

4.6 Infant formula

4.6.1 Summary of suggestions

A stakeholder commented that powdered infant formula milks must be prepared safely as this will reduce the risks of infant obesity, constipation and gastro-intestinal illness and that support should be given for the first bottle feed to be given with close skin to skin contact.

Stakeholders commented the use of whey based powdered formula milk throughout first 12 months of life prevents constipation and obesity. Only infant formula suitable for all babies should be available for purchase and all other formula currently sold for quasi normal infant symptoms should only be available on recommendation of a health professional.

4.6.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 9 to help inform the Committee's discussion.

Table 9 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Infant formula	NICE PH11 Recommendations 14 and 20 NICE CG37 Recommendations 1.3.42 - 1.3.45

<u>NICE PH11 – Recommendation 14</u>

- Midwives should 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 ('Guide to bottle feeding' 2011).

<u>NICE PH11 - Recommendation 20</u>

Implement DH guidance ('Guide to bottle feeding' 2011[1]) on the preparation and use of powdered infant formula to reduce the risk of infection to infants in care settings.

NICE CG37 - Recommendations 1.3.42 – 1.3.45

1.3.42 All parents and carers who are giving their babies formula feed should be offered appropriate and tailored advice on formula feeding to ensure this is undertaken as safely as possible, in order to enhance infant development and health, and fulfil nutritional needs.

1.3.43 A woman who wishes to feed her baby formula milk should be taught how to make feeds using correct, measured quantities of formula, as based on the manufacturer's instructions, and how to clean and sterilise bottles and teats and how to store formula milk.

1.3.44 Parents and family members should be advised that milk, either expressed milk or formula should not be warmed in a microwave.

1.3.45 Breastfeeding women who want information on how to prepare formula feeds should be advised on how to do this.

4.6.3 Current UK practice

The Infant Feeding Survey 2010 looked at how formula feeds are prepared and found that 49% of all mothers who had prepared powdered infant formula in the last seven days had followed all three recommendations for making up feeds (only making one feed at a time, making feeds within 30 minutes of the water boiling and adding the water to the bottle before the powder). This is a substantial increase since 2005 when 13% did so.

About two-thirds (65%) of mothers who had prepared powdered infant formula in the last seven days followed recommendations for feeding away from the home (either not using powdered formula, or doing so correctly by making up feeds with hot water or keeping pre-prepared feeds chilled). This was similar to 2005 (63%).

No current practice was identified for skin to skin contact when formula feeding, the use of whey based powdered formula milk or for the sale of formula milk for infant symptoms.

4.7 *Maternal diet pre and during pregnancy*

4.7.1 Summary of suggestions

A stakeholder commented that currently women are not given nutrition advice pre-conceptually despite evidence that nutritional status and body weight can impact on the pregnancy, pregnancy outcome and life chances of the infant. They highlighted that new technology such as apps presents an opportunity to expand health promotion in this area.

A stakeholder commented that excess maternal pre-pregnancy body weight and the weight gained during pregnancy can have adverse effects on both a mother's health and that of her baby.

A stakeholder commented that evidence shows improving the diet of women of childbearing age has the potential to ensure nutritional status at conception is adequate to support optimal fetal growth. A special diet pre/during pregnancy is not needed, women should have a healthy balanced diet consuming a variety of different foods daily to provide enough energy and the correct balance of nutrients to meet their needs and the growth and development of their baby.

4.7.2 Selected recommendations from development source

Table 10 below highlights recommendations that have been provisionally selected from the development sources that may support potential statement development. These are presented in full after table 10 to help inform the Committee's discussion.

Table 10 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Maternal diet pre and during pregnancy	NICE PH11 Recommendation 1 (KPI) NICE PH27, Recommendations 1 and 5

NICE PH11, Recommendation 1 (KPI)

- Professional bodies should ensure health professionals have the appropriate knowledge and skills to give advice on the following:
    - the nutritional needs of women and the importance of a balanced diet before, during and after pregnancy (including the need for suitable folic acid supplements)

NICE PH27 - Recommendation 1

- NHS and other commissioners and managers, directors of public health and planners and organisers of public health campaigns should ensure health professionals understand the importance of achieving a healthy weight before pregnancy. Local education initiatives should also stress the health risks of being obese, including during pregnancy.

- Health professionals should use any opportunity, as appropriate, to provide women with a BMI of 30 or more with information about the health benefits of losing weight before becoming pregnant (for themselves and the baby they may conceive). This should include information on the increased health risks their weight poses to themselves and would pose to their unborn child.

- GPs, dietitians and other appropriately trained health professionals should advise, encourage and help women with a BMI of 30 or more to reduce weight before becoming pregnant. They should explain that losing 5–10% of their weight (a realistic target) would have significant health benefits[2] and could increase their chances of becoming pregnant. Further weightloss, to achieve a BMI within the healthy range (between 24.9 and 18.5 kg/m2) should also be encouraged, using evidence-based behaviour change techniques. Losing weight to within this range may be difficult and women will need to be motivated and supported.

- Health professionals should offer a weight-loss support programme involving diet and physical activity. The programme should follow the principles of good practice, as outlined at the beginning of this section.

- Health professionals should offer specific dietary advice in preparation for pregnancy, including the need to take daily folic acid supplements. This includes professionals working in pre-conception clinics, fertility clinics, sexual and reproductive health services and children's centres.

NICE PH27 – Recommendation 5

- NHS health trainers and non-NHS health and fitness advisers should advise women that a healthy diet and being physically active will benefit both them and their unborn child during pregnancy. They should also explain that it will help them to achieve a healthy weight after giving birth – and could encourage the whole family to eat healthily and be physically active.

- NHS health trainers and non-NHS health and fitness advisers should encourage those who have weight concerns before, during or after pregnancy to talk to a health professional such as a GP, practice nurse, dietitian, health visitor or pharmacist. They should also advise women, their partners and family to seek information and advice on healthy eating and physical activity from a reputable source.

4.7.3 Current UK practice

In 2008, the Confidential Enquiry into Maternal and Child Health (CEMACH), now known as the Centre for Maternal and Child Enquiries (CMACE), commenced a 3-year UK-wide Obesity in Pregnancy project. As part of this, between 1 March and 30 April 2009, all maternity units in the UK, Channel Islands and Isle of Man prospectively identified and notified CEMACH of women delivering from 24 weeks' gestation who met specific BMI criteria. The results showed that out of a total of 128,290 women reported to have given birth (≥24 weeks' gestation), 6413 were identified as having a BMI ≥35 at any time during pregnancy. The UK prevalence rate was 4.99%.

This translates into approximately 38,478 maternities each year in the UK. The prevalence of women with a pregnancy BMI ≥40 (Class III obesity) in the UK is 2.01%, while super-morbid obesity (BMI ≥50) affects 0.19% of all women giving birth.

Nutrition advice in pregnancy 2013 is a survey carried out to assess the provision of training in nutrition for providers of maternity care in Bradford Women's and newborn unit. 80% of midwives and 89% of obstetricians reported that they discussed nutrition with women during pregnancy. 54% of midwives and 100% of obstetricians reported that this took less than 15 minutes over the whole course of their total contact with the women in the antenatal period. 30% of midwives reported it took 15 – 30 minutes.

4.8 *Additional Areas*

4.8.1 Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However these were felt either to be outside the remit of the quality standard referral or require further discussion by the Committee to establish potential for statement development. It is not the remit of the quality standard to change national policy or national campaigns.

There will be an opportunity for the QSAC to discuss these areas at the end of the session on 19 December 2014.

Ankyloglossia (tongue-tie)

A stakeholder suggested the inclusion of an assessment of tongue-tie within the new-born infant and physical examination and the inclusion of tongue-tie examination in the management of breastfeeding training curriculum for midwives and health visitors. In addition they suggested extending the provision of tongue-tie clinics.

These areas come under the remit of the postnatal care quality standard.

Inequalities and regional/ inter-regional variations in infant feeding

A stakeholder commented that there are variations in breastfeeding prevalence rates, timely introduction of solid food and correct technique for making up infant formula which all contribute to reducing infant illnesses. The stakeholder stated that there should be consistent implementation of evidence-based interventions to address inequalities and regional/ inter-regional variations in infant feeding.

Each of these specific areas are addressed within the briefing paper and will be discussed with the Committee. Whilst there are no specific recommendations for the overarching area of inequalities and regional/ inter-regional variations in infant feeding, it is hoped that this quality standard as a whole will address this.

Breastfeeding alongside taking medications for mental health needs

A stakeholder commented that 10% of the Breastfeeding Network Drugline calls are about mental health drugs for mothers with depression and anxiety and that the quality standard could offer guidance on offering support for mothers who are considering breastfeeding alongside taking medications for mental health needs.

This comes under the remit of the antenatal and postnatal maternal health quality standard due to be published in 2015.

Medicinal preparations list of nurse prescribers' formulary for community practitioners

A stakeholder suggested the addition of vitamins A, C and D to the medicinal preparations list of nurse prescribers' formulary for community practitioners. They commented that health visitors currently have scope to prescribe folic acid only. Health visitors see all pregnant women, so could increase vitamin C and D uptake by expanding this list to include these vitamins.

Changes to prescribing authorisation are not within the remit of a quality standard.

Food labelling

A stakeholder stated that foods sold as suitable for weaning should comply with Department of Health recommendations as not suitable before 6 months. They commented that health visitors promote the introduction of solids to infant diets at around 6 months and this would allow parents to receive a more consistent message.

This is not within the remit of a quality standard.

Change for Life

A stakeholder suggested advertising breastfeeding through the Change for Life campaign on TV and social media. This could include pregnant women being advised to increase their Omega 3 and 6 intake in the 3rd trimester of pregnancy (1-2 portions of oily fish).

The quality standard cannot change a national campaign.

Changes to NICE pathways/guidance

A stakeholder suggested removing "or other" from the requirement to go Baby Friendly in all NICE pathways and adding "responsive feeding" to the guidance on breastfeeding and formula feeding. They also commented that the wording in the guidelines should be matched.

This is not within the remit of a quality standard. However these comments will be provided to the NICE public health and clinical guideline teams.

Department of Health definition

A stakeholder suggested changing the Department of Health definition of prevalence of breastfeeding at 6-8 weeks to include only babies receiving breast milk.

It is not within the remit of a quality standard to change a definition from the Department of Health.

Appendix 1: Additional information

QS37 Postnatal care – statement 5

Quality statement

Women receive breastfeeding support from a service that uses an evaluated, structured programme.

Rationale

Breastfeeding contributes to the health of both the mother and child in the short and longer term. Women should be made aware of these benefits and those who choose to breastfeed should be supported by a service that is evidence-based and delivers an externally audited, structured programme. Delivery of breastfeeding support should be coordinated across the different sectors.

Quality measures

Structure

Evidence of local arrangements for breastfeeding support to be provided through a service that uses an evaluated, structured programme.

Data source: Local data collection.

Process

a) Proportion of women who receive breastfeeding support through a service that uses an evaluated, structured programme.

Numerator – the number of women in the denominator who receive breastfeeding support through a service that uses an evaluated, structured programme.

Denominator – the number of women who breastfeed (exclusively or partially).

Data source: Local data collection.

b) Proportion of women who wanted to continue breastfeeding but stopped before they had planned to.

Numerator – the number of women who wanted to continue breastfeeding but stopped before they had planned to.

Denominator – the number of women who breastfed (exclusively or partially).

Data source: Local data collection.

Outcome

a) ***Rates of breastfeeding initiation.***

Data source: The Maternity Services Secondary Uses Data Set, once implemented, will collect data on 'baby first feed breast milk status' (global number 17205882), 'baby breast milk status (at discharge from hospital)' including exclusive and partial breast milk feeding (global number 17207550). The Infant Feeding Survey 2010 collected self-report data on the prevalence and duration of breastfeeding in the first 8–10 months after the baby was born.

b) ***Rates of exclusive or partial breastfeeding on discharge from hospital and at 5–7 days, 10–15 days, 6–8 weeks and 16 weeks after the birth.***

Data source: The Maternity Services Secondary Uses Data Set, once implemented, will collect data on 'baby first feed breast milk status' (global number 17205882), 'baby breast milk status (at discharge from hospital)', including exclusive and partial breast milk feeding (global number 17207550). The Children and Young People's Health Services Secondary Uses Data Set, once implemented, will collect data on 'breastfeeding status' (global number 17101340), including 'Exclusively Breast Milk Feeding', 'Partially Breast Milk Feeding' and 'No Breast Milk Feeding at all', and also data on observation date (breastfeeding status) (global number 17104440). The Infant Feeding Survey 2010 collected self-report data on the prevalence and duration of breastfeeding in the first 8–10 months after the baby was born.

c) ***Women's satisfaction with breastfeeding support***.

Data source: The Care Quality Commission Maternity Services Survey 2010 collected information about women's experiences of maternity care and this included a section on 'Feeding your baby'.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers ensure that women receive breastfeeding support through a service that uses an evaluated, structured programme.

Healthcare practitioners ensure that women receive breastfeeding support through an integrated service that uses an evaluated, structured programme.

Commissioners ensure that they commission a service that delivers breastfeeding support through an evaluated, structured programme.

What the quality statement means for patients, service users and carers

Women receive breastfeeding support through a service that uses an evaluated, structured programme.

Source guidance

NICE clinical guideline 37 recommendation 1.3.3 (key priority for implementation)

NICE public health guidance 11 recommendations 1 (key priority for implementation) and 7 (key priority for implementation).

Definitions of terms used in this quality statement

Structured programme

NICE clinical guideline 37 recommends that all maternity care providers (whether working in hospital or in primary care) should implement an externally evaluated, structured programme that encourages breastfeeding, using the Baby Friendly Initiative as a minimum standard. If providers implement a locally developed programme, this should be evidence-based, structured, and undergo external evaluation. The structured programme should be delivered and coordinated across all providers, including hospital, primary, community and children's centre settings. Breastfeeding outcomes should be monitored across all services.

Breastfeeding support

All people involved in delivering breastfeeding support should receive the appropriate training and undergo assessment of competencies for their role. This includes employed staff and volunteer workers in all sectors, for example, hospitals, community settings, children's centres and peer supporter services.

Equality and diversity considerations

Breastfeeding support should be culturally appropriate and accessible to people with additional needs, such as physical, sensory or learning disabilities, and to people who do not speak or read English. Women should have access to an interpreter or advocate if needed. Special consideration will be needed if the mother and baby have been separated for any reason, for example if the baby has been admitted to neonatal care or the baby has been taken into care.

Appendix 2: Key priorities for implementation (PH11)

Recommendations that are key priorities for implementation in the source guideline and that have been referred to in the main body of this report are highlighted in grey.

Training

NICE PH11, Recommendation 1 (KPI)

Who is the target population?

Health professionals and support workers who care for children under 5 years and women who may become – or who are – pregnant.

Who should take action?

Professional bodies, skills councils and others responsible for setting competencies and developing continuing professional development programmes for health professionals, nursery nurses and support workers.

What action should they take?

- Professional bodies should ensure health professionals have the appropriate knowledge and skills to give advice on the following:
    - breastfeeding management, using the Baby Friendly Initiative (BFI) training as a minimum standard (www.babyfriendly.org.uk)
- As part of their continuing professional development, train midwives, health visitors and support workers in breastfeeding management, using BFI training as a minimum standard.

As part of their continuing professional development, train health professionals, including doctors, dietitians and pharmacists, to promote and support breastfeeding, using BFI training as a minimum

Folic acid

NICE PH11 - Recommendation 2 (KPI)

Who is the target population?

Women who may become pregnant and women in early pregnancy.

Who should take action?

- Primary care trusts (PCTs) and NHS trusts.
- Directors of public health, planners and organisers of public health campaigns.
- Pharmacists, GPs, hospital doctors and nurses, particularly those working in gynaecology, sexual health, contraceptive and family planning services, fertility clinics and school health services.
- Public health nutritionists and dietitians.
- Manufacturers of goods for women of childbearing age.

What action should they take?

- Health professionals should:
    - use any appropriate opportunity to advise women who may become pregnant that they can most easily 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 or rich in folate
    - advise all women who may become pregnant about a suitable folic acid supplement, such as the maternal Healthy Start vitamin supplements
    - encourage women to take folic acid supplements and to eat foods rich in folic acid (for example, fortified breakfast cereals and yeast extract) and to consume foods and drinks rich in folate (for example, peas and beans and orange juice).
- PCTs should ensure local education initiatives aimed at health professionals include information on the importance of folic acid supplements. They should provide the maternal Healthy Start vitamin supplements (folic acid, vitamins C and D) for eligible women. They should also ensure women who are not eligible for Healthy Start can obtain the supplements from their local pharmacy.
- GPs should prescribe 5 milligrams of folic acid a day for women who are planning a pregnancy, or are in the early stages of pregnancy, 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 defects
    - have diabetes.

- Manufacturers should include information with their products on the importance of folic acid supplements before and during pregnancy. Relevant products may include pregnancy tests, sanitary products, contraceptives and ovulation predictor kits.

  (See also NICE clinical guideline 63 on diabetes in pregnancy and its antenatal care clinical guideline 62)

Healthy Start

NICE PH11 - Recommendation 4 (key priority for implementation)

Who is the target population?

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

Who should take action?

- Primary care trust (PCT) commissioners and managers.
- GPs, midwives, health visitors, obstetricians, paediatricians, and community pharmacists.

What action should they take?

- PCTs should promote the Healthy Start scheme.
- PCTs should ensure an adequate supply of both types of Healthy Start vitamin supplements (for women and for children from 6 months to 4 years) is available for distribution by health professionals when they see pregnant women and parents of children under 4 years.
- PCTs should ensure an adequate supply of Healthy Start application forms is available and that the uptake of Healthy Start benefits is regularly audited.
- Health professionals should advise pregnant women and parents of children under 4 years about the Healthy Start scheme. They should ensure all women who may be eligible receive an application form as early as possible in pregnancy.
- Health professionals should use every opportunity they have to offer those parents who are eligible for the Healthy Start scheme practical, tailored information, support and advice on:
    - how to use Healthy Start vouchers to increase their fruit and vegetable intake

  - how to initiate and maintain breastfeeding
  - how to introduce foods in addition to milk as part of a progressively varied diet when infants are 6 months old.

- Health professionals should offer the maternal Healthy Start vitamin supplement (folic acid, vitamins C and D) to pregnant women who are (or who may be) eligible.
- GPs and health visitors should offer children's Healthy Start vitamin supplements (vitamins A, C and D) to all children aged from 6 months to 4 years in families receiving the Healthy Start benefit.
- Commissioners should consider distributing the maternal Healthy Start vitamin supplement (folic acid, vitamins C and D) to all women who receive Healthy Start benefit for children aged 1– 4 years, particularly those who may become pregnant.
- Community pharmacists should ensure the Healthy Start maternal vitamin supplements are available for purchase by women who are not eligible to receive them free of charge.

Breastfeeding

NICE PH11 – Recommendation 7

Recommendation 7

Who is the target population?

Pregnant women and breastfeeding mothers.

Who should take action?

Commissioners and managers of maternity and children's services.

What action should they take?

- Adopt a multifaceted approach or a coordinated programme of interventions across different settings to increase breastfeeding rates. It should include:
  - activities to raise awareness of the benefits of – and how to overcome the barriers to - breastfeeding
  - training for health professionals

  - breastfeeding peer-support programmes
  - joint working between health professionals and peer supporters
  - education and information for pregnant women on how to breastfeed, followed by proactive support during the postnatal period (the support may be provided by a volunteer).
- Implement a structured programme that encourages breastfeeding, using BFI as a minimum standard. The programme should be subject to external evaluation.
- Ensure there is a written, audited and well-publicised breastfeeding policy that includes training for staff and support for those staff who may be breastfeeding. Identify a health professional responsible for implementing this policy.

(See also NICE clinical guideline 37 on postnatal care)

Breastfeeding

NICE PH11 – Recommendation 11

Who is the target population?

Pregnant women and new mothers, particularly those who are least likely to start and continue to breastfeed. For example, young women, those who have low educational achievement and those from disadvantaged groups.

Who should take action?

Commissioners and managers of maternity and children's services.

What action should they take?

- Provide local, easily accessible breastfeeding peer support programmes and ensure peer supporters are part of a multidisciplinary team.
- Ensure peer supporters:
  - attend a recognised, externally accredited training course in breastfeeding peer support
  - contact new mothers directly within 48 hours of their transfer home (or within 48 hours of a home birth)

  - offer mothers ongoing support according to their individual needs. This could be delivered face-to-face, via telephone or through local groups
  - can consult a health professional and are provided with ongoing support
  - gain appropriate child protection clearance.
- Consider training peer supporters and link workers to help mothers, parents and carers follow professional advice on feeding infants aged 6 months and over. The advice should promote an increasingly varied diet using food of different textures in appropriate amounts (in addition to milk), in response to the baby's needs.

Appendix 3: Suggestions from stakeholder engagement exercise

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
1	RCPCH	Key area for quality improvement 1	Food poverty and its effect on nutritional health in this age group.	What interventions have worked to reduce inequalities in food adequacy in this age group?	The effects of poverty on child health and developm JL Aber, NG Bennett, DC Conley… - … review of public **health**, 1997 - annualreviews.org **...** Still based on the original ratios of **food** to other expenditures, the **poverty** line does not **...** account for the fact that housing and job-related expenses (e commuting and **child** care costs **...** taken up an increasingly large share of poor families' incomes conversely, **food** a much **...** Cited by 359 Related articles All 11 versions Cite Sa **[PDF]** from researchgate.net Long-term poverty and child development in the Uni States: Results from the NLSY S Korenman, JE Miller, JE Sjaastad - Children and Y Services Review, 1995 - Elsevier **...** Final Report to the **Food** and Nutrition ServiceU.S Department of Agriculture, (1992). **... Poverty**, nutritional status, growth, and cognitive developmen children in the United States. **... Child** home environment as a mediating construct between SES and **child** outcomes. **...** Cited by 394 Related articles All 15 versions Cite Sa **[PDF]** from fsu.edu Effect of child and family poverty on child health in th States D Wood - Pediatrics, 2003 - Am Acad Pediatrics **... Poverty** has been described as an economic stat does not allow for the provision of basic family and **child** needs, such as adequate **food**, clo and housing. However, the debate about the effects of **poverty** on the growth, development, and **health** of children is as much **...** Cited by 113 Related articles All 14 versions Cite Sa **[PDF]** from nih.gov Food insufficiency, family income, and health in US preschool and school-aged children. K Alaimo, CM Olson, EA Frongillo Jr… - … Journal (Public **Health**, 2001 - ncbi.nlm.nih.gov **...** an associa- tion between **food** insufficiency, **pove**

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					tus, and children's poor **health**, regardless of the causal direction, once again highlights that po American children are at increased risk of poorer **health**. This study confirms that our social net has **child**-sized holes. **...** Cited by 358 Related articles All 10 versions Cite Sa **[PDF]** from iatp.org [BOOK] Reducing food poverty with sustainable agri A summary of new evidence JN Pretty, R Hine - 2001 - iatp.org **...** Low birth weight is a key factor in **child** malnutritio premature death, which is, in turn **...** need more **food** – but there is also a need for better fema education, family **health** improvements, and **...** But there are doubts about the capacity of su systems to reduce **food poverty**. **...** Cited by 242 Related articles All 2 versions Cite Sav **[PDF]** from researchgate.net Maternal depression, changing public assistance, food security, and child health status P Casey, S Goolsby, C Berkowitz, D Frank, J Cook. Pediatrics, 2004 - Am Acad Pediatrics **...** Within the context of **poverty**, depression is very in women on welfare, and **...** to maternal depression and loss of federal financial assistance and **food** stamps either **...** Finally, problems in **child health** and development status may result eith maternal depression, loss **...** Cited by 170 Related articles All 11 versions Cite Sa **[HTML]** from nutrition.org Food insecurity is associated with adverse health ou among human infants and toddlers JT Cook, DA Frank, C Berkowitz, MM Black… - The of …, 2004 - Am Soc Nutrition **...** Outcome measures included **child's health** statu hospitalization history, whether **child** was admitted to hospital on day of ED visit (for subsampl kind of **food** insecurity is sometimes called "resource-constrained" or "**poverty**-linked" **food** insecurity, although some **...** Cited by 284 Related articles All 14 versions Cite Sa

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					The association of child and household food insecur childhood overweight status PH Casey, PM Simpson, JM Gossett, ML Bogle… - Pediatrics, 2006 - Am Acad Pediatrics **...** We used data collected in the 1999–2002 National **Health** and Nutrition Examination **... povert** status; and (3) does the association between housel and **child food** insecurity with childhood overweight persist after controlling for household **poverty**, **child** age, gender, and **...** Cited by 183 Related articles All 9 versions Cite Sav **[PDF]** from who.int Applying an equity lens to child health and mortality: the same is not enough CG Victora, A Wagstaff, JA Schellenberg, D Gwatkir Lancet, 2003 - Elsevier **...** 22. These damaging effects of **poverty** on **child health** can be reduced by well c policies. **...** 36 There is an urgent need to improve th evidence base on **child health** and **poverty**, and to build capacity in measurement of ec indicators. **...** Cited by 597 Related articles All 33 versions Cite Sa Child health-related quality of life and household food security PH Casey, KL Szeto, JM Robbins… - … of pediatric 2005 - archpedi.jamanetwork.com 1. Cited by 139 Related articles All 11 versions Cite Sa
2	SCM1	*Healthy Start*	As a national government scheme to improve the health of low-income pregnant women and families on benefits and tax credits, this is a core initiative to impact on health inequalities.	Research suggests that there is no consistent pattern of how the programme is managed, that GPs ere rarely involved and that there were few examples of links between Healthy Start and other initiatives. There is also concern because of the eligibility criteria some families who might benefit fall just outside of the scheme.	Report conducted by the School for Policy Studies at the University of Bristol *Healthy Vouchers Study: The Views and Experien Parents, Professionals and Small Retailer England* http://www.bristol.ac.uk/sps/research/proje mpleted/2013/finalreport.pdf *HEALTHY START: UNDERSTANDING T*

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				While Health Start is claimed by around 80% of people who are eligible and approximately 90% of the vouchers that are sent out are spent, only 1% of vitamin supplements are claimed.	*USE OF VOUCHERS AND VITAMINS – Summary for Practitioners* http://nursingmidwifery.dundee.ac.uk/sites gmidwifery.dundee.ac.uk/files/page-files/Healthy%20Start%20Evaluation%20s ry%20for%20health%20professionals.pdf
3	SCM2	Young and low income pregnant women who are eligible for the Healthy Start scheme should be given specific guidance and advice on how to maximise the use of their food vouchers and be sign posted to local cooking classes, group support at children's centres or other local authority funded initiatives.	Evaluations of the Healthy Start scheme have highlighted the lack of practical support given to eligible recipients around using the food vouchers effectively. The opportunity to engage with women who may otherwise be 'hard to reach' is often given by the need for a health professional to sign the eligibility form, and this contact should be used to its best advantage by relevant health professionals to discuss eating in pregnancy, vitamin use, family food choices and breastfeeding and how families can access support for this.	Healthy Start is highlighted in rec 4 of the NICE PHG11 with detailed advice on how HCP can support those eligible for HS. Despite the detailed guidance in the standard evaluations show that HCP have limited time and training to follow the guidance and the quality standard should consider how to reinvigorate this guidance with specific measures around training and contact time.	Lucas, P.J., Jessiman, T., Cameron, A., Wiggins, M. & Austerberry, K.H.C. (2013) *Healthy Start Vouchers Study: The Views and Experiences of Parents, Professionals and Small Retailers in England*. University of Bristol. Bristol. McFadden, A., Fox-Rushby, J., Green, J.M Williams, V., Pokhrel, S., McLeish, J., McCormick, F., Anokye, N., Dritsaki, M. & McCarthy, R. (2013) *Healthy Start: Understanding the use of vitamins and vo* University of Dundee. Dundee
4	SCM3	Recommendation 4 Change/addition Make Healthy Start vitamins available for sale in all areas of the country	Families ineligible for the Healthy Start scheme will be able to buy Vitamins in the correct configuration, but no more. (Buying a commercial Vitamin supplement is expensive and often contains more vitamins than is recommended) This will increase the awareness of need for supplementation in this population group.	Consistency of PH message. Some areas of the country already make "Healthy Start Vitamins" available for purchase, but not all.	On line comments on DH website (NHS Choices)
5	SCM4	Key area for quality improvement 1	Commissioners providing free universal vitamin supplements for pregnant and breastfeeding mothers	There is evidence that rickets is increasing. The higher levels are in the North West of the UK and in population	SACN

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			and infants	groups that are disadvantaged or for cultural reasons or ethnicity does not have adequate exposure of skin to sunlight.	
6	BfN	Definitions	3.1 Covers nutrition for women of childbearing age pre-conception, during pregnancy and post-pregnancy (up to a year after birth) and for babies and pre-school children particularly focussing on low-income and other disadvantaged households	Add definition of pre-school child – is this up to 4th birthday or 5th? We welcome the focus on low-income and other disadvantaged households is essential. Previous successes in reducing inequity in infant feeding	Definitions may matter when recommenda for vitamin supplements and Healthy Start vouchers are considered in order to ensur are no gaps for 4-5 year olds.
7	SCM3	Recommendation 4 Change/addition Extend the "Healthy Start" Vitamin scheme entitlement to include children up to their 5th Birthday.	Currently the recommendation is for all children to receive A,D&C supplementation up until aged 5 but Healthy Start Vouchers cease at the age of 4 years which includes vouchers for vitamins	Low income households will be more able to comply with recommendations for Vitamin supplement for this age of child. Improve consistency of PH message.	Current uptake of Vitamin vouchers is tho around 10% www.bristol.ac.uk/sps/research "Healthy Start Vouchers Study Increasing eligibility to include all children five will target vulnerable 4 year olds
8	Public Health England	Uptake of Healthy Start vitamins and vitamin D recommendations	Vitamin D deficiency impairs the absorption of dietary calcium and phosphorous, which can give rise to bone problems e.g. rickets in children. All pregnant and breastfeeding women (especially teenagers and young women) and infants are at risk of vitamin D deficiency and are recommended to take a daily vitamin D supplement. Women and children from families who are eligible for the Government's Healthy Start scheme can receive free vitamin supplements which include vitamin D.	The National Diet and Nutrition Survey suggests that almost a fifth of UK adults have a low vitamin D status. This means they have less than 25 nmol/litre of the main circulating form of vitamin D in their body – 25 hydroxyvitamin D (25[OH]D) ('National Diet and Nutrition Survey: results from Years 1 to 4 (combined) of the rolling programme for 2008 and 2009 to 2011 and 2012'). Uptake of free vitamin supplements for low income families in the UK (pregnant mothers and children under four years) among eligible families is low.	http://www.nhs.uk/Conditions/vitamins-minerals/Pages/Vitamin-D.aspx https://www.gov.uk/government/uploads/s uploads/attachment_data/file/213703/dh_ .pdf https://www.gov.uk/government/statistics/ l-diet-and-nutrition-survey-results-from-ye to-4-combined-of-the-rolling-programme-f 2008-and-2009-to-2011-and-2012 http://adc.bmj.com/content/98/8/587.full.p
9	Public Health England	Preconception/early pregnancy folic acid	Folic acid (also known as vitamin B9) is very important for the development	A recent cross-sectional study of the uptake of folic acid supplementation in	http://www.plosone.org/article/info%3Adoi .1371%2Fjournal.pone.0089354

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		supplement recommendations	of a healthy fetus, as it can significantly reduce the risk of neural tube defects (NTDs), such as spina bifida. Pregnant women and women who may become pregnant are advised to take a daily supplement of 400 µg folic acid prior to conception and until the 12th week of pregnancy, to reduce the risk of NTDs.	nearly ½ million women in England has reported that the proportion of women taking folic acid supplements before pregnancy (as recommended) fell from 35% in 1999-2001 to 31% in 2011-12. Non-Caucasian women were less likely to take supplements before pregnancy than Caucasian women. Young women (6% of those under 20) were less likely to take supplements than older women (40% of those aged 35-39). During the study period (1999-2012), the proportion of women who started taking folic acid supplements after pregnancy had been confirmed increased from 45% to 62%.	
10	UNICEF	Consistent implementation of evidence-based actions to promote the initiation and duration of breastfeeding.	There is strong evidence supporting the promotion, protection and support of breastfeeding to improve the health and wellbeing outcomes for both mothers and babies. The WHO and DH recommend that all infants are exclusively breastfed for six months and thereafter with other foods for two years.	In the UK breastfeeding initiation rates are improving but there are large social and demographic variations (39.1% in North Staffordshire compared to 92.4% in West Middlesex NHSE Q1 2014/15) young mothers and those from lower socio-economic groups are least likely to breastfeed. Improvements in breastfeeding prevalence is slow, in 2010, at 3 months only 17% of all mothers were still exclusively breastfeeding, at 4 months 12% and 6 months only 1% (HSCIC, 2012). Low breastfeeding rates in the UK lead to increased incidence of illness, which has significant cost implications for the health service. Investing in services to increase and sustain breastfeeding would make a	Evidence suggests that investing in evide based activities such as full implementatio the UNICEF UK Baby Friendly Initiative in maternity, neonatal and community servic help to support more mothers in the UK to breastfeed. For more information go to; www.babyfriendly.org.uk The Evidence and Rationale for the UNIC Baby Friendly Standards (2012) http://www.unicef.org.uk/BabyFriendly/Re s/General-resources/The-evidence-and-rationale-for-the-UNICEF-UK-Baby-Frienc Initiative-standards/ A guide for commissioners http://www.unicef.org.uk/BabyFriendly/Co oners/ NHS England NHSE (2014) Maternity and breastfeeding. http://www.england.nhs.uk/statistics/statis

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				significant contribution to reducing health inequalities and costs to the NHS (Renfrew et al, 2012).	work-areas/maternity-and-breastfeeding/ The Health and Social Care Information C HSCIC (2012) Infant feeding Survey UK, http://www.hscic.gov.uk/searchcatalogue? tid=9569&topics=1%2fPublic+health%2fM %2c+infant+and+child+health&sort=Relev size=10&page=2#top Renfrew MJ, Pokhrel S, Quigley M, McCo F, Fox-Rushby J, Dodds R, Duffy S, Truer Williams T (2012) Preventing disease and resources: the potential contribution of increasing breastfeeding rates in the UK, UNICEF UK BFI http://www.unicef.org.uk/Documents/Baby dly/Research/Preventing_disease_saving rces.pdf Renfrew MJ, Craig D, Dyson L, McCormic Rice S, King SE, Misso K, Stenhouse E, Williams AF (2009) Breastfeeding promoti infants in neonatal units: a systematic revi and economic analysis, August, Health Technology Association. 13.No.40. Renfrew MJ, McCormick FM, Wade A, Qu Dowswell T (2012) Support for healthy breastfeeding mothers with healthy term b (Review), The Cochrane Library, Issue 5 www.thecochranelibrary.com .
11	SCM1	Breastfeed rates/Baby Friendly Initiative accreditation	There is well-established evidence that breastfeeding has significant and long lasting health benefits to both mother and baby. There is also emerging evidence that breastfeeding positively impacts on mother-baby relationships. Evidence also indicates that increased breastfeeding rates would also bring	Although the NHS Infant Feeding Survey published in 2012 showed some improvements in terms of initial breastfeeding rates, the number of mothers breastfeeding at three months was17% and exclusive breastfeeding at six months is still around 1%. Information cited in previous NICE guidelines referred to research from the World Health	Previous NICE guidelines advised that commissioners and managers of maternit children's services should implement a str programme that encourages breastfeedin using BFI as a minimum standard. Evider the BFI website http://www.unicef.org.uk/BabyFriendly/Abo Baby-Friendly/Awards/Baby-Friendly-stati 2014/ indicates that in England only 38%

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			about important financial benefits in the long term through improving the health outcomes of citizens.	Organization that stated: 'If exclusive breastfeeding for the first 8 months were actively protected, promoted and supported, the health inequalities experienced by moths and children in low income families would be reduced.'	births are taking place in full accredited ho and that In the UK the percentage of services with Baby Friendly accreditation are: 44% of maternity services 38% of health visiting services Universities: 35% of Midwifery courses; 9 Health visiting courses
12	SCM2	Midwives and health visitors who support families with infants in the first year of life should have access to expert, independent and high quality information that allows them to practically support families around infant feeding and good nutrition in the first year of life. This should also support other family members in a holistic way.	Practical support around eating well for low income families was highlighted in NICE PHG11 recommendation 22 '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, 'cook and eat' clubs, 'weaning parties' and 'baby cafes' This should be extended to include the use by HCP of pictorial, film based and app information from independent organisations that have no commercial links to widen the opportunities for families to receive clear information on what eating well looks like for the whole family.	Overweight and obesity in young children has increased and is increasingly linked to low income and inequalities. Children who gain too much weight in infancy and the EY are more likely to become overweight and obese in adulthood and intervention in the first 1000 days of life should be prioritised. HCP should be given a wide range of tools to support families with infants and young children.	Breastfeeding, excess weight at 4-5 years tooth decay at 5 years are key early years indicators in the PHE Public Health Outco Framework. It is also highlighted in this po document that weight at 4-5y can be impr by encouraging breastfeeding and healthy weaning in line with guidelines, as well as healthy family nutrition. PHE Public Health Outcomes Framework https://www.gov.uk/government/uploads/s uploads/attachment_data/file/263658/290 PHOF_Improving_Outcomes_PT1A_v1_1 This should also link to the *Promotion of breastfeeding* and *Prevention of Obesity* sections of *The Healthy Child Programme Pregnancy and the first five years of life* a as those areas relevant to Infant Feeding. https://www.gov.uk/government/uploads/s uploads/attachment_data/file/167998/Hea ld_Programme.pdf
13	SCM4	Key area for quality improvement 3	Improve uptake of breastfeeding and continuation rates	Reduces likelihood of infant allergies, obesity and morbidities and protects mothers health and wellbeing	Del Bono E, Rabe B. Breastfeeding and c cognitive outcomes: Evidence from a hosp based breastfeeding support policy. ISER Working Paper Series: 2012-29 Cox et al (2014), Factors Associated with

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Exclusive Breastfeeding at Hospital Disch Rural Western Australia. Journal of Huma Lactation, doi: 10.1177/08903344145472 http://www.unicef.org.uk/BabyFriendly/Ne and-Research/Research/Breastfeeding-research---An-overview/ Brown AE, Raynor P, Benton D, Lee MD. of Multiple Deprivation predict breastfeedi duration in England and Wales. Eur J Pub Health 2010 Apr; 20(2):231-5. Epub 2009 10. McConnachie A, Wilson P, Thomson H, R Watson R, Muirhead P, Munley A. Modelli consultation rates in infancy: influence of maternal and infant characteristics, feedin and consultation history. Br J Gen Pract. 2004;54:598-603. Fairbank L, O'Meara S, Renfrew MJ, Woo M, Sowden AJ, & Lister-Sharp D (2000). A systematic review to evaluate the effective of interventions to promote the initiation of breastfeeding. *Health Technology Assess* Vol 4 No. 25, 161pp Spiby H et al. (2007) A systematic review education and evidence-based practice interventions with health professionals and breast feeding counsellors on duration of feeding. Midwifery 4 April 2007. Cleminson et al (2014), Being baby friend evidence-based breastfeeding support. Ar

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Child Fetal Neonatal Ed doi:10.1136/archdischild-2013-304873
14	SCM4	Key area for quality improvement 2	Health care professionals to be trained to support the development of early mother -infant relationships and early and continued breastfeeding	Reduces likelihood of infant allergies, obesity and morbidities and protects mothers health and wellbeing	baby_friendly_evidence_rationale.pdf Bystrova K, Ivanova V, Edhborg M et al (2 Early Contact versus Separation: Effects o Mother–Infant Interaction One Year Later. Birth:36; 97-108 Mikiel-Kostyra K, Mazur J, Boltruszko I (20 Effect of early skin-to-skin contact after de on duration of breastfeeding: a prospectiv cohort study. Acta Paediatr 91(12):1301-6 Stevens, J. et al (2014). Immediate or ear to-skin contact after a Caesarean section: review of the literature. Maternal and Child Nutrition. DOI: 10.1111/mcn.12128
15	Public Health England	Initiation, prevalence and duration of breastfeeding	There is good evidence that breastfeeding confers a range of positive health benefits to mothers and babies in both the short and long term.	Findings from the Infant Feeding Survey 2010 suggest that mothers are continuing to breastfeed for longer with initiation and prevalence rates showing increases over the last twenty years in the UK. However, the proportion of mothers following current guidelines on exclusively breastfeeding for the first six months of a baby's life have remained low since 2005 with only one in a hundred mothers following these guidelines. The prevalence of breastfeeding fell from 81 per cent at birth to 69 per cent at one week, and to 55 per cent at six weeks. At six months, just over a third of mothers	Infant Feeding Survey 2010 (http://www.hscic.gov.uk/catalogue/PUB08 fant-Feeding-Survey-2010-Consolidated- Report.pdf) Ip, S et al (2007). Breastfeeding and mate and infant health outcomes in developed countries. Evidence Report/Technology Assessment No. 153. AHRQ Publication N E007. . Rockville, MD: Agency for Healthc Research and Quality. Horta et al (2007). Evidence on the long-te effects of breastfeeding. Geneva: World H Organization.

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				(34 per cent) were still breastfeeding. The lowest rates of breastfeeding are seen in women from routine and manual occupations.	Kramer MS, Kakuma R. Optimal duration exclusive breastfeeding. Cochrane Databa Syst Rev. 2012;8
16	BfN	Primary source of recommendations NICE Guideline PH11 [3.2] Recommendation 11	This document should be the primary source of recommendations. Recommendation 11 relating to peer support for breastfeeding mothers is particularly important as there has been dilution of the recommendation. Practical experience shows this needs updating but the core recommendation is correct. Costings are dated. It needs to include some guidance on managing a peer support service.	Peer support has shown great promise at increasing breastfeeding prevalence rates, developing community support for breastfeeding and challenging a hostile culture. However more guidance is needed as the current description of a peer support service does not allow for differentiation between a service with barely trained peer supporters and experienced, skilled workers with regular supervision. When a service doesn't work it is assumed it is peer support that doesn't work rather than the quality of the commissioned service. The recommendation for peer supporters to 'contact new mothers directly within 48 hours of their transfer home (or within 48 hours of a home birth)' has been diluted to telephone contact. Our experience is that a home visit makes a bigger difference, than text or phone support alone, although in rural areas, costs may make phone contact a reasonable alternative but commissioners should understand the difference. Need more guidance to NHS about volunteering within NHS.	Breastfeeding Network have surveyed me Infant Feeding Leads and commissioners. Thomson, G. & Tricky, H. (2013). What w Breastfeeding Peer Support: Thomson, G and Trickey, H (2013) *What works for Breastfeeding Peer Support: Time to get r* EMJ Gynecology and Obstetrics, 1 . pp. 1 Thomson, Gillian and Crossland, Nicola (2 Callers' attitudes and experiences of UK breastfeeding helpline support. Internation Breastfeeding Journal, 8 (1). p. 3. ISSN 1 4358 Aiken, Annette and Thomson, Gillian (201 Professionalisation of a breast-feeding pe support service: Issues and experiences c supporters. Midwifery, 29 (12). e145-e151 02666138 Thomson, Gillian, Crossland, Nicola, Dyk Fiona Clare and Sutton, Chris J (2012) *Ul Breastfeeding Helpline support: An invest of influences upon satisfaction.* BMC Preg and Childbirth , 12 (22). pp. 1-13. ISSN 14 2393 Thomson, Gill, Crossland, Nicola and Dyk Fiona (2012) *Giving me hope: women's reflections on a breastfeeding peer suppo*

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					service. Maternal & Child Nutrition, 8 (3). p 340-353. ISSN 17408695
17	SCM4	Key area for quality improvement 4	Appropriate and timely introduction of weaning foods	Protective of infant gut and kidneys Prevention obesity	Garcia AL, Raza S, Parrett A, Wright CM Nutritional content of infant commercial we foods in the UK. *Arch Dis Child*. 98, 793-7 doi:10.1136/archdischild-2012-303386 2010 Infant Feeding Survey Wasser H, Bentley M, Borja J (2011). Infa Perceived as "Fussy" Are More Likely to R Complementary Foods Before 4 Months. Pediatrics; 127(2): p. 229-237 Smith JP, Harvey PJ. (2010) Chronic dise and infant nutrition: is it significant to publi health? Public Health Nutrition. Published 13.7.2010
18	SCM1	Nutrition in Pre-School Settings	The World Health Organization (WHO) regards childhood obesity as one of the most serious global public health challenges for the 21st century. Obese children and adolescents are at an increased risk of developing various health problems, and are also more likely to become obese adults.	For children attending reception class (aged 4-5 years) during 2011-12, 9.5% were obese. Evidence indicates a strong link between deprivation and obesity with obesity being significantly higher in deprived areas. 'Early years settings provide an ideal opportunity to help every child eat well, enjoy a varied diet and establish healthy eating habits to take with them into their school years.'	Statistics on Obesity, Physical Activity and Diet http://www.hscic.gov.uk/catalogue/PUB13 bes-phys-acti-diet-eng-2014-rep.pdf The 'Eat Better Start Better' guidelines pro by The Children's Food Trust give advice support to early years providers but the guidelines are voluntary rather than mand http://www.childrensfoodtrust.org.uk/pre-school/eat-better-start-better
19	SCM2	All early years settings should follow national guidance on food provision. Where children from low income families receive free nursery education this opportunity should be used	NICE PHG11 did not specify that EY settings should work to the voluntary food and drink guidelines in England which were not available at that time and this link should be strengthened. In addition younger children from lower income families are now	Better use should be made of existing detailed guidance to support EY settings and there should be new specific advice to include how EY settings can engage with younger children from lower income households now in EY settings and the opportunity this presents to support	**Voluntary food and drink guidelines for years settings in England: A practical g** Available at: http://www.childrensfoodtrust.org.uk/asset better-start-better/CFT%20Early%20Years%20Guide ctive_Sept%2012.pdf

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		to practically engage with families about food choices and the nutritional health of their child.	eligible for free nursery places and this opportunity to engage with lower income families should be made explicit.	families around good nutrition.	
20	SCM1	Food Education	Food education and, more specifically cooking skills, are important to allow individuals to exercise choice and control over their diet. This can be either by cooking their own meals or by understanding the processes that are used in already prepared. Community cooking programmes such as those analysed by Community Food and Health (Scotland) can improve cooking skills and confidence around health eating and, in turn, impact on nutrition across families	Maternal obesity (increases health risks for both the mother and child during and after pregnancy. Trend data from the Health Survey for England show that the prevalence of obesity among women of childbearing age increased during the period 1997-2010.	European Food Education Council http://www.eufic.org/article/en/artid/Cookir s_key_health/ Research has also focused on cooking sk a factor in socioeconomic dietary differenc Studies in the UK and Ireland have shown association between occupation or socioeconomic status and skills or confide cook, and suggested that the lack of confi and poor cooking skills contributes toward lower fruit and vegetable intake of low socioeconomic groups.3 Other European suggest that interventions targeting cookir skills could be an effective strategy to pror healthy eating The impact of cooking courses on families (Community Food and Health) http://www.communityfoodandhealth.org.u content/uploads/2013/04/CFHS-impact-cc courses-families.pdf
21	SCM4	Key area for quality improvement 5	Safe preparation of powdered infant formula milks Support to provide 1st feed in close skin-to-skin contact	Reduced risks infant obesity, constipation and gastro-intestinal illness	Renfrew MJ, Ansell P, Macleod KL (2003) Formula feed preparation: helping reduce risks; a systematic review. Arch Dis Child 88:855-8 Lynne Allison Daniels, L.A., Mallan, K.M., Nicholson, J.M. et al. (2013) Outcomes of Early Feeding Practices Intervention to Pr Childhood Obesity. Pediatrics; published c June 10, 2013; DOI: 10.1542/peds.2012-2 http://www.infantfeeding.info/preparation.h

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					Start4Life guide to bottle feeding http://www.who.int/foodsafety/publications PIF_Care_en.pdf
22	SCM4	Additional developmental areas of emergent practice	Use of whey based powdered formula milk throughout first 12 months of life	Prevents constipation, obesity	See above Formula_PTBReport.pdf Fortified milks - FINAL.pdf Infant_milks_May_2014_final_NEW.pdf
23	SCM3	Recommendation 14 Change/addition Infant Formula. Infant formula suitable for all babies should only be available for purchase. All other formula currently sold for quasi normal infant symptoms (colic, sleep, posseting) should only be available on recommendation of a health professional	The Infant formula market appears to be produce an increasing array of milks sold to cure digestive symptoms. By standardising the product will clarify for the public, which milks should be used if not breastfeeding	Many parents are misled into believing that by purchasing specific milk, for a symptom of normal baby behaviour, this will treat and cure the problem.	Suggestion from the East of England Infa feeding Group, part of the of National Infa feeding network UNICEF Baby Friendly
24	SCM2	Pre-conceptual nutritional guidance should be offered to all women who are planning, or who may become, pregnant. New technology such as apps presents an opportunity to expand health promotion in	Currently women are not given nutrition advice pre-conceptually despite evidence that nutritional status and body weight can impact on the pregnancy, pregnancy outcome and life chances of the infant.	There is currently no public health nutrition guidance routinely aimed at women pre-pregnancy beyond promotion of folic acid and work with women with, for example, who are obese or who have diabetes. HCP contacts with women who are planning, or who may become, pregnant can use this opportunity to highlight the	

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		this area.		importance of optimum nutritional status and body weight pre-conception. The use of evidence based apps from independent organisations might be able to effectively promote this information alongside local public health initiatives.	
25	Public Health England	Maternal diet preconception and during pregnancy	There is good evidence that improving the dietary intake of women of childbearing age has the potential to ensure that nutritional status at conception is adequate to support optimum fetal growth. Women who are pregnant or are planning a pregnancy do not need to follow a special diet, but should eat a healthy balanced diet, ensuring they are consuming a variety of different foods every day in order to provide them with enough energy and the right balance of nutrients to meet their own needs and to support the growth and development of their baby.	Findings from the latest National Diet and Nutrition Survey suggest that adults (including women of childbearing age) are exceeding recommendations for saturated fat, salt and added sugars intake, and are not meeting recommendations for fruit and vegetable, oily fish, and fibre intake.	COMA Scientific Review of the Welfare Fo Scheme (2000) SACN. The Nutritional Wellbeing of the Br Population (2008). http://www.nhs.uk/conditions/pregnancy-a baby/pages/healthy-pregnancy-diet.aspx# https://www.gov.uk/government/statistics/ l-diet-and-nutrition-survey-results-from-yea to-4-combined-of-the-rolling-programme-f 2008-and-2009-to-2011-and-2012
26	Public Health England	Achieving a healthy weight before pregnancy and weight management during pregnancy	Excess maternal pre-pregnancy body weight and the weight gained during pregnancy can have adverse effects on both a mother's health and the health of her baby. It is recommended that women should aim to be a healthy weight prior to becoming pregnant.	Maternal obesity in the UK is increasing; around 16% of women are obese and 50% of women are overweight at the start of pregnancy. Obesity has a strong association with health inequalities. In pregnancy, obesity is mostly seen among women residing in areas of highest deprivation, black women, and those who are unemployed (Heslehurst et al., 2010).	Heslehurst, N et al. (2010) 'A Nationally Representative Study of Maternal Obesity England, UK: Trends in Incidence and Demographic Inequalities in 619 323 Birth 1989-2007', *International Journal of Obes* pp. 420-428. http://www.noo.org.uk/securefiles/141121 AdultWeight_Aug2014_v2.pdf http://www.noo.org.uk/NOO_about_obesit rnal_obesity/uk_trends

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				The increasing prevalence of overweight and obesity in women of childbearing age means that more women will enter pregnancy overweight or obese, which will have serious implications for the health of mothers and infants, and for service providers.	http://www.nhs.uk/conditions/pregnancy-a baby/pages/overweight-pregnant.aspx#cl NICE guidelines [PH27]. Weight managem before, during and after pregnancy.
27	SCM3	Recommendation 1 Change/Addition Include an assessment of Tongue Tie(TT) within the New-born Infant and Physical Examination	Some Infants with some degree of Tongue Tie, struggle to breastfeed effectively. Health gains for both Mother and Infant are dose related. The more breast milk, the more health gains. If mothers have to give up breastfeeding earlier than they would like, due to pain, as the TTied baby cannot attach properly health gains will be curtailed for both of them.	If there is a mechanical difficulty in attaching to the Breast, mothers will struggle to breastfeed and babies will struggle to receive sufficient breast milk. Improved latch will improve Breast feeding duration rates.	Nice Guideline IPG 149 (2005) Buryk M (2011) Efficacy of Neonatal Rele Ankyloglossia: A randomised trial . Pediat 2011-0077
28	SCM3	Recommendation 1 Addition/change Include TT examination in the Management of Breastfeeding Training curriculum for Midwives and Health Visitors	If TT is identified as a possible cause of breastfeeding difficulties, provision to divide the Infants' tongue and support afterwards needs to be timely, local, accessible and available for all.	Tongue Tie as a cause for Breastfeeding difficulties is not universally recognised. Enhanced universal services for this procedure will allow for audit of effectiveness.	Suggestion from the East of England Inf feeding Group, part of the of National Inf feeding network UNICEF Baby Friendly
29	SCM3	Recommendation 10 Addition/change Extent the provision of TT clinics within the country to provide equitable accessibility. Set clinics within a Breastfeeding supportive environment			Suggestion from the East of England Inf feeding Group, part of the of National Inf feeding network UNICEF Baby Friendly
30	BfN	NICE Guideline PH11	10% of BfN Drugline calls are about mental health drugs for mothers with	This Quality Standard could offer guidance on offering support for mothers	The work of Wendy Jones and her collea the Breastfeeding Network is not referen

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		Recommendation 15	depression and anxiety.	who are considering breastfeeding alongside taking medications for mental health needs.	they take approximately 4,000 calls per ye from the public and health professionals. T service has never received any funding, is valued and yet cannot be sustained in the present form. http://www.breastfeedingnetwork.org.uk/d in-breastmilk.html
31	BfN	Scope Consistent implementation of evidence-based interventions to address inequalities and regional/ inter-regional variations in infant feeding.	Variations in breastfeeding prevalence rates, timely introduction of solid food and correct technique for making up infant formula all contribute to reducing infant illnesses.	Variations in hospital admissions for infectious illnesses, young child obesity at reception year age and infant mortality show these are all modifiable. We would like to see a recommendation for maintaining the data collection for initiation and 6-8 weeks to give communities intelligence on the impact of commissioning and decommissioning decisions.	NHS England (2014) Maternity and breastfeeding. http://www.england.nhs.uk/statistics/statis work-areas/maternity-and-breastfeeding/ Infant feeding profiles – data shows suffic large variations to overcome imperfection the data. https://www.gov.uk/government/publicatio nt-feeding-profiles-2010-to-2011
32	SCM2	All pregnant women should be given nutrition advice at their first booking-in visit by a Dietitian. This should include guidance on supplementation and appropriate advice on weight management during and post-pregnancy. Simple verbal screening of women who may be at nutritional risk (or who's infant may be at risk) through dietary choices (e.g. women who are strictly vegan, women who avoid dairy products and fish and may have low iodine status) should be	Current advice includes information to be given to pregnant women at the first contact at 10-12wks around diet, breastfeeding and infant feeding and The NICE ante-natal Quality Standard includes the statement that 'pregnant women with a body mass index of 30 kg/m^2 or more at the booking appointment are offered personalised advice from an appropriately trained person on healthy eating and physical activity'. This personalised advice is not extended to women who may be at risk of other forms of malnutrition including under-nutrition which can be harmful to mother and infant.	Women in pregnancy may be particularly receptive to information on good nutrition for them and other family members and this should be a separate review by a suitably qualified health professional rather than something added to the workload of the midwives at booking in visits who do not have the background knowledge needed to consider dietary risk and offer tailored guidance. If overweight and obesity in the population are to be tackled in line with all current public health priorities then this provides a unique opportunity to offer guidance and make links with other groups and agencies.	PHE Public Health Outcomes Framework https://www.gov.uk/government/uploads/s uploads/attachment_data/file/263658/290 PHOF_Improving_Outcomes_PT1A_v1_1 *Healthy Child Programme: Pregnancy and first five years of life (2009)* https://www.gov.uk/government/uploads/s uploads/attachment_data/file/167998/Hea ld_Programme.pdf

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		considered as part of this contact as well as links to breastfeeding information and healthy family nutrition.			
33	SCM3	Recommendation 15 Change/addition Add Vitamin A,C&D to the Medicinal Preparations list of Nurse Prescribers' Formulary for Community Practitioners	Health Visitors currently have scope to prescribe Folic acid only. Health Visitors see all pregnant women, so could increase Vit C and D uptake by expanding this list to include these Vitamins.	National Health Visiting Core Specification 2015-2016 includes an antenatal visit to all pregnant women to promote health. National uptake of Health Start Vitamins is low. Include this intervention during an individual antenatal consultation could vastly improve uptake.	Nurse prescribers Formulary for Commun Practitioners NPF 3013-2015 bnf.org
34	SCM3	Recommendation 16 Change/addition Food Labelling. Foods sold as suitable for Weaning should comply with DH recommendations as not suitable before 6 months	Health Visitors promote the introduction of solids to the infants diet at around 6 months. This will allow parents to receive a more consistent message.	Health Visitors are "Public Health Nurses" who provide information to empower parents to make healthy choices for their families. Health Visitors often have to defend their health promoting messages in a commercial environment. Compelling food manufacturers to change labelling on their products to reflect DH recommendations will validate this and other PH initiatives carried out by this group of health professionals	Garcia,A.L.et al (2014) Nutritional content infant commercial weaning foods in the U Achieves of Disease in Childhood,98(10) .pp.793-977 Links between early feeding practices and childhood obesity. Initiation and duration of Breastfeeding ha strong links with childhood obesity. Griffiths,L et al (2009) Effects of infant fee practices on weight gain from birth to 3 ye Archives of disease in childhood, 94(8) ,p 582 Redsell,S et al (2013) UK Health Visitors identifying and intervening with infants at developing obesity. Maternal and child nu (3),pp.396-408
35	SCM3	Recommendation 5 Addition/change Advertise breastfeeding through "change for Life" Campaign on TV/Social media Pregnant Women to be advised Omega 3 and 6 in			Suggestion from the East of England Inf feeding Group, part of the of National Inf feeding network UNICEF Baby Friendly

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		3rd trimester of pregnancy (1-2 portions of oily fish)			
36	SCM3	Recommendation for NICE Guideline 11,63 62 37,149 Remove “or other” from the requirement to go Baby Friendly in all NICE pathways. Add “responsive feeding” to the guidance on breastfeeding and Formula feeding. Match the wording in all these Guidelines			Suggestion from the East of England Infa feeding Group, part of the of National Infa feeding network UNICEF Baby Friendly
37	SCM3	Recommendation for NICE Guideline 11,63 62 37,149 Remove “or other” from the requirement to go Baby Friendly in all NICE pathways. Add “responsive feeding” to the guidance on breastfeeding and Formula feeding. Match the wording in all these Guidelines			Suggestion from the East of England Infa feeding Group, part of the of National Infa feeding network UNICEF Baby Friendly
38	SCM3	Recommendation for Research Recommendation1 Addition/change Change the DH definition of Prevalence of Breastfeeding at 6-8weeks to include only babies receiving breast	Currently the Prevalence rate includes partial breastfeeding as well as total breastfeeding. If this change to exclude those babies only partially receiving breast milk and just include those who are receiving exclusive breast milk, measurements of Health gain will be easier to extrapolate.	Better reliably of Data Much evidence gathering regarding Health Gains for Breastfeeding rely on these definitions. However, Health Gains of breastfeeding appear to be dose related, so a clearer picture regarding short and long term health gains could be extrapolated more reliably if the two categories of	

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		milk.(VSB11)		Breastfeeding pairs were separated (i.e. those who were exclusively fed and those who were partially fed)	
39	SCM1	Additional evidence sources for consideration	The Breastfeeding Network http://www.breastfeedingnetwork.org.uk/get-involved/make-your-business-breastfeeding-friendly/ Health Canada – Nutrition for Healthy Term Infants http://www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/recom/index-eng.php Australian Government Guidelines – Infant Feeding Guidelines http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/n56_infant_feeding_guidelines.pdf		
40	RCN	Key area for quality improvement 1	General	General	The RCN feels that this is a very worthy to appropriate for the development of a quali standard. This particularly in the light of co over an obesity epidemic.
41	NHS England	NHS England I wish to confirm that NHS England has no substantive comments to make regarding this consultation			