

**CEL 01 (2012)**

**16 January 2012**

Dear Colleagues

## **HEALTH PROMOTING HEALTH SERVICE: ACTION IN HOSPITAL SETTINGS**

### **Summary**

1. The concept that "every healthcare contact is a health improvement opportunity" is central to the Quality Ambitions for both:

- **Person-centred:** Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making; and
- **Effective:** The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

2. This CEL is an early product of the Improving Population Health Action Group which supports the Effective Ambition and the Efficiency and Productivity - Preventative and Early Intervention workstream.

3. The CEL extends the aspirations and range of actions set out in [CEL 14 \(2008\)](#) and includes community hospitals in the settings targeted. It aims to sharpen local leadership, governance and accountability in this area, and harness improvement capability for the health promoting health service approach.

### **Addresses**

#### For action

Chief Executives  
Directors of Public Health  
Medical Directors

#### For information

Directors of Operations  
Nurse Directors  
Health Promotion  
Managers  
Health Promoting Health  
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## **Action**

- Boards are asked to implement the specified health promotion actions contained in this CEL to support health improvement in all hospital settings, and to report annually in each of the next 3 years on progress against the actions.
  - Area Clinical Fora (ACF) and Managed Clinical Networks (MCNs) are tasked with acting as champions for the actions described in this CEL.
4. The specific monitoring arrangements for this CEL are currently being finalised and will be communicated separately to Boards in due course.

Yours sincerely

***Harry Burns***

**SIR HARRY BURNS**  
**Chief Medical Officer for Scotland**

## **HEALTH PROMOTING HEALTH SERVICE: ACTION IN HOSPITAL SETTINGS**

### **Rationale for the health promoting health service approach**

1. As CEL 14 (2008) set out, as well as treating illness, hospitals can help create a step change in health and wellbeing, while simultaneously contributing to a reduction in health inequalities, through promoting health and enabling wellbeing in patients, their families, visitors, and staff. Clinical teams and, indeed, whole hospitals are perfectly capable of incorporating health improvement into their day-to-day ethos and activities, taking advantage of opportunities to change behaviours, especially among people most at risk of poor health.

2. Key reasons for taking this approach include:

- Evidence of effectiveness of health promoting activity in hospital settings;
- Access to large numbers of patients, carers, visitors and staff;
- Efficiency, through making the most of opportunistic face-to-face contacts, and assessment processes at all stages of the pathway through hospital; and
- Good employment practice, which involves supporting staff's health and wellbeing.

3. Individuals living in deprived communities are at the greatest risk of preventable ill health because of their life circumstances. Given the proportionately greater use of acute services by patients from deprived communities, health promotion in hospital and maternity settings offers a major opportunity to improve health and reduce health inequalities.

4. The Scottish Cancer Taskforce (SCT) has recently updated its work programme to deliver *Better Cancer Care*. This includes 2 programmes in development – the enhanced recovery programme for surgery and transforming care after treatment – which align well with the Health Promoting Health Service's (HPHS) aims and interventions. Both programmes will draw on current examples of health improvement to optimise the individual patient's health before cancer surgery, and provide ongoing support for improved health and wellbeing after treatment for cancer. The SCT is also beginning to explore the significant potential of the various cancer screening programmes to deliver health improvement messages and interventions.

### **Action for Boards**

5. Chief Executives are asked to delegate responsibility for implementation to the appropriate committee and governance structures and to provide a report to the Board on progress, at least annually, in each of the next 3 years.

6. Boards will be expected to reflect the annual report in their self assessment for annual accountability reviews with Scottish Ministers - measuring progress through the set of level 3 indicators (performance measures) set out in this CEL which support related HEAT targets and contribute to progress in specific quality outcome indicators for the Quality Measurement Framework.

7. Area Clinical Fora (ACF) and Managed Clinical Networks (MCNs) are considered key routes through which the HPHS agenda can and should be championed. However, responsibility for delivery of the HPHS ultimately rests with Chief Executives.

8. The ACF should provide professional leadership and assume an oversight of progress with implementation of this CEL through relevant professional advisory and clinical leadership structures and roles. To achieve this, it is suggested that the HPHS is a standing agenda item at the ACF Chairs meeting.

9. MCNs should be empowered to assume specific responsibilities, in particular for actions in relation to smoking cessation and tackling alcohol problems. MCNs should be supported in this activity by Public Health colleagues to ensure that population health issues are fully factored in, and should link actions in primary, community and secondary care across a whole system pathway. Further central guidance on MCNs, building on [HDL \(2007\)21](#), is imminent.

10. Staff experienced in supporting self management, recovery and enablement approaches should be strongly encouraged to apply these generic competences for the purpose of promoting health.

11. Medical Directors and Directors of Public Health should jointly support and encourage all hospital Clinical Directors to take account of involvement in health improvement actions through the annual appraisal cycle for hospital consultants.

12. The development of core, generic and transferrable health improvement skills amongst staff will be essential for the successful implementation of the actions in this CEL. Boards are therefore strongly encouraged to ensure that staff have both the competence and confidence to deliver the proposed interventions.

13. Knowledge Skills Framework (KSF) leads should embed the attainment of generic health improvement competences within professional development.

14. Local expertise on improvement methodology should be made available to jointly support all hospital and public health staff to test, adopt and spread good practice.

15. Patient Focus and Patient Involvement (PFPI) and patient experience leads should enable patient, carer and volunteer participation in developing and implementing the action plan.

## **Performance measures**

16. Boards are asked to implement the interventions for health improvement that follow in all hospital settings, including community hospitals and maternity units, building on progress with CEL 14 (2008). There are other settings for which these interventions would be relevant and Boards are encouraged to expand the scope of their health improvement activity beyond hospital settings as and when feasible. It is recognised that the manner and extent to which some of these measures can be implemented will vary depending on local circumstances.

17. Similarly, while the measures focus on particular areas of health improvement, it is recognised that there are many more which might be considered, in areas such as mental health, drug abuse, gender-based violence and sexually transmitted diseases. Boards are encouraged to broaden the scope of their health improvement activities to additional topic areas wherever possible.

18. These interventions constitute a minimum set of actions and it would be helpful if Boards are able to do more, including integrating the separate activities outlined below into a whole-hospital approach.

18.1 **Smoking:** Ensure dedicated specialist smoking cessation support is available within the hospital/acute setting which is integrated with community-based cessation services; and commit to the development and implementation of more comprehensive organisational tobacco policies.

18.2 **Alcohol:** Opportunistically screen patients attending A&E departments and wider acute settings. For patients identified with harmful or hazardous drinking (screening positive), offer and deliver a brief intervention in accordance with the SIGN 74 Guideline. For patients identified as dependent drinkers, and those with harmful or hazardous drinking patterns who request further help, direct to an appropriate support service (including health, social services, local authority and voluntary).

18.3 **Breastfeeding:** Continue to implement the UNICEF Baby Friendly Initiative in all maternity units.

18.4 **Food and Health:** Develop a consistent approach to healthy eating for all food service providers across the NHS. Caterers will be required to follow HealthyLiving Award criteria at the point of contract (re)negotiation and retailers will be required to join the Scottish Grocers' Federation (SGF) HealthyLiving Programme and meet their Gold Standard criteria at the point of contract (re)negotiation.

18.5 **Healthy Working Lives:** Continue to work to attain Healthy Working Lives (HWL) awards for all acute services, working towards the Gold Award; and attainment of the Healthy Working Lives Mental Health Commendation Award.

18.6 **Sexual Health:** Ensure that, prior to discharge from maternity services, all women aged 16-50 are advised of their contraception options. In particular, vulnerable women at risk of poor sexual health outcomes should be offered effective methods of contraception, including long-acting reversible contraception (LARC). Prior to discharge from termination services, all women should be provided with an effective method of contraception, including LARC, where appropriate.

18.7 **Physical Activity:** Increase opportunities for staff, visitors and patients to be physically active; and encourage and support them to be more active, including the provision of advice to staff and patients on the importance and benefits of physical activity.

18.8 **Active Travel:** Encourage staff and visitors to make more active, green travel choices.

19. Actions 18.1 - 18.5 all build on activity set out previously in [CEL 14 \(2008\)](#). Actions 18.6 - 18.8 are new areas of focus for this CEL. There are opportunities for synergy, with health promoting activities contributing to performance measures and outcomes across more than one topic area. For example, encouraging stair use and active travel planning both fit with, and would contribute to, the HWL award programme.

20. Each of the CEL actions includes objective and quantifiable measures of progress which are aligned with the Quality Measurement Framework. Where relevant, data to measure progress are consistent with that required for associated HEAT targets. Performance measures should be included in annual reports to Boards and progress should be fed back through site, department and team-based governance arrangements on a regular basis, to motivate staff.

21. The Scottish Government Health Directorates fully recognise that primary and community care settings are also taking a HPHS approach. This programme, however, continues to concentrate on the use of acute care settings to improve health, an approach which has not been developed consistently across operational units to date. It is recognised that these interventions will already be in place in many primary and community settings. Boards are encouraged to assess how best to link and develop this existing provision to service models and developments in the acute setting.

### **Support for action**

22. Significant support is available to NHS Boards, at both national and local level, to implement the actions in this letter, and is detailed at **Annex A**.

## Smoking

**Action:** To ensure dedicated specialist smoking cessation support is available within the hospital/acute setting which is integrated with community-based cessation services.

**Outcome:** Increased availability and uptake of specialist smoking cessation support by hospital patients who are motivated to quit smoking. Improved overall smoking cessation success (quit) rates by providing better access to and continuity of support for patients preparing for, or maintaining, a quit attempt while moving in either direction between primary and secondary care settings.

### Example in practice:

NHS Greater Glasgow and Clyde's service for hospital in-patients includes Nicotine Replacement Therapy (NRT) and smoking cessation service information in the hospital prescribing formulary. The smoke-free hospital service provides briefings to hospital staff on what support is available to inpatients, and on their role in prescribing and referring on to the service.

NHS Grampian, as part of the development of pre-operative smoking cessation in partnership with GPs and outpatient consultants, has smoking cessation included on the standard pro-forma in pre-assessment clinics.

### Policy context

A Cochrane Review published by Rigotti, Munafo and Stead in 2007 on interventions for smoking cessation in hospitalised patients found that *“High intensity behavioural interventions that begin during a hospital stay and include at least one month of supportive contact after discharge promote smoking cessation among hospitalised patients.”* These interventions are effective regardless of the patient's admitting diagnosis. Interventions of lower intensity or shorter duration have not been shown to be effective in this setting.

The *Guide to Smoking Cessation in Scotland 2010* published by NHS Health Scotland and ASH Scotland recommends that:

- Patients should be reminded at every suitable opportunity of the health benefits of stopping and the advice linked to their medical condition;
- Patients referred for elective surgery or waiting to be admitted to hospital should be encouraged to stop smoking before the operation or pre-admission and should be offered timely access to an intensive support service;
- Hospital patients who use tobacco in any form should be offered:
  - Advice and, if appropriate, pharmacotherapy (e.g. to manage nicotine withdrawal symptoms through an enforced quit) from a suitably trained professional while in hospital to help them quit;
  - An appointment with an intensive support service (e.g. an NHS smoking cessation service). Intensive smoking cessation services should be provided for patients whilst in hospital, where appropriate/possible;
- Patients waiting to be discharged from hospital, particularly those who have tried to quit smoking in hospital, should be offered, and fast-tracked for, intensive support to stop-smoking, and an appointment for such support booked prior to their discharge.

The wide availability of smoking cessation support in Community Pharmacies, via the Public Health Service Contract, should also figure as an appropriate part of the planning, marketing, communication, delivery and recording of patient-centred integrated care pathways for

smoking cessation between primary and secondary care. Structured and effective smoking cessation pathways in acute child and maternal health settings, which link with appropriate community settings, would also align strongly with early years health improvement and health inequalities objectives, and reflect tobacco-use elements within the maternity services framework and the development of the Scottish Women Held Maternity Record.

### **Performance measures**

- Increased quit attempts and successful quits amongst hospital in-patients (already recorded on the ISD National Smoking Cessation Database). It would also be helpful if Boards recorded community-based quit attempts and quit successes following a referral, or delivery of brief advice, from a hospital setting;
- Evidence of existence and application of Integrated Care Pathways for smoking cessation in secondary care (and for patient flows to and from primary care);
- Evidence of appropriate training activity to support the delivery of brief advice for smoking cessation in secondary care;<sup>1</sup> and
- Evidence of Full-time Equivalent (FTE) hours of specialist smoking cessation support available within or to secondary care sites within Boards.

### **Performance management context**

The action and the performance measures are all aligned with the delivery of the refreshed HEAT target for 2011-14:

*“NHS Scotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most-deprived within-Board SIMD areas over the three years ending March 2014.”*

This new target aims to continue the success to date of the population-wide approach of the previous target but increases the focus on inequalities with Boards being asked to deliver a specific proportion of overall quits from the two most deprived within-Board Scottish Index of Multiple Deprivation (SIMD) quintiles. Smoking prevalence rates in the two most deprived SIMD quintiles are approximately double that in the remaining quintiles. There are 1.4 million hospital discharges in Scotland each year, including in-patient and day cases. Given the known impact of smoking on incidence of cancer, coronary heart disease, stroke and respiratory conditions and many other diseases, and the health inequalities which exist within each of these, this will encourage NHS Boards to target smoking in deprived populations in a more co-ordinated way in both community and acute settings.

Greater access to cessation support in acute settings - and more integrated and continuous care when moving in either direction between primary and secondary care - should increase both uptake and success rates amongst more deprived communities, by bringing smokers into contact with specialist support at times of greatest motivation (i.e. acute or planned health episodes).

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<sup>1</sup> All staff have different levels of contribution to make to the prevention agenda, and as a result this requires different levels of training. It is recommended that a view is taken across patient pathways and appropriate levels of training made available to staff according to their role and contribution, ranging from: awareness of the harm of smoking and supporting non-smoking policy; raising the issue and sign-posting to support services; giving brief advice and referring on for further support; and delivery of specialist smoking cessation services.

## Smoking

**Action:** To commit to the development and implementation of more comprehensive organisational tobacco policies. Wherever possible, consideration should be given to going beyond current legal requirements and moving towards the goal of being completely smoke-free.

**Outcome:** An increase in the number of NHS premises moving towards becoming completely smoke-free.

### Example in practice:

NHS Tayside was one of the first health boards in Scotland to prohibit smoking across all sites, even to the extent of asking people not to smoke in their private vehicles in car parks. This approach goes beyond the national legislation. For example, at Dundee's Ninewells Hospital Out-Patients, visitors, staff, contractors and students must leave the grounds to smoke. Hospital in-patients can smoke in designated external smoking areas only. There are exemptions, such as Adult Hospices, Psychiatric In-patient Hospitals and Units.

### Policy context

Given the inextricable links between smoking and ill-health, tobacco control will continue to be a priority for the Scottish Government. There are already very positive signs about the health benefits which are flowing from the smoke-free law in terms of heart attack admissions and on hospital admissions for asthma in children aged 0-14. The national tobacco control programmes which have been implemented in Scotland over the last decade have resulted in a shift in cultural attitudes to smoking. Action to stop people from starting to smoke in the first place has been balanced by action to help smokers to quit through the delivery of smoking cessation services that help individuals manage their own health and change their behaviour. Consequently smoking prevalence has dropped from 30.74% in 1999/00 to 24.29% in 2009/10.

NHS organisations provide services which protect, promote or treat people's health. In other words they have a vested interest in 'health'. It is very important, therefore, that Boards are in the vanguard, setting the pace and providing an example and leadership for others to follow. Although the national smoke-free legislation does not extend to open spaces, NHS Boards have the power to ban smoking on their premises and the Scottish Government is supportive of any moves in this direction.

We are aware that total smoking restrictions have been successfully implemented in a number of NHS premises throughout Scotland.

### Performance measure

- Implement more comprehensive organisational tobacco policies with specific timescales to enable progress to be measured. For example, evidence could include a statement of existing smoke-free policies plus proposals or updates (e.g. within Board papers, action plans, local tobacco strategies, monitoring reports and so on) with timescales that would indicate the extent and type of progress made or planned against relevant indicators, such as no smoking in hospital grounds, removal of smoking rooms in existing exempted premises or a wide range of other steps towards smoke-free.

## Alcohol

**Action:** To screen opportunistically patients attending A&E departments and wider acute settings. For patients identified with harmful or hazardous drinking (screening positive) to offer and deliver a brief intervention in accordance with the SIGN 74 Guideline. For patients identified as dependent drinkers, and those with harmful or hazardous drinking patterns who request further help, to direct to an appropriate support service (including health, social services, local authority and voluntary).

**Outcome:** Improved, consistent and embedded screening (in line with the Alcohol Brief Intervention (ABI) HEAT standard for 2012-13 and the SIGN74 Guideline) and appropriate referral, ensures that the most appropriate treatments, interventions, support and services are available at the right time to everyone who will benefit. This will help to deliver the long-term desired outcome of reducing alcohol consumption and therefore harm.

### Example in practice:

Alcohol screening (FAST) continues to be rolled out across the acute hospitals in NHS Greater Glasgow & Clyde. Introduction of screening in emergency departments promotes early intervention of patients with alcohol issues. It enables 'walk-in discharges' who screen positive to FAST alcohol screen to receive brief advice on sensible drinking limits, receive a leaflet and be signposted to community services for follow up and appropriate interventions.

For 'admitted patients' who are screened in the emergency department and screen positive using FAST, the care pathway is as follows: the screening score is recorded in the case notes and an ABI delivered on the ward as part of the admission process, or at a later stage of hospital stay prior to discharge.

### Policy context

Substantial evidence is already available to indicate that the delivery of ABIs is effective in reducing alcohol consumption among hazardous and harmful drinkers. Indeed a meta-analysis has shown that Brief Interventions are not only clinically effective, but also cost-effective. Guidance issued by the National Institute for Health and Clinical Excellence (NICE) recommended the use of screening and ABIs within the NHS and that priority should be given to alcohol-use disorder prevention as an 'invest to save' measure. Similarly, the House of Commons' Health Select Committee (January 2010) recommends the use of alcohol brief interventions, acknowledging the very strong evidence which exists to show that they can lead to a reduction in alcohol consumption among harmful and hazardous drinkers. By supporting early interventions on alcohol misuse, such as 'brief advice', the NHS may avoid or reduce the costs of later, more intensive and specialist support for people who develop dependency or suffer from an alcohol-related illness.

The Scottish Government's *Alcohol Framework*, published in March 2009, outlines an evidence-based package of measures designed both to help and support the record numbers of Scots currently experiencing alcohol problems, as well as to prevent future problems arising. Building a healthy and sensible relationship with alcohol is pivotal in realising our Purpose and 4 out of 5 of our strategic objectives. In order to emphasise the importance of reducing alcohol-related harm towards achieving our objectives, there is also a specific national indicator within the framework "to reduce alcohol related hospital admissions by 2011." The delivery of ABIs is therefore a key component of the Alcohol Framework.

ABIs contribute directly to all 3 Quality Ambitions. Involving people in maintaining and managing their own health and that of family members, and making evidence-based services available to those who need them are at the heart of alcohol prevention and treatment. The motivation of the individual and the support of those around them are critical factors for a successful outcome. Having services available at the point of need is crucial. Specialist support services are provided on the basis of person-centred care which takes account of the multiple and complex needs of the individual (e.g. mental health, drug use, housing issues, children).

## **Performance measures**

For A&E departments, quantification as follows:

- The number of A&E attendances who are screened opportunistically for alcohol misuse, as a % of total attendances;
- The number of A&E attendances screened for alcohol use disorders and the % screening positive (with % eligible for ABI and % eligible for referral); and
- The number of alcohol brief interventions delivered in accordance with the HEAT Standard.

For the purposes of the HEAT H4 target's 'A&E setting', ABIs will require to be delivered in accordance with the current national guidance on data reporting <http://www.healthscotland.com/documents/5061.aspx>

It is recognised that ABIs can be delivered in acute settings other than A&E, and Boards are encouraged to extend the scope of this CEL to wider acute settings, as appropriate, to fit with local arrangements. This will support the ABI HEAT standard for 2012-13.

## **Performance management context**

The action and the performance measures are all aligned with the 2011-2012 ABI HEAT H4 target and the planned ABI HEAT standard for 2012-13.

### H4 HEAT target

In 2008, an NHS HEAT target was introduced to deliver 149,449 ABIs, within the Primary Care, A&E and Antenatal priority settings using a setting-appropriate screening tool, by March 2011. NHS Scotland achieved this initial three year HEAT H4 target, delivering over 174,000 brief interventions by the end of 2010-11 to help individuals to cut down on their drinking to within sensible guidelines.

The national data reporting guidance for the HEAT H4 target outlines the following in respect of the A&E setting:

*“Interventions delivered by doctors and nurses as part of a patient's care initiated in an attendance at A&E, minor injury units/departments and community-based minor injury clinics. The intervention can be delivered either in the A&E department, minor injury units/departments and community-based minor injury clinics as part of the clinical consultation. It may also be delivered during follow on care from an A&E or minor injury attendance in the acute setting, such as an outpatient fracture clinic or in a hospital ward following an admission from A&E.”*

The longer term aim has always been that brief interventions will become embedded into routine practice. To support this, and to build on the good work already in place, including the ongoing work on the NHS Quality Strategy and Quality Measurement Framework, the HEAT target was extended for another year aiming to deliver a further 61,081 ABIs by 31 March 2012. This reflects the fact that: there is still an 'untouched' pool of individuals across Scotland who would benefit from receiving an ABI, including those eligible for a repeat ABI; the considerable resources that have been allocated to this target - in terms of financial support from government, training of appropriate staff (over 8,500 staff have been trained across Scotland by 2011), the development of a delivery infrastructure, etc; and the need to ensure that ABIs are mainstreamed into NHS delivery.

### **HEAT standard 2012-13**

On 30 November 2011, health boards and Alcohol and Drug Partnerships (ADP) were made aware, as part of the LDP process, that the delivery of ABIs will become a HEAT standard for 2012-13. The ABI HEAT standard is:

*“NHS Boards and Alcohol and Drug Partnerships will sustain and embed alcohol brief interventions (ABI) in the three priority settings (primary care, A&E, antenatal). In addition, they will continue to develop delivery of alcohol brief interventions in wider settings.*

*Boards and their ADP partners should maintain the same total level of delivery of ABIs under the ABI HEAT standard in 2012-13 as under the HEAT H4 target for 2011-12 (i.e. 61,081 ABIs nationally). It is expected that at least 90% of delivery (i.e. a minimum of 54,973 ABIs) will continue to be in the priority settings. The remainder can be delivered in wider settings in accordance with the ABI HEAT standard national guidance for 2012-13.”*

This national guidance will be available in due course on the HPHS portal – see **Annex A**.

This standard takes account of various pieces of work, including feedback received from the ‘Developing HEAT targets’ letter issued by the Performance Directorate in 2011 and findings from the ABI national evaluation ‘*An evaluation to assess the implementation of NHS delivered Alcohol Brief Intervention*’. It also builds on the *Quality Alcohol and Treatment Support (QATS) Report* recommendation i.e. that NHS Boards and their ADP partners have a key role to play in developing ABI delivery in wider settings and building the evidence base.

We would therefore encourage ABIs to be undertaken within HPHS as part of the HEAT standard in 2012-13, in order to embed ABI delivery into wider acute settings.

## Breastfeeding

**Action:** Continued implementation of the UNICEF Baby Friendly Initiative in all maternity units.

**Outcome:** An increase in the number of women exclusively breastfeeding at first visit and at 6-8 week review.

### Example in practice:

The Baby Friendly Initiative three day course in breastfeeding and lactation management for neonatal unit staff is designed to provide neonatal unit staff with the background knowledge and practical skills to support mothers to initiate and maintain lactation within the neonatal setting. There is a strong focus on the importance of family centred care with reference to the NHS toolkit for High Quality Neonatal Services and the BLISS Baby Charter Standards. The course is suitable for all staff working within a neonatal and transitional care unit.

### Policy context

The *Better Health, Better Care Action Plan* makes clear that making the best possible start in the early years is at the forefront of the government's future health agenda. It sets out a number of actions that the Government will take, including developing actions to promote infant nutrition within a new *Food and Health Delivery Plan*, the appointment of an Infant Nutrition Co-ordinator to improve breastfeeding rates and targeting NHS Boards to increase the proportion of newborn children who are exclusively breastfed.

The *Improving Maternal and Infant Nutrition: A Framework for Action* (2011) sets out actions to be taken by NHS Boards, local authorities and others to improve the nutrition of pregnant women, babies and young children with a particular emphasis on increasing the rates of exclusive breastfeeding in the first 6 months of a babies' life. NHS Boards will be asked to provide outcome focussed implementation plans which also link into the *Refreshed Framework for Maternity Care in Scotland* (2011).

The *UNICEF UK Baby Friendly Initiative*, recommended by Scotland's Chief Nursing Officer (NHS Circular 1994), is an award scheme based on a 10-step plan to encourage maternity units to adopt evidence-based practice and support for breastfeeding. Within the UK, Scotland has the highest level of participation in this initiative, with 86% of maternity units taking part. 46% of maternity units have achieved Baby Friendly status and 58% of Scottish babies were born in a Baby Friendly accredited maternity unit (UNICEF 2005). In 2006, a report commissioned by NHS Health Scotland in partnership with the Scottish Government, *Breast Feeding Initiation and Maintenance: What Works*, outlined the strategies to support breastfeeding through:

- Supporting local NHS Board breastfeeding strategies;
- Encouraging the implementation of the joint WHO/UNICEF Baby Friendly Initiative;
- Raising awareness of benefits, by promoting support by professionals, the voluntary sector and peers; and
- Enhancing opportunities for women to continue breastfeeding on their return to work.

## **Performance measures**

- Achievement and maintenance of UNICEF Baby Friendly Initiative in all maternity units;
- All new mothers who have initiated lactation are signposted to available breastfeeding support programmes in the community. Those with additional needs who are least likely to breastfeed, or breastfeed only for a short time, are supported to access and engage with services through an appropriate referral process; and
- Develop and establish pathways to maintain support and continuity of breastfeeding in the community, including measures aimed at reducing attrition rates of those initiating lactation.

## **Performance management context**

An action within the *Improving Maternal and Infant Nutrition: A Framework for Action* is that all maternity units will achieve and maintain UNICEF Baby Friendly accreditation as a minimum standard (80% by end 2013/14 and 100% by end 2015/16). The *Refreshed Framework for Maternity Care in Scotland* also includes a performance measure where NHS Boards are expected to have evidence that all maternity units and community health partnerships are working towards or achieving accreditation.

## Food and Health

### Action:

- To develop a consistent approach to healthy eating for all food service providers across the NHS. This will require private and voluntary sector operators to follow the lead of NHS caterers, 97% of whom have already achieved the Healthyliving Award;
- Caterers will be required to follow Healthyliving Award criteria at the point of contract (re)negotiation. If no contract exists, an implementation plan for the caterer's registration to the Healthyliving Award should be agreed;
- Retailers will be required to join the Scottish Grocers' Federation Healthyliving Programme and meet their Gold Standard criteria at the point of contract (re)negotiation; and
- NHS Boards to continue to encourage and support food co-operatives and other social enterprises selling healthy produce. NHS Boards may wish to support the sustainability of community food initiatives by encouraging retailers to source healthier, local produce from them.

**Outcome:** Access for staff, patients and visitors in hospitals to a wide range of affordable healthier options from all food outlets across NHS sites; and an increase in access to healthy drinks and a reduction in access to drinks with high sugar content.

### Examples in practice:

NHS Greater Glasgow and Clyde's Western Infirmary in Glasgow initially achieved the Healthyliving Award in January 2009. Two years on, the hospital has taken healthy eating to a new level by achieving the Healthyliving Award Plus in January 2011. The site has increased the availability of healthy options and actively avoids the promotion of confectionery and fizzy drinks. Healthier options are always at the forefront. Fruit is displayed every day and is the first thing people see. A make-your-own sandwich bar is available where customers can choose from a wide range of breads and healthier fillings.

Edinburgh Community Food runs fruit and vegetable stalls in four NHS Lothian premises, including the Royal Edinburgh Hospital. Established in 2009, this is the only fruit and vegetables stall operating in a psychiatric hospital. The hospital management is very supportive and sees the stall as part of the life of the hospital, involving patients through the hospital's Health and Wellbeing group. As well as helping to normalise the hospital experience, it also provides volunteering opportunities for a small number of patients.

### Policy context

There is currently no requirement made on non-NHS caterers and retailers in relation to the provision of healthier food options, leading to uneven availability and diverting customers to less healthy choices.

These steps build on the [CEL 14 \(2008\)](#) action to make affordable fruit and vegetables more widely available in retail settings and the successful introduction of the Healthyliving Award for NHS canteens. Providing healthier food alternatives is consistent with prevention of and recovery from ill-health, and contributes to both the person-centred and effective Quality

Ambitions. These actions complement the *Clinical Standards for Food, Fluid and Nutritional Care in Hospitals* and the *National Catering and Nutrition Specifications*. This work is cited as a specific action (Action 4.5) within the *Preventing Obesity Action Plan*.

### **Performance measures**

- Number of sites with hospital caterers from all sectors with HealthyLiving Award (or HealthyLiving Award Plus for those caterers who have already achieved the Healthy Living Award) as a proportion of total sector delivery units;
- Number of sites with retailers in the HealthyLiving Programme as a proportion of total sector delivery units;
- Number of sites with community food co-ops and other social enterprises selling predominantly healthier produce; and
- Number of sites with healthy vending machines<sup>2</sup> in place as a proportion of total sector vending machines. In addition, NHS Boards should continue to implement the actions to remove sugary drinks from vending machines on NHS sites outlined in CEL 14 (2008) and provide details of progress in their annual report.

It is recognised that the mix of retailers, caterers and other social enterprises selling food in hospital settings will vary between sites and implementation of these measures should take account of local circumstances.

### **Performance management context**

Action on diet contributes to meeting the national performance framework, specifically to reduce the rate of increase in the proportion of children outwith the healthy weight range by 2018. Action is also consistent with the HEAT H3 target monitoring the number of children with unhealthy weight successfully completing family-focused treatment programmes.

The HealthyLiving Award and HealthyLiving Programme are used as indicators for successful implementation of the *Preventing Obesity Action Plan* and *National Food and Drink Policy*. Provision of healthier food options to staff, visitors and patients outwith direct care is consistent with the National Catering and Nutrition Specifications and supports the *Clinical Standards for Food, Fluid and Nutritional Care in Hospitals*. Together they ensure that patients have access to food that helps promote good health. 'Healthier' food or produce is any food item listed in the Food Standards Agency Scotland document: "*Expanding the range of foods included in the SGF HealthyLiving Programme*". This distinction allows measures to apply to those NHS sites leased to private contractors.

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<sup>2</sup> A definition of 'healthy vending' is provided at **Annex B**

## Healthy Working Lives

**Action:** Continue to work to attain Healthy Working Lives Awards for all acute services, working towards the Gold award; and work to attain the Healthy Working Lives Mental Health Commendation Award.

**Outcome:** Improved health and wellbeing of staff, improved attendance, and enhanced productivity.

### Example in practice:

Each Healthy Working Lives Award holder has tackled the criteria in different ways to meet local needs and priorities. For more information contact the Healthy Working Lives Adviser for your Board area.

Further information on the Healthy Working Lives Award programme can be found at <http://www.healthyworkinglives.com/> or by calling the free national advice line on 0800 019 2211.

### Policy context

Promoting health and wellbeing in the workplace in its widest context needs a comprehensive and coherent approach to Healthy Working Lives that includes health promotion, health and safety, occupational health and HR.

*Health Works: A Review of the Scottish Government's Healthy Working Lives Strategy* (2009) reviews progress of the previous *Healthy Working Lives* strategy, taking into account new evidence, particularly the report of Dame Carol Black's review of the health of the working age population. This report re-emphasises the close links between good work and good health, the role of the employer in supporting health and wellbeing in the workplace, and in supporting staff to return to work from periods of illness or injury.

*Safe and Well at Work: Occupational Health and Safety Strategy Framework for NHSScotland* (2011) incorporates the principles of *Health Works* in the importance of taking a joined-up, person-centred approach to the health, safety and wellbeing of NHSScotland staff, including health protection, health promotion, and occupational health support.

The *NHS Health and Wellbeing Report of the Boorman Review of the NHS in England* (2009) concluded that there is a strong correlation between health trusts in England with better outcomes for staff health and wellbeing, and better clinical outcomes for patients.

### Performance measures

- NHS Boards commit to minimum achievements of a Bronze Healthy Working Lives Award by end of March 2013 and a Silver by end of March 2015;
- NHS Boards who already hold a Bronze Award should commit to attaining a Gold Healthy Working Lives Award by March 2015;
- NHS Boards should work towards attaining a Healthy Working Lives Mental Health Commendation Award; and

- NHS Boards should give consideration to self-monitoring of performance indicators. These should include, but are not limited to, monitoring of sickness absence.<sup>3</sup>

These actions can be for either individual hospitals or wider groupings within Boards.

### **Performance management context**

Positive management action to promote staff health and wellbeing has been shown to improve attendance, motivation and productivity. The review of health and wellbeing on the NHS in England (Boorman Review) made clear that investment in staff health and well-being services will more than pay for itself through reducing sickness absence and improving productivity. The review estimated that by reducing NHS sickness absence by a third, this would equate to 33.4 million additional available working days a year for NHS staff, the equivalent to an extra 14,900 whole-time equivalent staff, with an estimated annual direct cost saving of £555 million.

Sickness absence is a HEAT standard (not a target) i.e. performance should be maintained. The current standard for NHS Boards to keep the absence rate to no more than 4% will continue into 2012/13.

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<sup>3</sup> Performance indicators will likely vary across different Board areas and will be determined by what data is collected locally and also the approach taken to promote staff health and wellbeing. Further examples of self monitoring might include the number of line managers trained in supporting return to work, and the time between first absence and referral to occupational health advice.

## Sexual Health

**Action:** Prior to discharge from maternity services, all women aged 16-50 are advised of their contraception options. In particular, vulnerable women at risk of poor sexual health outcomes (e.g. women who abuse substances) should be offered effective methods of contraception, including long-acting reversible contraception (LARC); and prior to discharge from termination services, all women are provided with an effective method of contraception, including LARC, where appropriate.

**Outcome:** An increase in the number of women using LARC methods; and a decrease in the number of unintended pregnancies, terminations and repeat terminations, particularly amongst vulnerable women who are at risk of poor sexual health outcomes.

### Example in practice:

Women requesting termination of pregnancy at hospital assessment clinics in NHS Lothian are counselled by staff regarding future contraception, including LARC, facilitated by the use of contraceptive counselling check lists and local family planning information leaflets. Future contraception is prescribed by medical staff at the clinic so that all methods can be provided to women on the day of the abortion procedure. An accelerated programme of contraceptive implant insertion training has ensured significant numbers of staff are trained to insert this method at time of medical or surgical abortion. For women wishing an intrauterine method, this can be inserted at a surgical abortion. Fast-track systems are in place so that women choosing a medical abortion may have this inserted at the local family planning clinic in Edinburgh or West Lothian, without undue delay.

### Policy context

Scotland has a high rate of teenage pregnancy, terminations and repeat terminations. More than a quarter of women having a termination have had a previous termination. One of the outcomes of Scotland's *Sexual Health and Blood Borne Virus (BBV) Framework 2011-15* for delivery, by NHS Boards and other local partners, is fewer unintended pregnancies. The provision of accurate and up-to-date information is essential to allow users to make an informed and voluntary choice of contraceptive method. In doing so, it is important to ensure an inclusive approach which fully recognises the need to address issues of quality, diversity and the very personal nature of the subject. It is therefore essential that a person-centred approach is taken to the provision of information, advice and services which meet the needs of individuals and are delivered when needed. LARC methods have been shown to be more effective than barrier or oral contraception in preventing unintended pregnancy, as they are independent of adherence to therapy for their effectiveness. Furthermore, the NICE Clinical Guideline on LARC recommends that increased uptake should reduce unintended pregnancy rates. Longer lasting methods are particularly suitable for vulnerable young women, such as teenage mothers and those who may lead a chaotic lifestyle and are, therefore, at risk of poorer sexual health outcomes.

The recently *Refreshed Framework for Maternity Care in Scotland* (2011) emphasises the need for improved provision of contraceptive advice and contraceptive methods, such as longer lasting methods, prior to discharge. NHS Boards have also been advised to improve the uptake of LARC methods by Scottish Government Healthcare Planning, following discussion by the National Planning Forum. The Quality and Efficiency Support Team (QuEST) is taking forward work with NHS Boards and regional networks to examine cost effective service models in primary care, and sexual health and maternity services, including procurement issues.

## Performance measures

For maternity and termination services as appropriate:

- The number of women who have contraception methods recorded (expressed as a % of the total number of admissions); and the number of vulnerable women (including teenagers and women with drug and alcohol problems) who are provided with longer lasting contraception prior to discharge (expressed as a % of total number of vulnerable women admitted)<sup>4</sup>;
- The number of terminations and repeat terminations; and
- The number of unintended pregnancies, particularly amongst teenagers and others at risk of poor sexual health.

## Performance management context

The provision of LARC is one of the Key Clinical Indicators for sexual health and is evidence in support of the NHS QIS *Standards for Sexual Health Services* (2008). Standard 6, Termination of Pregnancy, states that “*women receive safe termination of pregnancy with minimal delay followed by contraceptive advice and psychological support.*” Advice about effective contraception following termination of pregnancy is essential to reduce termination rates. It is necessary that services have a mechanism in place to ensure that all women are offered at the time of termination a range of contraceptives, including longer lasting methods.

Many local authorities have a Single Outcome Agreement (SOA) in place to reduce teenage pregnancies in their areas. As part of performance management of the *Sexual Health and BBV Framework* outcomes, rates of termination and repeat termination and teenage pregnancies will be monitored. Improved provision of contraceptive advice and contraceptive methods will contribute to meeting the Framework outcomes.

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<sup>4</sup> Data currently being developed for maternity outcome indicators, as part of Reducing Antenatal Health Inequalities work.

## Physical Activity

**Action:** To increase opportunities for staff, visitors and patients to be physically active; and to encourage and support staff and patients to be more physically active, including the provision of advice to staff and patients on the importance and benefits of physical activity.

### Outcome:

- NHS staff routinely highlight the importance of physical activity for patients in hospitals as part of their rehabilitation and for prevention of future illness.<sup>5</sup> For example, develop a system of assessing input of physical activity interventions in patient rehabilitation and prevention of future illness, and evidence of physical activity interventions being included in patient pathways; and
- Increased opportunities for staff, patients and visitors to be more physically active are in place (e.g. stair use, walking paths, cycling infrastructure, walking groups, community/therapeutic garden).

### Example in practice:

NHS Forth Valley, Forestry Commission Scotland, Falkirk Council and the Central Scotland Forest Trust are taking a joined up approach to create a health promoting environment which will support and increase physical activity opportunities for staff, patients, visitors and local people within the new Forth Valley hospital grounds.

The partnership has developed a plan which sets out improvements which will radically improve the usability of the hospital grounds for all, including footpaths, signage and an outdoor classroom. Improving access to existing woodlands and greenspace will provide for active recreation, socialising, rehabilitation, relaxation and health improvement activity for staff, patients and visitors alike, with opportunities to develop community engagement and participation programmes based on woodlands and outdoor recreation.

### Policy context

This action will contribute to The Quality Strategy through a person-centred approach creating partnerships between patients, their families, visitors and the wider public and encouraging wider use of the NHS estate.

*Let's Get Scotland More Active (2003)* provides the primary driver for physical activity policy for the Scottish Government and its delivery partners. The goal of the Strategy is to increase and maintain the proportion of physically active people in Scotland. It sets a target of 50% of adults and 80% of children meeting recommended physical activity levels by 2022.

*A Games Legacy for Scotland* states that "We want to inspire the people of Scotland to be more active. To take part in physical activity and sport. To live longer, healthier lives." The Active Legacy will be delivered in partnership with a wide range of public, private and third sector partners, including Health Boards. They will have the potential to make a significant contribution to the success of an *Active Legacy for Scotland*, through engaging both their own employees and the wider community.

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<sup>5</sup> Start Active, Stay Active (July 2011) sets out revised physical activity guidelines for all age groups. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_128209](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128209)

*Safe and Well at Work: Occupational Health and Safety Strategic Framework for NHSScotland* (2011) sets out how NHSScotland Boards should approach occupational health and safety to keep staff motivated and healthy, engaged and safe. It provides a national statement of aims and priorities, together with a clear framework for delivering improvements in the occupational health and safety of NHSScotland staff.

*Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight* sets out 4 main priorities - energy intake, energy expenditure, early years and working lives. In energy expenditure the focus is on integrating physical activity into people's daily lives through changing everyday travel where possible to walking and cycling.

### **Performance measures**

- Evidence of brief interventions for the routine provision of information and advice to patients on physical activity. This should include defined pathways for the delivery of brief advice<sup>6</sup>;
- Plans in place to:
  - i) increase opportunities for staff to be more active e.g. walking groups, active travel information, bike purchase/ training schemes, walking paths, green spaces;
  - ii) increase uptake of opportunities to be more active by staff<sup>7</sup>; and
- Evidence of the use of promotional and motivational posters and other materials to encourage staff and visitors to make more active choices.

### **Performance management context**

Action in relation to physical activity contributes to the National Physical Activity Strategy target that “by 2022 50% of adults and 80% of children will meet the recommended levels.”

In addition, attainment of Gold and Silver Healthy Working Lives Awards require organisations/ workplaces to develop a statement of intent on promoting physical activity. Increased % of activity levels within each NHS Board area to be supported by the evidence base from the Scottish Health Survey and use of the Active Scotland Household Targeting Tool.

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<sup>6</sup> Brief advice describes a short intervention (usually from 30 seconds to 3 minutes) delivered opportunistically in relation to a client's reason for seeking help. It can be used to raise awareness of, and assess a person's willingness to engage in further discussion about healthy lifestyle issues. Brief advice is less in depth and more informal than a brief intervention and usually involves giving information about the importance of behaviour change and simple advice to support behaviour change. Ref; Powell, K and Thurston, M. (2008) “Commissioning training for behaviour change interventions. Guidelines for best practice”

<sup>7</sup> For year 1, Boards should provide a baseline for the first year against which to measure progress.

## Active Travel

**Action:** To encourage staff and visitors to make more active, green travel choices.

**Outcome:** Staff and visitors have increased awareness of the connection between travel choices and health, and have better information about the alternative options available to them.

### Example in practice:

NHS Lothian made a commitment in its Green Travel Plan to try to reduce single occupancy car journeys. Liftshare created a car share scheme which was made available to all NHS Lothian employees. The scheme also offered members to share journeys made by foot, bike and taxi alongside the more traditional car-share service. Besides the obvious economic benefits, staff were able to boost their confidence when walking or cycling with other Tripshare members.

### Policy context

Few factors connect health and sustainability as obviously as travel. Travel choices have a wide range of impacts on the environment and quality of life. NHSScotland's travel policies can influence the behaviour of staff, patients, visitors and suppliers, reduce single occupancy car travel and help reduce social exclusion.

*The Sustainable Development Strategy for NHS Scotland (2009)* provides guidance for NHSScotland bodies on how they can contribute to the sustainable development objectives set by the Scottish Government, and how and where to further improve their sustainability performance. The Strategy explains what needs to be done, how it will be achieved and monitored and who needs to be involved. Active travel contributes directly to one of the Strategy's six priority areas - Transport.

*The Good Corporate Citizen Assessment Model* provides practical advice for all NHSScotland organisations on how to develop sustainable practices through a series of questions relating to all aspects of their organisation, from travel through buildings to community engagement.

The carbon reduction HEAT target for 2011/12 requires *“NHSScotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.”*

### Performance measures<sup>8</sup>

- Evidence that NHS sites have developed and promoted an active travel plan;
- Evidence that NHS Boards have made available promotional material to raise awareness of active travel options e.g. make leaflets available to all staff, patients and visitors; and
- Evidence of initiatives and infrastructure in place to support active travel, such as walking maps, cycle friendly employer, bike purchase/training schemes, stair walking.

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<sup>8</sup> For year 1, Boards should provide a baseline for the first year against which to measure progress.

## Support for NHS Boards

### National

- Ongoing workforce development, leadership, knowledge management and governance work to support person-centred care e.g. NHS Education for Scotland (NES) are developing educational packages that will enable staff to interact effectively with clients, including carrying out holistic person-centred assessments;
- To provide an overview of national support, a **Health Promoting Health Service Portal** has been developed on the Knowledge Network. For more information on training and profession-specific materials and case studies that can be used within the context of these more general person-centred approaches follow: <http://www.knowledge.scot.nhs.uk/home/portals-and-topics/health-improvement/hphs.aspx>
- Further information on training is available through local health improvement teams or on the NHS Health Scotland website - <http://www.healthscotland.com/learning/support-heat/index.aspx>
- The Health Promoting Health Service (HPHS) Network will host a community of practice to share case studies and examples of effective interventions and pathways. The Network is a key resource in accessing and providing practical support on the relevance and effectiveness of public health interventions in hospital settings. Further examples will be developed through the Efficiency and Productivity Framework - Preventative and Early Intervention workstream and as part of The Quality Strategy Effective Ambition work on improving population health;
- The Quality Improvement Hub provides support, education, training and technical expertise in improvement science for NHS staff and combines resources from health boards throughout NHSScotland - <http://www.qihub.scot.nhs.uk/default.aspx>
- The Scottish Centre for Healthy Working Lives provides support for the Healthy Working Lives Awards and network of local staff - <http://www.healthyworkinglives.com/>
- The Person-Centred Delivery Group and the Better Together Patient Experience Programme, now hosted within Healthcare Improvement Scotland, are developing work on PROMS and enablement measures - [http://www.bettertogetherscotland.com/bettertogetherscotland/CCC\\_FirstPage.jsp](http://www.bettertogetherscotland.com/bettertogetherscotland/CCC_FirstPage.jsp)
- Long Term Conditions Alliance Scotland (LTCAS) supports the Self Management Fund and educational resources are developed through a range of community and third sector led projects e.g. Thistle Foundation - <http://www.ltcas.org.uk/>
- The Scottish Grocers' Federation (SGF) provides support and advice for convenience stores undertaking their Healthy Living Programme - <http://scottishshop.org.uk/>
- The Healthy Living Award website provides further information and support for establishments undertaking the Healthy Living Award - <http://www.healthylivingaward.co.uk/>

## **Local**

- Public Health and Health Improvement staff;
- MCNs (particularly those covering heart disease, stroke, diabetes, cancer and respiratory disease);
- Existing improvement expertise developed through current and recent improvement programmes; and
- Patient Focus Public Involvement (PFPI) and Better Together groups.

## Definition of Healthy Vending

The term 'healthy vending' is used in describing the actions that health boards and their food delivery partners, including those in the private and voluntary sectors, are required to take. This annex describes what we mean by the term 'healthy vending'. These criteria are adapted from the Healthyliving Award Plus criteria – see [www.healthylivingaward.co.uk](http://www.healthylivingaward.co.uk) for more details.

The criteria for healthy vending are provided for three types of vending machine:

- a. Drinks vending;
- b. Snack/confectionery vending; and
- c. Refrigerated food vending.

### Drinks Vending

- A drinks vending machine **MUST** contain water, unsweetened fruit juice and/or low-fat milk. These drinks must be prominently positioned, for example, at eye level in glass fronted machines or listed first in product lists.
- All soft drinks within a vending machine must be sugar-free (less than 0.5 grams of sugar per 100ml). Unsweetened fruit juice, drinks made with a combination of fruit juice and water and drinks made with a blend of fruit and/or vegetables are acceptable in addition to soft drinks.

### Snack/confectionery vending

- 'Healthier choices' **MUST** be available as an alternative to standard products. These products must meet the bought-in product specifications for healthier choices.
- At least 30% of the product range must be 'healthier choices'.
- At least one 'healthier choice' must be available for each type of product, for example, crisps and confectionery.
- 'Healthier choice' products must be prominently positioned, for example, at eye level, and should be priced competitively with other products.

### Refrigerated food vending

- 70% of the product range must be 'healthier choices'.
- At least one 'healthier choice' must be available for each type of product.
- 'Healthier choice' products must be prominently positioned and should be priced competitively with other products.

### Healthier Choices

To determine whether a product may be regarded as a 'healthier choice' you should look at the nutrition box on the product label or request the product specification from your supplier and compare the information on the label or product specification with the nutrient specifications below.

There are two sets of specifications. The first set of specifications apply to products which are served in portions of **less than 100 grams**, e.g. a packet of crisps weighing 35 grams.

The second set of specifications apply to foods that are served in larger portion sizes **greater than 100 grams**, for example, an individual portion of lasagne weighing 300 grams, or a tray of cottage pie weighing 1.5kg, which is divided into 6 portions (weighing 250 grams each).

**Nutrient specifications for smaller portion sizes (less than 100 grams)**

<b>Nutrient</b>	<b>Nutrient Must contain less than</b>
Fat	20 grams per 100 grams of product or 10 grams per 100 millilitres (ml)
Saturated fat	5 grams per 100 grams or 2.5 grams per 100 millilitres (ml)
Added sugar (not including sugars from dried fruit or milk)	12.5 grams per 100 grams or 6.3 grams per 100 millilitres (ml)
Salt*	1.5 grams per 100 grams or 1.5 grams per 100 millilitres (ml)
Sodium*	0.5 grams per 100 grams or 0.5 grams per 100 millilitres (ml)

**Nutrient specifications for portion sizes (greater than 100 grams)**

<b>Nutrient</b>	<b>Nutrient Must contain less than</b>
Fat	21 grams per portion
Saturated fat	6 grams per portion
Sugar	15 grams per portion
Salt*	2.4 grams per portion
Sodium*	1 gram per portion

\* Whenever possible you should use bread products that contain less than 1.1 grams salt per 100 grams (0.43 grams sodium per 100 grams), in line with the Food Standards Agency Scotland's voluntary salt reduction targets.

**Nutrient specifications for bought-in, single serve yoghurts**

For example, fruit yoghurt pots. To be regarded as a 'healthier choice', yoghurts must meet the following nutrient specifications:

<b>Nutrient</b>	<b>Nutrient Must contain less than</b>
Fat	3 grams per 100 grams
Sugars(Portion size up to 100 grams)	16 grams per 100 grams
Sugars(Portion size over 100 grams)	18.8 grams per portion