The Scottish Parliament
Pàrlamaid na h-Alba

PUBLIC PETITION NO.	PE01426

Name of petitioner

Donna Scott

Petition title

National Donor Milk Bank Service

Petition summary

Calling on the Scottish Parliament to urge the Scottish Government to ensure equal access to donor breast milk for all premature and sick babies, irrespective of geographical location, by establishing a national donor milk bank service.

Action taken to resolve issues of concern before submitting the petition

Dec 2010 – I contacted MSP Brian Adam after I was told by the Glasgow milk bank that they could not collect donations from out with their local area. He raised this matter in Parliament in Jan 2011 with the Public Health Minister MSP Shona Robison who stated that there were no plans to increase the number of donor milk banks in Scotland.

July 2011 – I contacted MSP Mark McDonald to ask why, when the Toolkit for High Quality Neonatal Services (England and Wales) and the Bliss Baby Charter Standards state that donor breast milk should be available for babies in clinical need, that this same objective is not pursued by the NHS in Scotland. I also asked whether increasing the capacity of the Glasgow milk bank would be more efficient than setting up separate banks around the country. MSP Nicola Sturgeon (Cabinet Secretary for Health) stated again that there were no current plans to increase the number of donor milk banks in Scotland but that the Glasgow milk bank will make milk available to other neonatal units but “this will be dependent on the supply at the time”. NHS Grampian raised the issues of cost and transportation when asked about the feasibility of establishing links with Glasgow.

Oct 2011 – I requested a meeting with MSP Nicola Sturgeon to discuss the issue further. This was felt to be inappropriate at this time due to the establishment of a pilot scheme at Yorkhill which would see Scottish Emergency Rider Volunteer Service (ScotsERVS) collect and transport milk around the GGC area and further afield as requested.

Jan 2012 – Meeting with NHS Grampian, MSP Mark McDonald, Scots ERVS and myself where the issues of lack of access to donor milk on the basis of clinical need in the NHSG area were discussed. NHSG felt establishing its own milk bank was too big a commitment at the time.

Petition background information

The World Health Organisation is quite clear that screened and pasteurised human donor milk ranks above artificial milk alternatives (infant formula) in the hierarchy of feeding choices for low birth weight and premature babies when maternal breast milk is not available. (Arnold, L [2006] 'Global health policies that support the use of banked donor human milk: a human rights issue' International Breastfeeding Journal 2006)

Over 50 000 babies are born in Scotland each year and 11% will spend time in one of the 16 neonatal units around the country. Most are admitted due to low birth weight which is mainly caused by being born prematurely (before 37 weeks gestation). Babies born too soon can face a number of serious health issues. One of the most basic problems is that of feeding. Infants born prematurely lack the ability to feed directly at the breast and mothers must instead express milk so that it can be fed down a nasal-gastric tube. However, as a result of a premature delivery and in many cases the mother's own ill health, not every mother will be able to produce the volumes needed especially in the first few days and supplementation with an alternative to her colostrum and expressed breast milk may be required.

Donor milk is the ‘next best’ option for feeding preterm and low birth weight babies. (Edmond. K, Bahl R. [2006] ' Optimal feeding of low-birth weight babies' Technical Review WHO p.2) Breast milk is "the optimal method of infant feeding" (Infant Feeding Strategy for Scotland 2006) and using artificial formula means that already vulnerable babies will be exposed to increased risks.

Babies fed breast milk are well documented to have a lower incidence of sepsis and other infections such as those of the urinary tract and they are likely to have better cognitive and visual development. (http://www.breastmilkproject.org/docs/Wight.pdf). In particular, necrotising enterocolitis (NEC) is also less likely to occur in babies fed breast milk. NEC is a significant risk for premature babies. The lining of the intestine can become infected and die and parts of the bowel may have to be removed. The condition has an overall mortality rate of around 20% and babies who survive NEC can go on to have continuing long term health complications. (Lucas, A. and Cole, T.J 'Breastmilk and neonatal necrotising enterocolitis' Lancet [1990]:336 1519-23)

However, a growing body of research shows that using donor breast milk rather than formula when maternal milk is not available can prevent NEC from occurring. One study found that NEC was 6-10 times less common in babies fed breast milk alone than in those given infant formula (Lucas, A. and Cole, T.J 'Breastmilk and neonatal necrotising enterocolitis' Lancet [1990]:336 1519-23) and another shows that infants fed donor breast milk were 4 times less likely to develop confirmed cases of NEC than those who received formula milk. (McGuire,W. and Anthony, M.Y.'Donor human milk versus formula for preventing necrotising enterocolitis in preterm infants: systematic review' Arch Dis Child Fetal Neonatal Ed [2003] 88:F11–F14).

In addition, preterm babies fed breast milk can tolerate full enteral (stomach) feeds earlier than those fed formula, which means intravenous drips can be taken out sooner, thus removing potential sites for infection. (Boyd, C.A. et al 'Donor breast milk versus infant formula for preterm infants:systematic review and meta-analysis' . Arch Dis Child Fetal Neonatal Ed [2007];92:F169–75).

Research has also demonstrated that neuro-developmental outcomes can be impaired for low birth weight babies fed formula rather than human milk. This is particularly important as premature babies often experience significant difficulties in this area. (Standing Committee on Nutrition of the British Paediatric Association 'Is breastfeeding beneficial in the UK?' Arch Dis Child [1994] 71:376-80)

Aside from the obvious medical considerations, however, the use of donor milk also has important cost-saving implications for the NHS in Scotland. An intensive care bed in a neonatal unit costs approximately £2000 a day and research shows that a resolved case of NEC extends a hospital stay by approximately two weeks. (Bisquera J, et al 'Impact of Necrotising Enterocolitis on length of stay and hospital charges in very low birth weight babies' Pediatrics [2002] 109: 423-428). Meanwhile, a recent costing statement has concluded that running milk banks in accordance with current NICE guidelines" is unlikely to result in a significant change in resource use in the NHS". http://www.nice.org.uk/nicemedia/live/12811/47504/47504.pdf

Recent recommendations from the Scottish Government published in January 2011 (Improving Maternal and Infant Nutrition: A Framework for Action) also underscore the importance of following the WHO policy of exclusively breastfeeding for the first 6 months of life, pointing out that breastmilk contains a wide range of important bioactive substances that cannot be manufactured for infant formula. The same document also specifically states that the visual and cognitive development of pre-term babies is improved and the risk of necrotising enterocolitis is reduced if they are fed breast milk. http://scotland.gov.uk/Publications/2011/01/13095228/0

Yet in Scotland, only sick and premature babies within the Greater Glasgow and Clyde area have guaranteed access to donor milk as this is the only health authority that runs a donor milk bank. All requests for milk from outwith this area are considered but these requests can only be acted upon once the needs of babies within GGC are met. In other words, a baby born at 27 weeks gestation in Aberdeen and a baby born at 27 weeks gestation in Glasgow may be in equal clinical need, but the baby in Glasgow will get donor milk ahead of the baby in Aberdeen simply because of geographical location. This kind of 'postcode lottery' is unacceptable.

The UN Universal Declaration of Human Rights in 1948 states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care." The Convention on the Rights of the Child (1989) Article 24 declares "the right of the child to the enjoyment of the highest attainable standard of health and to the facilities for the treatment of illness and the rehabilitation of health." Donor milk is therapeutic nutrition for premature babies (Arnold, L [2006] 'Global health policies that support the use of banked donor human milk: a human rights issue' International Breastfeeding Journal 2006) and the fact that 40% of the Scottish population are outwith the service area of the Yorkhill milk bank and thus can only access donor milk when there is a surplus means that NHS Scotland is falling short of globally acknowledged standards.

The Glasgow milk bank has been growing in recent years and in 2011 80 babies were recipients of donor milk, double the number of previous years. Since December 2011, the Glasgow milk bank has also been participating in a pilot project to get donor milk out to areas beyond the GGC boundaries. Issues of transportation are being overcome through the involvement of Scots ERVS. The impact of this new development has meant that the milk bank has had trouble keeping up with demand, as so many units out with Yorkhill are now requesting donor milk.

This expansion clearly demonstrates there is a demand for donor milk among clinicians and parents across Scotland but as the situation stands, babies outwith GGC can still only get donor milk when there is a surplus. In addition, Glasgow is hampered in accepting donations as full screening can only be done at Yorkhill at present so unless a donor is in the position to be able to go to Glasgow in person to have blood tests done, their milk cannot be accepted.

Ultimately, these problems could be solved if the Glasgow milk bank was expanded as a 'hub and spoke' model and funded as a national resource. Milk depots could be set up locally around the country to 'hold' milk for collection and donors could be screened where they live. Scots ERVS could then pick up donations and despatch processed donor milk to neonatal units as it was requested. This would avoid the considerable expense and workload associated with establishing separate milk banks around the country in line with the current NICE guidelines. (http://www.nice.org.uk/nicemedia/pdf/CG93FullGuideline.pdf)

All sick and premature babies in Scotland could then be considered for donor milk provision on the basis of their clinical need, not what hospital they happen to be in at the time. Balancing supply and demand would be more efficiently achieved under a national, appropriately resourced, fully co-ordinating milk bank service, which would also be much better placed to undertake research into donor milk as a preventative treatment for premature babies. (Williams et al [2007] 'Banking for the future: Investing in Human Milk' Archives of Disease in Childhood 92:F158-159)

Other countries display an impressive commitment to milk banking. Sweden has a

population of 9 million but has 28 milk banks. Brazil has a network of over 150 milk banks and collection stations that provide donor milk for over 300 000 premature infants. It is surely the mark of a civilised society that its most vulnerable members are cared for in the best way possible. This makes the inequity of access to donor milk throughout Scotland particularly disappointing. NHS Scotland is clear that breast milk is the optimal feeding choice for term babies. Why should that emphasis not extend to premature babies too?

Unique web address

http://www.scottish.parliament.uk/GettingInvolved/Petitions/PE01426

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