Public Health England

THE BABY FRIENDLY INITIATIVE

unicef UNITED KINGDOM

Commissioning infant feeding services: a toolkit for local authorities (Part 2)

Evidence-based good practice prompts for planning comprehensive breastfeeding support interventions

Foreword

Dame Sally Davies, CMO

Professor Viv Bennett

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About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Foreword

Professor Dame Sally C Davies
Chief Medical Officer

Earlier this year new research was published in the Lancet confirming that breastfeeding saves lives, improves health and cuts healthcare costs in every country, including the UK. Lancet author Professor Cesar Victora uncompromisingly pointed out: “There is a widespread misconception that breastmilk can be replaced with artificial products without detrimental consequences and that the benefits of breastfeeding only relate to poor countries. Nothing could be further from the truth. The importance of tackling this global issue is greater now than ever before.”

Yet despite the overwhelming evidence, the UK has some of the lowest breastfeeding rates in the world: only 34% of babies are receiving any breastmilk at six months compared with 71% in Norway. There are social, cultural and economic barriers which mean that many women are unable to breastfeed successfully despite genuine efforts to do so. This can lead to women experiencing feelings of pain, guilt and anger, and has brought us to a point where conversation about breastfeeding is highly emotive and fraught with accusations of pressure.

Improving breastfeeding rates is not the responsibility of individual women struggling alone in a culture that can be hostile towards breastfeeding – rather this is a public health challenge for which we all share responsibility. We **must** find a way to meet this challenge; failure to invest in breastfeeding leads to poorer health outcomes for children and women today and for generations to come.

We recognise great success in some areas of breastfeeding: peer support, workplace developments and implementation of the Unicef UK Baby Friendly Initiative, and of course the supportive work of health professionals in the NHS. There is of course more to do, and we need to support mothers, families, local authorities and health professionals to ensure that we are doing all we can to give children the best possible start in life.

After wide consultation, Public Health England and Unicef UK have developed this commissioning guidance to provide direction on how to make this a reality. Presented as a toolkit, the guidance is divided into three parts. Part 1, a set of infographics which highlight the key issues; Part 2, details of what success would look like for a commissioner working within their local authority to promote, protect and support breastfeeding; and Part 3, which sets out guidance on effective data collection, monitoring and reporting.

The publication of this commissioning guidance comes just days after the UN Committee on the Rights of the Child expressed specific concern about the extremely low breastfeeding rates in the UK and the alarming numbers of

overweight and obese children. It called on UK governments to promote, protect and support breastfeeding in all policy areas where it has an impact on child health, including obesity. We know that we have made progress in many areas, but there is unquestionably more work to do.

Given the wide-reaching and long-lasting benefits of breastfeeding, we must meet this challenge head on. Supporting mothers to breastfeed ensures that every child has the best start in life. I urge you all to seize this opportunity, read this guidance and consider how best to ensure that more of our babies are breastfed in future.

Professor Dame Sally C Davies, CMO

Professor Viv Bennett
Chief Nurse, Public Health England

There is extensive evidence to show that breastfeeding helps to give babies the best possible start in life. Breastmilk provides optimal nutrition tailored to a baby's unique needs, vital immunity against infection in the early weeks, helps to promote early bonding and emotional attachment and reduces the risk of common illnesses in infancy.

Due to the overwhelming evidence that demonstrates the benefits of breastfeeding, it is a public health priority within Public Health England's Best Start in Life national priority and the focus of one of the six high impact areas in health visiting.

The benefits of breastfeeding are clear. As well as health benefits to mother and baby, increased breastfeeding rates contribute to reducing health inequalities through improved outcomes. Financially, high rates of breastfeeding not only result in savings to family budgets, but also to the public purse due to reduced service costs associated with dealing with health problems which occur more frequently when babies are not breast fed.

Despite these obvious benefits, rates in England remain low. Of particular concern is the number of women who start to breast feed and stop very quickly, often citing lack of support or social embarrassment as reasons why they stopped.
We must therefore focus efforts to ensure that evidence based advice and personalised support is there when women need it. We must also work together to create communities where breastfeeding is welcomed so that women feel comfortable to breastfeed their babies in public.

There are brilliant examples all over the country of how services in a range of settings, from hospitals to community peer-to-peer support, have helped women to continue to breastfeed for as long as they want to. We also know there is more to do to drive rates up and to reduce regional and demographic variation.

Health visitors play an important role in delivering Early Years High Impact Area 3: Breastfeeding. They are specially trained to support families to breastfeed and to get additional help by signposting them to other local services.

We know that local areas welcome support from Public Health England to be able to commission the services that are most effective and which will give most benefit to the families in their area. We have developed this commissioning guide in partnership with Unicef to support the commissioning of evidence-based interventions to improve breastfeeding rates across England. If services work together, with midwives and health visitors leading the way, I know that we can foster a culture which is positive about breastfeeding and where we can help every child to have the best possible start.

Professor Viv Bennett

Professer Kevin Fenton
National Director, Health and Wellbeing

Breastfeeding provides substantial health benefits for mothers and babies which are experienced well beyond the period of breastfeeding itself. The UK government supports World Health Organization recommendations for babies to be exclusively breastfed for around the first six months. UK rates remain stubbornly low, with only 34% of babies receiving any breastmilk at all and only 1% of being exclusively breastfed at six months[1].

PHE remains committed to driving up the rates of breastfeeding across England and I am delighted that we have developed this commissioning resource in partnership with Unicef to support local areas to commission the services responsive to the needs of their local populations.

The overall data belie the vast inequalities that exist across England, where huge regional variation continues, with 92.8% of mothers in Richmond initiating breastfeeding, compared with 46.3% of mothers in Knowsley[2]. Breastfeeding is

[1] www.thelancet.com/series/breastfeeding
[2] www.england.nhs.uk/statistics/statistical-work-areas/maternity-and-breastfeeding

closely related to factors such as socio economic status and ethnicity. Rates are higher amongst black and minority ethnic populations and more affluent localities. Young mothers, mothers from routine and manual professions, mothers who left education early and white mothers are less likely to breastfeed their babies[3].

Mothers' reasons for not initiating breastfeeding are complex and varied, with a number of societal and cultural factors shaping their decision. We know that eight in ten women stop breastfeeding before they want to, saying they feel unsupported to do so or that they feel uncomfortable breastfeeding in public. Evidence shows that breastfeeding support at the right time and in the right place is effective in promoting successful breastfeeding. For some families that may be community based peer or group support whilst others may need more specialist hospital based support.

PHE's ambition is that breastfeeding is seen as normal and supported by everyone. This requires concerted action from across our communities: hospitals, workplaces, schools, parks and other public spaces and businesses to ensure that all women and feel supported to breastfeed wherever and whenever they need to. Working together to realise this ambition will help increase the number of babies who are breastfed, to give them the best possible start.

Professor Kevin Fenton

[3] www.hscic.gov.uk/catalogue/PUB08694/ifs-uk-2010-sum.pdf

Introduction

The Chief Medical Officer's (CMO) reports, 'Our children deserve better' (2013)[1] and 'The Health of the 51%: Women' (2014)[2] highlight worrying trends in low breastfeeding rates in England. They recognise the impact and the importance of improving breastfeeding rates to promote child and maternal health and wellbeing.

The substantial health benefits of breastfeeding for women and babies are experienced well beyond the period of breastfeeding itself. In order to promote breastfeeding, interventions should be delivered in a combination of settings by involving health systems, home, family and the community concurrently. In addition, there needs to be robust data collection, monitoring of services and thorough action planning to ensure continued progress.[3,4,5]

Comprehensive, multifaceted infant feeding interventions, implemented at a local level as part of a strategic partnership approach can increase breastfeeding prevalence, support parents to build a close and loving relationship with their baby and reduce social and health inequality, thereby increasing a child's life chances.[6,7]

Having a comprehensive approach to infant feeding can:

- **cut costs to local public services**

  Commissioning services to increase and sustain breastfeeding would deliver significant cost savings to the NHS and to the local authority. Reducing the incidence of just five illnesses, protected by breastfeeding, would translate into cost savings for the NHS of at least £48 million and tens of thousands fewer hospital admissions and GP consultations.[8,9] The evidence suggests that failure to invest in the early years does not make economic sense; acting early ensures a return on investment and future cost savings. Two examples illustrate this:

  1. Per annum childhood obesity costs for England are estimated to be £51 million and the long term cost of obesity into adulthood £588 to £686 million per annum, rising to £1.9 to £2 billion by 2030.

  2. The annual cost to the public sector in England associated with children born preterm until age 18 is around £1.24 billion. Premature infants who do not receive breastmilk are much more likely to suffer infections, sepsis and necrotising enterocolitis (NEC). Treatment of NEC and sepsis, increased inpatient stay and the lifetime cost of disability in the community is significant and preventable.[10]

- **increase children's life chances**

  Breastfeeding is associated with a higher IQ, translating into improved academic performance, as well as increased long-term earnings and productivity. Not breastfeeding increases a baby's risk of obesity, diabetes, respiratory infections, gastroenteritis, ear infections, tooth decay, allergic disease and sudden infant death syndrome.[11,12,13,14,15]

- **reduce childhood obesity**

  Breastfeeding is associated with a reduction in the prevalence of overweight and obesity and the onset of diabetes in later life.[16] Longer breastfeeding duration has been associated with a 13% reduction in the likelihood of overweight and/or obesity prevalence and a 35% reduction in type-2 diabetes incidence.[17]

  Longer breastfeeding may increase a mother's responsiveness to her infant's feeding cues, suggesting that the mother may show greater awareness of the infant's ability to communicate fullness after the initiation of other foods.[18] As the infant gets older a chronic mismatch of caregiver responsiveness to infant feeding cues has been linked to adverse feeding patterns such as feeding when a child is not hungry, which is linked in turn to overweight and obesity.

- **reduce health inequalities for disadvantaged families**

  Women from low incomes are the least likely to breastfeed, are more likely to have a premature or sick infant and have the worst health and wellbeing outcomes.

  Breastfeeding or providing breastmilk for premature and sick babies improves their short- and long-term health and well-being outcomes, reducing both mortality and morbidity.[19,20,21]

- **improve mother-infant relationships and wellbeing**

  Investing in breastfeeding and relationship building is now recognised as a positive, proactive mechanism to promote mother-infant attachment, improve the mental health and well-being for mother and child and reduce maternal neglect.[22,23,24,25]

- **drive improvement across key measures of population health**

  Increasing breastfeeding prevalence and improving the mother and baby bond will impact on core indicators included in the public health domains identified in "Improving outcomes and supporting transparency: A public health outcomes framework for England."[26] Examples of indicators which would be positively affected include:

  - obesity and type 2 diabetes

- infant mortality and all cause preventable mortality
- sudden infant death syndrome
- breast and ovarian cancer
- hospital admissions for infant infections; respiratory, gastric and ear
- sickness absence for parents due to sick infants
- postnatal depression
- parent-infant relationships
- school readiness

"Breastfeeding is a natural safety net against the worst effects of poverty…exclusive breastfeeding goes a long way towards cancelling out the health difference between being born into poverty or being born into affluence. It is almost as if breastfeeding takes the infant out of poverty for those few vital months in order to give the child a fairer start in life and compensate for the injustices of the world into which it was born."

James P. Grant, Executive Director of UNICEF, 1980 to 1995

Aim of this toolkit

Public Health England (PHE) supports local authorities in the delivery of locally appropriate interventions and services to improve the public's health and the life chances of all children, by providing data, interpretation and evidence. This pack supports a joint strategic needs assessment (JSNA) process and the commissioning of services that protect, promote and support breastfeeding and the development of close and loving relationships. Local authorities, and their partners, are encouraged to provide a comprehensive universal service with access to specialist support when required.

Format

The toolkit is based around 12 principles of good practice. Each statement of principle is drawn from the evidence base around what works best to support infant feeding. Each principle keeps the outcomes for the woman and her child at the centre of care.

Each statement of principle is followed by a vision of what service provision could look like locally if the principle is being met. There are a series of questions for each principle, that can be used as a check list to help you identify if there are any gaps in the service and where you are meeting the principle.

Case studies will follow on the Public Health England and Unicef UK Baby Friendly Initiative websites:

www.gov.uk/government/organisations/public-health-england
www.unicef.org.uk/BabyFriendly

Feedback
This is the first edition of PHE's infant feeding toolkit. It builds on the conversations and feedback from commissioners and other local stakeholders as a resource for reference, and to support investment in breastfeeding and very early child development. We would welcome your feedback as you use the documents.

> **"If breastfeeding did not already exist, someone who invented it today would deserve a dual Nobel Prize in medicine and economics. For while 'breast is best' for lifelong health, it is also excellent economics. Breastfeeding is a child's first inoculation against death, disease, and poverty, but also their most enduring investment in physical, cognitive, and social capacity."**
>
> Keith Hansen, 2016, Lancet Breastfeeding Series

The 12 statements of principle in brief:

1. Local authority public health commissioners work closely with all relevant partners to commission high-quality, evidence-led services that support women to feed their infants and build a close and loving relationship with their babies.
2. All pregnant women are given the opportunity to learn about infant feeding and relationship building.
3. All women have the opportunity for skin to skin contact at birth and throughout the postnatal period. All women are supported to respond to their babies' needs for food and love and are offered ongoing, one to one, practical and skilled help to get breastfeeding off to a good start.
4. All breastfeeding women are supported to learn how to breastfeed responsively and how to hand express their breastmilk. Parents are supported to understand a newborn baby's needs for closeness and comfort.
5. Women are enabled to continue to breastfeed for as long as they wish, and when required specialist support is available. Women are welcomed to breastfeed in their communities and are supported to continue to breastfeed when out and about.
6. Women who breastfeed are provided with information and support to enable them to maximise the amount of breastmilk their baby receives. Parents are supported to introduce their baby to solid food in ways which support optimal health and development.
7. All women are equipped with the knowledge to be able to plan their return to work whilst breastfeeding, and businesses, shops and public premises within the local authority welcome breastfeeding women.
8. When babies are not breastfed, care is provided to ensure that parents are enabled to formula feed as safely as possible. Women's decisions are respected, and parents are supported to feed their baby responsively and to build close and loving relationships.
9. Links are made to promote, protect and support breastfeeding in all policy areas where breastfeeding has an impact.
10. The local authority monitors and reports investment on services to support, promote and protect breastfeeding.
11. All public services ensure that there is no promotion of breastmilk substitutes, bottles, teats or dummies in any of their facilities or by any of their staff, so that breastfeeding is protected and parents receive unbiased information to support their decisions.
12. Commissioning considers the environmental as well as social and economic cost benefits to the community.

Commissioning principles for comprehensive breastfeeding support

Statement of principle 1

Local authority public health commissioners work closely with all relevant partners to commission high-quality, evidence-led services that support women to breastfeed their infants and build a close and loving relationship with their babies irrespective of method of feeding, and protect women and families from the harmful marketing of breastmilk substitutes.

What will you see locally if you are meeting this principle?

Effective, integrated commissioning of services that achieve positive outcomes for women, their infants, their family and the community by:

- having well-functioning partnerships between local authority-led public health, health and wellbeing boards (HWB), NHS clinical commissioning groups (CCGs), NHS England local area teams (LATs), maternity and neonatal services, health visiting teams and children's services
- operating transparently according to assessed need
- bringing partner agencies and service providers together into cost-effective delivery systems
- fully involving service users and local communities in every level of planning, monitoring and evaluation of services, including mother to mother breastfeeding support groups, breastfeeding peer supporters, voluntary organisations and children's centres[27]
- all staff in contact with mothers, babies and their families have the appropriate knowledge, skills and education to enable them to: support all parents to build a relationship with their baby, promote, protect and support breastfeeding, and as appropriate help parents when using other forms of infant feeding.

What questions should you ask to check that you are following the evidence and best practice that supports this principle?

1.1 Embedding in local systems.

1.1.1 Does the maternity strategy, children's services strategy, the local authority commissioning strategy, CCG commissioning strategy, and the joint health and wellbeing strategy (JHWS) demonstrate an explicit link between the evidence of need for breastfeeding support and service planning?

1.1.2 Do we have suitable mechanisms in place within the local public health structure to ensure breastfeeding prevalence is reported to the Health and Wellbeing board?

1.1.3 Do those responsible for commissioning breastfeeding services have established partnership arrangements in place with the CCGs, local clinical

networks (Regional Infant Feeding Network and Neonatal Network), and NHS England LATs? Is there a formal strategic partnership in place for infant feeding support involving key stakeholders and agencies (maternity and neonatal, public health, children's services and voluntary organisations)?[28,29,30,31]

1.1.4 Are these partnerships set up with a fully integrated and comprehensive strategy that aims to promote, protect and support breastfeeding, reduce the harm and inequalities caused by formula feeding and that advocates for increasing breastfeeding prevalence?

1.1.5 Have the leadership and strategic partners undertaken a self-assessment to enable you to:

- evaluate your local action on breastfeeding protection, promotion and support?
- ensure that local activity follows the latest evidence-based practice?
- identify priority areas for development?

1.1.6 Have strategic partner organisations acknowledged their responsibilities under the Healthy Child Programme[32] and Public Health Outcomes Framework[33] (PHOF) to promote and monitor breastfeeding initiation and prevalence?

1.1.7 Is there a plan in place to ensure the workforce has the knowledge, skills and education to implement the local infant feeding strategy? This includes the commissioners, early years leads, nursery nurses, midwives, health visitors, children centre staff etc.

1.1.8 Is information readily available to the general public, health care professionals and partner agencies, including the voluntary sector, that promotes understanding of breastfeeding services, how they can be accessed and how women and families can be referred to them for support?

1.2 Needs assessment (*see also Part 3: Monitoring Data):

1.2.1 Does the local JSNA include a section on infant feeding that reflects need across the whole spectrum for promoting, protecting and supporting breastfeeding to reduce inequalities of health and wellbeing outcomes, and acknowledge the impact of this across the PHOF and NHSOF through partnership, collaboration and support?

1.2.2 Is there a shared understanding of the local level of demand and need, based on a range of local and national data across a range of public services?

1.2.3 Is local data on breastfeeding provided within maternity and neonatal services and primary health care settings collected and analysed to inform needs assessment?

1.2.4 Does analysis of re-admissions of both breastfed and formula fed infants to hospital inform the targeting of interventions locally?

1.2.5 Do commissioners analyse and monitor local breastfeeding data so that service provision can be aligned with need?

1.2.6 Does the needs assessment build on the social capital of the local population to develop existing community services such as peer to peer

support and breastfeeding drop-ins to develop local assets and build a sustainable breastfeeding community?

1.2.7 Are the following fully identified:

a. Leadership with sufficient knowledge and skills to take this agenda forward.

b. An infant feeding strategy that describes how best to meet local need, with action planning that:

- has identified gaps in breastfeeding support services across all partner agencies and plans to overcome this
- has identified existing strengths and ways in which services can be commissioned to maximise positive outcomes
- has identified finances and resources available
- ensures the equity of access to breastfeeding services for key populations with lower prevalence of breastfeeding such as white, low income women, teenage pregnant women and those who have not breastfed before
- identifies the impact of how higher breastfeeding prevalence locally will impact infant and maternal morbidity and mortality, hospital admissions, length of stay and social care activity?

c. A plan in place to ensure the workforce has the knowledge, skills and education to implement the local infant feeding strategy? This includes the commissioners; early years leads; nursery nurses; midwives; health visitors; children centre staff etc.

1.3 Effective commissioning:

1.3.1 Do interventions commissioned follow evidence-based guidelines such as those outlined in NICE guidance, the Healthy Child Programme and the Chief Medical Officer's Report?

1.3.2 Do contracts for commissioned services specify key performance indicators and are these regularly monitored and reviewed?

1.3.3 Are interventions and services geographically and socio-culturally appropriate to those for whom they are designed?

1.3.4 Have commissioning functions undergone a review of their fitness for purpose?

1.3.5 Is there sufficient breastfeeding commissioning capacity and expertise?

1.3.6 Does formal evaluation of the range of breastfeeding support services feature within the commissioning strategy?

Supporting women to understand the importance of infant feeding and relationship building in the antenatal period

Statement of principle 2

All pregnant women are given the opportunity to learn about infant feeding and relationship building.

What will you see locally if you are meeting this principle?

- pregnant women recognise the importance of early relationships and breastfeeding on the health and well-being of their baby[34]
- pregnant women report having a meaningful conversation with a midwife in the antenatal period about infant feeding and getting to know their baby[35,36]
- all women are offered opportunities for participant-led antenatal classes, including breastfeeding workshops, and these will be interactive, tailored to the needs of individuals and learner-centred[37]
- all pregnant women are offered a health visitor visit in the home at 28 weeks and this will include discussions around attachment and infant feeding[38]
- services are promoted locally to raise awareness of the support available, including peer to peer support[39]
- there are clear and efficient referral pathways embedded in midwifery and health visiting services to support women with special needs in order to get breastfeeding off to a good start[40]
- all required monitoring data is reported to the NHS Digital (formally Health and Social Care Information Centre) through the quarterly reporting system

What questions should you ask to check that you are following the evidence and best practice that supports this principle?

2.1 Is the service design and delivery informed by the latest evidence base summarised in the NICE guidance, the Healthy Child Programme, Health Visiting Service specification and Unicef UK Baby Friendly Initiative?

2.2 Have all midwives and health visitors been trained to a recognised, externally evaluated programme (such as the Baby Friendly Initiative) that supports women to breastfeed effectively and build a relationship with their baby?

2.3 Can services provide support for women who have special needs such as obesity or planned caesarean section?

2.4 Do women know how to access local support services such as antenatal classes, peer support groups, breastfeeding drop-ins etc.?
2.5 Do women who are least likely to breastfeed receive the one to one, proactive support they need to understand the importance of infant feeding choices eg teenage women, women from lower socio economic groups, first time mothers?
2.6 Are services required to demonstrate how they meet women's needs in the local area, to the public and to health professionals, including appropriate policies and referral pathways?
2.7 Are services audited to assess the number of women reached, how effective the intervention is and if the service is evaluated and an action plan in place?

"Information should be given in a form that is easy to understand and accessible to pregnant women with additional needs, such as physical, sensory or learning disabilities, and to pregnant women who do not speak or read English."

NICE, CG62, 2016

Getting breastfeeding and relationships off to a good start: skin to skin and responsive feeding

Statement of principle 3

All women have the opportunity for unrestricted skin to skin contact at birth and throughout the first feed, irrespective of feeding type. Where women and babies are separated, skin to skin is offered as soon as possible. All women are supported to respond to their babies' needs for food and love and are offered ongoing, one to one, practical and skilled help to get breastfeeding off to a good start. Skin contact is encouraged throughout the postnatal period.

What will you see locally if you are meeting this principle?

- women report that they were able to have prolonged skin to skin contact after birth in an unhurried environment for as long as they wished and that support to initiate breastfeeding was provided
- more women are choosing to initiate breastfeeding at birth

- parents know how to start building a close and loving relationship with their baby and understand how on-going skin to skin and breastfeeding can support this[41]
- parents who are separated from their baby report that they were offered skin to skin contact when appropriate and that support was given to help the mother initiate her lactation as soon as possible after birth

What questions should you ask to check that you are following the evidence and best practice that supports this principle?

3.1 Does the local maternity service audit immediate post birth practices (eg using the Unicef UK Baby Friendly Initiative maternity audit tool or similar) and create robust action plans to address any weaknesses in their service?
3.2 Is breastfeeding initiation data collected, collated and reported to the local authority?
3.3 Is data collected for use of breastmilk for sick and premature infants?
3.4 Do sick or premature infants have access to donor breastmilk if needed?[42]
3.5 Has the local maternity and neonatal acute service achieved Unicef UK Baby Friendly Initiative accreditation and how is this being sustained? If not, how far are they on the process to full accreditation?
3.6 Is there a clear pathway of care across services that is utilised and ensures that all women have equal access to infant feeding support?
3.7 Does the local authority monitor the Care Quality Commission triannual report on local maternity services to ensure that local women's needs are being met within the acute services? How do the outcomes feed into local action plans?

Supporting breastfeeding and relationship building in the early days

Statement of principle 4

All breastfeeding women are supported to learn how to position and attach their baby for breastfeeding and how to hand express their breastmilk. They understand how to feed their baby responsively (including as a means of comforting and calming babies) and how to recognise that breastfeeding is going well. Parents are supported to understand a newborn baby's needs for closeness and comfort.

What will you see locally if you are meeting this principle?

- women are offered proactive, ongoing, practical, face to face breastfeeding support within 48 hours of giving birth. When they are transferred home from hospital after birth they know how to access further support if required[43] eg through the Midwife or Health Visitor, National Breastfeeding

Helpline44, local breastfeeding support services, peer to peer support workers etc

- women who are separated from their infant know how to express, store and transport their breastmilk
- in the early days the midwife and health visitor carry out regular breastfeeding assessments with the mother to help her to recognise when feeding is going well and when extra support is required

What questions should you ask to check that you are following the evidence and best practice that supports this principle?

4.1 Does the local maternity service audit support given with breastfeeding in hospital and via their community midwives (eg using the Unicef UK Baby Friendly Initiative maternity audit tool or similar) and create robust action plans to address any weaknesses in their service?

4.2 Does the local health visiting service audit support given at the new birth visit (eg using the Baby Friendly Initiative health visiting audit tool or similar) and create robust action plans to address any weaknesses in their service?

4.3 Do women know how to access support when challenges occur? Do you have evidence that interventions are being delivered and are meeting need?

4.4 Are women who are separated from their baby supported to express their breastmilk effectively and to start breastfeeding when this is possible? Is local data collected on breastfeeding prevalence at five to ten days? How does this inform breastfeeding 'drop off' rates? Is this data used to analyse how services can be developed to support women to continue to breastfeed, particularly those least likely to succeed?

4.5 Is infant feeding data collected by the health visitor at the new-birth visit? How is this information utilised to inform development of the service and to help women to maximise the amount of breastmilk the baby receives, keeping breastfeeding going?

Keeping breastfeeding going

Statement of principle 5

Women are enabled to continue to breastfeed for as long as they wish. Social support and help with difficulties are available according to need. Women requiring more specialist support have access to this. Women feel welcome to breastfeed in their communities and are supported to continue to breastfeed when out and about.

What will you see locally if you are meeting this principle?

- women have access to social support in their local communities and there is access to effective help when challenges occur
- women are supported to breastfeed out and about in their community

What questions should you ask to check that you are following the evidence and best practice that supports this principle?

5.1 What face to face services are available within the community to help women to continue breastfeeding? eg from the health visiting service, via peer to peer support, breastfeeding drop-ins, breastfeeding cafes etc.

5.2 How are breastfeeding support services audited in the local community? eg is attendance and satisfaction with the service audited by mothers, and if it is not working is it decommissioned and a more appropriate service developed to meet local need?

5.3 Are services available which provide social support and help with common breastfeeding challenges?

5.4 Is there a specialist service available to support women with more complex breastfeeding problems?

5.5 Has the local health visiting and children's centre service achieved Unicef UK Baby Friendly Initiative accreditation and how is this being sustained? If not, how far are they on the process to full accreditation?

5.6 Is local data collected on breastfeeding prevalence at six to eight weeks and reported nationally in line with the requirements of the LGA's Children's Improvement Board and PHOF? (*see also Part 3: Monitoring Data)

5.7 Is data used to inform how services can be developed to support women to keep breastfeeding going and reduce breastfeeding 'drop off' rates?

5.8 How is data collated, reported and evaluated from the specialist service eg has the service helped to reduce the number of infants readmitted to hospital?

> **"Children who are breastfed for longer periods have lower morbidity and mortality, fewer dental malocclusions, and higher intelligence than those that are breastfed for shorter periods, or not breastfed. This inequality persists until later in life. Growing evidence also suggests that breastfeeding might protect against overweight and diabetes in later life."**
>
> **Victora et al, Lancet Breastfeeding series, 2016**

Maximising breastmilk and introducing solid food

The nutritional needs of a healthy term infant can be met by exclusive breastfeeding for the first six months[45] and thereafter with other foods for around two years or as long as the mother and baby choose. Rather like their readiness to walk and talk, infants become physiologically ready to take other foods and this occurs at around six months. Optimal breastfeeding and complementary feeding practices save lives, reduce obesity, and increase life chances for all children. Helping all parents, breast, formula or mixed feeding, respond to their baby's needs for other foods, will enable them to feel confident as they begin to introduce a variety of foods into their baby's diet.

Statement of principle 6

Women who breastfeed are provided with information and support to enable them to maximise the amount of breastmilk their baby receives. Parents are supported to introduce their baby to solid food in ways which support optimal health and development.

What will you see locally if you are meeting this principle?

- women continue to breastfeed for as long as they wish and introduce other foods in a timely manner alongside breastfeeding in order to optimise the babies' health and wellbeing
- parents are responsive to their baby's changing developmental abilities and needs and have access to information and support about introducing other foods into the baby's diet[46]

What questions should you ask to check that you arefollowing the evidence and best practice that supports this principle?

6.1 Do front line staff members collect data about when solid foods are introduced and on breastfeeding prevalence at six months? Is this data used to analyse how services can be developed to support women to keep breastfeeding going?

6.2 Are there classes (or other equivalent education) that provide information and practical support available for parents to learn about introducing solid food? Where are they held? Is there good attendance? Do women from all social groups attend? How are these services monitored and evaluated? Are these services free from commercial interest?

6.3 How are parents who do not access information supported as to how/when to introduce other foods?

6.4 How are, for example, children's centres, nursery staff or troubled family teams trained to support women to breastfeed, introduce solids and continue to breastfeed alongside other foods?
6.5 Has consultation with appropriate stakeholders, including service user groups, influenced the design of the services?

Breastfeeding when out and about and when returning to work

> **The Equality Act 2010 has specifically clarified that it is unlawful for a business to discriminate against a woman because she is breastfeeding a child."**
>
> **The Equality Act, 2010[47]**

Statement of principle 7

All women are equipped with the knowledge to be able to plan their return to work whilst breastfeeding[48], and businesses, shops and public premises within the local authority welcome breastfeeding women.[49]

What will you see locally if you are meeting this principle?

Before they go on maternity leave, pregnant women have the opportunity to discuss breastfeeding and caring for their baby with their employer on return to work. Women will know:

- to give their employer written notification that she is breastfeeding before she returns to work
- that workplace regulations require that breastfeeding employees are provided with suitable facilities to rest
- the Health and Safety Executive (HSE)[50] recommends that it is good practice for employers to provide a private, healthy and safe environment for breastfeeding mothers to express and store milk
- which local premises welcome breastfeeding mothers

What questions should you ask to check that you are following the evidence and best practice that supports this principle?

7.1 Is there support for breastfeeding established in local workplace wellbeing initiatives?
7.2 Are there established channels of communication between local breastfeeding support services and local employers?
7.3 Do women in the local authority report that the social barriers to breastfeeding in their local community are improving eg they feel welcome

to breastfeed out and about, in public places, parks, cafes, sports centres, cinemas etc? How is this monitored and evaluated? When barriers are identified what actions are put in place to overcome them?

7.4 Do women know how to access support and information on returning to work whilst breastfeeding? How is this made publically available to all women?

7.5 Are employees routinely provided with information on returning to work whilst breastfeeding? Are staff allowed time off to breastfeed?

7.6 Are public sector breastfeeding policies an exemplar to other local employers? Are your breastfeeding policies regularly reviewed and updated?

7.7 Is there a mechanism within the local authority where women could seek advice and support about breastfeeding in the community and/or returning to work eg via the Citizens Advice Bureau?

7.8 How are authorised local nursery and child care staff trained and monitored to support women to breastfeed and/or the baby to receive expressed breastmilk or a combination of breast and formula milk?

7.9 Do local councils, local shops, public spaces, schools, parks and play areas etc. welcome breastfeeding women?

"Women are not getting the support they need to breastfeed. Success in breastfeeding is the collective responsibility of society, not the sole responsibility of a woman."

Lancet Breastfeeding series, 2016

Maximising outcomes when babies are not breastfed

Many women today grow up in a bottle feeding environment, where families have been formula feeding for three or four generations. Women growing up in an environment that is hostile to breastfeeding are unlikely to choose to breastfeed without support. 31% of women are giving their infants formula at birth, 52% at one week and this rises to 73% at 6 weeks.[51]

Statement of Principle 8

When babies are not breastfed, care is provided to ensure that parents are enabled to formula feed as safely as possible. Women's decisions are respected, even when this is contrary to the views of the healthcare professional.[52] Parents are supported to feed their baby responsively and to build close and loving relationships.

What will you see locally if you are meeting this principle?

- parents who formula feed report feeling supported in their decision and understand how to formula feed safely[53]
- parents understand that it is possible to over-feed a formula fed baby and know how to respond to their baby's feeding cues, recognising when their baby has had enough milk
- parents know not to add alternative foods into the bottle, including drinks containing sugar that can cause dental caries[54]
- parents know how to start building a close and loving relationship with their baby and understand how on-going skin to skin contact and limiting the number of care givers feeding the baby can encourage this[55]

What questions should you ask to check that you are following the evidence and best practice that supports this principle?

8.1 Does the local maternity and health visiting service audit support given to bottle feeding parents (eg using the Unicef UK Baby Friendly Initiative audit tools or similar) and create robust action plans to address any weaknesses in their service?

8.2 Is local data collected about the number of infants exclusively formula fed and those mixed feeding, formula and breastmilk?

8.3 Have the local maternity, neonatal, health visiting and children's centre services achieved Unicef UK Baby Friendly Initiative accreditation and how is this being sustained? If not, how far are they on the process to full accreditation?

8.4 Is accurate and effective information which is free from commercial interest (eg information from the Department of Health, Unicef UK or First Steps Nutrition) provided for all parents on how to feed their baby, how to prepare feeds and what milks to use? Do front line staff, in all settings, receive training on formula feeding eg how to make up feeds, how not to over feed baby and how to formula feed responsively?

8.5 Does the local authority have a reporting mechanism in place to protect the safety of the baby should a contraindication to a formula feed arise?

"There is a widespread misconception that breastmilk can be replaced with artificial products without detrimental consequences and that the benefits of breastfeeding only relate to poor countries. Nothing could be further from the truth"

Professor César Victora, Lancet author, 2016

Reducing obesity and improving a child's life chances: supporting breastfeeding areas in all relevant policy areas

Statement of principle 9
Links are made to promote, protect and support breastfeeding in all policy areas where breastfeeding has an impact.

What will you see locally if you are meeting this principle?

Evidence-based infant feeding practices are promoted and supported in local authority Children and Young People (CYP) plans: policy, strategy and guidance in all areas where infant feeding has an impact, including:

- an obesity strategy [56]
- diabetes care pathways [57]
- cancer reduction[58]
- teenage pregnancy[59]
- maternity and neonatal service specification[60]
- National Health Visiting Core Service Specification[61]
- neonatal mortality and morbidity reduction[62]
- maternal and child perinatal mental health wellbeing plans[63]
- emotional attachment development plans[64]
- parenting and relationship building strategy[26]
- oral health[65]
- school readiness plans[66] health and social inequality inclusion[67]
- workplace wellbeing plans[68]
- environmental sustainability community organisation[69]

What questions should you ask to check that you are following the evidence and best practice that supports this principle?

9.1 Do interventions commissioned for breastfeeding support take an evidence-based approach such as that outlined in NICE guidance?
9.2 Do those responsible for 'other' policy areas know how to contact the CYP team for information and support on how to link their own area to the importance of infant feeding?
9.3 Is there a mechanism for mapping infant feeding in each area and identifying any gaps?
9.4 Is there an action plan in place, with enough authority, an effective timeline and reporting structure, to ensure that infant feeding is incorporated across the CYP framework?

Return on investment

Recent research demonstrates that moderate increases in breastfeeding, by preventing just five illnesses resulting from formula feeding, would translate into cost savings for the NHS of £48 million and tens of thousands fewer hospital admissions and GP consultations per year.[70,71,72]

Statement of principle 10

The local authority monitors investment on services to support, promote and protect breastfeeding. This information is reported to the Health and Wellbeing Board/Local Government Association's (LGA) Children's Improvement Board (or equivalent) to inform future planning and investment, and also to decide where services may need to be de-commissioned, and new evidence-based interventions introduced.

What will you see locally if you are meeting this principle?

Investment in services, training and capacity building having a positive and measurable impact on outcomes over specified periods, including:

- ongoing evaluation that breastfeeding support services remain rooted in the direct experiences of local women and their families and continue to meet local need
- successful breastfeeding interventions are delivered to vulnerable populations and those identified as at risk in the JSNA
- data reporting of breastfeeding prevalence rates, hospital admissions and childhood illness related to infant feeding is monitored and reported to NHS Digital (formally Health and Social Care Information Centre) through the quarterly reporting system. *(*see also Part 3: Monitoring Data).

What questions should you ask to check that you are following the evidence and best practice that supports this principle?

10.1 Is investment commensurate with the level of identified need and sufficient for the range of services required to protect, promote and support breastfeeding?
10.2 Can commissioners identify the total level of local investment by all partners who contribute to delivery?
10.3 Have the partners identified the potential return on investment for funding breastfeeding interventions and does this include the economics to be achieved by the commissioning local activity?
10.4 Are reliable cost-effective data tools used to inform commissioning decisions and ensure that investment in breastfeeding is based on an understanding of expenditure, performance and effectiveness?

> **"If breastfeeding rates increased so that 45% of women exclusively breastfed for four months, and 75% of babies were breastfed at discharge from hospital, it has been estimated that more than £17 million in treatment costs could be saved in the UK each year."**
>
> **Advice to LAs in delivery of mandated HV reviews, DH, 2015.**

Tackling the promotion of breastmilk substitutes

The breastmilk substitute industry is large and growing, and its marketing undermines breastfeeding and parents' ability to make informed decisions regarding how they feed and care for their baby, free from the influence of commercial interests.[73,74]

Statement of principle 11

All health, social care and education settings ensure that there is no promotion of breastmilk substitutes, bottles, teats or dummies in any of their facilities or by any of their staff, so that breastfeeding is protected and parents receive unbiased information to support their decisions.

"The UK has the lowest breastfeeding rates in the world and the 11th largest formula industry in the world, predicted to be worth $907million by 2019."

Lancet Breastfeeding series, 2016

What will you see locally if you are meeting this principle?

- breastmilk substitutes, bottles and teats are not promoted through any form of advertising in public settings, or by the staff who work there. This means that there is no direct or indirect promotion such as the use of resources produced by formula milk companies or acceptance of support from formula companies to attend training or events
- all staff aim to work within the International Code of Marketing of Breastmilk substitutes (the Code) and subsequent WHO resolutions.[75,76]

What questions should you ask to check that you are following the evidence and best practice that supports this principle?

11.1 Is there a written statement signed by the head of each service that confirms that the facility is committed to working within the Code and resolutions?

11.2 Are there systems in place to monitor that there is no advertising of breastmilk substitutes, bottles, teats or dummies anywhere in services or by any of the staff?

11.3 Do staff have access to unbiased, evidence-based, information about breastmilk substitutes to share with parents who are formula feeding, such as information published by the Department of Health, Unicef UK and the First Steps NutritionTrust?[77]

Sustainability

Breastfeeding is eco-friendly and therefore sustainable. It requires no packaging, shipping or disposal, no landfill from plastic, paper and metals or production costs used in formulas.[78]

Statement of principle 12

Commissioning considers the environmental as well as social and economic costs benefits to the community.

What will you see locally if you are meeting this principle?

- increasing breastfeeding prevalence in the local authority helps to build a more environmentally sustainable community
- the local authority environmental department will work with the Public Health team to incorporate breastfeeding promotion into their strategy

What questions should you ask to check that you are following the evidence and best practice that supports this principle?

12.1 What links have been made with the environmental team, and how are they working to develop an action plan on how best they can be part of the community that collectively supports women to breastfeed?

Appendix 1: useful information

- local authority services are required to work closely with the NHS to develop and integrate their five year Sustainability and Transformation Plan (STP) 2016/17-2020/21, that reflects locally agreed health and wellbeing strategies, specifically in relation to prevention[79]

- commissioning children's public health services is now the responsibility of the local authority: six where health visitors have the most impact on the health and wellbeing of children aged nought to five have been identified. This includes breastfeeding initiation and prevalence and forms part of the Guidance to support the commissioning of the Health Child Programme.[80] The health visitor health review at six to eight weeks is currently mandated[81,82] which includes breastfeeding support and data collection[83]

- the Local Government Association report: Our ambition for children and young people, 2014[84, 85], identifies breastfeeding as a key area to improving a child's start in life, as part of the high level ambition for all children to be healthy, happy and free from poverty

- effective local commissioning which creates a better place can result in new ways of delivering outcomes; stronger partnerships between the voluntary and community sector; improved and more coherent services; joint assessment of local need; economies of scale and better engagement with citizens, who share assets, take more control over their lives and increase their social capital by supporting each other[86]

- the Public Service Transformation Network (2015)[87] identifies five tips for working with places to co-design service reforms:

1. **Trust** if you build a good trust relationship wonderful things can take place
2. **Flexibility** learn to be comfortable with some degree of ambiguity and uncertainty
3. **Honesty** be honest about what you can and cannot deliver
4. **Clarity** be clear about what your collaboration needs to achieve
5. **Sustainability** use your networks to build supportive alliances and identify champions

Appendix 2: Useful resources

NB: This list is by no means exhaustive – please add your own contacts to the list

Association of Breastfeeding Mothers (ABM)
A voluntary organisation of mothers experienced in breastfeeding counselling.
www.abm.me.uk

Baby Milk Action
Information on the International Code of Marketing of Breast-milk Substitutes.
www.babymilkaction.org

Best Beginnings
A charity that developed the DVDs from 'From Bump to Breastfeeding' and 'Small Wonders' and Baby Buddy App.
www.bestbeginnings.org.uk

Breastfeeding Network (BfN)
Aims to be an independent source of support and information for breastfeeding women and those involved in their care.
www.breastfeedingnetwork.org.uk

First Steps Nutrition
Provides independent information on Infant milks in the UK and early years nutrition.
www.firststepsnutrition.org

Healthy Start
A UK-wide government scheme to improve the health of low-income pregnant women and families on benefits and tax credits.
www.healthystart.nhs.uk

ISIS Infant Sleep Information Source
Information for parents and carers supported by Durham University, UNICEF, LLL and the NCT.
www.isisonline.org.uk

Lactation Consultants of Great Britain (LCGB)
Professional organisation for qualified lactation consultants that specialises in promoting, protecting and supporting lactation issues.
www.lcgb.org

Drugs in Breastmilk
The drugline is run by a qualified pharmacist who is also a BfN Registered Breastfeeding Supporter. The service is open to mothers and professionals.
www.breastfeedingnetwork.org.uk/detailed-information/drugs-in-breastmilk

La Leche League GB
The LLL aims to help mothers to breastfeed through mother-to-mother support, and education, and to promote a better understanding of breastfeeding.
www.laleche.org.uk

National Breastfeeding Helpline
Provides confidential, non-judgmental, independent, evidence-based information and support to women and families on breastfeeding through telephone and web chat. 0300 100 0212
www.nationalbreastfeedinghelpline.org.uk

NCT (National Childbirth Trust)
The NCT is the largest charity providing information for parents in the UK: antenatal classes, postnatal, breastfeeding and parenting support.
www.nct.org.uk

Maternity Action
Specialist resources on the law relating to breastfeeding on return to work and breastfeeding when out and about.
http://www.maternityaction.org.uk/

Unicef UK Baby Friendly Initiative
The UK Baby Friendly Initiative is based on a global accreditation programme of UNICEF and the World Health Organization. It is designed to support breastfeeding and parent-infant relationships by working with public services to improve standards of care.
www.unicef.org.uk/babyfriendly

Professional groups

Community Practitioners and Health Visitors Association CPHVA/Unite the Union
www.unitetheunion.org/how-we-help/list-of-sectors/healthsector/healthsectoryourprofession/cphva

Royal College of Midwives RCM
www.rcm.org.uk

Royal College of GPs
www.rcgp.org.uk

Institute of Health Visiting iHV
http://ihv.org.uk/

The National Infant Feeding Network (NIFN)
www.unicef.org.uk/BabyFriendly/Health-Professionals/Infant-feeding-networks

Royal College of Paediatrics and Child Health RCPCH
www.rcpch.ac.uk

Other Information

The Birth Charter for Women in Prisons in England and Wales
www.birthcompanions.org.uk/Birth-Charter

Evaluation of Breastfeeding Network Evaluation of the peer support schemes in England and Scotland
www.breastfeedingnetwork.org.uk/wp-content/uploads/2016/06/BfN-Blake-Stevenson-Evaluation-report-V5-1Apr.pdf

The evidence and rationale for the Unicef UK Baby Friendly Initiative standards
www.unicef.org.uk/BabyFriendly/Resources/Guidance-for-Health-Professionals/Writing-policies-and-guidelines/The-evidence-and-rationale-for-the-UNICEF-UK-Baby-Friendly-Initiative-standards/

Information for Food Banks: Supporting pregnant women and families with infants
www.babyfeedinglawgroup.org.uk/foodbankstoolkit
www.unicef.org.uk/Documents/Baby_Friendly/Statements/UNICEF_UK_Baby_Friendly_Initiative_Statement_Food_Banks_April_2014.pdf

Interim guidance on current European refuge crisis — applied to a formula feeding population in Europe
www.ennonline.net/interimconsiderationsiycftransit

E-alerts

ChiMat Knowledge Update
A weekly eBulletin highlighting the latest resources added to the ChiMat knowledge hub and covering all aspects of children's, young people's and maternal health.
www.chimat.org.uk

Children, Families and Maternity bulletin
(Department of Health)
Provides updates about policy, publications or
other relevant developments to anyone with an interest in the policy area of children and maternity health care.
http://bit.ly/18OTIpy

Unicef UK Baby Friendly News and Research
Regular updates about Baby Friendly activities and the latest information on infant feeding and very early childhood development.
www.unicef.org.uk/Signup/Subscriptions

Useful NICE guidance

- NICE (2010) Neonatal specialist care (QS4)
- NICE (2014) NICE Public Health Guidance 11: Improving the nutrition of pregnant and breastfeeding women and children in low-income households (PH11) Maternal and child nutrition (QS98)
- NICE (2015) Postnatal Care up to eight weeks after birth (CG37) (QS37)
- NICE (2016) Antenatal care for uncomplicated pregnancies. (CG62),
- NICE (2015) Antenatal and postnatal mental health: clinical management and service guidance (CG192) (QS115)
- NICE (2015) Diabetes in pregnancy: management from preconception to the postnatal period (NG3)

Quick guide to useful current evidence (see full reference list for further details):

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- Baby_Friendly/Guidance/guide_int_code_health_professionals.pdf
- Unicef (2012) The evidence and rationale for the Unicef UK Baby Friendly Initiative standards www.unicef.org.uk/Documents/Baby_Friendly/Research/baby_friendly_evidence_rationale.pdf

Some useful Twitter handles:

@PHE_children
@babyfriendly
@NIFNtweets
@first1001days
@LLLGB
@PHE_obesity
@babymilkaction
@DHgovuk
@1stepsnutrition
@AssocBfMothers
@NCTcharity

Please add your own links and contacts:

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