Making the Case for Breastfeeding

1. Background

Breastfeeding provides numerous health benefits for mothers and babies and economic benefits to the healthcare system and public sector. The factors that affect rates of breastfeeding are complex and require a multiagency and collaborative approach. Long term success and sustainability requires a shift in culture and attitudes towards breastfeeding amongst the public and professionals. Breastfeeding is also a health inequalities priority as there is a strong relationship between socio-economic status, educational attainment and breastfeeding prevalence. To improve breastfeeding rates a sustainable co-ordinated approach is needed enabled through effective partnerships between women, their families, the health sector, Local Authorities, the Voluntary Sector, communities, workplaces and professionals.

2. Policy Drivers

The key drivers for breastfeeding include:

- UNICEF Baby Friendly
- NICE Guidelines
- Healthy Child Programme
- Infant Feeding Survey
- UK Scientific Advisory Committee on Nutrition
- The Public Health Outcomes Framework (the number of women breastfeeding their babies at birth (the initiation rate) and at 6-8 weeks)
- The Children and Young People's Health Outcomes Framework
- Healthy Lives, Healthy People: Our Strategy for Public Health in England
- Operating Framework for the NHS in England
- Chief Medical Officer for England report - Our Children Deserve Better: Prevention pays
- Department of Health Infant Mortality Review

3. The Evidence Base

There is extensive evidence that breastfeeding has positive health benefits for mother and baby in the short and longer term beyond the period of breastfeeding. Breast milk provides infants with all the nutrients they need and current UK policy is to promote exclusive breastfeeding for the first 6 months, continuing for as long as the mother and baby wish while gradually introducing a more varied diet. Benefits of breastfeeding include reducing the incidence of infections, obesity, diabetes, childhood leukaemia and sudden infant death syndrome (SID); improved feeding tolerance; enhanced neurodevelopment and enhanced maternal self-esteem; enabling normal cognitive and physical development and breastfeeding may protect against obesity and chronic disease in adult life. For mothers it promotes maternal recovery from childbirth, reduces the risk of breast cancer and possibly of ovarian cancer, helps a return to pre-pregnancy body weight and prolongs the period of postpartum infertility.
4. The Economic Case

As well as health benefits, there are also potential economic and environmental reasons to promote breastfeeding. NICE \(^{xvii}\) estimates that the cost of implementing the Baby Friendly Initiative in the UK would be recovered in three years through reduced treatment costs for gastroenteritis, otitis media and asthma in babies achieved by increasing breastfeeding rates. Breastfeeding reduces the cost of treating non-breastfeeding related illness such as gastroenteritis, and reduces the need to use formula milk thereby reducing the costs associated with buying, manufacturing and the disposal of packaging associated with formula milk and bottle feeding equipment. Breastfeeding policies could benefit employers by improving productivity, reducing the amount of time mothers or parents take off work to care for sick children, and improving staff retention and morale.

“Preventing Disease and Saving Resources” \(^{xviii}\) looks at how raising breastfeeding rates could save the NHS money through improving health outcomes. The report was commissioned by UNICEF UK and written by a multi-university academic team. The authors' calculations show that moderate increases in breastfeeding could see millions in potential annual savings to the NHS and that figure might only be the tip of the iceberg. Investment in effective services to increase and sustain breastfeeding rates is likely to provide a return within a few years, possibly as little as one year. Investing in supporting women to breastfeed will improve the quality of life for women through the reduction in incidence of breast cancer; and for children through reducing acute and chronic diseases. The report shows that for just five illnesses, moderate increases in breastfeeding would translate into cost savings for the NHS of £40 million and tens of thousands of fewer hospital admissions and GP consultations. In addition, analyses on three conditions - cognitive ability, childhood obesity and SIDS – indicate that modest improvements in breastfeeding rates could save millions of pounds and, in the case of SIDS, children's lives. The report makes a strong financial case for investing in better support services for women, to enable them to start breastfeeding and continue for as long as they want to.

If 45% of women exclusively breastfed for four months, and if 75% of babies in neonatal units were breastfed at discharge, every year there could be an estimated:

- 3,285 fewer gastrointestinal infection-related hospital admissions and 10,637 fewer GP consultations, with over £3.6 million saved in treatment costs annually
- 5,916 fewer lower respiratory tract infection-related hospital admissions and 22,248 fewer GP consultations, with around £6.7 million saved in treatment costs annually
- 21,045 fewer acute otitis media (AOM) related GP consultations, with over £750,000 saved in treatment costs annually
- 361 fewer cases of NEC, with over £6 million saved in treatment costs annually.

In total, over £17 million could be gained annually by avoiding the costs of treating four acute diseases in infants. Increasing breastfeeding prevalence further would result in even greater cost savings. If half those mothers who currently do not breastfeed were to breastfeed for up to 18 months in their lifetime, for each annual cohort of around 313,000 first-time mothers there could be 865 fewer breast cancer cases with cost savings to the health service of over £21 million and 512 breast cancer-related quality adjusted life years (QALYs) would be gained, equating to a value of over £10 million. This could result in an incremental benefit of more than £31 million, over the lifetime of each annual cohort of first-time mothers.
5. Current Delivery Challenges

While UK breastfeeding rates are increasing, they are still among the lowest in Europe. Just one in three babies are still receiving breast milk at six months, despite recommendations that babies need nothing other than breast milk for the first six months of life. In the West Midlands 10 of 14 Local Authority areas are significantly worse than the national average for breastfeeding initiation and 11 of 14 are significantly worse for breastfeeding at 6 to 8 weeks. In addition one LA failed data quality requirements for the latter.\textsuperscript{xix} The number of West Midlands Units with accreditation or working toward it can be found on the UNICEF website.\textsuperscript{xx} As of May 2014, 43.17% of births take place in Baby Friendly hospitals.

The UNICEF UK Baby Friendly Initiative\textsuperscript{xxi} provides a framework for the implementation of best practice by NHS trusts, other health care facilities and higher education institutions, with the aim of ensuring that all parents make informed decisions about feeding their babies and are supported in their chosen feeding method. In 2012, a revised set of standards was launched that extended the programme to Neonatal Units and Children's Centres.\textsuperscript{xxii} These incorporate the previous standards as specified in the Ten Steps to Successful Breastfeeding and Seven Point Plan for Sustaining Breastfeeding in the Community but update and expand them to fully reflect the evidence base on delivering the best outcomes for mother and babies in the UK. These standards are being introduced during 2013-14. Further effort is needed in this and local infant feeding leads have reported that looking at breastfeeding across the system, barriers to integrated commissioning and delivery of local services remain following implementation of the reforms, suggesting that local areas need further support with this. Structural barriers to integrated commissioning and provision of breastfeeding services and support are evident in a more complex and fragmented system with breastfeeding priorities spanning local authorities, maternity services, NHS England, Clinical Commissioning Groups, Children’s Centres, the voluntary sector and Health and Wellbeing Boards.

5.1 Significant Risks Identified

Other concerns expressed by local areas include the need for clarity as to the location of particular commissioning responsibilities; poor communication between services and agencies; funding cuts and a challenging financial climate, with particular concerns about the vulnerability of peer support services and uncertainty where breastfeeding is figured in the 0-5 transition arrangements for early year’s commissioning, where aspects are aligned with health visiting. This all underlines the importance of action at a West Midlands and local level to continue to address barriers to joint working, which include different funding arrangements and different standards, outcome and performance measures and approaches to inspection across the different services along with fragmented commissioning. This indicates an area in which national and local bodies can provide additional support including engaging with the right people to improve breastfeeding services; supporting coordination and integration; pooled budgets; clearer communication and care planning and pathway protocols between professionals and teams in different services and encouraging co-located multi-professional teams.
6. A Renewed Approach to Achieving Improved Outcomes in Breastfeeding

Priority areas (in no particular order) to further reduce health inequalities by working to increase breastfeeding rates can involve:

6.1 Gaining further support for breastfeeding from the community and from across the public, private and voluntary and community sectors

6.2 Securing and enhancing local level leadership through engagement with Directors of Public Health, Strategic Clinical Networks, Heads of Midwifery, Health Visiting leads, CCGs and Health and Wellbeing Boards

6.3 Promoting a wider understanding among families and communities of the value of breastfeeding, and support for mothers who do so including maximising opportunities using social media should be further realised

6.4 Adopting the UNICEF Baby Friendly Initiative across local areas in different settings and increasing the number of organisations working towards Baby Friendly initiative standards. Planning ahead is key and investment locally needs to be negotiated with local system leaders. Continuing professional development for staff also needs resourcing and prioritising so that staff have the tools to do the job

6.5 Ensuring that people who are coming into contact with or providing support to potential mothers and breastfeeding mothers are trained to UNICEF Baby Friendly Initiative standards and maximising opportunities through Making Every Contact Count approaches xxiii

6.6 Developing integrated pathway and commissioning approaches ahead of the 0-5 transition (by October 2015) and maximising UNICEF approaches to ensure robust and joined up care pathways are adopted

6.7 Maintaining robust data collection systems locally whilst being cognisant of dependencies such as the Child Health Information System

6.8 Promoting evidence based good practice in relation to breastfeeding across the local system including sharing local stories using the National Infant Feeding Network site and local websites

6.9 Maximising opportunities to promote breastfeeding using previous and more recent NICE guidance e.g. “Helping Local Authorities to Tackle Obesity” xxiv

6.10 Ensuring that mothers are able to make fully informed decisions about breastfeeding their babies and receive high quality information and support when and where it is needed in a seamless and consistent way and ensuring the workforce is able to provide the necessary support

6.11 Enhancing peer support approaches xxv

6.12 Maintaining a high media profile for breastfeeding and maximising Change 4 Life xxvi and Start 4 Life xxvii social marketing opportunities

6.13 Providing welcoming and supportive breastfeeding friendly environments where mothers feel comfortable to breastfeed including workplaces

6.14 Strengthening breastfeeding education in schools and other youth settings
Continuing to target particular groups e.g. through the Family Nurse Partnership

7 Case Studies

7.1 The Royal Wolverhampton Hospitals NHS Trust

As part of its commitment to support breastfeeding mothers, The Royal Wolverhampton Hospitals NHS Trust employs a Breastfeeding Peer Support Co-ordinator to recruit and train a network of women, to provide breastfeeding information and support to pregnant women, new mothers and their families across Wolverhampton. Breastfeeding peer support is recognised as an effective way to increase the number of women who choose to breastfeed and to help them to continue breastfeeding for as long as they wish. It has been found that breastfeeding peer support is highly valued by breastfeeding mothers - in the early days after the birth of their baby, many mums find it really useful to be able to discuss any queries they may have about breastfeeding with a Peer Supporter.

Breastfeeding Peer Supporters are mothers who have breastfed their babies and who have had training on breastfeeding and the support of mothers. They continue to receive support, supervision and further training as they support breastfeeding women in their community. Peer Supporters provide breastfeeding information to pregnant women, support women as they start and continue to breastfeed, discuss topics such as the introduction of solid food, returning to work, moving on from breastfeeding and sources of local support. The provision of skilled support from women who have first-hand experience of breastfeeding and have undertaken further training in order to provide information and support, has been found to be invaluable. Peer supporters choose where they wish to provide breastfeeding support from antenatal classes or clinics, breastfeeding drop-in groups or post-natal wards or a mixture of all of them. Their support can be during the daytime, evening or weekend, for as much or as little time as they wish - there is no need to commit to regular timeslots, a number of hours or particular days.

Breastfeeding Peer Supporters in Wolverhampton:

- Make a positive difference to the women and their families
- Use your breastfeeding experience and skills to help others
- Give someone else the same positive support that you experienced
- Make sure other women benefit from your knowledge, experience and support
- Gain new skills and knowledge
- Make new friends and acquaintances
- Do something different from your paid job
- Have fun
- Keep busy
- Gain work experience for a change of career
- Have the opportunity to work alongside other peer support workers and health professionals including midwives, family support workers and health visitors

The Breastfeeding Peer Supporters are trained to learn more about Breastfeeding and how to support other mothers to breastfeed their babies and are offered continual ongoing support, supervision and training opportunities. In addition, the Trust assists Breastfeeding Peer Supporters with car park expenses and reimburses their travel expenses incurred while volunteering.

What do mothers say about breastfeeding peer support they have received?
• “I have found the excellent support from the New Cross Hospital Breastfeeding Peer Supporters to be invaluable. They have made me confident in my ability to feed my baby myself, and have supported me through my struggles. No matter how small, someone was able to listen and help me overcome my issues” RC, 2012

• “Before I had my baby, I only knew one person who breastfed, so breastfeeding just wasn’t the norm for my family. But after my son was born, the support I received from the Breastfeeding Peer Supporters who had breastfed their babies, was such a positive influence for me, it definitely helped me to carry on breastfeeding for much longer than I thought I would. Luckily, I didn’t really have any problems breastfeeding at the beginning, and feel that it’s such a shame that a lot of mums give up before they seek some help. I feel so proud of my amazing achievement and feel that breastfeeding has been so nice for myself and my son!” NR, 2012

• “I found the Breastfeeding Peer Supporters at the hospital to be really nice and really helpful. Without their help I do not think that I would have carried on breastfeeding. I found that they actually listened to me and what I had to say without being pushy or telling me what to do. I am still breastfeeding today, thanks to them, which makes me feel absolutely overwhelmed with happiness and pride”. NT, 2012

7.2 Dudley Joint Health and Wellbeing Strategy and Breastfeeding Priorities

The strategy is based on the Joint Strategic Needs Assessment’s key needs and also extensive consultation with stakeholders and residents in Dudley borough. The strategy identifies five priority areas:

• Making our neighbourhoods healthy – by planning sustainable, healthy and safe environments and supporting the development of health enhancing assets in local communities.

• Making our lifestyles healthy – by supporting people to have healthy lifestyles and working on areas which influence health inequalities, for instance, obesity, alcohol, smoking and the early detection of ill health.

• Making our children healthy – by supporting children and their families at all stages but especially the early years; keeping them safe from harm and neglect, supporting the development of effective parenting skills and educating young people to avoid taking risks that might affect their health in the future.

• Making our minds healthy – by promoting mental health and wellbeing.

• Making our services healthy – by integrating health and care services to meet the changing Dudley borough demography, starting with urgent care.

An ambitious work-plan for 2013/14 was agreed on the 29th April 2013, in order to take the five priorities forward. A focus for this has been a series of spotlight events with key stakeholders, one for each priority area. Each spotlight focused on specific challenging issues identified from the JSNA associated with the priority area and the events followed a process of diagnosing the issue, providing information on the key challenges and then stimulating the generation of ideas and action planning across partners. Outcomes and recommendations from the spotlight sessions were presented to the appropriate lead Commissioning Group or Board to agree key actions and performance indicators to take forward during 2013/14 and 2014/15. These collectively frame the implementation plan for the Joint Health and Wellbeing Strategy. The “Spotlight on Breastfeeding” session included a range of stakeholders and service users. Key discussions in relation to breastfeeding emphasised the need to develop strategies to gain its cultural acceptance, including with the health care profession. An outcomes report has been forwarded to the Strategic Breastfeeding Group which has agreed key actions and local indicators for improving breastfeeding rates.
7.1 Walsall Public Health Department

Walsall’s commissioners have given permission to share their local specification which shows a whole systems approach to the configuration of breastfeeding services in the borough. See Attachment.

8 Recommendations

8.1 This paper was discussed at the West Midlands Infant Feeding leads on 14th March 2014 with Public Health England, NHS England and UNICEF. It was recommended that the paper be shared widely at national and local levels to raise awareness, to encourage a wider debate and discussion on the issues raised herein. Local Infant Feeding Leads were also encouraged to use the paper to spotlight local issues. UNICEF was keen to use the paper to highlight specific issues around achieving Baby Friendly and Public Health England would share the paper with national colleagues and with the Area Teams across the West Midlands. Finally there is a need to engage Directors of Public Health further and Public Health England will facilitate this.

8.2 The commissioning of breastfeeding should feature in local arrangements for the transfer of responsibility for 0-5 commissioning to local government by October 2015. To support this Public Health England will share this paper with the Midlands and East Region Healthy Child Programme Board to highlight key issues and risks.

8.3 There is a need for ongoing discussions with UNICEF to maintain and enhance current arrangements as well as considering rolling out in other settings such as Children’s Centres. Local commissioners must be aware of what is needed to accommodate the programme now and in the future. UNICEF UK is very impressed by the content of this paper and has shared it with the Chair of a National Group which advises BFI on policy issues. UNICEF UK are considering updating their commissioners’ guide and have also asked to link to this document and share via their website.

8.4 There are opportunities to undertake further joint work on developing a pathway to set out who does (or can do), what, where as well as illustrating who potential providers are / could be and who the commissioners are for each stage through from ante-natal to post-natal stages. The Walsall approach enclosed is a useful template and starting point. Local Infant Feeding Leads should consider setting up a small working group supported by Public Health England and NHS England.

8.5 There are opportunities through the West Midlands Infant Feeding Leads to identify local training needs that are best met collectively. An example is training on use of social media which Public Health England will support. Links with “Learning for Public Health” xxviii and sector led improvement approaches should also be facilitated and Public Health England will broker these discussions.

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ANNEX 1

Alexandra Hospital, Redditch - Full accreditation
Birmingham City Hospital, Birmingham - Stage 1 accreditation
Birmingham Heartlands Hospital, Birmingham - Stage 1 accreditation
Birmingham Women’s Hospital, Birmingham - Full accreditation
George Eliot Hospital, Nuneaton - Stage 1 accreditation
Good Hope Maternity Hospital, Sutton Coldfield - Full accreditation
Hereford County Hospital, Hereford - Certificate of Commitment
Kidderminster General Hospital, Kidderminster - Full accreditation
Ludlow Community Hospital, Ludlow - Stage 1 accreditation
Princess Royal Hospital, Telford - Stage 1 accreditation
Queen’s Hospital, Burton-on-Trent - Stage 1 accreditation
Royal Shrewsbury Maternity Hospital, Shrewsbury - Stage 1 accreditation
Royal Wolverhampton Hospitals, Wolverhampton - Full accreditation
Russell Hall Hospital, Dudley - Full accreditation
Sandwell General Hospital, West Bromwich - Stage 1 accreditation
Stafford Hospital, Stafford - Stage 1 accreditation
The Robert Jones & Agnes Hunt District Hospital, Oswestry - Stage 1 accreditation
University Hospital (Walsgrave site), Coventry - Stage 1 accreditation
University Hospital of North Staffordshire, Stoke-on-Trent - Full accreditation
Walsall Manor Maternity Hospital, Walsall - Accreditation suspended
Warwick Hospital, Warwick - Stage 1 accreditation
Worcester Royal Hospital, Worcester - Full accreditation
REFERENCES

i http://www.unicef.org.uk/babyfriendly/
iii http://www.nice.org.uk/nicemedia/pdf/CG37NICEguideline.pdf
iv http://guidance.nice.org.uk/PH11
vi http://www.hscic.gov.uk/catalogue/PUB08694
vii http://www.sacn.gov.uk/
ix http://fingertips.phe.org.uk/profile/cyphof
xi http://www.england.nhs.uk/everyonecounts/

xv WHO Regional Publications, European Series, No.87 on Feeding and Nutrition of Infants and Young Children.

xvi Health Inequalities – Women from disadvantaged groups are less likely to breastfeed their baby than those who are better off financially


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