



department for
children, schools and families



Commissioning local breastfeeding support services



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Purpose of this guide and how it was developed



This commissioning guidance aims to assist commissioners and primary care trusts (PCTs) in 'providing coherent services that will promote breastfeeding and reduce inequalities', as set out in *Healthy Lives, Brighter Futures – the strategy for children and young people's health* (Department for Children, Schools and Families and Department of Health, 2009, para 3.43), and to work with local Children's Trust partners in delivering Public Service Agreement (PSA) 12.

It aims to:

- consolidate the case for breastfeeding care and support as an integral part of local strategies to improve child health and reduce health inequalities;
- signpost commissioners to sources of policy, practice and evidence; and
- set out some key considerations in relation to World Class Commissioning competencies within the three phases of the commissioning cycle.

It is recognised that commissioners will be operating in varied contexts – some will already have well-developed joint commissioning and Children's Trust arrangements in place, while others will be at different stages of development.

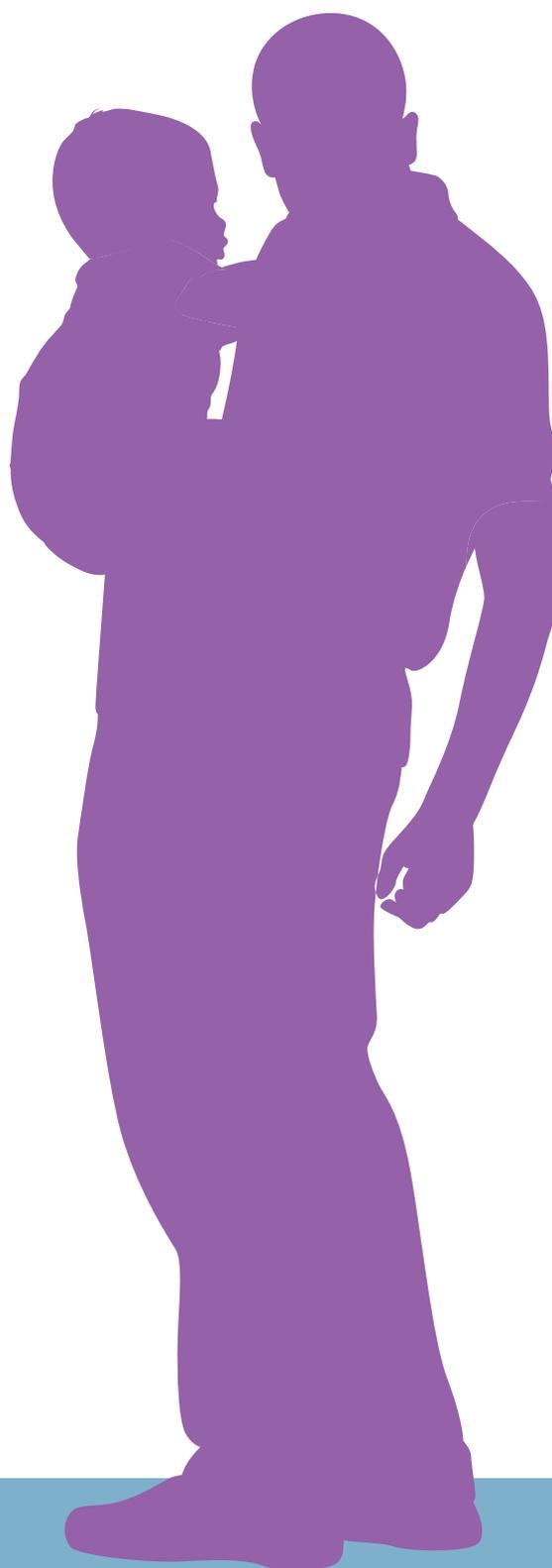
This guidance has been developed with advice from a national steering group and structured input from a national stakeholder forum.¹

Breastfeeding is one of the top ten health outcomes most frequently prioritised by PCTs in their strategic plans.²

¹ See Appendix 3.

² National analysis of PCT five-year strategic plans showed that breastfeeding was one of the top ten commissioning priorities.

Summary of key messages



- Breastfeeding saves lives and protects the health of mothers and babies both in the short and long term.
- More mothers are breastfeeding, but continuation rates in the UK remain among the lowest worldwide.
- Breastfeeding services are a cost-effective intervention, contributing to savings from reduced hospital admissions for gastro-intestinal and respiratory infections.
- Prevalence of breastfeeding at 6–8 weeks is a key indicator of child health and wellbeing and is included in PSA 12. The Government aims to increase breastfeeding rates so that they are as high as possible.
- Breastfeeding rates at 6–8 weeks are monitored through Vital Signs, and all PCTs are required to report progress on a quarterly basis.
- Commissioning services that will provide sustainable, high-quality, universal support, as well as targeted support for mothers who are least likely to breastfeed and who are at risk of poor health outcomes, is central to delivering better long-term outcomes for local children.

Policy priorities and performance drivers

- Breastfeeding is a global and a national priority, and a key area of focus for the NHS and local partners in tackling health inequalities.
- A comprehensive policy framework underpins breastfeeding. PSA 12 requires action by PCTs and partners, including the third sector, to:
 - provide adequate training to the primary care workforce to enable them to give consistent advice and support to mothers;
 - ensure that data is collected on breastfeeding prevalence at 6–8 weeks;
 - actively support mothers in the antenatal period;
 - support mothers to continue breastfeeding by identifying problems early; and
 - listen to parents' views on whether additional networks of support are needed.

Leadership and collaboration

- Effective leadership – at national, regional and local level – is essential to raise breastfeeding prevalence. It needs to be knowledgeable, visible, sustained and collaborative.
- Collaboration between a network of clinicians, children's services, health professionals and community partners that is as wide as possible is key to improving breastfeeding prevalence for all mothers – and particularly those from disadvantaged groups where breastfeeding is unlikely to be the norm.
- Services should be multifaceted to respond to the diverse needs of the population, and to target support to mothers and babies in different settings.

Assessing need and strategic planning

- Improving breastfeeding prevalence, and reducing health inequalities, will depend on knowing your local population well, mapping service provision and addressing service gaps, and assessing evidence of what works.
- Where data is not felt to be robust or complete, commissioners and their strategic partners should clarify data needs and ensure that systems are put in place to provide a detailed profile. Working closely with GPs, health visitors and other clinical and community partners will be important to achieve a reliable baseline assessment.

- Commissioners will need to assess workforce capacity and capability, including training and skills gaps in relation to enabling and supporting mothers to breastfeed, and decide how they will be addressed.
- Feedback from service users can be the most powerful evidence to support local commissioning decisions. Finding out why women don't intend to breastfeed, or the reasons that cause them to stop, is key to developing services that will drive up prevalence rates.

Shaping local breastfeeding services

- Commissioners will need to review the contribution of local services to increasing breastfeeding prevalence, and the extent to which these services are engaging with and having a positive impact on groups where breastfeeding prevalence is particularly low.
- Government policy, underpinned by National Institute for Health and Clinical Excellence (NICE) guidance, promotes the adoption and implementation of the UNICEF Baby Friendly Initiative (BFI) as the best evidence-based vehicle to raise levels of breastfeeding prevalence.
- Multifaceted breastfeeding support services are needed to provide continuity of care in a variety of settings, including community settings.

- NICE guidance recommends easily accessible breastfeeding peer support programmes, where peer supporters are part of a multidisciplinary team.
- Workforce development is key to shaping local services. Service specifications need to specify quality standards as set out in BFI accreditation and NICE guidelines.
- Global and national evidence is unequivocal that breastfeeding saves lives, is preventive and saves money. Increasing breastfeeding prevalence reduces NHS costs.
- An infrastructure should be in place to track mothers from the start of pregnancy – and children from birth – in order to target support where and when it is needed.
- Local commissioners should always bear the following questions in mind: Are services having a positive and measurable impact on outcomes and reducing health inequalities? Are they being delivered to quality standards as set out in BFI and NICE guidance?

Improving performance, monitoring outcomes

- Alongside quarterly data returns on breastfeeding prevalence, monitoring should include qualitative feedback from mothers and their partners, and from professionals and service providers.
- Sure Start Children's Centre staff, third sector partners, midwives, health visitors, GPs, and providers of peer support and other breastfeeding support services are all in a position to monitor prevalence levels and service effectiveness and to identify barriers to accessing services.
- Monitoring and evaluation that are rooted in the direct experiences of local mothers and their families will be most powerful in helping commissioners to shape and influence future services.

1. Introduction





Immunisation is preventative medicine par excellence. If a new vaccine became available that could prevent 1 million or more child deaths a year and that was moreover cheap, safe, administered orally and required no cold chain, it would become an immediate public health imperative. Breastfeeding could do this and more...

*(Lancet, 1994)*³



The case for investing in services to support breastfeeding as part of a local child health strategy that will reduce health inequalities is well documented, evidence based and compelling: breastfeeding saves lives and protects the health of babies and mothers, and increases children's future life chances.⁴

Breast milk is the best form of nutrition for infants, and exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant's life. Thereafter, breastfeeding should continue for as long as the mother and baby wish, while gradually introducing the baby to a more varied diet.⁵

In recent years, several large, good-quality studies and reviews⁶ have demonstrated that not breastfeeding can pose a range of significant health risks for both child and mother. These include short-term outcomes such as gastroenteritis and respiratory disease, requiring hospitalisation, and in the longer term evidence suggests that infants who are not breastfed tend to have higher levels of blood pressure and blood cholesterol in adulthood and may also be at a greater risk of type 2 diabetes.⁷ For mothers, breastfeeding is associated with a reduction in the risk of breast and ovarian cancers. A recent study also suggests a positive association between breastfeeding and parenting capability, particularly among single and low-income mothers.⁸

³ Editorial, A warm chain for breastfeeding, *Lancet*, 5 Nov 1994; 344(893Z):1239–41.

⁴ Department of Health, *Implementation plan for reducing health inequalities in infant mortality: a good practice guide*, 2007.

⁵ Department of Health, *Infant Feeding Recommendation*, 2003, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4097197

⁶ See Appendix 1.

⁷ Quigley et al, 2007 and Horta et al, 2007 in Appendix 1.

⁸ Gutman et al, 2009 in Appendix 1.

Not breastfeeding is therefore costly, not only in terms of consequences for mothers, babies and families, but to a range of services charged with meeting their needs. For commissioners, and all local authority and Children's Trust partners, commissioning services that will promote breastfeeding is about early intervention and prevention – an opportunity to invest at the start of every child's health pathway.

Despite evidence of overwhelming health benefits and potential cost savings, and a strong policy framework, breastfeeding rates in the UK remain among the lowest worldwide. More women are starting to breastfeed but many do not continue beyond a few days, and many children lose out on health benefits early in life.

A range of factors, including psycho-social and cultural factors and practical difficulties encountered early on, can make breastfeeding challenging for women. A comprehensive body of evidence points to ways in which particular interventions, as part of commissioned services, can help to address these constraints.⁹

The Scientific Advisory Committee on Nutrition (SACN) commentary on the Infant Feeding Survey (2008) also highlights continuing inequalities in infant feeding, in particular:

'Young mothers and mothers from lower socio-economic groups appear to be the least likely to adopt infant feeding practices recommended by Health Departments.'¹⁰

The Department of Health recommends exclusive breastfeeding for around six months and continued breastfeeding alongside the introduction of solid foods for as long as the mother wishes. PSA 12 on child health and wellbeing sets out specific expectations for all local areas to increase prevalence of breastfeeding at 6–8 weeks through effective commissioning and partnership working. All PCTs (since April 2008) are expected to collect data to calculate local prevalence of breastfeeding at 6–8 weeks.

Commissioning services that will provide sustainable, high-quality, universal support and targeted support for mothers who are least likely to breastfeed and who are at risk of poor health outcomes is central to delivering better long-term outcomes for local children and to having a positive impact on reducing health inequalities.

⁹ Dyson et al, 2006 in Appendix 1.

¹⁰ Scientific Advisory Committee on Nutrition, *Infant Feeding Survey 2005: a commentary on infant feeding practices in the UK*, 2008. (The Infant Feeding Survey has been conducted every five years since 1975.)

2. Policy priorities and performance drivers relevant to commissioning





Once a baby is born, breastfeeding offers long term emotional, physical and mental benefits to mother and child.

(Public Service Agreement Delivery Agreement 12.1, 2008)¹¹



Breastfeeding is a national and local priority. It is a key indicator of child health and wellbeing and is included in both PSA 12 and PSA 19, the Vital Signs (11) and National Indicator set (53).

PSA 12: Improve the health and wellbeing of children and young people – aims to improve prevention and early intervention and support from practitioners as part of reducing health inequalities. Improving breastfeeding prevalence at 6–8 weeks is one of five key indicators (PSA 12.1), which includes reducing childhood obesity. Sure Start Children's Centres are seen as central to delivery.

PSA 19: Ensure better care for all – stresses the importance of effective local commissioning frameworks in achieving maternity choice and outcomes rooted in what matters to users. Indicator 1 is about self-reported experience of users to inform commissioning and Indicator 4 relates to the percentage of women who have seen a midwife/healthcare professional for a needs assessment by 12 weeks of pregnancy.

Vital Signs Monitoring System Indicator VSB11 and National Indicator Set NI 53 – the NHS operating framework sets out measures of progress against national priorities.

The percentage of infants breastfed at 6–8 weeks is one of the tier two Vital Signs and is included within a National Indicator Set for Local Area Agreements (LAAs). For 2008–11, 32 of the 150 LAAs have included targets to improve breastfeeding prevalence.

National policy priorities – children's health and wellbeing

Overarching policy messages and government commitments are set out in the following:

- *Healthy Lives, Brighter Futures – the strategy for children and young people's health* (Department for Children, Schools and Families and Department of Health, 2009) reinforces the Government's commitment to raise breastfeeding prevalence at 6–8 weeks by 2011. The strategic plans and operating framework expect all PCTs, through commissioning, to ensure that hospital and community settings consider adopting the principles of the UNICEF BFI; £4 million was invested in 2008/09 to expand the BFI and breastfeeding strategies in areas with low breastfeeding prevalence. It also strengthens the role of Sure Start Children's Centres in relation to breastfeeding and early infant nutrition.
- The Healthy Child Programme (formerly the Child Health Promotion Programme) is the core universal programme to provide support and services throughout pregnancy and the early years.

¹¹ HM Treasury, (2008) *PSA Delivery agreement 12: Improve the health and wellbeing of children and young people*, 2008.

For further examples of policy documents on breastfeeding and commissioning and for a list of the various regulations and standards relating to breastfeeding and commissioning see Appendix 2.

Sure Start Children's Centres bring together childcare, early education, health and family support services for families with children. By March 2010, there will be 3,500 Sure Start Children's Centres – one for every community. All Sure Start Children's Centres must provide a universal range of services such as access to community health services – including antenatal services and the Healthy Child Programme, led and delivered by health visiting teams and tailored to meet different levels of risk and need – and access to specialist services. Sure Start Children's Centre planning and delivery guidance (<http://publications.everychildmatters.gov.uk/eOrderingDownload/DCSF-00665-2007.pdf>) emphasises the importance of collaborative working between PCTs, practice-based commissioners, local authorities and Sure Start Children's Centres.

Sections 3–6 follow the three phases of the commissioning cycle and the World Class Commissioning competencies that underpin them.¹²

¹² See Appendix 4.

The commissioning process

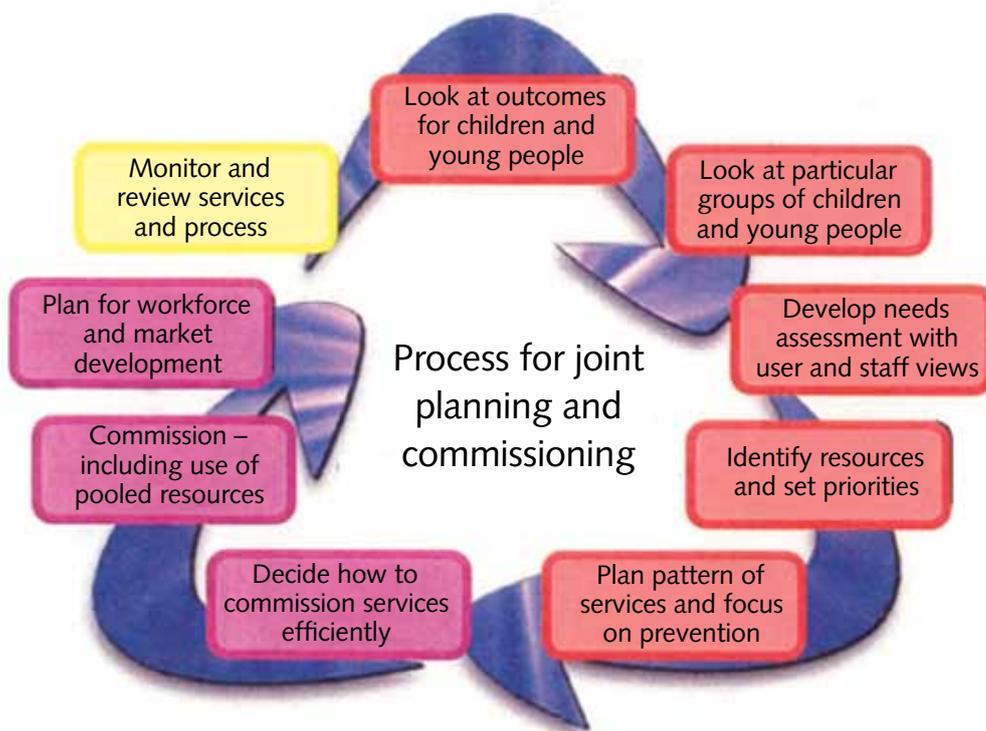
The world class commissioning competencies set out the behaviours needed for world class commissioning. There is still a need for a process to support commissioners in securing improved health outcomes for children, young people and their families.

Commissioning is a cyclical process that happens strategically across a population

as well as individually for a particular young person or family. This process has already been articulated in guidance from the Department of Health and the Department for Children, Schools and Families. The cycles set out in earlier guidance, referred to either as the 'health' cycle or the 'joint' cycle, may look different, but essentially they set out three similar stages for the commissioning process. This section aligns these two existing cycles

Joint commissioning and health commissioning cycles

Figure 1



 Phase 1: needs assessment and strategic planning

 Phase 2: shaping and managing the market

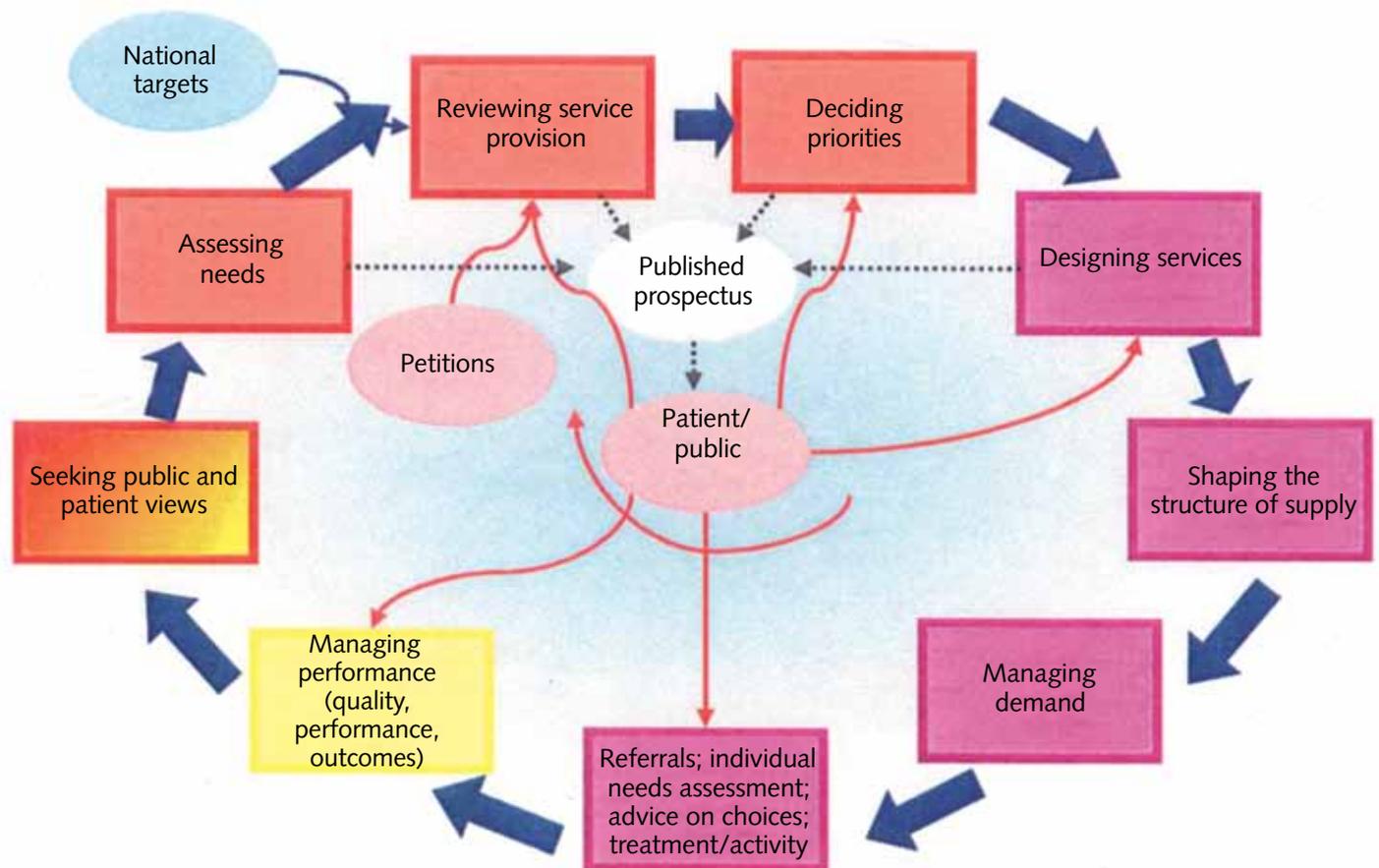
 Phase 3: improving performance, monitoring and evaluating

to show that both take commissioners through three common 'phases' of activity.

Each phase describes the set of activities that typically make up that phase of the cycle, as well as expectations for joint working.

Each stage shows the relevant world class commissioning competencies and a description of joint working. For example, in some cases

there is an expectation that the phase will be carried out fully in partnership; in others, there is a need to ensure that the extent of partnership working is appropriate to the activities.



Department of Health and Department for Children, Schools and Families, *Securing better health for children and young people through world class commissioning: A guide to support delivery of Healthy Lives, Brighter Futures: The strategy for children and young people's health*, 2009.

3. Leadership and collaboration (competencies 1, 2 and 4)





Virtually all mothers can breastfeed provided they have accurate information, and support within their families and communities and from the health care system.

(World Health Organization, 2003)¹³



Effective leadership – at national, regional and local level – is essential to raise breastfeeding prevalence. For leadership to achieve measurable outcomes it needs to be knowledgeable, visible, sustained and collaborative. Commissioners are in a key position to offer leadership and, where necessary, should signal the need for leadership within and across NHS and local authority services. In most instances PCT commissioners for children will be part of the Children's Trust, but in some instances of breastfeeding services will be undertaken by commissioners within the acute sector.

Stakeholders consulted in the process of producing this guidance felt leadership to be of paramount importance.

What would 'whole-system leadership' – to support the commissioning and delivery of breastfeeding services – look like?

Whole-system leadership would consist of:

- strategic senior leadership demonstrated by Children's Trust partners and PCTs in general, reflected in strategic plans and consistent messages communicated by all services about the role of breastfeeding in improving children's health outcomes and achieving shared ownership for delivery of PSA 12;
- a local policy and implementation strategy – developed by an expert group comprising clinical and wider partners, informed by local needs assessment and agreed at Children's Trust Partnership Board level – to provide a road map for commissioning;
- a strategic partnership forum that oversees implementation of a local strategy;
- a strategic leader, such as a director of public health, director of children's services, lead or joint commissioner, Cabinet member or portfolio holder, to ensure an informed high profile for breastfeeding at Children's Trust level locally and across all partner organisations (acute and community services, the PCT and local authority children's and family services);
- a regional infant nutrition lead to advise and support performance improvement and innovation, and facilitate networking and collaboration;

¹³ World Health Organization, *Global Strategy for Infant and Young Child Feeding*, 2003.

- local breastfeeding (strategy and development) coordinators in hospital settings and Children's Trusts with sufficient seniority, knowledge and strategic project management skills to work across systems and services in health, social care and education (NICE recommends one full-time equivalent coordinator per 3,000 births in each setting);
- a network of named leads in key services: strategic health authority (SHA) lead, maternity services lead, paediatrics and neonatal lead, GPs, PCT provider organisations, Sure Start Children's Centre managers, Extended Services and Healthy Schools leads, early years lead/adviser, teenage pregnancy lead, children's services obesity/weight management lead, parenting commissioner and smoking cessation lead;
- data collection, information-sharing protocols and performance monitoring arrangements agreed across the partnership that will yield robust and consistent data to inform the commissioning cycle; and
- accountability and scrutiny arrangements that monitor, support and challenge improvements.

Increasing breastfeeding prevalence demands fundamental changes in behaviours – particularly among young mothers and those from lower socio-economic groups – but social attitudes and professional and institutional behaviours need to change too. Whole-system leadership at a national, regional and local level therefore should:

- raise awareness of the short- and long-term health and wider benefits of breastfeeding;
- raise awareness of the risks in terms of costs and consequences of not breastfeeding;
- highlight the population groups where breastfeeding rates are particularly low;
- challenge professional policy and practice and public attitudes that deter or inhibit mothers from initiating and sustaining breastfeeding – the Government recommends that all training materials and equipment are free from advertising from the infant feeding industry so as not to undermine breastfeeding;
- create supportive environments where breastfeeding is the norm – this means environments that support women's self-confidence and psycho-social needs at work, in public and at home; and
- promote needs- and evidence-based approaches to supporting and increasing prevalence of breastfeeding in hospital and community settings.

CASE STUDY 1:

Tower Hamlets Community Health Services

Tower Hamlets, London: five years' experience of an integrated breastfeeding service in a socially deprived community

Department of Health recommends

Clear leadership and local action plans

Baby Friendly practice to increase initiation and prevalence rates

Community action to sustain and increase duration of breastfeeding

Change in societal attitudes to make breastfeeding the norm

Fully integrated service from acute trust, community health service and Sure Start Children's Centres. Initially funded by local authority; now mainstream NHS provision funded through public health.

Hospital community and Sure Start Children's Centres passed BFI accreditation Stage 1 July 2008; Stage 2 due autumn 2009. BFI training and audit team includes midwives, health visitors and peer supporters.

Team of paid breastfeeding support workers speak main community languages. Contact starts at antenatal clinics and continues on postnatal wards and through proactive home visits. Additional support at Sure Start Children's Centres and other local groups. Training, supervision and childcare for volunteer peer supporters enhance the service on wards and at groups. Local breastfeeding supporters cover telephone helplines (including a Bengali line). Out-of-hours support being developed.

Social marketing campaign – Healthy Borough programme – which seeks to make changes to the environment to enable healthy eating. Includes Breastfeeding Welcome places, breastfeeding promotion and support at public events.

Data submitted to the national data set demonstrates that breastfeeding initiation rates have risen from 75.8 per cent in 2005/06 to 80.5 per cent in 2008/09. According to data for quarter 4 of 2008/09, at 6–8 weeks 62.8 per cent of women were still breastfeeding their babies. Internal hospital audit data shows that at ten days after birth, exclusive breastfeeding has almost doubled since 2004/05.

Collaboration – planning and working together

Collaboration among a network of clinicians, children's services professionals and community partners that is as wide as possible is key to improving breastfeeding prevalence for all mothers – and particularly those from disadvantaged groups where breastfeeding is unlikely to be the norm. Those in a position to influence and support change will include family members (in particular fathers and partners), peer groups, businesses and a wide range of professionals working alongside young people, mothers and families.

It is particularly important that a coordinated continuum of care is achieved through commissioning, so that the PCT, hospitals and community partners work together – to the same agreed objectives – to promote breastfeeding and support mothers in initiating breastfeeding and continuing to breastfeed exclusively beyond 6–8 weeks.

In addition to providing direct support to mothers, babies and families in hospitals, in GP settings and through home visits, the PCT and partners should work closely with and through children's centres. Education and social care partners, schools and colleges and the wider community, including business and the third sector, should also be engaged in efforts to raise awareness, change attitudes and develop innovative services.

The task for those working at a strategic level is to lead effectively and identify the common ground: how does breastfeeding contribute to wider policy, performance and practice agendas? Commissioners should confirm

that systems are in place to ensure effective communication with, and coordination of, this network of allied professionals.

Policy, guidance and practice evidence suggest that commissioned services should be multifaceted to respond to the diverse needs of the population; to target support to mothers, babies and families in different settings; and to influence family and community support for breastfeeding.

Increasing breastfeeding initiation and prevalence embraces a wide range of need, from supporting mothers who are already convinced of the benefits, to supporting those who encounter difficulties or have complex needs, to influencing change among groups where there may have been no family or community experience or support for breastfeeding. Commissioning responsive, multifaceted services will demand a truly collaborative approach.

Commissioners will want to ensure that a wide range of clinicians, strategic groups representing them and community partners are able to contribute knowledge and expertise and inform needs assessment and commissioning decisions.

Clinical partners

These include:

- midwives working in hospital and community settings, heads of midwifery and maternity services liaison committees;
- health visitors;
- specialist practitioners, for example teenage pregnancy midwives;
- Family Nurse Partnership practitioners;
- clinical nurse specialists and school nurses;

- GPs and practice-based commissioning groups;
- dieticians, pharmacists and dentists;
- obstetricians, paediatricians, A&E staff and neonatal staff; and
- directors of public health and public health professionals working in maternity and early years settings.

Children's Trust and wider community partners

- Sure Start Children's Centre managers and staff;
- headteachers, college principals and pastoral leads;
- early years settings practitioners, including nurseries and childminders;
- peer supporters, maternity assistants, nursery nurses, breastfeeding counsellors and lactation consultants;
- local voluntary organisations such as the National Childbirth Trust, La Leche League, the Association of Breastfeeding Mothers and the Breastfeeding Network; local community groups that may host support services for mothers; and Baby Cafés;
- Healthy Schools and Extended Services coordinators;
- teenage pregnancy leads;
- services providing integrated youth support, such as Connexions and leaving care teams, youth offending teams and youth services;
- Children's Information Services;
- parenting commissioners and practitioners;
- faith and community groups;
- voluntary sector organisations working with children and families; and
- business and local media.

Some of these partners will be in the best position to help influence change through providing information, advice and encouragement at the right time, and helping build mothers' confidence to breastfeed.

GPs are crucial partners as they are able to both offer practical support and also contribute to improving consistent monitoring of breastfeeding prevalence through the six-week check. Consistent messages about the importance of breastfeeding and the risks of not breastfeeding, and the action required to improve prevalence and effective targeting, should be integrated into wider workforce planning and training agendas.

Family Nurse Partnership Programme (FNP)

The FNP is an intensive home-visiting programme for vulnerable, young, first-time mothers which begins in early pregnancy and continues until the child is two years old. The programme uses methods and materials that support behaviour change to improve child and family health and well-being.

Early results indicate that the programme seems to be engaging young women who are reluctant to breastfeed. Among FNP mothers, breastfeeding initiation was 63%, with more than a third (36%) of these clients still breastfeeding at six weeks, which compares favourably to the national Infant Feeding Survey 2005 for mothers under 20 (14%).

CASE STUDY 2: **NHS Knowsley and Knowsley Council**

The role of scrutiny in developing local breastfeeding services

In 2007/08, 32.5 per cent of babies in Knowsley were breastfed at birth (Department of Health outturn, 2007/08). This fell to 23.4 per cent at 10–14 days, and 16.9 per cent at 6–8 weeks. In light of this evidence, Knowsley's Health and Wellbeing Scrutiny Committee decided to set up a working group to:

- review why breastfeeding rates within Knowsley were significantly lower than the national average, and the lowest in the North West; and
- examine ways in which the council and its partners could work more effectively to improve breastfeeding rates and health outcomes in the borough.

Process

The working group met five times during September and October 2008 and received information and presentations from a variety of children and young people's services commissioners and providers.

Recommendations

The working group recommended the following:

- NHS Knowsley should commission a paid peer support service, building on the work of the voluntary service.
- The three maternity units serving Knowsley women should consider working towards Baby Friendly accreditation. Two units had already begun the process.
- There should be better information sharing and coordination between maternity units and the health visiting service, so that information is shared during the antenatal period.
- NHS Knowsley should commission an additional specialist midwifery resource, to work in partnership with Sure Start Children's Centres and target the most disadvantaged families.
- NHS Knowsley should consider how the health visitor service can be focused exclusively on children and families, and how health visitors can be enabled to carry out antenatal contact with all women, which includes discussion about breastfeeding and available support.
- Infant feeding should be incorporated into the key stage 1 and key stage 2 curriculum for Knowsley primary schools, and discussed within personal, social and health education (PSHE) in secondary schools.

CASE STUDY 2: **NHS Knowsley and Knowsley Council (continued)**

- Schools and all learning centres should sign up to the Breastfeeding Welcome scheme.
- Private facilities should be made available to the public for breastfeeding in all NHS and council premises that deliver services to the public, and relevant council directorates should encourage the inclusion and development of Baby Friendly facilities.

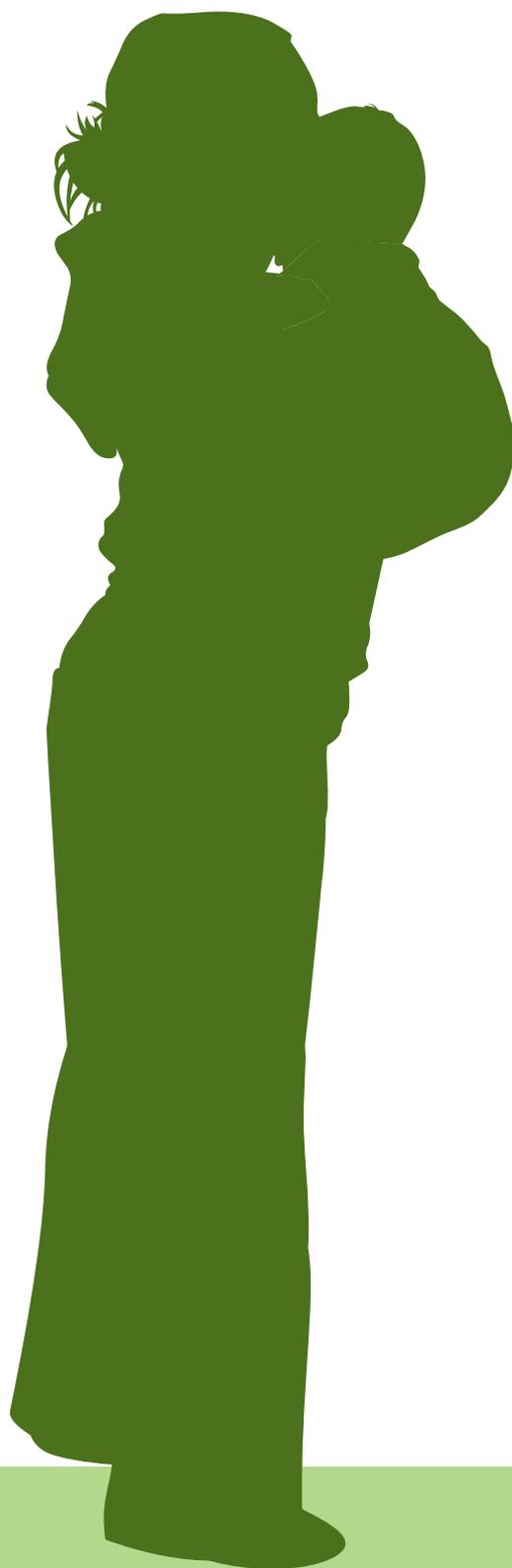
Benefits of scrutiny

Breastfeeding rates have begun to improve significantly in the last year and the initiation rate now stands at 39.7 per cent (Department of Health outturn, 2008/09). The scrutiny process added value to ongoing work through:

- bringing providers together to help build a collaborative and integrated approach; and
- demonstrating the range of services that is needed in order to improve breastfeeding prevalence, and how breastfeeding relates to other local agendas and targets.

A copy of the scrutiny report can be obtained from: Paula Simpson, Public Health Commissioning Manager, NHS Knowsley, paula.simpson@knowsley.gov.uk

4. Assessing need and strategic planning (competencies 1–6)





You need a lot of courage if you are wanting to go out ... you've just got to hold your head up high and think 'I am doing this for my baby'.

(Dykes et al, 2003)¹⁴



Successfully raising levels of breastfeeding prevalence, and reducing health inequalities as part of that effort, will depend on knowing your local population well, mapping service provision and addressing gaps in services, and assessing evidence of what works.

Strategic needs assessments are the product of a systematic review of local need informed by the full range of clinical and community partners. The Joint Strategic Needs Assessment (JSNA)¹⁵ should provide commissioners with an accurate overview of short and long-term local need in relation to promoting and achieving higher levels of breastfeeding prevalence, set against existing provision.

This guidance recognises, as in other areas of commissioning, that there will be variations in the quantity and quality of local intelligence and mapping about breastfeeding experiences, needs and services, and that identifying needs and gaps will be an ongoing process.

Data, service evaluations and qualitative feedback continue to highlight areas of unmet need, gaps in services and strategies that are proving successful in improving outcomes, and will be helpful data sources when refreshing JSNAs.

The JSNA should align with three-yearly LAAs, and will be informed by the needs assessment undertaken for the Children and Young People's Plan (CYPP).¹⁶

Mapping current services to promote and support breastfeeding, including hospital and community and those delivered by the NHS, local authority and third sector organisations, will be an important element of local needs assessment and gap analysis. The Regional Public Health Group in London has commissioned a service mapping exercise to inform the commissioning process and signpost users to services. It is being undertaken (2009) by the University of York, Durham University and the national Child and Maternal Health Observatory (ChiMat), and will be available at www.chimat.org.uk/ www.childrensmapping.org.uk

14 Dykes et al, Adolescent mothers and breastfeeding: experiences and support needs – an exploratory study, *Journal of Human Lactation*, 2003; 19:391–401.

15 Department of Health, *Guidance on Joint Strategic Needs Assessment*, 2007, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097

16 Department for Children, Schools and Families, *Guidance on CYPP*, 2009, www.dcsf.gov.uk/everychildmatters/strategy/managersandleaders/planningandcommissioning/cypp

CASE STUDY 3: NHS Warwickshire

Working towards the 85 per cent Vital Sign data coverage target

Achieving the Vital Sign target for breastfeeding at 6–8 weeks of 85 per cent coverage (2008/09 target) in Warwickshire has been a challenge. However, collaborative working and a proactive approach with Warwickshire's Breastfeeding Strategic and Partnership Group, GPs, Child Health, Public Health and NHS Warwickshire's intelligence teams is paying off.

GPs carry out the 6–8 week health check and share their data with the Child Health team.

Coverage rates varied across the county from 42 per cent in the north to almost 100 per cent in the south. It was agreed that a proactive approach was needed to increase coverage countywide. A variety of measures to increase coverage rates were put in place:

- a letter to all GPs reminding them to record breastfeeding status and share data with the Child Health team;
- ensuring that all involved understand the definitions for recording data;
- creating a centralised system for data collection;
- a monthly list of GP returns to identify missing or inaccurate data produced and shared with GPs and health visitors;
- child Health actively following up missing and inaccurate data;
- quarterly data shared with all health visiting teams; and
- awareness raising sessions for health professionals and partners.

Because of these measures Warwickshire achieved over 85 per cent coverage in quarter 4 (2008/9). Work will continue to ensure that NHS Warwickshire achieves the 2009/10 coverage target of 90 per cent.

**For further information contact: Fran Poole, Health Development Manager,
NHS Warwickshire, francine.poole@nhs.net**

Research evidence, national indicators and regional and local data

There is a rich body of research evidence on the long-term and cost-effective health benefits of breastfeeding, on which commissioners can draw. Appendix 1 signposts commissioners to some key sources of research and information.

Each PCT is required to submit data quarterly to the Department of Health on initiation and duration of breastfeeding. Commissioners will need a reliable baseline in order to plan and prioritise services. Where data is not felt to be robust or complete, commissioners and their strategic partners should clarify data needs and ensure that systems are in place to provide a detailed profile. Working closely with GPs, health visitors and other clinical and community partners will be important to achieve a reliable baseline assessment.

Commissioners can access national, regional and local data in relation to breastfeeding prevalence and continuation at www.dh.gov.uk/infantfeeding which sets out PCT performance against Vital Signs Monitoring System Indicator VSB11. Achieving data coverage of sufficient quality to be included in the national data set and increasing breastfeeding prevalence will be assessed in the Periodic Review (formerly Annual Health Check).

The Department of Health gives guidance to PCTs on how to collect the data to ensure that results meet the quality criteria for inclusion in the national data set (www.dh.gov.uk/en/Healthcare/Children/Maternity/Maternalandinfantnutrition/Breastfeedinginfantfeeding/DH_085657).

In addition to public health data on health outcomes and inequalities, commissioners will be able to draw on additional strands of demographic data collected by the local authority highlighting, for example, patterns of teenage pregnancy and deprivation in the area.

CASE STUDY 4: NHS Rotherham

Breastfeeding Health Equity Audit

NHS Rotherham recognised the importance in 2005 of interrogating their breastfeeding data. They undertook a breastfeeding health equity audit exploring the links between deprivation and breastfeeding initiation and continuation rates. This enabled NHS Rotherham to have a better understanding of the breastfeeding practice within the borough and within smaller geographical areas. It is important to note that the process of completing the health equity audit identified some data collection issues which needed to be addressed, and therefore the data has since been viewed with caution.

The process also provided important information on the success of local Sure Start programmes. This information was shared with the Sure Start Children's Centres Data Management Lead who mapped the data against Sure Start Children's Centre reach areas which provided the local Sure Start Children's Centre managers with the knowledge of breastfeeding rates within the communities that they served.

This information has supported commissioning activity within Rotherham and ensured that funding has been secured to maintain the focus of reducing inequalities and delivering a comprehensive breastfeeding strategy successfully across the Rotherham area.

For further information contact: Anna Jones, Public Health Specialist Maternity, Children and Young People, NHS Rotherham, anna.jones@rotherham.nhs.uk

ChiMat supports the Child Health Strategy and is a key resource for policy makers, commissioners, managers, regulators and other health stakeholders. It provides and updates information and intelligence through a 'knowledge hub', to improve decision-making for high-quality, cost-effective services (www.chimat.org.uk).

Series of the Infant Feeding Survey, conducted every five years, provide a wealth of information on infant feeding practice, mothers' experiences of services and trends (www.ic.nhs.uk/pubs/ifs2005). The next Infant Feeding Survey will be published in 2010.

London SHA has produced a Quick Reference Guide to help PCTs quickly map their performance (www.london.nhs.uk/publications/tools-and-resources/pct-performance--quick-guides).

The UNICEF Baby Friendly Initiative has produced a guide, 'Developing a breastfeeding strategy'. The guide follows the process from the initial stages of putting together a steering committee and agreeing objectives through to working out interventions for the various services in your trust and assessing where the priorities for intervention lie (www.babyfriendly.org.uk/page.asp?page=221). For more information see

Appendix 1. Other useful links include: www.babyfriendly.org.uk (provides information on implementation of BFI) and www.dh.gov.uk/en/Healthcare/Children/Maternity/Maternalandinfantnutrition/Breastfeedinginfantfeeding/index.htm (provides local data on breastfeeding initiation and prevalence).

Workforce capacity, training and development

Commissioners should also gain an overview of workforce capacity and capability, assess training and skills gaps in relation to enabling and supporting mothers to breastfeed, and decide how they will be addressed. BFI, supported by NICE guidance, offers a quality standards-based route to achieving this. Critically important are the skills of hospital maternity and neonatal teams and community midwives, health visitors and peer supporters. Expectations of existing training providers, particularly in relation to the training of midwives, neonatal nurses and health visitors, may need to be clarified and strengthened.

There should be scope to address some training needs, in collaboration with local authority and other partners, such as Sure Start Children's Centres, as part of wider public health and children and family services agendas. The importance of promoting breastfeeding, and creating environments conducive to breastfeeding, needs to be threaded through the training agendas of the wider workforce. For instance:

- How are messages about breastfeeding fed in to the PSHE curriculum, Healthy Schools programme, and parenting support programmes?
- Are services working with young vulnerable women and pregnant teenagers, such as

social care, integrated youth services and leaving care teams, equipped to advise, support and signpost?

Higher education authorities responsible for training midwives, neonatal nurses and health visitors should ensure that on qualification students are 'fit for practice' and able to support women to successfully initiate and continue breastfeeding.¹⁷

Qualitative feedback from service users

Feedback from service users can be the most powerful form of evidence to support local commissioning decisions. Finding out why women don't intend to breastfeed, or the (preventable and treatable) reasons that cause them to stop, is key to developing services that will tackle barriers, enable women to breastfeed and drive up prevalence rates. Methods of gathering feedback should be carefully considered to provide information that will illuminate local data and address gaps in information.

This could take the form of surveys, focus groups and face-to-face outreach interviews. Involving mothers and families from different ethnic and demographic groups, with different experiences of services in different settings, in the design of feedback exercises is important. Who gathers data, and in which setting – hospital, GP, children's centre – is likely to influence feedback. Maternity services liaison committees should be a key source of local intelligence for commissioners, especially in relation to feedback on local services. To gain maximum insight into what works, commissioners should try to ensure independence in gathering user feedback.

¹⁷ Nursing and Midwifery Council, *Standards for pre-registration midwifery education*, 2009, www.nmc.org.uk

CASE STUDY 5: University of Nottingham

Midwifery training

The University of Nottingham has achieved the UNICEF Baby Friendly University Standards award for both its long and short midwifery education courses. It was the first institution in the country to be assessed for both courses at the same time. The process took around two and a half years from registering intent with Baby Friendly in April 2006 to achieving the award in December 2008.

The motivation to undertake the assessment stemmed from concerns nationally that student midwives were exiting programmes with deficits in their knowledge, skills and competence to support breastfeeding. While the Nottingham programme prioritised theoretical aspects of infant feeding, there was room for improvement in relation to the practice aspects. The development of Nursing and Midwifery Council Essential Skills Clusters supported Nottingham's developments in breastfeeding education.

The Lead Midwife for Education and Division Head was pivotal in supporting the process and achieving funding from the university for each stage of the assessment. The experience has been motivating for students, teachers and service providers, but more importantly it ensures that families are supported by knowledgeable, competent midwives.

Confidence from practice sites used by the university is such that one large NHS trust which has longstanding BFI accreditation no longer feels it necessary to induct newly qualified midwives in BFI practices.

For further information contact: Lindsay Cullen, Midwife Teacher, The University of Nottingham, lindsay.cullen@nottingham.ac.uk

Further information about the Baby Friendly Initiative University Standards programme can be found on the UNICEF Baby Friendly website: www.babyfriendly.org.uk

Qualitative feedback will be most useful to commissioners if it relates to each stage of a mother's pathway:

- pregnancy/antenatal services
- birth and immediately post-birth
- 1 week
- 2 weeks
- 6–8 weeks

- 4 months
- 6 months
- 12 months.

Commissioners should consider whether it is necessary to fund or jointly commission qualitative feedback. Sure Start Children's Centres will be in a good position to help facilitate feedback, and third sector organisations can offer some independence

in carrying out focus groups. Particular care is needed to ensure that those groups least likely to take up conventional services are reached. Gaps in knowledge about the local population's needs and experiences should inform the focus of qualitative exercises.

To tailor services appropriately, commissioners may, for instance, need to know more about:

- geographical hot spots;
- mothers' experiences in hospital;
- mothers' experiences in community settings; and
- experiences of particular groups:
 - pregnant teenagers and young mothers;
 - mothers from lower socio-economic groups;
 - mothers from different minority ethnic groups;
 - disabled mothers and mothers with learning difficulties;
 - mothers with complex health needs; and
 - mothers of pre-term babies or babies with complex health needs, etc.

In some circumstances home visits and advocacy (perhaps through peer supporters) may be necessary to ensure that women and partners not normally able to give comments are included.

There may be opportunities to include questions about breastfeeding services in wider NHS or local surveys routinely planned or conducted. Commissioners will need more than 'satisfaction' surveys – it will be important to hear both good and bad user experiences,

and set questions about expectations of services, quality of care and consistency of provision against NICE guidelines and BFI accreditation standards.

Qualitative feedback should cover:

- whether and when information about breastfeeding was offered, how easy it was to access, whether it was tailored to local population needs e.g. languages other than English, and whether it influenced decisions to breastfeed;
- whether and when practical support to breastfeed was offered and how effective it was;
- whether mothers had a choice in how to feed their baby and whether, and how, they were supported in that choice;
- whether mothers were able to breastfeed exclusively, and for as long as they wished;
- what enabled mothers to breastfeed, what the barriers were and what helped to overcome problems;
- what/who made the biggest difference/helped in their decision to start breastfeeding/not to breastfeed/to continue breastfeeding;
- what (services/support) would help them next time/help others; and
- whether there were opportunities to express and store breast milk for babies separated from their mothers, and for those who wish to continue to give their babies breast milk, for instance where a baby is sick or where a mother returns to work.

While feedback from local service users will be of most value in shaping local services, there is considerable collective knowledge about users' experiences, and useful schedules of questions, in the national Infant Feeding Survey (The Information Centre), in the Healthcare Commission's *Towards better births: a review of maternity services in England* and from organisations such as the National Childbirth Trust, the La Leche League, the Association of Breastfeeding Mothers, Lactation Consultants of Great Britain and the Breastfeeding Network (see Appendix 1 for further details and web links).

The National Social Marketing Centre, a strategic partnership between the Department of Health in England and Consumer Focus (formerly the National Consumer Council), has developed benchmark criteria to help achieve behavioural change in areas of public health and features breastfeeding among its case studies (www.nsms.org.uk). See also Leatherman S and Sutherland K, *Patient and Public Experience in the NHS*, QQUIP (Quest for Quality and Improved Performance), The Health Foundation, 2007 (www.health.org.uk).

The Information Centre has a PCT data pack containing a range of indicators, including ones on breastfeeding prevalence, programme budgeting and demographics. PCTs can use the data pack to benchmark their performance and rate of improvement with their peers. It is available at www.ic.nhs.uk/commissioning.

Strategic planning should result in a local breastfeeding strategy. This should be based on performance data and strategic needs assessment, including data and intelligence from community partners – particularly in relation to reducing health inequalities among the local population. It should also be informed by evidence of what works – nationally and locally.

5. Shaping local breastfeeding services (competencies 1–4 and 6–11)





It would be nice if somebody could just come and spend ten minutes with you to talk about breastfeeding. If they did that they could learn about your concerns and anything you feel you need help with. I mean I'm not very confident at all.

(Dykes, 2005)¹⁸



PCTs should already have in place a range of services to support mothers during pregnancy and postnatally. As part of needs assessment commissioners should review and assess the current contribution of these services to increasing breastfeeding prevalence, and also the extent to which these services are engaging with and having an impact on groups where breastfeeding prevalence is particularly low. Consideration also needs to be given to assessing the prevalence, support and continuation of breastfeeding for those babies who are in neonatal services requiring special care.

¹⁸ Dykes, A critical ethnographic study of encounters between midwives and breastfeeding women on postnatal wards, *Midwifery*, 2005; 21:241–52.

Continuity of care – multifaceted services

Services will need to provide continuity of care in a variety of settings:

- **Pregnancy** – accessible antenatal information, education and services for mothers and partners, underlining the benefits of breastfeeding and the risks of not doing so. Each woman should be given the Department of Health-funded DVD *From Bump to Breastfeeding*¹⁹ at 28 weeks' gestation. Services should be proactive and tailored to meet the needs of groups least likely to access antenatal care and least likely to breastfeed. All women should be informed about the benefits of breastfeeding, and this should be audited on a regular basis.
- **Birth** – maternity services: midwives, maternity assistants, neonatal services and peer supporters offering skilled support and a positive ethos. All mothers should be encouraged to have skin-to-skin contact with their babies, and be helped to breastfeed within an hour of birth. If separated, mothers should be supported to initiate expression of breast milk which should be offered to the baby, and the mother's lactation maintained. Staff should be trained to BFI standards and be able to help mothers build confidence and overcome initial problems. According to the Infant Feeding Survey, the risk of mothers not initiating breastfeeding at birth, and of being given infant formula while in hospital, is high and detrimental to continued breastfeeding.

¹⁹ Bump to Breastfeeding (www.orderline.dh.gov.uk/ecom_dh/public/home.jsf, product code: 286873).

- **One week** – prevalence of breastfeeding is estimated to drop from 78 per cent to 66 per cent, and below in some areas, within the first week. The transition from hospital to community is critical and services need to achieve continuity of support: from hospital to community midwives, maternity assistants, neonatal services, Sure Start Children's Centres and peer supporters. A mechanism should be in place to assess which mothers are considered at high risk of stopping, for example young mothers or those with additional needs and from lower socio-economic groups, so that targeted support can be provided by designated staff, trained to BFI standards, within 48 hours of discharge from hospital.
- **Eight days to six weeks** – continuity of care also needs to be assured when postnatal care passes to a universal service provided by health visitors in week two. Again, staff should be equipped to provide specialist support for mothers and families who need it.
- **Six weeks to six months** – ongoing support and encouragement for mothers provided by peer supporters, GPs and health visitors at the six-week check and through voluntary sector and Sure Start Children's Centre support groups – to promote exclusive breastfeeding for six months with appropriate and timely introduction of other foods alongside breast milk. Information, advice and support provided (by health and community services, voluntary organisations and employers) to mothers returning to work.

UNICEF Baby Friendly Initiative

Government policy, underpinned by NICE guidance, promotes the adoption and implementation of the UNICEF BFI as the best evidence-based vehicle to raise levels of breastfeeding prevalence. Evidence suggests that mothers delivering in Baby Friendly accredited hospitals are more likely to initiate breastfeeding (see Appendix 1). PCTs with the lowest levels of breastfeeding prevalence demonstrate the greatest gains.

However, Bolling et al, *Infant Feeding Survey 2005, 2007* showed that 78 per cent of mothers in England breastfed their babies at birth, but that by six weeks the number had dropped to 50 per cent. The challenge is therefore to commission services that provide continuity of support to mothers in different settings. BFI provides a comprehensive framework based on ten steps to successful breastfeeding for maternity services and a seven-point plan for sustaining breastfeeding in the community. In 2008/09 the Government committed £4 million additional funding for 40 PCTs to fund BFI in areas of particularly low prevalence, and has committed a further £3 million for 2009/10.

BFI involves a staged approach to full accreditation. By Stage 2 all providers – acute and community – will be expected to routinely deliver a comprehensive package of training to all staff providing breastfeeding support for women. Commissioners should

assess where they are on the BFI 'trajectory' and assess the short-, medium- and long-term benefits in relation to their assessment of need and evidence of the impact of existing services on outcomes.

CASE STUDY 6: The Pennine Acute Hospitals NHS Trust

Baby Friendly

Achieving and maintaining Baby Friendly hospital status has made a dramatic difference to breastfeeding initiation rates in this area of the North West.

Pennine Acute Hospital NHS Trust is one of the largest NHS trusts in the country. It includes four hospitals and handles 11,000 births a year.

Both the Royal Oldham and North Manchester General Hospitals have maintained Baby Friendly status, with Oldham being accredited for ten years. Initiation rates have gone up from 29 per cent prior to accreditation in Oldham to the current figure of 68 per cent and in North Manchester from 29 per cent to 63 per cent.

The two remaining hospitals, Rochdale Infirmary and Fairfield General Hospital in Bury, are working towards achieving Stage 2 of the accreditation process later this year.

The service is coordinated by the Infant Feeding Coordinator, who is supported by two Band 7 midwives and four part-time healthcare support workers. In addition to providing support to breastfeed, a twice-weekly region-wide frenulotomy clinic is available.

**For further information contact: Val Finigan, Infant Feeding Coordinator,
Pennine Acute Hospital NHS Trust, val.finigan@pat.nhs.uk**

Information and support – voluntary sector providers

National and local voluntary sector organisations have provided and continue to provide a wide range of information and direct support to mothers and families. For commissioners they are an important source of experience and intelligence about local needs and mothers' experiences of local services, as well as being potential providers.

The Department of Health has funded a single National Breastfeeding Helpline (0300 100 0212, www.breastfeeding.nhs.uk), in collaboration with the Breastfeeding Network and the Association of Breastfeeding Mothers, which routes callers to their nearest trained volunteer mothers, providing a local – or nearly local – service seven days a week. The National Childbirth Trust, the La Leche League, the Association of Breastfeeding Mothers and the Breastfeeding Network all offer helplines in addition to support groups and published information.

The Baby Café Charitable Trust coordinates a network of drop-in centres to support breastfeeding mothers, and the charity Best Beginnings (in collaboration with the Department of Health) developed a DVD, *From Bump to Breastfeeding*, providing accessible support to mothers on how to breastfeed, which is now distributed to all mothers as part of antenatal care (see Appendix 1).

National Breastfeeding Helpline
0300 100 0210
www.breastfeeding.nhs.uk

Timely and accessible information and advice can influence and change individual behaviours. How information is provided and who provides it should be part of needs assessment, and included in service specifications. Local Children's Information Services, GPs and Sure Start Children's Centres will be key partners in providing information and signposting mothers and families to support. Needs assessment may also suggest the need for jointly commissioned public information and media campaigns, or social marketing exercises, to promote breastfeeding and influence attitudes in the local area.

Peer support

Peer support can be critical in giving mothers the confidence and encouragement to start and continue to breastfeed. Peer support programmes should be proactive, effectively managed and provide supervision, and wherever possible peer supporters should be paid or reimbursed. The NICE Commissioning Guide *Commissioning a peer-support programme for women who breastfeed* offers commissioners comprehensive guidance, suggests joint commissioning of peer support programmes and cautions that they should be commissioned 'only as part of a breastfeeding strategy'.

NICE Public Health Guidance 11 on maternal and child nutrition also recommends that commissioners and managers of maternity and children's services should provide local, easily accessible breastfeeding peer support programmes and ensure that peer supporters are part of a multidisciplinary team. Service models should focus on women who are least likely to breastfeed: young women, women with low educational achievements and those from disadvantaged backgrounds.

Peer supporters should:

- have attended an externally accredited peer support training programme;
- be able to consult a health professional for support;
- contact new mothers within 48 hours of their transfer home (or of a home birth) in addition to existing health professional visits; and
- offer ongoing support according to the mother's individual needs: either face to face, via telephone or through groups.

Data suggests that an estimated 85 per cent of breastfeeding women access peer support services when offered as above. NICE recommends that a whole-time equivalent supporter is available for every 250 breastfeeding mothers. Additional peer supporters may be needed to provide antenatal services.

Workforce development

Developing the capacity of the workforce, including leadership skills, may emerge as a priority in local breastfeeding strategies or from local needs assessment, and is likely to be an ongoing demand. Service specifications should specify quality standards as set out in BFI accreditation and NICE guidelines.

Prioritising investment

Prioritising investment should be driven by local improvement targets set out in the JSNA, CYPF and NHS operating plans – to deliver PSA 12 increases in breastfeeding prevalence.

The Care Quality Commission's Periodic Review (formerly Annual Health Check) is one of the major judgements of an organisation's performance. As part of the 2009/10 review, PCTs will be assessed against 37 indicators covering existing commitments and national priorities – of which PSA 12.1 (prevalence of breastfeeding at 6–8 weeks) is one. The indicators will contribute towards a PCT's overall score for quality of service. Furthermore, the NHS Litigation Authority (formerly the Clinical Negligence Scheme for Trusts) now includes newborn feeding as a Clinical Risk Management Standard (Standard 5). Maternity services complying with the standards receive a discount on insurance.

Value for money

Global and national evidence is unequivocal that breastfeeding saves lives, is preventive and saves money. Babies who are not breastfed are five times more likely to be admitted to hospital with gastroenteritis. A 10 per cent increase in breastfeeding prevalence at six months would avoid 1,700 cases of otitis media, 3,900 cases of gastroenteritis and 1,500 cases of asthma a year.

The available evidence suggests that breastfeeding may also have long-term benefits in adulthood, such as lower blood pressure and total cholesterol levels. Furthermore, breastfed infants were found to be less likely to be overweight/obese in later childhood. (see Horta et al, 2007, Appendix 1). Some studies suggest that breastfed infants perform better in intelligence tests.

In the longer term, breastfeeding can protect mothers against breast cancer – the relative risk of breast cancer decreases by 4.3 per cent for every 12 months of breastfeeding.

Increasing breastfeeding prevalence contributes to reductions in health service costs (NICE costing template 2006, see Appendix 1). An increase of 10 percentage points in prevalence at six months means that 60,000 extra infants are breastfed every year, resulting in 145 fewer cases of breast cancer every year, and providing estimated annual savings to the NHS in treatment costs as follows:

Otitis media – £0.5 million
Gastroenteritis – £2.3 million
Asthma – £2.6 million
Lower respiratory tract infection – £0.8 million
Breast cancer – £0.9 million
TOTAL SAVING – £7.1 million every year

NICE Clinical Guideline 37, *Routine postnatal care of women and their babies*, includes clear recommendations and a costing report and template to support implementation and to calculate national and local costs and savings, including costs in relation to implementing BFI.

Commissioners will also be able to draw on local demographic, employment and public health data to help prioritise investment among particular groups and geographical areas, by drilling down to GP practice and maternity unit level.

Some longer-term benefits, for example in relation to parenting styles and attachment, mental health and contributions to reducing worklessness, are difficult to quantify. Research evidence, however, supports the importance of looking at wider outcomes and benefits, including cognitive development (e.g. Gutman et al, 2009, Quigley et al, 2005 and Kramer, 2008: see Appendix 1).

Promote improvement and innovation

BFI is regarded as a key delivery mechanism to increase breastfeeding prevalence. Stakeholders also suggest that successful implementation of BFI constitutes both improvement and innovation – especially where it achieves continuity of care throughout a mother's maternity pathway.

Breastfeeding support services that demonstrate improvement and innovation will:

- be proactive and preventive;
- provide women with information that aids decisions, and the type of support that enables initiation and continuation of breastfeeding, resolving problems when they arise;

CASE STUDY 7: NHS Central Lancashire

Social marketing campaign

The 'Be a Star' campaign, which was originally commissioned by NHS Central Lancashire and has now been adopted by 15 PCTs around the country, is dedicated to increasing the number of young mothers who choose to breastfeed. This is done by showcasing the beauty, confidence and pride that comes with breastfeeding, as well as providing breastfeeding information and support and highlighting the unique health benefits that it brings to both baby and mother.

'Be A Star' is for young mothers, by young mothers, and the gorgeous girls you see fronting the campaign are also real, local, young mothers, breastfeeding their babies. The campaign has a dedicated website: www.beastar.org.uk.

**For further information contact: Glenis Tansey,
Public Health Specialist, NHS Central Lancashire,
glenis.tansey@centrallancashire.nhs.uk**



- provide evidence for commissioners of improved rates of prevalence among population groups where change is most needed, and evidence of saved costs in terms of admissions and re-admissions;
- provide evidence of institutional change: Baby Friendly environments (hospital and local authority); and
- provide evidence of impact on wider cultural change within the local area in terms of attitudes to breastfeeding.

Some evidence-based innovative service models should focus on 'big impact' to tackle the wider social barriers to breastfeeding, such as the 'Be a Star' campaign, initially developed by NHS Central Lancashire in the North West,

and now providing inspiring role models to young white women in the region. Similarly, the 'Get Britain Breastfeeding' art exhibition, produced by Best Beginnings, showcases award-winning images of breastfeeding to be used by PCTs and local authorities to target children approaching adolescence – in order to raise awareness and dispel myths (www.bestbeginnings.info).

Quality of services – specificity of contracts

Voluntary sector organisations are key partners in the delivery of quality services, and should inform the development of quality measures and how progress will be monitored and measured. Service specifications and contracts should be explicit about:

- service objectives, desired outcomes, targets and milestones;
- service management, staffing and resources, including required skills and competencies;
- strategic framework (national/regional/local) and expectations;
- target groups (and geographical areas) the service is for;
- access and referral to the service; and
- monitoring and evaluation arrangements.

As part of shaping services, commissioners should make links to other health and local authority agendas, such as strategies to tackle obesity, improve parenting support, develop the school curriculum and work with employers to enable mothers to breastfeed on return to work. In addition to procurement of discrete breastfeeding services, an overall breastfeeding strategy should ensure that promoting and supporting breastfeeding is integrated into delivery plans of existing services.

6. Improving performance, monitoring outcomes (competencies 1–6 and 10)





I was desperate to feed the first time and was devastated when I couldn't. I remember sitting and crying for the whole night because I could not breastfeed and I felt as though I had done something wrong. Whereas this time I have had support and I know I can do it ... I am thrilled – I have done 8 weeks so far, I am absolutely thrilled.

(Carole, Croydon, mum-to-mum breastfeeding support group)



Quarterly returns on prevalence levels represent a key monitoring tool.²⁰ However, prevalence levels, whether they are improving or not, will not in themselves capture the mother's journey, experience of services or the quality of services. Crucially they will not throw light on when and why a particular intervention or service worked for different groups of mothers. Qualitative feedback

from mothers and partners should therefore be an important element of monitoring for commissioners.

Quality and progress benchmarks could include:

- improved accuracy and consistency of data and increased sharing of data across Children's Trust partners;
- prevalence rates and length of breastfeeding broken down by: age of mother; geographical area; GP/midwifery practice/health visitor/children's centre; socio-economic group; and ethnicity;
- how many mothers were reached, and age of baby at first and last visit;
- access to services by targeted groups;
- progress towards BFI community and acute accreditation stages;
- whole time equivalent peer support workers (NICE guidance 1:250 breastfeeding mothers);
- retention of peer supporters;
- numbers of women who access peer support, where and when;
- monitoring numbers of women using Sure Start children's centres for breastfeeding support;
- re-admission to hospital as a result of gastro-intestinal and respiratory tract infections; and
- training delivered to BFI standards.

²⁰ www.dh.gov.uk/en/Healthcare/Children/Maternity/Maternalandinfantnutrition/Breastfeedinginfantfeeding/DH_085657

Who undertakes monitoring is something that should be agreed at partnership level and included in service specifications. Sure Start Children's Centre staff and third sector organisations – including providers of peer

support and other breastfeeding support services – midwives, health visitors and GPs are all in a position to monitor prevalence levels, service effectiveness and barriers to accessing services.

CASE STUDY 8: Staffordshire, Shropshire & Black Country Newborn Network

In the West Midlands the benefits of having specialist breastfeeding support available on neonatal units has been recognised and promoted.

The University Hospital of North Staffordshire (UHNS) employs a research breastfeeding midwife specialist. In addition to having a positive impact on breastfeeding practices on the neonatal unit, she also chairs the Staffordshire, Shropshire & Black Country Newborn Network breastfeeding group, thus allowing good practice to be shared and developed at a sub-regional level.

A study day entitled 'Helping Mothers to Express Milk and Breastfeed Premature Babies', training materials for staff new to the neonatal unit setting, and an educational CD-ROM are available for multidisciplinary training. All units in the network are encouraged to work towards the UNICEF Baby Friendly accreditation, and three units have already acquired Baby Friendly status.

Specialist milk expression guidelines for mothers who deliver pre-term babies have been developed to recognise and manage their special needs. These guidelines can be found on the UNICEF Baby Friendly website (www.babyfriendly.org.uk) as an example of good practice.

All parents of pre-term babies receive the specialist leaflet *Breastfeeding Your Premature Baby*, which is available to order or download from the premature baby charity Bliss (www.bliss.org.uk).

The milk expression rate for pre-term mothers is 82 per cent at UHNS and breast milk is highly recommended for all babies.

For further information contact: Elizabeth Jones MPhil RN RM, Specialist and Intensive Care of the Newborn Senior Breastfeeding and Neonatal Research Practitioner, elizabeth.jones@uhns.nhs.uk

An infrastructure to track mothers from the start of pregnancy and children from birth will facilitate effective monitoring and target support where and when it is needed. Crucially, commissioners will want to ensure that monitoring leads to action.

Commissioners should consider reviewing whether investment in services such as peer support, training and capacity building is having a positive and measurable impact on outcomes over specified periods, including reducing health inequalities, and whether it is being delivered to quality standards as set out by the BFI and NICE guidance. This information should be reported to relevant public health and Children's Trust strategic forums to inform future planning and investment, and also to decide where services may need to be de-commissioned, and new evidence-based interventions introduced.

Independent evaluation of breastfeeding support services – spanning acute and community – should help commissioners and Children's Trust partners to improve performance and strengthen commissioning. Monitoring and evaluation that is rooted in the direct experiences of local mothers and their families, including women whom services are currently struggling to reach, will be most powerful in helping commissioners to shape and influence future services.

Appendix 1: Key sources of evidence and further information

The following selected references provide evidence of the health and wider benefits of breastfeeding and the risks associated with not breastfeeding, and specific evidence in relation to BFI, peer support and education and training needs.

Breastfeeding

Beral V, Breast cancer and breastfeeding: collaborative reanalysis of individual data from 47 epidemiological studies in 30 countries, including 50302 women with breast cancer and 96973 women without the disease, *Lancet*, 2002; 360:187–95.

Bolling K et al, *Infant Feeding Survey 2005*, London: The Information Centre, 2007.

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Web-based resources

The following organisations and websites provide further resources and examples of service improvement and innovation.

www.abm.me.uk The Association of Breastfeeding Mothers is a charity run by mothers for mothers, giving friendly support and supplying accurate information to all women wishing to breastfeed. It also supports the National Breastfeeding Helpline.

www.amicus-cphva.org A professional organisation for health visitors, school nurses, nursery nurses and other community nurses working in primary care.

www.babyfriendly.org.uk Provides up-to-date information on research and breastfeeding activity in the UK, and information for commissioners on how to deliver the UNICEF UK BFI. Users can subscribe to email updates.

The UNICEF UK BFI has produced a guide, *Developing a breastfeeding strategy*. The guide follows the process from the initial stages of putting together a steering committee and agreeing objectives through to working out interventions for the various services in your Trust and assessing where the priorities for intervention lie. An appendix of evidence and references to support and inform your strategy is also included. The document includes guidance on: setting up a steering committee; consulting and involving stakeholders; writing the strategy document; staff roles and responsibilities; and a sample action plan. **www.babyfriendly.org.uk/page.asp?page=221**

www.babymilkaction.org Baby Milk Action is a non-profit organisation that aims to save lives and end avoidable suffering caused by inappropriate infant feeding. It works globally to strengthen controls on marketing by the baby feeding industry.

www.beastar.org.uk The Be a Star campaign is dedicated to increasing the number of young mums who choose to breastfeed. The campaign showcases the beauty, confidence and pride that can come with breastfeeding, as well as providing breastfeeding information and support.

www.bestbeginnings.info Best Beginnings is a charity dedicated to reducing child health inequalities. Features links to the *From Bump to Breastfeeding* DVD and the *Get Britain Breastfeeding* art exhibition.

www.bliss.org.uk Bliss is a special care baby charity that provides vital support and care to premature and sick babies across the UK.

www.breastfeedingmanifesto.org.uk The Breastfeeding Manifesto was produced in 2006 in consultation with over 20 UK organisations working to improve awareness of the health benefits of breastfeeding and its role in reducing health inequalities.

www.breastfeedingnetwork.org.uk The Breastfeeding Network provides breastfeeding support and information for mothers and those involved in their care. It also supports the National Breastfeeding Helpline.

www.breastfeeding.nhs.uk Designed to provide information and support for users and health professionals. Resources to support national breastfeeding awareness week, every May, can be ordered from this site.

www.chimat.org.uk The Child and Maternal Health Observatory provides information and intelligence to improve decision-making for high-quality, cost-effective services. It supports policy makers, commissioners, managers, regulators and other health stakeholders working on children's, young people's and maternal health.

www.dh.gov.uk/infantfeeding Provides guidance and details of breastfeeding initiation and continuation data for all PCTs. Contains up-to-date information relating to breastfeeding, including national policy documents and regional infant feeding coordinator details.

www.laleche.org.uk La Leche League strives to help mothers worldwide to breastfeed through mother-to-mother support, encouragement, information and education.

www.lcgb.org The Lactation Consultants of Great Britain is the professional association for qualified lactation consultants and specialises in promoting, protecting and supporting lactation issues.

www.littleangels.org.uk Little Angels is a community non-profit organisation, run by mothers for mothers. It aims to promote, support and protect breastfeeding within the community.

www.multiplebirths.org.uk The Multiple Births Foundation is an independent charity based at Queen Charlotte's and Chelsea Hospital in West London. A vital resource for professionals and families, it aims to improve care and support of multiple birth families through the education of all relevant professionals.

www.nct.org.uk The National Childbirth Trust is a leading charity for parents, supporting people through pregnancy, birth and early parenthood.

www.nice.org.uk Key documents referenced in this guide can be downloaded from the National Institute for Health and Clinical Excellence site as PDF files. Further information relating to the topic area will be signposted for the user.

www.rcm.org.uk The Royal College of Midwives (RCM) provides support and information to the UK midwifery sector – both NHS and private.

www.rcog.org.uk The Royal College of Obstetricians and Gynaecologists encourages the study and advancement of the science and practice of obstetrics and gynaecology. In 2008, with the RCM, Royal College of Anaesthetists (RCA) and Royal College of Paediatrics and Child Health; it published *Standards for Maternity Care*, which included guidance on breastfeeding (Standard 15).

www.rcpch.ac.uk The Royal College of Paediatrics and Child Health (RCPCH) is one of the medical Royal Colleges, with a major role in postgraduate medical education and professional standards. Recent developments include the launch of new UK growth charts to plot weight, height and head circumference of children from birth to four years of age, based on breastfeeding.

www.sacn.gov.uk The Scientific Advisory Committee on Nutrition is an advisory committee of independent experts that provides advice to the Food Standards Agency and Department of Health as well as other government agencies and departments.

www.thebabycafe.org The Baby Café Charitable Trust was set up in July 2005. It coordinates a network of branded drop-in centres that support breastfeeding mothers.

www.ukamb.org The United Kingdom Association for Milk Banking is a registered charity that supports human milk banking in the UK. The charity gives practical support to milk bank staff, who coordinate the provision of donor breast milk to premature babies. The charity shares expertise and good practice with milk banks and breast milk donors.

Appendix 2: Policy priorities and performance drivers relevant to commissioning

A comprehensive policy framework underpins breastfeeding:

- The *Global Strategy for Infant and Young Child Feeding* (World Health Organization, 2003) has shaped national policy, drawing attention to the impact of infant feeding practices on the very survival of infants and young children, including the need to ensure that all maternity settings fully implement the standards set by the UNICEF Baby Friendly Initiative and comply with the WHO *International Code of Marketing of Breast-Milk Substitutes*. It recommends exclusive breastfeeding for the first six months of life as a global public health recommendation 'to achieve optimal growth, development and health', and continued breastfeeding, alongside nutritionally adequate and safe complementary foods, up to two years of age or beyond.
- *Sure Start Children's Centres Practice Guidance* sets out how Sure Start Children's Centres can offer support to promote and maximise breastfeeding, as part of their broader health role – for example through information and guidance, group activities and/or peer support groups in welcoming settings. The practice guidance also includes case studies of good practice. It is available on the Every Child Matters website, at www.dcsf.gov.uk/everychildmatters/earlyyears/surestart/surestartchildrenscentres/practiceguidance/practiceguidance/
- *National Service Framework for Children, Young People and Maternity Services* (Department of Health, 2004), a ten-year programme setting out national standards for maternity and children's health and social care, recommended exclusive breastfeeding for the first six months of life, with breastfeeding continuing after this age, along with other types of solid foods.
- *Every Child Matters: Change for Children* is a cross-government, outcomes-focused change programme and performance framework to join up services across health, education and social care. 'Being healthy' is seen as integral to other outcomes and is one of five key outcomes.
- *The Children's Plan* (Department for Children, Schools and Families, 2007) highlights the importance of health and wellbeing as part of a set of actions needed to ensure that by 2020 England is the best place for children to grow up.

Specific commitments and expectations in relation to breastfeeding are set out in:

- *Maternity Matters: choice, access and continuity of care in a safe service* (Department of Health, 2007) outlines choices women should be able to make in who provides their antenatal care, and draws attention to the need for maternity services to collaborate with other agencies to deliver care to women with complex social needs. It sets out important considerations for workforce planning and has an accompanying self-assessment tool for commissioners.
- *Healthy Weight, Healthy Lives* (Department of Health and Department for Children, Schools and Families, 2008); *Healthy Weight, Healthy Lives: one year on* (Department of Health and Department for Children, Schools and Families, 2009) invested £4 million in 2009/10 to extend BFI to areas with substantial numbers of non-breastfeeding mothers, supports a National Breastfeeding Helpline, and promises a new antenatal education and preparation for parenthood programme to provide information and guide parents-to-be on nutrition and preventing obesity.
- *Health Inequalities – progress and next steps* (Department of Health, 2008) and *Tackling Health Inequalities: 10 years on* (Department of Health, 2009) outline government strategies to increase breastfeeding prevalence as part of breaking inter-generational cycles of health inequalities, and looks to PSA 12 and PSA 19 to deliver improvements.
- *Review of the Health Inequalities Infant Mortality PSA Target* (Department of Health, 2007) and *Implementation Plan for Reducing Health Inequalities in Infant Mortality: a good practice guide* (Department of Health, 2007) highlight the role of breastfeeding in reducing infant mortality, groups most at risk such as young mothers, and examples of multi-agency strategies to deliver breastfeeding support.
- *Infant Feeding Survey 2005: a commentary on infant feeding practices in the UK* (Scientific Advisory Committee on Nutrition, 2008). The Infant Feeding Survey has been conducted every five years since 1975.

National and local commissioning and performance drivers include:

COMMISSIONING

World Class Commissioning (Department of Health and Department for Children, Schools and Families, 2007)

Joint Planning and Commissioning Framework for Children, Young People and Maternity Services (Department of Health, 2006)

Commissioning Framework for Health and Wellbeing (Department of Health, 2007)

Indicators for Quality Improvement (IQIs) – recently published as a result of the Darzi Review, *High Quality Care for All* (Department of Health, 2008). Includes Vital Signs Indicator VSB11 Prevalence of breastfeeding at 6–8 weeks. See www.ic.nhs.uk/services/measuring-for-quality-improvement

The NHS in England: The operating framework for 2009/10 (Department of Health, 2008) – reporting on VSB11. Thirty-two of 150 LAAs agreed for 2008–11 include targets to improve breastfeeding prevalence.

Children's Centre Planning and Performance Management Guidance also identifies indicators of Sure Start Children's Centre performance, including breastfeeding rates. It is available on the Every Child Matters website: www.dcsf.gov.uk/everychildmatters/research/publications/surestartpublications/1852/

REGULATION AND STANDARDS

Care Quality Commission Periodic Review of NHS commissioners and providers (successor to the Annual Health Check).

Comprehensive Area Assessment – new joint assessment of how effectively local partnerships are working together to improve outcomes for local people.

NICE guidance – provides evidence-based guidance to support delivery of national priorities. Guidance in relation to commissioning breastfeeding services includes:

- *NICE Public Health Guidance 11: Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households; Quick Reference Guide: Maternal and child nutrition*, 2008. <http://guidance.nice.org.uk/PH11>
- *NICE Clinical Guideline 37: Routine postnatal care of women and their babies*, 2006 and implementation advice including costing tools. <http://guidance.nice.org.uk/CG037>
- *NICE Clinical Guideline 62: Antenatal Care: Routine care for the healthy pregnant woman*, 2008. <http://guidance.nice.org.uk/CG62>
- *Commissioning a peer-support programme for women who breastfeed*, NICE, 2007. www.nice.org.uk/usingguidance/commissioningguides/breastfeed/commissioning.jsp
- *Standards for Maternity Care: Report of a Working Party*, Royal College of Obstetricians and Gynaecologists, 2008.

Appendix 3: Steering group and stakeholder input

Members of the steering group:

Sue Ashmore – Programme Director, UNICEF Baby Friendly Initiative

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Phyll Buchanan – Infant Feeding Best Practice Adviser, Department of Health

Dawn Cox – Public Health Midwife, Croydon PCT

Rosemary Dodds – Senior Public Policy Officer, National Childbirth Trust

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Lorna Hartwell – Infant Feeding Best Practice Adviser, Department of Health

Sue Kardahji – Regional Infant Feeding Coordinator, Department of Health North West

Peter Kohn – Head of Performance Review, NHS London

Parminder Nijjar – Maternal and Infant Nutrition Policy Manager, Department of Health

Dr Sheela Reddy – Maternal and Infant Nutrition Lead, Department of Health

Deborah Redknapp – Commissioner, Havering PCT

Professor Mary Renfrew – Director, Mother and Infant Research Unit, University of York

Andrew Turnbull (Chair) – Programme Director Children and Families, NHS Commissioning Support for London

A national stakeholder event was held on 30 April 2009, attended by a wide range of commissioners and practitioners. Feedback was provided on the development of local breastfeeding services in relation to the 11 World Class Commissioning competencies. An additional workshop was held on 11 May 2009 as part of the Department of Health's National Breastfeeding Awareness Week conference. Our thanks to over 200 stakeholders who contributed to both events.

Appendix 4: World Class Commissioning competencies²¹

Below is a table summarising the 11 world class commissioning competencies in the context of children's health. The table sets out each competency, high-level summary and which phase of commissioning the competency applies to most directly. While it is true that commissioners should have regard to the full range of competencies throughout, it is worth noting that some have particular relevance in specific phases of the commissioning cycle (see page 15).

For reference, the three phases are:

1: Needs assessment and strategic planning

2: Shaping and managing the market

3: Improving performance, monitoring and evaluating

Competency	Fit with child health	Phase(s)
1. Locally lead the NHS	All partners involved in commissioning for child health work together through the children's trust to lead a comprehensive health service locally	1, 2, 3
2. Work with community partners	All commissioning partners develop relationships with strategic and operational bodies outside of the public sector and beyond traditional partners	1, 2, 3
3. Engage with the public and patients	All commissioning partners fully engage with children young people and their families using creative approaches to reach vulnerable young people	1, 2, 3
4. Collaborate with clinicians	All commissioning partners actively seek and use the input of professionals, clinicians and experts throughout the commissioning process	1, 2, 3
5. Manage knowledge and assess needs	All commissioning partners seek knowledge and information across the full range of expectations and service needs	1, 3
6. Prioritise investment	All commissioning partners invest across the full range of needs, balancing outcomes with efficiencies and sustainability	1, 2
7. Stimulate the market	All commissioning partners work with others, including those in the third sector, other local authorities and regional partners to build a robust and diverse market	2
8. Promote improvement and innovation	All commissioning partners use their contracting and investment decisions to agree outcomes, which are used to measure improvement. They are also investing in innovative ideas and testing new approaches	2
9. Secure procurement skills	All commissioning partners develop their own internal procurement skills or bring in support to ensure that they have the necessary contracting, negotiating legal skills and capacity	2
10. Manage the local health system	All commissioning partners have a shared vision and strategy for current and future priorities and pattern of services	1, 2, 3
11. Make sound financial investments	All commissioning partners tie investments to progress against agreed local children's health priorities as well as national ambitions	2

²¹ Department of Health and Department for Children, Schools and Families, *Securing better health for children and young people through world class commissioning: a guide to support delivery of Healthy lives, brighter futures: The strategy for children and young people's health*, 2009.



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