

Breastfeeding needs assessment summary

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| Breastfeeding

Why is Breastfeeding an Important Public Health Issue?

Breastfeeding has some of the most wide-reaching and long lasting effects on a baby's health.

Women at risk

The Infant Feeding Survey (2011) found that the highest incidences of breastfeeding were among mothers from managerial and professional occupations, those who were in full-time education until the age of 18, those aged 30 or over and first time mothers. These findings are consistent with previous surveys.

Teenage mothers are less likely to breastfeed, they are also more likely to smoke, which puts them and their babies at increased health risk. Conversely, older mothers are more likely to breastfeed. Non-white ethnic groups tend to have higher breastfeeding rates.

There is a very clear link with smoking behaviour, which is likely to also be associated with socio-economic status and age. Low birth weight is linked to mothers smoking during pregnancy and low birth weight babies are also less likely to be breastfed, both of which are modifiable behaviours.

Further work shows that breastfeeding initiation and prevalence have seen higher increases in areas with low initial breastfeeding, and increases for initiation in more disadvantaged areas. Although these results suggest that inequalities in breastfeeding have narrowed, rates have plateaued since 2010–2011. Sustained efforts are needed to address breastfeeding inequalities¹.

Babies who are breastfed are at a lower risk of

- gastroenteritis
- respiratory infections
- sudden infant death syndrome
- obesity
- type 1 and type 2 diabetes
- allergies (e.g. asthma, lactose intolerance).

Further evidence demonstrates the importance of early care, which breastfeeding can facilitate, including brain development and emotional attachment. A baby's earliest relationships lay the foundation for later developmental outcomes, from academic performance to mental health and interpersonal skills.

¹ Oakley, L. L., Kurinczuk, J. J., Renfrew, M. J., and Quigley, M. A. (2016) Breastfeeding in England: time trends 2005–2006 to 2012–2013 and inequalities by area profile. *Maternal & Child Nutrition*, 12: 440–451. doi: 10.1111/mcn.12159.

Benefits to mothers

- the longer mothers breastfeed, the greater their protection against breast and ovarian cancer, and hip fractures in later life
- however recent evidence has demonstrated an association between prolonged breastfeeding and postmenopausal risk factors for cardiovascular (CV) disease
- the World Cancer Research Fund includes breastfeeding as one of 10 recommendations to reduce the risk.

These illnesses all represent the greatest threats to women's health across all ages.

Financial benefits

The Baby Friendly Initiative report, *Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK*, found that moderate increases in breastfeeding would translate into cost savings for the NHS of many millions as well as tens of thousands of fewer hospital admissions and GP consultations².

What do we know?

All current guidelines, including those from the Department of Health, follow the World Health Organisation³ (WHO) recommendation of exclusive breastfeeding for the first six months after birth. The World Health Organisation also recommends continued breastfeeding along with appropriate complementary foods up to two years of age or beyond. Colostrum, the yellowish, sticky breast milk produced at the end of pregnancy, is recommended by WHO as the perfect food for the new born, and breastfeeding should be initiated within the first hour after birth.

All NHS Trusts except Maidstone and Tunbridge Wells NHS Trust have initiation rates below the England average (73.8%) as of Q1 2015-16, however rates have fallen since 2013-14. There has been an increase in rates in Dartford and Gravesham NHS Trust and East Kent Hospital University Foundation Trust over the same period. Medway Foundation NHS Trust rates have remained about the same.

² https://353ld710iigr2n4po7k4kgvv-wpengine.netdna-ssl.com/babyfriendly/wp-content/uploads/sites/2/2012/11/Preventing_disease_saving_resources.pdf

³ <http://www.who.int/mediacentre/factsheets/fs342/en/>

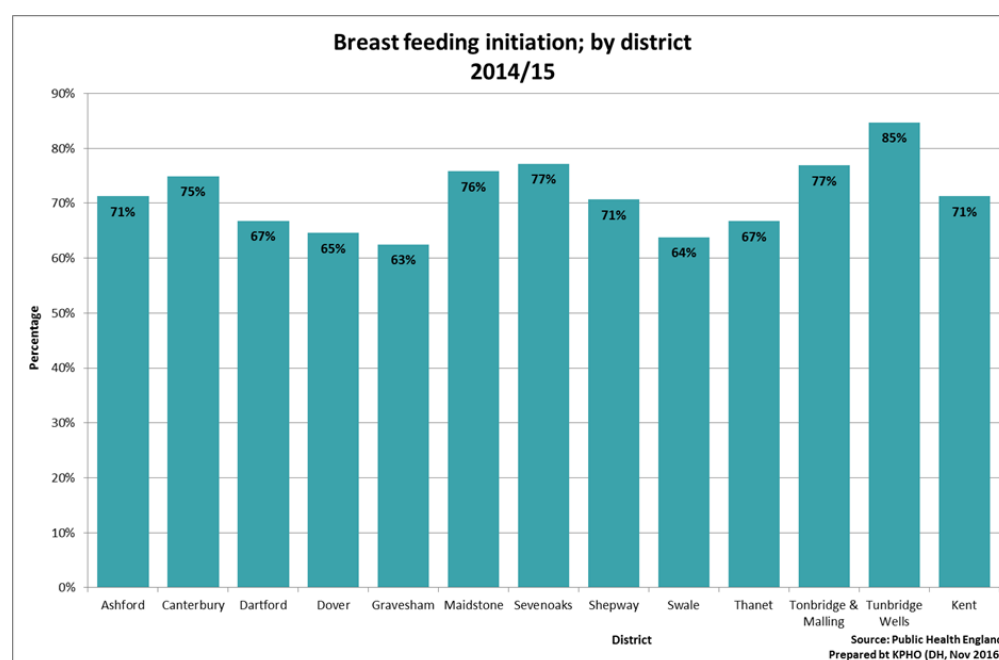
Table 1: Kent NHS Trust initiation rates 2013-14 to 2015-16 (Q1 only)

NHS Trust	Initiation Rate		
	2013-14	2014-15	2015-16 Q1 only
Dartford & Gravesham NHS Trust	65.1%	63.1%	69.8%
East Kent Hospital University Foundation Trust	69.1%	69.7%	70.1%
Medway Foundation NHS Trust	67.7%	68.0%	67.6%
Maidstone and Tunbridge Wells NHS Trust	81.8%	81.0%	80.4%

Source: NHS England
<https://www.england.nh.uk/statistics/statistical-work-areas/maternity-and-breastfeeding>
<https://www.nice.org.uk/guidance/cg37/resources>

Figure one shows breastfeeding initiation by district of residence. It is unsurprising that the districts of residence of women who are more likely to give birth at Maidstone and Tunbridge Wells NHS Trust have the highest rates of initiation. Rates broadly reflect deprivation.

Figure 1: Breastfeeding initiation by district 2014-15



The breastfeeding coverage and prevalence rates in all districts have improved since 2013-14 and it is anticipated that this will continue until data quality is deemed to be robust (95% coverage). Swale coverage rates are the highest and this reflects a real commitment from the whole system for service improvement, particularly from the Health Visiting Service that now collect this data.

Despite the fall-off of breastfeeding from initiation to continuation at six to eight weeks, the district differences between the initiation rates seem to be reflected in continuation, with women in West Kent, particularly Tunbridge Wells achieving the highest rates and Dover,

Thanet and Swale the lowest. It is therefore critical that antenatal interventions are strengthened to increase initiation rates.

Figure 2: Breastfeeding coverage and continuation at 6-8 weeks by district 2016-17 Q1

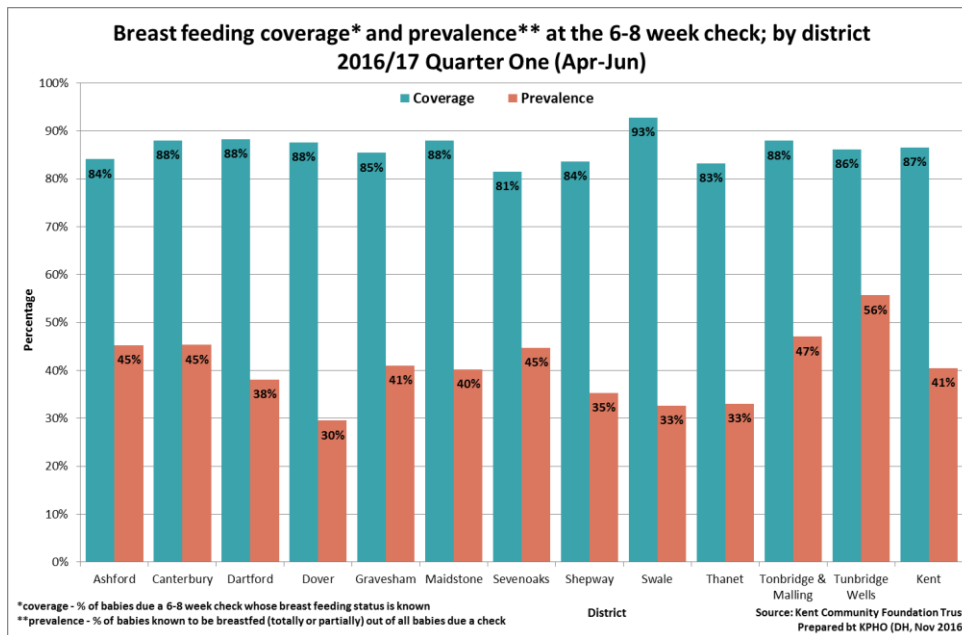
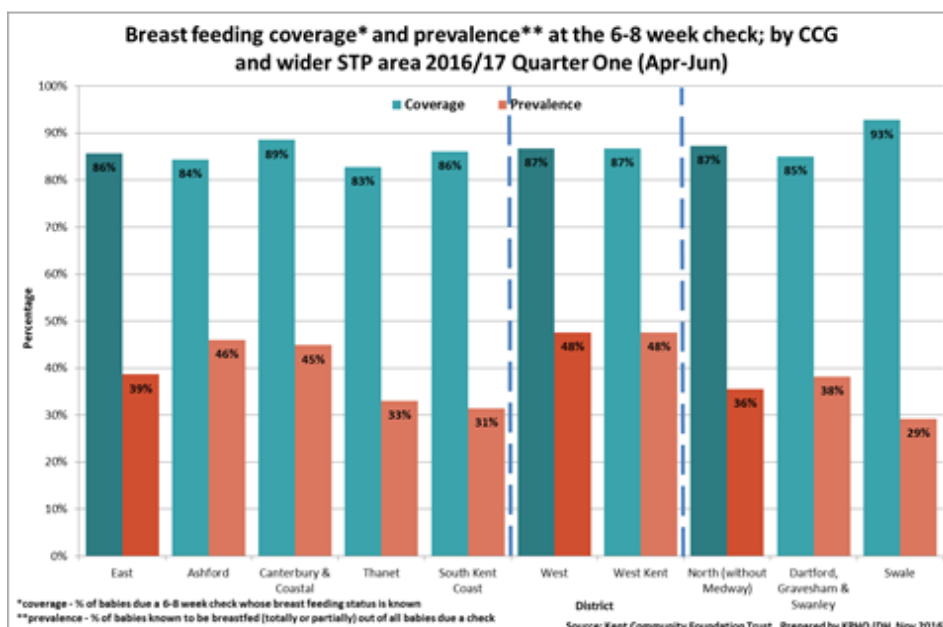


Figure three below shows the breakdown of six to eight weeks coverage and prevalence by CCGs and Service Transformation Plan (STP) areas. It clearly reflects the pattern already described. Swale remains the CCG with the lowest prevalence.

Figure 3: Breastfeeding coverage and prevalence at six to eight weeks by CCG and STP areas.



What are we doing in Kent?

Working in collaboration with partners and stakeholders to ensure that the breastfeeding aspects of National Institute for Health and Care Excellence (NICE) guidance and quality standards are adhered to⁴⁵.

Baby Friendly Initiative

The UNICEF UK Baby Friendly Initiative provides a framework for the implementation of best practice by NHS trusts, other health care facilities and higher education institutions.

Implementing Baby Friendly standards is a proven way of increasing breastfeeding rates. It also means health professionals can give mothers the support, information and encouragement they need. The following Kent organisations are on the journey towards Baby Friendly accreditation supported by Kent County Council:

- Maidstone and Tunbridge Wells NHS Trust
- Dartford and Gravesham NHS Trust
- East Kent Hospitals NHS University Foundation Trust
- Medway Maritime NHS Trust
- Kent Community NHS Healthcare Trust
- Kent County Council Children's Centres.

Peer Support

Peer support provided by volunteer peer supporters who have breastfed their own babies has a positive outcomes evidence base. Kent has an accredited Breastfeeding Peer Support training programme which typically trains in the region of 200 new volunteer peer supporters a year. Currently there are over 170 volunteers providing support in Kent.

Breastfeeding Welcome

This is for businesses and community centres to show that they support breastfeeding on their premises. A sticker is usually displayed in the window to show that mothers and babies are welcome. Work has been undertaken by the KCC Workplace Team, District Councils, Peer Supporters and the Health Visiting Service to increase the number of outlets welcoming mothers to breastfeed.

Insights

A great deal of insight work has been carried out across Kent since October 2014 by Activmob and before that in the Sheppey locality. Recent interviews (2016) with women have been undertaken in Dartford Gravesham and Swanley, Thanet and West Kent CCGs to inform the development of a Kent pathway.

Mothers are very clear about what they want and when. The research identified good practice but also identified a number of gaps and variations across the county. Swale is a bit ahead in terms of pathway development as it has had a working group since 2014.

The reports show a lack of a positive motivational based feeding conversation – especially antenatal. Fifty per cent of mothers interviewed report only having had one conversation about feeding.

The system often advocates artificial formula feeding too quickly, whilst health professionals in some localities assume continuing breastfeeding - either way support is lacking.

Clear opportunities to improve communication and information have been identified. Key times for intervention are at 24-30 and 36 weeks, and the golden hour after birth. Days 0-14 postnatal have been identified as a time between the midwifery and health visitor handover where there are gaps in support. This gives understanding of the midwifery turnaround time and pressures and may not allow mothers to be informed of the pathway.

Other opportunities to inform mother of the pathway may occur during admissions, for example for morning sickness or low birth weight, extending a welcome to pregnant women to attend peer supporter groups antenatally and engaging with YAPs groups.

Recommendations

1. Kent-wide group that includes the Heads of Midwifery, the Health Visiting Service, Public Health and Clinical Commissioning Group commissioners to develop system-wide pathways for infant feeding, smoking and parent-craft.
2. Pathways should prioritise the implementation of interventions at 36 months antenatal, during the 'golden hour' following birth and 0-12 days postnatal. The period between birth and 12 days has been identified as a key gap in service provision.
3. Campaign and media work, including the promotion of evidence based social media, should be promoted to support the UNICEF Call to Action⁶.
4. Health and Wellbeing Board Health Inequalities Plans should include the promotion of breastfeeding friendly environments.
5. Commissioners and providers should ensure that support is delivered to those mothers and their significant others who are most at risk of not breastfeeding.

⁶ <https://353ld710iigr2n4po7k4kgvv-wpengine.netdna-ssl.com/babyfriendly/wp-content/uploads/sites/2/2016/04/Call-to-Action-Unicef-UK-Baby-Friendly-Initiative.pdf>