Breastfeeding Strategies for

Nottingham City and

Nottinghamshire County

Preface

This document includes Breastfeeding Strategies for Nottinghamshire County and Nottingham City which have been developed in partnership. It is recognised that organisations in both localities need to work together across the geographical boundaries to ensure a coordinated approach, whilst also acknowledging the specific needs of the populations within each area.

The document is split into two parts. Part one includes the Nottingham City Strategy and part two the Nottinghamshire County one. They have been written in the same format and structure to allow easy reference from one document to the other as required.

Both strategies have the same strategic actions, although the approach and target groups may differ depending on the location.

The diagram found in appendix 1 provides a summary of the two strategies and is designed to be an easy reference document for all those involved in the strategies' coordination and implementation.

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PART ONE

Breastfeeding Strategy

for Nottingham City

2010-2014

NOTTINGHAM CHILDREN'S PARTNERSHIP

1.0 Summary

- Breastfeeding improves health outcomes for both mothers and children and makes a significant contribution to health at the population level.
- The choice and ability to breastfeed depends on many factors operating at the individual, community and service levels. The strategy therefore describes a broad partnership plan.
- Nottingham has made significant progress in increasing breastfeeding rates, but there remains considerable variation in uptake across the City.
- The aim of the breastfeeding strategy is to:
    - improve health outcomes and reduce health inequalities by increasing uptake of breastfeeding and increasing population coverage
    - support and empower mothers in their choices by removing barriers to breastfeeding, particularly in groups where there is a low uptake of breastfeeding.
- Key interventions included in the strategy are:
    - a breastfeeding campaign using social marketing principles and approaches
    - working in partnership to develop 'baby friendly' workplaces and premises
    - developing services to meet the UNICEF Baby Friendly Initiative accredited standards
    - development and strengthening of a peer support programme
    - continued commissioning and delivery of the Healthy Child Programme, Family Nurse Partnership and existing service developments through Children's Centres.
- The strategy will be supported with:
    - a stakeholder group to oversee the implementation of the strategy, with high level and detailed action plans;
    - monitoring of progress against agreed targets shared across the Children's Partnership;
    - robust data collection and analysis (performance monitoring, Health Equity Audit).

2.0 Benefits of Breastfeeding

The contribution of breastfeeding to the health of the population is frequently underestimated. Babies who are not breastfed have a greater risk of developing infections, allergic diseases, insulin dependent diabetes mellitus and sudden unexpected death in infancy, while breastfeeding mothers have a reduced risk of pre-menopausal breast cancer and ovarian cancer (Ip S, et al, 2007). Breastfeeding is associated with better infant health above and beyond the period of breastfeeding and a reduced risk of developing conditions such as heart disease and obesity (Horta B et al, 2007). Some evidence suggests breastfeeding promotes maternal/child bonding and better mental health outcomes. To maximise the health gain from breastfeeding the Department of Health recommend that infants are exclusively breastfed for a minimum of six months and that breastfeeding continues thereafter alongside suitable weaning foods (Department of Health, 2003).

At the population level breastfeeding rates are associated with important wider health outcomes and inequalities in health. Interventions aimed at improving rates of breastfeeding are significant contributors to key aims: reducing infant mortality, improving life expectancy and promoting healthy weight and nutrition. Despite the evidence of the benefits of prolonged exclusive breastfeeding England has one of the lowest breastfeeding rates in Europe (Renfrew M.,Dyson et al, 2005).

3.0 Aims of the Breastfeeding Strategy

The overarching aim of the breastfeeding strategy is simple: ***to maximise the uptake and duration of breastfeeding in Nottingham***. This does not preclude women making their own choices in relation to infant feeding. Rather, it seeks to empower women and support them in their choices, and to remove barriers that become determining factors of a 'best for me in the circumstances' choice.

Barriers to breastfeeding operate on many levels (for example cultural, economic, psychological as well as physical). Removing

Box 1: Getting the benefits of breast feeding:

Critical issues
1. Maximising initiation of breast feeding
2. Increasing duration of feeding

Critical factors
1. Women / society related:
    - *Age / Ethnicity / Deprivation*
2. Practice related:
    - *Support and follow-up*
3. Service related:
    - *Organisation of services*

Critical intervention times
1. Pre- pregnancy
2. Pregnancy
3. Establishing breast feeding
4. Maintenance phase

some of the key barriers will depend on influencing some critical factors that operate at different stages[1] (see Box 1).

The strategy will enable Nottingham to improve uptake and maintenance of breastfeeding by:

- Ensuring interventions with an evidence base or strong rationale are commissioned and put in place.
- Interventions are matched with leadership, capacity and effective organisation to ensure service delivery.
- Harnessing intelligence to inform development of the strategy and performance management.

3.1 Targets

Box 2: Nottingham City Breastfeeding Targets

- Deliver year on year improvement in overall breastfeeding initiation rates by at least 2 percentage points per annum until 2014, (this requires approximately 80 additional women each year initiating breastfeeding).
- Deliver year on year improvement in breastfeeding maintenance rates measured at 6-8 weeks and 6 months to meet locally agreed targets (see Appendix 2).
- Reduce inequalities by:
    - Improving breastfeeding rates in groups least likely to breastfeed at a faster rate (see Appendix 2).
    - Ensuring equitable delivery of interventions.

4.0 Breastfeeding in Nottingham – where we are now

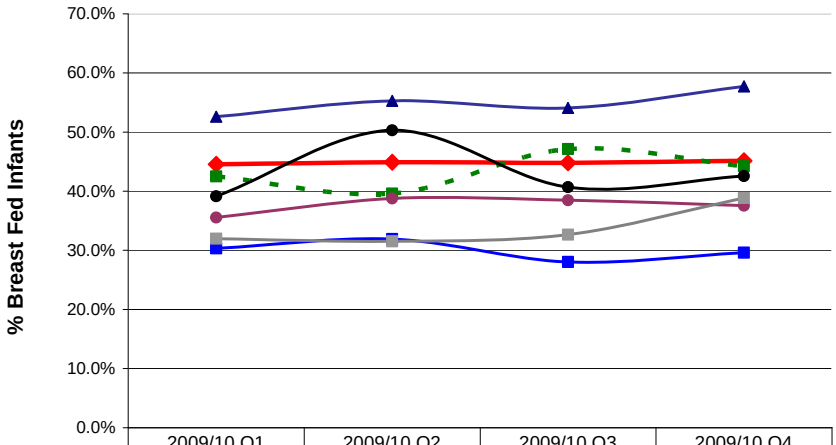
4.1 Comparative position – England Statistical neighbours

Our current targets for breastfeeding focus on rates at six to eight weeks because this reflects both initiation and continuation of breastfeeding. Figure 1 illustrates that during 2009/10, Nottingham City's breastfeeding prevalence rate is similar to the England average and amongst the ONS cluster - Centres with Industry Group B, it is only Barking and Dagenham PCT which consistently had higher rates than Nottingham.

[1] The context in which women make their choices should be fully informed and supported: through service provision; and also with wider societal support to make breast feeding culturally acceptable, convenient and the norm.

Generally breastfeeding rates are strongly tied to social factors and Nottingham has areas of high deprivation. The current breastfeeding rate is therefore a considerable achievement and represents the outcome of a significant investment into Children's Centres and early care.

Figure 1: Nottingham's Breastfeeding Prevalence at 6 to 8 weeks 2009/10 (England and Statistical Neighbours)[2]



	2009/10 Q1	2009/10 Q2	2009/10 Q3	2009/10 Q4
England	44.6%	44.9%	44.8%	45.2%
Nottingham City PCT	42.5%	39.6%	47.1%	44.2%
Barking And Dagenham PCT	52.6%	55.3%	54.1%	57.7%
Manchester PCT	35.5%	38.7%	38.5%	37.6%
Sandwell PCT	30.3%	31.9%	28.0%	29.6%
South Birmingham PCT	39.1%	50.3%	40.7%	42.6%
Wolverhampton City PCT	32.0%	31.5%	32.7%	38.9%

Source: Department of Health (May 2010) Statistical Release: Breastfeeding initiation and prevalence at 6 to 8 weeks Quarter 4, 2009/10

4.2 Patterns of breastfeeding

Underlying the overall breastfeeding rate there is considerable variability between different groups, geographic areas and care teams. Figures 2 & 3 show the geographic distribution of the 6-8 week breastfeeding rate, which varies between 18.1% and 66.4%. Figure 3 shows that five wards have rates which are significantly lower than the average value (40.2% red line) and six have significantly higher rates (as confidence intervals are not overlapping). This indicates that there are underlying factors for these differences and they are not likely to be due to random variation.

[2] Birmingham East and North and Leicester City are not included due to their incomplete data

Figure 2: Map of breastfeeding rate by ward at 6-8 weeks post partum 2008/9

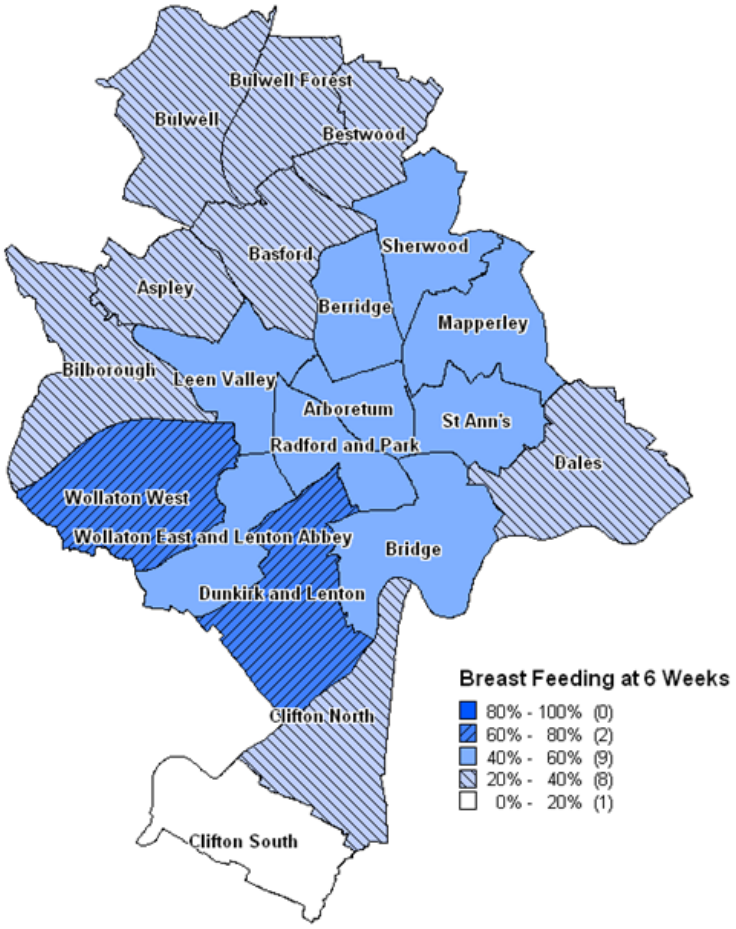
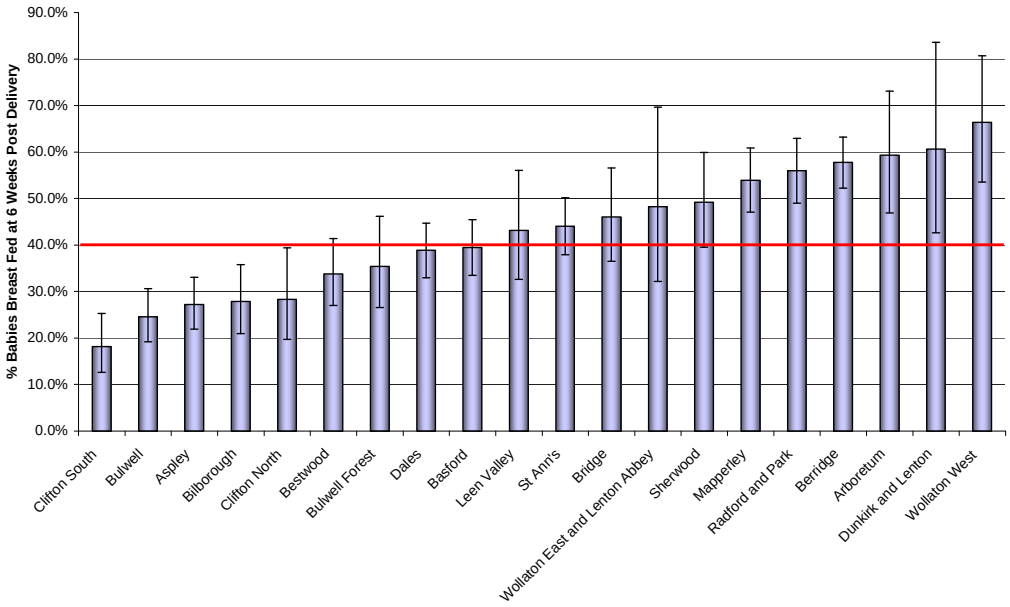


Figure 3: Graph of breastfeeding rate by ward at 6-8 weeks post partum 2008/9



Source: NHS Nottingham City Information Team: Breastfeeding data 2008/09

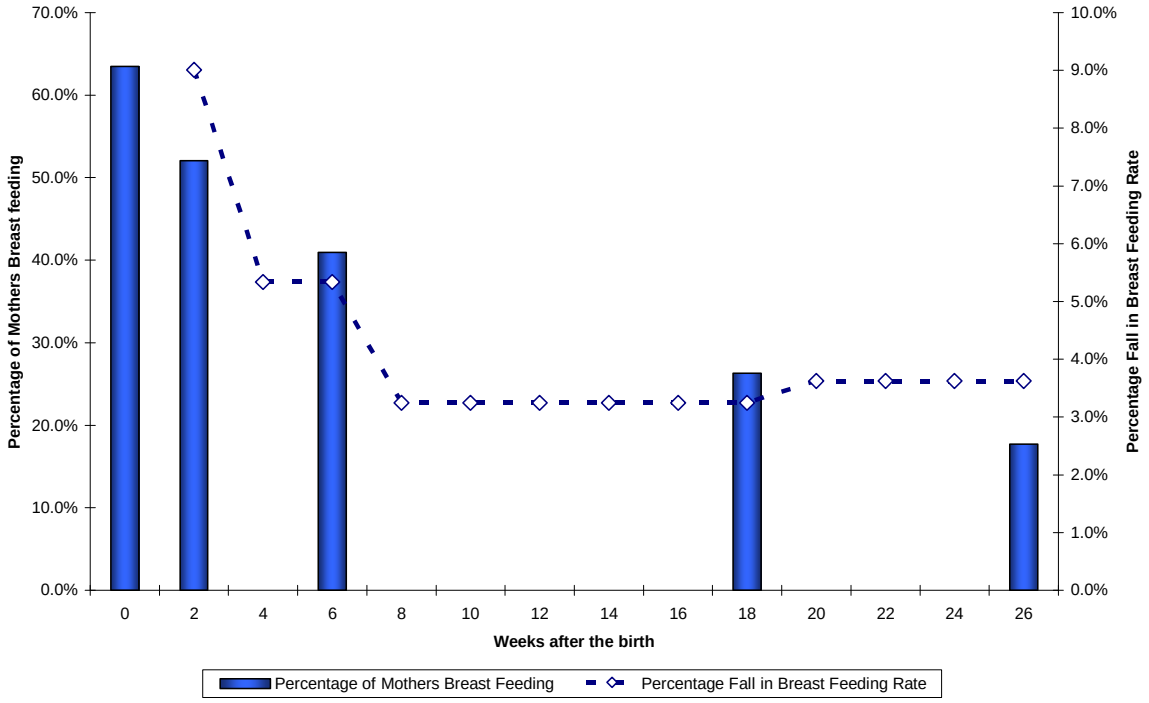
4.3 Critical issues

4.3.1 Initiation of breastfeeding

Nottingham City reports breastfeeding initiation rates of 70% (2008/9) which is based on the Department of Health definition of breastfeeding initiation.[3] 'It is acknowledged that this definition has in the past led to an overestimate of initiation rates. However, even when data is used which is derived from asking mothers retrospectively about initiation[4] as shown in Figure 4, Nottingham data shows the initiation phase to be critical.

Figure 4: Percentage of women breastfeeding and rate of decline with time from birth

Source: NHS Nottingham City Information Team: Breastfeeding data 2008/09



The greatest rate of fall-off with mothers who fail to establish initiation of breastfeeding is within the first two weeks following delivery (Figure 4). Therefore, once women have decided to breastfeed, interventions need to be effective at establishing breastfeeding.

4.3.2. Maintaining breastfeeding

Women will breastfeed for a varying length of time, depending on individual constraints and circumstances. However, at the population level, the proportion of women still breastfeeding at 6 months post delivery is strongly related to the proportion initiating breastfeeding. This is

[3] The mother is defined as having initiated breastfeeding if, within the first 48 hours of birth, either she puts the baby to the breast or the baby is given any of the mothers breast milk.

[4] Data is collected by health visitors who ask mothers whether they initiated breastfeeding. Therefore these breastfeeding initiation rates will differ slightly from that used for the Vital Signs Monitoring which uses data collected by University Hospital Trust and is based on the DH definition of breastfeeding initiation.

demonstrated when we look at the 'fall-off' in breastfeeding rates over time by geographic area. Although some areas have quite different rates, the trajectories (rate of 'fall-off') run parallel. Therefore, to improve maintenance rates it is important to ensure as many women as possible initiate and establish their breastfeeding properly, as well as to ensure that later difficulties in breastfeeding are addressed. Differences in initiation are likely to relate to intent and decisions taken in the first trimester or before pregnancy (Arora S. et al, 2000). This points to the importance of addressing background factors and factors in the period before initiation, as well as supporting the initiation and maintenance phases.

4.4. Influencing factors

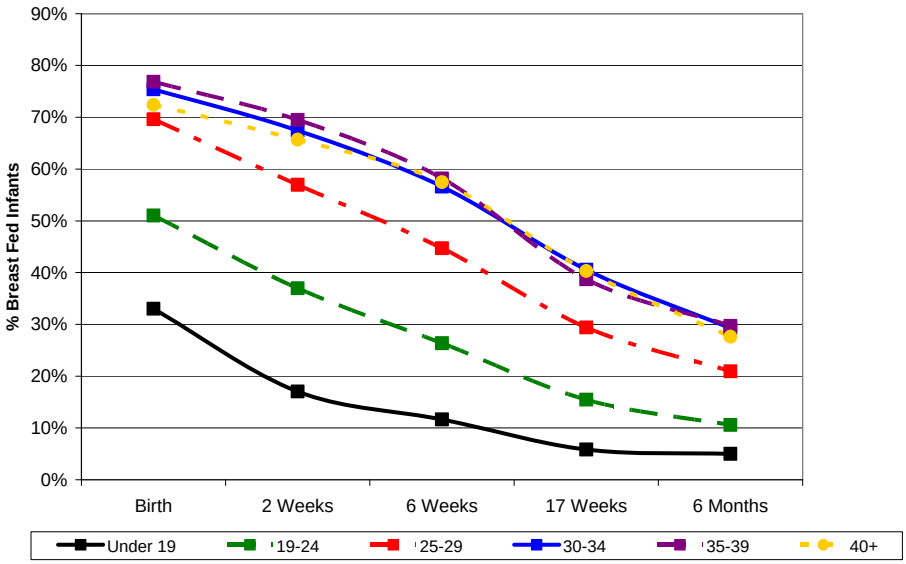
Influencing factors can be considered under two main headings: factors relating to individuals and their context in their local communities; and clinical or service related factors.

4.4.1 Individual / community factors

A number of individual / community related factors can be shown to have an influence on uptake of breastfeeding. The accompanying Figures show the following all to be related:

- **Age of mother** -Figure 5 shows women aged over 30 tend to have a high uptake with initiation rates above 70%; women under the age of 19 have the lowest uptake rates and intermediate age groups have intermediate rates.
- **Ethnicity** – Figure 6 shows that women from black and ethnic minority groups are more likely to breastfeed.

Figure 5: Breastfeeding rates at different times after birth by age of the mother: Nottingham 2008/9



Source: NHS Nottingham City Information Team: Breastfeeding data 2008/09

Figure 6: Breastfeeding uptake at various times after birth by ethnic group: Nottingham 2008/09

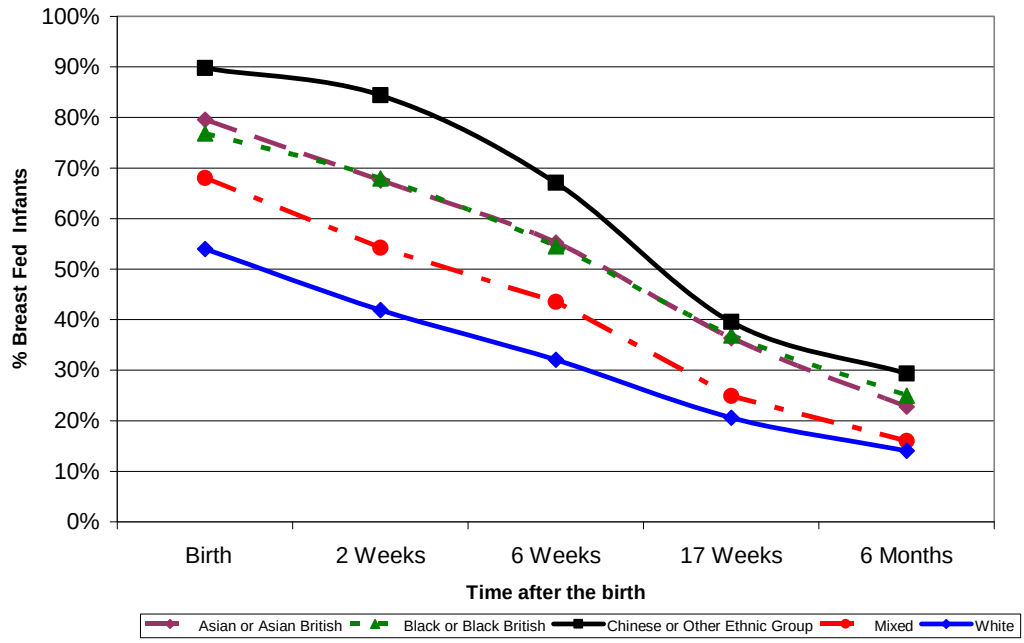
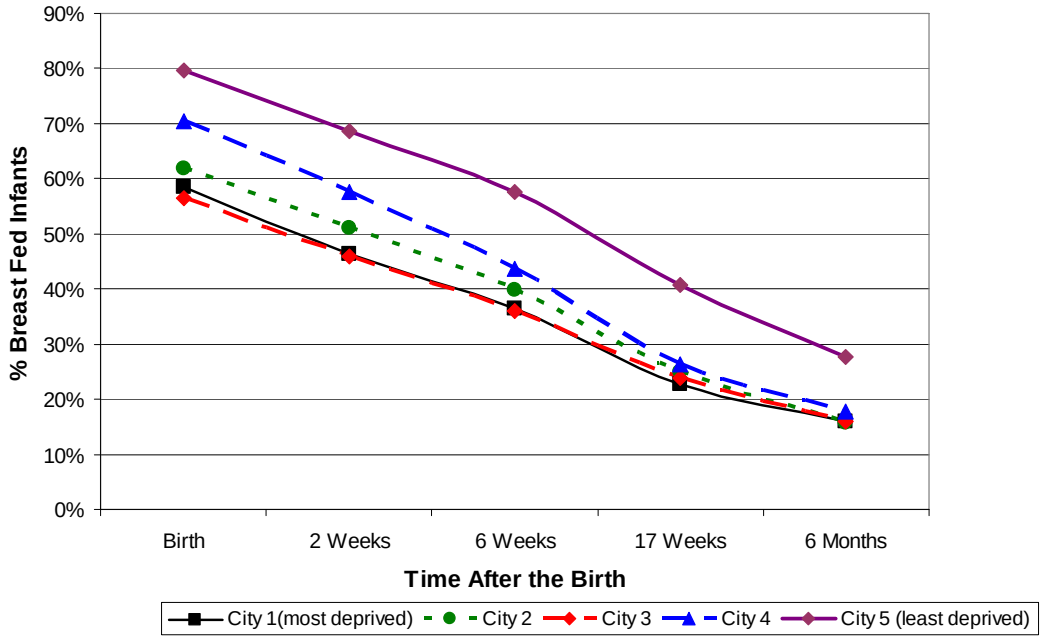
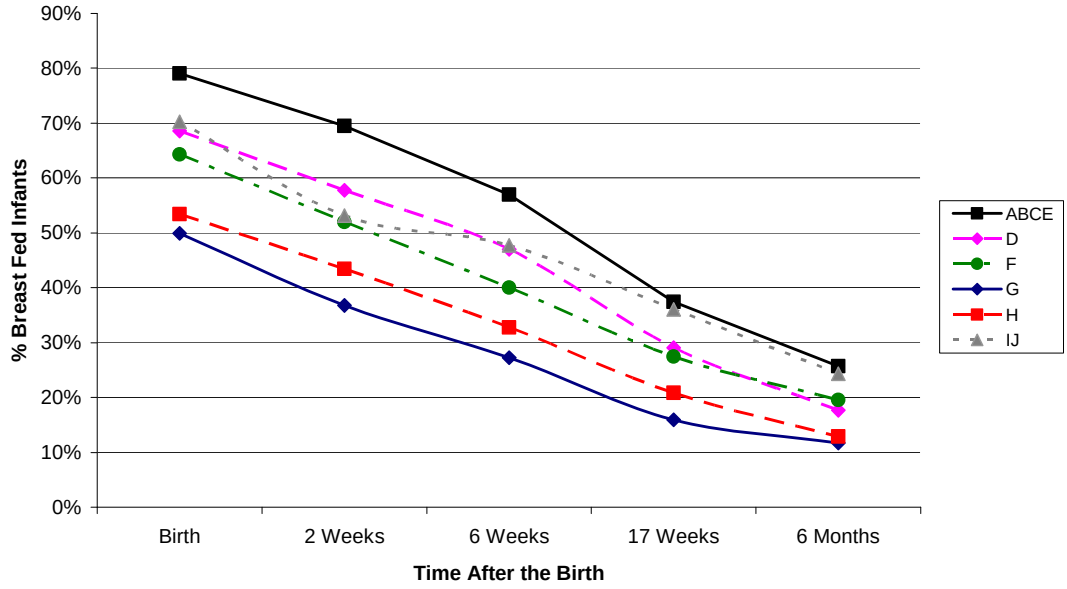


Figure 7: Breastfeeding uptake at various times after birth by deprivation quintile: Nottingham 2008/09



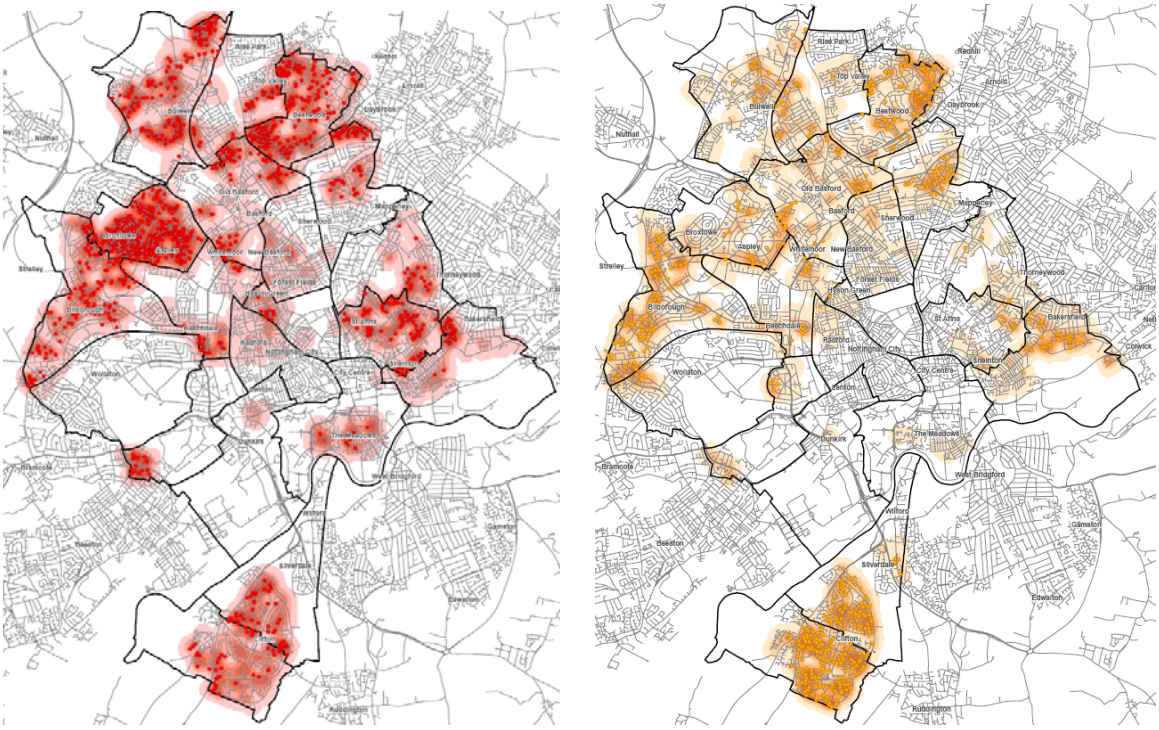
Source: NHS Nottingham City Information Team: Breastfeeding data 2008/09

Figure 8: Breastfeeding uptake at various times after birth by Mosaic subgroup: Nottingham 2008/09



Source: NHS Nottingham City Information Team: Breastfeeding data 2008/09

Figure 9: Distribution of Mosaic geodemographic groups in Nottingham (Group G (left) and Group H (right))



Source: NHS Nottingham City Information Team: Breastfeeding data 2008/09

- **Deprivation** – Figure 7 shows that the relationship with deprivation is not straight forward: the most deprived and the 3rd most deprived quintiles have similar rates of uptake. Further analysis using Mosaic geodemographic profiling shows these groups to

be predominantly white groups living on estates where there appears to be a shared culture of not breastfeeding (Figure 8). The geographic distribution of these groups

Source: *NHS Nottingham City Information Team: Breastfeeding data 2008/09*

Figure 9) closely matches the overall pattern of coverage.

Clearly the individual factors underlying these differences are complex. Although uptake is affected by deprivation, cultural issues related to the age and ethnicity of the mother also play a significant role[5]. These would appear to point to cultural issues amongst younger mothers and both deprived and less deprived white populations where rates of breastfeeding are lowest. The geographic distribution of these underlying factors correspond to the patterns of breastfeeding seen at ward level and require further investigation to identify barriers and to address low uptake.

4.4.2. Clinical / service related factors

Clinical and service related factors can influence outcomes either by differential effectiveness of practice or organisational factors such as those leading to access issues.

Breastfeeding is supported by universal services and considerable investment has been made in improving access through Children's Centres and development of a diversified workforce. Breastfeeding is promoted by individual practitioners, as a part of routine care (implementation of breastfeeding pathway/delivery of the Healthy Child Programme) or through extended services (e.g. the Family Nurse Partnership, family and midwifery support workers).

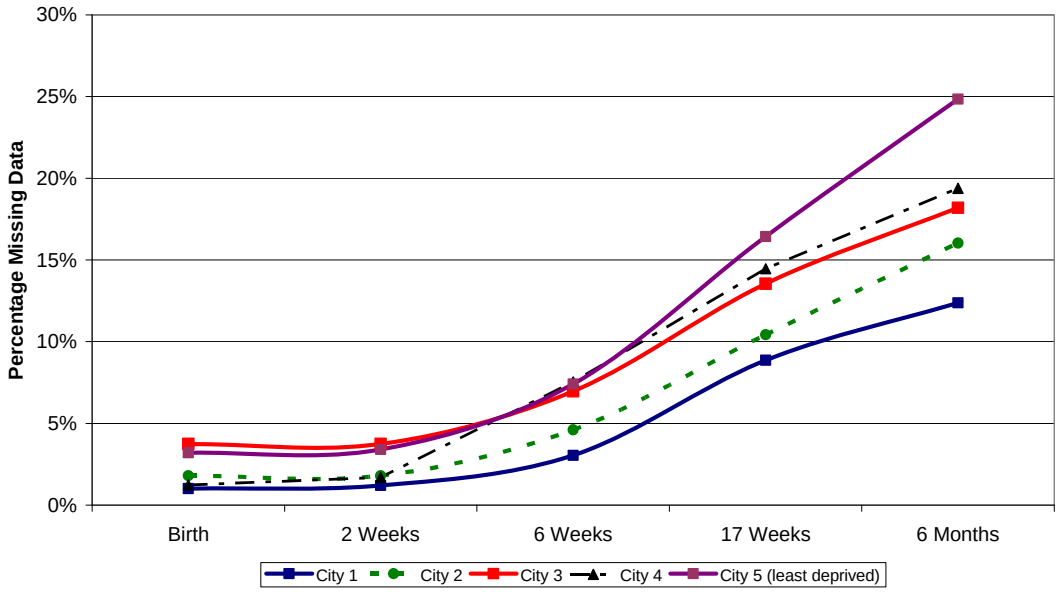
Analysis of uptake by service related factors shows:

- **Uptake by Children's Centre** - Rates reflect the geographic variation already demonstrated. These can be attributed largely to factors operating at the individual level rather than service factors. The challenge therefore would appear to be for local services to be able to redress rather than reflect the local patterns.
- **Follow up by groups** – It is assumed that level of contact by services (follow up) should reflect need and be therefore targeted at the youngest, most deprived and 3rd deprived quintiles (groups with the lowest breastfeeding rates). It appears that the current

[5] Further insight is provided by the geodemographic analysis that groups the population based on lifestyle factors (Figure 8). Although groups F and G are similarly deprived, uptake is much lower in group G. Group G are described as 'mostly families on lower incomes that live on large municipal council estates located in the outer suburbs'. They are predominantly white having a lower than average proportion of ethnic minorities. Other deprived groups such as F and D have higher proportions of ethnic minority groups. Group H are less deprived and described as 'people who, though not necessarily highly educated, are practical and enterprising in their orientation. Many of these people live in what were once council estates but where tenants have exercised their right to buy. They own their cars, provide a reliable source of labour to local employers and are streetwise consumers'.

provider is targeting the youngest and most deprived groups (where data is most complete). However, the 3rd deprived quintile appears to have similar rates of follow up to the least deprived quintile (Figure 10). This merits further investigation as to the reasons for this and to ensure this group also receives appropriate follow up.

Figure 10: Missing data on breastfeeding uptake at various times after birth by deprivation quintile: Nottingham 2008/09



Source: NHS Nottingham City Information Team: Breastfeeding data 2008/09

4.5. Implications for the breastfeeding strategy

This analysis shows that although the overall uptake of breastfeeding is comparatively good in Nottingham, there is significant variation between different groups and geographic areas. There are underlying cultural and social barriers and it seems likely that there is a need to address these *before* women come to make their choices around breastfeeding as well as to address factors at the individual level supporting women to breastfeed. Clinical practice (level of support/follow-up) and organisation may need further review to ensure the support is present for groups with low uptake at the appropriate stage. These issues are addressed within the rest of the strategy through the sections outlining the evidence based interventions and organisation for delivery.

5.0 Objectives

We want to see:

- A cultural, organisational and social environment which enables all women and infants to enjoy the health benefits of breastfeeding.

- As many mothers as possible initiating and continuing breastfeeding.
- A reduction in inequalities in health outcomes related to breastfeeding.

This will be achieved by a package of multifaceted interventions in line with NICE guidance (2008) as outlined below.

6.0 Strategic actions and high level action plan

Nine interventions will impact on breastfeeding rates at various stages from before pregnancy to 6 months post partum and beyond (Table 1). These interventions can be categorised into 4 themes:

A. Wider cultural influence/social marketing
B. UNICEF Baby Friendly Initiative
C. Peer Support
D. Existing initiatives

6.1 Theme A: Wider cultural influences and social marketing

6.1.1. Social Marketing and Breastfeeding Awareness Programme

Attitudes to breastfeeding will only improve if the level of knowledge and understanding among the general population is raised. At present there is no obligation to teach children anything about breastfeeding within the national curriculum. However the World Health Organisation's Global Strategy on Infant and Young Child Feeding recommends that information on breastfeeding is provided by schools in order to increase awareness and positive perceptions, and address barriers in particular groups (young people, white ethnic groups). It is also important to address wider background factors within society and communities that frame women's choices. Social marketing will assist in shifting community norms around breastfeeding, particularly amongst young, white women with the lowest breastfeeding rates by ensuring that interventions to help increase breastfeeding rates will be rooted in a deep understanding of the target audience, the issue and the behaviour we are trying to influence and change.

KEY ACTION 1:

Develop local programmes to help change underlying attitudes and community norms around breastfeeding through:

- Promotion of positive breastfeeding messages at schools and colleges
- A campaign using social marketing principles and approaches (e.g. 'Be a star')
- Community awareness raising events

Table 1: Time of influence/support of various interventions

Theme	Interventions	Time of influence/support						
		Prior to pregnancy	Early pregnancy	Mid-late pregnancy	At birth	24-48 hours post partum	6-8 weeks post partum	6 months post partum
A. Wider cultural influences/social marketing	1. Breastfeeding awareness through schools and colleges	✓	✓					
	2. Other breastfeeding awareness programmes	✓	✓	✓			✓	✓
	3. 'Baby Friendly' workplaces and premises	✓	✓	✓			✓	✓
	4. Social marketing	✓	✓	✓		✓	✓	✓
B. UNICEF Baby Friendly Initiative	5. UNICEF Baby Friendly Initiative (Maternity Services)		✓	✓	✓	✓		
	6. UNICEF Baby Friendly Initiative (Community Health Services)					✓	✓	✓
C. Peer Support	7. Peer Support programme					✓	✓	✓
D. Existing Initiatives	8. Healthy Child programme		✓	✓	✓	✓	✓	✓
	9. Family Nurse Partnership		✓	✓	✓	✓	✓	✓

6.1.2. 'Baby Friendly' Workplaces and Premises

Breastfed babies feed frequently and need to be able to feed whenever required. Mothers cite fear of breastfeeding in public as a barrier to continuing to breastfeed. Returning to work is also seen as a barrier to starting or continuing to breastfeed when in fact there are a number of ways women can combine breastfeeding and work with support from their employer. Nottingham City Council is currently developing a Food Policy for all City Council premises and workplaces which will include breastfeeding policies. This will contribute significantly to this area of the strategy.

KEY ACTION 2:

Create supportive environments which enable women to breastfeed through:

- Breastfeeding policies in workplaces, nurseries and other public buildings/premises;
- Providing relevant information on returning to work to all breastfeeding mothers;
- Breastfeeding-friendly cafes, restaurants and others public places.

6.2. Theme B: UNICEF Baby Friendly Initiative (BFI)

6.2.1. BFI – Maternity Services

The vast majority of mothers give birth to their babies in hospital, where their experiences in the first hours and days after birth can have a profound effect on whether or not they breastfeed. Ensuring that hospital practices protect, promote and support breastfeeding is essential. The information and support women receive during pregnancy and following birth through community midwifery teams can also contribute significantly to their choices around breastfeeding. The UNICEF BFI aims to introduce best practice standards for breastfeeding into all maternity health-care services. These standards form the Ten Steps to Successful Breastfeeding (appendix 4).

KEY ACTION 3:

Maternity services to achieve UNICEF BFI accreditation through:

- Review and development of breastfeeding policy based on BFI best practice standards
- Staff training programme
- Education for pregnant women
- Best practice education and support for new mothers and their families.

6.2.2. BFI – Community Health Services

Community midwives are instrumental in providing post-natal care within the initial 10-14 days after birth. Following this, core health care for breastfeeding mothers in the community is provided by the health visiting service, Children's Centres and General Practitioners. The

KEY ACTION 4:

Community health services to achieve UNICEF BFI accreditation through:

- Development of breastfeeding policy
- Staff training programme
- Education for pregnant women, including antenatal interventions to reach those least likely to breastfeed
- Best practice education and support for new mothers and their families
- Interventions to support mothers to continue breastfeeding.

BFI ensures the same standard of care is available for all women by adopting the Seven Point Plan for Sustaining Breastfeeding in the Community (appendix 5). The health visiting service generally provides the frontline care for breastfeeding mothers through the Healthy Child Programme and will therefore be instrumental in the implementation of the Seven Point Plan.

6.3. Theme C: Peer Support for Mothers

There is much evidence to suggest that mothers are more likely to start and continue breastfeeding if they are supported by someone who is confident, both in breastfeeding and in the ability of the mother to be successful. In a predominantly breastfeeding culture this support is given by family, friends and society as a whole. In the UK, where bottle feeding is the norm, many mothers do not receive this support. Peer support programmes, designed to enable local mothers who have breastfed to support new mothers, have been shown to be successful. Support groups and telephone support can also be effective.

KEY ACTION 5:

Strengthen existing community support programmes targeting those with the lowest breastfeeding rates through:

- Peer support programmes;
- Drop-in centres;
- Support groups;
- Telephone support.

6.4. Theme D: Implementation of existing initiatives

A number of existing initiatives have supported the current level of achievement and will be continued as a basis for delivery and development.

- **The Family Nurse Partnership** – will focus on young parents – in particular ensuring that young parents are picked up early on transiting to the community and supported if they decide to breastfeed.
- **The Healthy Child Programme** – will integrate Baby Friendly into delivery and pick up on individuals with additional needs for support through implementation of the breastfeeding pathway.

KEY ACTION 6:

- Ensure continued delivery of these programmes and alignment with the breastfeeding strategy.
- Review breastfeeding pathway to ensure it meets BFI standards.

7.0 Implementation of Strategy

7.1. Setting priorities and action planning

- A high level action plan will detail specific objectives, timelines and lead organisation with detailed action plans drawn up for each area.
- The Maternity and Early Years Health Services Group will drive the implementation and evaluation of the strategy. Reporting arrangements will be to Children's Partnership lead for infant health.
- Various groups will be involved in the implementation of the different aspects of the strategy including the Early Years Infant Feeding Group, the Healthy Child Steering Group and the Breastfeeding Improvement Group.
- Close partnership working with NHS Nottinghamshire County will ensure an effective and coordinated approach.

7.2. Performance monitoring

In addition to the above interventions the development of robust mechanisms for monitoring and evaluation in all interventions to ensure effective implementation of the strategy and action plan are critical to ensure overall aims of strategy are met (e.g. equitable access to services and improved outcomes).

7.3. Timescales

The strategy will pave the way for Nottingham to gain Baby Friendly Initiative accreditation for maternity and community health services by 2016, completing the stage 3 assessment by 2014, with Children's Centres playing a key role. The strategy has been developed to cover a 5 year period from 20010-2014. Timescales for delivery of the different areas of the strategy are to be specified in the detailed action plans. It should be noted that although this is a refreshed strategy, much work is already taking place or is being taken forwards.

7.4. Resources

Increasing breastfeeding is a key priority within local strategic commissioning plans and is supported by continued investment. In the past 3 years additional investment has been allocated to acute/community midwifery and health visiting to increase service provision and improve breastfeeding rates. Future funding priorities are identified in the NHS Nottingham City 5 Year Strategy (2009/10 – 2013/14) and includes investment to increase targeted

services to support women breastfeeding. Funding sources will be reviewed as a part of the commissioning process in the light of the developing situation and risk and contingency plans will be drawn up to support the implementation of the strategy.

KEY ACTION 7:

- Continue to gather a clear understanding of breastfeeding rates in Nottingham through robust monitoring of performance and use to update and improve programmes.
- Share details of breastfeeding rates widely across all partners.
- Identify clear responsibility for actions, with overall leadership and governance agreed by all partners.
- Identify funding streams, risks to future implementation of the strategy and contingencies as a part of commissioning within the developing economic context.

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PART TWO

Breastfeeding Strategy

Nottinghamshire County

2008 - 2012

1.0 Summary

NHS Nottinghamshire County have made a clear policy statement regarding the recognised benefits of breastfeeding for mothers and infants. As part of this, they have pledged to develop their services in order to improve breastfeeding initiation and continuation rates. More specifically, Nottinghamshire County have outlined the following objectives:

- To increase breastfeeding initiation rates by 2% per year across Nottinghamshire County.
- To ensure monitoring of breastfeeding continuation for the first 6 – 8 weeks of an infant's life to establish baseline data with the aim of increasing by 2% the rates at 6-8 weeks year on year.
- To reduce inequalities and regional differences in breastfeeding initiation and continuation rates.
- To ensure that all health professionals receive appropriate and up-to-date training regarding breastfeeding.
- To implement the UNICEF Baby Friendly Initiative accreditation programme.

To monitor progress against these objectives an evaluation protocol is utilised with each contract. The aim of this evaluation is to provide quantitative and qualitative data to demonstrate how effective each organisation has been in achieving the service standards and outcome measures specified within their Service Specification.

2.0 Aims

- To increase breastfeeding initiation rates by a minimum of 2% per year, in accordance with current target, across Nottinghamshire.
- To engender a culture of continuous improvement and sharing of good practice across the county.
- To support women to continue breastfeeding in order to directly influence the target to increase breastfeeding continuation by demonstrable rates year on year, for the first 6 to 8 weeks of an infant's life.

- To reduce the inequalities in breast and infant/early years feeding across Nottinghamshire.
- To manage the implementation of the effective, evidence based UNICEF Baby Friendly Initiative accreditation programme for maternity and early years services, which will facilitate and increase breastfeeding initiation and continuation rates.
- To ensure all health and children's centre professionals in contact with pregnant women and families with early years aged children receive appropriate and up to date training on breastfeeding. The targets for staff trained will comply with BFI requirements.
- All accredited facilities are also required to practice in line with the International Code of Marketing of Breast milk substitutes.

3.0 Breastfeeding

Breastfeeding has a major role to play in public health. It promotes health and prevents disease in both the short and the long term for mother and baby. For example, babies who are not breastfed are many times more likely to acquire infections such as gastroenteritis in their first year (Ip S, Chung M, Raman G et al. 2007, Horta BL et al. 2007) It is estimated that if all UK infants were exclusively breastfed, the number hospitalised each month with diarrhoea would be halved, and the number hospitalised with a respiratory infection would be cut by a quarter (Quigley MA, Kelly YJ, Sacker A, 2007). Exclusive breastfeeding in the early months may reduce the risk of atopic dermatitis (Department of Health 2004a). In addition, there is some evidence that babies who are not breastfed are more likely to become obese in later childhood (Department of Health, 2004a; Li L et al 2003; Michels KB et al 2007). Mothers who do not breastfeed have an increased risk of breast and ovarian cancers and may find it more difficult to return to their pre-pregnancy weight (Department of Health 2004a; World Cancer Research Fund, 2007*).*

The UK infant feeding survey 2005 (Bolling K et al. 2007) showed that 78% of women in England breastfed their babies after birth but by 6 weeks, the number had dropped to 50%. Only 26% of babies were breastfed at 6 months. Exclusive breastfeeding was practiced by only 45% of women 1 week after birth and 21% at 6 weeks.

Three quarters of British mothers who stopped breastfeeding at any point in the first 6 months (and 90% of those who stopped in the first 2 weeks) would have liked to have continued for longer (Bolling K et al, 2007). This suggests that much more could be done to

support them. Prolonged, exclusive breastfeeding, which results in the greatest benefits, is far from universally practiced in the UK. Indeed, breastfeeding initiation rates in the UK are around the lowest in Europe with rapid discontinuation rates for those who do start. Further, initiation and continuation rates are lowest among families from lower socio-economic groups, adding to inequalities in health and contributing to the cycle of deprivation.

As a result of a systematic review published by World Health Organisation on exclusive breastfeeding in 2000, WHO revised its guidance to recommend exclusive breastfeeding for the first six months of an infant's life. This revised guidance was adopted by the United Kingdom Health Departments from 2003 onwards. U.N.I.C.E.F. "Baby Friendly Initiative" *Ten Steps* - best practice standards and the *Seven Point Plan* - for sustaining breastfeeding in the community is a minimum requirement in line with N.I.C.E. guidelines (National Institute for Health and Clinical Excellence, 2006; National Institute for Health and Clinical Excellence 2008).

Patterns of breastfeeding can be described using several different measures:

- The government target defines initiation of breastfeeding as "The mother puts the baby to the breast, or the baby is given any of the mother's breast milk, within the first 48 hours of birth"
- Incidence of breastfeeding is described as the proportion of babies who were breastfed initially, including if this was on one occasion only.
- Prevalence of breastfeeding is defined as the proportion of babies being breastfed at specific ages, including babies that also receive infant formula or solid food
- Duration of breastfeeding is the length of time that a mother who breastfed initially continues to do so, even if they were also giving other milk or solid food.

The Priorities and Planning Framework contains a target for breastfeeding to deliver an increase of two percentage points per year in the initiation rate, focussing especially on women from disadvantaged groups.

Breastfeeding initiation and duration depend on the interaction of many factors including the attitude of individuals, families, communities and professionals. Supporting breastfeeding requires action both at government level and across agencies locally. The overall aim of the strategy is to promote the benefits of breastfeeding and support women who breastfeed.

4.0 Breastfeeding in Nottinghamshire: where are we now?

4.1 Comparative position – England statistical neighbours

Nationally breastfeeding initiation rates have steadily increased from 1995 onwards, and the Infant Feeding Survey (I.F.S) 2005 (Bolling K et al, 2007) reported an incidence rate of 78% in England. Nottinghamshire County has made significant improvements towards reaching the national average. The Office of National Statistics (O.N.S.) places Nottinghamshire County PCT in the group 'Manufacturing towns A'.

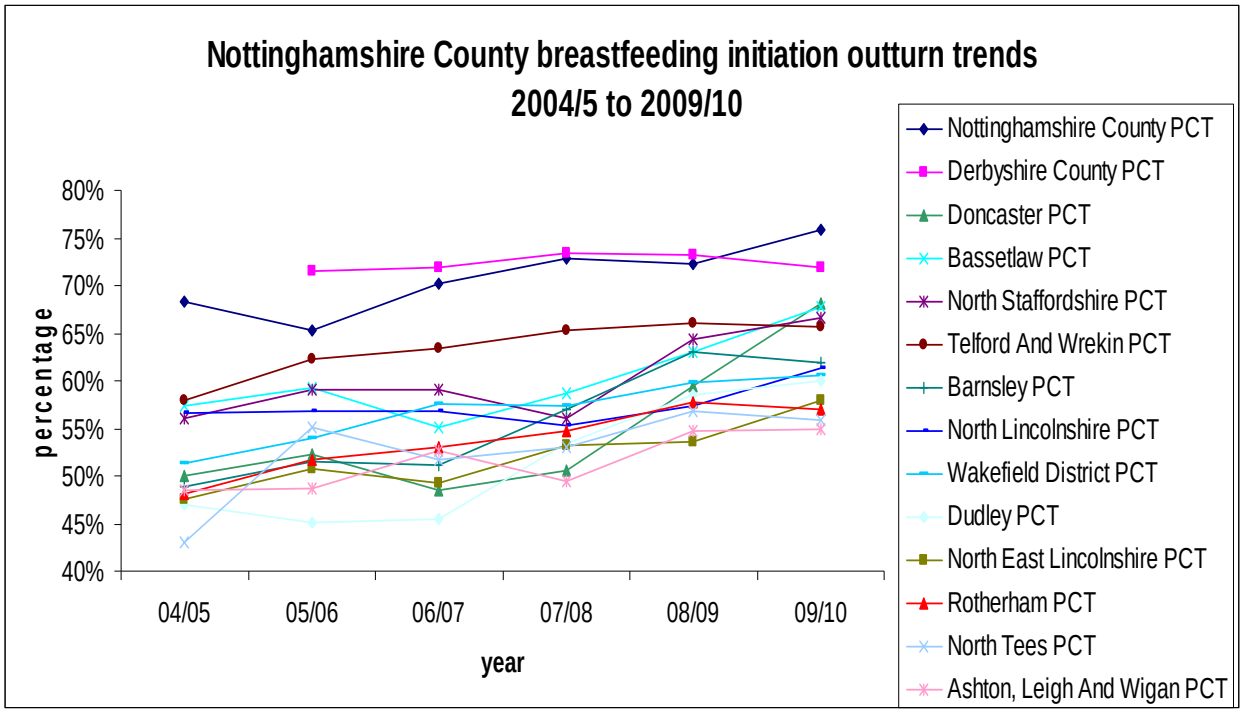
Nottinghamshire County has numerous providers of maternity and early years services that have begun to reach the standards stipulated by U.N.I.C.E.F. Baby Friendly Initiative:

- Sherwood Forest Hospitals NHS Foundation Trust: Stage 1 accreditation 2009 (Ten Steps)
- Nottinghamshire Community Health and health led Children's Centres: Certificate of Commitment 2010 (Seven Point Plan)
- Nottingham University Hospitals NHS Trust and Citihealth community midwifery service: Register of intent 2010 (Ten Steps)

4.2 Breastfeeding initiation

Figure 4.1 shows that the percentage of mothers initiating breastfeeding between 2004 and 2010 in Nottinghamshire compared to its O.N.S. statistical neighbours. The proportion of mothers initiating breastfeeding has increased steadily during this period, other than in 2005/06 and a slight decrease in 2008/09 giving an overall rise during the period 2006 - 2010 of 5.87%. In 2009/10 Nottinghamshire County achieved the highest initiation rate in the cohort, 3% higher than the England average of 72.78%.

Figure 4.1



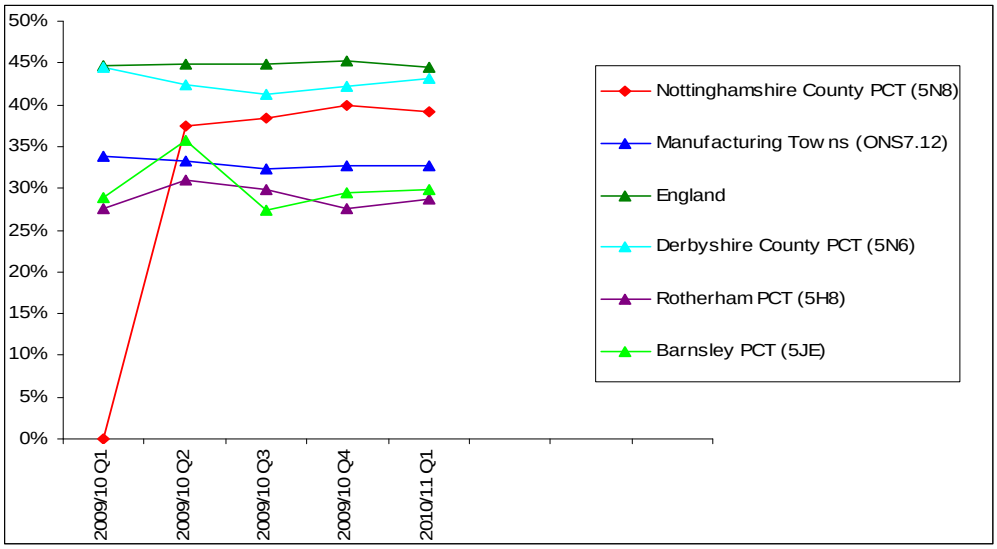
PCT	04/05	05/06	06/07	07/08	08/09	09/10
Nottinghamshire County PCT	**68.3%**	**65.3%**	**70.1%**	**72.8%**	**72.2%**	**75.9%**
Derbyshire County PCT		71.5%	71.9%	73.3%	73.2%	71.9%
Doncaster PCT	50.0%	52.3%	48.5%	50.5%	59.5%	68.1%
Bassetlaw PCT	57.4%	59.3%	55.0%	58.6%	63.1%	67.8%
North Staffordshire PCT	56.0%	59.0%	59.0%	56.1%	64.4%	66.6%
Telford And Wrekin PCT	57.8%	62.3%	63.4%	65.4%	66.0%	65.6%
Barnsley PCT	48.9%	51.5%	51.2%	56.9%	63.0%	61.9%
North Lincolnshire PCT	56.6%	56.9%	56.7%	55.2%	57.3%	61.3%
Wakefield District PCT	51.4%	54.0%	57.6%	57.4%	59.7%	60.6%
Dudley PCT	47.0%	45.1%	45.5%	53.5%	58.5%	60.0%
North East Lincolnshire PCT	47.5%	50.8%	49.3%	53.3%	53.6%	57.9%
Rotherham PCT	48.1%	51.6%	53.0%	54.6%	57.8%	57.0%
North Tees PCT	43.0%	55.2%	51.7%	53.1%	56.8%	55.9%
Ashton, Leigh And Wigan PCT	48.4%	48.8%	52.6%	49.4%	54.8%	54.8%

Source: Department of Health (May 2010) Statistical Release: Breastfeeding initiation and prevalence at 6 to 8 weeks Quarter 4, 2009/10

4.3 Breastfeeding prevalence at 6-8 weeks

In 2007 six PCTs in Nottinghamshire amalgamated to form a new organisation; NHS Nottinghamshire County. Numerous electronic data systems existed and a single data collection system was a high priority. Prior to Q2 2009/10 data submitted to the Department of Health failed validation standards. Following the introduction of SystmOne, data has exceeded these standards. Nottinghamshire County has the second highest 6-8 week breastfeeding prevalence in its statistical peer group, but is 5.25% below the England average.

Figure 4.2 Breastfeeding prevalence at 6-8 weeks



Breastfeeding prevalence at 6 to 8 weeks

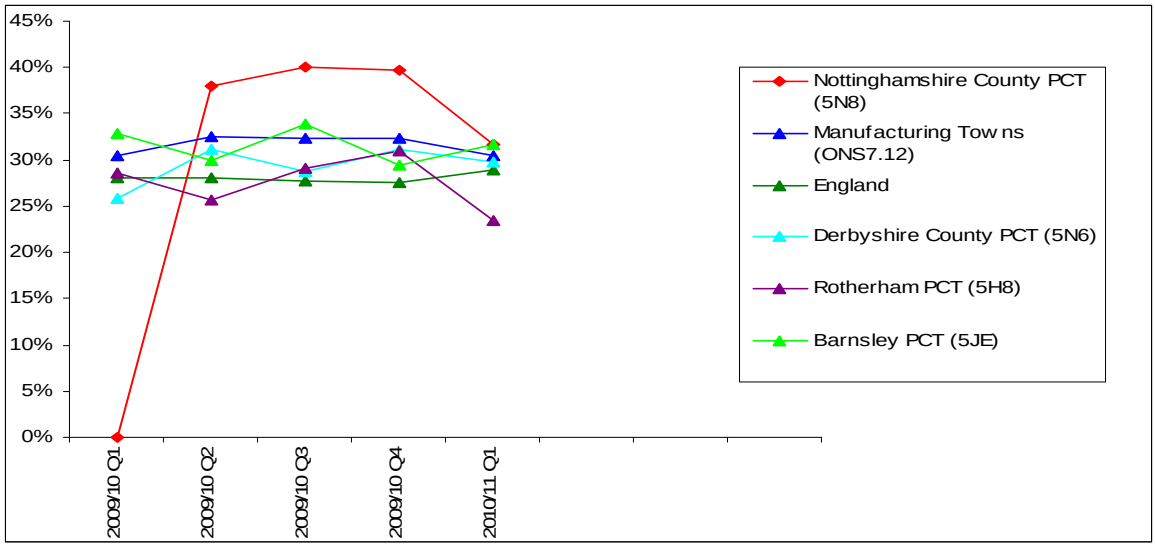
	% of all infants				
	2009/10 Q1	2009/10 Q2	2009/10 Q3	2009/10 Q4	2010/11 Q1
Nottinghamshire County PCT (5N8)		37.4%	38.4%	39.9%	39.2%
Manufacturing Towns (ONS7.12)	33.8%	33.3%	32.3%	32.7%	32.7%
England	44.6%	45.0%	44.8%	45.2%	44.4%
Derbyshire County PCT (5N6)	44.5%	42.5%	41.3%	42.3%	43.2%
Rotherham PCT (5H8)	27.6%	30.9%	29.8%	27.5%	28.7%
Barnsley PCT (5JE)	29.0%	35.7%	27.3%	29.5%	29.9%

Source: Department of Health (May 2010) Statistical Release: Breastfeeding initiation and prevalence at 6 to 8 weeks Quarter 4, 2009/10

4.4 Difference between initiation rate and prevalence at 6-8 weeks

Women will breastfeed their babies for varying amounts of time depending on a variety of factors. The difference between initiation and the 6-8 week prevalence rate has been as high as 40% in Q3 2009/10, this was the second highest 'drop off' rate recorded in the England validated data set. Q1 2010/11 has seen an improvement to 31.7%. It is a priority to reduce this figure to ensure the number of babies' breastfeeding to six months of age is increased.

Figure 4.3 Difference between initiation rate and prevalence at 6-8 weeks (percentage points)



	2009/10 Q1	2009/10 Q2	2009/10 Q3	2009/10 Q4	2010/11 Q1
Nottinghamshire County PCT (5N8)		37.9%	40.0%	39.7%	31.7%
Manufacturing Towns (ONS7.12)	30.5%	32.5%	32.4%	32.4%	30.4%
England	28.1%	28.1%	27.8%	27.5%	28.9%
Derbyshire County PCT (5N6)	25.9%	31.2%	28.8%	31.1%	29.8%
Rotherham PCT (5H8)	28.6%	25.6%	29.1%	30.9%	23.4%
Barnsley PCT (5JE)	32.8%	30.0%	33.9%	29.5%	31.7%

Source: Department of Health (May 2010) Statistical Release: Breastfeeding initiation and prevalence at 6 to 8 weeks Quarter 4, 2009/10

5.0 Contributing factors to breastfeeding rates

5.1 Deprivation

In the UK, differences in deprivation between areas are a major determinant of health inequalities, including infant mortality and low birth weight.

Table 5.1 Number and percentage of the population living in the most deprived quintile in England, by local authority in Nottinghamshire according to Indices of Deprivation 2007 (based on data from 2005)

	% Deprived	Number in most deprived quintile	Significance compared to England average
England	19.9	10023471	
East Midlands	16.6	717204	Better
Nottinghamshire	**14.1**	**108195**	**Better**
Ashfield	19.8	22749	No significant difference
Bassetlaw	23.7	26217	Worse
Broxtowe	2.7	2994	Better
Gedling	2.0	2286	Better
Mansfield	41.0	40839	Worse
Newark and Sherwood	11.9	13110	Better
Rushcliffe	0.0	0	Better

Source: Health Profiles 2009 APHO and Department of Health

As can be seen in Table 5.1, 14.1% of the population of Nottinghamshire live in deprivation versus 19.9% of England as a whole. The most deprived areas in Nottinghamshire County are largely within Mansfield (41.0%), Bassetlaw (23.7%) and Ashfield (19.8%). Analyses at a lower geographical area the Lower Super Output Area (LSOA) identify Sutton in Ashfield Central (Ashfield); Ravensdale (Mansfield) as having higher levels of need[i].

Between April 2003 and March 2009 a quarter (25.6%, 12142) of maternities were mothers in the most deprived quintile of the PCT population. One in five maternities (20.8%) were mothers in the second most deprived quintile.

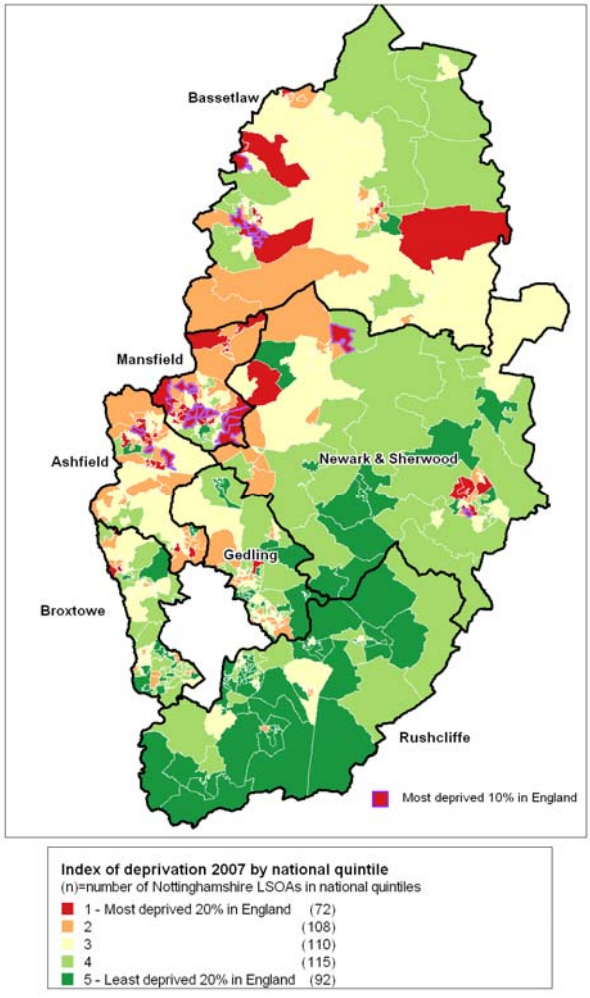
Nottinghamshire has a significantly lower proportion of children living in families receiving means tested benefits than the England average (18% Nottinghamshire vs. 22% England). However, there are differences within the county, with Mansfield being significantly higher than the England average and Ashfield having no significant difference.

Table 5.2 Maternities by maternal deprivation quintile Nottinghamshire County and Bassetlaw (April 2003 – March 2009)

Deprivation quintile	Total No maternities	Proportion of total maternities
5(most deprived)	12,142	25.6%
4	9,877	20.8%
3	8,280	17.5%
2	8,438	17.8%
1(least deprived)	8,680	18.3%
Nottinghamshire County total recorded	47,417	100.0%

Source; HES and the Index of Deprivation 2007

Nottinghamshire: Index of deprivation by national quintile 2007



5.2 Birth and fertility rates

In 2007 the birth rate in Nottinghamshire County (57 per 1,000 female population aged 15-44) was significantly lower than both the England and East Midlands averages. There were differences by area with Broxtowe having a significantly lower rate than Nottinghamshire County as a whole.

All areas in Nottinghamshire have seen an increase in maternities in the period 2003-2007 (with an average annual increase of 173 maternities), with the greatest percentage increases taking place in Gedling, Mansfield and Bassetlaw.

The highest fertility rate was in the 30-34 year old age group and lowest in women under 20 years of age which was in line with the pattern nationally.

5.3 Teenage Parents

Teenage pregnancy is a significant public health issue in England. Teenage parents are prone to poor antenatal health, lower birth weight babies and higher infant mortality rates. Their health, and that of their children, is worse than average. Teenage parents are more likely to come from a disadvantaged background. Teenage mothers are less likely to finish their education, less likely to find a good job, and more likely to end up as single parents and bringing up their children in poverty. They are also more likely to suffer postnatal depression than older mothers, more likely to smoke in pregnancy and less likely to breastfeed. Teenage parents are more likely to have an unstable relationship than older parents (Department for Children, Schools and Families, July 2008). Teenagers are less likely to access maternity care early in pregnancy, less likely to keep appointments, less likely to attend antenatal education. Children of teenage mothers run a much greater risk of poor health, and have a much higher chance of becoming teenage mothers themselves.

Table 5.3 Under-18 conception numbers per year and rate per 1000 females England, East Midlands and local authority in Nottinghamshire 2005-07

	Number per Year 2005-07	Rate per 1000 females	Significance compared to England
England	39757	41.2	
East Midlands	3393	40.1	Better
Nottinghamshire	**535**	**36.2**	**Better**
Ashfield	98	42.4	No significant difference
Bassetlaw	92	42.3	No significant difference
Broxtowe	68	33.8	Better
Gedling	62	28.5	Better
Mansfield	99	49.7	Worse
Newark and Sherwood	76	34.7	Better
Rushcliffe	41	20.8	Better

Source: APHO and Department of Health.

6.0 Objectives

- To increase the uptake and continuation of breastfeeding across Nottinghamshire.
- To ensure that robust infant feeding data is collected and shared across Nottinghamshire in line with agreed service specifications'.
- For Nottinghamshire Community Health, Nottingham University Hospitals and CitiHealth Community Midwifery to achieve UNICEF 'Baby Friendly Initiative' status
- For all staff in contact with mothers and mothers to be, both in the maternity units and in the community to be trained in the promotion and continuation of breastfeeding
- For all women and their families to receive appropriate, consistent and up to date information on breastfeeding.
- For women/families identified as at risk or in vulnerable groups to be targeted e.g. teenage parents.

7.0 Strategic actions

This will be achieved by a package of multifaceted interventions in line with NICE guidance as outlined below and to be viewed together with the current Nottinghamshire County Breastfeeding Action Plan.

KEY ACTION 1:

Develop local programmes to help change underlying attitudes and community norms around breastfeeding through:

- Promotion of positive breastfeeding messages at schools and colleges
- Utilising the Best Beginnings "Get Britain Breastfeeding" exhibition
- Community awareness raising events

KEY ACTION 2:

Create supportive environments which enable women to breastfeed through:

- Breastfeeding policies in workplaces, nurseries and other public buildings/premises;
- Providing relevant information on returning to work to all breastfeeding mothers;
- Breastfeeding-friendly cafes, restaurants and others public places.

KEY ACTION 3:

Maternity services to achieve UNICEF BFI accreditation through:

- Review and development of breastfeeding policy based on BFI 'Ten Steps' best practice standards
- Staff training programme
- Education for pregnant women
- Best practice education and support for new mothers and their families.

The vast majority of mothers give birth to their babies in hospital, where their experiences in the first hours and days after birth can have a profound effect on whether or not they breastfeed. Ensuring that hospital practices protect, promote and support breastfeeding is essential. The information and support women receive during pregnancy and following birth through community midwifery teams can also contribute significantly to their choices around breastfeeding. The UNICEF BFI aims to introduce best practice standards for breastfeeding into all maternity health-care services. These standards form the *Ten Steps to Successful Breastfeeding* (appendix 3).

NHS Nottingham City and NHS Nottinghamshire County have jointly commissioned 1.4wte Infant Feeding Coordinators at Nottingham University Hospitals Trust to implement the BFI standards for NUH and the Citihealth community midwifery service utilising Department of Health funding for the improvement of breastfeeding 2009-3/2012. Service specification monitored with the agreed evaluation protocol.
Sherwood Forest Hospitals Foundation Trust achieved Stage 1 accreditation July 2009.

KEY ACTION 4:

Community health services and health led children's centres to achieve UNICEF BFI accreditation through:

- Development of breastfeeding policy based on the 'Seven Point Plan'
- Staff training programme
- Education for pregnant women, including antenatal interventions to reach those least likely to breastfeed
- Best practice education and support for new mothers and their families
- Interventions to support mothers to continue breastfeeding.

Community midwives are instrumental in providing post-natal care within the initial 10-14 days after birth. Following this, core health care for breastfeeding mothers in the community is provided by the health visiting service, Children's Centres and General Practitioners. The

BFI ensures the same standard of care is available for all women by adopting the Seven Point Plan for Sustaining Breastfeeding in the Community (appendix 4). The Healthy Child Programme will therefore be instrumental in the implementation of the Seven Point Plan. A service level agreement is in place with Nottinghamshire Community Health to raise 6-8 week breastfeeding prevalence and to work towards 'Baby Friendly Initiative' accreditation (2008-2011). SLA monitored with the agreed evaluation protocol.

There is much evidence to suggest that mothers are more likely to start and continue breastfeeding if they are supported by someone who is confident, both in breastfeeding and in the ability of the mother to be successful. In a predominantly breastfeeding culture this support is given by family, friends and society as a whole. In the UK, where bottle feeding is the norm, many mothers do not receive this support. Peer support programmes, designed to enable local mothers who have breastfed to support new mothers, have been shown to be successful. Peer supporters will be available in children's centres' groups following local training utilising the Nottinghamshire County training package.

KEY ACTION 6:

- Continue to gather a clear understanding of breastfeeding rates in Nottingham through robust monitoring of performance and use to update and improve programmes.
- Share details of breastfeeding rates widely across all partners.
- Identify clear responsibility for actions, with overall leadership and governance agreed by all partners.
- Identify funding streams, risks to future implementation of the strategy and contingencies as a part of commissioning within the developing economic context.

Prior to the introduction of SystmOne in 2009 the Nottinghamshire recording rates of 6-8 week breastfeeding prevalence was below the Department of Health validation threshold. Since Quarter 2 2009-10 this has been resolved and is exceeding the target. Drop-off trends identified and targeted work to address issues identified.

KEY ACTION 5:

Strengthen existing community support programmes targeting those with the lowest breastfeeding rates through:

- Peer support programmes;
- Support groups;

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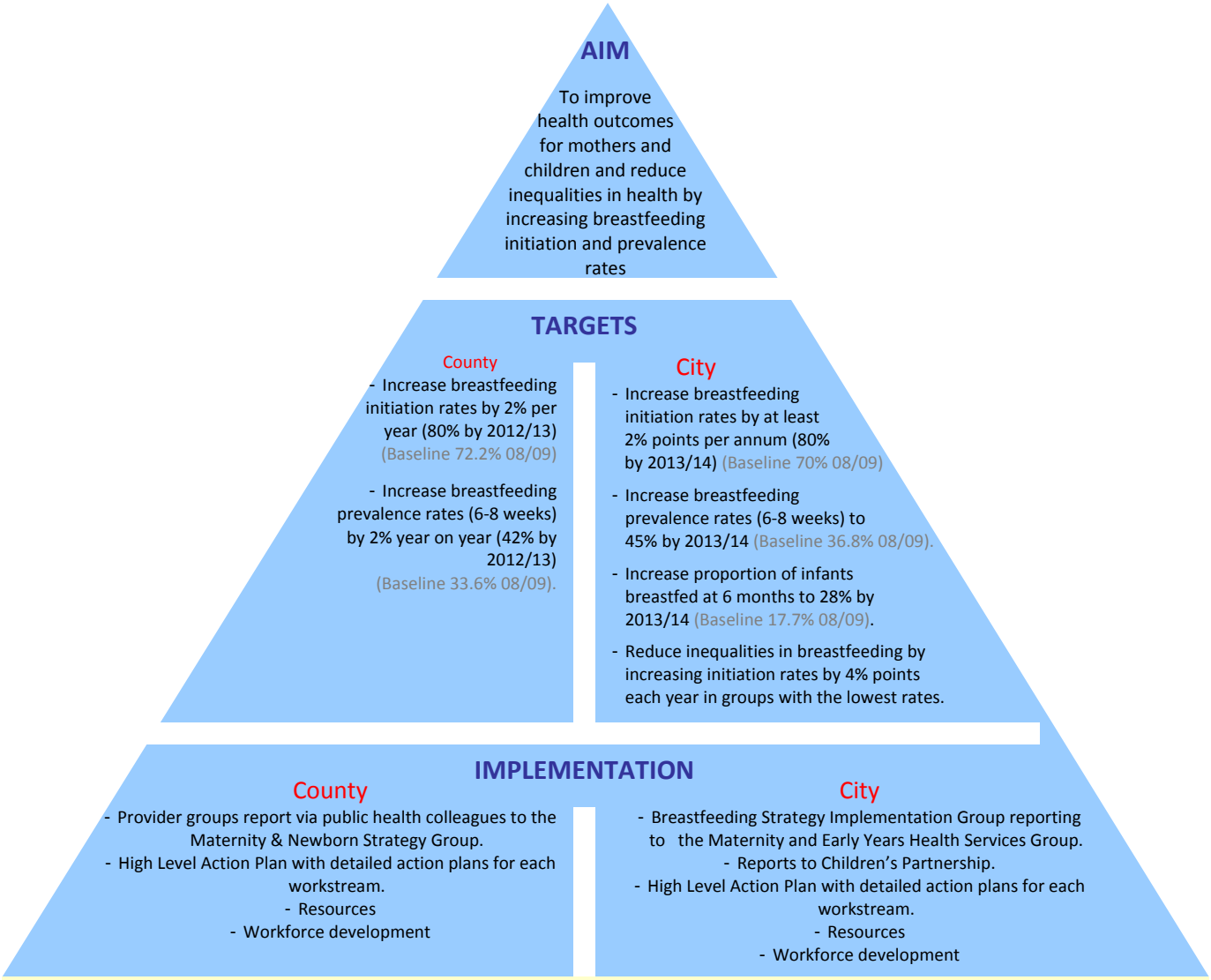
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Appendix 1: Summary of Nottingham City & Nottinghamshire County Breastfeeding Strategies



STRATEGIC ACTIONS

Theme	Interventions
A. Wider cultural influences/social marketing	1. Breastfeeding awareness through schools and colleges
	2. Other breastfeeding awareness programmes
	3. 'Baby Friendly' workplaces and premises
	4. Social marketing
B. UNICEF Baby Friendly Initiative	5. UNICEF Baby Friendly Initiative (Maternity Services)
	6. UNICEF Baby Friendly Initiative (Community Health Services)
C. Peer Support	7. Peer Support programme
D. Existing Initiatives	8. Healthy Child programme
	9. Family Nurse Partnership (Nottingham City only)

Appendix 2: Nottingham City Breastfeeding Targets

Deliver year on year improvement in overall breastfeeding initiation rates by at least 2 percentage points:

	2008/09 Actual	2009/10	2010/11	2011/12	2012/13	2013/14
Nottingham City breastfeeding initiation rate	70%	72%	74%	76%	78%	80%

Nottingham City Target: Percentage of infants breastfed at 6-8 weeks

	2008/09 Actual	2009/10	2010/11	2011/12	2012/13	2013/14
Local Operational Plan 2008-2010	36.8%	38%	40%			
Nottingham City Commissioning Strategy 2009-2014	36.8%	38%	40%	41%	43%	45%

Percentage of infants breastfed at 6 months[1]

	2008/09 Actual	2009/10	2010/11	2011/12	2012/13	2013/14
Breastfeeding prevalence at 6 months	17.7%	20%	22%	24%	26%	28%

Targets for addressing inequalities in breastfeeding initiation (increase by 4 percentage points each year)

Target Group	2008/09 Actual	2009/10	2010/11	2011/12	2012/13	2013/14
Aged under 25 years	48%	52%	56%	60%	64%	68%
White ethnicity	54%	58%	62%	64%	68%	72%
Deprivation – quintiles 1,2 and 3	59%	63%	67%	71%	75%	79%

[1] A 2% point increase has been selected for the 6 month breastfeeding prevalence target. This reflects a larger proportionate increase than the 2% point increase at initiation. This accounts for the expected increase in initiation rates as well as increased maintenance rates due to implementation of the strategy. It presumes similar levels of data collection as currently occur.

Appendix 3: Nottinghamshire County Breastfeeding Targets

Increase breastfeeding initiation rates by 2% per year:

	2008/09 Actual	2009/10	2010/11	2011/12	2012/13
Nottinghamshire County breastfeeding initiation rate	72.2%	Target 74% Actual 75.87%	76%	78%	80%

Percentage of infants breastfed at 6-8 weeks:

	2008/09 Actual	2009/10	2010/11	2011/12	2012/13
Nottinghamshire County breastfeeding continuation rate	33.6%	Target 36% Actual 38.6%	38%	40%	42%

Appendix 4:

Ten Steps to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.

2. Train all healthcare staff in the skills necessary to implement the breastfeeding policy.

3. Inform all pregnant women about the benefits and management of breastfeeding.

4. Help mothers initiate breastfeeding soon after birth.

5. Show mothers how to breastfeed and how to maintain lactation even if they are separated from their babies.

6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.

7. Practice rooming-in, allowing mothers and infants to remain together 24 hours a day.

8. Encourage breastfeeding on demand.

9. Give no artificial teats or dummies to breastfeeding infants.

10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

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Appendix 5:

The Seven Point Plan for Sustaining Breastfeeding in the Community

1. Have a written breastfeeding policy that is routinely communicated to all health-care staff.

2. Train all staff involved in the care of mothers and babies in the skills necessary to implement the policy.

3. Inform all pregnant women about the benefits and management of breastfeeding.

4. Support mothers to initiate and maintain breastfeeding.

5. Encourage exclusive and continued breastfeeding, with appropriately-timed introduction of complementary foods.

6. Provide a welcoming atmosphere for breastfeeding families.

7. Promote co-operation between healthcare staff, breastfeeding support groups and the local community.

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