Surrey Breastfeeding Strategy: Building a Happy Baby 2016-2021

"No other health behaviour has such a broad-spectrum and long-lasting impact on public health." Unicef

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SURREY

Acknowledgements

Thanks are due to members of the Surrey Breastfeeding Strategy Board for both their tireless work supporting breastfeeding and their input to this strategy. We would also like to thank the participants of the workshop day, who gave up their time to help shape this strategy.

Equality Statement

Equality, fairness and respect strategy – Surrey County Council

The Equality, Fairness and Respect Strategy demonstrates the Council's commitment to deliver fair and inclusive services to meet the needs of all Surrey's communities. It also reflects our commitment to be a best practice employer for all our staff and reflect the diversity of Surrey's population. The priorities enable us to meet the requirements of the public sector equality duty to publish specific equalities objectives for the organisation.

The Strategy has been developed closely with colleagues across the council and partners from the voluntary, community and faith sector, through the Surrey Equality Group and was approved by Cabinet on 23 June 2015.

To ensure that we are delivering our priorities for equality, fairness and respect, the council will provide updates on the progress it is making annually through the Council's performance reporting system.

Confident in our future: Equality Fairness and Respect Strategy 2015-2020

Our Purpose

Ensure services support all Surrey residents and our staff are healthy, safe and confident about their future.

Our Vision

Equality
Fairness
Respect

Context

The makeup of Surrey’s 1.1 million residents is continuing to change, and over the next 25 years the population is projected to increase by over 20%. We will see an increase in the number of residents aged over 65 and an increase in the number of children and young people too. Residents are living longer with a range of different health and care needs, some have multiple and complex needs. Surrey is also a more ethnically diverse place to live than ever before.

This strategy sets out our priorities and demonstrates our commitment to deliver fair and inclusive services to meet the needs of all Surrey’s communities. As one of the largest employers in Surrey this document also supports the Council’s commitment to be a best practice employer for all our staff and reflect the diversity of Surrey’s population.

This meets the Council's duty in the Equality Act 2010 to publish objectives that show how we will promote equality of opportunity and tackle discrimination.

There are an estimated 110,000 unpaid carers of all ages in Surrey. The majority of carers are women and includes an estimated 14,000 young carers.
We support around 30,000 people each year with a range of physical and learning disabilities as well as mental health issues. Over 20,000 people each year in Surrey access NHS mental health services.
In Surrey's most deprived areas life expectancy is on average five years lower than areas of higher wealth.
17% of Surrey's population identify themselves as being from a minority ethnic group. Since 2001, the non-white British population has doubled to 9.8%.
Supporting all disabled women to breastfeed is an important part of ante-natal and postnatal care; individualised care may need to be provided to these mothers. There is a variety of equipment available for supporting women who are disabled to breastfeed.

Our Equality, Fairness and Respect Priorities

Drawing on a robust evidence base from sources such as Surrey-i, and following engagement with internal and external stakeholders, we have set the following four priorities. These complement our Corporate Strategy, People Strategy and Customer Promise, and support the design and delivery of inclusive and accessible services that help meet the needs of our communities.

1. Ensure Surrey's children, adults and families are supported and helped to lead more independent lives.
2. Support all children and young people to participate and succeed in education, training and employment.
3. Support preventative actions to reduce health inequalities and increase wellbeing for our communities.
4. Be a local employer of first choice for people from all our diverse communities, particularly for disabled and younger people.

Our Values

Listen
Responsibility
Trust
Respect

Our Strategic Goals

1. Wellbeing - aiming for everyone in Surrey has a great start to life and can live and age well.
2. Economic prosperity - ensuring Surrey's economy remains strong and sustainable.
3. Resident experience - making sure residents in Surrey experience public services that are easy to use, responsive and value for money.

Contents

1. Foreword

It is with great pleasure that we present this Breastfeeding Strategy for Surrey that recognises the importance of breastfeeding as a key public health issue, our vision for 'Building a Happy Baby' is to create a County where:

• Every family is fully aware of the benefits of breastfeeding and therefore able to make an informed decision about how to feed their baby.
• Every family is able to access the information, support and help they need in hospital and community settings from appropriate publicly funded and voluntary services.
• Public and private sector services and settings all welcome and support breastfeeding mothers.

There are a number of actions that need to take place in order to achieve this vision and they will require leadership, co-ordination and support from a variety of different organisations across Surrey. Fundamental to this strategy is the belief that breastfeeding for at least the first 6 months of a baby's life should be seen as the social norm. This is in recognition of the profound importance of early relationships to future health and wellbeing and the significant contribution that breastfeeding makes to good physical and emotional health outcomes for infants and mothers

We know that there is robust evidence to show the numerous health benefits of breastfeeding to both the mother and the child, both in the short and long-term. We also know that mothers from lower socio-economic groups are less likely to start and more likely to stop breastfeeding early and that supporting these mothers to breastfeed has an important role to play in reducing health inequalities. Improving breastfeeding rates is a complex process that requires the input of different agencies and disciplines. We need to work in partnership to develop local services to encourage and support breastfeeding mothers. The previous five year breastfeeding strategy for Surrey provided a framework which enabled a number of health providers to become Unicef Baby Friendly Initiative (BFI) accredited. There is still significant work to be done by bringing children's centres and all neo-natal units on board with BFI as well and this next five year strategy provides the framework for building upon previous achievements.

A number of stakeholders have been involved in developing this new strategy and the implementation of this will continue to be overseen by these stakeholders as part of the Surrey Breastfeeding Strategy Steering Group. We are jointly committed to the vision of this strategy which will enable relevant professionals and agencies to take forward the work to improve the health and well-being of infants and mothers in Surrey.

Helen Atkinson

Strategic Director of Adult Social Care and Public Health

Dr Suzanne Moore

GP and Chair of Surrey Maternity Clinical Advisory Group

2. Strategy vision, aims and objectives

The Vision

The vision of 'Building a Happy Baby' is to create a County where:
• Every family is fully aware of the benefits of breastfeeding and therefore able to make an informed decision about how to feed their baby.
• Every family is able to access the information, support and help they need in hospital and community settings from appropriate publicly funded and voluntary services.
• Public and private sector services and settings all welcome and support breastfeeding mothers.

Achieving this vision requires that:

- Breastfeeding for at least the first 6 months of a baby's life is accepted as the norm.
- Women are supported to continue breastfeeding, for as long as they wish.
- Health (including neo-natal) and children's centre professionals provide the highest standard of care to support expectant and new mothers and their partners to feed their baby and build strong loving parent infant relationships.
- This is in recognition of the profound importance of early relationships to future health and wellbeing and the significant contribution that breastfeeding makes to good physical and emotional health outcomes for infants and mothers
- Women are free to breastfeed without stigma in public places.
- Evidence based information is provided about the introduction of appropriate healthy family foods from six months alongside continued breastfeeding
- Young people are able to learn about evidence based facts and discuss their beliefs about breastfeeding.
- The gap in breastfeeding rates between different parts of the county and different communities is reduced.
- Robust, standardised data collection and evaluation systems are in place to monitor and report progress.

Objectives

To achieve these aims we need to achieve the following objectives:

1. Achieve and maintain Baby Friendly Initiative accreditation in all appropriate hospital, community health care, neo-natal units and children's centre locations across Surrey by 2020.
2. Provide appropriate ongoing support for breastfeeding in local communities to encourage continuation of breastfeeding paying particular attention to areas with low breastfeeding initiation and continuation rates with a view to facilitating support networks and peer support groups.
3. Maintain an accurate audit mechanism for collecting breastfeeding data at birth, ten days and 6-8 weeks
4. Ensure that we use social media and IT effectively
5. Support programmes which work towards making breastfeeding the social norm
    - Education – schools and university training for health professionals
    - Returning to work
    - Ensuring that public health programmes in other topic areas recognise the profound importance of early relationships to future health and wellbeing and the significant contribution that breastfeeding makes to good physical and emotional health outcomes for infants and mothers

3. Introduction

For the past five years organisations across Surrey have been working hard to achieve the aims of the 2010-2015 Breastfeeding Strategy. There has been an increase in hospitals and community health providers across Surrey achieving BFI accreditation; we have put robust data collection methods in place for ensuring we have access to breastfeeding rates and data across Surrey and whilst initiation rates have remained constant we have increased continuation of breast feeding at 6-8 weeks across Surrey by 7%, this is a great achievement. This new strategy aims to build on the good practice and work that has taken place by addressing some of the gaps in the previous strategy and working towards having a County where breastfeeding is seen as the social norm.

There is often a fear that if breastfeeding is actively promoted, bottle feeding mothers will be left out or made to feel guilty. Good antenatal information allows all women to make informed choices, skin-to-skin contact, keeping baby close and baby-led feeding are important for all mothers. We want to ensure that all mothers are enabled to make an informed choice about how they feed their baby. Therefore we would expect all pregnant women to have had the opportunity for a 1:1 discussion about caring for and feeding her baby. We would then expect that she is supported in her choice by her health professionals.

Unicef recommend that “no pregnant woman is asked her feeding intention during pregnancy. This keeps the door open for the 1:1 discussion. Many health professionals open with telling the woman about skin-to-skin contact after the birth, keeping her baby close to her and baby-led feeding. Then move on to asking about what she knows about breastfeeding. All women should be offered help with the first feed after their baby is born.”

For generations in the UK, formula feeding and care based on strict routines has become the cultural norm (Crossland & Dykes, 2011). As a consequence, the physiological norm of breastfeeding, and subsequently emotional attachment and parenting skills, have been interrupted. In addition to this, media attention and social trends undermine women’s confidence in their ability to breastfeed (Groskop, 2013). For some women living in this environment, breastfeeding can be very challenging. Women make decisions about their infant feeding choices for a variety of reasons, including their own cultural expectations and personal circumstances (Marshall et al, 2007). If women then choose not to breastfeed, they need the best possible evidence-based information to help them to minimise the risks of formula feeding. (Crawley & Westland, 2012)

Breastfeeding brings many advantages to both mothers and babies, including preterm infants. A total of 926 preterm infants were studied by Lucas and Cole (1990). 51 of whom developed nectrotising enterocolitis (NEC). Exclusively formula-fed infants were 6 to 10 times more likely to develop NEC than those who received breastmilk. Although NEC is rare in babies over 30 weeks gestation, it was 20 times more common if the baby had received no breastmilk. There is also a correlation between higher rates of breastfeeding prevalence and lower rates of inpatient admissions among infants under one year old for 10 conditions: lower respiratory tract infections, infant feeding difficulties, wheezing, gastroenteritis, non-infective gastroenteritis, eczema, otitis media (ear infections), infant feed intolerance, lactose intolerance and asthma (Ladomenou et al. 2010). This reduction in admissions has the potential to bring cost savings to the NHS. In the longer term, infants who are not breastfed tend to have higher blood pressure and are at greater risk of type 2 diabetes and obesity. (American Academy of Paediatrics, 2012). In addition to this

the impact on outcomes for children who have been breastfed such as IQ and other measures of development is being consistently seen in high-quality studies. (Horta & Victoria, 2013). Breastfeeding provides a unique opportunity for attachment between mother and baby and can protect the child from maternal neglect. (Strathearn et al, 2009).

Benefits to the mother include:

- Reduction in the incidence of pre-menopausal breast cancer (WCRF/AICR, 2009)
- Reduction in the incidence of ovarian cancer (WCRF/AICR, 2009)
- Reduction in the incidence of hip fractures, low bone density, osteoporosis and rheumatoid arthritis (Paton LM et al, 2003)
- Increased likelihood of returning to pre-pregnancy weight (Baker et al 2008)

Young mothers and mothers from lower socioeconomic groups, are least likely to breastfeed. (McAndrew et al, 2012; SACN, 2008). Evidence has demonstrated that a child from a low-income background who is breastfed is likely to have better health outcomes than a child from a more affluent background who is formula-fed. (Wilson et al, 1998).

Key performance targets and indicators

The Public Health Outcome Framework (2013-2016) identifies three outcome indicators which relate to breastfeeding

- Breast feeding initiation
- Breast feeding continuation at 6 weeks
- Reducing Infant Mortality

In 2012, UNICEF UK Baby Friendly Initiative published revised standards for maternity, neonatal, health visiting (or specialist public health nursing) and children's centre (or equivalent early years' community settings) services. These were the result of a large consultation involving clinicians, academics, policy makers and mothers/ women. These new standards incorporate the previous standards as specified in the Ten Steps to Successful Breastfeeding and Seven Point Plan for Sustaining Breastfeeding in the Community, but update and expand them to fully reflect the evidence base on delivering the best outcomes for mother and babies in the UK. The new standards focus on the interconnectedness of systems and place at the heart of the standards, the relationship between mother and baby.

Under the NHS plan (2015-2016) increasing breastfeeding rates will contribute to a number of indicators and improvement areas.

- Emergency admissions for acute conditions that should not usually require hospital admission
- Emergency admissions for children with Lower Respiratory Tract Infection
- Reducing infant mortality
- Improving women and their families' experience of maternity services

The Chief Medical Officer Report (2013) recommends increasing involvement with WHO and UNICEF's Baby Friendly Initiative, as a minimum standard, to support breastfeeding.

Recommendations include the need to monitor and examine the effects of formula advertising on child health outcomes.

The Healthy Child Programme (2009) recommends the Baby Friendly Initiative as a minimum standard to support breastfeeding and reduce obesity.

4. Interventions that improve breastfeeding rates

Multiple factors influence a mother's choice on how to feed her baby. NICE guidelines (2008) on Maternal and Child Nutrition makes recommendations for promoting breastfeeding. These include:

- Adopt a multifaceted approach or a coordinated programme of interventions across different settings to increase breastfeeding rates. It should include:
  - activities to raise awareness of the benefits of – and how to overcome the barriers to – breastfeeding
  - training for health professionals
  - breastfeeding peer-support programmes
  - joint working between health professionals and peer supporters
  - education and information for pregnant women on how to breastfeed, followed by proactive support during the postnatal period (the support may be provided by a volunteer).
- Implement a structured programme that encourages breastfeeding, using BFI as a minimum standard. The programme should be subject to external evaluation.
- Ensure there is a written, audited and well-publicised breastfeeding policy that includes training for staff and support for those staff who may be breastfeeding. Identify a health professional responsible for implementing this policy.

In 2012 UNICEF UK Baby Friendly Initiative published revised standards for maternity, neonatal, health visiting (or specialist public health nursing) and children's centre (or equivalent early years' community settings) services.

These were the result of a large consultation involving clinicians, academics, policy makers and mothers. These new standards incorporate the previous standards as specified in the Ten Steps to Successful Breastfeeding and Seven Point Plan for Sustaining Breastfeeding in the Community, but update and expand them to fully reflect the evidence base on delivering the best outcomes for mother and babies in the UK.

Overview of the new Baby Friendly Initiative standards

Building a firm foundation

1. Have written policies and guidelines to support the standards.
2. Plan an education programme that will allow staff to implement the standards according to their role.
3. Have processes for implementing, auditing and evaluating the standards.
4. Ensure that there is no promotion of breastmilk substitutes, bottles, teats or dummies in any part of the facility or by any of the staff.

An educated workforce

Educate staff to implement the standards according to their role and the service provided.

Parents' experiences of maternity services

1. Support pregnant women to recognise the importance of breastfeeding and early relationships on the health and wellbeing of their baby.
2. Support all mothers and babies to initiate a close relationship and feeding soon after birth.
3. Enable mothers to get breastfeeding off to a good start.
4. Support mothers to make informed decisions regarding the introduction of food or fluids other than breastmilk.
5. Support parents to have a close and loving relationship with their baby.

Parents' experiences of neonatal units

1. Support parents to have a close and loving relationship with their baby.
2. Enable babies to receive breastmilk and to breastfeed when possible.
3. Value parents as partners in care.

Parents' experiences of health visiting services

1. Support pregnant women to recognise the importance of breastfeeding and early relationships on the health and wellbeing of their baby.
2. Enable mothers to continue breastfeeding for as long as they wish.
3. Support mothers to make informed decisions regarding the introduction of food or fluid other than breastmilk.
4. Support parents to have a close and loving relationship with their baby.

Parents' experiences of children's centres

1. Support pregnant women to recognise the importance of early relationships to the health and wellbeing of their baby.
2. Protect and support breastfeeding in all areas of the service.
3. Support parents to have a close and loving relationship with their baby.

Building on good practice

Demonstrate innovation to achieve excellent outcomes for mothers, babies and their families.

Overview of the stages

1 Stage: Building a firm foundation

The aim of this first stage is for the service to put into place the foundations for achieving the changes needed. This includes an infant feeding policy (or equivalent), a plan for staff training (including a curriculum) and the protocols and guidelines which underpin how the staff will implement the standards. Stage 1 is assessed at a distance to keep costs low. The relevant documentation is submitted to a designated Baby Friendly assessor who will check in detail that all the documents meet the required standard. A report with detailed feedback on progress will be provided, which will outline any amendments required.

→ For more information see unicef.org.uk/babyfriendly/stage1

2 Stage: An educated workforce

The aim of stage two is to ensure that all staff caring for mothers, babies and their families have the knowledge and skills they need to implement the standards according to their role. When the education programme is complete, and audit results show that it has been largely effective, Stage 2 assessment can take place. At assessment we will visit your service(s), and talk to staff and managers to gather evidence about how successful the training programme has been.

→ For more information see unicef.org.uk/babyfriendly/stage2

3 Stage: Parents' experiences

The aim of this stage is to ensure that the standards are being implemented, benefiting mothers and babies, and achieving improved outcomes. When internal audits show that the standards have been implemented, Stage 3 assessment can take place. Assessors will visit your service(s) and talk to mothers/families who have consented to an interview about their experiences of the service. The assessors will also review the internal audit results, outcome data and other supporting evidence.

When all three assessment stages have been achieved, full Baby Friendly accreditation is awarded. It is at this stage that services usually see improvements in breastfeeding rates.

→ For more information see unicef.org.uk/babyfriendly/stage3

Building on good practice

Periodic reassessments are needed to make sure that mothers, babies and their families are still experiencing Baby Friendly care. Moving beyond the basic standards is encouraged once they become embedded in everyday practice. Innovations that support enhanced standards of care, evidence of improving outcomes and more advanced staff education can all contribute towards a services application for Advanced or Beacon Baby Friendly status.

5. Surrey Breastfeeding picture

In 20013/14, 81.7% of mothers giving birth in Surrey initiated breastfeeding their babies. The data for breastfeeding at 6-8 weeks (2012/13) based on information from 81.8% of babies, indicates that 57.3% were either totally or partially breastfed 6 to 8 weeks after birth. This compares to data in 2009/10 which, based on information from 84% of babies, indicated that 51% were either totally or partially breastfed 6 to 8 weeks after birth. Fewer babies in NW Surrey (Spelthorne, Runnymede, West Elmbridge and Woking) than elsewhere in Surrey receive any breastmilk at 6 to 8 weeks.

The National Infant Feeding Survey (Hamlyn et al 2002) shows that breastfeeding rates decrease further with time, with only 25% of mothers breastfeeding and fewer than 1% exclusively breastfeeding at six months. National research further indicates that:

- 91% of women who stopped breastfeeding at 1-2 weeks would like to have breastfed for longer, but stopped because of problems or lack of support. (Thomas and Avery, 1997)
- When women stop breastfeeding before six weeks; nine out of ten would have liked to have breastfed for longer. (Hamlyn et al 2002).
- Fewer teenage mothers than older mothers breastfeed. (In Surrey only 40% of mothers aged under 20 initiate breastfeeding).
- Asian and Black women living in the UK are less likely to breastfeed exclusively than white women, despite relatively high rates of initiation and breastfeeding at 6 to 8 weeks. (Lawrence, 1994)
- Some Asian mothers avoid feeding colostrum to newborn babies depriving them of protection against infection. (Thomas and Avery, 1997)

All acute and community providers in Surrey are working towards BFI accreditation. Their current status is presented in table 1.

Table 1: Current BFI status of Surrey acute and community providers

Provider	Current status	Date
Ashford St Peter's Hospital	BFI compliant	Reaccreditation due Nov 2017
ASPH SCBU	BFI compliant	Reaccreditation due Nov 2017
Central Surrey Health	BFI compliant	Reaccreditation Nov 2016
Epsom St Helier	BFI compliant	Reaccreditation 16-18 November 2016
ESH SCBU/ NNU	BFI compliant (with maternity)	Reaccreditation 16-18 November 2016
Frimley Park Hospital Trust	BFI compliant	
FPH NNU	BFI compliant (with maternity)	
Royal Surrey County Hospital Trust	BFI compliant	Reaccreditation Dec 2016
RSCH SCBU		
Surrey and Sussex Hospital	***Register intent***	
First Community Health and Care	BFI compliant	Reaccreditation summer 2016
Virgin Care	BFI compliant	Reaccreditation summer 2017

Community breastfeeding support in Surrey

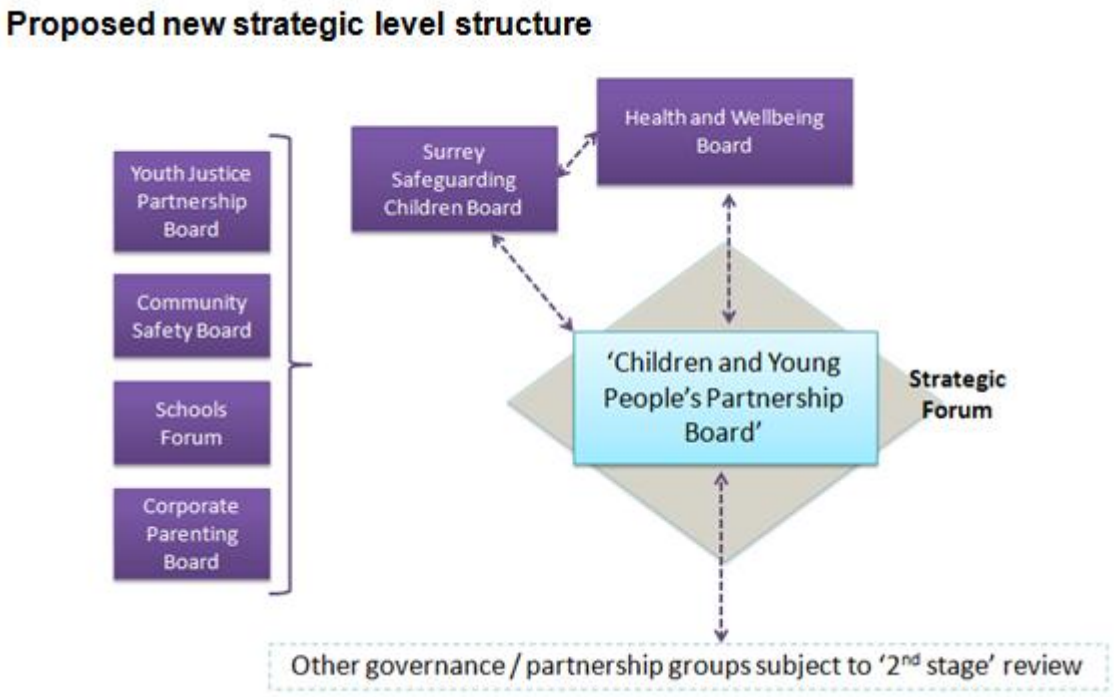
At present, different models for community breastfeeding support operate in Surrey. Healthcare professionals run drop in clinics in acute hospitals and some children's centres. Community providers runs Breastfeeding drop- ins and peer support groups from a number of health centres and Children's centres. In some places breastfeeding support is delivered following the Baby Café charity model which is delivered in partnership with health professionals, Children's Centres, confederations and voluntary sector.

Baby Cafés operate in areas of low breastfeeding prevalence. Evaluations show that mothers appreciate the informal contact with health professionals and peer supporters, but further work is needed to attract more vulnerable young mothers.

Children's Centres in Surrey play an important part in this strategy and the implementation of BFI in Children's Centres across Surrey will be at the heart of this strategy. The map in Appendix 4 illustrates their locations with current breastfeeding rates.

6. Governance and Accountability: Management of the Strategy

Delivery of this strategy depends on partners, including Surrey County Council, NHS community providers, CCGs and the voluntary sector working collaboratively. Accountability for this strategy therefore lies within with children's health and wellbeing board as this is a partnership board. The current Breastfeeding Strategy Group will feed into this board.



7. Commissioners and Providers action plan for improving breastfeeding rates

Objective	Action	Responsibility	Timescale	Outcomes and monitoring
1. Achieve and maintain Baby Friendly Initiative accreditation in all appropriate hospital, community health care, neo-natal units and children's centre locations across Surrey by 2020.	1.1 Identify Breastfeeding Lead for children's centres	Children's centres	March 2016	• Breastfeeding Lead identified • Register Intent with Unicef
	1.2 Ensure breastfeeding policies are in place.	NHS Providers/ Children's centres		• Policy written and implemented • Policy routinely communicated to all staff. Evidence documented
	1.3 Train all staff in skills necessary to implement the BFI.	NHS Providers/ children's centres	Ongoing	• Key children's centre staff are trained by Unicef to support health providers with children's centre training • Relevant staff equipped to implement BFI • Training outline, dates of training and attendance list available • Relevant staff equipped with skills to work with our priority groups and those with disabilities
	1.4 Inform all pregnant women and their partners about the benefits and management of breastfeeding and support services available.	NHS Providers/ Children's centres	Ongoing	• Women and their partners have an informed choice regarding breastfeeding and know how to access support service
	1.5 Ensure that all literature available is BFI compliant	NHS providers/ Children's centres	Ongoing	• All health and children's centre venues will only provide BFI compliant literature
	1.6 Establish and review breastfeeding support groups (Ensure support for fathers, grandparents and families and involvement of minority and vulnerable groups of mothers and fathers)	NHS Providers/ children's centres	Ongoing	• Support service available across the County targeting our priority groups • Support services are evaluated and reviewed annually to meet the needs of the population

	1.7 Improve links and communication between breastfeeding support service providers and HENRY[1]	Providers NHS Surrey/ children's centres	Ongoing	• Joined up approach to infant feeding
	1.8 A welcoming atmosphere provided for breastfeeding families in all NHS provider and SCC premises, including GP practices and all children's centres	NHS Providers/ children's centres	Ongoing	• Patient satisfaction surveys (ensuring representative) • GPs and practice staff attending training • Posters welcoming breastfeeding
	1.9 Conduct audits and evaluation of BFI regularly	NHS Providers/ children's centres	Ongoing	• Early years staff trained to complete audits • Audit timetable available • Annual qualitative and quantitative evaluation completed • Annual reviews

[1] Health Exercise & Nutrition for the Really Young, an evidence-based parenting programme to prevent childhood obesity being implemented in target Surrey Children's Centres.

2. Provide appropriate ongoing support for breastfeeding in local communities to encourage continuation of breastfeeding paying particular attention to areas with low breastfeeding initiation and continuation rates with a view to facilitating support networks and peer support groups.	2.1 Include breastfeeding support services flyers in Patient Held Record books	Acute Trusts CCGs	Ongoing	• All women are given breastfeeding support services flyer when they are discharged from hospital
	2.2 Champion peer support programmes across the County focusing on priority groups	NHS, public health, children's centres	Ongoing Annually	• Peer support programmes monitored • Pool of active volunteer peer supporters available • Women feel more supported in breastfeeding • All peer support services mapped across the County and recommendations made
	2.3 Children's Centres offer breast feeding support/ ante natal/ post natal classes	Surrey County Council NHS Providers Voluntary sector	Ongoing	• Breastfeeding support available in priority children centres • Record number of people accessing services and their demographic background

	2.4 Community support groups/ Baby Cafés ensuring easy access and equity across the County (Link with 2.3)	Surrey County Council NHS Providers Voluntary sector	Ongoing	• Support service available across the County in priority places • Supports services are evaluated and reviewed to meet the needs of the population
	2.5 Promotion of Healthy Start and distribution through health venues and children's centres	NHS Providers Children's Centres	Ongoing	• Uptake of Healthy Start vitamins and children's drops improved across of the County • Awareness of healthy start increased
	2.6 Evidence based information is given about the introduction of appropriate healthy family foods from six months alongside continued breastfeeding, in line with the Surrey Infant Feeding Guidelines	NHS Providers, Children's Centres, Public Health	Ongoing	• Up to date advice is referenced in Surrey Infant feeding guidelines which is accessed through Healthy Surrey website
3. Maintain an accurate audit mechanism for collecting breastfeeding data at birth, ten days and 6-8 weeks	3.1 Ensure contracts with providers cover accurate data collection recording and audit of breastfeeding initiation and continuation	Public Health	Ongoing	• Reliable data
	3.2 Standardise terminology and definitions of initiation and continuation.	Public Health	Ongoing	• Data collection is consistent and comparable in line with the patient held child record (Total/Partial/None)
4. Ensure we use social media and IT effectively	4.1 Ensure that appropriate messages are distributed effectively and use the Healthy Surrey website appropriately	Public health	Ongoing	• Healthy Surrey website will be monitored and updated
	4.2 Ensure that evidence based websites are referenced for easy use by breastfeeding mothers and families	NHS providers/ children's centres	Ongoing	• Parents will have evidence based literature on which to inform their decision making
5. Support programmes which work towards making breastfeeding	5.1 In collaboration with the Healthy Schools Team ensure that breastfeeding is integrated into a personal, health and social education programme.	Public Health Babcock 4S	March 2016	• Breastfeeding incorporated into PSHE scheme of work • Teachers provided with lesson plans • More children and young people aware of the benefits of breastfeeding and able to make an informed choice

the social norm – Education – schools and university training for health professionals	5.2 Work with the University of Surrey to ensure they are working towards adopting Baby Friendly best practice standards as a routine part of their educational programme for midwives and health visitors	Public Health NHS providers NHS England	Ongoing	• Student midwives and Student Health Visitors understand and apply effective practice in supporting women to breastfeed • Midwives and health visitors that qualify at the University of Surrey use effective practice to support women to breastfeed
Support women who are returning to work to continue breastfeeding	5.2 Distribute Department of Health resources on how to continue breastfeeding when returning to work or college	Surrey county council NHS Providers	Ongoing	• Breastfeeding continuation rate improved annually
	5.3 Support employers and colleges to support women to continue breastfeeding when they return to work and education	Surrey county council Education providers NHS providers	Ongoing	• Businesses and colleges have clear support mechanisms in place
	5.4 Work with HR dept in all NHS providers, Surrey county council and districts and boroughs to ensure that policies are in place to support Breastfeeding when returning to work	NHS providers, Surrey County Council, D and B councils	Ongoing	• Returning to work policy to include breastfeeding • More women returning to work being able to breastfeed
Ensure that public health programmes in other topic areas recognise the profound importance of early relationships to future health and wellbeing and the significant contribution that breastfeeding makes to good physical and emotional health outcomes for infants and mothers	5.5 Ensure that links of the benefits of breastfeeding are made with obesity programmes, mental health programmes, dental health programmes, cost savings to the NHS should be made explicit where ever possible.	Surrey County Council NHS provider	Ongoing	•

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Appendix 1: In year cost savings made in last 5 years to Surrey CCGs through reductions in number of infants with ear infections, asthma and gastroenteritis by increasing breastfeeding rates by 7%

Calculations based on NICE guidance CG37 on postnatal care (costing template, linked to the population and live births for Surrey over the last 5 years, with a 7% increase in breastfeeding rates) indicates annual savings. These figures are:

- Reductions in otitis media (ear infections) – £7,407.40
- Expenditure on formula milk and teats – £2,921.80
- Reductions in asthma – £31,416
- Reductions in gastroenteritis – £38,096.10

Total **annual** savings in these areas from improvements in breastfeeding rates would therefore total £79,841.30.

In addition to treatment costs, increasing breastfeeding rates would reduce NHS expenditure on artificial baby milk bottles and teats. The health economic evaluation used a unit cost based on teats and formula milk for immediate neonatal spending of £1.69 per baby. Surrey has an 81% breastfeeding initiation rate; therefore at least 19% of babies are bottle fed. If 100% of babies start to breastfeed, potential savings are £4174. However, the circumstances of some births make this difficult to achieve.

Appendix 2: Potential cost savings to Surrey CCGs and SCC in the future by increasing breastfeeding rates

As well as the above savings for reductions in otitis media (ear infections), reductions in asthma and gastroenteritis. Research shows that exclusively formula-fed preterm infants were 6 to 10 times more likely to develop necrotising entercolitis (NEC) than those who received breastmilk. Although NEC is rare in babies over 30 weeks gestation, it was 20 times more common if the baby had received no breastmilk. Research shows that increasing breastfeeding in neonatal units to 75% could save £6.12 million per year across the NHS by reducing the incidence of NEC. It is estimated that each individual case of NEC costs the NHS around £16,500.60.[2] The same study also showed that the cost of each neonatal unit admission could be reduced by between £30 (if any breastmilk feeding at discharge increased to 50%) and £125 (if any breastmilk feeding at discharge increased to 100%).

Overall 24% of infants with NEC had one major neuro-developmental disability compared with 10% among control infants. Infants who developed NEC had significantly higher cognitive delay (i.e. cognitive index <70) and visual impairment. A logistic regression model identified NEC as a predictor of cognitive delay. Soraisham et al, (2006).

There are also the longer-term costs savings associated with childhood obesity and type-two diabetes, as well as maternal breast and cervical cancer.

In terms of childhood obesity, modest increases in breastfeeding could potentially save £100 per child per year and reduce childhood obesity by 5%.[3] In Surrey, 1992 children in year R and year 6 were obese in 2013-2014, reducing this number by 5% would see cost savings of approximately £10,000 per year. 90% of adults with obesity have type 2 diabetes, it is estimated that routine treatment without complications costs the NHS £335 per person. So lifetime costs for those 5% of children for diabetes alone could be estimated to be £1.5million.

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[2] S Pokhrel, M A Quigley,J Fox-Rushby, F McCormick, A Williams, P Trueman, R Dodds, M J Renfrew, 'Potential economic impacts from improving breastfeeding rates in the UK' *Arch Dis Child* doi:10.1136/archdischild-2014-306701

[3] These figures are merely illustrative and must be interpreted with caution. They take no account of the lifetime costs that might result from cost savings extending into adulthood. This would increase substantially the cost savings that would accrue if breastfeeding were more prevalent. Nor do these figures capture the broader impacts of obesity, including the impact on well-being, life expectancy and the economy as a whole. It is difficult to quantify these impacts but such broader societal costs need to be further studied.

There are also other economic benefits of breastfeeding. Studies have concluded that increasing both the proportion of infants who are breastfed and the duration of breastfeeding are associated with improved cognitive outcomes[45] The table below shows the estimated economic implications of adverse cognitive effect in the UK.

Number of live births in 2009 – adjusted for neonatal (28 days) mortality	788,486 (ONS)
% never breastfed	19% (Infant Feeding Survey 2010)
Number never breastfed	149,886
Adverse cognitive effect resulting from this	2 IQ points (assumed as above)
Lifetime income losses that result from adverse cognitive effect	£34,936 per individual never breastfed

[4] Quigley et al 2012

[5] Jacovou and Sevilla- Sanz 2010

Going forward with this new strategy with an annual increase in breastfeeding rates, short-term annual savings can be expected along with the long term benefits.

Investment/disinvestment rationale

Investing in a five-year strategy to increase breastfeeding rates in Surrey, especially in disadvantaged areas, will result in:

- A better experience for mothers
- More mothers choosing to start and continue breastfeeding
- Improved health for babies, including reduced infections and hospital admissions in the short term, narrowing the health gap in Surrey
- Potential improvements in children's cognitive functioning
- Longer-term improvements to health, including reduced risk of childhood obesity and the long-term conditions asthma and type-two diabetes
- Reduced risk of breast and ovarian cancer for mothers who continue to breastfeed

The most significant costs of implementing the strategy are:

- ***Coordination:*** Health providers, children's centres and Surrey County Council need ongoing, dedicated staff time for coordinating the staff training, audits and communication required to reach and maintain BFI standards in breastfeeding promotion.

- ***Staff training:*** Releasing staff to attend the required training with the resultant cover to replace those staff in the clinical areas on training days is the biggest cost to provider trusts. Also the cost of buying in external courses or employing and training teachers to provide the training courses has to be considered. These costs will fall once all staff have received training and only updates and training of newly employed staff are required. Trust and children's centre staff trained as accredited trainers reduce training costs.

- ***Assessment and accreditation:*** Children's centres working towards BFI accreditation will need to budget for assessment and accreditation costs amounting to about £10k spread over the next year. Along with community provider costs and costs to acute trusts.
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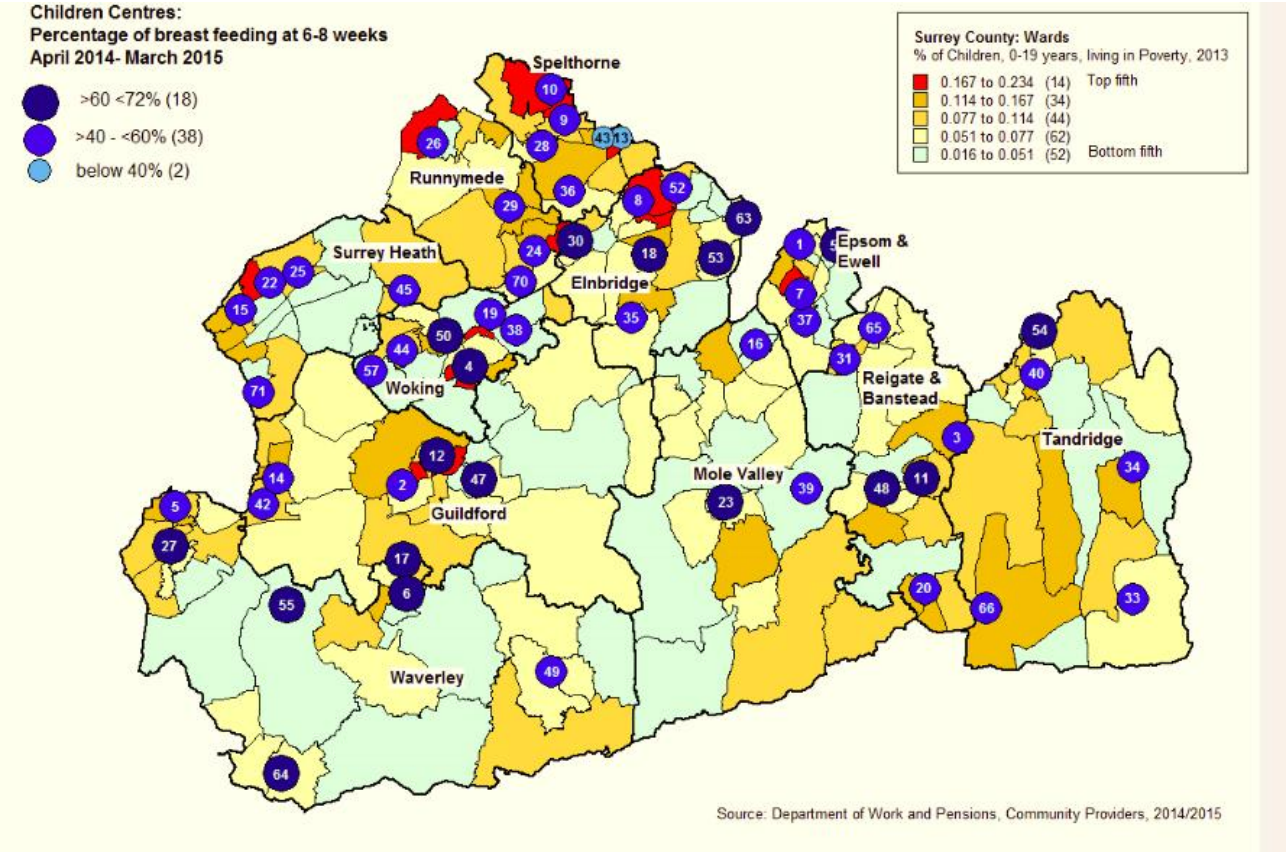
The costs to each organisation of implementing BFI depends on the number of relevant staff to be trained and amount of staff time needed for co-ordination. With time, as more staff are trained in effective breastfeeding management as part of their initial training, these costs will go down and the savings generated by higher breastfeeding rates will increase.

Appendix 3: Reasons why mothers do not breastfeed (UNICEF UK, 2009)

International and national factors	**National and regional factors**	**Individual factors – amenable to medium to long-term change at the macro socio-economic level**	**Individual factors influencing decision to breastfeed – amenable to change in the short term at the micro socioeconomic level**	**Individual factors influencing a woman's decision to stop breastfeeding before she wishes – amenable to change in the short term at the micro level**
▪ Globalisation of formula feeding in developed countries promulgated by commercial interests. ▪ Cultural shift to regimented feeding patterns and growth monitoring based on formula feeding regimes. ▪ Increase in work opportunities for women without supportive childcare/feeding facilities. ▪ Media portrayal of bottle feeding as the norm and as safe. ▪ Increased media portrayal of women's breasts as symbols of sexuality. ▪ Lack of full implementation of WHO Code on Marketing of Breastmilk Substitutes.	▪ Lack of importance/ understanding of breastfeeding in the organisation of health services; embedded practices or routines, which interfere with successful breastfeeding. ▪ Lack of appropriate education and training for health and related professionals. ▪ Lack of integration across sectors – acute, community, social services, voluntary. ▪ Lack of supportive environments outside the home and in the workplace. ▪ Lack of breastfeeding education in schools.	▪ Maternal age – younger mothers are less likely to breastfeed. ▪ Maternal education – breastfeeding rates are lowest among those who left school at 16 or less. ▪ Socio-economic status of mother (and partner) – breastfeeding rates become lower for lower socio-economic groups. ▪ Marital status. ▪ Ethnicity – cultural tendency for white women to choose not to breastfeed. ▪ Biomedical factors (parity, method of delivery, infant health). ▪ Return to work before the baby is four months old.	▪ Attitudes of partner, mother and peer group. ▪ Social support provided by woman's partner, family and friends. ▪ Loss of collective knowledge and experience of breastfeeding in the community resulting in a lack of confidence in breastfeeding. ▪ Whether mothers were breastfed themselves as babies. ▪ Embarrassment about, difficulty in, or perceived unacceptability of, breastfeeding in public, both in and outside the home, especially for younger mothers. ▪ Difficulty of involving others, especially partner, in feeding. ▪ Perceived inconvenience of breastfeeding and anxiety about total dependence of the baby on the mother.	▪ Mother's or health professionals' or family's perception of 'insufficient milk'. ▪ Painful breasts and nipples. ▪ Baby would not suck or 'rejected the breast'. ▪ Breastfeeding takes too long, or is tiring. ▪ Mother or baby is ill. ▪ Difficult to judge how much baby has drunk. ▪ Baby can't be fed by others

Appendix 4: Location of Children's Centres in Surrey with deprivation and breastfeeding rates.



Appendix 5: Details of consultation process for strategy

A multi-agency Breastfeeding Strategy Group led the consultation process on what the new strategy should focus on. A one day consultation event with speakers was organised for April 2015, following on from this a small working party of representatives from different organisations, who volunteered on the day, met to take forward the vision. This group has now evolved into smaller groups which will be responsible for taking forward the work with Children's Centres and supporting them to become BFI accredited.