Breastfeeding support within Maternity Transformation Plans

A guide to the guidance

October 2017
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Summary

Form a strategy group that includes all stakeholders

Provide seamless support across boundaries

Implement Baby Friendly across all settings

Include peer support, additional and specialist support

Mothers receive breastfeeding support, wherever they are

Ensure adequate staffing levels

Create a wider environment that is supportive of breastfeeding

Monitor outcomes and feed back into strategy
Who is this guide for?

*Better Births*, the report of the National Maternity Review, was published in February 2016. It set out a vision for transforming maternity services in England over the next five years.

To implement this vision at a local level, 44 Local Maternity Systems (LMSs) were set up, corresponding to the 44 Sustainability and Transformation Partnership (STP) areas in England. Each LMS is expected to produce a local maternity transformation plan by October 2017.

While *Better Births* highlights the importance of breastfeeding support – and includes improved breastfeeding rates among its intended outcomes – it provides little detail on how this can be achieved.

However, there is a range of detailed and useful guidance from other national bodies on how best to commission and organise breastfeeding support services.

This guide summarises all the relevant national guidance on breastfeeding support in one place. It is intended to be of use to LMSs in developing their maternity transformation plans. It will also be of use to STPs, CCGs, Local Authorities and Health and Wellbeing Boards in setting infant feeding strategies and commissioning local services.

This guide has been produced by Better Breastfeeding, a non-profit organisation that is committed to improving support for all mothers who want to breastfeed [www.betterbreastfeeding.uk](http://www.betterbreastfeeding.uk)
Breastfeeding – a national priority

*Better Births* emphasises the importance of breastfeeding, which is a key measurable outcome of the maternity strategy.

“The benefits of breastfeeding are clear. Breastfeeding improves children’s physical health by reducing infections, obesity, diabetes, allergic diseases, and sudden infant death; but it can also improve educational achievements and reduce social inequalities... [It] can provide the child with a natural safety net against the worst effects of poverty. The mother’s health will also benefit from reduced incidences of breast and ovarian cancers, diabetes, osteoporosis and coronary artery disease.

*Despite this women told us that care was poor. There needs to be much better support for breastfeeding focused on practical help that supports and empowers women, rather than pressurises them.*”

Public Health England’s latest guidance *Commissioning infant feeding services: a toolkit for local authorities* contains a foreword by the **Chief Medical Officer, Dame Sally Davies**, who says:

“Improving breastfeeding rates is not the responsibility of individual women struggling alone in a culture that can be hostile towards breastfeeding – rather this is a public health challenge for which we all share responsibility. We must find a way to meet this challenge; failure to invest in breastfeeding leads to poorer health outcomes for children and women today and for generations to come.

*I urge you all to seize this opportunity, read this guidance and consider how best to ensure that more of our babies are breastfed in future.*”

The Chief Medical Officer’s reports *Our children deserve better* (2013) and *The Health of the 51%: Women* (2014) also highlight the worrying trend of low breastfeeding rates in England.

Public Health England has identified breastfeeding as a **Best Start in Life national priority** as well as one of six **High Impact Areas** for health visiting.

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**Breastfeeding saves lives**

With optimal breastfeeding in the UK, each year:

- 250 premature babies’ lives could be saved\(^1\)
- Over 100 deaths of babies from SIDS could be avoided\(^2\)
- 865 cases of breast cancer could be avoided\(^1\)
Breastfeeding – a vital investment

Breastfeeding has a wide range of health, economic, social and environmental benefits.

**Short and long-term health outcomes**

- Breastfeeding protects babies from *respiratory, gastrointestinal* and *ear infections*¹
- Breastfeeding protects babies from *Sudden Infant Death Syndrome*¹ (SIDS)
- Breastfeeding and donor breastmilk protect premature babies from the *life-threatening disease necrotising enterocolitis*¹ (NEC)
- Children who were breastfed have a *13% lower risk of obesity*³
- Children who were breastfed have a *35% lower risk of type 2 diabetes*³
- Mothers who breastfeed have a *50% lower risk of postnatal depression*⁴
- Mothers who have breastfed have a lower lifetime risk of *type 2 diabetes, heart disease, breast and ovarian cancer, and osteoporosis*⁵

**Reduces inequality**

Mothers on low incomes are more likely to have a sick or premature baby, but they are also the least likely to breastfeed

- Breastfeeding improves *parent-infant relationships*⁵
- Breastfeeding is associated with *higher IQ*³
- Improving breastfeeding rates among disadvantaged families helps to *reduce health and social inequality*⁵, giving children a fairer start in life

**Better for the environment**

- Breastfeeding produces no waste packaging and *does not contribute to CO₂ emissions*⁶ as formula milk does

**Reduces costs to local public services**

Moderate improvements in breastfeeding rates would result in:

- *54,000 fewer GP visits* and *9000 fewer hospital admissions*¹
- Save the NHS around *£48 million per year*¹
Sources of guidance for service commissioners

There are several useful sources of national guidance on commissioning breastfeeding support are now available, which this guide summarises.

Implementing Better Births: A resource pack for Local Maternity Systems

Commissioning infant feeding services: a toolkit for local authorities

Maternal and child nutrition [PH11]
National Institute for Health and Care Excellence (NICE), updated 2014
http://www.nice.org.uk/guidance/ph11

Postnatal care up to 8 weeks after birth [CG37]
National Institute for Health and Care Excellence (NICE), updated 2015
https://www.nice.org.uk/guidance/qs37

Guide to the Baby Friendly Initiative standards
Unicef UK (2012)

Guidance on provision of additional and specialist services to support breastfeeding mothers
Unicef UK (2016)

Early years high impact area 3: breastfeeding
Public Health England (2016)

Breastfeeding in children's wards and departments: Guidance for good practice
Royal College of Nursing (2013)
https://www.rcn.org.uk/professional-development/publications/pub-003544

Monitoring infant feeding data support pack (Part 3)
Details of existing guidance

Planning and coproduction

NHS England’s guidance *Implementing Better Births* is clear that each LMS board should include the Directors of Public Health from the local authority areas covered by the STP. This is essential as local authorities have ultimate responsibility for increasing breastfeeding continuation rates (at 6–8 weeks) as part of their public health role.

*Implementing Better Births* is also clear that each LMS must involve local service users in the design of services – so-called “coproduction”. It recommends the setting up of Maternity Voices Partnerships (MVPs) – “independent formal multidisciplinary committees which come together to influence and share in the decision-making of the Local Maternity System and its constituent parts”.

These should consist of maternity service users, charities and advocacy groups, commissioners, local providers, statutory partners (such as Healthwatch) and a range of appropriate clinicians and managers.

Similarly, Public Health England (PHE) gives similar guidance in its *Commissioning infant feeding services* toolkit. The first of their 12 commissioning principles states:

> “Local authority public health commissioners [should] work closely with all relevant partners to commission high-quality, evidence-led services that support women to feed their infants.”

It recommends that effective, integrated commissioning of services should be achieved through

> “…well-functioning partnerships between local authority-led public health, health and wellbeing boards (HWB), NHS clinical commissioning groups (CCGs), NHS England local area teams (LATs), maternity and neonatal services, health visiting teams and children’s services”

> “…fully involving service users and local communities in every level of planning, monitoring and evaluation of services, including mother-to-mother breastfeeding support groups, breastfeeding peer supporters, voluntary organisations and children’s centres”
Integrated support

Support for mothers to breastfeed comes in many forms and through many different health professionals and community organisations. Midwives, obstetricians, paediatricians, health visitors, GPs, maternity support workers, lactation consultants, breastfeeding counsellors and peer supporters may all give mothers information or practical help to breastfeed at different times.

The Implementing Better Births resource pack emphasises the vision of providing

“...seamless care for women and their babies across organisational boundaries.”

PHE’s Commissioning infant feeding services toolkit echoes this approach, stating that

“...comprehensive, multifaceted infant feeding interventions, implemented at a local level as part of a strategic partnership approach can increase breastfeeding prevalence.”

Principle 1 of the toolkit contains detailed instructions on how to achieve this through a coproduction model.

Similarly, NICE guideline CG37 Postnatal care up to 8 weeks after birth states:

“All maternity care providers (whether working in hospital or in primary care) should implement an externally evaluated, structured programme that encourages breastfeeding, using the Baby Friendly Initiative as a minimum standard... The structured programme should be delivered and coordinated across all providers, including hospital, primary, community and children's centre settings. Breastfeeding outcomes should be monitored across all services.”

Unicef UK Baby Friendly Initiative

The Unicef UK Baby Friendly Initiative (Baby Friendly) is a structured programme that is externally evaluated by Unicef UK and is proven to improve breastfeeding rates. There are separate standards for maternity, community, neonatal and community settings.

There are three stages to the accreditation process. Stage 1 of the process involves setting up policies to support breastfeeding. Stage 2 involves the training of staff within the services, Stage 3 details the practices and support available to parents within the service. Once all three stages have been
assessed, the service can be said to have “Baby Friendly accreditation”. To maintain their accreditation, services must be reassessed every three years.

Although each service is evaluated separately, evidence of collaboration with other services must be provided to achieve accreditation. The Guide to the Baby Friendly Initiative standards states:

“Working together across disciplines and organisations is vital for effective implementation of the [Baby Friendly] standards, and leads to improved experiences for mothers.”

Some services may choose to employ an alternative externally evaluated programme, but in order to comply with NICE guidance this programme must be at least equivalent to Baby Friendly as a minimum standard.

Antenatal support

NICE Guideline Ph11 Maternal and Child Nutrition states that mothers should receive good quality information about breastfeeding during their pregnancy so that they can make an informed choice and are aware of what to expect once their baby is born. This includes a group class on breastfeeding.

“Midwives and health visitors should ensure pregnant women and their partners are offered breastfeeding information, education and support on an individual or group basis. This should be provided by someone trained in breastfeeding management and should be delivered in a setting and style that best meets the woman’s needs. A midwife or health visitor trained in breastfeeding management should provide an informal group session in the last trimester of pregnancy.”

Such antenatal support is also part of the Baby Friendly maternity standards. Principle 2 of PHE’s Commissioning infant feeding services toolkit also requires that all pregnant women have the opportunity to learn about breastfeeding. It recommends that, in addition to conversations with their midwife and health visitor, group classes are also made available.

“...all women are offered opportunities for participant-led antenatal classes, including breastfeeding workshops, and these will be interactive, tailored to the needs of individuals and learner-centred”
Additionally, those with more complex needs should be identified during pregnancy and provided with additional support (e.g. mothers with gestational diabetes should be supported to express and store colostrum antenatally).

“...there are clear and efficient referral pathways embedded in midwifery and health visiting services to support women with special needs in order to get breastfeeding off to a good start”

Postnatal support

There is considerable research to show that skin-to-skin contact within the first hour of birth enables breastfeeding to get off to a good start. This is an essential part of the Baby Friendly standards. This represents Principle 3 of PHE’s Commissioning infant feeding services toolkit.

“All women have the opportunity for unrestricted skin-to-skin contact at birth and throughout the first feed, irrespective of feeding type. Where women and babies are separated, skin-to-skin is offered as soon as possible. All women are supported to respond to their babies’ needs for food and love and are offered ongoing, one-to-one, practical and skilled help to get breastfeeding off to a good start.”

Similarly, NICE guideline CG37 Postnatal care up to 8 weeks after birth states:

“From the first feed, women should be offered skilled breastfeeding support (from a healthcare professional, mother-to-mother or peer support) to enable comfortable positioning of the mother and baby and to ensure that the baby attaches correctly to the breast to establish effective feeding and prevent concerns such as sore nipples.”

NICE guideline Ph11 Maternal and Child Nutrition also states that:

“[Commissioners and managers of maternity and children's services should] provide local, easily accessible breastfeeding peer support programmes and ensure peer supporters are part of a multidisciplinary team. Ensure peer supporters contact new mothers directly within 48 hours of their transfer home (or within 48 hours of a home birth). [Ensure peer supporters] can consult a health professional and are provided with ongoing support.”

A similar recommendation is found under Principle 4 of PHE’s Commissioning infant feeding services toolkit.
Peer support

Public Health England, NICE and Baby Friendly all emphasise the importance of peer support. NICE guideline Ph11 *Maternal and Child Nutrition* explicitly states that peer support should be commissioned and be available within 48 hours.

“[Commissioners and managers of maternity and children’s services should] provide local, easily accessible breastfeeding peer support programmes and ensure peer supporters are part of a multidisciplinary team. Ensure peer supporters contact new mothers directly within 48 hours of their transfer home (or within 48 hours of a home birth).”

From July 2017, Baby Friendly standards require that services must include “additional” and “specialist” support in order to achieve accreditation. “Additional support” here means both practical help with basic breastfeeding problems as well as social support. This is most simply achieved through a breastfeeding peer support programme that provides both, as recommended by NICE.

Unicef has provided clarification about what is meant by “additional support” and how this can be delivered. In its *Guidance on provision of additional and specialist services to support breastfeeding mothers* it states:

“Many mothers have concerns about feeding and caring for their baby... Often what is needed is support with positioning and attachment and/or reassurance that what they are experiencing is normal. Meeting other mothers who are breastfeeding can also be enormously beneficial, helping to normalise breastfeeding and provide much needed social support. Mothers are more likely to continue breastfeeding if they have people in their lives who believe they can succeed.”

“When considering what will work best in your area, it is important to think about both elements of additional services – social and help with challenges. Some services address both – e.g. a social group where trained supporters help with basic challenges. Effective promotion of these services is crucial. They need to be made as attractive as possible to mothers so that they will engage and benefit from them. Part of making them attractive is personal recommendation.”

“Service provision will differ depending on local need, culture, geography etc. and so it is unlikely that any single model will suit all services. Baby Friendly assessments will concentrate on the effectiveness as experienced by mothers.”
Specialist support

From July 2017, Baby Friendly standards require that services must include specialist support in order to achieve accreditation. In its Guidance on provision of additional and specialist services to support breastfeeding mothers it explains:

“Most mothers’ needs for basic help and social support can be effectively met through standard health service provision and locally developed additional services. A small number of mothers will experience complex challenges with breastfeeding... Specialist support, with an appropriate referral pathway, [should be] available for mothers experiencing complex challenges with breastfeeding.”

The importance of a referral pathway for peer supporters (as well as non-specialist health professionals – e.g. those who have undergone a basic Baby Friendly two-day training training course), is also emphasised in NICE guideline Ph11 Maternal and Child Nutrition:

“[Commissioners must ensure peer supporters] can consult a health professional and are provided with ongoing support.”

Principle 5 of PHE’s Commissioning infant feeding services toolkit states:

“Women are enabled to continue to breastfeed for as long as they wish. Social support and help with difficulties are available according to need. Women requiring more specialist support have access to this. Women feel welcome to breastfeed in their communities and are supported to continue to breastfeed when out and about.”

Tongue tie

It is estimated that 4–11% of babies will have a tongue tie. NICE guidance IPG149 Division of ankyloglossia (tongue-tie) for breastfeeding (2005) recognises that tongue ties can interfere with breastfeeding and has approved the frenulotomy procedure (division of the tongue tie) to resolve these problems and enable breastfeeding to continue. It also recognises the advantage of early division of tongue ties.
“Evaluation for ankyloglossia should be made if breastfeeding concerns persist after a review of positioning and attachment by a skilled healthcare professional or peer counsellor... Babies who appear to have ankyloglossia should be evaluated further.”

To support mothers whose babies have tongue tie, services should ensure robust referral pathways to breastfeeding specialists. In order to ensure timely division of tongue ties, commissioners should plan appropriate service provision, e.g. a rapid access tongue tie clinic to meet local demand.
Training, skills and staffing

NICE guideline Ph11 *Maternal and Child Nutrition* states that:

“All people involved in delivering breastfeeding support should receive the appropriate training and undergo assessment of competencies for their role. This includes employed staff and volunteer workers in all sectors, for example, hospitals, community settings, children's centres and peer supporter services.”

Principle 1 of PHE’s *Commissioning infant feeding services* toolkit also recommends that

“...leadership with sufficient knowledge and skills to take this agenda forward [are fully identified, and there is] a plan in place to ensure the workforce has the knowledge, skills and education to implement the local infant feeding strategy. This includes the commissioners; early years leads; nursery nurses; midwives; health visitors; children centre staff etc.”

Baby Friendly’s new ‘Achieving Sustainability’ standards for reaccreditation also include the recommendation that

“There is a named Baby Friendly lead/team with sufficient knowledge, skills and hours to meet their objectives... [and] there is a mechanism for the Baby Friendly lead/team to remain up to date with their education and skills.”

**Competencies**

It can be difficult for commissioners to understand the range of skills and training of those who typically support mothers to breastfeed. It can be useful to think in terms of three tiers of competencies – basic support, additional support and specialist support.

**Basic support** with “positioning and attachment” and hand expressing may be provided by health professionals and others who have undergone the 18-hour Baby Friendly training. Breastfeeding peer supporters will usually have 16–36 hours training and ongoing training and supervision of around 16 hours per year. Peer supporters also provide social and emotional support.

**Additional support** with common breastfeeding problems that are not fixed by simple adjustments may be provided by breastfeeding counsellors who have undergone two years’ (part-time) training and who have ongoing training of around 12 hours per year. This additional support can also be delivered by health professionals with extra training in breastfeeding management to achieve similar competencies.
Specialist support can be provided by lactation consultants (International Board Certified Lactation Consultants – IBCLC), who have 1000 hours of breastfeeding support experience, 90 hours of lactation education (certified by exam) and 15 hours of yearly continuing education. Some midwives and health visitors may hold the IBCLC qualification, while others may have acquired similar competencies through many years of experience and additional CPD.

PHE’s guidance on health visiting, *Early years high impact area 3: breastfeeding* makes particular mention of the importance of identifying different skills and competencies to inform integrated working, as well as access to specialist lactation consultants.

**Note:** Better Breastfeeding will soon be publishing a detailed list of specific competencies needed at each level. In the meantime, this *Who’s Who in Breastfeeding Support* from the Lactation Consultants of Great Britain may be useful to commissioners

**Staffing levels**
NICE guideline Ph11 *Maternal and Child Nutrition* states:

“[Commissioners and managers of maternity and children’s services should] provide local, easily accessible breastfeeding peer support programmes and ensure peer supporters are part of a multidisciplinary team. Ensure peer supporters contact new mothers directly within 48 hours of their transfer home (or within 48 hours of a home birth). [Ensure peer supporters] can consult a health professional and are provided with ongoing support”

Additionally, NICE guideline CG37 *Postnatal care up to 8 weeks after birth* states:

“Healthcare professionals should have sufficient time, as a priority, to give support to a woman and baby during initiation and continuation of breastfeeding... Breastfeeding support should be made available regardless of the location of care.”

In order to ensure that all mothers, in all places and in all situations, have access to basic support, and to additional or specialist support when needed, the infant feeding strategy will need to consider the number of births in each area and calculate the appropriate staffing levels at each tier.
It should be noted that, when health professionals are well trained and there is a culture of valuing breastfeeding within the hospital and community, as well as good access to high-quality peer support, only a small number of mothers will need to access specialist support. When breastfeeding gets off to a good start, and minor problems are corrected early, then breastfeeding can continue without any major problem in most cases.

However, where access to good-quality basic and additional support is not available – or where hospital practices interfere with breastfeeding getting off to a good start – minor problems can quickly develop into major problems. In such an environment a much higher proportion of mothers will require specialist support in order to continue breastfeeding.

Similarly, when good-quality basic support is available but no specialist service is provided, breastfeeding rates will not be as high as they otherwise might be.
Special circumstances

There are many situations in which mothers or babies may face complications or challenges, but in almost all cases breastfeeding can continue with the right support. Commissioners and clinicians should consider how they can support all mothers to breastfeed, whatever their circumstances.

NICE guideline CG37 Postnatal care up to 8 weeks after birth states:

“Breastfeeding support should be made available regardless of the location of care”

Neonatal wards

Unicef UK Baby Friendly Initiative has developed standards for neonatal settings – Guidance for Neonatal Units (2012) – and includes Standard 14:

“Additional support is provided to help with expressing and feeding challenges when needed, including specialist help when required.”

PHE’s Commissioning infant feeding services toolkit recommends that commissioners ensure access to donor breastmilk for sick and premature infants, where needed (Principle 3).

Paediatric wards

The Royal College of Nursing has developed guidance for supporting breastfeeding in paediatric wards, and service commissioners should consider how the support they put in place can be extended to include paediatric wards or children’s hospitals. The guidance states:

“During admission the breastfeeding mother should have information to support breastfeeding and have access to trained staff (throughout the hospital and community services) or to counsellors with specialist knowledge in breastfeeding management (NICE 2008).”

Other settings

Provision should be made for the support of breastfeeding mothers in all settings, including:

- adult hospital wards
- mother and baby units
- prisons

Birth Companions have produced the Birth Charter for women in prisons in England and Wales, which has been endorsed by Unicef UK and the Royal College of Midwives.
Wider support in the community

Supporting breastfeeding mothers as outlined in this guide will go a long way towards improving low breastfeeding rates. However, on its own, breastfeeding support is not enough. Some communities have an entrenched bottle-feeding culture, and mothers breastfeeding in public may feel unwelcome. PHE’s Commissioning infant feeding services toolkit has further suggestions for commissioners to help tackle these societal barriers to breastfeeding.

Monitoring

In order to assess whether commissioned services are effective, close monitoring is required. Accompanying PHE’s Commissioning infant feeding services toolkit is its Monitoring infant feeding data support pack. This provides detailed advice to ensure that all relevant data is collected in accordance with government requirements under the Public Health Outcomes Framework.
Case study – Blackpool “Star Buddies” peer support

From 2008–2017, the Breastfeeding Network delivered a systematic and integrated peer support service for breastfeeding mothers in Blackpool – an area with low breastfeeding initiation and continuation rates. NICE has highlighted the service as an example demonstrating how parts of statement 5 of NICE Quality Standard QS37 (Postnatal Care) could be implemented.

The service was developed as a result of feedback from mothers, who said they would value having peer supporters on the hospital ward, and the case was made by the Maternity Services Liaison Committee to set up the integrated service. The “Star Buddies” peer supporters held breastfeeding workshops for pregnant mothers at local children’s centres. They were also available 7 days a week to help mothers in the maternity unit at Blackpool Victoria Hospital, or in paediatrics when babies were readmitted. Mothers were contacted within 48 hours (often less than 24 hours) of transfer home, and offered home visits, phone and text support by the Star Buddies for up to 8 weeks postpartum, as well as at breastfeeding groups across the town.

A dedicated peer supporter was available on the neonatal unit 10 hours per week to support new mothers with expressing and pumping breastmilk. Donor milk was made available when needed, and a peer supporter helped to recruit donors to the local milk bank. The peer supporters also worked closely with the specialist midwife for diabetes to educate and support mothers with gestational diabetes in expressing and collecting colostrum. This could be stored ready for use when babies were born, if needed. This helped to increase rates of breastfeeding initiation among these mothers and to lower the rates of artificial supplementation for their babies.

The service was run by an infant feeding coordinator, who trained peer supporters, children’s centre staff and the health visiting team. The service contributed to Blackpool gaining Baby Friendly accreditation across its maternity, community and children’s centres settings.

The Star Buddies service also extended into the wider community, as it ran the Breastfeeding Welcome scheme for local businesses. Peer supporters also visited local schools to help educate the next generation about the importance of breastfeeding.

Within the first four years of the service, breastfeeding continuation rates at 6–8 weeks increased from 18% to 27.5%. Further details of this case study are available on the NICE website at:
Further guidance for clinicians

This guide is aimed at commissioners of infant feeding support, and only guidance relevant to commissioning is included. For clinicians interested in guidance relating to breastfeeding, the following NICE guidelines will also be useful.

Antenatal and postnatal mental health: clinical management and service guidance [CG192]
National Institute for Health and Care Excellence (NICE), published 2014, updated 2017
https://www.nice.org.uk/guidance/cg192

Antenatal care for uncomplicated pregnancies [CG62]
National Institute for Health and Care Excellence (NICE), published 2008, updated 2017
https://www.nice.org.uk/guidance/cg62

Caesarean section [CG132]
National Institute for Health and Care Excellence (NICE), published 2011, updated 2012
https://www.nice.org.uk/guidance/cg132

Diabetes in pregnancy: management from preconception to the postnatal period [NG3]
National Institute for Health and Care Excellence (NICE), 2015
https://www.nice.org.uk/guidance/ng3

Diarrhoea and vomiting caused by gastroenteritis in under 5s: diagnosis and management [CG84]
National Institute for Health and Care Excellence (NICE), 2009
https://www.nice.org.uk/guidance/cg84

Division of ankyloglossia (tongue tie) for breastfeeding [IPG149]
National Institute for Health and Care Excellence (NICE), 2005
https://www.nice.org.uk/guidance/ipg149

Faltering growth: recognition of faltering growth in children [NG75]
National Institute for Health and Care Excellence (NICE), 2017
https://www.nice.org.uk/guidance/ng75

Food allergy in under 19s: assessment and diagnosis [CG116]
National Institute for Health and Care Excellence (NICE), 2011
https://www.nice.org.uk/guidance/cg116
Gastro-oesophageal reflux disease in children and young people: diagnosis and management [NG1]
National Institute for Health and Care Excellence (NICE), 2015
https://www.nice.org.uk/guidance/ng1

Gastro-oesophageal reflux in children and young people [QS112]
National Institute for Health and Care Excellence (NICE), published 2016
https://www.nice.org.uk/guidance/qd112

Jaundice in newborn babies under 28 days [CG98]
National Institute for Health and Care Excellence (NICE), published 2010, updated 2016
https://www.nice.org.uk/guidance/c98

Jaundice in newborn babies under 28 days [QS57]
National Institute for Health and Care Excellence (NICE), 2014
https://www.nice.org.uk/guidance/qd57

Intrapartum care for healthy women and babies [CG190]
National Institute for Health and Care Excellence (NICE), published 2014, updated 2017
https://www.nice.org.uk/guidance/cg190

Postnatal care up to 8 weeks after birth [CG37]
National Institute for Health and Care Excellence (NICE), published 2006, updated 2015
https://www.nice.org.uk/guidance/cg37

Postnatal care [QS37]
National Institute for Health and Care Excellence (NICE), published 2013, updated 2015
https://www.nice.org.uk/guidance/qd37

Maternal and child nutrition [PH11]
National Institute for Health and Care Excellence (NICE), published 2008, updated 2014
https://www.nice.org.uk/guidance/ph11

Neonatal specialist care [QS4]
National Institute for Health and Care Excellence (NICE), 2010
https://www.nice.org.uk/guidance/qd4
References and notes

   www.unicef.org.uk/Documents/Baby_Friendly/Research/Preventing_disease_saving_resources.pdf
   Renfrew et al (2012) estimate 361 fewer cases of NEC at 75% breastfeeding in neonatal units. NEC has a mortality rate of 40–60%. Therefore, 100% breastfeeding would lead to approximately 250 deaths avoided.

   Hauck et al (2011) find that exclusive breastfeeding reduces SIDS risk by 73%. Vennemann et al (2009) find that any breastfeeding in the first 6 months reduces SIDS risk by 50%. There are approximately 300 cases of SIDS in the UK each year. Rates of exclusive breastfeeding are 23% at 6 weeks and 1% at 6 months. At 6 months, 36% of mothers are doing any breastfeeding. Conservatively, it can therefore be estimated that over 100 deaths from SIDS could be avoided in the UK with optimal breastfeeding (exclusive breastfeeding to 6 months)


   http://www.birthcompanions.org.uk/media/Public/Resources/Ourpublications/Birth_Charter_Online_copy.pdf
Appendices

Appendix A – 12 principles of good practice in commissioning comprehensive breastfeeding support

From Commissioning infant feeding services: a toolkit for local authorities, Public Health England/Unicef UK (2016)

1. Local authority public health commissioners work closely with all relevant partners to commission high-quality, evidence-led services that support women to feed their infants and build a close and loving relationship with their babies.

2. All pregnant women are given the opportunity to learn about infant feeding and relationship building.

3. All women have the opportunity for skin to skin contact at birth and throughout the postnatal period. All women are supported to respond to their babies’ needs for food and love and are offered ongoing, one to one, practical and skilled help to get breastfeeding off to a good start.

4. All breastfeeding women are supported to learn how to breastfeed responsively and how to hand express their breastmilk. Parents are supported to understand a newborn baby’s needs for closeness and comfort.

5. Women are enabled to continue to breastfeed for as long as they wish, and when required specialist support is available. Women are welcomed to breastfeed in their communities and are supported to continue to breastfeed when out and about.

6. Women who breastfeed are provided with information and support to enable them to maximise the amount of breastmilk their baby receives. Parents are supported to introduce their baby to solid food in ways which support optimal health and development.

7. All women are equipped with the knowledge to be able to plan their return to work whilst breastfeeding, and businesses, shops and public premises within the local authority welcome breastfeeding women.

8. When babies are not breastfed, care is provided to ensure that parents are enabled to formula feed as safely as possible. Women’s decisions are respected, and parents are supported to feed their baby responsively and to build close and loving relationships.

9. Links are made to promote, protect and support breastfeeding in all policy areas where breastfeeding has an impact.

10. The local authority monitors and reports investment on services to support, promote and protect breastfeeding.

11. All public services ensure that there is no promotion of breastmilk substitutes, bottles, teats or dummies in any of their facilities or by any of their staff, so that breastfeeding is protected and parents receive unbiased information to support their decisions.

12. Commissioning considers the environmental as well as social and economic cost benefits to the community.
### Key NICE guidelines for commissioners of breastfeeding support

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<thead>
<tr>
<th>NICE guideline</th>
<th>Recommendation</th>
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<tr>
<td>Ph11 Maternal and Child Nutrition, Recommendation 9</td>
<td>&quot;Midwives and health visitors should ensure pregnant women and their partners are offered breastfeeding information, education and support on an individual or group basis. This should be provided by someone trained in breastfeeding management and should be delivered in a setting and style that best meets the woman’s needs. A midwife or health visitor trained in breastfeeding management should provide an informal group session in the last trimester of pregnancy.&quot;</td>
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<td>Ph11 Maternal and Child Nutrition, Recommendation 10</td>
<td>&quot;Ensure a mother can demonstrate how to position and attach the baby to the breast and can identify signs that the baby is feeding well. This should be achieved (and be documented) before she leaves hospital or the birth centre (or before the midwife leaves the mother after a home birth). Provide continuing and proactive breastfeeding support at home, recording all advice in the mother's hand held records. Provide contact details for local voluntary organisations that can offer ongoing support to complement NHS breastfeeding services.&quot;</td>
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<td>Ph11 Maternal and Child Nutrition, Recommendation 11</td>
<td>&quot;[Commissioners and managers of maternity and children's services should] provide local, easily accessible breastfeeding peer support programmes and ensure peer supporters are part of a multidisciplinary team. Ensure peer supporters contact new mothers directly within 48 hours of their transfer home (or within 48 hours of a home birth). [Ensure peer supporters] can consult a health professional and are provided with ongoing support&quot;</td>
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<tr>
<td>CG37 Postnatal care up to 8 weeks after birth</td>
<td>&quot;From the first feed, women should be offered skilled breastfeeding support (from a healthcare professional, mother to mother or peer support) to enable comfortable positioning of the mother and baby and to ensure that the baby attaches correctly to the breast to establish effective feeding and prevent concerns such as sore nipples.&quot;</td>
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<tr>
<td>CG37 Postnatal care up to 8 weeks after birth, Quality Statement 5</td>
<td>“All maternity care providers (whether working in hospital or in primary care) should implement an externally evaluated, structured programme that encourages breastfeeding, using the Baby Friendly Initiative as a minimum standard. If providers implement a locally developed programme, this should be evidence based, structured, and undergo external evaluation. The structured programme should be delivered and coordinated across all providers, including hospital, primary, community and children's centre settings. Breastfeeding outcomes should be monitored across all services.”</td>
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<tr>
<td>CG37 Postnatal care up to 8 weeks after birth, Quality Statement 5</td>
<td>&quot;All people involved in delivering breastfeeding support should receive the appropriate training and undergo assessment of competencies for their role. This includes employed staff and volunteer workers in all sectors, for example, hospitals, community settings, children's centres and peer supporter services.&quot;</td>
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<tr>
<td>CG37 Postnatal care up to 8 weeks after birth, Infant Feeding</td>
<td>&quot;Healthcare professionals should have sufficient time, as a priority, to give support to a woman and baby during initiation and continuation of breastfeeding.&quot;</td>
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<tr>
<td>CG37 Postnatal care up to 8 weeks after birth, Infant Feeding</td>
<td>“Breastfeeding support should be made available regardless of the location of care.”</td>
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