Breastfeeding problems are often caused by positioning and attachment difficulties. An early intervention service was set up to provide support to new mothers.

Breastfeeding: how to increase prevalence

**In this article...**
- Why women need more support to continue breastfeeding
- How an early intervention feeding team increased prevalence
- The importance of peer support

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Increasing breastfeeding prevalence is essential to reduce health inequalities and improve health outcomes for all mothers and babies. Evidence-based services need to be commissioned and developed in line with UNICEF’s Baby Friendly Initiative Seven Point Plan, to ensure positive outcomes for breastfeeding.

Support services offered early in the neonatal period can increase prevalence at 6–8 weeks of age and encourage longer-term breastfeeding, recommended by the World Health Organization and Department of Health. This article describes how an early intervention infant feeding service successfully supported mothers to continue breastfeeding and increased prevalence.

Breast milk is the best form of nutrition for infants. The World Health Organization and Department of Health recommend exclusive breastfeeding for six months. Talayero et al (2006) concluded that full breastfeeding lowers the risk of hospitalisation as a result of infectious diseases during the first year of life in developed countries. T

**Background to the service**

Despite continuous research supporting the benefits of breastfeeding and the acknowledgement that breastfeeding initiation rates are improving, which means that more mothers want to breastfeed, continuation rates in the UK remain among the lowest worldwide (DH, 2009).

Primary care trusts have been required to report on breastfeeding rates at 6–8 weeks on a quarterly basis since 2008. They are monitored through vital signs targets, with the prevalence result depending on PCTs achieving a high coverage of data collection, which in turn depends on receiving results for babies who have had their 6–8 week developmental screening indicating a feeding method.

To achieve the targets, which vary between trusts but aim to increase prevalence by 2% per year, PCTs need to commission services that provide sustainable, high-quality, universal support, as well as targeted support for mothers who are least likely to breastfeed and at risk of poor health outcomes (DH, 2009). Furthermore, PCTs are expected to set up services that adhere to UNICEF’s Seven Point Plan as part of the Baby Friendly Initiative (UNICEF, undated).

I was employed as an infant feeding coordinator in Redbridge Children’s Trust in April 2009 to develop services to improve breastfeeding prevalence. Although frontline staff were being trained in three-day breastfeeding management, antenatal workshops were

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- This article has been double-blind peer reviewed

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5 key points

1. The World Health Organization and Department of Health recommend exclusive breastfeeding for six months
2. Breastfeeding can reduce the risk of specific health problems in both mother and baby
3. Breastfeeding continuation rates in the UK remain among the lowest worldwide
4. An early intervention infant feeding service can provide vital support to mothers to boost breastfeeding prevalence
5. Easily accessible breastfeeding peer-support programmes are also recommended to help mothers maintain breastfeeding

Breastfeeding reduces the risk of gastroenteritis
breastfeeding prevalence targets at the end of April 2010. The project would also collect substantial data such as mothers’ ethnicity, age and postcode to enable targeting of services.

The project
In order to start the project at the beginning of January 2010, I trained two whole-time equivalent band 4 staff in three-day breastfeeding management (Box 1) and prepared an in-depth service specification with clear guidelines for staff to deliver the service. The team would contact all mothers in the trust area by telephone to offer support and advice on infant feeding.

We felt it was important to offer support and advice to all mothers, regardless of their feeding method, as it may be possible to support mothers to initiate breastfeeding if they wished, although they may have been formula-feeding.

Details of new babies were taken from the new birth notification on the child health system and logged on a spreadsheet, noting all the demographic indicators necessary for targeting services. I screened the new birth notifications to ensure it was appropriate for the team to contact families; this was to eliminate the risk of a parent being contacted in the event of neonatal illness or death. The team subsequently contacted every mother, by telephone, within the recommended 5–12 days after delivery, the key performance indicator set by the commissioners.

The team received training on making telephone contact, including appropriate language and approach, and followed strict criteria for offering a home visit or face-to-face contact in clinic (Box 2). We set criteria according to expected difficulties mothers might be experiencing that would need face-to-face contact to address the issue. This was needed due to the fact that this was a small, relatively new team being asked to contact more than 100 mothers a week. The need to achieve contact within the appropriate timescale meant workload had to be managed carefully.

If we needed to make face-to-face contact with a mother, this would happen within 24 hours and the team member would continue to support the mother until she achieved successful breastfeeding. The team member would liaise with the health visitor linked to the family to advise them on the outcome of the early intervention.

Team members attended weekly supervision sessions with me and had constant telephone access for ad-hoc supervision throughout the project. During supervision sessions, staff returned birth notifications, together with a liaison form to enable data on contact to be uploaded onto the spreadsheet in order to evaluate the project.

Difficulties encountered during the project related to not accounting for the amount of administrative time needed to maintain the database. The project started with an administrative assistant for half a day per week, but this needed to be increased to one day a week. The current substantive service needs support for two days a week.

Workload was increased due to the trust not using an electronic care record system and the need to manually create liaison forms. The trust now uses an electronic care record system, which has reduced the volume of work through shared record keeping.

Evaluation
We evaluated the project, corresponding to births from 29 December 2009 to 26 March 2010, through: data collection (stage 1); a questionnaire to parents (stage 2); and a focus group with parents (stage 3).

The most common feeding problem that mothers reported was positioning and attachment difficulties, which led to nipple pain, breast discomfort and poor milk transfer. This is a common reason that mothers give for discontinuing breastfeeding.

Support from the early intervention infant feeding team meant this issue was addressed in an appropriate timescale, reducing problems resulting from this issue and minimising the impact on breastfeeding prevalence rates.

As the pilot project was commissioned to increase the prevalence of breastfeeding in Redbridge, it was important to observe its impact and outcome in relation to this. Breastfeeding prevalence at the start of the project was 60.5% at 6–8 weeks. The project’s initial impact would be noticed 6–8 weeks after the start date as these babies would have been born at the beginning of the initiative.

Six weeks on from the project’s launch, Redbridge reported the largest increase in breastfeeding prevalence since data collection had started with a coverage rate to ensure the data set was adequate. The coverage data did not achieve an excess of 90% until quarter 1 2009–10, therefore increase in prevalence seen on the graph in 2008–09 was not valid data. Prevalence steadily increased from the initial increase 6 weeks after the start of the project. At the end of the project, prevalence at 6–8 weeks was 61.6%. At the end of quarter 2, 2010–11, nine...
months after the project started, prevalence reached 67.45% of babies breastfeeding at 6–8 weeks (Fig 1).

The follow-up questionnaire to parents in the project cohort revealed that all mothers were pleased the infant feeding team had contacted them and found this a useful intervention. A high percentage felt this contact had supported them to continue breastfeeding and some said they had discontinued formula supplements in favour of exclusive breastfeeding.

The focus group, held six months after the project started, gave the public health department and community engagement team the opportunity to establish local mothers’ perception of the service and whether it benefitted them. All mothers in the focus group were still breastfeeding and some said they had initiated breastfeeding without the help they received from the infant feeding team, whether it was by telephone or face-to-face contact.

The focus group also gave parents the opportunity to express their views on what they thought would make it easier to breastfeed. Many said they would have liked to have been able to attend antenatal workshops, and a breastfeeding-friendly environment locally was essential.

Fig 1 shows the increase in breastfeeding prevalence since the start of data collection. The project started at the end of quarter 3, 2009–10 and progressed to a substantive service. Quarter 1 and quarter 2 are particularly low due to poor coverage of 6–8 week data.

Conclusion
Commissioners recognised the significant success of the early intervention infant feeding service in supporting mothers and increasing breastfeeding prevalence in Redbridge. This led to the public health department commissioning it as a substantive service.

The infant feeding team now successfully contacts all mothers before day 10 post-delivery and has achieved effective links with midwives, GPs and children’s centres, ensuring a seamless service for mothers for infant feeding.

First-stage evaluation of the project enabled the trust to recognise specific areas that need targeted services, leading to the team working with disadvantaged groups, offering antenatal workshops specific to their needs and breastfeeding cafes in areas of greatest need.

Demographic data collection continues as part of the substantive service to enable the team to observe changes within areas and consider decommissioning services that are unsuccessful, in order to target areas of greater need. As a provider service, the team is expected to report back to commissioners on developments and changes in demographics to ensure a continuing positive impact to reduce health inequalities.

Future developments being considered for the team may involve developing a linked peer-support service. National Institute for Health and Clinical Excellence (2008) guidance recommends easily-accessible breastfeeding peer-support programmes, where peer supporters are part of a multidisciplinary team. Peer support is recognised as being extremely beneficial in supporting mothers to maintain breastfeeding. A substantive infant feeding team is critical to ensure peer supporters are supervised and have the opportunity to develop personally when delivering a service to mothers.

The early intervention infant feeding team in Redbridge is now the focus point for delivering breastfeeding services and will continue to support the development of further services to sustain and increase prevalence at 6–8 weeks and beyond.

References

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QUiCK FACT
The amount the NHS spends a year treating gastroenteritis in formula-fed babies

£35m

FUTURE DEVELOPMENTS

Turn to page 25 to find out how an infant feeding coordinator designed and launched an app to support women to breastfeed.