Breastfeeding Joint Strategic Needs Assessment

What is a JSNA?

The Joint Strategic Needs Assessment (JSNA) is the comprehensive assessment of the current and future health and social care needs of children and young people aged 0 to 19 (25 with SEND) and their families, with a focus on improving the health and wellbeing and reducing inequalities. There are nine individual chapters that comprise this JSNA.

A Joint Strategic Needs Assessment (JSNA) looks at all the information available around the current and future health and social care needs of populations in the local area. It will then use the data to inform and guide the planning and commissioning of health, well-being and social care services within a local authority. The implementation of recommendations will be overseen by the Health and Wellbeing Board.

As part of the JSNA's development, we have ensured the following principles and values have been considered:

- Think Family
- Our Way of Working and trauma informed practice.
- Prevention, early intervention and avoiding escalation of need.
- The voice of children, young people and families is central to the design, delivery and evaluation of service provision.
- Strength-based, personalised service provision focussed on relationships.
- Integrated services which mean that families tell their story once and can easily access seamless support.
- Equality.
- Reducing inequality.

Chapters Introduction

Cheshire West and Chester Councils 0-19 (25 with SEND) JSNA aims to bring benefits by identifying key health, wellbeing, and social care needs. Findings will help the Council and its partners to make more informed decisions about how we provide support and services to achieve the best outcomes for our children, young people, and their families/carers.

Each chapter has considered literature relevant to the assigned area of focus, drawing on this information to highlight key points that could contribute to findings and recommendations.

Although each JSNA chapter can be read as an individual report. Throughout every chapter, there were common themes relating to how we collect and analyse data particularly in relation to outcome information for certain groups; how inclusive and consistent messages are communicated and how we would like to do more coproduction and peer mentoring.

Breastfeeding Joint Strategic Needs Assessment

Contents

1 Introduction

Breastmilk is recognised by the World Health Organization as the ideal first food for babies to promote the best start in life. Exclusive breastfeeding is recommended for the first six months of life with continued breastfeeding alongside solid foods for two years and beyond (WHO, 2021).

Breastfeeding has many known health benefits, improving infant and maternal health and wellbeing in both the short and longer term. Breastfed babies have a reduced risk of sudden unexpected deaths in infancy and breastfeeding protects babies from infection and disease, reducing their risk of respiratory infections, gastroenteritis and ear infections (PHE, 2021). Breastfeeding can also be protective against obesity, particularly in those who are genetically predisposed; breastfeeding for 3 months in the first year of a baby's life reduces the risk of obesity by 13% in later life (PHE, 2021). Likewise, breastfeeding up to 12 months of age is associated with a decreased risk of tooth decay (PHE, 2019).

In terms of maternal health benefits of breastfeeding, for those who breastfeed, there is a lowered risk of breast cancer and some protection against ovarian cancer (PHE, 2021). In addition to this, mothers who breastfeed benefit from a faster return to pre-pregnancy weight (PHE, 2021). Breastfeeding also has benefits for mother-infant bonding.

Nevertheless, breastfeeding is a complex and multi-faceted issue and the decision whether to breastfeed and for how long is a complex one, with powerful cultural and familial factors involved. In the UK, and in Cheshire West and Chester, many mothers stop breastfeeding before they want to due to the barriers they face.

Breastfeeding rates (initiation and at six to eight weeks) in Cheshire West and Chester have been significantly lower than rates for England for several years. Alongside this, significant inequalities persist in breastfeeding rates between the least and most deprived areas of the borough.

Improving breastfeeding rates not only will benefit child health, helping children to get the best start in life, but improving breastfeeding rates in lower socioeconomic groups and young parents will also play an important role in reducing health inequalities in Cheshire West and Chester. Therefore, this JSNA chapter looks at how we can optimise breastfeeding support for families, using available evidence of 'what works', and through hearing the voices of local families about their infant feeding journeys.

The ambition in Cheshire West and Chester, as set out in a Notice of Motion at Full Council in July 2022 is that families across the social spectrum are supported to feel confident and comfortable in breastfeeding their babies, in line with WHO recommendations. This will help all babies (and mothers) to receive the benefits of breastfeeding and will support the ambition in Cheshire West and Chester's Place Plan to increase breastfeeding rates.

2 Summary

- Supporting families to breastfeed and increasing the number of babies who are breastfed helps to give babies the best possible start in life. Breastfeeding is therefore an important public health priority.

- There have been increases in breastfeeding rates in Cheshire West and Chester between 2017-18 and 2021-22, however some of this may be associated with improved data recording as rates of babies being bottle fed (particularly at first feed) have remained fairly static.
- There are significant inequalities in breastfeeding rates between the most and least deprived quintiles (areas) of Cheshire West and Chester. This is the case at first feed, at ten days and 6-8 weeks after birth. Between 2017-18 and 2020-2021, the gap between the most and least deprived areas had generally been narrowing, however the inequality gap widened in 2021-2022 compared to previous years, in some cases (ten days and 6-8 weeks) surpassing the inequality gap in 2017-18.

- National evidence highlights that many women in England stop breastfeeding before they want to (PHE, 2016). In Cheshire West and Chester there is a notable drop off in breastfeeding rates between initiation (first feed) and 6-8 weeks. The percentage of women breastfeeding (either exclusively or mixed feeding) in 2021-22 decreased from 62% at first feed to 46% at 6-8 weeks. There are also noticeable geographical differences in drop off rates. In 2021-22, the highest decrease was seen in Parklands children's centre footprint with a decrease of 24 percentage points between first feed and 6-8 weeks, and Wharton where a decrease of 22 percentage points was seen.

- Antenatal support is an important component of effective infant feeding support. All women should have meaningful, empathetic and mother-centred antenatal conversations about infant feeding. However, the need to strengthen antenatal support was a theme within this JSNA.

- Multicomponent strategies are the most effective way to increase breastfeeding rates. This should include providing effective professional support to mothers and their families and ensuring that mothers have access to support, encouragement and understanding in their community, such as peer support, 'Breastfeeding Welcome' schemes in public spaces, and support from employers to breastfeed when returning to work and study.

- Continuity of support across services is also key and good outcomes are seen when midwives and health visitors work in partnership to support parents by providing expert information and support to families, and developing relationships that enable difficulties to be identified early and help to be offered when needed.

- Although face to face support is crucial, there is a role for complementary written, digital and telephone support.

- A whole system approach to promoting breastfeeding is needed, by implementing the UNICEF UK Baby Friendly Standards and supporting settings to become baby friendly. An educated workforce is a crucial component of UNICEF's Baby Friendly Initiative standards, however training for GPs has been identified as a gap in Cheshire West and Chester.

- There is a variety of data available which helps to provide a picture of breastfeeding prevalence locally. However, there are opportunities to improve data collection and reporting in order to better understand access to, and the experiences and quality of service delivery.

3 Breastfeeding in Cheshire West and Chester

The collection of breastfeeding data by health visiting and maternity services provides a picture of breastfeeding prevalence locally. The Public Health Outcomes Framework focuses on two main areas: the initiation of breastfeeding at birth (known as baby's first feed) and whether breastfeeding has been maintained after six to eight weeks. Data is also recorded by maternity on breastmilk within 48 hours, and by health visitors on breastfeeding at ten days. This JSNA has focused on breastfeeding rates at birth, ten days and 6-8 weeks. This data is available at small geographies.

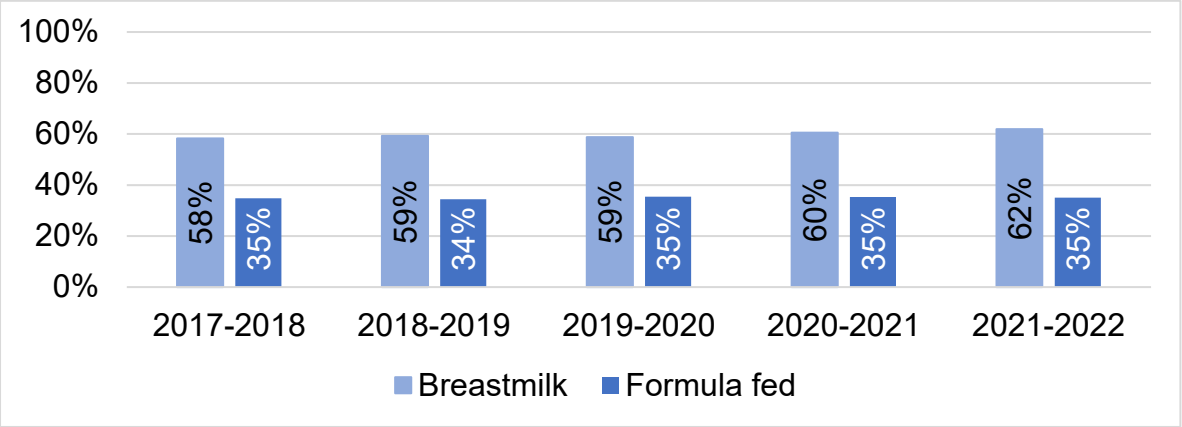
The following data relates to 2021/22. Further analysis would need to take place to confirm the conclusions with more recently available data.

3.1 Baby's first feed

Baby's first feed is measured by maternity at birth in the hospital (or at home for home births), at which time the prevalence of children being at least partially breastfed is recorded. Baby's first feed is defined as the percentage of babies whose first feed is maternal or donor breast milk. Some babies will receive a mixture of breastmilk with added supplements as their first feed, and this is classed as breastmilk.

In 2021/2022, 62% of newborns (2,004 babies) in Cheshire West and Chester received breastmilk as their first feed. This has generally been increasing over the last five years. This increase may be due to better recording with a decrease in the numbers of 'not knowns' as the rate of babies being bottle fed at birth has remained fairly static over the last five years at just over a third. The percentage of babies being exclusively breastfed increased slightly from 51% in 2020/21 to 53% in 2021/2022. It should be noted that the percentage of babies who have received breastmilk within 48 hours is usually slightly higher than breastmilk at first feed; however, this data was not available at the time of writing.

Chart 1: First feed of newborns



Note: For those who received breastmilk, babies were either exclusively breastfed or received a mixture of breastmilk with supplements.
Source: Cheshire and Wirral Partnership Health Visit Report

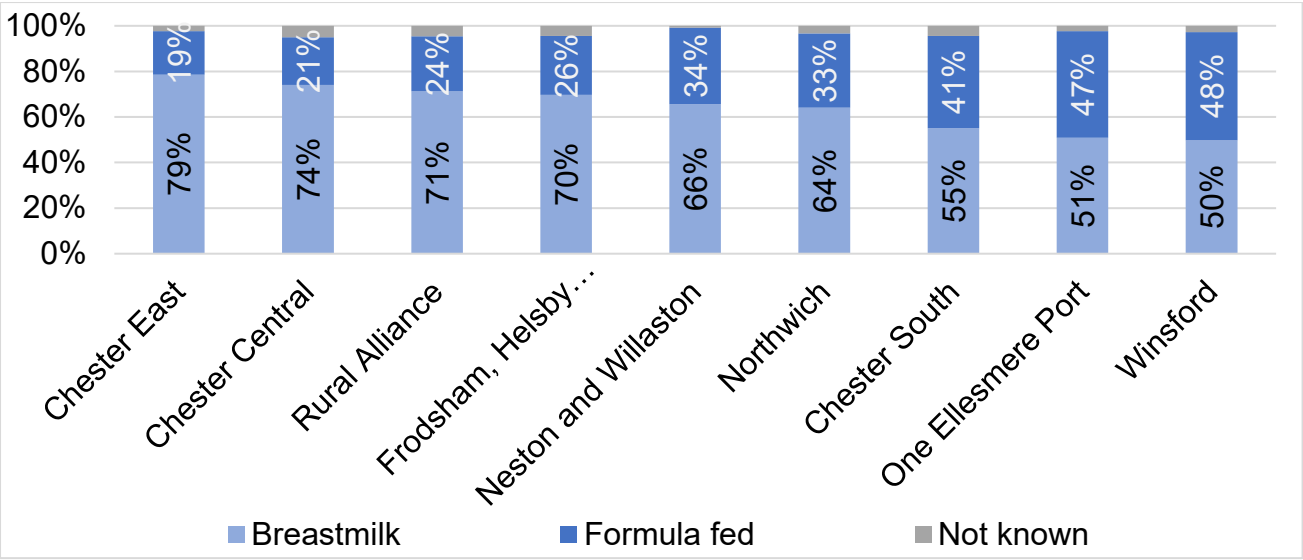
Table 1: Percentage of newborns first feed

Year	Exclusively breastfed	Breastmilk and supplements	Totally formula fed	Not known
2021/2022	53%	9%	35%	3%
2020/2021	51%	9%	35%	4%
2019/2020	51%	8%	35%	6%
2018/2019	50%	9%	34%	6%
2017/2018	51%	8%	35%	7%

Source: Cheshire and Wirral Partnership Health Visit Report

There are big differences in the rates of babies receiving breastmilk across the borough. On a care community footprint, Winsford has the lowest rate of babies receiving breastmilk at their first feed at 50%. This is followed by One Ellesmere Port (51%) and Chester South (55%). This is in comparison to 79% in Chester East care community.

Chart 2: Percentage of newborns by feeding type at first feed by care community, 2021/2022



Source: Cheshire and Wirral Partnership Health Visit Report

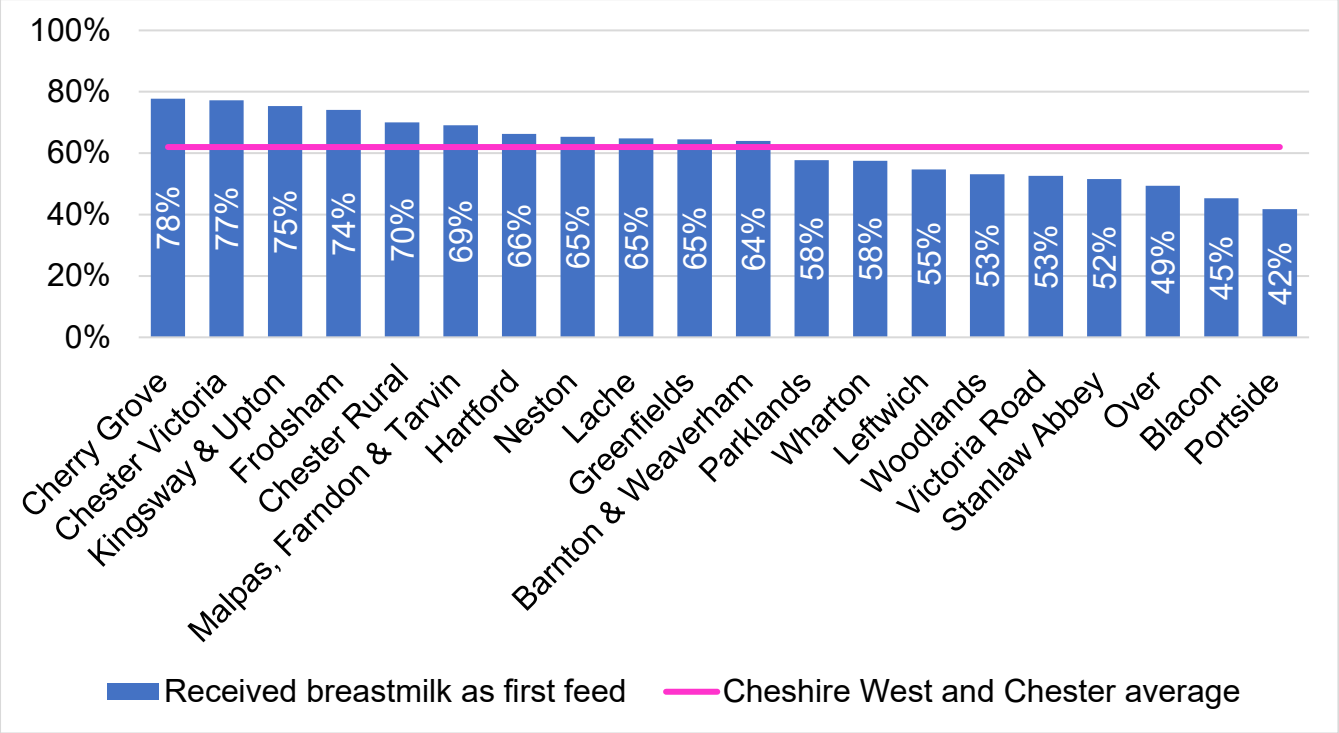
Table 2: Percentage of newborns by feeding type at first feed by care community, 2021/2022

Care community	Exclusively breastfed	Breastmilk and supplements	Totally formula fed	Not known
Chester East	69%	9%	19%	2%
Rural Alliance	63%	8%	24%	5%
Chester Central	58%	16%	21%	5%
Frodsham, Helsby and Elton	58%	12%	26%	4%
Neston and Willaston	56%	10%	34%	1%
Northwich	56%	8%	33%	3%
Chester South	47%	8%	41%	4%
Winsford	43%	7%	48%	3%
One Ellesmere Port	39%	12%	47%	2%

Source: Cheshire and Wirral Partnership Health Visit Report

Differences across the borough are better shown at a smaller footprint. At children's centre geography, the rate of babies first feed being breastmilk ranges from 78% in Cherry Grove footprint, compared to 42% in Portside footprint. The children's centre footprints with the lowest rates of first feed being breastmilk are Portside, Woodlands and Blacon. There are nine footprints with a rate of breastmilk being the first feed below the borough average. Note Leftwich has recorded 8% as 'not known' (see table 3).

Chart 3: % of newborns received breastmilk at first feed by children's centre geography, 2021-2022



Source: Cheshire and Wirral Partnership Health Visit Report
Note: Children's centre geography uses data for children who live in that children's centre geographical boundary rather than data for children who attend the children's centre

Table 3: Percentage of newborns by feeding type at first feed by children's centre, 2021/2022

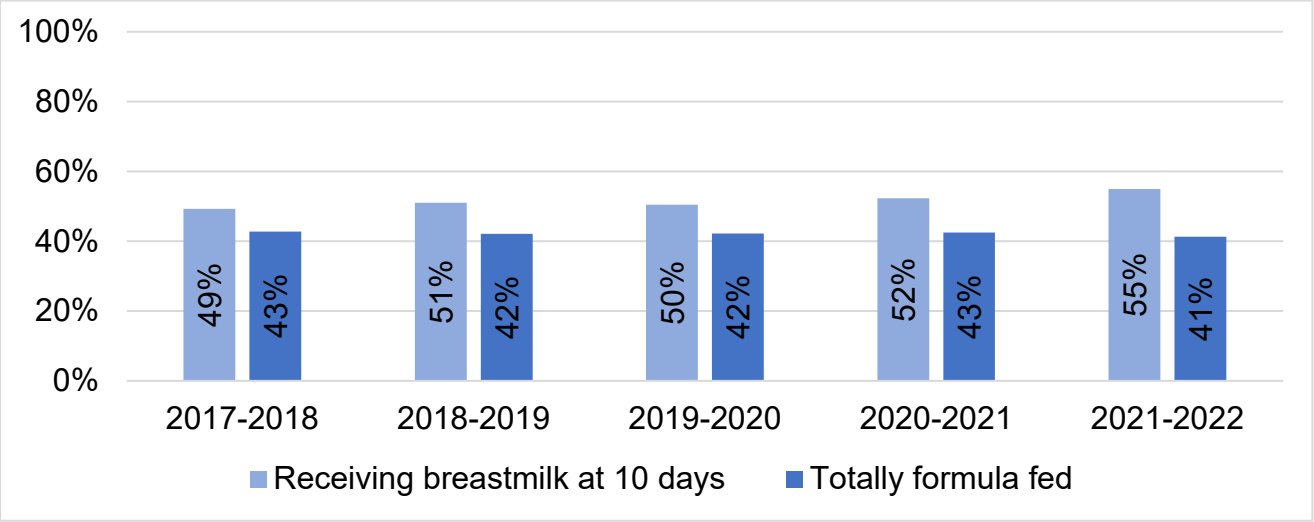
Childrens Centre footprint	Exclusively breastfed	Breastmilk and supplements	Totally formula fed	Not known
Cherry Grove	70%	8%	20%	3%
Chester Victoria	67%	10%	19%	3%
Kingsway & Upton	64%	12%	22%	3%
Frodsham	62%	12%	21%	5%
Malpas, Farndon & Tarvin	61%	8%	26%	4%
Hartford	60%	6%	30%	3%
Lache	58%	6%	30%	6%
Greenfields	58%	6%	33%	3%
Neston	56%	9%	34%	1%
Chester Rural	56%	14%	26%	4%
Barnton & Weaverham	55%	9%	35%	1%
Wharton	49%	9%	39%	3%
Leftwich	47%	8%	38%	8%
Victoria Road	46%	6%	43%	4%
Parklands	45%	12%	41%	1%
Over	41%	9%	48%	2%
Stanlaw Abbey	41%	11%	46%	2%
Blacon	39%	6%	52%	3%
Woodlands	38%	15%	45%	2%
Portside	33%	9%	55%	3%

Source: Cheshire and Wirral Partnership Health Visit Report

3.2 Breastfeeding continuation at ten days

The proportion of mothers continuing breastfeeding at ten days after their child's birth was 55% in 2021/22 (either exclusively breastfed or mixed feeding/partially breastfed). This is an increase from previous years, but again this could be due to a lower percentage of not knowns compared to previous years. At ten days, there is an increase in the proportion of mothers totally formula feeding to 41%, 6 percentage points higher than at birth. There is also an increase in mixed feeding (see table 4).

Chart 4: Percentage of babies at ten days old by feeding type



Note: For those who received breastmilk, babies were either exclusively breastfeed or mixed feeding/partially breastfed
Source: Cheshire and Wirral Partnership Health Visit Report

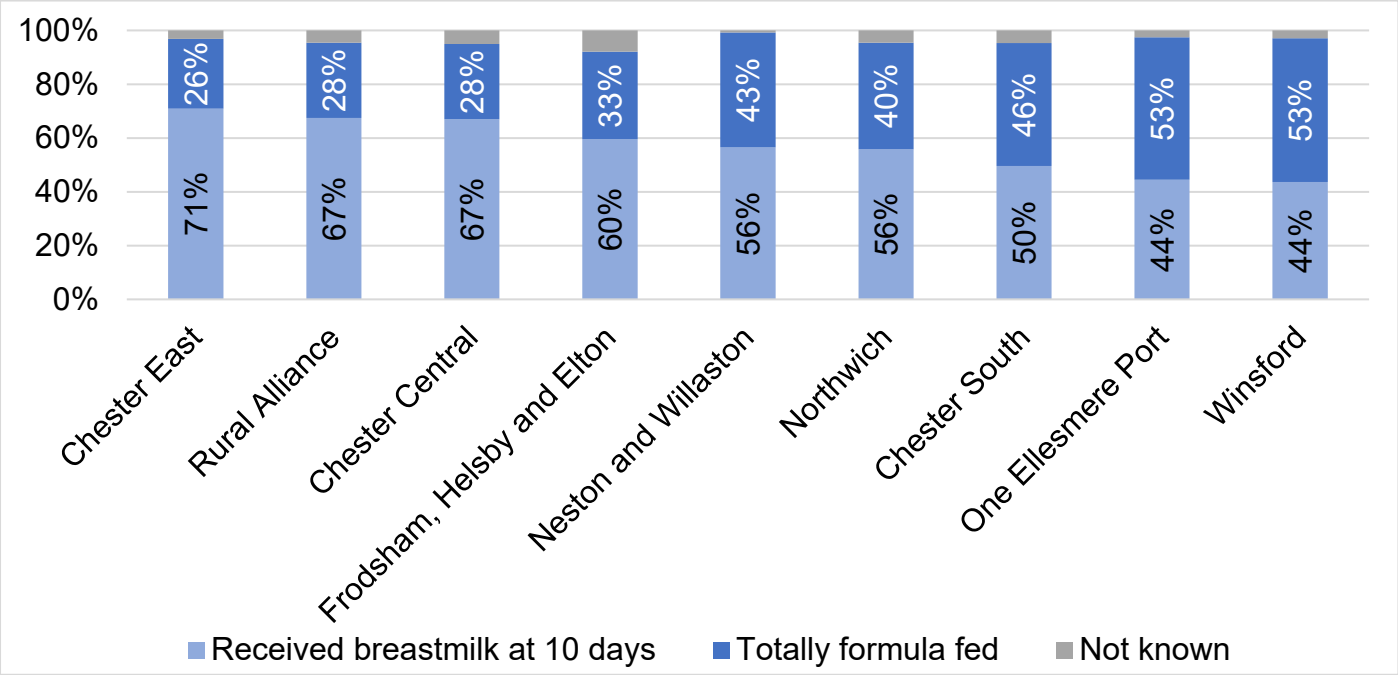
Table 4: Feeding type ten days after birth

Year	Exclusively breastfed	Mixed feeding (partially breastfed)	Totally formula fed	Not known
2021/2022	38%	17%	41%	4%
2020/2021	36%	16%	43%	5%
2019/2020	36%	15%	42%	7%
2018/2019	36%	15%	42%	7%
2017/2018	34%	15%	43%	8%

Source: Cheshire and Wirral Partnership Health Visit Report

At care community geography, large differences remain, with a breastfeeding at ten days range of 71% in Chester East, to 44% in Winsford (exclusively breastmilk or mixed feeding). Mixed feeding is particularly popular in Chester Central and Chester East. Frodsham, Helsby and Elton care community, and Neston and Willaston care community, saw the biggest reduction between receiving breastmilk at initiation and at ten days, both by ten percentage points (exclusively breastmilk or mixed feeding).

Chart 5: Percentage of babies at ten days old by feeding type by care community, 2021/2022



Source: Cheshire and Wirral Partnership Health Visit Report

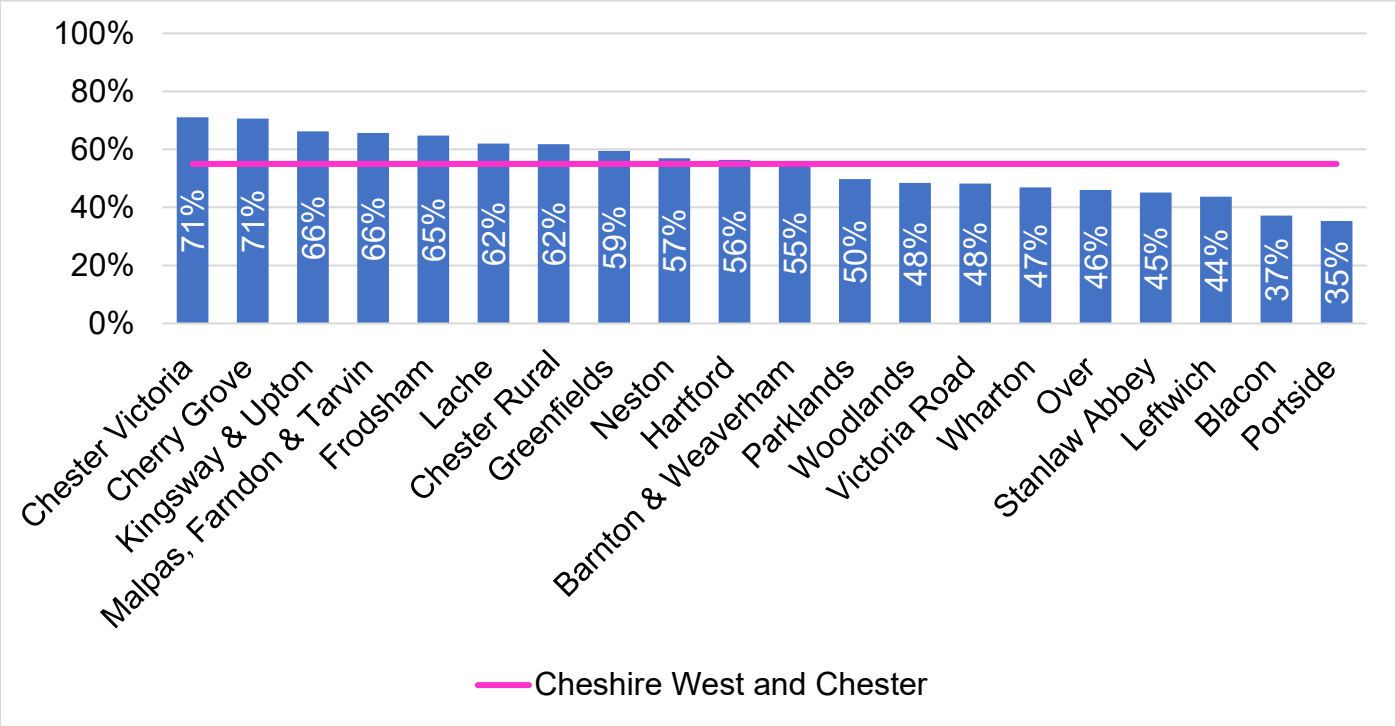
Table 5: Percentage of babies at ten days old by feeding type by care community, 2021/2022

Care community	Exclusively breastfed	Mixed feeding (partially breastfed)	Totally formula fed	Not known
Rural Alliance	52%	16%	28%	5%
Chester East	48%	23%	26%	3%
Neston and Willaston	47%	9%	43%	1%
Frodsham, Helsby and Elton	44%	16%	33%	8%
Northwich	39%	17%	40%	5%
Chester Central	38%	29%	28%	5%
Chester South	34%	15%	46%	5%
Winsford	32%	12%	53%	3%
One Ellesmere Port	28%	16%	53%	3%

Source: Cheshire and Wirral Partnership Health Visit Report

At the smaller children's centre geography, the range of babies receiving breastmilk, either exclusively or mixed feeding, ranges from 71% in Chester Victoria (of which 48% are exclusively breastfed) to 35% in Portside (of which 23% are exclusively breastfed). The children's centre footprints with the lowest rates of breastfeeding at ten days are Portside, Blacon, and Leftwich. Leftwich, Wharton and Barnton and Weaverham footprints saw the greatest reduction in breastfeeding between initiation and ten days, all a reduction of 11 percentage points (exclusively breastmilk or mixed feeding). Note Leftwich and Frodsham have 9% of babies recorded as 'not known' (see table 6 below).

Chart 6: % of babies at ten days old receiving breastmilk by children's centre geography, 2021-2022



Source: Cheshire and Wirral Partnership Health Visit Report
Note: Children's centre geography uses data for children who live in that children's centre geographical boundary rather than data for children who attend the children's centre

Table 6: Percentage of babies by feeding type ten days after birth by children's centre, 2021/2022

Childrens Centre footprint	Exclusively breastfed	Mixed feeding	Totally formula fed	Not known
Malpas, Farndon & Tarvin	51%	15%	30%	4%
Cherry Grove	49%	22%	27%	3%
Frodsham	48%	17%	27%	9%
Chester Victoria	48%	23%	25%	4%
Neston	48%	9%	42%	1%
Greenfields	44%	15%	37%	3%
Hartford	43%	13%	37%	6%
Lache	42%	20%	34%	4%
Chester Rural	41%	21%	34%	5%
Kingsway & Upton	40%	26%	30%	4%
Barnton & Weaverham	37%	19%	43%	1%
Leftwich	36%	8%	47%	9%
Over	32%	14%	52%	2%
Victoria Road	32%	17%	47%	4%
Parklands	31%	18%	48%	2%
Wharton	31%	16%	49%	4%
Stanlaw Abbey	30%	15%	52%	3%

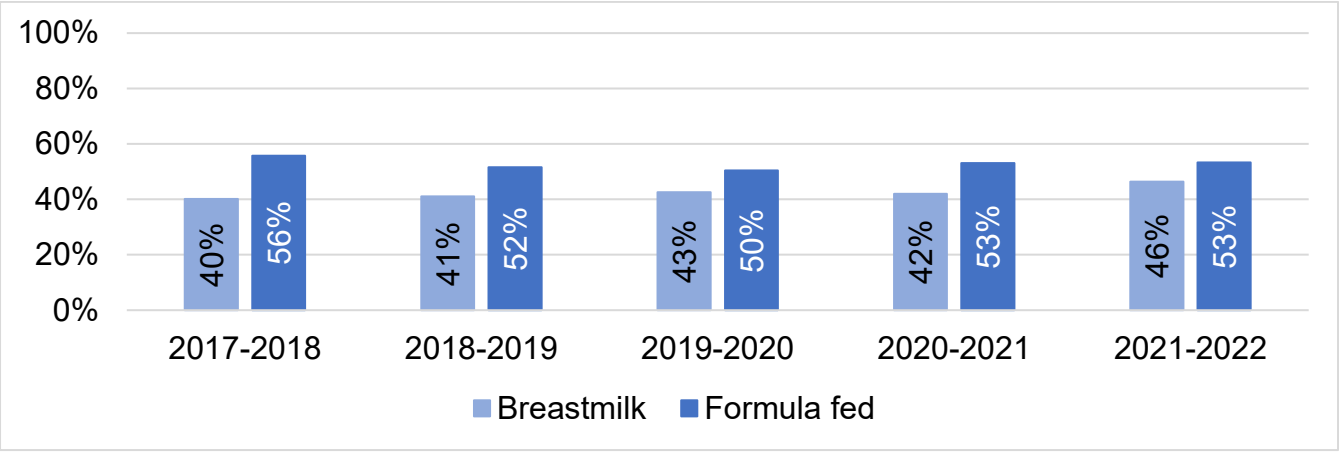
Woodlands	29%	20%	49%	2%
Blacon	27%	10%	58%	5%
Portside	23%	12%	62%	3%

Source: Cheshire and Wirral Partnership Health Visit Report

3.3 Breastfeeding continuation at 6-8 weeks

At 6-8 weeks there is a shift to more mothers totally formula feeding their baby compared to feeding breastmilk, either exclusively or mixed. The proportion of mothers continuing breastfeeding was 46% in 2021/22 (either exclusively or mixed feeding). This is an increase from 2020/2021, which again may be due to improved recording of data with a lower percentage of not knowns recorded, as those totally formula fed has remained the same. 53% of mothers are totally formula feeding in 2021/2022, the same as in 2020-2021 and an increase from 2019/2020.

Chart 7: Percentage of babies at 6-8 weeks old by feeding type



Note: For those who received breastmilk, babies were either exclusively breastfeed or partially breastfed
Source: Cheshire and Wirral Partnership Health Visit Report

Table 7: Percentage of babies by feeding type 6-8 weeks after birth

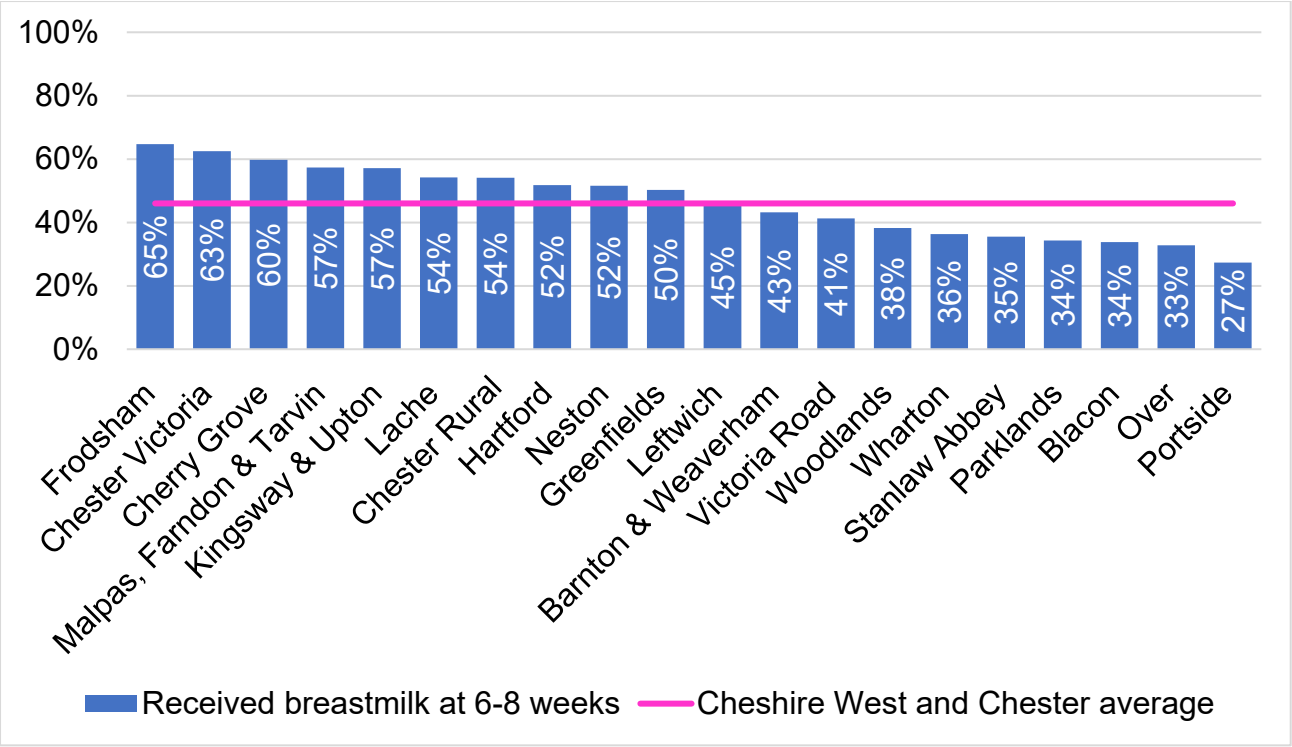
Year	Exclusively breastfed	Mixed feeding	Totally formula fed	Not known
2021/2022	34%	12%	53%	0%
2020/2021	30%	12%	53%	5%
2019/2020	32%	11%	50%	7%
2018/2019	31%	10%	52%	7%
2017/2018	30%	10%	56%	4%

Source: Cheshire and Wirral Partnership Health Visit Report

At care community geography, there are large differences in breastfeeding at 6-8 weeks, with a range of 60% in Chester East, to 33% in Winsford (exclusively breastmilk or mixed feeding). Over two thirds of mothers are totally formula feeding in Winsford and One Ellesmere Port. Winsford, One Ellesmere Port, and Chester East care community, saw the biggest reduction between receiving breastmilk at ten days and at 6-8 weeks, all by 11 percentage points (exclusively breastmilk or mixed feeding).

At the smaller children's centre geography, the range of babies receiving breastmilk, either exclusively or mixed feeding, ranges from 65% in Frodsham (of which 45% are exclusively breastfed) to 27% in Portside (of which 21% are exclusively breastfed). The children's centre footprints with the lowest rates of breastfeeding at 6-8 weeks remain as Portside, Blacon, and Leftwich. Parklands and Over footprints saw the greatest reduction in breastfeeding between ten days and 6-8 weeks, a reduction of 16 and 13 percentage points respectively (exclusively breastmilk or mixed feeding). Recording of 'not known' is low at 6 weeks.

Chart 8: % of babies at 6-8 weeks receiving breastmilk by children's centre geography, 2021-2022



Source: Cheshire and Wirral Partnership Health Visit Report
Note: Children's centre geography uses data for children who live in that children's centre geographical boundary rather than data for children who attend the Children's centre

Table 8: Percentage of babies at 6-8 weeks by feeding type by children's centre, 2021/2022

Childrens Centre footprint	Exclusively breastfed	Mixed feeding	Totally formula fed	Not known
Cherry Grove	46%	14%	40%	0%
Frodsham	45%	20%	35%	0%
Chester Victoria	44%	18%	38%	0%
Malpas, Farndon & Tarvin	44%	14%	43%	0%
Hartford	42%	9%	48%	0%
Chester Rural	41%	13%	44%	2%
Lache	39%	15%	46%	0%
Kingsway & Upton	39%	18%	42%	1%

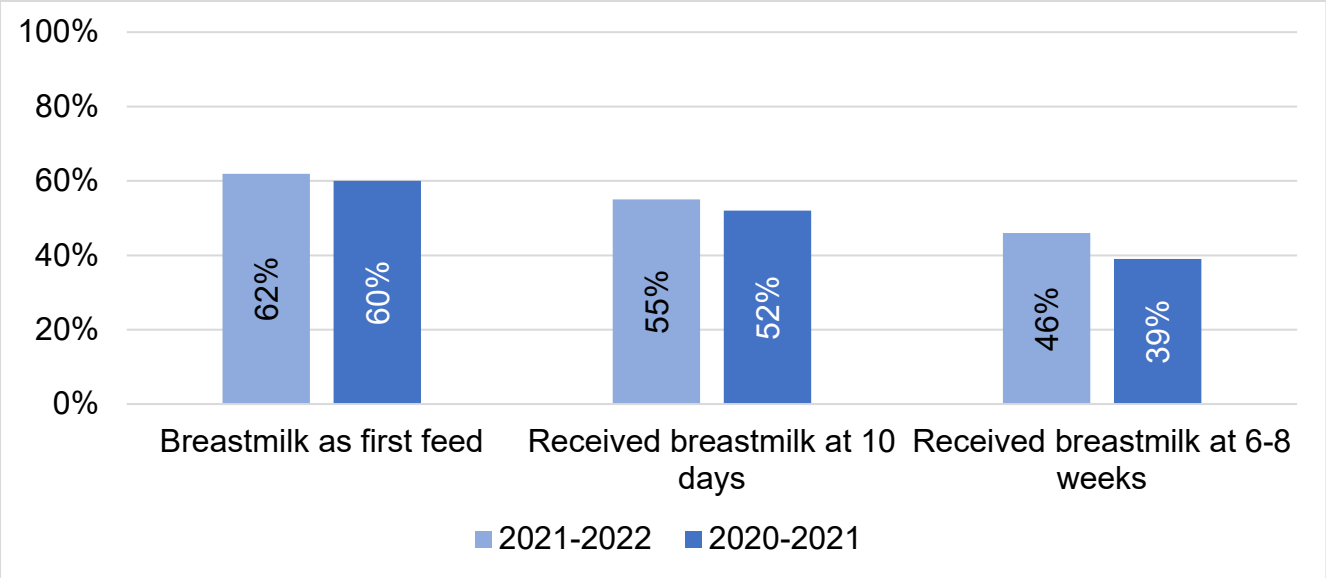
Neston	38%	14%	48%	1%
Greenfields	37%	13%	50%	0%
Barnton & Weaverham	34%	9%	57%	0%
Leftwich	31%	14%	55%	0%
Victoria Road	29%	12%	59%	0%
Over	28%	5%	67%	0%
Woodlands	27%	11%	62%	0%
Parklands	27%	7%	66%	0%
Wharton	27%	10%	63%	1%
Blacon	25%	9%	66%	1%
Stanlaw Abbey	21%	14%	64%	1%
Portside	21%	6%	73%	0%

Source: Cheshire and Wirral Partnership Health Visit Report

3.4 Breastfeeding changes between first feed and 6-8 weeks

The 2010 UK Infant Feeding Survey highlighted that eight out of ten women in England stop breastfeeding before they want to and could have continued with more support (PHE, 2016). In Cheshire West and Chester, in 2021-22 the percentage of women breastfeeding (either exclusively or mixed feeding) decreased from 62% at first feed to 46% at 6-8 weeks. This is a 16 percentage points reduction. It is difficult to compare this to previous years as recording of feeding has improved over the last five years, but we are able to compare the last two years more accurately. This shows that more women chose to continue breastfeeding in 2021-2022 than in 2020-2021.

Chart 9: Breastfeeding from first feed to 6-8 weeks, 2021-2022 and 2020-21



Source: Cheshire and Wirral Partnership Health Visit Report
Note: breastfeeding/ breastmilk includes both exclusively breastfed and mixed feeding

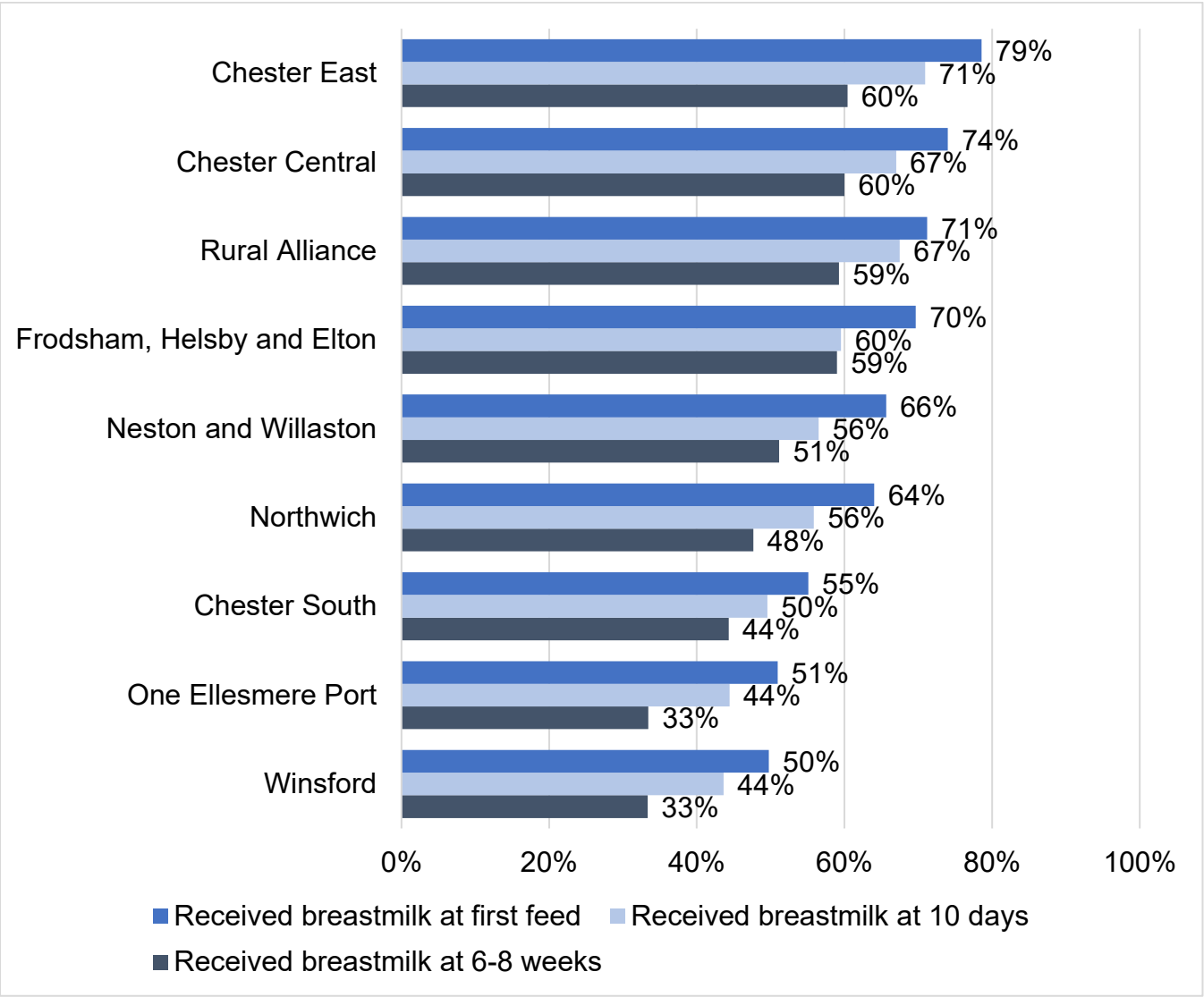
Table 9: Breastfeeding from first feed to 6 weeks, 2021-2022 and 2020-21

Year	Received breastmilk at first feed	Received breastmilk at 10 days	Received breastmilk at 6-8 weeks	% point difference in breastfeeding from first feed
2021-2022	62%	55%	46%	16
2020-2021	60%	52%	39%	21

Source: Cheshire and Wirral Partnership Health Visit Report
Note: breastfeeding/ breastmilk includes both exclusively breastfed and mixed feeding

At care community geography Chester East saw the biggest reduction in breastfeeding from first feed to 6-8 weeks (a reduction of 19 percentage points), but this care community has the highest rates of breastfeeding. The care communities of One Ellesmere Port and Winsford are of concern as they have the lowest breastfeeding rates at first feed and see a larger decrease in breastfeeding by 6-8 weeks. Frodsham, Helsby and Elton, Chester South and Rural Alliance see the lowest decrease in breastfeeding.

Chart 10: Breastfeeding from first feed to 6-8 weeks by care community



Source: Cheshire and Wirral Partnership Health Visit Report
Note: breastfeeding/ breastmilk includes both exclusively breastfed and mixed feeding
See table 10 below for figures.

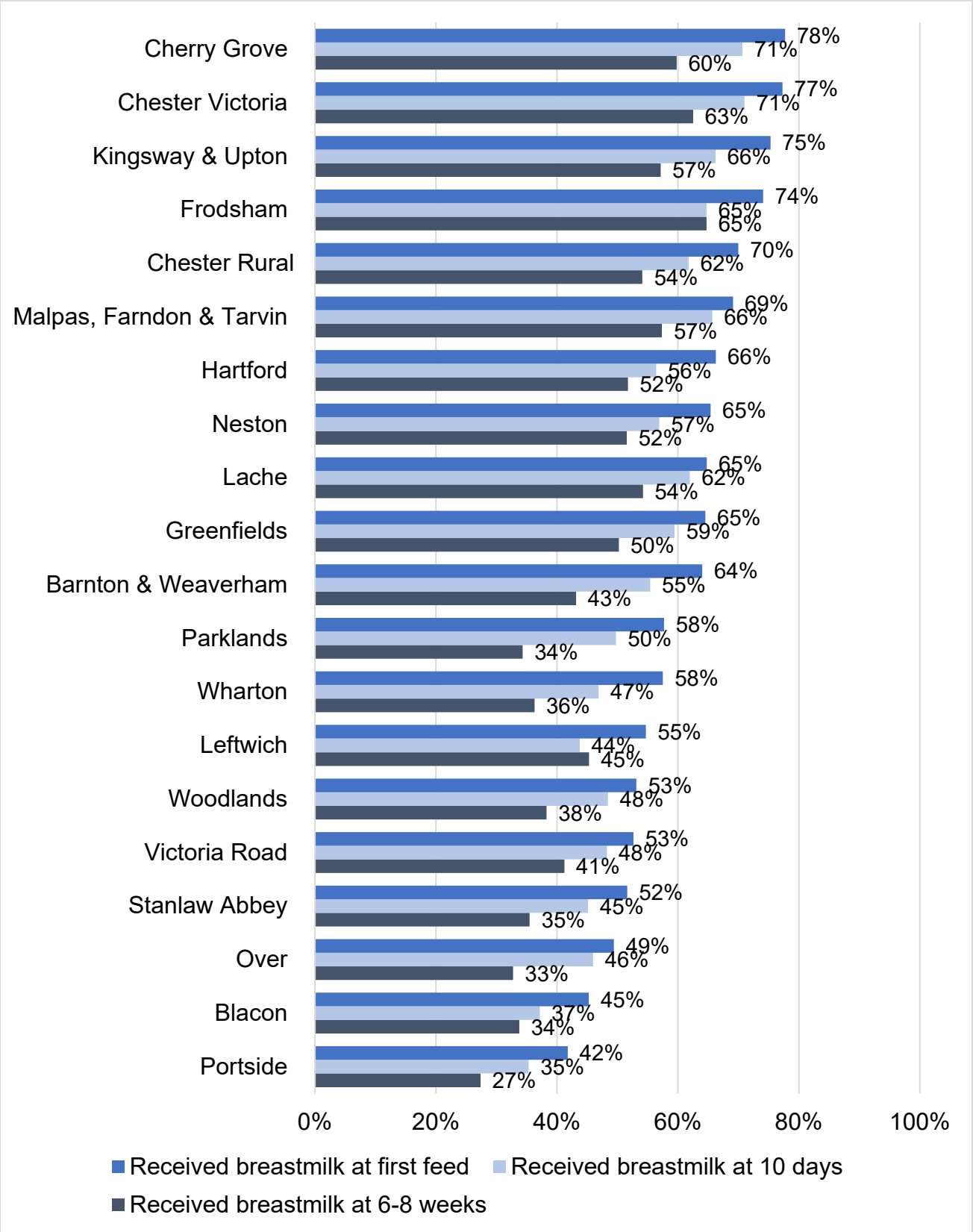
Table 10: Breastfeeding from first feed to 6-8 weeks by care community

Care community	Received breastmilk at first feed	Received breastmilk at 10 days	Received breastmilk at 6-8 weeks	% point difference in breastfeeding from first feed
Chester East	79%	71%	60%	19
Chester Central	74%	67%	60%	14
Rural Alliance	71%	67%	59%	12
Frodsham, Helsby and Elton	70%	60%	59%	11
Neston and Willaston	66%	56%	51%	15
Northwich	64%	56%	48%	16
Chester South	55%	50%	44%	11
One Ellesmere Port	51%	44%	33%	18
Winsford	50%	44%	33%	17

Source: Cheshire and Wirral Partnership Health Visit Report
Note: breastfeeding/ breastmilk includes both exclusively breastfed and mixed feeding

At a smaller children's centre footprint, Frodsham saw the lowest decrease in breastfeeding, with a decrease of nine percentage points between first feed and 6-8 weeks. The highest drop off rates were seen in Parklands where a decrease of 24 percentage points was seen, and Wharton where a decrease of 22 percentage points was seen.

Chart 11: Breastfeeding from first feed to 6-8 weeks by children's centre footprint



Source: Cheshire and Wirral Partnership Health Visit Report
Note: breastfeeding/ breastmilk includes both exclusively breastfed and mixed feeding
See table 11 below for figures.

Table 11: Breastfeeding from first feed to 6-8 weeks by children's centre footprint

Care community	Received breastmilk at first feed	Received breastmilk at 10 days	Received breastmilk at 6-8 weeks	% point difference in breastfeeding from first feed
Cherry Grove	78%	71%	60%	18
Chester Victoria	77%	71%	63%	14
Kingsway & Upton	75%	66%	57%	18
Frodsham	74%	65%	65%	9
Chester Rural	70%	62%	54%	16
Malpas, Farndon & Tarvin	69%	66%	57%	12
Hartford	66%	56%	52%	14
Neston	65%	57%	52%	13
Lache	65%	62%	54%	11
Greenfields	65%	59%	50%	15
Barnton & Weaverham	64%	55%	43%	21
Parklands	58%	50%	34%	24
Wharton	58%	47%	36%	22
Leftwich	55%	44%	45%	10
Woodlands	53%	48%	38%	15
Victoria Road	53%	48%	41%	12
Stanlaw Abbey	52%	45%	35%	17
Over	49%	46%	33%	16
Blacon	45%	37%	34%	11
Portside	42%	35%	27%	15

Source: Cheshire and Wirral Partnership Health Visit Report
Note: breastfeeding/ breastmilk includes both exclusively breastfed and mixed feeding

3.5 Inequalities in breastfeeding rates

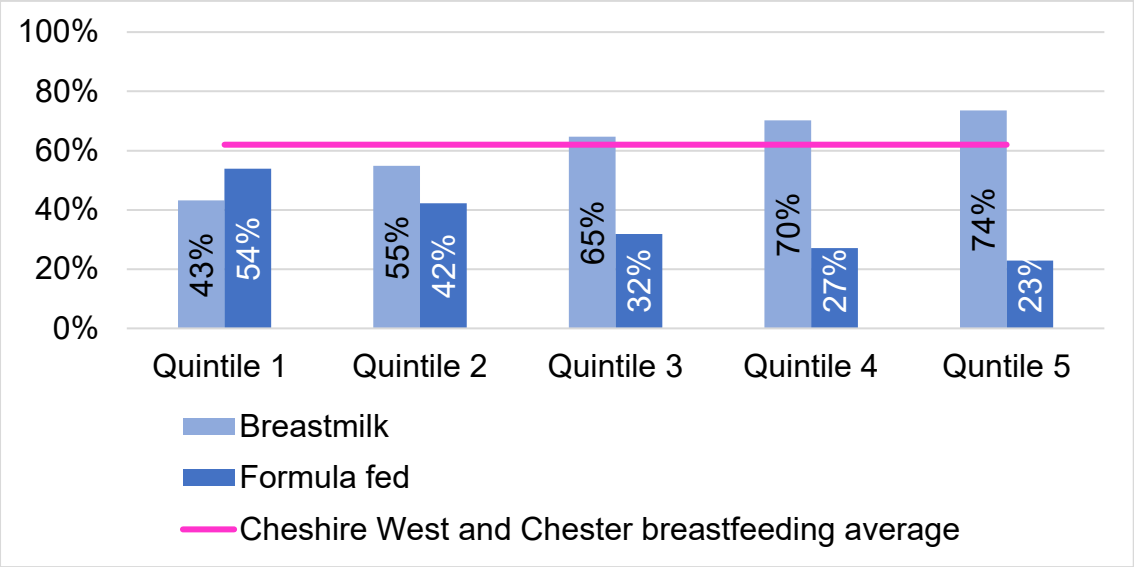
The above indicates that breastfeeding rates vary by geographical location in the borough. Nationally, socially disadvantaged areas have lower breastfeeding rates (Public Health England). Improving rates in these areas can help to reduce health inequalities.

The Index of Multiple Deprivation (IMD) is a measure of relative deprivation for small geographical areas. IMD classifies these geographical areas into five quintiles based on relative disadvantage, with quintile 1 being the most deprived and quintile 5 being the least deprived. We can look at breastfeeding rates in each of these quintiles.

3.6 Inequalities in breastfeeding at first feed

The difference in breastfeeding rates between the IMD quintiles is drastic with the proportion of newborns receiving breastmilk at first feed increasing as deprivation lessens, from 42% in quintile 1 (most deprived) to 74% in quintile 5 (least deprived). In the most deprived areas, there is a preference for using formula rather than breastmilk.

Chart 12: Breastfeeding at first feed by IMD quintile, quintile 1 is most deprived and quintile 5 is least deprived



Source: Cheshire and Wirral Partnership Health Visit Report
Note: breastfeeding/breastmilk includes both exclusively breastfed and mixed feeding

There is a 31 percentage point gap in breastfeeding rates (first feed) between those living in quintile 1 (most deprived) and quintile 5 (least deprived). Over the last 5 years the gap had been generally narrowing between those in the most and least deprived areas, but in 2021-2022 the gap in rates widened back to levels seen in 2017-2018 (see table 12 below).

Table 12: Percentage of newborns who first feed is breastmilk by IMD quintile for the last 5 years, quintile 1 is most deprived and quintile 5 is least deprived

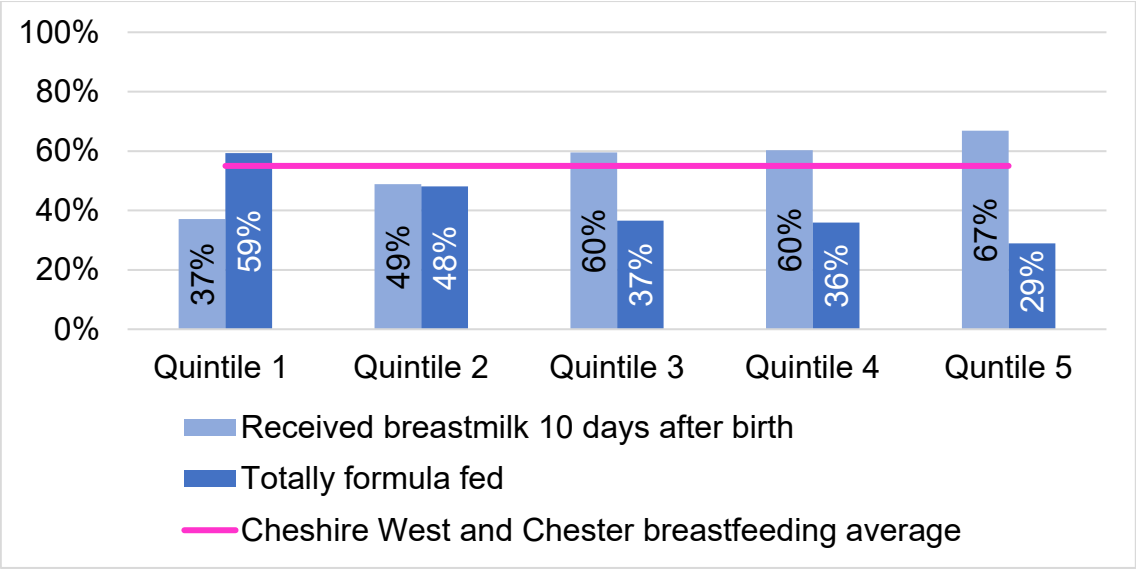
Year	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	% point difference between quintile 1 and 5
2021-2022	43%	55%	65%	70%	74%	**31**
2020-2021	44%	57%	60%	70%	70%	**26**
2019-2020	42%	52%	63%	67%	70%	**28**
2018-2019	42%	56%	64%	66%	68%	**26**
2017-2018	41%	54%	58%	64%	72%	**31**

Source: Cheshire and Wirral Partnership Health Visit Report
Note: breastfeeding/breastmilk includes both exclusively breastfed and mixed feeding

3.7 Inequalities in breastfeeding ten days after birth

All quintiles see a reduction in breastfeeding by ten days after birth, with quintiles 4 and 5 (least deprived) seeing a larger decrease, 10 percentage points and 7 percentage points respectively. These deciles still see a much larger proportion of mothers breastfeeding than more deprived areas, with a difference of 30 percentage points between quintile 1 (most deprived) where 37% of mothers were still breastfeeding in 2021-22, compared to 67% in quintile 5 (least deprived). Again, the inequality gap widened in 2021-2022 compared to previous years.

Chart 13: Breastfeeding 10 days after birth by IMD quintile, quintile 1 is most deprived and quintile 5 is least deprived



Source: Cheshire and Wirral Partnership Health Visit Report
Note: breastfeeding/breastmilk includes both exclusively breastfed and mixed feeding

Table 13: Percentage of babies receiving breastmilk ten days after birth by IMD quintile for the last 5 years, quintile 1 is most deprived and quintile 5 is least deprived

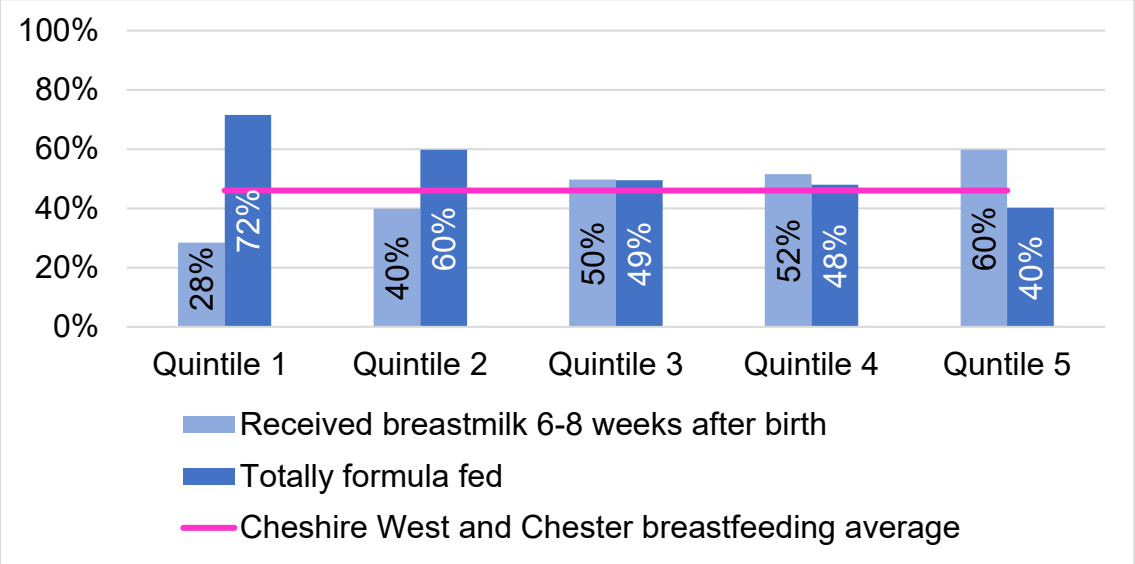
Year	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	% point difference between quintile 1 and 5
2021-2022	37%	49%	60%	60%	67%	**30**
2020-2021	36%	49%	52%	61%	64%	**28**
2019-2020	33%	43%	55%	60%	61%	**28**
2018-2019	33%	46%	59%	57%	62%	**29**
2017-2018	34%	42%	54%	54%	62%	**28**

Source: Cheshire and Wirral Partnership Health Visit Report
Note: breastfeeding/breastmilk includes both exclusively breastfed and mixed feeding

3.8 Inequalities in breastfeeding 6-8 weeks after birth

By 6 weeks just 28% of babies in quintile 1 (most deprived) are receiving breastmilk, compared to 60% in quintile 5 (least deprived). This is a 32 percentage point difference. Again, this is a wider inequality gap than in previous years, particularly since the previous year 2020-2021 when it was 26%. Quintile 3 shows a 10 percentage point reduction in breastfeeding since recording at 10 days, and quintiles 1 and 2, 9 percentage point reduction.

Chart 14: Breastfeeding 6-8 weeks after birth by IMD quintile, quintile 1 is most deprived and quintile 5 is least deprived



Source: Cheshire and Wirral Partnership Health Visit Report
Note: breastfeeding/breastmilk includes both exclusively breastfed and mixed feeding

Table 14: Percentage of babies receiving breastmilk 6-8 weeks after birth by IMD quintile for the last 5 years, quintile 1 is most deprived and quintile 5 is least deprived

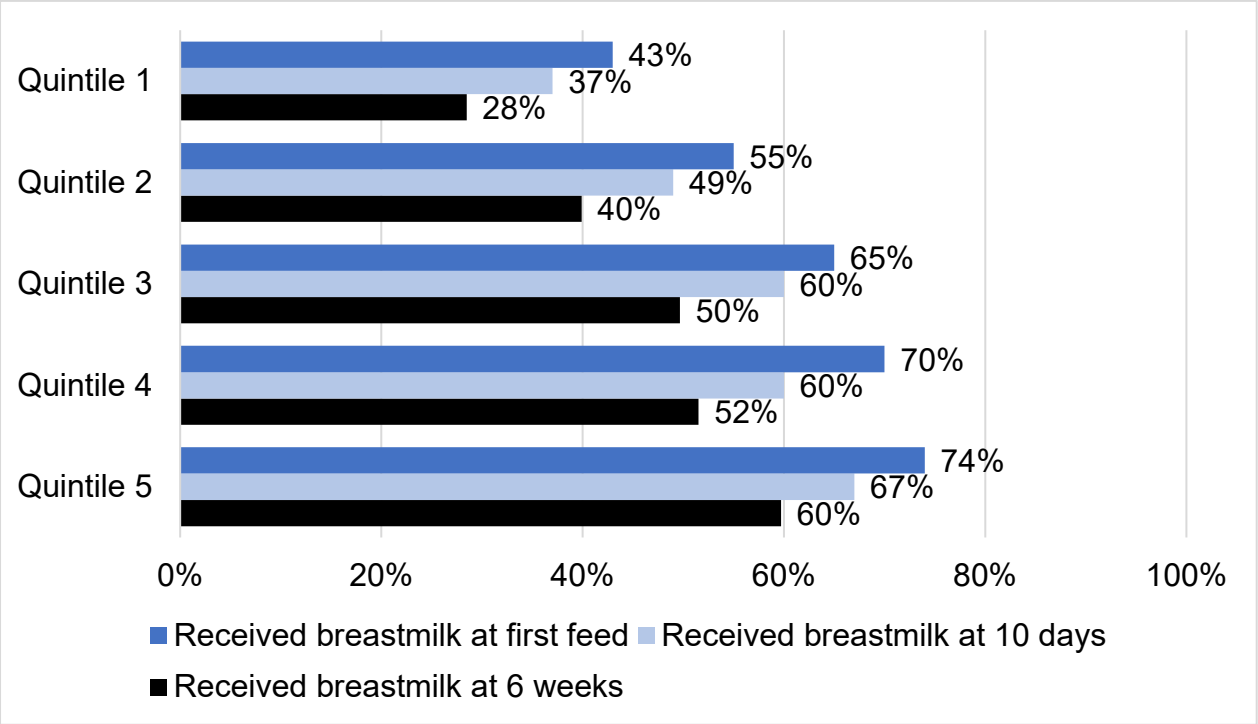
Year	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	% point difference between quintile 1 and 5
2021-2022	28%	40%	50%	52%	60%	**32**
2020-2021	28%	34%	42%	49%	54%	**26**
2019-2020	24%	35%	47%	52%	55%	**31**
2018-2019	26%	37%	45%	46%	52%	**26**
2017-2018	23%	35%	40%	47%	53%	**30**

Source: Cheshire and Wirral Partnership Health Visit Report
Note: breastfeeding/breastmilk includes both exclusively breastfed and mixed feeding

3.9 Inequalities from babies first feed to 6-8 weeks

As detailed in the sections above, there is a marked difference in breastfeeding rates between those living in the most deprived and least deprived areas both at first feed, at ten days and 6-8 weeks after birth. All quintiles see a decrease in breastfeeding rates as time passes.

Chart 15: Breastfeeding 2021/2022, from initiation to 6-8 weeks by IMD quintile, quintile 1 most deprived and quintile 5 least deprived



Source: Cheshire and Wirral Partnership Health Visit Report
Note: breastfeeding/breastmilk includes both exclusively breastfed and mixed feeding
See table 15 below for figures.

Table 15: Breastfeeding from first feed to 6-8 weeks by care community

Care community	Received breastmilk as first feed	Received breastmilk at 10 days	Received breastmilk at 6-8 weeks	% point decrease in breastfeeding from initiation
Quintile 1	43%	37%	28%	15
Quintile 2	55%	49%	40%	15
Quintile 3	65%	60%	50%	15
Quintile 4	70%	60%	52%	18
Quintile 5	74%	67%	60%	14

Source: Cheshire and Wirral Partnership Health Visit Report
Note: breastfeeding/breastmilk includes both exclusively breastfed and mixed feeding

3.10 Other inequalities to consider

As well as socioeconomic status, the following factors are associated with breastfeeding rates nationally:

- Age (women younger than 30 years are less like to breastfeed).

- Ethnic group (White British women are less likely than Black & Minority Ethnic women to breastfeed).
- Smoking (women smoking in pregnancy are less likely to initiate breastfeeding and continue with breastfeeding).
- Mental health (women experiencing post-natal depression are less likely to breastfeed.
- Premature birth (babies born preterm are less likely to be breastfed).
- Antenatal care (women attending antenatal care irregularly are less likely to breastfeed).

Additional information about the mother is not available in the breastfeeding data for analysis, however the following data is available in table 16 below.

Table 16: Indicators related to breastfeeding uptake

Measure	CW&C rate	England rate	Significance to England	Direction
Teenage mothers (2021/22)	0.5%	0.6%	Similar	No significant change
Smoking status at time of delivery (2022/23)	9.4%	8.8%	Similar	No significant change
Deliveries to women from ethnic minority groups (2021/22)	5.2%	22.9%	Lower	No significant change
Premature births (2019-2021)	84.9 per 1,000	77.9 per 1,000	Higher	Could not be calculated

Source: Child and Maternal Health Profile, Office for Health Improvement and Disparities

3.11 Comparison to national averages

Breastfeeding prevalence at birth and at 6-8 weeks after birth is considered an important measure of public health and is therefore included in the Public Health Outcomes Framework.

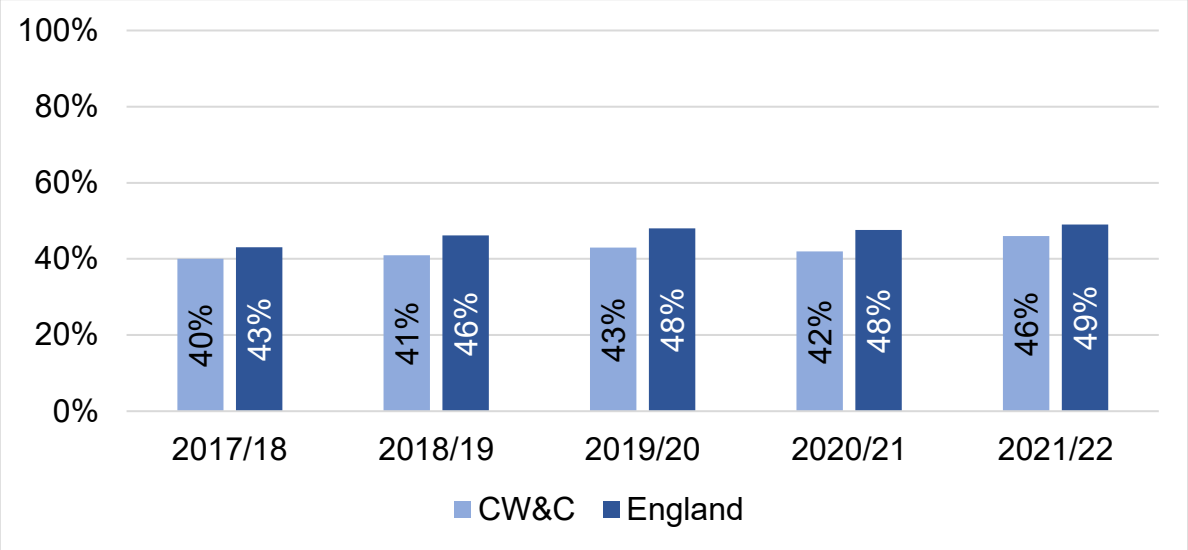
3.11.1 Baby's first feed comparative data

It is currently not possible to compare Cheshire West and Chester data to the national average. Since 2017/18, data relating to breastfeeding status immediately after birth has been captured and reported by NHS Digital via the Maternity Services Data Set (MSDS). In April 2019, the MSDS changed to a new version (MSDSv2). Data quality and coverage reduced from levels seen in previous publications. There have been issues with non-response from providers which in turn has impacted on the ability to interpret the data at levels higher than provider level – this means that figures cannot be presented for England. National rates have not been published since 2018/19. NHS Digital expect completeness to improve over time and are looking at ways of supporting the improvements.

3.10.2 Breastfeeding at 6-8 weeks comparative data

Breastfeeding data at 6-8 weeks shows that Cheshire West and Chester has consistently been below the England average for rates of breastfeeding at 6-8 weeks.

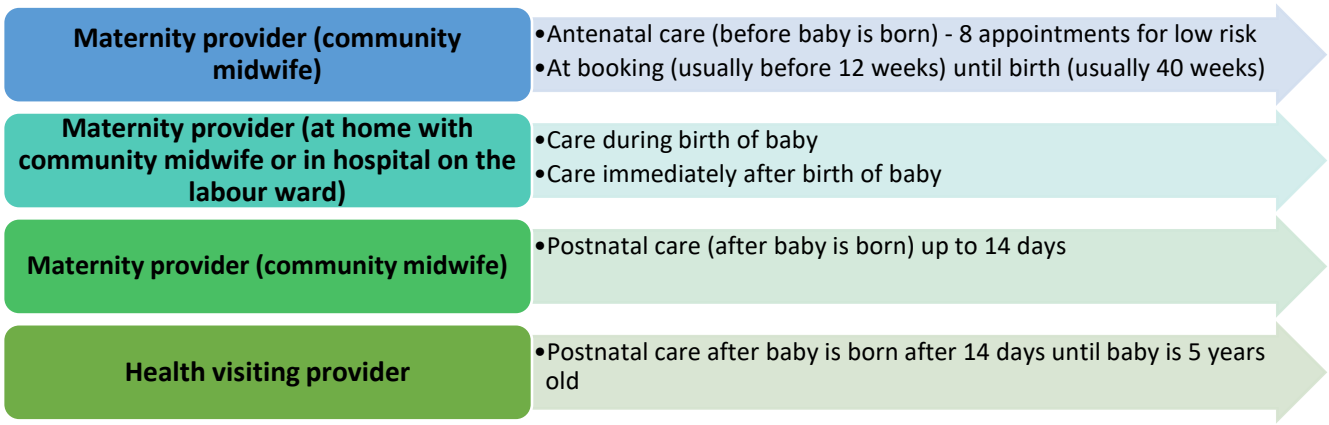
Chart 16: Breastfeeding at 6-8 weeks, Cheshire West and Chester compared to England average



Source: Cheshire and Wirral Partnership Health Visit Report
Note: breastfeeding/breastmilk includes both exclusively breastfed and mixed feeding

4 Service provision

The following is the standard pathway that families follow before, during and after the birth of their baby. Infant feeding and breastfeeding support is delivered at each stage of the pathway by each service provider.



Due to their locations, Cheshire West and Chester families are likely to access the Countess of Chester or Leighton Hospital to provide their maternity care. The Starting Well 0-19 Service, provided by Cheshire and Wirral Partnership Trust (CWP), deliver health visiting services for the borough of Cheshire West and Chester. Koala North West deliver breastfeeding peer support.

Families who live in Cheshire West may also go to Wrexham Maelor Hospital or to Arrowe Park Hospital, Wirral for their antenatal, during birth and postnatal care depending on their preference of maternity provider and their proximity to the border. However, service provision at these hospitals has not been mapped for the JSNA and would need to be explored further.

The following table maps the Infant Feeding support provided by the Countess of Chester Hospital, Leighton Hospital, the Starting Well Service and Koala North West, against the criteria in the Department for Education and Department of Health and Social Care's Start for Life programme.

The Start for Life programme aims to ensure that all parents and families can access the information, support, and practical advice they need, including ensuring that support is accessible to those who are most in need of it. From 1 April 2024, all local authorities, including those who did not receive Start for Life funding, will need to demonstrate that they are meeting the minimum expectations outlined in the Start for Life programme guide. In terms of Infant Feeding support, a combination of face to face and virtual support is expected. Cheshire West and Chester deliver many of the services and support outlined for the Start for Life programme, however, there are some recognised gaps in support, which are outlined below.

Table 17: Current Infant Feeding service provision mapped against Start for Life programme expectations

Start for Life criteria	What is already in place?	Recognised gaps
Welcoming environment	All Children's Centres welcome breastfeeding and where possible will provide a private space for feeding if required.	
Antenatal offer	The Starting Well Service launched a new antenatal model on the 1st of July 2023 with a tiered approach to ensuring the right level of care for all (antenatal video, antenatal group or antenatal home visit). This contact includes information on the benefits of breastfeeding and how to get breastfeeding off to a good start and information about the support available within the children's centres for breastfeeding. All families who have additional vulnerabilities receive an antenatal home visit where infant feeding is discussed. Community midwives provide feeding advice during all routine antenatal appointments. A 2-hour Infant Feeding workshop is delivered once a week for families at the Countess of Chester (mixture of face to face and online delivery). The online Infant Feeding workshops are delivered by the NCT and the face to face workshops are delivered by the Countess of Chester Infant Feeding Team. For first time mums accessing maternity care at the Countess of Chester, an antenatal breastfeeding home visit is	

	offered as standard. Women who are pregnant for the second or more time can also access this offer if it is felt extra feeding support is required. At Leighton Hospital, a 4.5 hour workshop of parent education is delivered by community midwives once a month. This touches on feeding, responsive parenting and feeding cues. The Infant Feeding Team at Leighton Hospital also deliver a 2.5-hour face-to-face session every other week with 15 couples as a maximum number.	
Peer support on wards	Peer support is available in the Countess of Chester Hospital, although only on certain days. Peer Supporters are supervised and managed by the hospital's volunteer team and provide evidence-based information and signposting, offer practical help with positioning and attachment and emotional support. Conversations are ongoing about re-introducing Cherubs support on the ward at Leighton Hospital – there is currently a trust wide hold for onboarding of new volunteers.	
Peer support in the community	Koala North West provide a breastfeeding peer support offer (Bosom Buddies) in Cheshire West and Chester, including running breastfeeding peer support groups and a Breastfeeding Peer Support Facebook group. Breastfeeding peer support groups are available in the majority of the main children centres in Cheshire West and Chester. In April 2023 there were 40 different mums attending and 100 attendances at groups.	Koala North West do provide a triage service so may arrange one to one support from a health visitor or infant feeding lead. However, Koala North West are not currently funded to offer one to one support and so peer supporters cannot offer home visits or telephone support.
Postnatal support in the hospital	Following birth, 4 BFI birth standards are met, which are: unhurried & unrestricted skin to skin	

	contact, recognising early feeding cues, offering the first feed in skin to skin contact and offering help with the first feed. Midwives and maternity support workers do the majority of feeding support following birth. Support is offered with first feed and ongoing feeding support is offered if required. Midwives give all women information on where to get breastfeeding support including Koala bosom buddies support groups, community midwives and maternity support workers and the Starting Well Service. If a midwife or maternity support worker feels specialist support is required, a referral is made to the Infant Feeding Team.	
Postnatal support in the community	Home visits and breastfeeding assessments are offered as part of standard postnatal care (from midwifery and health visitors). In both hospitals, the primary visit from a community midwife which happens the day after discharge/home birth is a home visit, whereas the day five contact can be a home visit or an appointment in the hospital. Families can have more support postnatally if they need it or request it. This includes feeding support at home by their midwife or a midwifery support worker or from the Starting Well Service. At the time of writing this JSNA, peer supporters were not able to offer home visits.	
Workforce knowledge and skills	All staff in the Starting Well Service receive Infant Feeding training, including those who are not in front facing roles. This includes a New Starter Induction to Infant Feeding Guidance (1 hour) on commencement of employment. There is then a Level 1/2 Breastfeeding Awareness Training (1.5 hours) for Starting Well staff who have contact with mothers and babies but do not support directly. A Level 3 Breastfeeding and Relationship Building Training (2-day BFI training) is provided for all staff who support mothers and babies directly with infant feeding. Additional training is provided according to needs identified during audits or local patterns of support being identified (e.g., faltering growth and tongue-tie). In the Countess of Chester Hospital, the infant feeding team provide 2-day BFI training to every staff member in maternity services, a half day induction with the infant feeding team when they start at the trust and ongoing support.	

	In Leighton Hospital, the Infant Feeding Team meet with all new maternity staff within their first week of employment. The Infant Feeding Team facilitate a 2 day Infant Feeding and Relationship Building Training to all new midwifes and maternity support workers. There is also joined up training with nursing staff on the children's ward.	
Drop in infant feeding support	The breastfeeding peer support groups are drop-ins.	
Support for more complex issues	Specialist clinics are run in each district weekly by the Infant Feeding Lead in the Starting Well (0-19) Service. A faltering growth pathway is in place that details the steps that the Starting Well Team will take if there are concerns about weight. For feeding, this includes the pathways and management plans for the Health Visitors to follow and guidance on when to refer to the Infant Feeding Lead Specialist Clinic. There is also a specialist clinic at the Countess of Chester Hospital which reviews dyads (mothers and babies) experiencing feeding difficulties within the first 16 weeks. Women can attend the specialist clinic at the Countess of Chester antenatally for support and a feeding plan as well (with a referral). At Leighton Hospital, the Infant Feeding Team provides face-to-face appointments in the hospital on a one-to-one basis, for more complex feeding issues. Phone support can also be offered. The Infant Feeding Team at Leighton supports families during the first 28 days postnatally, after which there is a handover to health visiting. Whilst specialist support from the hospital Infant Feeding Teams is hospital based (i.e. women attend the hospital for an appointment or for a clinic), home support for more complex issues can be provided by the Infant Feeding Lead in Starting Well.	
Tongue tie support	Tongue tie division is offered in the specialist clinic at the Countess of Chester Hospital, which will see babies up to 16 weeks for tongue tie division. Leighton Hospital also offers a tongue tie clinic. The tongue tie clinic at Leighton sees babies up to 12 weeks. Babies over 16/12 weeks are referred to Alder Hey within each hospital's pathway. Waiting times at the Countess of Chester vary but the aim is to offer an appointment within 2 weeks	

	of referral. This clinic is available for women and babies in the Countess of Chester catchment area or women with babies born at the Countess of Chester. Waiting times at Leighton Hospital are impacted as the service sees out of area families, particularly from Stoke where this service isn't offered. Referrals to the tongue tie clinic at Leighton have to be made after day 5 so that appropriate time has been given to implement a feeding plan with support with feeding (positioning and attachment) and then follow up.	
Equipment loans	The Countess of Chester have approximately 30 breast pumps to loan. These are available for women who are experiencing difficulty or who are on a feeding plan and are loaned for 1 month, free of charge. All women are shown how to use them and are provided with feeding support alongside the loan. Leighton Hospital have 8 breast pumps available free of charge for home loan. These are loaned for 2 to 4 weeks. The Infant Feeding Team provide ongoing support and keep in regular contact with the patients for follow up.	
Information and advice, including online offer	The Countess of Chester Maternity Padlet provides a range of information for families, including how to book onto classes, videos on hand expression, and support available, etc. Leighton Hospital offer infant feeding videos (antenatal, hand expressing, feeding your baby), leaflets and signposting, e.g., to UNICEF, First Steps Nutrition and the NHS. They also have a Facebook page. The Starting Well Service have a section on their website about breastfeeding support. Midwives and health visitors give all women information on where to get breastfeeding support including Koala bosom buddies support groups.	
Virtual support	There is a Breastfeeding Peer Support Facebook Group for Cheshire West, which provides support to over 3,000 breastfeeding families. This is run by Koala North West staff and volunteers. Telephone support is available from the Infant Feeding Teams at Leighton Hospital and the Countess of Chester Hospital. The Starting Well Service can also provide telephone support, and they have a duty service (email and telephone) which Mums can contact during working hours.	
Breastfeeding Friendly Schemes	There is a volunteer led 'Breastfeeding Friendly Chester' scheme. Businesses (in and outside of	

	Chester) have signed up to this scheme. However, a commitment was made at Full Council in July 2022 (through a Notice of Motion on Breastfeeding) to create a Borough-wide Breastfeeding Charter/breastfeeding welcome scheme.	
Multi-disciplinary infant feeding working group	Cheshire West's Breastfeeding Strategy Group is in the process of being re-formed. The meetings will re-start from January 2024 and have representation from: • Maternity Voices Chester • Maternity Voices Mid-Cheshire • Koala North West • National Childbirth Trust • The Starting Well 0-19 service • The Infant Feeding leads at the main hospitals used by residents of the borough (Countess of Chester and Leighton Hospitals) • The Project Manager in the Starting Well Team (Cheshire West place) of Cheshire and Merseyside ICB who has responsibility for the maternity portfolio • The Children and Young People Commissioning Manager at Cheshire West and Chester Council • Public Health at Cheshire West and Chester Council	
Support for partners	Partners can attend the antenatal infant feeding classes offered at Leighton Hospital and the Countess of Chester Hospital.	

5 Lived experience

In 2022, Cheshire West's Breastfeeding Strategy Group developed a survey to ask families in Cheshire West for their views on infant feeding service provision. This survey was widely promoted in early 2023. The survey was aimed at all families who had had a child in the past three years and had accessed services before, during and after the birth of their baby/babies in Cheshire West. This included families who had accessed hospital and/or health visiting provision in Cheshire West, but not necessarily both. The survey was open for six weeks, during which time 230 responses were received, with families providing feedback on how well services were working to help them with infant feeding.

In interpreting the results of the Infant Feeding Survey, a degree of caution is needed. Between 2018 and 2020 there were an average of 3,212 births a year and so 230 responses will represent a very small proportion of the total number of parents who had a child between 2020 to 2022. Likewise, there were some voices which were underrepresented in the survey responses, notably young parents, parents from ethnic

minority backgrounds, and parents who did not breastfeed. As the National Institute for Health and Care Excellence (NICE) note, younger women and women from a low income or disadvantaged backgrounds may need more support and encouragement to start and continue breastfeeding. Further targeted engagement work with these groups would therefore be helpful. Nonetheless, the survey highlights several areas for further consideration.

As previously noted, a notable proportion of survey respondents will have had a baby when certain aspects of service delivery were affected by the Covid-19 pandemic. This may have affected responses to certain questions. For example, lack of early identification of tongue tie was flagged by several respondents to the survey. In the initial months of the pandemic, New Baby Reviews were delivered by video conferencing. It was recognised that during the eight-week period when New Baby Reviews were conducted virtually, the lack of physical contact possibly hindered the identification of tongue tie and/or falling weights. The pandemic therefore may have had an influence on support with tongue tie, although it must be noted that regional evidence highlights that the identification of tongue-tie is a gap in knowledge for many clinicians. This is therefore being addressed within the Cheshire and Merseyside Infant Feeding Plan.

Likewise, only 43% of survey respondents were either very satisfied or fairly satisfied with the infant feeding information they received from the health visiting service whilst they were pregnant. In terms of support after birth, only 54% of respondents were very satisfied or fairly satisfied with the help and support they received from the health visiting team after handover from midwifery. As with tongue tie, satisfaction with the health visiting service may have been impacted by the pandemic, which had a significant impact on service delivery. The relatively low satisfaction may also reflect previous staffing challenges (now resolved) in the Starting Well Service which impacted on the service's ability to provide antenatal contacts universally. Further investigation of responses to explore variation by year of birth would therefore be helpful. Nevertheless, the free text responses indicated that some respondents felt more help and support was needed during pregnancy.

The survey highlighted that several families are accessing private breastfeeding support, including private support for tongue tie, private independent lactation consultants, and private courses prior to the birth of their child. Likewise, only slightly over half of respondents (55%) felt that support was easy to access when they needed it, suggesting that some families may be struggling to access timely support with breastfeeding. If this is the case, there are likely to be equity issues given that not all families in Cheshire West will be able to afford to pay for private breastfeeding support.

The survey also highlighted that sometimes parents felt they had to find their own information on breastfeeding, suggesting that information may need to be given more proactively. Free text responses to the question asking about satisfaction with the information provided during pregnancy highlighted that some respondents felt more advice and support needs to be given during pregnancy.

Similarly, whilst only 13% of respondents stated that they had not used a children's centre in Cheshire West, a higher proportion of survey respondents (20%) answered that the help and support provided by children's centres to continue to breastfeed was not applicable to them. 8% of respondents were also not sure who provided their health visiting care. This

may suggest a lack of awareness amongst some families of service provision and may need some further investigation.

Most survey respondents (74%) stated that they had experienced breastfeeding difficulties or problems. Likewise, across several questions allowing free text responses, respondents noted that information about breastfeeding needs to be realistic, and that breastfeeding is hard initially, but that you can get through difficulties and breastfeeding is worth it in the long run. Explaining common breastfeeding challenges was seen as important for helping women to understand what is normal. This should be considered in designing future information and advice offers, including when considering the antenatal offer as it also reflects the guidance in the Start for Life programme that woman should be told antenatally what the challenges might be with breastfeeding and what support is available.

Although there were very few respondents to the survey who did not breastfeed their child/children, the responses to the question asking about reasons for not breastfeeding mirror some of the findings of NICE's evidence review of breastfeeding barriers and facilitators. There was high quality evidence in NICE's evidence review that bottle feeding can be perceived as a way for Dads and wider family members to bond with babies and as a way for families and partners to ease the workload of the mother (NICE, 2021). This latter point was highlighted by survey respondents who had not breastfed. Confidence over breastfeeding outside the family home and insufficient support from employers are also recognised barriers to breastfeeding, and these issues were highlighted by some survey respondents.

Evidence suggests that breastfeeding interventions are more likely to be effective if delivered regularly, face to face, in a combination of settings, including the home environment, hospital, and wider community (Food Active, 2023). This can encompass professional, community or family support or a combination of these (Food Active, 2023). The responses from the lived experience work reflect this. Home visits, face to face support (breastfeeding support groups and breastfeeding specialist clinics) and peer support were the most popular responses when survey respondents were asked what the most helpful feeding support was. Nevertheless, although families had a strong preference for face-to-face support, survey respondents did suggest a wide variety of online resources which they had found useful on their breastfeeding journeys. This also mirrors the current evidence base, which has concluded that face-to-face support for breastfeeding is most effective, (McFadden et al., 2017), but that mothers are engaging with and reporting benefits from online support (Morse & Brown, 2021).

6 Identifying needs and gaps

The main providers of infant feeding support for Cheshire West and Chester residents (the Countess of Chester Hospital, Leighton Hospital, the Starting Well 0-19 Service and Koala North West) were asked to fill in a provider survey in 2023. This survey gave providers the opportunity to detail their service provision, as well as articulate any gaps they felt existed in service provision. Responses were received from the infant feeding leads of all four main providers.

Antenatal contacts

Antenatal contacts were viewed by the majority of respondents as an essential component of infant feeding support, helping to ensure parents have all of the information needed so that they can make an informed infant feeding decision and so that parents are aware of services and support before their baby is born. It was also noted that antenatal groups provided in another area by Koala North West had been very successful for supporting breastfeeding initiation.

However, there have been recognised gaps in the antenatal offer in Cheshire West and Chester. Due to staffing issues, there has previously been a lack of antenatal health visiting contacts universally which may have impacted breastfeeding initiation rates. Respondents to the provider survey suggested increasing antenatal provision/conversations should be a priority. Peer support during pregnancy was also flagged as a gap in provision.

Staff training

It was flagged by respondents to the provider survey that some issues which mothers and babies present to GPs with may be related to positioning and attachment or oversupply and that some babies are commenced on medication or specialist formulas unnecessarily. As is detailed in the following section, training for staff working with mothers and babies is crucial for supporting breastfeeding and an important component of UNICEF's Baby Friendly Initiative. A UNICEF Baby Friendly Initiative e-learning package is available for GPs, however, at the time of writing, this has not been purchased for GP practices in Cheshire West and Chester. It was suggested in the responses to the provider survey to consider a joined-up training plan for the community and hospitals to support UNICEF BFI.

Continuity of support across services

The need for a joined-up approach and integrated working is highlighted in the Start for Life programme's expectations. Notably, integrated working and seamless support between maternity services and health visiting services has a significant impact on the quality of support and breastfeeding outcomes for families. Continuity of support across services is underpinned by effective communication between services, information sharing across providers and appropriate referral pathways. There were comments from respondents to the provider survey regarding the need to streamline referral processes between health care practitioners and community support. It was also suggested by respondents that GPs who see breastfeeding mothers and babies should signpost to breastfeeding groups or the duty health visitor for support when mothers attend with any infant feeding related issues.

Home visits

When asked about priority areas for the commissioning of services and/or service development and improvement, respondents to the provider survey suggested having an increased team of staff specifically for breastfeeding support in the home (breastfeeding champions) or provision for volunteers to support in the home. This mirrors the preference in the infant feeding survey for home visits. At the time of writing, Koala North West (who provide breastfeeding peer support) are unable to visit mothers in their homes, which excludes many women who have had a caesarean section from accessing this support.

Staffing challenges

Several respondents to the provider survey flagged staffing challenges (for example, staff shortages) as having an impact on infant feeding support. This mirrors the findings from the lived experience work, as a small number of parents who responded to the infant feeding

survey flagged staffing challenges as having an impact on their care, for example midwives being stretched. Respondents to the provider survey suggested increasing the number of feeding specialists/lactation consultants and expanding the peer support offer.

Tongue tie division

The infant feeding survey highlighted the importance of timely access to tongue tie treatment due to the impact which tongue tie can have on breastfeeding. Work is occurring across the sub-region to clarify access to frenulotomy services. As is detailed in section four, tongue tie division is available in both the Countess of Chester Hospital and in Leighton Hospital. However, access for out of area families, (in particular Stoke), at the tongue tie clinic at Leighton Hospital may have an impact on waiting times for Cheshire West families. Arrowe Park Hospital also do not currently offer tongue tie division, and babies over 12 weeks (Leighton) and 16 weeks (Countess of Chester) are referred to Alder Hey for tongue tie.

Data

The infant feeding survey suggests that some families may be struggling to access timely support with breastfeeding. Improving data collection and reporting in Cheshire West and Chester would help to improve our understanding of access to, uptake of and the impact of support with breastfeeding, as well as any equity issues. In producing this chapter of the JSNA, we did not consider the following data sources:

- Data from maternity – for example, data on breastmilk within 48 hours, data on colostrum harvesting, uptake of antenatal education classes
- Data on peer support – for example, numbers of peer supporters, hours of support delivered in both the community/on hospital wards
- Data on breastfeeding group attendance
- Data on specialist clinic attendance
- Feedback from families as part of BFI assessments, e.g. UNICEF Baby Friendly Initiative Mother Audits
- Inequalities in breastfeeding rates by age of mother and other demographic factors
- Data on reasons for drop off in breastfeeding rates, for example insight from BFI Bottle Feeding Audits.

The service mapping in section four also highlights that there are differences in the support available between the Countess of Chester Hospital and Leighton Hospital. For example, there is no peer support on the ward in Leighton Hospital, whereas this is available three days a week at the Countess of Chester Hospital. Although peer support on maternity wards is not one of the minimum expectations for Start for Life programme areas, this is a suggested ‘go further’ option for those areas looking to enhance their Infant Feeding support. It would be useful to explore whether satisfaction with maternity care varied between respondents to the infant feeding survey based on where respondents gave birth, to get a sense of whether differences in service provision may or may not alter satisfaction with infant feeding support. Greater monitoring of the uptake and impact of peer support on breastfeeding continuation rates would also be helpful.

7 Evidence of what works

Twenty-nine pieces of evidence on infant feeding were reviewed for this JSNA, including NICE guidance, Cochrane reviews, and government and NHS guidance. This evidence is summarised below:

7.1 Key messages

- Multicomponent strategies are the most effective way to increase breastfeeding rates. This should include providing effective professional support to mothers and their families as well as ensuring that mothers have access to support, encouragement and understanding in their community.

- Breastfeeding Welcome schemes in public spaces, support from employers to breastfeed when returning to work and study, and peer support are all important components of effective community support.

- Continuity of support across services is key and good outcomes are seen when midwives and health visitors work in partnership to support parents by providing expert information and support to families and developing relationships that enable difficulties to be identified early and help to be offered when needed.

- Peer support is emphasised as a model to support parents and families with breastfeeding in the government's Best Start for Life report (HM Government, 2021). Research shows that peer support is highly valued by mothers and peer support groups appear to increase the likelihood of breastfeeding, whether in person or online. Nevertheless, peer support is most effective when delivered in conjunction with professional support across a combination of settings (Ingram, 2013; Sinha et al., 2015).

- Although evidence reviews have concluded face-to-face support for breastfeeding is most effective, (McFadden et al., 2017), social media functionality and use have changed considerably since the data they examined was collected. As the provision of online breastfeeding support has become more widespread and accessibility has improved, mothers are engaging with it and reporting benefits (Morse & Brown, 2021). Therefore, although face to face support is crucial, there is a role for complementary written, digital and telephone support.

- The UNICEF UK Baby Friendly Initiative (BFI) is a nationally recognised mark of quality care for babies and mothers. Implementing the UNICEF UK Baby Friendly Standards and supporting other settings to become baby friendly, including training for early years staff, can help to develop a whole systems approach to breastfeeding.

- All public services should 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.

7.2 Antenatal support

Antenatal care for pregnant women is a crucial time for all services to start supporting families in their breastfeeding journey. All professionals delivering antenatal consultations should

deliver effective information and education about breastfeeding. These conversations should be meaningful, empathetic and mother-centred. Antenatal education should involve and support partners and targeted antenatal education should be delivered for specific groups.

7.3 Postnatal care

NICE are clear that face-to-face breastfeeding support should be integral to the standard postnatal contacts for women who breastfeed, and that support should be continued until breastfeeding is established and any problems have been addressed. Breastfeeding assessment should also be an integral part of postnatal contacts as assessment aids detection of breastfeeding concerns. A minimum of two formal breastfeeding assessments should take place in the first week and an assessment should also take place at approximately 10-14 days.

7.4 Information, advice and guidance

Personalised, consistent, high-quality information should be provided to families. Improving parents' knowledge about the benefits of breastfeeding has proven to be beneficial in increasing the likelihood of breastfeeding (Food Active, 2023). However, research suggests that educational interventions alone may not be enough to sustain breastfeeding and are more likely to be effective when combined with regular peer support groups (Food Active, 2023).

7.5 Targeted support

Practitioners should be aware that younger women and women from a low income or disadvantaged backgrounds may need additional encouragement and support to initiate and continue breastfeeding. Continuity of carer is particularly important for these women.

There should also be a focus on understanding access to and impact of services for specific groups of women, including women from different ethnic backgrounds.

7.6 Normalisation of breastfeeding

Local health promotion campaigns and education are important for ensuring that breastfeeding is seen as normal and is supported. There are also calls from WHO, UNICEF UK and the Royal College of Paediatrics and Child Health for breastfeeding to be taught in schools to contribute to the renormalisation of breastfeeding in the UK.

7.7 Managing difficulties

Specialist support, with an appropriate referral pathway, should be available for mothers experiencing complex challenges with breastfeeding[1], and staff should be aware of the referral pathway for specialist help, and know how to refer mothers to this. Collaborative working is encouraged to ensure that this specialist help is available along with social support.

7.8 Engagement with families

The experience of families and satisfaction with service delivery is crucial to the delivery of breastfeeding support, and a central component of BFI specific standards for Maternity,

[1] Mothers and babies experiencing difficulties may require specialist support and/or may have an underlying feeding issue which requires specialised support. NICE guidance is available detailing standard management and care for a variety of issues which can affect feeding, for example, tongue tie and mastitis.

Neonatal, Health Visiting and Children's Centres. Feedback and engagement should be used to develop and improve the breastfeeding offer across agencies.

7.9 Partners and extended family

Partners and extended family are an essential component of an effective support network around breastfeeding mothers. NICE recommend that partners or the mother's chosen supporter(s) should be given information about how they can support the mother with breastfeeding, the importance of their support and involvement and ways of comforting and bonding with the baby.

7.10 Workforce education and training

An educated workforce is a crucial component of UNICEF's Baby Friendly Initiative. All people involved in delivering breastfeeding support, including employed staff and volunteer workers, should receive appropriate training and undergo assessment of competencies for their role. This includes staff and volunteers in hospitals, community settings, children's centres and peer supporter services.

Training is crucial for staff in maternity and health visiting services and in GP surgeries. However, NICE guidance also highlights the importance of wider health professionals, such as doctors, dietitians and pharmacists, having training to promote and support breastfeeding, using BFI training as a minimum standard (NICE, 2008).

7.11 Mental health

There is a recognised link between perinatal mental health and infant feeding. A study using data on mothers from the Avon Longitudinal Study of Parents and Children (British survey) investigated the effects of breastfeeding on mothers' mental health. This found that, for mothers who were not depressed during pregnancy, the lowest risk of post-partum depression (PPD) was among women who had planned to breastfeed, and who had breastfed their babies (Borra, Iacovou & Sevilla, 2015). By contrast the highest risk of PPD was found among women who had planned to breastfeed and had not gone on to breastfeed, suggesting that mothers who stop breastfeeding due to pain or physical difficulties are at greater risk of depressive symptoms (Borra, Iacovou & Sevilla, 2015).

This study highlights the importance of ensuring that mothers receive the high-quality support they need to meet their breastfeeding goals, but also of providing compassionate support to women who had intended to breastfeed, but who experience difficulties.

7.12 Data

The High Impact Areas for the Healthy Child Programme highlight the importance of data collection, and in particular the importance of measuring access to, the delivery and impact of and people's experiences of support.

8 Conclusions

There is overwhelming evidence that breastfeeding saves lives, improves health and reduces healthcare costs. Improving breastfeeding rates in groups that are least likely to breastfeed is also a powerful means of reducing health inequalities. Nevertheless, whilst there have been increases in breastfeeding rates in Cheshire West and Chester since 2017-18, significant inequalities in breastfeeding rates remain. This JSNA therefore makes

a series of recommendations for improving infant feeding support in Cheshire West and Chester and reducing inequalities in breastfeeding rates.

9 Recommendations for the 0-19 Partnership

1. Each provider should work to achieve the BFI Gold award and achieve sustainability through re-validation as required by UNICEF. Cheshire West and Chester Council and Cheshire and Merseyside ICB should also explore whether BFI accreditation can be included as a contractual requirement for providers to work towards.
2. Consider options to expand the peer support offer in Cheshire West and Chester, including any opportunities to offer peer support antenatally, through home visits, and postnatally on hospital wards.

10 Recommendations for the wider system

3. The evidence review along with the feedback from families has demonstrated the importance of improving data collection in order to understand access to service provision and the impact that services are making for families. Ideally, an integrated dataset across Cheshire West providers should be established. This dataset can be used to understand need and the quality of service delivery.
4. The evidence review highlights how important information is to support families with their infant feeding journey. Opportunities to develop a 'one stop shop' for infant feeding advice for families in Cheshire West, which is jointly owned by the partnership of commissioners and providers, should be explored as part of Family Hub developments. This should detail the multi-agency offer so that families know what to expect from all agencies and can ask for support.
5. Certain groups were underrepresented in responses to the infant feeding survey, including young parents, parents from ethnic minority groups, and parents who did not breastfeed. The Breastfeeding Strategy Group should review the approach to engaging with vulnerable groups and families and consider additional engagement/co-production with these groups.
6. The Breastfeeding Strategy Group should monitor the uptake of peer support and its impact on continuation rates.
7. Look to develop a clear pathway for infant feeding support, to ensure effective information sharing and seamless support and transition between services, for example, from midwifery/health visiting into community (peer) support. This should include work to strengthen the antenatal offer to ensure that all families receive advice antenatally on the importance of early relationships, the benefits of breastfeeding for the health and wellbeing of the baby and mother, common breastfeeding challenges and what support is available.
8. Develop communications campaigns, especially in targeted communities where breastfeeding rates are lowest, to help to normalise breastfeeding.
9. Explore reasons for drop off in breastfeeding, and for geographical variation in drop off, for example using insight from the BFI Bottle Feeding Audits.
10. The Breastfeeding Strategy Group should use the JSNA findings and the Cheshire and Merseyside LMNS Infant Feeding Strategy to develop and implement a local breastfeeding action plan.
11. A joined-up training plan should be developed to ensure that all staff and volunteers who work with families during pregnancy and after birth (including GPs) have the appropriate knowledge and skills to support breastfeeding. This should include

exploration of commissioning options and contractual levers to support the uptake of training.

12. This Breastfeeding Strategy Group should ensure the JSNA is updated to consider more recent data, in order to understand the potential impact of service changes.

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