The Breastfeeding Network and Cardiff University

An exploration of
Trends and experiences of delivery of breastfeeding support in England and Wales, since 2015

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Views expressed in this report are those of the researchers and not necessarily those of the Breastfeeding Network.

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The Breastfeeding Network provides independent, evidence-based information and support on infant feeding to women, parents and families. They offer support through a peer model and have over 600 trained peers across England, Scotland and Wales. A key aim is to share the evidence in infant feeding with the families we support. Their support services reach parents both antenatally and after birth and many of the parents we support go on and train with the charity to support others in their community. They provide the National Breastfeeding Helpline in partnership with the Association of Breastfeeding Mothers, which is funded by Public Health England and Scottish Government. The charity has also provided a Drugs in Breastmilk information service founded by Dr Wendy Jones MBE and supported by volunteers. The charity also works very closely with national partners including UNICEF, Baby Friendly and other charitable organisations and universities. The Breastfeeding Network is a Registered Charity No SC027007. For more details visit www.breastfeedingnetwork.org.uk

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Key Findings

Background and aims

By international standards, breastfeeding rates in the UK are low (Victora et al. 2016), with social and geographical polarisation in feeding decisions (McAndrew et al., 2012). The World Health Organisation's (WHO) Global Strategy for Infant and Young Child Feeding recommends national governments take forward breast feeding peer support (BFPS) interventions as part of a package of measures aimed to improve breastfeeding outcomes (WHO, 2003). WHO recommends that national governments develop 'community-based mother-to-mother breastfeeding support groups' and 'lay and peer counsellors' to enhance existing services. In the UK, this recommendation is reflected in guidance from the National Institute of Health and Clinical Excellence (NICE), and peer support for breastfeeding is part of NHS commissioning guidance for England (Clinical NNIfHa, 2003). The All-Wales Breastfeeding Plan 2019-2024 also includes a recommendation for each Health Board in Wales to include peer support in its co-ordinated support model, recommending production of local guidance on inclusion of peer support in NHS provision (Welsh Gov. 2019). Implicit in this recommendation is an understanding that breastfeeding is a complex biopsychosocial process and that informal networks are helpful to in enabling skill-learning, problem solving and psychological adjustment, and in supporting decisions to breastfeed practically and socially over time (Trickey, 2018).

Successive infant feeding surveys indicated that overwhelmingly UK mothers stop breastfeeding before they plan to (McAndrew et al., 2012). Stopping breastfeeding in the early weeks is strongly associated with breastfeeding problems, which have a high prevalence. Repeated surveys have indicated that many UK mothers do not experience a supportive postnatal care context for help with infant feeding, particularly breastfeeding (Bhavnani & Newburn, 2010; Plotkin, 2017).

Qualitative studies indicate that BFPS is highly valued by UK women, and that they often credit BFPS with saving their breastfeeding relationships (Thomson et al., 2012; Trickey, 2018). However, in 2014 a survey of provision of BFPS in the UK found that only 56% of NHS trust areas had availability of peer supporters, and that coverage within areas was variable

(Grant et al. 2017). Training, supervision and peer supporter roles varied considerably between areas. BFPS was felt by Infant Feeding leads to be poorly integrated in around a third of areas and financial considerations were perceived to be having a negative impact on provision.

Aims of the research

This study was commissioned by the Breastfeeding Network to understand more about provision of breastfeeding support in England and Wales, including any changes since 2015 and the impacts of those changes on service providers and service users. It also aimed to capture the wider perceptions of service users on accessing peer support services, including experiences and benefits. The research questions were:

1. Describe trends and patterns in commissioned BFPS provision in England and Wales since 2015.
2. Explore the current priorities for provision (mode, timing, training, target population etc.)
3. Explore experiences of provision in three case study areas from the perspective of peer supporters and supported women.

Methods

This study utilised a mixed methods design, incorporating analysis of data obtained through, Freedom of Information requests, survey data collection and analysis and semi-structured qualitative interviews. All data was collected between February 2020 and April 2021.

Freedom of Information requests

A total of 484 Freedom of Information (FOI) requests were submitted in England and Wales, to include: Local Health Boards (Wales); Clinical Commissioning Groups, Unitary Authorities, Borough Councils, County Councils, Metropolitan Districts, Unitary Authorities and London Boroughs (England). The following information was requested:

- Q1) Whether the receiving authority commissioned a breastfeeding support service (including peer support) between the years 2014-2019, with details of budgets per year and numbers of service users accessing per year
- Q2) Where no commissioned service existed, did the receiving authority provide funding for any other provision of breastfeeding support from 2014-2019 by any

other health professionals, including who provided the service, budget per year and numbers of service users accessing per year

- Q3) Where no commissioned service existed, did the receiving authority provide funding for any other provision of breastfeeding support (including peer support) from 2014-2019 by any non-health professionals, including who provided the service, budget per year and numbers of service users accessing per year

Infant Feeding Leads (IFLs) Survey data collection

A survey, which replicated and updated questions from a 2014 survey (Grant et al. 2018) of infant feeding leads (IFLs), was developed for online completion. The IFL survey utilised a combination of closed and open questions to support mapping of current breastfeeding peer support provision across England and Wales and to identify changes in its provision since 2015. The link to this survey was sent by email via the UNICEF UK Baby Friendly Initiative to their mailing list. A direct link to the survey was then also emailed to the National Infant Feeding Network Regional Coordinators for distribution within their areas. The aim was to reach Local Authorities in England (N=151) and Local Health Boards in Wales (N=7).

Qualitative interviews

Semi-structured interviews were conducted with breastfeeding peer supporters and peer support service users from 3 case study regions, 2 in England and 1 in Wales. These regions were selected to represent different contexts of peer support provision, selected to represent areas with varied breastfeeding rates and where services (i) have been cut, (ii) have non-commissioned service provision in operation, and (iii) where provision has been commissioned and remained constant since 2015.

Results

Freedom of information request data

Of 484 FOI requests, 463 responses were received (96%). All 7 Local Health Boards in Wales provided data on Health Board provision of breastfeeding support. 307 responses were

received from authorities in England where the response was a 'No' to all three questions on provision of breastfeeding support or where the response included no information and instead made a direct reference to others service providers that are responsible for breastfeeding support. In England reference was typically made to other service providers, such as 0-19/Healthy Child Programme/Health Visitor services as being the main provider. A much smaller number referred to Family or Children's Centres, while CCG's were most likely to refer on to the Local Public Health team within the Local Authority. Borough Councils typically directed to their County Council who hold the responsibility for public health services.

FOI breastfeeding support information

156 remaining responses provided some data including information about the breastfeeding support services but also other breastfeeding related information and/or other funding such as breastfeeding friendly schemes.

In England, 83 responses included information on the provision of breastfeeding support services in their area. Of the total responses received, 39% London boroughs, 45% Unitary authorities, 69% of metropolitan districts, 52% County councils, 0.5% borough councils, 7% of CCGs, commissioned a service at any point between 2014 and 2019.

Of the total 83 commissioned breastfeeding support service across England, including London borough, Unitary authorities, Metropolitan boroughs, County and Borough councils, 44 were stand-alone breastfeeding/peer support services. Externally commissioned services included delivery through: health teams (midwifery, healthy child programme/health visiting); early years' services (children's and family centres), third sector providers; as well as services reliant on individual staff roles.

A high proportion of responses specifically mentioned voluntary/peer support and for others we extracted this information from the most recent specification attached with the response.

All Wales Health Boards had provided a breastfeeding support service at any point between 2014 and 2019, which was often led by Infant Feeding Coordinators across the health teams and other dedicated breastfeeding roles, 1 including a lactation consultant. 6 of 7 included peer or voluntary support as part of this service with only 1 outlining dedicated annual funding for peer support.

FOI budgetary information

Of the total number that commissioned/provided a breastfeeding support service, 57 provided full budgetary information either for each year of the contract/service covering the requested period 2014-2019 or for each year of the service/contract but that were delivered between these dates, whether they ended before 2019 or started after 2014. 17 provided partial budgetary information on the total years of the service/contract. This equated to 74 total responses. Of these, 16 reported a decrease to budgets over time; 8 reported an increase (often associated with an increased total budget due to greater expectation of overall service provision); 40 reported no change and the remainder reported fluctuation.

Where information on standalone peer support services was reported, budgetary trends were similar compared to all breastfeeding support services. Some stand-alone services have been maintained, a small number reported an increase in funding, but more often a decrease in funding was stated over the years. There was significant regional variation in the amount provided for commissioned services. For example, with the range of figures reported by CCGs, the lowest was £6,500 for a peer support service and the highest was £488,000 for an integrated infant feeding service delivered by Health Visiting.

Partial budget data was typically recorded when a stand-alone breastfeeding (including peer) support services had moved to being part of a Health Visitor service with an overall budget where spending was not reported as a distinct part of this budget. Breastfeeding peer support was reported as not ring-fenced within overall budgets, however some areas reported maintaining the specific breastfeeding support service despite this.

Survey of Infant Feeding Leads (IFLs)

The survey was completed by 65 individual respondents in England and 6 in Wales, with the respondent identifying themselves as being the main person that supports/coordinates Infant Feeding (IF). This represented significant spread and geographical representation. Time in post ranged from 2 months to 20 years, illustrating a broad range of role experience. Full response rates are included in the Report following this Executive Summary but it is notable that the survey experienced relatively high levels of missing data, which is acknowledged in analysis.

In 62 of 65 responses for England, 84% reported a specific job description in place for the IFC role but only 40% (of 63 responses) stated that the IFC role was a full time position, with time spend ranging from only 3 hours per week up to 30. 78% reported additional support for their IFC role, from sources such as midwives, specialist Health Visitors, neonatal nurses, Children Centre IF leads, peer support trainers. 61% of respondents stated that their role had evolved to include more breastfeeding-related responsibilities over time, while 15% reported more responsibility for non-breastfeeding activities, for example where a role had been amalgamated with overall infant feeding public health in the region, meaning a broader remit.

In Wales 50% reported a specific job description in place for the IFC role with only a third stating that the role was full time. Time spent on this role ranged from 2 days per week to full time, and two-thirds indicated that they have additional support, from sources such as community nursery nurses and maternity care assistants. All respondents reported that over time their role had changed to require more responsibilities (Two thirds non-breastfeeding-related such as childhood obesity and one third breastfeeding-related, such as including neonatal standards.

Change in provision since 2015

From 2015 onwards, 40% of respondents in England stated that the level of breastfeeding peer support provision had remained stable, with 23% suggesting a decrease and 27% an increase in commissioned services and remainder did not know. IFCs were asked for further comment on the impact of any change and, of those reporting a decrease, effects included

decommissioning and reduction of services and a reduction in availability of peer support training as well as a reduction in geographic coverage of peer support services. Conversely, where funding increases were reported, IFCs described increased activity of peer supporters, in a few areas translating into increased breastfeeding rates with one increased rates at 6 weeks.

In Wales, the profile of peer support provision had changed significantly since 2015, with 50% reporting that there had been a commissioned/funded peer support service prior to 2015 and none reporting that at present. All reported that peer support services were now provided by volunteers in their area, observing that the changes meant less support for peer supporters and reduced availability of peer support for local families. 40% of respondents reported a decrease in the number of peer support groups running in their area now, with 20% stating an increase and 40% no change. In a majority of cases groups were now delivered by midwives and health visitors rather than specific peer supporters.

Access to breastfeeding support

In terms of access to – and level of – support available, the vast majority of peer support in England is provided in group-based community settings (87%). Less than half of services report proactively contacting women in the post-birth period or providing any form of one to one telephone peer support, with some citing differences in access across their area, such as universal versus targeted or paid versus voluntary services. 40% of respondents stated that the peer support service accepts referrals from other services, with some indication of concerns over data sharing regulations as a barrier to more widespread practice.

In non-commissioned areas of both England and Wales, there was a high percentage that stated health teams signpost parents to access peer support, however both nations also stated that there is poor integration between peer support and other health teams. The location of support provision also varied in Wales with peer supporters more likely to operate in postnatal wards than community settings, reflecting the increased level of community-based provision by other health professionals, such as midwives.

When considering the reach of peer support services, only 13% agreed or strongly agreed that services target areas with low breastfeeding rates, with 50% disagreeing with this statement. The challenge of engaging service users in areas with lowest breastfeeding rates

was acknowledged in free text responses including the importance of a paid element of the service to increase reach and the observation that groups are still heavily attended by, and seen as being for those who are white and middle class. However, a higher number (43%) agreed that peer support is effective in reaching those who most need help. In Wales, where 33% of respondents stated that services target areas with low breastfeeding rates, with 33% disagreeing with this. Stated barriers to reach in both nations included lack of penetration in areas with high ethnic diversity, absence of suitable venues and dependence on volunteers, who may deliver only in the area they live in.

Valuing Peer Support

Almost all IFLs in England and Wales agreed or strongly agreed that health professionals valued peer support, despite the broad range of levels of provision across different areas suggesting that 'peer support' varies widely. In both areas with a commissioned peer support service and those without, 90% felt that peer support complements the work of health professionals in their breastfeeding support role. Almost half in England stated that health professionals felt confident about referring into peer support services for more challenging issues.

The stated benefits of peer support were echoed in England and Wales and included a range of outcomes beyond increases in breastfeeding rates, including normalising breastfeeding in public and challenging community-level attitudes, providing emotional as well as practical support and being a valued form of social engagement. This was reflected in the 'any other comments' free text, where some took the opportunity to describe their desire to commission more peer support but a lack of budget to do so, with this lack of investment seen as reflecting the limited value placed on peer support. Of those from areas in England with no commissioned peer support service, 91% reported that they would like more provision. Some feared further cuts to funding in light of the impacts of Covid-19, despite widespread awareness of the value mothers placed on the support received. Two-thirds of respondents in Wales stated that they would like more peer support provision in their area, with comments suggesting that this should be prioritised in the Welsh Government All-Wales Breastfeeding Action Plan, with the feeling that little progress had been made.

Interviews with key stakeholders

Interviews were conducted with both peer supporters and service users, to discuss issues such as: expectations of peer support; journey into peer support services; experience of delivering/receiving the service and barriers to provision.

Expectations of peer support

Both peer supporters and service users were asked to reflect on what they felt peer support was or should be, with response often similar across both participant groups and across regions. This generally emphasised the underlying values of the service, including being trustworthy, non-judgemental and supportive. Several peer supporters cited the importance of a service that was not driven by health professionals and others with a professional interest, in encouraging mothers to behave in certain ways. This was seen as essential in a space where women feel not listened to and overwhelmed by professional advice, with 'empowerment' frequently cited as a key benefit for service users.

Many service users reported seeking out peer support services as a result of emergent difficulties with breastfeeding and, for some, receiving what they felt to be inconsistent or inadequate advice from health professionals on how to resolve the issues they were facing. There was inconsistency both within and between areas on experiences of being signposted to peer support by health professionals, with some reporting that their midwives had made them aware of the service and was well-informed about it, while others had less satisfactory experiences. This included those who had sought additional advice on breastfeeding from midwives or other health professionals but where issues had not been resolved.

Being a peer supporter

Peer supporters cited increased enthusiasm for breastfeeding promotion as a result of attending training, with increased motivation to help others have more positive experiences. Many reported an increase in personal self-esteem and confidence as a result of gaining the qualification, as well as gaining skills to support and actively listen to the experiences of others. When reflecting on the experience of running groups post-training, many suggested that low attendance at groups was initially de-motivating and a challenge for newly-qualified peer supporters. Attendance was attributed to many factors, including

accessibility of venues and promotion of groups by health professionals. Where groups had been able to be delivered consistently in the same venues and at the same times, attendance appeared to have remained more stable, suggesting that enforced changes to service delivery may be damaging for access and for building the reputation of a service. It was widely perceived that overall awareness of peer support among the public was low due to lack of consistent promotion and awareness raising. This was associated with underfunding and with changes to service providers over time and, for some, was illustrative of the generally undervalued nature of the service within the wider healthcare system, despite the value placed on it by those accessing it.

Receiving peer support

Ahead of attending a peer support group for the first time, most interviews suggested that they didn't know what to expect and therefore had limited expectations of what it would be like and how it could help. It was noted by many that one of the biggest challenges they faced in engaging with peer support was the act of walking in the room in the first place, particularly if they hadn't previously known anyone who had attended a group and advised them on what to expect. Some observed that not everyone will have the confidence to take this step, particularly if they have been confronted with competing messages or not encountered situations where breastfeeding is normalised. This was often located in wider familial and local cultures of breastfeeding – if you hadn't observed it being done in your area or your network of family and friends, you may be carrying our own 'hang ups' about it before attending a group. A majority of interviews felt that they had gained positive benefits from attending peer support groups. This frequently included the opportunity to get out of the house at a time when isolation is a significant challenge, as well as the social support and opportunity to chat with others in a similar position. Being able to access a wider range of practical advice was also identified as reassuring, whether this was accessed more or less regularly, with simply knowing it was there seen as a positive.

Across all areas, it was noted that there was an issue of whether those involved in both providing peer support and accessing as service users, were representative of diverse populations of women who may find the service most beneficial. In terms of equity of service provision, it was often lower in areas with lower breastfeeding rates, with a cycle of

absence of perceived demand feeding absence of provision and suggesting that services may not be accessible to those most at need. However, the issue of who may 'need' the service the most was considered to be complex, with those more affluent and with higher educational attainment still needing the service and benefitting significantly from it. However, the absence of diversity, including among peer supporters, was acknowledged as perhaps acting as a barrier for women from other ethnic groups in attending.

Accessing services

Participants were asked to consider barriers that may prevent new parents accessing breastfeeding peer support services. Many of the identified barriers were practical in nature, with lack of accessible locations, absence of good public transport and absence of weekend delivery of peer support particularly important. Others cited systemic problems in the support provided to new mothers, including absence of signposting to peer support from hospital and GP services, some of whom were themselves unfamiliar with the services available or provided inaccurate information on what the service could offer. Further, the timing of promotion of peer support services could be problematic, constituting yet another leaflet provided to new mothers at a time when they are perhaps being overwhelmed by information and unlikely to refer back to the numerous leaflets provided in the initial post-birth period. An absence of information in languages other than English was identified as a barrier to access to parents from other ethnic groups, as was the absence of diversity currently evident both among peer supporters and group attendees.

Suggestions were also made for selection of venues conducive to practicalities of accessing the venue and accommodating other young children, as well as being able to provide a relatively private space not disrupted by other activities that may be occurring at the venue. It was seen as essential that services continue to be freely provided to encourage a broad range of women to go.

Impacts of changes to service provision over time

Some differences were identifiable between peer supporters in areas with recent reductions in funding or with non-commissioned services, and those areas that had maintained/increased funding in recent years. In the latter, it was observed that more peer

supporters were paid for running services, with different types of hospital and community support on offer such as home visits while the former areas suggested greater reliance on volunteers and community groups. Those who were volunteering reported more barriers to service delivery, including issues with arranging childcare for their own children, as well as having to travel further to find volunteering opportunities.

Interviewees in Wales had undertaken peer support training from the third sector, some still receiving third sector support to continue their support work through their registration with them, such as through ongoing supervision. However, in particular they cited lack of statutory funding as a barrier to running groups, with limited funds to secure appropriate venues in areas accessible for transport and parking. This was felt to have impacted on attendance, with numbers increasing when accessible venues were secured and decreasing where changes to less accessible venues had been forced on the service by lack of funds. Notably, service users in Wales, where services are non-commissioned and often provided by volunteers, frequently stated that a genuine statement of the value of the peer support groups to health services would be for the providers to be funded, which would add stability and consistency of delivery. Despite these barriers, it was observed that peer support provision had actually improved in recent years in one area, which was attributed primarily to having an Infant Feeding Coordinator who was more supportive of the service and more likely to act as a champion for continuance.

In areas of England where funding had been reduced in recent years, those involved with services over this period of time cited issues attributed to these changes, including reductions in the level of support peer supporters received and with suggestions that peer support had become a skeleton service in recent years. For some, this was associated with the move in responsibility for service delivery from third-sector bodies to local health visiting teams. This move had been followed by a reduction in partnership working and access to supervision, as well as cuts to peer supporter training availability. It was also noted that there was no evidence to suggest that demand for services had changed even though provision had decreased, creating a gap in provision and 'letting down' new mothers.

Key findings and recommendations:

Ring-fenced or allocated funding for peer support was difficult to assess due to reporting, whereby budgets are sometimes contained within other spending, such as a total 0-19 services funding allocation. However, data from the IFC survey shows a pattern of decreased funding for commissioned peer support services, with impacts on levels of service provision. Notably in Wales, no commissioned/funded peer support services now exist. Although breastfeeding support is still being provided, including by health visitors and midwives, the peer to peer benefits cited by service users, along with the advantages of community-based delivery close to where people live, risk being lost in Wales. The perception of peer support as an undervalued service is likely to persist unless a clear funding pathway, with dedicated allocation of spending, is identified. This should include resourcing for training, supervision and, in Wales, support for volunteers.

This study highlights barriers to equity of access to peer support, including lack of different types of support, a reliance on community groups with issues around consistent access to suitable locations for group sessions as well as limited weekend and evening provision. Consideration should be given to practical issues of access when selecting settings for group session, as well as – where possible – maintaining services in the same settings to increase community familiarity with the service. Increasing diversity among peer supporters would also aid in challenging the view that the service is more suited for some women than others. Consultation with existing community groups on how to increase recruitment, as well as funding for proactive peer support work and peer supporter training in accessible, community-based locations would contribute to this.

Consideration should be given to how the peer support service can be consistently promoted to new parents, including the timing and location of this promotion to avoid being lost in an overwhelming amount of information. Increasing awareness of what peer support can offer among health professionals and publicising referral pathways into peer support services would also aid in increasing access for those who would benefit.

Infant Feeding Coordinators, service users and peer supporters all acknowledged the importance of the peer support service and report valuing its role in providing both social value and direct breastfeeding support to women and also in the wider normalisation of breastfeeding, which is seen as particularly valuable in areas with low breastfeeding rates. However, this is not reflected in the perceived value of peer support at policy and strategic levels. Peer support should be integrated into an overall strategic approach to improving breastfeeding experiences, with clear policy commitment to increasing both provision of, and access to, support within relevant breastfeeding strategies.

Key findings:

- There is a pattern of decreased funding since 2015 across England and loss of commissioned/funded peer support services across Wales
- Peer support is seen as part of an overall strategic approach to improving breastfeeding experiences, including addressing norms and low breastfeeding rates in some areas
- However, the perception of peer support as an undervalued service is likely to persist unless a clear funding pathway, with dedicated allocation of spending, is identified

Recommendations:

- Provide ring-fenced, allocated funding for peer support when part of a wider contract such as 0-19 services
- Commission services to address equity of access to peer support and to stabilise current peer support
- Reduce reliance on volunteer-led community groups in unfunded areas to address practical barriers to access
- Diversify recruitment of peer supporters
- Better integrate peer support with local health teams, increasing awareness of what peer support can offer among health professionals

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