
A report by the Regional Public Health Group for London, Department of Health.

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What is this report about?

This report provides evidence of the value of breastfeeding peer support (BfPS) services and provides an overview of BfPS services operating in some of London’s boroughs. It is a snapshot of different organisational models in use across the capital and highlights some of the main issues of the different models.

Commissioners of BfPS make funding decisions based on a range of criteria including which services are most effective, offer best value for money and provide added value, for example, increased social capital.

This report will give commissioners of maternity and children’s services, and public health commissioners, an understanding of types of different organisational models of breastfeeding peer support in London. This will help to inform decision-making when commissioning breastfeeding services.

Throughout the text, you will see quotes from mothers of new babies in London and from infant feeding coordinators in the capital. The quotes give more context and an insight into the thoughts and feelings of people with experience of, and who are closely involved with services.

Case studies are also included (appendix 2) to give an in-depth picture of some breastfeeding support services in London. The case studies also provide contact details of people running BfPS services in London who are happy to share their experiences and answer queries on BfPS.

Key points:

Throughout the report, these boxes highlight the key messages from each following section. Each section will then expand on the key points and the issues around them. These boxes will help commissioners quickly find key information.
Why commission breastfeeding peer support in London?

There are many good reasons to commission breastfeeding peer support (BfPS) services and few reasons not to:

- Properly commissioned and adequately funded breastfeeding peer support (BfPS) services are effective and are relatively low cost for the benefits they can achieve.

- Properly commissioned and adequately funded BfPS services can have far reaching benefits. Not just for the health and wellbeing of the mother and baby, but also in increased social capital in some of the poorest areas of London.

Commissioning guidance

There are helpful tools and guidance available for commissioners of breastfeeding services.

Breastfeeding peer-support programmes should be commissioned only as part of a breastfeeding strategy and commissioners should be aware of all the recommendations about breastfeeding including:

- NICE public health guidance PH11. Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households


There is also helpful NICE guidance specifically on commissioning breastfeeding peer support services:

- A guide for commissioning peer-support programme for women who breastfeed: [http://www.nice.org.uk/media/63D/7B/BreastfeedingCommissioningGuide.pdf](http://www.nice.org.uk/media/63D/7B/BreastfeedingCommissioningGuide.pdf)

See appendix 1 for an extract from the NICE guidelines on commissioning breastfeeding peer support.
Executive summary

The following is a summary of the main findings from the study:

- Breastfeeding peer support (BfPS) offers an effective, evidence based method of increasing rates of breastfeeding.

- Where it has been evaluated, BfPS has clear, identifiable benefits; it is valued by new mothers, increases breastfeeding initiation and continuation rates and increases social capital.

- The rate of new mothers in London who start breastfeeding their baby is relatively high. However, a significant proportion stop breastfeeding by 6-8 weeks. Supporting mothers to continue to breastfeed, rather than focussing on increasing initiation may have a greater impact on increasing overall breastfeeding rates. Peer supporters can provide a valuable role helping mothers to continue to breastfeed.

- Different models of BfPS operate across a number of London boroughs. Breastfeeding peer support schemes vary widely across London from low cost, small reach services to fully funded, full coverage services.

- The future of many BfPS services is under threat in the current economic climate. Value for money is therefore a key issue when determining which services should continue and which should not. Breastfeeding peer support can offer low cost, effective services to women who are most in need of support.

- Peer support can succeed in reaching women who do not easily identify with health professionals.

- There are many benefits for peer supporters as well as for the mothers and babies they support. Peer supporters grow in confidence, often going on to further training and new careers, including midwifery. This can help to increase social capital with women bringing new skills back to their communities.

- It is clear from the information gathered for this report that support for BfPS is crucial at a senior level within an organisation for it to operate effectively. If there is support at a senior level, it is likely to be well resourced, well managed and is likely to continue, as the benefits and value for money are recognised and championed.
• Almost all feedback regarding BfPS is positive – any negative feedback, of which there was very little, related to poor infrastructure and organisation of services in boroughs without senior support or dedicated funding and staff for the service.

• Where there are no champions of BfPS at a senior level, services are more likely to be ad-hoc, have poor peer supporter retention rates, be poorly managed and rely on the goodwill of health professionals to operate. These services are vulnerable in a difficult economic climate as they are not valued by senior executives, despite being highly valued by users. Senior buy-in for BfPS therefore is a strong indicator of the success and sustainability of the service.

• Among health professionals involved with BfPS across London, there is enthusiasm and good will. Many health professionals are committed to their service and are rightly proud of the achievements of their services and of the peer supporters in their teams.

• Some health professionals work over and beyond what they are contracted to do to ensure BfPS services continue to operate. There is also frustration however, where health professionals can see the benefit of BfPS, yet have little senior support, and have to operate on an ad-hoc basis with intermittent funding. Some health professionals spend a lot of time on admin work to try to secure funding.

• Evaluation of services is important for sustainability. There is a need to show that services are operating effectively to justify costs. Again, well funded services with senior buy-in are more likely to be evaluated as they have the resources, will, and infrastructure to conduct evaluations. Consequently, being able to provide evidence of the benefit of services is more likely to result in the continuation of a service.

• In boroughs where there is no peer support, breastfeeding support may still be in operation and be highly effective. The Redbridge case study included in this report clearly demonstrates this. What is clear from the Redbridge case study is support at a senior level and dedicated funding, staff and resources make it work. Redbridge are also considering using voluntary peer supporters in addition to the current service.

• Breastfeeding peer support should be multifaceted, should be commissioned in line with the NICE guidelines (appendix 1) and complement the Unicef Baby Friendly Initiative (BFI).

• BfPS is not an alternative to health professional support, but a valuable part of a breastfeeding support service. Breastfeeding support should be an integrated approach involving both health professionals and peer supporters for optimum outcomes. BfPS therefore should be an integral addition to, and not instead of, health professional support.
The findings of this report suggest that the success of a breastfeeding peer support service is dependent on:

1. Senior support within organisations
2. Active support and management from health professionals and paid administration staff
3. Active recruitment, training, support and retention of peer supporters

This study shows that the most successful peer support services have buy-in at a senior level within maternity and health visiting professions, maternity services and PCTs. **This is probably the key element in ensuring the success and sustainability of peer support programmes.**

Without senior support, items two and three above are unlikely as health professionals need senior support to free up time and resources to enable them to actively support and manage programmes.

Without active management and support from health professionals and paid administration, effective recruitment, training, support and retention of peer supporters is unlikely.
Methods – how the information for this report was collected

**Key points:**

- 25 London Infant Feeding Network members completed questionnaires.
- A sample of ten London boroughs were studied in detail.
- The sample was chosen to reflect the range and breadth of services operating in London.

Twenty-five members of the London Infant Feeding Network (LIFN) completed a basic questionnaire to determine what, if any, breastfeeding peer support (BfPS) services operate in their borough.

Most of those completing the questionnaire were infant feeding coordinators.

Infant feeding coordinators are paid professionals who set up and manage or oversee breastfeeding peer support services. Most infant feeding coordinators are health professionals, either midwives or health visitors. Coordinators who are not health professionals work closely with health professionals and jointly on many aspects of the work.

A sample of ten infant feeding coordinators with active BfPS services in London took part in telephone interviews and gave detailed information about their services. It is the content from these interviews, plus further follow up where required, which provided more in-depth information of ten peer support programmes in different London boroughs. The ten boroughs studied are good examples of the range and breadth of services operating in London.

There are many examples of BfPS good practice in London. Non-inclusion in this report is not an indication of the quality of breastfeeding support in a borough. The ten boroughs were chosen to reflect the range and breadth of models in use. The choice of boroughs does not in any way reflect any value judgements about the services included or not included in the study.

The Regional Public Health Group for London (RPHG-L) at the Department of Health would like to thank everyone who contributed to this report by providing information and participating in telephone interviews. Particular thanks also go to the infant feeding coordinators who provided the case studies and commented on various drafts of this report.
Breastfeeding statistics

**Key points:**

- England has one of the lowest breastfeeding rates in Europe
- 40% of London babies are not breastfed by 6-8 weeks. More than a quarter of these babies will have been breastfed at birth.
- Supporting women to continue breastfeeding is more likely to be effective than encouraging women to initiate breastfeeding.
- Peer supporters are effective in helping women to continue breastfeeding and efforts should focus on using peer supporters to prevent drop-off rates. This will have greater impact than efforts to improve initiation rates.

England has one of the lowest breastfeeding rates in Europe with the current prevalence of breastfeeding at 6-8 weeks around 46%. Initiation rates – women starting breastfeeding – are relatively high in London at around 85% compared to the rest of England where initiation rates are around 74%.

Continuation of breastfeeding levels in London and the rest of the country however drop considerably within the first 6-8 weeks. Continuation rates in London at 6-8 weeks are still higher than the rest of the country with the drop off rate at around 26% compared to a national drop off rate of around 36%\(^1\). London doing so well is good news, but should not lead to complacency. The above figures show that around 40% of London babies are not being breastfed by 6-8 weeks, leaving potential big gains for increasing breastfeeding in the capital.

In light of such high initiation rates in London, and high drop off rates, efforts should focus on supporting breastfeeding mothers to maintain breastfeeding.

As well as any breastfeeding, whereby the baby may be fed both breast and formula milk, there is also the issue of exclusive breastfeeding. Evidence shows\(^2\) that exclusive breastfeeding for the first 6 months, where the baby is fed

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2. Cochrane Database Syst Rev. 2002;(1):CD003517. Kramer MS, Kakuma R. Optimal duration of exclusive breastfeeding, McGill University, Faculty of Medicine, 1020 Pine Avenue West, Montreal, Quebec, Canada, H3A 1A2. mikek@epid.lan.mcgill.ca
only breast milk, and then continued breastfeeding along with solid foods thereafter, results in the greatest health benefits for both baby and mothers, but is less likely to be maintained. For example, the overall rate for any breastfeeding at 6-8 weeks in London is almost 65%. However, the exclusive breastfeeding rate is around 38% (also reference 2 on previous page). This means that a significant percentage of the benefits of breastfeeding are diluted through mixed feeding.

A number of factors including social and familial norms can affect initiation of breastfeeding. For example, a mother who was bottle fed herself, and whose mother was also bottle fed may be less likely to breastfeed as this would not be considered the norm in her environment. To go against these cultural norms would take significant attitude and behavioural changes.

Less of a challenge would be to support women who begin breastfeeding to continue to do so, potentially increasing breastfeeding rates at 6-8 weeks by around one quarter of London mothers who currently do so.

Peer support can be effective in initiating breastfeeding, but focussing on peer support for women to continue breastfeeding may be more effective and have a greater impact on increasing overall breastfeeding rates.

As more women succeed at initiating and maintaining effective breastfeeding, this will provide more positive role models within the community and also help to promote more positive attitudes to breastfeeding. This may help to increase the proportion of women initiating breastfeeding.

‘Peer support has given me hope that I will be able to breastfeed my baby and kept me going when I have felt like giving up’ – London mother.
Government policy on breastfeeding

Breastfeeding delivers significant health benefits for the mother and her baby. The Public Health White Paper - Healthy Lives, Healthy People: Our strategy for public health in England - sets out the Government’s long-term vision for the future of public health in England. The government recognises in the White Paper that one of the opportunities to reduce infant mortality is by increasing breastfeeding rates.\(^3\)

The Department of Health is committed to supporting breastfeeding through the Healthy Child Programme. The Healthy Child Programme, Pregnancy and the First Five Years of Life\(^4\) is the evidence-based prevention and early intervention programme to promote optimal health and wellbeing and reduce health inequalities. Peer support for breastfeeding features in this document from helping to support delivery of public service agreement (PSA) indicators for breastfeeding through to preparation for parenthood.

The Department of Health, as part of the Change4Life programme, has published a leaflet ‘Off to the best start: Important information about feeding your baby’.\(^5\) The leaflet is full of helpful information for mothers about breastfeeding including the benefits of breastfeeding and gives tips on how to breastfeed. It also advocates speaking to a midwife, health visitor or peer supporter if more help is needed.

The Department of Health’s Public Health Outcomes Framework\(^6\) published in January 2012 includes the breastfeeding indicator "Breastfeeding initiation and prevalence of breastfeeding at 6-8 weeks after birth" as one of the indicators for health improvement. The objective for this domain being that people are helped to live healthy lifestyles, make healthy choices and reduce health inequalities.

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Why support breastfeeding?

**Key points:**

- The case for investing in services to support breastfeeding, as part of a local child health strategy that will reduce health inequalities is well documented, evidence based and compelling. Breastfeeding:
  - saves lives
  - protects the health of babies and mothers
  - increases children’s future life chances.

- This is particularly important for mothers from low-income groups who are less likely to breastfeed.

- Breastfeeding services are a cost-effective intervention, contributing to savings from reduced hospital admissions.

The case for investing in services to support breastfeeding, as part of a local child health strategy that will reduce health inequalities is well documented, evidence based and compelling:

- breastfeeding saves lives
- breastfeeding protects the health of babies and mothers
- breastfeeding increases children’s future life chances.

This is particularly important for mothers from low-income groups, as it is known that they are less likely to breastfeed. Breastfeeding protects the health of babies and mothers, and reduces the risk of illness.7

Breast milk is the best form of nutrition for infants, and exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant’s life. Thereafter, breastfeeding should continue for as long as the mother and baby wish, while gradually introducing the baby to a more varied diet.

In recent years, research has shown that infants who are not breastfed are more likely to have infections in the short-term such as gastroenteritis, respiratory and ear infections, and particularly infections requiring hospitalisation. In the longer term, evidence suggests that infants who are not breastfed are more likely to become obese in later childhood, to develop type 2 diabetes, and to have slightly higher levels of blood pressure and blood cholesterol in adolescence and adulthood. For mothers, breastfeeding is

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associated with a reduction in the risk of breast and ovarian cancers, and lower risk of obesity, type 2 diabetes and other chronic health problems.

A recent study also suggests a positive association between breastfeeding and parenting capability, particularly among single and low-income mothers with the positive impact continuing when their children were five years of age. Not breastfeeding seemed to have particularly negative consequences for the parenting behaviours of single and lower income mothers.  

Breastfeeding services are a cost-effective intervention, contributing to savings from reduced hospital admissions from, for example, gastrointestinal and respiratory infections. Breastfed babies have 15% fewer GP consultations than babies fed formula milk during their first six months of life.

Commissioning services that provide sustainable, high quality, universal support and targeted support for mothers who are least likely to breastfeed and who are at risk of poor health outcomes, is central to delivering better long-term outcomes for local children and have a positive impact on reducing health inequalities.

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What is breastfeeding peer support (BfPS)?

**Key points:**

- Breastfeeding peer supporters offer support to other women who wish to breastfeed.

- The peer supporter is not a healthcare professional and is not intended to replace health professionals but to support and complement professional roles, referring appropriately if concerns are identified.

- Peer support can succeed in reaching women who do not easily identify with health professionals.

Peer support is effective in facilitating successful breastfeeding.\(^{11}\)

Breastfeeding peer supporters offer support to other women who wish to breastfeed. The intention is that women receive support from ‘someone like themselves’. The peer supporter is not a healthcare professional and should not replace health professionals, but support and complement professional roles, referring appropriately if there are concerns.

Breastfeeding peer support should be multifaceted and should not replace the Unicef Baby Friendly Initiative (BFI)\(^{12}\) but complement and support it.

*The peer supporters have been able to answer all of my queries, provide encouragement and support without making any judgment. They also offer suggestions and advice without being prescriptive or using the word ‘should’ which I have experienced a lot amongst health professionals as a new mother.‘*  
– London mother

A breastfeeding peer supporter is usually a woman who has breastfed her own children, has undergone some training in breastfeeding support, and is available from the local community to support a breastfeeding mother, usually on a voluntary basis. Having breastfed is not a mandatory requirement, but most peer supporters have breastfed their own children.

Peer support can address the needs of mothers in communities with very low breastfeeding rates, with little tradition of breastfeeding for new mothers\(^{13}\) to

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\(^{13}\) The term new mother/s in this report refers to women with newborn babies, not first time mothers, although new mothers may well also be first time mothers.
draw on. In such areas, social networks that promote breastfeeding are often lacking, resulting in women having little experience of breastfeeding as an everyday activity and a learned practical skill. It can be difficult for women to breastfeed if they rarely see other women breastfeeding, and if formula feeding is normal practice among their friends and family.

**Peer support can succeed in reaching women who do not easily identify with health professionals.**

A predominantly bottle-feeding culture has led to barriers to breastfeeding including lack of support, social embarrassment, and negative social attitudes towards breastfeeding in public. This is compounded by a lack of designated facilities.

Peer support also reduces social isolation, and offers women an opportunity to socialise and exchange experiences. Sharing experiences encourages mothers to breastfeed in a community with few informal support networks.

Thus, peer supporters can overcome such obstacles by:

- forming relationships with pregnant or breastfeeding women
- sharing experiences and information
- being a role model
- giving time or being available
- normalising breastfeeding
- providing social support
- providing breastfeeding expertise

‘The drop-in groups are brilliant for meeting other mothers who can also give you support and advice’ – London Mother

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14 Health Promotion Agency for Northern Ireland, *Peer support as an intervention to increase the incidence and duration of breastfeeding in Northern Ireland: what is the evidence?* December 2004.
Benefits of peer support for breastfeeding

**Key points:**

- The benefits of breastfeeding peer support is recognised by NICE guidance.
- The health and social benefits of breastfeeding are clearly documented in the extract from the NICE guidelines (see appendix 1)

‘The peer supporter got me through a very hard time. It was encouraging and comforting to be able to talk through some of the difficulties and dilemmas of having a tiny baby.

Now the group is my anchor. It's really nice and empowering to have a place to go and talk to people who understand what I'm going through and give me the space and time to think things through without forcing their opinions on me.

Without their support I would have felt very lost and low at times, and would possibly have made choices that would not have been good for me, my baby or my family.’ – London mother

The benefits of breastfeeding peer support are recognised and well documented in the National Institute for Health and Clinical Excellence (NICE) guide for commissioning a peer support programme for women who breastfeed\(^\text{15}\).

Further details and an extract of the NICE guidelines are included as an appendix (appendix 1) at the end of this report.

The guidelines can be downloaded from:
www.nice.org.uk/usingguidance/commissioningguides/breastfeed/commissioning.jsp

\(^{15}\) Nice commissioning guide – commissioning a peer-support programme for women who breastfeed www.nice.org.uk/usingguidance/commissioningguides/breastfeed/commissioning.jsp
Breastfeeding peer support in London

Key points:

- BFPS models in London vary widely depending on available funding and resources
- This report is a snapshot of BFPS services in London to help commissioners have a better understanding of BFPS, of models adopted in London and advantages/disadvantages of these models.
- Case studies highlight what is achievable with different levels of funding and will help commissioners to understand and make decisions about BFPS. (Appendix 2).

Breastfeeding peer support (BFPS) in London comes in a variety of models with a range of associated costs and benefits. There is no ‘one way’ to provide peer support and the various models in use in London each have their own merits.

This report is not a definitive analysis of the range of breastfeeding support services in London, but intended as a guide to the types of services available. It will help commissioners of maternity services have a better understanding of BFPS, of some of the models currently adopted in London and some of the advantages and disadvantages of these models.

Three case studies (Camden, Hillingdon and Islington) are included (appendix 2) as examples of good practice of BFPS. They provide in-depth information and points of contact to help commissioners to further understand and make decisions about BFPS.

The case studies give a more detailed overview of types of peer support and describe some of the issues and challenges of implementing BFPS services. They represent three different models of BFPS services, particularly with regard to size and cost. The case studies highlight what is achievable with fully resourced, moderately resourced and more modestly funded services.

The fourth case study (Redbridge) included is an example of good practice of breastfeeding support not using peer supporters. It is included for contrast, and to show that good quality breastfeeding support also exists in boroughs without peer supporters. The service in Redbridge is substantial as it stands as the infant feeding advisors are in effect paid peer supporters. They are peers from a range of ethnic backgrounds relevant to the demographics of the borough with no formal health professional training other than breastfeeding training. Redbridge may enhance the service with additional voluntary peer supporters now that the baseline service is in place - this will enhance the development of the peer support service.
Models of BfPS in London

**Key points:**

- There are a number of models of BfPS
- Senior level buy-in largely dictates the type, level and success of the service especially regarding funding
- Untargeted programmes are available to all
- Targeted programmes target those in most need of support such as young single mothers and areas of deprivation. They usually cost less than programmes open to all.

All London boroughs provide some level of breastfeeding support for new mothers. This is usually through the midwifery and health visiting service. The level and type of support varies. Not all London boroughs use peer supporters. This report will focus on ten boroughs that do. These are not the only boroughs in London providing peer support, but they are a good overview of the types of services available in the capital.

BfPS in London consists of different models; some have been in place for some time and are well established, some are undergoing considerable change to provide a more effective service, others are introducing new services and are at a pilot stage, while some services are under threat of closure.

Some boroughs provide BfPS services that have ring fenced funding, have buy-in at a senior level within the borough, and have dedicated staff, both health professional and administrative to coordinate services.

Some boroughs provide less structured, piecemeal services, often with little funding and without dedicated staff to run them. These services often lack buy-in at a senior level, which contributes to funding difficulties and issues around future sustainability of the service. It also effects the success of the programme.

**Targeted and untargeted services**

BfPS services are generally available to all new mums in a borough, although some services only target specific populations. Targeted services usually target new mothers in hard to reach groups such as very young mothers, mothers from minority ethnic groups, mothers in deprived areas, and areas where breastfeeding is generally lower. Targeted services aim to reach those in most need of support.
Targeted services can be highly effective and generally cost less than non-targeted services.

Although boroughs offering only targeted services are theoretically open to all new mothers, it is unlikely that mothers outside the targeted groups will attend, as the services are not borough wide and therefore not local to all.

Borough wide fully coordinated non-targeted services have the benefit of being locally available to all new mothers and provide opportunities for mothers and children across the social spectrum to interact. Non-targeted services also provide a more democratised service in that it is available to all.

There are cost implications to offering targeted and untargeted services. Untargeted borough wide services will usually cost more as they provide a large, fully inclusive service needing greater coordination, organisation and staffing.

In an ideal world, breastfeeding peer support would be available to all new mothers in a borough. Limited funding however usually means this level of cover is not possible everywhere. Islington is one of the boroughs with senior support at both PCT and local authority level and are able to offer this full coverage to all new mothers. Full details of the Islington BfPS service are available in the case study included at the end of this report (appendix 2).
Access to BfPS services

Key points:

- The way a service is marketed can be critical to its success.
- There are different access routes to services including:
  - Antenatal clinics
  - Post natal wards
  - Telephone after discharge/24 hr help lines
  - Children's centres etc
- Access reflects type of service available
  - Active = more funding/better resourced/senior buy-in
  - Passive/opt in = low funding/resources/ little senior buy-in
- Coverage levels usually reflect funding levels. More funding = more mothers using the service.

New mothers find out about and access BfPS through different routes; from direct contact made to all new mums to leaflets included in antenatal and postnatal information packs.

Health professionals may not always understand the importance of marketing their services and keeping their publicity materials up to date. The way a service is marketed to mothers can be critical to its success.

The way new mothers find out about BfPS services often reflects the type of service available within a borough. For example, in one borough with little senior support, there is no funding to print new leaflets about the service, therefore old leaflets are photocopied and included in new mothers’ information packs. Contrast this to services with higher levels of support and/or funding where personal contact is made with every new mother after delivery about BfPS services in her borough.

First contact with a peer supporter can take place on the postnatal ward following delivery, in the home after discharge, or by telephone and is available in a range of community locations including children’s centres, baby cafés, mother and baby groups, libraries and community centres. Twenty four hour telephone help lines, staffed by peer supporters, are also available in some boroughs to provide local 24/7 cover.

‘The peer support was a great help because in the hospital, the midwife did not have enough time to explain breastfeeding to me.’ – London mother

There is also support available via a telephone helpline manned by volunteers from the Breastfeeding Network and Association of Breastfeeding Mothers.
Available everyday from 9:30am – 9:30pm, the National Breastfeeding Helpline is funded by the Department of Health, provides one to one telephone support and information about local support services, and can refer women to these services. (Tel: 0300 100 0212 or www.nationalbreastfeedinghelpline.org.uk).

Most commonly, new mothers access BfPS services at children’s centres in targeted areas across London boroughs.

BfPS is open to all women where the service is available within the limitations described previously - targeted or untargeted - but the means by which women access the service varies.

Some boroughs adopt a pro-active approach whereby a member of the BfPS team contacts all women after delivery. This may be face to face on antenatal wards or by telephone after discharge or after a home delivery.

Some boroughs use a more targeted pro-active approach whereby only women with greater need ie those less likely to initiate or continue breastfeeding, for example, young single mothers and women living in deprived areas contacted directly.

‘We should be taking the service to mothers especially those who do not access services & have the lowest breastfeeding rates.’– London infant feeding coordinator.

Other boroughs operate on a more passive, opt-in basis whereby mothers are not contacted, but are able to attend group sessions where available, usually in children’s centres or similar. How this service is marketed and promoted varies including leaflets in antenatal packs and posters in doctor’s surgeries and Children’s Centres.

A midwife or health visitor often refers mothers to a BfPS service if they experience breastfeeding problems.

The proportion of new mothers who have contact with a peer supporter will depend on the range and extent of the service provided by a borough, ranging from direct contact of all new mothers, to limited contact of those most in need.

‘What works is a service that provides support from pregnancy and for as long as the mum is breastfeeding - with a combination of one to ones, clinics, classes, ward work, home visits, groups. It’s really important to see mothers in the hospital and contact them soon after discharge.’– London infant feeding coordinator.
Coverage
Newly delivered mothers receiving breastfeeding support from a peer supporter varies from less than 5% to around 52% (97% in targeted areas)\(^{16}\) of all births within a borough. Most of the boroughs that provided information for this report have a small reach of 5% or less.

The generally small levels of reach of the service usually reflect funding availability. Most boroughs would like to be able to offer more help to new mothers who need support. If they had more funding and resources, they would adopt a more pro-active approach to contacting new mothers from hard to reach groups.

One of the issues of access from groups most in need of support is when support is only or mostly provided through breastfeeding support groups. It can take a lot of courage and motivation to attend a drop-in centre alone, especially for a new mother who may be very young and/or not able to speak English.

It is also important for women, at a vulnerable time in their lives with a new baby, if they do attend a drop-in session, that they feel welcome and are able to identify with peer supporters and other women in the group.

Boroughs with more resources and funding are able to offer one to one contact and buddy services to accompany women on their first visits to drop-in centres. They are also able to spend more time trying to recruit and retain peer supporters who truly reflect their communities.

’It has been a great meeting place and has given me confidence. Apart from this group, I don’t know any other breastfeeding mums’ – London mother

\(^{16}\) These are the figures for Islington from the equity audit Public Health carried out in 2010-11, on the 2209 statistics. Further details of this audit are available in the Islington case study included as an appendix to this report.


Set up and management of BfPS services

**Keys points:**

- BfPS in London is managed differently in different boroughs with the most usual arrangement being a midwife or health visitor in overall charge of the service.
- Usually set up by health professionals (HPs) in trusts/PCTS, sometimes in partnership with the LA, and commissioned to breastfeeding support charities such as the Breastfeeding Network.
- Day to day running is the responsibility of:
  - Midwife/HV
  - Breastfeeding coordinators (clinical/non-clinical)
  - Peer supporter coordinators or peer supporters
  - Combination of the above
- Some services have little hospital/PCT input
  - HPs take on extra roles such as admin which could be done by non-clinical staff – poor use of skilled professionals
  - Many services operate on goodwill

Management of BfPS services in London differs in different boroughs. PCTs or hospital trusts usually initiate set up the service, sometimes in partnership with local authorities. The service may be commissioned out to a breastfeeding support charity such as the Breastfeeding Network.

Infant feeding coordinators are paid professionals who are usually responsible for setting up and running peer support services. Most infant feeding coordinators are health professionals, either midwives or health visitors.

Infant feeding coordinators usually also support training and development of all staff in breastfeeding peer support services and most have a strategic role in developing breastfeeding cafes and other aspects of the service.

Day to day running and management of the service may be the responsibility of these same health professionals, non-clinical breastfeeding coordinators, breastfeeding organisations such as the Breastfeeding Network (BfN) or the National Childbirth Trust (NCT), peer supporters themselves or a combination of some or all of these.

The most usual arrangement involves a midwife or health visitor in overall charge of the service. Dedicated admin staff are sometimes also employed on a full or part-time basis to coordinate the service, freeing the health professionals to concentrate on the more clinical aspects of the service.
Many BfPS services however operate with very little input from PCTs, hospital trusts or local authorities and rely on the goodwill of clinical staff that set up and run services in addition to their designated roles.

‘A paid coordinator is essential - whether peer supporters are paid or not.’ – London infant feeding coordinator

Where there is little high level support for a service, and health professionals have to take on additional admin duties to keep a service going, this is, understandably, often resented by the health professional. One health visitor recounted the disproportionate amount of time she needs to spend on admin duties to keep the service running in her locality.

As there is no ring fenced funding for the service, each time any funding is needed to support BfPS, for example, to recruit and train new peer supporters, a new business case needs to be written and submitted.

Admin tasks could be seen as an expensive waste of a health professional’s time, as could the admin surrounding recruitment, training and running a service. All tasks which a non-clinical administrator could do.
Breastfeeding peer supporters (BfPSs)

Who are BfPSs?

**Key points:**

- Although Peer supporters may come from a variety of backgrounds, it is important to recruit peer supporters whose background match client groups as they are considered ‘true peers’ by mothers.

- Some peer supporters are paid, some are voluntary and paid expenses, while others are voluntary with no expenses.

Breastfeeding peer supporters are not health professionals; they are usually women who have breastfed a child of their own. This however is not always the case, in some boroughs communication skills are considered more important than having breastfed.

BfPSs are sometimes paid for their time but more usually work on a voluntary basis, sometimes receiving some recompense such as travelling expenses and childcare. Some BfPSs receive no recompense at all.

A number of services experienced challenges in attracting BfPss who could truly be considered peers of the new mother they support. In some boroughs, peer supporters may be better educated and/or from different social backgrounds than the majority of the population.

There are criticisms in some London boroughs that peer supporters are often from more affluent backgrounds than the mothers they are helping and therefore not representative of these communities or true peers. Some new mothers find it difficult to relate to BfPSs from different backgrounds and life experiences.

To redress this balance, many boroughs are specifically targeting women who are more representative of their communities. This strategy has been successful in many boroughs with BfPSs coming from a range of social, ethnic, educational and age backgrounds. Where peer supporters are representative of their communities, uptake of the service is often greater and more sustained, with targeted groups more likely to attend sessions.

‘There is a difference between the mother to mother support element and that of the health professional relationship with a mother.’ – London infant feeding coordinator
Recruitment, training and supervision

**Key points: Recruitment**

- Recruited in own communities by health professionals or other peer supporters
- Strict recruitment/entry criteria in some boroughs, not in others
- Active, targeted recruitment leads to better success
- Time, energy & resources needed for active recruitment

**Recruitment**

Health visitors, midwives or other peer supporters usually recruit BfPSs from their own communities. Sometimes, BfPSs are members of charitable organisations, for example, the National Childbirth Trust (NCT), La Leche League (LLL) and the Breastfeeding Network (BfN).

Although most volunteers will have breastfed and have children, some areas – Hillingdon is an example – have identified in a person specification for the role of BfPS that communication skills are most important. Hillingdon are also looking for male peer supporters for father-to-father support.

Some boroughs have a strict recruitment and entry criteria with formal interview procedures. Other boroughs have more relaxed recruitment criteria without strict entry criteria and formal interviews. The size and scope of the service often determines this with fully funded services more likely to have stricter recruitment processes as they have the resources to operate them. All potential BfPSs have enhanced Criminal Records Bureau (CRB) checks before they are able to become peer supporters.

Where peer supporters are recruited from their own communities and are reflective of the women they will be helping, these services are usually more successful than where peer supporters are from different social backgrounds, who may have little in common with the women they are helping.

Active and targeted careful recruitment therefore helps to ensure that peer supporters are more likely to be true peers, that they understand and support the philosophy of peer support, and are willing to commit themselves to volunteer regularly. Successful recruitment is an important part of the service and takes time and energy. In boroughs without dedicated BfPS resources, it is difficult to devote the amount of time and energy needed to ensure successful recruitment of peer supporters.
**Training**

**Key points: Training**

- All BfPSs are trained – training usually consists of around 8 -12 half day sessions and is provided in-house or by third sector organisations.

- Training costs vary from around £3 - 5K per course for 10 women from outside providers. Room hire, refreshments, childcare for participants’ children may be an additional cost.

- In-house training costs may be considerably lower but will not provide nationally recognised certification. This is not however, a reflection on the quality of in-house training.

- Training costs are less where there is senior support within an organisation as additional costs such as child care, room hire etc are then often provided free of charge.

- An integrated approach with senior support can help training to be regular and professional and help to ensure a constant supply of peer supporters.

All BfPSs receive training. Training regimes vary across boroughs depending on available funding and which model is in place, but basic BfPS training largely follows similar patterns regarding the topics covered and length of training; around 8-12 weeks of one or two half day session per week.

Training providers vary. Training may be provided by a charity, for example, BfN, LLL or NCT. Alternatively, health visitors, midwives and breast feeding coordinators may also provide training in-house. As well as practical sessions on breastfeeding techniques and supporting mothers to breast feed, training will cover a number of other topics including counselling skills, home visiting, lone working policy and child protection. An example of the type of training provided by a charity is the following, provided by the Breastfeeding Network (BfN):

**BfN Breastfeeding Helpers**

This is BfN’s peer support course giving learners a nationally recognised qualification, which along with the work experience and up-to-date references could help with future job applications or as a route into further education. Successful completion of this course qualifies women to work as Breastfeeding Helpers, (BfN peer supporters). There are a minimum of 12 sessions, which cover the skills needed to support women in the local community:

- Basics of breastfeeding management
- Reflection on personal experience
- Introduction to listening skills
- Introduction to group work
- Role of BfN and other breastfeeding support
• Sources of breastfeeding information
• Role of research
• Introduction to measures needed to protect infant feeding from commercial interests

The BfN also runs advanced training sessions for peer supporters who would like to develop further skills:

**BfN Breastfeeding Supporter training**

Having completed the Breastfeeding Helper course plus sufficient breastfeeding experience to meet the course requirements, including a period of exclusive breastfeeding, helpers may apply to continue on to Breastfeeding Supporter training. This is the ‘gold standard’ training required to qualify and register as a Breastfeeding Supporter. It involves around 20 sessions, usually one per fortnight. Once qualified, probationary supporters are required to undertake some voluntary supporting work, including telephone support. All aspects of training introduced in the Breastfeeding Helpers course are covered in more depth.

The Breastfeeding Network also offers training courses to enable its own Registered Breastfeeding Supporters to train as tutors and supervisors. (The above information on BfN training and standards is taken from the BfN training leaflet, as are the following standards 17).

Charities providing training are well regarded and some follow strict training standards:

**BfN Training standards**

• The Breastfeeding Network aims to keep standards high, which is why courses are in line with the recommendations set out in the National Institute for Health and Clinical Excellence (NICE) guidance
• Courses are in line with UNICEF Baby Friendly Initiative standards
• BfN is a member of the British Association for Counseling and Psychotherapy and an associate member of the Telephone Help Lines Association
• BfN require all our volunteers to have an Enhanced CRB check
• BfN have a child protection policy and safe home-visiting guidelines in place
• BfN courses are Open College Network accredited which includes external moderation ensuring quality and consistency across the UK
• All BfN courses are evaluated
• BfN volunteers work within a Code of Conduct
• BfN volunteers attend regular supervision and complete on-going learning to fulfil re-registration requirements.

The above BfN training is used as a detailed example of the type of training available from charities. The La Leche League (LLL) and the National Childbirth Trust (NCT), the other two main voluntary organisations working in this area, also offer high quality certificated training.

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Costs of training

Costs of training depend on whether training is bought in or provided in-house. Costs of bought-in training vary depending on provider from around £3-5K to train 10 women, with courses commissioned around twice a year. Therefore an annual cost of around £10K plus any additional costs including room hire, out-of-pocket expenses and child care for attendees. Additional costs of room hire and childcare are often provided free of charge by Children’s Centres.

In-house training costs can be much lower and not have direct costs associated with them if they fall within the remit of health professional’s existing roles. Proportions of the salaries of these staff are of course a cost, but are indirect and not separately budgeted for. Again, additional costs of room hire and child care are usually provided free of charge by Children’s Centres, although this is not always the case and additional charges may sometimes be required for these.

If peer support training is run in-house, people who contributed to this report suggested that a business plan should be in place, as duties that the health professional may be required to address would be prioritised, due to time spent training and coordinating peer supporters. Commissioners should link this to key performance indicators (KPIs) set for the service.

Where there is this senior support, this is mirrored across the borough with children’s centres etc being part of the process by acknowledging the value the service brings and supporting BfPS services. They are able to do this by offering venues and children’s centre resources such as refreshments, crèche facilities and staff on a cost free basis. This integrated approach can help training to be regular and professional and help to ensure a constant supply of peer supporters. It also shows investment in peer supporters who are a valuable resource and help them feel valued.

‘A robust and accredited training programme with regular supervision is needed - ideally associated with a national organisation - this gives progression for those who would like to do further training.’ – London infant feeding coordinator
Supervision

Key points: Supervision

- Supervision varies, from informal on the job, to more formal with organisations providing supervision as part of their training contract.

- Most BfPSs work alongside health professionals. Those who run groups independently have mostly had additional training.

- BfPSs usually only work alone if they are visiting mothers at home on a one-to-one basis. They would then report any issues to a health professional.

- Supervision is important because it can prevent small issues becoming major problems and is necessary for the safety of the mother and baby, and to support the peer supporter through any difficulties. There have been problems where there is no ongoing management or supervision.

- Supervision should be built in to a business plan so that commissioners are aware that extra funding and time required. Governance for the organisation should back this up.

- Peer supporters should be supervised through a policy with robust governance procedures.

- If BfPS services are not properly managed and supervised by a member of the health care team, there is a risk that the service will reflect the personality of the peer supporters rather than the ethos of peer support itself.

BfPSs receive various levels of supervision. In most of the boroughs who contributed to this report, volunteer peer supporters do not work in the absence of a health professional, breastfeeding coordinator or Children’s Centre staff member. Where peer supporters are paid, they have often received additional training and may be able to work independently.

Supervision usually takes place ‘on the job’ during breastfeeding sessions. Charities such as BfN also provide supervisory services as part of their training provision contract. Some areas have dedicated one to one supervision as well as BfN group supervision.

Most supervision is informal but necessary to ensure that peer supporters continue to be clear about the scope of their role and the information they give to women. Ongoing supervision also helps peer supporters if they are having any difficulties in the role and can help to identify problems while they are still small and easily solved. It also provides opportunities for ongoing learning.
The presence of a healthcare professional is also valued by new mothers who may not have easy access a midwife or health visitor.

‘It is wonderful having the chance to talk to a health visitor every week. Plus, I feel like I know my health visitor and breastfeeding peer supporter very well. Because of this I trust them completely and would ask them anything’ – London mother.

Peer supporters though are also highly valued in their own right and can often give advice not given by health professionals, based on their own experiences.

‘The peer supporter gave me practical advice that health visitors did not provide. She was the only person to suggest breast milk top ups and not formula that the health visitor had suggested.’ – London mother.

Again, contributors to this report suggest that supervision is built in to a business plan so that commissioners are aware that extra funding and time is required. Governance for the organisation should back this up. There should be an expectation that peer supporters are supervised through a policy with robust governance procedures.

There have been problems in some boroughs where peer supporters, if not properly managed or supervised, can create problems. An example of this was in Hillingdon, where the previous BfPS service evolved into informal coordination by a volunteer due to the enormity of the management role, which was formally overseen by the maternity trust. This led to a number of difficulties, which has shaped the current service.

If BfPS services are not properly managed and supervised by a member of the health care team, there is a risk that the service will reflect the personality of the peer supporters rather than the ethos of peer support itself.

Hillingdon’s BfPS service has now been completely redesigned and managed carefully by health professionals, in collaboration with Children’s Centres. Further details of the previous problems and how these have been overcome can be found in the Hillingdon case study included in this report (appendix 2).
Retention of breastfeeding peer supporters

**Key points:**

- Retention of volunteers can be a problem; once maternity leave has finished, many women have no choice but to return to paid work to support their family.

- Peer supporters often move in and out of the service as their family situation changes eg having another child.

- Retention of peer supporters overall is around 50% two years after recruitment. This is an achievement given mothers' other commitments and that most are voluntary.

- Retention is better where there is more support and resources for peer supporters such as childcare and expenses.

- Retention rates are excellent when peer supporters are paid - financial pressures make voluntary working an unaffordable prospect, especially in areas of most need where more peer supporters are needed.

- Some form of payment, and support such as creating or enhancing opportunities for future employment can make a big difference to retention.

Retention of volunteers can be a problem with BfPSs. By the very nature of the fact that peer supporters are women with children, this in itself can account for retention difficulties. For example, some peer supporters have very young babies themselves and are on maternity leave from their regular paid employment. Once maternity leave has finished, many women have to return to work and can no longer continue in their peer support role.

Women who are peer supporters may also have older children, meaning there are childcare issues to consider, or they may become pregnant again and therefore not have the capacity to support other women with the demands of a new baby. Mothers often move in and out of peer support as their family grows. Some come back to peer support once their own babies and their children have started school, when they may have more time.

Having outlined the above problems however, some BfPSs stay in the service for many years, long after their own children have started full-time education.

Retention of peer supporters overall is around 50% two years after recruitment. This may seem a high drop off rate, but should be considered in the context of
the other commitments mothers have and that most women carry out the role on a voluntary basis. Viewed in this context, a 50% retention rate should be considered an achievement.

Retention rates however vary across boroughs and poor retention appears to correlate with boroughs offering little support to peer supporters in terms of childcare and out of pocket expenses.

In organisational structures where peer supporters are paid, retention rates are excellent. Where retention rates are poor, most breastfeeding coordinators who were interviewed for this report felt that payment for peer supporters would have a significant impact on retention rates. Often, peer supporters have little choice about leaving the service if they have financial pressures to return to work.

‘Paid workers ensure sustainability. It is not good to rely entirely on volunteers especially in areas of deprivation where the volunteers need to find work.’ – London infant feeding coordinator.

Some form of payment or support for peer supporters such as free childcare, refreshments, out of pocket expenses and refresher courses can help peer supporters feel valued. The service they provide is highly valued by new mothers and is usually very low cost, but in some boroughs, the service is not valued by the senior staff and therefore either poorly or not resourced.

When peer supporters are valued retention rates are better, where no help is given with basics such as childcare, women often have little choice but to leave the service. Some payment, however small, could make a big difference to retention rates of peer supporters who sometimes reluctantly have to leave because of economic reasons.

*Even though paying peer supporters is more expensive than training volunteers, paid supporters are much more reliable and productive. A regular and consistent service cannot be delivered depending on the commitment of volunteers alone. Volunteers can arrange childcare for a regular volunteering slot such as helping with a drop-in, but it is almost impossible for them to do this to cover referrals requiring home visits, which arrive without warning. It is more likely that other personal activities will take precedence over the volunteering commitment, making planning very difficult. Many volunteers move out of the borough, take time off for reasons such as having a baby, or stop volunteering due to family crisis, the need to look for paid employment, starting further education or other personal reasons - Extract from Islington case study*

We have seen above in the section on training that some organisations such as the BfN offer recognised training and certification which can provide a stepping stone to a career path or further qualifications. If peer supporter training is completed in-house, there is less likelihood of this being the case. This lack of investment in the future career progressions of peer supporters can also affect recruitment and retention. Again, like some form of payment and support, valuing peer supporters by creating or enhancing opportunities for the future can make a big difference to retention.
How much does BfPS cost and who pays?

**Key points:**

- Costs vary widely from no direct costs to > £200K pa

- Untargeted services are more expensive than targeted services as they reach larger populations and need greater resources.

- Services with no direct costs can be ad-hoc and have little senior support. Many operate on the goodwill of health professionals and peer supporters.

- Where there are direct costs, these are usually met by the PCT or local authority or jointly.

- It costs around £50 - £60 for each new mother benefitting from peer support. Given the benefits for mother and baby of initiating and continuing breastfeeding, plus the added social capital for the peer supporters, this is extremely good value for money.

- More detailed examples of costs and what they provide are included in the case studies

- ‘You get what you pay for’ applies to BfPS in London where the more funding and investment available, the more expansive the service. However, lower cost services can also be highly effective in reaching and helping specific populations.

- Even where costs are highest, it is still relatively low cost for the service provided and provides immeasurable added value.

Based on the diversity of BfPS services available in London, costs vary widely. Of the ten London boroughs who contributed information for this report, the most costly of the service was around £150K per year with the least expensive having no direct costs at all. There are services that are more expensive in other boroughs that were not part of this report, with at least one breastfeeding peer support service costing upwards of £200K per year. Where services are most expensive, these direct costs usually also include staff salaries.

The most expensive service of the ten boroughs is not targeted at specific groups and is available to all new mothers in the borough. The service is managed by a dedicated team of both health professionals and admin staff and has both paid and unpaid peer supporters.

Middle range cost programmes of around £60K per year are usually targeted at specific groups, and can have full coverage of target groups meaning that all
new mothers in a target group are contacted and offered peer support as required.

Lower cost programmes are usually also targeted at specific groups. Costs often include training and expenses for peer supporters plus a proportion of a health visitor or midwife’s time. They have a smaller reach as they do not have the capacity or resources to reach every new mother in a target group and may reach less than 5% of all new mothers in a borough.

Programmes with no direct costs are smaller and again usually reach less than 5% of all new mothers. No cost services tend to be more ad-hoc and sporadic as there is little support for these services at PCT level, with schemes often operating on the goodwill of health professionals and peer supporters.

Where there are direct costs, these are usually met either by the PCT or the local authority or jointly by both.

It is difficult, given the diverse nature of the models used, funding available and lack of evaluation of some services to measure accurately how much it costs to help each new mother who has benefitted from BFPS. Two services, which are fully funded at a cost of around £150,000 per annum, are Islington and Camden. Both of these services have been evaluated and it is possible to estimate cost per head for use of the service. A rough estimation would be that it costs around £50 - £60 for each new mother who has benefitted from access to and help from a breastfeeding peer supporter. Given the benefits for both mother and baby of initiating and continuing breastfeeding, plus the added social capital for the peer supporters, this seems to be extremely good value for money.

Examples of different costs of services are in the case studies included (appendix 2). These case studies reflect some of the diversity of funding levels and arrangements. What these case studies, and some of the other boroughs who contributed to this report, have in common is that, in line with the NICE guidance, they have implemented a structured programme that encourages breastfeeding using the Unicef Baby Friendly Initiative as a minimum standard. This demonstrates that it is possible to offer an effective service, in line with NICE recommendations, within different budgets.

As with most things, ‘you get what you pay for’ applies to BFPS in London where the more funding and investment available, the more expansive the service. However, lower cost services can also be highly effective in reaching and helping specific populations.

The range of costs for BFPS reflects the level and reach of a service. BFPS, even where costs are highest, is still relatively low cost for the service provided and the immeasurable added value for mother, babies and peer supporters.
Sustainability

**Key points:**

- Sustainability is dependent on the following:
  - Recruitment and retention of peer supporters
    - Where payment or expenses are available, recruitment and retention is higher
  - Active support from health professionals
  - Evaluation to show effectiveness
  - Senior support within organisations to secure funding

Sustainability is an issue for a number of BfPS programmes in the current climate of change, with many BfPS coordinators uncertain if their services will continue in the future. Some boroughs however are confident about the future of their service, particularly where BfPS is valued at a senior level as an effective low cost intervention.

Regarding sustainability, again, much seems to depend on support for the service at a senior level, with boroughs with high-level support, such as senior midwifery and health visiting managers, and PCT managers, more likely to continue to receive funding than boroughs without senior support who have a more uncertain future.

Sustainability also depends on recruitment and retention of peer supporters. Boroughs who can offer something in return for their time, either payment – which is rare – and expenses, ongoing training, supervision and support, and childcare facilities are more likely to remain peer supporters. There could be no BfPS service without peer supporters; therefore retention is a key issue for sustainability.

In boroughs where there is payment for peer supporters, as mentioned previously, retention is high - most boroughs do not pay their peer supporters. Whereas volunteer peer supporters commitment is admirable, to recruit and retain women who are true peers, many of whom would therefore need to be recruited from more deprived areas, lack of payment is a real issue.

The over reliance on volunteers is likely to be the reason why so many peer supporters are from higher income groups and those from lower income groups are unable to remain peer supporters for long because of the need to contribute
financially to the home. Non-payment of volunteers therefore can exacerbate the problem of not being able to recruit women to the service who are true peers and who can identify with the issues faced by new mothers in their communities.

‘Any level of peer support is beneficial but to be able to offer a consistent, sustainable service you need to have paid support workers. Locally we have a mix of paid support workers and volunteers. This makes us able to offer a guaranteed level of service which is not affected by school holidays.’ – London infant feeding coordinator.

Health professionals' views and support for a service also affects sustainability. Where BfPS is valued by health professionals, the service is more likely to be well run and supervised and therefore more likely to continue.

Sustainability therefore appears dependent on three main things:

1. Retention of peer supporters
2. Active support from health professionals
3. Senior support within organisations to secure funding.
Advantages, effectiveness and evaluation of peer support in London

**Key points:**

- BFPS has many advantages over a ‘health professional only’ breastfeeding support service, many of these advantages are evidence based.

- Outcomes include:
  - Increased breastfeeding
  - Women breastfeeding for longer
  - Positive feedback from new mothers
  - Increased social capital
  - Increased opportunities for peer supporters

- There are few disadvantages and many more advantages of BFPS.

- Any disadvantages stem from inadequate funding and resources.

- Robust commissioning, ring fenced funding and formal management should eliminate any of the disadvantages.

- Formal evaluation could be key to sustainability and investment.

Effectiveness and evaluation of peer support

Using peer support for breastfeeding in addition to health professional support has many advantages which have been documented above. There is also evidence available to show how advantageous BFPS can be on many levels, as can be seen from some of the references cited in this report.

‘The peer supporter spent a large amount of time giving me practical advice and sympathetic reassurance which helped me through a difficult period. She made it clear that I could call on her for help at any time and I took advantage of that offer.’ – London mother.

There are few disadvantages to running peer support services and very many more advantages. The few disadvantages stem from inadequate funding and resources, which can affect the quality and reach of a service. Robust commissioning, ring fenced funding and formal management of services should all but eliminate any of the disadvantages.

‘The service is essential. I was in such pain and the peer supporters were amazing’ – London mother
Few BfPS services in London have been formally evaluated. Those with ad-hoc services with little senior support are unlikely to undergo formal evaluation, as there are not the resources or will to do so.

Some services have not yet been evaluated as they are still in the very early or even pilot stages, and some services have undergone or are undergoing significant change. Hillingdon (see case study) is an example of a service which has undergone recent significant change. Whilst it is still too early for the new service to be evaluated, breastfeeding statistics from Hillingdon show a marked improvement on 2010/11 total year average with a 4% increase in breastfeeding initiation and a 5% increase in continuation of breastfeeding at 6-8 weeks. Whilst, without a formal evaluation, it is not possible to attribute these increases to the new improved breastfeeding peer support service, the service is likely to have been a contributory factor, in addition to a number of other service improvements involving partner agencies.

External evaluation is a recommendation of the NICE guidelines for commissioning a peer support programme for women who breastfeed, and boroughs still in the early stages have plans for evaluation once the service is up on running. Any evaluations will of course be dependent on sustained funding.

Of those that have been evaluated, there are a number of positive outcomes. These include increased breastfeeding rates and continuation of breastfeeding, positive feedback from new mothers who value the service and increased social capital both for new mothers who widen social networks and for peer supporters who gain self-confidence.

Where there is a proactive peer support service with a salaried coordinator, there can be measurable benefit. One example is an increase of 8% in breastfeeding rates in a borough in the targeted area only six months after a salaried peer support coordinator was appointed.

Results from other evaluations have shown that the majority of women breastfeed for longer due to the support they receive for peer support services.

Many peer supporters go on to further training, gaining qualifications and skills which are taken back into their local communities. Some peer supporters have gone on to be midwives and other health professionals, most of whom would have been unlikely to do so if not for the experience and confidence gained by becoming a peer supporter.

A good example of the achievements of peer supporters and the difference it has made to their lives is included as an addition to the case study of Camden’s Baby Feeding Service. The testimonials with Camden’s case study show how life-changing being a peer supporter can be, and the dedication of peer supporters in helping other mothers. The testimonials have been included with the permission of the peer supporters featured and we are very grateful to them for sharing their experiences.
Even without formal evaluation, there is a lot of positive feedback from BfPS services across London from the mothers who use the service and a lot of anecdotal evidence regarding the benefits of peer support.

‘I cannot believe such an incredible team exists and honestly without the kind attention from them I would have given up breast feeding as it was just too painful- and I am not the giving up type. The peer supporter has been so attentive and kind and supportive over the last couple of days; really got me through it. Discovering the peer support team has been incredible and such a relief as I don't feel so alone dealing with the problems. I can’t thank them enough. Really on a different level to anything I have experienced so far in maternity care anywhere.’ – London mother.

Formal evaluation of BfPS services could be key to future sustainability and investment. If a service can show it is cost effective and provides a valuable service, it is more likely to continue than a service that cannot provide evidence of its effectiveness.

There is much value in having a robust database to provide evidence for evaluation. Islington find their database invaluable in both evaluating services and future planning. Ideally, this needs to be set up from the beginning. Islington are happy to share their experience of setting up such a database. Contact details are available at the end of the Islington case study.
Conclusions

To repeat the opening statement of this report, and what has been demonstrated from the findings of this study; there are many good reasons to commission breastfeeding peer support (BfPS) services and few reasons not to:

- Properly commissioned and adequately funded breastfeeding peer support (BfPS) services are effective and are relatively low cost for the benefits they can achieve.

- Properly commissioned and adequately funded BfPS services can have far reaching benefits. Not just for the health and wellbeing of the mother and baby, but also in increased social capital in some of the poorest areas of London.

The findings of this study suggest that the success of a breastfeeding peer support service is dependent on:

1. Senior support within organisations

2. Active support and management from health professionals and paid administration staff

3. Active recruitment, training, support and retention of peer supporters

This report has shown that the most successful peer support services have buy-in at a senior level within maternity and health visiting professions, maternity services and PCTs. This is probably the key element in ensuring the success and sustainability of peer support programmes.

Without senior support, items two and three above are unlikely as health professionals need senior support to free up time and resources to enable them to actively support and manage programmes.

Without active management and support from health professionals and paid administration, effective recruitment, training, support and retention of peer supporters is unlikely.

For further information about this report, please contact Debbie Romney-Alexander at the Regional Public Health Group for London via email at debbie.romney-alexander@dh.gsi.gov.uk
Appendix 1: Commissioning peer support services

Guidelines are available from the National Institute for Health and Clinical Excellence (NICE) on how to commission BfPS services. NICE have produced a commissioning guide, details of which are available below.

The four case studies included at the end of this report are examples of good practice of three BfPS services which deliver components identified in the NICE guidance, and one breastfeeding support service not using peer supporters. The case studies give more details of the services they provided and some of the issues and challenges in implementing breastfeeding support.

The contributors of the case studies have generously included contact details if you would like to contact them with a view to commissioning breastfeeding support services.

**Nice commissioning guide – commissioning a peer-support programme for women who breastfeed**

The following is taken from the NICE guidelines:

www.nice.org.uk/usingguidance/commissioningguides/breastfeed/commissioning.jsp

The Infant feeding survey 2005 showed that 78% of women in England breastfed their babies immediately after birth but, by 6 weeks, the proportion had dropped to 50%. Only 26% of babies were breastfed at 6 months. Exclusive breastfeeding was practised by only 45% of women 1 week after birth and 21% at 6 weeks.

Maternal age, educational attainment and socio-economic position have a strong impact on patterns of infant feeding. Three quarters of British mothers who stopped breastfeeding in the first 6 months (and 90% of those who stopped in the first 2 weeks) would have liked to have continued for longer. This suggests that much more could be done to support them.

Breastfeeding peer-support programmes should be commissioned only as part of a breastfeeding strategy and commissioners should be aware of all the recommendations about breastfeeding in NICE public health guidance PH11\(^{18}\). Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households and NICE clinical guideline CG37. Postnatal care.\(^{19}\)

The guidance recommends implementing a structured programme that encourages breastfeeding using the Baby Friendly Initiative (BFI)\(^{20}\) as a

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www.nice.org.uk/guidance/index.jsp?action=download&o=40097

\(^{19}\) NICE clinical guideline CG37, *Routine postnatal care of women and their babies*, July 2006

www.nice.org.uk/Guidance/CG37/NiceGuidance/pdf/English

minimum standard. The programme should be subject to external evaluation. The guidance also recommends the adoption of a multifaceted approach or a coordinated programme of interventions across different settings to increase breastfeeding rates. It should include:

- activities to raise awareness of the benefits of - and how to overcome the barriers to - breastfeeding
- training for health professionals
- breastfeeding peer-support programmes
- joint working between health professionals and peer supporters
- education and information for pregnant women on how to breastfeed, followed by proactive support during the postnatal period (the support may be provided by a volunteer).

**Benefits:** The potential benefits of robustly commissioning a peer-support programme for women who breastfeed, within a breastfeeding strategy, include:

- increasing the number of women who initiate and continue to breastfeed at 6-8 weeks
- increasing the number of women who breastfeed exclusively for the first 6 months
- reducing the number of hospital admissions for diarrhoea and respiratory infections in infants
- reducing the risk of ovarian and breast cancer in women who breastfeed
- reducing the risk of obesity in children, and lowering their risks of developing coronary heart disease and diabetes in later life
- raising public awareness of the benefits of breastfeeding
- building capacity within local communities through workforce development and employment opportunities
- reducing inequalities and improving access to breastfeeding support for women in low-income groups
- increasing choice, by providing access to a range of services across different settings
• improving performance and family-centred care by implementing the recommendations outlined in NICE public health guidance PH11 on maternal and child nutrition

• better value for money through helping commissioners to manage their commissioning budgets more effectively - this may include opportunities for clinicians to undertake local service redesign to meet local requirements in novel ways.

Key issues in commissioning/providing an effective peer-support programme for women who breastfeed are:

• recruiting peer supporters as part of a multidisciplinary team and ensuring the team is integrated with other services for women requiring support for breastfeeding within the clinical setting and the community

• implementing the BFI Seven-point plan for communities as part of a wider breastfeeding strategy

• ensuring that women least likely to start and continue breastfeeding are actively engaged and that all pregnant women and new mothers are offered support for breastfeeding

• educating women about breastfeeding during the antenatal and postnatal periods in line with NICE public health guidance PH11 on maternal and child nutrition and NICE clinical guideline CG37 on postnatal care

• providing a quality assured service.
Appendix 2 - Case studies

Case Study – Camden Baby Feeding Service

The Camden Baby Feeding Service (CBFS) was set up in 2005 to promote positive infant feeding practices with the ultimate aim of improving breastfeeding rates. Camden Sure Start commissioned the programme from Camden Primary Care Trust (now NHS Camden) with roll-out health funding.

What was the motivating factor?

- The public health white paper ‘Choosing Health’ (2004) highlighted the importance of promoting good nutrition in early life and the need to support mothers.
- Increasing breastfeeding rates was a Sure Start/NHS target.
- Camden parents, in a consultation on the use of health roll-out funding, identified the need for breastfeeding peer support.
- A randomised controlled trial had been conducted at UCL in 2002 to evaluate the effect of peer support on a range of infant feeding outcomes in a lower income sample of women. It was reported that there were ‘early indications that peer support had increased mothers’ confidence and knowledge around infant feeding.

Brief overview of service

The CBFS is a peer support service that offers mother-to-mother support for Camden mothers/carers/families with children under the age of one.

Aims and objectives of the service

The CBFS aims to increase the initiation of breastfeeding and to encourage breastfeeding until six months or for as long as the mother wishes, through offering evidence based information and support. The service also signposts users to other support services for families with babies in Camden.

The objectives are:
- Peer supporters to visit new mothers on the postnatal and neonatal wards of the Royal Free and UCLH 5 days a week during school term time.
- Peer supporters to be available at selected baby/postnatal clinics in (locations of peer support to be reviewed as necessary).
- All self referral or referrals from external agencies receive at least one phone call to give support/encourage to attend group/arrange home visit as appropriate within 48 hours (outside of weekends and bank holidays).
- Peer supporters to visit mothers in their own homes if the mother meets the referral criteria:
  - Women under the age of 25/In low income households/in temporary accommodation/women with babies who have experienced significant weight loss/ women who have recently given birth and are unable to get to a group/clinic.
- To facilitate weekly baby feeding drop-ins.
The team
The Camden Baby Feeding Service consists of 4 paid staff: two part-time coordinators (WTE 1.2) and two baby feeding support workers (WTE 1.6). On 1.4.11 there were 19 active volunteers, in addition 3 are on maternity leave, 2 of whom plan to return this year.

If childcare is required, to enable the volunteer to work, this is paid for by the Camden Baby Feeding Service. The CBFS also pays for volunteers’ travel and phone calls while working.

There is no administrative staff. Admin tasks including data input takes up a significant proportion of the baby feeding support workers’ time.

The service is managed by two infant feeding coordinator managers who are Unicef baby Friendly trained.

Training, recruitment and supervision of peer supporters
Selection and recruitment of ten volunteers takes place annually in September. Advertisements/flyers are circulated throughout the borough, to all partners, throughout the summer, in a variety of ways. Posters are placed in clinics, information handed out to women at the baby feeding drop-ins, information circulated in the children’s centre bulletins. Women who have received support from the service also apply and three of the CBFS’s current volunteers were themselves supported by the service.

Training is provided by the Breastfeeding Network (BfN), and lasts for seven weeks (4 hours per week). This training consists of the ‘BfN Breastfeeding Helpers (peer supporter) course and is accredited by the Open College Network (OCN). Volunteers who complete the course receive two certificates one with OCN with 6 credits and the other from the service signed by NHS Camden Director of Public Health and the Head of Children’s Centre Services. Those who complete the BfN Breastfeeding Helper training can access a clear training pathway to BfN Breastfeeding Supporter training and may in time become tutors and supervisors.

The training aims to equip the volunteer with the skills to work safely and competently as a ‘Helper’. Learning outcomes include:

- Being able to support and help breastfeeding women with normal breastfeeding experiences: how to help the mother to achieve pain free breastfeeding, how to hand express her milk, how to store her milk.
- Being able to offer support to mothers with issues around returning to work and stopping breastfeeding; Understanding the need for the protection and promotion of breastfeeding in their local area, i.e. Camden.
- Being able to locate sources of research and evidence-based information.
- Being able to listen and communicate effectively with women - applying ‘active listening skills’ (as defined by BfN).
Being able to work in a variety of settings including baby feeding drop-ins.

An additional eight sessions (28 hours in total) is provided by the CBFS, including sessions on:

- Introducing solids and safe bottle feeding, facilitated by Community Dietician NHS Islington
- Practical session on healthy eating for under 1’s, facilitated by a Community Food Worker, Healthy Eating Team, NHS Camden
- Safe Home Visiting, facilitated by CBFS co-ordinators
- How to work effectively in different settings (clinics, hospitals, drop-ins) facilitated by CBFS co-ordinators
- Child Protection Level 2, facilitated by Named Nurse for Safeguarding
- Services available to families through Camden children’s centres – facilitated by representatives from family support, midwifery, health visiting and Camden family information service.

The CBFS provides monthly two hourly supervision sessions for all peer supporters and CBFS workers. These are facilitated by a BfN tutor. Attendance is mandatory and many peer supporters value the time to be together and gain further skills and knowledge. Peer supporters also can access study days run by the service and others such as Tower Hamlets PCT or the Breastfeeding Network.

Regular mandatory training is provided in accordance with NHS Camden Essential Training guidelines.

Individual supervision for the volunteers is carried out individually by the coordinators termly.

**Costs:**

**Who pays for the service?**

<table>
<thead>
<tr>
<th>Camden Baby Feeding Service</th>
<th>Paid by</th>
<th>Annual Cost up to end March 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary – 2 x band 6/ 1.2 WTE</td>
<td>NHS Camden</td>
<td>58599.36</td>
</tr>
<tr>
<td>Salary – 2 x band 4/1.6 WTE</td>
<td>NHS Camden</td>
<td>36382.80</td>
</tr>
<tr>
<td><strong>Total salary</strong></td>
<td>NHS Camden</td>
<td><strong>£94982.16</strong></td>
</tr>
<tr>
<td>Top – up running costs inc. childcare</td>
<td>NHS Camden</td>
<td>35000.00</td>
</tr>
<tr>
<td>Remaining running costs inc. childcare</td>
<td>LB Camden</td>
<td>30000.00</td>
</tr>
<tr>
<td><strong>Total running cost budget allocated for 2011/112</strong></td>
<td></td>
<td><strong>£65000.00</strong></td>
</tr>
<tr>
<td><strong>GRAND TOTAL</strong></td>
<td></td>
<td><strong>£159982.16</strong></td>
</tr>
</tbody>
</table>

**CBFS Running Costs - breakdown**

| Training (BfN helper course) + 9 supervisions x 10 peer | 3650.00 |
Service provision
The CBFS provides information and support to every mother who calls the service and every mother who is referred to the service. Mothers can access the service directly by calling and self-referring, or visiting the drop-ins, or via a health professional or other practitioner. Increasingly the service receives referrals from family support workers. The CBFS provides both a universal and targeted service.

Peer supporters see women on the postnatal wards at the RFH and UCLH, in the neonatal unit at RFH and UCLH (if requested by staff or a mother), at some baby clinics, at four baby feeding drop-ins and at baby massage courses (1 session per course in each locality per term). Some mothers can be seen at home or other convenient place (part of targeted service).

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Quarters 1-3 2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. women visited at home</td>
<td>280</td>
</tr>
<tr>
<td>No. Camden women seen on p/n ward (Guesstimated figure. Systems now implemented to improve identification of Camden women.)</td>
<td>510</td>
</tr>
<tr>
<td>No. days covered on the p/n ward (% available weekdays Mon-Fri)</td>
<td>77% UCLH 75% RFH</td>
</tr>
<tr>
<td>No. peer supporters on each p/n ward per day</td>
<td>1 to 2</td>
</tr>
<tr>
<td>No. distinct women attending drop-ins:</td>
<td>Q1 - 155 Q2 - 145 Q3 - 121</td>
</tr>
<tr>
<td>Service Metrics</td>
<td>Q1</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>No. repeat attendances at drop-ins:</td>
<td>407</td>
</tr>
<tr>
<td>No. entirely new families seen/registered by service</td>
<td>400</td>
</tr>
<tr>
<td>No. of referrals received (sources self, FSWs, HVs, GPs, MWs)</td>
<td>700</td>
</tr>
<tr>
<td>No. of new peer supporters trained 2010</td>
<td>9</td>
</tr>
<tr>
<td>No. families not registered with children’s centre (Systems in place to follow up those who have not registered)</td>
<td>76</td>
</tr>
</tbody>
</table>

**Who is service targeted at and why?**

One-to-one visits are targeted towards women identified as being least likely to breastfeed and least likely to access support (see objectives). The CBFS encourage and receive an increasing number of referrals via FSWs (6% currently). Also the presence of volunteers on the post natal wards enables greater targeting at an early stage. Effective targeting remains a challenge however, particularly as the service has limited ability to engage with women in the antenatal period. The high number of self referrals means the coordinator has to ‘triage’ the need for a home visit based on her judgement at the time.

The mix of social/private housing and renting makes it difficult to work on a postcode basis alone. Demographic data is not reliably entered at the point of registration with the children’s centres (30% receiving home visits in Q3 2010-11 did not enter ethnicity for example) making analysis of ethnicity and social need unreliable. In Q1 2010-11 47.2% of 300 women recorded as receiving one-to-one support (phone contacts included) were in two most deprived ‘quintiles’ and 24% lived in 4 most deprived Camden wards.

**Who are the peer supporters?**

The CBFS strives to recruit peer supporters of different ages, ethnicities, socio-economic backgrounds, with other languages, etc. All applicants are interviewed by 2 staff members. The service also looks for women who are well linked into their community and have experience of using the local services. Not all applicants are successful. A significant proportion of the Camden population is from a Bengali background, and the service has been successful in recruiting from this community. Similarly, women have been recruited from the growing eastern European community. The CBFS has had less success with women from an African background. The CBFS has a small budget for interpreters and also works with partner agencies in an attempt to be able to communicate effectively with women. Language, however, remains a challenge for the service as there is such a wide range of languages spoken in Camden.

**Benefits for the peer supporters**

- self-esteem
- life skills
• transferable skills
• employability (many have successfully gone on to further training or employment – several left to become maternity support workers, some have plans to pursue midwifery as a career)
• Up to date references

It can be life changing – see personal testimonies below.

Benefits for the users
• Breastfeeding for longer (see feedback from evaluations below)
• Knowing where to find local support with infant feeding.
• Receiving help to resolve problems with, or answer questions about, infant feeding.
• Feeling listened to and supported.
• Learning from other mothers.
• Being linked into other local activities and support networks.

Benefits for the community
• Increased body of knowledge around infant feeding
• Increased access to children’s centres services
• Increased social cohesion

Benefits for the local services
• Registering families with Children’s Centre services.
• Raising awareness of services and encouraging families to use services.
• Encouraging families to participate in parents’ forum.
• Encourage women to participate in Maternity Service Liaison Committee.
• Promotes NHS Camden services e.g. Healthy Eating Team.

Challenges
• Peer supporters by definition have young families and they are balancing the demands of family life with volunteering, this inevitably has a knock on affect on the service.
• Working in partnership with other health providers who are under strain, midwifery and health visiting which means women may not be referred to the service in a timely manner.
• Keeping data input up to date.

Best aspects of the service
Local mums helping other local mums - supporting and encouraging them to access local services that they often have personal experience of themselves.
• The dedication of the peer supporters. Volunteers are asked to volunteer to commit to one year of volunteering, 9 hours p.w. after completing training, to ensure value for money. Many stay longer.
• The service responds quickly to the needs of mums.
• Service well regarded by families and other professionals, and is promoted by word of mouth.
• Embedded into integrated Early Years service, with effective lines of communication and clear referral routes between services.
Least positive aspects of the service
The service has no administrative support. Trying to balance the competing demands on the support workers' time is difficult. Providing help to women, or support and mentoring to inexperienced volunteers, takes priority over the administration. Consequently there is always a backlog of data input (currently running at about 4 weeks).

There are no employment pathways for volunteers within the CBFS, consequently when peer supporters need to find paid employment their skills are lost to the service /borough when they get jobs.

There is limited capacity to expand the service, for example to do work in schools, develop a more strategic approach to work with women antenatally and increase outreach beyond that in health and early years settings (i.e. local shopping areas, post offices etc)

Feedback: Postal questionnaire evaluation of women who received one to one targeted support between Jan-March 2010

- 33 questionnaires were returned (36%).
- The majority of women who responded received peer support in the month following the birth of their baby.
- Common reasons for referral were sore nipples, not enough milk and baby not gaining weight.
- 8/33 were exclusively breastfeeding at 6 months
- 9/33 were partially breastfeeding their babies at 6 months
- 22/33 had introduced solids at around the recommended time (around six months).
- 27/33 reported the service as ‘good’ or ‘excellent’.
- 9/33 stated that the support they received enabled them to breastfeed for longer.
- Demographic data was not reliably completed.

The qualitative component of the questionnaire allowed women to comment further:

“I really feel I might have given up without them” and “Without the support encouragement and practical advice from the team I would have had to formula feed my son which was not what I really wanted for him”.

Five negative comments were received. Some highlighted a frustration with the inconsistency of breastfeeding advice that the women had received from health professionals (not just peer supporters). Peer supporters are trained to offer suggestions and are specifically instructed not to give advice. One woman’s problems were eventually resolved by a lactation consultant. Consequently she had a negative view of the help she had received from a peer supporter.
There has been some feedback from professionals:

- A team of midwives at UCH said that having regular CBFS volunteers on the ward has “transformed our lives”.
- A student nurse who attended a baby feeding drop-in said it was the most positive and useful experience she had had within the community.
- A hospital baby feeding advisor and lactation consultant has recently emailed, “Well done to (volunteer) on identifying posterior tongue tie which was referred to be divided, this resulted immediate improvement in breastfeeding”.
- A lead family support worker emailed “thank you for referral, ….you are often the first contact many of our mums have knowing about sure start and what is available in their community”

Evaluation and monitoring

**Quarterly monitoring of the service/annual summary report**

The service regularly inputs service user contact data into the children’s centre database. This facilitates quarterly reporting on a number of outcomes:

**Baby feeding drop-ins**
- Number of women accessing baby feeding drop-ins in total, by session, by drop-in
- Age and ethnicity of users, postcodes, disability.
- The postcodes enable analysts within the public health department to see which users live in the most deprived wards etc.

**The one-to-one service:**
- Number of referrals
- Number of mums received phone support
- Number of mums receiving home visits
- Ethnicity, age, disability, postcode information.

In addition the CBFS records:
- Number of Camden women seen on the postnatal wards of UCLH & RFH.
- Information about volunteers i.e. number recruited p.a./ethnicity/age/number active each quarter/ job status prior to and after volunteering.

Evaluation:
- Six-monthly qualitative evaluation – users of the one to one service are sent postal questionnaires.
- Six-monthly survey of users of the drop-ins
- Case studies: 2 x quarter

**Overall conclusions**

The CBFS provides a valuable service for Camden families. It successfully achieves its objectives and numbers of women receiving support increases year
on year. Results from the evaluation of baby feeding drop-ins shows that a majority of women attending feel the support they have received has encouraged them to breastfeed for longer. An evaluation of users of the one to one service (2010) also found that women were helped to breastfeed for longer.

The CBFS supports Camden’s Children and Young People’s Plan and helps NHS Camden to meet its 6-8 week breastfeeding targets. Also the service helps LB Camden to meet Ofsted children’s centre inspection requirements (which assesses the core offer) to implement the Healthy Child Programme ie provision of both targeted and universal breastfeeding support, contributing to health improvement and the reduction of health inequalities.

The CBFS will also assist in the successful implementation of UNICEF BFI. The CBFS fulfils the UNICEF BFI requirement to provide targeted postnatal support and would be instrumental in developing an appropriate antenatal intervention.

Would you be willing for potential commissioners of breast feeding services to contact you directly to discuss aspects of you service?
Yes. Jane Taylor and Sally Vincent, Infant Feeding Coordinators, NHS Camden, 020 7974 8961.
Email: sally.vincent@camden.gov.uk or jane.taylor@camden.gov.uk

The following are testimonies from peer supporters in Camden speaking of their experiences as a peer supporter:

Moni
Moni has been a peer supporter for over two years, she volunteers every week and supports women on the post-natal ward and in their own homes.

‘I am studying for the certificate of higher education in life sciences for subjects allied to medicine.

The admissions tutors were very impressed with my work as a peer supporter, which proved my motivation and capabilities of successfully completing a course.

Being a peer supporter has also helped me in completing a successful UCAS application for a degree in Nutrition and Dietetics. I was able to draw out a multitude of skills I had acquired on the course as well as all the practical experience, which was very important for my personal statement. The Baby Feeding Peer Support Service has really helped open up a Pandora’s Box full of opportunity for me.’

Monika

‘I recently successfully applied for a job as a Maternity Health Care Assistant at a local hospital. I will be working alongside midwives to support mothers with their newborn babies.'
I am Polish, I came to England 12 years ago with the intention to learn English, but having met my husband here, we decided to stay. When I came my English was very basic, it was hard to understand other people and my spoken English was bad. I went to college to learn English part-time for two and a half years. It did improve, but never felt good enough. I was afraid to communicate in case people didn’t understand me, it caused me stress.

I had my little boy four years ago. My English was still not good and when I was on the postnatal ward having problems breastfeeding I felt I would have got more help if I could speak English better. In fact that is why I wanted to be a peer supporter, because I felt I could help other Polish speaking women, actually any woman who doesn’t have much English, she doesn’t have to be stressed about her language when talking to me, or worried about making a mistake.’

Agnieszka

‘When I saw the notice in the Children's Centre Newsletter last year looking for volunteers to help breastfeeding mums, it was obvious to me that I had to do something.

Almost four years ago, when my baby girl was born, I was really struggling myself with breastfeeding. If not for the help I received from the Camden Project, I don’t think I would have been able to breastfeed and my daughter wouldn’t have become such a strong little girl. I ended up breastfeeding her for three years.

Something that most of us believe should come so naturally, can in fact be a very difficult ordeal - sometimes more difficult than giving birth. Being able to be there for new mums with all the information about positioning and attachment, but also reassurance and encouragement is a life changing experience for me, the mum and more importantly for the baby. It is a wonderful feeling to be able to help with something so important which influences the quality of the whole life of that little vulnerable person.

Giving birth is often a beautiful but traumatizing experience, it feels very important to me to be able to listen to the mums. Usually none of the medical staff have time for it and it is not their job, I guess. Recently I helped a mum who stopped breastfeeding on the fifth day after delivery. She was offered help in the hospital by one of my colleagues but refused it.

Maybe because we are both of the same nationality it was easier for her to talk to me (although her English was perfect). During the home visit on day 10, she decided to have another go with breastfeeding and was successful. Within the next few days I stayed in close touch with the mum and despite difficulties she managed to swap the bottle for the breast and breastfeeds exclusively now.'
It is hard to put in to words how much the volunteering changed my life. It feels great to be able to help people and it changed the way I see certain things. One person can bring so much to another's life - Camden Project helped me almost four years ago and now I have the chance to give something back.’

**Natalia** (mother of twins)

‘My first experience with The Camden Baby Feeding Service (CBFS) was at the end of my pregnancy. I went to the “Twins Drop-in” hoping to find other people who had been through this and could share some experiences. I lumbered into the room with my giant belly not really knowing what to expect and was greeted by smiling faces and felt immediately welcomed. It was such a relief to meet people who made me feel like what I was going through was normal and that my plan to breastfeed my twins was a perfectly achievable goal. It was such a relief to know that the help was out there and that there were people who had done this before me.

The Camden Baby Feeding Service has played an important part in my life. As a woman pregnant with twins, it provided information and practical solutions for breastfeeding two babies at one time. The people that I met when I was pregnant were encouraging and supportive. As a mother it continues to provide support, information and a social network. As a working woman, it continues to provide me with amazing training opportunities that exceed my expectations. I have gained so much knowledge and developed skills that I use daily and will continue to use throughout my parenting and work life. It has given me the opportunity (and privilege) to help other Camden mothers at an incredibly important and vulnerable time in their lives and to help their children and families to get the best possible start.’

**Tamera:**

‘I look forward to going to the post-natal ward every Monday. I enjoy my role as a peer supporter immensely and I feel very privileged to be able to help new mothers establish breast feeding. I benefited greatly from the service myself when I had my son and without their support and help I would not have been able to breastfeed my son. A lot of the midwives at the hospital expected me to know what to do which was very scary but with the help of the project I succeed. Hence the reason why I volunteer because my peer supporter was great towards me both in the centre and when she came to visit me at home. Also I do not want anyone to go though the terrible experiences of feeling inadequate..

I get a lot of satisfaction from helping people. When I meet a woman for the first time with all her doubts about being able breast feed. I remember how I felt and being able to help them through their doubts is amazing. Seeing the women able to breast feed and watching them bond with their child is very rewarding. Through the peer support training program I was able to do various training courses which have given me the confidence to help new mothers and give necessary information.

A lot of the new mothers tell me the time I am able to spend with them is extremely helpful. Listening to them and being patient with them, is very
reassuring. As they sometimes feel that some of the health care professionals are always watching the time and expect them to know what to do.

I believe my life has been enriched by meeting the different mothers from different background and cultures. I learn something new from them which I sometimes put to use in my own day to day life.’

Deborah:
‘Being a Peer Supporter has changed my life. I became a Peer supporter after having my first child. Before that I had been a nurse for 10 years, a job I enjoyed immensely and found very rewarding. After having my child I decided not to return to work. Unfortunately I suffered from post-natal depression. As a result, I lost a lot of confidence and felt like I would never get back to work. I felt I wasn’t capable of doing anything. At the same time I had begun to miss being a nurse, being part of a team and the feeling that I am doing something worthwhile and good. I felt I had lost part of my identity. At the same time however I wasn’t ready to go back to work.

I can’t remember where I saw the advert or how I heard about becoming a Peer Supporter but I remember thinking how good it would be to learn something new and give something back to new mums. By the time I started the training I was on the road to recovery but by no means 100% better. I found the course fantastic and really enjoyed learning again and being stimulated by a new topic. It also meant I had a new group of friends and felt like I belonged to something. I have now been volunteering for just over a year and have decided not to go back to work as a nurse. I find the work incredibly rewarding and really see the difference I make in new mum’s lives. Camden Baby Feeding Service provides me with on going training which is not only relevant to this work but can be used in many fields of social care. I feel like part of a team and this is something that I find has given my life a lot of meaning again.

When I was feeling very vulnerable and low and not able to return to work, Peer Supporting was a perfect ‘Halfway House’, giving me a purpose without the pressure a Nursing job would have. It is also the first building block in developing a new career for me, something I would not have considered had I not become a Peer Supporter.’
Case study - Breastfeeding Peer Support in Hillingdon

Introduction
Hillingdon Breast Friends was a voluntary breastfeeding support service which was set up in 2008. In 2006/07 the annual breastfeeding initiation rate for Hillingdon was 49.2%, one of the lowest in London. In December 2007 Hillingdon Hospital ‘registered their intent’ to work toward UNICEF Baby Friendly Accreditation, a commitment supported by the local council and PCT. The initiation of the volunteer service was driven via the Maternity Service Liaison Committee (MSLC), and a breastfeeding subgroup. The first recruits were women that had taken an interest in the local MSLC, and had breastfed; additional recruits were friends of the former, recruited by midwives and health visitors associated with the MSLC subgroup. In 2010 a management decision was made not to progress further at this time with the Baby Friendly Initiative due to the lack of funds to support the project.

Due to the hard work of a group of professionals (and improved data collection and reporting) the initiation rates have increased hugely to 77% (2009/10). In 2009/10 breastfeeding rates in Hillingdon dropped an average of 20% from initiation (76.3%) to the 6-8 week interval (56.1%). In the first two weeks, it has been found (using local RiO data) that approximately 15% of women have stopped breastfeeding at the time of their first contact with the health visitor (more have begun to mix feed). The need to support women in the initial weeks is paramount, but can we solely rely upon volunteers to reduce this drop in percentage?

In the years 2008-09, the volunteers were jointly managed by the Practice Development midwife, the volunteer service manager and the MSLC Breastfeeding Subgroup. In this time the volunteers developed an internal management system which derived from two ‘natural leaders’ within the volunteer workforce taking responsibility of a website, recruitment of further volunteers, advertising and problem solving between members and venues.

The appointment of an Infant Feeding Coordinator (based in the hospital setting) in August 2009 aimed to address the management of the volunteer service as part of the role. The management and supervision of 26 volunteers was difficult to address along with the specialist role responsibilities, in addition to interrupting the informal management arrangements that had formed within the service, this in turn led to some miscommunication, confusion, and unrest in the volunteer service. In light of this each volunteer was assigned a team (that would be the base that they most worked as a volunteer), communication regarding changing shifts was to take place firstly amongst their team and as a final resort with the infant feeding lead. This resulted in the volunteers feeling part of a smaller team, better communication systems and less confusion; in contrast, they no-longer felt that they had much communication with people they had made friends with or had been over communicated with previously via an internet forum.
The volunteers originally signed up to a maximum of four hours work a month, which left very little room for illness and holiday cover, and expansion of the service with the reduced number of volunteers. The venues chosen for the drop in support sessions had originally been trialled in church halls, community health centres, and children’s centres. There were a number of venue issues, the volunteers worked alone and unsupervised. Due to feedback from health professionals and volunteers the decision was made to align all community support to children’s centres, where volunteers can be supported and supervised by children’s centre staff in purpose built buildings, where there is a clear management structure. Local children’s centres were keen to house volunteer breastfeeding support groups due to local authority Children’s centre goals, increasing breastfeeding and reducing obesity is an expected outcome of service provision.

In January 2010 a Breastfeeding coordinator was appointed for Provider Services (aligned to the Health Visiting Service). At this point it was assumed by the hospital volunteer services that all community based volunteers would now become part of the provider service management role. This posed a number of difficulties as there was not a dedicated volunteer service within the (former) PCT, nor was there a Human Recourse pathway to support this; in addition the time taken to support volunteers had been identified as excessive. At this point the decision was made to restructure the management of the peer support service, a review of the service followed in February 2010, the recommendations shaped the service that currently exists and is developing today.

**Overview of service**

The former service was able to provide up to eight drop in sessions across the borough when the volunteers were at their most active (16 at the most at one time) in October 2009, however due to sickness, maternity leave, family life, moving home and returning back to work this number halved quickly. Highlighting the concern that volunteer support alone is unsustainable due to a number of life related factors. At the beginning of 2010, there were three drop-in services staffed by breastfeeding volunteers, two community based, and one in the maternity unit in the evening.

Overall during 2010 the sessions were very poorly attended across the borough. In November 2009 the hospital based volunteers began to support women by the bedside on the postnatal ward when the drop-in session was quiet. In 2010 the drop-in service stopped completely due to lack of volunteers, and hospital volunteers are now completely ward based. All hospital volunteers are managed by the Infant Feeding Coordinator, supported minimally by the volunteer service.

The local peer support review (February 2010) recommended the following points which have been developed in the new service.

- Training children’s centre staff from all 18 local centres to be breastfeeding support workers as part of their role (attending the two day Breastfeeding Management Course, based on the UNICEF training model).
Breastfeeding support in the community to be offered in mother and baby groups, not purely groups for breastfeeding mothers alone

Children’s centres to deliver basic antenatal parent craft to local parents, meeting mothers in the antenatal period to form relationships with parents, deliver breastfeeding education antenatally, offer support from birth in children’s centres for breastfeeding and include volunteers in breastfeeding education

Develop a centralised volunteer recruitment system led by the Breastfeeding Coordinator (Community based) comprising of an interview pack (information about the role before applying and application form), code of conduct, person spec, interview guidelines for those interviewing, the recruitment process to be ongoing

Develop an in-house volunteer training programme based on the UNICEF Training package to be delivered by both the Breastfeeding Coordinator and the Infant Feeding Coordinator

The hospital based volunteer workforce expand to work toward volunteer breastfeeding support at the bedside, on labour ward and neonatal unit to be available every day for a number of hours

All community based volunteers will be assigned to a children’s centre and become a member of their team. They will comprise of local women, meeting the needs of local families in terms of ethnicity, language, and social background. Children’s centre managers to manage the volunteers and create initiatives of supporting local women, involving volunteers in groups, one to one work and antenatal education

Supervision of volunteers to be by children’s centre managers, or in the case of hospital based volunteers, the Infant Feeding Coordinator. Breastfeeding coordinator available for supervision for community volunteers if required

Annual educational updates will be offered to all volunteers and children’s centre staff

**Aim**
The aim of the Breastfeeding Peer Support Programme is to provide sustainable, friendly, accessible, consistent and evidenced based information to women within both the hospital and community settings.

**Objectives:**
- Cost effective, sustainable and embedded within current management structures to achieve this
- In house training provides cost effective and consistent education to that of the professional training delivered, ensuring consistency and control over the curriculum content
- Volunteers who receive training from the breastfeeding leads are developed over the programme having understood the local picture and vision for collaborative services, feeling part of the service from day one
- Volunteer management can be divided into the eighteen children’s centres and the hospital allowing a larger manageable workforce, ongoing mandatory training can be easily managed and funded when divided between children’s centre or maternity services rather than provider services
• Basing volunteers within their local children’s centre allows each volunteer to contribute and support local families that reflect their own characteristics, whether this be language, ethnicity, or age as examples.

• The volunteers should feel part of a team within a children’s centre or the hospital setting, and be managed in smaller systems rather than all by one organisation or person, aiding workload and capacity to mentor the volunteers.

• Supervision by the Children’s centre manager or Infant Feeding Coordinator can be achieved more frequently when managing smaller groups of individuals. Issues arising from supervision can be dealt with by the Children’s Centre manager (when community based) (or by the Infant Feeding Coordinator at the hospital if appropriate) – this is particularly pertinent to issues concerning people management, systems management or venue concerns for example. The breastfeeding leads are available for supervision specific clinical and breastfeeding related concerns.

• Better use of time for Breastfeeding Coordinator and Infant Feeding Coordinator.

The team
As stated, the former system (prior to alteration in 2010) comprised primarily of the Infant feeding coordinator (maternity) and the volunteer service (at times), with the later addition of the Breastfeeding Coordinator (community). All admin work was absorbed within the above roles.

The team is now primarily the Breastfeeding Coordinator (Community, full time), the Infant Feeding Coordinator (Maternity, part time), each children’s centre manager who interviews the volunteers applying to their centre (Infant Feeding Coordinator interviews all hospital applicants), and the children’s centre that is rotated to house the training who supply the staff to maintain the crèche without charge, children’s centre clerical staff to support the CRB application process in children’s centres, and the volunteer service at the acute Trust to support the CRB application process for maternity. There is no further admin assistance available, therefore primarily absorbed in the Breastfeeding Coordinator role.

Training, recruitment and supervision
The original training was provided externally by the National Childbirth Trust (NCT) in courses of 12 weeks duration, costing £4,500. Annual funding was secured for the purpose (obtained by via the MSLC); a crèche was supplied for the candidate’s children. Owing to this, training courses were was restricted to once or twice a year. Only three courses ran between 2008/2009. In total 26 volunteers were trained, some did not use this qualification locally once trained. Volunteers did not undertake a formal interview for selection; the CRB process was completed and followed up by the hospital volunteer manager. Additional training for child protection was arranged, and for those specifically wishing to work at the hospital drop-in support session - fire safety, infection control, and occupational health clearing was arranged. The further training was difficult to arrange, due to childcare arrangements, timings and agreeing dates to suit the team and the trainer.
The new volunteer recruitment process involves an advert placed in all libraries, clinic bases, maternity unit and children’s centre’s, is published in the local council family magazine and on the back of the breastfeeding support in Hillingdon leaflet. We ask for people (men and women of all ages) who may have had some experience with breastfeeding. The advert is purposely worded to move away from the idea that you have to have breastfed ‘successfully’ to support women, or be breastfeeding currently, or have small children. Our prime concern is that volunteers understand breastfeeding (following training), are kind, friendly and above all have excellent communication skills in order to support, promote, and sustain breastfeeding in Hillingdon.

Applicants are asked to identify where they would like to work (identify a children’s centre or the hospital). All advertising requests for applications via the community Breastfeeding Coordinator, however application packs are available at all children’s centres, and can be returned directly to them. The Infant Feeding Coordinator also passes on the pack when requested. Completed application packs are sent to the appropriate person, and interviews are then conducted. If the applicant is not suitable, the person spec is referred to justify the decision, for example, inability to listen and communicate effectively, or expressing concerning opinions such as marginalisation or racism.

We have recruited a retired physiotherapist, social worker, public health worker, a nurse and midwife (some of whom do not have children). In light of the fact that we began to attract professional applicants, we developed a two tiered training system; for those who have a health background and are proficient in the skills of communication skills, confidentiality, documentation and accountability - these candidates attend the two day breastfeeding management course along with the children’s centre staff or health professionals.

The ten week training programme is 2.5 hours per week, allowing for settling into crèche and interruptions; the curriculum covers 2 hours a week. The curriculum is based on the UNICEF Baby Friendly Initiative (Breastfeeding Management Course) and in addition covers confidentiality, difficult situations, boundaries, communication skills and allows the candidates time to develop over the programme. The first course began in March 2011, and had 9 candidates. The second course was extended to 12 weeks in duration to accommodate evaluation from both infant feeding leads and the candidates. This ran from September to December 2011, 9 women attended, 7 languages spoken amongst them. In December 2011 there are 31 registered volunteers, (4 of which on maternity leave).

Community based volunteers are based in children’s centres and will be given supervision by both the children’s centre manager and when appropriate the community based breastfeeding coordinator. They will work alongside professionals in children’s centre based health clinics, mother and child groups and antenatal education programmes. Supervision is delivered for the hospital based volunteers by the Infant feeding coordinator at the maternity unit, in both groups and on a one to one basis. They will work alone by the bedside, and access support via maternity staff and the Infant Feeding Coordinator when necessary.
The final day of the course programme contains training for all volunteers to ensure flexibility in their base of work, consisting of fire safety and infection control for the Hillingdon Hospital and a child protection e-learning package for completion at home.

**Costs**
The cost of the training is provided as part of the hours of both the Breastfeeding Coordinator (community) and the Infant Feeding Coordinator (maternity services) who share the training time. Photocopies of information are minimal as information is sent to the volunteers via email following each session, in order to reduce costs and avoid over photocopying. A crèche is supplied by children’s centre staff, and if required an agency member of staff has been paid for on one occasion for the duration of the course to allow all mothers to attend with their infants. This has been kindly paid for by the children’s centre hosting the training. It is hoped that staff from children’s centres will be used to provide this facility. We now have a dedicated navy blue polo shirt with embodied writing (pink) on the back (breastfeeding support) and the logo for the children’s centre or hospital and ‘breastfeeding support worker’ on the front. This is at a cost of approximately £11 per shirt. This gives both the hospital and community volunteers an identity, which is different from the staff purposefully. This has enabled safety in identifying the volunteer at a glance; protection in that everybody knows who they are and to leave them with women, not to take volunteers away for other hospital tasks; and continuity in that this uniform is followed into the community.

**Service provision**
There are currently 40 opportunities across the borough to access breastfeeding support in the community (children’s centre settings). This can be as a drop in, one-off assistance, or attend a group in Hillingdon where breastfeeding support is available. Home visiting from children’s centre will be considered in the future as this service develops. Currently volunteer bedside support is available at times for four days a week, this will be increased to every day of the week as the workforce increases. A data base is maintained with contact details and languages spoken, permission is sought during training to be able to access the language skills of the volunteers to assist mothers if needed.

**Who is service targeted at and why?**
Midwives will direct the volunteers to mothers who require additional support, this can be any mother. As the hospital volunteer service grows it is hoped that each mother will see a volunteer on the postnatal ward, this is hoped to extend to NNU and labour ward.

Children’s centres are urged to meet women antenatally, and begin to form relationships, identifying those who may benefit from targeted services, making links and following families through. There are no rules about how breastfeeding support services are delivered, however, we have found that groups that are just for breastfeeding women are not well attended and can isolate women into their feeding type. Women, children and families lose out on seeing
breastfeeding first hand when segregated from formula feeding mothers. The opportunities to learn and promote breastfeeding can be lost when segregating groups of women by their feeding choice, this could also add to the negative feelings about those who breastfeed, and adding to the problem that breastfeeding is socially unacceptable. There are currently no trends in those accessing breastfeeding support, this will be closely monitored in the coming months.

**Who are the peer supporters?**
The are at least 97 languages spoken in Hillingdon, our volunteers are now beginning to reflect this diversity. As children’s centres know their local areas so well, they can encourage mothers to become volunteers who they feel will be good local advocates, in terms of age, social background, ethnicity and language skills. The former volunteer recruits were limited in terms of diversity of its members, predominantly white and a smaller percentage of Asian women. In the latest volunteer programme there are fourteen different languages fluently spoken amongst nine women, we have had no problems in filling the first course with a range of women in terms of age, ethnicity and social background.

Children’s centres have been asked to take into account the local need when planning their support services. In one area where breastfeeding drop off rates are highest, a localised action plan is being developed to address the trends that are appearing a high percentage of black/ British black mothers and Asian mothers mix feed. Further work on identifying local trends can help support a positive change of behaviour of families.

**Benefits for the peer supporters**
Free training with the provision of a crèche. Confidence building in a key subject area, enabling an understanding of working in a team and delivering health promotion information. An informal qualification leading onto volunteer work, and hopeful employment having gained some work experience. To be a valued member of the team, and give something back to the local community and acute trust. Having a children’s centre team approach allows the volunteer access to supervision more frequently than one manager can provide for a large workforce. Working as part of a professional team will limit informal bullying and informal management that occurred in a larger team of volunteers.

**Benefits for the users**
Women can have one to one, unhurried bedside support in the maternity unit from a friendly member of the team, removed from the ward staff and the pressures of hospital work load. This will enhance the patient experience, quality and longevity of breastfeeding having been assisted in establishing breastfeeding.

A bespoke service to each children’s centre that is local, accessible, and friendly. Providing community services in children’s centres collaborates with the overriding strategy for joint working for the health authority and early years intervention, it is a sensible collaborative approach. Women can access breastfeeding support from a children’s centre at any time of the week, not just when there is a volunteer present. Women will get to know the children’s centre
team antenatally, thus increasing the likelihood of early access to breastfeeding support.

**Benefits for the community**

Increased prevalence of breastfeeding rates will hopefully be contagious; this has huge implications of the health of the local community. Volunteers who are attached to children's centres are a real pull for the community, centres then become part of the furniture, locals working alongside children’s centre staff can be empowering for residents to see and can enhance trusting relationships amongst professionals and communities. Role models that are community based are easily applicable to your own life.

**Benefits for the local services**

Having the ‘ownership’ of a volunteer specifically trained in breastfeeding management, in addition to members of the team will enhance the service provision for local centres, enables real control in the challenge to increase local breastfeeding rates and reduction in obesity. The ability to deliver parent craft courses for families without commissioning services will be cost effective and enable early intervention at the very start of life. Having breastfeeding support at the bedside can assist the larger workforce in supporting women, and not depleting ward staff to do this (although breastfeeding support is a key midwifery skill, it is clear that not all women receive support in hospital).

**Challenges**

The biggest challenges came from taking the lead of a peer support workforce who had evolved and appointed their own leaders. In comparison to the original challenges this has been relatively straigh forward. Provision of a crèche for training, but having excellent relationships with the children’s centres having trained over 100 members of their staff has enabled a joint problem solving approach. We are in this together, training for all is free, and the volunteers will be part of the children’s centre team.

**Best aspects**

The ability to reshape a programme with management support and full commitment and enthusiasm of 18 children’s centres has been overwhelming. Having lived through the worst parts of the old system gave the best possible insight into what needed to be changed and what not to do this time.

**Least positive aspects**

The children’s centres in the north of the borough have been the slowest to provide support services, and this has been seen as negative by the health visiting teams, however the North of the borough has fewer centres due to the overall reduced health inequalities of the population. One children’s centre is reluctant to have volunteers again having a negative relationship with the former system, however 5 members of their team have been trained to support local women to breastfeeding.

One example of a forward thinking service is a group called ‘Bumps, Boobs and Babies’, a group in a children’s centre running alongside the health visitor drop-in - attracting pregnant mothers to talk to breastfeeding mothers, and non-
breastfeeding mothers are also welcomed as part of the mother and baby group. There are discussions of, ‘next time I will give it a go’ and ‘I might have persevered if I had help like this’; children are also seeing breastfeeding as normal, even if their mother formula fed them.

**Evaluation and monitoring**

A monitoring form has been developed to be sent to children’s centres quarterly, asking how many mothers have been supported, in the home, in centre services, how many services are they offering each week? Can they provide examples of case studies and service evaluations? Geographical breastfeeding monitoring will take this into account when identifying trends. The training programme will also be evaluated at the end of each term.

There is a maternity survey that is completed when leaving hospital; any feedback can be collected here, as there is a section re feeding and free text box, mothers are encouraged to add additional information.

**Overall conclusions**

This project is in its early days; the feedback so far has been remarkable, from the new volunteers to the local professionals. A year and a half ago we had three sole breastfeeding support groups that were poorly attended; now we have forty opportunities a week where breastfeeding support can be accessed, in addition to accessing support throughout the week at children’s centres. Children’s centre staffs provide the sustainable mechanism to breastfeeding support in the community, and will be complemented by local mothers as the months and years progress.

Training children’s centres alone in breastfeeding management may be responsible for our largest rise in breastfeeding rates for a number of years. In Q20010/11 the 6-8 week prevalence was 54.9%; in Q3 we saw the highest rate ever at 58.2%. Only time will tell if this is a positive trend.

**Would you be willing for potential commissioners of breast feeding services to contact you directly to discuss aspects of you service?**

Yes

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Case study - Breastfeeding peer support in Islington

Introduction
In 2006 the Islington Strategic Partnership wanted to initiate a Breastfeeding Peer Support Project as part of their healthy eating interventions to tackle the obesity in children of Islington and following the government aims of increasing breastfeeding rates to improve child health and reduce health inequalities. The aim was to improve the rate of initiation and continuation of breastfeeding in Islington. As well as initiating the post of Infant Feeding Coordinator to lead Islington towards Baby Friendly accreditation, Islington commissioned the Breastfeeding Network to provide the peer support service.

The service has developed over the intervening years, based on on-going evaluation, and now provides both universal and targeted services that reaches a high and representative proportion of mothers breastfeeding in Islington, with very positive feedback from clients and professionals involved with women with young children. In 2009, when the enhanced service was only in 3 wards of Islington, 52% of all Islington mothers accessed breastfeeding peer support, with 97% in the enhanced project areas.

Brief overview of service
We have 2 projects under the programme.

1. General project: this was the peer support set up at the beginning using volunteers. We recruit and train local mothers who receive 14 weeks training (including home visiting and child protection) to become breastfeeding helpers. They all have enhanced CRB clearance. They help at various venues including breastfeeding drop-ins, baby clinics and some do home visits. They can claim travel and childcare expenses during their volunteer work. There are about 25 volunteers currently active.

2. Enhanced Project: started in 2009, and now employs 7 peer supporters working in 3 WTE paid positions under this umbrella.
   - They help for 2 hours in the morning in the postnatal wards of UCLH and Whittington hospitals
   - Call mothers in the targeted area (6 wards with the lowest breastfeeding rate in Islington) to offer home visits within 2-3 days of them coming home from hospital
   - Visit mothers in their own home and support them in the first 2 weeks, also signposting them to drop-ins for on-going support
   - Lead and Support mothers at the drop-ins.

All peer supporters attend monthly group supervision sessions with their tutor supervisor and their ongoing registration as supporters is dependent on regular attendance. The peer support coordinator supervises and facilitates their day-to-day work, as well as allocating incoming referrals to individual supporters.

All client contacts are recorded on a detailed database, which enables ongoing evaluation of the service and informs future planning.
**Aims and objectives of the service:**
Following the infant feeding recommendations and targets of the World Health Organisation and Department of Health, the main aims of our project are to:

- Encourage Islington mums to initiate breastfeeding from birth and support them to continue breastfeeding.
- Encourage and enable Islington mums to exclusively breastfeed for 6 months by helping them to overcome any initial challenges they may face.
- Support Islington mums in understanding the principles of starting babies on solids, helping them to start offering their babies solid foods at around 6 months and to develop healthy baby-feeding practices.
- Create a breastfeeding friendly environment in the whole borough.
- Eliminate health inequalities by targeting young mums and mums from disadvantaged socio-economic backgrounds who are least likely to initiate and maintain breastfeeding.

**The team**
- The Peer Support Coordinator manages the project. She is responsible for the planning and execution of targeted activities, evaluation, promotion of the project, communication with health professionals and hospitals to do with peer support, line-managing paid and volunteer supporters, covering at drop-ins, maintaining the client contact database and helping with other Islington Baby Friendly activities. She is directly employed by the Breastfeeding Network, who have the commission for the peer support, but also has an honorary contract with NHS Islington/Whittington Health.

- The Infant Feeding Coordinator for NHS Islington is the NHS link and the health professional on the team. She is involved in planning, development and proposal writing for the programme, including the enhanced project and the client contact database, as well as recruitment and interviewing of peer supporters. She is also involved in evaluation of the service and report writing to support ongoing and additional funding. She links the peer support project with the overall Islington breastfeeding strategy and activities, and provides some line management and guidance for the peer support coordinator. She is involved in training health care and children’s centre professionals in breastfeeding and starting on solids, setting policy and leading the borough towards Baby Friendly accreditation.

- One BfN Programme advisor gives overall guidance. She has been involved in the initial and ongoing planning and development of the programme, providing clinical supervision for the peer support coordinator and interviewing of paid peer supporters. She is one of the peer support tutors and oversees the overall training of peer supporters.
• BfN tutors are commissioned to deliver training and ongoing supervision for peer supporters.
• Administrative help by one person to do data entry of peer support statistics into peer support database, enabling evaluation of project
• Seven paid peer supporters working in three full-time equivalent posts
• 25-30 active volunteers at this time. For some who have done the higher level training and have been very committed and have more experience, we pay them an hourly rate for the work they do, in order to encourage retention.
• Administrative input has been employed on an ad hoc basis to carry out data entry of the peer support client contacts into the database. This is now about to become regular part-time (10 hours a week) support.

Training, recruitment and supervision of peer supporters
• The Breastfeeding Network provides training and ongoing supervision. There are two levels of training:
  o “helper” level – 14 week x 2 hour a week training, using various learning styles and suitable for mothers with different educational and ethnic backgrounds. Open College Network accredited. Includes training in home visiting and child protection
  o “supporter” level – for those “helpers” who show their commitment to continuing significant involvement in peer support. The training is fortnightly over 6 months and requires significantly more in terms of assignments. It equips the supporters to work more autonomously and be able to take the lead in various ways. All supporters complete information governance training, and paid peer supporters also complete the induction training for the hospital in which they are working.
• Monitored and supervised by the peer support coordinator and the Breastfeeding Network tutors.
• Recruited through newspaper ads or word of mouth. Sometimes they are mothers who have been helped themselves by the peer support service and then are interested in helping others. We interview them after receiving their application.
• All the paid supporters and some others who give significant amounts of time to supporting mothers have also had the opportunity to do the UNICEF Baby Friendly training in Islington, to increase networking and understanding of the roles of health professionals and peer supporters
• Supporters have also attended the UNICEF Baby Friendly conference and ongoing training workshops.
Costs
From December 2006 to March 2011- the general project was funded by a local area agreement (LAA). From January 2009, we received additional funding from Islington PCT (though the Public Health department) which enabled the start of the enhanced project. Since April 2011, the whole project has been funded through Public Health commissioners in NHS Islington (now part of NHS North Central London for commissioning, Whittington Health NHS for provider side).

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
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<tr>
<td>3 WTE Paid supporters</td>
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<tr>
<td>Coordinator’s salary</td>
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<tr>
<td>Travel expenses of paid peer supporters</td>
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</tr>
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<td>Resources like leaflets, dolls, Royal Mail freepost service</td>
<td>£1,500</td>
</tr>
<tr>
<td>Phone for paid supporters</td>
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</tr>
<tr>
<td>Supervision Tutor’s fee and travel</td>
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<td>Crèche for supervision</td>
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<td>BfN admin cost</td>
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<td>1 helper course</td>
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<tr>
<td>Volunteer expenses</td>
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<td>Printing of statistics books, drop-in flyers</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>£149,947</strong></td>
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</table>

Service provision
- breastfeeding drop-in support groups – 7 during the week, at least 1 on each weekday, spread in different children’s centres around the borough. Mothers can come to any or all, without any need to make an appointment. They are staffed mostly by peer supporters and an independent lactation consultant who has worked in breastfeeding in Islington for many years.
- postnatal wards of ULCH and Whittington hospitals: peer supporters try and meet as many Islington mothers as possible, giving them information about the breastfeeding support services, as well as providing information and help to get breastfeeding off to a good start.
- targeted home visits: mothers from the targeted wards are offered a home visit within 2-3 days of discharge from hospital. These home visits are either arranged whilst on the ward, or via the telephone. The peer supporter provides follow-up visits or contact as required.
- baby clinics and other groups: peer supporters provide support with breastfeeding and starting on solids alongside health visiting teams in an increasing number of baby clinics (9 at present). Since a greater cross-section of mums access baby clinics than will come to support groups, it was felt this would increase their possibility of accessing breastfeeding support.
- telephone support: mothers can directly phone the peer support coordinator who can help them over the phone and/or refer them to other peer supporters.
or the support groups. Midwives, GPs and health visitors can also refer mothers via the phone or email.

- ad hoc home visits: when it is not possible for a mother needing urgent help to come to a support group, we will try and arrange a home visit, subject to availability.

A credit-card size leaflet about the support available is given to mothers on the postnatal wards by peer supporters, and also via midwives and health visitors. A poster is also displayed in hospital, children’s centre and health centre areas.

Who is service targeted at and why?

1. **Target group 1**: all Islington mothers with young babies and pregnant women. We aimed particularly to reach mothers from lower socio-economic backgrounds, so drop-ins were based in children’s centres in areas of deprivation. During 2007-2008 we mainly helped at the breastfeeding drop-ins, at some baby clinics and through some home visits. We were not reaching our target group adequately as we found out that younger mothers and mothers from lower economic background were not attending the drop-ins. As a result, with additional funding in 2009, we started the enhanced project to provide universal support every weekday to Islington (and some from other boroughs, as capacity will allow) women in the postnatal wards of the Whittington (since April 2009) and UCLH (since April 2010) hospitals.

2. **Target group 2**: Since 2009 we have taken a more pro-active approach. With extra funding from the PCT we initiated the enhanced project to offer home visits within the first 2-3 days after hospital discharge to every mother living in the 6 wards with the lowest breastfeeding rates in Islington (also among the most deprived wards in Islington). The targeted support has now been extended to eight Islington wards.

Who are the peer supporters?
Mothers who live in Islington and who have experience of breastfeeding. The majority are white, middle class women in their 30s or 40s, but we do have a few active supporters from other backgrounds. We have 1 Korean, 1 French, 1 Spanish, 1 Italian, 1 Ugandan, 1 West African, 1 Japanese, 1 Eritrean peer supporter and some other supporters who speak different languages fluently. We have some who were young mums, and others with different breastfeeding experiences (e.g. prematurity, tongue tie, twins, child with Downs syndrome). We have trained several from other ethnic and social backgrounds, including some teenage mums, but find that a greater proportion of them do not continue to do peer support for very long, or drop out during the training.

Benefits for the peer supporters

- Free Open College network accredited training. Further higher level training is also available, as well as access to ongoing training workshops.
- Increased confidence in themselves and their abilities, as they have the opportunity to develop knowledge and skills in an area where they have experience
• Preparation to go back to work after career break or no previous work experience and improved confidence. Some peer supporters have gone on to train in midwifery, social work, or other study.
• Work experience and reference useful to add to resume.
• Opportunity to work in NHS and children’s centre settings, interacting with health and child social care/education professionals.
• Social networking with other women of similar interests, though often from different backgrounds.

Benefits for the users
• Exposure to somebody with experience of breastfeeding
• Practical and emotional support with breastfeeding
• Undivided attention and listening – mums report that the peer supporters are willing to spend more time and also have a less lecturing/didactic approach than health professionals.
• Coming out of isolation and opportunity to meet other mothers.
• Receive proactive support in the hospital, as peer supporters approach them, rather than them having to take the initiative
• Provides very early support to prevent and resolve any problems quickly, rather than problems only being identified later, when they are much more difficult to resolve successfully and some mothers would already have given up

Benefits for the community
• Promotes breastfeeding as the norm and raises the profile of breastfeeding in the community. More people from groups where bottle feeding has been the norm are getting exposed to breastfeeding.
• Increased initiation and duration of breastfeeding, and increased exclusivity, leads to decreased illness for both babies and their mothers, reducing ill health and inequalities and reducing health care costs.
• Greater pool of mothers who have successfully breastfed in the community, enhancing positive attitudes to breastfeeding within the community and media.

Benefits for the local services
• All the drop-ins and training sessions are held in the children’s centres. This is often the first contact with a children’s centre and leads to increased enrolment in other activities. This also aids the centre in reaching their breastfeeding targets which are part of their healthy children’s centre and other priorities.
• It increases the exposure of children’s centre staff to the needs of breastfeeding (and other) mothers with young children, and how they can signpost, provide encouragement etc.
• Promotes partnership working
• Peer supporters help at the two local hospitals and in the community, providing significant amounts of supplementary help to that given by midwifery and health visiting teams. They are able to help mothers who have more complicated issues with breastfeeding. Their input helps to improve breastfeeding rates for the hospitals and community services. It
also provides learning opportunities for the health professionals, as they experience peer support as part of their orientation and learn from contact with other mothers. Many health visitors have voiced how their job is so much easier, because, by the time they meet the family, the peer support has already prevented or resolved issues.

Challenges

1. **Maintenance of volunteers:** Coordinator’s role involves keeping the peer supporters motivated and encouraging them to continue volunteering, giving support at difficult times. All applicants for training are interviewed before recruiting to try and ensure they have the right motivation before starting the training and will be willing to commit themselves to regular volunteer work (at least 2 hours a week for the first year).

Motivation is provided through:

- providing ongoing monthly supervision, which encourages building of good relationships and teamwork, as well as allowing debriefing and ongoing learning
- new volunteers are placed with a more experienced supporter when they finish their training, to enable them to build up their confidence in a safe environment
- giving free opportunities to attend other workshops on breastfeeding topics, which also gives the chance to network with other supporters from elsewhere
- attendance at UNICEF training alongside health professionals – helps to build good relationships and increase confidence with health professionals, as well as increasing knowledge and understanding of their role in the Baby Friendly accreditation process.
- travel and child care expenses are covered during the period of volunteering
- an annual party around Christmas time and a summer get-together, with free food
- a small gift at Christmas time, such as a breastfeeding calendar, fridge magnet
- opportunities to be considered for paid work – all but one of our paid peer supporters gave voluntary peer support in Islington beforehand. The exception worked in peer support in a neighbouring borough, but had been involved in the setting up of some new support groups in Islington as the project developed.

**Even though paying peer supporters is more expensive than training volunteers, paid supporters are much more reliable as well as more productive. A regular and consistent service cannot be delivered depending on the commitment of volunteers alone.**

Volunteers can arrange childcare for a regular volunteering slot such as helping with a drop-in, but it is almost impossible for them to do this to cover referrals requiring home visits which arrive without any warning. Also it is
more likely that other personal activities will take precedence over the volunteering commitment, making planning very difficult. Many volunteer peer supporters move out of the borough, take time off for reasons such as having a baby, or stop volunteering due to family crisis, the need to look for paid employment, starting further education or other personal reasons.

2. **Reservation from health professionals:** At the beginning there was a lot of scepticism from health professionals about the ability of the peer supporters to help mothers. After working alongside them for some time and liaison with them, this issue has largely been resolved. Including some peer supporters on the UNICEF breastfeeding management courses has also helped to break down barriers and misconceptions and encouraged more teamwork.

3. **Lack of capacity to help every mother in the borough:** We do not have the capacity to offer home visits to all mothers in the borough. We have had seven drop-ins running during each week to make sure that the mothers can access the service in another way, but are aware that it takes quite a lot of organisation and courage to come to a drop-in, not knowing exactly what it will be like. This is why the enhanced project was set up and it has very significantly increased the ability to reach a much higher and more representative proportion of breastfeeding women in Islington, as proven in an equity audit conducted by the Public Health department on the 2009 statistics (see evaluation below)

**Best aspects of the service**

1. Free service
2. Accessible to everyone
3. Provides immediate and early help, enabling prevention of problems and the resolution of any difficulties more successfully
4. Peer supporters offer evidence-based information only and they get regular supervision and learning opportunities
5. Peer supporters are good at listening to mothers and mothers feel they understand their situation better and approach them at the same level, rather than being seen as an authority figure
6. We work really closely with health professionals and children’s centre staff.
7. Training and continuing, robust supervision by the BFN is unique. If training alone was provided, good quality and continuation of peer support could not be achieved, as much learning still has to take place as the peer supporters start seeing mums for themselves. Thus the monthly supervision provides them with an opportunity to debrief situations they have experienced, continue to learn as well as benefit from the support of their tutor and fellow peer supporters. Also we place them with a more experienced supporter when they start work, so that they can gain confidence as they work with someone who has done it before. All this is
also crucial for retaining the peer supporters. Peer Supporters enjoy feeling that they are part of a national organization.

8. Many of our peer supporters are mothers who themselves received and appreciated peer support in Islington. One writes:

‘I am the mother of a 9 month old boy and I successfully breastfed him with the help of my local breastfeeding drop-in group. We had many difficulties with breastfeeding at the start, but we got through it and made it to 9 months! I would be very grateful if you could send me some additional information on becoming a Peer Supporter.’

**Evaluation and monitoring**

The Islington service has been fully evaluated. We have a robust and comprehensive client contact database that enables us to know on an ongoing basis who has accessed the service, when and where, and the issues raised.

The following table summarises some of the activity of the peer support programme:

<table>
<thead>
<tr>
<th>Islington Breastfeeding and Weaning Peer Support Programme</th>
<th>Summary of work 2008-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUMBER of:</td>
<td></td>
</tr>
<tr>
<td>Peer supporters</td>
<td>No paid supporters.</td>
</tr>
<tr>
<td></td>
<td>1.5 paid supporters &amp; 25 volunteers active on average</td>
</tr>
<tr>
<td></td>
<td>3 paid supporters &amp; 25 volunteers active on average</td>
</tr>
<tr>
<td>Number of contacts</td>
<td>1000</td>
</tr>
<tr>
<td></td>
<td>3484</td>
</tr>
<tr>
<td></td>
<td>6274</td>
</tr>
<tr>
<td></td>
<td>80% increase from 2009</td>
</tr>
<tr>
<td>Number of mothers</td>
<td>2215</td>
</tr>
<tr>
<td></td>
<td>3734</td>
</tr>
<tr>
<td>Home visits</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>339</td>
</tr>
<tr>
<td></td>
<td>869</td>
</tr>
<tr>
<td>Percentage of contacts with mothers under 24</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>12%</td>
</tr>
<tr>
<td>Percentage of contacts with non-white mothers</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td>35%</td>
</tr>
<tr>
<td>Percentage of contacts with babies less than 1 week old</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>43%</td>
</tr>
<tr>
<td></td>
<td>49%</td>
</tr>
<tr>
<td></td>
<td>(2229 contacts)</td>
</tr>
</tbody>
</table>
An equity audit was carried out of the 2009 database, as well as the 6-8 week breastfeeding prevalence statistics from the RiO database, and the client satisfaction questionnaire survey. Due to some data quality issues, it was not possible to analyse the two sets of data in such a way as to definitively show the effect of peer support on breastfeeding rates, but completion of the client contact forms has since been enhanced by ensuring some ready identifiers to enable this analysis in the next equity audit, which is planned for this year.

What the equity audit did show was that:
* 52% mothers in Islington accessed some peer support
* 97% mothers in the enhanced project area accessed peer support
* access by the more deprived mothers was higher in the enhanced project areas than for other mothers

An ongoing client satisfaction evaluation survey is carried out, using an anonymous postal questionnaire, sent to women who have accessed the service, with a freepost envelope for return.

In 2009, 99 out of 500 questionnaires were returned (20%). The equity audit analysed these and found that, of those who responded:
* 63% said that they had found breastfeeding difficult or very difficult in the first 6 weeks
* those who had had contact with the service in hospital were significantly more likely to have responded that their experience of breastfeeding in the first 6 weeks had been good or very good
* the commonly reported issues were positioning and attachment, painful breasts or nipples, issues with frequency of feeding, expressing breastmilk or the baby's weight gain.
* 50% respondents agreed strongly with the statement that 'by being in contact with a peer supporter I felt I was not on my own'
* 47% agreed strongly that they felt more confident, 43% that they felt happier and more relaxed
* 43% agreed strongly that they were able to breastfeed for longer
* 64% agreed strongly that it was important the peer supporter was a mother who had breastfed
* 75% agreed strongly that the peer supporter was easy to talk to
* 72% agreed strongly that they would recommend the service to a friend
* respondents were more likely to agree strongly with the statements presented to them than to disagree, suggesting a high level of satisfaction from using the service

Social marketing insight work was also commissioned with mothers who had initiated breastfeeding from social classes D & E. This provided useful pointers about peer support, not least the importance of proactive and not just reactive support, as mothers encountering problems tended just to give up rather than...
seeking for help. Some mothers were reluctant to seek help from health professionals as they distrust authority figures and were reluctant to let professionals into their homes and lives. Others found it difficult to go into a strange group where they feared they may not find anyone of similar background to themselves. Those mothers who had encountered the peer support service were very positive and the report gives examples of these. They felt they were able to interact with peer supporters in a different way and that peer supporters listened to them more effectively than health professionals.

The equity audit and social marketing reports are available using the contact details below.

**Overall conclusions**

During the last 4 years the breastfeeding peer support programme has become an integral part of Islington’s children's services. It is valued by both users, health and children’s centre professionals and policy makers in Islington, and seen by commissioners as a “strong service”. The enhanced peer support team won an NHS Islington Health Stars award in 2010 for the non-clinical team of the year.

Comments from mothers accessing the Islington service include the following:

**Practical help:**

- “Particularly useful was talking to people who had practical experience in getting the baby to latch and then maintain feeding. Reassurance and practical tips were helpful when feeding was going badly and weight gain was not fast”
- “The service is essential. I was in such pain and the supporters were amazing “
- “Gave me practical advice that health visitors did not provide. …only person to suggest breast milk top ups and not formula that HV had suggested.”

**Time and availability:**

- “Found the fact that someone was available on the phone when I needed advice very helpful. Excellent service”
- “……..great to get a home visit over Christmas.”
- “The peer support was a great help because in the hospital the midwife did not have enough time to explain breastfeeding to me.”
- “Good to have time to talk to someone about issues”
- “……..spent a large amount of time giving me practical advice and sympathetic reassurance which helped me through a difficult period. She made it clear that I could call on her for help at any time and I took advantage of that offer.”
Group settings:
- “Also the drop-in groups are brilliant for meeting other mothers who can also give you support and advice”

Supportive approach:
- “They were so supportive, patient, constructive- much more so than the midwives”
- “It’s a fantastic service. Very supportive.”
- “Most specifically, … they….. have been able to answer all of my queries, provide encouragement and support without making any judgment. They also offer suggestions and advice without being prescriptive or using the word “should” which I have experienced a lot amongst health professionals as a new mother,“
- “I cannot believe such an incredible team exists and honestly without the kind attention from them I would have given up breast feeding as it was just too painful- and I am not the giving up type. X has been so attentive and kind and supportive over the last couple of days; really got me through it. …….. So discovering your team has been incredible and such a relief as I don’t feel so alone dealing with the problems. I can’t thank them enough. Really on a different level to anything I have experienced so far in maternity care anywhere.”

A health visitor emailed to say: ‘Just wanted to tell you that I had a very grateful mother on the phone… She was very effusive on the phone and said the home visit was fantastic and her breastfeeding is sorted now. She said that she had been determined to feed anyway, but had got off to a bad start, so her nipples were very cracked and painful. She had thought of accessing the breastfeeding support at (the hospital) which is where her baby was born, but couldn't summon the energy to go. She said it made all the difference having someone come to see her at home without her having to concentrate and pick up the phone to call someone. X suggested it would be great if breastfeeding support was part of the antenatal service, so I agreed - it would be great!’ (2012)

A mother who experienced several problems with breastfeeding, including significant pain for herself and tongue tie in her baby, emailed the following: ‘Since January 1st I have had no pain and hardly any discomfort. So now happily breastfeeding and hope to continue doing so for a few more months. Thank you and your team for all your support. I wouldn't have been able to do it without your help.; (2012)

‘I just wanted to say how incredible it has been to discover X & Y (two of the per supporters). I was having the most terrible time breast feeding- really awful and they came to my rescue. I cannot believe such an incredible team exists and honestly without the kind attention from them I would have given up breast feeding as it was just too painful- and I am not the giving up type. X has been so attentive and kind and supportive over the last couple of days; really got me through it. Y came round last week and also sorted me out at the beginning showing me the proper techniques in a way that I could understand.” (2012)
Just wanted to thank you so much for getting all those breastfeeding-supporters to call me, that was really sweet of you!! It was really a great help, instead of having to find phone numbers etc myself (which seems like a huge task when being sleep-deprived :-)… Even if (son) is not gonna get on the breast, it is still great to talk to these people who actually KNOW something about feeding (as opposed to many of the midwives I have been subjected to). Even if I end up expressing a bit of milk for him and feeding formula for the rest, all by bottle, at least talking to the breastfeeding counsellors helps me to decide on a manageable feeding plan (instead of unrealistic ones…which are impossible but still end up making me feel really guilty). So, once again many many thanks for all your help from both me and (son), you’ve been great! (2011)

Would you be willing for potential commissioners of breast feeding services to contact you directly to discuss aspects of you service? Yes. We are always very happy to talk with anyone, and/or for them to visit us.
Rosemary Brown, Infant Feeding Coordinator,
Whittington Health NHS Trust (incorporating NHS Islington)
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Email: rosemarybrown1@nhs.net

and
Faizun Nahar, Breastfeeding Peer Support Coordinator
Islington Breastfeeding and Weaning Peer Support Programme
T: 020 3316 8439 M: 07770 685501
Email: faizun.nahar@nhs.net

We are both based at River Place Health Centre, Essex Road, London N1 2DE
Case study - Breast-feeding support in Redbridge

Redbridge does not currently use voluntary peer supporters but is looking to do so in the future. The service in Redbridge is substantial as it stands as the infant feeding advisors are in effect paid peer supporters as they are peers with a range of ethnic backgrounds relevant to the demographics of the borough. Redbridge may enhance the service with voluntary peer supporters now that the baseline service is in place - this will enhance the development of the peer support service.

Introduction
The Early Intervention infant feeding service started as a telephone pilot project in January 2010. It was set up to attempt to improve the prevalence of breastfeeding at 6 – 8 weeks. Redbridge was reporting a steady initiation rate of around 83%, however, the prevalence was around 58% at 6 – 8 weeks. The target for the end of quarter 4 was 67% of babies’ breastfeeding at 6 – 8 weeks.

The infant feeding co-ordinator had been in post since April 2009 and had set up services to support mothers such as antenatal breastfeeding workshops and breastfeeding support groups. Frontline staff had been trained in 3 day breastfeeding management; an ‘in house’ approach had been taken in an attempt to engage staff involvement in the strategic development of the service. A mapping exercise had been carried out to look at when the greatest drop off in the breastfeeding prevalence rate occurred as despite all of this development, no significant increase in prevalence was noted. Data collected at the 10-14 day new birth visit by health visitors showed very clearly that cessation of breastfeeding was occurring in the first 10 days and this was widespread across the Trust and not specific to one area. This information identified a need to offer intensive support during this period. Public Health commissioned a telephone support project for a 3 month period to cover the whole of Redbridge.

Overview of service
As an outcome of the success of the pilot in achieving an increased prevalence rapidly and positive feedback from mothers, the service has now been commissioned as a substantive early intervention infant feeding team. A remit of the team is to contact all mothers in Redbridge as early as possible within the first 10 days post delivery, regardless of method of feeding.

New birth information is accessed via Rio, a web based health record system. The team then contact all mothers from the central caseload to enquire about infant feeding and whether they would like any further information or support. Due to the extent of the task, clear guidelines were set for the team in relation to when to conduct face-to-face contacts and home visits. It is considered important to offer the support to all mothers, those who are formula feeding often require support with feeding but will not be offered a home visit unless they would like to breastfeed. There have been instances whereby the team have supported mothers to commence breastfeeding who initially commenced formula feeding, on some occasions moving on to exclusive breastfeeding.
Once contact has been made, the team will support the mother until she is confident to breastfeed and is able to access local support from the groups and the child and family health team. The team will attempt to contact each mother by telephone 3 times, leaving messages if possible. If no contact is made, information on the team and the local support groups is sent to the family home. Mothers frequently contact the team once this information is received.

All telephone contacts and face to face interventions are recorded on Rio to be shared with the child and family health team.

If the team have concerns about a mother or baby, they will refer to the appropriate practitioner by telephone or letter according to the criteria set in the guidelines.

All mothers can contact the team at any time for further support and advice on infant feeding.

Aims and objectives
The service aims to reach 100% of mothers living in Redbridge to offer support with infant feeding as soon as possible post delivery.

All mothers will be given impartial evidence based best practice advice in all aspects of infant feeding.

Demographic data is collected to ensure that targeted services are best placed to meet the needs of the client group.

The prevalence of breastfeeding will increase and through signposting parents to longer term support networks, exclusive breastfeeding to 6 months and beyond will be supported.

The team
The early intervention infant feeding team is led by the infant feeding co-ordinator. The team members are 2 WTE band 4 clinical staff with a background in either clinical support or nursery nursing supported by a 0.5 WTE Band 3 administrator. All members of the team have received a 3 day breastfeeding management training with practical skills review.

The administrative time allows for collection of demographic data and level of contact of families as well as telephone support, management of breastfeeding group data, ordering of information and planning for training and update events. The administration assistant has also received breastfeeding management training in order for her to be able to provide telephone advice should mothers contact the team whilst the advisors are unavailable.

Training, recruitment and supervision
The team members were recruited from the child and family health team following expressions of interest in December 2010. They received training in
the 3-day breastfeeding management by the infant feeding co-ordinator. A service specification for delivery of the telephone pilot was developed by the infant feeding co-ordinator and the team were trained to deliver this service. The team were supervised weekly by the infant feeding co-ordinator whilst the project was in progress with continuous telephone access to the co-ordinator. Group supervision sessions were held as this was deemed beneficial to all members to support knowledge and share skills.

The team now have monthly supervision, a monthly education session and a monthly team meeting; they continue to have access to the infant feeding co-ordinator throughout the working week.

**Why this model?**

This model of intervention was chosen to ensure the service was accessible to all mothers as early as possible following the birth of their baby. The team are paid employees of the organisation, therefore clear planning for the service is possible, the staff are trained and have a duty to attend work, follow guidelines and work within a team. They are supported to achieve targets set by the organisation and are able to develop an understanding of aims and objectives of the service.

Having a team of staff in place with a good understanding of the requirements to support mothers to breastfeed enables us to further develop by training peer supporters to work alongside the team. The team is required to offer the foundation support for women who are able and would like to offer some of their time to support other mothers. They can offer the additional supervision of the peer supporters and be a contact base for them to feel part of a team.

Peer supporters can also consider moving on to paid employment if positions become vacant within the team which gives them a sense of belonging and progression. It was not considered wise to rely on the peer supporters to be available to all mothers, nor to attend regularly. This would impact on the planning and delivery of a universal infant feeding service and in turn would not allow us to achieve prevalence targets.

**Costs**

The infant feeding team were trained as part of a mandatory training programme in 3-day breastfeeding management for all staff who have face to face contact with new mothers. The training programme is run by the infant feeding co-ordinator and either the professional development nurse or a trained health visitor. The breastfeeding trainers are trained through UNICEF baby friendly and have received a 3 day breastfeeding management training at a cost of £380 each, followed by a UNICEF Baby Friendly train the trainer programme at a cost of £680 each. As the staff are paid employees, there was no expense for childcare or refreshments during training or subsequent work within the team.

The initial project was run from individual bases; once the team became substantive an office base was located within an existing clinic. Desk space,
telephones (including a mobile phone) and computers were made available for 3 members of staff.

Staff costs include 2WTE band 4 practitioners, average £54,000, 0.5 band 3 practitioner, average £12,500. Further funding is required within the budget to cover, training and marketing materials that may be required.

The service is funded from the infant feeding team budget which is part of the universal child and family health team. The funding stream for the service is obtained from the obesity prevention public health funding.

**Service provision**
The service provides a telephone contact to all new mothers and those that have been unable to be contacted by telephone are sent information by post. Face to face contact takes place in the family home, at a children’s centre, clinic or within the infant feeding room at the team base. All possible choices of contact areas are offered to mothers.

Mothers can access the service either by telephone, via email or text. The contact details are widely advertised in clinics, children’s centres, GP surgeries, some shops and the local hospitals. All mothers are given the details when they have delivered, with some mothers receiving the team details ante natally.

**Who is service targeted at and why?**
The service is not targeted as it is considered that all mothers are entitled to access support with infant feeding. The service is effective in reaching a very high percentage of mothers. Approximately 80% of mothers will speak to an infant feeding advisor, 100% of mothers will receive information about the team and the groups offered.

**Benefits for the users**
All mothers in Redbridge are now able to contact a health professional with extended knowledge about infant feeding from 9-5 Monday to Friday to gain support and advice to enable them to feel confident that they are feeding their baby appropriately. They have access to a face to face consultation with a health professional within 24 hours of making contact, often within 6 hours or less. This contact facilitates an assessment of feeding practice and positioning and attachment. This may prevent problems escalating and possibly leading to the mother or baby becoming ill due to poor feeding practice. It also supports women to breastfeed when previously they may have stopped due to pain or concern that their baby is receiving insufficient nutrition.

**Benefits for the community**
Breastfeeding has proven benefits, reducing the risk of many diseases in both the baby and the mother. By increasing the breastfeeding prevalence in the community, the risk of poor health outcomes is reduced. The team is now embedded in the services offered by Redbridge, all members of the community are able to access advice or support from the team in relation to breastfeeding if they so wish. The team is active in marketing and communication within the community raising the profile of breastfeeding and evidence based feeding practises.
Benefits for the local services
All local services including acute trusts, GP’s and children’s centres have open access to the team for advice and support and referral of a mother and baby. This supports delivery of a seamless service in respect of infant feeding facilitated by a clear referral pathway.

Challenges
Initially the challenges during the telephone pilot were linked to liaison with the child and family health team as Redbridge was not using a computerised record system at that time. Paper copies of liaison forms were required to be sent to individual health visitors. This has now been resolved due to the use of the computerised care record system.

Insufficient administrative time was allocated to the project at the early implementation stage as the extent of the task of managing the data and liaison requirements had not been anticipated. This was resolved by allowing an increase in administrative WTE following completion of the pilot phase.

The quality of demographic information on birth notification forms proved challenging as telephone details were frequently inaccurate resulting in the team being required to access this information from other sources such as GP surgeries. GP’s and hospitals were reluctant to provide contact numbers to the team initially; they often required a fax requesting the information. This extended the already heavy workload for the team. In the short term this was resolved by visiting the GP surgeries to advise of the use of a password by the team which would identify the service as having a valid requirement for patient contact information. Efforts are ongoing with the local maternity units in respect of attention to detail when completing the birth notifications and the quality of information is steadily improving which is of benefit to all services.

Difficulties were experienced by the team due to the trend of failure by the mothers to respond to attempts to contact them by telephone. A decision was made to make only three attempts to contact by telephone and if unsuccessful to send contact details and information by post.

Best aspects
The service provides contact and offers support to all mothers in Redbridge in respect of infant feeding and on occasion has supported the early identification of other issues such as signs of postnatal depression. Breastfeeding prevalence has increased from 58% to 69% at 6 – 8 weeks over the period of one year. This achievement indicates that those mothers in Redbridge are now receiving the required support and also the infant feeding team have been able to see a positive and swift outcome as a result of their intervention. This motivates and encourages the team to seek new ways to develop the service to support mothers with a view to further improving the prevalence.
Least positive aspects
The team has been set up to offer early intervention to mothers and babies in respect of infant feeding however due to their background and experience they are frequently required to respond to mothers with older babies with different issues. This requirement impacts on the time allocated to breastfeeding resulting in delay in contacting other mothers. As the work of the service has become widely known there is a tendency for health care professionals such as midwives and health visitors to refer mothers that they would have previously supported to the service resulting in increased capacity pressure.

Feedback
Feedback from users has been extremely positive, all have been grateful for the intervention at a time when they perceived that they were at their most vulnerable. Occasionally mothers have been contacted who have not wanted to engage but this has not elicited any negative feedback.

Health professionals have been positive about the support mothers receive from the team as this reduces the amount of time they are required to spend discussing infant feeding issues allowing for more time to address other health issues.

The PCT, in recognition of the positive outcome of the service, have commissioned the service substantively. Targets are met and there is a clear understanding that by achieving the targets health inequalities are being addressed and the health of our population is improving.

To date there has been no negative feedback.

Evaluation and monitoring
The telephone pilot project was evaluated in 3 stages with an interim assessment after 6 weeks and a full evaluation at the end of the 3 month pilot. The first stage evaluation assessed the demographics of the mothers, the breastfeeding status and the intervention. This provided a good understanding of the demographics in relation to breastfeeding as the mother’s ethnicity, age, gravida and post code was recorded.

The second stage evaluation was by means of a telephone questionnaire to mothers within the cohort to ascertain their views. All mothers contacted were positive about the intervention, many said they would not have continued breastfeeding if the team had not contacted them, some stated they had been formula feeding and were now breastfeeding.

The third stage was through a focus group 9 months after the start of the project. This was held in a children’s centre and co-ordinated by the public health department and the communications team. A full report of the project and the evaluation has been produced by public health. All mothers were positive about the intervention and considered it to be professional, approachable and friendly. They were receptive to factual information rather than myths and stated that although they used their friends and family for
information, they valued the input of the team in respect of the evidenced based support offered.

Further evaluation is planned on a yearly basis through interrogating demographic data collected in order to target any services and by means of audit to ensure evidence based information continues to be received by mothers.

**Overall conclusions**
The service is considered to be of value in supporting the provision of consistent evidence based advice and support in respect of infant feeding for all local mothers. The prevalence at 6-8 weeks continues to increase on a quarterly basis following the initial increase 6 weeks after the service commenced. At this point the largest increase in local breastfeeding prevalence was noted since data collection had been initiated.

The early intervention infant feeding team has laid the foundations for a developing service and will continue to support the education and training of other professionals in the trust in order to improve their knowledge base.

**Would you be willing for potential commissioners of breast feeding services to contact you directly to discuss aspects of you service?**

Yes

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NB The Child and Family Health team members are Health Visitors, School Nurses, Community Staff Nurses, Community Nursery Nurses, Clinical and Admin Assistants.