Thurrock - An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future

Health and Wellbeing Board

The meeting will be held at **10:30am – 12.30pm on Friday 10 December 2021**
The Old Courthouse, Orsett Road, Grays, RM17 5DD

Membership:

Councillor Halden (Chair)
Councillor Huelin
Councillor Liddiard
Councillor Johnson
Councillor Kent
Kristina Jackson, Chief Executive, Thurrock CVS
Kim James, Chief Operating Officer, Healthwatch Thurrock
Michelle Stapleton, Interim Director of Operations, Basildon and Thurrock University Hospitals Foundation Trust
Ian Wake, Corporate Director for Adults, Housing and Health
Sheila Murphy, Corporate Director for Children's Services
Jo Broadbent, Director of Public Health
Mark Tebbs, NHS Thurrock Alliance Director, Thurrock Clinical Commissioning Group
Anthony McKeever, Interim Joint Accountable Officer for Mid and South Essex CCGs
Preeti Sud, Executive Member of Basildon and Thurrock Hospitals University Foundation Trust
Carmel Micheals, North East London Foundation Trust (NELFT)
Dr Anil Kallil, Chair of Thurrock CCG
Alex Green, Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT)
Stephen Mayo, Deputy Chief Nurse, Thurrock Clinical Commissioning Group
Julie Rogers, Chair Thurrock Community Safety Partnership Board/Director of Environment and Highways
Karen Grinney, HM Prison and Probation Service
Andy Millard, Director for Place
Andrew Pike, Executive Member, Basildon and Thurrock Hospitals University Trust

Agenda

Open to Public and Press

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1	**Apologies for Absence**	
2	**Minutes**	**5 - 12**
	To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 29 October 2021.	
3	**Urgent Items**	
	To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.	
4	**Declaration of Interests**	
5	**Better Care Fund Plan Approval**	**13 - 38**
6	**Health and Wellbeing Strategy Refresh Update**	**39 - 58**
7	**Breastfeeding Joint Strategic Needs Assessment (JSNA)**	**59 - 180**
8	**GP Item Part Two. Improvements in Primary Care Long Term Condition Management**	**181 - 190**
9	**Any Other Business**	

Queries regarding this Agenda or notification of apologies:

Please contact Darren Kristiansen, Business Manager - Commissioning by sending an email to DKristiansen@thurrock.gov.uk

Agenda published on: **2 December 2021**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

Breaching those parts identified as a pecuniary interest is potentially a criminal offence

Helpful Reminders for Members

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

When should you declare an interest *at a meeting?*

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

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Does the business to be transacted at the meeting

- **relate to; or**
- **likely to affect**

any of your registered interests and in particular any of your Disclosable Pecuniary Interests?

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

A detailed description of a disclosable pecuniary interest is included in the Members Code of Conduct at Chapter 7 of the Constitution. **Please seek advice from the Monitoring Officer about disclosable pecuniary interests.**

What is a Non-Pecuniary interest? – this is an interest which is not pecuniary (as defined) but is nonetheless so significant that a member of the public with knowledge of the relevant facts, would reasonably regard to be so significant that it would materially impact upon your judgement of the public interest.

Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:

- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps

Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

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You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.

Our Vision and Priorities for Thurrock

An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future.

1. **People** – a borough where people of all ages are proud to work and play, live and stay

    - High quality, consistent and accessible public services which are right first time
    - Build on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing
    - Communities are empowered to make choices and be safer and stronger together

2. **Place** – a heritage-rich borough which is ambitious for its future

    - Roads, houses and public spaces that connect people and places
    - Clean environments that everyone has reason to take pride in
    - Fewer public buildings with better services

3. **Prosperity** – a borough which enables everyone to achieve their aspirations

    - Attractive opportunities for businesses and investors to enhance the local economy
    - Vocational and academic education, skills and job opportunities for all
    - Commercial, entrepreneurial and connected public services

PUBLIC Minutes of the meeting of the Health and Wellbeing Board held on 29 October 2021 10.30am-12.35pm

Present:	Councillor Halden (Chair) Councillor Huelin Councillor Liddiard Councillor Kent Ian Wake, Corporate Director for Adults, Housing and Health Jo Broadbent, Director of Public Health Mark Tebbs, NHS Thurrock Alliance Director, Thurrock Clinical Commissioning Group Preeti Sud, Executive Member of Basildon and Thurrock Hospitals University Foundation Trust Tania Sitch, North East London Foundation Trust (NELFT) Dr Anil Kallil, Chair of Thurrock CCG Lynnbritt Gale for Alex Green, Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT) Julie Rogers, Chair Thurrock Community Safety Partnership Board/Director of Environment and Highways Karen Grinney, HM Prison and Probation Service
Apologies:	Councillor Johnson Kristina Jackson, Chief Executive, Thurrock CVS Anthony McKeever, Interim Joint Accountable Officer for Mid and South Essex CCGs Sheila Murphy, Corporate Director for Children's Services Kim James, Chief Operating Officer, Healthwatch Thurrock Gill Burns, North East London Foundation Trust (NELFT) Stephen Mayo, Deputy Chief Nurse, Thurrock Clinical Commissioning Group Andrew Pike, Executive Member, Basildon and Thurrock Hospitals University Trust Michelle Stapleton, Interim Director of Operations, Basildon and Thurrock University Hospitals Foundation Trust
Guests:	William Guy, NHS Christopher Smith, Thurrock Council Janet Simon, Thurrock Council

1. Welcome, Introduction and Apologies

Colleagues were welcomed and apologies were noted.

2. Minutes

The minutes of the Health and Wellbeing Board meeting held on 23 July 2021 were approved as a correct record.

3. Urgent Items

There were no urgent items raised in advance of the meeting.

4. Declaration of Interests

There were no declarations of interest.

Cllr Halden advised the Board that the three Health and Wellbeing Board Chairs (Thurrock, Southend and Essex) will become Vice Chairs of the ICS Partnership Board.

5. MSE Health and Care Partnership Report on Learning from COVID

This item was presented by Mark Tebbs. Key points included:

- The report was produced by Kaleidoscope Health and Care and provides a reflection on the first wave of the COVID-19 pandemic.
- The learning identified within the report has been summarised under the following headings:
    - When you prioritise, you can deliver significant change at pace;
    - Shared purpose helped create a culture of enablement;
    - Local people help local people if they are given the tools to do so;
    - Strong relationships grow out of trust and connection to place;
    - COVID-19 and health inequalities.
- The report also provides a number of actions and commitments following the pandemic:
    - Work with the CVS to ensure all partners are united around the purpose and vision for reducing inequalities and teams see a connection between their work and the impact on the community;
    - Embed a community focus into how services are delivered so that social value is integral part of how organisations work;
    - Drive the development of PCNs and neighbourhood level delivery to work differently with communities;
    - Support staff so they can deliver their best work by role modelling the behaviours that deliver strong culture and excellent decision-making.
- The Thurrock Integrated Care Partnership already demonstrates progress against many of the place based actions and commitments outlined.

During discussions the following points were made:

- Members recognised the hard work of all partners and acknowledged the challenges experienced, such as information sharing between health and social care to identify vulnerable cohorts. Partners worked together to ensure individuals had access to the right care, however, some vulnerable residents did not meet specific thresholds and therefore did not receive the support they needed.
- Colleagues supported a more effective use of data as part of identifying vulnerable cohorts, such as a population health management approach and stronger links with analytic databases.
- The transformative work of the Local Area Coordinators helped to identifying some of the residents who had fallen through the gaps in the system, however, their contribution has not been included within the report.
- A strengths and assets based approached is fundamental to reaching those most at risk, in conjunction with a human learning system approach.
- Members recognised the important role of volunteers in all aspects of the pandemic response, including the vaccination rollout. The CVS had a very short period of time to recruit and DBS check all volunteers therefore their involvement has been invaluable.
- A number of NHS staff were redeployed as part of the COVID response therefore there were staff shortages across other areas of the organisation.
- Some partners have raised concerns that a number of elements within the system are now working much slower, however, enhanced powers given by central government enabled the COVID response to be accelerated.
- Colleagues noted the work on anchor institutions and how the subsequent charter can feed into the learning included within the report. This could include workforce planning, how care leavers and those with disabilities and criminal records can be engaged further.
- Digitalisation of services and a wider digital platform could also be included within the report.
- Members noted the report was completed by an external organisation and could have possibly been completed by those colleagues directly involved, however, capacity for this was recognised as an issue.

ACTION: The Board will provide further feedback on the following points:

- **Identification of vulnerability risk and links to data;**
- **The speed at which things are now being done;**
- **The ongoing work of the anchor institutions;**
- **Use of volunteers;**
- **Use of digital resources.**

RESOLVED: Members noted and commented on the contents of the report.

6. GP Item Part One. Primary Care Access

This item was introduced by Dr Kallil and Mark Tebbs, CCG. Key points included:

- Access to primary care continues to be an area of great interest both nationally and regionally. The report completed a deep dive on Primary Care access, challenges, mitigations, support and improvement initiatives being implemented to address these challenges in Thurrock.
- From March 2020, Primary Care was expected to deliver services in a new way and in response to the pandemic. Evolving from in person services, to total virtual triage with increased reliance on IT and digital technology. This has meant most appointments were undertaken remotely, either through video, online and telephone consultations and face to face appointments reserved for urgent and where clinically indicated.
- Since April 2021, Primary Care services have been in recovery and reset, working towards business as usual whilst ensuring continued safety measures.
- The pandemic has impacted on all areas of health care, for example long waits in secondary care. As a result, more complexities are being managed at the Primary Care level, with discontent and concerns raised within the community. This discontent includes waiting times for secure an appointment and the limited availability of same-day appointments.
- It is recognised the Primary Care offer is not at the level it needs to be, for example, the impact of capacity concerns and exhaustion of front line workers.
- The report includes findings from the GP Patient Survey, which is an independent survey run by Ipsos MORI on behalf of NHS England. The results show how people feel about their GP practice through a range of questions. The CCG is working with specific practices and PCNs to carry out a deep dive of their Survey results and identify where improvements need to be made.
- The root cause of Primary Care issues for Thurrock are challenging as these include capacity and poor quality of estates. However, the introduction of Integrated Medical Centres will help to support new models of care and will address some the estates issues.

During discussions the following points were made:

- Members recognised the NHS is under a huge strain due to the pandemic and the back log this has caused for services. Primary Care acts as the front line to the NHS and is therefore more exposed to this pressure than other areas of the system.
- It was noted morale in GPs is very low as their focus at present remains the pandemic. GPs have seen increased demand with fewer resources, including increased numbers of complex patients and those with challenging mental health issues.
- Face-to-face appointments are now beginning to increase as many patients cannot be dealt with over the telephone and infection control measures still need to be adhered to and impacts the capacity of smaller GP surgeries.

- Sickness of staff within Primary Care was also acknowledged as a concern, along with diabetes and heart failure not currently being managed in the most effective way.
- Colleagues discussed the Winter Access Programme whereby the focus is on face-to-face appointments, with £250k being made available nationally over five months.
- In relation to national and local data on practice outliers in the GP Survey, these are in the process of being identified and further discussions will be held. There are some data quality issues, with some variation in data counting therefore consistency has been raised as a concern.
- Some of Thurrock's metrics are substantially lower than the national average on certain aspects and have been pre-pandemic therefore this needs to be addressed.
- Thurrock is an under-doctored area, with a higher aged clinical workforce therefore Thurrock needs to be made an attractive place to work. This could include a Thurrock Health Awards initiative whereby good practice is celebrated and acknowledged. Furthermore, links can be made with the work of anchor institutions on how to retain trainees from acute services.
- Colleagues discussed the allocation of resources as this is generally not in a fair and equitable way in Thurrock therefore as an Integrated Care System this needs to be considered further. Also, resources are not used in the most efficient way, for example there is a separate long term conditions register.
- Members considered GP surgeries being categorised into league tables, similar to those used in the Education sector. PCNs would benefit from the opportunity to spread best practice and reduce variation between surgeries.
- Furthermore, practices need to be willing to discuss comments from patients as part of wider community engagement.
- The Cloud based telephony system was discussed and the CCG is working with PCNs to collaborate on options as the interface with the public needs to be improved.
- In addition, the Council has invested in preventative health measures to reduce pressure on the system and the Annual Public Health Report for 2021/2022 focuses on matching capacity to need and will also feed into the place based strategy for Thurrock.
- Members noted the recovery plan within the appendix of the report and wish to discuss further at the Board scheduled for February 2022.

ACTION: Secretariat

RESOLVED: Members noted and commented on the contents of the report.

7. The Better Care Fund, S75 Agreement

This item was introduced by Christopher Smith, Thurrock Council. Key points included:

- Thurrock's initial Better Care Fund Plan, and Better Care Fund Section 75
  Agreement between the Council and NHS Thurrock CCG, was approved in 2015. The arrangement allowed the creation of a pooled fund, to be operated in line with the terms of the Plan and the Agreement, to promote the integration of care and support services. The focus of the Better Care Fund to date has been on adults aged 65 and over who are most at risk of admission to hospital or to a residential care home.
- The Section 75 Agreement must be agreed for the Council to be able to pay providers of services contained within the Better Care Fund. In the absence of guidance for 2021/22, Cabinet have agreed to the Council entering into the
  Agreement based on the terms set out in the previous Agreement.
- The Better care Fund Plan for Thurrock and associated template are currently being drafted and will be circulated to the Board for comment and then approval no later than 1 November 2021.
- The national submission date for the planning template is by 16 November 2021.

During discussions the following points were made:

- Section 4.2 of the report is to be amended to reflect delegation to the Corporate Director and Chair of the Health and Wellbeing Board.
- Members welcomed sign off through the CCG governance routes.

ACTION: Christopher Smith to liaise with CCG colleagues for sign off.

ACTION: The final template is to be circulated to the Board. A virtual meeting may be arranged if members are not content with the document.

RESOLVED: Members agreed the arrangements for the approval of the Better Care Fund Plan for 2021/22.

8. Feedback from Ofsted Focused Visit

This item was introduced by Janet Simon, Thurrock Council. Key points included:

- Thurrock received a recent Ofsted Inspection of Local Authority Children's Services (ILACS) Focused Visit undertaken between 30 June and July 2021 in relation to the Local Authority's arrangements for the protection of vulnerable children from extra-familial risk. This focus includes, children missing from home or care, children involved in criminal exploitation and by gangs, child sexual exploitation and radicalisation.
- As part of the Focused Visit, numerous documents and audits were reviewed by Ofsted and inspectors met with children, their parents / care givers, the Chief Executive of Thurrock Council and the Portfolio Holder for Children's Services.
- The outcome of the Visit was positive, with hard work and commitment of the Local Authority being recognised. Children remain the key focus for the Local Authority and partners which has led to a multi-agency approach. This approach helps to better identify and engage with vulnerable children exposed to risk of extra-familial harm, and improve the offer of support to them and their families.
- The report included the following three recommendations:
    - Earlier transition planning for children in care and care leavers who are exposed to risk of child exploitation, gangs and extra-familial harm;
    - The involvement of children in the take-up of return home interviews and the information the authority relies on to capture activity and the impact of these interviews;
    - The arrangements for support and engagement with children at risk of extra familial harm; in particular, the agility of services to meet the diverse and complex needs of these children and their families.
- These recommendations are being taken forward accordingly.

During discussions the following points were made:

- Earlier transition planning is key and a cross-directorate workshop with Children's Services and Adults, Housing and Health had recently been held and attended by the Corporate Directors. A follow-up meeting is scheduled for early 2022.
- The Transitions Strategy is not broad enough as the focus mainly relates to those with disabilities, however, it should encompass all children in care.
- The Board considered if free prescriptions to care leavers would be beneficial as part of transitions planning.
- It was agreed an update on transitions will be added to the Health and Wellbeing Board forward planner for the next municipal year.

ACTION: Secretariat.

RESOLVED: The Board considered the Ofsted Focus Visit letter and provided comments. The three areas for improvement identified by Ofsted were considered by members and supported the recommendations.

The Chair deferred the remaining items to the next meeting, scheduled for 10 December 2021.

The meeting finished at 12:35pm.

CHAIR……..

DATE……

10 December 2021	ITEM: 5
Health and Well-Being Board	
The Better Care Fund Plan 2021/22	
Wards and communities affected: All	**Key Decision:** Not Applicable
Report of: Ian Wake, Corporate Director of Adults, Housing and Health and Mark Tebbs, NHS Alliance Director for Thurrock	
Accountable Head of Service: Les Billingham, Assistance Director, Adult Social Care and Community Development	
Accountable Director: Ian Wake, Corporate Director of Adults, Housing and Health	
This report is Public	

Executive Summary

Thurrock's initial Better Care Fund Plan, and Better Care Fund Section 75 Agreement between the Council and NHS Thurrock Clinical Commissioning Group, was approved in 2015. The arrangement allowed the creation of a pooled fund, to be operated in line with the terms of the Plan and the Agreement, to promote the integration of care and support services.

The planning requirements for the Better Care Fund Plan for 2021/22 were published by NHS England on 30 September 2021. Unfortunately it was not possible to seek Board approval for the Plan prior to the submission deadline of 16 November set by NHS England. The Board are asked to review and approve the plan, and to agree for that approval to be communicated to NHS England as required in their planning guidance.

1. Recommendation(s)

1.1 The Board is asked to note this report.

1.2 The Board is asked to approve the Better Care Fund Plan for 2021/22.

2. Introduction and Background

2.1 As noted in the report presented to the Board at its last meeting on 29 October 2021, Thurrock's initial Better Care Fund Plan, and associated Section 75 Agreement between the Council and NHS Thurrock Clinical Commissioning Group, was approved in 2015. The Plan and Agreement allowed the creation of a pooled fund, to be operated in line with the terms of the Agreement, to promote the integration of care and support services.

2.2 The Council is the 'host' organisation for the pooled fund, which means that once the Section 75 Agreement is agreed it allows the funding of community health care services provided in line with the Better Care Fund Plan.

2.3 The pooled fund is overseen by the Integrated Care Partnership (previously the Integrated Commissioning Executive) made up of officers from the Council and CCG. The Partnership receives regular reports on expenditure, quality and activity. The Partnership reports on the performance of the Fund to the Health and Wellbeing Board, as well as Cabinet and the Board of the Clinical Commissioning Group.

2.4 The focus of the Better Care Fund to date has been on adults aged 65 and over who are most at risk of admission to hospital or to a residential care home. Despite 2020/21 being a year of unprecedented challenge following the onset of the coronavirus pandemic, the targets in the BCF Scorecard were met by year-end.

2.5 The planning requirements for The Better Care Fund Plan for 2021/22 were published by NHS England on 30 September 2021. The short timescale did not allow for the plan to be prepared and shared with the Board prior to submission of the Plan by the deadline set by NHS England: Tuesday 16 November 2021. In line with the planning requirements, that approval is now sought and, when received, will be communicated to NHS England.

3. Issues, Options and Analysis of Options

Changes to Guidance

3.1 Thurrock has had a Better Care Fund Plan and associated Section 75 Agreement in place since 2015-16. To date, the requirement has been to produce a yearly plan but this was set aside in 2020/21 during the COVID emergency. The Cabinet of Thurrock Council has agreed to enter into the Better Care Fund Section 75 Agreement for the current year 2021/22 in line guidance received from NHS England.

Value of the Better Care Fund

3.2 The value of Thurrock's Better Care Fund for 2021/22 has been increased to £50.804m from £50.198m. This amount is made up of a £17.021m contribution from NHS Thurrock CCG, £5.046m from the Improved Better Care Fund grant and £28.377m contribution from the Council. The Fund consists of a mandatory minimum amount, and an additional contribution agreed locally by the Council and CCG. The mandated amount for Thurrock CCG in 2020/21 was £11.436m and this has been uplifted by 5.3% to £12.042m.

3.3 In future years, as part of preparations for the Better Care Fund, the Council and CCG will need to agree how much they are adding to the Fund over and above the mandated amount.

Focus of the Fund

3.4 The focus of the Better Care Fund to date has been on adults aged 65 and over who are most at risk of hospital admission or residential home admission. The schemes chosen for the Fund reflect this focus. The future plans are likely to continue this focus, and will include elements that are population wide including initiatives linked to preventing, reducing and delaying the need for health and social care interventions.

3.5 Despite 2020/21 being a year of unprecedented challenge following the onset of the coronavirus pandemic, the targets in the BCF Scorecard were met by year-end:

- In particular, the percentage of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement services was 86.4% at year-end (Q4 snapshot), which is 0.1% above target and is significantly higher than the current national average of 82.0%.
- There was also a reduction in the number of older people (aged 65 and over) being permanently admitted to residential and nursing care homes in the year, with 149 admissions in the year compared to 178 in 2019/20. This equates to a rate of 619.2 per 100,000 population[1] compared to 739.7 last year, and is a reduction of 29 admissions. This is also 29 admissions under target.
- 2020/21 also saw a significant reduction in the number of long stay patients in hospital beds. In the year there has been a 38% reduction in the number of patients staying in hospital for 21 days or longer.
- Delayed transfers of care measures were suspended by NHS England throughout 2020/21 and for this reason it is not possible to report on the measures.

3.6 The year saw a reduction in non-elective activity (reduction of 14%) and A&E attendances for people aged 65+ (reduction of 26%) compared to last year. This has almost certainly been due to the impact of COVID-19 and lockdown restrictions imposed by Government which has reduced non-COVID-19 related admissions where many patients would have been advised to stay at home and self-isolate, as well as many people being reluctant to attend NHS services due to the risk of exposure to the virus.

Overspends and Underspends in the Better Care Fund

3.7 The Section 75 Agreement sets out arrangements for overspends and underspends to the Fund. The arrangements will continue and mean that any expenditure over and above the value of the Fund will be the responsibility of either the Council or CCG depending on whether the expenditure is incurred on social care functions or health functions. Arrangements for monitoring expenditure and managing any overspend in an individual scheme are set out in detail within the Section 75 Agreement. Underspends will stay within the Pooled Fund unless otherwise agreed by both parties.

[1] Please note that a new population figure is due to be published in June 2021 that will be used to calculate the official 2020/21 outturn for this indicator. As such the rate of 619.2 is provisional and is subject to amendment.

Governance

3.8 The Council continues to be the host for the pooled Fund. The management of the pooled Fund includes regular oversight by both the Council and CCG through the Thurrock Integrated Care Partnership (previously the Integrated Commissioning Executive). The Partnership reports to the Health and Wellbeing Board who receive the meeting minutes at each Board meeting. A Pooled Fund Manager exists to provide regular reports covering performance, finance and risk.

Contracting arrangements

3.9 The Council, as host of the Fund, enters into contracts with third party providers – largely NHS providers. The standard NHS contract is used for these services with the Council becoming an equal commissioning partner.

The Annual Governance Statement

3.10 This Statement sets out how the Council and NHS Thurrock CCG (the CCG) are, through effective governance arrangements, complying with the responsibilities set out within the Better Care Fund Section 75 Agreement for Thurrock, and the extant Better Care Fund Operating Guidance[2]. The Statement for 2020/21 was approved by the Board on 29 October 2021.

Policy and Planning for 2021/22

3.11 The Department of Health and Social Care published the 2021-22 Better Care Fund Policy Framework on 19 August 2021. The framework sets out the national conditions, metrics and funding arrangements for the Better Care Fund (BCF) in 2021 to 2022.

3.12 The Policy Framework states that "Given the ongoing pressures in systems, there will be minimal change to the BCF in 2021 to 2022. The 2021 to 2022 Better Care Fund policy framework aims to build on progress during the COVID-19 pandemic, strengthening the integration of commissioning and delivery of services and delivering person-centred care, as well as continuing to support system recovery from the pandemic.

3.13 The continued focus on improving how and when people are discharged from hospital is described below.

3.14 The non-elective admissions metric is being replaced by a metric on avoidable admissions. This reflects better the focus of joint health and social care work to support people to live independently in their own home and prevent avoidable stays in hospital. Wider work on the metrics for the BCF programme will continue in 2021 to 2022 to take into account improvements to data collection and to allow better alignment to national initiatives such as the Ageing Well programme."

[2] https://www.england.nhs.uk/wp-content/uploads/2018/07/better-care-fund-operating-guidance-v1.pdf

3.15 The Policy Framework also advised of the intention to undertake a full planning round in 2021 to 2022, with areas required to formally agree BCF plans and fulfil national accountability requirements. NHS England published the BCF Planning Requirements for 2021-22 on 30 September 2021, including details of the national planning and assurance processes.

3.16 The Planning Requirements from NHS England stipulate that for 2021-22, BCF plans will consist of:

- a narrative plan
- a completed BCF planning template, including:
  - planned expenditure from BCF sources
  - confirmation that national conditions of the fund are met, as well as specific conditions attached to individual funding streams
  - ambitions and plans for performance against BCF national metrics
  - any additional contributions to BCF section 75 agreements.

3.17 Allocations of the CCG minimum have been published alongside the planning document on the NHS England website. This document sets out contributions from CCGs to the BCF overall and also the ring-fenced sums for each CCG that must be spent on CCG commissioned out-of-hospital services under National condition 3.

3.18 In view of the timescales, the Better care Fund Plan for Thurrock and associated template were submitted on 16 November2021, before they could be presented to the Board. The Plan submitted is appended to this report and the Board is now asked to approve the plan, and for its approval to be communicated to NHS England in line with the planning guidance.

4. Reasons for Recommendation

4.1 NHS England planning guidance require the Board to approve the Better Care Fund Plan for Thurrock.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 A specific consultation on the establishment of the pooled fund to drive through the integration of health and social care services, as required under the terms of the Health and Social Care Act 2012, was held in September and October 2014.

6. Impact on corporate policies, priorities, performance and community impact

6.1 A key aim of the Better Care Fund is to reduce emergency admissions, which brings within it the potential to invest in services closer to home to prevent, reduce or delay the need for health and social care services or from the deterioration of health conditions requiring intensive health and care services. This will contribute to the priority of ‘Improve Health and Wellbeing’ and the vision set out within the refreshed Health and Wellbeing Strategy 2016-2021.

6.2 Achieving closer integration and improved outcomes for patients, services users and carers is also seen to be a significant way of managing demand for health and social care services, and so manage financial pressures on both the CCG and the Council.

7. Implications

7.1 Financial

Implications as per report of 29 October 2021 verified by:

Jo Freeman
Finance Manager

The Better Care Fund consists of contributions from the Council and Thurrock CCG and are included in the body of this report. The mandated amount consists of £11.436m from NHS Thurrock CCG. Additional contributions have been confirmed and the value of the pool is £50.804m

The nature of the expenditure is an agreed ring-fenced fund. Financial risk is therefore minimised and governed by the terms set out in the Agreement. Paragraph 3.6 refers.

The Fund will be accounted for in accordance with the relevant legislation and regulations, and the agreement between the Local Authority and CCG.

Financial monitoring arrangements are in place, ensuring that auditing requirements are met, as well as disclosure in the financial statements.

7.2 Legal

Implications as per report of 29 October 2021 verified by:

Courage Emovon
Principal Lawyer / Manager- Contracts & Procurement Team

This report outlines the arrangements for a Better Care Fund Section 75 Agreement between the Council and NHS Thurrock Clinical Commissioning Group. The Council and the NHS Thurrock Clinical Commissioning Group can pursuant to regulations made by the Secretary of State as provided by Sec 75 of the National Health Service Act 2006 enter into prescribed arrangements in relation to the exercise of prescribed functions of NHS bodies and prescribed health related functions of local authorities. This arrangement can include establishment and maintenance of a pooled fund made up of contributions by one or more NHS bodies and one or more local authorities out of which payments may be made towards expenditure incurred in the exercise of both prescribed functions of the NHS body and prescribed health related functions

of the local authority. Legal Services is available to provide advice on any specific issues arising from this report.

7.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**
Community Engagement and Project Monitoring Officer

The vision of the Better Care Fund is improved outcomes for patients, service users and carers through the provision of better co-ordinated health and social care services. The commissioning plans developed to realise this vision will be developed with due regard to the equality and diversity considerations.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

2021 to 2022 Better Care Fund policy framework, Published 19 August 2021

- Available via the following link: https://www.gov.uk/government/publications/better-care-fund-policy-framework-2021-to-2022/2021-to-2022-better-care-fund-policy-framework

Better Care Fund planning requirements 2021-22, Published 30 September 2021

- Available via the following link: Better Care Fund policy framework: 2021 to 2022 - GOV.UK (www.gov.uk)

9. Appendices to the report

- Better Care Fund Planning templates 2021

Report Author:

Christopher Smith
Programme Manager
Adults, Housing and Health

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BCF narrative plan template

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s)

Thurrock

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

The Health and Wellbeing Board has agreed a memorandum of understanding between the locality and place and the wider Mid and South Essex Health and Care Partnership. The purpose of this MOU is to establish the governance framework covering the delivery roles and commissioning functions across the three distinct population geographies in order to create an effective Population Health System:

- System - Mid and South Essex
- Place - Thurrock Health and Wellbeing Board area
- Locality - Thurrock footprint/Primary Care Networks

Alignment with Primary Care Services (PCNs)
Our 'Case for Change' set out how capability and capacity could be built in to Primary Care, with Thurrock having some of the most under-doctored areas in the Country which was undoubtedly adding pressure to an already stretched health and care system. As a result, the Primary Care Networks were established and a number of additional practitioners were employed - including pharmacists, physiotherapists, community psychiatric nurse, advanced nurse practitioners and paramedics. The enhanced Primary Care Networks align with and complement our social care transformation programme which included Wellbeing Teams and also the Community-Led Support Social Care Team.

Alignment of services and the approach to partnership with the VCS
Thurrock Community and Voluntary Sector (CVS) is an equal partner on our social care transformation programme and our health and care infrastructure. They also lead on the Stronger Communities element of the programme via Stronger Together Thurrock. CVS facilitated the development of Thurrock's vision, aims and objectives for health and care via running Theory of Change workshops. CVS, representing Thurrock's Third Sector has influenced our agenda to ensure that it is focused on delivering the outcomes that matter most to people. This means growing community resilience and enabling the community to play a key part in ensuring that people can achieve their version of a 'good life'.

To deliver this vision with Providers we work with them to ensure they are able to play their full part in Better Care Together. This means that services and support will be

- personalised and reflect the outcomes that are most important for each person

- deeply rooted in the local community, and able to make use of community assets

- increasingly geared up to respond to the integrated commissioning of social care and health in Thurrock, and better able to provide holistic services

- able to make the most of Technology Enabled Care Services

- equipping service users to have more choice and take more control over their lives and working to reduce dependence of services.

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

The focus of the Better Care Fund to date has been on adults aged 65 and over who are most at risk of hospital admission or residential home admission. The schemes chosen for the Fund reflect this focus. The future plans are likely to continue this focus, and will include elements that are population wide including initiatives linked to preventing, reducing and delaying the need for health and social care intervention.

Priorities for 2021/22 include a focused review of our schemes with a view to ensuring they:

- Continue to have maximum impact
- Reflect the changes in patterns of health and care needs which have resulted from the pandemic
- Reflect the needs of our communities in the face of unprecedented demand for half and social care services and reducing resources in real terms.

Integration

- The BCF part funds two integrated posts Director and Assistant Director across NELFT and the Council to support integrated health and social care service delivery in the community within PCN footprints.
- The Community Response Team (which used to be called RASS) is an integrated team dedicated to maintaining people in the community with health and social care interventions supporting discharge from acute settings and also preventing admission.
- The Joint Reablement team provides reablement with therapist and social workers supporting carers to deliver reablement to those discharged from hospital.
- The primary care MDT co-ordinator is funded to ensure that all professionals are brought together to support individuals in a meaningful way.
- By Your Side is a key service offering a settling at home service and welfare checks that support timely discharge.

Prevention - there are a number of services within the BCF that support admission avoidance and discharge from hospital

- Stroke prevention services offer information and practical support.
- The Community Response Team enable people to remain in their own homes and prevent the need for emergency intervention.
- The Bridging service supports timely hospital discharge and our plan going forward is to start discussions in early 2022 with Health colleagues to explore the model and consider moving to change the model to a wider discharge to assess approach across the MSE footprint.
- The voluntary organisation budgets sit with this area offering a range of support to enable people to stay in their own homes.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Governance arrangements for the health and car transformation programme at Thurrock have developed over time and have recently been reviewed and approved by the Health and Wellbeing Board and Thurrock Integrated Care Partnership. The arrangements include:
- a single Thurrock Integrated Care Partnership Board that has overall strategic oversight of the health and care transformation agenda - including the Better Care Fund (the plan is synonymous with the transformation agenda), the commissioning agenda and acting as the financial delivery mechanisms for health and care integration;
- a finance group reporting to the Partnership which has responsibility for financial monitoring and oversight of the BCF and other system level financial modelling, integration of health and care budgets, and identification of system-level savings which could inform issues such as risk and reward in an alliance contract
- a Better Care Together Thurrock Operations Delivery Board that sits under the Partnership - with responsibility for the overall delivery of the transformation programme
- to support integrated working at locality level, a Locality Working Programme Board - which oversees a combined strategic programme of integrated health and care at locality level. This includes scaling up across the Borough Primary Care Networks' mixed skill workforce, Wellbeing Teams, and Community Led Support Teams
- four Locality Delivery Groups where clinicians, Adult Social Care professionals and other front line staff can refine individual locality integrated models. Locality Groups have a key function in driving the priorities of the ICP by identifying and communicating upwards key local priorities.

The Health and Wellbeing Board, as the highest level strategic board remains responsible for delivery of the Health and Wellbeing Strategy including place and wider determinants of health.

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.

- How BCF funded services are supporting your approach to integration. Briefly

Our approach to integrated services at a HWB level has been developed, delivered and overseen by the Better Care Together programme. Our entire approach to system redesign is integrated and includes a number of elements:
a) An integrated vision;
b) An integrated set of principles and success factors, co-designed by the community;
c) An integrated approach to developing and delivering the vision - through a steering group and four work streams.

Joint Commissioning Arrangements
The budgets for Adult Social Care and Community Health are contained within the Better Care Fund. Decisions as to how the Fund is used is taken through the Thurrock Integrated Care Partnership which meets monthly and includes the Corporate Director of Adults, Housing and Health, Accountable Officer and Chief Finance Officer for the Clinical Commissioning Group, Director of Public Health, Director of Commissioning for the CCG and Strategic Lead for Commissioning for Adult Social Care. This includes developing and piloting arrangements for place-based commissioning, community-led commissioning, and community-led priority setting.

The Integrated Care Partnership includes executive officers from commissioning and provider organisations across health and social care. It has overall responsibility for the development of the Better Care Together health and care transformation programme

The aim is for 80% of activity to be commissioned to take place on a Thurrock footprint or smaller (e.g. locality-based) in line with the King's Fund evaluation of integrated care systems, and by our understanding of the proportion of the population requiring a community-based solution.

Key achievements include:

• The development of a Shared Lives Scheme which was delivered in collaboration with Social Finance an entrepreneurial group of businesses wanting to invest in social support. This 5 year contract aims to deliver 75 matches to offer positive alternatives to more traditional service responses.

• The implementation of Individual Service Funds which support people to have more control of their service provision without having the full responsibility of a direct payment. • The development of over 50 micro enterprises. We recognised the need to diversify the market in the last Market Position Statement. As such we undertook a two year project to develop this segment of the market.

• Accommodation and support is key and a great deal has been achieved through the development of a refurbished complex of flats for people with learning disabilities, the agreement between the Council and Peabody Housing Association to develop 6 specialist units of accommodation for people with autism in Medina Road and the expansion of capacity for people requiring support who have dementia.

The attached report – Integrating Health and Care in Thurrock – tells the story of our integration journey. In addition, the following Integration Priorities have been agreed by the Thurrock Integrated Care Partnership:

1. Strengths-led and integrated public-facing workforce
2. Integrated support in the home
3. New Generation Integrated Care Facilities
4. Improving access and quality and reducing variation
5. Population health management – preventing ill health and promoting good health

describe any changes to the services you are commissioning through the BCF from 2020-21.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

Our Better Care Fund Plan focuses on:

Early discharge planning - working with Southend Council to act as Trusted Assessors when Southend residents are at Basildon Hospital and when Thurrock residents are at Southend Hospital. We have implemented a new information portal to allow trusted assessors to upload assessment information on to the Council's system. We also carry out discharge planning pre-admission to enable early discharge.

Systems to monitor patient flow - we have extracted information from our information system Mede Analytics which allows us to monitor patient flow and to analyse activity
Trusted Assessors - we are broadening our approach to Trusted Assessors. We are piloting Domiciliary Care providers as trusted assessors and also working with Southend Council as a trusted assessor

The key schemes and initiatives contributing to supporting discharge are as follows:
- Bridging Service - which is enabling people to be discharged from hospital when they are medically fit to do so but unable to go home;
- Additional investment in domiciliary care to build sufficient capacity and reduce the likelihood of people waiting for care;
- The provision of intermediate care beds;
- Investment in a scheme known as 'By Your Side' which ensures people's homes are ready for them when they come out of hospital
- Recruitment of a DTOC coordinator
- implementation of 7 day working - for example the Hospital Social Work Team.

The attached proposal - Extended Enhanced Discharge to Assess (EED2A) Pathway – was approved by the Thurrock Integrated Care Partnership (which includes the Council, CCG, the Hospital Trust - MSE Group, as well as community and mental health providers NELFT and EPUT) in April 2021, and the scheme forms part of the Better Care Fund Plan for Thurrock. The proposal sets out the local approach to safe and timely discharge, as well as home first. Funding began in April 2021 and the BCF Delivery Group meets monthly to review the performance of this and other schemes.

The CHC team in Thurrock CCG, currently do not have any delay transfer of care from the hospital for the home first health lead enhanced discharge to assess pathway. All therapy and care support are implemented within 24 hours of the referral indicating the patient is medically fit to leave hospital. (If a patient requires interim 24 hour care placement there may be a delay in sourcing the appropriate care /nursing home but this is when home is no longer an option).

The metrics around admission avoidance is ambitious and stretching as with most systems we are experiencing extremely high levels of demand and the acute hospitals are struggling to maintain flow however the schemes within our BCF Plan offer a range of responses which we consider will enable those targets to be reached. The integration and transformation work is supporting joint solutions utilising our preventative and integrated services. The metrics have been discussed and agreed with the Hospital Trust.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to

The Council has adopted a strength-based approach to delivering Disabled Facilities Grants to enhance independence and improve health and wellbeing for tenants and owner occupiers. In line with the Royal College guide to adaptations, our newly introduced pathway means DGF applicants can do more for themselves with a self-serve approach providing significant benefits for all. Completed cases and overall expenditure has doubled since 2016.

Transformation of the DFG services continues with a greater understanding and promotion of health equality. It is acknowledged that there is a primary focus to support people through home adaptations via the mandatory grant; recognising the home environment can have a considerable bearing on people's safety, independence and overall health and wellbeing. However, it is also recognised that an integrated and holistic approach across health, social care and housing is essential to not only realise the benefits of accessible housing, but also achieve an understanding of, and subsequent approach to, meeting an individual's needs and the needs of the wider community in which they live.

The Council has completed a review of the DFG service and implemented a strength-based approach to service delivery, which has greatly enhanced the support available for the residents of Thurrock. Inclusive in this approach is improved awareness and accessibility, with our newly introduced pathway meaning DGF applicants can do more for themselves with a self-serve approach, which in turn provides significant benefits for all. The service is now hosted alongside the Occupational Therapy Service within Adult Social Care. This has enabled the DFG service to be more assessable and compliment integrated approaches already established across health, social care and housing, such as the integrated first point of contact service, placed based support services across health, social care and housing, and the established Integrated Community Equipment Service.

The Council is currently in the process of finalising, and implementing phase two of the intended transformation of the DFG Service. This includes greater opportunities to support wider services within health, social care and housing, especially where there is a recognised crossover with DFG services in supporting individuals to remain in their home and meet their wider housing needs. Furthermore, the Council intends to provide additional support by virtue of the Regulatory Reform (Housing Assistance) (England & Wales) Order 2002, which would enable the Council to provide Thurrock residents with financial assistance from a range of discretionary grants. Examples include:

- 'top up' to a mandatory grant and / or to fund unforeseen works
- adaptations for a child's second home where the parent's live separately
- adaptations for a child / young person in foster care
- adaptations for an adult supported in "shared lives" or similar supported living scheme
- assist a disabled person or their family to move to more suitable accommodation
- dispense financial assessment for works below £5000
- facilitate timely discharge from hospital or other non-residential settings (individual and schemes)
- avoid unnecessary hospital admission or other non-residential settings
- facilitate fast track adaptations for end of life / life limiting conditions
- improve accommodation of a nature that supports residents in supported living and step down / rehabilitation services, or in need of interim support
- provide non-fixed solutions, including, but not limited to Tech Enabled Care and ICES
- explore and provide innovative housing solutions / schemes for a range of client groups, such as dementia, autism etc (purpose build housing solutions)
- support safe / warm homes initiatives
- support complimentary services in meeting an individual's wider housing needs
- support handyman / minor adaptations schemes

support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

The prevailing ethos of our approach remains to ensure all individuals and communities have a health and care system that is equitable and designed around their specific requirements. For example, ensuring that the system looks to deliver a broad range of solutions that meet the outcomes most important to the individual. The focus on shifting the system upstream by redesigning it around principles relating to early intervention and prevention ensures that significantly more activity takes place within the community. This in itself will not only reduce health inequalities, but increase the health and wellbeing of the population. The approach is whole-population meaning that all protected characteristics (Equalities Act 2010) will benefit from the principles of redesign.

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Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
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- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Thurrock
Completed by:	Catherine Wilson
E-mail:	cwilson@thurrock.gov.uk
Contact number:	01375 652068

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Chair of the Health and Well-Being Board
Name:	Cllr James Halden

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting	
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Fri 10/12/2021	<< Please enter using the format, DD/MM/YYYY Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	James	Halden	JHalden@thurrock.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Mark	Tebbs	mark.tebbs@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		None	None	mark.tebbs@nhs.net
	Local Authority Chief Executive		Lyn	Carpenter	LCarpenter@thurrock.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Ian	Wake	Iwake@thurrock.gov.uk
	Better Care Fund Lead Official		Catherine	Wilson	cwilson@thurrock.gov.uk
	LA Section 151 Officer		Sean	Clark	Sclark@thurrock.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

10 December 2021	ITEM: 6
Thurrock Health and Wellbeing Board	
Thurrock Health and Wellbeing Strategy refresh	
Wards and communities affected: All	**Key Decision:** None
Report of: Jo Broadbent, Director of Public Health	
Accountable Director: Ian Wake, Director Adults, Housing & Health	
This report is Public	

Executive Summary

This paper provides an update on progress in refreshing the Health & Wellbeing Strategy (HWBS) for 2021-26. An 8 weeks consultation exercise commenced, as planned, on Wednesday 13 October. The consultation was scheduled to close on Friday 3 December.

There have been a variety of ways that people could get involved and provide their views on proposals for the refreshed Health and Wellbeing Strategy:

Have your say online

- Residents and partners have been provided with an opportunity to comment on the detailed Health and Wellbeing Strategy proposals and send us your comments online by going to the Council's online portal and completing the questionnaire[1]

Have your say face-to-face

- The consultation has been supported by Healthwatch Thurrock and Thurrock CVS (Community & Voluntary Services). People from these independent organisations have attended events across the borough and run community sessions to ask what residents what they think about our proposals.

Have your say at a workshop / Presentations

- Residents and members of existing community forums or focus groups, as well as wider, professional partnership groups and forums have taken the opportunity to learn more about our proposals with officers attending events and meetings throughout the consultation period.

[1] Have My Say: Thurrock Health & Wellbeing Strategy and https://consult.thurrock.gov.uk/thurrock-hwb-strategy-refresh

The engagement activity has successfully engaged a wide audience. However, there are a number of wider consultation events planned that focus on the Local Plan and Housing Strategy that would provide additional evidence and feedback from the public on their priorities.

It is proposed to facilitate the additional consultation opportunities the consultation exercise is extended until the end of December. This will not delay the publication of the final Strategy, planned for summer 2022.

1. Recommendation(s)

1.1 That members

- Agree to extend the consultation exercise until the end of December and consider and propose opportunities to engage the public and interested parties during the remainder of the consultation period.
- Consider and provide feedback on the consultation activities to date described in this report.

2. Introduction and Background

2.1 The HWBS is a whole system plan for health & wellbeing and a means to engage all partners in the wellbeing agenda, co-ordinating strategic thinking of all elements of the council and all system partners to deliver quantifiable gains in health and wellbeing of residents.

2.2 Thurrock agreed its first HWBS in 2013. The second and current HWBS was launched in July 2016 and can be accessed here: https://www.thurrock.gov.uk/strategies/health-and-well-being-strategy

2.3 The Health and Wellbeing Board considered proposals that had been developed and were being refined at its meeting in July, including plans to consult with the wider public.

3. Issues, Options and Analysis of Options

3.1. Preparatory work with system partners and HWBB Chair to date has identified the 6 key influences and suggested that the HWBS needs to:

- Be high level and strategic
- Be highly ambitious and set out genuinely new plans rather than just describe what has already been done
- Provide a clear narrative that drives the work of all aspects of the local authority, NHS and third sector
- Address resident priorities and be co-designed with residents
- Be place and locality based and take a strengths and assets approach, not focused only on deficits or services

3.2. Proposals have been developed based around six areas of people's lives, which we refer to as domains, that impact on people's health and wellbeing.

An eight week consultation process commenced on Wednesday 13 October and was scheduled to conclude on Friday 3 December 2021.

3.3. Following the consultation closing a report will be produced setting out the findings of the consultation exercise and how public feedback will be reflected in the refreshed Strategy. The report will be provided to Board at its meeting in February 2022, along with a draft Health and Wellbeing Strategy.

4. Reasons for Recommendation

4.1. The Health & Wellbeing Board (HWBB) has a collective statutory duty to produce a HWBS. It is one of two highest level strategic documents for the Local Authority and system partners, the other being the Local Plan. The statutory status of the document means that the new Integrated Care System (ICS) must have regard to it when planning their own strategy.

4.1. To alert Health and Wellbeing members to the live consultation exercise on the Health and Wellbeing Strategy refresh, secure agreement to an extension to the end of December and request support to raise awareness of the opportunity for people to get involved.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 The consultation material and approach has been considered and informed by a number of key council and partner strategic boards and governance structures.

5.2 As set out in the Executive Summary there have been a number of ways that the public and professionals could provide their views during the consultation exercise:

<u>Awareness raising</u>

To support awareness raising and promotion of the consultation exercise materials, were developed to provide a consistent, recognisable approach for raising awareness of the consultation exercise. These included branding, standard text to share information about and promote the consultation exercise and posters providing a QR code to the consultation portal.

Substantial and sustained communication and engagement activity has taken place to raise awareness of the consultation exercise amongst residents and partners. This has included:

- A press release issued in October
- Targeted emails and promotional material circulated by officers across the council, the CCG and the Council's Corporate Communications teams Thurrock VCS and Health Watch
- Regular promotional material made available through social media including Twitter and Facebook.

- A banner being included in Housing News enewsletter, Business Buzz enewsletter, Essex Violence & Vulnerability Unit newsletter
- Promoted on the Council's staff Intranet carousel and on the Thurrock Council website carousel
- Attendance at strategic and operational partnership meetings such as Thurrock Integrated Care Partnership (TICP)
- Included it in all editions of Thurrock News resident newsletter throughout the consultation period
- Included articles in Team Thurrock, our weekly staff enewsletter
- Promoted as part of the Council's Chief Executive's weekly blog and engagement of all council employees
- Discussion at all Council DMT and Overview & Scrutiny meetings
- Discussion at Conservative and Labour Group meetings
- Attendance at community forums and events including the Aveley Charrettes Local Plan, the Purfleet on Thames Community Forum and the Thurrock Diversity Network.
- Promotion via the Council Portal newsletter, reaching over 4000 residents.
- Joint engagement with other key plans such as the Local Plan and the Housing Strategy

Facilitating and supporting the public and partners to provide views

The Council's consultation portal provides detailed proposals for the refreshed Strategy. To facilitate and encourage feedback consultation respondents are only asked to provide feedback on areas that matter to them. Each of six proposed areas of people's lives, or domains, can be completed separately and will take between 10-30 minutes to complete.

User focused questionnaires have been created to facilitate members of the public providing feedback on specific domains and priorities that have been proposed for the refreshed Strategy. The content of the consultation portal has been reviewed and is in line with the engagement materials being used by CVS / Healthwatch.

Additionally, as the Strategy consultation exercise developed members of the public attending forums and meetings were provided with opportunities to set out their thoughts and priorities on each of the six proposed Strategy domains as a simple and easy way to provide feedback.

Engagement overview

At the time of writing this report (30 November 2021) the consultation exercise had resulted in:

- Over 1300 visits to the Council's consultation portal with over 100 visitors being engaged in the consultation questionnaire.

- 258 people engaged via Healthwatch, Community Builders and Thurrock CVS – 258
- 305 user focused summaries completed via Healthwatch, Community Builders and Thurrock CVS
- Additional feedback provided by partners and members of the public attending forums which will be reflected in the final consultation report.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The HWBS is one of two highest level strategic documents for the Local Authority and system partners, the other being the Local Plan. It is a whole system plan for health & wellbeing and a means to engage all partners in the wellbeing agenda, co-ordinating strategic thinking of all elements of the council and all system partners to deliver quantifiable gains in health and wellbeing of residents.

6.2 In order to support delivery of the Council's Vision, the 6 Domains of the HWBS Strategy each relate to one of the Council's key priorities of People, Place and Prosperity, as outlined in the attached slide set.

7. Implications

7.1 Financial

*Implications previously verified have not changed.

The cost associated with the strategy refresh will be delivered within existing budgets or agreed through existing Council and partner agencies governance finance arrangements.

7.2 Legal

*Implications previously verified have not changed.

The Health and Social Care Act 2012 established a responsibility for Councils and CCGs to jointly prepare Health and Wellbeing Strategies for the local area as defined by the Health and Wellbeing Board.

7.3 Diversity and Equality

Implications verified by: **Becky Lee**

Community Development and Equalities Team

Implications have not changed since previous approval provided in July 2021. The aim of the strategy is to improve the health and wellbeing of the population of Thurrock and reduce health and wellbeing inequalities. A

community equality impact assessment (CEIA) will underpin the strategy and mitigate the risk of disproportionate negative impact for protected groups. This approach will ensure the strategy itself and implementation supports delivery of the council's equality objectives while maintaining compliance with the Equality Act 2010 and Public Sector Equality Duty.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder, or Impact on Looked After Children)

The refreshed Health and Wellbeing Strategy will facilitate crime and disorder priorities that relate specifically to health and wellbeing, further strengthening the relationship between the Health and Wellbeing Board and Community Safety Partnership. The focus of the strategy is to broadly focus on addressing inequalities in Thurrock.

8. Appendices to the report

Appendix 1 – Summary Slides of HWB Strategy content being consulted on

Report Authors: Dr Jo Broadbent, Director for Public Health
Darren Kristiansen, Business Manager AHH, Secretary to HWB

HEALTH AND WELLBEING STRATEG 2022 TO 2026

Levelling the playing field in Thurrock

We want to hear your views on proposals to address health inequality

Jo Broadbent
Director of Public Health

HEALTH AND WELLBEING STRAT
2022 TO 2026

Levelling the playing field in Thurrock

We want to hear your views on proposals to address health inequality

Slide Pack Contents

1. Introduction – Purpose of the Health & Wellbeing Strategy
2. Vision - “Levelling the Playing Field”
3. 6 Key Domains of Health & Wellbeing in Thurrock
4. Outcomes Framework
5. Stakeholder & Community Engagement

1. Introduction

- Purpose of the Health & Wellbeing Strategy
  - The Health & Wellbeing Board (HWBB) has a collective statutory duty to produce a Health & Wellbeing Strategy (HWBS)
  - It is one of two highest level strategic documents driving Place Making for the local system partners, (alongside the Local Plan), which can engage all partners in the wellbeing agenda
  - It is a whole system plan for the HWBB, co-ordinating strategic thinking of all elements of the council and all system partners to deliver quantifiable gains in health and well being of residents
  - The statutory status of the document means that NHS partners must have regard to it when planning strategy
- Health & Wellbeing Board Aspirations for the Strategy
  - High level and strategic
  - Highly ambitious and set out genuinely new plans
  - Provide a clear narrative that drives the work of all aspects of the local authority, NHS, third sector and beyond
  - Address resident priorities and be co-designed with residents
  - Be place and locality based and take a strengths and assets approach

- Vision – "Levelling the Playing Field"
  - Intergenerational health inequalities still persist in Thurrock
  - Opportunities for every resident to reach their full potential are not shared equally
  - There is an unacceptable variation in access, service quality and outcome across health, care and wellbeing services with those with the greatest need often getting the poorest services and outcomes, which is genuinely unfair
  - The strategy will drive collective action across every council department, and through the NHS and through other key system partners to address this unfairness
  - Only by taking a *whole systems approach* can we hope to "level the playing field" and address this inequality of opportunity as part of our Place Making. Too often services work in isolation and do not support a shared goal, e.g. the impact housing and community can have on recovery from serious mental illness
- Key Milestones
  - Engagement Period = 11 October – 3 December 2021
  - Final Strategy sign-off by HWBB = March 2022
  - Full Council sign-off = June 2022
  - Launch = July 2022

HWB Strategy Guidance can be found here

2. Vision - "Levelling the Playing Field"

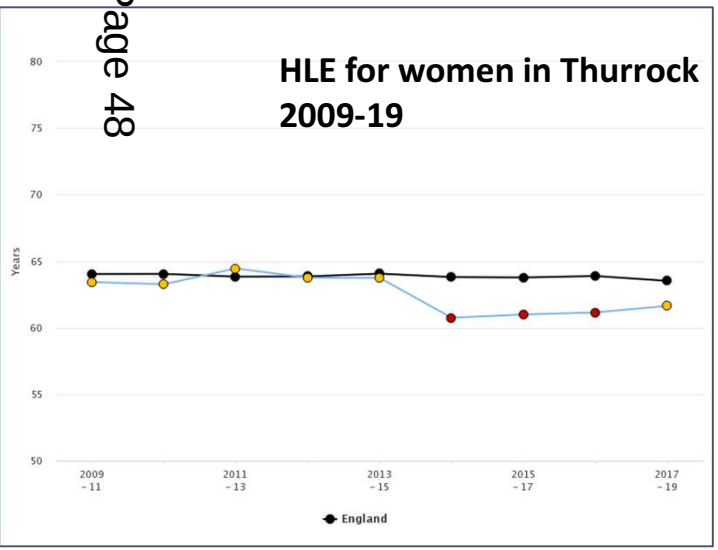
Thurrock experiences inequalities both as a whole when compared to England averages and also within the borough -

Life Expectancy (LE) in Thurrock compared to England

- LE in Thurrock has fallen **below England average** in the past 10 years
- For women, current LE is **significantly lower** than England average

Healthy Life Expectancy

- HLE for women is **significantly lower than England average:**



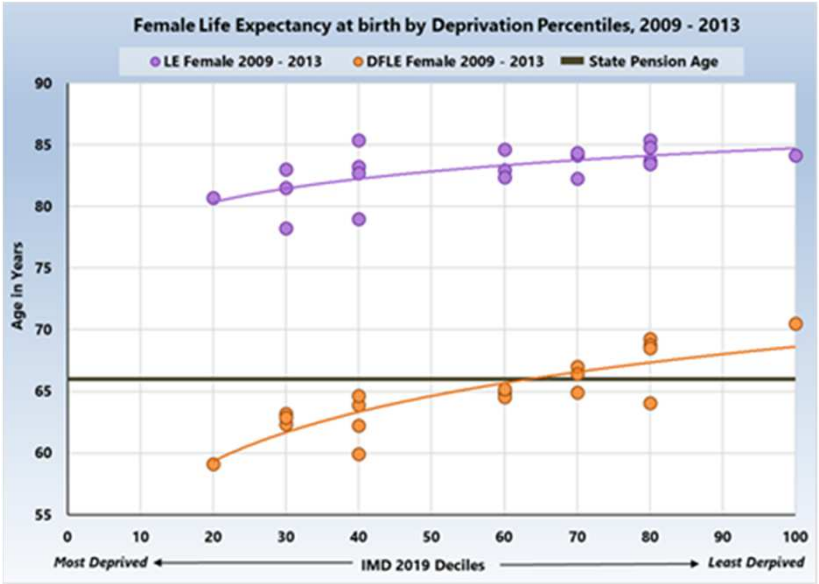
Healthy / Disability-Free Life Expectancy = the average number of years that an individual is expected to live in a state of self-assessed good or very good health (Health Profile for England, 2017)

Life Expectancy within Thurrock

- **9/6 year LE gap** between men/women in most and least affluent communities

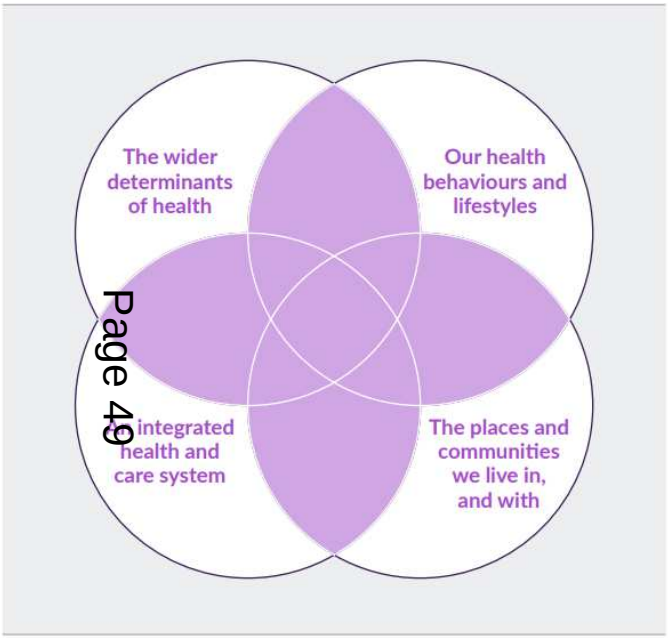
Healthy Life Expectancy

- Women in the most affluent areas of Thurrock experience **8 years more healthy life** than those in the most deprived
- Women in the most deprived areas experience **22 years in poor health:**



2. Vision – How do we Level the Playing Field in Thurrock?

Health & wellbeing status is driven by broad and complex influences –



The King's Fund highlight the following wider health determinants:

- Income
- Housing
- Education
- Best Start in Life
- Spatial planning
- Strong & Resilient Communities
- Access to Green Spaces
- Transport & Active Travel
- Jobs & Work
- Environment

[Source: https://www.kingsfund.org.uk/publications/vision-population-health](https://www.kingsfund.org.uk/publications/vision-population-health)

To Level the Playing Field, Thurrock HWB Strategy needs to take a broad approach and focus on all these areas as part of Place-Making eg:

National 'Levelling Up' agenda opportunities for Thurrock :

- Thames Freeport & Backing Thurrock agenda – secure inclusive growth
- The Towns Fund – creating opportunity in more deprived areas; promoting arts, culture & physical activity
- Skills Fund & Apprenticeships – opportunities for local young peop

ASELA Anchor Programme opportunities for Thurrock:

- Infrastructure & Housing – affordable housing, transport & infrastructure
- Technical University – skills development for adults & young people
- South Essex Estuary Park - green & blue spaces, improved air qualit

3. 6 Key Domains of Health & Wellbeing in Thurrock

- To truly Level the Playing Field, the HWBS needs to take a whole system approach, being a key driver not just of Council Directorate and Service Plans, but across the wider Thurrock system and the NHS Mid & South Essex Integrated Care System as well

- To have maximum impact, the HWBS needs to align with and draw on the resources and levers in other key strategies for Thurrock, including the Local Plan, and plans shared with neighbouring boroughs such as the Thames Freeport and ASELA

In order to support delivery of the Council's Vision, the 6 Domains of the HWB Strategy each relate to one of the Council's key priorities of People, Place and Prosperity :

PEOPLE	PEOPLE	PEOPLE	PROSPERITY	PLACE	PEOPLE
osed Domain 1 ng Healthier for Longer	**Proposed Domain 2** *Wider Determinants of Health* **Building Strong and Cohesive Communities**	**Proposed Domain 3 Person-Led Health and Care**	**Proposed Domain 4** *Wider Determinants of Health* **Opportunity for All**	**Proposed Domain 5** *Wider Determinants of Health* **Housing and the Environment**	**Proposed Domain 6** *Wider Determinants of Health* **Community Safety**
thier Thurrock"	**"Stronger Together Thurrock"**	**"Better Care Thurrock"**	**"A Fairer Thurrock"**	**"Healthy Places Thurrock"**	**"Safer Thurrock"**

omain 1 - Staying Healthier for Longer

gned with Thurrock Health & Care Case for Change & Brighter Futures Strategy

. Work with communities to reduce noking and obesity in Thurrock

- Implement a whole system plan for tobacco control and obesity, including focusing on priority groups including children & young people, pregnant women and minority ethnic groups.
- Work in partnership with communities and the voluntary sector to reduce inequalities through reducing smoking, obesity, and lack of physical activity.
- Embed smoking cessation in all relevant health & care pathways, including mental health and maternity pathways.

. Work together to improve evention of ill health and promotion of od health in all communities to duce Health Inequalities in Thurrock

- Work in partnership with communities to reduce inequalities through reducing smoking, obesity, and lack of physical activity
- Make prevention of ill health and promotion of good health everybody's business – with system-wide action to promote good physical and mental health for all, and address barriers to staying healthy in all communities including those experiencing multiple deprivation and marginalization
- All Health, Care and Council strategies in Thurrock should identify health inequalities within and caused by the strategy, the communities affected and identify actions to address those
- Ensure that children are able to access the services they need and be healthy, focusing on prevention and early intervention

. Continue to enhance identification d management of Long Term nditions to improve physical and ental health outcomes for all

- Continue with improvements in identification and management of Long Term Conditions in primary care
- Ensure access to joint clinical and social care to improve health outcomes for individuals with multiple needs, including support for self-care and health coaching, with a focus on individuals living with both physical and mental ill health problems and/or with substance misuse problems
- Innovate beyond traditional models of healthcare planning and delivery such as co-production with Community & Voluntary sector, building community-led approaches to wellbeing, and using preventative data-based approaches such as Population Health Management
- Review and enhance support for transition from young people to adult to older adults services so they are person-centered, holistic and seamless

. Prioritise post-COVID-19 service covery and reset to meet new and orsening health needs

- Understand and treat new or worsened health needs as a result of the COVID-19 pandemic, including mental ill health and Long Covid
- Ensure a robust Health Protection response to infectious diseases and environmental threats to health, including: outbreak surveillance & management, maximising uptake of immunisations and promoting sexual health
- Cancer pathway delays due to COVID-19 will be addressed as a priority and more cancers will be prevented, identified early and successfully treated by 2026

omain 2 - Building Strong and Cohesive Communities

igned with Stronger Together Thurrock

A. Improve the way we engage with ur residents to ensure everyone an have their voice heard

- We will implement a new approach to engaging local communities to understand what matters to them and the types of services and support that they need where they live and across Thurrock.
- Use priorities from community conversations to influence health and care priorities and resource allocation

B. Ensure people have the skills, onfidence and ability to contribute s active citizens and are mpowered to influence the ecisions that affect their lives

- We will commit to a strengths-based approach to how resources are used to support community-led initiatives.
- We will seek to maximise local investment and consider a range of funding opportunities such as grants which enables the voluntary sector to deliver against agreed outcomes
- We will continue to lead work on volunteer recruitment and promoting active citizenship, for example via Our Road
- We will ensure the Stronger Together directory is used widely across partners as the 'one-stop-shop' for residents to seek information about support in Thurrock
- We will use our Social Value Framework to increase social, environmental and economic outcomes that reflect local priorities

C. Promote opportunities to bring ifferent communities together to nhance shared experience and to mbed a sense of belonging

- We will invest in supporting staff from across different agencies to work together within localities, supporting people where they live to help better connect them with local community led support
- We will seek to better embed existing community assets into the heart of community life, seeking opportunities to enhance and improve to enable more local activities that support wellbeing
- We will encourage events that demonstrate our commitment to equality, diversity and inclusion and pursue education and discussion to tackle discrimination, e.g. Holocaust Memorial Day, Pride Month and wider events that support inclusion.

main 3 - Person-Led Health and Care

ned with Better Care Together Thurrock

Development of more integrated adult health care services in Thurrock

- Developing new ways of working with flexible solutions delivered close to home and focused achieving what is most important to the individual, such as locality social work teams who wo alongside NHS and Housing colleagues
- Developing and building on innovative and creative approaches that deliver new and varied models of care such as expanding Wellbeing Teams and Micro-Enterprises

mproved Primary Care response that includes ly access, a reduced variation between tices and access to a range of professionals

- Define what the offer looks like i.e. improved telephony, greater use of digital access such as online platforms, remote/video consultations for those that prefer these methods whilst still retaining the traditional face to face consultations where required
- Recruitment of wider health care professionals (eg clinical pharmacists, physiotherapists, me health practitioners, social prescribers) within the primary care workforce, to add capacity an help make best use of GP time

elivery of a Single Workforce Locality Model – alth & care workforce that works across nisational boundaries to be able to provide a nless and integrated response

- A new model of community care delivered by local teams based in each of the four Primary C Networks based in Grays, Tilbury & Chadwell, Stanford-Le-Hope and Aveley, South Ockend and Purfleet)
- Empower staff to work across organisational boundaries and trial innovative health and care solutions such as multi-skilled professional roles to reduce the number of professionals invo in delivering someone's care

elivery of a new place-based model of missioning that makes the best use of able resources to focus on delivering omes that are unique to the individual

- Development of four Community Investment Boards and four integrated locality budgets (alig to Primary Care Networks) that enable local people and users of services to direct how availa resource should be used
- Develop a new relationship with health and care providers that enables them to work with oth to design and deliver improved solutions and outcomes for those they support

omain 4 – Opportunity for All

gned with Backing Thurrock and Brighter Futures Strategies

hrough raising aspirations and reducing the vantage gap, all Thurrock Children and Young e are able to achieve their potential	• All children in Thurrock will be making good educational progress, with improved educational attainmer all disadvantaged children and young people. • Increase applications to higher education and apprenticeships from young people from disadvantaged backgrounds.
aising aspirations and opportunities for Adults to nue learning and developing skills, with a focus on s that can benefit most	• Through identifying what the key skills needed are (e.g. literacy, numeracy, IT and resilience), adults ar young people will be supported with developing these skills to increase access to opportunities for furth skills development and employment. • An increased proportion of people in Thurrock are engaged in enterprise including social enterprise an volunteering.
elivering the Backing Thurrock Plan in a way that orts the economically vulnerable in developing ence will result in more residents being able to it from employment opportunities	• More adults are able to access sustained employment and therefore a reduction in those needing to cl benefits • Those from vulnerable groups or places in the borough who have lost jobs through the pandemic are supported so they are able to find work and benefit from opportunity to re skill or upskill where this is w they want to do. • Opportunities will be maximized for residents to find and retain jobs during the construction and operati the major regeneration projects.
orking in partnership to level up opportunity and e the inequality that exists physically and socially ople living in disadvantaged circumstances	• A holistic, joined up approach to levelling up will be taken through early intervention and support throug life course approach, starting with children and young people. • A holistic approach will be taken to supporting the most vulnerable in the community, tackling inequaliti and integrating skills and employment projects with for example DWP, NHS, criminal justice, wellbeing support services.
reating a vibrant local culture & economy, uraging investment in people and in places across ock to benefit from the enormous opportunities ated through the Thames Freeport and other major opments such as SEE Park	• The Council will work with the Business Board and Anchor Institutions to establish new ways of workin together by building on our strengths and collaborating to increase local recruitment, develop local sup chains, attract public and private inward investment and make best use of assets. Social Value opportu will be explored in doing this. • Enable residents to start and develop new businesses, including social enterprises that will grow and generate wealth and employment in Thurrock

omain 5 - Housing and the Environment

gned with the Local Plan, Housing and Homelessness Strategies

educe homelessness in Thurrock	• Identify people at risk of homelessness early and prevent homelessness by adopting a holistic offer across services. This will focus on enabling people to progress to housing that offers more security, stability and is more suitable for their needs than their current situation delivers. • Provide appropriate and timely support for people experiencing rough sleeping by sharing knowledge between partners to help identify those individuals.
cilitate and encourage maintenance of quality homes in Thurrock to support the of residents, protecting them from ls such as cold, damp and mould	• Thurrock Council will ensure properties are of good condition (safe, suitable) in the public sector. • New homes will be developed that will keep people well and independent, based on recognised quality design standards.
ovide safe, suitable and stable housing ons for people who have or who are encing domestic abuse / violence and / ual abuse / violence	• Deliver expert advice through a single route to support regarding housing, skills, employment and other needs of people experiencing or who have experienced domestic and/ or sexual abuse and / or violence. • Review and revise the existing joint protocol for supporting those at risk of homelessness because they are fleeing domestic and sexual abuse. • Implement Thurrock Council's new Housing Domestic Abuse Policy, ensuring all relevant council departments are aware and applying this.
cal Plan Design Principles will improve through opportunities to increase cal activity, promote mental wellbeing duce exposure to air pollution	• Improve accessibility and equity of access through walking and cycling infrastructure and public transport to services; especially to education, employment, healthcare and nature. The priority will be to deliver these accessibility improvements where deprivation is most apparent. • Reduce car dependency through a well-connected and sustainable transport system, which encourages a modal shift to more sustainable modes of transport such as walking and cycling, particularly in the urban areas. • Adopt a whole council approach to prioritising park maintenance and improvements, to increase the quality and experience, especially in areas where access is poorest and where health outcomes related to physical inactivity and mental health are worse.
generation and future developments will o build community resilience and social , and reduce antisocial behaviour, to ve the quality of environment enced by all people in Thurrock	• A responsive service should be provided to all residents and tenants experiencing anti-social behaviour. • Local Plan Design Principles, Policy and Strategy, and the design of new neighbourhoods, will focus on opportunities to enhance community resilience and social capital, and reduce antisocial behaviour

omain 6 - Community Safety

gned with Thurrock Community Safety Partnership Priorities

Enable all children to live safely in ir Communities

- Facilitate a coordinated strategic approach to tackle Serious Youth Violence and Vulnerability
- Continue to tackle Exploitation by Organised Crime Groups (i.e. gang related activity) including the u offensive weapons, and support young people and vulnerable people at risk of being exploited by g (including cuckooing)
- Ensure a multi-agency approach to tackling Child Sexual Exploitation and ensuring all possible ac are taken to protect victims

Reduce local levels of crime which result in fewer victims of crime and ke Thurrock a safer place to live

- Work in partnership to strengthen local approaches to reducing crime including designing out crime
- Strengthen local approaches to reducing crime through early intervention with those displaying ha behaviours
- Implement a Contextual Safeguarding Approach across the Thurrock Partnership in order to children and young people safe and disrupt criminal activity and exploitation
- Implement approaches to reduce perpetrator offending, with a targeted focus on scams, modern sla adult sexual exploitation, cuckooing and hate crime
- Consult with residents in order to address locations of concern and increase public perceptions of sa

Improve the local response to pporting victims/survivors of crimes mprove their health and wellbeing

- Work in partnership to enhance holistic approaches to supporting victims/survivors cope and re from their experiences, including physical and mental health outcomes
- Consult with victims/survivors of crime to understand the barriers and facilitators to accessing supp order to inform local service provision
- Prioritise the identification and offer of support to those who have experienced abuse/exploitation d the COVID-19 pandemic
- Upskill the workforce to identify victims/survivors of crimes and respond appropriately to disclosures

Work in partnership to prevent and er crime, with a focus on those with reased risk of experiencing crime

- Provide strong local leadership to transform the way we tackle Violence Against Women and Girls, w key focus on domestic abuse and sexual violence and abuse
- Ensure a dedicated focus on safeguarding vulnerable groups and those with increased likeliho being the victims of crime and exploitation

4. Outcomes Framework

The outcomes framework will include key metrics with 5 year aspirations of improvement, for each of the priorities in the strategy. The 2016-21 framework was structured as below:

DOMAIN	PRIORITY	Indicators	Baseline	Target %by 2020	Source
A. OPPORTUNITY FOR ALL	A1. All children in Thurrock making good educational progress	% of children achieving GLD at the end of year R	72.5%	80%	SFR36. www.gov.uk.
		Gap between above indicator and % of children on pupil premium achieving GLD at end of year R			
		% of all children achieving National Standard or greater depth	85%		
		% of young people gaining the higher grades in attainment and progress across the 8 subjects making up the National Curriculum (Attainment 8 and Progress 8)	70%		
		% of children achieving 5 good GCSEs at A – C including English and Maths			
	A2. More Thurrock residents in employment, education or training.	% of working age population who are economically active	77.7%		NOMIS
		% of the population of working age claiming Employment Support Allowance and incapacity benefits	5.0		NOMIS
		% of population claiming JSA	1.4%		NOMIS
		% of 16 – 19 year olds Not in Employment, Education or Training	5.3%		
	A3. Fewer teenage pregnancies in Thurrock.	Under 18 conception crude rate per 1000	36.1		PHOF indicator 2.04

5. Stakeholder & Community Engagement

The consultation period for the refreshed Strategy will take place from 13 October – 3 December and comprises:

Have your say online

- You can read our proposals and send us your comments online by going to Have My Say: Thurrock Health & Wellbeing Strategy @ https://consult.thurrock.gov.uk/thurrock-hwb-strategy-refresh

Have your say face-to-face

- The consultation is being supported by Healthwatch Thurrock and Thurrock CVS (Community & Voluntary Services). People from these independent organisations will attend events across the borough and run community sessions to ask what you think about our proposals.

Have your say at a workshop

- If you would like to discuss ideas by attending a workshop, please let us know by emailing us at the address below. If enough people are interested, we'll organise workshop sessions and contact you with the details.

Invite us to your community meeting

- If your community forum or community group would like us to attend one of your meetings so we can discuss the proposals with you, please let us know by emailing us at the address below. We'll be happy to attend, subject to availability of our staff on the meeting date.

Contact us @ ahh-bmt@thurrock.gov.uk to get involved or invite us to your meeting or event.

Friday 10th December 2021	**ITEM: 7**
Thurrock Health and Wellbeing Board	
Breastfeeding Needs Assessment for Thurrock	
Wards and communities affected: All	**Key Decision:** Not applicable
Report of: Beth Capps, Senior Public Health Programme Manager	
Accountable Assistant Director: Dr Jose Ortega (interim)	
Accountable Director: Dr Jo Broadbent	
This report is public	

Executive Summary

Every Health and Wellbeing Board has the responsibility to produce a Joint Strategic Needs Assessment (JSNA) for their area, which should give a comprehensive overview of the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, wellbeing and social care services.

In Thurrock, the Public Health team produce Joint Strategic Needs Assessment documents themed around particular topics, one of the most recent of these covers Breastfeeding Initiation and continuation. Low breastfeeding prevalence in Thurrock as well as nationally presents a serious public health issue.

The report sought to further our understanding of the complexities surrounding breastfeeding and provide evidence based recommendations to inform service delivery. Findings informed the recommendations using knowledge from the service description and demography in Thurrock, examination of the published evidence base, a review of good practice working in other areas and a commissioned piece of social marketing research to explore the lived experience of Thurrock families.

The report was written in 2019 and was due to be presented to the Health and Wellbeing Board in March 2020. This has been delayed due to the Covid-19 pandemic. The data has been refreshed in October 2021 to the most up to date available however the literature review and social marketing research has remained from the original report. The Covid-19 pandemic is likely to have impacted on the uptake of breastfeeding and inequalities between different groups of mothers. The recommendations from this piece of work are recommended to be taken forward in the context of Covid recovery.

1. Recommendation(s)

1.1 The partnership board consider and endorse the Breastfeeding Needs Assessment for Thurrock.

1.2 The partnership board support the development of a breastfeeding strategy and delivery plan with partner organisations engaging with this work through the new 'Child Health Group' delivering Strategic Priority 2 of the Brighter Futures Strategy.

1.3 The board are requested to highlight any links that need to be made with a view to alignment across the system, in particular with primary care.

2. Introduction and Background

2.1 Low breastfeeding rates present as a serious public health issue. Infants who are not breastfed may be unable to take advantage of a number of health and wellbeing benefits, such as; positive impact on attachment, a reduction in Sudden Infant Death Syndrome (SIDs), reduction in childhood illnesses and disease, as well as nutritional benefits. The low rates of breastfeeding in the UK, which can also have an impact on future health, represent a serious public health challenge. There is a need therefore to prioritise breastfeeding as part of Early Years and Public Health policy and to better understand why this picture presents.

2.2 In Thurrock 59.1% of babies born in 2018/19 had their first feed as breastmilk. The average for babies in England was 70% and in the East of England region as an average it was 67.4% for 2018/19[1] (see Figures 18 and 19 included in the data section 2.4 on p 20 & 21 of the main Needs Assessment document).

2.3 In Thurrock as with the UK nationally, breastfeeding rates (exclusive or partial/combination feeding) reduce quite considerably by 6-8 weeks post birth, to only 48%[2] in 2019/20.

2.4 There are numerous policies relating to breastfeeding nationally. National Institute for Health and Care Excellence (NICE) guidance recommend development of an overall infant feeding strategy which promotes breastfeeding, supports safe formula feeding and helps families to develop positive emotional relationships with their babies. This guidance places emphasis on positively influencing the child's future educational attainment, social skills, self-efficacy and self-worth. At the other end of the spectrum: Health Matters, World Health Organisation (WHO) and United Nations International Children's Emergency Fund (UNICEF) advocate for the Baby Friendly Initiative (BFI) in which breastfeeding is promoted for the first 2 years

[1] Public Health England, Child and Maternal Health Profiles, 2018/19
[2] Public Health England National child and maternal health intelligence network 2019/20

of life and exclusively for the first 6 months. If organisations become BFI accredited, they should not promote formula feeding, bottles or teats, and the standards advocate for breastfeeding care being the standard offer opting for a hard line nudge towards breastfeeding.

2.5 The purpose of this Health Needs Assessment is to gain a better understanding of the complexities surrounding breastfeeding and provide evidence based recommendations to inform service delivery.

2.6 The objectives of the Needs Assessment are to:

- Understand the demographics relating to Breastfeeding in Thurrock including; key health data, breastfeeding prevalence, local contextual information, and how the national context in relation to breastfeeding relates to this.
- Describe the local offer in Thurrock to support families to breastfeed.
- Understand what the published evidence base tells us works to support families to initiate and continue breastfeeding.
- Review what other areas locally and nationally are doing to increase breastfeeding prevalence by supporting families to breastfeed.
- Develop an in depth understanding of local families and professionals experiences of breastfeeding.
- Articulate a call to Action, making recommendations from the findings of this health needs assessment.

2.7 <u>Recommendations</u>

A series of strategic system recommendations are made within the needs assessment report. The Covid -19 pandemic has posed challenges worldwide in terms of provision of maternal and new born support which are likely to have impacted on uptake of breastfeeding and inequalities between certain groups of new mothers. The recommendations of the needs assessment need to be taken forward as part of COVID recovery.

The themes include:

2.7.1 System wide change – Including the development of a Thurrock approach; within the Mid and South Essex (MSE) Local Maternity & Neonatal System(MSE) that follows National Institute for Health and Care Excellence (NICE) guidance as well as local findings to offer support to families in making a healthy choice to exclusively breastfeed for 6 months and longer. The development of a single point of access information pack containing consistent advice across the pathway.

2.7.2 Digital support offer- to be provided through the Early Years Wellbeing workstream to offer families information in an accessible digital way.

2.7.3 Messaging/Normalising breastfeeding- Developing a place based approach to normalise breastfeeding in the community and wider environment by working with businesses to enhance the number of

breastfeeding friendly venues in Thurrock making this visible to the community.

2.7.4 ***Service and support offer***-Development of a training offer, expansion of this within the workforce to improve consistency of information given to families. Introduction of the concept of a family 'plan' to demonstrate the commitment to breastfeeding. This will support the wider family to understand and respect parents' decisions to breastfeed whilst promoting inclusion of family member, who are able to support in other ways.

2.7.5 ***Involving Dads and partners*** - work with the LMNS towards routine inclusion of dads and partners in all feeding discussions as part of the antenatal provision through maternity services (linked to the training re-fresh and incorporated in the Early Years wellbeing offer). Building in provision to the antenatal offer of an inclusive session focussing on breastfeeding; targeted to both parents.

2.7.6 ***Specialist support*** – To undertake a review of breastfeeding support for women who have had C-Sections within the existing maternity offer. Earlier identification and treatment of tongue tie to be explored through the LMNS and review any existing pathway for treatment and support for this issue, to maximise opportunities to advise new parents and support them to continue breastfeeding. Strengthen pathways for women with postnatal depression and those identified with or suspected postnatal illness to ensure timely support with breastfeeding to facilitate initiation and maintenance.

2.8 During the delay with the governance process for this JSNA product some of the recommendations have been able to be partially progressed along with linked pieces of work. The Thurrock Early Development Digital Initiative (TEDDI) has involved the commissioning of an app for parents and carers called 'Ask Teddi' looking to improve health outcomes for Thurrock's youngest residents and increase parent/carer confidence with breastfeeding, providing a healthy diet and offering physical activity opportunities. The first evaluation of the app and the impact on families in Thurrock is due to be completed at the end of 2021. The app has used the intelligence gathered through the Social Marketing element of this needs assessment in developing and designing the breastfeeding content.

2.9 The development of the delivery plan following agreement of the recommendations outlined in section 2.7 has been aligned to the Brighter Futures Strategy Strategic Priority 2: Children are able to access the services they need and be healthy, focussing on prevention and early intervention. The Child Health Group has been established to deliver the aims and objectives of Strategic Priority 2 which includes delivering the recommendations within this Needs assessment.

3. Issues, Options and Analysis of Options

3.1 These are set out in detail in the needs assessment report itself.

4. Reasons for Recommendation

4.1 Need has been identified in a robust way by providing;

- a descriptive analysis of the demography and the service offer in Thurrock,
- a web search and discussions with relevant stakeholders to support the development and mapping of the local offer in Thurrock,
- a review of the published evidence base and comparison of good practice in other areas,
- a commissioned piece of social marketing research, consulting with Thurrock families and stakeholders to provide in depth look at families' experiences of breastfeeding.

4.2 By identifying what supports families in Thurrock to breastfeed, what prevents or stops families from breastfeeding and identifying how can we maximise and extend the positive elements to overcome barriers, a series of themed strategic recommendations have been made to support to development of a strategy to deliver this (see chapter 7 of the needs assessment report).

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 The Needs Assessment has been presented and approved at Public Health Leadership Team (Jan 2020), the Brighter Futures Operational Steering group as well as the Brighter Futures Children's Partnership Board (March 2020).

5.2 The Needs Assessment is on the forward plan to be shared with the Health Overview and Scrutiny Committee in 2022.

5.3 Consultation with Parents and professionals has taken place through the social marketing research commissioned from Upshot Marketing that formed part of the Needs Assessment process (see chapter 6 of appendix 1). The full social marketing research report is also included in the Needs Assessment document appendix 2 - submitted as appendix 1 to this report.

5.4 The social marketing research focussed on the lived experiences of women and their families in Thurrock relating to breastfeeding, using surveys and focus groups, taking a thematic analysis approach. The recommendations are incorporated in chapter 8 of the needs assessment report

6. Impact on corporate policies, priorities, performance and community impact

6.1 The report contributes towards the 'People' priority – *a borough where people of all ages are proud to work and play, live and stay*, as the recommendations

support more families making informed and healthy choices around breastfeeding through

- building on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing; and
- communities being empowered to make choices and be safer and stronger together.

6.2 The recommendations also contribute towards the Thurrock Health and Wellbeing Strategy 2016-21 goals A and E: Opportunity for All and Healthier for Longer respectively and the proposed domain 3 with the refreshed strategy due for publication in 2022.

7. Implications

7.1 The sign off for these implications was given in March 2020, as the implications have not changed further sign off was not sought.

7.2 Financial

Implications verified by: **Mike Jones**

Strategic Lead- Corporate Finance

Any specific investment decisions arising from the recommendations in this report would be subject to the approval of a detailed business case. This will be reviewed in line with the grant allocation for the financial year and subject to approval by the public health leadership team and Public Health Director.

7.3 Legal

Implications verified by: **Judith Knght**

Strategic Lead for Safeguarding (legal services) and Deputy Monitoring Officer

Under Section 116 of the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care act 2012) the Local Authority and CCG must prepare a Joint Strategic Needs Assessment. The government produced statutory guidance in 2013 on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

The Joint Strategic Needs Assessment can be undertaken in a manner appropriate to local circumstances and can be informed by more detailed needs assessments such as those which relate to specific parts of the community.

Where a Joint Strategic Needs Assessment has been prepared the Local Authority and CCG must prepare a strategy to meet those needs under Section 116A of the 2007 Act.

7.4 **Diversity and Equality**

Implications verified by: **Becky Lee**

Team Manager – Community Development and Equalities

Mothers from Black and Minority Ethnic (BME) groups are more likely to initiate breastfeeding than white mothers. Due to the higher than average proportion of BAME groups in Thurrock this could be masking true breastfeeding rates observed. The report explores the barriers to breastfeeding in non-BAME groups in particular and makes recommendations to address those barriers to increase uptake in this sub-group of the population.

A diversity of socio economic status exists in Thurrock with varying rates of child poverty observed and highlighted within the report. The report also highlights evidence that women in more socioeconomically deprived groups are less likely to breastfeed, the recommendations have been made to contribute to reducing this variance.

Low breastfeeding rates in Thurrock coupled with the fact that families on low income are less likely to breastfeed has the potential to widen the gap in health inequalities and life expectancy.

7.5 **Other implications: Health**

Recommendations within the needs assessment report should contribute to improving the health and wellbeing of infants and mothers in Thurrock and reduce the inequality between subgroups.

Breastfeeding is associated with reduced risk of children becoming obese later in life. There are significantly higher rates of obesity in year six pupils than the England and regional averages. The current low breastfeeding rates in the borough could be contributing to the obesity prevalence observed in year six children; although it is recognised that obesity is an extremely complex and multi-faceted issue.

8. Background papers used in preparing the report

- Detailed references are given in the main Needs Assessment included as an appendix.

9. Appendices to the report

- Breastfeeding Needs Assessment for Thurrock

- Executive Summary Breastfeeding Needs Assessment for Thurrock

Report Author:

Beth Capps
Senior Public Health Programme Manager
Public Health

Breastfeeding Needs Assessment for Thurrock

Executive Summary

March 2020

Contents

Note:
This report was initially written in 2019 ahead of the Covid-19 pandemic and therefore the search parameters of the literature review and the social marketing element reflect this. The data in sections 1 and 2 have been updated subsequent to the pandemic due to a refreshed method for collecting breastfeeding initiation data being established and published.

A copy of the full version of this report will be available on the Thurrock Council website at: thurrock.gov.uk/public-health-reports

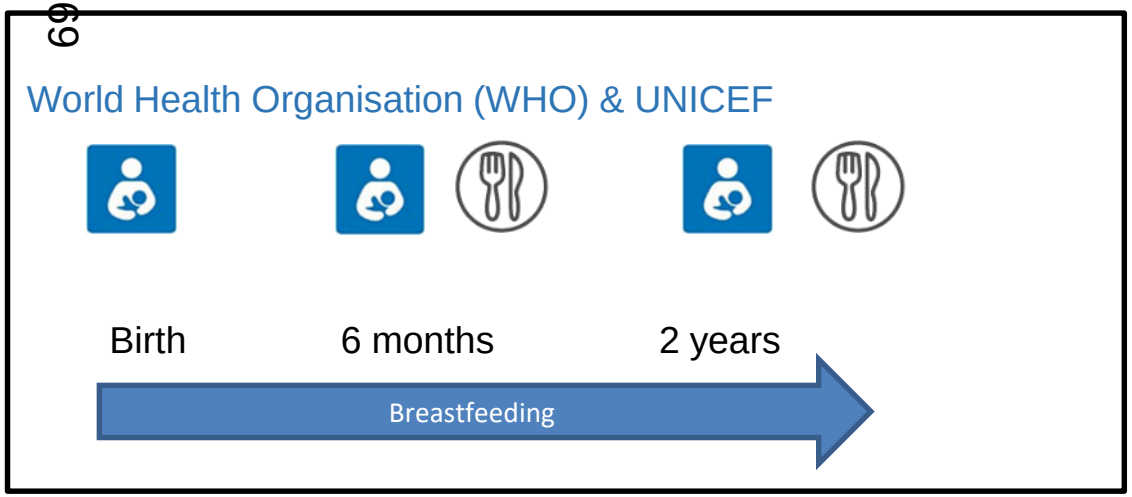
Abbreviations

Abbreviation	Full Form
BFI	Baby Friendly Initiative
BME	Black & Minority Ethnic Groups
BRAs CIC	Breastfeeding Reassurance & support Community Interest Company
BTUH	Basildon & Thurrock University Hospital
CF	Combination Feeding
C-Section	Caesarean Section
EBF	Exclusive Breastfeeding
HWBS	Health & Wellbeing Strategy
LMNS	Local Maternity & Neonatal System
NCT	National Childbirth Trust
NICE	National Institute of Health and Care Excellence
NELFT	North East London Foundation Trust
SIDs	Sudden Infant Death Syndrome
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organisation

National Context:

Low breastfeeding rates present as a serious public health issue. Infants who are not breastfed may be unable to take advantage of a number of health and wellbeing benefits; such as positive impact on attachment, a reduction in Sudden Infant Death Syndrome (SIDs), reduction in childhood illnesses and disease, as well as nutritional benefits. The low rates of breastfeeding in the UK, which can also have an impact on future health, represent a serious public health challenge. There is a need therefore to prioritise breastfeeding as part of Early Years and Public Health policy and to better understand why this picture presents.

The UK is one of the most poorly performing countries in the world in terms of breastfeeding continuation. Nationally, 68% of babies receive breastmilk as their first feed but only 48% mothers continue to breastfeed at 6-8 weeks. This falls even further by 6 months of age with only an estimated 1% of babies being breastfed exclusively. The World Health Organisation (WHO) and United Nations International Children's Emergency Fund (UNICEF) recommend that breastfeeding continue from birth to age 2 years and exclusively for the first 6 months of life.



Nice Guidance recommend development of an overall infant feeding strategy which promotes breastfeeding, supports safe formula feeding and helps families to develop positive relationships with their infants. This guidance places emphasis on positively influencing the child's future outcomes in terms of educational attainment, social skills, self-efficacy and self-worth.

In turn, Health Matters, WHO and UNICEF advocate for the Baby Friendly initiative (BFI) whereby breastfeeding is promoted for the first 2 years of life with exclusive breastfeeding from birth to 6 months. In line with this WHO and UNICEF produced their 'ten steps to successful breastfeeding' in which it suggests that hospitals should not promote formula feeding, bottles or teats, with breastfeeding offered as standard care, with a hard line nudge towards breastfeeding.

unicef UNITED KINGDOM
THE BABY FRIENDLY INITIATIVE

NICE
National Institute for Health and Care Excellence

Objectives:

This Needs Assessment supports Goals A and E of Thurrock's Health and Wellbeing Strategy 2016-2021, namely; Opportunity for All and Healthier for Longer respectively and will provide a deeper insight into how we can work to meet these goals and improve breastfeeding initiation and duration. With the Health and Wellbeing Strategy under consultation to be refreshed with publication in 2022 this will support the proposed domain 3: Healthier for Longer.

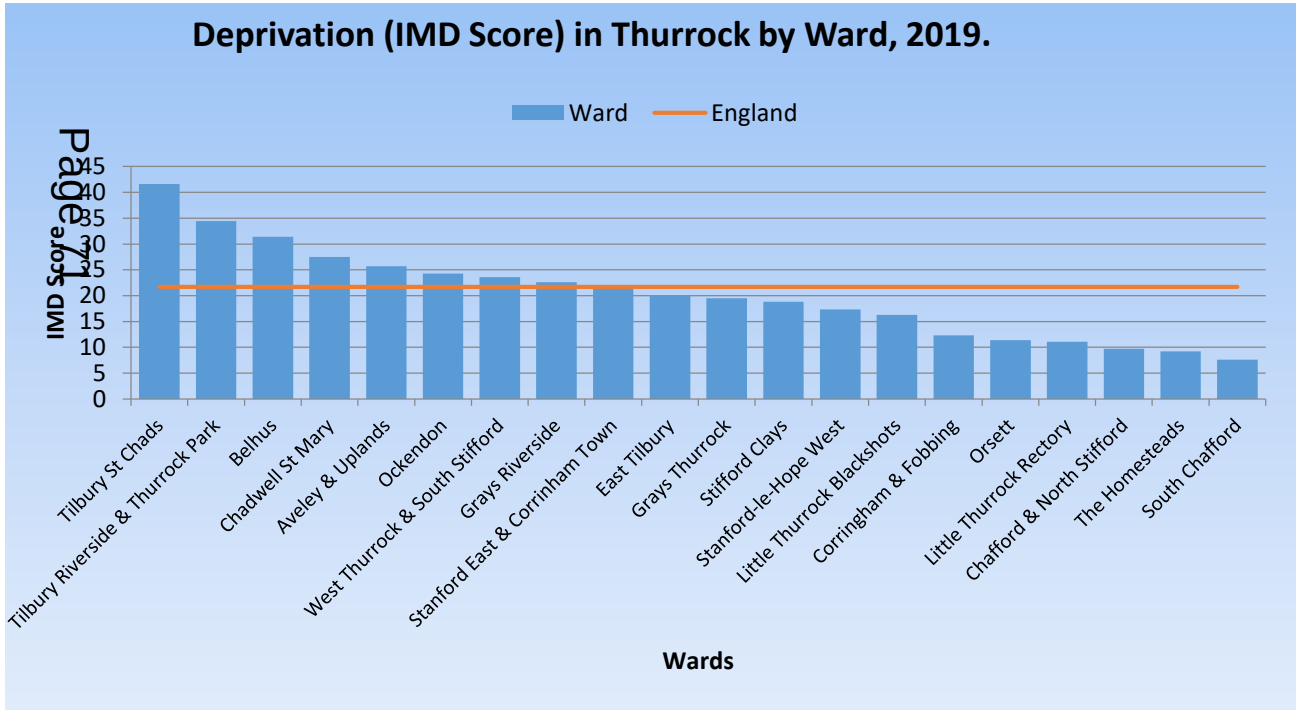
The Needs Assessment will achieve the following objectives:

- understand the demographics relating to Breastfeeding in Thurrock including key health data, breastfeeding prevalence, local contextual information and how the national context in relation to breastfeeding relates to this.
- Describe the local offer in Thurrock to support families to breastfeed.
- Understand what the published evidence base tells us works to support families to initiate and continue breastfeeding.
- Review what other areas locally and nationally are doing to increase breastfeeding prevalence by supporting families to breastfeed.
- Develop an in depth understanding of local families and professionals experiences of breastfeeding.

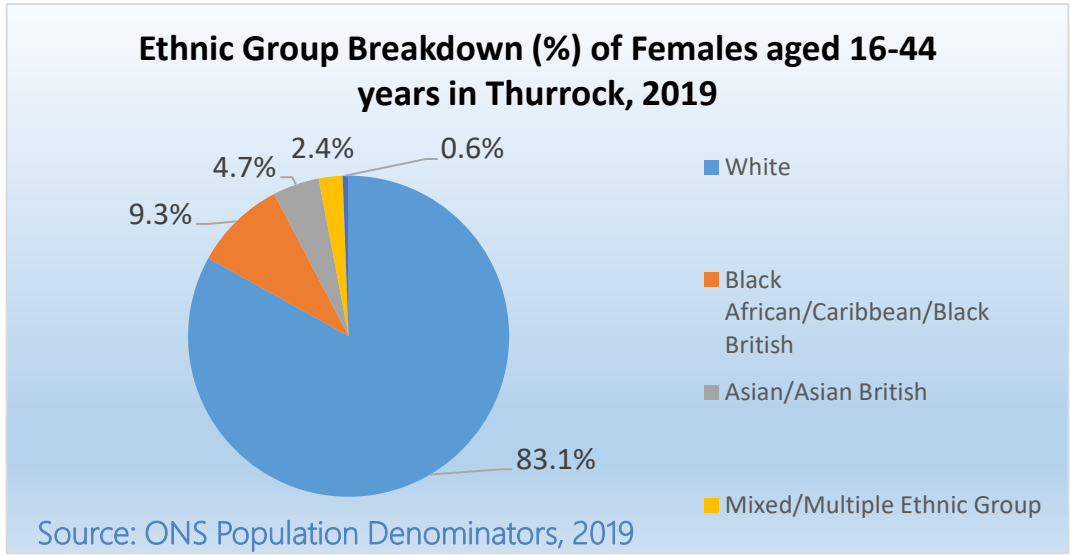
Local Context -Who lives in Thurrock?

In 2020 Thurrock had a total population of 175,531. Of this total population there were 37,002 women defined as being of child bearing age. The majority of females of child bearing age were recorded as white (83.1%) followed by those from black ethnic groups (9.3%) (see top adjacent figure). Research suggests that women from BME groups are more likely to initiate and maintain breastfeeding than white women.

Deprivation in the borough varies by ward and as can be seen in the adjacent figures, both wards comprising Tilbury having the highest deprivation score with South Chafford experiencing the lowest levels of deprivation. Evidence suggests that breastfeeding rates in the UK are significantly lower among families on low income.



Source: Local Health, 2019.



Source: ONS Population Denominators, 2019

In 2011 45.8% of households in Thurrock have children of which 34.8% have dependent children.

Those who are married or in a civil partnership with dependant children make up the largest household type (17.9%) followed by lone parent households (7.6%).

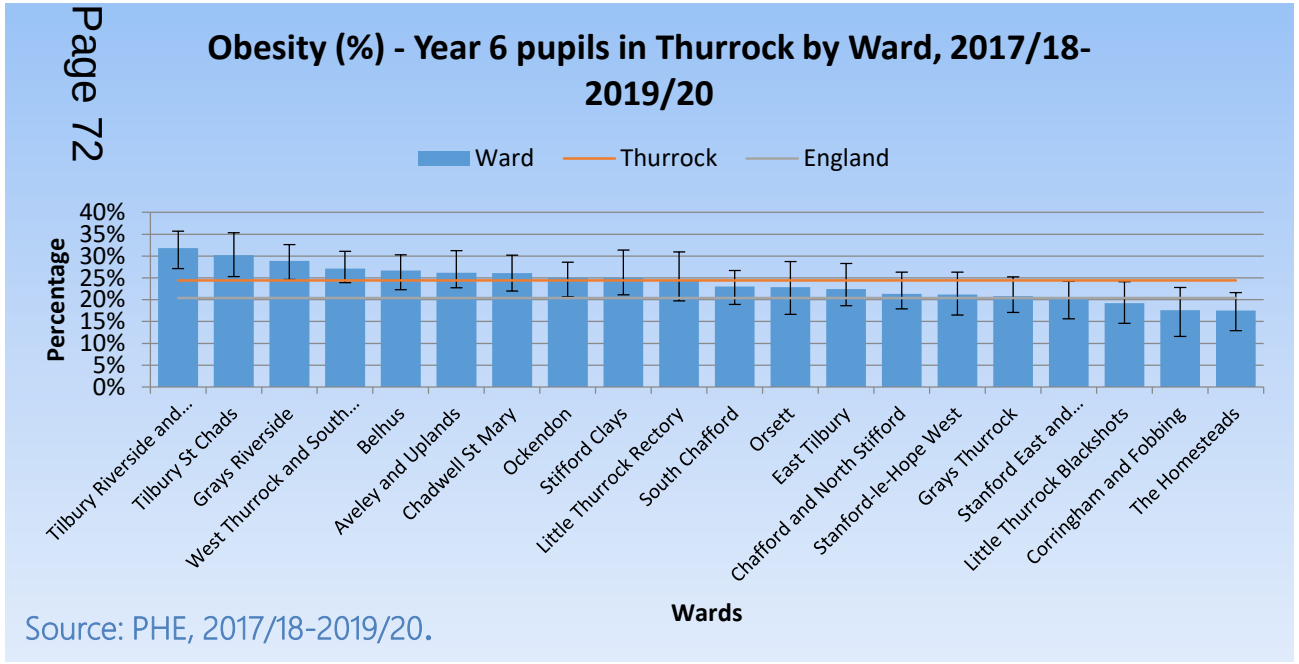
65,569 people of child bearing age (15-45 years) living in Thurrock (2018).

7,487 0-2 year olds residing in Thurrock (2020).

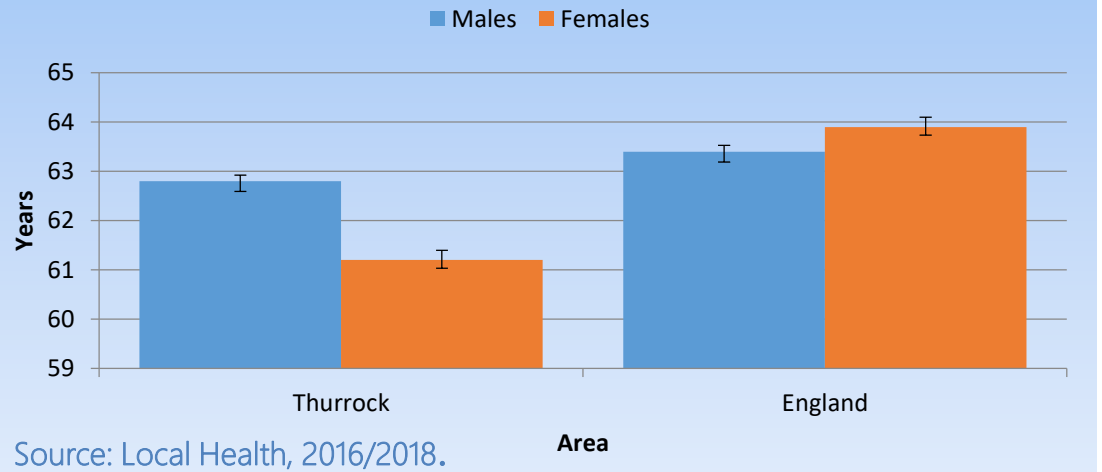
Local Context- Key Health Indicators

Life expectancy for both males and females varies by ward in Thurrock. For males there is a difference of **9.3 years** in life expectancy between the wards with the highest and lowest life expectancy rates. Similarly, for females there is a difference of **6.2 years** in life expectancy between the ward with the highest and lowest life expectancy rates. The healthy life expectancy for males is similar to the England average. Conversely the healthy life expectancy for females is significantly lower than the national average. Women are living longer in poorer health.

Low breastfeeding rates in Thurrock coupled with the fact that families on low income are less likely to breastfeed has the potential to widen the gap in health inequalities and life expectancy.



Source: PHE, 2017/18-2019/20.



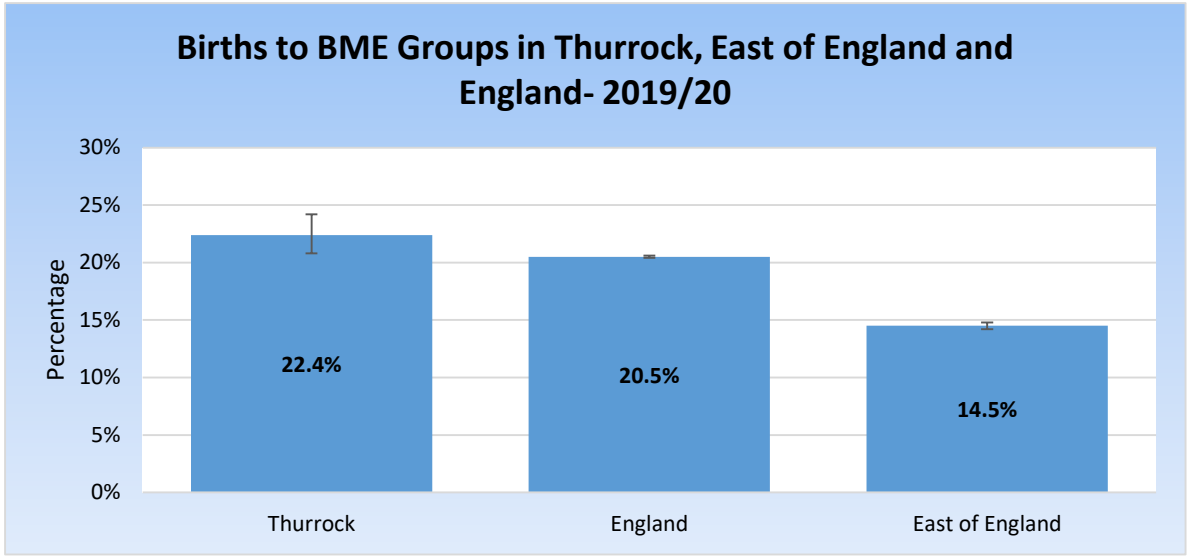
Source: Local Health, 2016/2018.

Breastfeeding is associated with reduced risk of children becoming obese later in life. There are significantly higher rates of obesity in year 6 pupils than the England and regional averages. The current low breastfeeding rates in the borough could be contributing to the obesity prevalence observed in year 6 children. Although it is recognised that obesity is an extremely complex and multi-faceted issue.

Pregnancies and births in Thurrock

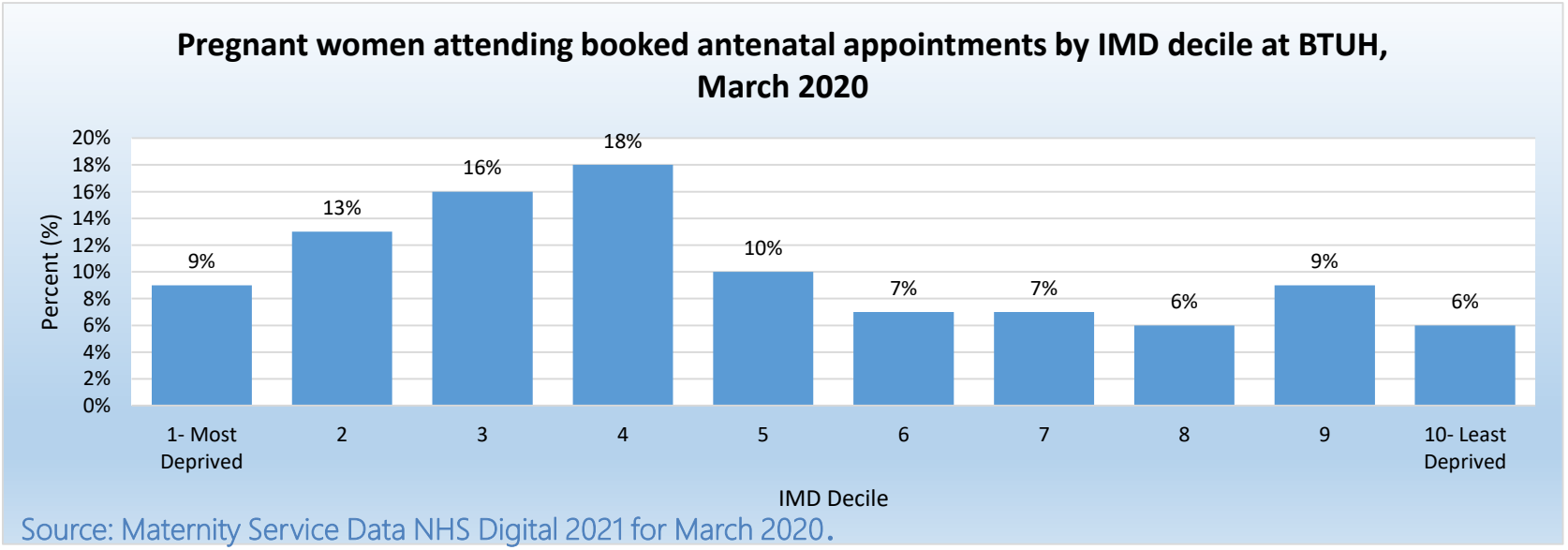
Births to BME groups accounted for 22.4% of births in Thurrock (2018/19). This was significantly higher than the East of England average. Women from BME groups are more likely to breastfeed and so the low prevalence of breastfeeding in Thurrock does not reflect this.

There was a higher proportion of pregnant women attending antenatal booking appointments who reside in the most deprived areas of the borough compared to the least deprived. This is important given the fact families on low income are less likely to breastfeed.



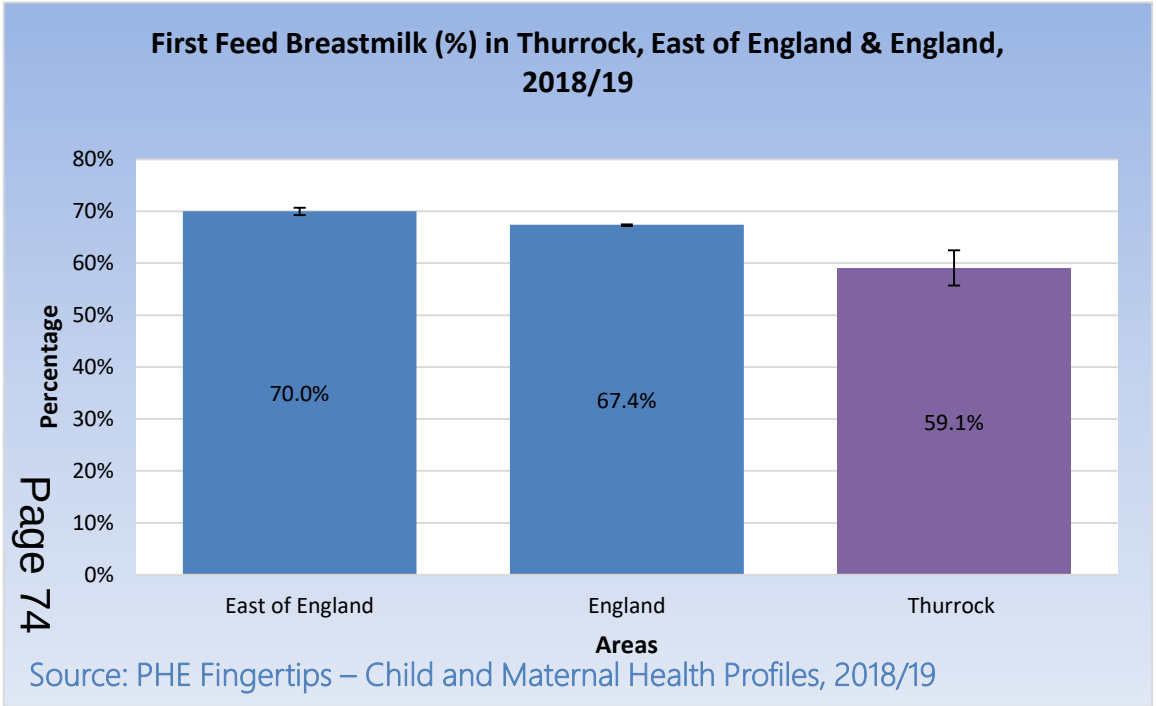
Source: PHE Fingertips – Child and Maternal Health, 2019/20.

Births to 25-34 year old women account for the largest percentage of births in Thurrock.

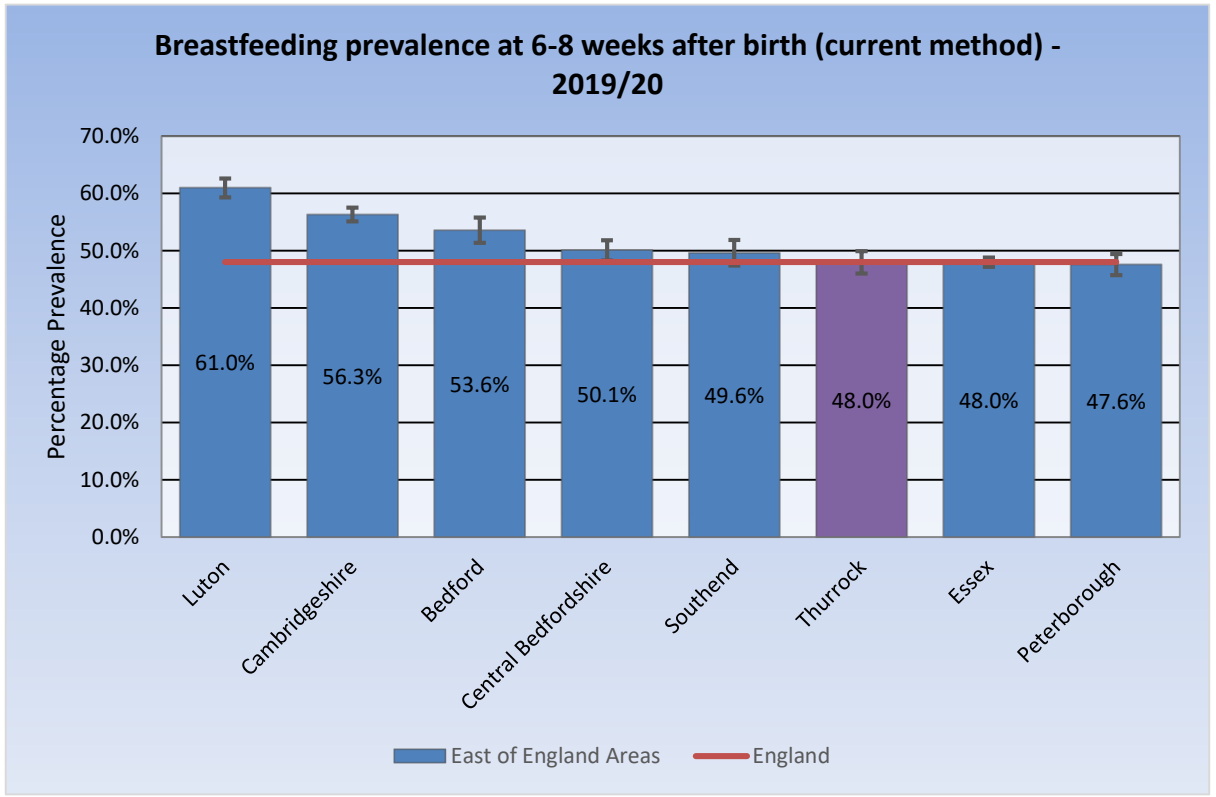


Source: Maternity Service Data NHS Digital 2021 for March 2020.

Breastfeeding prevalence



Source: PHE Fingertips – Child and Maternal Health Profiles, 2018/19



Source: Public Health England National Child and Maternal Health Intelligence Network

In Thurrock, first feed breastmilk rates are low at 59.1%; this is significantly lower than the regional and national averages.

Reductions in breastfeeding rates in Thurrock are large, by 6-8 weeks post birth, breastfeeding (exclusive or partial) was 48% (2019/20)*. This is statistically similar to the England average and a similar drop is observed in comparator authorities and regionally.

*Data was not available from Norfolk, Hertfordshire, Suffolk, or Milton Keynes as comparators.

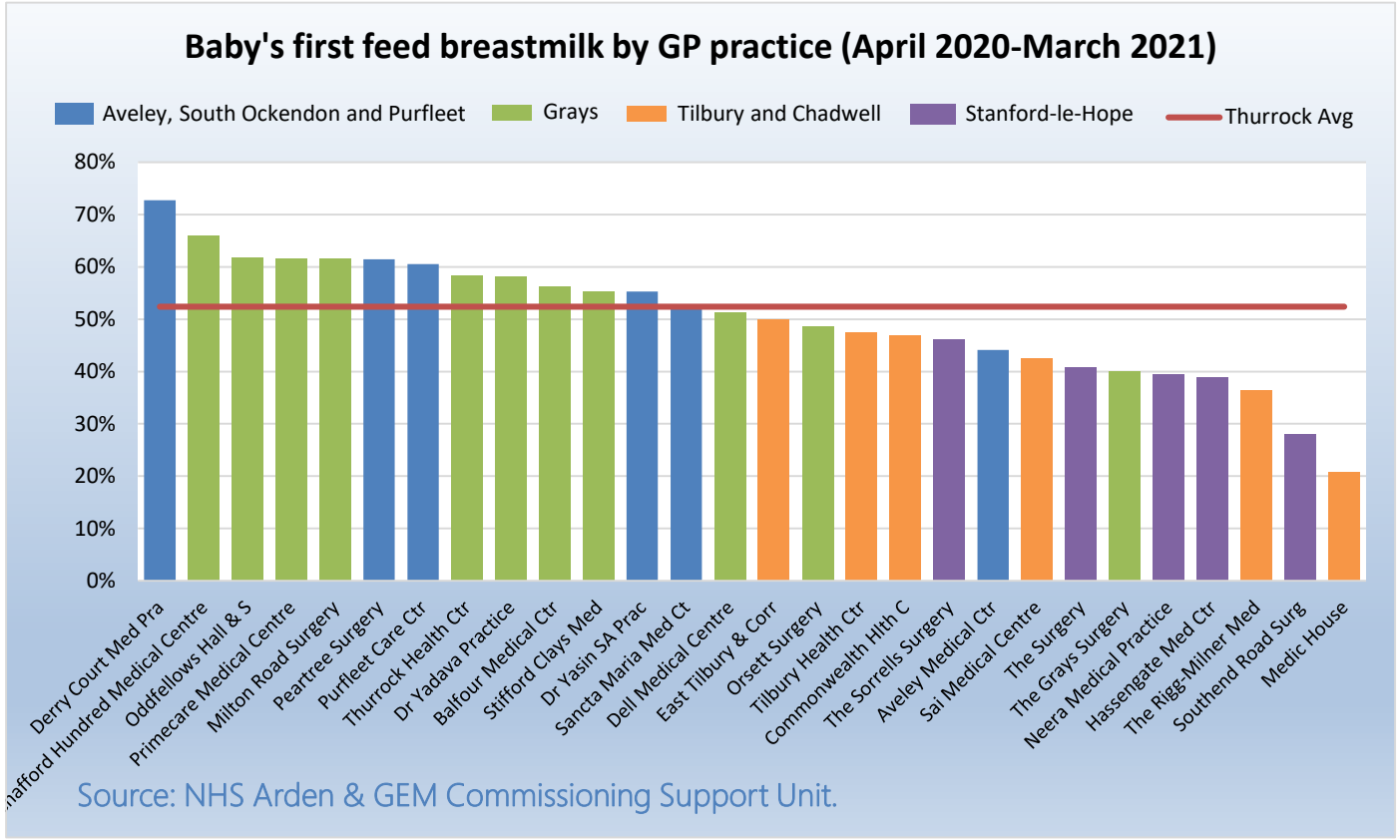
Breastfeeding prevalence

Within Thurrock, there is a level of variation in rates of early breastfeeding. This can be seen in the graph at practice level.

Practice-level breastfeeding prevalence ranges from 20.8% (Medic House) to 72.7% (Derry Court Medical Practice).

Most of the GP practices with the highest prevalence are within the Grays PCN area (green), and all of the Tilbury and Chadwell and Stanford-le-Hope PCN practices have lower First Feed Breastmilk rates than the Thurrock average.

Research suggests women from BME groups are more likely to initiate and continue to breastfeed than white women. The increased ethnic diversity in the West and Central parts of the borough and the higher rate of breastfeeding at first feed in these geographical areas looks likely to support this.



Note – in order to understand approximate locations of these GP practices, a colour code has been applied to show the Primary Care Network area of each practice.

Existing local offer in Thurrock to support Breastfeeding

NELFT Healthy Families offer – NELFT are BFI accredited and all staff are trained at level 3 to enable them to deliver support around breastfeeding. Infant feeding assessments conducted routinely during the antenatal and postnatal period containing information and support around breastfeeding and assesses intention to breastfeed. Once a baby is born NELFT contact the new parents and send out a Mother's questionnaire (twice annually) to assess how new families are getting on and to signpost as needed. The key contact points are; antenatally, new-born (10-14 days), 6-8 weeks. These contact points enable support to be offered in terms of breastfeeding e.g. positioning. There is a tongue tie clinic at BTUH.

NELFT work in partnership with the Children's Centres to deliver support to new mothers around breastfeeding. The offer varies across children's Centres with some providing a more comprehensive offer than others. In terms of equity of service this is something that needs to be reviewed and addressed.

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Children's Centre

Brighter Futures

Existing local offer in Thurrock to support Breastfeeding

Thurrock Breastfeeding Reassurance & Support (BRAs) Community Interest Group	Parents 1st	Feeding Together
A local breastfeeding peer support group. Groups are run by trained Association of Breastfeeding Mothers (ABM) supporters and a qualified breastfeeding counsellor. BRAs aims to support families with any breastfeeding concerns or worries and meets weekly (term- time only) at Hardy park. They provide wider support to families e.g. introducing solids. BRAs have a Facebook page which provides support and advice through posts and provides information about events that may be useful to families.	Specialise in effective volunteering and peer support during the key life change of pregnancy, birth and becoming a parent. Support includes: - One-to-one visits to expectant parents from a pregnancy pal - Birth buddy support throughout the pregnancy, birth; immediately after birth and with feeding - Antenatal sessions for mums which cover information about both breast and bottle feeding. Expectant dad workshops cover the following topics: - Relaxation for you and your partner - Labour and birth - Changes ahead - Practical baby care including feeding and winding.	The NHS BTUH Feeding Together infant feeding service encompasses provision of information support and understanding to ensure a positive feeding experience for all mothers and their babies. The offer includes: - A fully accredited UNICEF Baby Friendly maternity unit - Information and support to pregnant women and new mums on breastfeeding and infant feeding issues. - Home visits and telephone support to assist mums in getting feeding off to a good start - Training, resources, and support for infant feeding across South West Essex. A Facebook page where practical advice and support can be found around infant feeding (includes breast and bottle feeding e.g. how to get a good latch and how to implement paced feeding for mothers who are bottle feeding.

Benefits and Barriers to Breastfeeding

The benefits and barriers to breastfeeding are well documented in the evidence base. Below are some of the most common benefits/barriers that may influence a families' choice around breastfeeding.

Benefits

Health Benefits

For infant:

- Reduced risk of Sudden Infant Death Syndrome
- Reduced risk of allergies developing later in life
- Reduced risk of contracting respiratory and ear infections
- Protects against pneumonia and necrotising enterocolitis.
- Reduced risk of developing Diabetes, Cardiovascular disease or becoming obese.

For Mother:

- Reduced risk of developing breast and ovarian cancer
- Reduced risk of developing diabetes, osteoporosis and cardiovascular diseases or becoming obese.

Wider Benefits

- Supports bonding through skin-to-skin and eye contact
- Provide children with a head start in education through optimal brain development, protection from illness, enables better eye focus leading to reading and learning readiness.
- Convenience
- Cost at an individual and system level (savings to the NHS)

Barriers

Practical Difficulties

- Other children to care for
- lifestyle
- Lack of freedom or independence – leading to perceived inability to undertake daily activities
- Need to return to work
- Lack of public facilities in which to breastfeed comfortably

Support

- Lack of support from services and/or family
- Perceived insufficient milk supply
- Health of mother or infant and lack of support to assist with facilitating breastfeeding.
- Perception that bottle feeding is easier and more convenient

Societal

- Embarrassment/concerns about the views of others
- Feeling uncomfortable to breastfeed in public (relates to perceived lack of freedom/independence)
- Misconceptions about breastfeeding

Key points from the evidence base

Research with Mums:
- Having encouragement from social and support networks makes mums more likely to breastfeed and breastfeed for longer.
- Women experience breastfeeding past six months as being viewed as socially unacceptable.
- Mums report feeling 'shamed' if they choose not to or struggle to breastfeed and discontinue.
- Mums report often feeling insufficiently reported and unprepared for the realities of breastfeeding.
- There is good evidence that support from fathers is critical to breastfeeding success in terms of initiation and maintenance and should be central in breastfeeding strategies and education.
- It shouldn't be assumed that teenage mums are less likely to breastfeed.

Research with Fathers and Partners:
- Fathers and partners role in breastfeeding can be easily overlooked or undervalued.
- Partners, fathers and families are influential in women's choices around breastfeeding.
- Men have reported feeling excluded by health professionals from breast feeding education
- In particular in lower income households it is reported that the infants father plays a crucial role in supporting decisions around breastfeeding
- It is acknowledged that a lot of research around Fathers is second hand information and reflects the views of the mother. More research into fathers' opinions attitudes and beliefs would be beneficial.

Health promotion resources:
- Research suggests some mums are not convinced by the information around the benefits of breastfeeding.
- Knowledge and benefits of the health benefits alone is not enough to encourage women to breastfeed.
- Providing information to adolescents that corrects misconceptions about breastfeeding is vital in supporting them to develop positive attitudes towards breastfeeding at an early age.

Health professionals:
- Some studies report health professionals feeling uncomfortable telling a mother how to feed their baby and have concerns they will make a women feel guilty for choosing not to breastfeed, highlighting a confidence and training issue.
- Capacity and resourcing is highlighted in the literature as a barrier to adequate support to families from health professionals
- Health professional can play an important role in supporting mothers returning to work around maintaining breastfeeding although capacity is highlighted as an issue here too.

Cultural differences:
- Breastfeeding is more prevalent in families where English is not the first language and where an additional language to English is spoken.
- In some cultures breastfeeding is viewed positively as a natural way to feed infants however in some culture feeding in public and particularly in front of men is forbidden as compromising a women's modesty.
- Breastfeeding policies and strategies need to be aware of differing cultural acceptability's in order to be inclusive and successful.

Societal influences:
- Research suggests that cessation of breastfeeding is largely related to negative influences culturally and socially.
- Breastfeeding education and promotion needs to be targeted more widely in society.
- The social research in Thurrock found feeding in public to be a key concern of the mothers taking part.
- The sexualisation of breasts as well as celebrity culture around body image may be playing an important part in the low breastfeeding prevalence in the UK
- Formula advertising and misconceptions around formula being of equivalent benefit to infants could be playing an important part in families' choices around infant feeding.

Breastfeeding Social Marketing Research

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Purpose

- Aims to explore the underlying and complex relationship and drivers associated with the large drop out rate of breastfeeding in Thurrock-
- Understand the lived experiences of women and their families.

Key Findings

- Majority of expectant mums intended to breastfeed either exclusively or by combi-feeding (mix of breast and bottle). Similarly 80% of mums with babies and 69% of mums with toddlers reported that they were breastfeeding.
- Main reasons for not choosing to breastfeed related to feeling uncomfortable abut breastfeeding in public, concerns baby wasn't getting enough milk, difficulties with latch and feeling breastfeeding is too stressful.
- Undiagnosed tongue tie and the need for more support for mums who had had a C-section was cited throughout the research as an important barrier to breastfeeding.
- The need for accurate, consistent information that reflected the 'realities' of breastfeeding that was offered in a supportive way and that reassured families that difficulties in the early days were normal but would get better was a recurring theme of the research findings.
- The science behind breast milk was viewed as important to families in supporting them to make an informed decision.
- More focus on breastfeeding as part of the antenatal offer was suggested by participants.
- Support with breastfeeding difficulties via virtual support and digital offer was also suggested as a way to support multiple families in a cost-effective way.
- Development of a single resource containing all information to support families to make an informed decision was suggested by participants.

Key Findings/Recommendations

Key Theme 1	Key Findings	Key Recommendations
System Wide Change	• The system in Thurrock does not operate independently from the wider health system. The local hospital where the majority of women give birth (BTUH) is sited in Basildon and part of a wider Mid and South Essex (MSE) Health and Care Partnership area. • There is a need for system wide change to impact on all pathways relating to breastfeeding and as part of the messaging and normalising of breastfeeding locally. • Findings from the social marketing research undertaken to inform this needs assessment suggest that families would value more information about all infant feeding choices. This is supported by NICE guidance.	• A Thurrock (MSE & LMNS) approach will follow NICE guidance and local findings to offer support to families in making a healthy choice to exclusively breastfeed for 6 months and longer; including information around safe and responsive bottle feeding practices to support choices around expressing breast milk and formula feeding as needed (although formula feeding will not be actively promoted). • To incorporate findings into the 0-5 wellbeing model to be tackled and driven as part of a wider piece of work collaboratively with Brighter Futures Partners. • Seek agreement with the LMNS to develop a single point of access information pack and pathway containing consistent information and practical advice around: - Nutritional benefits & Science behind Breastfeeding - Practical support with latch & tongue tie - Wider benefits - Health benefits - Information on sources of support (should be co-produced with families to ensure it captures the lived experience of families, meets families needs and provides a 'realistic picture' of breastfeeding, the potential challenges that is supportive and reassuring). • Strengthen links between Midwives, Primary Care and wider health professionals to ensure that the antenatal offer is equitable and consistent between professionals and across the LMS area to ensure families receive the same messages and approach throughout the pathway.

Key Theme 2	Key Findings	Key Recommendations
Digital Offer to support Breastfeeding uptake and initiation	• Digital resources and communications have been highlighted through the social marketing research and the evidence base as being a good way to increase the capacity of services that supports families. This medium has been found to be acceptable to families in Thurrock with the opportunity to reach an increased number of families in a cost effective way. • Findings of the social marketing research suggest that families found information about the science behind breast milk and the nutritional differences between breastmilk and formula useful in informing them to make an informed decision regarding breastfeeding.	• Public Health lead the development of a digital solution to provide information to families in an accessible way with links to videos and information about the science behind breastfeeding as part of the 0-5 wellbeing offer. This offer could include weekly text messaging/email service also providing encouragement an reassurance to families. • Provision of information to families that explains the science behind breastmilk and the nutritional differences between breastmilk and formula . Videos and other resources do exist that focus on the science and could be shared as part of the digital offer (included above). • Commissioners develop and incorporate virtual support via Skype or Face Time which could be held in the style of a webinar where families can ask for advice and support and health professionals can responds to multiple families at the same time who may be experiencing similar issues.

Key Theme 3	Key Findings	Key Recommendations
Messaging/ Normalising Breastfeeding	• Messaging and the need to normalise breastfeeding has been consistently raised throughout the social marketing research and within the evidence base. • The local offer needs to consider 3 elements of messaging in to relation to breastfeeding: 1) being really clear on what the message is including: - nutritional benefits and science behind breastfeeding - wider benefits - health benefits - normalising breastfeeding - supporting families' choices around breastfeeding and offering guidance. 2) The level and sufficiency of the message – is it delivered at the right time, in the right way, accurate/factual and realistic 3) Consistency of the message – developing a consistent approach across the landscape to include Thurrock and South Essex through the LMNS.	• Develop a place based approach to normalise breastfeeding in the community and wider environment by working with businesses through the business forums to enhance the number of breastfeeding friendly venues (through the BFI) in Thurrock and make this visible to the community. • Support employers with information and advice about being breastfeeding friendly and how to support mothers to continue to breastfeed once they return to work. • Influence the production of local/new resources or literature to provide positive images that normalise breastfeeding in everyday scenarios (as part of the Brighter Futures communications plan).

Key Theme 4	Key Findings	Key Recommendations
Service Support/Offer	• Consistency is required in terms of the training, knowledge, confidence and skills across Health professional including Midwives, Health Visitors, Primary Care and other professionals and requires strengthening to ensure the equity of and consistency of the offer to families across the entire pathway. • The current service offer requires more multi-agency working to ensure that families receive the support they need in terms of breastfeeding. • There is a need for professionals to offer consistent, non-judgemental information, encouragement, support and reassurance – that families are doing well, that things will get easier and that many women find it difficult in the early days but that is normal and okay. • The evidence base highlighted that new parents can feel pressured to bottle feed by other members of the family who wish to be able to bond with the baby and offer respite to parents. • Recognition that breastfeeding decisions are often made before pregnancy and even as early as during adolescence.	• Training offer – develop a consistent training offer and deliver a re-fresh of training for Primary Care, Maternity and other health professionals including wider support staff in the system such as Children's Centre staff. • Expansion of breastfeeding training for primary care, including the development of Breastfeeding Champions within Primary Care and Children's centres as part of the strategy delivery plan. • As part of the 0-5 wellbeing offer and universal service introduce the concept of a family 'plan' to demonstrate the commitment to breastfeeding. This will support the wider family to understand and respect parents' decisions to breastfeed whilst promoting inclusion of family member, who are able to support in other ways e.g. with bath-time etc.… The purpose of this is to give new parents periods of respite whilst enabling bonding with other families members but without disrupting the breastfeeding relationship. There is the potential to allow this plan to incorporate other important areas such as immunisations. • Work with School Nurses (through Healthy Families Service) and schools to offer an education programme as part of PHSE to children about breastfeeding.

Key Theme 5	Key Findings	Key Recommendations
Involving Dads/Partners	• Evidence highlights that the role of the fathers is often undervalued, although conversely fathers do want to be involved in decision making about breastfeeding and are receptive to receiving information about breastfeeding which can in turn have a positive impact on breastfeeding success. • As per the views of women, men report having a misconception that breastfeeding will be easier and would like more information about the realities of breastfeeding. • Research consistently emphasised the important role that fathers play in their partners' decision to breastfeed.	• The LMNS work towards routine inclusion of dads and partners in all feeding discussions as part of the antenatal provision through maternity services (linked to the training re-fresh and incorporated in the 0-5 wellbeing model). • Build in provision to the antenatal offer of an inclusive session focussing on breastfeeding; targeted to both parents. • Public Health to work with Children's centres to improve the equity of their offers – to include breastfeeding classes tailored to both parents as part of the Early Help transformation project.

Key Theme 6	Key Findings	Key Recommendations
Specialist Support	• Throughout the research support for women who give birth via C-Section was noted as an area that requires review in terms of support with breastfeeding. • The social research allowed a rich exploration of a sample of Thurrock families' views in relation to support for specialist areas that may be acting as a barrier to breastfeeding such as when a women has a c section and when a baby has tongue tie. • Emerging evidence highlights the potential bi-directional relationship between breastfeeding and post-natal depression or illness.	• A review of breastfeeding support for women who have had C-Sections within the existing maternity offer, to be driven through the LMNS. • Earlier identification and treatment of tongue tie to be explore through the LMNS and review any existing pathway for treatment and support for this issue, to maximise opportunities to advise new parents and support them to continue breastfeeding. • Strengthen pathways for women with postnatal depression and those identified with or suspected postnatal illness to ensure timely support with breastfeeding to facilitate initiation and maintenance.

Acknowledgements

Editors and Authors

Karen Balthasar	Public Health Graduate Trainee (Author)
Katie Powers	Public Health Graduate Trainee (Data refresh/edits)
Beth Capps	Senior Public Health Programme Manager (Editor)
Teresa Salami-Oru	Assistant Director and Consultant in Public Health (Project Supervisor)

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With special thanks to Lisette Harris and the maternity staff at BTUH and most importantly the parents and babies who took the time to share their experiences and views with us.

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Breastfeeding Needs Assessment for Thurrock

March 2020

Editors and Authors

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Note:

This report was initially written in 2019 ahead of the Covid-19 pandemic and therefore the search parameters of the literature review and the social marketing element reflect this. The data in sections 1 and 2 have been updated subsequent to the pandemic due to a refreshed method for collecting breastfeeding initiation data being established and published.

Insight kindly provided from Thurrock Mums & Dads:

"None of them covered the fact that baby feeds so often to stimulate milk and not to worry. The biggest criticism I found from people around me was how baby was on all the time. 'Clearly not getting enough' is people's view. I felt pressure from those around me to give baby a bottle."

"Brilliant – hate breast is best with no explanation. Also hate mums feeling they failed because they stopped. I know mums that have suffered terribly because of this. I think lots of mums don't know how milk is made. How the baby gets the milk out. The feedback cycle – feeding or expressing to produce more.

Contents

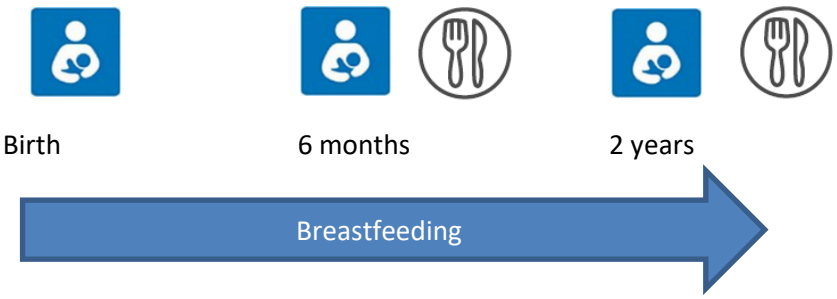
1. Introduction

1.1 National and International context

Low breastfeeding rates present as a serious public health issue. Infants who are not breastfed may be unable to take advantage of a number of health and wellbeing benefits; such as positive impact on attachment, a reduction in Sudden Infant Death Syndrome (SIDs), reduction in childhood illnesses and disease, as well as nutritional benefits. The low rates of breastfeeding in the UK, which can also have an impact on future health, represent a serious public health challenge. There is a need therefore to prioritise breastfeeding as part of Early Years and Public Health policy and to better understand why this picture presents.

The UK is one of the most poorly performing countries in the world in terms of breastfeeding continuation. Nationally, 68% of babies receive breastmilk as their first feed (1) but only 48% mothers continue to breastfeed at 6-8 weeks. This falls even further by 6 months of age with only an estimated 1% of babies being breastfeed exclusively. (2) The World Health Organisation (WHO) and United Nations International Children's Emergency Fund (UNICEF) recommend that breastfeeding continue from birth to age 2 years and exclusively for the first 6 months of life. (1), (2). The WHO have set a global target to achieve 70% first feed breast milk and 70% exclusive breastfeeding up to 6 months by 2030. (5)

World Health Organisation (WHO) & UNICEF (1)



1.2 National policy context

There are numerous policies relating to breastfeeding. NICE guidance recommend development of an overall infant feeding strategy which promotes breastfeeding, supports safe formula feeding and helps families to develop positive emotional relationships with their babies. This guidance places emphasis on positively influencing the child's future educational attainment, social skills, self-efficacy and self-worth. At the other end of the spectrum: Health Matters, WHO and UNICEF advocate for the Baby Friendly Initiative (BFI) in which breastfeeding is promoted for the first 2 years of life and exclusively for the first 6 months. If organisations become BFI accredited they should not promote formula feeding, bottles or teats, and the standards advocate for breastfeeding care being the standard offer opting for a hard line nudge towards breastfeeding (see Appendix 1 for WHO and UNICEFs' 'ten steps to successful breastfeeding').

1.3 Local Context

In Thurrock 59.1% of babies born in 2018/19 had their first feed as breastmilk. The average for babies in England was 70% and in the East of England region as an average it was 67.4% for 2018/19 (see Figures 18 and 19 included in the data section 2.4 on p21).

In Thurrock as with the UK nationally, breastfeeding rates (exclusive or partial/combination feeding) reduce quite considerably by 6-8 weeks post birth, to only 48% in 2019/20.

This Health Needs Assessment supports Goals A and E of Thurrock's Health and Wellbeing Strategy, namely; Opportunity for All and Healthier for Longer respectively (3) This will support domain 3 within the Health and Wellbeing Strategy refresh due to be published in 2022.

The Brighter Futures Children's Partnership Strategy due for publication in 2021 is supported by this needs assessment with Breastfeeding featured in Strategic Priority 2 'All Children are able access the services they need and be healthy' as one of the aims to increase the proportion of children as a healthy weight.

1.4 Local Response

A deeper understanding of the complexities relating to the drivers and influences associated with breastfeeding discontinuation at 6-8 weeks is needed at both a local and national level. The purpose of this Health Needs Assessment is to gain a better understanding of the complexities surrounding breastfeeding and provide evidence based recommendations to inform service delivery.

1.5 Objectives

The objectives of this Health Needs Assessment are to:

- Understand the demographics relating to Breastfeeding in Thurrock including key health data, breastfeeding prevalence, local contextual information and how the national context in relation to breastfeeding relates to this.
- Describe the local offer in Thurrock to support families to breastfeed.
- Understand what the published evidence base tells us works to support families to initiate and continue breastfeeding.
- Review what other areas locally and nationally are doing to increase breastfeeding prevalence by supporting families to breastfeed.
- Develop an in depth understanding of local families and professionals experiences of breastfeeding.
- Articulate a call to Action, making recommendations from the findings of this health needs assessment.

1.6 How we undertook this piece of work

1.6.1 Analysis of need

Need has been be identified in a robust way by providing;

- a descriptive analysis of the demography and the service offer in Thurrock,
- a web search and discussions with relevant stakeholders to support the development and mapping of the local offer in Thurrock,
- a review of the published evidence base and comparison of good practice in other areas,
- a commissioned piece of social marketing research, consulting with Thurrock families and stakeholders to provide an in depth look at families' experiences of breastfeeding.

By identifying what supports families in Thurrock to breastfeed, what prevents or stops families from breastfeeding and identifying how can we maximise and extend the positive elements to overcome barriers will lead to the development of recommendations for a strategy to support this.

1.6.2 Literature Review

Aubrey Keep Library (NELFT) have completed a literature search of the published evidence base.

The main search parameters for the literature review were "Effective interventions for promoting uptake and maintenance of breastfeeding" and "Best practice for increasing breastfeeding rates". Keywords included; breastfeed, breastfed, community, local area, promotion, intervention, education, increase, uptake, maintenance; and continuation. The inclusion criteria for the literature review included papers published within the last 10 years (2008-2018), and written in English. Papers were excluded if they were written in a language other than English or were older than 10 years.

1.6.3 Social Marketing Research

A piece of qualitative social marketing research was commissioned from Upshot Marketing in 2019. The research focussed on the lived experiences of women and their families in Thurrock relating to breastfeeding, using surveys and focus groups, taking a thematic analysis approach. This piece of research is discussed later in the report in section 6 and the findings and insights from this research are incorporated within the recommendations in section 8.

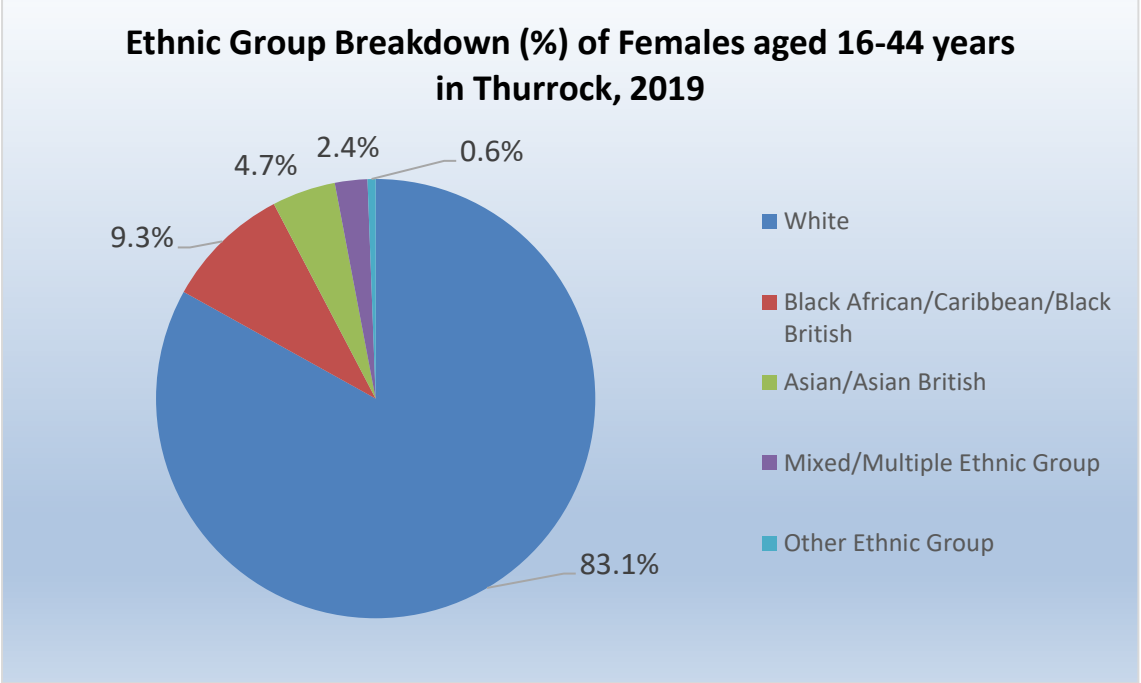
2 Data

2.1 Local Demographic information

In 2020 Thurrock had a total population of 175,531. Of this total population there were 37,002 women defined as being of child bearing age during the same time period. The age range used is in accordance with the Office of National Statistics definition that a women's childbearing age commences at age 15 and ends when they reach 45 years of age (4). The population of 0-2 year olds was 7,487 in 2020.
The total population is set to rise to 205,470 by 2043 (17% increase). The population of individuals of child bearing age is also set to rise to 39,377 (6.4% increase) with the 0-2 year olds cohort projected to increase to 8,241 by 2043 (10% increase during the same time period).

Figure 1 below shows that the majority of women of childbearing age are of white ethnicity, followed by those from black ethnic groups. This is interesting to note because there is evidence that suggests mothers from Black and Minority Ethnic (BME) groups are more likely to initiate breastfeeding than white mothers are. Moreover, evidence has told us that they are also more likely to continue breastfeeding at 3, 4 and 6 months after birth (5). In Thurrock, births to BME women account for 22.4% of all births, which is significantly higher than the East of England and England percentages (see Figure 17 below). This suggests that the figures relating to breastfeeding rates in Thurrock could be skewed by the proportion of breastfeeding mothers from BME groups, particularly in certain areas of the borough such as South Chafford, Chafford & North Stifford, West Thurrock & South Stifford, Grays Riverside, Grays Thurrock, and Tilbury Riverside & Thurrock Park where there are a high proportion of BME groups (see Figure 3 below). This knowledge is important when exploring the barriers to breastfeeding in non-BME groups in particular and work to remove those barriers to increase uptake in this sub-group of the population. Further Information relating to births in BME groups is included later in this report under section 2.4.

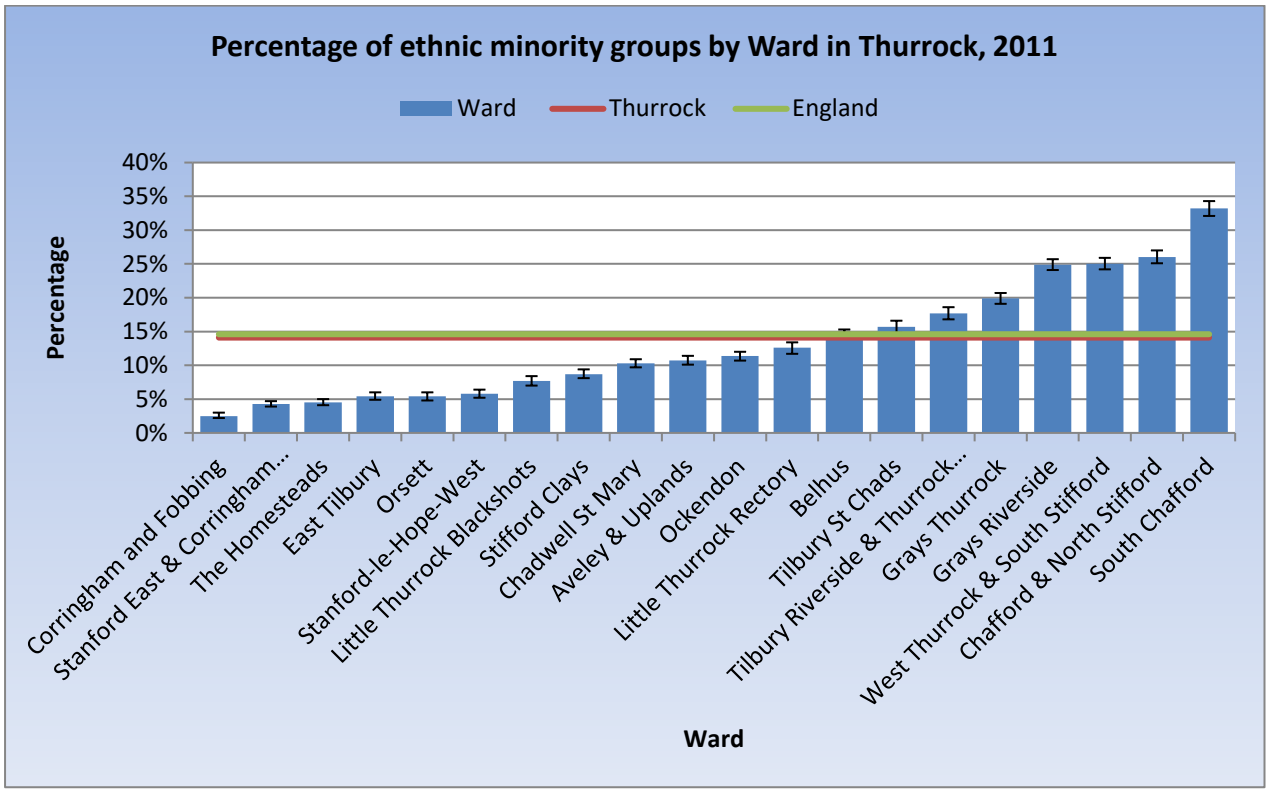
Figure 1: Ethnic Group Breakdown (%) of Females aged 16-44 years in Thurrock, 2019.



Source: ONS Population Denominators

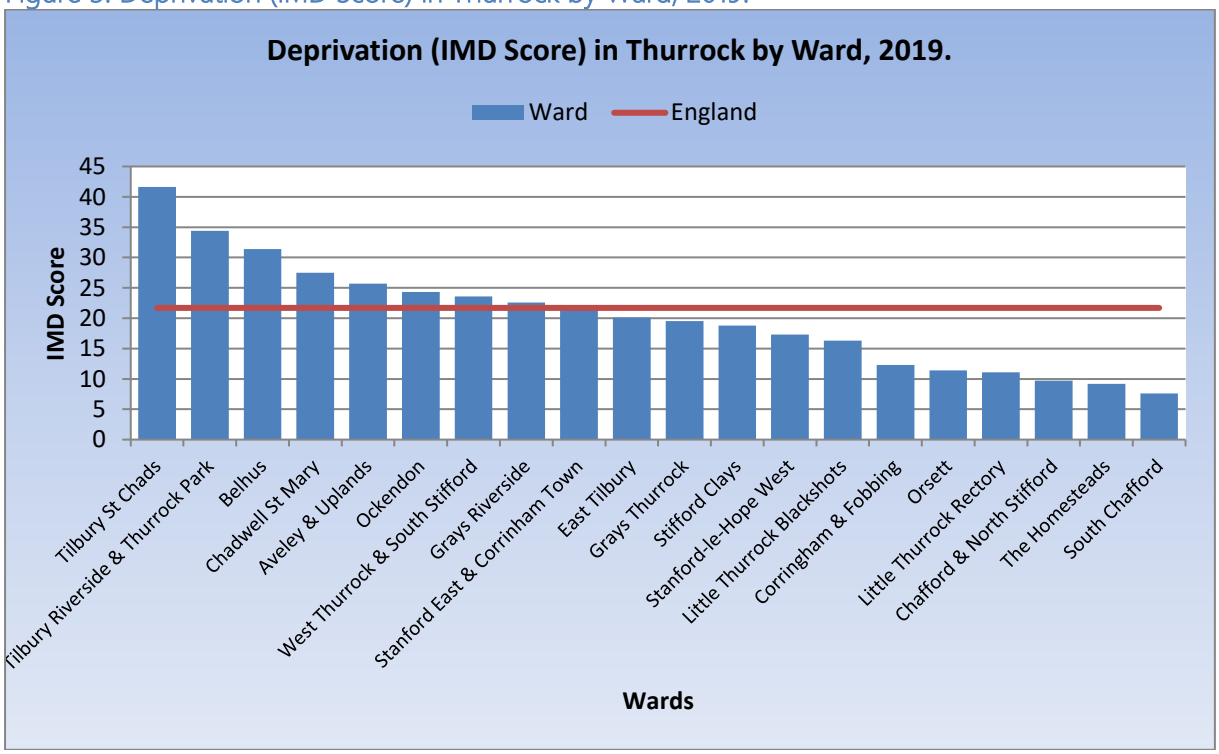
There is a wide variance in the percentage of BME groups by ward in Thurrock ranging from 2.5% (Corringham) to 33.2% (South Chafford) as shown by Figure 2. Some caution needs to be taken when interpreting this data as it is from the 2011 census, population changes are likely to have affected ethnicity prevalence within Thurrock wards. Migration patterns into and out of the borough since the census will likely impact the diversity of ethnicity observed within Thurrock. This may be seen in terms of the number of adults of child-bearing age as well the number of infants being born and general population growth. Further information can be found in the demography JSNA (6). In terms of promoting breastfeeding, it will be important to monitor and understand how the population changes over time so that services can be responsive to changes in terms of breastfeeding support.

Figure 2: Percentage of ethnic minority groups by Ward in Thurrock, 2011.



Source: Local Health 2011.

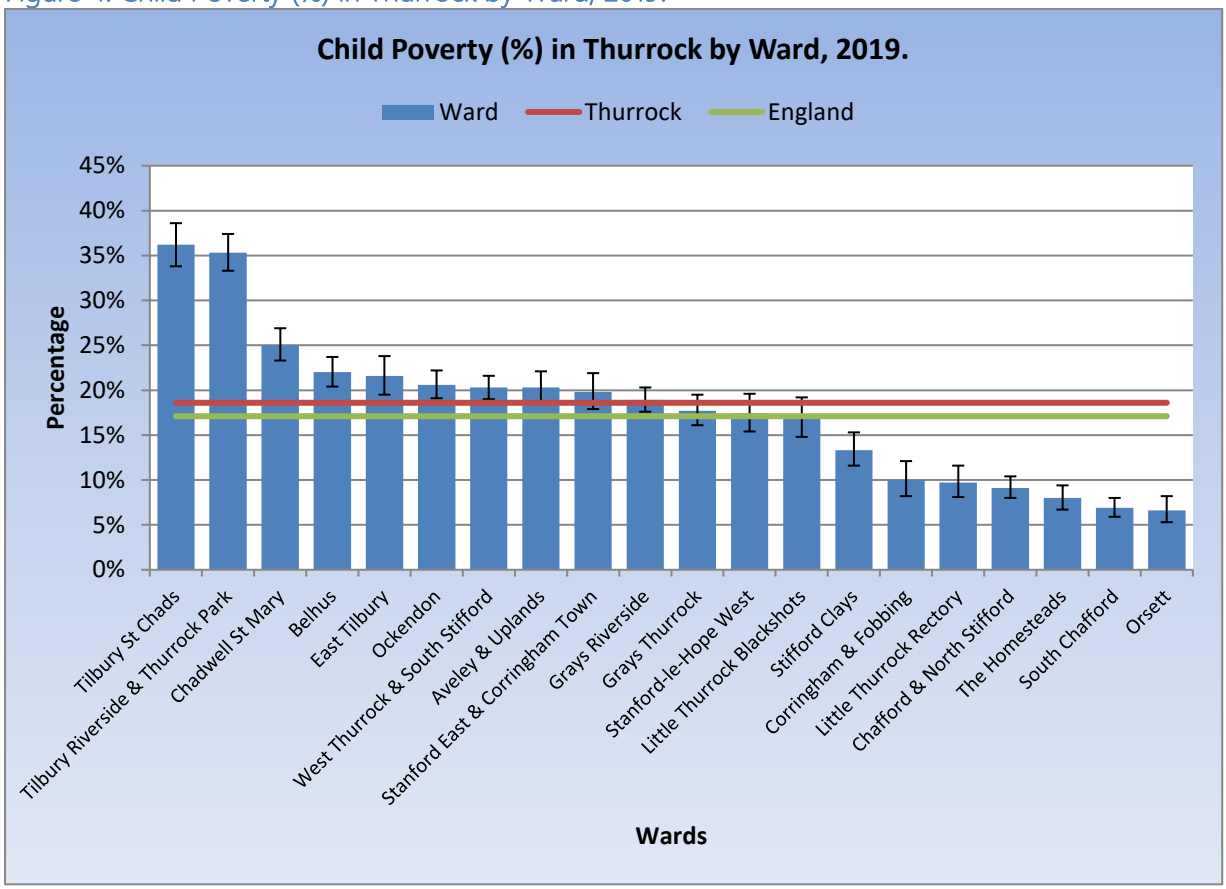
Figure 3: Deprivation (IMD Score) in Thurrock by Ward, 2019.



Source: Local Health, 2019.

Thurrock is a very diverse borough with a wide variety of ethnicities, cultures and religious groups. There is also wide variety in affluence with pockets of high deprivation alongside more affluent areas. Figure 3 above shows deprivation (IMD Score) by ward in the borough. As can be seen, both wards that comprise Tilbury have the highest IMD score as well as the largest proportion of child poverty. Conversely South Chafford experiences the lowest level of deprivation and second lowest proportion of child poverty (see Figure 4 below).

Figure 4: Child Poverty (%) in Thurrock by Ward, 2019.



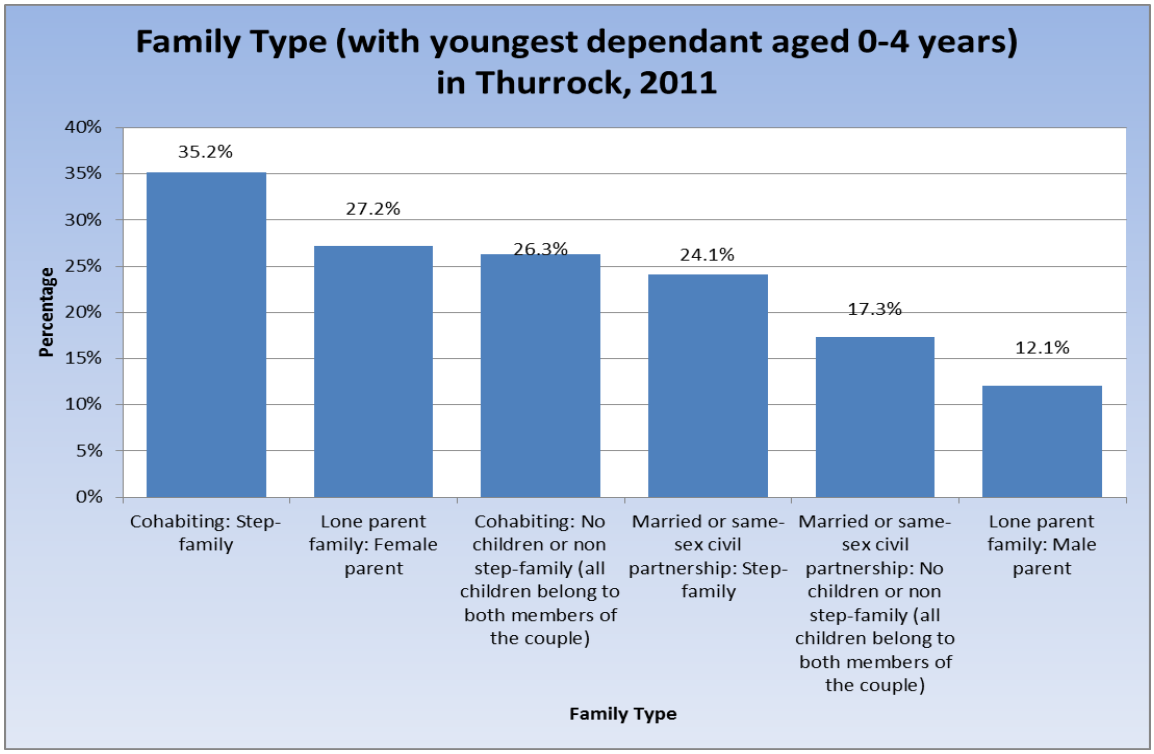
Source: Local Health, 2019.

In Thurrock a total of 45.8% of households have children, with 34.8% of households having dependent children. Those who are married or in a civil partnership with dependent children make up the largest household type in Thurrock (17.9%) followed by lone parent households (7.6%). It should be noted that this data is from the 2011 census and as such household composition may have changed, particularly in light of migration patterns, population change and growth.

The majority of parents within 'couple families' who both work, are employed full-time (74.9%). Of 'couple families' where only one parent is working, this is largely due to the family reporting the other parent looking after the family or home (56.6%). Conversely for lone parent families where the parent is working, the largest proportion are working part-time (24.9%). This could be due to a number of reasons which may include childcare costs. Just over a quarter of lone parents are not working due to looking after their family or home. Figures are similar for families with two or three plus dependants (7).

Cohabiting[1] families with step-children make up the largest family type whose youngest dependent child is aged 0-4 years (35.2%). This is followed closely by lone parent families (female parent) who account for 27.2% of families with a young child/children (see Figure 7 below). As lone female parents make up the second largest proportion of family types with very young children, it could present additional challenges to breastfeeding if they are the sole earner and need to return to work quickly to support their family (see Figure 6 above). It is important to be mindful of this understanding in interpreting the evidence base and making recommendations. Considering how to support lone female parents to continue breastfeeding even upon returning to work is one such consideration. Working with employers around their workplace offer in relation to breastfeeding is one possibility as well as looking to ensure this family type is represented in the social marketing research and any coproduction of service offer and development is another consideration.

Figure 5: Family Type (with youngest dependant aged 0-4 years) in Thurrock 2011.



Source: Nomis/ONS Census 2011 (most recent available)

[1] A 'cohabiting family' can be defined as a couple living together in the same household who are not married but may be in a civil partnership and of the same or opposite sex.

What does this mean for Thurrock?

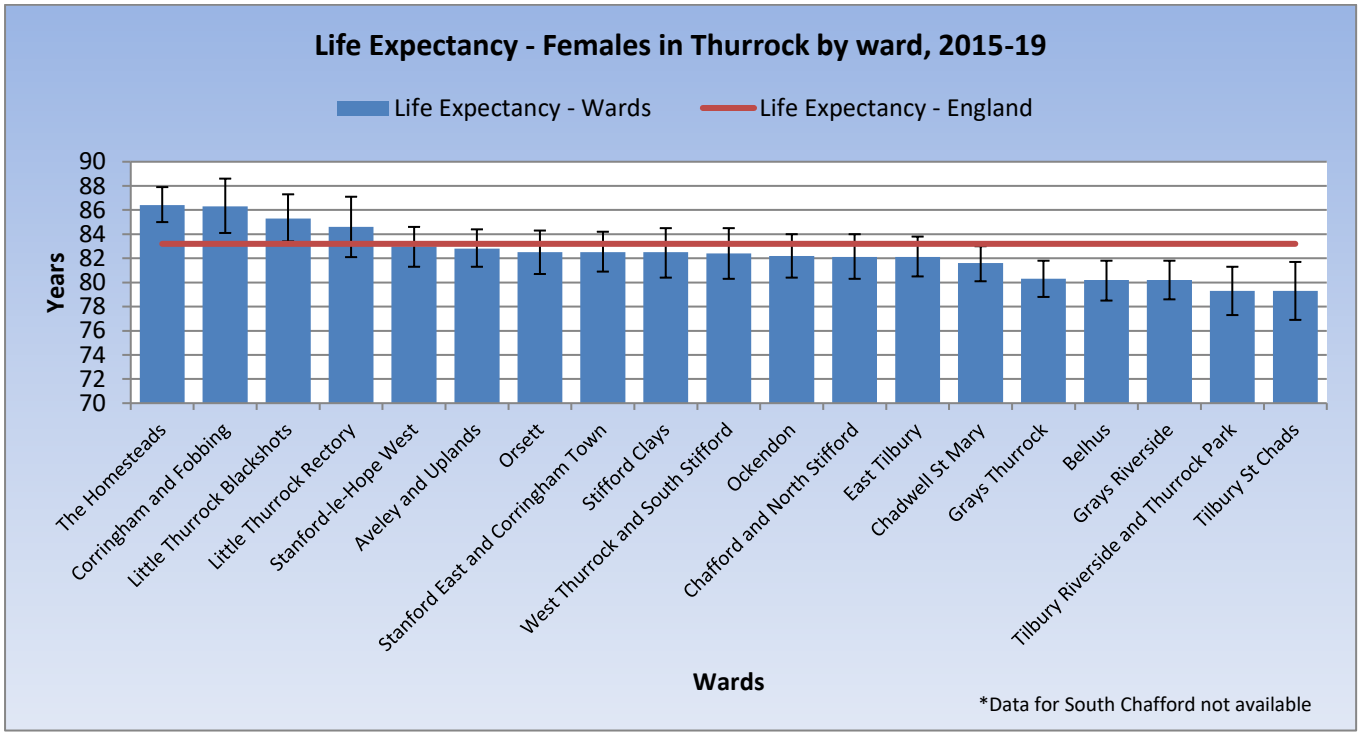
- During the next 20 years, the population in Thurrock is predicted to rise both in women of childbearing age and in children aged 0-2 years.
- There are more people from BME groups in Thurrock than the regional average. Births to BME women account for 22.4% of all births in Thurrock. Mothers from Black and Minority Ethnic (BME) groups are more likely to initiate breastfeeding than white mothers are. This could be masking true breastfeeding rates observed in Thurrock. Attention to this is important when exploring the barriers to breastfeeding in non-BME groups in particular and work to remove those barriers to increase uptake in this sub-group of the population.
- A diversity of affluence/deprivation exists in Thurrock with varying rates of child poverty observed in different wards ranging from approximately 8% in South Chafford to 40 % in Tilbury Riverside and Tilbury Town. The is important in relation to breastfeeding as evidence shows that women in more disadvantaged circumstances are less likely to breastfeed.
- In Thurrock a total of 45.8% of households have children, of which 34.8% have dependent children. Most families have two parents cohabiting or married and of those who both work, 75% both work full time, conversely of single parent families where the parent works only 25% work full time. Supporting parents to be able to return to work whilst breastfeeding will be important for Thurrock.

2.2 Key Health Data

Life expectancy in Thurrock varies widely across and within wards. For females this ranges from 86.4 years in The Homesteads to only 79.3 years in Tilbury St Chads (a difference of 7.1 years). For males, those residing in Corringham and Fobbing have a life expectancy of 83.1 compared to only 75.9 years for those living in Tilbury Riverside and Thurrock Park (a difference of 7.2 years) – see Figures 6 and 7 below. The healthy life expectancy for males in Thurrock is similar to the England average. However, the healthy life expectancy for females in the borough is significantly lower than the England average, as shown in Figure 10 below. Healthy life expectancy is defined as the number of years of life lived in good health.

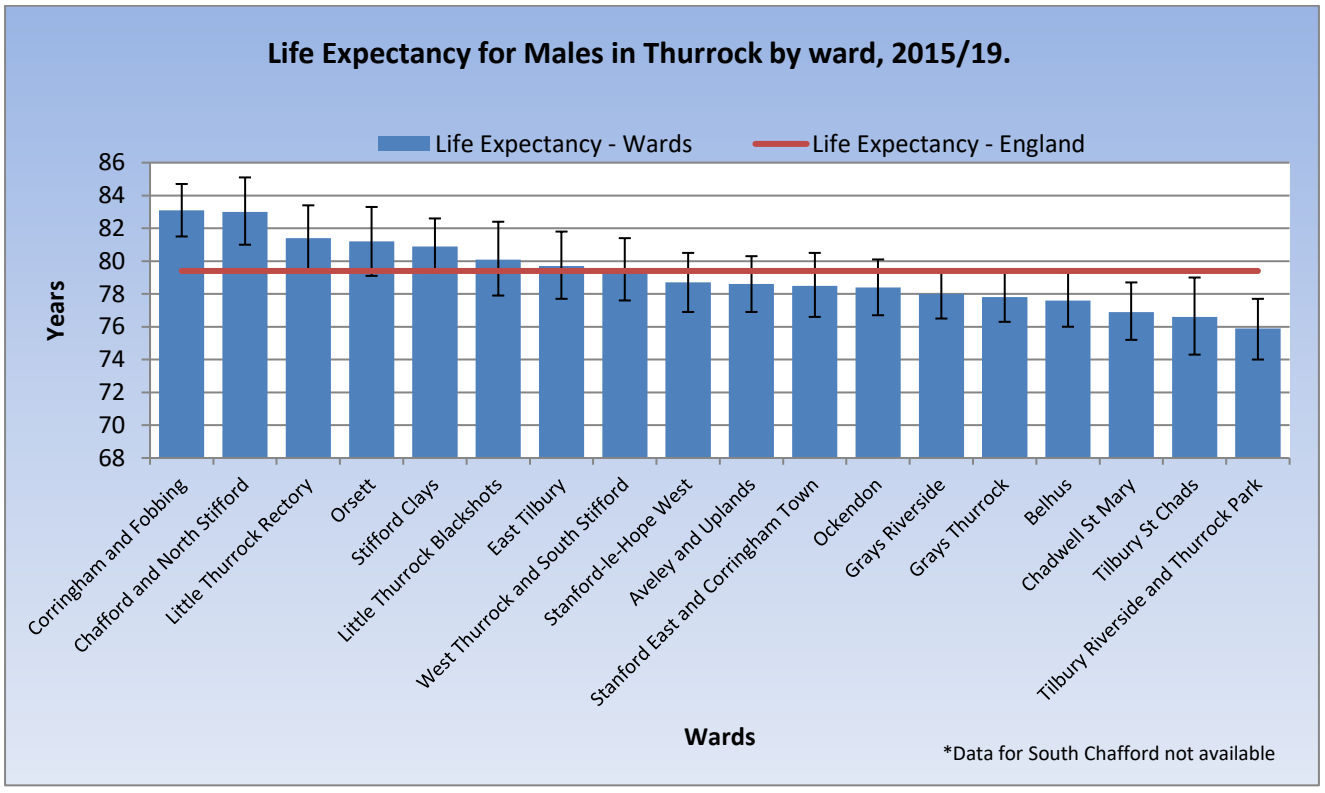
Breastfeeding prevalence in Thurrock may be indirectly contributing to observed healthy life expectancy. The benefits of breastfeeding are well established within the evidence base including a reduction in the risk of becoming obese, developing Diabetes, Cardiovascular and other diseases as well as reducing the risk of mothers developing some Cancers. Breastfeeding is also known to protect against Sudden Infant Death Syndrome (SIDS) and reduced incidence of some childhood illnesses that may also affect infant mortality rates. Low breastfeeding rates in Thurrock coupled with the fact that families on low income are less likely to breastfeed has the potential to widen the gap in health inequalities and life expectancy (5).

Figure 6: Life Expectancy (Females) in Thurrock by Ward, 2015-19.



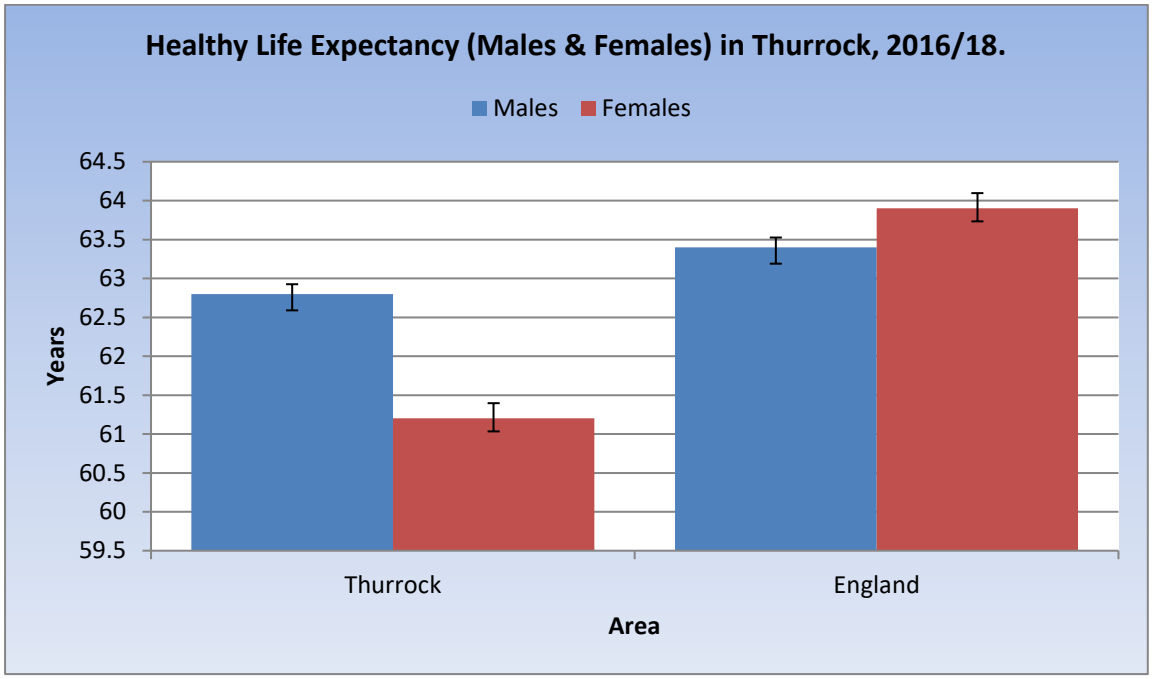
Source: Local Health, 2015-19.

Figure 7: Life Expectancy (Males) in Thurrock by Ward, 2015-19.



Source: Local Health, 2015-19.

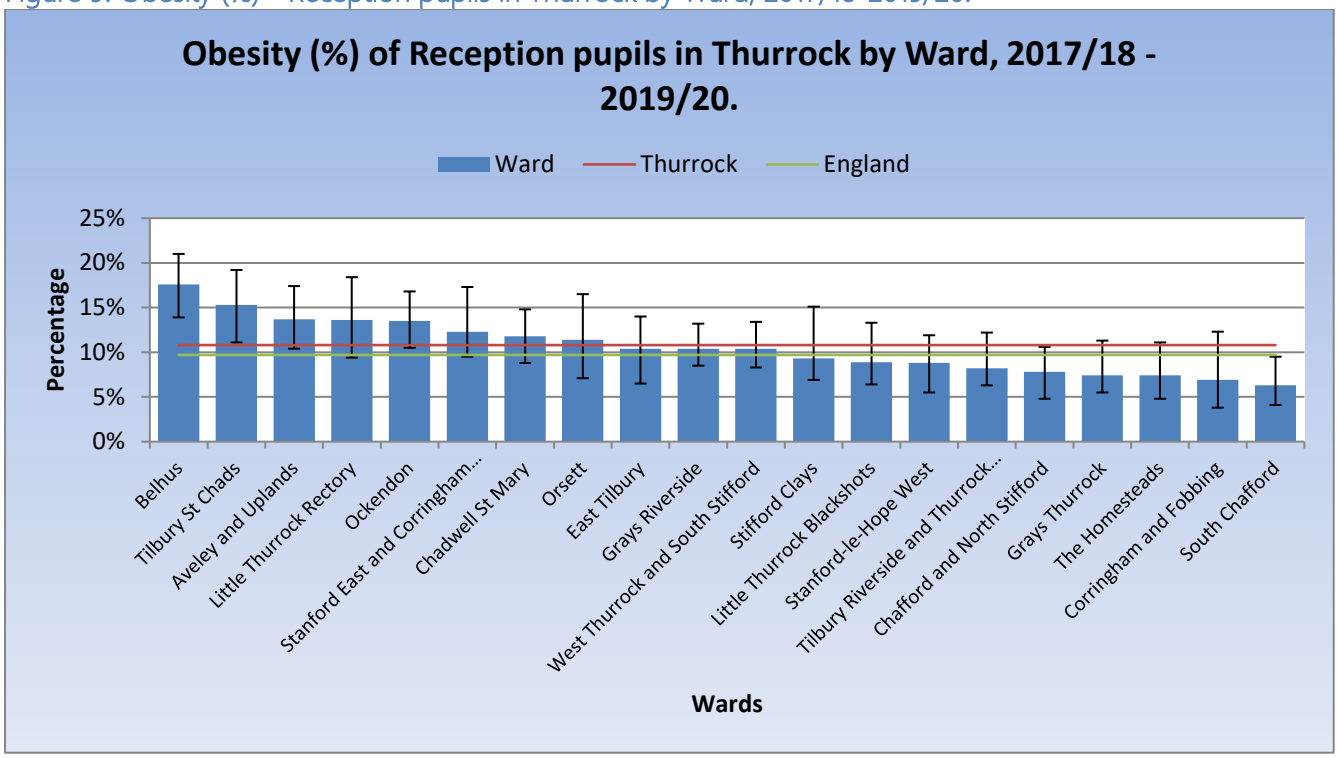
Figure 8: Healthy Life Expectancy in Thurrock & England (Males & Females), 2016-18.



Source: ONS, 2016/2018.

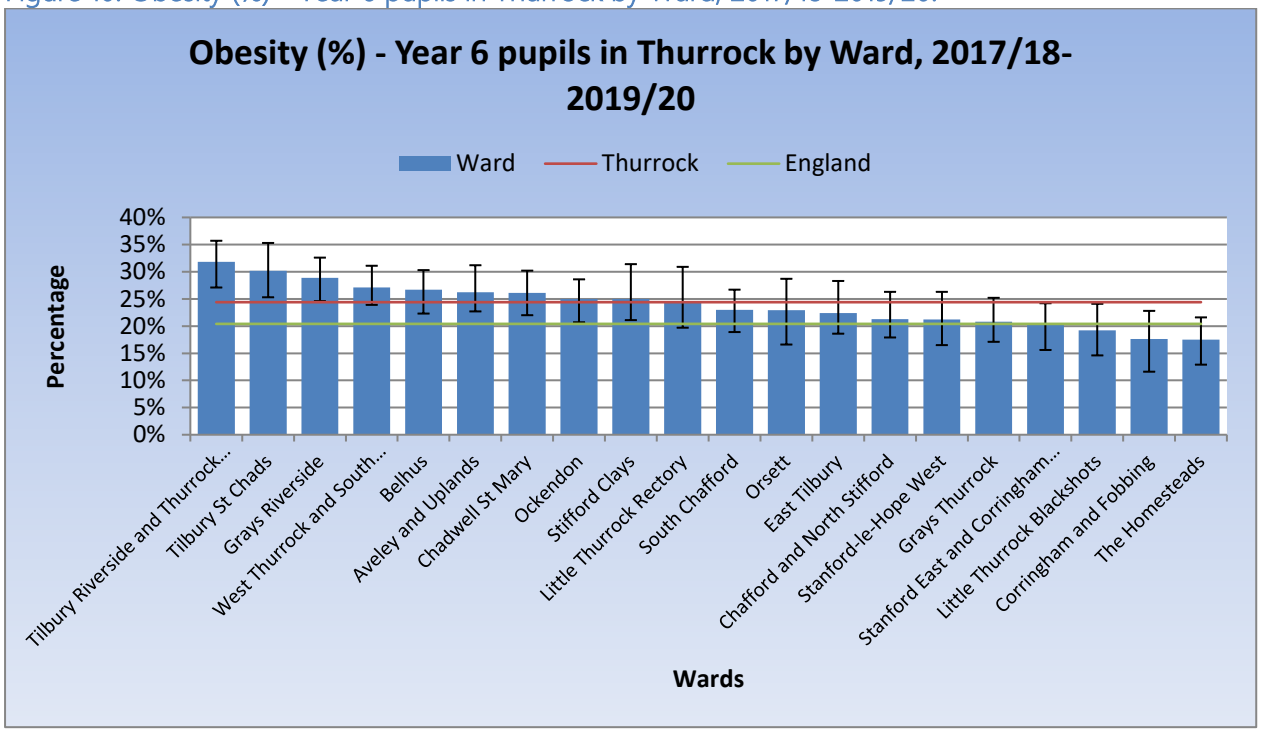
Figures 9 and 10 below show the obesity rates of Reception and Year 6 pupils by ward in Thurrock. Obesity rates in Reception pupils are similar to the Thurrock and England averages for the majority of wards, with the exception of Belhus where rates are significantly higher than the National average and South Chafford where rates are significantly lower. There are significantly higher rates of obesity in year 6 pupils than both Thurrock and England averages in Tilbury Riverside and Thurrock Park, Tilbury St. Chads and Grays Riverside. Obesity rates are significantly higher than the England Average in 8 Thurrock wards (Tilbury Riverside and Thurrock Park, Tilbury St. Chads, Grays Riverside, West Thurrock and South Stifford, Belhus, Aveley and Uplands, Chadwell St Mary and Ockendon). At Year 6, four wards have significantly lower obesity prevalence than Thurrock average (Homesteads, Corringham and Fobbing, Little Thurrock Blackshots, and Stanford East and Corringham). It should be noted that the ward level data in the figures below is modelled data estimated from MSOA prevalence and should be interpreted with caution. Breastfeeding is associated with reduced risk of children becoming obese later in life. The current low breastfeeding rates in the borough could be contributing to the obesity prevalence observed in year R and year 6 children. Although it is recognised that obesity is an extremely complex and multi-faceted issue.

Figure 9: Obesity (%) - Reception pupils in Thurrock by Ward, 2017/18-2019/20.



Source: PHE 2017/18 – 2019/20

Figure 10: Obesity (%) - Year 6 pupils in Thurrock by Ward, 2017/18-2019/20.



Source: PHE, 2017/18-2019/20

What does this mean for Thurrock?

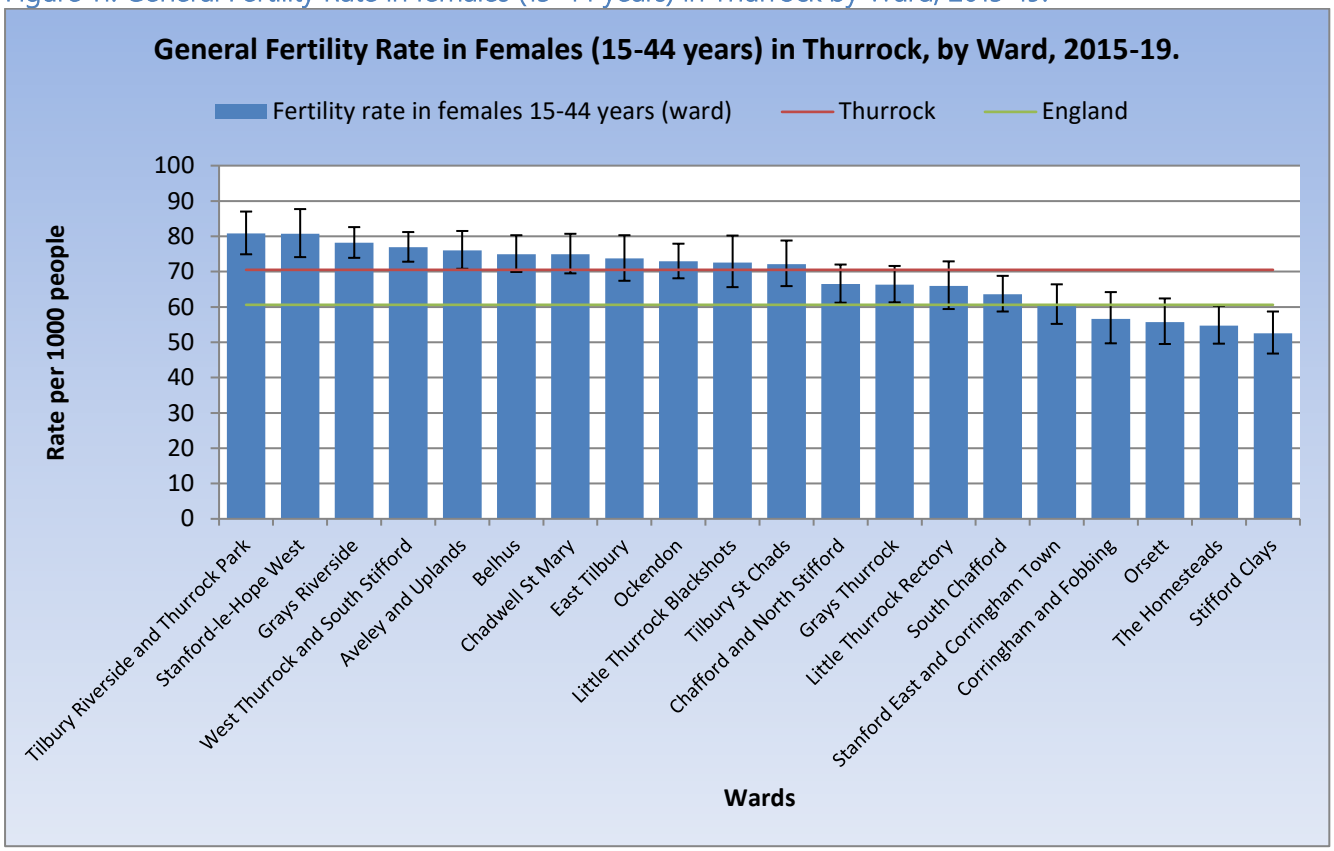
- On average women in Thurrock live longer than men with a smaller gap in life expectancy between the most deprived and affluent wards than observed in men.
- Healthy life expectancy for men in Thurrock in statistically similar to the England average however in women it is significantly lower. This tells us that on average women live longer but in poorer health. Healthy life expectancy in women could be linked to a low breastfeeding prevalence.
- Health benefits of breastfeeding are well established in the evidence base. Low breastfeeding rates in Thurrock coupled with the fact that families on low income are less likely to breastfeed has the potential to widen the gap in health inequalities and life expectancy.
- Obesity at reception year is statistically similar to the national average however, there are two wards in the West of Thurrock where obesity is statistically higher than the national average: Belhus and Ocekndon. In year 6 (age 10-11) obesity is Thurrock significantly higher than the regional and national average. This is important, as breastfeeding is associated with a reduced risk of children becoming obese later in life. We know that if a child is obese at reception year in school only 2 in 10 return to a healthy weight by year 6. Preventing obesity is a complex challenge requiring system wide change; increasing breastfeeding initiation and duration could play an important part in this.

2.3 Maternal and Paternal data

There is a wide variance in the fertility rates of females (aged 15-44 years) by ward in Thurrock. This ranges from 80.8 live births per 1,000 in Thurrock Riverside & Thurrock Park to only 52.5 per 1,000 in Stifford Clays. The fertility rates in 13 of the 20 wards) are significantly higher than the England average as seen in Figure 13 below. It appears that more couples in the more deprived boroughs become pregnant than in the more affluent wards, there may be a variety of factors contributing to this. This data does not tell us how individual lifestyle choices impact on this.

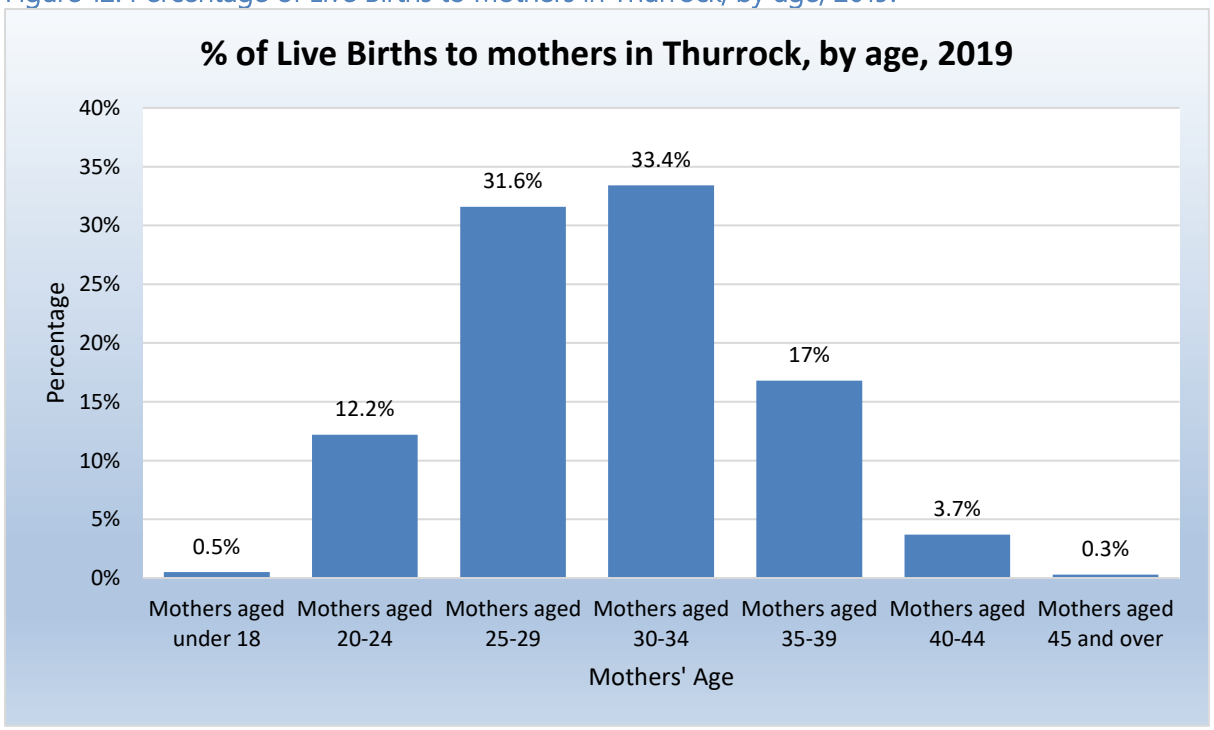
At Basildon and Thurrock University Hospital (BTUH) there were 4062 births in 2019/20 with an additional approximate 150 births taking place in the community. Of these births, approximately just over half – 2,415 births) (59% in 2019/20) are to Thurrock residents with the rest coming from surrounding areas, mostly from the Basildon area (NELFT 2019/20).

Figure 11: General Fertility Rate in females (15-44 years) in Thurrock by Ward, 2015-19.



Source: Local Health, 2015-19.

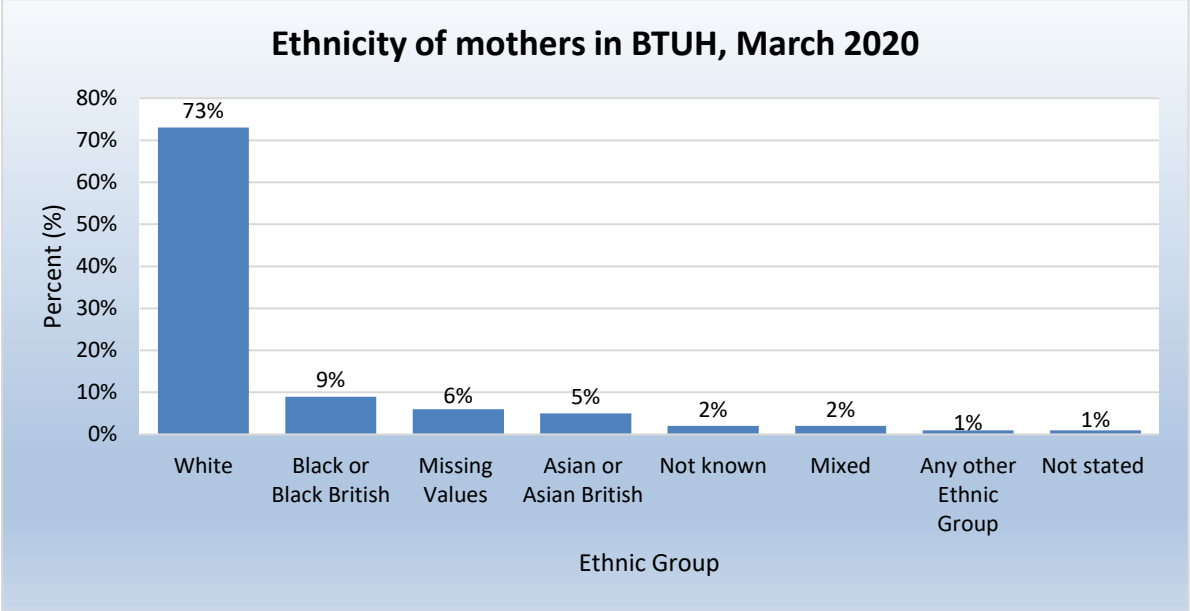
Figure 12: Percentage of Live Births to Mothers in Thurrock, by age, 2019.



Source: NOMIS, 2019.

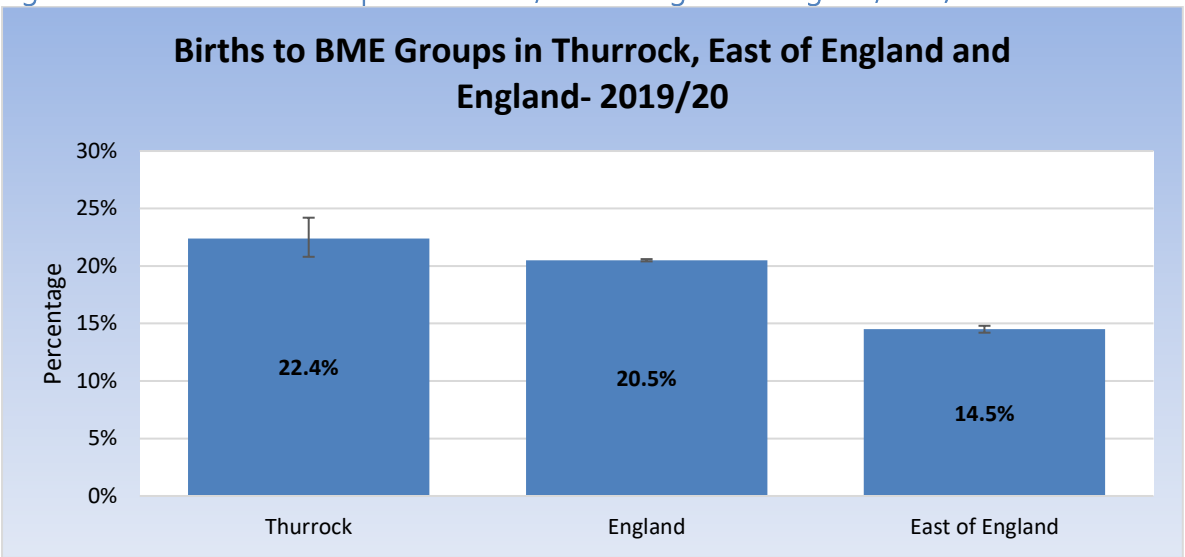
Figure 12 above highlights that women aged between 25 and 34 account for the largest percentage of births in Thurrock. In addition, there is a much higher percentage of white mothers in Thurrock and other local areas as outlined in Figure 13 below. However, births to BME women account for 22.4% of births in Thurrock which is significantly higher than the East of England and England percentages (see Figure 14 below) although this is consistent with the ethnic diversity observed in Thurrock, highlighted in figure 1 (p7).

Figure 13: Ethnicity Status of Pregnant Women at BTUH and all submitters, 2018.



Source: Maternity Service Data NHS Digital 2019 for October 2018.

Figure 14: Births to BME Groups in Thurrock, East of England & England, 2018/19.

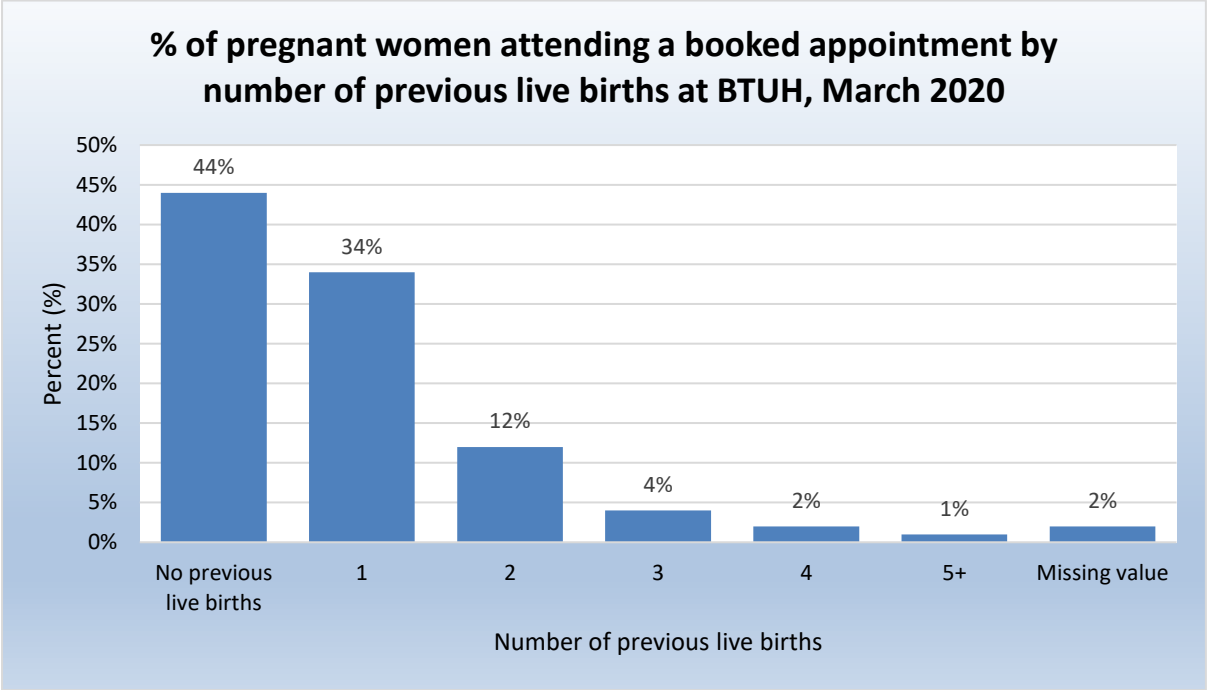


Source: PHE Fingertips – Child and Maternal Health, 2018/19.

Figure 15 below shows the percentage of pregnant women who attended antenatal booking appointments at BTUH by number of previous births. In March 2020 at BTUH 44% of the women were attending booked appointments for their first child with 7% of those attending having previously had at least three children. Most of the booking

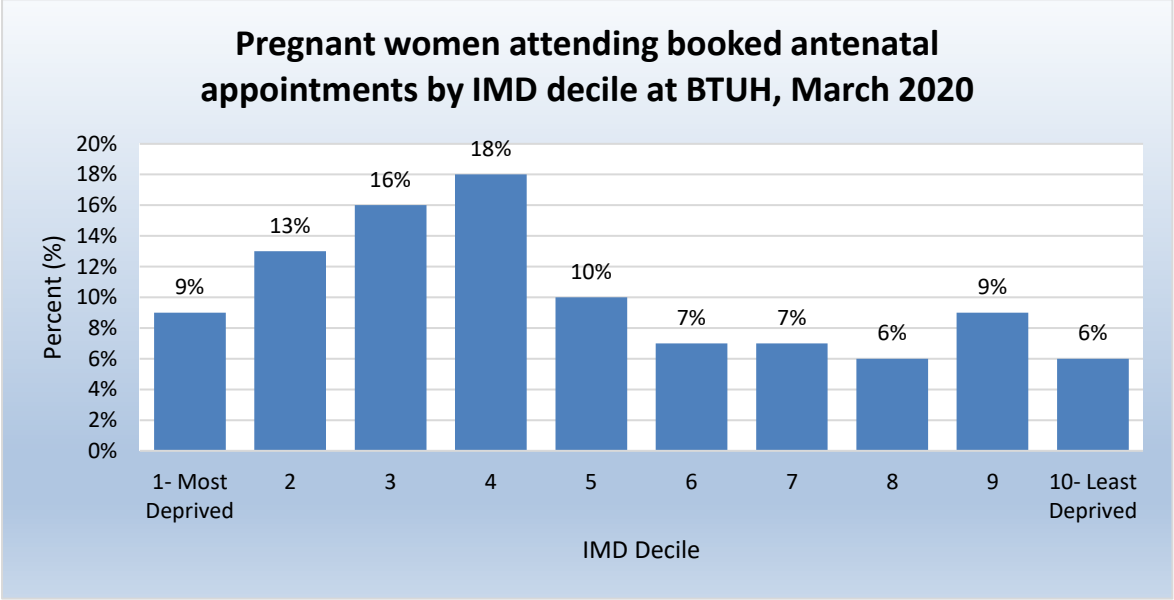
appointments were for the first or second child. Families attending appointments were able to seek and receive advice and initiate early conversations with health professionals about breastfeeding.

Figure 15: % of pregnant women attending a booking appointment by number of previous live births at BTUH, 2020.



Source: Maternity Service Data NHS Digital 2021 for March 2020.

Figure 16: % of pregnant women attending antenatal appointments by IMD decile at BTUH, March 2020.



Source: Maternity Service Data NHS Digital 2021 for March 2020.

Pregnant women living in areas of higher deprivation (decile 1-4) make up the largest percentage (56%) of booking appointments within antenatal services at BTUH (see figure 16 above). This initial antenatal appointment presents an opportunity for health professionals to initiate early conversations with these families.

The Healthy Child Programme recommends that a pregnant woman is offered an antenatal visit from a health visitor from 28 weeks of pregnancy, as well as within the two weeks following the birth. As highlighted earlier in this report there are currently between 2200-2400 births to mothers in Thurrock each year (2018-20). Health Visitors have a target to visit all new mums (a minimum of 95%) and their babies and partners if possible, within their home within 14 days of birth. In 2016/17 this was achieved for only 93.7% of new births. This increased to 94.5% in 2017/18 and meeting the performance target in 2018/19 at 97.2%. It was subsequently 98.1% in 2019/20 and 97.6% in 2020/21.

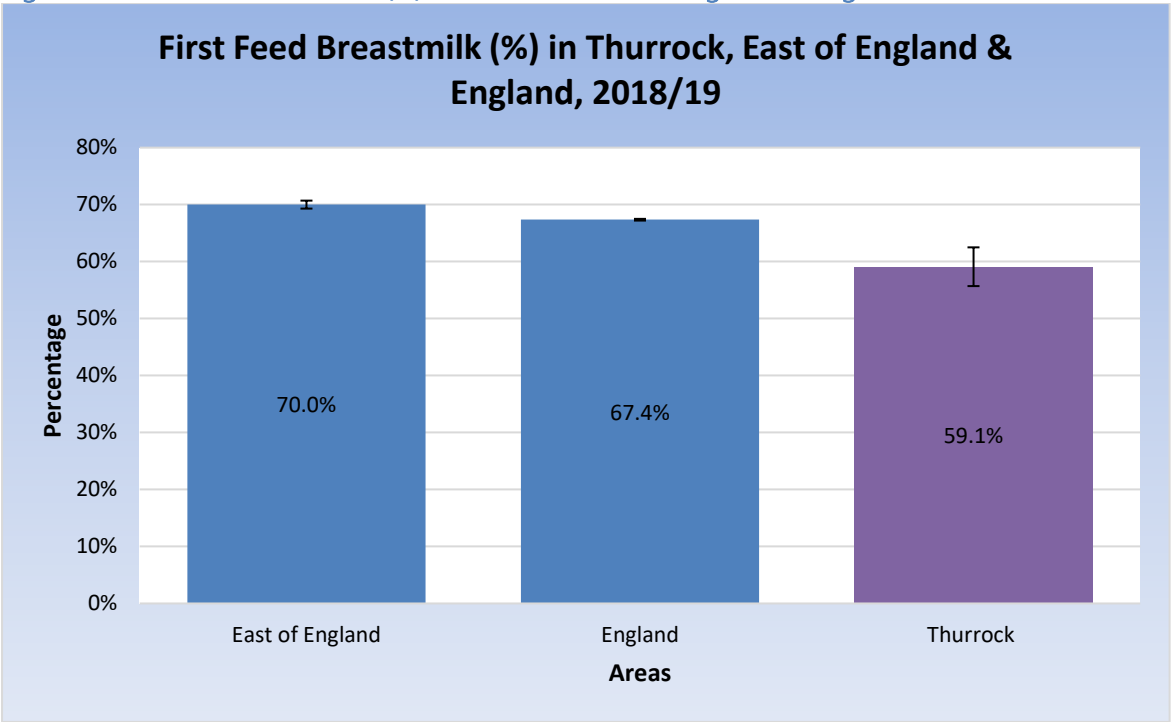
What does this mean for Thurrock?

- Fertility in Thurrock is variable although on average it is higher than the England average.
- There are approximately 2200 to 2400 births in Thurrock every year, the majority take place at BTUH.
- There are a higher proportion of births to BME mothers in Thurrock (22.4%) than in the East of England. Women from BME groups are more likely to breastfeed and so the low prevalence of breastfeeding in Thurrock does not reflect this. Data showing the ethnicity of women breastfeeding is not available to be able to explore this further at a lower level.
- Pregnant women living in areas of higher deprivation in decile 1-4 make up the largest percentage, 60% of booking appointments within antenatal services at BTUH. This is important given the fact families on low income are less likely to breastfeed (5).
- Families attending appointments were able to seek and receive advice and initiate early conversations with health professionals about breastfeeding. It is important to ensure that there are multiple opportunities and methods to engage pregnant families in conversations about breastfeeding whilst looking to engage families within booking appointments.

2.4 Breastfeeding Data

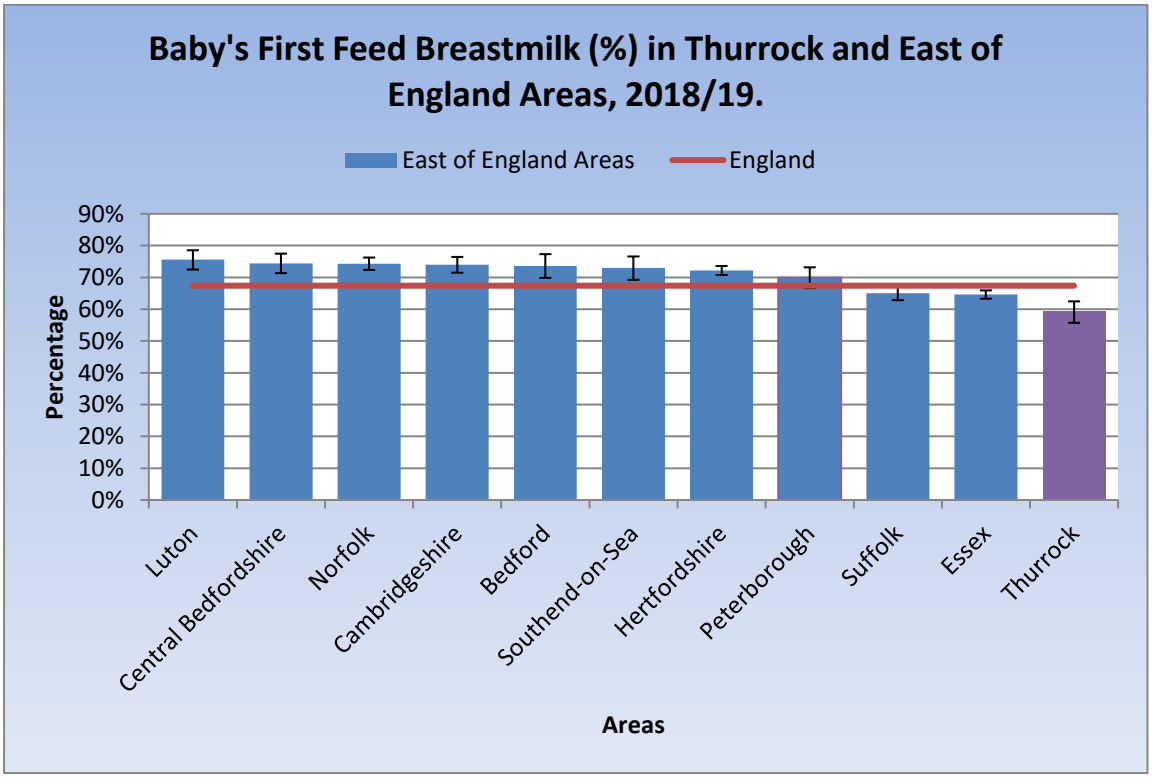
In Thurrock, first feed breastmilk rates are low at 59.1%; this is significantly lower than the regional and national averages (70% and 67.4% respectively in 2018/19) (see Figures 17 and 18 below). Moreover, Thurrock has the lowest first feed breastmilk rate across the whole of the East of England (See Figure 18). Reductions in breastfeeding rates in Thurrock are large, by 6-8 weeks post birth breastfeeding (exclusive or partial) was only 48% in 2019/20 (see figure 19). This is statistically similar to the England average. *Data was not available from Norfolk, Hertfordshire, Suffolk, or Milton Keynes as comparators.*

Figure 17: First Feed Breastmilk (%) in Thurrock, East of England & England, 2018/19



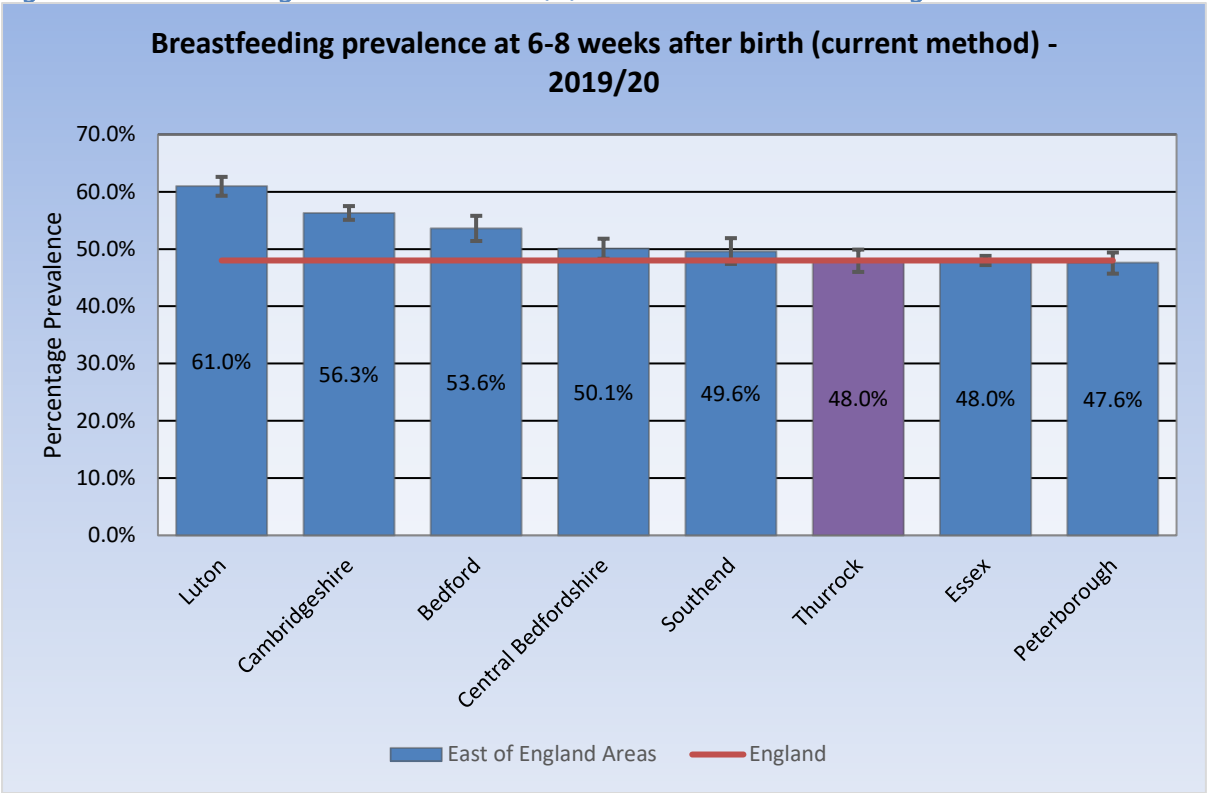
Source: PHE Fingertips – Child and Maternal Health Profiles, 2018/19

Figure 18: First Feed Breastmilk (%) in Thurrock and East of England Areas, 2018/19



Source: PHE Fingertips – Public Health Profiles, 2018/19 (most recent comparable data available)

Figure 19: Breastfeeding Rates at 6-8 weeks (%) in Thurrock and East of England Area, 2019/20



Source: Public Health England Fingertips National Child and Maternal Health Profile

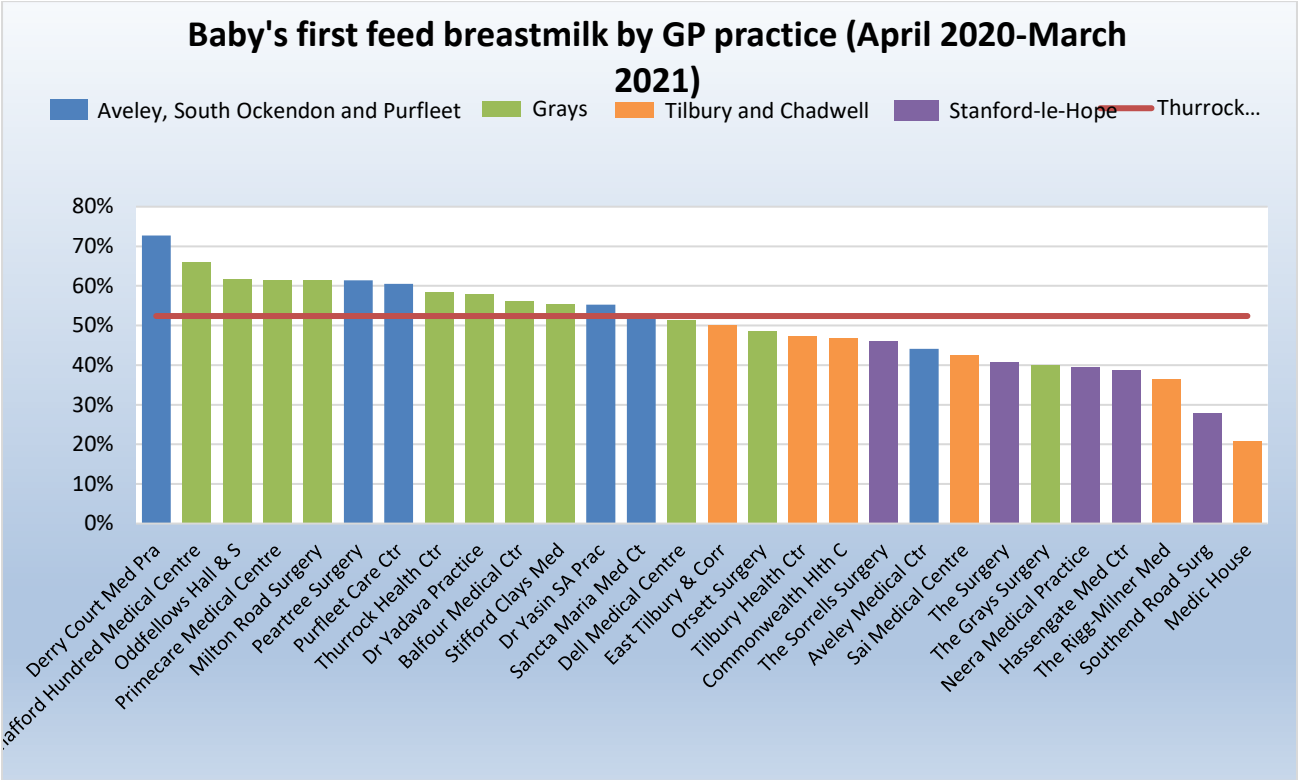
Within Thurrock, there is a level of variation in rates of early breastfeeding. This can be seen below at practice level[2].

It can be seen that practice-level first feed breastmilk (FFBM) prevalence ranged from 20.8% (Medic House) to 72.7% (Derry Court Medical Practice). It appears from Figure 20 below that most of the GP practices with the highest prevalence are within the Grays PCN area, and conversely all of the Tilbury and Chadwell and Stanford-le-Hope PCN practices have lower FFBM rates than the Thurrock average.

The breastfeeding rates in the East of Thurrock more generally are lower at 6-8 weeks than areas with a higher proportion of BME groups which seems to support the research that suggests women from BME groups are more likely to breastfeed and to maintain breastfeeding than white women (5). Figures 6 and 7 on p10 and 11 show deprivation (IMD Score) and percentage of Child Poverty by ward. The East of the borough and in particular Tilbury have much higher levels of deprivation than Aveley and Grays. The lower prevalence of breastfeeding observed in the more deprived wards supports the evidence that breastfeeding rates in the UK are significantly lower among families on a lower income (5).

[2] Note – in order to understand approximate locations of these GP practices, a colour code has been applied to show the Primary Care Network area of each practice.

Figure 20: Percentage of babies who received breastmilk as their first feed, by GP practice in Thurrock, 2020/21.



Source: NHS Arden & GEM Commissioning Support Unit.

The map below shows the location of GP surgeries who have either low breastfeeding uptake (Gold) or high drop-out rates (Red) as well as the location of the Children's Centres (Blue). As can be seen by the map the location of the Children's Centres are well placed to support families, as they are in close proximity to GP practices where low uptake and high drop-out rates are prominent.[3]

[3] This map (2) was created when completing the social marketing research in 2019 and so the currency of the data is noted and caution applied in interpretation.

Map 1: Location map of GP surgeries with low uptake &/or high drop-out rates of breastfeeding and location of Children's Centres.

Source: PHE Annual Breastfeeding Statistical Release 2017/18

Key:
Gold = GP cohorts with low breastfeeding uptake
Red = high drop-out rates
Blue = children's centres (blue)

What does this mean for Thurrock?

- In Thurrock first feed breastmilk rates (59.1%); are significantly lower than the regional and national average.
- Thurrock also has the lowest first feed breastmilk rate across the whole of the East of England (See Figure 23).
- Reductions in breastfeeding rates in Thurrock are large, by 6-8 weeks post birth, breastfeeding (exclusive or partial) was 48% (2019/20).
- Children's Centres are well placed to support families, as they are in close proximity to GP practices where low uptake of breastfeeding and high drop-out rates by 6-8 weeks are observed.

3 Existing Local Offer

NELFT – Healthy Families offer around Breastfeeding (2019)

The commissioned offer from the Public Health team at the Council in relation to Breastfeeding is delivered by NELFT through the Healthy Child Programme; Brighter Futures Healthy Families Service. All staff within the service are Baby Friendly Initiative (BFI) level 3 accredited (over a 2 day course) to support them to deliver support around breastfeeding[4]. As part of their core offer through the Healthy Families Service NELFT conduct an Infant Feeding assessment routinely, both during the antenatal and postnatal periods. This assessment contains provision of information/support relating to parents feeding intention and staff give evidence based information for parents to inform their choice. This is recorded on a Parent Health Record. Although the Healthy Families Service offer is mostly delivered once the child is born, support is offered in the form of an antenatal visit to as many parents as possible, this is dependent upon notification from maternity services that a woman is pregnant.

NELFT contact all parents once they have given birth via telephone, and send out a Mother's questionnaire (twice annually) to assess mothers, and to enable signposting/support as needed. As part of this biannual audit 30 breastfeeding and bottle feeding parents are contacted and their feedback informs the annual update for staff and changes are made to the service in response.

There are five mandated contact points within the Health Visiting service (Healthy Families) the first three offer the most opportune times to support with breastfeeding: antenatal, new-born (10-14 days after birth), and 6-8 weeks following birth. Support and advice is offered for positioning, attachment and where any other concerns can be discussed and methods found to alleviate these issues. For example, there is a tongue tie clinic at BTUH – should infants be struggling to feed that health visitors can refer to.

In partnership with the Children's Centres, NELFT run infant feeding drop in sessions, Child Health Clinics and 'Introduction to Solid food' sessions both within the Children's Centres and Thurrock Health Centre (outlined below)[5]. The team also link with BRAs[6] and signpost to this service which is a local breastfeeding peer support group in Stanford-le-Hope (detailed below) and part of the community and voluntary sector.

NELFT also provide information about Parents 1st (who offer a course for fathers) on all of their promotional resources e.g. leaflets and website who are also part of the community and voluntary sector and not currently commissioned by the Council.

[4] Recently (August 2021) the Healthy Families Team have been re accredited at level 3 for the Baby Friendly Initiative.

[5] Virtual support has continued to families throughout the Covid 19 pandemic in 2020/21. The infant feeding clinics have been running by appointment throughout the pandemic.

[6] Breastfeeding Reassurance And Support (BRAs)

As part of the new birth visit and visit at 6-8 weeks after birth, Health Visitors support breastfeeding and are required to undertake a Maternal Mood Assessment that aims to identify whether new mums are having any difficulties in adjusting to motherhood and identify any mothers that may be at risk of post-natal depression. During the last few years between 89 and 85% of mums received one, this proportion has remained similar between 2016/7 (95.8%) 2017/18 (90.7%) and 2018/19 (89.2%) (Healthy Families Service NELFT performance data) Since 2017 there has been a target to increase this to a minimum of 93%, this target has been delivered every month of the contract year 2019/20 at the time of writing this report, ensuring as many women as possible benefit from this assessment. The evidence base has demonstrated that that postnatal illness can affect breastfeeding with emerging evidence suggesting this relationship could be bi-directional (8). Therefore maximising this opportunity to support women's emotional health and wellbeing can play an important part in supporting breastfeeding as well.

Children's Centres

Children's centres work in partnership with other services to deliver support for families including breastfeeding and infant care. Children's centre staff are trained by the Healthy Families staff in regards to infant feeding. All the premises adhere to the Unicef international infant feeding Code[7]. Full details of the timetables for Children's centres can be found on the Thurrock Council Website (9) and it is also included as Appendix 8. The offer varies between Children's Centres with some offering a more comprehensive offer than others e.g. Ockendon. In terms of equity of service this is something that needs to be reviewed and addressed, particularly in relation to breastfeeding prevalence. Offering the same service in each area is important in terms of access to universal provision but providing targeted support in areas of greater need as identified in the data section could contribute to increasing breastfeeding prevalence. Looking at the areas of highest deprivation and areas with families of white British ethnicity as shown in the data section as well as looking at the areas where the GP practice observed prevalence is low could form part of this strategy.

Thurrock BRAs (Breastfeeding Reassurance and Support) Community Interest Company (CIC)

Thurrock BRAs Incorporated Community Interest Company (CIC) is a local breastfeeding peer support group in Stanford-le-Hope launched in 2016. Groups are run by skilled trained Association of Breastfeeding Mothers (ABM) Mother Supporters and a qualified breastfeeding Counsellor. They aim to support families with any breastfeeding issues, concerns or worries and meets weekly (during term-time) at Hardy Park. They also provide support on introducing solids and general parenting support. BRAs has a Facebook page providing support and advice through posts and information about events that may be useful to families (10).

[7] The International Code of Marketing of Breastmilk Substitutes - Baby Friendly Initiative (unicef.org.uk)

Parents 1st

Parents 1st specialise in effective volunteering and peer support during the key life change of pregnancy, birth and becoming a parent.

The team offer a range of friendly and free activities during pregnancy, birth and post birth.

They include:

- One-to-one visits to expectant mothers and fathers from a Pregnancy Pal;
- Birth Buddy support; support through the pregnancy, birth; buddies and can be with the family immediately after birth and can support with feeding.
- Antenatal sessions for mums; which cover information about both breast and bottle feeding.
- Expectant dads workshops cover the following topics;
    - Relaxation for you and your partner
    - Labour and birth.
    - Changes ahead.
    - Practical baby care including feeding and winding (11).

Further information can be sound on the Parent's 1st website. As noted above NELFT promote this service via their website and within their services.

Feeding Together

The NHS BTUH Feeding Together infant feeding service encompasses provision of information, support and understanding, to ensure a positive feeding experience for all mothers and their babies. The offer includes:

- A fully accredited UNICEF Baby Friendly maternity unit
- Information and support to pregnant women and new mums on breastfeeding and infant feeding issues
- Home visits and telephone support to assist mums in getting feeding off to a good start
- Training, resources and support for infant feeding across South West Essex (12).

Feeding Together also have a Facebook page where practical support and advice can found around infant feeding (covers breastfeeding and bottle feeding) for example on how to get a good latch and how to implement paced feeding for mothers who are bottle feeding. It also promotes local events that may be useful for families (13). The Feeding Together work is undertaken by health professionals at BTUH.

Table 1: Places of Support in Thurrock

The table below details the full offer of services to support Thurrock families to breastfeed.

Universal Services: - Midwife (appointments with midwifes are available at most Children's Centres in Thurrock). - Health Visitor appointments/visits. (NELFT Healthy Families Service) - Breastfeeding drop-ins e.g. at clinics. - Children's Centres - see table of events above. (Including drop in sessions for infant feeding) - NHS BTUH Feeding Together Service - National Breastfeeding Helpline on 0300 100 0212.
Charity/Voluntary Sector: - Local breastfeeding support groups e.g. BRAs in Stanford-le-Hope - Peer mentors (volunteer mothers) - Thurrock NCT groups - Parents 1st
Websites/Forums: - Feeding Together Facebook Page - BRAs Facebook Page - Net Mums Online Community Forum - https://www.netmums.com/ - http://human-milk.com – this covers the science behind breastmilk and breastfeeding. - https://www.babycentre.co.uk – commercial site but contains information about common concerns families might have in relation to infant feeding including, milk supply, expressing, managing sore and painful nipples and latching amongst others. - Start4Life breastfeeding website – https://www.nhs.uk/start4life/baby/breastfeeding/ - Start4Life breastfeeding friend (operated by Facebook Messenger or Amazon's Alexa). - Maternity Direct+ - has a website page where expectant or new parents can ask questions/request support and advice 24/7 https://www.facebook.com/maternitydirect/
Other: - Family and breastfeeding friends.

What does this mean for Thurrock?

- There is a universal offer from commissioned Public Health and Acute Health services as well as some community and voluntary sector services to support families along with the national websites and helplines from charities and NHS partners.

- Looking at the equity of provision in the localities around Children's Centres in Thurrock alongside the data showing breastfeeding prevalence is an important approach when designing or revising the service offer. There is an opportunity for Children's Centres to play a key role in increasing breastfeeding prevalence in Thurrock.

- The social marketing research in chapter six looks at Thurrock families' awareness of and satisfaction with the service offer and will be important insight when looking at promoting the services and the best approach to this, as well any future commissioning and design.

4 Literature Review Summary

4.1 Introduction to Breastfeeding

What is breastfeeding?

Breastfeeding, also known as nursing, is defined as …'the feeding of babies and young children with milk from a woman's breast'. Breastfeeding is one of the most effective ways to ensure child health and survival however nearly two out of three infants are not exclusively breastfed for the recommended six months. (14)

What proportion of new mums breastfeed?

As noted in the introduction of this needs assessment the UK is one of the most poorly performing countries in the world in terms of breastfeeding continuation past the early weeks. Although initiation rates are comparatively high (to 6-8 week rates) at around 80%, reductions in breastfeeding rates from birth to 6-8 weeks are quite large, reducing to approximately 43.2% of mothers still breastfeeding at all (either exclusively or partially. Exclusive breastfeeding refers to the mother only feeding their infant breastmilk, whilst partial breastfeeding involves mixed feeding practices of both formula and breast milk). These rates fall even further at 6 months with only about 1% of all mothers breastfeeding their infants exclusively (1), (2).

Why is this important?

These low rates of breastfeeding can have an impact on infant health through increased risk of infection and illness in the first few months of life. Breastmilk contains anti-bodies that help to protect the infant from contracting infections and supports their developing immune systems. In addition breastfeeding protects infants against pneumonia and necrotising enterocolitis (1) and lowers the risk of infants developing other respiratory and ear infections. There are multiple examples in the evidence base of the science behind breastfeeding and its protective factors.

One study reviewed suggests that use of breastfeeding substitutes is also associated with increased risk of infants developing these illnesses (15). Hospital admissions for respiratory tract infections in 1 year olds in Thurrock (57.5 per 10,000 population) were similar to both the regional and national rates (72.4 and 83.5 per 10,000 population respectively) in 2016/17 (16). Moreover, hospital admissions for asthma in 10-18 years olds in Thurrock was similar to the East of England rate (65 and 100.7 per 100,000 population) (16). This is perhaps indicative of the relatively low breastfeeding rates nationally as well as locally. Perhaps surprisingly, 67% of people do not believe there are any biological differences between breast and formula milk (17). Health professionals cite the importance of supporting families to understand the difference between breast milk and formula to enable them to make an informed decision (18).

In turn evidence from the Early Intervention Foundation suggests that there are lower levels of infant mortality attributable to infections in breastfed babies, and although reasons for this are unclear there are theories which propose that an infant's dietary system is unable to tolerate and fully digest complementary foods such as formula milk at such a young age (1). The rate of infant mortality in Thurrock is 3.1 per 1,000 population and is similar to both the regional and national rates (19). Furthermore, mortality from causes considered preventable is significantly higher in Thurrock (197.3 per 100,000 population) compared to the East of England and England rates (160.2 and 181.5 per 100,000 population respectively) (19). Infants who are not breastfed (either partially or exclusively) place both mother and infant at increased risk of poor health later in life, including increased risk of becoming obese, developing Diabetes and Cardiovascular disease amongst other conditions.

Why do more women not choose to breastfeed?

This literature search aims to review the published evidence for effective interventions to promote uptake and maintenance of breastfeeding and look at any areas of best practice to support with the development of recommendations for a Thurrock strategy to address this. The published policies related to breastfeeding are reviewed alongside published research supporting and challenging the guidance within the policies in section 4.3.

4.2 Promotional material to encourage and inform families about breastfeeding

Key points:

- Research suggests some mums are not convinced by the information around the benefits of breastfeeding.
- Knowledge and benefits of the health benefits alone is not enough to encourage women to breastfeed.
- Providing information to adolescents that corrects misconceptions about breastfeeding is vital in supporting them to develop positive attitudes towards breastfeeding at an early age.

Despite the numerous health benefits, breastfeeding rates remain low and it has been suggested by some that knowledge and promotion of the health benefits alone is not enough to encourage women to breastfeed and in-fact some mothers believe that focusing on only the health benefits can take away from breastfeeding becoming normalised (18), (20). There is an abundance of research that explores additional factors that may also be acting as barriers to breastfeeding, such as feeling uncomfortable about breastfeeding in public (20), (21). This suggests a need for promotion and awareness raising of the wider benefits such as convenience, cost and closeness/bonding which women involved in research have reported would be welcomed (18). In one piece of research one women stated:

"Breastfeeding is about so much more than health. It is about cuddles, closeness and bonding. It saves time, costs nothing and you can never forget to take it out with you. Why don't we emphasise these things more?" (18).

For low income families not knowing about the wider benefits, particularly perhaps cost could in part explain the low uptake of breastfeeding in this cohort of the population.

Published research suggests that successful breastfeeding promotion depends upon understanding an individual's point of view and intervening on those terms. This was part of the rationale for undertaking a piece of social marketing research relating to infant feeding (see Section 6).

Much of the research highlights the fact that current promotional materials fail to provide 'real world' images of breastfeeding and can therefore deter some women from making the choice to breastfeed (20), As such promotional resources are more likely to be effective if they depict mothers and babies in 'everyday' social situations. The Baby Friendly Initiative uses an evidence based approach to supporting families around breastfeeding and good infant nutrition as well as developing positive loving relationships with their baby/babies (22). Introduction of the Baby Friendly Initiative (BFI) has supported

some improvements to resources e.g. the BFI 'You're Welcome to Breastfeed here' posters for businesses to display.

There are also some issues relating to timing of breastfeeding education, promotion and support which are usually targeted towards pregnant women. This is significant in light of the growing recognition that decisions regarding infant feeding choices are often made before pregnancy and the beginnings of this thought process may commence as early as during adolescence (23). Findings from one study that examined the impact of an infant feeding classroom activity on breastfeeding knowledge and intentions suggests that adolescents' knowledge of, and intention towards breastfeeding may be positively influenced during their teen years. Furthermore, providing information to adolescents that corrects misconceptions about breastfeeding is vital in supporting them to develop positive attitudes towards breastfeeding at an early age (23). At 10-weeks post-intervention increases in intentions to breastfeed remained and it is possible that this was due to students further discussing the topic with friends and families or undertaking their own research following the study. Moreover, of the pupils who participated in this study 87% reported believing that breastfeeding should be included in the school curriculum.

4.3 Research exploring how policies influence families to breastfeed.

Key points:

- NICE recommend an overall infant feeding strategy is developed promoting breastfeeding although supporting safe formula feeding and promoting families developing positive emotional relationships with their babies.
- WHO and UNICEF advocate breastfeeding promotion for the first 2 years of life and exclusively for 6 months
- BFI accredited organisations should not promote formula feeding, bottles or teats.
- A Thurrock approach should take the positives from all of these approaches in developing a strategy that supports families to breastfeed and promotes healthy choice.

Research in 2012 (24) examined goals, assumptions and dilemmas associated with breastfeeding education and support. The authors highlighted three main dilemmas based on the different ethos and approaches to breastfeeding support. National Childbirth Trust's (NCT) ideology centres on 'quality of experiences' and parents having every opportunity for positive feeding experiences contrasted by WHO/UNICEF's 'health outcomes' view; the authors pose ways to overcome these dilemmas.

Dilemma 1 – should we promote breastfeeding or promote choice?

The authors propose that ongoing support should be offered to mothers in relation to their infant feeding decisions whilst equally protecting their decisions to breastfeed.

Dilemma 2 – Should we prepare parents for difficulties they might experience during the breastfeeding journey or give the view that breastfeeding is straightforward and easy?

It is suggested by Trickey et al (24) that professionals should be promoting the concept of investment and adjustment here; being realistic that breastfeeding can be difficult, particularly in the early days but that investing time and responding to the baby's need can help overcome problems; offering reassurance that it does become easier over time.

Dilemma 3 – should professionals provide proactive or reactive support e.g. waiting for mothers/families to initiate requests for support?

The authors suggest developing models that are both mother-centred and proactive.

The findings of the social marketing research described later in this report (Section 6) reflect these dilemmas and resonate with the views of families in Thurrock.

Research suggests that although there are policies and guidance in place to support families around breastfeeding these are not necessarily getting through to families; or are being diluted by other attitudes or influences (18).

4.4 Benefits of, and Barriers to Breastfeeding

Key points:

- There are multiple short and long term health benefits to mothers and babies in breastfeeding.
- Increased exclusive breastfeeding in the population could result in cost savings to the NHS
- Increasing the number of infants who are breastfed could be an important strategy for improving the health and wellbeing of children, women and families as well as society in general (23).
- There are numerous barriers, beliefs and misconceptions relating to breastfeeding resulting in women choosing not to breastfeed.

Benefits

The benefits of breastfeeding are well evidenced. For example, breastfeeding has multiple health benefits for both mother and baby, some of which are outlined in Section 4.1 above. Other health benefits include reduced risk of Sudden Infant Death Syndrome

(SIDS), ear and respiratory infections, childhood Leukaemia and development of allergies later in life.

One study suggests that supporting women to continue exclusively breastfeeding up to 4 months could save the NHS at least £11 million annually. Moreover, doubling the percentage of mothers who are breastfeeding for between 7-18 months could potentially save £31 million, by reducing maternal breast cancer, reducing A&E attendance and hospital admissions due to infant or mother poor health as well as enhancing quality of life and life expectancy (15).

Breastfeeding also reduces the risk of long term health conditions later on in life, including type 2 diabetes, cardiovascular disease as well as protecting the infant from becoming obese in later childhood and adulthood. Some researchers suggest that breastmilk may contain hormones that support the body to metabolise food more readily and efficiently (1).

Health benefits for the mother include lowered risk of developing both breast and ovarian cancer, osteoporosis, diabetes and cardiovascular diseases.

It is also widely recognised that the many health benefits associated with breastfeeding also provide children with the best start in education e.g. through optimal brain development, protection from illness which can lead to visual or hearing impairments or Learning Disabilities (LDs) and enables better eye focus leading to reading and learning readiness (23).

The wider and tangible benefits of breastfeeding are perhaps not as widely promoted as the health benefits are but perhaps should receive a higher profile in terms of supporting breastfeeding to become normalised. They include benefits such as reduced cost, convenience and opportunity to bond with the baby.

Breastfeeding is an intimate experience that involves skin-skin touch, eye contact and closeness. It can support the infant in recognising their mother's face and voice and the mother can talk or sing to the infant, which research shows to be supportive of later language development. It also creates a great opportunity for quality time between the mother and infant. The positioning of infants during breastfeeding is optimal to allow these things to take place, although it could be possible to maximise these benefits with bottle feeding (if breastfeeding is not possible) if they are widely understood by families. UNICEF provide comprehensive information about the benefits and importance of skin-to-skin contact (25). For example, families can initiate skin to skin contact while feeding their infant or at other times whilst at home. Some websites such as Essential Parent (who work with leading medical experts such as UNICEF) provide guidance and tutorials about how this can be achieved, as well as how to safely bottle feed (26). It is unclear to what extent these behaviours will impact maternal and child outcomes in the absence of breastmilk.

Interestingly whilst women report mainly being told about the health benefits of breastfeeding, in one study with male partners, some males cited viewing breastfeeding as cheaper and more convenient (21). This research aimed to highlight the different perspectives, of parents in terms of what fathers thought about or were told about breastfeeding compared to mothers.

Based on the evidence reviewed the following represent key drivers that promote breastfeeding:

- Mother-centred discussion and information
- Convenience
- Cost
- Being (perceived) as being/ or being a good mum
- Being able to provide their baby with something no-one else can.
- Peer support
- Giving mum the option for wider involvement of the father and other family members in supporting and encouraging breastfeeding.

Barriers

The perceived barriers are also well documented throughout research with mothers and can be broken down into several key themes, including but not limited to; practical difficulties, freedom and independence – leading to perceived inability to undertake daily activities, lack of support from wider family, health and needs of the baby, time, views of others and societal embarrassment (20).

One of the most commonly cited reasons for choosing to bottle feed relates to perceived insufficient milk supply. A pilot study using a home-based programme was undertaken which aimed to reduce the number of women who perceive having insufficient milk supply, with a focus on evaluating the short term impacts of the programme. It was hypothesised that mother's lack of confidence around breastfeeding as well as their misinterpretation of infant's behaviour would be contributory factors to this perception. The programme was delivered during 3, 10 and 15 hour home interventions at 6, 13 and 27 weeks postpartum. Results suggest that the programme significantly increased (over time) the mother's self-efficacy and sensitivity to their baby's behaviour and self-efficacy as well as a reduced mother's perception of their baby's crying as related to insufficient milk supply. Based on the results, this programme has the potential to support breastfeeding continuation by building mother's confidence around breastfeeding (27).

Other more practical barriers relate to the presence of other children and needing to care for them, need to return to work and also the lack of public facilities in which to breastfeed. For some, breastfeeding is perceived as requiring prolonged unpaid maternity leave and this added to the feelings of dependency and lack of freedom (20).

The barriers to breastfeeding from the perspectives of dads have some similarities with those reported by mums. In terms of feeling uncomfortable about their partner breastfeeding in public, lack of support from wider family or the belief that bottle feeding is better and more convenient, wanting to get involved in feeding their baby and to give their partner a break (21). However, one study that aimed to explore the relationship between men and breastfeeding found that the majority of participants (65%) reported that they would feel comfortable with their partner breastfeeding in public, with only 3.4% reporting they would feel completely uncomfortable. One limitation of this study was that it relied on self-reporting by participants, as such it may have been subject to bias, in terms of men wanting to give socially acceptable answers. It is still an interesting insight and one that was explored as part of the social marketing research undertaken in Thurrock (see Section 6).

4.5 Mothers and Breastfeeding

Key points:

- Having encouragement from social and support networks makes mums more likely to breastfeed and breastfeed for longer.
- Women experience breastfeeding past six months as being viewed as socially unacceptable.
- Mums report feeling 'shamed' if they choose not to or struggle to breastfeed and discontinue.
- Mums report often feeling insufficiently reported and unprepared for the realities of breastfeeding.
- There is good evidence that support from fathers is critical to breastfeeding success in terms of initiation and maintenance and should be central in breastfeeding strategies and education.
- It shouldn't be assumed that teenage mums are less likely to breastfeed.

Some research suggests that background is really important; mothers who were breastfed, had family and friends who were or had breastfed, were encouraged to breastfeed, had a supportive network, attended antenatal classes and who had positive beliefs about breastfeeding were more likely to breastfeed and continue to breastfeed over a longer duration (28). In one study where young mothers were interviewed about their experiences of breastfeeding, one participant suggested that the term infant feeding 'choice' is one of the barriers to breastfeeding and cites:

"I believe that having the choice about how to feed your baby is where the problems start! If breastfeeding was considered the normal way to feed your baby and formula only used when this was not possible then mothers wouldn't be so confused about having to choose and would breastfeed with confidence." (28).

In the same research mothers acknowledged that breastfeeding was not always straightforward and they were not void of any difficulties or the negative attitudes of others e.g. as the infant grew past the newborn stage and particularly as the baby reached 6 months. This is reflected in other research such as in one study with women who continued to breastfeed beyond 6 months and who reported that they felt they were viewed as 'suspicious' and experienced disapproval particularly in a public context (29). However, they were able to overcome these problems due to their beliefs around breastfeeding coupled with the feeling that there was nothing to be ashamed of/worried about.

Mum shaming

*R*esearch from Cardiff University highlights that for a minority of mums the literature provided at appointments is perceived to be 'pushy' and 'insulting.' Additionally, some mums felt that there is too much pressure applied by midwives to breastfeed and this resulted in them feeling judged and as though they had failed when they stopped breastfeeding, didn't feed for as long as they had hoped, or weren't able to at all.

This feeling of negativity is cited as a reason for not breastfeeding for as long as some women would like and it is thought that this can contribute to post-natal depression (30) .

This research termed this concept 'mum shaming' and this is referred to in online forums and anecdotally in focus groups although it is acknowledged that each individual's construct of what this includes could be different. The Urban Dictionary defines 'Mom' Shaming as criticising or degrading a mother for her parenting choices because they differ from the choices the shamer would make. For example 'this woman is mum shaming me for not breastfeeding my daughter' (31).

Echoed widely throughout the research, was the fact that women did not feel that they were sufficiently supported and prepared for the realities of breastfeeding. This was also mirrored in the views provided by men within the evidence base as well as by mums and dads in Thurrock who participated in the Social marketing research (see Section 6). The research suggests that equipping women and their families with support about how to overcome any challenges is likely to increase their confidence and in turn support them to breastfeed for longer (18).

There is clear evidence across the research base that support from fathers is critical to breastfeeding success, both in terms of breastfeeding initiation and maintenance perhaps relating to reduced stress on mothers, with several studies highlighting a need for programmes to be developed that offer support to both parents. Currently, antenatal and post-natal care do not usually include information and training for fathers/partners as a priority (32), (33). Some evidence proposes that men/partner's greater involvement at all stages of the pregnancy not only helps them to support their partners but also gives couples an opportunity to conceptualise and adapt to their family transition together (33).

The views of adolescent and young mothers mirror those found in other research particularly around the need for consistent information that informed them about the realities of breastfeeding. Adolescent and young mothers often also cited that they perceived it as difficult to get information about breastfeeding from health professionals. They reported that they found health professionals tended to assume that they would formula feed and therefore did not talk to them about breastfeeding (34).

4.6 Fathers, Partners and Breastfeeding

Key points:

- Fathers and partners role in breastfeeding can be easily overlooked or undervalued.
- Partners, fathers and families are influential in women's choices around breastfeeding.
- Men have reported feeling excluded by health professionals from breast feeding education
- In particular in lower income households it is reported that the infants father plays a crucial role in supporting decisions around breastfeeding
- It is acknowledged that a lot of research around Fathers is second hand information and reflects the views of the mother. More research into fathers' opinions attitudes and beliefs would be beneficial.

The role of fathers and partners in the decision about whether to breastfeed or not is often undervalued and not always given as much consideration by health professionals. However, increased attention is starting to be paid to the role of men in breastfeeding (21). The evidence highlights that fathers and partners have an important influential role to play in determining the initiation and continuation of breastfeeding in terms of how actively they participate in the breastfeeding decision, their knowledge about the benefits of breastfeeding and their attitudes towards breastfeeding.

Research suggests that education and support about breastfeeding for fathers improves breastfeeding rates and that women who enjoy the full support of their partners are more closely bonded to their children and are more responsive and sensitive to their needs (35).

The table below illustrates that including dads in education and support around infant feeding choices can have a positive impact on breastfeeding rates. For example, offering manual demonstrations and education during visiting hours in hospital leading up to discharge increased the breastfeeding rate from 12.8% at baseline to 56.4%, an increase of 44%.

Table 2: Research highlighting the effectiveness of targeting dads for breastfeeding education.

Effectiveness of targeting dads for breastfeeding education				
	Control baseline	Mums only	Mums and dads	Improvement
	Exclusive breastfeeding at six months			
Manuals, demonstrations and education during visiting hours, up to discharge	12.8%	33.3%	56.4%	44%
Couples session + leaflet	15%		25%	10%
6 sessions (3-4 hrs) + certificate	24%		63%	39%
60-90 min session	18%		40%	22%

Source: Mahesh et al 2018 (35).

In particular, women from low income households report the vital role that the infant's father plays in supporting their decision about whether to breastfeed (36). For example if fathers view breastfeeding as best for the infant and its ability to develop close bonds then a woman is more likely to breastfeed. Conversely, fathers who are concerned or embarrassed about the mother of their baby breastfeeding in public, or feel that breastfeeding is bad for the breasts, makes them ugly or de-sexualises them then a woman may choose to initiate bottle-feeding practices (36). Clearly addressing some of these attitudes and beliefs may have an important impact on breastfeeding initiation for some families.

However, much of the research provides indirect reports of father's views via mothers and as research directly with fathers is growing it is being uncovered that father's actual views differ and are often more positive than the previous perceptions and accounts given by women suggest. One aim of the Social Marketing Research specifically aimed to target dads/partners to gather their views on this topic (see Section 6 for details).

Furthermore, it is also reported that men seldom receive information directly from health professionals and research suggests they often feel directly or indirectly excluded from health promotion around breastfeeding with one participant stating:

"The information was all aimed at my wife. What she could eat, do experience etc... I know she was the key player here but I felt that it is was nothing to do with me. When we went to the antenatal classes they did a session on breastfeeding. They sent all the dads down to the pub that night." (21).

This reflects other research that notes the importance of fathers in breastfeeding success and the need for programmes of support targeted towards both parents (32) (33), (37). Furthermore, the means by which a father can support their partner may not be apparent

to them and thus providing guidance and useful information on the types of support may help fathers to feel more competent and included. For example, supporting with household chores and the care of other children as well as emotional support through encouragement (37). The research goes on to say that if fathers are more included in the process then mothers will feel better supported, fathers will feel more included and the infant will reap the benefits of an environment in which breastfeeding is the norm (37).

As with mothers, fathers often report having the misconception that breastfeeding will be easy and would like health professionals to provide information about the realities of breastfeeding (21), (37).

4.7 Extended breastfeeding and feeding twins and multiple babies

Key points:

- Breastfeeding past one year in the UK is not common practice despite WHO and UNICEF recommendations, although this is not being routinely recorded to have an evidenced picture of this.
- A survey in 2010 found 2/3rds of mums who stopped breastfeeding by 8 months would have liked to carry on for longer.
- Benefits to breastfeeding a toddler are less acknowledged and discussed.
- Benefits of breastmilk for twins and multiples are the same as for single babies however as multiple babies are more likely to be born prematurely there are extra benefits.

Long-term breastfeeding (extended breastfeeding) is considered to be when women continue to feed their baby/babies past one year of age which is consistent with WHO and UNICEF recommendations as previously outlined.

However, there are few women in the UK that breastfeed past the age of six months and even fewer past the age of 12 months, with this not routinely being recorded. Although in many societies, extended breastfeeding is culturally normal with the age of weaning from the breast ranging from two to four years, this is not yet socially accepted in the UK or more widely (38). One reason for this may be related to the reported experiences of mothers who choose to breastfeed for longer. Unfortunately these women often face criticism for their choices and as previously cited; in one study women who breastfed past 6 months reported that they perceived being viewed as 'suspicious' (29). This could in turn influence others' decisions about whether to breastfeed for longer and may continue to prevent breastfeeding from becoming normalised. Dr Amy Brown states that until society changes its views, extended breastfeeding is likely to continue to attract criticism and misunderstanding; suggesting that more needs to be done to promote the normality of

extended breastfeeding, coupled with raising awareness about the continued benefits of breastmilk for older infants as well as mothers (38).

It is difficult to put a figure on how many UK mums breastfeed beyond the first year. But in a 2010 survey, about a third of mums in England and Scotland were continuing to breastfeed their babies at six months and about two thirds of mums who stopped breastfeeding by eight months to ten months said that they would have liked to have carried on for longer. (39)

Although babies over the age of one get most of their nutrition from solid food, breastmilk still provides immunity from some illnesses, as well as nutrients and vitamins (40). Breastfed toddlers get ill less often than those who do receive breastmilk, it is also beneficial for a toddler fighting illness (41).

Baby Centre UK cites one of the benefits of breastfeeding a toddler to be giving both mother and child the opportunity to relax at a busy time in a toddler's development with the prolactin and oxytocin released to mums on feeding helping to make mums feel calm and connected with their growing toddler. (42) Feeding an older child can help them to be independent rather than the misconception that it can make children clingy, with Baby Centre pointing out that forced weaning from the breast may not necessarily create a more confident child (43).

The benefits of breast milk for twins or multiples are the same as for single babies. However, as multiple babies are more likely to be born prematurely, there are extra benefits. Premature babies may find breast milk easier to digest and tolerate due to their immature digestive system although it may need to be expressed and tube fed to very premature babies if they are unwell or very tiny (44).

Mothers can opt to breastfeed their infants either separately or simultaneously and there are a variety of different breastfeeding positions to support mums with finding a way that works for them and their babies. Guidance exists which provides information to enable health professionals to support families with multiples to breastfeed. It is important to remember that each individual baby is different and as such may require different support to establish and maintain breastfeeding (44).

It is important to ensure that families who are expecting twins or multiples are supported during the antenatal stage to feel empowered to make an informed feeding decision. This should be reinforced by factual information and families should be offered additional support around a breastfeeding approach to meet their families' needs.

4.8 Health Professionals and Breastfeeding

Key points:

- Some studies report health professionals feeling uncomfortable telling a mother how to feed their baby and have concerns they will make a women feel guilty for choosing not to breastfeed, highlighting a confidence and training issue.
- Capacity and resourcing is highlighted in the literature as a barrier to adequate support to families from health professionals
- Health professional can play an important role in supporting mothers returning to work around maintaining breastfeeding although capacity is highlighted as an issue here too.

Many providers still feel uncomfortable 'telling a mother how to feed their baby' with many feeling that they will make the mother feel guilty recommending breastfeeding especially if the mother chooses not to breastfeed (45). Additionally, for some health professionals' their lack of knowledge and/or confidence that they will be able to solve breastfeeding problems may mean that they do not promote breastfeeding even if they have a positive attitude towards it (46). The personal experience of health professionals can also have a positive or negative impact on the support and advice they provide to families about breastfeeding.

In one study in which health professionals were interviewed about their views and approach around breastfeeding three main themes emerged that impact on the support offered to families by professionals.

- Theme 1 – helping women to make a decision about breastfeeding was deemed to be a big responsibility and health professionals often struggled to find a balance between supporting mothers to breastfeed versus being seen as 'bullying' women to breastfeed.
- Theme 2 – factors shaping professional practice which is informed by 3 key dynamics; professional experience, training and CPD and personal experience. One study found that 90% of pediatricians felt that their breastfeeding experiences affected their clinical advice to mothers (45). Other research suggested that although personal experience may impact on clinical advice given this can be either helpful or unhelpful. One participant felt that it was okay to share personal experience (either positive or negative) as long as it was supplemented with advice about how to overcome any difficulties by sharing experience of what worked for them and focusing on the research (46).
- Theme 3 – Practical issues with accessing training e.g. capacity, which may make it difficult to stay-up-to-date with current knowledge (46).

Research suggests that there is a crucial role for health professionals in supporting women and their families around breastfeeding. For example, health professionals can help dispel myths or concerns about breastfeeding by asking open-ended questions about what the families have heard and then providing them with factual, evidence-based information to support them to make an informed decision. It is recognised that due to capacity and resourcing restrictions health professionals do not always have time to hold these conversations with families and this suggests a need for investment in resource within the current NHS system.

Reseach highlights that health professionals who suggest converting to formula are not only undermining a families' confidence, but if followed will actually reduce the amount of breast stimulation and in turn reduce the milk supply which will affect a mother's ability to breastfeed exclusively. Furthermore, while there are some maternal or infant factors that deem formula supplementation necessary these are very rare in terms of healthy babies (45).

In terms of addressing the support needs of mothers who are returning to work, professionals can start conversations about how to maintain breastfeeding at regular health visiting and other health professional checks. As above it is recognised that current capacity issues within the workforce may reduce professional's time to have these conversations which as noted is something that requires addressing.

4.9 Cultural Differences in Breastfeeding

Key points:

- Breastfeeding is more prevalent in families where English is not the first language and where an additional language to English is spoken.
- In some cultures breastfeeding is viewed positively as a natural way to feed infants however in some culture feeding in public and particularly in front of men is forbidden as compromising a women's modesty.
- Breastfeeding policies and strategies need to be aware of differing cultural acceptability's in order to be inclusive and successful.

Culture profoundly influences health knowledge, attitudes and behaviour and this is particularly true of infant feeding (20). In the UK there is a high rate of breastfeeding among black and Asian mothers. Moreover, breastfeeding initiation tends to be more common in those who speak a language other than English (82%), or in addition to English (82%) compared to English alone (63%) (5). The research also proposes that it is possible that more 'traditional' mothers within Black and Minority Ethnic (BME) groups are more likely to breastfeed. For some cultures although breastfeeding is viewed positively as a natural way to feed an infant and is often linked to beliefs around the milk providing

spiritual nourishment, breastfeeding in public, particularly in front of men is forbidden as it is viewed as compromising a women's modesty (47).

Research with men relating to their views and experiences of infant feeding found that in some cultures men had strong views on breastfeeding with one participant stating:

"I have always pushed it with her to. Even if she wanted to stop I don't think I would just let her stop right away" (21).

Similarly in some countries such as Eastern Uganda women choosing not to breastfeed would likely incur cultural sanctions:

" I would report her to the LCs (Local Chairman) and she will cease being my wife" (21).

As such this research highlights the need for those implementing breastfeeding policies to pay attention to the different social, economic and cultural profiles of all ethnic groups. Thurrock has an increasingly diverse ethnic profile and so policy and strategy in relation to breastfeeding can benefit from drawing from different cultural perspectives; as well as recognising the need to be reflective and responsive to difference.

4.10 Society and Breastfeeding

Key points:

- Research suggests that cessation of breastfeeding is largely related to negative influences culturally and socially.
- Breastfeeding education and promotion needs to be targeted more widely in society.
- The social marketing research in Thurrock found feeding in public to be a key concern of the mothers taking part.
- The sexualisation of breasts as well as celebrity culture around body image may be playing an important part in the low breastfeeding prevalence in the UK
- Formula advertising and misconceptions around formula being of equivalent benefit to infants could be playing an important part in families' choices around infant feeding.

Research suggests that cessation of breastfeeding is largely related to negative influences within the cultural and social environment (20). In one study women highlighted a need for breastfeeding promotion and education to be targeted towards the wider family and society rather than just women themselves (18). Breastfeeding in public appears from the research to be one of the key reasons women stop breastfeeding. As highlighted earlier some women believe that breastfeeding restricts independence and their ability to undertake daily tasks such as going out and this may in turn be related to feeling

uncomfortable about breastfeeding in public. There is a need for breastfeeding to become the normal course of behaviour, however this relies on work being undertaken to break down the barrier around breastfeeding public which can only be achieved if women and their families experience breastfeeding in public as an everyday occurrence. This creates quite a 'catch 22' cycle. A good starting point would be for promotional materials to show breastfeeding in everyday settings rather than in clinical settings as has been the tradition.

The sexualisation of breasts coupled with the celebrity culture of having the 'perfect' figure immediately following birth may also play a part in the low rates of breastfeeding in the UK. The new age of social media which is so readily available may be further exacerbating this issue by openly promoting breasts as sexually provocative rather than as maternal, natural and designed to feed a women's young. Some researchers suggest that in many western countries including the UK breasts are portrayed with a sexual connotation whereby they are often more exposed than a mother feeding her infant, and yet the latter is perceived as being more uncomfortable (48).

Formula advertising may also play a role in the low breastfeeding rates in the UK, particularly as babies get older. Although in the UK there are regulations which place restrictions on what formula companies can promote or market about formula or breastmilk substitutes to families with babies under six months, currently no regulations exist to control how formula companies market their products to families with children aged six months and over. This loophole allows widespread advertising across various mediums and companies can potentially make claims that there are no real differences in breast or formula milk. Furthermore, by using similar or the same branding across all of their products companies can effectively promote all of their products including those for babies under six months without breaking UK law (49). This in turn provides families with misleading information that may influence their behaviour and may account for the high percentage (67%) of individuals who believe that there are no differences between breast and formula milk (18).

5 How other areas are supporting families to Breastfeed.

Other areas are doing some good work in terms of promoting breastfeeding and trying to raise initiation and maintenance rates of breastfeeding within their locality. Each is described briefly below (please note this is not exhaustive list and there are other local authorities who are providing good breastfeeding support).

Southend-on-Sea Midwifery 1-2-1 Breastfeeding Support Service

This one year pilot (running from September 2018) in partnership with Southend University Hospital Foundation Trust provides 1-2-1 breastfeeding support at home during the first 6 weeks post-birth and is delivered by Infant Feeding Support Workers to mothers who are eligible for this additional support with referral via several pathways.

The aim of project is to increase initiation and maintenance rates by providing information about the benefits of breastfeeding, how to get off to the best start, developing a relationship with baby and what support partners can provide. It mirrors the support offered by midwives during the antenatal period. Sessions focus on good positioning and attachment, hand expressing of milk, safe parenting and relationship building, brain development and about how partners can support, coupled with advice about how to access support groups and provision of additional information. The pilot is running alongside the Breastfeeding Support Group being undertaken by Southend YMCA (50).

Brighton and Hove – Breastfeeding Team

Brighton and Hove have a comprehensive breastfeeding support offer coordinated by their Breastfeeding Team. Their work includes provision of drop in clinics which are open to all pregnant and breastfeeding mothers, peer support volunteer run groups which are located both in the postnatal ward and in the community and targeted work towards areas where breastfeeding rates are lowest. The team also promote breastfeeding awareness through their Facebook page. They use the page to share stories and videos and provide advice about common issues that families might experience. The team work closely with the Children's Centres. Additionally, they have implemented a Brighton Breastfeeding Initiative (BBI), a network of health professionals and voluntary groups/organisations that are promoting breastfeeding across the locality (51).

Bristol City Council – Baby Friendly City

Bristol was the first city to achieve UNICEF Baby Friendly City status in 2010 and this required health professionals such as maternity staff and Children Centre staff to undertake additional training around supporting breastfeeding. Since 2010 the breastfeeding offer has expanded and now includes a network of 14 community breastfeeding support groups run across the city, attended by trained breastfeeding supporters and Children's Centre staff. Some of these groups offer additional support that is provided by breastfeeding trained counsellors employed by the council and located in each of the 4 localities across the city. As well as attending groups Breastfeeding Supporters also make home visits and provide contact via telephone.

For the last eight years Bristol have provided a targeted intervention aimed at mothers living in areas where breastfeeding rates are lowest. Women are contacted by a trained breastfeeding supporter at 28 weeks of pregnancy and offered time to discuss feeding and nurturing their baby. They provide support, information and encouragement and partners and wider family members such as grandmothers are encouraged to be part of the discussion as it is recognised in the research that family play an important role in breastfeeding success (52).

Leicestershire County Council – Support Fathers works

Leicestershire has created an offer targeted towards fathers which aims to involve fathers and offer support to prepare them for parenthood and to ensure that they do not feel isolated. The offer includes production of a film produced by young fathers (which is also used as a training resource for professionals), a dedicated website 'Becoming Dad' which contains the video alongside information and support, coupled with Father's groups run at Children's Centres.

6 Social marketing research in Thurrock

6.1 Background

Nationally much is known about the benefits of and barriers to breastfeeding, views of mothers, health professionals and others. In scoping this needs assessment it was acknowledged that the local data for Thurrock provides a limited understanding of infant feeding behaviour in the borough but that there were still several key questions that warranted further exploration and understanding:-

- What would support/influence the uptake of breastfeeding in Thurrock?
- What would support/influence maintenance and duration of breastfeeding in Thurrock?
- How do women's partners influence initiation and maintenance of breastfeeding?
- Is there a consistent approach across the health landscape in relation to breastfeeding?
- Who is best placed to support women and their families around initiating/continuing breastfeeding?
- Where are the opportunities for initiating/continuing conversations about breastfeeding?

The Social marketing research [8] aims to answer these key questions in exploring the underlying and complex relationship families have with breastfeeding and the drivers associated with breastfeeding in Thurrock, particularly exploring maintenance beyond the initial weeks following birth. Understanding the lived experience of women and their families in Thurrock triangulates need in a robust way to inform this needs assessment.

Although the research was aimed at all expectant parents/ parents with babies/toddlers, it aimed to target certain groups, where gaps in local knowledge relating to breastfeeding choices exist. These included:-

- Black and Minority Ethnic Groups (BME)
- Low income families

[8] A link to the full report is included in Appendix 2. Additionally, appendices 3-7 contain poll and survey questions (for various stakeholders) as well as topic guides for the qualitative research.

- Single parent families
- Different age groups (younger and older mothers)
- Those with disabilities
- Working women/families
- Partners (to better understand their role and perspective. Much of the research undertaken relating to infant feeding is undertaken with women or where women are asked to give their views on men's perspectives relating to this topic. In reality the views of male partners in terms of breastfeeding differ to those women believe men hold (see section 4.6 above).

6.2 Methodology

A mixed methodology was used for this social marketing insight, including:

Desk research

- Thematic analysis on forum posts on Mumsnet and other South Essex groups to steer the development of topic guides for qualitative and quantitative insight.
- A brief literature scan, taking in relevant research, to inform topic guide development.
- Review of literature given to women about breastfeeding, taking in all information sources mentioned in polls, focus groups, surveys and interviews

Consulting key staff

- Midwives, maternity nurses and health visitors were invited to share their experiences and views and specify the support they offer, including any variances and challenges by area. Clinical leads were contacted by phone and asked to distribute an e-survey link to members of staff. The e-survey was anonymous. (n=35)
- GPs were also invited to contribute their views via an anonymous e-survey. As there were no responses, printed copies were handed out at a council meeting, which generated two responses (one from a safeguarding role and the other unknown) 12 surgeries were contacted to complete phone interviews, targeted according to maternity cohort; low uptake and high breastfeeding drop out rates. Phone interviews were completed with five of these – from surgeries with large maternity cohorts, resulting in 39% coverage (n=7).

Consulting mums and their partners (qualitative and quantitative)

An opinion poll was completed using a short online survey that asked about intentions to breastfeed; what influenced choice and how they would describe themselves in terms of age, ethnicity, location and work status. The poll was promoted via Maternity Direct and Feeding Together Facebook pages, via Mumsnet, the maternity teams at Basildon

Hospital and in the community; the health visiting team and via outreach at Lakeside Shopping Centre, Children's Centres, food banks, community venues and GP surgeries.

The online poll (n=342) was the gateway to further research, allowing mums to opt in as they wanted to and ensuring continuing data capture:

- A longer online survey covering the whole user journey (n=111)
- Focus groups (n=26) with expectant mums; mums with babies; mums with toddlers and a group with mums and partners so we could discuss the importance of their role.

In each group a discussion was had regarding information and support, interspersed with key questions arising from the e-survey, answered by a BTUH infant feeding expert, as well as an open Q&A session.

- Telephone interviews (n=30) with mums and dads.

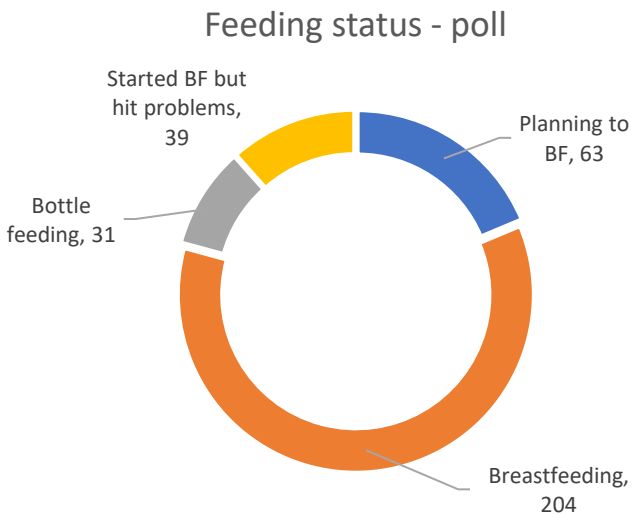
6.3 Main Findings/Themes

The full social marketing research report is included as appendix two, the Key findings and themes are summarise in the section below and have been incorporated in to the recommendations in section seven.

6.3.1 Findings from the online poll:

A poll was conducted with a total of 337 participants including expectant mums or mums (N= 329) and dads (N=8). Of these participants, 204 reported that they were breastfeeding, 63 participants were planning to breastfeed, 39 participants had started breastfeeding but converted to bottle feeding after experiencing problems and the remainder of participants (N=31) reported that they were bottle-feeding (formula).

Figure 23: Poll; Participants self-reported Feeding Status.



Source: Upshot Marketing, 2019.

It is important to note that poll respondents are likely not a proportionate representation of the Thurrock population of mothers of infants as a whole. The age of the babies of the respondents was not recorded making it difficult to explore with accuracy how similar or representative the sample was. Thurrock published data shows that 70.6% of women initiate breastfeeding and by 6-8 weeks this has reduced to 48% (PHE-Fingertips).

As more of the respondents of the poll report breastfeeding their babies, the views of the respondents in the interviews and focus groups are likely to be more supportive and knowledgeable about breastfeeding than the general population of Thurrock mothers. It is important to be aware of this potential bias when drawing conclusions from the research.

Table 1 below shows the breakdown in more detail. The majority of participants reported that they either intended to breastfeed (expectant parents) or were breastfeeding (to include exclusive or combination feeding) at the time of the research.

An overwhelming proportion of expectant mums (N=71) were intending to breastfeed (N= 65, 91%). Of those intending to breastfeeding 35% (N=23) intended to exclusively breastfeed and 40% (N=26) were planning to combination feed. Combination (combi) feeding or partial feeding involves the family both breast and formula feeding their baby. Of expectant mums who planned to breastfeed 25% (N=16) did not state or were undecided about whether they would exclusively breastfeed or combi feed.

Similarly mums with babies (N=212) largely reported that they were breastfeeding N= 170, 80%). Of those were breastfeeding 41% (N=70) were exclusively breastfeeding and 37% (N=63) were combi feeding. Of mums with babies, 22% (N=37) who reported that they were breastfeeding at the time of research did not specify whether they were exclusively breastfeeding or combi feeding. Of mums with toddlers the largest percentage were exclusively breastfeeding their child.

At the time of the research 13% (N=28) of mums with babies had reported that they had started to breastfeed but had experienced problems and had converted to bottle feeding making a total of 20% (N=42) of women with babies bottle feeding. Similarly of mums with toddlers 16% (N=10) had experienced problems with breastfeeding and had converted to bottle feeding making a total of 31% (N=19) of mums with toddlers bottle feeding. There was a mix of responses from dads regarding their partner's breastfeeding status (see Table 3).

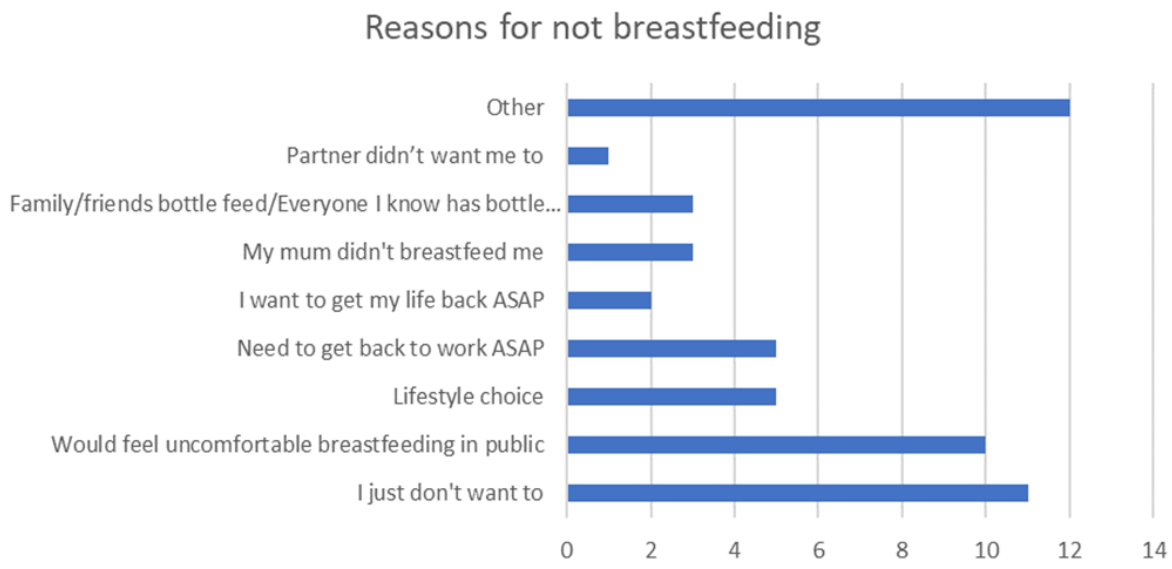
Table 3: Poll; Participant's Feeding Status by Segment. N= 337 (5 missing responses).

Feeding Status by Segment			
	Expectant Mums (Intentions) N= 71	Mums with Baby (including New-born) N=212	Mums with Toddlers N = 51
Breastfeeding (%)	91%	80%	69%
Bottle Feeding (%)	9%	20%	31%
Exclusive Breastfeeding (EBF) (% of total breastfeeding)	35% (of the 91% intending to breastfeed)	41% (of the 80% who were breastfeeding)	83%(of the 69% who were breastfeeding)
Combination Feeding (CF) (% of total breastfeeding)	40% (of the 91% intending to breastfeed)	37% (of the 80% who were breastfeeding)	17% (of the 69% who were breastfeeding)
Half of all Dads surveyed (4/8) said that their partner hit problems and stopped breastfeeding. 2 dads reported that their partner was breastfeeding with the remaining 2 dads reporting that their partner was bottle feeding.			

Source: Upshot Marketing, 2019.

The Chart below shows the reasons the poll participants selected for choosing not to breastfeed.

Figure 24: Poll Results: Reasons for choosing to bottle feed.



Source: Upshot Marketing, 2019.

One of the most common reasons for choosing to bottle feed selected was that women and their families felt uncomfortable about breastfeeding in public. 'Partner did not want me to' was not a common reason given in Thurrock (see Figure 25 below). Other reasons provided by participants for choosing to bottle feed included but were not limited to; there was not enough support in hospital, health of mother or infant, complications during birth and previous bad experience.

One of the main reasons for women opting to bottle feed within the poll element of the research was that they did not like the idea of breastfeeding. Within the qualitative elements this was explored further and it was found this related to concerns about body image e.g. concerns about changing appearance, anxiety and confidence about appearance, the research discusses the rise of the celebrity culture and pressure to lose weight quickly after birth. These lifestyle choices were sometimes reinforced by family and friends.

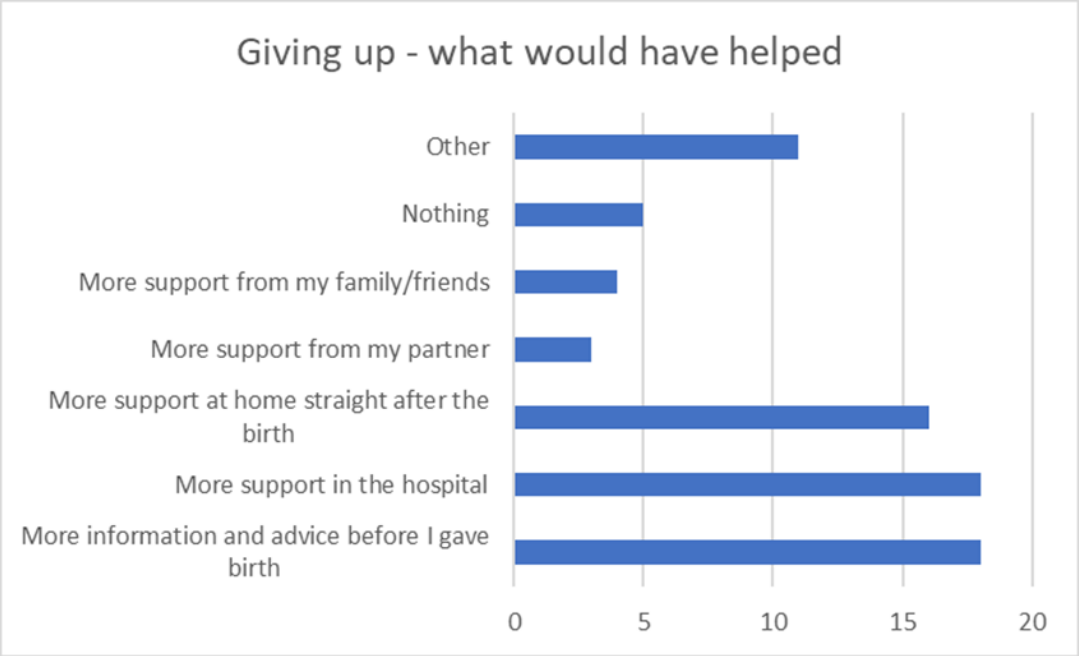
It is also noted that the category with the largest response is 'other' and it is likely that this response along with the choice selected 'I just didn't want to', which was the second largest option chosen by respondents; may indicate an inability or unwillingness to articulate their feelings behind their choice. It is probable that the reason(s) may be one of the other options given. Therefore, caution is prudent when looking at the weighting given to this poll alone in implementing changes and recommendations.

Although these findings suggest a need to promote existing resources such as Start4Life and provide support for women to help them to feel confident and reassured about breastfeeding in public in terms of practical support, for example, positions that make it easier to breastfeed in public coupled with support around women's legal rights to breastfeed in public.

Figure 25 below outlines the reasons chosen by the poll participants for stopping breastfeeding and what may have supported them to continue.

Figure 25: Poll Results: Reasons for Stopping breastfeeding/ what would have helped to support continuation.

Concern baby wasn't getting enough milk	**15**
Latching on	11
Too difficult/stressful	10
Too painful	9
Other medical reasons	6
Wanted to share feeding with partner	5
Took too long/constant feeding too restrictive	4
Didn't like feeding in front of others	3
Mastitis	3
Didn't fit with routine	2
Placenta delivery injection (too difficult/painful)	2
Too tiring	2
Didn't fit with routine	2
Felt bottle would help baby sleep	1
Inverted nipples	1
Just didn't like it	1
No time - other children	1
Felt bottle would help baby sleep	1
Just didn't like it	1
Other medical reasons – C-section, tongue tie	6
Other – could have been addressed with support	10



Source: Upshot Marketing, 2019.

As can be seen the main reasons given by the poll participants for stopping breastfeeding were concern that the baby wasn't getting enough milk, difficulties with the baby latching on (which may relate to the concern about them not getting enough milk), and feeling that breastfeeding was too difficult or stressful. Conversely more advice and support was cited as the biggest support mechanism that would have helped women to continue breastfeeding.

For example, information on the science of breastmilk and about the size and capacity of a baby's stomach may help to reassure women about how much milk is enough, alongside better face to face support or virtual support in terms of techniques for developing a good latch. Support around these issues would potentially ease the stress women experience in relation to breastfeeding.

> *"It's good to understand how my milk adapts to what my baby needs at that time. So when he's unwell, my body reacts. Helps spur you on at times when you want to give up."*

Families felt health professionals were often quick to turn to formula or supplementing with formula when families experienced problems with breastfeeding particularly in relation to weight gain.

Of those who participated in the poll broken down in the chart 23, 24 and 25 (n=337) 23% reported taking to breastfeeding well which leaves over three quarters (77%) of women requiring support. Based on local maternity data this accounts for 1,893 families per annum, and 158 families per week requiring support.

Additionally there is the potential for the need for support to increase if C-Section rates continue to increase (by 4% annually - (53)) which can make breastfeeding more difficult, perhaps due to medical needs, separation following birth and recovery for mothers. Better support for women who give birth via C-Section needs to be developed and embedded within the existing local offer in Thurrock,. C-Section was given as a frequent treason for stopping breastfeeding (Figure 25, poll responses) and so awareness around this for midwifes and health visitors to be able to offer additional support for these families and reassurance that it need not be a reason to stop breastfeeding should be reinforced in the Thurrock offer in the future.

Similarly women felt undiagnosed tongue tie[9] was a reason for them stopping breastfeeding and is another area that would benefit from midwifes and health visitors being aware to offer additional support and information to families around treatment for this and to dispel any myths that it needs to stop women from breastfeeding. Additionally

[9] **Tongue-tie** (ankyloglossia) is a condition in which an unusually short, thick or tight band of tissue (lingual frenulum) tethers the bottom of the **tongue's** tip to the floor of the mouth. If necessary, **tongue-tie** can be treated with a surgical cut to release the frenulum (frenotomy).

earlier identification of this issue could lead to a quicker resolution with less disruption to the feeding process.

Figure 26 below shows the sources of information that the families in the poll would find useful or value in making a decision about breastfeeding:

Figure 26: Poll Results: Useful sources of information as ranked by participants.

Information sources you would value and/or use	
Information in my maternity pack	246
Discussions with my health visitor	185
Discussions with my midwife	150
Information from the Children's Centre	143
Breastfeeding support team at hospital	132
Advice from my mum	115
Antenatal classes	115
NHS website	115
Advice from my friends	98
Breastfeeding apps (AmazonAlexa/Google/Facebook)	89
Parenting book	85
Peer supporter (a local mum)	70
Local support group	68
Parent/infant feeding charity e.g. Parents 1st / NCT	56
Telephone helpline	31
Baby parenting app	11
Online forum	12
Other - breastfeeding groups (3); info about bottle/formula feeding (2); Yummmy Mummies FB group; lactation consultants	8

Source: Upshot Marketing, 2019.

The value of maternity packs was highlighted as the leading useful source of information for families in Thurrock, followed by face to face support through discussions with a Health Visitor or midwife (see Figure 26 above). Throughout the research the need for more support/information that is factual, up-to-date and realistic about what breastfeeding is like, delivered at the right time and available in the first few weeks following birth was emphasised.

Although participants reported that face-to-face was their preferred support mechanism they were open to virtual support through Facetime or Skype, if it meant more women could get the support they need, as they recognised that resources are limited and felt that virtual support may reduce the burden on resources.

Participants also suggested development of a 'single point of access resource', which contains all of the information that a family requires to make an informed decision about breastfeeding.

6.3.2 Findings from the Surveys

A summary of the findings from the survey carried out with 111 participants online, driven from the online poll is included below in the form of thematic analysis:

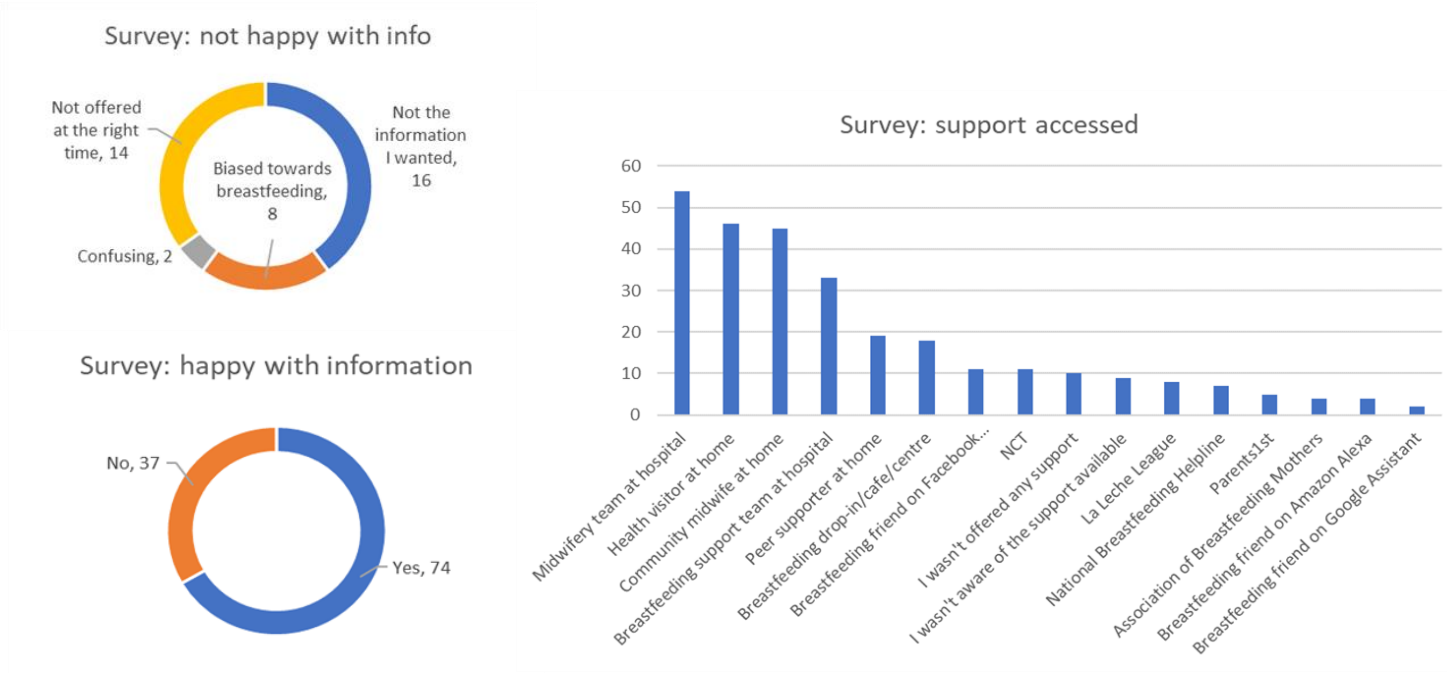
Views on the Sources of Information available

> *"Information that tells you it's going to be a tough journey would be good. The need to stay more hydrated than normal. I didn't research breastfeeding because I didn't think it would be a big deal. But if I'd been better informed I wouldn't have given up so quickly."*
>
> *"It's easy to not realise how you have to learn how to do it and the baby does too."*

As reflected in the findings of the poll, the most valued resources were discussions with midwives or maternity consultant and health visitors as well as information contained in the maternity packs. Interestingly, advice from family and friends was rated higher than the NHS website. This may have been due in part to the fact that family and friends were readily available.

As can be seen in Figure 27 below for the most part families were happy with the information provided but of those who were unhappy, the main reasons given were issues with the content and timing. Suggested improvements to the information provided included; problem solving information, honesty about how difficult breastfeeding can be coupled with reassurance it will get better, unbiased and current information, sharing of case studies, information about combi-feeding (reoccurring theme), practical videos e.g. showing a good latch as well as sufficient information to support families to make an informed choice. It should be noted that there are many resources available which offer support to combat some of the suggested improvements to information, which highlights the need for better promotion and awareness raising of resources to families.

Figure 27: Survey Results: Views on Information around Breastfeeding.



Source: Upshot Marketing, 2019.

Views on practical support available to support breastfeeding.

For the most part women and their families reported that the support provided by different professionals across the maternity landscape was consistent (N=77). For those who did not find this to be the case (N=34) they reported the following issues:

- Outdated information
- Insufficient support for problems
- Need for encouragement and support
- More information needed at different times during the antenatal to postnatal journey – importance of the right information provided at the right time
- Differing advice provided – which was confusing
- Emphasis on breastfeeding, no information provided on bottle feeding to support making an informed choice.
- Participants reported that some professionals were more helpful than others and/or had more knowledge about managing difficulties.

6.3.3 Qualitative Findings

The below is a summary of the findings from the focus groups held with 26 participants and the phone interviews held with 30 participants:

Information

The researchers tested out different types of information sources to evaluate what is useful and needed in Thurrock. The main information source being promoted in Thurrock is the 'Off to the Best Start' leaflet from Start4Life. Mums with toddlers were more likely to have seen this leaflet than mums with new-borns with one in four expectant mums reporting seeing this leaflet. The reason why expectant and new mums may not have seen this leaflet was that the full version is not currently available in print as the Department for Health are no longer supplying them to hospitals.

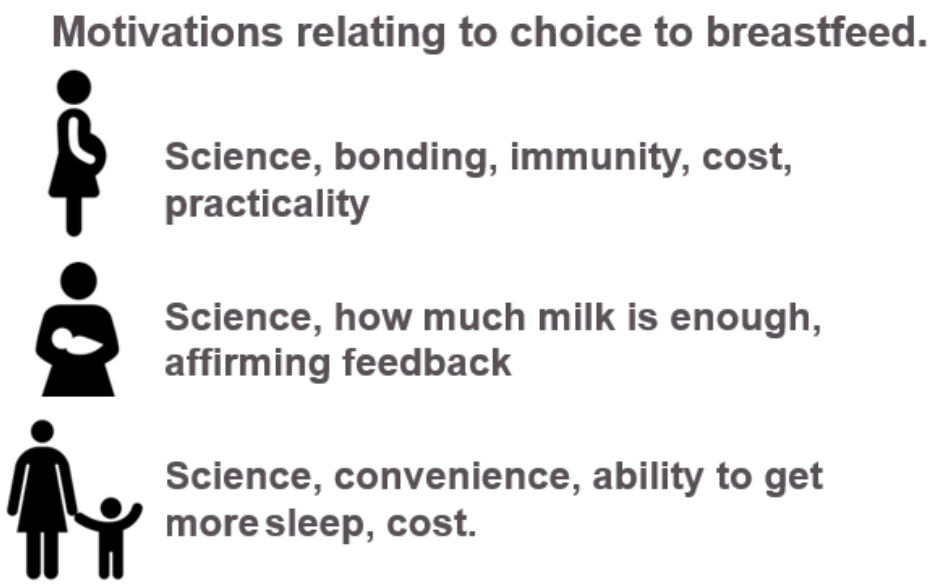
Of the mums who participated in the focus groups or phone interviews most indicated that they preferred printed literature that they could take away with them and reference when needed and which could be shared with partners. Conversely expectant mums preferred a conversation with a health professionals than printed literature, although they did report finding some elements of the printed information relating to expressing and latching useful.

Although the infant formula and responsive bottle feeding leaflet is available, families in the focus groups did not recall being provided with any information relating to bottle feeding from their midwife and gained information on this from family and friends.

The UNICEF breastfeeding checklist was very popular with the mums who participated in the focus groups and of those who did not receive this checklist they felt it would have been useful.

Information and resources that illustrated the science behind breastmilk and differences between breast and formula milk were viewed as really important by parents in the focus groups, with dads finding the science and logic behind breastfeeding particularly useful. As can be seen in the figure below regardless of where women and their families were in the antenatal/postnatal journey, all valued the information that supported their understanding of the science behind breastmilk and believed it to be a motivating factor relating to infant feeding choice.

Figure 28: Motivations relating to breastfeeding choice by participant type.



Source: Upshot Marketing, 2019.

Forum post analysis within the social marketing research carried out suggested that some mums are not convinced by the information around the benefits of breastfeeding and the science behind breastmilk and feel that and negativity regarding the impact of not breastfeeding is scaremongering tactics and that formula milk is just as good.

Antenatal classes

Around half of mums in the focus groups had participated in antenatal classes. The main feedback was that infant feeding was either not covered in antenatal classes, where the focus was on care of the baby more generally or where it was included this was very light touch. All participants felt that an antenatal class focusing specifically on infant feeding would be really useful.

Support

> *"The team on the ward at Basildon hospital gave me great hands on help when I was there. I'm not sure how successful I would have been without them!"*

Figure 29 below highlights the types of support that women and their families at different stages of the antenatal/postnatal journey rated as most important in supporting them to make an informed decision around infant feeding and to encourage breastfeeding initiation and maintenance past the early weeks. Video was also suggested as an effective

medium for offering support to solve practical difficulties e.g. around positioning and promoting a good latch.

Support to promote breastfeeding for those who had had a C-Section was reported as high priority alongside the need to for earlier identification and treatment of tongue tie.

The key support that parents suggested in hospital included:

- Encouragement
- Health professionals not making assumptions e.g. that young mums will want to formula feed or that that mums with other children will not require support.
- Further training for midwives and health visitors and provision of current information for better signposting.
- Resource to enable midwives to spend more time with mother and baby
- Help to use a breast pump
- More information about combi-feeding.

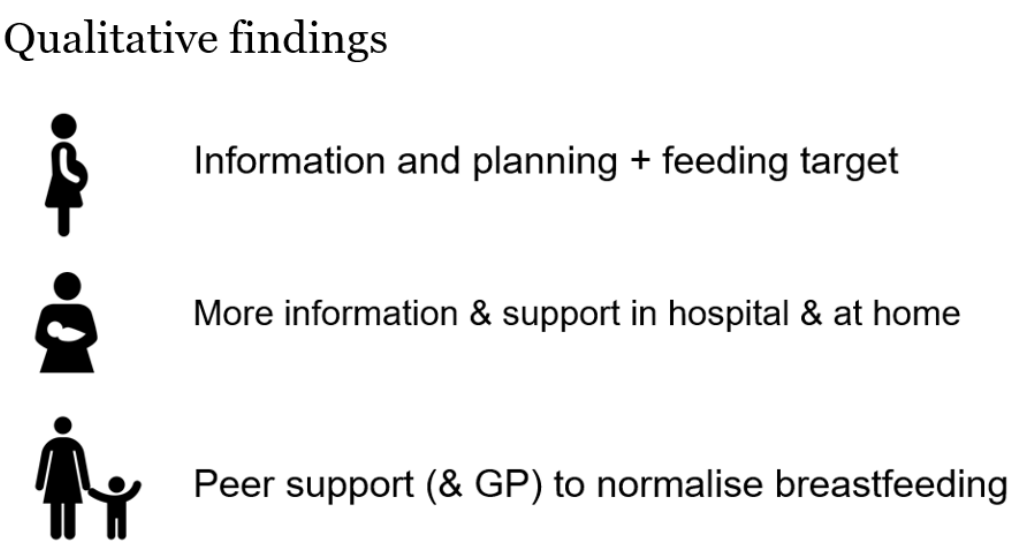
The key support that parents suggested for at home included:

- Weekly texts to reinforce information provided before the birth or whilst in hospital.
- Drop in clinics at the hospital, GP practice or community centre
- Better promotion of the Feeding Together Facebook page.
- Face to face support groups.
- Virtual support through Skype or Facetime.

The key support that parents suggested for in the community included:

- Local support groups
- Online forums
- Support around returning to work

Figure29: Support Mechanisms for encouraging breastfeeding initiation and maintenance as outlined by participants.



Source: Upshot Marketing, 2019.

In terms of who is best placed to support families with breastfeeding, parents reported that the role was unimportant to them and that what matters is health professionals:

- Having good, current and specialist knowledge.
- Are encouraging and supportive – help mums to build their confidence and reduce anxiety
- Offer person-centred support
- Are able to diagnose tongue tie and offer support.

6.3.4 Role of Dads/Partners

The social marketing research found that in Thurrock there are several types of dads in terms of their views and perspectives on breastfeeding:

- Desire to be involved – support through maternity nurses is usually to encourage dads to develop a bond with their baby through other means such as skin-to-skin contact. Conversely the UNICEF bottle information highlights that bottle feeding can be a bonding experience for dads and their babies however, it does not include information about expressing milk to enable dads to be able to be involved or other bonding activities such as participating in bath/bedtime routines.
- In support of breastfeeding and happy to support
- Supportive of breastfeeding but fairly passive in terms of seeking information
- Ambivalent.

Some mums wanted dads to be involved in feeding the baby and as such bottle feeding was the default for achieving this.

However, all of the dads involved in the research reported being pro-breastfeeding although there was variance in terms of the research they undertook prior to birth. Mums in Thurrock tend to be the information seekers but dads were keen to be involved in decision making and were receptive to information. Some dads focussed more on the welfare of their partner particularly if the birth was complicated or their partner had a C-Section.

Although for the most part dads were supportive of breastfeeding they reported feeling unprepared for the realities of breastfeeding and like mums want factual and realistic information about what breastfeeding will be like.

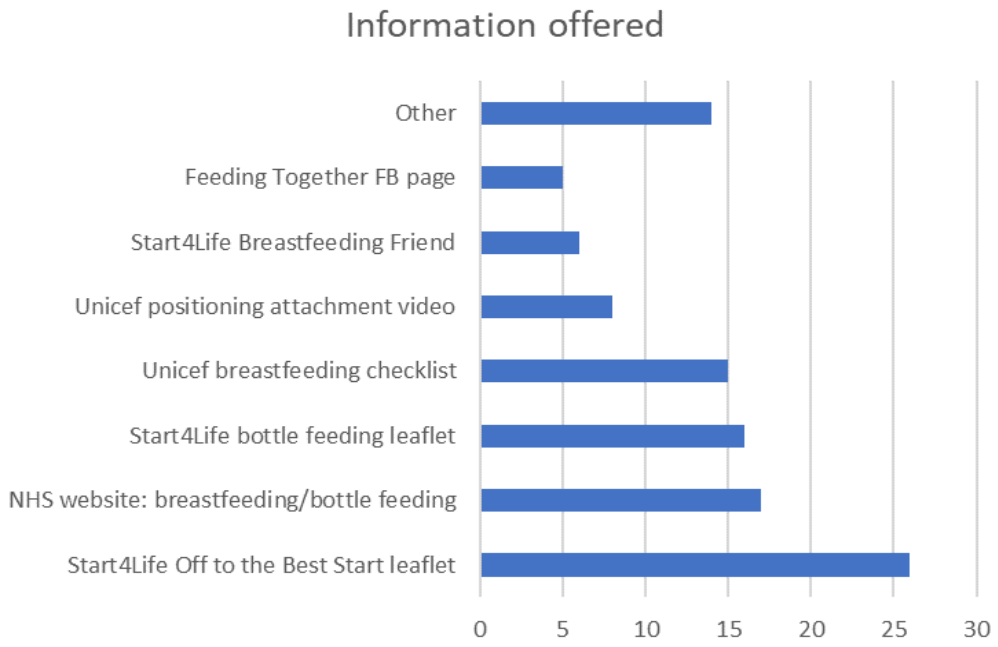
Dads also reported that if they were able to stay overnight at BTUH where applicable (as in Darenth Valley hospital) with their partner and new-born the first night after birth they would be able to support their partner with any difficulties, help build their confidence and reduce some of the burden on NHS staff.

6.3.5 Views of Maternity Professionals

A total of 35 maternity professionals participated in the research. The views of maternity professional's largely mirrored parents' views. The majority of maternity professionals reported that services could be more joined up and highlighted that support is greatly reduced when services are understaffed. There is a recognition that midwife and health visitors' capacity building is required. They reported that investment in training is now a third of the value in 2014/15 but that all professionals' need regular training and frequent information updates. There is a need for all professionals to promote policy and key messages.

The figure below shows the types of information offered by maternity professionals and as mentioned earlier in this report the 'Off to the Best Start Leaflet' was promoted most often in Thurrock (although as noted this is no longer available in hard copy).

Figure 30: Information offered by Maternity Professionals to support breastfeeding.



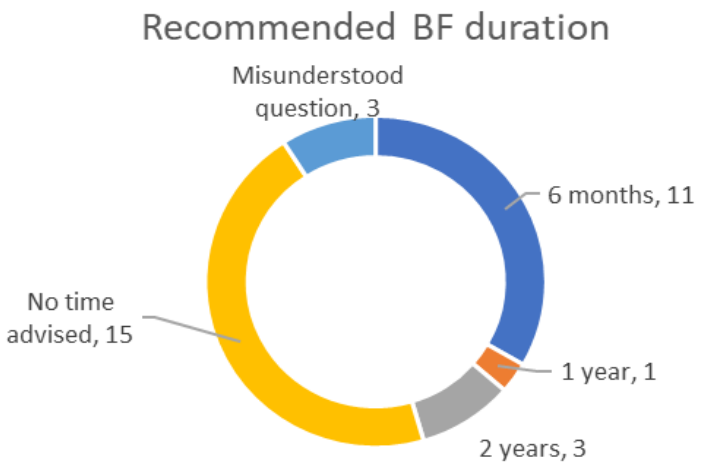
Source: Upshot Marketing, 2019.

Maternity professionals were asked if they recommend a timeframe for breastfeeding and if so, how long did they recommend. As can be seen in the figure below most maternity professionals did not advise on a recommended length of time to breastfeed, followed by those advocating for six months. Only two of the professionals who participated in the research stated they recommend breastfeeding for two years (as per WHO and UNICEF's recommendation).

One professional said that they advise women to take each day individually and to view each day of continued breastfeeding as a bonus. They did advise that weaning should not take place until after six months. This advice does not support the perspective put forward by WHO and UNICEF and makes it difficult for families wishing to develop an infant feeding strategy, as this requires them to identify a common goal. Moreover, it is well evidenced that intention predicts behaviour and omitting this information could lead to confusion about how long to breastfeed for. For example, the Theory of Planned behaviour states that a person's attitude, societal norms and perceived behavioural control influence their intentions to engage in a particular behaviour which in turns influences behaviour (54).

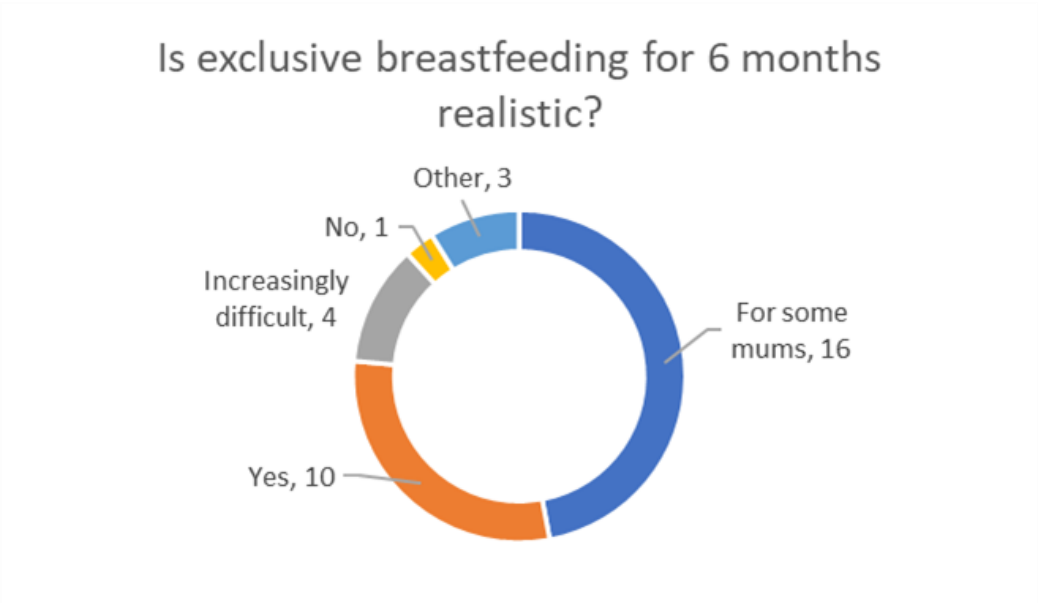
Conversely, for the most part maternity professionals did report that they felt that exclusive breastfeeding for the recommended (WHO and UNICEF) six months is realistic (See Figure 31 below). Like families maternity professionals highlighted a need for more awareness raising about the different options available to families e.g. combi feeding.

Figure 31: Views of Maternity Professional about recommended breastfeeding duration.



Source: Upshot Marketing, 2019.

Figure 32: Views of Maternity Professionals about whether exclusive breastfeeding for 6 months is realistic.



Source: Upshot Marketing, 2019.

6.3.6 Views of GPs

A total of seven GPs participated in the research. The main views/information provided by GPs included:

- View that there are not enough Health Visitors or Midwives
- Recognition that GPs have insufficient knowledge, and are not as influential as they could be with a view that mass re-education is required.
- Consistent guidance on the information and support they should be offering o families is needed. GPs suggested that this could be added to EMIS/SystemOne.
- Highlighted that Thurrock CCG are developing an online resource for GPs around breastfeeding.
- GPs highlighted that they would be happy to promote breastfeeding via their websites and TV screens in their reception/waiting rooms.
- Need for more E-Communications via Maternity Direct
- Informed researchers that they used to work more closely with maternity professionals but due to pressures on resources this is no longer the case.

7 Conclusion:

In Thurrock, the BFI approach has been promoted and has been a requirement of commissioned services. The learning from this Health Needs Assessment has led to consideration of alternatives to be able to support families effectively given that current rates at 6-8 weeks are so low. In an ideal scenario the BFI would be promoted in the fullest sense and women would feel empowered and supported. However, with families currently reporting[10] mixed satisfaction with support services, acknowledged disinvestment in services and pressure on staffing, women not feeling comfortable to breastfeed in public and not feeling supported by 'society' in their choice around breastfeeding; it is recommended that a fresh 'Thurrock approach' is taken. Responsive to families' views and experiences, supporting choice whilst still remaining consistent with the guidance from NICE and the NCT.

[10] See section 6 – Social marketing research in Thurrock, for a full analysis of Thurrock families' views.

8 Recommendations:

1. System wide change:

The system in Thurrock does not operate independently from the wider health system. The local hospital where the majority of women give birth (BTUH) is sited in Basildon and part of a wider Mid and South Essex Health and Care Partnership area.

Therefore, it is recommended that:

- Public Health develop a breastfeeding strategy for Thurrock to deliver these recommendations collaboratively with partners and stakeholders.

- That a 'Thurrock approach' will follow NICE guidance and be responsive to local findings. Offering support to and empowering families in making a healthy choice to exclusively breastfeed for 6 months and longer. The approach will include information around safe and responsive bottle feeding practices to support choices around expressing breast milk and formula feeding as needed (although formula feeding will not be actively promoted).

- To incorporate the findings of this Health Needs Assessment into the 0-5 wellbeing model to be tackled and driven as part of a wider piece of work collaboratively with Brighter Futures partners.

- Seek agreement with the Local Maternity and neonatal System (LMNS) to develop a Single Point of Access Information pack (to include online offer) and pathway containing consistent information and practical advice around :
    - Nutritional benefits and the science behind breastfeeding
    - Practical support with latch and tongue tie
    - wider benefits
    - health benefits
    - information on sources of support
- This information pack should contain the UNICEF breastfeeding checklist (which was reported as a popular and useful resource in the social marketing research) and be co-produced with families to capture lived experience and ensure the resource is meeting the needs of families in relation to providing a 'realistic picture' of breastfeeding and the potential challenges which is supportive and reassuring.

- Through the strategy delivery plan work with partners within the LMS area to strengthen the links between Midwives and Health Visitors, Primary Care and wider health professionals to ensure that the antenatal offer is equitable and consistent between professionals and across the LMS area in message and approach throughout the pathway.

2. Develop a Digital Offer:

Digital resources and communications have been highlighted through the social marketing research and the evidence base as being a good way to increase the capacity of services that support families. This medium has been found to be acceptable to families in Thurrock with the opportunity to reach an increased number of families in a cost effective way.

Therefore, it is recommended that:

- Public Health lead on the development of a digital solution to provide information to families in an accessible way, with links to practice videos and information about the science behind breastfeeding as part of the 0-5 wellbeing offer. This offer could include weekly text messaging/email service also providing encouragement and reassurance to families.

- The findings of the Social marketing research suggest that parents found information about the science behind breastmilk and nutritional differences between breast milk and formula useful in supporting them to make an informed decision. Video and other resources do exist that focus on the science and should be incorporated as part of the digital offer (included above).

- Commissioners develop and incorporate Virtual Support via Skype or Face time into service specifications for breastfeeding support in future contracts. This could be via a webinar where families can ask for advice and support and health professionals can respond to multiple families at the same time who may be experiencing similar issues.

3. Messaging/Normalising Breastfeeding:

Messaging and the need to normalise breastfeeding has been consistently raised throughout the social marketing research and this is also extensively discussed within the evidence base.

Therefore, it is recommended that:

- The new improved local offer needs to consider three elements of messaging in relation to breastfeeding:
  1) Being really clear on what the message is including:
     a. Nutritional benefits and the science behind breastfeeding
     b. Wider benefits
     c. Health benefits
     d. Normalising breastfeeding including extended breastfeeding
     e. Supporting families' choices around breastfeeding and offering guidance.

  2) The level and sufficiency of the message – is it delivered at the right time, in the right way, accurate/factual and realistic

  3) Consistency of messages- developing a consistent approach across the landscape to include Thurrock and Mid and South Essex through the LMS.

- A place based approach is taken as part of the strategy delivery plan to normalise breastfeeding in the community and wider environment by working with businesses through the business forums to enhance the number of breastfeeding friendly venues (through the BFI) in Thurrock and make this visible to the community.

- As part of the strategy delivery plan, actions to support employers with information and advice about being breastfeeding friendly and how to support mothers to continue breastfeeding once they return to work.

- The production of local/new resources or literature to provide positive images that normalise breastfeeding in everyday scenarios be developed to support the local offer (as part of the Brighter Futures communications plan).

4. Service/support offer:

The social marketing research highlighted that there was a differing level of knowledge and advice provided by different professionals, that there is opportunity for further professional groups and services to be more supportive of breastfeeding. The observed prevalence rates of breastfeeding in GP practice areas highlights very different rates that do not appear to be consistent with other demographic factors related to breastfeeding such as deprivation and ethnicity.

Therefore, it is recommended that:

- A consistent training offer is developed and a re-fresh of training for Primary Care, wider Maternity and other health care professionals be delivered, including wider support staff in the system such as children's centre staff.

- Expansion of breastfeeding training for pharmacies and GPs with the development of Breastfeeding Champions within Primary Care and Children's centres as part of the strategy delivery plan.

- As part of the new improved service offer introduce the concept of a family 'plan' to demonstrate the commitment to breastfeeding. This will support the wider family to understand and respect the parents' decision to breastfeed whilst promoting inclusion of family members being able to support in ways other than feeding the infant.
For example; providing a drink or snack for the new parents, helping with bath time, changing or winding the infant. The purpose being to give the new parents periods of respite and allow bonding to still occur with other family members without disrupting the breastfeeding relationship. There is potential for the 'plan' to incorporate other important areas such as immunisations.

- Work with school nurses (through Healthy Families Service) and schools to offer an education programme as part of PHSE to children about breastfeeding. This is in line with evidence that decisions about infant feeding are usually made before pregnancy and often in adolescence (23).

5. Involving Dads and partners

The evidence reviewed in section 4 and the social marketing research in section 6 highlight that Dad and partners do not always feel involved in antenatal and newborn care in particular around breastfeeding education and decision making. Evidence shows Dads can play an important support role in this process and their view is particularly influential in families of lower socio economic status.

Therefore it is recommended that:

- The LMNS work towards routine inclusion of Dads and partners in all feeding discussions as part of antenatal provision through maternity services (linked to the training refresh and incorporated into the 0-5 wellbeing model).

- An inclusive session focussing on breastfeeding and targeted to both parents is built into the future antenatal offer (To be actioned by maternity and health visiting services as appropriate)

- Public Health work with Children's Centres to improve the equity of their offers – to include breastfeeding classes, tailored to both parents as part of the Early Help transformation project.

6. Specialist Support

The social marketing research allowed a rich exploration of a sample of Thurrock families' views in relation to support for specialist areas that may be acting as a barrier to breastfeeding such as when a women has a c section and when a baby has tongue tie.

Therefore, it is recommended that:

- A review of breastfeeding support for women who have had C-Sections within the existing maternity offer is undertaken (arose as feedback within the social marketing research) to be driven through the LMS.

- Earlier identification and treatment of tongue tie to be driven through the LMS and review any existing pathway for treatment and support for this issue, to maximise opportunities to advise new parents and support to them continue breastfeeding.

- Strengthen the pathways for women with postnatal depression and those with identified or suspected postnatal illness to ensure timely support with breastfeeding to facilitate initiation and maintenance.

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10 Appendices

Appendix 1 - WHO and UNICEF 'ten steps to successful breastfeeding'

These steps outline the ten principles of best practice that NHS professionals should utilise in supporting women and their families to have a positive experience of breastfeeding. They are split into two categories entitled 'critical management procedures' and 'key clinical practice.'

Critical Management Procedures

1.

a) Comply fully with the international code of marketing of breastmilk substitutes and relevant World Health Assembly resolutions.

b) Have a written infant feeding policy in place that is routinely communicated to staff and parents/carers.

c) Establish on-going monitoring and data management systems.

2) Ensure staff members have sufficient knowledge, competence and skills to support breastfeeding.

Key Clinical Practice

3) Discuss the importance and management of breastfeeding with pregnant women and their families.

4) Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.

5) Support mothers to initiate and maintain breastfeeding by supporting them to manage common difficulties.

6) Do not provide breastfed new-borns any food/fluids other than breastmilk unless medically advised.

7) Enable mothers and their infants to remain together and practise rooming-in 24 hours per day.

8) Support mothers to recognise and respond to their infant's cues for feeding.

9) Counsel mothers on the use and potential risks of feeding bottles, teats and dummies.

10) Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

Evidence suggests that by NHS professionals following the 10 abovementioned steps, this significantly improves breastfeeding rates, including uptake, duration and exclusive breastfeeding.

Appendix 2 – Link to Full Social Marketing Research Report

Infant_feeding_rep
ort_final FINAL V1 - I

Appendix 3 – Summary of Poll Questions

Thank you for taking the Thurrock infant feeding poll, which is anonymous and for mums (including mums to be) and their partners.
We'd appreciate your honest views, which will be used to help Thurrock Council and the local NHS shape their services around your needs.
You will have the option at the end of the poll to answer a short survey, for which we are offering a £10 e-gift card as a thank you for your time.
But if you only have a few minutes to do the poll, we are very grateful for your opinions. Thanks for joining in!

Which of the following are you?										
Expectant mum	Are you planning to breastfeed?	Y = How long for?	What info / support do you value?			Interested in continuing with survey? £10 e-gift card Yes/No	If yes, additional questions include: 6 tick boxes for demographic profiling 3 questions about service access and parental experience 7 questions about info and support	Interested in further research? Free Q&A session with a breastfeeding specialist Opt in to a telephone interview and receive a £15 e-gift card	Thank you. Please provide your email address so we can get back to you on that.	Anything you'd like to add?
		N = What made you decide not to breastfeed?	What info / support do you value?							
Mum with new-born / mum with baby / mum with toddler	Are you breastfeeding?	Y = How long have you been breastfeeding?	How long do you plan to breastfeed for?	How have you found it?	What info / support do you value?					
		N = What made you decide not to breastfeed			What info / support do you value?					
		I started but hit problems and stopped	What problems did you encounter?	What would have helped you overcome these problems?	What info / support do you value?					

Dad	Is your partner breastfeeding?	Yes	How long does she plan to breastfeed for?	How have you found it?	What info / support do you value?					
		No but we're expecting and she is planning to	What info / support do you value?							
		She started but hit problems and stopped	What problems did she encounter?	What would have helped her overcome these problems?	What info / support do you value?					
		No	Why is that?	What info / support do you value?						

Appendix 4 – Topic Guide for online Survey

Topic Guide for Mums who CHOSE TO BREASTFEED

- What made you decide to breastfeed?
    - To my baby from infection and disease
    - It's more convenient than bottle feeding
    - It's free
    - To bond with my baby
    - My milk is a perfect match for baby's need

- Was there enough/the right information available to you about breastfeeding?
    - Yes/No

- Was information available to you at the right time?

- How long did you breastfeed for / have you been breastfeeding for?

- Are you feeding breast milk alone or a combination of breast and bottle?

- How long do you plan to breastfeed for?

- What should we be doing in Thurrock to support mums who choose to breastfeed?

- What do you think women need to help them maintain breastfeeding for the recommended 6 months?

- How does your partner feel about your breastfeeding?
    - Did you choose together?
    - Is he supportive?
    - How long would he like you to breastfeed for?

- Who is best placed to support women and their families around initiating breastfeeding?
    - Examine the entire journey from Antenatal to postnatal care, exploring where opportunities exist for initiating/continuing conversations about breastfeeding.
    - Is there a consistent approach across the health landscape?

- Who is best placed to support women and their families around continuing breastfeeding?
    - Examine the entire journey from Antenatal to postnatal care, exploring where opportunities exist for continuing conversations about breastfeeding.
    - Is there a consistent approach across the health landscape?

Topic Guide for Mum who CHOSE NOT TO BREASTFEED

- What made you decide not to breastfeed?

- How did your partner feel about breastfeeding?
    - Did you choose together?
    - Had you chose to breastfeed, would he have supported you?
    - Did anyone else influence your choice?

- Were you happy with the information available to you about infant feeding?
    - Yes/No
    - If no, what? Timing / content / format
    - If yes, what info was most useful?

- How could health professionals improve the information provided to mums about infant feeding?

- Did you feel that all the health professionals who supported you (before and after the birth of your baby) were supportive of your choice?
    - Yes/No
    - If no, why?

- Did you ever consider giving breastfeeding a go?
    - Yes – what happened?
    - No – why not?

- Which of the benefits below do you feel are strong reasons to breastfeed?
    - To protect my baby from infection and disease
    - It's more convenient than bottle feeding
    - It's free
    - My milk is a perfect match for baby's need
    - For the health of both me and my baby
    - None of these
    - Other

- Is there anything that would change your mind about breastfeeding?

Appendix 5 – GP Consultation Survey

GP survey - infant feeding

Independent agency Upshot has been commissioned by Thurrock Council to conduct research into the local drivers, barriers, information and support needs around infant feeding, to help inform a Needs Assessment and subsequent strategy.

As part of this, we're keen to hear your views and experiences around infant feeding information and support in Thurrock, The aim of this research project is to understand what is needed to better encourage and support breastfeeding uptake and continuation in Thurrock.
Thank you for sharing your thoughts.

1) Uptake in Thurrock varies enormously, from 30% at its worst to 86% at its best.
What needs to be done to support/influence the uptake of breastfeeding in Thurrock?

2) Where do you refer pregnant and new parents for support?

Basildon & Thurrock University Hospital (or other hospital)

Maternity Direct

Health visitors

Children's Centres

Start4Life

NHS website

*Other - Write In (Required): **

*Other - Write In (Required): **

*Other - Write In (Required): **

3) Do you feel that maternity services work well together in supporting mums?
Is it joined up enough? Consistent? Could it be improved?

4) Who is best placed to support women and their families around initiating breastfeeding?

5) What infant feeding resources do you give / promote to parents?

Start4Life Off to the Best Start leaflet

Start4Life Breastfeeding Friend

UNICEF breastfeeding checklist

NHS website content around breastfeeding and bottle feeding

Start4Life bottle feeding leaflet

UNICEF positioning and attachment video

*Other - Write In (Required): **

*Other - Write In (Required): **

*Other - Write In (Required): **

6) What guidance and support do you currently offer around complimentary feeding?

7) What do you advise as the ideal duration for breastfeeding? The Start4Life leaflet (which is the main leaflet used in Thurrock) doesn't specify advised timescales.

8) How do mums respond to the advice on continuing breastfeeding? Do you feel that exclusive breastfeeding for 6 months is realistic?

9) Is there anything missing to support women in breastfeeding for at least 6 months? What needs to be done to support/influence breastfeeding in Thurrock, especially in the first weeks when mums struggle the most?

10) Who is best placed to support women and their families around continuing breastfeeding? (Exclusive breastfeeding up to 6 months and continued alongside complimentary feeding up to 2 years as per WHO guidance)

Appendix 6 – Maternity Professionals Survey

Thurrock Maternity Professional's Survey

1) Uptake in Thurrock varies enormously, from 30% at its worst to 86% at its best. What needs to be done to support/influence the uptake of breastfeeding in Thurrock?

2) Do you feel that maternity services work well together in supporting mums?

3) Who is best placed to support women and their families around initiating breastfeeding?

4) What are the key decision points around infant feeding, for mums, from your perspective?

5) In your experience why do parents not engage with ante-natal sessions? How would you describe them– is there a mixed profile or a specific type, or a bias?

6) We know that the majority of mums start breastfeeding in hospital, but struggle to maintain it at home and need help in the first few days. How do the various teams work together to ensure mums get the help they need?

7) What is required to enable more support for women who want to breastfeed? And who is best place to do this?

8) What infant feeding resources do you give / promote to parents?

[ ] Start4Life Off to the Best Start leaflet

[ ] Start4Life Breastfeeding Friend

[ ] UNICEF breastfeeding checklist

[ ] NHS website content around breastfeeding and bottle feeding

[ ] Start4Life bottle feeding leaflet

[ ] UNICEF positioning and attachment video

[ ] Other - Write In (Required): _____ *

[ ] Other - Write In (Required): _____ *

[ ] Other - Write In (Required): _____ *

9) What guidance and support do you currently offer around complimentary feeding?

10) What do you advise as the ideal duration for breastfeeding? The Start4Life leaflet (which is the main leaflet used in Thurrock) doesn't specify advised timescales.

11) How do mums respond to the advice on maintaining breastfeeding? (Exclusive breastfeeding up to 6 months and continued alongside complimentary feeding up to 2 years as per WHO guidance)

12) Do you feel, based on your experience, that 6 months exclusive breastfeeding is realistic?

( ) Yes

( ) For some mums

( ) Increasingly difficult to breastfeed exclusively for lifestyle/work reasons

( ) Other - Write In (Required): _____*

( ) No

13) Is there anything missing to support women in breastfeeding for this duration? What needs to be done to support/influence the maintenance of breastfeeding in Thurrock?

14) Who is best placed to support women and their families around continuing breastfeeding?

Appendix 7 – Topic Guide for Focus Groups/Phone Interviews

Focus groups topic guide

INFORMATION

- What info was given to you by your maternity nurse in the run up to your birth?
- Was there anything missing?
- Did you search out info on your own – what?
- Did you attend any antenatal classes that covered feeding options?
- Here are some examples of leaflets and links… would any of these have been useful to you?

a) Leaflets

- Off to the best start leaflet
- Infant formula and responsive bottle feeding leaflet – pages 3-6
- Mothers breastfeeding checklist

b) Apps/websites?

- Best beginnings app – two very short videos on infant feeding
https://web.bestbeginnings.org.uk/web/videos/breastfeeding
https://web.bestbeginnings.org.uk/web/videos/formula-feeding

- Feeding together FB page – run by Basildon Hospital infant feeding support specialists – soon to become an app
https://www.facebook.com/FeedingTogether/

- NHS
https://www.nhs.uk/conditions/pregnancy-and-baby/problems-breastfeeding/

c) Do these videos fill information gaps and answer questions you may have?

- The science behind breast milk – very short videos
https://www.youtube.com/watch?v=xJxBl2DtV30

https://www.youtube.com/watch?v=vUvwLhcqgtM
https://www.youtube.com/watch?v=B6VvF44aWrk

- What's right for mum and baby

https://www.youtube.com/watch?v=NuS2lnOkBWE

- Personal experiences and tips on combination feeding

https://www.youtube.com/watch?v=flQblK0L2ig

Q&A SESSION

Common questions arising from our research:

- Sore nipples – what works and are cabbage leaves a myth?
- How much is enough milk?
- How can I boost milk supply through diet?
- Topping up with formula – does it make baby sleep better?
- Pros and cons of combination feeding and how to go about choosing formula as / when / if you're ready to
- Community support – what groups are available?
- Transition when returning to work. Expressing and bottle feeding.
- Introducing solids – baby led or fixed time? Why 6 months? When to convert to cow's milk?

SUPPORT

- Talk me through your experiences of breastfeeding

- What do you feel should have happened to make you feel better supported?

- What led to you stopping and what might have helped you to maintain breastfeeding?

OR IF STILL BREASTFEEDING

- What would you say has contributed to your breastfeeding success?

THE ROLE OF PARTNER (GROUP WITH DADS)

Research facts:

- Education and support about breastfeeding for fathers improves breastfeeding rates (Maycock et al, 2013)
- The quality of mothering provided to an infant has been linked with supports the mother receives from her partner (Guterman & Lee, 2005)

- Women who enjoy the full support of their partners are more closely bonded to their children, and more responsive and sensitive to their needs (Feiring, 1976)
- Greater father involvement in infant care and other household tasks is correlated with lower parenting stress and depression in mothers (Fisher et al, 2006)

What dad's need/want/feel:

- Knowledge about breastfeeding
- Positive attitude towards breastfeeding
- Involvement in the decision making
- Practical support
    - Accepting, learning and implementing the support role
    - Meeting mum's needs
    - Parental leave
- Emotional support
    - Affection, reassurance, encouragement

AND FINALLY….

- What support is needed for Thurrock mums to help them maintain BF for as long as they wish to – availability, timing, format.

- Who is best placed to provide that?

- Anything else?

THANKS AND CLOSE

Appendix 8 – Thurrock Children's Centres local offer around Infant Feeding and Care

Table 4: Children Centre's offer around infant feeding and infant support 2018/19.

Name of Children's Centre	Monday	Tuesday	Wednesday	Thursday	Friday
Aveley			Midwife appointments** 9.30-3.30pm	Midwife appointments** 9.30-3.30pm Introduction to solids*** 9.30-11am 2 year old development assessment checks 1-5pm	Child health clinics, baby weighing 9.30-11.30am 1 year old development assessment checks 12.30-5pm
Chadwell		Midwife appointments** 9-2pm	Child health clinics, baby weighing 9-12.30pm	Introduction to solids*** 10-11.30am	
Ockendon	Midwife appointments** 1-4pm Child health clinics, baby weighing 2-3.30pm	Midwife appointments** 9-1pm 1 year old development assessment checks 9.30-1pm 2 year old development assessment checks 12.30-5pm	Midwife appointments** 9-1pm Child health clinics, baby weighing 9.30-11.15am Parents first support course 9-11am	Infant feeding drop-in for 0-12 months 1-4pm	Midwife appointments** 9-1pm

			Introduction to solids*** 9.30-11.30am		
Purfleet	2 year old development assessment checks 9.30-1pm	Introductions to solids*** 9.30-11.30am 1 year old development assessment checks 9.30-1pm Child health clinics, baby weighing 1.30-3.30pm		1 and 2 year old development assessment checks 9.30-1pm	
Stanford		Child health clinics, baby weighing 9.30-11.30am Introduction to solids*** 1.30-3pm	Child health clinics, baby weighing 1.30-3pm		
Stifford	Midwife appointments** 9-1pm				Midwife appointments** 9-1pm
Thameside	1 year old development assessment checks 12.30-4pm	2 year old development assessment checks 9-12.30am	Midwife appointments 9-1pm Child health clinics, baby weighing 9.30-10.30am at Stifford children's centre and 3-4pm at Thameside	2 year old development assessment checks 1-4pm Midwife appointments** 1-4pm Child health clinics, baby weighing 1-2.45pm at Beacon Church,	

			Introductions to solids 10-11am Infant feeding support **** 2-4pm	Drake Road, Chafford Hundred	
Tilbury	Child health clinics, baby weighing 9.30-11.30am Parents first support course 9.30-12.30pm 1 year old health checks 12.30-5pm Infant feeding support**** 1-3.30pm	Midwife appointments **9-5pm 2 year old health checks 9.30-1pm	Midwife appointments** 9-3pm	Child health clinics, baby weighing 1.30-3.30pm Midwife appointments** 9-5pm	Midwife appointments** 1-4.30pm

** Midwife appointments include pre-natal checks and support for mother and baby and should be booked in advance.

***For ages 0 to 8 months. A programme that supports parents and Carers with introducing solid foods to their baby. Should be booked in advance.

**** Support sessions for families to discuss any matters relating to feeding their baby, such as breast feeding, formula feeding and introducing solid foods.

Friday 10 December 2021	**ITEM: 8**
Thurrock Health and Wellbeing Board	
GP Item Part Two. Improvements in primary care Long Term Condition management	
Wards and communities affected: All	**Key Decision:** None
Report of: Vikki Ray – Senior Programme Manager (Healthcare Public Health)	
Accountable Head of Service: Emma Sanford – Strategic Lead (Public Health and Social Care)	
Accountable Director: Jo Broadbent – Director of Public Health	
This report is Public	

Executive Summary

The report provides an outline of the Stretch QOF contract for 2021-22 which seeks to incentivise general practice to make improvements in both case finding and management of selected long term conditions and an update on the LTC profile card with relation to its content and proposed implementation steps.

1. Recommendation(s)

1.1 That the Health and Wellbeing Board note and comment upon the proposed developments in delivering improvements in long term condition management and a renewed LTC profile card.

2. Introduction and Background

2.1 The main objective of this programme is to improve population health and reduce inequalities through improved quality of LTC management in Primary Care. In this paper we detail the plans for the programme this 2021-22 and current thinking for major revisions for 2022-23 financial years.

3. Issues, Options and Analysis of Options

3.1 The Global Burden of Disease (GBD) study shows that the top five causes of early death for the people of England are: heart disease and stroke, cancer, respiratory conditions, dementias, and self-harm. It also reveals that the slower improvement since 2010 in years-of-life-lost is “mainly driven by distinct condition-specific trends, predominantly in cardiovascular diseases and some cancers”. Furthermore, it quantifies and ranks the contribution of various risk factors that cause premature deaths in England. The top five are:

smoking, poor diet, high blood pressure, obesity, and alcohol and drug use. These priorities have guided the NHS prevention programme as part of the NHS Long Term Plan.

3.2 The role of the NHS includes secondary prevention, by detecting disease early, preventing deterioration of health and reducing symptoms to improve quality of life.

3.3 Within Public Health we continue to develop programmes of work and support the NHS to move from reactive care towards a model embodying active population health management, and together with local authority colleagues and voluntary sector partners on the broader agenda of prevention and health inequalities.

3.4 The Annual Public Health Report (2016) quantified the effect that low levels of long term condition management were having on emergency care for specific indicators in Thurrock. Whilst the NHS GP contract 'QOF' (Quality Outcomes Framework) currently pays Practices based on the percentage of patients who receive specific, evidence based interventions and/or treatments, this is capped. The value at which it is capped is dependent upon the indicator. Mostly incentivisation happens for around 70-85% of patients receiving the intervention. Practices generally score around the level that they require for maximum payment. This either suggests that this is an "achievable" level or that Practices do not have the resources to obtain higher with no potential of funding, but has the effect of excluding 15-30% of the population and this excluded group can often include vulnerable groups and those experiencing multiple inequalities who have the greatest potential to benefit from improved quality of care.

3.5 As a result of this a Stretch QOF contract was launched in 2018 and has been reviewed/renewed annually since, incentivising practices to aspire to achieve above the maximum Quality and Outcomes Framework threshold for a subset of indicators. Diseases incentivised for management were informed by a number of long term conditions multiple regression analysis models developed by the Health Intelligence/Healthcare Public Health Team that identified and quantified the impact that significant QOF indicators had on the incidence of serious health events with a view to reducing emergency admissions to secondary care and preventing patients from having major health events, such as a Stroke. These have included Asthma, Hypertension, Atrial Fibrillation, Coronary Heart Disease, Stroke, Depression, COPD, Smoking and Diabetes. The indicators for 2021 – 22 are outlined below.

3.6 Stretch QOF 2021/22 Indicator Set

The indicators have been selected on the basis of the following:

- Public Health multiple regression analysis models indicated these indicators impacted on unplanned care admissions in Thurrock
- The indicator rationale has been nationally recognised as high impact (NICE guidance)
- Stretch QOF appears to be positively influencing general practice to complete the intervention at a rate greater than previously achieved without incentivisation
- Indicators that require a focused effort to address backlog/drop in performance attributable to the Covid pandemic
-

3.7 Blood Pressure Management - Blood pressure is a comorbidity in over 70% of the Thurrock population with a long term condition and a significant risk factor for other cardiovascular diseases if undiagnosed or poorly managed. Due to capacity and the required operational running of general practice during COVID there was a reduction in those with a recorded or well managed blood pressure in the previous QOF year, making this a high priority area for focus.

This priority is complimented by the CCG's workstream 'BP at Home' which has supplied 243 BP machines to Primary Care to loan to the most clinically vulnerable/at risk patients to monitor their blood pressures at home.

Indicator	Description
CHD008	The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (NICE 2013 menu ID: NM68)
CHD009	The percentage of patients aged 80 years and over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (NICE 2019 menu ID: NM191)
HYP003	The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (NICE 2012 menu ID: NM53)
HYP007	The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (NICE 2012 menu ID: NM54)
STIA010	The percentage of patients aged 79 years or less with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or Less (NICE 2013 menu ID: NM69)
STIA011	The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or Less (based on NM93)

3.8 Smoking - Smoking is noted as in the top five risk factors contributing to the burden of disease and continues to be the leading cause of premature and preventable death in England. It is also the largest single contributor to health inequalities, accounting for half the difference in life expectancy between those living in the most and least deprived communities. Case finding of smokers particularly in those with cardiovascular disease, respiratory disease and mental ill health is therefore a high priority. It also supports improving recording of smoking status for other programmes in the Thurrock system such as the Targeted Lung Health Check which would benefit from ensuring its full eligible cohort is identified given it invites both smokers and those who have ever smoked for a check.

Indicator	Description
SMOK002	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (NICE 2011 menu ID: NM38)
SMOK005	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 Months (NICE 2011 menu ID: NM39)

3.9 Case Finding/ Surveillance - Case finding remains crucial in identifying those requiring onward interventions to support good management of their condition. In 2021-22 we continue to incentivise blood pressure checks in those aged 45 and over to case find for hypertension. We also continue to support review of those with identified risk of developing a long term condition or those that are potentially developing greater risks as part of their existing conditions via non-diabetic hyperglycaemia blood testing and atrial fibrillation stroke risk assessments respectively.

Indicator	Description
BP002	The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years (based on NM61)
NDH001	The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months (NICE 2017 menu ID: NM150)
AF006	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more) (NICE 2014 menu ID: NM81)

3.10 Quality Management

Ensuring patients newly-diagnosed with depression receive a timely review is crucial for supporting them with the most appropriate treatment regime.

Continuing to incentivise this indicator will also help the performance of other programmes of work to improve mental health in primary care, such as the new Depression Diagnosis Pathway which aims to ensure newly-diagnosed depression patients receive wellbeing calls and has a point of contact whilst waiting for this GP review to take place.

Indicator	Description
AF007	In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (NICE 2014 menu ID: NM82)
DEP003	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis (Based on NM50)

3.11 New Models of LTC care for the future and how stretched QOF will need to adapt

Thurrock's transformation programme includes looking at models of care for the future, this includes a new model for LTC care in the future (at least in advance of our Integrated Medical Centres becoming operational. Work to date suggests that the main problems we need to solve in designing a new model are:

1. Early detection – we still have many patients presenting in the acute setting due to Long Term Conditions that were not pre-diagnosed in Primary Care.
2. Joined up approaches – we have many patients who receive emergency care for a LTC, are not previously known to Primary Care, and data suggests that following the emergency care a large number do not get appropriately coded on a disease register in Primary Care. This means that we are losing the ability to identify and contact these individuals for any services or interventions we may need to offer to them to reduce their risks of further urgent care or even death. For example offering flu vaccinations or annual reviews. Furthermore, following a major health event individuals are often at their most motivated to make changes to their lifestyle, we could be missing windows of opportunity with these patients.
3. Improved management – There are still far too many individuals on Primary Care Long Term Condition registers whose Long Term conditions are not well managed e.g. Clinical biomarkers are not within recommended thresholds, annual reviews are not being done, patients identified as "at risk" are not being referred to appropriate evidence based interventions.

4. Holistic care – the data shows us that of all individuals who are on registers for Long Term Conditions, in excess of 40% of them have multi-morbidities. We still review these patients in terms of each condition rather than as a whole individual.
5. Lack of a pathway – currently there is no specific LTC pathway, individuals get referred to services in a non-co-ordinated and variable way.

3.12 A new model should aim to resolve these issues. We should look to have multi-disciplinary Long Term Condition specialists who support individuals in a holistic way to manage their condition. A pathway should take a patient through stages of removing barriers before working with them to make lifestyle changes that will better support their best possible health outcomes along with clinical interventions. Existing fragmented care needs to be more accessible, co-ordinated and joined up. Individuals / patients support package should be personalised to what works for them with sustainable self-care at the heart.

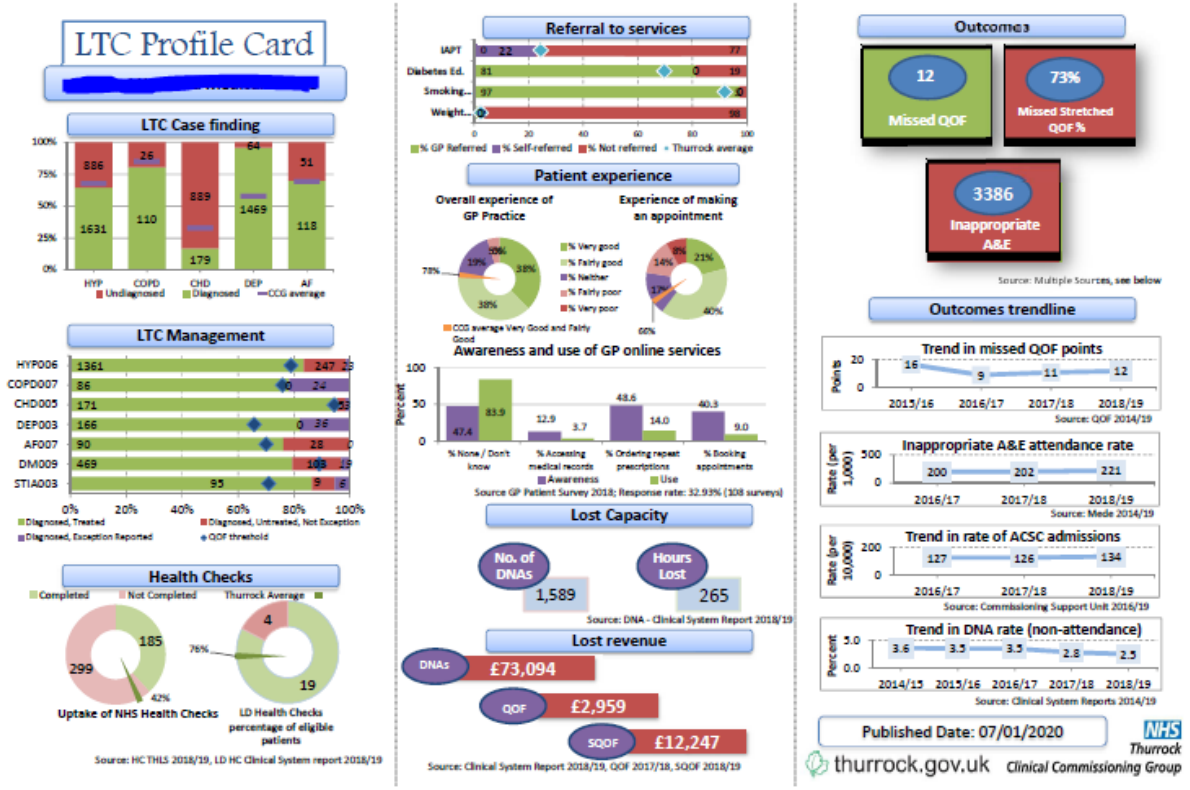
3.13 Alongside this our Stretched QOF programme will need to change, and we have started to think about these changes ready for the 2022/23 financial year. We will no longer top up individual condition indicators and look to move to incentivising a more holistic care approach which looks at individuals as a whole. We will look to bring Healthy Lifestyle contracts and the current stretched QOF contract together to do this. We will also move away from sole reliance on existing QOF indicators in favour of indicators that support this way of working (even if that means we have to generate/calculate our own). A name change will be inevitable.

3.14 The recent investment in Mental Health Primary Care practitioners has brought workers from EPUT into the PCNs so they can work closely with wider health professionals and Peer Workers from Thurrock & Brentwood MIND to improve the way mental health needs are identified and supported. The depression screening work previously described in former Health and Wellbeing Board papers will be re-invigorated in line with some work previously completed on identification of local population groups at most risk of unidentified mental ill-health, meaning it is more likely to find and treat individuals before they otherwise need more urgent care.

3.15 Long Term Condition Profile Card - The Long Term Condition (LTC) profile card was initially created by the Healthcare Public Health Improvement team in 2017 to respond to the high levels of variation within primary care across Thurrock in regards to the individual needs, available resources and overall quality of services.

3.16 Similar to a dashboard, the LTC profile card is a visual overview of each practice, focusing on the LTC case finding and management but also looks at the possible reasons why, such as lack of capacity, increased workload or lack of engagement from the practice population. Furthermore it makes links to secondary care outcomes.

Fig 1. Example LTC Profile card 2019/20

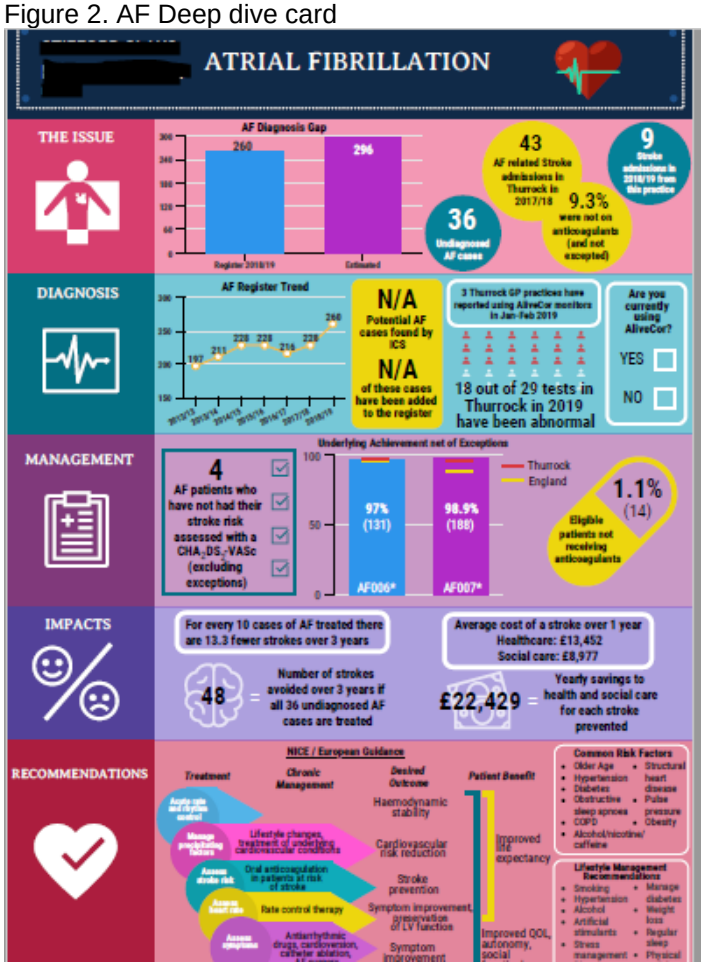


3.17 Development of the profile card for 2021 is underway and proposes the following amendments:

Section	Changes to note
LTC Case Finding	Addition of Obesity (BMI 30+)
LTC Management	Update to reflect Stretch QOF indicators for 2021-22 Visual aid of work to do (patient numbers spanning multiple indicators e.g. number of patients with 8 or more indicators still outstanding)
Outcomes Trendline	Addition of attendance rate for high users (frequent flyers)

3.18 In addition to the LTC Profile card, from 2019 the Healthcare Public Health and Intelligence Teams have been developing some ‘deep dive’ profile cards into particular areas of focus such as Atrial Fibrillation and Mental Health.

Figure 2. AF Deep dive card



3.19 For 2021 Healthcare Public Health are working with Macmillan and wider Cancer stakeholders to develop a deep dive into Cancer care which will support practices and more collectively the Primary Care Networks (PCNs) to work on improvements in early detection and diagnosis as part of their PCN directly enhanced service with NHS England.

3.20 Delivery of the LTC profile card work is not only through sharing the profile card with each practice, but includes visits to the practice, discussions with the practice managers, the GP leads and wider clinical team. It aids identification of agreed priorities and development of individualised action plans for each practice.

3.21 For 2021-22 visits with the refreshed profile cards will be scheduled for late October/early November to discuss progress to date, areas of focus and required support up to March 2022. Some of these will be done via PCN meetings as appropriate, however individual practice visits will still happen if any of the following is true:

1. There is something specific to the practice that needs to be discussed
2. A practice specifically requests

3. A PCN requests that we visit all or some individual practices
4. The CCGs primary care team identifies a practice as being poor in terms of patient satisfaction or quality of care (including CQC reports)

3.22 For the 2022/23 financial year the profile card will need to change in line with the Stretched QOF programme.

4. Reasons for Recommendation

4.1 The Thurrock transformation piece, Stretch QOF and the Long Term Condition profile card form are key programmes of work in improving standards in Primary Care across Thurrock; one of the key public health priorities.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Public Health Leadership team, Thurrock CCG and clinical leads from Primary Care Networks have been consulted on proposals.

6. Impact on corporate policies, priorities, performance and community impact

6.1 This work dovetails with Thurrock Councils corporate priority under people and the proposed Domains 1 and 2 ‘Quality Care centred around the person’ and ‘Healthier for longer’ under the Joint Health and Wellbeing Strategy. The work seeks to address unmet physical and mental health needs and the development of an integrated health and care system that prevents and/or reduces need for health and care services.

7. Implications

7.1 Financial

Implications verified by: Not provided

This will be met within existing agreed budgets across the Public Health Grant and the Better Care Fund.

7.2 Legal

Implications verified by: Not provided

The Stretch QOF contract is commissioned to and delivered by GP practices as it is an enhancement of their existing NHS Quality and Outcomes Framework contract.

7.3 **Diversity and Equality**

Implications verified by: Not provided

This programme of work seeks to improve quality in management of long term conditions and reduce variation in management across patients within GP practices but also to reduce the gap in variation across all practices in Thurrock and therefore supports tackling inequalities.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

Not Applicable

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):
Not Applicable

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