HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 15 December 2015.

PRESENT: Councillors J G Cole, E Dryden, A Hellaoui, C Hobson, B A Hubbard, T Lawton and J McGee

ALSO IN ATTENDANCE: C Blair, Associate Director, Commissioning, South Tees Clinical Commissioning Group
D Budd, Elected Mayor and Chair of the Health and Wellbeing Board
L Green, Public Health Intelligence Specialist, Tees Valley Public Health Shared Service
M Reilly, Assistant Director, Public Health Intelligence, Tees Valley Public Health Shared Service
F Toller, Managing Director, Women and Children's Services
D Welsh, Senior Commissioning Manager, Provider Manager, North of England Commissioning Support

OFFICERS: E Kunonga, E Pout and C Lunn.

APOLOGIES FOR ABSENCE Councillor S Biswas, Councillor S Dean.

15/30 **MINUTES - HEALTH SCRUTINY PANEL - 24 NOVEMBER 2015**

The Minutes of the Health Scrutiny Panel held on 24 November 2015 were submitted and approved as a correct record.

AGREED

15/31 **IMPROVING LEVELS OF BREAST FEEDING IN MIDDLESBROUGH.**

The Chair outlined the current position of the Scrutiny investigation and felt that the point had now been reached for all findings to be discussed and recommendations to be made.

The Panel considered a report by the Scrutiny Support Officer, the purpose of which was to present them with an outline of the meeting and to introduce a number of professionals who were in attendance to provide evidence.

Members were advised that Mike Robinson, Chief Executive of Middlesbrough Council, was unfortunately unable to attend the meeting. However, a joint response to a number of questions posed by the Panel from both he and the Elected Mayor were tabled for Members' information.

Over the course of the Scrutiny investigation, the Panel had received a wide range of evidence on the topic of improving levels of breast feeding in Middlesbrough. Discussions had taken place with the Public Health Team, Teesside University, Tees Valley Public Health Shared Service, the South Tees Infant Feeding Team and midwives.

The Scrutiny Support Officer circulated a handout which illustrated the salient points that the investigation had identified. These were as follows:

- Breastfeeding at birth statistics for 2014/2015:
  - 881 infants (47.2%) were breastfed.
  - 986 (52.8%) were artificially fed.
  - To reach the England rate would have required an additional 510 infants per year, or about 10 per week, to be breastfed at birth.
- Breastfeeding at 6-8 weeks statistics for 2014/2015:
  - 322 (16.8%) were totally breastfed.
  - 469 (24.5%) were totally or partially breastfed.
  - 1,446 (75.5%) were not at all breastfed.

    - To reach the England rate would have required an additional 338 infants per year, or 6 to 7 per week, to be totally or partially breastfed at 6-8 weeks.
- The benefits of breastfeeding:
    - For babies, breastfeeding lowered risks of: diarrhoea, vomiting and constipation; ear infection; sudden infant death syndrome; respiratory infections; obesity and diabetes; and asthma and eczema.
    - For mothers, breastfeeding lowered the risk of breast and ovarian cancers; naturally burned 500 calories per day; and helped bonding with the baby.

It was highlighted to the Panel that, in comparison with similarly deprived areas, Middlesbrough had the lowest breastfeeding initiation rate. In addition, with regards to breastfeeding at birth statistics, the England average was 74%, whereas in Middlesbrough it was 47%. With regards to breastfeeding at 6 weeks, the England average was 24%, whereas in Middlesbrough it was 16%.

In response to a Member enquiry regarding breastfeeding at birth statistics for 2014/2015, it was indicated that if one extra infant from each Ward within the town was breastfed per year, and this rate was sustained over time, this would provide the same rate of improvement that was being seen in similar areas such as Sunderland, Gateshead and Blackpool. Those areas had made a steady rate of progress and were still improving, whereas the Middlesbrough rates were not increasing. It was clarified that the statistics in 2014/2015 would have reflected the previous Ward boundaries when there were 23 Wards within Middlesbrough. The Chair indicated that it did not seem as though a large number was required to improve the statistics, but the question arose as to how further encouragement for breastfeeding could be made.

Members heard that approximately ten years ago, the breastfeeding rates in this catchment area were very poor. At that time, a number of initiatives were undertaken in order to improve the situation. This included: joint working between Sure Start and the University of Teesside; improved training for midwives; and development of peer support programmes. This resulted in a marked increase in the breastfeeding rates between 2006 and 2008; however since then, numbers had not increased any further.

It was explained that within the Women and Children's Service, the number of women breastfeeding after delivery and the number of women still breastfeeding once discharged from hospital was monitored. The statistics did indicate that women were breastfeeding for longer periods, however fundamentally, drop off did occur, and was greater than the national average. It was felt that the reason for this related to cultural change. Although a town wide issue, it was indicated that this was more prominent in deprived areas.

It was indicated to Members that generational matters such as a prevalent bottle feeding culture within Middlesbrough would have made it very difficult for new mothers to undertake breastfeeding, particularly if they had never witnessed or experienced it before. It was felt that this linked into the opportunity of how well breastfeeding was advertised and accepted in public places and by families.

It was explained that a recent initiative implemented by the Women and Children's Service concerned a five day maternity care assistant programme. This meant that new mothers were visited for the first five days after discharge from hospital in order to try and maintain breastfeeding practice. However, this had had minimal impact.

Reference was made to an antenatal scheme currently being undertaken in Sunderland, whereby ladies were provided with breastfeeding information in advance of birth, with support carrying on through to the postnatal period. A peer-to-peer support group had been established; supporters would visit women to provide advice, prior to any feeding intention decisions being made. In addition to this, a training programme around breastfeeding was also being provided. It was explained that some similar work was undertaken in Middlesbrough on an antenatal basis; however, this was not as intensive as the work carried out in Sunderland, owing to the resources available.

A discussion ensued with regards to the acceptance of breastfeeding; it was felt that significant work needed to be carried out in order to generate the message that there was

nothing unnatural about it. This would potentially include advertisements in public buildings, commercial premises and GP Surgeries, accompanied by a local media campaign. A further suggestion was made with regards to schools and the promotion of this message within educational environments. Reference was made to a private building that held a mother and baby group where women regularly breastfed, though this was not advertised. It was felt that more explicit advertising of allowing breastfeeding on sites needed to be undertaken.

Reference was made to the consistency in the statistics for breastfeeding at birth and breastfeeding at six weeks, in respect of both the England average and the Middlesbrough rate, with the drop-off loss rate equating to 2/3 on each. It was suggested that a common factor was occurring that caused new mothers to stop breastfeeding after those periods of time. One suggestion for this was that, as the child got older, a return for mothers to the workplace and into community settings had caused this. It was felt that the statistics were both a cultural and national issue.

It was indicated that breastfeeding rates tended to be higher in more affluent areas where, culturally, there was a long history of breastfeeding. It was felt that culture was imperative regardless of locality. It was suggested that a Teesside and Middlesbrough effect was taking place, in that the areas of Middlesbrough expected to have higher breastfeeding rates were not actually that high.

It was highlighted that the Women and Children's Service offered a core service to women across the catchment, which included Middlesbrough, Redcar and Cleveland, Hambleton and Richmondshire. The breastfeeding rates in Redcar and Cleveland were 57%, whereas in Middlesbrough they were 47%. One explanation for this was the varying sub-cultures within the catchment areas. The usual common factors were the level of affluence and generational influences.

With regards to peer support and generational influence, it was felt that support from mothers and grandmothers was pivotal in order to overcome the immediate intention of bottle feeding. It was considered that many parents in Middlesbrough were quite young, and may themselves have had younger mothers and grandmothers. It was felt that in order to captivate and influence multigenerational change and peer support, innovative thinking was required.

In response to a Member enquiry regarding the peer support project in Sunderland, it was explained that this was carried out by way of a multi-faceted approach. Mothers were visited at a variety of sites - at home and in clinical settings for example. Although acknowledged that the home environment was particularly key in terms of influencing generational change, access to this setting was particularly difficult.

A discussed ensued regarding commissioning of services. A range of services were being commissioned across public health and local authorities. It was felt that services being commissioned were done so for a particular point in time and, similarly to the cultural issues being faced, services were being offered in response to cultural beliefs and the population being served. For example: services were being commissioned around supporting mothers who had just given birth within a hospital setting; over-reliance on hospital services was being seen because the number of home births was not particularly high. This reflected the cultural factors within the North East of England and particularly in Middlesbrough.

It was felt that work did need to be done differently in order to break the bottle feeding cycle, and the point of challenging multigenerational behaviour and attitudes was supported.

There may have been potential for establishment of an antenatal health visiting service, so that the postnatal information was provided earlier. It was felt that the services being commissioned did deliver what they were supposed to do, but they did not change embedded culture. It was acknowledged that further work needed to be undertaken to support cultural change.

It was considered that issues wider to the health field were playing a significant role in this matter. Reference was made to initiatives such as UNICEF BF accreditation that had been applied to every site, including The Friarage, James Cook University Hospital, Neonatal Units,

and paediatrics, which had been undertaken in order to meet the commissioning requirements of promoting and increasing breastfeeding. However, akin to the practice of smoking, regardless of the work undertaken and the health messages conveyed, people still continued to do it. The last step up in breastfeeding rates occurred in 2006-2008, but it was felt that with a new approach and focused intervention; further advancement in the figures could be made.

It was commented that single mothers with additional children may not have been able to consider breastfeeding because of time constraints. Reference was made to the statistics that had been provided and a query raised as to whether these reflected all mothers as an entirety, or if a difference between single parent families and a complete family unit could be identified. In response, it was explained that such break-down statistics would be available, however, by default; statistically more people would be found in a full family unit in more affluent areas than in non-affluent areas. Cultural influences were suggested as the reasoning for this.

It was highlighted that there were a number of myths surrounding breastfeeding and the health professional present explained that it was not harder or more time consuming to breastfeed, it was actually easier. It was felt that single mothers in particular should be targeted in respect of this, as it was more expensive, more time consuming and more difficult to bottle feed.

It was felt that every mother in Middlesbrough wanted the best for their child. In order to support these values, it was suggested that the attainment of additional resources from different areas, such as education, health, and planning and building control, be achieved. It was suggested that additional support, such as from local businesses or establishment of peer support groups, would also assist in this regard.

There was a disproportionately high number of young mothers in Middlesbrough and it was felt that increased education within schools, to promote or increase an awareness of the benefits of breastfeeding, could be undertaken in order to challenge the innate generational behaviours that had been passed down. Reference was made to the current school curriculum and citizenship studies.

The Assistant Director, Public Health Intelligence acknowledged that a cultural shift and improved breastfeeding rates could be achieved with changes. Reference was made to paragraph seven of the submitted report and the questions that had been compiled from the Panel's previous comments.

A document detailing suggested requirements to improve infant breastfeeding in Middlesbrough was circulated for Members' information. The document consisted of a model, which considered a number of systemic issues and how change could be initiated, which included:

- A public buildings programme that would embed the 'breastfeeding welcome scheme' in appropriate local venues.
- A schools education component that would improve current learning for students that was appropriate for age and setting.
- An effective and accessible programme for antenatal education to embed breastfeeding awareness throughout the programme.
- A comprehensive staff training programme for professionals in various settings who would influence and support mothers and families.
- A professional support staff level for helping mothers and infants to initiate and continue breastfeeding as required. The level of this would need to be determined accordingly.
- A system manager with executive level authority, responsibility and accountability with one single aim to improve breastfeeding.

It was highlighted that in order to see a population shift for the longer term, it was imperative that any initiatives were undertaken across the board, with respective changes being introduced across all areas, and not just in specific Wards.

In terms of the model and the potential for the commissioning of the work, it was indicated that

whatever action was proposed would need to be commissioned. However, this responsibility would span a number of different agencies and sectors, including the CCG as the commissioner of secondary care health, the local authority and public health in terms of the public health messages and education, with discussions also being undertaken with the Health and Wellbeing Board.

The Chair queried whether there would be any problems with the model as a basis for the Panel to form recommendations. It was explained that although there was not anything illustrated in the model that could not potentially be pursued, the issue that regularly presented itself was that the various agencies involved allocated their resources towards those individuals that were presenting at the other end of the pathway. To start spending money or using professionals to do things differently would not be achievable, as the same individuals or money to treat what comes out of the other end could not be used. For example: at present, the CCG spent its money dealing with babies who were presented at hospital with diarrhoea, vomiting and constipation. Therefore, the money could not be spent treating them as well as commissioning something different at the same time. If additional resources would be required for the implementation of such a model, it may not be achievable. However, the requirement for additional resources would need to be assessed.

In response to an enquiry regarding the 2006-2008 statistical increase, it was explained that additional resources had been provided at that time, which had taken the form of Sure Start and Health Workers. Funding was provided to put Health Care Workers in centres to develop public peer supporters. It was felt that what was required now was another intervention to give a step increase and integrate it into core practice.

It was explained to the Panel that there may be a mechanism available that would potentially provide additional in-year resource - better care funding for example. If it was demonstrated that schemes or initiatives could potentially impact upon matters such as admissions or hospital attendances, then resources could be freed up to do something different. For example: a significant number of babies had been admitted to hospital with gastrointestinal problems, therefore the suggestion that the benefits of breastfeeding could reduce the likelihood of babies with gastrointestinal problems could permit the release of resources that were being used for dealing with causal factors.

With regards to budget, it was explained that a pool budget was currently in place. A case could be put forward for access to this budget, but the final details would need to be considered. In terms of a timescale for a final plan, there was an expectation that this would be in place by the end of March 2016 in order to align with each organisations' operating plan.

The Chair highlighted that any recommendations put forward by this Panel needed to be achievable.
It was felt that a sustainable plan with longevity needed to be considered. This matter was not something that could be implemented and then discontinued after one year.

In terms of social marketing, it was suggested that inclusion of a '5 point plan' be prepared to align with other health related initiatives, such as '5-a-day', which would assist with this.

A query was raised regarding NHS provision of powdered milk, which would have encouraged bottle feeding. It was felt that it would perhaps be more beneficial for other items, such as additional nappy provision, to be made. In response, it was explained that from a CCG perspective, funding of formula milk for babies with certain intolerances was undertaken. In terms of the free milk scheme, this would need to be checked with NHS England.

A short discussion ensued with regards to national advertising campaigns. At present, although literature was produced, there were no breastfeeding adverts currently being undertaken nationally. Reference was made to the 'breast is best' tagline used as part of the 2008 campaign and the small presence that it had on some formula milk adverts. The Panel felt it appropriate to make a recommendation to the Government to ensure that any baby food manufacturers make the message more explicit and visible to consumers.

The Chair clarified that at this stage of the Scrutiny investigation, the intention of the Panel

was to make recommendations and have them accepted. The details of the final plan, which may include reference to matters such as dealing with cultural and generational issues, would be presented at a future meeting.

Reference was made to a successful Middlesbrough Council workforce screening programme that had been carried out previously. Consideration was given as to whether a programme aimed at younger members of staff regarding breastfeeding could be undertaken.

It was felt that once a model had been established and implemented, the visible changes would result in a cultural shift. Reference was made to previous campaigns such as stopping smoking.

It was suggested that relevant information be included in the Love Middlesbrough magazine, statistics or success stories for example, as well as in other Council literature. The Panel agreed that this would be useful. It was felt that this would help to reach other organisations such as voluntary groups as well.

With regards to the Panel's recommendations, a query was raised as to where these would go. It was explained that these would be forwarded to the CCG, the Council's Executive, and the South Tees Executive Board. It was suggested that the recommendations also be forwarded to the Health and Wellbeing Board.
The Panel discussed potential joint working initiatives with commercial businesses, Teesside University and South Tees Hospitals Trust.

The Scrutiny Support Officer summarised the recommendations that the Panel had considered so far.

A discussion ensued with regards to incentives and the potential for these to increase breastfeeding rates. A suggestion of free gym membership was made; however, it was felt that although this would improve wider public health, it would not necessarily improve breastfeeding rates. In addition, there may have been wider implications, such as the requirement for provision of free childcare to enable mothers to attend the gym. It was felt that offering incentives would not necessarily have any lasting longer term benefits. Reference was made to schemes that had been undertaken elsewhere, where incentives of free breast pumps and feeding pillows had proven unsuccessful.

Reference was made to a report by the Chief Medical Officer that had been published earlier in the week, and a section that had considered the benefits of breastfeeding for mothers. It was felt that this could provide a useful route for social marketing purposes. It was suggested that notices at the Health Village and on bus shelters would also help to raise awareness.

With regards to the statistics pertaining to breastfeeding at birth and breastfeeding at six weeks for single parent and two parent families, the representative from Women and Children's services would provide these to the Panel.

The Chair conveyed his thanks to the Members and invited representatives for their attendance and helpful contributions.

RECOMMENDED:

1. **That the CCG, Local Authority and Public Health have a discussion via the Health and Wellbeing Board about the suggested requirements to improve infant breastfeeding, and to develop a detailed plan for 2016/2017.**
2. **Write to the Secretary of State regarding advertising of children's food.**
3. **Write to NHS England about the development of a long running national campaign to promote the health benefits of breastfeeding.**
4. **Initiatives to be undertaken to support staff welfare; ensure that this be targeted towards breastfeeding mothers.**
5. **Information and/or success stories be placed in the Love Middlesbrough magazine. Contact also be made with Thirteen Group (Erimus Housing) to determine the possibility of having details included in their magazine as well.**

6. **Develop a scheme for local businesses to sign-up to, in particular those located in shopping centres, to demonstrate support for breastfeeding.**
7. **Notices be placed in Council-controlled public places to demonstrate support for breastfeeding.**
8. **The representative from Women and Children's services would provide the Panel with statistics pertaining to breastfeeding at birth and breastfeeding at six weeks for single parent and two parent families.**
9. **That a feedback session be undertaken in April 2016 to review the progress made.**
10. **That the information be noted.**

15/32 **ANY OTHER BUSINESS.**

No further business was discussed.