

# Providing effective lactation care: The Merton NHS Specialist Breastfeeding Clinic

## › Abstract

The aim of this review was to assess the impact of an NHS specialist breastfeeding clinic staffed by International Board Certified Lactation Consultants, and to identify whether it improves breastfeeding outcomes and duration. This retrospective clinical review evaluated data from consultations at the Merton Specialist Breastfeeding Clinic. The data from each consultation forms the basis of the analysis. In the majority of cases (76%;  $n=56$ ), the clinician findings differed from the mother's presenting concerns. This highlights the importance of specialist care to correctly identify issues and underlying causes. The majority (83%) of infants in this cohort were receiving some mother's own milk beyond 6 months. Women who faced complex breastfeeding challenges reached their breastfeeding goals with the support of specialist lactation care.

## Key words

› Healthcare leadership › Postnatal care › Maternal health › Breastfeeding

**B**reastfeeding improves both short- and long-term health outcomes for mothers and infants. It is protective against a wide range of illnesses including, but not limited to, infections, cancers, type 1 and 2 diabetes, heart disease and obesity and cot death (Ip et al, 2007; Horta et al, 2013; Horta et al, 2015a; Duijts et al, 2010; Thompson et al, 2017). In mothers, it reduces maternal risk of breast and ovarian cancers and heart disease, type 2

diabetes and cardiovascular disease (Natland et al, 2012; Aune et al, 2014; Chowdhury et al, 2015). It also supports brain development in infants, and protects mental health of mothers (Tashakori et al, 2012; Horta et al, 2015b). The World Health Organization (WHO) recommends that all infants are breastfed exclusively for 6 months and thereafter with other foods for up to 2 years or more (Unicef, 2013).

Despite the known benefits, the UK has one of the lowest duration breastfeeding rates in the world (<1% exclusive breastfeeding at 6 months) (Public Health England, 2016). While UK rates of breastfeeding initiation have risen from 62% in 1990 to 81% in 2010, there remains a steep decline in breastfeeding rates during the early weeks, with 55% of women still breastfeeding (partial or exclusive) at 6 weeks and just 34% at 6 months.

The last Infant Feeding Survey showed that 80% of women stopped breastfeeding before they wanted to and that many did not receive the help they needed, experiencing problems that were not resolved (McAndrew et al, 2012). This led to the introduction of infant formula feeds and, ultimately, to the cessation of breastfeeding (Renfrew et al, 2012a). Nearly a quarter of mothers felt more skilled support could have helped them with early breastfeeding problems (McAndrew et al, 2012).

When breastfeeding support is provided to women, the duration and exclusivity of breastfeeding is increased. Strategies that rely mainly on face-to-face support are more likely to succeed with women practicing exclusive breastfeeding (McFadden et al, 2017; WHO, 2017). There is also a financial benefit to investing in efficient services that increase and sustain breastfeeding, as well as making a significant contribution to reducing health inequalities.

The report *Preventing Disease and Saving Resources: The potential contribution of increasing breastfeeding rates in the UK* looks at how raising breastfeeding rates could save the NHS money through improving health outcomes. Moderate increases in breastfeeding would result in 54 000

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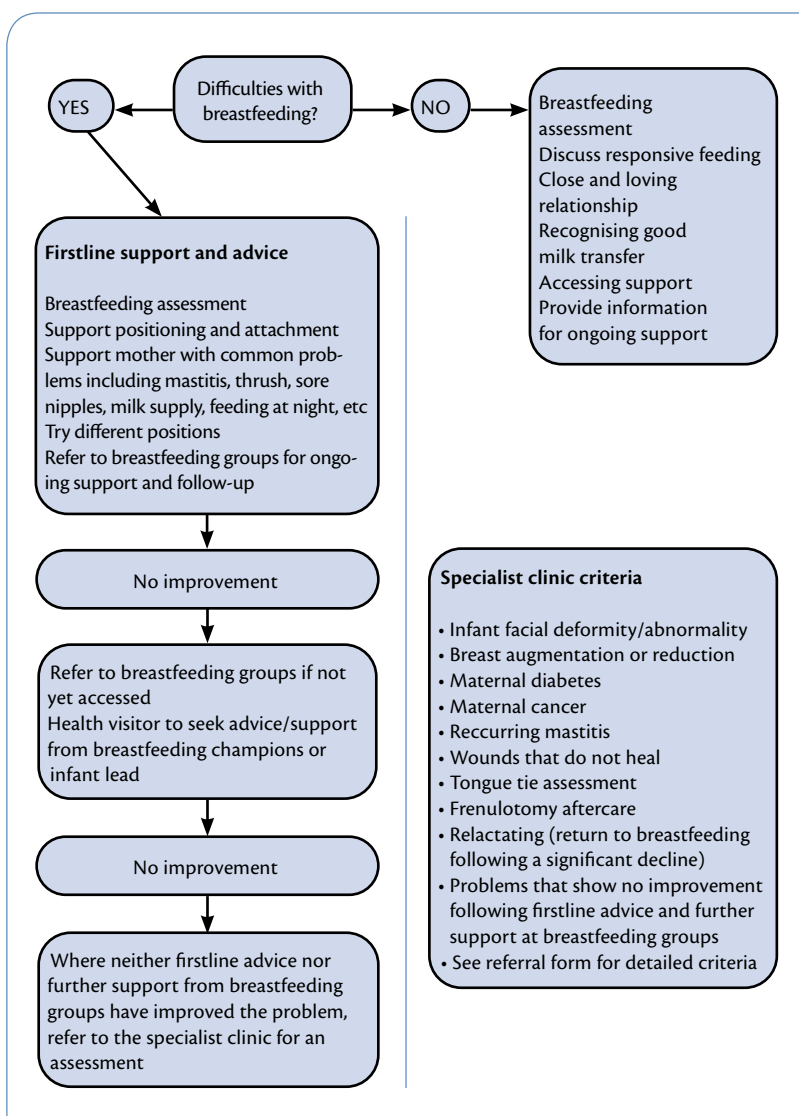


Figure 1. Specialist breastfeeding pathway

fewer GP visits, 9000 fewer hospital admissions and save the NHS around £48 million per year. (Renfrew et al, 2012a).

Support for mothers through the global Baby Friendly Initiative (BFI) is seen as an essential element to achieving exclusive breastfeeding (Renfrew et al, 2012a). Working within the Unicef BFI framework helped the Merton Health Visiting Service define and identify areas where intervention would have the greatest impact. One such area was the provision of an International Board Certified Lactation Consultant- (IBCLC-) led specialist breastfeeding clinic. The International Board Certified Lactation Consultant profession has become a synonym of the international gold qualification profession in breastfeeding practice. To qualify candidates need to fulfil entry requirements set

by the examining board, the International Board of Lactation Consultant Examiners. Requirements include 1000 hours of clinical practice and 95 hours of lactation education (including 5 hours focused on communication skills) in the 5 years prior to applying for the exam. In addition, non health professionals need evidence of learning in 14 health education subjects.

The first step was to design a referral pathway and criteria, incorporating local health, maternity services and voluntary agencies who were able to link in through direct referral into the clinic (Figure 1). The aim was that, regardless of where Merton mothers sought help, they had access to a local, high-quality NHS service that provided the appropriate level of support and, if needed, they had access to clinician IBCLCs.

The aim of this service evaluation was to examine if this specialist service, staffed by IBCLCs, increased breastfeeding duration rates for mothers in the community. Ethical approval was granted by the Central London Community Healthcare NHS Trust.

## Methods Design

This retrospective service evaluation review examined data from appointments that took place at the NHS Merton Specialist Breastfeeding Clinic. The aim was to quantifiably measure the impact of a specialist breastfeeding service by IBCLCs in the NHS. In addition to standard operational data, additional data points were collected to understand the impact of specialist support on client outcomes, focusing particularly on identification of breastfeeding challenges, resolution of symptoms, and continuation and duration of breastfeeding.

## Setting

This review evaluated data from appointments during the 12-month period after the clinic's inception in May 2018. The clinic is delivered in the community at one of the local children's centres. There is a designated clinical room in the centre equipped with a nursing chair, infection control-compliant pillows, scales and consumables used to deliver specialised lactation care, including nipple shields, nasogastric tubes, syringes, tongue depressors, gauzes and bottles for at breast supplementation. The clinic is situated in one of the most deprived areas of the borough, which scores four out of 10 on the English Indices of Deprivation (Ministry of Housing, Communities and Local Government, 2019).

The clinic sees mothers who live in the borough of Merton and have been referred by their health

professional (health visitor, midwife, GP or infant feeding lead) or an accredited breastfeeding counsellor from the voluntary sector. The clinic runs weekly and is staffed by IBCLCs.

Nationally, basic breastfeeding management care is delivered by midwives and health visitors. The care model is universal antenatal contact from midwifery and targeted antenatal contact from a health visitor. Mothers are then usually seen twice by the community midwives in the first 10 days and discharged to the health visiting service when birth weight has been surpassed and if there are no concerns.

The health visitor has a new birth contact with the mother on day 10–14. Referrals can be made where firstline support does not resolve challenges with breastfeeding. The specialist breastfeeding clinic is unique as it is staffed by IBCLCs with a high degree of clinical competency.

## Sample

The reviewed data was from all breastfeeding mothers who attended the clinic from September 2018–August 2019 (Table 1). Total sample size was 75. Each consultation was analysed. According to the National Statistics Socio-economic Classification, 40% of Merton's population are categorised in managerial, administrative and professional occupations (Merton Council, 2018; Office for National Statistics, 2021). The largest proportion ( $n=32$ ; 43%) of the mothers in this study identified themselves as white, but families came from many ethnic backgrounds, with 20% ( $n=18$ ) self-identifying as black, Asian or minority ethnic (BAME). We did not have ethnicity data for 33% of service users. CLCH is working on improving data recording to help prevent inequalities in our populations.

In September 2021, the CLCH Information Governance team has established data sharing agreements with North West London, North Central London and South West London Integrated Care System so that a patient's ethnicity on a GP record can be shared with CLCH which will improve ethnicity recording. A notable number of mothers did not self-identify as belonging to any ethnicity (33%). The proportion of Merton's BAME population group is 37.1% (Merton Council, 2018).

## Measurement

The data used in this service evaluation was collected by clinician IBCLCs after the consultation(s) with breastfeeding mothers and based on the contents of each consultation. Data were anonymised (individuals were allocated an

Table 1. Sample characteristics

Population sample characteristics	Number	%	<i>n</i>
Average age of baby (weeks)	8.6		
Average age of mother (years)	34		
Ethnicity			
White		43	32
Black		4	3
Asian		8	6
Mixed		8	6
Other		4	3
Not known		33	25

Table 2. Consultation characteristics

Consultation characteristics	<i>n</i>
Average number of appointments per client (range)	2 (1–6)
Number of occurrences of more than three consultations	
When IBCLC findings were:	
Tongue tie ( $n=11$ )	6
Insufficient milk supply ( $n=10$ )	4
Perceived insufficient milk supply (PIMS) ( $n=6$ )	3
What the reason for consultation was:	
Maternal pain ( $n=14$ )	5

electronic health record number) and entered into an Excel database without any patient identifiable information.

Demographic variables recorded included ethnicity, age of baby and age of mother. Clinical variables/categories included mother's chief complaint, IBCLC findings, feeding method, growth concerns, suspicion of ankyloglossia (tongue tie) from a health professional, performed frenulotomy with nil resolution of symptoms, intra-oral exam if applicable at consultation (using the Hazelbaker Lingual Frenulum Assessment Tool (Hazelbaker, 2017), NHS referral for frenulotomy, post-consultation feeding plan, including (if applicable) post-consultation supplementation, and continued breastfeeding beyond 6 months.

Definitions of infant feeding used the standard definition system by Noel-Weiss et al (2012). The WHO definitions were used as a basis and then further refined for precision and clarity. The definitions used were:

- ◆ Exclusive breastfeeding – exclusive feeding of human milk by any means, including expressed breast milk
- ◆ Mixed feeding – receiving a mix of human milk and formula feeding by any means
- ◆ Infant feeding – exclusive feeding of infant formula.

Table 3. Results

Group	%	n
<b>Receiving mother's own milk beyond 6 months</b>	83	50
By feeding method (n=62*):	97	30
Any mother's own milk	69	20
Breastfeeding		
Mixed		
<b>Receiving mother's own milk beyond 6 months</b>		
Where mother's main concern at initial consultation was (n=37):		
Maternal pain	92	11
Perceived insufficient milk supply (PIMS)	76	16
Transition to exclusive breastfeeding	100	4
<b>Other findings</b>		
Where mother's main concern was 'transition to exclusive breastfeeding' (n=5):		
The issue was resolved	80	4
Where health professional 'diagnosed' tongue tie (n=14)		
Were then referred for frenulotomy by clinic	64	9
IBCLC findings in line with mother's main concerns (n=75)	25	19

\*= excludes data for which there is no value for the variable in observation

### Data collection

Data were collected at the clinic during September 2018–August 2019 and captured on a secure clinical platform. Data were extracted retrospectively by the clinic team from NHS records.

### Data analysis

Anonymised raw data were analysed using Microsoft Excel as well as relationships between variables and data subsets. The full results are shown in Table 3. Data for which there was no value for the variable in observation were excluded.

### Results

The average age of babies was 8.6 weeks, ranging from the youngest at 2 weeks to the eldest at 5 months. The fact that most of the babies were older suggests that earlier breastfeeding support had not resolved the issue. The model at the clinic includes continuity of care and the average

number of consultations was two, with a range of one to six (Table 2). For more complex issues, continuity of care is especially important to ensure patient-centred feeding plans are effective and sustainable. More complex problems, such as insufficient milk supply, mastalgia (breast pain), nipple pain and tongue tie had the highest occurrence, involving more than three consultations.

In the majority (83%) of cases, infants were receiving some of their mother's own milk beyond 6 months. Nipple pain and insufficient milk supply are leading causes of early cessation of breastfeeding. This evaluation shows that when mothers received specialist IBCLC care, infants were being fed some mother's milk after 6 months in 92% of the cases where the main reason for the consultation was maternal pain, and in 76% of the cases of insufficient milk supply. Data for which there was no value for the variable in observation were excluded.

The IBCLC findings of the aetiology differed from the reasons the mother attributed to her presenting concerns in the majority of cases (n=56), highlighting the importance of specialist care to correctly identify issues and underlying causes, and work with a mother to implement effective and sustainable care plans. Further demonstrating the importance of qualified skilled assessment in identifying the true aetiology was the finding that, of the infants previously 'diagnosed' with tongue tie by a health professional, just over half (64%; n=14) were referred by the clinic for a frenulotomy.

There was a group of mothers whose main concern was to transition to exclusive breastfeeding. These mothers were motivated to breastfeed and had a strong desire to do so. Given the clinic is referral only, they would have received previous support (possibly multiple times). In the vast majority of cases (80%; n=5), the issue was only resolved when they received care from an IBCLC.

### Discussion

The most striking message from this study was that specialist IBCLC support increases breastfeeding duration; 83% of the mothers in the care of the clinic were still giving their own milk beyond 6 months. This is in line with Thurman and Allen's findings (2008) that there is an association between IBCLC care and duration of breastfeeding.

Given the significant clinical demand of these mothers, the quality of assessment and advice delivered by the clinic is key and requires a

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» *Integrating experienced clinician IBCLCs into the NHS health team has become crucial given the gap in provision of this service; however, this is challenging where the qualification is not listed as an allied health profession* «

specialist with both a breadth and depth of knowledge and experience. IBCLC certification ensures a quality standard and IBCLCs around the world are making a difference to improving the care of breastfeeding mothers (Haase et al, 2019). Mothers often arrive having had contact with numerous health professionals, breastfeeding counsellors and even private lactation consultants. Early breastfeeding care intervention is vital (Puapornpong et al, 2017). The clinic has proven to be a model that will aid in developing new and exciting care pathways to improve practice and client outcomes.

One of the unique traits of the clinic is that it works closely with other health professionals in the community. Health visitors were actively involved where weight was of concern (including faltering growth). In addition, referrals were made to speech and language therapy services where infants were identified as needing extra support; and requests were made to GPs requesting microscopy testing or hormone blood tests. GPs were also routinely involved in care where, based on the IBCLC's clinical findings, enquiries were made with regard to prescription of medications or to consider a differential diagnosis in complex and chronic cases.

Reference was made to the available National Institute for Health and Care Excellence (NICE) guidelines (NG194, NG75, NG1, IPG149, CG93 and the *Scenario: Breastfeeding problems – management*) to support clinical practice. The GP Infant Feeding Network UK was often referred to as it provides valuable information for health professionals (<https://gpifn.org.uk>). Working collaboratively and up-skilling the workforce is crucial in supporting the journey towards ongoing and sustained Unicef UK Baby Friendly accreditation. However, current NICE guidelines mainly reflect basic management of breastfeeding issues and our experience at the clinic demonstrates how a high degree of clinical competency is needed, often beyond what is described in the available NICE guidelines. In these cases, it is useful to refer to the Academy

of Breastfeeding Medicine protocols (2019) when working in conjunction with GPs. These list examples of expertise in clinical lactation care:

- ♦ All our IBCLCs are trained and competent in doing intra oral exams (Hazelbaker, 2017) to assess ankyloglossia
- ♦ Mothers who need supplementation are offered at breast supplementation (Borucki, 2005) to discontinue bottle use and avoid flow preference or nipple confusion
- ♦ Cervical auscultation, defined as listening with a stethoscope over the infant's neck or chin during milk transfer (Cichero and Murdoch, 2002) is used if all other methods to identify issues with the suck, swallow, breathe triad have been attempted
- ♦ Assessing milk transfer through test weighing (Rankin et al, 2016) is sometimes used if all other methods to assess milk transfer have been attempted
- ♦ We have clinical experience of working with infants who have craniofacial anomalies and devised the assisted nursing technique (use of a nasogastric tube placed behind a nipple shield), which helped an infant with a complete unilateral cleft and palate feed at the breast until reconstructive surgery took place (Lopez-Bassols, 2021).

Many mothers seen at the clinic presented with a 'vicious cycle of supplementation' – using supplementation for valid (and on many occasions invalid) medical reasons (with mother's own milk or with infant formula) in the first few days or weeks of life. Without proper ongoing support, however, families are not able to reduce supplementation and return to exclusive breastfeeding as they are trapped in a cycle of ever-increasing supplements and a concurrent decreasing milk supply.

The main driver of this cycle is a lack of continuity of care, where supplementation plans put in place in the early days or weeks are not adjusted to take account of changing circumstances. Mothers are also often not referred to infant feeding teams. Current evidence shows that any introduction of infant formula significantly shortens breastfeeding duration (Parry et al, 2013) and that expressing and bottle feeding are difficult to sustain long term. In our experience, from those mothers receiving specialist IBCLC support, 69% of those who were mixed feeding were still receiving mother's own milk beyond 6 months. IBCLCs are considered skilled experts in the management of



complex breastfeeding challenges. Although the total number of IBCLCs in the UK has steadily increased, with 666 IBCLCs currently working, the IBCLC is still not recognised as a stand-alone credential by NHS services (i.e. not held by an individual who is also a registered midwife/nurse or Health and Care Professions Council registered). The implication is that for IBCLCs to work in the NHS above a certain pay scale that recognises their level of clinical expertise, a dual credential is required.

Integrating experienced clinician IBCLCs into the NHS health team has become crucial given the gap in provision of this service; however, this is challenging where the qualification is not listed as an allied health profession (AHP). By contrast, drama, art and music therapists ([www.england.nhs.uk/ahp/role/](http://www.england.nhs.uk/ahp/role/)) are included. Given its less than sub-optimal breastfeeding duration rates, the UK ought to increase the number of IBCLCs working within the NHS, and meet the unmet but growing demand for professional lactation specialists (Li et al, 2019).

## Conclusions

In the UK, the Unicef BFI programme has made enormous strides in imbedding breastfeeding support, skills and services within healthcare settings. Most hospitals and community services in the UK are either fully accredited or are working towards full accreditation. There remains, however, a lack of specialist support for breastfeeding mothers in the NHS.

Specialism in healthcare is an expected norm: a complex fracture will require an orthopaedic surgeon and its rehabilitation the support of specialised physiotherapy. It is curious, then, that where a parent deals with complex lactational issues, expertise in the field is notable in its absence. This is, in part, due to the fact that the need for higher tiered breastfeeding support is not recognised in the healthcare system. It is also because the IBCLC qualification is not yet widely recognised as a quality standard in lactation support. Perhaps less palatable, and more political, is the issue of women's health not being prioritised, with breastfeeding largely viewed as a women's issue and a lifestyle choice.

The specialist breastfeeding clinic was created in an attempt to address shortcomings in breastfeeding support. This experience showcases that in the clinic, women who had faced more complex challenges could, with the right level of support, reach their breastfeeding goals. This starts with the correct identification of the challenge, where the experience and professional qualification of an IBCLC plays a crucial role.

## Key points

- Mothers who face complex breastfeeding problems need specialist lactation care
- The specialist breastfeeding clinic, part of the Merton health visiting team, is embedded in the community and works alongside other health professionals through a referral system
- The clinic is staffed by International Board Certified Lactation Consultants who provide expertise in breastfeeding care
- This service evaluation demonstrates that, with adequate and timely support, most complex breastfeeding issues can be overcome and mothers can continue breastfeeding beyond 6 months
- This model of lactation care could be replicated among other NHS Trusts nationally to improve overall breastfeeding duration rates

During the Covid-19 pandemic, the clinic was one of the few around the UK that remained open and delivered in-person patient care, growing the service to meet the demands from many breastfeeding support drop-ins that had to close. This highlights once more the importance of the service, and the need to find ways to share the learning from the clinic and replicate the model across other NHS Trusts nationally. **JHV**

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