Consultation Report

Nourishing Our Next Generation: A five-year infant feeding strategy for Kent 2024-29

May 2024

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1 Executive Summary

This is the report of a consultation on Nourishing our Next Generation: a five-year infant feeding strategy for Kent 2024-29. The strategy is a partnership between Kent County Council (KCC) and Kent and Medway Maternity and Neonatal System (LMNS). Better Breastfeeding was commissioned by KCC to co-produce the strategy with parents, carers, and professionals during 2023.

The purpose set out in the draft strategy is to help give babies in Kent the best start in life and to support the health and wellbeing of mothers, with a focus on reducing health inequalities. It aims to reduce the barriers to breastfeeding so that mothers can breastfeed for as long as they would like to and to ensure that all mothers and families get the support they need with feeding their babies. The strategy is structured around five themes which are:

1. Ensuring that mothers and families are well informed and well prepared for feeding their babies.
2. Providing the support mothers and families need in the right place and at the right time.
3. Offering seamless support from an integrated and skilled workforce.
4. Involving the wider community.
5. Continuously improving our service as we learn over time.

During the consultation period, we received comments from 55 people directly, as well as some combined feedback from young parents groups visited by KCC staff. Many people had already contributed to the development of the draft strategy, with 394 mothers and 88 staff/volunteers having responded to online surveys during the co-production phase.

1.1 Feedback on the strategy

1. Most respondents found the strategy easy to understand (42 agree, 6 disagree). A few suggested it could be improved by being shorter, more concise and having a lower reading age.
2. Most respondents agree that the strategy clearly sets out what is important to achieve its aims (38 agree, 5 disagree).
3. There is strong support for all five of the strategy's themes and for every objective within those themes.

1.2 Themes arising from the consultation

The following themes were mentioned by at least 3 respondents:

1. Concern about whether the strategy is realistic. Questions are asked about whether there will be sufficient funding, staff time and volunteer hours to implement the strategy. It is suggested that the objectives should be more specific and measurable.
2. Suggestion that the strategy should include more detail about supporting formula feeding, bottle feeding and mixed feeding.
3. Emphasis of the skills and expertise of voluntary sector organisations in relation to infant feeding support and desire to see greater collaboration between the statutory and voluntary sectors.
4. Feeling that the strategy does not sufficiently acknowledge all the services that are already in place or the hard work and commitment of the staff in those services. Suggestions that it could build more on what is working or has worked in the past, such as the Beside You campaign.
5. Concern about recognition of, and payment for, infant feeding expertise and about whether there would be excessive reliance on volunteers in delivering peer support. A call for clarity about the roles of different infant feeding support workers such as breastfeeding counsellors, hospital infant feeding teams and peer supporters.
6. Request for greater clarity about who would deliver antenatal sessions. Suggestions included breastfeeding counsellors, lactation consultants, the voluntary sector, and joint delivery by midwives and health visitors. Suggestion that there is scope for streamlining this offer and reducing duplication.
7. A call for more support to be available by video call or phone call, so that mothers could access support from their own homes.
8. Suggestion that there should be flexibility about the location of support services as Family Hubs may not always be the most accessible location.
9. Suggestion that mothers should be able to self-refer to specialist infant feeding support services, and that a drop-in rather than a fixed-appointment service would better meet the needs of mothers and families.
10. Doubts about whether implementation of quality standards such as the UNICEF UK Baby Friendly Initiative is having the intended effect and calls for this to be reviewed.
11. A call to establish a local milk bank in Kent.

2 The strategy

The purpose of this consultation has been to seek feedback on Nourishing our Next Generation, which is a draft five-year infant feeding strategy for Kent. This draft strategy was co-produced in the second half of 2023 as a partnership between Kent County Council (KCC) and Kent and Medway Maternity and Neonatal System. Better Breastfeeding was commissioned by KCC to support the co-production of the strategy.

The purpose set out in the draft strategy is to help give babies in Kent the best start in life and to support the health and wellbeing of mothers, with a focus on reducing health inequalities. It aims to reduce the barriers to breastfeeding so that mothers can breastfeed for as long as they would like to and to ensure that all mothers and families get the support they need with feeding their babies. The strategy is structured around five themes which are:

1. Ensuring that mothers and families are well informed and well prepared for feeding their babies.
2. Providing the support mothers and families need in the right place and at the right time.
3. Offering seamless support from an integrated and skilled workforce.
4. Involving the wider community.
5. Continuously improving our service as we learn over time.

The strategy supports implementation of the Kent and Medway Integrated Care Strategy. It sets out how KCC will develop support for infant feeding through implementation of Start for Life and the Family Hubs Transformation Programme. It also incorporates system-wide actions for Kent as part of the implementation of Kent and Medway Local Maternity and Neonatal System's Equity and Equality Action Plan.

3 The strategy development process

The strategy has been developed through co-production. Many people have fed into this strategy, through surveys, interviews and co-production meetings.

During the strategy development phase, Better Breastfeeding:

- Interviewed infant feeding leads for maternity, neonatal and community services about the service they currently provide and produced a gap analysis of how the current service compares with expectations in national recommendations and good practice guidelines.
- Conducted a survey of mothers in Kent, which received 394 responses from across all districts.
- Conducted a survey of staff and volunteers who support mothers and families with infant feeding, which received 88 responses.
- Met with multidisciplinary groups of staff and Maternity and Neonatal Voices Partnership (MNVP) service uer chairs to review findings from the gap analysis and surveys and to plan content for the strategy.
- Reviewed findings from other completed and ongoing outreach work including:
    - University of Kent research on barriers to breastfeeding for women in deprived areas
    - Kent and Medway LMNS Equity and Equality Action Plan outreach by community organisations
    - Involve Kent research on the maternity experiences of ethnic minority women in Dartford, Swanley and Gravesham
    - Kent Dads' perinatal support project
    - Perinatal Mental Health and Parent Infant Relationships strategy.

The strategy is structured around themes emerging from our analysis of responses to our surveys, our interviews, meetings and findings from other outreach work. The objectives in the strategy are based on what mothers and staff told us is important and are also informed by national guidance and good practice guidelines, including from UNICEF, NICE and NHS England.

Development of the strategy has been overseen by the Kent Infant Feeding Strategy Group, which brings together staff responsible for commissioning and providing infant feeding support in maternity, neonatal and community settings.

4 The consultation process

The consultation was conducted by KCC and was carried out alongside the consultation for the Nurturing Little Hearts and Minds: a perinatal mental health and parent-infant relationship strategy for Kent 2024-2029.

The consultation ran from 8 February to 3 April 2024.

The consultation was hosted on KCC's Let's talk Kent website. The consultation webpage[1] contained a short introduction, the draft strategy, and Equality Impact Assessment. Feedback was captured via a consultation questionnaire, which was also available in Word and hard copy for those that did not want to or couldn't complete the online version. An Easy Read version of the draft strategy and questionnaire were also available from the website and on request.

Promotional materials (and the website and draft strategy) included details of how to request hard copies and alternative formats. A telephone number and email address were available for queries and feedback.

A consultation stage Equality Impact Assessment (EqIA) was carried out to assess the impact the strategy could have on those with protected characteristics. The EqIA was available as one of the consultation documents and the questionnaire invited respondents to comment on the assessment that had been carried out.

4.1 Promotional activities

There were several activities to promote engagement in the consultation process:

- Staff were available at activity events throughout the consultation period (nine events across the county and one online evening event to support engagement from parents with very young children) to engage with participants about the proposals, answer queries and encourage participation. A recording of the online event was made available from the consultation webpage.
- Across the consultation period many multi-agency partnership meetings were attended to raise awareness of the consultation and share information.
- Young people were engaged directly and had the option of how they participated (for example, questionnaires, group discussion etc).

[1] https://letstalk.kent.gov.uk/start-for-life-strategies

To raise awareness of the consultation and encourage participation, the following activities were undertaken:

- Promotional material sent to Health Visiting service and community-based midwifery.
- Social media and paid Facebook advertising.
- Posters and promotional postcards in Children's Centres / Family Hubs, Youth Hubs, Kent Libraries, and Gateways.
- Emails to stakeholder organisations, including to all early years and childcare providers that operate within the Kent Local Authority area (over 1,700). With reminder sent two weeks before the consultation closed to those who had not yet responded.
- Invite to people registered on Let's talk Kent who had asked to be kept informed about new consultations about 'Children and families' and 'Public health and wellbeing' (7,456).
- E-bulletin for Early Years and Childcare professionals throughout Kent.
- Promotional banner on kent.gov homepage and links to consultation from service pages on Kent.gov
- Articles in KCC's residents' e-newsletter (approx. 7,500 subscribers)
- Briefing to KCC Members and Kent MPs and promoted Town and Parish Councils through the Kent Association of Local Councils (KALC).
- Media release issued at the launch of the consultation.
- Articles on KCC's staff intranet and e-newsletters and email to staff groups.

The consultation webpage had a total of 9,530 visits by 8,676 visitors. Of these:

- 531 downloaded the draft strategy and 28 downloaded the Easy Read version.
- 58 downloaded the Word version of the questionnaire and 13 downloaded the Easy Read questions.
- 36 downloaded the EqIA.
- Most visits to the website were direct from the weblink (4,617) or from social media posts (3,263).

Organic posts from KCC's corporate Facebook and Instagram accounts had a reach of 36,141. There were 252,527 impressions across all KCC's channels (Facebook, X, Instagram, Nextdoor and LinkedIn. Reach refers to the number of people who saw a post at least once and impressions are the number of times the post is displayed on someone's screen. The posts generated 398 clicks through to the consultation webpage. (Not all social media platforms report the same statistics).

Points to note:

- Consultees were given a number of opportunities to provide feedback in their own words throughout the questionnaire. This report includes thematic feedback across consultee responses.
- Feedback received by the KCC team via email has been reviewed for the purpose of analysis and free text comments have been included where applicable in this report.

5 Analysis and methodology

The full questionnaire is included as an appendix.

5.1 Closed (quantitative) question analysis

Respondents were asked closed questions about the strategy as a whole as follows:

- Is the draft Infant Feeding Strategy easy to understand?
- How much do you agree or disagree that the draft infant feeding strategy clearly sets out what is important to support the health and wellbeing of mothers and families with infants, with a focus on reducing health inequalities, in order to give babies in Kent the best start in life?

Respondents were asked a closed question about the strategy's five themes:

- How much do you agree or disagree that the five themes set out in the draft strategy will help to give babies in Kent the best start in life and support the health and wellbeing of mothers?

Each theme contained a number of objectives. Respondents were asked, for each objective, whether they thought it would help to achieve the purpose of that theme:

- How much do you agree or disagree that these objectives will help make sure that mothers and families are well informed and well prepared for feeding their babies?

As the total number of respondents to the questionnaire was 53, the data has been presented as numbers of respondents rather than percentages. As the questions were not mandatory, the number of respondents varies between questions.

5.2 Open (qualitative) question analysis

After each closed question, participants were invited to give more detail about their answer or to share any suggestions.

At the end of the questionnaire, participants were asked three further open questions:

- If there is any further information, details or links that you feel should be included in the final strategy, please provide them in the box below.
- We welcome your views on our equality analysis, including suggestions for anything else we should consider relating to equality and diversity. Please add any comments below.
- If there is anything else you would like to tell us about the draft strategy, please provide your comments in the box below.

Responses to the open questions have been grouped by theme. For the first questions about the whole strategy, these are presented in tables. For the questions

on the themes and objectives, we have provided a narrative outline of the issues raised, indicating how many respondents made each point.

In some cases, points were made in general questions that actually related to a specific objective. We also received some comments by email that were not arranged by theme or objective. To provide a clear overview of the issues raised, comments that relate to a specific theme or objective are analysed under the relevant theme or objective, which may be different to where the respondent actually gave that answer. Where comments were repeated in response to multiple questions, we have briefly indicated that the same point was made.

6 Who we heard from

The following feedback was received in response to the consultation:

- 52 responses to the online questionnaire
- one response to the paper questionnaire (completed by KCC staff on behalf of a young parent)
- two emails from mothers
- one email from KCC, summarising feedback collected in person from young parents

6.1 How people responded to the questionnaire

Response	No. of responses
As a Kent resident	36
As a resident of somewhere else, such as Medway or further afield	1
As a professional working with parents and families in Kent	14
Providing the official response of an organisation, group, or business	1
Total no. of responses	**52**

6.2 Professional roles of respondents

Respondents who selected that they were responding as a professional were asked to select their profession from a list, with the option to select 'Other' and write their profession.

Response	No. of responses
Breastfeeding support staff	2
Infant feeding support staff	1
Children's Centre / Family Hub staff	5
Health Visitor	1
Midwife or student midwife	1
Other: Childhood sleep consultant	1
Other: Engagement and participation officer	1
Other: Communications	1
Other: Infant feeding specialist midwife	1
Total no. of responses	**14**

6.3 How many respondents were parents/carers?

Respondents who selected that they were responding as a Kent resident or a resident of somewhere else were asked if they were a parent or carer.

Response	No. of responses
A parent or carer	30
Pregnant or an expectant parent	1
Neither of these	8
Total no. of responses	**39**

6.4 How did the parents/carers describe their role?

Most of the parents/carers who responded stated that they are a mum, with one saying they are a grandparent.

Response	No. of responses
Mum	30
Grandparent	1
Total no. of responses	**31**

6.5 Age groups of children cared for by respondents

Most of the parents/carers who responded had children under eleven years old, with the most common age group of children cared for being 13-24 months.

Response	No. of responses
Expecting a baby	4
0-2 months of age	1
3-6 months of age	4
7-12 months of age	1
13-24 months of age	17
3-4 years old	9
5-10 years old	11
11-19 years old	1
20 years old and over	1
Total no. of responses	**31**

6.6 Are respondents the primary carer for the child(ren) they regularly care for?

Most of the respondents were the primary carer for the children they regularly care for.

Response	No. of responses
Yes	29
No	2
Total no. of responses	**31**

6.7 How often did respondents use relevant services?

Respondents were asked how frequently they use the following services.

Service	At least once a week	Once a fortnight	Once a month	Twice a year	Less regularly	Used it in the past	Never used this service
Children's Centres / Family Hubs	4	0	4	3	5	14	9
Health Visiting	0	0	2	5	5	19	6
Infant feeding groups e.g. Information on feeding an infant	1	0	0	1	4	18	14
Breastfeeding support e.g. guidance on 'latching on'	0	0	0	1	4	18	15
Specialist infant feeding support e.g. guidance to re-establish breast milk supply	0	0	0	1	4	10	23

6.8 How did respondents use these services?

Those who had used the services had mainly accessed them in person at a building.

Service	In person at a building	Online	Both	I don't use this service	Total no. of responses
Children's Centres / Family Hubs	21	0	1	16	38
Health Visiting	22	1	4	11	38
Infant feeding groups	20	0	1	17	38
Breastfeeding support	17	0	3	18	38
Specialist infant feeding support	12	0	1	25	38

6.9 How often other people in the respondent's household use these services

Respondents were also asked how often other people in their household used the services. Other members of the household were much less likely to have used these services than the respondents themselves.

Service	At least once a week	Once a fortnight	Once a month	Twice a year	Less regularly	Used it in the past	Never used this service
Children's Centres / Family Hubs	0	0	2	1	3	3	25
Health Visiting	0	0	0	3	5	7	20
Infant feeding groups	1	0	0	0	4	0	30
Breastfeeding support	1	0	0	0	4	1	29
Specialist infant feeding support	0	0	1	0	4	1	29

6.10 How other people in the respondent's household use these services

Where other household members had accessed the services, this was in person at a building.

Service	In person at a building	Online	Both	They don't use this service	Total no. of responses
Children's Centres / Family Hubs	7	0	0	27	34
Health Visiting	9	0	0	25	34
Infant feeding groups	1	0	0	33	34
Breastfeeding support	2	0	0	32	34
Specialist infant feeding support	2	0	0	32	34

6.11 Sex of respondents

All respondents who answered this question were female.

Response	No. of responses
Male	0
Female	33
Total no. of responses	**33**

6.12 Gender of respondents

All respondents who answered this question stated that their gender was the same as at birth.

Response	No. of responses
The same as at birth	32
Different from at birth	0
Total no. of responses	**32**

6.13 Age of respondents

Respondents who gave their age where mainly aged 25-49.

Response	No. of responses
0-15	0
16-24	1
25-34	11
35-49	15
50-59	1
60-64	1
65-74	2
75-84	1
85 and over	0
Total no. of responses	**32**

6.14 "Do you regard yourself as belonging to a particular religion or holding a belief?"

Two thirds of respondents to this question did not regard themselves as belonging to a particular religion or holding a belief. The remaining third described themselves as Christian.

Response	No. of responses
Yes	10
No	21
Total no. of responses	**31**

6.15 "Do you consider yourself to be disabled as set out in the Equality Act 2010?"

A fifth of respondents who answered this question stated that they were disabled.

Response	No. of responses
Yes	5
No	25
I prefer not to say	1
Total no. of responses	**31**

Of the five respondents that considered themselves to have a disability:

- three reported learning disability (including neurodivergence),
- one reported a mental health condition, and
- one reported multiple disabilities;
- Physical impairment,
- Sensory impairment (hearing, sight or both),
- Longstanding illness or health condition, such as cancer, HIV/AIDS, heart disease, diabetes or epilepsy,
- Mental health condition,
- Learning disability.

6.16 Ethnicity of respondents

Most of the respondents who gave their ethnicity were white English.

Response	No. of responses
White English	27
Mixed White & Asian	1
White other	1
White British	1
British Iranian	1
Total no. of responses	**31**

6.17 Are you a carer?

One sixth of respondents to this question stated that they are a carer.

Response	No. of responses
Yes	5
No	26
Total no. of responses	**31**

6.18 Sexuality of respondents

Response	No. of responses
Heterosexual/straight	27
Bi/bisexual	1
Gay woman/lesbian	2
Other	1
Total no. of responses	**31**

7 Findings

7.1 Is the draft infant feeding strategy easy to understand?

42 respondents thought that the strategy was easy to understand, while six people thought that it wasn't.

Yes	No	Don't know	Total no. of responses
42	6	3	51

The following suggestions were made for making the strategy easier to understand

Suggestion	Mentions
Make it shorter	3
Lower the reading age	2
Less text, more bullet points and infographics	1
Fewer abbreviations	1
Use less "management speak"	1
"Was not in a format that people with disabilities could access"	1
Translate into community languages (Igbo, Yoruba, Krio, Creole, Punjabi were specifically mentioned)	1
"to be able to provide feedback without having to register anonymously would be helpful for those concerned leaving their details"	1

Comments included:

> "This needs to be shorter and more concise, truly highlighting the main principles that you want parents to comment on." (Professional working with families)

> "The reading age is WAY too high. A quick assessment shows this is at a Level 4 or 5 (National Literacy Trust) which would be PhD level. This is unacceptable for a document that is at LEAST meant to be used by professionals (aim for a level 2) or the general public (reading age average is entry level 3, which is nine-years-old.) … Please get someone to put together this document in a clear, cohesive, and readable way! Otherwise it will be utterly useless." (Mother and professional copywriter)

"Having resources translated to Punjabi and other ethnic minority languages could help those family members with influence such as mothers and grandmothers help to spread the KCC messages to those in need of your services" (Kent resident)

7.2 How much do you agree or disagree that the draft infant feeding strategy clearly sets out what is important to support the health and wellbeing of mothers and families with infants, with a focus on reducing health inequalities, in order to give babies in Kent the best start in life?

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	Total no. of responses
25	13	6	4	1	1	50

Comments from those who strongly agree or tend to agree:

Reason	Mentions
Support for more timely and accessible services	5
The strategy is clearly expressed	3
Challenges of meeting those most in need	3
Agree in principle, some concern about whether effective implementation is realistic	3
Parents need realistic expectations about infant feeding	2
"Recognises that the strategy must be kept up to date and relevant"	1
"You have included both natural and artificial feeding in the strategy"	1
"normalising breastfeeding within the community is integral"	1
Staff attitudes: "we need to do away with that's not my job today attitude and all be willing to support when we can."	1

"there should be local support within a 30 min drive for all parents to seek help" (Childrens centre/family hub staff member)

"I work in an area which is very multicultural we do not have resources in all the languages required, if we want to use a face to face interpreter which is always best practice when supporting a client with breast feeding problems we are challenged about why we want a face to face one. The infant feeding team do not carry out home visits which would benefit some of our clients." (Health visitor)

"Many parents aren't prepared around the norms of frequent feeding, day and night. They are given inaccurate advice and told they have a 'hungry baby' or they need to 'top up' with formula. Or led to believe/diagnosed with undersupply (which is actually extremely rare)… I still think feeding past early infancy carries some stigma from some and unfortunately isn't normalised due to low rates. Imagery in even non related advertising or information would be amazing, with children of varying ages!" (Childhood sleep consultant)

Comments from those who strongly disagree or tend to disagree

Reason	Mentions
Too much emphasis on breastfeeding	2
Strategy unclear/too long	2
The service described is similar to the current service	1

Comments from those who neither agree nor disagree, or who don't know.

Reason	Mentions
Promote choice and support mothers who mixed feed or formula feed as well as those who breastfeed.	1
"You positioned the 'benefits' of breastfeeding, as opposed to the risks of formula feeding. Breastfeeding is the biological norm. The stats need to be flipped."	1
Need more specifics	1
More services needed from professionals, including a 3-6 month health visitor contact.	1

"More services are required from professionals and more money needs to go into professionals such as Health Visitors to provide additional support to universal families, not just offering the 5 mandated contacts but adding a contact at 3-6 months to review how feeding is going and also talk about weaning." (Mother of a 3-6 month old baby)

7.3 How much do you agree or disagree that the five themes set out in the draft strategy will help to give babies in Kent the best start in life and support the health and wellbeing of mothers?

Themes	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	Total no. of responses
Theme 1: Ensuring that mothers and families are well informed and well prepared for feeding their babies.	36	12	2	0	1	0	51
Theme 2: Providing the support mothers and families need in the right place and at the right time.	36	11	3	0	1	0	51
Theme 3: Offering seamless support from an integrated and skilled workforce.	35	13	2	0	1	0	51
Theme 4: Involving the wider community.	31	13	6	0	1	0	51
Theme 5: Continuously improving our service as we learn over time.	38	8	3	1	1	0	51

Please tell us about the reason for your answer (General comments relating to the whole strategy are included here. Comments relating to specific themes are included in the analysis of responses on that theme).

Theme	**Mentions**
Need more specifics/ is it realistic?	5
General agreement with the intentions and how they are expressed	4
Seek expertise from the voluntary sector	2
Connection with parent infant relationship strategy	1
“Please message that bottle feeding is ok!”	1
We are already doing all this	1
This is not a good use of taxpayers’ money	1

There were positive comments stating agreement overall with the themes (three mentions) and that they are expressed clearly (one mention). Some said that more specifics were needed to clarify how the objectives would be achieved (three mentions) and there were questions about where the funding would come from (two mentions).

It was suggested that expertise should be sought from the voluntary sector (two mentions), at a strategic level and in relation to skills needed to support mothers. One respondent pointed out that the parent infant relationship strategy would support the infant feeding strategy as responsive parenting facilitates breastfeeding. Another asked for messaging to state that bottle feeding is OK.

Comments expressing disagreement with the themes were that all of this is already being done (one mention) and that it is not a good use of taxpayers money (one mention).

The following comments included specific suggestions:

> “I think we should have clear targets and suggestions laid out. Changing attitudes to breastfeeding at the moment it just says talk to communities about what they want - I think clearer objectives around this and how this would be monitored would be more useful. I also think clearer objectives around organisations working together would be useful, e.g. every parent informed about Beside You and Kent Baby by their midwife and health visitor, every public building has a Beside You breastfeeding sticker in a public location. These are more tangible and can be tracked and audited to see if they have been implemented.” (Communications professional working with Kent families)

> “Health professionals could really learn from The Lay infant feeding world where the Counselling skills, group facilitation are key. Antenatal classes need to be run by BFC and LC who have had additional training. HV don’t have the skill set. Also where these courses are offered is key. HV who become IBCLC seem to lack the Counselling skills, the supporting families to come to there own conclusion because the have very tight time constraints the 1:2:1 appointment slots are just not working.” (Mother)

7.4 Feedback on the themes and objectives

Theme 1 - Ensuring that mothers and families are well informed and well prepared for feeding their babies

How much do you agree or disagree that these objectives will help make sure that mothers and families are well informed and well prepared for feeding their babies?

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	Total no. of responses
1.1. Make nurseries and schools aware of resources for including breastfeeding in the curriculum.	27	11	7	2	4	0	51
1.2. Provide 1-1 peer support for young and/or vulnerable mothers before their baby arrives.	38	9	2	1	1	0	51
1.3. Provide group learning sessions about infant feeding for mothers to attend before and after they have their baby and make these sessions welcoming for fathers/partners.	41	7	1	1	1	0	51
1.4. Support mothers and families to know how to provide a healthy diet for themselves and their children.	40	6	2	1	2	0	51

1.5. Provide high quality, accessible information for mothers and families about infant feeding and about where they can get support.	44	3	2	1	1	0	51

Comments and suggestions on theme 1

There were four comments supporting the general case for better antenatal support, including reference to one-to-one discussion, information for partners and promoting the benefits of breastfeeding:

> “I think having the information and support in place antenatally is key. There's so much emphasis on having a birth plan, but not a postpartum plan for things that can support you once the baby has arrived.” (Mother)

> “It would have been good to have access to information about infant feeding before giving birth and for my husband to receive the information as well. So we could have more informed discussions about feeding our baby” (Mother)

> “Make feeding information especially around breastfeeding more important antenatally and provide access to peer supporter / lactation specialist for Mums to be to talk to and discuss how hard it is.” (Mother)

> “There is a need for learning about breastfeeding while pregnant and few opportunities to do so. By the time people are pregnant some have already decided not to breast feed so if you wish to widen uptake you need to better disseminate information about it's positive impact for mother and child as these benefits are not widely known.” (Mother)

A young mother commented that she didn’t get any antenatal advice on infant feeding prior to having her baby.

Three members of staff commented that some or all of this work is already happening and one mentioned feeling undermined:

> “Some of this work is already there - we have staff in place e.g. health visitors and midwives and resources like Beside You and Kent Baby with the information there, so how do we get this out to families more effectively? Does the strategy suggest more paid advertising, more staff - what is this above what we already have?” (Communications professional working with Kent families)

> “Your literature and suggestions to parents are very undermining to staff who work hard and give well meaning advice and support” (Midwife or student midwife)

Two respondents commented on the role played by the voluntary sector:

> “Look at what’s already working well in the community.

> “I don't think we should disrupt 3rd sector provision as it works so well in some areas, but it does also potentially create variation in provision across the county.” (Mother)

Two mothers asked that information about formula be included alongside antenatal support for breastfeeding.

Other comments were:

> “Misinformation about wait times and service can be a big factor. Also the heavy advertisement and pressure from the private sector preying on new families, choice is important but conflicts of interest in areas such as midwifery with midwife’s who are also LCs encouraging private appointments and such.” (Infant feeding support staff member)

> “There needs to be huge investment in this.” (Mother)

> “We cannot afford these luxury ideals with the taxes etc levied on us already. Save our roads and infrastructure first.” (Kent resident)

Objective 1.1 Make nurseries and schools aware of resources for including breastfeeding in the curriculum

One mother provided personal experience in support of the objective:

> “I think it's really important to normalise breastfeeding - my children have been breastfed their whole lives but have both learned from nursery to feed the babies/ dolls with bottles as this the "norm". This is of course, a society level change, but with all our services and things set out in this strategy we have some power to change the tide over time.”

Two respondents (an infant feeding specialist midwife and a voluntary organisation) questioned whether the objective is realistic:

> “While I agree that it's important to include learning about the function of breasts, the importance and normality of breastfeeding in everyday learning. Unless it's in the curriculum, it's just something nice to offer that may or may not be taken up in schools and nurseries. It may only be highlighted in schools where teacher have a personal passion or interest in the topic.” (Voluntary sector organisation)

One engagement professional and two mothers questioned the purpose of this objective, the two mothers stating that this is too late to influence parents’ decisions. These respondents appeared not to have understood the intention behind this objective of reaching the next generation of parents:

> “seems a bit too late - you have already tackled breastfeeding by the time you enter these settings with your children”

A grandparent expressed concern about the effect of implementing this objective:

> “I’m not sure info for schools and nurseries is a good idea as this tends to create a lot of half baked experts who often feel the right to interfere, when you will have enough well informed relevant people to help at the right time and place.”

Objective 1.2 Provide 1-1 peer support for young and/or vulnerable mothers before their baby arrives.

Three comments emphasised the value of 1-1 antenatal support, with a suggestion that this should be available to everyone:

> “Agree with antenatal support but personally I think 121s will be more effective than groups - my experience is parents don't ask questions in groups but will open up in 121s.” (Communications professional working with Kent families)

> “Offer 1-1 support to everyone to take up if needed. Some families are not perceived as vulnerable But still need this support” (Mother)

> “Make feeding information especially around breastfeeding more important antenatally and provide access to peer supporter / lactation specialist for Mums to be to talk to and discuss how hard it is.” (Mother)

Three respondents raised issues about the roles of peer supporters, in relation to recruitment, training, retention, payment and skills. One suggested that the family partnership should be funded to provide this antenatal support for vulnerable families:

> “If every expectant family was offered a 121 appointment with a volunteer, the county would need to have the capacity to offer 326 appointments each week. I'm unsure of the numbers of young and/or vulnerable mothers so cannot comment on the numbers for this, but the challenges would then lie in recruiting and training these same Mothers into a voluntary role (which raise additional challenges that are not impossible, but need much more time, money and energy to overcome).” (Voluntary organisation)

> “Yes, absolutely, but will the peer supporters be paid? You are expecting free labour from women and this just isn't acceptable. The peer supporters should also be highly trained, which should also be funded.” (Mother)

> “More money for family partnership so they're able to do 121s with vulnerable families - this is too much for volunteers, they aren't trained to support vulnerable families.” (Communications professional working with Kent families)

Objective 1.3 Provide group learning sessions about infant feeding for mothers to attend before and after they have their baby and make these sessions welcoming for fathers/partners.

One respondent commented on the importance of providing antenatal classes:

> “Increase health visiting workforce to provide effective antenatal support. Mothers retain more information antenatally. More face to face classes / groups regarding feeding are also required antenatally to give mothers information.” (Mother)

Four respondents commented on who should provide these services:

> “Antenatal classes need to be run by BFC and LC who have had additional training. HV don’t have the skill set.” (Mother)

> “THESE CLASSES ALREADY EXIST. A multitude of incredible charities are doing this ALREADY. But they are in severe need of funding, and opportunities to advertise their services. For goodness sake, these charities have been BANNED from putting their leaflets in Kent Hospitals!!” (Mother)

> “Someone has to decide who is best placed to provide antenatal education on behalf of the government and then put all efforts into that. We have a situation at the moment where both KCC and ICB are both paying NHS services to offer antenatal support. Does someone access feeding support classes given by midwifery at Maidstone birthing centre or do they access a class run at a local Children's Centre? Where are people finding out about these classes? What do people want? Why are tax payers paying for both? Are they being accessed and evaluated?” (Voluntary organisation)

> “Try to get providers to work together from the antenatal stage, shared health visitor and midwifery antenatal classes.” (Communications professional working with Kent families)

One respondent welcomed the proposed inclusion of fathers:

> “this would have been amazing to have when I was pregnant as really wanted to breastfeed and my partner had a child from a previous relationship which was bottlefed. He didn't understand all the benefits of breastfeeding so when I was struggling … he kept saying to not worry and bottle feed instead.” (Mother)

Other comments mentioned that classes need to be inclusive, that the location is important, and that there should be separate antenatal and postnatal classes.

Objective 1.4 Support mothers and families to know how to provide a healthy diet for themselves and their children.

Two respondents commented in relation to introducing solids sessions:

> “I attended an introduction to solid foods at a children centre and was the only person that turned up. Maybe remote sessions would be beneficial.” (Mother)

> “I'm worried that this wasn't already happening. Children's Centres have run introducing solids sessions for years, surely they were inviting all families to attend.” (Voluntary organisation)

One respondent commented in relation to Healthy Start vouchers:

> “I've attended meetings for the last 10 years where the plan has been to increase uptake of healthy start vouchers. I'm wondering what the barriers are and why they haven't been discovered yet. Perhaps it is the timing of sessions? or the location? If almost all expectant mothers see midwifery during their pregnancy, perhaps the midwife could ask them to complete the application form there and then.” (Voluntary organisation)

A mother commented about vitamin supplements:

> “would it be a possibility to provide breastfeeding mums with vitamin supplements on prescription whilst they are receiving free prescriptions? I found them so expensive and was struggling on SMP. Also, I had to purchase vitamin D drops for the baby which would have been much preferable on prescription but was told that wasn't an option (I also wasn't advised that was something I should be doing until a health visitor visit at 2 weeks and found it embarrassing like I had failed by not knowing this).” (Mother)

One respondent questioned the value of including this objective:

> “Everyone knows how to have a healthy diet. It's a simple Google. The problem isn't knowledge, it's money. We are in a cost of living crisis, making it impossible for families (even with two incomes) to earn enough to eat a healthy diet. This is a much larger, government issue.” (Mother)

Younger mothers, in conversation with KCC staff, suggested there is a need for support with eating disorders during breastfeeding so that milk supply is protected.

Objective 1.5 Provide high quality, accessible information for mothers and families about infant feeding and about where they can get support.

Young parents, in conversation with KCC staff, stated that they think more information on breastfeeding would be helpful. This was also supported by a respondent to the questionnaire:

> "It would have been good to have access to information about infant feeding before giving birth and for my husband to receive the information as well. So we could have more informed discussions about feeding our baby." (Mother)

Two respondents emphasised that the information is already available:

> "Women have access to lots of information via the internet. They need help knowing whether things are normal/okay and someone there in person to help a baby latch." (Mother)

> "Go to the infant feeding charities - they have an abundance of resources. Have a system in place for signposting to them!!" (Mother)

Other comments were:

> "This will just need to be fully funded as information changes daily." (Voluntary organisation)

> "Place information and resources somewhere it can be easily accessed without having to be requested." (Kent resident)

Theme 2 Providing the support mothers and families need in the right place and at the right time

How much do you agree or disagree that these objectives will help to provide the support mothers and families need in the right place and at the right time?

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	Total no. of responses
2.1. Work towards healthcare professionals having sufficient time to support mothers with feeding their babies.	41	6	3	0	1	0	51
2.2. Enable mothers to access additional support when and where they need it.	44	5	1	0	1	0	51
2.3. Enable breastfeeding mothers to access social support and peer support in a group setting through the Family Hubs programme.	39	7	3	0	2	0	51
2.4. Reduce waiting times for specialist support.	44	4	2	0	1	0	51
2.5. Support those mothers who have difficulty feeding as a result of their baby having a tongue-tie and enable babies who need it to access tongue-tie division without unnecessary delay.	43	5	2	0	1	0	51
2.6. Provide support for mothers who are experiencing breastfeeding grief.	39	6	4	1	1	0	51

2.7. Support mothers to access equipment that will support them with breastfeeding their baby.	40	6	4	0	1	0	51

Comments and suggestions on theme 2

Two respondents stated general support for this theme, with 2 others agreeing the importance of support being offered at the right time:

> “Access to support in a timely fashion is essential. If there is a week's wait it will probably be too late to help at that point” (Mother)

Two further respondents expressed support for the intentions but expressed some doubt about whether it would be implemented:

> “Of course we agree that all of these are important, but worry that they are not always realistic.” (Voluntary organisation)

A young mother reported that she got very little support for infant feeding after her baby was born.

One respondent stated that the objectives are too vague and suggested asking infant feeding charities for relevant research to inform the development of more measurable objectives.

Five respondents emphasised that there should be support available with bottle feeding, formula feeding and mixed feeding, e.g. where a mother is unable to breastfeed or where she chooses to formula feed:

> “There’s not enough support for mothers who have to stop breastfeeding for whatever reason. There’s still a big stigma with health care professionals if you say you are bottle feeding” (Mother)

> “It is a choice!!! If people cannot breast feed it is their choice yes they might be disappointed but it’s only a big thing because the messaging and pressure is so skewed to breastfeeding and bottlefeeding is not seen as a positive choice” (Kent resident)

> “Education on bottlefeeding is also needed, especially around how to begin transitioning babies to bottles as this can be difficult and current breastfeeding services are very reluctant to provide this support.” (Mother)

> “Information about combination feeding is missing from this strategy and it is important that it is included. … I could not find any reliable information when I asked the health visiting team, or online. The health visitors advise you to keep breastfeeding (as per the guidance) and when you stop, they can then give you advice on bottle feeding. … A friend was able to advise me that breastfeeding at the same time every day would help my supply to continue, but I was really afraid my milk supply would stop altogether and I had nowhere to turn to for professional advice.” (Mother)

Three respondents questioned the value of including this objective:

> “Unfortunately we cannot afford these side services.” (Kent resident)

> “This is not a matter for KCC” (Kent resident)

> “most of this should be happening in the outer world.” (Kent resident)

One member of staff emphasised that much of this work is already being done:

> “After baby is born there are baby massage groups, breastfeeding groups, baby groups. Parents come along and receive help and support, build relationships with other new parents and gain confidence through peer support alongside professional support.” (Children’s centre/Family Hub staff)

One respondent suggested that:

> “In the hospital after the baby is born will be the best time to help struggling mothers with breastfeeding/advice.” (Mother)

Young mothers, in conversation with KCC staff, stated that practical info on how to support the weight of the baby’s body when breastfeeding with C-section would be helpful.

Another respondent asked where neonatal care features in the strategy.

Objective 2.1 Work towards healthcare professionals having sufficient time to support mothers with feeding their babies.

One mother emphasised that she would have liked more health visitor support:

> “Email communication or phone communication more often from the health visitors after baby is born. From my experience nobody contacted me after my baby was born. … mothers can feel very lonely and unsure of the care they are providing for their baby.”

Two respondents questioned how realistic this objective is:

> “Healthcare professionals having time to deal with these issues as they arise within existing appointments and touch points is important but potentially not very viable - where is this extra time/ resource going to come from?” (Mother)

> “We can only train so many midwives, because they all need mentors during their training and we only have so many of those. There are huge issues with midwifery training that can't be remedied quickly (funding, childcare, placement availability local). This objective is perhaps more of a ten to twenty year strategy and outside the control of local government.” (Voluntary organisation)

Another respondent suggested that the objective needs to be more specific and measurable:

> “This is utterly vague and silly. 'Work towards them having sufficient time' what does that even mean?! 'Ensure all midwives in Kent dedicate 5 minutes of every ante-natal appointment to preparing the patient for breastfeeding' perhaps? Or maybe 'Every person who has given birth will be given a minimum of 20 minutes breastfeeding support within the first 2 hours of their baby's life, 5 minutes of support every hour for the first 72 hours, and 20 minutes of support every 3 days after that until the baby is 6 weeks old.' Something MEASURABLE would be useful! And based on scientific research! Just ask infant feeding charities - they will already have the data.” (Mother)

Objective 2.2 Enable mothers to access additional support when and where they need it

Five respondents mentioned the importance of mothers being able to access additional support at home, either virtually or in person:

> “WIll you make some support available via zoom or video. Not all people will need a HCP in the room with them” (Kent resident)

> “Online services should be more available with nurse on duty who could pick up a phone call and advice.” (Mother)

> “Relating to the relaxation of mother, I feel the service should be available at home, whether through physical visits or video calls, as mothers won’t feel stressed having to get their newborn baby to appointments and impact on the time that could be spent with skin-to-skin bonding. I feel the number of visits I was asked to attend with my first child seriously impacted the success of our journey.” (Mother)

> “Also, nhs community nursery nurses should be more active as an outreach workers doing home visits especially after baby is born. This way more families will have a chance to see someone face to face.” (Mother)

Two respondents commented about the roles and pay for members of maternity infant feeding teams:

> “Infant feeding teams are needed in the local hospital paid post like Lactation consultants band 6 and infant feeding support workers band 4 look at east Kent and replicate in the other hospital except I feel the room of infant feeding support worker should be a band 4 not three and this is what it is in other areas ie Croydon, Chelsea and Westminster NHS, MTW, Medway.” (Mother)

> “I still have concerns that midwives who are suggesting families seek out additional support are referring to midwifery support workers and volunteers for more specialist help. Where else in the health system do we refer people down the hierarchy for more specialist support. Could we consider paying these people with specialist knowledge and skills more money please? … Infant feeding teams - often the most skilled person in lactation is not used clinically, and then the less skilled are those actually working clinically on the ward. If those staff then become more qualified they are being hugely underpaid. This isn't the best possible system for offering the best support for families.” (Voluntary organisation)

A voluntary sector organisational response stated:

> “I have no experience in the neonatal wards, but I have experienced resistance from staff to a breastfeeding volunteer even delivering flyers. The neonatal teams will have to be very strong and very skilled indeed to go up against the staff and consultants there.”

Objective 2.3 Enable breastfeeding mothers to access social support and peer support in a group setting through the Family Hubs programme.

Two respondents commented generally in favour of more support groups:

> “Fund more infant feeding cafes” (Mother)

> “I would have liked to benefit from a peer support group for breastfeeding mums, as it can be challenging, but you can give each other advice.” (Mother)

Another supported the idea of additional groups for specific needs:

> “Additional support groups across the County for specialist groups such as twins, LGBTQ+ etc would be amazing as numbers may not be high enough for a local in-person group to be helpful.” (Voluntary organisation)

Three respondents commented on the number and location of groups:

> “Women should be able to access social support but do not see the need for it to be in Family Hubs which are not necessarily accessible eg ones that are planned to be in libraries. VCS much better placed to offer this as trusted and easy to access” (Mother)

> “We need group in other areas not just HUBs” (Mother)

> “How will it be decided where to start new groups if areas where we need them the most are those with the lowest breastfeeding rates and those most young/vulnerable mothers who are less likely to advocate for groups or attend Family Hub co-production meetings.” (Voluntary organisation)

Two respondents expressed concern that too much would be expected of volunteers:

> “a peer support team is mentioned here, offering a 48 hour call. A volunteer offering this call worries me a little. There would need to be a really good understanding of what is normal and healthy at this age, a script so that nothing is missed in terms of what a healthy newborn looks like. These peer supporters would need additional training above and beyond the usual to cover this, and they would need to be closely monitored with someone to ask questions of immediately. Would these peer supporters be paid? would they be allowed to work with their children? would they be at home? how would we share data with them? I'm also worrying again about training enough. If 70% initiate breastfeeding of 17K births then we would need to make 32 calls each day of the year. The typical peer supporter might volunteer a couple of hours either weekly or monthly depending on their situation and would usually have a child with them. Wouldn't it be amazing if they were paid peer supporters who were able to have a case load and get to know families throughout their feeding journey.” (Voluntary organisation)

> “I just KNOW you're going to be relying on volunteers with little training. We need well paid, highly trained experts providing this support.” (Mother)

In response to the suggestion that breastfeeding peer supporters attend general baby groups as some younger mothers had found that breastfeeding groups exacerbated feelings of failure, a voluntary organisation commented:

> "I wonder what groups were being talked about, perhaps there needs to be thought into how the groups are run to encourage families to continue to attend once they no longer feel a need for support with problems. … At ___ we often pair mothers together for specific reasons with a positive response. … additional training should be given if they are to be accessing other groups. It's a totally different experience supporting at a breastfeeding group where everyone has come to receive support than attending a group where people may not welcome your attendance."

Another respondent suggested:

> "Rebranding of breastfeeding groups to infant feeding groups to make these more inclusive and encourage normalising breastfeeding." (Mother)

Objective 2.4 Reduce waiting times for specialist support

A comment was made expressing concern about waiting times for support:

> "More needs to be done to make hospital to feeding support in the community seem less without waits of over 2-3 weeks. Urgent referrals made in the Thursday are not being offered appointments until the 10-14 days later." (Mother)

Most comments on this objective focus on how waiting times can be reduced. Two comments ask for more specifics about how this can be done and one asks if there will be additional funding to support this.

A number of suggestions are made including:

- Improving infant feeding support would reduce the need for referrals to specialist support:

  > "I do think specialist support is important but where is the line about who needs that level of support. If support all round was improved hopefully the referrals would decrease." (Infant feeding support staff member)

  > "Not all problems are tongue tie staff need the skills to support families and not just refer to tongue tie services" (Mother)

- Families should be able to self-refer:

  > "Need open access to lactation consultants" (Mother)

  > "We feel that barriers can be removed by allowing families to self-refer" (Voluntary organisation)

- Change the appointment slot system:

  “How can you expect to manage breastfeeding issues with a set appointment rather than open drop ins allowing mums and babies to be relaxed and reviewed at a time that works for them and their baby.” (Mother)

  “HV who become IBCLC seem to lack the Councilling skills, the supporting families to come to there own conclusion because they have very tight time constraints the 1:2:1 appointment slots are just not working.” (Mother)

- Work with the voluntary sector:

  “We welcome conversations to work together with KCC to increase capacity and reduce waiting times. We welcome working together so that we know what might increase/decrease waiting times, help our practitioners to work together, get to know each other and even train together.” (Voluntary sector organisation)

- Issue a referral receipt:

  “There is definitely a barrier due to communication and the crossover between maternity and health visiting. Something as simple as a referral receipt sent to parents could easily overcome this by giving parents proof of referral, as well as information about what will happen next, where they can access support before then and contact information for them to use if they have any questions. This could be totally automated and an amazing, transparent way to run the service, reducing worry and chasing.” (Voluntary organisation)

There was also a comment about the location of specialist clinics:

> “The location of specialist clinics could definitely be improved. We hear from many families that they have to travel great distances to access support with little choice over the options they are given. Families travelling from Edenbridge to Maidstone for a 9am appointment who have children at school as an example. The Maidstone clinic (Molehill Copse) is not near a train station. Many families we see in Tunbridge Wells have been asked to travel to Paddock Wood as a closer option which involves 2 trains. More thought could go in to making sure that specialist services are provided at locations that are more easily accessible for vulnerable families, those without funds, those without cars and those who can't drive due to a c-section.” (Voluntary organisation)

Objective 2.5 Support those mothers who have difficulty feeding as a result of their baby having a tongue-tie and enable babies who need it to access tongue-tie division without unnecessary delay.

There were several suggestions for improving the tongue tie service and some strength of feeling, with one respondent stating:

> "Honestly the tongue tie process could not be any worse than it is currently." (Mother)

Six respondents emphasised the need for waiting times to be reduced:

> "Tongue-tie procedure delay nearly ended my breastfeeding journey. I am sure many mothers have stopped breastfeeding early due to the long waiting list." (Mother)

> "Having tongue-tie services available immediately is so key, as I waited 5 weeks with my son and by this point my nipples were wrecked and my son was so used to working around his tongue-tie that he struggled to ever get out of that habit when breastfeeding." (Mother)

> "Time and again we see families having to ask others to pay for private services because they just cannot wait." (Voluntary organisation)

> "access to timely specialist support, and tongue tie for example, are really important. Lots of people in Kent seem to need to go private to get issues corrected in time; although there is also probably some education around this required - about the fact that it does not always need correcting etc. But there is a perception in many areas that if you have a tongue tie issue you will need to pay to sort it yourself in a timely fashion, which is problematic." (Mother)

There were two comments about the location of tongue tie division services:

> "Tongue tie service is required at DVH families are currently traveling to EKHUFH Ashford or Kent and Canterbury or MTW Pembery hospital this is making one of the poorest demographic have extra travelling costs." (Mother)

> "Those living on the borders are also a challenge in West and North West Kent." (Voluntary organisation)

Other comments relating to support with tongue tie were:

> "Post tongue tie support needs improving. My baby had TT division and there was no support following this and we were left to our own devices. Following the procedure I was not given a comfy room to sit in, just a cupboard to try and feed my baby and did not get any positioning support from staff." (Mother)

> “We would also like to see families being able to access services in Kent above 12 weeks of age.” (Voluntary organisation)

> “As mentioned before, understanding of the process is really important and a receipt sent to parents telling them what the process is once they have been referred would be amazing. Parents often assume the first referral is for the procedure and don't know there will be an additional wait after seeing the infant feeding team within health visiting.” (Voluntary organisation)

> “Yes but this again is too vague.” (Mother)

Objective 2.6 Provide support for mothers who are experiencing breastfeeding grief

Two respondents commented in support of this objective:

> “I didn’t know breastfeeding grief as a concept until reading this consultation, and I think I experienced it – support with this would be helpful.” (Mother)

> “We know that a large percentage of breastfeeding journeys end prematurely, so this could be offered to everyone.” (Voluntary organisation)

Two respondents raised concerns:

> “Maybe dealing with breastfeeding grief (though important) shouldn’t be separated out to make those mothers feel that they are ‘different’” (Mother)

> “2.6 Whilst important, what is the data to show this will improve infant breastfeeding rates? This is more of a mental health issue.” (Mother)

Staff awareness beyond Family Hub staff was mentioned:

> “It's not only Family Hub staff who need to be aware, it is also Health Visitors and Midwives who need to know where to refer. … If we have peer supporters offering antenatal contacts, they would also need additinal training in this area and a place to refer on when necessary.” (Voluntary organisation)

Objective 2.7 Support mothers to access equipment that will support them with breastfeeding their baby.

A voluntary sector organisation provided extensive comments on this objective, making the following points:

- Are the schemes joined up?
- Can we see the outcome of the pilot studies?
- Pumps being available within 24 hours would be fabulous. Currently the process is a little long-winded, there are never enough pumps and families don't know what pump they need or how to access them.
- Is there provision to support families not on Healthy Start vouchers who need help with funding pumps?
- Pumps should be available out of hours and within the community. Could a delivery service be offered for isolated families? (voluntary sector could support this if funded)
- Will the pilot bra scheme continue? How do people learn about the scheme? Most women don't know their size, so pilot results would be interesting.
- If Family Hubs offer a sling hire service, please partner with existing sling libraries across Kent. People running these work really hard and would love to partner with Family Hubs to reach more families.
- Any staff handing out slings or pumps should have additional training to support parents using them safely, comfortably and effectively. They should be supported by a babywearing consultant/breastfeeding specialist for any situations outside of normal.

Other comments on this objective were:

> "Yes, but renting a mother a NHS breastpump is NOT a replacement for deliberate, careful, frequent, in-person support for feed their baby at the breast." (Mother)

> "Nobody informed me of breast shields and when my child was about 2 weeks old I stumbled upon them on a net mums blog. Managed to order one on amazon at 4am and arrived by 11am. It literally changed my experience! Would have been useful to have been recommended this before I left hospital when there was a suspected diagnosis of tongue tie." (Mother)

Theme 3 Offering seamless support from an integrated and skilled workforce

How much do you agree or disagree that these objectives will help to offer seamless support from an integrated and skilled workforce?

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	Total no. of responses
3.1 Continue to implement recognised quality standards in relation to infant feeding.	36	5	6	2	1	0	50
3.2. Expand availability of donor milk to all babies who would benefit from it.	37	7	4	0	1	1	50
3.3. Establish expectations for the peer support service relating to recruitment, training, supervision and integration.	37	4	5	0	1	2	49
3.4. Enable all staff and volunteers to access training and develop the competencies they need to support mothers and families with infant feeding.	38	5	3	0	2	2	50
3.5 Facilitate integration between organisations and across the multidisciplinary team, so that	41	5	2	0	1	1	50

mothers experience a seamless service.							
3.6. Engage with mothers, families and staff to co-create and continually improve infant feeding support services.	37	5	4	0	1	3	50
3.7. Plan support for those in isolated and vulnerable communities.	40	6	2	0	1	1	50
3.8. Develop a plan for providing infant feeding support in emergencies	40	4	3	0	1	2	50

Comments and suggestions on theme 3

Two respondents emphasised the need for more staff:

> “Increase health visiting workforce to allow them time to support families in the community.” (Mother)

> “There are not enough breastfeeding specialists in hospitals and none available to babies born at the weekend. This is not good enough.” (Mother)

Two staff members pointed out the work that is already taking place and the need for this to be recognised:

> “Recognise the work that staff and infant feeding teams are already putting in, tirelessly and relentlessly. Postnatal ward support for breastfeeding is incredibly hard work for midwives and msw / mcas, not to mention very time consuming with a full ward and back breaking and painful, it's a labour of love. It's very very hard work and there is literally no recognition or thanks. Working within unicef baby friendly standards is restrictive enough as it is and the training and updates we receive are already intense.” (Midwife or student midwife)

Other comments on this theme were:

> “This is the crucial part!” (Mother)

> “I do support the whole approach of education but please recognise individual choice and support it.” (Kent resident)

> “We cannot afford this” (Kent resident)

Objective 3.1 Continue to implement recognised quality standards in relation to infant feeding.

There are three comments relating to this objective, all raising concerns about whether it will be effective.

Objective 3.2 Expand availability of donor milk to all babies who would benefit from it.

There were four comments on this objective, all in support.

Three respondents suggested establishing a local milk bank:

> “Could this be expanded to enabling families in Kent being able to donate too? Perhaps a partnership with HeartsMilk Bank to have a local processing and distribution point. This could also be incorporated with the pump programme.” (Voluntary organisation)

> “As far as I am aware, there are no donor milk distributors in Kent; with the nearest ones being in London and maybe Surrey? The London ones are always at capacity but I don't know if Kent families are then benefitting from this so maybe a local run milk bank would be good.” (Mother)

> “I tried to donate my breastmilk as I ended up with so much. There was nowhere available in Kent to take it and I would have loved to have helped other struggling mums.” (Mother)

One respondent made a case for more staff training:

> “I would also like to see better education among healthcare professionals about the use of donor milk and WHO standards. I have personal experience that proves Kent midwives have zero understanding on this topic (unless based on their personal breastfeeding experience).” (Mother)

Objective 3.3 Establish expectations for the peer support service relating to recruitment, training, supervision and integration.

A voluntary organisation response provided extensive comments on this objective, including the career pathway for peer supporters:

> “Wouldn't it be amazing if there was a recognised training pathway for volunteer peer supporter to paid peer supporters, to paid hospital peer supporters to paid midwifery support workers to paid trainee midwives to midwives where paid actually means enough to live on and pay for childcare and food.” (Voluntary organisation)

And challenges of recruiting and training peer supporters:

> “recruitment, training and retention of such a huge volunteer team is a lot of work and I wonder if it's even possible. Peer supporters are generally women of childbearing age, and usually during their maternity leave. This gives us a very niche group to recruit from and very limited amount of time they will be with us for, so turnover is high. I don't think the current training strategy fits this bill, so it will need to be ramped up considerably. Challenges will include working between organisations (hospitals vs. Children's Centres vs. Health Visiting), different roles leading to different situations (no children with them in the hospital as an example). Training might be slightly different for each role. If focusing on different communities, ages, languages then additional training needs may present (lower reading levels, outside of work hours, English as a second language etc). If paid peer supporters require additional training or breastfeeding counsellors become the level required then it would need to be calculated how many would be trained over the next 5 years and how that might work as there are many different training programmes (ABM, BfN, NCT, LLL) and they would take various amounts of time to complete.” (Voluntary organisation)

One respondent commented about who should run the service:

> “HV does not understand peers support this needs to be an outside agency who has proven track record such as PSB or ABM or BFN” (Mother)

Another argued for payment of peer supporters:

> “Yes, absolutely, but will the peer supporters be paid? You are expecting free labour from women and this just isn't acceptable. The peer supporters should also be highly trained, which should also be funded.” (Mother)

Objective 3.4 Enable all staff and volunteers to access training and develop the competencies they need to support mothers and families with infant feeding.

Two respondents commented in favour of all relevant staff having a basic level of understanding around infant feeding:

> “I feel that any professional coming in to contact with a new mother should have a basic understanding of breastfeeding. When in hospital and with the subsequent visits from the community team I was told several times that “I cannot help with breastfeeding”, which is not accessing support when it’s needed and even the most basic training could give that mother confidence to keep trying.” (Mother)

> “All of those working in the perinatal period should have a basic understanding of breastfeeding and infant feeding, but there just isn't the time to give when feeding cannot be observed at an appointment if baby isn't hungry. We are still hearing of staff giving out old and outdated knowledge or just plain incorrect, so is the current training not good enough? Is it missing something? Could it be done differently (experience learning alongside a specialist)? or is it just that some professionals don't have an interest in the subject or just can't know everything about everything.” (Voluntary organisation)

Two respondents mentioned staff personal experience or commented on the suggestion of debriefing for staff, in support of this but also raising some challenges:

> “health professionals may already hold very personal views around infant feeding which do affect their practice. … Training is one thing but passion and professionals working through their own feelings around infant feeding is another. Having attended training sessions where professionals who are supposed to be offering support are still holding a lot of their own breastfeeding grief or that they don’t think it’s important as ‘fed is best’. I think this is a key factor.” (Infant feeding support staff member)

> “It's true that many staff don't have the opportunity to de-brief their own feeding journey and experiences. This in itself would be a big project taking staff away from their work and finding the right people to provide the service. Some might need more time than others and some might be resistant. It may be decided after de-briefing that some staff shouldn't be in their field. How would that be handled?” (Voluntary organisation)

Two respondents supported the principle of hands-off breastfeeding support and consent being sought for physical contact:

> “I fully support the strategy to train all professionals in a consistent approach to breastfeeding and would emphasize focus on professionals who use ‘old-school’ maternity practices (such as manipulating mum and baby to achieve a successful latch) and where there is a refusal to participate in updated practices that they are not allowed to support students. I had a student use very outdated methods to achieve a successful latch with my second child and when I asked if she was taught this in her course she advised that it hadn’t been covered in the course (if this is the case then this should also be a priority in the strategy to look at midwife teaching) and she had been shown by a current practicing midwife.” (Mother)

> “We agree that practitioners should on the most part be hands-off when supporting feeding, and consent should always be in place. We hear about unwanted hands-on situations regularly.” (Voluntary organisation)

Two further suggestions were made for the content of training:

> “I’m so glad to see ‘time’ given to new mums in the strategy, as this is so important to get a mum to feel relaxed and comfortable to achieve a successful latch. Many rooms that women are asked to ‘demonstrate’ their latch in are cold, with upright, uncomfortable chairs and the window of time is minimal. My hallelujah moment with both my children was spending time with breastfeeding specialist __ in her warm, inviting space with comfortable chairs and with __’s relaxed and unhurried approach. It was the first time that relaxing was made so important in the success of the feeding. I’d also like to see the relaxing element written into any literature that is produced for both professionals and the people they support, not just the mechanics.” (Mother)

> “Please message that bottle feeding is ok!” (Kent resident)

Two comments were made about the accessibility of training:

> “I'm wondering how you will enable GP's and Paeds to access training. It's challenging enough for midwives to find the time. There will be costs involved. How will these costs be covered?” (Voluntary organisation)

> “You've got to make training more accessible for those who want to do more and also support their communities. Driven by volunteers. Make more paid positions available to keep these vital feeding support services open.” (Mother)

A comment was made about clarifying competencies of different roles, particularly breastfeeding counsellors and peer supporters:

> “I think first we need to clarify the roles of a volunteer peer supporter, paid peer supporter and breastfeeding counsellor. We have some highly trained breastfeeding counsellors in Kent that would feel undervalued in these descriptions. They are providing specialist breastfeeding support. Within __ [our voluntary organisation] we use lactation consultants and breastfeeding counsellors and pay them the same, offering them the same roles. I'm not sure why a breastfeeding counsellor would be needed to lead a peer support group. It's either a peer support group or a breastfeeding counsellor-led group. This needs to be discussed and decided in co-production with practitioners from all levels. Paid roles need to pay enough for the needs of the role (with or without child as an example). This discussion would then lead to an idea of the recruitment and training that would be needed to cover all the roles described in this strategy - antenatal conversations, 48 hour contacts, hospital wards, community groups, community ambassadors etc.” (Voluntary organisation)

Another respondent suggested that more IBCLCs (lactation consultants) and breastfeeding counsellors could be employed within the NHS:

> “More paid positions utilising the BFC and IBCLC already trained in Kent. Why don’t they want to work in the NHS? There is more than 25 Trainined IBCLCs in Kent and even more BFCs what is the public sector doing to not employ or make it attractive to be employed. FLEXABLE working hours, locations and conditions. Why should these women be giving there time for free they need to be values and recognised for plugging the gaps of the Current NHS services.” Mother

Objective 3.5 Facilitate integration between organisations and across the multidisciplinary team, so that mothers experience a seamless service.

There were two comments in favour of greater integration between the statutory and voluntary sectors, including this from a voluntary organisation:

> “Something else we see is families accessing both health visiting and ___ (our) services for the same reason, This is another reason we would love to work more closely to make sure that families get what they need as that funding isn't wasted. … ___ (we) would like to work together within the local community to offer greater continuity of care and seamless care. We'd love to be involved in the conversation to be able to access and edit infant feeding records so that we can work smarter and not give contradicting information. We'd love to share training with practitioners across the County so that we are all singing from the same hymn sheet and get to know each other. … as a charity, we strive to fill gaps created by the local mandatory services. We do

this only with the support of families and organisations funding our work. Charities and third sector organisations cannot do anything without funding. However, we exist outside of the system for various reasons, and although we would love to work alongside the NHS, would welcome funding and support, the way we work is different for a reason. When the pandemic started we were able to get back up and running almost immediately, starting face to face before a lot of NHS services. We value our independence." Voluntary organisation

One respondent said more focus should be given to the faltering growth pathway:

> "I think more space needs to be given to what you're calling the Faltering Growth pathway. My experience of having a big baby who settled on an inadequate (in the eyes of hcps) growth trajectory was awful. The health visitor, GP and eventually paediatric team at MTW spent 5 months hounding me without offering any practical support (that came from the breastfeeding drop in). I was told more than once to stop breastfeeding, and to wean early to promote weight gain (because a spoonful of carrot would somehow help?) They missed opportunities to actually help because they jumped straight to "stop breastfeeding" - after having very high milk supply with my older child, nobody questioned reasons for low supply (retained placenta which hung around for a month). I was made to feel like a bad mother for persisting with breastfeeding." (Mother)

Objective 3.6 Engage with mothers, families and staff to co-create and continually improve infant feeding support services.

Two comments were made about the challenges of co-production:

> "Co-production is important in every aspect of services. I don't think this has been done well across Kent. I've been involved with MNVP's for many years and not seen co-production done very well. This could be improved in all areas. I've also taken part in Children's Centre meetings and there could definitely be improvements (timing, location, language used, time wasted reduced etc). It really takes a passionate new parent to go out of their way to push for change in their community. It's challenging engaging new parents for consultations and feedback. They are just super busy and don't have time. How can we make this easier?" (Voluntary organisation)

> "Think we can ask parents to feedback on services, quite difficult to get them to actually co-create, there is only so much we can ask of families to contribute time-wise and they dont always understand all the technical reasons we have with IT / IG etc that hold our hands slightly with service delivery and would involve explaining that all the time." Communications professional working with Kent families

Objective 3.7 Plan support for those in isolated and vulnerable communities

Two comments were made about the challenges of supporting those in isolated and vulnerable communities:

> “It's challenging to offer support in areas with low numbers. Are there existing services that people are already attending which could be used. Are there community leaders who could approach their community to determine the local needs? If this is something we are still striving for, yet Children's Centres were supposed to be doing already, then we obviously haven't found the solution yet.” (Voluntary organisation)

> “We have virtual groups in COVID - not sure these were well used - what is the suggestion for isolated and vulnerable communities - unless you train up people and have them working autonomously in areas, they'll always need a staff presence and could be a waste of resources to have staff in remote places without many families living there.” (Communications professional working with Kent families)

One suggestion was made about supporting these communities:

> “Would really like to see inclusion of community transport schemes in helping mothers access support, this is often a huge barrier, particularly in very remote areas,” (Mother)

Objective 3.8 Develop a plan for providing infant feeding support in emergencies.

A voluntary organisation commented in support of this objective:

> “There were a lot of errors during the pandemic, and we should learn from them and should have already started planning for the next time. Yes, we agree that infant feeding is very important and we would hate to go through another pandemic if nothing changes because we had to pick up the pieces and that's how the charity came to be. There does seem to be confusion around formula use and food banks. It's not typically something food banks are encouraged to give out, but when families are referred to health visiting the healthy start programme only covers younger parents and very low incomes. There is a missing piece that needs to be put in place so that formula can be sourced for families in need. Even food banks that are given formula don't know much about safety/preparation/types of formula/special formula/sell by dates etc and this could be extremely dangerous for vulnerable families.”

Theme 4 Involving the wider community

How much do you agree or disagree that these objectives will help to involve the wider community?

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	Total no. of responses
4.1. Encourage early years settings to facilitate breastfeeding and the healthy introduction of solid foods.	34	8	4	1	2	1	50
4.2 Ensure that all NHS and local authority services supporting families are compliant with the World Health Organization Code of marketing of breastmilk substitutes.	37	6	4	1	1	1	50
4.3. Encourage and support businesses and employers to adopt policies and practices that reduce barriers to breastfeeding.	40	4	3	0	2	1	50
4.4. Work with local communities to change attitudes towards breastfeeding.	37	4	6	0	1	1	49

Comments and suggestions on theme 4

One respondent described this theme as “very important”. Another argued that it should not be the top priority:

> “I haven't chosen strongly agree in this section because too often this part is focused on and it feels to me that if we take our eye off the support in the first few weeks, then these other areas are really only helping minimal families. I know it all works together, and we need everything in place for it all to work, but we'll see bigger successes if we focus more on antenatal and the first two weeks.” (Voluntary organisation)

Young mothers, in conversation with KCC staff, reported that they felt uncomfortable at the thought of breastfeeding in public, particularly as a teenager (social pressure, breasts seen as sexual by peers, etc).

A staff member questioned her workplace’s commitment to supporting breastfeeding:

> “Even the breastfeeding room in the hospital is a chair next to the toilets, what does this say about the importance we put on bf” (Midwife or student midwife)

Two staff members emphasised the work that is already happening and felt strongly that this wasn’t being sufficiently recognised:

> “we do have a local normalising breastfeeding campaign Beside You that has been running for some time but this isn't mentioned in the strategy, seems a shame to not include when this campaign is trying to do exactly what you're suggesting. Either it isn't working and needs a rethink or it needs to be built upon and expanded etc.” (Communications professional working with Kent families)

> “Its really frustrating to read a document that outlines proposals for something that is already being implemented and has been for years and years. Its insulting to read a document that outlines proposals that are already successful and in place to support our community.” (Children’s centre/Family Hub staff member)

Other comments on this objective were:

> “ensure mums who formula feed are supported to not just breastfeeding mums” (Mother)

> “Stop wasting money and replace or repair the infrastructure of our communities first” (Kent resident)

Objective 4.1 Encourage early years settings to facilitate breastfeeding and the healthy introduction of solid foods

There were two comments in support of this objective:

> "include knowledge of storing and using breastmilk in nurseries in their training so that it is something normal and accepted in every setting." (Voluntary organisation)

> "Educating nurseries is key. There is a lot of misinformation. Helping them to help mothers continue to feed despite going back to work is essential." (Mother)

Objective 4.2 Ensure that all NHS and local authority services supporting families are compliant with the World Health Organization Code of marketing of breastmilk substitute.

A voluntary organisation commented:

> "We agree that the local authority and NHS should be WHO code compliant. Are there still health professionals still attending courses and conferences sponsored by formula companies?"

Objective 4.3 Encourage and support businesses and employers to adopt policies and practices that reduce barriers to breastfeeding.

There were two comments about support for employers and for parents with returning to work:

> "I'd say that we see most families at __ (our support group) in the first few weeks, then at 4 months and then before going back to work. … This might also be run alongside the education for nurseries mentioned in another section. Education sessions for parents might also be useful in Family Hubs." (Voluntary organisation)

> "With businesses it is also about discussions or that knowledge about breastfeeding when returning to work and in the antenatal workshops it would be too much to have that discussion so maybe further information alongside that already available on the KCHFT sites." (Infant feeding support staff member)

There were four comments about breastfeeding friendly venues:

> “More money should be available for local businesses with IBCLC or BFC educating the owners to help improve the experiences” (Mother)

> “Should be able to access a list of hospitality venues signed up to a breastfeeding friendly scheme online” (Mother)

> “More breasfeeding friendly areas in Kent.” (Mother)

> “I found feeding in cafes was a bit hit and miss. Sometimes the staff were very friendly and would bring drinks over for you and other times you were left to struggle with a baby, buggy and your drinks. In addition furniture wasn't always the most suitable for breastfeeding (especially more uncommon positions). Could you consider producing guidance for local eateries about how to support breastfeeding mothers with furniture choice, customer service etc?” (Mother)

One respondent also made a suggestion about seating in public parks:

> “While breast feeding my daughter I would often pop to a local park but found the environment didn't always support feeding. One thing that was sometimes missing was shaded seating. On a hot summer's day babies feed so much more frequently and at times I struggled to find a bench that was located in the shade during the heat of the day. Is this something that could be considered for all public parks in Kent? Also could tables or shelves near seating be considered so you have somewhere to place drinks and snacks without having to balance them on you precariously?” (Mother)

Objective 4.4 Work with local communities to change attitudes towards breastfeeding.

One respondent commented in favour of this objective:

> “I like the idea of working with community assets/leaders/centres as each area will respond differently to different campaigns. I also feel that the more families that breastfeed lead to more feeding in public, and more people being exposed to breastfeeding and taking this new knowledge in to their family/work, a grass roots effort.” (Voluntary organisation)

Young parents, in conversation with KCC staff, said that they look to peers and family members for guidance on breast or bottle feeding. This demonstrates the relevance of attitudes in the wider community.

One respondent shared personal experience of being affected by attitudes from members of the public:

> “I never felt ashamed to be breastfeeding in public except for one time when someone (a female I should add!) looked me up and down in disgust. I also had trouble on one occasion on a bus when someone sat next to me and asked me to move the baby (again a female), I explained that I couldn't as they were feeding and pointed to other available seats but they wanted to remain in that seat. Another passenger on the bus (oddly a male) ended up getting involved and telling the woman to stop being ridiculous and move.” (Mother)

Another respondent suggested that this needs its own strategy:

> “how do you work with communities to change attitudes to breastfeeding - I feel this needs a strategy of its own its so big.” (Communications professional working with Kent families)

Theme 5 Continuously improving our service as we learn over time

How much do you agree or disagree that these objectives will help to continuously improve our service as we learn over time?

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	Total no. of responses
5.1. Provide effective oversight for implementation of the strategy through the Family Hubs Programme and the Infant feeding Steering Group	34	8	3	2	2	1	50
5.2. With engagement through the Kent and Medway Integrated Care Board, ensure resources are in place to support the implementation of the infant feeding strategy	37	7	2	2	1	1	50
5.3. Conduct a health equity audit to inform the implementation of the strategy.	34	11	1	2	1	1	50
5.4. Develop information sharing	36	8	1	1	1	2	49

agreements to centrally gather data from providers to inform the implementation of the strategy and to evaluate progress.							
5.5. Keep the strategy relevant and up-to-date.	37	7	1	1	1	1	48

Comments and suggestions on theme 5

One respondent commented on the timing of the strategy:

> "When it states about developing the strategy through the Family Hub model, surely this should have been put in place before the Family hubs are put in place as they are in place now and changes to service is happening." (Children's centre/Family Hub staff member)

Two themes were reiterated from earlier responses:

- Need for recognition of work already being done
- Concern that this is not the best use of taxpayers' money.

Objective 5.1 Provide effective oversight for implementation of the strategy through the Family Hubs Programme and the Infant feeding Steering Group

Three comments about oversight of the implementation phase focused on service user input and leadership:

> "I'm excited to see how this plays out once we start thinking about implementation. We still don't have users on the steering group though. Are there users on the ICB?" (Voluntary organisation)

> "Someone (a person/body) needs to take responsibility and ownership of this. Suggestions for improvement should be taken directly to this body. It is too easy for the issue to fall through the the gaps." (Mother)

> "This needs to be led by people passionate about its success." (Mother)

Objective 5.2 . With engagement through the Kent and Medway Integrated Care Board, ensure resources are in place to support the implementation of the infant feeding strategy

One respondent commented on this objective:

> “This will be one to watch. There doesn't seem to be an actual budget for this strategy and yet it will taken 1000's of people hours to implement and 100's of volunteers and staff will need to be recruited. Definitely a challenge. This whole strategy could fail based on this one part.” (Voluntary organisation)

Objective 5.3 Conduct a health equity audit to inform the implementation of the strategy.

One respondent commented on this objective, in favour and raising an issue about location of services:

> “This is a really important piece of work that needs to be done for all areas of Kent. Breastfeeding is slightly different to other public health issues in that you may need more support in areas or less deprivation because more people will breastfeed and numbers are just greater. This needs to be taken into account, as in areas of less deprivation, children's centres are more likely to have closed.” (Voluntary organisation)

Objective 5.4 Develop information sharing agreements to centrally gather data from providers to inform the implementation of the strategy and to evaluate progress.

There were two comments in favour of this objective:

> “Yes please come up with a streamlined robust monitoring system” (Kent resident)

> “We are really excited to see more breastfeeding data for Kent. It would be amazing to have more district level data published which can help drive this strategy implementation.” (Voluntary organisation)

Objective 5.5 Keep the strategy relevant and up-to-date.

There was one comment in favour of this objective:

> “It's important that the steering group continue and that we reassess regularly as we decide that something is or isn't working as intended.” (Voluntary organisation)

7.5 General comments

Respondents were asked two general questions at the end of the questionnaire:

- If there is any further information, details or links that you feel should be included in the final strategy, please provide them in the box below. If your suggestion relates to a specific section in the strategy, please provide details.
- Anything else? If there is anything else you would like to tell us about the draft strategy, please provide your comments in the box below. If your suggestion relates to a specific section in the strategy, please provide details.

Points not already covered earlier in the report are set out in this section:

There were five suggestions of issues to consider relating to support for mothers and families:

> “the need to monitor and safeguard mothers through this difficult hormonal period and transition. It can be a hormonal minefield especially when lacking weeks of sleep and needs high standards of care linked to the correct mental health support . Domestic and emotional support IE Homestart , is highly under rated. These situations often needs just domestic or emotional support and not the stigma and often intrusiveness of medication, and inconvenience imposed by mental health services and problems accessing them with a hard domestic situation and children. Generally where mothers are beginning to struggle and only Mild to moderate PND symptoms emerge, mothers prefer this and holistic therapies and time out from the domestic pressures. See British Psychological Society 2018 executive summary.” (Grandparent)

> “domestic abuse around birth and breastfeeding - opportunities for coercive control” (Kent resident)

> “Right now families can’t afford baby milk at its extortionate price and this should be subsidised. Not all mothers can cope with breastfeeding especially long term for a multitude of reasons and familes are going without to pay for babymilk! At 9 months old this costs a fortune.” (Grandparent)

> “Liaison and communication between all professionals , family and all concerned is crucial, and sensitivity to where some traditional family members IE dads, may not want to get heavily involved and mothers prefer it that way.” (Grandparent)

> “A focus on improving perceptions of 'extended' breastfeeding amongst all services. I experienced negative attitudes from early years settings who told me I needed to reduce breastfeeding to enable my daughter to settle into nursery (aged on 10 months!) and then also from A&E staff who told me extended breastfeeding was 'wrong' and clearly the reason why my 2 year old was 'clingy'. Absolutely shocking and disheartening. I learnt to just not

disclose that I was still breastfeeding (my daughter self weaned at the age of 3 years 10 months)" (Mother)

There were two further comments about bottle feeding:

> "This is a breastfeeding strategy, not infant feeding. Very little mention of weaning and bottle feeding. Not one image of a baby being bottle fed or eating solids. Why not just call it what it is. I am not against the overall importance of supporting women to breastfeed, but commissioning a breastfeeding organisation to develop a feeding strategy was always going to result in a very BF heavy strategy." (Mother)

> "Thank you it is the first time I have been able to share my views on infant feeding. I am not at all a anti-breast feeding at all but I am pro-choice! :) I do think there are some people that don't think they would be successful but are with support and this should definitely be encouraged. Those that struggle should be supported through positive choices which are right for them so they can put their other resources into their babies development. My daughter came on leaps and bounds when I stopped worrying about the feeding and she was a happy healthy bottle fed child." (Kent resident)

There were six comments asking for aspects of existing services to be recognised and built on. These were:

Beside you:

> "Utilise Beside You to provide information and support as part of the strategy." (Infant feeding support staff member)

> "Can we use local imagery, Beside You has lots of photography that we could use featuring local families in Kent. Not sure why we are using stock images when we have that." (Communications professional working with Kent families)

NHS services:

> "it would be good to know what's currently working or what has worked in the past and be able to have that as a starting point and go from there rather than completely changing everything again." (Voluntary organisation)

Voluntary sector:

> "Honestly, you need to consult with existing infant feeding charities that have literally done all of this research for YEARS. These organisations are packed with highly trained experts who simply need to be consulted, funded, and empowered to make large-scale change." (Mother)

> “Inclusion of the VCS is vital, very trusted by individuals who use those organisations and much more flexible and agile in offering services, don't have to adhere to lots of red tape or long processes to get things set up.” (Mother)

Respondents were asked for any comments on the Equality Impact Assessment, including suggestions for anything else that should be considered relating to equality and diversity.

There were five comments on this section:

> “consider intersectionality” (Kent resident)

> “Yes please include transgender people” (Kent resident)

> “Sex based language makes this very clear and understandable.” (Mother)

> “We have reduced access to services by closing children's centres. I'm sure this has only reduced access for those protected characteristics.” (Voluntary organisation)

> “Please the best person for the job , not filling a quota” (Kent resident)

8 Conclusions

8.1 Feedback on the strategy

1. Most respondents found the strategy easy to understand (42 agree, 6 disagree). A few suggested it could be improved by being shorter, more concise and having a lower reading age.
2. Most respondents agree that the strategy clearly sets out what is important to achieve its aims (38 agree, 5 disagree).
3. There is strong support for all five of the strategy's themes and for every objective within those themes.

8.2 Themes arising from the consultation

The following themes were mentioned by at least 3 respondents:

1. Concern about whether the strategy is realistic. Questions are asked about whether there will be sufficient funding, staff time and volunteer hours to implement the strategy. It is suggested that the objectives should be more specific and measurable.
2. Suggestion that the strategy should include more detail about supporting formula feeding, bottle feeding and mixed feeding.
3. Emphasis of the skills and expertise of voluntary sector organisations in relation to infant feeding support and desire to see greater collaboration between the statutory and voluntary sectors.
4. Feeling that the strategy does not sufficiently acknowledge all the services that are already in place or the hard work and commitment of the staff in those services. Suggestions that it could build more on what is working or has worked in the past, such as the Beside You campaign.
5. Concern about recognition of, and payment for, infant feeding expertise and about whether there would be excessive reliance on volunteers in delivering peer support. A call for clarity about the roles of different infant feeding support workers such as breastfeeding counsellors, hospital infant feeding teams and peer supporters.
6. Request for greater clarity about who would deliver antenatal sessions. Suggestions included breastfeeding counsellors, lactation consultants, the voluntary sector, and joint delivery by midwives and health visitors. Suggestion that there is scope for streamlining this offer and reducing duplication.
7. A call for more support to be available by video call or phone call, so that mothers could access support from their own homes.
8. Suggestion that there should be flexibility about the location of support services as Family Hubs may not always be the most accessible location.

9. Suggestion that mothers should be able to self-refer to specialist infant feeding support services, and that a drop-in rather than a fixed-appointment service would better meet the needs of mothers and families.
10. Doubts about whether implementation of quality standards such as the UNICEF UK Baby Friendly Initiative is having the intended effect and calls for this to be reviewed.
11. A call to establish a local milk bank in Kent.

8.2 Other suggestions made (not already addressed in the strategy)

1. Review access to interpreting for health visiting
2. Include imagery of breastfeeding past infancy in non-related Kent materials
3. Present the statistics in the strategy in terms of the risks of formula-feeding rather than the benefits of breastfeeding, on the basis that breastfeeding is the biological norm.
4. Offer antenatal 1-1 support to all parents as some are not perceived as vulnerable but still need the support.
5. Fund the Family Partnership to provide antenatal support for vulnerable families.
6. Midwives to complete Health Start application with eligible mothers antenatally.
7. Offer vitamin supplements on prescription for breastfeeding mothers and babies.
8. Provide support for those experiencing eating disorders during pregnancy.
9. Make the role of an infant feeding support worker a band 4 not a band 3.
10. Rebrand breastfeeding groups to be infant feeding groups.
11. Issue a referral receipt when a mother is referred for specialist infant feeding support, so that she has confirmation of the referral and knows where to seek support in the meantime and how to ask any questions.
12. Set up a tongue tie division service at Darent Valley Hospital.
13. Provide a comfortable room and breastfeeding support immediately after tongue tie division.
14. Can the outcomes of the pilot studies to loan breastfeeding equipment from Family Hubs be made available?
15. Provide a breast-pump delivery service for isolated families.
16. Partner with existing sling libraries if the Family Hubs offer a sling hire service.

17. Ensure staff giving out pumps or slings have ongoing training and are supported by specialists.
18. To include in staff training the importance of relaxation in supporting mothers to breastfeed.
19. Make use of community transport schemes to support isolated communities.
20. Produce guidance for local eateries about how to support breastfeeding mothers with furniture choice, customer service, etc.
21. Consider the needs of parents feeding their babies when planning seating in public parks.
22. Provide district-level data.
23. Include reference to domestic abuse around birth and breastfeeding.
24. Subsidise the cost of formula for families.

Appendix: Consultation Questionnaire

(Excluding Section 2 which related to a separate strategy and is not relevant to this report).

KCC is consulting on two draft strategies, which have been co-created with parents, families and partners as part of our activity to support and inform families to enable their infants to have the best start in life. The strategies are:

- Nurturing little hearts and minds – a perinatal mental health and parent-infant relationship strategy for Kent 2024-2029.
- Nourishing our next generation – a 5-year infant feeding strategy for Kent 2024-2029

Drafts of both strategies are available from the consultation webpage www.kent.gov.uk/startforlifestrategies

We have provided this questionnaire for you to give your feedback. Your responses will help us to finalise the strategies before they are agreed and adopted by KCC.

This questionnaire can be completed online at www.kent.gov.uk/startforlifestrategies.

If you are unable to complete the questionnaire online, please complete this Word/paper form and return it to:

- **Email:** startforlife@kent.gov.uk
- **Address:** Start for Life Strategies, Public Health Office, Sessions House, County Hall, Maidstone ME14 1XQ

You can answer all or as many of the questions as you like. If you would rather not provide feedback on both strategies, a section or question, just move on to the next one.

Please do not include any personal information that could identify you or anyone else in your responses.

If you need any help taking part in this consultation or have any questions, please contact us at startforlife@kent.gov.uk.

Please ensure your response reaches us by midnight on Wednesday 3 April 2024.

Alternative formats: If you require any of the consultation material in an alternative format or language, or Large Print copies, please email: alternativeformats@kent.gov.uk or call: 03000 42 15 53 (text relay service number: 18001 03000 42 15 53). This number goes to an answering machine, which is monitored during office hours.

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Section 1 – About you

Q1. Please tell us how you are responding to this consultation.

Please select the option from the list below that most closely represents how you are responding to this consultation. Select **one** option.

- ☐ As a Kent resident
- ☐ As a resident from somewhere else, such as Medway or further afield
- ☐ As a professional working with parents and families in Kent
- ☐ As a professional working with parents and families outside of Kent, such as Medway or further afield
- ☐ Providing the official response of an organisation, group, or business
- ☐ Other, please tell us:

Q1a. If you are a professional working with parents and families, please select from the list below your profession. Select **one** option.

- ☐ Breastfeeding support staff
- ☐ Infant feeding support staff
- ☐ Children's Centre / Family Hub staff
- ☐ General Practitioner (GP)
- ☐ Health Visitor
- ☐ Perinatal Mental Health Worker
- ☐ Midwife or student midwife
- ☐ Community Nursery Nurse
- ☐ Children's Social Worker
- ☐ Other, please tell us:

Q1b. If you are providing the official response of an organisation, group, or business or responding as a professional, please tell us the name of your organisation:

If you are responding as a professional or on behalf of an organisation, you do not need to answer questions 2, 3, and 4 please go to question 5.

If you are responding as a resident, please continue to question 2.

Q2. Are you …? Select **one** only. When we say 'parents or carers' we mean any person who looks after a baby regularly.

- ☐ A parent or carer
- ☐ Pregnant or an expectant parent
- ☐ Neither of these, please go to question 3

Q2a. If you are a parent / carer or pregnant / expectant parent, which of the following best describes your role? Select **one** only.

- ☐ Mum
- ☐ Dad
- ☐ Adoptive parent
- ☐ Co-parent
- ☐ Foster carer
- ☐ Grandparent
- ☐ Step-parent
- ☐ I prefer not to say
- ☐ Other, please tell us

Q2b. Please select the age group(s) for the child(ren) that you regularly care for:

Select **all** that apply.

- ☐ **Expecting a baby**

- [ ] 0-2 months of age
- [ ] 3- 6 months of age
- [ ] 7-12 months of age
- [ ] 13-24 months of age
- [ ] 3-4 years old
- [ ] 5-10 years old
- [ ] 11-19 years old
- [ ] 20 years old and over

Q2c. Are you the primary parent / carer for the child(ren) you regularly care for? Select **one** option. By 'primary' we mean the parent / carer with whom the child or children spends the majority of their time.

- [ ] Yes
- [ ] No

Q3. Please tell us how often <u>you</u> use the services listed below.

There will be another question later in this section where you can tell us which services other people in your household use. Select **one** option per row / service.

Service	At least once a week	Once a fortnight	Once a month	Twice a year	Less regularly	Used it in the past	Never used this service
Children's Centres / Family Hubs							
Health Visiting							
Infant feeding groups e.g. information on feeding an infant							
Breastfeeding support e.g. guidance on 'latching on'							
Specialist infant feeding support e.g. guidance to reestablish breast milk supply							
Specialist perinatal mental health services e.g. support from a specialist community PNMH nurse / midwife							
Perinatal mental health advice / support e.g. accessed a local helpline or talked to							

staff in the health visiting service							

Q3a. Please tell us how <u>you</u> use these services.

Select **one** option per row / service.

Service	In person at a building	Online	Both	I don't use this service
Children's Centres / Family Hubs				
Health Visiting				
Infant feeding groups				
Breastfeeding support				
Specialist infant feeding support				
Specialist perinatal mental health services				
Perinatal mental health advice / support				

Q4. Please tell us how often <u>other people</u> in your household use the services listed below.

Select **one** option per row / service.

Service	At least once a week	Once a fortnight	Once a month	Twice a year	Less regularly	Used it in the past	Never used this service
Children's Centres / Family Hubs							
Health Visiting							
Infant feeding groups							
Breastfeeding support							

Specialist infant feeding support							
Specialist perinatal mental health services							
Perinatal mental health advice / support							

Q4a. Please tell us how <u>other people</u> in your household use these services.

Select **one** option per row / service.

Service	In person at a building	Online	Both	They don't use this service
Children's Centres / Family Hubs				
Health Visiting				
Infant feeding groups				
Breastfeeding support				
Specialist infant feeding support				
Specialist perinatal mental health services				
Perinatal mental health advice / support				

Q5. Please tell us the first five characters of your postcode: ☐

Please do not reveal your whole postcode. If you are responding on behalf of an organisation, please use your organisation's postcode. We use this to help us to analyse our data. It will not be used to identify who you are.

Section 2 – The draft Perinatal Mental Health (PNMH) and Parent-Infant Relationship (PIR) Strategy for Kent

(This section is not included here as it is not relevant to this report.)

Section 3 – The draft Infant Feeding Strategy for Kent

Q15. Is the draft Infant Feeding Strategy easy to understand?

Select **one** option.

- ☐ Yes
- ☐ No
- ☐ Don't know

Q15a. If you have any suggestions on how to make the strategy easier to understand, please tell us.

If your suggestion relates to a specific section/page please provide details.

Q16. How much do you agree or disagree that the draft infant feeding strategy clearly sets out what is important to support the health and wellbeing of mothers and families with infants, with a focus on reducing health inequalities, in order to give babies in Kent the best start in life? Select **one** option.

- ☐ Strongly agree
- ☐ Tend to agree
- ☐ Neither agree nor disagree
- ☐ Tend to disagree
- ☐ Strongly disagree
- ☐ Don't know

Q16a. Please tell us about the reason for your answer.

If your suggestion relates to a specific section / page, please provide details in your answer.

The draft strategy sets out five themes:

Theme 1: Ensuring that mothers and families are well informed and well prepared for feeding their babies

Theme 2: Providing the support mothers and families need in the right place and at the right time

Theme 3: Offering seamless support from an integrated and skilled workforce

Theme 4: Involving the wider community

Theme 5: Continuously improving our service as we learn over time

Q17. How much do you agree or disagree that the five themes set out in the draft strategy will help to give babies in Kent the best start in life and support the health and wellbeing of mothers?

Select **one** option for each theme/row. You will be given the opportunity to provide feedback on each of the themes individually later in the questionnaire.

Themes	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
Theme 1: Ensuring that mothers and families are well informed and well prepared.						
Theme 2: Supporting mothers and families need in the right place and at the right time.						
Theme 3: Offering seamless support from an integrated and skilled workforce.						
Theme 4: Involving the wider community.						
Theme 5: Continuously improving our service as we learn over time.						

Q17a. Please tell us about the reason for your answer.

If your suggestion relates to a specific theme / page, please provide details in your answer.

Theme 1 - Ensuring that mothers and families are well informed and well prepared

Pages 15-18 of the draft strategy set out what we will do to achieve theme 1.

Q18. How much do you agree or disagree that these objectives will help make sure that mothers and families are well informed and well prepared for feeding their babies?

Select **one** option for each objective / row.

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
1.1. Make nurseries and schools aware of resources for including breastfeeding in the curriculum.						
1.2. Provide 1-1 peer support for young and/or vulnerable mothers before their baby arrives.						

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
1.3. Provide group learning sessions about infant feeding for mothers to attend before and after they have their baby and make these sessions welcoming for fathers/partners.						
1.4. Support mothers and families to know how to provide a healthy diet for themselves and their children.						
1.5. Provide high quality, accessible information for mothers and families about infant feeding and about where they can get support.						

Q18a. Do you have any comments or suggestions on the objectives for theme 1?

If your comment / suggestion relates to a specific objective, please provide details in your answer.

Theme 2 - Providing the support mothers and families need in the right place and at the right time

Pages 19-25 of the draft strategy set out what we will do to achieve theme 2.

Q19. How much do you agree or disagree that these objectives will help to provide the support mothers and families need in the right place and at the right time?

Select **one** option for each objective / row.

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
2.1. Work towards healthcare professionals having sufficient time to support mothers with feeding their babies.						
2.2. Enable mothers to access additional support when and where they need it.						
2.3. Enable breastfeeding mothers to access social support and peer support in a group setting through the Family Hubs programme.						
2.4. Reduce waiting times for specialist support.						
2.5. Support those mothers who have difficulty feeding as a result of their baby having a tongue-tie and enable babies who need it to access tongue-tie division without unnecessary delay.						

2.6. Provide support for mothers who are experiencing breastfeeding grief.						
2.7. Support mothers to access equipment that will support them with breastfeeding their baby.						

Q20a. Do you have any comments or suggestions on the objectives for theme 2?
If your comment / suggestion relates to a specific objective, please provide details in your answer.

Theme 3 - Offering seamless support from an integrated and skilled workforce

Pages 26-33 of the draft strategy set out what we will do to achieve theme 3.

Q21. How much do you agree or disagree that these objectives will help to offer seamless support from an integrated and skilled workforce?

Select **one** option for each objective / row.

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
3.1 Continue to implement recognised quality standards in relation to infant feeding.						
3.2. Expand availability of donor milk to all babies who would benefit from it.						
3.3. Establish expectations for the peer support service relating to recruitment, training, supervision and integration.						

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
3.4. Enable all staff and volunteers to access training and develop the competencies they need to support mothers and families with infant feeding.						
3.5 Facilitate integration between organisations and across the multidisciplinary team, so that mothers experience a seamless service.						
3.6. Engage with mothers, families and staff to co-create and continually improve infant feeding support services.						
3.7. Plan support for those in isolated and vulnerable communities.						
3.8. Develop a plan for providing infant feeding support in emergencies.						

Q21a. Do you have any comments or suggestions on the objectives for theme 3?

If your comment / suggestion relates to a specific objective, please provide details in your answer.

Theme 4 - Involving the wider community

Pages 34-36 of the draft strategy set out what we will do to achieve theme 4.

Q22. How much do you agree or disagree that these objectives will help to involve the wider community?

Select **one** option for each objective / row.

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
4.1. Encourage early years settings to facilitate breastfeeding and the healthy introduction of solid foods.						
4.2 Ensure that all NHS and local authority services supporting families are compliant with the World Health Organization Code of marketing of breastmilk substitute.						
4.3. Encourage and support businesses and employers to adopt policies and practices that reduce barriers to breastfeeding.						
4.4. Work with local communities to change attitudes towards breastfeeding.						

Q22a. Do you have any comments or suggestions on the objectives for theme 4? If your comment / suggestion relates to a specific objective, please provide details in your answer.

Theme 5 - Continuously improving our service as we learn over time

Pages 37-39 of the draft strategy set out what we will do to achieve theme 5.

Q23. How much do you agree or disagree that these objectives will help to continuously improve our service as we learn over time? Select **one** option for each objective / row.

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
5.1. Provide effective oversight for implementation of the strategy through the Family Hubs Programme and the Infant Feeding Steering Group						
5.2. With engagement through the Kent and Medway Integrated Care Board, ensure resources are in place to support the implementation of the infant feeding strategy						
5.3. Conduct a health equity audit to inform the implementation of the strategy.						
5.4. Develop information sharing agreements to centrally gather data from providers to inform the implementation of the strategy and to evaluate progress.						

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don’t know
5.5. Keep the strategy relevant and up-to-date.						

Q23a. Do you have any comments or suggestions on the objectives for theme 5?
If your comment / suggestion relates to a specific objective, please provide details in your answer.

Q24. If there is any further information, details or links that you feel should be included in the final strategy, please provide them in the box below.

If your suggestion relates to a specific section in the strategy, please provide details.

We have completed an initial Equality Impact Assessment (EqIA) for the draft Infant Feeding Strategy for Kent.

An EqIA is a tool to assess the impact any proposals would have on the protected characteristics: age, disability, sex, gender reassignment, sexual orientation, race, religion or belief, and carer's responsibilities. The EqIA is available online at www.kent.gov.uk/startforlifestrategies or in hard copy on request.

Q25. We welcome your views on our equality analysis, including suggestions for anything else we should consider relating to equality and diversity. Please add any comments below.

Anything else?

Q26. If there is anything else you would like to tell us about the draft strategy, please provide your comments in the box below.

If your suggestion relates to a specific section in the strategy, please provide details.

Section 4 – More about you

We want to make sure that everyone is treated fairly and equally, and that no one gets left out. That's why we are asking you these questions. We will use this information only to help us make decisions and improve our services.

If you would rather not answer any of these questions, you don't have to.

It is not necessary to answer these questions if you are responding on behalf of an organisation.

Q27. Are you…? Select **one** option.

- ☐ Male
- ☐ Female
- ☐ I prefer not to say

Q28. Is your gender the same as at your birth? Select **one** option.

- ☐ Yes
- ☐ No
- ☐ I prefer not to say

Q29. Which of these age groups applies to you? Select **one** option.

0-15	☐	16-24	☐	25-34	☐	35-49	☐	50-59	☐
60-64	☐	65-74	☐	75-84	☐	85+ over	☐	I prefer not to say	☐

Q30. Do you regard yourself as belonging to a particular religion or holding a belief? Select **one** option.

- [ ] Yes
- [ ] No
- [ ] I prefer not to say

Q30a. If you answered 'Yes' to Q30, which of the following applies to you? Select **one** option.

- [ ] Christian
- [ ] Buddhist
- [ ] Hindu
- [ ] Jewish
- [ ] Muslim
- [ ] Sikh
- [ ] Other
- [ ] I prefer not to say

If you selected Other, please specify:

The Equality Act 2010 describes a person as disabled if they have a long standing physical or mental condition that has lasted, or is likely to last, at least 12 months; and this condition has a substantial adverse effect on their ability to carry out normal day-to-day activities. People with some conditions (cancer, multiple sclerosis, and HIV / AIDS, for example) are considered to be disabled from the point that they are diagnosed.

Q31. Do you consider yourself to be disabled as set out in the Equality Act 2010?
Select **one** option.

- ☐ Yes
- ☐ No
- ☐ I prefer not to say

Q31a. If you answered 'Yes' to Q31, please tell us the type of impairment that applies to you.

You may have more than one type of impairment, so select all that apply. If none of these applies to you, select 'Other' and give brief details of the impairment you have.

- ☐ Physical impairment
- ☐ Sensory impairment (hearing, sight or both)
- ☐ Longstanding illness or health condition, such as cancer, HIV / AIDS, heart disease, diabetes or epilepsy
- ☐ Mental health condition
- ☐ Learning disability
- ☐ I prefer not to say
- ☐ Other

Other, please specify:

Q32. **To which of these ethnic groups do you feel you belong?** Select **one** option. (Source 2011 Census)

White English		Mixed White & Black Caribbean	
White Scottish		Mixed White & Black African	
White Welsh		Mixed White & Asian	
White Northern Irish		Mixed Other*	
White Irish		Black or Black British Caribbean	
White Gypsy / Roma		Black or Black British African	
White Irish Traveller		Black or Black British Other*	
White Other*		Arab	
Asian or Asian British Indian		Chinese	
Asian or Asian British Pakistani		I prefer not to say	
Asian or Asian British Bangladeshi			
Asian or Asian British Other*			

*Other - If your ethnic group is not specified on the list, please describe it here:

A Carer is anyone who provides unpaid care for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. Both children and adults can be carers.

Q33. Are you a Carer? Select **one** option.

- ☐ Yes
- ☐ No
- ☐ I prefer not to say

Q34. Are you …? Select **one** option.

- ☐ Heterosexual/Straight
- ☐ Bi/Bisexual
- ☐ Gay man
- ☐ Gay woman/Lesbian
- ☐ Other
- ☐ I prefer not to say

Thank you for taking the time to complete this questionnaire; your feedback is important to us. All feedback received will be reviewed and considered as we finalise the strategies.

We will report back on the feedback we receive, but details of individual responses will remain anonymous, and we will keep your personal details confidential.

Closing date for responses: 3 April 2024