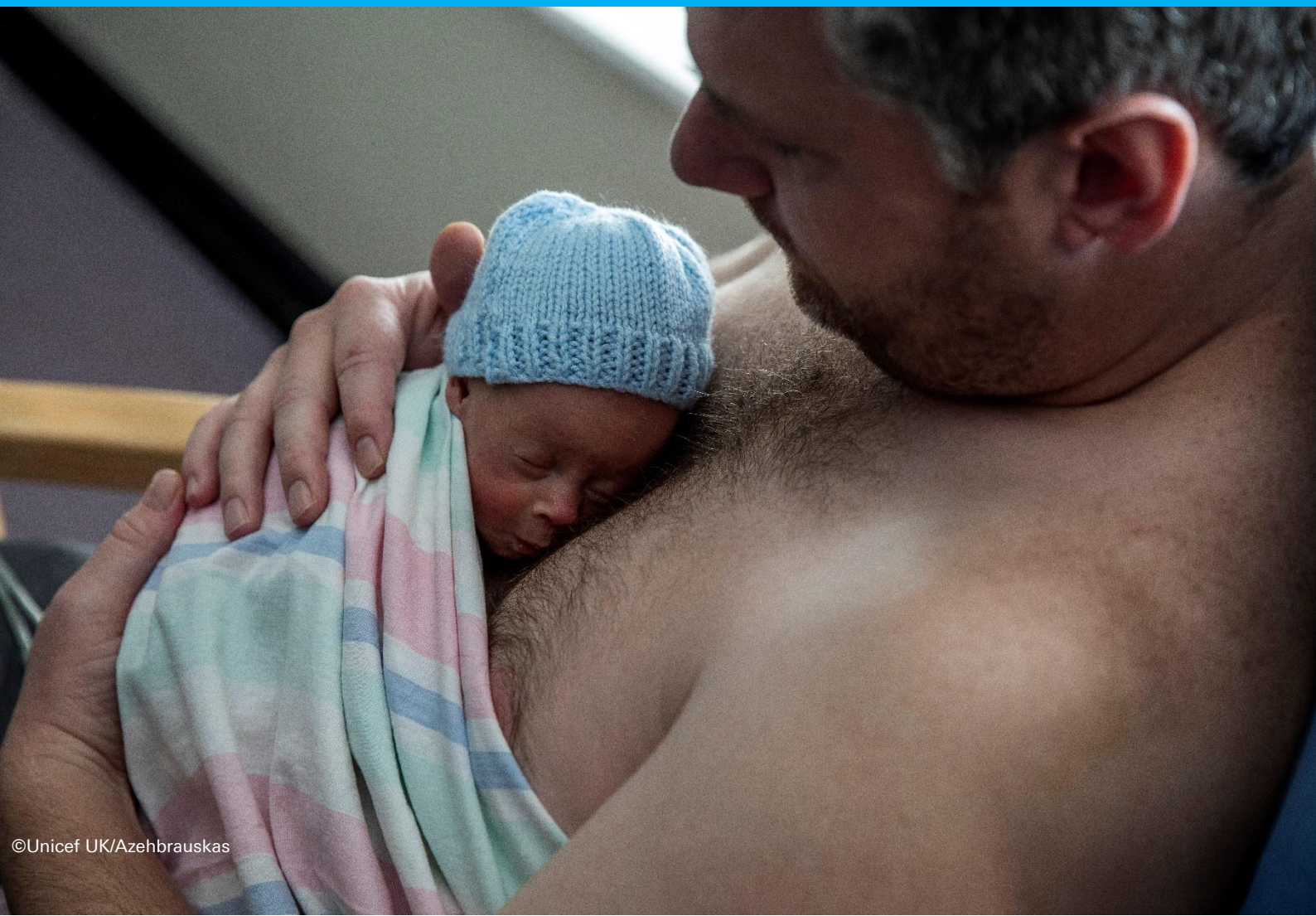
THE BABY FRIENDLY INITIATIVE

unicef UNITED KINGDOM

UNICEF UK BABY FRIENDLY INITIATIVE

BURDETT EVALUATION: TRANSFORMING CARE ON NEONATAL UNITS



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EXECUTIVE SUMMARY

This report outlines the findings of an evaluation of the Baby Friendly neonatal programme which ran from 2016-2019 and aimed to provide neonatal staff with the knowledge and skills required to implement the Unicef UK Baby Friendly neonatal standards.

In 2015, Unicef UK launched bespoke standards for neonatal units covering:

- **supporting parents to have a close and loving relationship with their baby**
- **enabling babies to receive breastmilk and to breastfeed when possible**
- **valuing parents as partners in their baby's care.**

THE BABY FRIENDLY NEONATAL PROGRAMME

In 2016, the Baby Friendly Initiative received a grant from the Burdett Trust for Nursing to support implementation of the neonatal standards in six units across the UK.

The units were provided with a package of support that included:

- education and training for unit leads, including a Train the Trainer course
- bi-annual meetings to share knowledge and best practice
- mentorship from the Baby Friendly team
- financial support to cover training and some assessment costs.

IMPACT OF THE PROGRAMME

Five units have achieved full accreditation and one unit has reached Stage 2. This was much more rapid progress than typically seen. Across each unit, the programme achieved significant change in capacity building, unit culture and care practice, including a range of innovations to improve care for parents and babies.

LEARNING

The evaluation identified four key components which were essential to the programme's success:

1. senior support, commitment and a project leadership group
2. local programme leads with the knowledge, skills and dedicated time for planning, implementation and audit
3. willingness to change the cultural environment, including a commitment from staff, time and financial resources to enable ongoing training (particularly when staff turnover is high)
4. parent involvement in the process, using parent feedback and testimony.

BACKGROUND

One in seven babies born alive in the UK receives specialist neonatal care and this number is increasing.[1] When a baby is born prematurely or sick, the distress caused can have a long-term impact on the entire family. Parents not only face the anxiety associated with their baby's poor health, but they also miss the opportunity in the first precious days to spend time with their baby, holding and caring for him in their own home. Parents may be limited in the time they can spend on the unit due to distance from home or other caring responsibilities, and the clinical needs of their baby may limit the amount that they can hold or touch him when they are there. Mothers may also be recovering from complicated or traumatic labours and may be experiencing poor physical health themselves.[2] All these factors can make it difficult for parents to establish a close relationship with their baby at this early stage and for mothers to establish breastfeeding.

The benefits of breastfeeding are well-established in protecting against a range of illnesses, including infection, diabetes, asthma, heart disease and obesity, as well as reducing the risk of Sudden Infant Death Syndrome (SIDS)[3]. For preterm infants, breastfeeding is particularly associated with reducing the risk and severity of Necrotising Enterocolitis (NEC).[4]

Supporting mothers of pre-term and sick babies on neonatal units to breastfeed requires neonatal units to understand the barriers that exist in these specific circumstances. Where babies arrive early, mothers may not yet have considered how they wish to feed their baby and may not have accessed any information to support them. They may not be able to feed their baby directly from the breast initially and may require support about expressing. The organisation and environment of a neonatal unit can also impact parents' ability or confidence to have skin-to-skin contact with their baby and to be actively involved in their baby's care. Health professionals require the knowledge and skills to offer culturally sensitive care practices, practical guidance and the physical environment to facilitate parent-infant closeness (physical and emotional) and family-centred care.[5] The Baby Friendly Initiative standards for neonatal units guide staff to reduce barriers and create innovations that can support the development of close and loving relationships, support breastfeeding and enable parents to be partners in the care of their baby.

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[1] RCPCH (2018). National Neonatal Audit Programme (NNAP) 2018 annual report on 2017 data. https://www.rcpch.ac.uk/resources/national-neonatal-audit-programme-annual-report-2018-2017-data

[2] Renfrew MJ, Craig D, Dyson L et al (2009). Breastfeeding promotion for infants in neonatal units: a systematic review and economic analysis. Health Technol Assess 2009;13(40) https://www.ncbi.nlm.nih.gov/pubmed/19728934

[3] Cesar G Victoria, Rajiv Bahl, Aluisio JD Barros, et al (2016). Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(15)01024-7.pdf

[4] Quigley M, McGuire W (2014). Formula versus donor breast milk for feeding preterm or low birth weight infants. Cochrane Database of Systematic Reviews 2014, Issue 4. Art. No.: CD002971. DOI: 10.1002/14651858.CD002971.pub3 https://www.ncbi.nlm.nih.gov/pubmed/24752468

[5] Flacking R, Lehtonen L, Thomson G, Axelin A, Ahlqvist S, Moran VH, Ewald U, Dykes F, SCENE group (2012). Closeness and separation in neonatal intensive care, Acta Paediatrica, 101, pp 1032-1037 ISSN 0803-5253.

THE BURDETT PROJECT OVERVIEW

UNICEF BABY FRIENDLY INITIATIVE

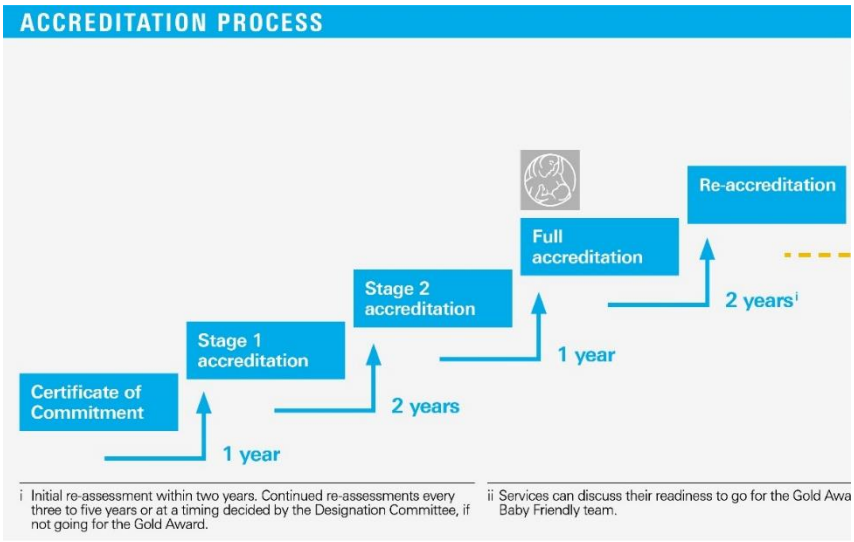
The Baby Friendly Initiative in the UK is based on a global accreditation programme of Unicef and the World Health Organization. It is designed to support breastfeeding and parent-infant relationships by working with public services to improve standards of care. The programme is well-established in maternity and health visiting services throughout the UK. In 2015, Unicef UK launched bespoke standards for neonatal units[6], covering:

- **supporting parents to have a close and loving relationship with their baby**
- **enabling babies to receive breastmilk and to breastfeed when possible**
- **valuing parents as partners in their baby's care.**

Accreditation as a Baby Friendly neonatal service takes place in three stages:

- **Stage 1** ensures that policies, guidelines, information and mechanisms are in place to allow healthcare providers to implement the Baby Friendly standards effectively
- **Stage 2** assesses staff knowledge and skills
- **Stage 3** assesses the implementation of the Baby Friendly standards by interviewing parents about the care they received.

Re-assessment takes place after two years to ensure that the standards are being maintained. Ongoing assessment is carried out every three to five years thereafter. Assessments are reviewed by a Designation Committee, made up of impartial experts in the field of breastfeeding and neonatal care, including representatives from paediatrics, midwifery and health visiting, voluntary organisations and mother support groups, as well as representatives from Baby Friendly accredited facilities.



[6] Unicef UK, (2015). Neonatal unit guidance: Implementing the standards. unicef.uk/neonatalguidance

THE BURDETT PROJECT

In 2016, the Baby Friendly Initiative received a grant from the Burdett Trust for Nursing to support implementation of the neonatal standards in six units across the UK.

The project intended to achieve four aims:

1. to enable staff to provide support and information to parents around building a close and loving relationship with their baby
2. to enable staff to provide support and information to parents around breastmilk consumption and breastfeeding
3. to improve parents' experience of involvement as partners in the care of their child
4. to increase the percentage of babies receiving breastmilk or being breastfed.

Ultimately, through increasing the consumption of breastmilk and rates of breastfeeding in preterm and sick babies, the project aims to improve childhood health outcomes, including reducing childhood obesity.

Thirty-seven percent of neonatal units in the UK applied to take part in the Burdett Project. Through a competitive process, six units were selected:

- Neonatal Unit, Royal Cornwall Hospitals NHS Trust, Truro
- Dyson Centre for Neonatal Care, Royal United Hospital Bath NHS Trust
- Neonatal Unit, St George's Hospital NHS Trust, London
- Neonatal Care Unit, Royal Victoria Infirmary, Newcastle upon Tyne
- Neonatal Unit, Bradford Royal Infirmary
- Abertawe Bro Morgannwg University Health Board; Singleton Hospital, Neonatal Intensive Care Unit and Princess of Wales, Local Neonatal Unit.

Unicef UK provided a package of support to participating units consisting of:

- training on implementing the neonatal standards, developing staff skills, project management and audit
- bi-annual support and coordination meetings to facilitate learning between units
- implementation support visits and ongoing telephone support
- a comprehensive package of training materials
- assessment costs for Stages 1 and 2, and 50% of the Stage 3 assessment costs.

Selected units were required to release all staff for training and provide some materials. A named project lead and a manager at each unit committed to attend bi-annual meetings at Unicef UK.

EVALUATION

The evaluation aimed to explore what changed as a result of implementing the Baby Friendly neonatal standards and what the impact of this was. This includes:

1. To what extent did the training provide staff with the skills required to implement the Baby Friendly standards?
2. What changes were introduced in the units to reach the Baby Friendly standards?
3. Do staff feel more confident to support parents with breastfeeding and building close relationships?
4. Did the programme result in increased breastfeeding, consumption of breastmilk, responsive feeding, skin-to-skin contact and parental access?

The evaluation gathered data from units at six-month intervals and combined this with stakeholder interviews, the results of internal skills audits and external Baby Friendly assessments. The Baby Friendly assessments draw on a range of data including interviews with staff and families in the unit.

Breastfeeding and breastmilk consumption data was collected by the units using their existing data collection systems. However, we were unable to get sufficiently consistent data through these reporting systems and as a result the data is not evaluated in this report. Further improvements in collecting feeding data for neonatal units is being developed (see page 12).

PROJECT LEADERSHIP

A key tenet of the project approach was to provide unit leads with the skills and support required to implement Baby Friendly standards in their units. Unicef UK's Baby Friendly team delivered a bespoke, five-day training package to between three and six staff per unit, covering NHS Bands 5 to 8.

A total of 25 key staff from across the units received five days of bespoke training, delivered by the Baby Friendly team.

The five-day training covered:

- Train the Trainer – skills and materials for delivering a staff education programme in their unit
- Audit and project management – covering action planning, internal audits and evaluation, including how to use the internal audit tool
- E-learning for paediatricians and neonatologists on supporting mothers to breastfeed.

Units were also provided with materials to support learning, including neonatal-specific workbooks.

"It was like watching a lightbulb go on [when their colleague attended training]. That moment when someone really gets it."

- Neonatal unit lead

Feedback on the training suggested that it was seen as high in quality and relevance and that it provided the information and skills required to implement the standards.

Staff turnover was a challenge, however, and some participants attending the five-day training left their positions shortly after. The effect of staff turnover was mitigated by ensuring that more than one person per unit attended the initial training.

SHARED LEARNING ACROSS UNITS

Following the initial training, lead staff from each unit attended bi-annual meetings at Unicef UK. This gave them the opportunity to share experiences and challenges, hear about approaches used in other units and offer each other peer support. Between meetings, a Facebook group was used to allow communication between these leads.

This group was highly valued by the leads in the units for fostering a collaborative approach to achieving change. The meetings provided a safe, confidential and supportive space in which challenges could be discussed and ideas shared. Those attending could draw on others' expertise and experience from hands-on practice.

The main challenge of this approach was the geographical distance to attend the meeting. It was sometimes hard to get more senior staff to attend, particularly when coming long distances. A few participants also felt that some of the challenges they faced were so particular to their service that they were not well understood by those from other units.

"Finding a group of like-minded colleagues very keen to take a similar journey to yourself has been incredibly useful."

- Neonatal unit lead

"The bi-annual meetings, Facebook group and peer support helped the group to share experiences and become more confident and innovative. The environment was one of trust which grew and developed, the group bonded – at first they were reticent to share challenges, but as they developed, so did their knowledge, skills and openness with each other."

- UUK Baby Friendly rep

SUMMARY

Intensive training, resources and an ongoing collaborative project approach were important to build the capacity of the unit leads. While this required considerable investment on the part of the units, it did equip them with the skills and support they needed to implement the Baby Friendly standards.

Peer support provided through bi-annual meetings and a virtual communication forum was valued as a safe and supportive environment to share ideas and expertise.

STAFF SKILLS AND PRACTICE CHANGES

Following the Baby Friendly training, project leads in each unit delivered in-house training programmes to nursing and medical staff. Baby Friendly standards require that a minimum of 80% of all staff groups are facilitated to undertake the training programmes relevant to their role.

By October 2018, all units had trained at least 85% of nursing staff and four had trained at least 98% of all medical and nursing staff.

Units conducted individual practice skills reviews with staff to help embed understanding and apply theory in their practice. By October 2018, more than half of all staff in each unit had received a practice skills review – ranging from 57% to 100% of staff.

Internal audits were conducted to ensure that staff knowledge and skills had reached the required standards. Units used the Baby Friendly audit tool for neonatal units to track the staff knowledge and skills. External Stage 2 assessments were conducted when the unit leads found that most audits were achieving the required standard of 80%. The external assessments were conducted by the Unicef UK Baby Friendly team. All units had achieved the required standard for Stage 2 by January 2019. In some units, champions were recruited to support staff skill development.

Unit leads told us that they had witnessed improvements in staff skills and awareness around the importance of breastmilk consumption, how to get breastfeeding off to a good start, and how to support parents with responsive bottle feeding.

Feedback from the unit leads indicated that through implementing training across the whole unit, rather than among a small number of staff, the project was able to change culture and attitudes of staff, as well as improve knowledge and skills.

By October 2018, all units had provided Baby Friendly standards training to at least 85% of unit staff.

By January 2018, over 80% of staff across all units demonstrated the required skills to meet the Baby Friendly neonatal standards.

"We have empowered staff with knowledge and skills that will make a difference. It's not all breastfeeding, it's so much more… close relationships, parents as partners – whole cultural changes as well as helping Mum. They learn what is in breastmilk – and how important it is. It's so much more than how to breastfeed."

- Neonatal lead

Providing training for all staff did require considerable investment of time and effort, however. Significant staff turnover required frequent training sessions to be delivered. Unit leads also highlighted challenges where units were understaffed or facing specific pressures which made staff less receptive to training.

All unit leads described a change in staff culture as a result of the training and the other changes on the unit. This shift was supported by other complementary initiatives being implemented on the units, such as Family Integrated Care and Bliss standards.

This culture shift was not always straightforward, and some units did report staff resistance to changes. One reflected that staff had to relinquish some degree of control to allow parents to be genuine partners in caring for their baby. High levels of staff turnover and resource pressures – particularly pressure on beds – were felt to make it more difficult for staff to embrace these changes.

One unit lead pointed out that resistance to change among some staff could lead to inconsistencies in practice. Over a baby's stay on the unit, many different staff members will be providing their care, so the experience for parents can be variable. This could lead parents to report inconsistencies in information provided by staff, particularly in relation to their involvement in the baby's care.

"There's been a definite culture change for nursing and medical staff, recognising parents' role and the importance for babies' long-term futures and brain development."

- Neonatal unit lead

"When initially we started talking about things, some feared relinquishing their role to parents… fears have proven to be unfounded and staff appreciate the changes on the whole."

- Neonatal unit lead

SUMMARY

Regular internal audits allowed unit leads to assess progress on staff skill development and to judge their readiness for external assessment. By taking a whole-unit approach to training, units were able to change the culture and attitudes of staff working on the unit.

Culture change takes time, however, and receptivity to change is influenced by enablers such as complementary initiatives like Family Integrated Care and barriers such as staff turnover and resource pressures. Staff need support and to be involved to enable culture changes, particularly when there is resistance from parts of the service.

POLICIES, PRACTICE AND ENVIRONMENT

For all units, changes in the policies, practice and physical environment were implemented to ensure that the standards could be met. Unit leads provided summaries of these changes in reports submitted throughout the project and reflected on the impact of these changes in evaluation interviews. A full list of changes implemented as part of this project is provided in appendix 1.

SUPPORTING PARENTS TO BUILD CLOSE AND LOVING RELATIONSHIPS WITH THEIR BABY

Parents of babies admitted to neonatal units are often unable to spend prolonged periods of time in close contact with their baby and this can affect the bonding and attachment process that occurs in the days and weeks after birth. Baby Friendly standards require units to give parents opportunities to develop close and loving relationships with their baby while they are still in neonatal care.

"Little touches make [parents] feel at home. Parents change into slippers, which proves they feel at home."

- Neonatal unit lead

As a result of the implementation of the neonatal standards, several units extended access for parents and siblings and developed guidelines that supported more open visiting for wider family and friends.

"There's much more skin-to-skin […] all the time there's someone doing it. On the ward rounds, babies are examined in skin-to-skin. There are blood tests when babies are in skin-to-skin."

- Neonatal unit lead

Other changes focused on making parents as comfortable as possible when on the unit to allow them to maximise the time spent with their baby. Parents were increasingly encouraged to have skin-to-skin contact with their babies. One unit recognised that this was often disrupted by routine monitoring and care. To address this, they purchased kneeling pads, so that staff could kneel beside a baby while they were being held by a parent and conduct basic clinical care tasks.

Units reflected that changes could help parents to feel more at home on the ward and that this could facilitate them to build a relationship with their baby. One unit introduced a memory book and diary to record their baby's stay in the unit. A unit lead reflected that as a result of these changes, they had some parents who rarely left their baby throughout their stay.

VALUING PARENTS AS PARTNERS IN CARE

Standard 3 of the Baby Friendly neonatal standards requires a unit to show that parents are being valued as partners in their baby's care. A key element of demonstrating this was enabling unrestricted, open access for parents to the unit.

Enabling greater access to the unit allows parents more opportunities to be actively involved in their baby's care, for example with nappy changes, tube feeding and taking their temperature. This can be helpful in reducing parents' sense of being separated from their baby, allowing them to build a closer relationship with them. It can also increase parents' confidence when they are able to take their baby home.

Relationships between staff and parents are also important for parents to feel like genuine partners in their baby's care. Units recognised that staff often do not know parents' names, referring to them as 'mummy' and 'daddy'. This was seen as dismissive and disempowering rather than supporting effective partnership.

Some units introduced cot tags and boards so that staff would be able to address parents and babies by their names. One unit introduced communication skills training to improve how nursing staff communicate with parents. This was felt to help reduce the exclusion of parents and help to build relationships between staff and parents.

Units also made it easier for parents to bring older siblings with them, removing a common barrier to their ability to be with their baby. Two units are exploring the possibility of fingerprint access for parents which can enable parents to gain access to the unit to be with their baby when they wish, rather than having to wait for staff to grant access. Not all units found it easy to introduce these changes, sometimes encountering staff resistance.

"Parents are welcome at all times. We used to think of parents as visitors and now we think about parents as carers."

- Neonatal unit lead

"Families reported high satisfaction levels with how staff involved them in the care of their baby through the Family Integrated Care package. They valued being enabled to tube feed, take temperatures and lift the baby from the incubator independently"

- BFI Assessment Report

"Staff used to use the term "my baby" and we would not know who the parents were. Now we have white boards with their names on – what they would like to be called as. It's empowering. I think you take the power away by calling them "Mummy", they are individuals. Calling them their names makes them more empowered."

- Neonatal unit lead

VALUING BREASTMILK AND BREASTFEEDING

Ensuring that babies can receive breastmilk from their mother as early as possible is important to breastmilk consumption and to show parents how breastmilk and breastfeeding are valued.

Two units introduced mouth care with colostrum / breastmilk as part of this project. Other units were already doing this prior to the Burdett Project. There are many recognised benefits of this practice, from supporting a healthy mother to showing parents that even small amounts of milk are beneficial to their baby. Early in a baby's care, when they may not be consuming milk at all, or only in very small quantities, it can be important for parents to see the value of breastmilk to help them support and sustain expressing. Several units introduced colostrum packs for mothers to help in these very early stages of lactation.

Units introduced environment changes to support mothers to breastfeed or express breastmilk where they chose to. These included introducing comfortable chairs that made it easier for parents to spend time with their baby, hold and feed them and have skin-to-skin contact. Units introduced camp beds and improved access to bedrooms so that mothers could stay with their babies overnight to feed or be with them.

Facilities were put in place to support mothers who were breastfeeding or expressing, including access to food and drink and better breast pumps on site.

In interviews, unit leads reported that over the project they had seen an increase in the use of breastmilk for mouth care, the occurrences of positive breastfeeding amongst mothers and the overall consumption of breastmilk for babies.

"Before, they [staff] would get 1ml of colostrum and ignore it, put it to one side. Now they are using it. So mums feel valued [and] dads see it is worth it."

- Neonatal unit lead

"Before [camp beds], parents could sleep in the reclining chair, but it's not comfortable. Camp beds mean that some parents haven't left their preterm baby and have taken them home exclusively breastfed. We've had twins go home exclusively breastfed."

- Neonatal unit lead

SUMMARY

Units have successfully implemented a wide range of changes to the policies, practices and environment of the unit to support the aims of the Baby Friendly standards. Many of these changes are small and inexpensive, but some have been met with resistance or proved difficult to implement in some units. By facilitating shared learning, good ideas that worked in one unit were often replicated elsewhere.

DATA ON BREASTMILK CONSUMPTION & BREASTFEEDING

The Burdett Project aimed to improve uptake of breastmilk feeding and breastfeeding. However, current data collection systems made it difficult to collect consistent data related to breastmilk feeding and breastfeeding outcomes. In addition, the complexity of feeding preterm and sick babies, the transfer of babies in and out of units and the challenges of collecting this information cohesively meant that units were not able to present meaningful data that could be analysed for this project.

In 2018, in response to these data collection challenges, Unicef UK Baby Friendly established an expert group of neonatal unit staff members from Burdett units and Royal Devon & Exeter's Neonatal Unit (the first fully accredited Baby Friendly neonatal unit) to clarify exact requirements for neonatal units to achieve and maintain Baby Friendly accreditation. The aim was to develop a clearly defined and easy-to-use data collection tool that allowed individual units to monitor outcomes related to the Baby Friendly standards in order to evaluate the effect of changes to practice and progress over time.

The data collected is not intended to allow exact comparisons between units, as there are considerable differences between units in terms of unit level, size, staffing, gestation age and condition of babies, treatments offered, etc. Data should therefore only be used to monitor an individual unit's progress over time.

The data collection tool was piloted by seven units (the 'Burdett' units and Exeter Neonatal Unit) and was then amended based on their feedback and piloted again. A summary of the pilot findings and the new minimum data requirement for neonatal units is available in appendix 2. Unicef UK are exploring how this tool can be implemented into the national data collection systems within the national database for neonatal services (BadgerNet). This pilot provides important learning and processes with the potential to inform national data collection processes.

IMPROVING BREASTFEEDING DATA IN NEONATAL UNITS

The new data collection tool enables neonatal units to measure:

1. percentage of mothers expressing breastmilk (or attempting to express breastmilk) during the first 24 hours following admission
2. percentage of babies who receive human milk (including for mouth care) in the first 24 hours following admission
3. percentage of babies receiving human milk when they leave the unit
4. percentage of mothers expressing breastmilk when their baby leaves the unit
5. percentage of mothers breastfeeding their baby when they leave the unit.

UNIT PROGRESS TOWARDS BABY FRIENDLY STANDARDS

At the start of the Burdett Project, only one of the units had already achieved Stage 1 of Baby Friendly accreditation. By January 2020:

- All units had achieved **Stage 1**: they had the necessary policies, guidelines and processes in place to allow healthcare providers to implement the Baby Friendly standards effectively.
- All units had achieved **Stage 2**: all staff had been educated according to their role, and this training had prepared staff to care for babies, their mothers and families effectively. All staff who had contact with new mothers and babies were educated to allow them to implement the standards according to their role.
- Five of the units had achieved **Stage 3**: where families are supported to have close and loving relationships with the baby, are enabled to provide breastmilk and to breastfeed when possible and are valued as partners in care. The remaining unit is in the planning stages for an assessment.

Each of these achievements has been validated through Baby Friendly external assessments, involving visits, interviews with staff and parents (at Stage 3), review of data and documentation and observations on the unit. Over the course of the project, every unit planned to recruit a Baby Friendly Guardian and developed a Baby Friendly steering group that has overseen implementation of the project. This strongly supports their sustainability after this project and their continued progression along the Baby Friendly journey. The overview of progress by year in Table 1 below shows how the journey to achieving the standards has varied by unit.

Region	Pre-Burdett	Year 1 (2016)	Year 2 (2017)	Year 3 (2018)	2019/2020
Newcastle	Stage 1			Stage 2	
St George's			Stage 1	Stage 2	Stage 3
Bradford			1 / 2 / 3		Stage 3
ABMU Singleton & PoW			Stage 1 / Stage 2		Stage 3
Truro			Stage 1	Stage 2	Stage 3
Bath			Stage 1	Stage 2	Stage 3

Table 1: Summary of Baby Friendly accreditation dates for Burdett neonatal units

Getting the foundations in place for Stage 1 typically took the most time. It is often found that accreditation can take 4-5 years in maternity units. The neonatal units in this project experienced a faster pace of change to achieve the required standards for the Baby Friendly Initiative accreditation.

Several reasons were identified for varying rates of progress across units. Being part of the Burdett Project was felt to have increased the pace of change by providing momentum through regular meetings and reporting, supporting senior level buy-in and offering dedicated resource and funding. These factors elevated the status of the work within the unit and across the Trust and helped to keep it in focus.

Each unit had a different starting point in terms of existing practice and resources. This therefore influenced the differing barriers to change that were faced by the individual units. Challenges existed around staff turnover and the training expectations, physical building space and parental facilities, as well as the then-current breastfeeding ethos within the staff and patient groups. All these factors determined the rate of change within the units.

Some units were already engaged with complimentary initiatives, such as Family Integrated Care or the Bliss Baby Charter, which may have influenced change. All the neonatal units are attached to Baby Friendly Initiative accredited maternity units.

LEARNING FROM THIS PROGRAMME

The Burdett Model was received positively by the units, but participants did identify some possible improvements.

The bespoke five-day training was highly valued by recipients and was felt to effectively equip key staff with the information needed to implement the Baby Friendly standards. Senior manager training slides in particular helped project leads gain buy-in from senior staff. The bi-annual meetings of project leads with the Baby Friendly team were felt to be an effective mechanism for sharing ideas and expertise and for maintaining momentum.

Unit leads reported that the individuals from the Unicef UK Baby Friendly team who provided support were knowledgeable, supportive and available when needed. It was suggested that Unicef UK staff could consider contacting units directly during difficult periods to check-in, rather than requiring units to be proactive. The Baby Friendly standards were viewed positively, and the accreditation process was seen to be fair, transparent and thorough.

The project plan set out at the beginning helped to clearly identify what was expected of units taking part. The sign-up process for senior management helped gain commitment and buy-in, and the part-funding model helped the units value what they received. Having a dedicated lead for implementation is important, but further guidance on the role and hours required for different types of units could help the feasibility and sustainability of this role in the context of resource constraints.

LEARNING FOR UNICEF UK

The Burdett Project has already been instrumental in informing wider activities within the Unicef UK Baby Friendly Initiative. An adapted version of the Burdett Model has been used as the basis for further neonatal projects, such as those in the South West, West Midlands and Scotland. Guidance on how to develop a 'Joint Neonatal Baby Friendly project', based on experience from this project, is now available on the Baby Friendly website.[7]

As a result of learning from this project, Unicef UK has appointed a Baby Friendly neonatal lead to provide a consistent point of support for neonatal units and to sustain further roll-out. This post was established in June 2019.

In rolling out this training further, consideration should be made to how proactive support can be provided to units with specific challenges. Possible models to explore include 'buddying' with other units to provide support for staff and demonstrate possible solutions, and sustaining a

[7] Unicef UK (2018). Joint neonatal projects infosheet. https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/implementing-standards-resources/joint-neonatal-projects-infosheet/

regional network to share best practice and facilitate collaboration, perhaps through the National Infant Feeding Neonatal Network (NIFN) or through online collaborative working.[8] The existence of a specific project to support this group of units helped to ensure rapid and effective progress. Where possible, Unicef UK should explore further funding opportunities to support units in this way, including providing resources to participating units.

LEARNING FOR FUTURE NEONATAL UNITS

Through feedback from unit leads, nine key pieces of learning were identified and may help other units implementing the standards.

1. Secure senior support and commitment from nursing teams and consultants. Senior buy-in may be essential for implementing some policy and resource changes.
2. Put a steering group in place to support the project, including a senior nurse, neonatologist, infant feeding lead and a Baby Friendly Guardian.
3. Ensure the project delivery lead has enough dedicated hours to implement initiative.
4. Audit practice frequently. Results are helpful in providing internal evidence to the steering group and offering impetus for change.
5. The Baby Friendly culture is key and must be in place to fully make the changes required. Ensuring that training is offered to *all* staff is important to achieving this.
6. It is important for morale to understand and believe that being Baby Friendly is possible even if the physical environment of the unit is difficult. Peer support and networking is helpful.
7. Invest sufficient time and financial investment in training. This investment should be ongoing and should continue after the accreditation is achieved.
8. Involve parents in the process and listen to parents' views – parent feedback and testimony is powerful.
9. If the unit is already implementing Family Integrated Care and/or the BLISS Baby Charter, these are complementary to the Baby Friendly standards and the ethos they engender will help full implementation of Baby Friendly.

"When we started, we thought we'd never get [Baby Friendly], our environment was rubbish, tiny… It is about state of mind more than environment. Once that is there, you can make the geography work for you even if it is sub-optimal. We can make this Baby Friendly within the resources we have."

\- Neonatal unit lead

[8] Neonatal National Infant Feeding Network. https://www.unicef.org.uk/babyfriendly/about/infant-feeding-networks/neonatal-nifn/

APPENDIX 1 – CHANGES IMPLEMENTED IN UNITS THROUGH THE BURDETT PROJECT

This table does not show initiatives in place prior to the project and is not, therefore, a full picture of the provisions in any given unit. Green squares indicate an initiative newly in place as part of the Burdett Project. Orange squares indicate a planned initiative.

Action	Unit					
	Newcastle	Truro	St George's	Singleton	Bradford	Bath
New equipment/facilities/materials to support breastfeeding and bonding						
Introducing slings						
Introducing/increasing breastfeeding friendly chairs						
Introducing camp beds						
Introducing/increasing access to bedrooms for parents						
Providing activities for parents and babies (e.g. books)						
Providing access to fridges/parent kitchen						
Providing packs/materials for parents e.g. packs for breastfeeding or formula feeding mothers, colostrum packs, bonding squares, baby photos, breastfeeding/expressing scarfs						
Establishing or improving facilities in parents' room						
Providing meals for parents						
Introducing/increasing access to breast pumps						
Increasing use of bank milk (donated breastmilk)						
Refurbishing expressing room						
Introduced kneeling pads for staff						
Making bags of resources for staff prompts/parent teaching on breastfeeding available in rooms						
Improving access for families						
Extending access for parents						
Extending visiting hours for wider families/siblings						
Increasing number of visitors permitted per cot (trial)						

Investigating fingerprint entry						
Improving staff skills						
Regular staff skills updates						
Study days						
Recruiting additional skilled staff						
New mandatory training sessions						
Online peer support training/pilot online forum						
Changes to policies and care standards/practice						
Introducing mouth care with colostrum/breastmilk						
Extending/emphasising skin-to-skin contact						
New Transitional Care Pathway						
Home tube feeding development						
New or revised policies in line with Baby Friendly standards						
Increasing role and support for parents as partners in care						
Providing new or revised information resources for parents						
Working on 'Family Integrated Care Programme'						
Enabling parent involvement in care rounds/handovers						
Increasing collaboration with parents on decisions in unit						
Teaching parents how to get babies out of incubator						
Improvements to communication						
Providing 'Communication tags' / 'cot cards' (to address by name)						
Introducing other new communication systems						
Establishing parent inclusion initiative e.g. coffee morning, parent involvement meetings						
Establishing parent peer support mechanisms						
Introducing communication skills training						

APPENDIX 2 - UNICEF UK BABY FRIENDLY INITIATIVE

REQUIRED BREASTFEEDING DATA FOR NEONATAL UNITS

November 2019

BACKGROUND

The Baby Friendly Initiative programme for neonatal units was launched in 2015 in order to support practice around infant feeding and parent-infant relationships, with the aim of improving outcomes for some of the UK's most vulnerable babies. This document outlines the minimum required data to support Baby Friendly assessments of neonatal units and guidance on how to collect this data.[1]

The Baby Friendly standards require the on-going monitoring of breastfeeding and breastmilk feeding data to inform action planning and to support units to improve care for breastfeeding mothers.

Neonatal units currently capture data using the *BadgerNet* database which allows them to monitor provision on both a local and national level and share data with other health professionals. Unicef UK is seeking to work with *BadgerNet* to improve data collection in relation to Standard 2* of the Unicef UK Baby Friendly neonatal standards.

Neonatal units across the UK are very different and direct comparisons between units do not provide an accurate picture of progress against Baby Friendly Standards. However, tracking data over time *within* a unit allows them to monitor progress and identify areas for improvement.

THE UNICEF UK BABY FRIENDLY INITIATIVE NEONATAL STANDARDS

1. Supporting parents to have a close and loving relationship with their baby
2. *Enabling babies to receive breastmilk, and to breastfeed when possible
3. Valuing parents as partners in their baby's care.

Guidance for the Baby Friendly Initiative standards in neonatal units
https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/implementing-standards-resources/neonatal-guide-to-the-standards/

[1] *The minimum data requirements were developed with neonatal expertise and piloted in eight neonatal units across the UK providing different levels of care. Further details of this pilot are available on request.*

GUIDANCE FOR NEONATAL UNITS

Aim: The minimum data requirements for Baby Friendly Standards are intended to ensure that units can effectively monitor their own progress towards Baby Friendly accreditation and demonstrate this at assessment.

Context: In setting the minimum data requirement, we recognise that neonatal units across the UK face challenges in attributing outcomes for babies in their care, particularly where babies move between units. Data is therefore only intended for tracking outcomes within the unit over time. Consistency in recording is essential to make this tracking useful.

Inclusions: The minimum data requirement should include *all* babies admitted to a neonatal unit, regardless of gestation, condition, or length of stay. The data collection fields are designed to be applicable to all levels of neonatal unit, including those offering neonatal surgery. Definitions are deliberately broad to capture:

- **any** breastmilk expression,
- **any** use of human milk and
- **any** breastfeeding.

THE MINIMUM DATA REQUIREMENTS:

DATA COLLECTION ON ADMISSION TO THE UNIT:	*Calculation*
1 Percentage of mothers expressing breastmilk during the first 24 hours following their baby's **admission** to the neonatal unit.	*Number of mothers expressing divided by total number of mothers on the unit, multiplied by 100.*
2 Percentage of babies who receive human milk in the first 24 hours following **admission** to the neonatal unit	*Number of babies receiving any human milk, divided by total number of babies on the unit, multiplied by 100*
DATA COLLECTION ON DISCHARGE FROM THE UNIT:	
3 Percentage of babies receiving human milk when they **leave** the unit	*Number of babies receiving any human milk, divided by total number of babies leaving the unit, multiplied by 100*
4 Percentage of mothers expressing breastmilk when their baby **leaves** the unit*	*Number of mothers expressing breastmilk, divided by total number of mothers leaving the unit, multiplied by 100*
5 Percentage of mothers breastfeeding their baby when they **leave** the unit*	*Number of mothers breastfeeding, divided by total number of mothers leaving the unit, multiplied by 100*

**Mothers may be counted in both these categories if they are both breastfeeding and expressing.*

DESCRIPTORS

Admission: Any baby admitted to the unit for any episode of care, including babies born in the hospital, those transferred in from other units and those re-admitted - even if they have been admitted previously.

24 hours following admission: The first 24 hours from time of most recent admission.

Breastfeeding: Putting baby to breast, regardless of quality of breastfeed.

Expression: Mother expressing her breastmilk by hand or pump, any frequency or volume of milk

Human milk: Mother's own fresh or frozen colostrum, mothers own fresh or frozen breast milk, or donor milk.

Neonatal unit: One neonatal unit of any level and any size. Transitional care should only be included if this is entirely managed and staffed by the neonatal unit.

Leave the unit: Discharge into the community **or** transfer to another unit, even if expected to return (this would be counted as a new admission).

SUBMITTING THE DATA

Neonatal units who are working towards Baby Friendly accreditation, will be asked to submit data as detailed above. Baby Friendly is seeking guidance and support from *BadgerNet* to create fields within the current database to enable all neonatal units to record and monitor the information detailed above combined with an easy to create report format.

Neonatal units seeking accreditation must submit the relevant data with applications for assessment. The data will be included in the Unicef UK Baby Friendly Initiative assessment reports and associated documentation.

SOME FREQUENT QUESTIONS ASKED BY STAFF TAKING PART IN THE PILOT STUDY

Question	Answer
Some mothers are not successful at expressing initially. If they are attempting but obtaining no colostrum would this be included?	**Yes,** this would be included in required data point 1.
Babies may be nil-by-mouth but may be receiving buccal colostrum. Would this be a included in point 2?	**Yes,** the baby is receiving breastmilk
Should babies who are admitted to the unit but are not well enough to be breastfeeding be opted out of point 1?	These babies would be listed as **No** on point 1. If this number became significant this should be detailed in the additional information
There are some babies who are ward attenders, not admissions, should they be recorded?	**No,** if babies are attending for review and are not admitted for care under the neonatal unit in the hospital's admission system, they should not be included in the data collection
Babies who are nil-by-mouth could skew the data?	In each unit there will be similar numbers of babies admitted who are nil-by-mouth each year. As long as this data is consistently recorded this will not affect the validity of this data for tracking over time.
We do not routinely document when the mother starts expressing.	This is an important aspect of initiating lactation and so therefore should be monitored and recorded under point 1 and 4. The support provided for mothers who are expressing is an important element of care that will enable mothers to maximise their milk production. Therefore, this data should be collected.
Should babies who are cared for in transitional care be included?	Transitional care should be included only if this is entirely managed and staffed by the neonatal unit.
The collection of data is from 24 hours after admission, not birth?	**Only the data after admission to your unit should be recorded**, as this is what is affected by the care offered in the unit. These criteria were designed to enable all units to record care that has happened within 24 hours of the family coming into their care, recognising that babies do not always come into a unit straight after birth.
Points 4 and 5, there will be many mothers who only fit one category or the other. Should there be a rephrasing of the questions to ensure less 'no' answers?	**No,** the data should be recorded accurately for both, even if this includes a lot of 'no' answers. The data collected is to monitor care improvements in both these categories over time, within the unit.