**Guidance notes**

**Stage 3 assessment – Parent’s experiences**

**Maternity**

**Introduction**

The achievement of Stages 1 and 2 of the Baby Friendly Initiative assessment process confirms that the necessary mechanisms have been put in place, and that staff have been educated appropriately, to provide the foundation for delivery of a high standard of care for pregnant women and new mothers and babies. Stage 3 assesses the practices which make that care a reality. Evidence is gathered via interviews with mothers and key senior staff and the review of documentary evidence (including internal audit results) to determine whether the Baby Friendly standards are being met.

**Parent’s experiences of maternity services**

1. **Support pregnant women to recognise the importance of breastfeeding and early relationships for the health and well-being of their baby**
2. **Support all mothers and babies to initiate a close relationship and feeding soon after birth**
3. **Enable mothers to get breastfeeding off to a good start**
4. **Support mothers to make informed decisions regarding the introduction of food or fluids other than breastmilk**
5. **Support parents to have a close and loving relationship with their baby**

You will be ready for Stage 3 assessment when your audit results give a good indication that, by the date you consider that you will be ready, at least 80% of pregnant women and mothers are receiving a high standard of care in all areas (see below and Sections 1 and 2 of this guidance). Using the Unicef UK audit tool throughout the time when you are working towards assessment at both Stages 2 and 3, will help you to monitor your progress, judge when you are ready to be assessed and minimise the chances of a disappointing outcome at the assessment. It will also enable you to complete the application form easily.

When you are planning your Stage 3 assessment, please contact the Baby Friendly Initiative office to discuss the preparations to be made and to arrange an assessment date. This is likely to be several months ahead and we will ask for the Stage 3 application form ***at least three months*** before the agreed date for the assessment. This is to allow consideration of the audit results and discussion with you about whether and how any outstanding issues can be addressed within the timescale. After this discussion, you may feel that you would rather re-schedule the date of the assessment and we will be able to postpone without penalty, *provided that* you have submitted he application form at least three months in advance. We anticipate that Stage 3 assessments will where possible, be carried out on-site and therefore we also need to have this discussion in time to enable plans to be made for travel/accommodation for the assessment team. Any applications received later than this may incur costs should a decision be made to postpone.

🖳 Please read this guidance document in conjunction with the Stage 3 assessment application form.

**Understanding the requirements**

Throughout this document, each piece of evidence is identified as being either ***required*** or ***recommended.***

1. When a piece of evidence is said to be ***required*** this means that itforms a key part of the standards and is therefore necessary in order for the unit to be accredited as Baby Friendly. We will not be able to award a pass at Stage 3 if any evidence identified as a ***requirement*** is lacking.
2. When a document or action is said to be ***recommended*** this means that we believe it to be an effective way of implementing the standards and therefore the Baby Friendly Initiative recommends that this is what is done.

As an example:

The standards state that all pregnant women must be offered the opportunity for a discussion about feeding their baby and recognising and responding to their baby’s needs. A certain percentage of mothers who can confirm, at interview, that the discussion took place and that the information was helpful and enabling to the mother is therefore ***required***. Different ways of enabling this discussion may be utilised for example as part of a class or face-to-face or by telephone. Guiding staff in how best to offer the information, using a guidance sheet is ***recommended*** to ensure that all mothers are offered this important information.

**Background information required prior to Stage 3 assessment**

We need you to supply us with certain pieces of information to help us to plan the assessment. This includes demographic, birth and infant feeding data. We will send an email to ask for this information (or an update to the information we previously have on file). A prompt response would be appreciated as the details will help us to organise the assessment.

**Documentary evidence required at a Stage 3 assessment**

The infant feeding policy, staff training curricula and mechanisms for ensuring attendance at training and for auditing practice were assessed at Stages 1 and 2. We will review all of these in the light of practice found at the Stage 3 assessment. We will also examine other policies and materials, as explained in this guidance. Please submit these two weeks before the assessment.

🖳 For further information about the standards please refer to the [Guide to the Unicef UK Baby Friendly Initiative Standards](http://unicef.uk/babyfriendlystandards) and [The evidence and rationale for the Unicef UK Baby Friendly Initiative standards](https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/advocacy/the-evidence-and-rationale-for-the-unicef-uk-baby-friendly-initiative-standards/)

🖳 **A range of Baby Friendly resources are available at** [**unicef.uk/babyfriendly-stage3-maternity**](https://www.unicef.org.uk/babyfriendly/accreditation/maternity-neonatal-health-visiting-childrens-centres/stage-3-parents-experiences/parents-experiences-of-maternity-services/) **to help you implement Stage 3 in maternity services**

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| **Coronavirus, Covid -19 assessments**During the coronavirus pandemic and in the immediate aftermath, Baby Friendly assessments were routinely carried out remotely. As such, all aspects of the assessment which would normally be carried out on-site were conducted remotely by the assessment team. As we move forward and recover from the pandemic, our aim is to begin to return to on-site assessments where possible. Irrespective of how we carry out the assessment the following will apply:* Submission of documents electronically in advance of the assessment
* Interviews with staff carried out face to face or via video link using a platform such as Microsoft Teams. This will be arranged in discussion with your lead assessor
* Interviews with mothers carried out by phone
* Observations in the facility. This may be complimented by submission of photographic or other evidence to show display boards in larger services or where an on-site visit is not possible.

Introductory and feedback meetings will be held face to face or via video link depending on the service need. Please complete the application form which will guide you regarding how to make sure we receive all of the necessary evidence. We have included a section for you to tell us about how you have adapted care to meet the needs of mothers during the pandemic and in recovery. |

**Results of internal audit**

We will base our decision as to whether your facility is ready to undergo an external assessment on the results presented. The aim of asking for this data is to avoid the disappointment and additional costs of having to undergo a follow-up assessment, should the results of the assessment fall short of what is required. In addition, the results submitted will help inform the assessment outcome with the external assessment being intended as a process of validating the internal audit results. It is therefore vital that the results are valid. In order to facilitate this, your audit should:

* Use the recognised Unicef UK audit tool (latest vesion)
* Be carried out by staff who have been trained to audit in order to ensure that the results are consistent and accurate.
* Be based on a sample which is of sufficient size (see table below), chosen at random and representative;
* Be carried out face-to-face or by telephone with mothers
* Enable you to be confident that the information and care provided would support a mother effectively.

**Audit programme**

The audit tool suggests sample sizes based on the number of births. It is ***recommended*** that an audit programme is developed in order that any necessary changes to practice to improve care can be identified and the necessary data can be made available to Baby Friendly as part of the assessment process. The following example of frequency and numbers is appropriate whilst the facility is progressing to Stage 2 and 3.

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| **Stage 2 assessment** | **Stage 3 assessment** |
|  | **Frequency** | **Numbers** | **Frequency** | **Numbers** |
| **Staff** | Quarterly | 10-20 (up to 3000 births)20-30 (3000+ births) | Six monthly | 10-20 (up to 3000 births)20-30 (3000+ births) |
| **Mothers\*** | Six monthly | 10-20 (up to 3000 births)20-30 (3000+ births)Plus 6 mothers with a baby on NNU | Quarterly | 10-20 (up to 3000 births)20-30 (3000+ births)Plus 6 mothers with a baby on NNU |
| **Supplement audit** | Ongoing for all mothers | 10 interviews per month10 sets of records reviewed per month | Ongoing for all mothers | 10 interviews per month10 sets of records reviewed per month |
| **Environment (Code and information e.g. Bounty Bags)** | Six monthly | All areas | Six monthly | All areas |

*\*Mother interviews look at the care provided in pregnancy as well as that provided once the baby is born.*

Supplementation rates will be collected and reported to Baby Friendly as part of the assessment process. It is anticipated that steady progress to reduce supplementation rates (specifically those supplements given without medical indication or fully informed choice) will be made. Whilst the ***recommended*** method of monitoring supplements is an ongoing continuous audit, we recognise that implementing such a process may take some time. The minimum ***requirement*** would therefore be a regular sampling and review of written records by the Baby Friendly Lead at a rate of around 10 of each per month (*based on an average sized unit of 3000-4000 births*).

Facilities with computer systems may find these easier to use to track their supplementation rates and it is hoped that in time, all services will be able to track their rates electronically. Details about both will be required with each assessment and annual audit submission.

Please see our [Supplementation guidance](https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/guidance-for-health-professionals/implementing-the-baby-friendly-standards/further-guidance-on-implementing-the-standards/supplementation-guidance/) for more details.

🖳 The [Baby Friendly audit tool for maternity services](http://www.unicef.org.uk/BabyFriendly/Resources/Guidance-for-Health-Professionals/Audit/Audit-tools-to-monitor-breastfeeding-support/) should be used to carry out the audits

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| **Standard 1 – Antenatal care** |

Listed below are the standards which will be assessed at Stage 3.

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| **Standard****Women…..** | **This applies to…** | **How assessed?** | **Minimum % required to pass?** |
| **1.** Have the opportunity for a discussion about feeding and recognising and responding to their baby’s needs | All women who have received care during pregnancy from the facility | Via records, internal audit data and interview\*  | 80% |
| **2.** Are encouraged to develop a positive relationship with their baby in utero | All women who have received care during pregnancy from the facility | Via records, internal audit data and interview\* | 80% |
| **3.** Confirm that the information was helpful and enabling | All women who have received care during pregnancy from the facility | Interview | 80% |
| **4.** Written information is largely accurate and effective | All written information provided for pregnant women, to include DVDs and posters | Review  | Yes |

*\*Mothers who are on the postnatal ward or have recently been transferred home will be interviewed.*

The facility is required to make sure that all women have the opportunity to have a meaningful discussion about caring for their baby to include feeding and recognising and responding to their baby’s needs. In addition, all pregnant women should be encouraged to develop a positive relationship with their growing baby. The discussion should take into account the woman’s own individual circumstances and needs. The discussion can take place as part of routine antenatal care or as part of a class or can be with a peer supporter face-to-face or on the telephone. The standard will be assessed on whether or not the discussion took place, whether the information given was evidence based and whether it was helpful and enabling to the mother.

Those facilities which provide antenatal parent education classes for pregnant women (+/- partners) should ensure that they make the most of the opportunity to provide good quality and effective information. It is also vital that information provided does not undermine or conflict with other information given and that women can rely on a consistent standard of provision irrespective of which class they choose, or are allocated to attend. Therefore, we will have reviewed curricula for infant feeding and related sections of the antenatal parent education classes as part of the assessment process at Stage 1 assessment and will ask mothers at Stage 3 about their experiences.

Services are asked to document conversations about feeding and developing a relationship with their unborn baby. As part of an on-site assessment we will review 10 sets of antenatal records during the visit. If this is not possible, or for remote assessments, please select 10 random sets of records and check whether the antenatal conversation was completed, partially completed or not completed.

Written information used to back up discussion can be very helpful. Ensuring that the information is accurate and effective is ***required.*** If leaflets or online information for parents has been developed in-house, we ***recommend*** that these compliment any standard national materials, and consider:

1. the need for clarity, accuracy and simplicity of the messages
2. avoidance of duplication
3. that the layout is attractive and readable

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| **Standard 2 – Care after the birth** |

Listed below are the standards which will be assessed at Stage 3.

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| **Standard.** **Mothers…** | **Applies to…** | **How assessed?** | **Minimum % required to pass?** |
| **1.** Have skin-to-skin contact at least until after the first feed and for as long as they wish | All mothers | Via interview and internal audit data  | 80% |
| **2.** Are encouraged to offer the first feed in skin contact | All mothers | Via interview and internal audit data | 80% |
| **3.** Are encouraged to commence skin contact as soon as possible should this have been delayed  | All mothers  | By interview | 80% |

The Baby Friendly Initiative ***requires*** that all mothers and babies have skin to skin contact with their baby as soon as possible after birth, at least until after the first feed and for as long as they wish. Mothers should be encouraged to have the first feed in skin-to-skin contact. If it has not been possible straight after the birth, skin-to-skin contact should be encouraged as soon as the mother and baby are able.

The opportunity to offer a first breastfeed when the baby shows signs of wanting to feed should be available, even for mothers who intend to bottle feed.

For those mothers who go on to bottle feed, skin contact remains an important way to support the bonding process and therefore offering the first feed in skin contact is encouraged. Extra precautions may be needed to ensure that babies remain warm when bottle feeding in skin contact, as there will necessarily be less of the baby’s body in close contact with their mother than when feeding from the breast.

**Safety**

Vigilance as to the baby’s well-being is a fundamental part of postnatal care in the first few hours after birth. For this reason, all normal observations of the mother and baby should continue and sensible safety precautions taken when required. For example, if a mother has taken drugs during labour that have made her drowsy, she should not be left alone with her baby in skin contact. In this situation her birth partner could keep an eye on the mother-baby pair, but would need to be properly informed about the responsibility. See SUPC Guidelines for more details: [bapm.org/resources/sudden-and-unexpected-postnatal-collapse-supc](https://www.bapm.org/resources/sudden-and-unexpected-postnatal-collapse-supc)

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| **Standard 3 – Getting breastfeeding off to a good start** |

Listed below are the standards which will be assessed at Stage 3.

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| **Standard.** **Mothers…** | **Applies to…** | **How assessed?** | **Minimum % required to pass?** |
| **1.** Are enabled to achieve effective breastfeeding according to their needs (includes appropriate support with positioning and attachment, hand expression) | All breastfeeding mothers  | Via interview and internal audit data  | 80% |
| **2.** Understand responsive feeding, including feeding cues and breastfeeding as a means of comforting and calming babies | All breastfeeding mothers | Via interview and internal audit data | 80% |
| **3.** Receive information abut how to recognise effective feeding prior to transfer home from hospital | All breastfeeding mothers | Via interview and internal audit data | 80% |
| **4.** Have a formal breastfeeding assessment as often as required in the first week on a minimum of two occasions | All breastfeeding mothers | Via interview and internal audit data | 80% |
| **5.** Are informed that support is available from the midwifery service and know how to access this | All breastfeeding mothers | Via interview and internal audit data | 80% |
| **6.** Are given details of telephone helplines/support available from the voluntary organisations | All breastfeeding mothers | Via interview and internal audit data | 80% |
| **7.** Are given specific local information about additional services both those providing social support and basic problem solving, for example, peer support, support groups, Baby Cafes, social media | All breastfeeding mothers | Via interview and internal audit data | 80% |
| **8.** With a complexchallenge with breastfeeding were referred for specialist support and this was helpful and effective | Breastfeeding mothers with a complex challenge | Via interview and internal audit data | 80% |
| **9.** Are enabled to start expressing as soon as possible and supported to express effectively | All mothers with a baby on the neonatal unit | Via interview and internal audit data | 80% |
| **10.** Written information is largely accurate and effective | All written information provided for mothers, to include DVDs and posters | Review  | Yes |

We ***require*** that breastfeeding mothers are enabled to achieve effective feeding according to their needs. We encourage care which enables a mother to feel confident, such as sitting with her through a feed, ensuring that she recognises effective breastfeeding and understands how to achieve this.

This will include appropriate support with how to position and attach their baby and how to hand express. The support offered should enable mothers to achieve this for themselves, so that they can breastfeed independently. For some mothers this will involve teaching the skills from scratch, whereas for others this may involve observation, reminders and checking that she is confident. The assessors will expect the mothers they interview to be able to give a reasonable explanation of the support they have received and will also consider the outcome, in other words, did the support result in a mother who felt confident and supported to breastfeed, relevant to the age of the baby.

Mothers are being discharged from hospital earlier and the first visit from the midwife is sometimes being delayed. This leaves breastfeeding mothers and babies vulnerable to inadequate support with breastfeeding. Of particular concern is the possibility that parents may not recognise when there is inadequate milk transfer and so not seek help soon enough. We therefore ***require*** that all mothers are given information about how to recognise effective milk transfer, both verbally and in writing prior to transfer home from hospital.

In addition, facilities are ***required*** to ensure that a full feeding assessment is carried out, as often as is required in the first week, with a minimum of two assessments to ensure effective feeding and wellbeing of the mother and baby. The outcome of the assessment should be discussed with the mother and documented on a standard assessment tool to ensure consistency and effectiveness. Where any issues are identified, a plan of care should be agreed with the mother and documented. The assessment should be aimed at supporting mothers to gain skills and confidence, and at averting crisis points where mothers are most likely to give up breastfeeding. The development and implementation of a standard assessment tool such as the sample is recommended. See the [breastfeeding assessment tool](http://unicef.uk/bfassessmenttool) on the Baby Friendly website.

It is a ***requirement*** that mothers should be encouraged to feed their baby in response to their baby’s hunger cues, but also that they should be encouraged to view breastfeeding as a way of comforting and calming babies or for when the mother’s breasts are full, or she wishes to spend time with her baby, sit down for a rest or to fit in a feed before other activities for example. .Where a more managed feeding programme is indicated because of clinical need, we would expect mothers to have been advised to offer a minimum number of feeds in a 24 hour period and that once the risk is passed, that responsive feeding remains the ultimate goal.

Where possible, care should recognise that mothers feed their babies within the context of their families and close friends. Staff are encouraged to take advantage of opportunities to provide information to key supporters, particularly fathers and grandmothers who are known to be influential.

We ***require*** that all breastfeeding mothers are informed of the support available to them when they leave the hospital. This should be given on or before discharge from the maternity unit and should include details of midwifery support and how to access this, support from voluntary organisations and telephone helplines, additional support to help deal with basic challenges and social support. In addition, a specialist service to support the small number of mothers who will experience complex problems should be established with an appropriate referral pathway.

Evidence suggests that the periods around 3 days and 10-14 days are potential ‘pivotal’ or crisis points where women who are experiencing breastfeeding difficulties or lack confidence in how well breastfeeding is going are likely to give up. Services should be planned mindful of this risk, involving all available local resources including voluntary organisations and peer support. Careful attention should be paid to ensuring an effective and flexible approach to handover of care between midwife and health visitor, so that the needs of mothers and babies come first.

Further information about the varying levels of support to be provided is available in the statement [**Guidance on provision of additional and specialist services**](https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/guidance-for-health-professionals/implementing-the-baby-friendly-standards/further-guidance-on-implementing-the-standards/guidance-on-provision-of-additional-and-specialist-services-to-support-breastfeeding-mothers/)

If a standard pack of information is given to all mothers when they are discharged home, the expectation is that mothers are aware that they have been given this information; it is not sufficient for them to have been handed a pack with no explanation of what it contains. This also applies to links to on-line information.

We ***recommend*** that staff are encouraged to provide relevant information and support according to the mother’s individual need, with guidance/documentation developed to support this. Written information used to back up discussion can be very helpful. Ensuring that all written/on-line information given is accurate and effective is ***required.*** If leaflets have been developed in-house, we ***recommend*** that these compliment any standard national materials, and consider:

1. the need for clarity, accuracy and simplicity of the messages
2. avoidance of duplication
3. that the layout is attractive and readable.

Poster displays should be informative, and contain information which is accurate, effective and proportionate and cover issues such as breastfeeding and relationship building. If we are not present in the unit for the assessment, we ask you to take photographs of a sample of the displays and submit these.

**Mothers with a baby on the neonatal unit**

If the facility is implementing the full neonatal unit standards, please refer to the separate set of guidance document and application form. Where this is not the case, or the Neonatal unit has yet to be assessed at Stage 3, the unit will undergo a basic level assessment in the neonatal unit and the following ***requirements*** apply:

Mothers should be provided with information about the value of breastmilk for their baby in pregnancy, or as soon as possible after birth.

Skin-to-skin contact should be facilitated as soon as the mother and baby are well enough.

We alsorequirethat mothers with a baby on the neonatal unit are enabled to start expressing as soon as possible after the birth, ideally within two hours and are supported to express as effectively as possible. Those who elect to do this should be taught how to express their milk both by hand and using a breast pump. They should be encouraged to express *at least* 8 times in 24 hours, including at night.

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| **Standard 4 – Informed decisions regarding the introduction of food or fluids other than breast milk** |

We recognise the crucial importance of exclusive breastfeeding, and this should be clearly communicated. However we also acknowledge that there are mothers who are unable to do this, or choose not to. In these circumstances we want to ensure that mothers are encouraged, and that any breastfeeding is valued so that the baby is able to benefit from receiving the maximum amount of breastmilk possible. Minimising the disruption to breastfeeding includes choosing an alternative method of feeding which best supports the return to full breastfeeding when possible.

We ***require*** that no supplements of any kind be given to breastfeeding babies, except where clinically indicated or as a result of a fully informed maternal decision. ‘Informed decision’ is often interpreted to mean ‘telling’ mothers the disadvantages of formula feeding once a supplement has been requested. This can cause distress especially when a mother feels that she has no option because breastfeeding is not going well. Listening carefully to mothers concerns, and supporting her to consider alternative strategies where appropriate with the aim of continued breastfeeding / return to full breastfeeding or maximising the amount of breastfeeds, is how this standard should be interpreted. It is ***recommended*** that staff education programmes address this sensitive communication issue carefully.

We ***strongly recommend*** that robust policies should be in place for the management of at-risk babies and babies who are reluctant to feed. In addition, it is ***recommended*** that any additional guidelines such as the management of the jaundiced baby or the management of excessive weight loss should also be protective of breastfeeding whilst ensuring the safety of the baby. In order that any guidelines you have produced are effective, we ***require*** that the content does not undermine the ability of the unit to meet the standards. These policies should be made available to the assessors so that they can review them in the light of practice found. For guidance on writing/amending a hypoglycaemia policy, we ***strongly recommend*** that you refer to the document available from the Baby Friendly Initiative web site.

Robust processes for documentation of supplements given are ***required.*** Supplementation rates will be collected at suggested intervals and it is anticipated that steady progress to reduce those given without medical indication or fully informed choice will be made.

Where supplements are indicated, we ***require*** that these be given in a way which will minimise the disruption to breastfeeding.

For those mothers who have chosen to formula feed their baby, it is required that they be shown how to make up feeds and given any information necessary to enable them to feed their babies as safely as possible according to their individual need. This will include information to explain that newborn or ‘first’ milk is suitable from birth until the baby is a year old and information about how to offer the bottles responsively. It would not be necessary to show mothers how to prepare formula feeds when these are given for a clinical reason or for a short period only in hospital. However, if mothers are partially bottle feeding at home, staff are expected to ensure that they are able to make up formula feeds as safely as possible.

**Responsive formula feeding**

There is very limited research to guide us when talking about responsive formula feeding, and unfortunately it is possible to overfeed a formula-fed baby. It is suggested that parents are informed about responsive feeding and encouraged to:

* Respond to cues that their baby is hungry.
* Invite the baby to draw in the teat rather than forcing the teat into the mouth.
* Pace the feed so that the baby is not forced to feed more than they want to.
* Recognise their baby’s cues that they have had enough milk.

Forcing babies to take a bit more milk so that they will go longer between feeds can lead to overfeeding and should be discouraged.

We ***recommend*** that staff are encouraged to cover the relevant areas according to the mother’s individual need, with guidance/documentation developed to support this. Supplementation rates will be collected at suggested intervals. It is anticipated that steady progress to reduce supplementation rates (specifically those given without medical indication or fully informed choice) will be made.

Ensuring that there is no advertising for breastmilk substitutes, bottles, teats and dummies within the facility is ***required.*** It is ***recommended*** that regular checks are made in all areas accessed by mothers and of materials provided for them, including sample packs, leaflets and visual materials such as film/DVD.

Please refer to the [guidance document on supplements](https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/guidance-for-health-professionals/implementing-the-baby-friendly-standards/further-guidance-on-implementing-the-standards/supplementation-guidance/) for further information.

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| **Standard 4 - The International Code of Marketing of Breastmilk Substitutes** |

4.1 Adherence to the International Code of Marketing of Breastmilk Substitutes

In accordance with the International Code of Marketing of Breastmilk Substitutes (1981) and subsequent relevant WHA resolutions, we ***require*** that there is no advertising or promotion of breastmilk substitutes, bottles, teats or dummies in any part of the facility or by its staff. This includes the use of company-sponsored leaflets, posters, diary covers, pens, mugs, obstetric wheels and other materials.

This standard is necessary to ensure that breastfeeding is protected and that parents receive unbiased information to support their decisions. It means that:

* There should be no display or distribution of any materials produced by the manufacturers of breastmilk substitutes, bottles, teats or dummies, in any part of the health care facility. This includes gifts bearing company logos intended for health professionals (including pens, diary covers, obstetric calculators, notepads, etc) and written materials intended for mothers (including leaflets that do or do not relate to infant feeding).
* Images which ‘normalise’ bottle feeding should not be displayed.
* There should be no sale of breastmilk substitutes on health care premises.
* Health care facilities should not accept free or subsidised supplies of breastmilk substitutes, bottles or teats.

This standard does not restrict the provision of accurate and impartial information about formula feeding. Parents who have chosen to formula feed their baby should be given clear written instructions and shown how to make up a feed safely before they leave hospital. This discussion should include guidance to use a first stage milk for the first year and how to bottle feed responsively. All community-based staff should ensure that this information has been given and is understood and that should a mother start to offer infant formula while still under the care of the maternity service, that this support is offered.

We will ask you to confirm that the Code is implemented fully through the maternity service, including to check any sample bags such as those provided by Bounty.

🖳 The Baby Friendly Initiative has produced a [guidance document](https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/guidance-for-health-professionals/the-code/a-guide-for-health-workers-to-working-within-the-international-code-of-marketing-of-breastmilk-substitutes/) aimed at health care facilities and describing what practices are and are not acceptable within the Code.

🖳 For accurate and impartial information on infant milks in the UK please visit [First Steps Nutrition Trust’s website](http://www.firststepsnutrition.org/)

4.2 Full payment for infant feeding supplies

The Baby Friendly Initiative ***requires*** that all supplies of infant formula and related products, and teats, be paid for at the full market price. Please note: this standard does not restrict the provision of accurate and impartial information about infant feeding. Parents who have chosen to formula feed their baby should be given clear written instructions and shown how to make up a feed safely before they leave hospital (see Section 3). Community based staff should make sure this information has been given and understood.

We will ask you to show us proof of purchase as part of the assessment.

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| **Standard 5 – Close and loving relationships** |

Listed below are the standards which will be assessed at Stage 3.

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| **Standard.**  | **Applies to…** | **How assessed?** | **Minimum % required to pass?** |
| **1.** Skin-to-skin contact is encouraged throughout the postnatal period | All mothers  | Via interview and internal audit data  | 80% |
| **2.** Parents are supported to understand a newborn baby’s needs | All parents | Via interview and internal audit data | 80% |
| **3.** Mothers who bottle feed are encouraged to hold their baby close during feeds and offer the majority of feeds themselves | All formula feeding mothers | Via interview and internal audit data | 80% |
| **4.** Parents are given information about local parenting support that is available | All parents | Via interview and internal audit data | 80% |
| **5.** Written information is largely accurate and effective | All written information provided for mothers , to include DVDs and posters | Review  | Yes |

We ***require*** that all mothers are informed about and encouraged to care for their baby in a way which will optimise the development of a close mother-baby relationship in the early days following the birth. This should involve keeping their baby close, learning how to recognise and respond to their baby’s cues for feeding, communication and comfort and encouraging skin-to-skin contact throughout the postnatal period. Training and guidance for staff to enable them to do this effectively is ***recommended.***

We ***recommend*** that staff are encouraged to cover the relevant areas according to the mother’s individual need, with guidance/documentation developed to support this.

**Mother baby closeness and safety issues**

Young babies need to be close to their mother, as this is the biological norm. We want to see services/ staff telling mothers about the benefits of keeping their baby close, and encouraging them to do so. However, in day-to-day life there can be risks associated with mothers and babies being close to each other, particularly when the mother falls asleep (which could be night or day).

It is therefore vital that safety issues, in particular safe sleeping, are discussed in a way that is proportionate to the risks involved and that does not frighten parents or close down discussion. Training and guidance for staff to enable them to do this effectively will be needed. See our information on [Co-sleeping and SIDS: Guidance for health professionals](http://unicef.uk/safesleeping) on the website.

**The mother-baby relationship**

Encouraging a close mother-baby relationship is important in the early days following birth. When mothers and babies breastfeed they spend a great deal of time in close contact which helps build and enhance their relationship. Encouraging formula feeding mothers to give most feeds themselves while holding their baby close will support relationship building.

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| Unicef UK has collaborated with the [Lullaby Trust](https://www.lullabytrust.org.uk/) and [Basis](https://www.basisonline.org.uk/) to develop a set of materials to support staff to have sensitive conversations with parents about the crucial importance of safer sleep. These materials include a [quick reference guide](https://www.lullabytrust.org.uk/wp-content/uploads/Safer-Sleep-for-babies-quick-reference-card.pdf) and a more detailed [guide for parents](https://www.lullabytrust.org.uk/wp-content/uploads/Safer-Sleep-for-babies-a-guide-for-parents.pdf) together with a [guide for professionals](https://www.lullabytrust.org.uk/wp-content/uploads/Safer-sleep-saving-babies-lives-a-guide-for-professionals.pdf) to support them to have a helpful and evidence based conversations. The materials are available to purchase from the Lullaby Trust as printed copies or to download free of charge, and are translated into a number of languages. As part of this work, we have agreed with the Lullaby Trust and Basis that we will include assessment of the effectiveness of the work undertaken by maternity, neonatal and health visiting services to support safer sleep in all families. At the Stage 1 assessment services will be asked to describe the mechanism for providing the information both verbally and in writing. At the Stage 3 assessment and at Re-assessment mothers being interviewed will be asked a question to establish whether a conversation about safer sleep has taken place and whether the mother has been given written information or a link to a website where the material is easily accessible. The information provided at Stage 1 and the question asked of mothers at Stage 3 and Re-assessment **will not** be scored formally and **will not** impact on the services ability to pass the assessment or retain their accreditation, however we will give feedback about the process and the responses we have received from mothers.Audit tools have been amended to include the relevant questions. If you do not have the 2019 version please contact the office at bfi@unicef.org.uk  |

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| **The Stage 3 assessment process** |

Stage 3 assessment involves a review of the service, usually over a two day period by a number of Baby Friendly Initiative assessors. Timings will depend on whether the assessment is on-site or carried out remotely.

A short introductory meeting will be held with key members of staff at the beginning of the assessment to explain what will happen, and a feedback meeting will be held at the end to explain the findings. These meetings will be in-person for on-site assessments and via video call for remote assessments.

The assessors will select a representative sample of mothers for interview from the lists provided by the hospital (see below). In on-site assessments we will also aim to talk to a small sample of mothers face to face. In order to gain a representative sample in your area, it may be necessary to interview some mothers via a translator or using a service such as language line. The same consenting processes will apply – see below. The aim of the assessment is to establish the overall standard of care delivered, not to ‘test’ individuals’ knowledge or unearth personal details. The assessors will therefore do their best to put mothers at their ease so that they feel confident to discuss the care they have received.

A selection of managers will be interviewed to ascertain how they support the process of implementing and maintaining the standards.

It is important that the staff are made aware that all interviews will be carried out in confidence and that the assessors will not record interviewees’ names. The assessors have a background in midwifery, nursing, health visiting and/or public health and are bound by the Nursing and Midwifery Council’s Code of Professional Conduct and Unicef UK’s own policies. They are particularly aware of the requirement to protect the confidentiality of information provided during an assessment.

In addition to the interviews, the assessors will review the application form and associated documents with the aim of ensuring that all adhere to the standards. Service leads will be expected to confirm adherence to the International Code of Marketing of Breastmilk Substitutes and to ensure any visual materials are largely accurate and effective.

**Preparations in advance of the assessment**

Certain preparations need to be made in advance of the assessment to help the process to run smoothly on the day. Once the dates of the assessment have been agreed, please:

* Have a conversation with your lead assessor to discuss the arrangements and confirm whether the assessment will be carried out on-site.
* Inform all staff who may be involved that the assessment will be taking place, giving them as much information as possible on how the assessment will be run and what to expect.
* Consider what video technology is available for the staff to use for interview in case this is needed.
* For an on-site assessment, please arrange a room (lockable) for the assessors to use for the duration of their time in the unit and rooms for the introductory and feedback meetings.
* Organise an appointment time for the Head of Service to be interviewed. Interviews should generally not take longer than 30 minutes.
* Arrange a (video) meeting for an introductory and feedback meeting and invite key members of staff including senior staff and medical staff if relevant.
* Arrange for one key member of staff to be available at all times during the assessment to assist the assessors as necessary. This is most likely to be the infant feeding lead, however please consider alternative arrangements should these be needed at short notice e.g. due to sickness.
* Assessors will ideally need access to wi-fi. Establish whether this is a possibility in your organisation, either by enabling use of a Trust computer or a wi-fi password so that UNICEF laptops can be used.

**Video calls for meetings**

You will need to check what technology you have access to for video calls, for example Microsoft Teams. If you have not set up video calls before please ensure you have plenty of time to check with your IT team. It may also be helpful to set up some practice sessions. It is important to ensure that your video link can be accessed externally by the Baby Friendly assessors.

**Guidance for collecting telephone numbers and consenting mothers**

**Consenting mothers for interview**

In order to ensure that a fair and representative sample of mothers is interviewed, it is crucial that the following is adhered to:

**Sample size**

Many mothers don’t answer the phone, so in order for us to talk to sufficient mothers, we need a big list of names of mothers who have consented to be interviewed. For most services**\***, this means that we will need to receive *at least* 150 names.

**Sample validity**

When consenting mothers, it is important to select entirely at random. Therefore the following is required:

* Commence consenting mothers 5-6 weeks in advance of the assessment.**\***
* *All* mothers giving birth within the timeframe should be asked to consent to interview. We suggest that you ask all mothers for consent to be interviewed prior to their departure from the postnatal ward (see exclusion criteria below).
* It is not acceptable to bias the sample by selecting mothers based on their feeding history, or to select only those who have accessed classes, groups or been seen by the Infant Feeding Lead. However, some of these mothers are suitable for interview as part of a random sample.
* It is not acceptable to bias the sample by asking staff to select only two or three mothers each from their caseload or by selecting mothers from certain areas only.
* Please consent mothers who do not use English as a first language. The telephone numbers list has a column for you to identify preferred language spoken. Your lead assessor will discuss with you about how we can interview a sample of these mothers, if appropriate.

The goal is to achieve a random list of mothers – different types of birth, parity, feeding experience, babies with varying ages, living in different areas, breast and formula feeding in order to give the fairest representation of the care the facility provides.

***\*****For average sized facilities – we may need more or fewer numbers so smaller or larger facilities may need to collect numbers for a longer/shorter period.*

**Exclusion criteria**

There may be reasons to exclude some mothers from your sample. The following mothers should be excluded. Mothers:

* who are under the age of 18
* who could be too ill to take part in an interview
* with vulnerabilities where the service feels contact would be inappropriate
* with a baby who is unwell
* who live out of the area.

**Obtaining consent**

We suggest that you ask all mothers for consent to be interviewed, prior to their departure from the postnatal ward. We provide a sample Mother consent form ([unicef.uk/motherconsent](http://unicef.uk/motherconsent)) to help you obtain consent. You may wish to use our sample, or adapt the wording into your own format, however it is essential that the wording retains the following information:

*What happens to the information I give?*

* *Your contact details will only be used for the purpose of the interview, and will not be passed on to anyone else. Unicef UK will destroy your contact details within a week of our conversation.*
* *What you tell Unicef UK is confidential and won’t be linked to you by name. We’re talking to many mothers in your area and will use all the answers together to find out what is working well and where we could do better.*
* *Unicef UK will only feedback your individual information to the service if you or your baby need urgent help or are in danger.*

If mothers are being consented by telephone, it is important that the member of staff gaining consent covers all of the information on the form and signs and dates the form. The assessors will confirm consent with each mother before proceeding with the interview.

**Safeguarding policy**

Throughout our work in the Baby Friendly Initiative, the welfare of children is our paramount consideration. Under Working Together 2018, we have a duty to both report any concerns we have that a child may be at risk of harm, and to follow up with the agency to whom we have reported these concerns, to confirm that action has been taken to protect the child. In order to conduct Baby Friendly assessments, we routinely work in partnership with experienced healthcare professionals and our normal reporting process will be to inform the Infant Feeding Lead that we are working with of any concerns, so that these can be processed in the usual way within the healthcare setting.

We would only report directly to statutory agencies if our concern was so urgent that contacting the Infant Feeding Lead would cause delay that could prejudice the child’s welfare, or where we were unable to confirm that action had been taken and therefore needed to escalate our concern in order to ensure the child was protected from harm.

A copy of our full safeguarding procedures can be provided upon request.

**Record keeping**

Please collect all consent forms from and transfer contact numbers into the telephone grid. You do not need to send each copy of each mother consent to us. Please keep copies of the individual consents until your assessment is complete (i.e. you have received your assessment report) and then destroy the forms securely.

Unicef UK will not keep any data of the consented mothers you submit to us after the assessment; all phone numbers are deleted and would not be used for any other purpose other than the Baby Friendly assessment.

For more information about Unicef UK’s privacy statement please visit

[unicef.org.uk/legal/cookies-and-privacy-policy/](https://www.unicef.org.uk/legal/cookies-and-privacy-policy/)

**Sending the telephone numbers**

There is a sample grid provided to submit these telephone numbers (see website Stage 3 page). Please use the form as it will help us to divide telephone numbers between assessors, including the telephone assessor/s. The list will need to be sent to the lead assessor **at least a week in advance of the assessment** (occasionally this can be up to two weeks in advance as the phone interviewers may be doing the calls up to a week before the actual assessment).

Sending data such as names and phone numbers should be done securely;

* We strongly recommend you send the files via a secure file sending system and password protect the document. Please avoid sending the lists via email without any encryption.
* You may wish to use the Box upload link to send the file (see guidance below) or your own internal IT department may have a preferred approach or system to use. Allowing plenty of time to research and finalise safe sending of the data will help avoid delay and potential threat to us being able to carry out your assessment effectively.

Please contact the Baby Friendly office with any queries.

To send us these files directly, please visit this uploading page on our website

[**unicef.org.uk/BabyFriendly/Health-Professionals/going-baby-friendly/Health-professionals-contact-us/**](http://www.unicef.org.uk/BabyFriendly/Health-Professionals/going-baby-friendly/Health-professionals-contact-us/)

Select ‘choose file’ and select the file you’d like to send from your computer.

Add details in the description box to include your organisation name and dates of assessment.

Add your email address, so we know who has sent the file and who to contact with any queries. You can send additional files by returning to the link again.

If you have password protected the file, please call or email the Baby Friendly office to give the password for the files you’ve sent.

*If you are unable to use this uploading page, please send the files by any secure method used by your organisation and ensure the files are password protected.*

🗐 **Please confirm that the consents list has been collected in accordance with the above guidance and is a true reflection of the mothers cared for by the facility in the application form (signature page 3)**

Please ensure that the following are submitted two weeks prior to the assessment:

* The lists of mothers who have consented to be interviewed, with their telephone numbers (see above)
* A copy of the current infant feeding policy
* A copy of the current hypoglycaemia policy or guidelines and any policy or guidance on the management of babies who are reluctant to feed.
* A copy of any other policy/ies which may be relevant to the care provided in relation to infant feeding, e.g. guidelines on the management of jaundice.
* A copy of the curricula for staff training and an outline of the induction programme for new staff
* Antenatal parent education class curriculum/a for infant feeding and related topics (if provided)
* Copies of all written materials on infant feeding and relationship building currently provided for pregnant woman and/or new mothers, including those whose babies are in the neonatal unit.
* Copies of the antenatal and postnatal prompts sheets and associated documentation.
* A copy of the information given to mothers about how to recognise effective milk transfer.
* A copy of the breastfeeding assessment tool.
* A copy of the specialist referral pathway, audit and evaluation data.
* Completed action plan for dealing with issues from supplementation audits.
* Proof of purchase of infant formula, bottles and teats

**What happens after the assessment**

**Feedback of findings**

You will be informed of the results of the assessment at a (video) feedback meeting towards the end of the visit. We request that you consider carefully who is invited to attend this meeting. We suggest that this is limited to the Baby Friendly lead/s, line manager and other managers and medical staff with involvement in implementing the standards together with the Head of Service. This meeting is an opportunity to discuss and plan how any shortfalls can be addressed in order that this assessment is passed or to consider how progress can be made towards the next assessment/reassessment.

**Confirmation of the outcome of the assessment**

After the assessment, the results will be written up in a detailed report. A copy of this report will be sent to the Baby Friendly Initiative’s Designation Committee, which has to approve the report. They will normally do this within ten days of receiving it and you will then receive a copy of the report and any requirements suggested by the Committee. Occasionally, the report has to be considered at one of the Committee’s meetings, which take place every two months. In this case you will need to wait a little longer for confirmation of the result of the assessment.

Although standards assessed on the basis of the information provided at Stages 1 and 2 will not be formally re-assessed at Stage 3, the assessors will comment at this assessment on anything they notice which conflicts with the information provided previously. They will then include recommendations for addressing these anomalies in their Stage 3 report. If Stage 3 is deemed passed, the facility will be accredited as Baby Friendly. Once the facility is accredited, this typically lasts for two years, at which point you will be invited to undertake a re-assessment in order to maintain Baby Friendly status. Re-assessment takes place in one go, not in stages.

🗁 **Stage 3 application form**

To download, please visit [the Stage 3 page on the website.](https://www.unicef.org.uk/babyfriendly/accreditation/maternity-neonatal-health-visiting-childrens-centres/stage-3-parents-experiences/parents-experiences-of-maternity-services/)