The Baby Friendly Initiative

UNITED KINGDOM

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# GUIDE TO THE UNICEF UK BABY FRIENDLY INITIATIVE NEONATAL STANDARDS

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# FOREWORD

**As we mark the tenth anniversary of the UNICEF UK Baby Friendly Initiative neonatal standards, we reflect on a decade of significant progress and transformative change in the way vulnerable babies, their mothers, parents/primary caregivers and families are cared for.**

Over the past ten years, the Baby Friendly neonatal programme has gone from strength to strength. What began as a vision to embed evidence-based, family-centred care into neonatal settings has now become a national benchmark for infant care. Neonatal units across the country have embraced the standards, creating environments where parents/primary caregivers are supported as partners in care and babies are supported to receive the best possible start in life.

This journey of improvement has occurred alongside meaningful progress at a national level, including legislative changes that better recognise and protect the rights and needs of families. The introduction of Neonatal Care Leave and Pay (April 2025) represents a significant win for employed parents to take up to 12 weeks of paid leave when their baby requires more than 7 days of neonatal care. This piece of legislation will enable families to be more present and involved in the care of their baby from the outset and will help to reduce anxiety related to balancing work and being with their baby.

We have also seen encouraging developments in clinical practice, particularly around skin-to-skin contact. Increasingly recognised as a vital component of neonatal care, skin-to-skin is now more widely implemented across units. It supports bonding, stabilises vital signs, reduces stress and improves feeding outcomes.

Whilst promising, these advances come at a time of significant challenge. The launch of a national enquiry into the safety of neonatal and maternity care underscores the urgent need to address systemic issues and ensure that every family receives safe, high-quality and compassionate care. We acknowledge the immense pressures faced by services and the dedication of staff working tirelessly to provide the best possible outcomes in what are often difficult circumstances.

The Baby Friendly neonatal programme has been further strengthened by two externally funded projects that have been instrumental in driving innovation and enhancing support available to neonatal units. This includes the Burdett Project and the National Neonatal Project. These projects have enabled neonatal units across the UK to begin their Baby Friendly journey, helping to improve standards of care for the families they support.

We hope that you find this guidance document useful in understanding and embedding the Baby Friendly neonatal standards in your unit. Whether you are just beginning your journey or working to sustain the standards, we hope this resource will guide and encourage you.

As we look ahead, we are proud to witness how far the programme has come — and how much it continues to shape the culture of care across neonatal services. We remain committed to building on this strong foundation.

**Shereen Fisher**

**Programme Director**
**UNICEF UK Baby Friendly Initiative**

# INTRODUCTION

## WELCOME

This guide by the UK Committee for UNICEF (UNICEF UK) Baby Friendly Initiative aims to support those tasked with implementing the Baby Friendly neonatal standards by providing a road map for the journey towards Baby Friendly accreditation, including helpful tips and ideas. This guidance should be read alongside the Guide to the Baby Friendly Standards which details the standards and assessment process.

## BACKGROUND

The Baby Friendly Initiative is a global programme of UNICEF and the World Health Organization which aims to improve practice for infant feeding in healthcare settings. Introduced to the UK in 1994, the Baby Friendly Initiative has been very successful in changing routine care for babies, their mothers, parents/primary caregivers and families.

Until 2012, neonatal units had been included as part of the UNICEF UK Baby Friendly Initiative maternity standards by concentrating on the care of mothers currently on the postnatal ward with a baby on the neonatal unit. Following a review of the programme in 2012, the Baby Friendly neonatal standards were introduced as an expanded set of evidence-based standards encompassing the holistic care of families related to building close relationships, feeding and supporting parents to be partners in care. This enabled the programme to succeed greatly in improving care on neonatal units, especially around skin-to-skin contact, expressing breastmilk and breastfeeding.

Following this review and an external consultation, an audit tool was developed to support units to internally audit the standards. This tool uses interviews with clinical staff and parents to allow trained staff to map progress over time. An external assessment tool was also developed consisting of interviews with managers, parents/primary caregivers and staff of all disciplines and grades, as well as reviews of policies, guidance and mechanisms to support good practice.

Learn more about the Baby Friendly neonatal programme on our website.

# OVERVIEW OF THE STANDARDS

## STAGE 1: BUILDING A FIRM FOUNDATION

1. Have written policies and guidelines to support the standards
2. Plan an education programme that will allow staff to implement the standards according to their role
3. Have processes for implementing, auditing and evaluating the standards
4. Ensure that there is no promotion of breastmilk substitutes, bottles, teats or dummies in any part of the facility or by any of the staff.

## STAGE 2: AN EDUCATED WORKFORCE

1. Educate staff to implement the standards according to their role and the service provided.

## STAGE 3: PARENTS' EXPERIENCES OF NEONATAL UNITS

1. Support parents to have a close and loving relationship with their baby
2. Enable babies to receive breastmilk and to breastfeed when possible
3. Value parents as partners in care.

## OVERVIEW

The first piece of work is deciding how the project is going to be led and the roles that staff will undertake. This is a major change management project and so it is important to consider available resources carefully.

## PROJECT LEAD

It is common for there to be an infant feeding coordinator within the maternity unit who leads on the implementation of the Baby Friendly standards. While this person brings a wealth of knowledge and expertise, experience has shown that it is also beneficial to have a project lead based in the neonatal unit. This brings the expertise and focus needed to support staff with the changes required.

Depending on unit size and number of staff, the project lead will need protected hours. They will also need the experience to manage the project and command staff respect. Training requirements should be considered, including support needed to update clinical skills/knowledge, learn project management, educate staff and complete audits.

Much of this can be provided by the maternity infant feeding coordinator. There are also courses offered by UNICEF UK and other organisations which can provide the necessary support.

## PROJECT CHAMPION

We suggest that a project champion be identified from the start. This is usually a senior staff member who represents the project at senior management level and helps identify resources and offers support to the project lead and other team members. The project champion should be part of the senior management team (e.g. consultant neonatologist / paediatrician or head of nursing) and should be willing to offer their experience and influence to take the project forward.

Although the project champion is not expected to have a 'hands-on' role, they should be regularly informed on progress and be fully conversant with what is required of the unit as the standards are implemented.

## PROJECT STRATEGY GROUP

It is suggested that a forum exists for a senior group to oversee project implementation. In some services this will be an overarching strategy group, including maternity. The group should be small enough to be effective and should include representatives who can steer the project. Membership will depend on unit size and complexity, but could include the unit lead, senior clinical staff member, neonatologist, project lead, maternity infant feeding lead, relevant allied profession e.g. dietitian, speech and language therapist, psychologist or developmental care lead, and a representative of an active neonatal peer support group. Terms of reference should be produced with agendas, notes and actions agreed.

Project planning may depend on existing progress with Baby Friendly. In almost all hospitals in the UK, the maternity unit has made some progress towards Baby Friendly accreditation with the involvement of the neonatal unit.

The project strategy group should also contain a Guardian. This is someone with sufficient seniority within the organisation and interest in Baby Friendly who is appointed and has access to the Trust Board. The Guardian should be a member of the strategy group so that they are aware of progress being made and challenges encountered. There can be more than one Guardian where appropriate.

**There are two initial steps your organisation can take to begin your Baby Friendly journey.**

## REGISTER OF INTENT

Complete the Register of Intent form to indicate your service's intention to start working towards accreditation. You can also choose to book a planning meeting with a member of the Baby Friendly team to discuss your service and how you can start your journey. This will enable you to develop a structured action plan suitable for local need, as well as an infant feeding policy.

Register of Intent form: unicef.uk/register-intent
Planning meeting: unicef.uk/planning-meeting

## CERTIFICATE OF COMMITMENT

This is the first award given by UNICEF UK in recognition that a service:

- Has completed an action plan and submitted it to the Baby Friendly office
- Has adopted an infant feeding policy (or equivalent) that covers all of the standards
- Is committed to implementing the plan, demonstrated in the Certificate of Commitment application signed by the Chief Executive.

Useful resources for preparing to go Baby Friendly can be found at: unicef.uk/babyfriendly-preparing

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STAGE 1

# BUILDING A FIRM FOUNDATION

## OVERVIEW

The purpose of a Stage 1 assessment is to ensure that all policies, systems and paperwork are in place in order to provide a solid platform for implementation of the project. It is important that you commit to completing all the Stage 1 paperwork as this lays the foundation for the project.

Please print or download the Stage 1 guidance and submission document and proceed through each section carefully. Once the form is completed, consider where the gaps are. This will help form the basis of your first action plan.

You can make use of the following Baby Friendly sample documentation and resources:

- Sample infant feeding policies
- Curriculum guidance document
- Having meaningful conversations with mothers
- You and Your Baby: Supporting Love and Nurture on the Neonatal Unit leaflet
- Train the Trainer course and materials
- Embedding Baby Friendly Standards in Neonatal Care neonatal course and materials
- Audit tools and courses
- A Workbook for Neonatal Nurses

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## MONITORING PROGRESS: AUDIT & EVALUATION

Monitoring implementation of the standards is an ongoing process. The neonatal audit tool aims to help keep you informed as to how well you are doing and when it is appropriate to book external assessments.

We strongly recommend that a baseline audit of the standards is carried out as soon as possible. This will allow you to identify the areas that are working well and areas where there is work to do. It will also allow you to map the progress that is being made to improve care right from the start. This is important as it provides evidence of improvements in outcomes for all the work and investment that is taking place.

It is important to assess the effectiveness of the training as soon as possible so that any weaknesses can be addressed before training the rest of the staff. Therefore, after the baseline audit, the second audit of staff should be carried out on those who have completed the training package. As more staff attend training, practice should begin to change. When enough staff have been trained to affect care, further audits of practice can begin. The mother interview audit tool will provide insight into the care parents/primary caregivers have experienced.

When selecting mothers to interview, it is important to select those at different stages of their journey through the neonatal unit, as well as those whose babies have been discharged home. This is because perceptions change over time. We suggest that interviews start with mothers whose baby is at least 30 weeks corrected age as this will allow enough care to have been provided to ensure relevance.

The Baby Friendly audit tool is designed to be used by clinicians with knowledge and skills in the Baby Friendly standards. Elearning packages are provided to support the auditors to learn how to audit effectively.

STAGE 2

# AN EDUCATED WORKFORCE

## OVERVIEW

Staff education is key to ensuring implementation of the standards and improvements in practice. Quality training which engages and inspires participants can exert profound influence over the culture within a unit. Time is required to plan training that is interesting, relevant and fun. You also need to ensure that key learning outcomes are met and participants have an opportunity to discuss, question and unpick issues which impact their work.

The Baby Friendly Initiative has developed guidelines for developing a training curriculum with an outline of key topics which need to be covered. There are also a number of courses to help staff leading on training and audit.

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## PROGRAMME

As you begin to plan the training programme, you will need to consider various issues including:

- Commitment from managers to support the training, including allocation of preparation time and support for the training needs of the trainers.
- How staff are to be released to attend training, which requires agreement at the outset.
- Using the Baby Friendly audit tool to conduct a baseline audit of staff skills and knowledge to identify strengths, weaknesses and gaps.
- The training needs of medical staff.
- Delivery of training, including sourcing and booking a training venue. Delivery may depend on unit size, as larger units may be able to release 10+ staff at a time for block training whereas smaller units may release fewer. Some areas have combined basic training with midwifery colleagues and provided additional training in bite-sized workshops and one-to-ones in clinical practice. Others run the entire training via small workshops based within the practice area. Workbooks, e-learning and other innovative approaches can further support training.
- Non-commercial training and conferences which may enhance local offerings. See UNICEF UK's Guide to Working Within the International Code of Marketing of Breastmilk Substitutes.
- Developing a system for keeping records of staff members' completion of all parts of the training.
- Carrying out further audits of training to identify additional education needs and then amending the training programme as necessary.
- Auditing practice through face-to-face interviews with parents/primary caregivers using the Baby Friendly audit tool and developing action plans to address theory or practice gaps.

STAGE 3

# PARENTS' EXPERIENCES OF CARE

**The following section explains the three standards in detail, including what they mean for practice and what the Baby Friendly assessment team will be looking for at assessment.**

## STANDARD 1:
## Support parents to have a close and loving relationship with their baby

### 1. Parents understand why close and loving relationships are important now and in the long term.

We are looking for parents/primary caregivers to be supported to understand that their relationship with their baby is crucial for their baby's wellbeing and development, both now and in the longer term. The goal is to empower them to feel that they are a vital part of their baby's care rather than a visitor who is less important to their baby's wellbeing than the staff carrying out the majority of care. We are also looking for caregivers to understand in simple terms the general principles of the science that underpin this standard, preparing them to nurture their baby now and in the future in a loving, responsive way.

It is recognised that great sensitivity is required with this standard, as some very preterm/sick babies may have poor long-term health outcomes. Being separated from their baby at birth and faced with the possibility that their baby might not live can also result in some caregivers distancing themselves in order to protect their own emotional wellbeing. Staff therefore need to be gentle and sensitive in their approach and help them to take small steps towards understanding the theory which then leads to gradually applying this to their own situation in a way that is right for them and their family.

Steps towards making this happen could include:

- Providing quality training to enable everyone on the neonatal unit to understand the basic neuroscience that underpins this standard, including considering the different challenges faced by a preterm baby growing inside an incubator as opposed to their mother's womb.
- Training programmes which address communication skills so that staff are enabled to feel confident to listen, tailor information and help parents'/primary caregivers' voices to be heard.
- Considering ways to revisit the key messages through the use of posters, leaflets and links to quality information on websites. Because of the stress caregivers are under, it is unlikely they will be able to absorb much information in one go.
- Pointing out how the baby responds to their parent's/primary caregiver's voice, touch and smell as a way of staff starting conversations and reinforcing the key messages.
- Considering the longer term. This information is not just important while a baby is very ill, but also as they grow stronger and once they leave the unit and throughout their childhood and into adulthood.

**FIND OUT MORE**

### HELPING WITH COSTS

A 2022 report by the charity Bliss identified the hidden costs of having a premature or sick baby on a neonatal unit. Parents surveyed reported paying £405 in additional weekly costs while their baby was in hospital.

These costs arise from parents paying for travel to and from neonatal units daily, relying on high-cost food and drink available on-site at hospitals and paying additional unaffordable childcare costs. Parents also reported losing an average of around £3000 in lost income during their baby's stay.

Learn more: bliss.org.uk/research-campaigns/our-campaigns/hidden-costs

### 2. In the absence of parents/primary caregivers, the baby's needs for comfort and emotional support are met by an individual selected by the caregiver or by a staff member.

Babies thrive in close contact with their main carer (for very young babies this is most often the mother, but fathers/partners have an important role). Parents and primary caregivers are thus most appropriate to provide comfort and contact and should be encouraged to do so as much as possible.

However, caregivers may not be able to be in the unit at all times because of work and family commitments. It is important that the needs of the baby for care and comfort continue to be met. Consider what would happen if baby was at home; it is unlikely that they would be left alone for long periods without contact. Sadly because of pressure of work within busy neonatal units, staff can find it easier to carry out basics functions, administer drugs, tube feed, etc. without providing touch, communication or comfort. Comfort and emotional support should be seen as second only to survival in the priority it is given on a neonatal unit so that babies are not left for hours without human contact.

Steps towards making this happen could include:

- Supporting caregivers to select other family members to provide this care in their absence.
- Looking at other schemes to help families and staff provide this care to babies. Strategies include supporting families to understand how to support their baby through positive touch, talking and developmental care practices when delivering care.
- Supporting nurses to feel comfortable taking on this role. Our experience is that nurses worry that they will be seen as not working hard enough if they are talking to and cuddling a baby. They may also worry that they will be considered as taking on a parental role. Supporting nurses and other staff to feel confident that this is part of their role needs to be incorporated into training and the culture change over time. Both parents/primary caregivers and staff also need to be supported to understand that this is in the very best interests of babies and not an optional extra.
- Recording all contact as part of general care so that it is not forgotten and so that babies' experiences and responses can be mapped over time.

### 3. Parents/primary caregivers and staff are enabled to recognise baby's behavioural cues and tolerance for stimulus and parents are supported to build close relationships via touch, talking, comforting, etc. as appropriate.

The normal interactions between a parent/primary caregiver and their baby can be severely restricted in a neonatal unit. They can feel 'on show' and there can be many barriers to getting close with their baby. Behavioural cues in preterm and sick babies are also different and more subtle than in a well baby. Understanding these cues and feeling able to interact with their baby is therefore a vital part of offering appropriate close and loving care.

Steps towards making this happen could include:

- Including behavioural cues in staff training and making sure that all parents/primary caregivers are supported to understand the cues of their baby.
- Providing screens, books and other tools as aids for caregivers. It can be difficult to talk and comfort in an open plan public environment, and it is also harder for some depending on background and culture.
- Recognising that staff with expertise in developmental care can offer much support. There are also excellent materials and courses that can help support staff to gain the necessary expertise.
- Written material, posters etc. which can help support conversations and information sharing.
- Supporting parents/primary caregivers to recognise when baby needs time out, as overstimulation can be just as distressing as none.
- Encouraging staff to listen, accept and respect parents'/primary caregivers' input about their baby's condition and needs. As they get to know their baby they will be more attuned to their baby's individual needs and nuances.

### 4. Prolonged, frequent skin-to-skin contact is encouraged for all babies. Skin contact is prevented only for acceptable clinical reasons, not due to lack of staff training or resources.

Skin contact needs to be recognised as a part of essential care, not as a desirable 'add on' if there is time, resources and/or staff availability.

Steps towards making this happen could include:

- Educating all staff to be confident to assist with the transfer of the baby from the incubator and to be aware of how to position them for safety and comfort.
- Educating all staff to support parent-led transfers for skin contact as and when the parents/primary caregivers feel confident to do this.
- Making sure that the chairs provided are comfortable enough to allow skin contact for prolonged periods.
- Recording occurrence/duration of all skin contact.
- Supporting parents/primary caregivers to become confident in recognising their baby's behavioural cues so that they can take a lead on initiating skin contact.
- Ensuring that skin contact is not viewed as only important in a high-dependency environment, but is encouraged for parents/primary caregivers and babies throughout the neonatal stay and beyond.

### 5. Parents and staff who are bottle feeding are supported to do this responsively, recognising the baby's cues and need for comfort and closeness during feeding.

Feeding is a key time for babies to be close to their carers and to receive comfort and communication. In a neonatal unit, feeds are often seen as a clinical intervention with the objective being to make the baby swallow a prescribed amount of milk. Whilst it is recognised that nutritional intake needs to be carefully regulated and monitored, it is important that babies experience feeding as a safe and pleasurable experience where their needs for closeness and comfort are also met.

Steps towards making this happen could include:

- Helping babies learn to coordinate their suck, swallow and breathing as they feed in a gentle, supportive way. The teat provides a very strong stimulus to suck and hyper-stimulation caused by rubbing it against the palate can be distressing. Educating caregivers and staff to invite the baby to draw in the teat rather than forcing it into the mouth and to pace the feed (including recognising baby's cues they want to stop) will make feeding less stressful.
- Encouraging staff and parents/primary caregivers to finish feeds by nasogastric tube rather than force-feeding babies. It is better that babies take a smaller amount and experience feeding as pleasurable than be forced to take a larger amount which causes them stress and could lead to feeding problems later on.
- Supporting both staff and parents/primary caregivers to feed babies close in a semi-upright position with plenty of eye contact so that they feel safe and comforted. Preterm babies have limited core stability so the common practice of holding them away with support only behind their shoulders is stressful for them.
- For babies who may need additional support when establishing bottle feeding, implementing supportive measures such as elevated side-lying feeding with support from speech and language therapists should be considered.
- Encouraging eye contact and gently talking to and reassuring the baby throughout the feed so that signs of distress or cues that the baby has taken enough are responded to.
- Supporting staff to feel confident with responsive bottle feeding. Staff may sometimes feel that holding babies close is inappropriate for them as it makes feeding less of a clinical intervention and they may look as if they are taking time out. Supporting them to understand why this is important for the baby is therefore vital. Nurses are also important role models for caregivers.
- Ensuring that all parents/primary caregivers are supported to learn how to make up bottle feeds correctly and what milk to use prior to going home with their baby.

## STANDARD 2:

## Enable babies to receive breastmilk and to breastfeed when possible

### 1. A discussion with parents takes place about the value of breastmilk as early as possible.

Breastmilk is crucial for preterm/sick babies. It is important that all parents/primary caregivers with or likely to have a preterm/sick baby understand this. Many who may have never considered breastfeeding will be open to providing breastmilk when its value to their baby is understood.

Steps towards making this happen could include:

- Developing a mechanism with the maternity service to ensure that the neonatal unit is alerted to all those who are pregnant who may have a preterm or sick baby so that a conversation about breastmilk and expressing can be arranged.
- Having a conversation with parents/primary caregivers about breastmilk and expressing as part of the admissions procedure for every baby.
- Having written information to leave with parents/primary caregivers after the conversation to help them recall and consider the information.
- Ensuring the key staff responsible for conducting these conversations have the information and communication skills to do this effectively.

### 2. Mother's own breastmilk is always the first choice of feed (except for a small number of acceptable clinical indications, e.g. HIV infection or mother undergoing chemotherapy).

Mother's own breastmilk and particularly colostrum will bring the greatest benefits to the baby.

Steps towards making this happen could include:

- Ensuring that all staff understand the value of colostrum for priming and protecting the very immature 'gut' of preterm and vulnerable babies.
- Labelling/numbering colostrum to be used in the order of expression. The properties of colostrum provide a protective coating to the lining of the gut which prevent bacterial transfer. Evidence indicates it should be used in order of expression, as it changes to meet the infant's requirements in the hours and days post-birth.

### 3. Mothers are enabled to express milk as soon as possible, ideally within the first two hours.

The earlier a mother begins to express breastmilk the better long-term production will be.

Steps towards making this happen could include:

- Developing a mechanism whereby neonatal staff and midwifery colleagues on the delivery suite are reminded to support and record this.
- Introducing colostrum packs (ready-made packs containing all equipment/information to support hand expressing of colostrum) to help staff implement the mechanism for supporting early expression.
- Monitoring via audit the percentage of mothers expressing within two hours and setting targets/timelines for improvements when required.

### 4. Breastmilk is used for mouth care and tempting the baby to feed.

The anti-bacterial properties of breastmilk combined with the sweet familiar taste (babies appear to recognise their own mother's milk) provides comfort, stimulates enzyme release and is an excellent way to keep baby's mouth clean. Even when baby is not tolerating feeds, using breastmilk for mouth care is valuable and staff should be encouraged to use this in preference to other mouth care solutions.

Steps towards making this happen could include:

- Educating staff and parents/primary caregivers on the value of using breastmilk for mouth care.
- Showing parents/primary caregivers how to do this and providing them with the necessary equipment.

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### 5. Mothers learn how to express effectively by hand and pump (as appropriate to individual need) and learn how to store milk.

Hand expressing is a useful skill for all breastfeeding mothers, as it requires little equipment and can be used at any time. It is particularly useful for expressing colostrum, as the small amounts can be collected in a syringe ready to be stored or used immediately. Mothers need to be enabled to use available breast pumps and therefore need instruction on how to do this, with follow up to ensure effectiveness.

Steps towards making this happen could include:

- Liaising with the maternity unit to ensure that all mothers are shown how to hand express as soon as possible after birth.
- Developing prompts in baby's records to remind staff to check that mothers know how to hand express and to educate mothers on pump use.
- Introducing and using the Baby Friendly expressing assessment form for all mothers.
- Educating staff to be flexible in their approach to how mothers express milk whilst employing strategies that are known to increase production and yield, such as combining hand and pump expression, massage and double pumping.
- Suggesting mothers try hand expressing at the start and end of an expression with a pump. Touch is important for production of the milk-making hormone prolactin.
- Ensuring that hospital-grade breast pumps are always available as these are the most efficient.
- Increasing the availability of different funnel sizes. Too large a funnel will result in decreased milk expression; too small will cause damage to the nipple and breast.
- Promoting double pumping as this can be more efficient in gaining larger volumes in a shorter period of time as opposed to expressing both breasts separately.
- Providing mothers with storage containers and labels and ensuring that there is a system whereby milk is labelled to enable it to be used in order of expression so as to help maximise the effectiveness of breastmilk. Once the gut has been primed with colostrum, breastmilk should be used fresh whenever possible.

### 6. Mothers are supported to express frequently to optimise supply, especially in first 2-3 weeks.

The first couple weeks after birth are crucial for optimising future milk supply. It is recognised that the more a baby feeds in those first couple of weeks, the better the milk supply will be in the future. Mimicking what a mother and baby would do if they were together is therefore the best way to support expression.

Steps towards making this happen could include:

- Encouraging mothers to express between 8-10 times (minimum) in 24 hours, including at least once at night.
- Educating mothers not to leave long gaps between expressions. However, mothers do not need to express to a strict three-hourly regime, as they are more likely to express frequently if given flexibility. Cluster expressing (expressing 2-3 times in a short period) can help to increase the frequency of expressing and enable mothers to fit expressing around other commitments.
- Providing mothers with their own expression log so they can record expressions. It is the responsibility of the staff to check the logs and discuss expressing with mothers so they can monitor and support progress.

### 7. Mothers have access to adequate and effective expressing equipment to use on the unit and at home.

There should be easy access to pumps on the unit, including a choice of funnel size. There also must be an effective breast pump loan scheme that the unit takes some responsibility for. It is not acceptable for the unit to simply refer mothers to a third party provider of breast pumps and never check the quality of the service provided.

Steps towards making this happen could include:

- Ensuring that hospital-grade pumps are provided in all units with a range of funnel sizes available.
- Auditing the current system for provision of breast pumps to use at home. This can be carried out by asking mothers if they have always had a pump available and if the pump used is effective enough for expressing breastmilk for a preterm or sick baby.

- Planning to develop an effective breast pump loan system if current arrangements are inadequate. Provision of high quality electric pumps for home with a double pumping feature should be considered in order to continue to support effective expressing when the mother is unable to be resident on the neonatal unit. If a third party is used to provide this service, audit should be undertaken to ensure effective support and provision of equipment.

### 8. A formal review of expressing takes place a minimum of four times in the first two weeks and there is access to further help with expressing if milk supplies are inadequate or less than 750mls by day 10.

It is important that mothers have the support that they need to maximise the amount of breastmilk they are able to express. The first two weeks are crucial for priming the breasts and so it is essential that mothers are not left to manage expressing alone during this period. Further support should be provided if the milk supply is not increasing sufficiently during this time. Evidence suggests that approximately 750mls or more by day 10 is an indicator of an ongoing milk supply.

Individual circumstances such as extreme prematurity and changing infant or maternal condition could affect effective expressing. Sensitive communication should be employed alongside support to encourage any breastmilk for the baby. Steps towards making this happen could include:

- Using the Baby Friendly Initiative sample expressing assessment form which can be adapted for individual hospital use.
- Ensuring all mothers have a formal assessment carried out at least four times in the first two weeks to ensure they are not experiencing problems. Assessments should be recorded and remain with the mother.

### 9. Expressing is frequently checked on an informal basis after the first two weeks.

Whilst it may be unnecessary to continue checking technique formally if a mother has mastered expressing, it is important to check how they are doing and talk through challenges/obstacles. Long-term expressing is relentless and empathy, praise and interest will help support mothers to continue.

Steps towards making this happen could include:

- Having reminders in the records so that staff remember to raise the topic with mothers.
- Encouraging mothers to maintain an expressing log which is regularly checked by staff.
- Encouraging mothers to seek help if they are experiencing difficulties/if their supply reduces.

### 10. The unit has an environment conducive to expressing.

Neonatal units may offer little privacy and it can be daunting to express breastmilk if mothers don't feel safe. Providing comfortable, private space is therefore essential.

Steps towards making this happen could include:

- Encouraging mothers to express near their baby by providing curtains or screens and adequate chairs to allow privacy and comfort.
- Ensuring that the room provided for mothers to express is comfortable and pleasant enough to spend significant amounts of time in.

### 11. Skin contact is used to induce instinctive feeding behaviours.

Skin-to-skin contact has many emotional and physiological benefits for parents/primary caregivers and babies. When mothers and babies spend lots of time together in this way with baby's head close to the mother's breast, instinctive pre-feeding behaviours are encouraged. Enabling baby to root, lick and familiarise themselves with their mother's breast provides the perfect introduction to breastfeeding and should be seen by staff as important to the transition to breastfeeding.

Steps towards making this happen could include:

- Educating staff to understand the value of skin contact for encouraging breastfeeding.
- Providing privacy and an unhurried environment for mothers as they learn to breastfeed.

### 12. Mothers can be close to their baby in order to respond to feeding cues.

Long before babies are ready to feed, mothers can be taught to recognise early and pre-feeding cues e.g. rooting, tongue movement, turning towards the breast, opening eyes and hands to mouth. As the baby develops, cues will become more evident and provide the basis for responsive feeding.

Steps towards making this happen could include:

- Educating staff to be alert to cues so they can help caregivers tune into their baby.
- Providing education for parents/primary caregivers including written material so that they are aware of the importance of feeding cues.

### 13. Support with positioning and attachment and recognising effective feeding.

Mothers can be supported with the principles of positioning long before the baby is ready to feed. As baby develops they will go through a process where they may appear to attach to the breast and suckle, but their co-ordination may be poor. Over time they will begin to co-ordinate their suck/swallow/breathe patterns to enable some transfer of milk.

Steps towards making this happen could include:

- Educating staff and parents/primary caregivers in how to recognise effective positioning and attachment whilst ensuring awareness that this can be a slow process and so patience is needed. Staff need to be especially vigilant to ensure realistic parental expectations regarding the pace at which their baby learns to breastfeed.

### 14. Additional support is provided to help with expressing and feeding challenges as needed, including specialist help when required.

It is important that mothers can access additional skilled support when faced with challenges, including creating a plan of care as appropriate to need, which staff are then supported to implement.

Steps towards making this happen could include:

- Identifying staff with a particular interest in infant feeding and enabling these staff to access extra training to gain skills in supporting mothers.
- Working with the maternity infant feeding lead to develop a system whereby mothers with particular challenges are referred to their team.
- Monitoring referrals to the specialist staff, including numbers referred/reasons for referrals. The aim should be to ensure that mothers with particular challenges are supported and that staff are coping with the day-to-day care of most mothers without over referral to specialist staff.

### 15. Mothers are prepared for going home.

Parents/primary caregivers need to feel safe and confident about feeding their baby when they go home and so preparation for this needs to be built into feeding plans.

Steps towards making this happen could include:

- Involving parents as partners in care from the beginning with the nurse's role being as much about being a teacher or enabler as that of a clinician.
- Supporting them to become responsive to their baby's feeding and behavioural cues rather than sticking with a rigid regime as the time for discharge draws near.
- Giving all parents/primary caregivers the opportunity to room in with their baby for as long as needed and to take full responsibility for their baby's care.
- Supporting mothers to understand that, although nutrition remains a key priority, they can also breastfeed responsively as a means of offering comfort and nurture to their baby. Helping them to understand that they can't spoil or overfeed their baby through too much breastfeeding is key.
- Ensuring parents/primary caregivers understand that their baby needs a minimum of eight feeds in 24 hours, but that more is better. Many mothers will also need to continue expressing after discharge home.

### 16. Information about how to access support with feeding in the community.

Experience suggests that lack of confidence often results in mothers introducing infant formula and stopping breastfeeding soon after discharge. The pressure on space within neonatal units can result in babies being discharged home before breastfeeding has become fully established. It is thus important that mothers are as prepared as possible for going home breastfeeding and that they have support to continue breastfeeding once they are at home.

Steps towards making this happen could include:

- Supporting staff and parents to understand that continued breastfeeding is important. It provides nutrition and protection from infections which can save babies from being readmitted to hospital, saving considerable financial cost to the health service and emotional cost to the family.
- Training for all staff who support parents/primary caregivers after discharge on how to support continued breastfeeding effectively.
- Referring mothers and babies who are making the transition to breastfeeding to the infant feeding lead within the hospital/unit so that a plan of care can be developed. This should include details of where they can continue to get follow up help and support after discharge.
- Ensuring that all mothers have both written and verbal information about where to access help and support once they are discharged home.
- Fostering support groups/peer support for those with a baby who has been cared for on a unit.

### 17. There is no advertising for breastmilk substitutes, bottles, teats or dummies.

All facilities working towards the Baby Friendly standards are required to adhere to the International Code of Marketing of Breastmilk Substitutes (the Code). This standard does not restrict the provision of accurate and impartial information about formula feeding but is designed to protect families from commercial influences at this most vulnerable time.

Steps towards making this happen could include:

- Having staff education, including for medical staff, on the principles of the Code and what this means for their practice, including where to access unbiased, evidence-based information on infant formula.
- Putting into place systems for dealing with company representatives who come under the scope of the Code in order to protect families and staff from marketing. It is important to ensure that families who are formula feeding are given clear written instructions and shown how to make up feeds safely before they leave hospital and are given evidence-based information on the types and brands of infant formula.
- Ensuring that community-based staff enable parents/primary caregivers to bottle feed safely.

You can read our Guide for Health Professionals to Working within the Code or visit First Steps Nutrition Trust for accurate and impartial infant formula information in the UK.

## CASE STUDY: ROYAL DEVON AND EXETER

### INCREASING AVAILABILITY OF EXPRESSING EQUIPMENT

For the Royal Devon and Exeter NHS Foundation Trust, it was recognised that the frequency and effectiveness of mothers expressing was impacted by the limited number of pumps. Mothers described having to wait for hours to use a pump or the expressing room, impeding their ability to pump effectively. To overcome this, the Trust ensured a breast pump was available for each cot space and parent room and increased the number of electric pumps for home use.

The senior management team described the availability of a breast pump for every mother as 'as important as having a ventilator.' This innovation helped to ensure that every mother had access to a breast pump whenever needed and that they were able to pump next to their baby, thereby increasing frequency and effectiveness of expressing.

## STANDARD 3:

### Value parents as partners in care

Parents being true partners in care requires a significant culture shift for most neonatal units in the UK. It is the aim for parents to be seen as the primary caregivers, with clinical staff providing specialised care while acting as teachers and supporters as they learn to care for and take responsibility for their baby.

#### 1. There is a policy of 24 hour access; staff routines/practices do not interfere with this.

With the exception of neonatal units, it is expected and accepted in the UK that parents are the key carers and advocates for their children. Refusing them access in the absence of safeguarding issues would be considered unacceptable in almost all circumstances. Legislation supports the concept that children in hospital should have a parent/primary caregiver with them at all times and on paediatric wards it would be expected that they remain with their child throughout. Extending this philosophy to neonatal units is therefore considered pivotal to the concept of parents as partners in care.

Steps towards making this happen could include:

- Creating a policy/mission statement around 24 hour access as the philosophy of the unit and communicating this to staff and families.
- Identifying when access is denied to fit in with routines, practices and procedures other than emergencies and agreeing alternative practices and routines to ensure parents/primary caregivers can be with their baby whenever they wish.
- Considering the overall principle of 24 hour access and the message it conveys about parents' rights and responsibilities rather than becoming enmeshed in covering every eventuality. For example, denying access for 1-2 hours a day for ward rounds conveys that the baby is primarily the staff's responsibility and parents are visitors who must 'fit in'. The need to change this becomes obvious when staff appreciate the culture change required. However, denying access as a one-off because another baby in the room is ill and the staff are talking to / comforting them is reasonable and conveys common courtesy. Applying common sense while aiming for the overall principle of changing culture over time is required.
- Using the Baby Friendly audit tool to audit parents' experiences and identify barriers they have to being with their baby. Action planning and working jointly across disciplines to find solutions with innovative thinking is required, so encourage staff to think 'outside the box'.

#### 2. Measures are taken to ensure that practical difficulties do not prevent parents/primary caregivers from being with their baby.

It is not possible to address every barrier that parents/primary caregivers face to being with their baby, however many can be alleviated with some time spent 'walking in the their shoes'.

Steps towards making this happen could include:

- Spending time on the unit observing what families do when they are on the unit in order to spot where care and facilities could be improved.
- Gathering small groups of parents/primary caregivers to enquire about their experiences on a practical level. Ask them about their daily routines and what would help make life easier. Consider transport, car parking fees, siblings, food and drink and the physical environment on the unit. Start with the most pressing problems and consider what can be done.
- Considering where families will be while on the unit. There needs to be a permanent space with comfortable chairs and places to leave belongings, otherwise they will always feel like visitors and may worry that they are in the way.

#### 3. Parents are welcomed on the unit and treated with dignity, respect and equality.

For parents to be partners in care they must feel equal to staff in importance/relevance for the wellbeing of their baby.

Steps towards making this happen could include:

- Staff communication training, perhaps using the principles of transactional analysis in a simple form. Communication plays a huge part in achieving a sense of equality. "Parental style" offers of care and concern for parents, no matter how well meaning, can rob them of a sense of confidence and equality. Conversely, too much deference can leave them feeling unsafe and out

of their depth. Power and control are nuanced issues. Staff need a framework to consider them and how best to build productive relationships.

- Assuming parents/primary caregivers are responsible for their child from the beginning, which will set the scene and make an equal relationship easier.
- Ensuring all staff in the baby's room introduce themselves, giving families their attention as a priority, and recording when they will be on the unit and planning their workload around this.
- Ensuring staff know parents'/primary caregivers' names. Calling them 'mum' and 'dad' can feel patronising within a professional relationship.

### 4. Parents are respected as primarily responsible for their child. Their opinion is sought/they are involved in decision making.

Babies on a neonatal unit are highly dependent on the clinical team and their caregivers. Information sharing and joint decision making, with the most relevant person taking the lead depending on the situation, is desirable. For example, the consultant neonatologist or paediatrician is the most appropriate person to lead on complex clinical issues, and specialist staff will lead on their specialism. Parents/primary caregivers will lead on the wellbeing of their baby, taking more of a lead as the condition improves. All parties working together to discuss issues and arrive at consensual decisions will deliver the best outcome for the baby.

Steps towards making this happen could include:

- Having mechanisms in place to keep everyone fully informed at all times. This may include access to records, providing a notice board for parents/primary caregivers and providing time for staff to update families and vice versa.
- Involving parents/primary caregivers in all discussions about their baby and educating them so that they understand the treatment and care that is being suggested.
- Creating a staff/parent journal where day-to-day changes and messages are recorded. This can be a memento to take home after discharge.
- Auditing parents' experiences over time. Asking parents if they feel more like a parent or like a visitor can be revealing.

### 5. Parents are enabled to carry out as much of the care as possible.

Whilst there is no one more concerned about their baby's care than parents/primary caregivers, their capabilities are often underestimated, with staff concerned that they cannot manage simple tasks.

Steps towards making this happen could include:

- Thinking beyond the basiscs (e.g. nappy changes) to consider what they could achieve around care for their baby. A lot of nursing care can be taught to parents, with staff as teachers and supporters.
- Encouraging them to take the lead as their competence/confidence grows. Experience shows that caregivers feel 'allowed' to carry out care only with permission and that this is dependent on staf. Empowering them to take responsibility for care supports their sense of being a parent and being in control.
- Developing a culture where staff could be encouraged to ask parent's permission to carry out procedures (apart from emergency situations) is an excellent way of shifting the power balance.

### 6. Parents are encouraged to comfort and support their baby during procedures.

In most paediatric settings, parents would be expected to be present during a distressing procedure. In neonatal units there can be an attitude that they need to be shielded from this or that they will be in the way. Changing this culture will better recognise the parents' role and the humanity of a baby undergoing a frightening experience.

Steps towards making this happen could include:

- Educating staff to take a child rights approach to care. This means putting the baby at the heart of care and considering what is best for them. Encouraging staff to imagine what it would feel like to be the baby can help with this.
- Educating staff to assume that parents will be with their baby during treatment as a general philosophy of care and the default approach.
- Considering how this is managed in paediatric settings to help overcome practical difficulties.
- Remembering that this is a general principle, not a rigid dogma. Situations vary and parents may or may not be able to cope at any given time.

## CASE STUDY: ROYAL DEVON AND EXETER

### 24-HOUR ACCESS

On the Royal Devon and Exeter neonatal unit, inconsistencies in managing parent attendance at ward rounds across different medical teams and unit areas resulted in parents feeling they had limited access to be with their baby. To combat this, the senior team arranged focus groups with staff to discuss their current approach and find ways to prevent parents from feeling excluded.

The team considered a number of factors, including ensuring confidentiality, restricting professional numbers at ward rounds, and where and how rounds should be held and conducted. Parents were also able to feed directly into this through SNUG, a parent support group.

Changes resulting from discussions included a limit on the number of professionals in attendance to minimise noise and not overwhelm parents, and to ensure information relating to the baby is discussed in an appropriate environment. Parents are also always informed of rounds and are actively encouraged and welcome to attend and participate, and are not asked to leave.

Parents/primary caregivers are also encouraged to phone the unit at any time they are unable to be with their baby. To facilitate this, cord-free telephones were installed on the unit, enabling staff to update from the cot side and to accurately describe the baby at the current time, helping families unable to be on the ward to feel close.

## SUPPORTING THE STAFF

Adopting a culture and routine that supports implementation of the Baby Friendly standards requires a fundamental shift in routines, attitudes and working environment. This needs to be considered when implementing the changes.

Steps towards making this happen could include:

- Helping staff to see their role as one of teaching / supporting as well as of clinical care, including taking time to discuss implications of this.
- Ensuring effective staff communication and using meetings, notice boards, e-mailings etc. to inform of changes and ideas. Experience shows that staff rarely complain of being over-informed, but frequently of being under-informed.
- Having staff forums to discuss ideas/concerns. This could be via a moderated group that meets in-person, via email or a social media group.
- Creating a safe space for staff to interact and reflect. If the clinical areas are 'owned' by the parents, then staff need places where they can be with colleagues other than the clinical areas.
- Creating a formal mechanism for staff to receive feedback and support with their individual progress towards implementing the standards.
- Recognising that some parents can be challenging and providing mechanisms to develop appropriate coping strategies/solutions.

## PLANNING YOUR ASSESSMENTS

Please review the below options when considering when and how you apply to have your service assessed.

**Option 1:** You can work through the entire assessment pathway, completing a formal Stage 1 assessment followed by separate Stage 2 and 3 assessments when your internal audit results demonstrate that the service provided meets the Baby Friendly standards.

**Option 2:** You can complete a formal Stage 1 followed by a combined Stage 2 and 3 assessment when your internal audit results demonstrate that the service provided meets the Baby Friendly standards.

## CONTACT US

If you have any queries regarding the best option for your service please contact the Baby Friendly office at bfi@unicef.org.uk

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