The Baby Friendly Initiative
UNITED KINGDOM
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UNICEF UK BABY FRIENDLY INITIATIVE
NATIONAL NEONATAL PROJECT
FINAL REPORT
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The Baby Friendly Initiative would like to thank all the parents and families who generously shared their experiences through the assessment process in the services included in the project. We would also like to thank all the units who took time and effort to participate in the evaluation of the project for their commitment to improving care for families and babies.

Please note, the UK Committee for UNICEF (UNICEF UK) Baby Friendly Initiative fully supports inclusivity in accordance with Article 2 (non-discrimination) of the UN Convention of the Rights of the Child and the Equality Act 2010. Learn more about our inclusivity policy and the language we use at: unicef.uk/bf-inclusivity

INTRODUCTION

Every year in the UK, one in seven babies born require specialist neonatal care, a figure that has shown a gradual increase over recent years.[1] Neonatal care presents a complex set of challenges for both families and healthcare professionals. When a baby is born prematurely or sick, the experience can be traumatic for parents, often resulting in long-term emotional and psychological impacts. Families face not only the anxiety of their baby's health but also the disruption of early bonding opportunities, such as holding, feeding, and caring for their baby. An increase in high profile press coverage in recent years has also increased parental anxiety when their baby requires neonatal care.

Premature and sick babies are particularly vulnerable and have an increased need for breastmilk, which plays a critical role in supporting their development and overall survival. Research indicates that the risk of neonatal mortality increases and is associated with an increased delay in breastfeeding initiation.[2] For preterm infants, breast milk feeding is particularly associated with reducing the risk and severity of necrotising enterocolitis.[3] Medium to high levels of breastmilk feeding contribute positively to motor and behavioural neurological development in extremely preterm infants.[4] Human milk also significantly reduces the chances of severe medical complications in preterm infants. [3 5]

Premature and sick babies are also much more like to experience separation from their parents due to a variety of reasons including practical barriers such as lack of parental facilities within the hospital, distance between home and hospital, other caring responsibilities, or the clinical needs of the baby or their mother. Together, these factors can make it more difficult for parents to establish a close relationship with their baby at this early stage and for mothers to establish breastfeeding or an effective breastmilk supply.

For health professionals, it is important to acquire the knowledge and skills to offer culturally sensitive care practices, practical guidance and the physical environment to facilitate parent-infant closeness, both physical and emotional, and family-integrated care.

[1] RCPCH (2018). National Neonatal Audit Programme (NNAP) 2018 annual report. See National Neonatal Audit Programme (NNAP) - past annual reports and data | RCPCH

[2] Smith, E. R., Hurt, L., Chowdhury, R., Sinha, B., Fawzi, W., Edmond, K. M., & Neovita Study Group. (2017). Delayed breastfeeding initiation and infant survival: a systematic review and meta-analysis. PloS one, 12(7), e0180722.

[3] Quigley, M., Embleton, N. D., & McGuire, W. (2019). Formula versus donor breast milk for feeding preterm or low birth weight infants. *Cochrane Database of systematic reviews*, (7).

[4] Gao, Y., Lu, X., Pan, M., Liu, C., Min, Y., & Chen, X. (2024). Effect of breast milk intake volume on early behavioral neurodevelopment of extremely preterm infants. International Breastfeeding Journal, 19(1), 3.

[5] Villamor-Martínez, E., Pierro, M., Cavallaro, G., Mosca, F., Kramer, B. W., & Villamor, E. (2018). Donor human milk protects against bronchopulmonary dysplasia: a systematic review and meta-analysis. Nutrients, 10(2), 238

THE BABY FRIENDLY INITIATIVE AND THE BABY FRIENDLY NEONATAL STANDARDS

The Baby Friendly Initiative (BFI) was launched in the UK in 1994. It aimed to increase support for breastfeeding within maternity services and improve breastfeeding rates. Over the last 30 years the programme has evolved and introduced tailored standards for different care settings.

In 2015, BFI launched bespoke standards for neonatal units. This development recognised both the vital role of breastmilk in supporting the health of the sick or preterm babies, and the importance of parental presence and involvement in nurturing close and loving relationships between parents and babies.

The Baby Friendly neonatal standards are designed to:

- Support parents to have a close and loving relationship with their baby
- Enable babies to receive breastmilk and to breastfeed when possible
- Value parents as partners in their baby's care

The National Neonatal Project - Catalysing change: Targeted support for the Neonatal standards

Since the introduction of the neonatal standards, UNICEF UK BFI has leveraged grant funding and a corporate donation to deliver two high-impact initiatives aimed at accelerating implementation across selected neonatal units. The Burdett Project (2016–2019) provided tailored support to six units. The National Neonatal Project (2021–2024) scaled up this approach, by supporting 18 units with a stronger focus on increasing skin-to-skin contact.

This report presents evaluation findings from the National Neonatal Project, highlighting its role as a catalyst for implementation of the standards and improvements in neonatal care. (See Appendix for details on the support provided and participation requirements.)

Our approach to evaluation

A Monitoring and Evaluation framework was developed with the dual purpose of fostering continuous learning and to assess progress in implementing the standards. The evaluation was carried out by UNICEF UK's Research and Evaluation Unit.

Evaluation Objectives

The evaluation utilised a combination of quantitative and qualitative methods to understand:

- Factors that supported or hindered successful implementation of the standards
- How the Baby Friendly Neonatal Standards drives change in practice

- Current skin-to-skin contact practice and how to make improvements
- The realities of ensuring parents are partners in care
- How the Baby Friendly Initiative (BFI) interacts with other initiatives

Evaluation methods

Quantitative data focused on changes in key metrics, and qualitative insights drawn from compelling stories of change that highlighted the programme's effects on staff, parents, and babies, both across and within individual units.

Our methodology included:

- A biannual online survey
- Semi-structured interviews conducted midway and at the end of the project
- Two focus groups
- Submission of photos illustrating change
- Analysis of accreditation reports

Participating units completed a biannual online survey (every March and September between 2022 and 2024) over the three-year project, referred to in this report as Survey 1–6. The survey included:

- Quantitative questions on staff training, infant feeding and skin-to-skin contact
- Qualitative questions designed to explore implementation in more depth

Completion rates for the online survey were consistently high at 90% and above for Surveys 1–5. However, this declined to 70% in Survey 6.

Data on skin- to- skin was collected via a skin-to-skin audit tool. This was piloted and refined in Survey 1 and reported on from Survey 2 onwards (See Chapter Five for further details)

Data on infant feeding was collected and reported across Surveys 1 to 5. In Survey 5, units were asked to provide information on missing data, and the analysis indicated that this was a significant issue. Due to a combination of lower response rates and high levels of missing data, we excluded quantitative data from Survey 6 (see Chapter Six for further details).

To support learning a summary of findings was shared with the units every six months to support reflection and improvement.

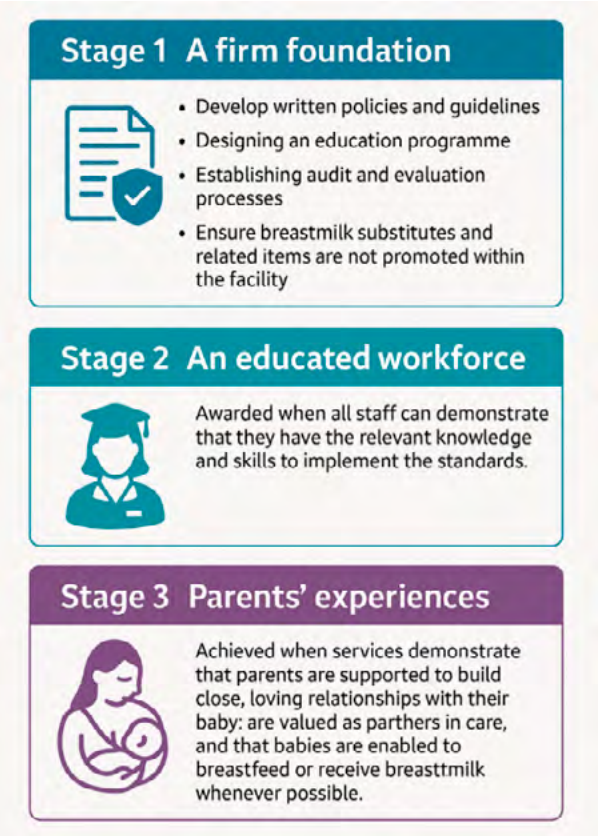
CHAPTER ONE: IMPLEMENTATION OF THE BFI NEONATAL STANDARDS

This chapter presents findings from the National Neonatal Project (NNP) relevant to implementation processes.

BFI's requirements for implementing the standards

The National Neonatal Project was designed to support 18 units to advance through the 3 stages of the UNICEF UK Baby Friendly (BFI) accreditation process to full accreditation.

The 18 units involved in the project began with differing levels of readiness to implement the standards. Whilst a few had already started implementation or had relevant systems in place to support certain elements, the majority had not and faced a steep learning curve. This project commenced in the period immediately following the COVID-19 pandemic and this created some challenged for units mainly related to staffing and parental access.



Find out more about implementing the Baby Friendly Standards[6]

By the end of the project:

- All units (100%) achieved a **Stage 1** award. Three units (17%) progressed more slowly due to challenges such as staffing shortages, limited senior leadership support and resource constraints. These units encountered a range of challenges, primarily related to staffing, senior leadership support and resourcing.
- Fifteen units (83%) achieved **Stage 2** accreditation. Nine units (50%) undertook a **Stage 3** assessment, and six of these units (33%) successfully achieved **full accreditation**, demonstrating full implementation of the BFI standards. The remaining three units were required to complete further work and undergo a follow-up assessment process to attain full accreditation.
- All units within the project have expressed commitment to complete the implementation of the standards in due course.

[6] See Baby Friendly standards: Baby Friendly Standards - Baby Friendly Initiative

Enablers and Barriers to Successful Implementation

The evaluation identified several enabling factors that contributed to the successful implementation of the standards. These included: the appointment of a designated Baby Friendly lead with sufficient time and seniority; strong commitment and support from senior leadership; capacity building within the infant feeding team; ongoing commitment; the development of a robust training programme; and participation in the National Neonatal Project.

The Importance of a Designated Baby Friendly Lead

Units that provided infant feeding leads with sufficient protected time made the most progress in implementing the standards. This was identified as a key enabler of success and a requirement for participation in the NNP project. However, in some units, securing protected time required prolonged negotiations with senior leadership, which delayed progress:

> **"Our guardian was escalating the need for hours, but we were just hitting a brick wall with that. It was almost like we had to fail to get what we needed."**

Experiences in developing an infant feeding role varied. For example, one Trust created a new full-time infant feeding lead role as a job share across two sites, whereas another unit described how they negotiated additional hours once they had commenced the project:

> **"Initially, we were thrilled to join the project, but soon realised the expectations were overwhelming. I only had one extra hour per week for the role, which was unsustainable. BFI emphasised the importance of dedicated hours, and with our senior leadership's support, we established a job role with 12 hours per week solely for Baby Friendly."**

The allocation of hours for those in infant feeding roles varied considerably across units. For example, in Survey 5, 11% reported that they had no allocated hours, 22% reported that they had one day or less per week. By contrast 44% of units reported that they had 20 hours or more.

Banding and Recognition of the Role

Appropriate recognition of the Baby Friendly lead role was also identified as a key enabler as the role demands not only leadership and strategic planning, but also specialist knowledge tailored to the complexities of neonatal care. Within the NNP, leads were commonly graded between pay bands 4 and 6 (NHS Agenda for Change), whereas equivalent roles in maternity services are generally a band 7. A more standardised and equitable approach for appropriate banding of the lead role is urgently needed to reflect the complexity, responsibility, and impact of the Baby Friendly lead in neonatal settings.

Senior Leadership Commitment and Support

Leadership commitment at senior level was consistently identified as a critical enabler of success and essential to securing the resources needed for role development, staff release for training, action planning and any practical changes required to embed the standards. Although not mandatory for senior leaders at initial accreditation, one infant feeding lead described how the attendance of their senior manager at the five-day training provided by BFI was pivotal in unlocking support:

> **"I think it just really changed their views on what was required and that's when our team grew significantly and then my role became a permanent role."**

BFI Strategies to Support Senior Leadership Commitment

The BFI programme recommends a range of strategies to secure senior leadership commitment.[7] These include appointing a Baby Friendly Guardian, undertaking a planning meeting, and setting up governance structures to support implementation of the standards. Through the evaluation, it was apparent that participating units progressed well when these strategies were implemented effectively and were vital in sustaining implementation.

Baby Friendly Guardian

A Baby Friendly Guardian[8] is intended to be a high-level member of staff, for example a senior manager or board member, who has taken on the responsibility of promoting, protecting and supporting the Baby Friendly standards.

By survey 2, 84% of units reported that they had appointed a Baby Friendly Guardian. Qualitative feedback highlighted the value of this role in supporting implementation and promoting long-term sustainability. Guardians often acted as advocates for the Baby Friendly Initiative (BFI) within their Trusts by ensuring BFI was included on relevant agendas and helping to secure relevant resources.

However, a small number of units noted that their Guardians faced challenges in accessing the resources needed to fully support their role.

The Planning Meeting

The Planning Meeting facilitated by BFI is designed to support services to develop a clear action plan for implementing the standards in their area.[9] 95% of units in the project reported that they found the planning meeting helpful or extremely helpful in supporting effective implementation. Additionally, 74% agreed it helped ensure BFI was supported at all levels of their and played a pivotal role in

[7] See Achieving Sustainability: Standards and Guidance Document: Achieving Sustainability: Standards and Guidance - Baby Friendly Initiative

[8] See The role of the Baby Friendly Guardian: The role of the Baby Friendly Guardian - Baby Friendly Initiative

[9] See Action Plan and Planning Meeting: Action plan and planning meeting - Baby Friendly Initiative

levering resources, ensuring leadership and staff commitment and enabling the development of a robust training programme. One area of challenge raised was that despite the overall positivity and helpfulness of these meetings it did not necessarily translate into protected time for leadership for the project.

Implementation Structures

Participating units were advised to establish structures such as a steering group to oversee implementation. By survey 2, 89% of units reported that they had established relevant structures. Approaches varied, some established dedicated, unit-level steering groups, and others integrated the BFI workstream into existing joint maternity/neonatal forums or broader neonatal leadership meetings. Membership and meeting frequency also differed but despite this variation they were widely recognised as critical to promoting wider ownership and engagement, supporting long-term sustainability and enabling access to additional resources.

Strategies to Build Capacity

Implementation is complex and time intensive and therefore some units deployed strategies to build capacity, including leveraging existing BFI-accredited maternity services, establishing cross-site leadership structures, and developing local support teams.

Collaboration with Maternity Services

Units with BFI accredited maternity services found these to be a major enabler in supporting implementation by offering joint training, sharing knowledge and collaboration:

> **"Our maternity services are gold accredited. There's a lot of crossover, so when we ask for colostrum, they're fully on board. That alignment made a real difference."**

Cross-Site Leadership Structures

Some services had neonatal units on two or more sites. This provided additional challenges for the infant feeding lead role and engaging leadership teams across all sites. To address this, different models were implemented including appointing infant feeding leads at each site, a job share to cover two sites and one lead to cover three sites. The differing structures were reported as enhancing capacity and consistency in each service.

Increasing Capacity within Units

To strengthen implementation at the unit level, several units established additional support structures including BFI Champions who assisted with audits, training, and communication. One unit appointed a supernumerary BFI champion on each shift. A large unit described their approach:

> **"We trained two staff through the 'train the trainer' course and recruited five or six infant feeding champions. With 155 staff audits and practical reviews to complete, plus daily demands, it was impossible without a team on the ground."**

Ongoing Commitment

Implementation of BFI is a complex and long-term process and sometimes progress can be perceived as being, slow, uneven and challenging. For example, staff may resist change, or there may be barriers to introducing practices that support parents as partners in care or services may have to retrain all staff following an unsuccessful accreditation attempt. Over time, project leads identified ongoing commitment and resilience in the face of these challenges as a key factor in successful delivery.

> **"You have to be persistent, even when it's tough. Keep going, believe it makes a difference, and find ways to communicate that—though it's not always easy."**

Benefits of participating in the National Neonatal project

Accelerated Implementation of the Standards

Participation in the project helped to secure leadership engagement, which in turn led to the prioritisation of the initiative, the allocation of resources, and faster progress through the accreditation process.

> **"Being in the National Neo-Natal project, it put it front and centre. Prior to going on the project, it was something I was trying to do in our so-called spare time... It's just that I had nothing concrete that I could take to say you've signed up for this. You've been given the funding for it. I think I was always able to use it as a bit of a stick really in the background."**

Some services reported that implementation of the standards would not have occurred if they had not been part of the NNP.

> **"We 100% would not have been fully accredited had we not been on the project. The support has been invaluable. The entire culture of the unit has been changed."**

Peer Learning

The BFI Neonatal lead facilitated group support sessions every 6 months for all participating units. Infant feeding leads and a senior manager from each service were invited to attend. These online meetings provided a dedicated space to reflect on feedback from the six-monthly surveys, share challenges and to learn from each other. In addition, infant feeding leads were encouraged to participate in the National Infant Feeding Network[10], further expanding opportunities for collaboration and shared learning with units outside of the project.

Participants spoke positively about the impact of these peer support structures:

> **"I think the support meet ups were really useful, because sometimes you sit in a bit of a silo all by yourself. And I think just meeting up and knowing that people have still got the same issues and are in the same position as you just helped."**

[10] See National Infant Feeding Network (NIFN) https://www.unicef.org.uk/babyfriendly/about/infant-feeding-networks/

"That sharing of ideas is just brilliant. It just makes sense that we all work together because it's not one unit superseding another, we all want to give best care."

Access to Additional Support from BFI

Across the three years participants were able to access one-one support from the UNICEF UK Professional lead for Neonatal standards and this support was highly valued. For example:

"The project lead was outstanding, I don't know how I would have got through it without her because she was just so supportive. They were influential in the progression and success of it."

Pressure to Complete within the Three-Year Project Period

One of the key challenges reported by participants was the pressure to progress through the Stages of the Baby Friendly accreditation process within the three-year project timeframe. Funding for the accreditation process was only available for the three-year period and while the funding support was welcomed, some units reported that they progressed to assessment before they felt fully prepared.

"We went from 0 to stage 2 in three years. We achieved a lot in those three years, but when it came to stage three, Ideally, we would have had another six months, but the funding was ending in November. So, we decided to go for it and see what happened. In the end, we missed passing by just a few borderline elements."

Alignment with Other Initiatives

In recent years, several initiatives have been introduced to improve the quality of care for premature and sick babies. These include the Bliss Baby Charter, The PERIPrem care (Perinatal Excellence to Reduce Injury in Premature Birth), Family and Infant Neurodevelopmental Education and Family Integrated Care.

Alongside these, there has been a growing emphasis on workforce development. The NHS Long Term Plan 2019[11] and Neonatal Critical Care Review (2019)[12] highlighted the need to strengthen the expert neonatal workforce and expand roles for Allied Health Professionals to support clinical care.

BFI was widely recognised as aligning closely with other neonatal care improvement frameworks, particularly the Bliss Baby Charter and FiCare. Interviewees noted significant crossover and complimentarily between these programmes:

"I think Bliss and BFI are very much under the umbrella of FiCare. We talk about FiCare a lot... I think they really complement each other."

[11] The NHS Long Term Plan (2019) https://webarchive.nationalarchives.gov.uk/ukgwa/20230418155402/https:/www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

[12] Neonatal Critical Care Review (2019) Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf

In some units the BFI lead also led on other improvement initiatives and in others there was an additional lead role.

One interviewee described how the introduction of BFI helped enable other initiatives:

> **"Since BFI started, there's been a much more robust infrastructure, and it's easier to attach other programmes to what we already have in place."**

Although there was general alignment across workstreams, some challenges were identified. For instance, some leads expressed concerns about the significant administrative burden caused by implementing multiple initiatives. They suggested that improving collaboration between these initiatives could help reduce this burden and improve coherence and overall impact across the programmes.

Allied Health professionals (AHP's)

The expansion of AHP roles within neonatal units has coincided with the implementation of national programmes such as the Baby Friendly Initiative (BFI). AHPs were generally perceived as receptive, supportive, complimentary to BFI and offering an holistic approach to neonatal care. In some cases, AHPs had completed BFI training, which was seen as instrumental in deepening their understanding of its aims. As one interviewee explained:

> **"They are very proactive with all of the Baby Friendly messages. The speech and language therapist really values breast milk and talks a lot about breastfeeding and the importance of breast milk. And then the physiotherapist is always recommending lots of skin-to-skin."**

Summary

This chapter has identified several key enabling factors that support successful implementation. The evaluation underscores the efficacy of the guidance provided by BFI, including appointing a dedicated lead with sufficient time and seniority to lead implementation, the designation of a Baby Friendly Guardian, and the role of the planning meeting, all of which play a critical role in driving progress.

Other significant enabling factors included strong commitment and support from senior leadership, capacity building and ongoing commitment and resilience in the face of challenges. Participation in the National Neonatal Project offered a range of benefits including access to one-to-one support and peer learning that enabled accelerated implementation of the standards. However, some units found the three-year completion target challenging and felt that more time was required.

BFI compliments other neonatal care improvement initiatives however further in service collaboration between these initiatives could reduce the administrative burden and improve the overall impact of these programmes.

CHAPTER TWO: TRAINING

Training for health care staff is a cornerstone of the Baby Friendly Initiative (BFI) approach, supporting both the practical and cultural changes required to embed the standards effectively and a requirement for Stage 2 accreditation. The 'Train the Trainer' model adopted by the BFI programme, equips others to cascade training within their service. Over the three years of the project, training was a central focus of our evaluation of the National Neonatal Project and a key catalyst for change.

In this chapter, we present key findings from the evaluation related to training. This includes perspectives on BFI's training support; challenges in the design and delivery of in-house training including the effective integration of practical skills reviews and the role of training in engaging medical staff.

The NNP funded two staff from each participating unit to attend a five-day course facilitated by the BFI team. The course included:

- Understanding and embedding the BFI standards in Neonatal Units
- How to design and deliver 'an effective training programme
- The role of auditing in effective implementation of the standards
- Project Management to support implementation of the BFI standards

This training was widely recognised as pivotal in equipping Infant Feeding Leads to develop their own training programmes. Feedback from both surveys and interviews reinforced the value of the five-day training programme, with 95% of units agreeing or strongly agreed that the 'Train the Trainer' programme and associated resources were helpful in designing a training programme.

By Survey 6, 94% of nursing staff and 90% of medical staff had completed core training in the standards.

"I found the Train the Trainer course very helpful, as I had never created lesson plans or delivered teaching sessions before. It really helped prepare me for this part of the project."

However, a small number of respondents felt that the training and resources were primarily focused on maternity settings, with neonatal standards perceived as an 'add-on' rather than integral. Some resources required significant adaptation to ensure they were relevant for neonatal settings.

Training as a Catalyst for Change

A well-designed and engaging training programme was identified as an important catalyst for securing nursing staff buy-in and changing practice. Infant feeding leads noted that the training provided a positive environment for staff to discuss any concerns related to changes in practice.

> **"In the early days, there was a lot of negative pushbacks. The changing point was following the two-day training. I made it very interactive. A couple of nurses who were very old school and resistant came on board and said listen, everybody's got to do this and started helping out with audits."**

Challenges in the design and delivery of in-house training

Creating an Engaging and Innovative Curriculum

For many BFI Leads, this was their first experience in designing a curriculum and delivering a training programme. Feedback consistently highlighted the importance of making the curriculum as engaging and relevant. One unit described using classroom discussion to help staff understand key concepts, while another emphasised the value of guest speakers, such as Allied Health professionals (AHP's). Parent feedback was used to motivate staff and reinforce the importance of the neonatal standards.

> **"When I do the update, I always share the parent audit. That is helpful for getting people on board."**

Staffing issues

A key challenge encountered by units as they began to roll-out their core training programme was staff shortages and staff turnover. These shortages often led to infant feeding leads being redeployed to clinical duties or training sessions being cancelled due to unit acuity. To address these barriers, infant feeding leads made use of any protected time to prioritise training and negotiated additional hours to ensure that nursing staff were able to attend core training and complete Practical Skills Reviews, some units paid staff an additional pay or time-off in lieu to support attendance at training sessions.

> **Delivering training through a single lead was seen as challenging. "It's not ideal for one person to be responsible for delivering all the training."**

To address this some units supported additional staff to attend the five-day training course. This increased the number of facilitators available to deliver training and helped support long-term sustainability.

Effectively integrating Practical Skills Reviews (PSRs)

Practical Skills Reviews (PSRs) are a core component of BFI training. They play a vital role in ensuring staff are equipped with the knowledge, confidence, and skills in key areas such as positioning, attachment, hand expression, responsive bottle feeding and skin-to-skin contact.

By Survey 6:

- 86% of nurses had completed PSRs in positioning and attachment and hand expressing (both core requirements).
- 73% of nurses had completed an optional PSR in responsive bottle feeding.
- 60% had completed an optional PSR in Kangaroo/skin-to-skin care.

Whilst infant feeding leads recognised the value of PSRS in consolidating knowledge and improving practice, PSRs were also noted to be time-intensive, requiring detailed scheduling and resource allocation.

> **"I think it's a really good opportunity for people to ask questions and I use it a little bit more like that. If people are not sure about something or they're worried about it, that tends to be where it comes out, so that's useful."**

To address these challenges, different strategies were deployed including detailed scheduling with individuals; completing PSRs during quieter periods; and employing additional staff to enable easier release of team members for training.

Training for Medical Staff

Training was recognised as a vital tool for engaging medical staff and strengthening their understanding of the BFI, which is essential for successful implementation. Over time, units developed strategies to ensure medical staff completed the required training. Most adopted the BFI e-learning package designed for paediatricians, which was generally well received and helped build understanding. However, feedback highlighted the need for additional training tailored specifically to the neonatal context.

Some units encountered challenges in ensuring that medical staff understood the requirement to complete BFI training, as well as in establishing systems to systematically monitor training completion. Two key enablers helped address these issues: incorporating BFI training into medical staff inductions and appointing a consultant lead responsible for overseeing and ensuring completion.

The benefits of regular skills audits

Infant feeding leads are required to regularly utilise the BFI audit tool to identify knowledge and skill gaps among nursing and medical staff. This tool was widely recognised as a valuable resource for guiding the development of targeted training programmes. Knowledge and skills gaps were addressed through a range of methods, including refresher training sessions, educational posters, and pocket cards to reinforce key messages. Over the three years of the project, the two most frequently identified gaps related to the International Code of Marketing of Breastmilk and Responsive Bottle Feeding.

Summary

This chapter highlights the pivotal role of training in implementing the standards. Through the NNP, most nursing and medical staff have been trained in the standards across the 18 units. However, completion rates for PSRs are lower than for core training and consideration needs to be given to how to close this gap.

Delivering a robust training programme is complex. Investing in comprehensive, high-quality training was recognised as a key enabler to successful implementation. Units identified a range of challenges including the need for detailed scheduling to enable staff to complete both core training and PSR's and securing resources to release staff for training. The BFI neonatal audit tool played an important role in enabling infant feeding leads to identify knowledge gaps.

Training for medical staff was essential for securing their engagement in implementing the standards. Practical barriers were addressed by incorporating BFI into staff inductions and involving senior medical staff in tracking completion.

Feedback from units showed high satisfaction with both the training and support provided by BFI. This was perceived as critical to the successful design and delivery of training by individual units. However, there was a clear demand for more bespoke materials specific to neonatal care settings for both nursing and medical staff.

Given ongoing staff turnover, training must be continuously maintained to ensure consistent implementation of the standards.

Case Study: Training as a Catalyst for Progress in the National Neonatal Project

The neonatal units under the Northwest Anglia NHS Foundation Trust (Peterborough City Hospital and Hinchingbrooke Hospital) provide specialist care for premature and critically ill newborns. By the end of the project, both units have been awarded full accreditation.

Training was the cornerstone of the units' progress. By Survey 6, 100% of nursing staff trained in Baby Friendly in neonatal standards. There were progressive increases in nursing staff completing PSRs across all key areas including positioning and attachment, hand expressing, kangaroo care, and responsive bottle feeding, rising to 100% by Survey 6. These figures reflect a deliberate and sustained effort to embed Baby Friendly practices across all staff levels. The five-day training attended by the leadership team has been highlighted as a turning point:

> **"That was the key thing. If the leadership team are not on board, you're never going to get anywhere... It was that course that supported our leadership team to realise what the size of the team needed to be and how it needed to look."**

In order to promote training, the unit employed a flexible, multi-pronged approach to training:

- Monthly PSR cohorts to maintain momentum.
- Drop-in sessions to incentivise participation.
- Integration into mandatory training to maximise reach.
- Virtual training during COVID, followed by a return to preferred face-to-face formats.

Despite these efforts, the scale of training, especially staff capacity, remained a challenge. To address this, the team trained additional staff and involved the practice development team to complete skills review on all staff and cover for staff to release them for the skills reviews.

The case study provides clear evidence supporting the impact of training on the implementation of the project. Specifically, data consistently shows moderate to strong correlations between both PSR in early hand expressing and responsive bottle-feeding, and all measured outcomes.

Lessons Learned

- **Leadership training/buy-in is foundational:** The five-day course was a turning point that unlocked structural and cultural change.
- **Training should be continuous and embedded:** Regular audits, PSRs, and refreshers are essential to sustain momentum.
- **Training delivery should be flexible:** A mix of formats and incentives helped overcome logistical barriers.
- **Training outcomes should be tracked:** Correlation data provides compelling evidence of impact and should inform future strategy.

CHAPTER THREE: THE IMPACT OF BABY FRIENDLY NEONATAL STANDARDS ON PARENTS AS PARTNERS IN CARE

This chapter presents findings from the evaluation on implementation of Standard 3: Parents as Partners in Care. This standard recognises parents as the primary caregivers and enables them to be fully involved in decisions about their baby's care. We begin by examining the overlap and interaction between Standard 3, the Bliss Baby Charter and the Family Integrated Care (FiCare) model. We then assess how Standard 3 - an essential enabler of Standards 1 and 2 - is prioritised and understood by infant feeding leads. Finally, we explore the practical and cultural changes that have followed implementation of Standard 3, for staff, parents and primary caregivers and babies.

Standard 3: Parents as Partners in Care and Other Initiatives with a Shared Vision to promote family integrated care and parental presence

Many of the units involved in the NNP were also implementing a family integrated care (FiCare) philosophy. Both Standard 3 and FiCare promote unit cultures that actively listen to and engage with parents and carers, aiming to create environments where families are empowered, respected, and fully integrated into care teams. All elements of the Ficare philosophy can be implemented through innovate interpretation of the criteria within Standard 3. Elements of the Bliss Baby Charter also align with BFI Standard 3, with both accreditation schemes evaluating parents' presence and involvement in care and decision making.

Embedding Standard 3: A Catalyst for Standards 1 and 2

The implementation of Standard 3, Parents as Partners in Care, mutually reinforces the aims of the other two standards. For example, for parents to form strong emotional bonds with their baby, unrestricted access and physical proximity is paramount. To enable successful expressing and breastfeeding, the parent-baby relationship is vital and can only be achieved if parents are valued and seen as partners in care. Small practical changes such as fold out beds and provision of food can have big impact and enable parents to stay close to their babies for prolonged periods. However, evaluation findings revealed that many neonatal units initially prioritised Standards 1 and 2, viewing them as more immediately achievable and necessary foundations for the cultural and operational shifts required by Standard 3. While Standards 1 and 2 were seen as stepping stones, Standard 3 was perceived as more complex, requiring greater resources and deeper systemic change, with one lead describing it as *'a bit more tricky'*.

Perspectives of Infant Feeding leads on "Parents as Partners in Care"

Midway through the project, we held a focus group to explore how infant feeding leads understood and interpreted the concept of parents as partners in care. At that stage, understanding appeared to be evolving, one lead observed that:

> **"I think there is much more to parents as partners in care, you can interpret it in different ways. Everyone on the call seems to have done that."**

Few infant feeding leads offered concrete views, and parents as partners care was perceived as aspirational rather than embedded in practice.

> **"We want parents to feel as comfortable as they can, spending as much of the day here as possible. We want to break down barriers. Staff can then step back and focus more on meeting clinical needs. We now do that with a minority of babies, and we want to do that with most babies."**

At the end of the project, we revisited the concept in semi-structured interviews. A clearer consensus had emerged: the focus was on ensuring that nursing staff work in partnership with parents, enabling them to take the lead and be fully involved in their baby's care.

One participant explained:

> **"For me, it's basically that they are ultimately responsible for their baby. So, the decisions and the care that we deliver they need to be part of that from the start. We're a very scary, unique place, and babies often need very specialist help. But there is so much that parents can do from the beginning. It's just about empowering them to do it."**

An Infant feeding lead highlighted how this approach supported the promotion of babies' rights through the mother-baby dyad.

> **"Being a partnership. We are working for the parents not just the babies. Our role is to support them to do things for their baby...Really empowering them to speak up on their babies behalf."**

Practical Changes as Enablers to Parents as Partners in Care

To support the implementation of parents as partners in care, many neonatal units focussed on removing practical barriers that limited parental presence. These changes aimed to enable parents to spend as much time as possible with their babies and often required significant negotiation with senior leadership. Practical changes that were commonly introduced included:

Enabling Access to Units

Several units introduced technologies to support 24-hour access, including fingerprint recognition and Bluetooth systems. These innovations were implemented with care to enable access whilst at

the same time minimising disruption, such as frequent buzzing on the door and to minimise parental waits to be let in to the unit.

Creating a More Comfortable Environment

To encourage parents to be on the units longer, many units invested in comfortable chairs, some of which could be converted into beds for overnight use. However, due to limited space and overcrowding not all units could place a chair beside every cot. Others provided additional bed spaces to enable parents to stay overnight on the unit. However, this was again more challenging for units constrained by space. It is essential that there is overnight accommodation for families particularly because many babies are admitted to units located some distance from their family home.

Provision of Food

Over time, units introduced various strategies to support the wellbeing of families through the provision of food. Access to nutritional food is important for the parents' wellbeing and also to minimise the time they are separated from their baby when shopping or cooking away from the unit. Some units provided three meals a day, others provided food vouchers for use in the hospital canteen. Sometimes this was financed by a charity or the Trust.

> **"We now have free meals for everyone. We can order a hot meal for families that need one. We have a snack basket in the parents' kitchen for parents and extended family members to help themselves too, alongside free drinks."**

One Infant Feeding Lead explained that, although they had received support in other areas of practical provision, they faced considerable resistance from senior managers regarding the provision of meals, due to the absence of a specific budget for meals or financial code to which the cost could be allocated.

Support for Siblings

Some units introduced initiatives aimed to make the unit more welcoming for siblings. Changes included employing play therapists establishing creche type facilities and reorganising parent ensuite rooms during the day to create safe play areas.

Parking and Travel Support

A report highlighting the additional costs faced by parents during neonatal care identified travel expenses as a significant challenge.[13] To help reduce financial barriers, some neonatal units waived parking fees for parents and introduced travel support measures, such as free bus passes.

Implementation of Standard 3 Parents as partners in care has resulted in a range of practical improvements that have had a transformational impact on families:

[13] Bliss(2022) Bliss briefing: Impact of cost of living crisis in neonatal care September 2022 Bliss-cost-of-living-impact.pdf, September.

> **"We have still got a long way to go, we're still pushing, pushing all the time for more. But simple things like the meals. It impacts the family so much. I know just from speaking to parents. It makes it feel a more welcoming place to be, if you're getting your car parking, you're getting your meals. The facilities are there, you're, you know, you've got a layout bed by the cot that you can sleep in, it makes the whole experience different."**

For one unit implementation coincided with a refurbishment. The new unit was designed to support families to spend more time with their baby. Each cot space was equipped with a fully reclining bed chair, and the redesigned layout made it easier to wheel beds in and out. The changes also helped create a more peaceful environment for babies and parents.

Change in Nursing Culture and Practice

The implementation of Standard 3 has had a transformative impact on nursing culture and practice. Changes identified included:

Care is more parent driven

> **"We don't have routines for blood taking or bathing or weighing. Parents decide when they want to do that as well. So, things have changed massively."**

Nursing practice is supporting parents to lead on their baby's care

> **"I would say in terms of actual care provision, we have it commented often, particularly by external people, either new nurses or midwives. That basically the parents do everything. including stoma care and our surgical nurses are very good at teaching parents how to do that and making them feel confident."**

Parents are spending more time on the unit

> **"We had a culture where the nurses would very much tell the parents to go home and get some rest. They are now at the bedside more and the reclining chair helps with that."**

Improved parental confidence on leaving the unit

> **"It just prepares them so much for going home, you know to build their confidence with their baby, as it is such a shock to have a premature baby at home."**

An increased focus on parents' views

There is now a greater emphasis on listening to parents. Units are required to undertake parent audits once they are progressing towards the stage 3 award and beyond. There is growing evidence of a cultural shift towards valuing parent feedback as a driver for improvement. Some infant feeding leads described how they used parent feedback to influence practice, highlighting areas for improvement to staff and senior managers and sharing positive feedback to reinforce good practice and encourage greater engagement with BFI.

A review of Stage 3 accreditation reports enabled us to capture parents' perspectives on the impact of Standard 3 and reinforces a shift towards 'parents as partners' in care.

> **"We were encouraged to be with our baby all of the time even when she was having a test."**
>
> **"The nurses were always there to ask, but they didn't interfere which was good for my confidence."**

There was also a recognition of the way in which babies' rights were promoted:

> **"Loved how the staff spoke to the babies, so warm and nurturing."**

A key development in gathering parents' views has been the way that ward rounds and handovers are facilitated. Some units adopted a more formal approach, such as parent-led ward rounds, while others introduced simpler strategies like routinely asking parents how their baby is each day. Transitioning to parent-led ward rounds required a significant shift in practice for medical staff and, in some cases, involved extensive negotiation. There was clear evidence that these changes were leading to positive and empowering outcomes for families.

> **"I think the Parent Led Ward round is really empowering for parents. You know when you think back to the nurse presenting the baby to the doctor with mum or dad sitting there. You know that has changed. You know, it's lovely to hear to hear a mum just talking about her baby and being fully informed."**

There were also barriers:

> **"A lot of our families come from all over the place, so it can be really hard for them to get here and especially, make ward rounds. But the consultants are very good at meeting them outside of ward, round time if they can't make it."**

Some units adjusted the timing of ward rounds to better accommodate parents' other commitments, recognising that parental presence when making decisions is integral to their model of care.

Change for Babies

The implementation of Standard 3 has resulted in babies' rights becoming more prominent across neonatal units. Babies have benefitted from reduced separation, of parents and babies, thereby enabling increased skin-to-skin contact, increased use of breastmilk, and improved parental responsiveness to their baby's cues. It has also resulted in a growing awareness of the need to create a calmer, more nurturing environment within care settings.

> **"There is a lot more consideration for the baby, Understanding brain development and cortisol distress for the baby. Protecting the baby from unnecessary light and environmental stimuli. It's just a lot calmer. I think, and a lot more nurturing for babies compared to before."**

Overall, the introduction of Standard 3, has supported a shift towards a more enabling and family-focused model of care.

> **"Parents have become true partners in care. Feedback has shown massive improvements during our BFI journey. Parents are around on the unit more and staff have been supporting parents earlier for discharge and empowering parents to be leading ward rounds in a non-official way."**

Summary

In this chapter, we have highlighted some of the challenges associated with implementing Standard 3, which is widely perceived as more complex and requiring a more transformational cultural shift. Nevertheless, it is a is a key enabler to Standards 1 and 2 and needs to be equally prioritised when implementing the standards.

The findings show that implementation of Standard 3 can lead to significant change for babies, parents and staff and marks a meaningful shift towards recognising and valuing parents as partners in care. Many units introduced practical changes to enhance parental comfort and support parents remain close to their baby. These changes were accompanied by a cultural shift in nursing practice, with staff increasingly focused on supporting and empowering parents.

While in some units the physical environment limited the scope for practical change, it should not be seen as a barrier to cultural change. Just as parents are expected to stay overnight with their child on a children's ward, there should be a similar expectation for parents of some of the most vulnerable babies in neonatal settings, as enabling babies to stay close with their parents is crucial to implementing a child rights approach to care.

Case Study: Creating Space for Connection – Supporting Close and Loving Relationships at Royal Surrey NHS FT, Special Care Baby Unit

This photograph of one of the newly designed rooms captures the transformation of the Special Care Baby unit at Royal Surrey NHS FT in order to embed the BFI neonatal standards into their everyday care.

Previously, the unit offered only two rooming-in spaces, and parents had limited options to stay overnight beside their baby's cot or incubator. While staff did their best to promote skin-to-skin contact and expressing at the bedside, the physical environment restricted the ability to keep families together during critical early moments.

Motivated by the desire to improve family-centred care, the team launched the **Closer to Care** campaign, successfully raising funds to rebuild the SCBU. The redesigned unit now places parents at the heart of their baby's care, offering:

- **Reclining chairs that convert into beds**, complete with duvets and pillows for comfort
- **Space for hospital beds**, allowing mothers who are not yet discharged to spend time with their baby and engage in skin-to-skin contact
- A **dedicated bedroom** for both parents to stay prior to discharge, providing a relaxed environment to prepare for life at home
- **Facilities for siblings**, enabling the whole family to bond with the baby
- **Access to snacks, sandwiches, and hot meals**, ensuring parents' basic needs are met during their stay

These enhancements encourage both mothers and fathers to remain with their baby for as long as they wish, fostering close and loving relationships. In addition, each cot space is equipped with a breast pump and expressing kit, including baby bonders, buccal colostrum leaflets, and guidance materials with video links. These resources support early expressing and reinforce the Baby Friendly Standards in daily practice.

CHAPTER FOUR: THE IMPACT OF BABY FRIENDLY NEONATAL STANDARDS ON EXPRESSING AND BREASTFEEDING

This chapter presents the evaluation findings on the impact of the implementation of the BFI neonatal standards on infant feeding outcomes, including expressing and breastfeeding outcomes, improved facilities, staff and parents' knowledge, confidence and changes in practice. Challenges and opportunities regarding the use of BFI audit tools will also be discussed.

How was infant feeding data collected and analysed?

In order to assess changes in infant feeding practice, units were required to record data on the UNICEF UK tab on BadgerNet (an electronic maternity healthcare record system) and to submit data bi-annually in the online surveys for the preceding month on five infant feeding measures[14]:

- % of mothers expressing within 24 hours of admission
- % of mothers expressing when they leave the unit
- % of mothers breastfeeding when they leave the unit
- % of babies receiving human milk when they leave the unit
- % babies receiving human milk in 24 hours after admission

These measurements were specifically developed by BFI to capture data relating to the neonatal standards. This data offers complementary insights to the consistently collected National Neonatal Audit Programme (NNAP) breastfeeding composite measure which focuses on babies less than 34 weeks gestation. Units also provided qualitative information on trends in infant feeding in the online surveys and in semi-structured interviews. Towards the end of the project, the UNICEF UK tab was updated to include an additional tab for each measurement on missing data. From Survey 5 onwards, units were required to submit information on missing data.

The final analysis includes data from Surveys 1 to 5. Survey 6 was omitted due to a low response rate and persistently high levels of missing data. It should be noted that Survey 5 also showed significant missing data across infant feeding outcomes—12 out of 19 units reported missing data, while others did not report at all. Missing rates varied widely, with some outcomes (e.g. mothers expressing within 24 hours) ranging from 10% to 98%. Missing data was not collected or quantified between Survey 1 to Survey 4, limiting our ability to assess data completeness over time. These limitations mean the findings should be interpreted with caution, as data completeness and consistency may affect reliability and representativeness of specific figures.

[14] See Guidance for neonatal units on collecting breastfeeding data: New guidance for neonatal units on collecting breastfeeding data - Baby Friendly Initiative

Expressing Outcomes

Our evaluation shows a steady upward trend and significant improvements in expressing outcomes across all participating units. By Survey 5, the percentage of mothers expressing within 24 hours of admission increased from 15% to 36% and that of mothers expressing when their baby left the unit increased from 18% to 37% (See Appendix, Figure 1). Units also reflected positively about the improvements in practice and staff attitudes which ultimately influenced mothers and expressing outcomes.

> **"On average our babies are getting breast milk within four to five hours of admission. In comparison to what we were two years ago, it was looking like 12 to 18 hours."**

> **"Expressing support would be inconsistent [at the beginning of the project]. You might not get milk for days [...] now that has changed completely [...] there would be early breast milk whereas before that probably wouldn't be a thing for days."**

Breastfeeding Outcomes

Over the three-year period, all breastfeeding measures showed a consistent upward trend, indicating continuous improvements in breastfeeding outcomes within the participating units. In particular, the percentage of mothers breastfeeding when they left the unit increased from 19% to 44%, the percentage of babies receiving human milk when they left the unit increased from 26% to 52% and the percentage of babies receiving human milk in 24 hours after admission increased from 17% to 37% (see Appendix, Figure 2).

This trend also mirrors the NNAP breastfeeding data for participating units. Specifically, between December 2021 and December 2024, all but two units showed an increase in the proportion of babies at less than 34 weeks receiving their mother's own milk at 14 day and at discharge in their NNAP data.

The sustained improvement and cultural shift in breastfeeding practices and outcomes was discussed by participating units at the end of the project.

> **"Our rate of babies leaving doing some breastfeeding has improved, with very little drop off rates. If they leave breastfeeding, on the whole they will still be breastfeeding 6-8 weeks after discharge. This is far higher than the city average at 6-8 weeks."**

It is important to note that despite the improvements in breastfeeding rates, this remains a challenge.

> **"More improvement is required on baby's going home breastfeeding. Parents sometimes think breastmilk in a bottle is just as good when really the babies need the breastfeeding for protection, love and comfort and to avoid overfeeding."**

> **"We now have more babies receiving higher volumes of breast milk and being discharged receiving breastmilk; however, the rates of babies being discharged home breastfeeding compared to having EBM in a bottle has not improved as well as other parameters."**

Challenges and Opportunities

Despite improvements in expressing and breastfeeding practices in the 18 units, challenges persist in relation missing data and accuracy. Inaccurate or missing data can obscure the true extent of progress, leading to frustration and missed opportunities for recognition and learning.

Several units reported ongoing issues with large percentages of missing data, particularly around the first human milk feed and early expressing. These gaps were often due to staff not completing the relevant fields or being unsure how to document specific scenarios, such as when a baby is repatriated from another hospital or when formula feeding is chosen. Staff turnover, sickness, and reliance on temporary or agency staff unfamiliar with BadgerNet further contributed to inconsistent data entry.

> **"We continue to have problems with missing data with the first human milk feed... there is also some confusion on how to fill this out if baby is a REPAT or mother chooses to formula feed."**
>
> **"Our unit encourages early expressing and I know it is much higher in the 24 hours but there is a failure to document this."**

In addition, even when data was entered, it was not always accurate. Staff noted that small errors, such as ticking the wrong box, can significantly distort results. In some cases, data was entered retrospectively or estimated, which undermines its reliability.

> **"I think it's definitely better than what the data is showing in terms of how quickly your mum expresses [...] I can see that and if that data was put in, it would show us how quickly those babies get their breast milk. And I know that they do because I'm there a lot of the time [...]"**

Additionally, double data entry and lack of integration with electronic patient record systems created inefficiencies and increased the risk of errors.

In order to address these issues, some units introduced dedicated roles who contribute to monitoring data input and providing ongoing support to colleagues. Other units reported improving BadgerNet usability and streamlining data entry by providing specific training.

> **"That [Documentation] has improved and is down to the Infant feeding supporters monitoring the inputting of data. We have seen improvements in early breastmilk administration and breastmilk on discharge.**
>
> **"Poor data entry was a problem. Since BAPM optimising early preterm toolkit and recently PERI-prem, amazing increase in babies receiving EBM in the first 24 hours. PERI-prem nurse now supports data entry."**

The evaluation offers evidence that when feeding data is consistently and accurately recorded, it becomes a powerful tool for demonstrating progress and guiding improvement. It's important to highlight the value and benefits of the BFI specific data fields.

While NNAP breastfeeding data continues to be a trusted and widely used benchmark, it only tracks outcomes in babies born at less than 34 weeks. The BFI specific data fields offer distinct and complimentary advantages as they capture data across a broader gestational age range, allowing for a more inclusive and representative picture of expressing and breastfeeding outcomes. This wider scope enables units to monitor progress not only for the most premature infants but also for those born at later gestations, who equally benefit from breastfeeding support.

Moreover, the BFI specific data fields provide more granular insights into specific practices such as early expressing, administration of human milk within the first 24 hours, and breastfeeding at discharge. These details are crucial for identifying targeted areas for improvement and celebrating nuanced successes that may be less visible through broader national metrics.

Improved Facilities to Enable Expressing, Breastfeeding and Provision of Breastmilk

A recurring theme across the participating units is that implementation of the project resulted in increased access to facilities and equipment that enabled expressing, breastfeeding and provision of breastmilk. For example, several units facilitated greater access to breast pumps which enabled more mothers to express early and sustain milk production over time. This practical support contributed to improved rates of early expressing and higher volumes of breastmilk being provided to babies.

> **"More mothers expressing early and continuing to express for longer. I think the increase of pumps to loans has made a huge difference."**

Staff Knowledge, Confidence and Practice in supporting Expressing and Breastfeeding

Prior to the project, expressing and breastfeeding support were often seen as a specialist responsibility, handled by a small group of experienced staff. By the end of the project, staff across units showed a significant increase in their knowledge and confidence in supporting and promoting expressing and breastfeeding.

> **"All the nurses are doing it. They're not just getting the nurse who was interested in breastfeeding. Everybody's doing it. Everyone feels confident to do it and problem solve with parents. They know how to support parents to make informed choices."**

> **As a result of implementing the standards, early expressing and breastfeeding have become more embedded in routine care and a shared responsibility among staff across participating units.**

> **"Babies are now being offered the breast earlier. Staff are educating families on feeding cues much earlier, assisting in the bonding and earlier breastfeeding. There is increased use of the breastfeeding/top up guide while establishing breastfeeding, resulting in more being discharged breastfeeding."**

Parents Knowledge and Confidence in Expressing and Breastfeeding

Improvements in staff knowledge, confidence and practice had a ripple effect on parents. As a result, parents became more informed, confident, and empowered in their role. This enabled them to make informed decisions about feeding their baby and, in some cases, to hold professionals accountable and challenge decisions that may not align with their breastfeeding goals. It signals a cultural shift where parental voice is respected and integrated into care planning, reinforcing breastfeeding as a shared value between families and staff.

> **"We have had a few parents with extreme preterm babies. The dietitian said the weight gain isn't as big as we would like, so let's do a supplementary formula and we will give some breast milk as well. But the parents have been really vocal about saying for the last 2 1/2 months I have expressed 10 times a day religiously because you told me that's what's best for my baby now it's not good enough [...] the dietitian really had to listen to that because it was such a valid point. We're definitely seeing parents just being way more confident because they understand how beneficial it is to their baby."**

Summary

Overall, the evaluation identified a cultural shift toward supporting and prioritising early expressing and breastfeeding across units. Expressing and breastfeeding are no longer be seen as specialist tasks but increasingly as shared, embedded practices. Staff confidence has grown through structured training and practical skill reviews, enabling earlier and more consistent support for families. For many units, early expressing starts to be as part of care routine, and breastfeeding is viewed as the norm rather than the exception. This shift can be seen in improved outcomes, increased parent engagement, and a collective sense of responsibility across teams—highlighting a fundamental change in both practice and unit culture .

By capturing data across a range of indicators not previously collected, BFI infant feeding data provide a more complete picture of progress, helping teams validate changes in practice and drive continued improvement. However, units still faced persistent challenges with missing or inaccurate data. To address this, some units have introduced dedicated roles, streamline data entry, leading to better documentation and more reliable reporting. Yet, the disconnect between practice and recorded data remains a barrier to reflection and learning.

Case Study: Enhancing Early Breast Milk Feeding through Birthday Cuddles – Jessop Wing Unit (Sheffield Teaching Hospital)

As the result of the implementation of the National Neonatal Project and QI Project, Jessop Wing unit supports as many preterm/sick babies as possible to receive antenatally expressed breast milk (EBM) during a Birthday Cuddle. Parents are encouraged to antenatally express and give this buccal colostrum as part of the birthday cuddle so parents can see their baby receiving their milk.

Previously, at the unit, wherever possible, parents were antenatally counselled about the importance of EBM for their preterm/sick baby, but they did not support expressing until after the baby was born. This often resulted in delays to get EBM in a timely manner post-delivery.

Now, a multidisciplinary team including obstetricians, midwives, and neonatal staff, works to support all women in preterm labour to begin antenatal expression either upon receiving Magnesium Sulphate or when seen in the Fetal Maternal Unit after 36 weeks—if neonatal admission is anticipated. This approach ensures that EBM would be available immediately after birth, whether in theatre or on the labour ward, helping to provide the baby's first feed within the first two hours of life.

Parents have reported that the Birthday Cuddle really helped them bond with their baby and helped them feel less stressed. Supporting antenatal expressing and helping parents give the buccal EBM or watch the antenatally expressed EBM being given at the delivery has helped increase maternal milk volumes and increased the numbers of babies leaving our unit receiving breastmilk.

"This was my third preterm baby, all I have ever wanted is to hold my babies after they have been born, but unfortunately the first 2 were whisked off to NICU before I could hold them. To be able to hold my third baby and give them some of my magic milk whilst still in theatre has been amazing, it really helps."

Case study: Strengthening Breastfeeding Support at West Middlesex Neonatal Unit (Chelsea and Westminster Hospital)

As part of the National Neonatal Project, the West Middlesex Neonatal Unit (part of Chelsea and Westminster Hospital) implemented a comprehensive approach to embed breastfeeding and expressing support into routine practice—resulting in one of the most consistent reported upward trends in breastfeeding outcomes across all participating units.

It is worth noting that the unit maintained relatively low levels of missing data across all indicators—an ongoing challenge for many units. By Survey 6, the figures have increased from:

- 14% to 43% mothers expressing within 24 hours of admission
- 20% to 72% babies receiving human milk in 24 hrs after admission
- 5% to 71% babies receiving human milk when they leave the unit
- 5% to 42% mothers expressing when baby leaves the unit
- 5% to 45% mothers breastfeeding baby when they leave the unit

By the end of the project, one of the infant feeding leads commented:

> **"It's like a completely different unit... we've come on leaps and bounds"**

Our evaluation identified a number of factors contributing to the significant improvements in WMNU's rates, including:

- High number of staff completed training and practical skills reviews (PSRs)
  - Every nurse—permanent, agency, and bank—was retrained in BFI standards
  - By Survey 6, 92% or nurses completed PSRs in hand expressing, positioning and attachment, and responsive bottle feeding
  - Training was delivered face-to-face and reinforced annually, with new nurses receiving two days of training before starting clinical work
- Regular engagement and recognition
  - "BFI Question of the Week" was used to reinforce knowledge
  - "BFI Star of the Month" celebrated staff who stood out
- Improved infrastructure and resources
  - Recliner chairs, mirrors for skin-to-skin, and bonding squares were introduced

CHAPTER FIVE: THE IMPACT OF BABY FRIENDLY NEONATAL STANDARDS ON SKIN-TO-SKIN CONTACT

This chapter presents the evaluation findings of the implementation of the BFI neonatal standards on skin-to-skin practices, including improved facilities, staff and parents' knowledge, confidence and outcomes. Challenges and opportunities regarding data collection using BFI skin-to-skin audit tools will also be discussed.

How was skin-to-skin data collected?

A key intention of the project was to increase the amount of skin-to-skin contact each baby received. Therefore, the systematic recording of data on skin-to skin contact was essential to enable us to quantity and capture change over time. We piloted a skin-to-skin audit tool in Survey 1 and refined it for Survey 2 following a focus group with participating units and used this as a baseline. The tool was designed to measure duration and frequency.

Units were required to provide data on:

- The number of babies on the Unit
- The number of babies included in the audit
- The total number of minutes babies were in skin-to-skin contact in the audit week
- The total number of episodes of skin-to-skin contact in the audit week.

This enabled us to calculate the average number of episodes and the average number of minutes per baby. Units were encouraged to devise their own approach to data collection.

Skin-to-skin outcomes

Over the three-year period, participating neonatal units demonstrated measurable improvements in both the frequency and duration of skin-to-skin contact. The average number of episodes of skin-to-skin contact per baby fluctuated ranging from 5 to 3.6 per week and then increasing to 4.6 in Survey 6. The average length of each episode increased from 43 minutes in Survey 2 to 73 minutes in Survey 6. Most notably, the total minutes of skin-to-skin per baby across the audit week rose from 217 to 336 minutes. (For details, see Appendix, Figure 3).

These improvements in skin-to-skin outcomes within these units were reflected in qualitative feedback in online surveys, a focus group and semi-structured interviews by the participating units towards the end of the project.

> **"It is happening a lot more - babies having skin-to-skin episodes earlier on and with lines or chest drains."**

Challenges and Opportunities

Similar to infant feeding data, collecting skin-to-skin data presented several challenges. Firstly, the absence of electronic tabs meant that units relied on paper-based audit systems. This created issues around data storage and raised concerns about lost forms potentially affecting data reliability. To ease the burden on units, we asked units to undertake a bi-annual audit week. Many units actively promoted the audit week, for example, by displaying posters and reminding staff, which may have led to increased skin-to-skin contact during that week compared to others. To address this units were advised to ensure that practice during the audit week reflected typical routines, and guidance was provided to help mitigate this risk.

Another early challenge was the additional workload for staff in completing audit forms. To address this, units encouraged parents to fill in the forms themselves, aligning with the principle of *Parents as Partners in Care* and helping to reduce staff burden.

The evaluation shows that when BFI skin-to-skin data is consistently and accurately recorded, it has **significant benefits in tracking meaningful trends and demonstrating improvements** in both the frequency and duration of skin-to-skin. This level of insight supports targeted improvements, validates staff efforts, and helps embed skin-to-skin as a routine and measurable component of neonatal practice. Therefore, regular skin-to-skin audits would support the promotion of evidence-based practice.

Improved Facilities to Enable Skin-To-Skin and Close and Loving Relationships

The project resulted in physical and environmental improvements that in turn played a critical role in facilitating skin-to-skin contact and enhancing the quality of parent-infant bonding. Physical changes included increased access to appropriate equipment such as comfortable chairs, kangaroo care mirrors, and skin-to-skin wraps. These changes were sometimes accompanied by environmental improvements that included redesigned spaces, increased accessibility even where space was limited, facilitating a calmer environment and increased privacy. These improvements together have helped parents to feel more comfortable and empowered to engage in skin-to-skin without needing staff permission.

> **"A mum came through on her bed and the staff actually managed to get the baby into skin to skin while Mum was on a bed on high flow... she stayed there for an hour."**

Staff Knowledge, Confidence and Practice on supporting Skin-to-Skin

Increased staff knowledge and confidence on skin-to-skin was strongly reported across units. Such increase in knowledge and confidence has led to a gradual shift in their practice and the culture around skin-to-skin in the units.

> **"General awareness amongst staff of skin to skin has grown. Most staff will promote it daily. Parent led transfers are common and have been supported and promoted by our OT and physio."**

Despite significant improvements, it was acknowledged that the cultural change is gradual and takes time to be embedded in the units.

> **"We were concerned that with the training and environmental changes, we were not seeing enough change. The most recent audit is much more positive, demonstrating that culture change takes time."**

Parents' Knowledge and Engagement

For some units, staff reported improvements in parents' understanding of the benefits of skin-to-skin contact, and hence their increased engagement with skin-to-skin. This change was attributed to targeted education, increased staff-parent communication, and the integration of skin-to-skin messaging into routine care.

> **"During parent audits the level of knowledge around the benefits of skin-to-skin has increased greatly. Parents are talking about brain development, hormones, milk production temperature control."**

For some other units, the lack of support and low engagement from parents is highlighted as a potential barrier to skin-to-skin. Specifically, some units reported that despite efforts such as providing educational materials, creating private spaces, and involving parents in audits and discussions, many parents still decline skin-to-skin.

In line with this, units noted that building knowledge capacity for both parents and staff remain a work in progress and that this barrier can be addressed by ongoing education and communication.

> **"We are working on changing the view a lot of parents have that skin-to-skin is only beneficial whilst babies are sick or in the first few days after birth. We are looking at education of both staff and parents to address this."**

Strategies to increase skin-to-skin

Units reported that distributing products aimed at promoting skin-to-skin contact and raising awareness on skin-to-skin are effective in increasing skin-to-skin.

Distributing products aimed at promoting skin-to-skin

One unit reported distributing bonding bags, including a skin-to-skin top, a water bottle, biscuits, a hot drink cup, a diary and a cool bag, to promote skin-to-skin contact, whilst other units distributed boob tubes and vest tops, all of which were funded through charity funding.

Raising Awareness

A variety of strategies were implemented to raise awareness of skin-to-skin contact among parents and staff. For example, awareness campaigns featured short teaching sessions for parents and staff, leading to increased uptake of skin-to-skin contact. Resources were also translated into different languages to improve accessibility for all parents.

"We had an awareness campaign for a month. We did parent teaching sessions, staff teaching sessions aimed at raising awareness. They tended to be fifteen-minute sessions. As a result, a lot of special care babies started to get skin-to-skin care."

Other practical examples include a bespoke form encouraging parents to record skin-to-skin contact, admission leaflets on skin-to-skin contact, and a laminated love heart letter that could be placed at the end of the incubator with space for a photo of the baby's first skin-to-skin moment. One unit reported incorporating discussions about the baby's readiness for skin-to-skin into ward rounds.

A Practice Still in Progress

Despite measurable progress, there are ongoing challenges and areas of improvement remain in relation to skin-to-skin contact. Although we have seen notable progress in the amount of time babies spend in skin-to-skin contact, the evidence suggests that to fully realise its benefits, babies should ideally spend most, if not all of their time in skin-to-skin contact.[15] This indicates we are only at the start of a transformative journey, with considerable potential for further improvement.

Summary

The evaluation supports a meaningful gradual shift in how skin-to-skin contact is practiced and perceived in participating units while highlighting the importance of continued work in this area. Over the three-year period, staff across units showed increase in confidence and became more proactive in integrating skin-to-skin into routine care, even in intensive settings and during complex deliveries. Parents increasingly understood its benefits, leading to earlier and more frequent engagement, though some barriers to engagement remain. Environmental improvements, such as redesigned cot spaces and calmer, more private rooms, helped make skin-to-skin more accessible and comfortable. Together, evidence supports a gradual cultural shift across units toward making skin-to-skin a more consistent and valued part of neonatal care, while acknowledging that many babies still spend significant time without skin-to-skin contact.

The evaluation highlights the role of the BFI audit tool in capturing and demonstrating the improvements in skin-to-skin practice. By enabling units to track both the frequency and duration of skin-to-skin, the tool provides valuable insights into practice patterns and supports its integration as a routine component of neonatal care. However, missing data and inaccuracy around skin-to-skin data collection remain ongoing challenges for units, but monitoring trends is useful. Strengthening documentation and prioritising skin-to-skin—even during busy or complex clinical scenarios— will therefore be essential to better understanding current practice, identifying missed opportunities, and guiding meaningful improvements in care delivery.

[15] Sivanandan, S., & Sankar, M. J. (2023). Kangaroo mother care for preterm or low birth weight infants: a systematic review and meta-analysis. *BMJ Global Health*, 8(6), e010728.

RECOMMENDATIONS

Recommendations for Infant Feeding Leads and Neonatal Units

Leadership and Strategic Commitment

- Secure senior leadership support early, as this is essential for accessing resources and driving change, including senior members of the medical team.
- Appoint a dedicated infant feeding lead with sufficient protected time and appropriate role recognition to lead implementation effectively.
- Appoint a Baby Friendly Guardian at the outset to champion the standards and maintain momentum.
- Build capacity within the infant feeding team by developing infant feeding champions to support and strengthen implementation and where appropriate by leveraging the experience of maternity units within the trust who have or are implementing BFI.

Implementation

- Introduce all three standards concurrently to maximise impact.
- Establish effective implementation and governance structures

Training and Workforce Development

- Invest time in designing a comprehensive, high-quality, and engaging training programme.
- Give equal priority to core training and PSR's
- Recognise the importance of detailed scheduling to ensure staff can attend training, including securing resources to release staff.
- Ensure medical staff complete training and engage with ongoing implementation of the standards.

Data Collection and Evaluation

- Prioritise systematic approach to monitoring and evaluation on infant feeding practices and outcomes, and to track the frequency and duration of skin-to-skin contact.
- Use audit tools effectively to assess staff knowledge, skills, and parent experiences to inform action planning and demonstrate progress.

Recommendations for Infant Feeding Leads and Neonatal Units

- Develop bespoke projects modelled on the NNP to act as catalysts for implementing the standards, with built-in contingency for extended accreditation timelines.
- Continue promoting BFI guidance to support consistent and effective practice across units.
- Develop tailored training materials aligned with the neonatal standards to support consistent and effective implementation
- Continue to emphasise the value of effective auditing in monitoring BFI standards, capturing a comprehensive view of the care and supporting broader learning and continuous improvement.
- Continue to work with BadgerNet and infant feeding leads to support the accurate recording of infant feeding data.

APPENDIX

The National Neonatal Project

The services and units that participated in the project are as follows:

- Sheffield Teaching Hospitals NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Foundation Trust
- Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
- South Tees Hospitals NHS Foundation Trust
- The Dudley Group NHS Foundation Trust
- University Hospitals of North Midlands NHS Trust
- Buckinghamshire Healthcare NHS Trust
- Barnsley Hospital NHS Foundation Trust
- Frimley Health NHS Foundation Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- Southport and Ormskirk Hospital NHS Trust
- North West Anglia NHS Foundation Trust
- Royal Surrey NHS Foundation Trust
- The Rotherham NHS Foundation Trust
- Salisbury NHS Foundation Trust

Support provided by BFI and requirements for participating units

Induction	Structured induction to ensure staff understand the baby friendly standards and how to apply them in practice.
Training	Two places per unit at a Baby Friendly Initiative (BFI) five-day training course.
Implementation Support	One-to-one guidance and support through all three stages of implementation.
Assessment Costs	Full coverage of fees for stages 1, 2 and 3 of the assessment process for those completing within timeline of the NNP project
Teaching Materials	Training resources including slides and workbooks. Each relevant member received a copy of the 'Embedding Baby Friendly Standards in Neonatal Care' workbook.
Parent Resources	Copies of the 'You and your baby booklets' for distribution to parents during the NNP project period.
Networking and Learning	Bi-annual meetings with participating units and the Baby Friendly team to share learning and progress.
Planning Meeting	Dedicated planning session involving relevant NHS and BFI staff.
Conference Attendance	Each unit received 10 free places to attend the BFI annual national conference in 2021.

Requirements for participating units

- Appoint a Baby Friendly project lead with sufficient time allocated to lead the project effectively.
- Ensure attendance of both the project lead and a relevant manager at the five-day Baby Friendly Initiative (BFI) training course.
- Provide a signed memorandum of understanding from the clinical director (or equivalent), committing to support the project through to Stage 3 accreditation.
- Assess staff knowledge and parent experiences using the Baby Friendly Audit tool.
- Establish and maintain a project steering group for Baby Friendly and submit meeting notes bi-annually.
- Appoint a Baby Friendly guardian from senior staff or trustees.
- Support key staff to engage with and attend the National Infant Feeding Network.
- Support staff members to attend the BFI 2021 online neonatal conference.
- Participate in monitoring and evaluation activities as part of the project.

Tables and Figures

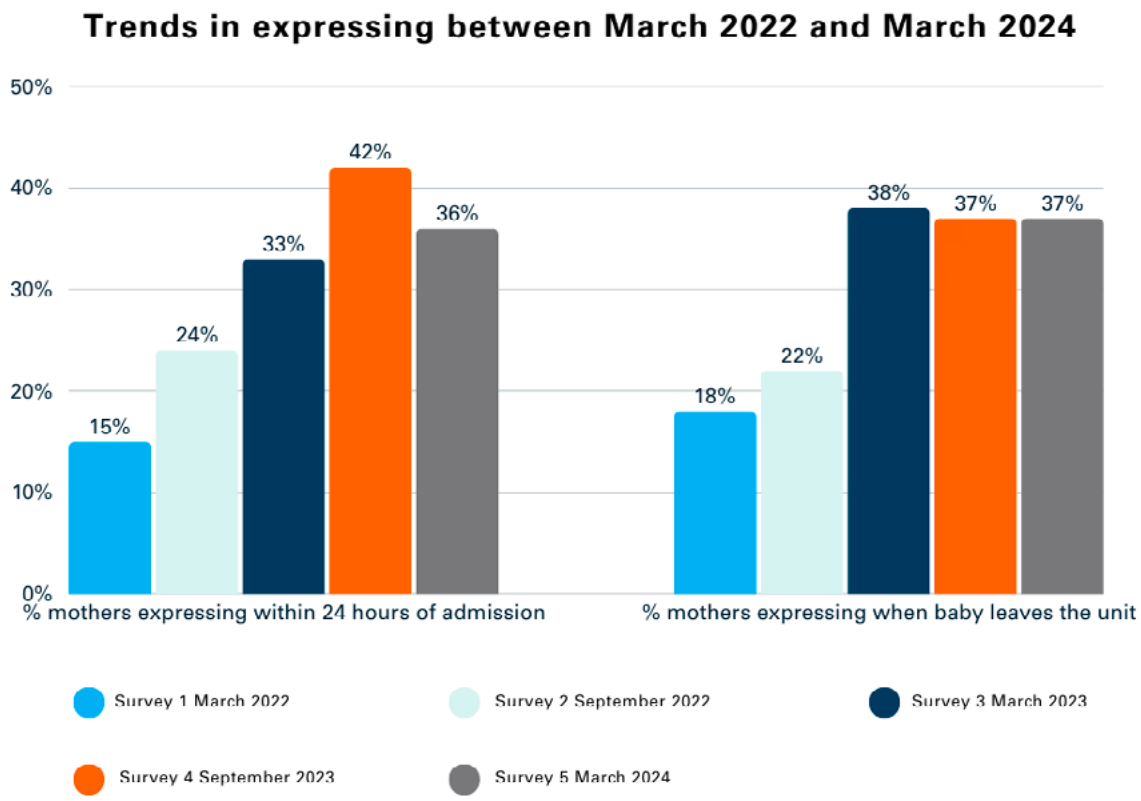


Figure 1. Trends in expressing between March 2022 and March 2024

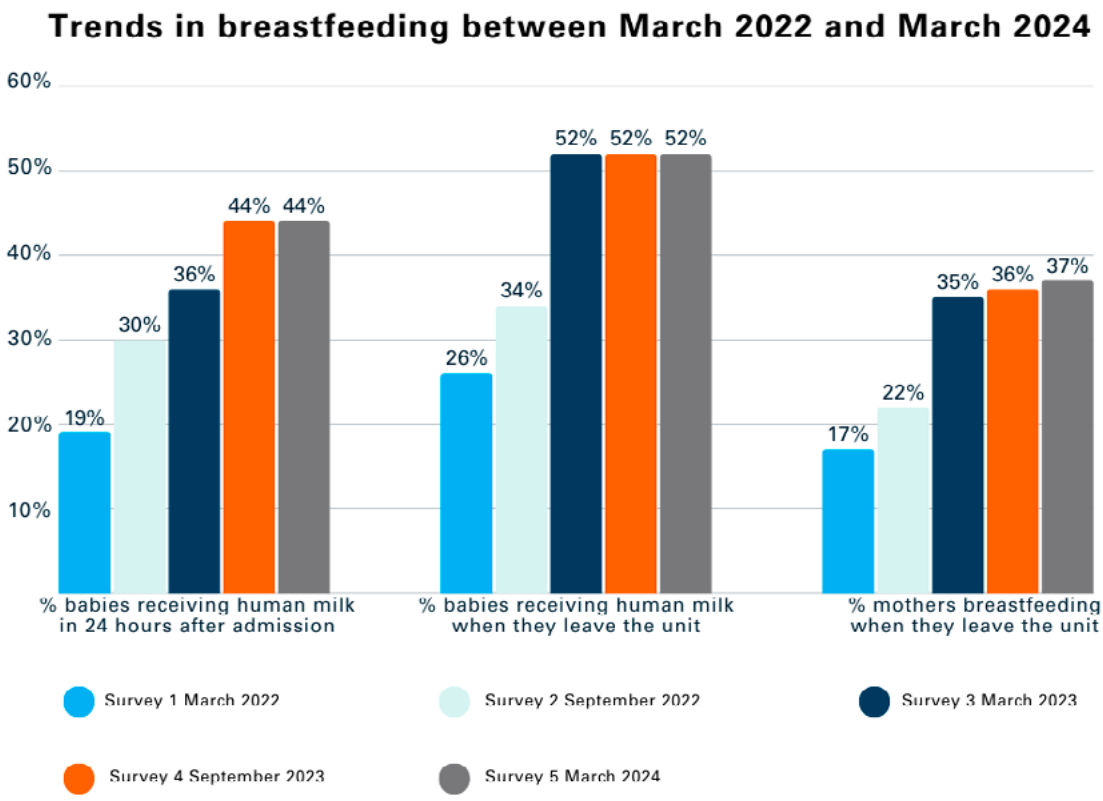


Figure 2. Trends in breastfeeding between March 2022 and March 2024

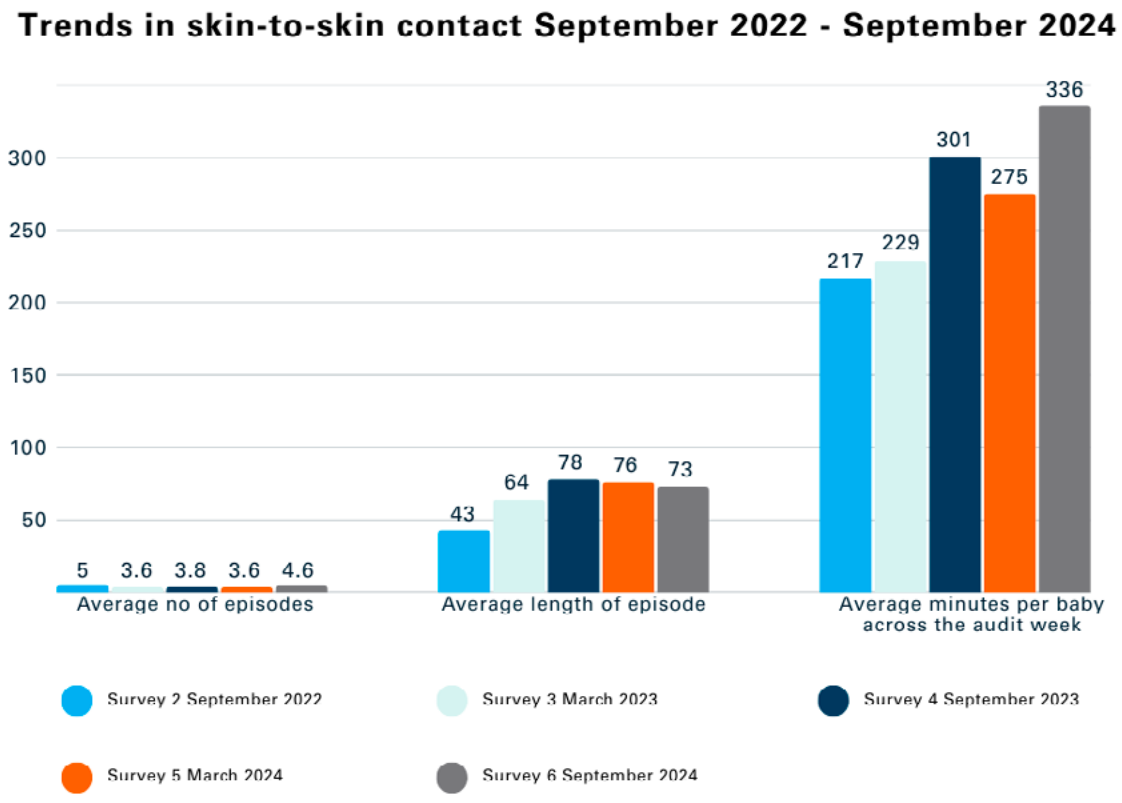


Figure 3. Trends in skin-to-skin contact between March 2022 and March 2024

Table 1. Summary of Baby Friendly accreditation dates for the National Neonatal Project neonatal units (Note: This table does not include the assessment activities during this period.)

Units	Pre- NNP	Year 1 (Jan 2022 - Dec 2022)	Year 2 (Jan 2023 - Dec 2023)	Year 3 (Jan 2024- Jan 2025)
North West Anglia NHS Foundation Trust - Hinchingbrooke Neonatal Unit		Stage 1	Stage 2 / Stage 3	
North West Anglia NHS Foundation Trust - Peterborough Neonatal Unit		Stage 1	Stage 2 / Stage 3	
Chelsea & Westminster NHS FT - Chelsea & Westminster Neonatal Unit		Stage 1	Stage 2	
Chelsea & Westminster NHS FT - West Middlesex Neonatal Unit		Stage 1	Stage 2	
Frimley Health NHS FT - Frimley Park Neonatal Unit			Stage 1	Stage 2
Frimley Health NHS FT - Wexham Park Neonatal Unit			Stage 1	Stage 2
Barnsley Hospitals NHS FT, Neonatal Unit			Stage 1	Stage 2
Betsi Cadwaladr University Health Board Neonatal Units -Wrexham Maelor Hospital	Stage 1			Stage 2
Betsi Cadwaladr University Health Board Neonatal Units - Glan Clwyd	Stage 1			Stage 2
Betsi Cadwaladr University Health Board Neonatal Units - Bangor	Stage 1			Stage 2
James Cook University Hospital Neonatal Unit, South Tees Hospitals NHS FT J		Stage 1	Stage 2	Stage 3
King's Mill Hospital, Sherwood Forest Hospitals NHS FT,		Stage 1	Stage 2	
Rotherham NHS Foundation Trust			Stage 1	
Royal Stoke Neonatal Unit, University Hospital of North Midlands NHS Trust		Stage 1		
Royal Surrey NHS FT, SCBU		Stage 1 / Stage 2	Stage 3	
Russells Hall Hospital, The Dudley Group NHS FT,	Stage 1			
Salisbury NHS Foundation Trust, Neonatal Unit		Stage 1	Stage 2	Stage 3
Sheffield Teaching Hospitals NHS FT, Jessop Wing			Stage 1	Stage 2
Southport & Ormskirk Hospital NHS Trust, SCBU			Stage 1	Stage 2
Stoke Mandeville Neonatal Unit, Buckinghamshire Healthcare NHS Trust			Stage 1	Stage 2