



EVALUATION REPORT

Delivered by



Creating emotionally healthy neonatal units

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1. EXECUTIVE SUMMARY

The Neonatal Families and Staff Together (NFaST) project was funded by Cheshire & Merseyside and Lancashire & South Cumbria Local Maternity Systems as part of the Maternal Mental Health (NHSEi underspend) workstream for 2020/21. The North West Neonatal Operational Delivery Network (NWNODN) commissioned Spoons, a Greater Manchester based charity specialising in neonatal family support, to undertake a piece of work exploring how units could become more emotionally supportive environments and to make recommendations around future best practice.

Project activity

From January - May 2021, the project worked with 13 neonatal units across the North West Coast in the following ways:

- Exploring the emotional needs of neonatal families and staff through a range of evaluation methods.
- Supporting units across the region to engage with veteran parents, with a view to establishing, or further developing, a peer support offer.
- The 3-month placement of Clinical Psychologists in 7 units for 1 session a week, to better understand where the strengths and gaps were and to trial an offer of psychological support to staff and parents.

Staff, current and veteran parents responded enthusiastically to all elements of the project with over 800 pieces of data collected.

Conclusions

Neonatal families and staff are exposed to traumatic events on a regular basis within the neonatal environment and the emotional wellbeing of babies, parents and staff are closely interlinked.

The experience of neonatal care has a profound long-term impact on parents and their infants. In turn the experience of working on a neonatal unit is emotionally challenging and can have significant impact on the individual wellbeing of unit staff. Despite this, a consistent, pervasive,

narrative throughout has been that the mental health impact of being a baby, parent, family or staff member on a neonatal unit is invisible and misunderstood. This lack of understanding leads to the emotional needs of all concerned being overlooked and unacknowledged.

We propose that a relatively small investment into specialist provision and better use of current services could have a wide-ranging impact on parental, infant and family mental health and wellbeing.

We identified the following four core principles;

- That every family who has had an experience of neonatal care should be considered vulnerable to emotional distress and trauma, regardless of the length or nature of their neonatal stay.
- That the provision of emotional support for neonatal families should always be guided by those with lived experience of a neonatal journey.
- That staff caring for neonates and their families need to have their emotional support needs met, in order to be able to provide that care to others.
- That a family's neonatal experience does not end with their discharge from the unit, this is simply a transition to the next stage of a lifelong journey. Therefore emotional support needs to be universal and accessible to all neonatal families, at whatever point they identify as requiring it.

Recommendations

All evidence suggested that an optimum model for an Emotionally Healthy Neonatal Unit requires thought and appropriate structures at every level of the system. The 'key tasks' we recommend to improve wellbeing and longer-term outcomes are as follows, for full details see page 59.

Tasks to promote family wellbeing

Tasks to promote staff wellbeing / embed wellbeing in the whole unit system

Parent and infant emotional wellbeing are seen as a core part of 'business as usual' and this is recognised within unit systems and processes

The role of 'Emotional Wellbeing Champion' is created and resourced appropriately

Wellbeing pathways and family resources are co-produced with parents

Informal peer support between current parents on the unit is supported

Peer support, delivered by trained veteran parents on the unit and post discharge, is available to all families

Families have access to timely, responsive counselling / psychological therapy on the unit and post discharge

There is access to specialist mental health support as needed (ideally from a dedicated unit professional)

There is access to specialist mental health support as needed (ideally from a dedicated unit professional)

The role of 'Staff Wellbeing Champion' is created and resourced appropriately

Training on emotional wellbeing is incorporated into unit training plans

Staff have access to consultation from psychological professionals

Peer to peer support between staff members is supported

Staff have access to a timely, responsive counselling / therapy offer

Opportunities for supervision and reflective practice are consistently provided

Debriefs after challenging events include psychological input

2. SETTING THE SCENE

2.1 An introduction to this report

The purpose of this document is to report in full on all three elements of the NFAST project; data collection, peer support and the placement of Clinical Psychologists.

The report is divided into the following sections:

Section 3: Establishing what's needed

An overview of the existing literature.

A summary of our methods and the results of our data collection.

Section 4: Describing our findings

What did we see and hear?

Section 5: Exploring different offers

What did we do, and what did we learn?

Section 6: The Cost of Inaction

Summary of some key themes and costs of not intervening

Section 7: Recommendations

How should emotional wellbeing be embedded within the neonatal unit? What are the tasks, functions and expected outcomes?

Section 8: What good looks like

What components might be needed? What resources do these require?

Section 9: Delivering a legacy

Describing the outputs from the project and some next steps.

3. ESTABLISHING WHAT'S NEEDED

3.1 Exploring the literature: what's difficult about the neonatal journey?

The experience of neonatal care brings together the heightened emotional vulnerability of a new infant and its parents with a series of traumatic events, often compounded over several days, weeks and months. It is recognised, therefore, that the experience of having a premature or sick baby has the potential to have a profound and long-term effect on infants, parents and families (1).

Some of the key sources of stress include (2,3):

- Anxieties around risk or an unpredictable prognosis in pregnancy.
- The trauma of an unexpectedly early or complicated delivery.
- The challenges of immediate separation from baby.
- Adjustment to the parental role within a neonatal setting.
- The infant's appearance and signals associated with prematurity.
- Baby's complex and fluctuating medical status.
- Environmental stresses such as machine sounds (and the risk implicit in these).
- Communication difficulties with staff – including a sense that staff are not aware that situation, which are routine for them as professionals, are often stressful and bewildering for parents.
- Separation from baby or other family members, travel and the practicalities of living apart. (4)

There is also a complex interplay between the different challenges' families face. For example, one study found that mothers reported breastfeeding to be both a core part of their sense of maternal role but also physically and mentally challenging and exhausting. Another also highlighted the interaction between all of these factors and parents'

existing psychological resources and sources of social support (6).

Although some factors can be used to predict vulnerability to an extent, this doesn't always follow the pattern expected. For example, being married may be experienced as a source of stress if the experience of neonatal care puts a strain on the marriage (4). One team attempted to develop a father-friendly NICU, addressing fathers' needs through different activities, but found that this actually caused higher stress scores among fathers. They attributed this to the fathers feeling under pressure from staff to be involved in the physical procedures of care when they also felt under pressure from obligations such as work and caring for siblings (7). Levels of PTSD, depression or anxiety have been shown to be similar in mothers of moderate -v- late-preterm infants (8), suggesting that it cannot automatically be assumed that parents of the most premature infants will automatically be the worst impacted.

The experience of transition, and particularly discharge from neonatal care, is a key source of stress and vulnerability. Preparing parents and families for a positive transition might include appropriate training and support for parents to understand the unique needs of their baby; attention to parental mental health and the employment of neonatal outreach nurses to smooth the transition (1).

3.2 What is the impact on families and on staff?

Infants

Although it can be hard to dwell on the psychological impact of neonatal care on infants, it is important that we continue to spotlight their needs in order to promote optimal longer-term development. There are different routes through which neonatal infants might experience psychological adversity, including directly (via dysregulation associated with pain, discomfort or sensory overstimulation) and via the 'toxic stress' that is characterised by not having the buffer of adult support during these experiences (9,10).

This can come from the physical absence of the parent(s) due to ill-health, outside pressures or the physical environment of the NNU (e.g., not being able to access parent accommodation); or from the impact of parents experiencing negative psychological effects of their own, including a sense of role alienation, which can interrupt the development of a secure attachment relationship (11).

There is evidence that the toxic stress of the 'un-buffered' neonatal experience can disrupt numerous biological systems and thereby have a harmful effect on the infant's psychological, cognitive and physiological development in the longer term (12). For example, infants who were thought to have 'less than optimal bonding' with parents during the NICU experience had reduced self-regulatory behaviours at 3 months (13). The hope is that providing the optimal conditions for care could buffer this experience, and therefore lead to significantly improved neonatal outcomes.

Parents

There is now a significant body of evidence charting the impact of the neonatal experience on the mental health of parents.

Evidence consistently suggests that parents who experience neonatal care are at significantly increased risk of mental health difficulties. Levels of distress found in the research vary significantly, for example rates of PTSD have been reported to be approximately 15% (14) right up to 53% in mothers and 33% in fathers (15) – in contrast to rates of approximately 3% in the wider birth population (16). Rates of depression and anxiety show a similar contrast to non-neonatal peers (28-67% vs 19% (17) and 26% vs 7% (18), respectively). There is also strong anecdotal evidence to support the idea that these figures underrepresent the true scale of the issue. It is believed that many parents experience symptoms of poor mental health but do not receive a formal diagnosis or treatment. Reasons for this include, not recognising their symptoms or not knowing where to go to access support.

There is also evidence that these impacts can still be felt much further down the line, with one study finding that PTSD rates were equivalent in parents of neonatal infants over and under age one (19). Another found that mothers who experienced extreme distress and high depression scores remained at significant risk of psychological distress one year after discharge and experienced fewer positive perceptions of their infant (including greater worry and higher perceptions of child vulnerability) (20). Again, these findings support the importance of healthcare professionals screening for psychological distress over time and offering tailored therapeutic intervention as early as possible.

Staff

There is also compelling evidence that working on a neonatal unit has a significant impact on the emotional wellbeing of staff. Tawfik et al (2017) defined burnout as “a condition of fatigue, detachment and cynicism resulting from prolonged high levels of stress” (pp 315) and found average rates of 25% in the US neonatal units studied, with higher rates for nurses and for staff who had been working there for longer.

In one study, 50% of NICU nurses reported above threshold symptoms of secondary traumatic stress. NICU staff were thought to be particularly vulnerable compared to other healthcare professionals as they face a greater frequency of particular triggers, including regularly experiencing ethical dilemmas in care provision, the death of their patients and having to manage the risk of medical errors that can have serious consequences (22). These rates were recently confirmed in the East of England, where 40% of neonatal staff reported moderate to severe secondary traumatic stress, 30% met criteria for PTSD and 55% of staff reported symptoms of burnout (23).

There is evidence that staff burnout is related to increased detachment from patients and therefore has a potential impact on the care that the professional provides (24), with Bry and Wighert (2019) identifying that “The challenges inherent in judging what support parents need and providing such support are compounded if staff themselves are stressed, tired or emotionally depleted” (pp9).

Consequently, there is a compelling argument from an ethical, financial and patient care perspective for interventions to improve the psychological wellbeing of staff.



3.3 What do we know about what helps?

A multisystemic approach

Hynan and Hall (2015) describe neonatal care as “akin to a trauma centre for all participants. Fragile babies struggle to survive and grow. Parents and families worry constantly while trying to maintain optimism and hope. Staff attempt to avoid burnout while both encouraging distraught parents and acknowledging the times of poor prognosis. Distress is the companion of everyone”. They emphasise, then, that psychosocial intervention needs to be targeted at all levels of the system in order to be effective. They highlight some key features of this approach, including:

- Interdisciplinary collaboration.
- Continuity of care (from the antenatal period to NNU to post discharge).
- Layered care, with a universal level of care available to all parents (e.g., family centred developmental care and peer support), targeted care provided by neonatal staff where additional needs are identified, and then what they term ‘clinical care’ available via mental health professionals as needed.

A multidisciplinary framework is key, with the knowledge that an intervention in one area can often lead to change in another. Intervention should ultimately focus on supporting families to feel safe, connected, close and involved, supporting parents to be ‘present, sensitive, responsive and engaged’ with their baby (27).

Others have emphasised the role of unit culture in underpinning these wider changes in relationship quality. Fostering trauma informed care and social connectedness between parents, their baby and the NICU staff has been shown to be critical in providing a buffer to mitigate stress and improve outcomes for both baby and parents (28). This reflective stance also allows neonatal professionals to not only support optimal mental health for babies and families, but also regulation and relational health for staff themselves (29).

There is also evidence that heightened self-compassion and greater satisfaction with the ward culture provide some protection from secondary traumatic stress and burnout, suggesting that interventions to support self-compassion and wider psychological safety on the unit might be beneficial (23).

Individualised care

A key feature in the literature is in recognising and exploring the individual needs of each family in order to tailor care appropriately. For example, there is some evidence that parents of different ages, ethnicities and genders use different coping strategies (30). Speaking to parents about how they feel and what feels significant to them, without making assumptions, is key to tailoring care appropriately.

Attending to family and developmental care

There are a whole host of approaches that have been repeatedly shown to support parent, infant and parent-infant outcomes (13,31), including:

Family integrated care	Skin to skin Kangaroo Care
Parental presence	Additional interventions to regulate the baby’s autonomic, motor, state and interactive systems
Environmental interventions	Mitigating infant distress
Auditory exposure	Infant mental health assessment
Positive touch	

At the heart of all of these interventions is an emphasis on infant and family regulation and optimal nurturing relationships (32). At a practical level this might be facilitated by encouraging regular, detailed documentation of these aspects of care to ensure that they are seen as key to infant outcomes (33).

Peer support

Peer support is now recognised as a crucial mechanism to support the emotional wellbeing of neonatal families (34). This can helpfully begin with family-to-family support on the unit, where organised support groups and provision of an environment where parents can meet and support each other are both important in order to embed a culture of peer support (35).

One 2003 study (36) found that pairing mothers on the unit with another trained veteran peer supporter and providing telephone support was effective in reducing anxiety and depression and increasing perceived social support by 16 weeks post-enrolment. Parents were matched with a buddy based on similarities in their infants' medical conditions, language and ethnic background and, if possible, geographic proximity; which the authors reflect may have been a helpful factor in increasing impact.

Peer support has been shown to be variable in a number of respects, including the:

- Background and infrastructure of the service.
- Timing, location and nature of peer support.
- Recruitment and suitability of peer supporters.
- Training provision.
- The professional and emotional support provided.

It is crucial that any peer support offer is embedded safely and effectively through engagement with leadership and building in training, supervision and support (37). This might include,

- Having a paid parent support coordinator or links with a third sector organisation.
- In-person peer support provided by volunteer 'veteran' parents to all current parents.

- The provision of peer support to parents beginning in the antenatal period, when possible, through the NNU and on to the transition to home.
- Training for peer supporters.
- The inclusion of wider family such as grandparents and siblings.
- Forging ongoing collaboration between hospitals and veteran parents outside of the peer support offer itself (38).

The impact of introducing peer support can also be much wider-reaching – for example a 'parent navigator' peer support intervention in one area was shown to increase staff awareness of and focus on parents' needs, thereby improving overall awareness of perinatal mental health (39).

Additional therapeutic support

Having access to effective, timely psychotherapeutic intervention on the unit and post-discharge is seen as important by families. This can often be seen as a point of consistency and stability, offering unconditional emotional support that isn't directly linked to the care being offered to baby (40).

Two key papers (26,38) outline a number of features of an effective psychosocial programme:

- Interacting daily with all parents on the unit and providing low key support.
- Providing both informal and formal mental health support to NNU staff.
- Screening all parents periodically to identify those in need of higher levels of care and making appropriate referrals.
- Training and supporting NNU staff to respond to their own and families' needs.
- Holding therapeutic parent education groups.
- Providing a range of models of psychotherapy for those parents at highest risk.
- Providing debriefing sessions with NNU staff after critical events.

One suggests that all NICUs with more than 20 beds should have one full time social worker and one full or part time psychologist, as well as a comfortable area for group and 1:1 discussions (26). There is also evidence of the benefit of baby massage (41) and music therapy (42), underlining the importance of a holistic approach.

Post discharge support

There is clear evidence of discharge being a particularly vulnerable time for families. Establishing individualised, flexible (but realistic) pre- and post-discharge plans with parents is recognised as an important part of supporting their transition to home and community (43). One group intervention pilot at discharge was shown to be effective at reducing parents' anxiety (44) by identifying their needs, building on staff-parent communication and addressing parents' fears and concerns; in order to support a smooth transition.



3.4 What does the UK guidance say?

The importance of parental involvement and of psychosocial aspects of the neonatal experience have been identified for more than a decade, with the NHS 'Toolkit for High Quality Neonatal Services' (2009) highlighting the importance of ensuring that:

"Family-centred care, including psychological support [is available] for mothers and families" (pp19).

While this standard remains in the BAPM (2017) Neonatal Service Quality Indicators, there is very limited guidance about 'what good looks like' with respect to offering psychosocial support. The British Psychological Society (2016) outlines the role of Neonatal Clinical Psychologists as including: supporting parental bonding, helping families adjust to bad news or make difficult treatment decisions, and whole-family psychological support. Both they and NHS Scotland (2019) have published suggested staffing levels to meet the needs of families, but these are provided across the maternity and neonatal context so it is difficult to extrapolate staffing figures. However, in response to these standards, for Bliss Baby Charter accreditation units have to demonstrate that the following are available:

- Parents have access to psychosocial support provided by a trained professional such as a clinical psychologist, counsellor or mental health worker.
- Training is available to support other staff on the unit to promote psychological wellbeing.
- There is a lead role for psychological wellbeing.
- Support is available at admission, during the family's time on the unit and at discharge.
- Support is also available for staff.



3.5 Data collection

The first element of the NFaST project involved data collection with neonatal staff and families in order to explore the needs of our population. Overall, we received more than 550 survey responses, supported by a 28-family focus group and targeted interviews with other cohorts. For full details of the data collection methods employed by the project team see Appendix 1.

3.6 Creating safety

We were acutely aware of the potential for these explorations to both elicit and highlight difficult emotions in a vulnerable population of parents – both current or recent parents and prospective peer supporters.

In order to mitigate this, psychological therapy was offered to all parent participants in the project (including survey respondents, Facebook group members, those chatting to psychologists on units and prospective peer supporters). Seven individuals took up this offer and of these one was still accessing therapy at the end of the project. Two of these individuals completed a discharge evaluation. They both rated all aspects of the process as 5/5 for meeting their needs. One commented:

“I was able to adjust my way of thinking to see positives rather than worst case scenarios and negatives... I think it should be available to all parents who leave NICU”

(Parent receiving EMDR therapy via Spoons)

4. DESCRIBING OUR FINDINGS

This section draws out key themes from the data we collected, painting a picture of the common experiences of families and staff and highlighting what they would like to be different.

4.1 Hearing families' stories

"People don't understand unless they've been there – they don't really understand what it all means. You think your baby's going to die. Every time the monitor beeps you think it might be now. You're expecting the worst all the time."

(Dad)

The experience of being on a neonatal unit is a terrifying one for many families. The traumatic nature of what parents are experiencing on an hour by hour and sometimes month by month basis means that distress is inevitable.

During the course of the NFaST project we were privileged to hear the stories of more than 260 parents and families. While it's hard to do justice to the full depth of what we heard, some key themes stand out, in terms of how it felt, what contributed to that feeling and what might have helped.

4.2 The impact

Of the 228 parents who responded to our broadest parents' survey, 86.1% described the experience of neonatal care as having a significant impact on their mental health, with 55.9% describing themselves as experiencing severe anxiety or symptoms of PTSD.

Significant Mental Health Impact



Significant Anxiety/PTSD



This feeling is long lasting and was still present for many families several years after discharge. As one mum put it:

"It has left me more anxious and still feel not quite myself since the experience. My boy is very healthy and doing well but certain things still trigger big emotional responses in me."

While other stories indicate the significant and long-lasting nature of the experience:

"Still feeling repercussions today over four years later"

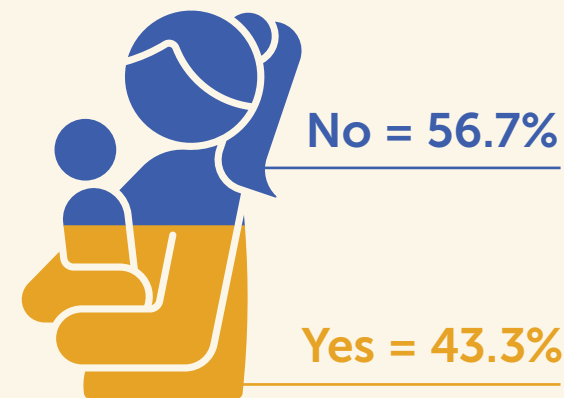
"It destroyed my mental health"

"I think it's an extremely isolating experience and I haven't recovered from it."

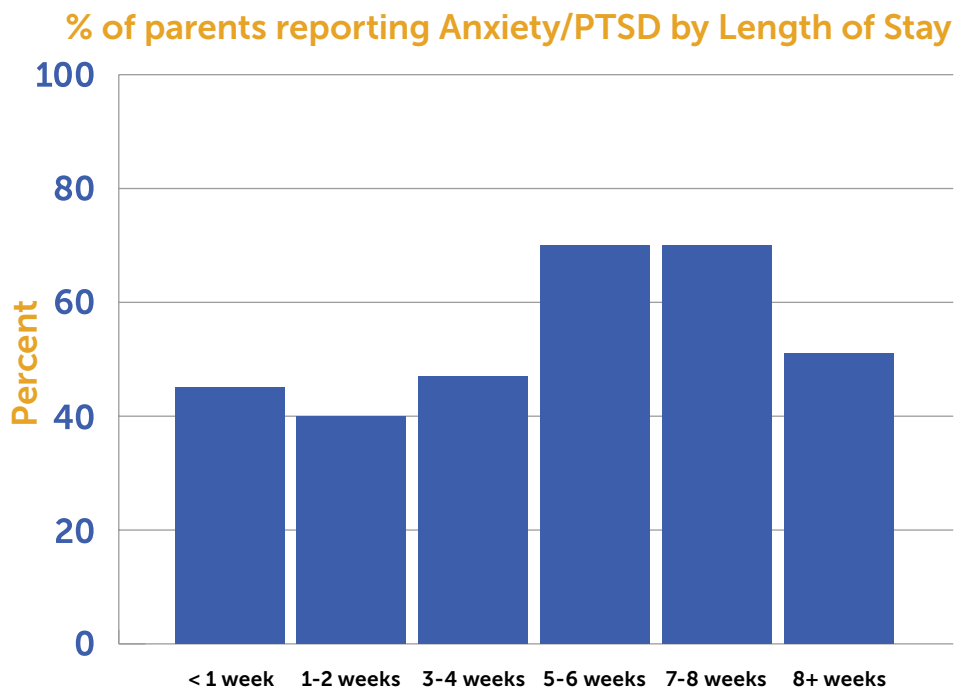
"I have PTSD and Severe Anxiety which I am medicated for and I'm awaiting trauma therapy"

Interestingly, duration of stay made little difference to reports of anxiety and PTSD, emphasising the need to acknowledge the potential impact of the neonatal experience on all families.

Impact on Bonding



43.3% of parents also described the experience as having had a significant impact on their relationship with their baby – either in terms of it taking longer or being harder to form a bond, or in the sense that anxiety made it difficult to parent in the way that they otherwise might.



43.3% of parents also described the experience as having had a significant impact on their relationship with their baby – either in terms of it taking longer or being harder to form a bond, or in the sense that anxiety made it difficult to parent in the way that they otherwise might.

This impact on family relationships is also long lasting:

“I developed attachment disorder with both my babies and fear being without them. It also impacted the relationship with my husband due to my anxiety and PTSD”

Given what we know about the importance of emotional wellbeing and early relationships for the baby and family’s longer term emotional wellbeing (UK Gov DHSC, 2021), it is crucial that we consider the potential cost / benefit ratio of not offering further intervention (see section 6, Table 1).

4.3 What experiences contribute to this?

“Neonatal care is an experience I never want to go through again. Even though the unit & staff were great it was still a very lonely place. Walking in and seeing your little baby in an incubator is heart-breaking”

There was a strong narrative that the unit ‘saved’ babies and that parents were extremely grateful for this. On the other hand, parents shared several aspects of unit life that were particularly difficult and often had a strong negative impact. The conflict between the ‘saviour / angel’ narrative and the reality of the emotional experience for the parents can have the consequence of closing down opportunities for learning. Parents feel unable to articulate negative experiences as a result of their intense gratitude for the care their baby has received.

Cumulative trauma

Parents and staff frequently shared the sense of one trauma compounding another, building up over time to have an overwhelming impact on wellbeing. Parents have often experienced a traumatic birth and have a fear that their baby could die. They may feel the loss of the pregnancy and parenting experience they had hoped for and can feel stretched thin by travelling to and from the unit and feel constantly on alert. They are also frequently exposed to the trauma of other families which can layer on top of and compound their own.

“I felt like I wasn’t supported quite as much as I would like as a new mum who had a traumatic birth, which resulted in an emergency c section.” (Mum)

“One stress is that you’re part of everyone else’s journey – you see other people struggling and it hurts. One of our friends struggled with real survivor guilt as both the other babies in her cohort died.” (Dad)

“Very drained and strung out having to come backwards and forwards from the hospital, especially with trying to care for a mother with mental health concerns and another child at home. Also, the constant unknowns about our child’s condition and progress created a lot of anxiety.” (Dad)

Shame and self-blame

Parents, and particularly mums, also spoke about the shame and self-criticism that they felt for their baby being on the unit. This was exacerbated by the responses of staff who at times contributed to the parents' sense of not being 'enough'.

"There was a constant feeling of failure like I'd failed my baby for him being on the unit, and my partner too" (Mum)

"I often felt like I was being judged as a parent when I had literally only just started being one." (Parent)

"Often got the impression from nurses that I was asking too many questions or worrying too much." (Mum)

Isolation

Many parents described feeling isolated as a neonatal parent, and this was exacerbated for those who had been on the unit during the COVID-19 pandemic. This related to both physical isolation and the experience of not being understood by friends or family who hadn't been through the neonatal experience. For many, this sense of isolation continued into the community following discharge.

"NICU is a very lonely and isolating experience that very few parents can relate to. I had extreme lows and felt very desperate at times." (Mum)

"The reaction from family and friends I still don't know how to address this issue often. They made 'supportive' comments like what an awful start for you, and he looks like a normal baby - which I found really hard" (Mum)

"I found that when we went home and the outreach team discharged us, I felt alone and struggled to easily integrate with baby groups etc. I missed NCT etc so I didn't make any mum friends really. I then struggled with my mental health after some of my experiences and the birth and found that support for this was lacking." (Mum)

Inconsistency and Communication

Parents frequently described their frustration with inconsistency in both practice and communication, citing this as a key factor impacting on their ability to develop trusting relationships with unit staff. They described the uncertainty and anxiety caused by inconsistencies in communication from and between staff members.

“At times you would be told ward round would start at a certain time. I’d arrive after sorting childcare out (due to pandemic) I’d get there and it would have either been done or start hours later. The Dr’s and nurses were amazing but have very different views. We were often told different bits of the same information by different Dr’s.” (Mum)

One psychologist also reflected on the impact on parents who don’t speak English. Staff acknowledged that this group of parents are often excluded from information about their baby’s wellbeing but also from being cared for themselves. In some cases, this results in a breakdown in communication and conflict between the families and staff team.

“I was directed away from a mother because I was told “she can’t understand”. This issue of language being a barrier has also come up in the training when nurses have described trying to use google translate on their phones (even though they are not supposed to have their phones) to communicate with parents.” (Psychologist)

Admission, Transition and Discharge

There were repeated references to the challenges of transition, from pregnancy to birth to admission; transition between rooms on the unit and transition between units; and then discharge home. At all stages parents described the potential benefit of better information, someone to talk them through the process and a lack of assumptions about what parents might know or need to know.



“I don’t think there is anywhere near enough information on premature births during pregnancy, nobody hopes for that but you should be given some information into it and made aware it’s a possibility” (Parent)

“All units work so different so would be good to have maybe someone there to explain the unit to new parents, how things work etc. as on arrival it was very scary arriving from an ambulance and just being left to work out what we could and couldn’t do.” (Mum)

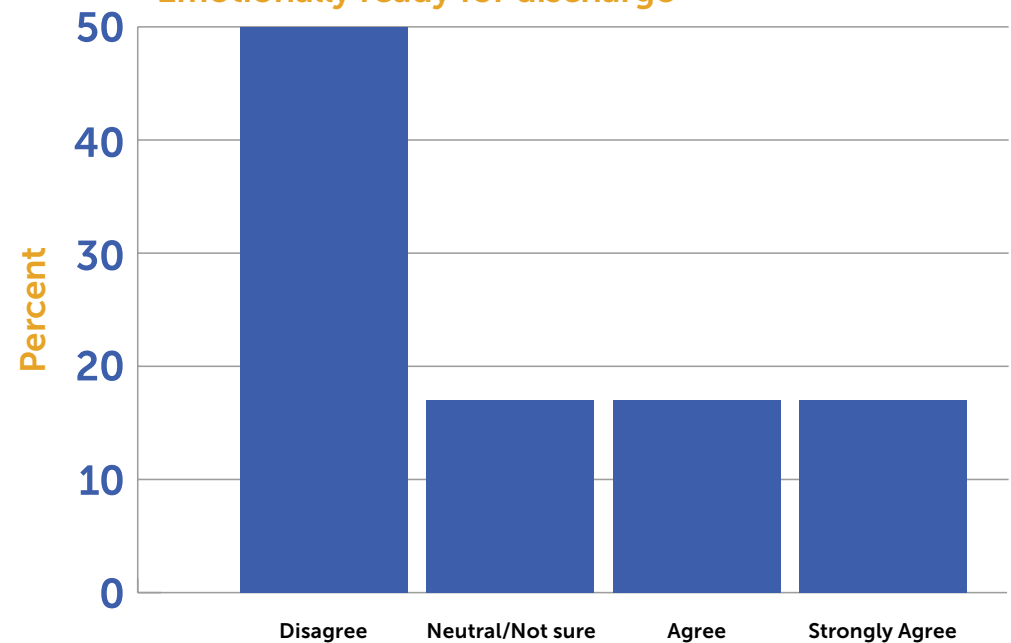
“Ideally there would be two different induction processes for brand new families and those transitioning. You probably won’t trust the nurses in the same way – you need to build that trust.” (Dad)

Discharge was a particular 'pinch point' for families and several people identified that the lack of preparation left them woefully unprepared for how difficult this might be.

"Although going through the experience at the time was very stressful and full of anxiety, I feel as though the full impact of the events over the course of my pregnancy and then of our stay on the units only really hit me when I was home and had time to digest what had happened." (Mum)

"We were offered nothing emotionally and that's what I personally struggled with the most. I think our discharge is partly the reason we struggled to start with at home. It's all about how baby is and it's actually the parents who need more support after being on the unit, I think. 24/7 medical care to nothing is a huge jump and I think the staff underestimate that transition." (Mum)

Emotionally ready for discharge



The wider family

There was an acknowledgement from both parents and staff that a lot of the support and time available focused on mums. The importance of getting to know the family as a whole system, understanding both their individual needs but also their shared needs and experiences, was seen as important.

"The questionnaire (from the NFaST project) was the first time I'd been asked about any of this – and that's three years on. If that had been a mum's experience, I think people would rightly be shocked." (Dad)

Key themes for babies

Relatively few parents or staff overtly reflected on the emotional experiences of babies on the unit, despite being highly aware of their physical wellbeing. It seems possible that given the acute experiences of trauma on the unit, it is too painful for parents or staff to really connect with the baby's experience. Psychologist's tentatively explored babies' needs in conversation with staff and parents and also took time to try and see the unit 'through the babies' eyes'.

"Discussed how often parents don't think sitting and cuddling baby is "doing" something and nurse said she often gives them the evidence behind it... brain development etc... so that they know the importance of it but also so that they do feel they are 'doing'"
(Psychologist)

"My husband found it harder to be supported or encouraged to come as he wasn't breastfeeding baby. But he is equally important to baby." (Mum)

"I don't remember any staff really encouraging me and baby to bond. I remember only being asked after a long time had passed and at least one visit to NICU if I had held him and I hadn't. I just sort of looked on for what felt like a long time. Couldn't tell you exactly. I don't blame staff for this. I was really supported to do cares and breastfeed.... oddly I would say the one aspect that wasn't really discussed early was skin to skin and I thought you couldn't hold the baby. I distinctly remember the first time and lady who offered me a cuddle. It was quite a big thing." (Mum)

Key themes for mums

In addition to the wider experiences (which often came from mums), there was a recognition that mums often missed out on the postnatal care and support that they should have experienced, despite their birth and postnatal journey being so much more traumatic than most.

"I missed post-natal checks because I chose to be with my babies... no one explained why they did the checks and so my decision was not an informed decision." (Mum)

"Better communication between maternity and neonatal. For example, the night shift midwife always told me to just go down and ask as she didn't know anything. I had to beg her to ring for me on one occasion as no one had contacted me to feed him over 6 hours (breastfed) and when I had gone down, they had sent me away." (Mum)



Key themes for dads

Both parents frequently described dads as feeling side-lined, as though they had to minimise their own needs as their partner and baby were the priority. However, they also described carrying a huge level of separate burden, worrying about mum and about work and finances as well as about their baby. Many described finding it difficult to share this burden with anyone, and often not feeling encouraged to express their needs.



Siblings and the wider family

The impact of neonatal care on siblings and wider family was frequently mentioned, especially in the context of COVID. Many parents felt that their families weren't truly able to understand their experiences, leaving them feeling relatively isolated. They worried about the impact of the experience on siblings, who had to make sense of all the changes, and their separation from parents who often themselves had less to give.

"As a dad you have 3 sets of worries – worry about the baby, worry about mum and worry about work and money. Partners have no idea about this – their absolute focus is on the baby. Whereas you're asking yourself "How are we all going to survive?". (Dad)

"Sometimes I would withdraw and not express myself – then the world closes in a bit." (Dad)

"It would have been helpful if they'd been checking up on me and (mum) and our mental health – we didn't get asked about this. When you go home it really hits you." (Dad)

"Keeping family members up to date was tough and they wanted more from me than I could give which I struggled with." (Parent)

"We would also have liked support for our other children - they didn't get to meet their sibling until the day she came home. It was hard trying to help them with their emotions, our own and also put a brave face on when on the ward and when friends and family were asking for updates" (Mum)



Barriers to accessing support

Parents felt their biggest barriers to accessing support were time (time away from baby, not physically having time, and not accessing this at the right time), shame (feeling like a failure, shows they weren't coping, not deserving, the focus should only be the baby) and knowledge of support (availability, some told there was no support available).

"I didn't always know who/where to go and I also didn't feel like someone I didn't know would get my emotions about what we'd been through. (Mum)

Parents found it difficult to think of themselves and their own thoughts and feelings when their baby was their primary focus. Upon reflection, many parents thought some type of emotional support would have been useful, but felt if they asked for this it would show nurses or staff that they were not coping, ultimately affecting discharge.

"If anyone had tried gentle conversations around emotional health for me that wouldn't have landed during a time of high stress. I'm afraid it may even have been annoying or made me think ok yep sure one day... like a stress response to just push something away" (Mum)

There was also a frequent sense that services didn't quite 'fit', which in turn meant that staff were often reluctant to dig too deeply into parents' experiences because of a fear that they would highlight a need that they weren't confident to meet.

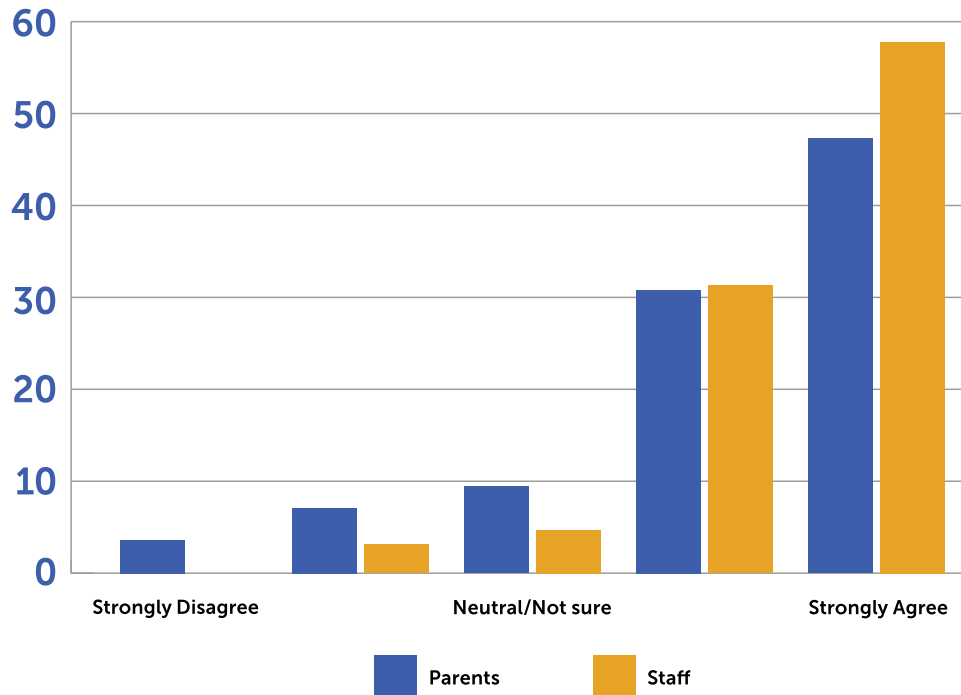
"Staff feel they are good at recognising distress in families; however, they often do not ask further questions/dig deeper because they know there are no services available to meet families' needs. This then creates difficulties for staff if they identify need and there is nowhere to signpost families to" (Psychologist)



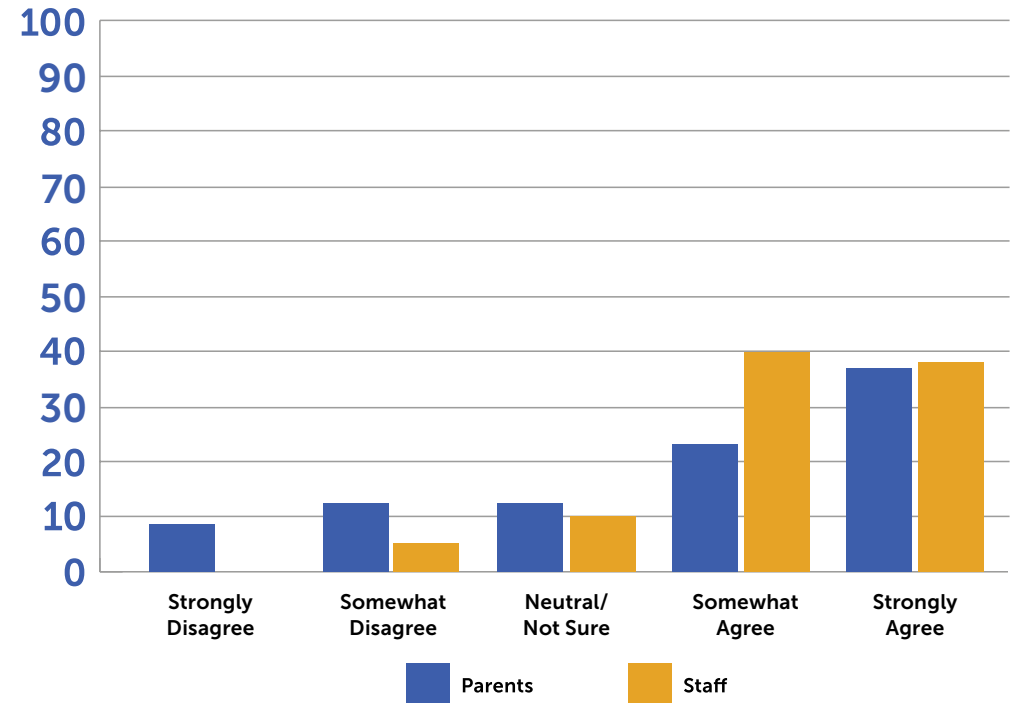
Perceptions of care

When asked about the care that the family received, many parents were very positive. The majority described feeling involved in their baby's care and supported to get to know their baby:

Parents feel included as partners in their baby's care



Parents' emotional wellbeing is supported



Interestingly, though, this didn't automatically connect to the experience of feeling well supported emotionally. There was a notable difference between how staff and parents perceived the level of emotional support on the units. This suggests that the practical processes of **Family Integrated Care (FiCare)** in themselves may not be sufficient for all families to feel well emotionally supported on the unit.

4.4 What might make a difference?

'True' Family Integrated Care

There was a sense across the board that although FiCare has been a hugely positive shift on units (as reflected in the 'perceptions of care' ratings above) there is still more to do. This includes, making it practically easier for parents to be on the unit and making sure that the processes of care are routinely welcoming and accessible. Staff were also aware of the impact of their approach on family engagement and were keen to respond despite pressures of time and workload.



"Getting parents involved in ward rounds, at the moment they are not included until the presentation of the baby has been completed - parents tend to know the details better than a clinician reading off of a screen." (Nurse)

"We were an integral part of our daughters care which was so important to ensure we bonded and also understood her care needs. Family centred care was key to managing this time and allowing myself, husband and our other children the opportunity to be a family despite the medical environment and at times harrowing situations when our daughter was very sick". (Mum)

Family Integrated Care (FiCare) is an extension of the principles of Family Centred Care, which places parents at the heart of care giving. The goal of FiCare is to facilitate a partnership and collaboration between parents and the NICU staff, to promote parent-infant interactions, and to build parent confidence. FiCare represents a paradigm shift in thinking about the way in which healthcare is delivered. FiCare invites parents in to become part of the primary care team, moving away from traditional care delivery by only highly trained healthcare professionals.

Exploring families' needs routinely

Ultimately, there is a need for care to wrap around the family and their unique needs, rather than for the focus to be purely on integrating parents into the processes of care. Outreach teams in particular highlighted that once families are discharged, they become aware of a whole raft of wider issues and pressures on the family that have never been picked up during their stay.

Staff and parents alike highlighted the benefit of parents being asked more explicitly about their emotional experiences, acknowledging that it can be difficult to find the courage to acknowledge these and share them spontaneously.



"On the whole I think that staff perceive the parents experience as being good. I'm not so sure that is accurate. We can miss many cues from parents that all is not well, because we are not asking the right questions or actually don't have the time to ask." (Nurse)

"Need better understanding of holistic needs of families earlier in the journey – often outreach team pick up on housing, safeguarding issues etc which impact mental health but aren't known about until after discharge. Need to assess families earlier on." (Psychologist)

"I get embarrassed sharing how I feel. So, I wouldn't be likely to tell someone when I need help. I have to be asked, which isn't fair on anyone else but I'm probably not the only one." (Mum)

"At the point of discharge, I was probably too keen to leave, and too much in 'survival' mode to realise that I needed any help, although on balance I clearly needed (possibly quite a lot) of help. I think it would have needed a health care professional to approach me and ask me some screening type questions to assess the need." (Dad)

"Staff want more thoughtful conversations about mental health... for these conversations to begin earlier than a few days before discharge. They wondered about screening on admission and having more conversations and thinking about psychological needs of families throughout the admission. Also thought about how this can change perceptions of families if they have more knowledge of their psychological needs" (Psychologist)

4.5 Mechanisms to make this easier

Over the course of the NFaST project, practical options to improve the integration of families' needs were explored. These included having a space and prompt system for notes about parental emotional wellbeing to be recorded, offering greater continuity of care to build trust and openness, and ensuring that there is space in the ward round process to think specifically about parents' and families' emotional needs.

"There is a 'family' section on the notes page of Badger, but there could be benefits to having a separate page for this with specific questions to encourage staff to look at parents' emotional wellbeing in more depth."
(Unit manager)

"When allocating babies to nurses at the start of a shift, a "take away" that they have taken from the training is that the relationship built up with parents needs to be considered." (Psychologist)

"Discussions in ward round, very much focused on the baby with very limited mention on potential impacts on parents and parent's needs." (Nurse)

Improving transition and discharge pathways

Transitions, and in particular discharge home, were highlighted as key priorities for improving the longer-term wellbeing of families. There was a broad consensus from parents that despite the excitement about taking their baby home, discharge was also a source of huge anxiety. They frequently described it was only following discharge that the enormity of their neonatal journey hit them, at the point where they had less access to support.

"It's how intact that family is that you're discharging home. Are they prepared for what's to come?" (Unit manager)

"It 'hits you' more after the baby left the unit and that was not really accounted for/ no one warns you that might happen" (Mum)

Several people referred to the importance of preparing families for discharge from much earlier in their stay, potentially even from admission. This might include having a better understanding of families' holistic needs from an earlier stage, and making space to discuss the potential for a wave of grief and anxiety to accompany this much wished for moment. Peer supporters were identified as playing a vital role in this process, bridging the gap between life on the unit and the ongoing journey beyond.

"[Outreach] Staff wondered about screening on admission and having more conversations and thinking about psychological needs of families throughout the admission. Also thought about how this can change perceptions of families if they have more knowledge of their psychological needs - families where the child has no health needs - but family are struggling psychologically" (Psychologist)

Parents also frequently referred to the difficulties with the transition to primary care teams, in particular Health Visitors, who might not have a good understanding of their needs. Non-tailored, generic advice from community healthcare professionals, left families feeling more anxious and less well supported.

"More warning about discharge, other parents to keep in touch with. Communication with familiar nurses from the unit. Warning that feelings may not all be positive once you leave the unit" (Parent)

"The peer support gives you positive visions of the future...You just need someone who understands how you're feeling and who knows it might just be beginning when you go home. Who might ask 'have you thought about going home' when it's coming up to that point."
(Dad)

"Health visitors don't seem to have any knowledge of premature babies I felt like we were telling her things she should have been telling us. A healthcare professional who understands the circumstances would help" (Parent)

"I think we should be following up most patients that leave our unit to ensure mental health is ok. I also think we should be interacting a lot more with health visitors as they can also help assist in the community" (Nurse)

The benefit of support over and above that from the core team

Large numbers of parents and staff highlighted the benefit of families having access to interventions to support their wellbeing over and above what neonatal staff themselves are able to offer as standard. Several members of staff wondered whether offering baby massage and similar interventions on the ward might support parent-infant relationships as well as providing an opportunity for parents to socialise.

"I have suggested us learning baby massage techniques that we could teach to parents during their stay to facilitate bonding and reducing stress and anxiety" (Nurse)

Peer support

The ability to talk to other parents who had experienced something similar repeatedly came up as a very powerful intervention, offering the type of support that neither professionals nor family and friends outside the unit were able to provide.

"It would be great to have peer supporters to welcome you, tell you 'this is how it works here'. If other parents are willing to return to do this it would also help you feel more confident in the unit" (Mum)

"It helped to talk and make friendships with other parents on the unit as they knew exactly what I was going through" (Parent)

"I think [it would have helped] seeing other families going through the same thing and meeting other families. However due to Covid this wasn't possible so at times we did feel very alone and our family and friends didn't fully understand what we had been through so this was a barrier too." (Mum)



Several people identified the value of being able to talk to other parents on the ward but felt that this came with its own challenges.

“The parents that are on the unit at the time are in the same emotional and sometimes physical situation as you. You will be having the same worries, thoughts and experiences at the same time. This can help you to be more open” (Mum)

“The longer you are on the ward, the more of your peer support network are discharged... you are less inclined to engage with “newer” parents because you don’t want to have to tell your story from the start and are reluctant to start up a new peer support network but as your peer support diminishes it is quite lonely. Previous week, the only other baby who had been on the ward as long as them died, described how sad and difficult this was”.
(Psychologist)

Parents frequently spoke about the value of peer support being not only in the shared understanding but also in being in contact with veteran parents who were further along on their journey:

“People who have successfully come out of NICU experience, success stories from other peer supporters really helps.” (Mum)

“A few days in a peer supporter turned up. She had pictures of her kids and that was the first time it felt like ‘it might turn out alright’.” (Dad)

“Volunteers who are returning can offer advice and support about the whole journey and life after the hospital. This can bring current parents hope and reassurance.” (Mum)

One dad discussed his experience as a peer supporter and how powerful the peer support experience had been for reducing stress and thereby aggression on the unit. This highlights the importance of parents feeling really understood by someone, in order to help manage the impact of trauma.

“We set up a dad’s group in [other unit] with one aim being to curb violence and aggression from dads towards staff. They feel disempowered and often feel like they’re getting in the way. We saw a quantifiable reduction in violence and aggression from offering peer support.” (Dad and peer supporter).

Access to therapies

“Peer support can only help you to a point and then you need something to take you to that next stage. It’s very hard to ask how someone is when you know the services aren’t available to help.” (Dad and peer supporter)



Large numbers of parents and staff highlighted the need for responsive therapeutic support to be available for parents and infants, as well as to support the couple relationship which can be challenged under such conditions of stress. Some went so far as to describe feeling wary of asking too much about parental wellbeing without knowing what services might be available to meet these needs.

“Also, to help support parents who are struggling together to come to terms with bad news. I find a lot of parents react differently and it causes tension between both parents and I never know how to help them come back together to support each other through.” (Nurse)

“Our psychological support is improving with the recent hiring of a senior psychological wellbeing practitioner. Even though this is relatively new I feel parents are better supported and support on discharge is more available. Staff are very supportive to families but sometimes need someone to refer families to.” (Unit manager)

There was also an acknowledgement that there is a stigma attached to seeking emotional support as well as numerous practical barriers - and several people suggested ways to overcome these:

"A lot of parents don't like the idea of being referred for help from a psychologist as they feel it's not common for a lot of families to need the help. So, for parents to be able to have access to a psychologist freely without having to worry about being different from other people I'm sure will take a lot of pressure off them." (Nurse)

Again, the importance of therapeutic support following discharge was highlighted as being equally, if not more important, as families begin to come to terms with everything that has happened and the uncertainty of what is to come.

But crucially, regardless of the form of emotional support offered, it must be delivered in an attuned way, from someone who understands the neonatal journey.

"At the time I might of felt in denial about needing support as I would be too focused on my baby so maybe having staff promote the therapies and have a board that show all this with positive imagery would really help" (Mum)

"There is a definite need for some sort of support in collaboration with the neonatal units for parents following discharge as I for one am still haunted by what happened and struggle still 2 years later to understand and come to terms with what happened, despite our daughter being amazing and healthy. I do know that some such services along these lines exist in other trusts." (Mum)

"I would have really benefited from some sort of emotional help, or to talk through feelings I might have on discharge. I thought we'd be elated to have our baby home but all I felt when he actually came home was fear. I was absolutely petrified of something not being right." (Parent)

"Someone who was around to help to support both staff and parents/families who was easily/readily accessible on the unit and who understood the specific issues around NICU." (Nurse)

4.6 Staff perspectives

When our psychologists first visited their neonatal units for this project, many of them commented on the impact of entering such a complex and often emotionally intense environment. A strong theme in the conversations we have had with neonatal staff has been how normalised this working environment becomes. This, in turn, can make it hard for staff to fully appreciate the impact on families.

4.7 The impact on staff of working on a neonatal unit

Four predominant themes were reported by staff, both in our surveys and in discussions with the unit psychologists.

Holding own, parents' and babies' distress

During staff training, wellbeing and reflective practice sessions with the psychologists' staff spoke candidly about the fact that they are often the only people present to sit with families in distress and 'hold' all of those difficult feelings. One psychologist reflected on the impact of working with vulnerable infants for a staff team who are often primarily comprised of young women, who may be mothers themselves.

"Staff talked about emotional impact on them – questioning whether they could have done anything different, lose sleep, increase in anxiety, find themselves afraid to care for other babies. 5 people brought up staff wellbeing during my shift today."

(Psychologist)

"Staff spoke about the challenges of the role – how looking after parents 'most precious gift' brings responsibility like no other. They also spoke about the pressure from families when what they want from us is not achievable – feels really hard that you can't make it better, take the pain away" (Psychologist)

Stressful and busy working environment

Staff reported high workloads, understaffing and the pressure of shift demands having a significant impact on their wellbeing.

"Lack of staffing, time pressure, not feeling listened to."

(Nurse)

Having been introduced to the 'Threat, Drive, Soothe' **compassion focused model** several staff reported that to work on the unit was to spend a great deal of time in their 'threat system':

"Staff described thoughts such as 'I'm not cut out for this, not good enough, it's my fault a mistake was made/something happened to a baby'. Even though this feeling is shared by many in the staff team they described it being difficult to know where to take these concerns." (Psychologist)

Staff also spoke about how hard it could be to seek support from friends and family or feel really understood outside of the neonatal context.

"Staff described how family and friends have no idea about the trauma they deal with and struggle to relate to it, often resulting in them feeling sorry that they shared about their day or not bothering in the first place." (Psychologist)

This sense of busyness and stress also presents a challenge to having emotional conversations with parents:

"Nurses spoke about how they know there is a benefit to building up a rapport with parents but that when the unit is very busy it is easy to forget about the importance of this/prioritise it or justify spending time "chatting" when staff are under pressure." (Psychologist)



Challenges with parents

Another theme in the data was the range of challenges that could be presented when caring for babies and families. Some of these were direct challenges, while others related to discomfort at not feeling equipped to meet particular needs.

While it was fantastic to hear that over 80% of staff reported feeling 'fairly' or 'very' confident in recognising if a parent was struggling with their mental health or bonding with their baby, confidence in what to do with this awareness was lacking. Several staff members discussed their anxieties about asking parents about bonding for fear of causing distress.

Staff identified a number of barriers to having these conversations, including:

Language barriers	Time	Anxiety
When parents have little or no English.	Which is only allocated to focus on the physical health of baby.	That the conversation will open up emotions or themes that they do not feel equipped to deal with.

They reported less confidence in responding to parents who were presenting as angry or agitated (64% describing feeling 'fairly' or 'very' confident).

"They recognise that they often find it easy to empathise/understand when families are sad, but find it difficult to understand other responses – anger, fear, avoidance of the baby" (Psychologist)

Some staff were able to reflect on the infrequent, but regular incidences where there is a significant breakdown in relationships between parents and staff. One staff member spoke with the psychologist about how:

"She feels that this is because earlier warning signs that parents are struggling are not noticed/addressed and then a gulf develops between staff and parents (us against them) that is really hard to repair. She feels that if parents had more emotional support to explore some of their feelings around these difficult decisions, then this would reduce the risk of these situations escalating." (Psychologist)

Another nurse described how:

"In general, we are good about checking in with parents about their wellbeing but it is the families who are perceived as difficult who staff probably avoid a bit and don't check in with about their wellbeing." (Nurse)



Culture on the unit

At least 10% of staff anonymously (via survey) reported feeling frustrated and disenfranchised by the interpersonal dynamics on their units. Several staff commented on a sense of negativity, either from senior to junior staff or vice versa. Some described feeling undervalued and unsupported by colleagues and managers.

When speaking with psychologists placed on their units, staff spoke on a number of occasions about feeling that showing certain emotions was seen as unacceptable or a sign of weakness. Many spoke about an emerging conflict in expectations between a younger generation of nurses who were more emotionally expressive and an older generation who could find this uncomfortable or frustrating.



“Discussed emotional wellbeing of staff in general and how mental health in staff does not feel like a priority and thoughts of mental health being a weakness therefore some may try to hide difficulties”

(Psychologist)

In contrast, on at least one unit there was a sense that senior staff can be so keen to support their colleagues that this becomes a source of overwhelm and burnout itself:

“X has also learnt a lot over the last few weeks – she wants to take it on, being the peacemaker, do everything – you could see her burning out too. It’s being mindful that you can’t achieve everything today”

(Unit Manager)

Impact on staff

Unsurprisingly, all of these experiences (compounded by the COVID 19 Pandemic) have had a significant impact on staff morale and wellbeing. Only 6.4% of staff 'very much' agreed that adequate support was available to staff following a difficult incident at work, with more than 25% rating at the bottom half of the scale.

“Staff talked about emotional impact on them – questioning whether they could have done anything different, lose sleep, increase in anxiety, find themselves afraid to care for other babies. 5 people brought up staff wellbeing during my shift today.” (Psychologist)

“Staff spoke about the challenges of the role – how looking after parents ‘most precious gift’ brings responsibility like no other. They also spoke about the pressure from families when what they want from us is not achievable – feels really hard that you can’t make it better, take the pain away” (Psychologist)

Your experiences as staff

When there is a difficult incident at work (e.g a baby dies, or a parent is in crisis), is there adequate space and support provided for staff?

When parents are angry, hostile or distant, how able do you feel to understand and respond to them?

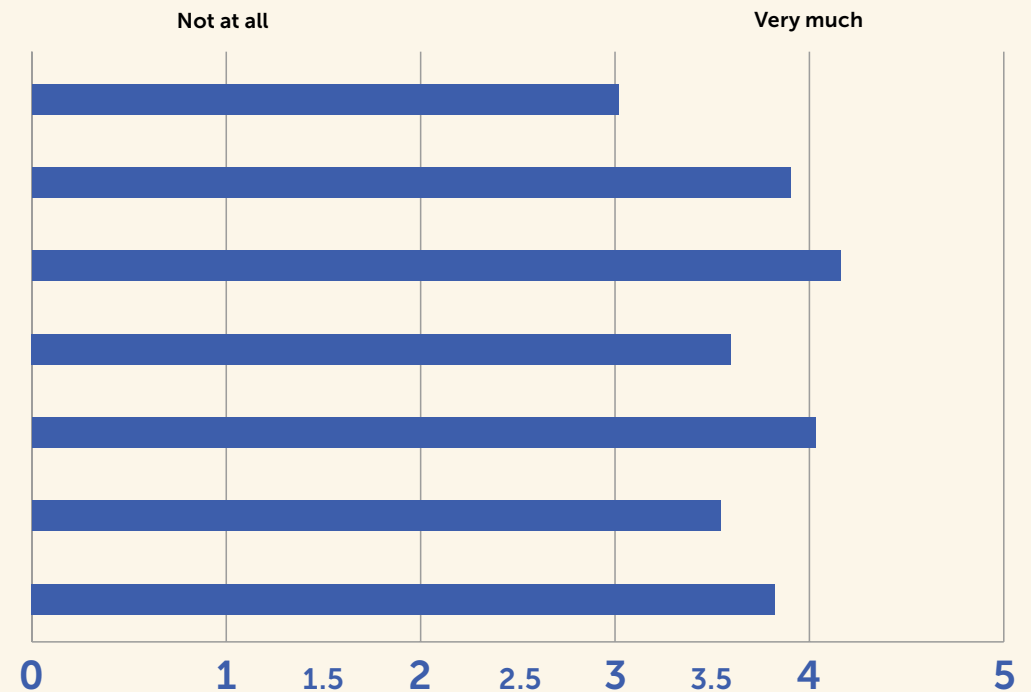
When parents are distressed, how confident are you to support them?

Do you know what options there are for additional support if you need it?

Do you have people that you can turn to if you're finding things difficult at work?

Is there a culture on the unit of being able to say if you feel you're struggling?

To what extent do you feel valued by your team?



- Only 56% of staff scored a 4 or 5 on the same scale when asked 'to what extent do you feel valued by your team'
- Only 43% of staff answered 4 or 5 when asked 'is there a culture on your unit of being able to say if you're struggling?'

One trust shared their sickness absence data to illustrate the scale of the impact. On that unit, mental health reasons accounted for 50% of staff absence (possibly greater as many other reported reasons were thought to be mental health related). This equated to 2.7% of the total available staff hours being lost to mental health related absence during 2020/21. In turn, this impacts on the stress levels of other staff members and on continuity of care for families, perpetuating the cycle of emotional struggle on the unit.

4.8 What might help

Staff, unit managers and psychologists identified a number of ways in which staff experiences of emotional wellbeing might be improved.

Training

A number of different training needs were identified, including:

- How to approach and support parents who are angrier in conflict with staff and / or the care plan.
- Perinatal mental health and 'red flags'.
- Psychological first aid.
- Infant mental health.
- How to use screening tools to support conversations with parents.
- Discharge and transition.
- Knowledge about the impact of trauma so they can feel more confident asking about this.

"To know if I recognise when parents are struggling especially with bonding and to know how to improve/develop my skills" (Nurse)

Spaces to think (consultation, reflective practice and supervision)

In addition to formal teaching sessions, staff members described the potential benefit of having the opportunity to discuss family needs, challenging scenarios or the impact on their own wellbeing:

"In [previous unit] we had a psychosocial meeting – we could go through every patient and make a plan for everything. It opens your eyes. Sometimes we can just see the medical point of view" (Doctor)

"Staff would like regular access to reflective practice sessions to help with this. Identified that initiatives are sometimes offered but staff do not take this up as they don't want to appear to be struggling." (Psychologist)

Debriefs

"Debriefs have been mentioned consistently as something they feel could support their wellbeing. Staff feel that debriefs often serve the function of talking about medical processes and learning from that, but they don't currently discuss emotional wellbeing as part of debriefs." (Psychologist)

This perspective was echoed repeatedly by staff on the units and in our surveys. There was often a sense that the debrief process had become compressed, removing the emotional thinking space that had once been intended within it. There was a sense that both individual and group options might be needed, that the experience could be time critical and that it was important for it to be actively encouraged and normalised.

One Consultant Neonatologist reflected that they would like to improve their practice in offering debriefs to staff, they recognise the potential benefit of receiving additional support.

"Being able to talk to someone who is neutral about stressful situations and experiences you have had would be v useful... [but] If they are only here once a week it may be too late then as sometimes it's difficult to talk about it if too much time has passed." (Nurse)

"Where there's a difficult case, where things didn't go well – it's hard to meet the emotional needs of the team. We review well how the clinical care did or didn't go well, but there's a gap in the emotional support." (Doctor)

Individual staff support

Many staff spoke about the need for individual support for staff members and of how difficult it could be to find either the courage or the time to access existing staff support services within the hospital. There was a strong suggestion that they often had to reach crisis point before this felt like an option.

Staff described needing support that was accessible, non-stigmatising and where their unique needs on the neonatal unit could be understood. One unit manager reflected on the importance of staff support for the overall wellbeing of the unit.

“Many people suffer in silence – especially medics. We try and check on each other but sometimes people need more than that. We would never make a self-referral – we need that support to come and talk and engage.” (Doctor)

“We need a proper support service [for staff], not just playing at it. If you don’t, it can easily flip into ‘management don’t care’ or ‘X didn’t make the right decision’. If not resolved it can turn quite negative and blaming. It’s tough and it can have a domino effect in the team – once one staff member goes then they can all start to crumble.” (Unit Manager)

Supportive culture

Despite all of the concerns, there were also some examples of how staff felt very well supported on their units. One psychologist reflected on a conversation where a whole host of positive features were identified, including:

- The leadership team are very supportive, available and accessible.
- Feeling listened to, valued at work and appreciated.
- Feeling as though concerns are taken seriously.
- Feeling as though staff support each other and work well together as a team.
- Feeling connected through WhatsApp groups and pre-covid through social events and opportunities to meet up.
- Feeling as though everyone is treated the same.
- Feeling that senior staff have recognised when someone is struggling and offered support, linked them into external support, and supported taking sick leave if needed.

4.9 Impact of the Covid-19 pandemic

Staff have worked tirelessly during the pandemic, and nurses, doctors and unit managers alike acknowledged that this has had a profound impact on their emotional reserves. In order for staff to be able to 'hold' babies and their parents effectively, they too need to feel replenished.

Recent research from Bliss has also demonstrated that large numbers of neonatal parents feel their mental health has been impacted significantly by the experience of having a baby on the neonatal unit during the pandemic, and that mental health support has not been available (50).

The impact of lockdown and separation has been a theme that has come up frequently in conversation with staff and parents, with our numeric findings closely mirroring those in the Bliss report. However, given the robust rates of distress in the literature and the strong parallels in themes between our own work and previous research, we are keen to emphasise that while there may have been a significant exacerbation of stressors over the last 18 months, there is no evidence of the key experiences of parents or staff being fundamentally different as a result of the pandemic.

The COVID-19 pandemic has undoubtedly shone a spotlight on some of the particular challenges of neonatal care, in particular with regards to parental access to units. However, it is our firm conclusion that the underlying causes of emotional distress in neonatal staff and families predate the current pandemic and, unless change is sought, will continue well beyond it.



5. EXPLORING DIFFERENT OFFERS

5.1 Peer support

For the peer support element of the NFaST project we adopted a capacity building and upskilling approach. Preliminary conversations were held with staff at those hospitals that had either previously engaged with peer support or were enthusiastic to do so. These were supported by evidence from the project literature review, a mapping exercise to identify existing peer support offers and similar discussions with volunteers involved in those groups.

A common narrative was swiftly identified. The benefits of well-executed peer support for families, both on units and post discharge in the community was well understood. Where there were issues, these arose from the quality and sustainability of the peer support offer. Where attempts had been made by staff to establish peer support, recruitment and retention of volunteers was a primary barrier to success. Where veteran parents had started their own groups, volunteer recruitment and retention was also a key theme, alongside difficulties in creating a strong partnership working culture with unit staff.

Due to the extremely limited timeframe of the project, and the overwhelming evidence showing the benefits of peer support in the literature, the project team took the decision not to start by establishing the case for peer support. Instead, the team adopted the position that the case was already proven, and instead moved to identifying the barriers to successful provision and developing tools and resources to mitigate these.

This work included,

- Engagement events with staff and potential peer support volunteers to thoroughly prepare both cohorts for the realities of staff/parent partnership working and the role of a volunteer peer supporter.
- Managing the recruitment of new peer support volunteers on behalf of existing groups and neonatal units.
- Acting as liaison with hospital volunteering services to move volunteers through Trust induction processes.
- Facilitating connections between named unit contacts and new volunteer peer supporters to kick start the development of new offers.
- Linking new volunteer peer supporters with existing groups.
- The provision of a 'start-up' pack of resources to assist with launching peer support, such as uniform t-shirts, printed materials to promote the offer and items for parents and siblings.
- Design services to ensure all groups had a strong, professional visual identity and had digital versions of all key materials, such as logos, leaflets, posters and calling cards for future use.
- Creating and maintaining a forum for volunteer peer supporters to network and share best practice.
- Developing and publishing a 'Neonatal Volunteering Toolkit' to provide guidance on how to achieve best practice in neonatal volunteering.
- Collecting data from current and veteran neonatal parents and unit staff around their experiences of peer support to inform service design and delivery.

What went well

Veteran parent recruitment to our 'Welcome to Peer Support' event was swift and effective. We ended up running two events to accommodate all those who wished to attend and could have provided a third, had the project timeframe allowed. Units who already had an established online veteran parent community (even if this was staff-led) received far more potential volunteers than those who did not. Feedback from the sessions was overwhelmingly positive, and can be found in Appendix 2.

Of the 26 initial enquirers, 20 went on to attend the welcome event and 17 are now linked with a North West Coast neonatal unit and actively continuing their peer support journey. Of those who dropped out following the training, all expressed their appreciation of the opportunity to make an informed decision around whether the role was right for them. When it came to reasons for not continuing these included the time commitment and the fact that the session had highlighted their own emotional vulnerabilities.

Once we had managed to identify relevant staff members and invite them to our 'Working in Partnership with Parents' session these events proved useful. They served both to impart key information to staff members (and empower them to take this on to their teams) and also as an information gathering exercise for the NFaST project team. The sessions also provided an opportunity to build relationships, which proved to be a key factor in the ability of some units to capitalise on the project offer. Please see Appendix 3 for further detail.

Once the potential volunteers were linked with their new unit the role of NFaST in facilitating meetings, pushing along volunteer induction training, providing guidance on best practice as well as being able to provide basic materials to assist start-ups was highly valued by volunteers and unit staff. The coordination required to set up and run a peer support offer is a significant task for unit staff (who usually do not have dedicated time to spend on this) or a solely volunteer workforce (juggling this around their own employment

and family commitments) and is a key reason why previous enthusiasm has frequently not translated into activity. Furthermore, the opportunity to establish a uniform delivery framework and quality standards afforded by having a single, overall, point of coordination allowed for the development of a more universal offer, which will better meet the needs of families.



What was a struggle

Initial enthusiasm for the peer support arm of the project did not translate into action across the entire project area with not all units engaging with the project. Reasons for this remain unclear, but the complexity of attempting to conduct stakeholder engagement work in order to launch a new initiative whilst working entirely remotely must not be underestimated. Limited to email, phone and MS Teams meetings communication was, on occasion, slow and unwieldy. However, once a key contact or 'champion' had been identified to take responsibility for this area of work some units were able to move swiftly to take up the opportunities provided by the project.

The process of undertaking a Trust induction varies widely from hospital to hospital across the North West Coast. In our best-case example, we had new volunteers booked onto a welcome event, DBS checked and undertaking online learning within 3 weeks of attending the welcome event. In other areas existing groups reported pre-COVID wait times of up to 18 months to get a new volunteer through induction. One area was unable to support volunteer training at all, requiring instead the volunteers to take responsibility for training and mandatory checks – an enormous barrier to activity in the absence of a structured voluntary sector organisation or similar to co-ordinate these bureaucratic tasks. Clearly these variations have an enormous impact on the recruitment and retention of new volunteers. Enthusiasm for the role is understandably going to wane when someone is faced with a seemingly endless wait to start. The work of the NFaST project team to smooth through some of the impediments to volunteer recruitment, such as the development of a template role description and the mapping of individual hospital volunteering processes should help to reduce these wait times, but there remains work to be done to streamline the volunteer induction process.

Managing the short timeframe of the project with the need to embed sustainable practices was challenging. As mentioned above, without the input of the NFaST project team this area of work is reliant on a combination of staff and volunteers giving of their free

time. Whilst the project team could outline best practice in areas such as the training and supervision of volunteers, they could not guarantee the ongoing provision of these key elements leaving the ongoing sustainability of the less mature offers vulnerable.



What we learnt

- Whilst the delivery of peer support should always be provided by those with lived experience of neonatal care, there is a significant support function that needs to surround these volunteers. Continuous recruitment, training, development and supervision of volunteers is vital to the creation of a safe peer support offer and this needs to be managed in a sustainable way.
- Emotional wellbeing (including peer support) needs to be within a named staff members portfolio with dedicated time provided to allow them to develop provision. Without this championing of veteran parent volunteering, staff may not realise the advantages of staff/parent partnership working and parents may not feel valued or included. This will ultimately lead to the disintegration of the offer.
- Not all units are currently in a position to move forward with face-to-face peer support. In some areas a virtual offer is required to lay the groundwork for a veteran parent community to draw on for volunteers. In other areas unit culture currently precludes success in this area.
- Physical peer support often begins virtually. Using online (e.g., a Facebook group) to retain contact with families post-discharge is key to volunteer recruitment further down the line.
- Relationships are key. This area of work requires the establishment of a strong working partnership with named contacts, otherwise it becomes easily deprioritised in the maelstrom of unit life.
- Investing the time to prepare staff and potential volunteers through welcome events manages expectations and provides the foundation to develop a sustainable offer. It is tempting to skip this stage and jump straight into delivering a service. This leads to increased volunteer churn and staff dissatisfaction and ultimately undermines everyone's hard work.
- Transitions are highly stressful for neonatal families and peer support can smooth these out, but only if the provision itself is consistent from unit to unit. This can be achieved by having a centrally driven approach to the recruitment, training and development of volunteers.



5.2 Psychological support into units

Seven psychologists (six qualified clinical psychologists and one trainee clinical psychologist) offered one, 4-hour session per week into the following North West Coast neonatal units; Alder Hey, Arrowe Park, Blackpool, Burnley, Chester, Liverpool Women's and Preston. The number of sessions varied slightly based on practicalities, but in most cases consisted of twelve sessions over three months.

The psychologists were tasked with:

- Hearing the stories of parents and staff and exploring what the strengths and struggles are in relation to emotional wellbeing on the unit.
- Offering a range of activities, as agreed with the unit manager, to explore how these were received and what might prove useful if additional psychology resource were to be available in the future.

The activities undertaken by psychologists included:

- Formal teaching sessions re: 'psychological aspects of neonatal care' (4 units).
- Staff wellbeing session (2 units).
- Reflective practice sessions (4 units).
- Working with emotional wellbeing champions to develop ideas and resources to take forward (4 units).
- Working with senior staff to establish plans around clinical supervision (1 unit).
- 1:1 discussion with parents (5 units).
- 1:1 or small group consultations with staff (4 units).
- 1:1 support session with staff (4 units).
- Attending ward round weekly to add a psychological perspective (1 unit).



What went well

Overall, the psychology team had an extremely positive experience working on this project. In the majority of units, they felt very welcomed onto the unit and that staff had lots of ideas about how they could effectively make use of psychology provision.

While some staff had expressed concerns that parents would be wary of being approached by a psychologist, this was not always the case. Some parents were happy to speak about their experiences, with a number reporting that this was a welcome opportunity to do so for the first time. On one unit the psychologist was able to attend the ward round each week and parents were very positive about this, reporting that it helped to normalise her role on the ward and made them more confident about talking to her at other times.

A number of nursing and medical staff also took the opportunity to speak to the psychologists about issues that had affected them. The psychologists operated a '2 session model', where they could have space to think together on one or two occasions and then signpost on as needed. This helped to maintain accessibility without swamping the resource available. Several staff reported that they were much more likely to use a support service that was based on the unit, with someone they knew and trusted who could be accessed informally.

Some of the things that the psychologists most enjoyed about this experience were:

"Hearing from parents, listening to their stories and learning about how we could better support them psychologically. Parents have been so open and willing to share their experiences - parents spoke unanimously about how helpful it would be to have psychology provision on the unit"

"Working with an incredibly passionate team - with so many ideas and such compassion for the families they work with. Having the flexibility to try different ideas and suggestions and work really collaboratively to discover what may be most helpful in the time of the project."

"I most enjoyed the diversity of the work that the project offered in terms of supporting families and staff from an emotional perspective but also being able to deliver staff training and helping staff to change the culture of the unit to see the baby as part of a wider system and how intrinsic families' wellbeing is to the long-term outcomes for baby."

Training sessions

Various training and development sessions were delivered, each using a mixture of online and in person sessions.

Session name	Number of units	Attendees
How psychology can support the creation of emotionally healthy units	4 – plus one online session open to any staff in the region	100
Staff wellbeing	2	44

Emotionally Healthy Units session

This was between 1-1.5 hours long and covered some key messages from parents, an introduction to the 'Compassion Focused Approach' and how to use this to make sense of families' struggles, alongside space to think about the ways in which families communicate distress and how to respond to these. Staff engaged extremely well and evaluation was very positive, for details see Appendix 4.

Staff wellbeing session

An additional session focusing specifically on staff wellbeing was set up in response to feedback that this was currently of particular concern. This session offered some information, but also space for staff to share their experiences. Detailed feedback can be found in Appendix 5.

Consultation / reflective practice sessions

In a number of units staff were keen to use 1:1 or small group time with the psychologist to explore different areas of practice or to reflect on their own experiences within the work. These sessions were again very well received, often to the surprise of managers who weren't sure whether staff would be willing to engage. Collecting data on these was more difficult, but 13 people responded to the request to feedback and detailed evaluation results can be found in Appendix 6.

What was a struggle

Inevitably, not everything was as smooth or as powerful as we might have hoped. There was a marked difference in the ways in which different units made use of the psychologist placed with them. Some psychologists were overrun with requests for input from their first visit to the unit, while in other settings there was more reticence from staff and less clarity about what they might use the sessions for. Interestingly, in all contexts the parents were equally engaged with the work, as were the outreach teams who identified that they are often picking up on issues that hadn't been identified while the family was on the unit.

One unit received virtual input via MS Teams, for both geographic and COVID reasons. Although this meant that work was more focused early on (with staff members bringing specific pieces of work to develop), overall it was more of a challenge. The psychologist described how much harder it was to support staff to make changes without being on the unit to develop relationships and build trust.

Other practical challenges included space, time and environment, for example:

"It's challenging to complete the work on a very busy environment in a very short amount of time - difficult to speak to staff, parents, do liaison, no confidential space"

The psychologists also recognised the challenges of the emotional nature of the work – reflecting on how much of this emotion is being carried by parents and by staff on a daily basis.

What we learnt

While psychologists and unit managers alike were impressed by the quantity and quality of the work completed and the impact that it had, some clear barriers and facilitators to success were identified:

- There needs to be good support at management level for this work to happen. Much of the work involves embedding an additional 'lens' into the systems and processes on the unit and more junior staff aren't able to facilitate this alone.
- There is a clear benefit to having Emotional Wellbeing Champions on the unit to help 'hold this work in mind'. This includes giving them time and resources to do so.
- Similarly, if staff are going to make the most of consultation, reflective practice etc then they need to be supported to attend these sessions wherever possible.
- Many staff are very keen to learn more, but training can feel like another demand on their time. Coordinating with the education team to deliver this training as part of core update sessions minimised this.
- Space needs to be considered – particularly the availability of confidential, accessible space where parents and staff can talk safely.
- Referral routes to other services need to be clarified. It is harder for staff to ask parents to open up if they're concerned about what they will do if they hear something that worries them.
- To have the greatest impact, information about families needs to be recorded somewhere, so that staff feel supported to build on their understanding and develop these relationships.

- Staff need physical space to decompress and connect with each other in order to maintain their wellbeing on a shift. Parents and families also need this (separate) space.
- Timeliness and accessibility are key. On several occasions staff would comment that 'we could have done with you here on X Day'. There was a sense that neither staff nor parents wanted to go back to revisit something difficult later on, although it might still leave a scar.
- And, as with the peer support work, ultimately, it's all about building strong relationships.

"Building relationships with the matron, shift leads etc. felt important to facilitate discussions with parents. I think staff consultation and support would be best built up over time as this is all about relationships, I noticed that the more I got to know people they more they would reach out in formal or informal ways or recommend that others talk to me. I think that it is for this reason that someone needs to be onsite to build up that rapport over time."

6. THE COST OF INACTION

The aim of this project was to discover 'what good looks like' when considering the emotional wellbeing of babies, parents and staff on neonatal units and post-discharge, then to suggest ways of putting this into practice.

What was clear throughout was that the emotional wellbeing of all those on the unit are closely interlinked. The neonatal environment is often a sensorily intense, highly emotionally charged environment. To quote Winnicott (1960) "There is no such thing as a baby, there is a baby and someone". Babies' experiences of the world are defined by the people on whom they depend, and on the neonatal unit there is a complex web of people caring for and 'holding them in mind'. The emotional labour involved in holding in mind babies who may be in pain or distress and whose lives are under threat cannot be underestimated. Parents spoke of being overwhelmed, often traumatised and spending the majority of their time 'in survival mode'. For many parents, that feeling persists long after they are discharged home with their baby.

"After experiencing a premature baby, I felt numb. The time he spent in there affected my mental health and I felt very low at times. As a mother you try to stay strong and not let it impact you. But seeing your child being tube fed and having wires everywhere is heart-breaking. Two years on and mentally I'm definitely not over the whole situation" (Mum)

Staff, then, have to care for not only a vulnerable baby but also a vulnerable family who are clinging on and often unable to contain their distress. They hold the emotional pain of both babies and of parents and families. On top of this, staff are carrying their own distress – of seeing babies in pain, not progressing well, or dying; of making complex ethical and clinical decisions on an hour-by-hour basis; of feeling stretched and under-resourced and unable to always do the job that they would like to; and often of struggling silently in a culture of 'getting on with it'.

6.1 The impact on Family Integrated Care

The introduction of Family Integrated Care has been a huge leap in acknowledging the importance of putting parents at the centre of their baby's experiences. For many parents, this in itself has had a profound impact on their connection with their baby and their sense of themselves as a parent. But where parents are traumatised by the environment and the pervasive fear for their baby's life or future, taking on the role of parent is not always easy.

On the whole, staff are enthusiastic and motivated by the concept of FiCare and talk positively about the work that has been done and their hopes to revive this work post-Covid. However, there is a general recognition that the 'Fourth Pillar' of FiCare (Psychosocial Care) is less consistently met. As one unit manager put it:



“Generally, parents are so overwhelmingly positive but when you read the undertone of that – they had a great experience or we saved their baby but in the longer term they haven’t bonded very well or in the long term they’re still suffering with PTSD symptom – now that we know that, we have a responsibility to put measures in place to help.” (Unit Manager)

Without addressing the barriers to achieving the 'Fourth Pillar', for both staff and parents, the potential transformative impact of Family Integrated Care may be substantially undermined.

6.2 What are the costs of not intervening?

Asking an already stretched health system to find additional funding, particularly for a new service, is understandably a challenging prospect. We believe that the moral and clinical argument for change is compelling – but we appreciate that financial considerations are necessary.

There are three core ways in which investment in additional Peer Support, Clinical Psychology and/or wider Psychological Therapies can contribute to cost reductions to the wider healthcare economy.

1. Costs to wellbeing

In 2014 the Centre for Mental Health and London School of Economics published their analysis of the costs of untreated perinatal mental health difficulties. They calculated the costs to the family (which included care costs, productivity loss, child outcomes requiring intervention and quality of life impact) and the costs to the public sector (which included cost implications for health, social care and education).

Table 1: Fiscal cost of inaction

	Total cost – mother	Total cost – child	Total cost – mother and child
Perinatal depression	£22,630* (£1688**)	£51,462* (£7971**)	£74,092* (£9659**)
Perinatal anxiety	£20,794* (£4320**)	£14,017* (£5362**)	£34,811* (£9682**)

In 2019, the North West Coast region admitted 3864 babies to neonatal care.

Our review of the literature suggests that the minimum expected level of significant anxiety or PTSD is 15% of the neonatal parent population (much of the research literature, and our own data, suggests that this proportion may be significantly higher).

If the mothers of

15%



of the babies admitted to neonatal care across the NWC region annually experienced significant anxiety OR depression, the LSE figures suggest that the lifetime cost to the public sector would reach a minimum of: **£5,611,687**

with the overall costs to families representing **£20,176,455**

While additional support will certainly not eradicate these rates of distress, the subsequent figures strongly suggest a significant cost saving could be realised by timely psychosocial intervention with the aim of prevention.

2. Costs of staff sickness

One of the neonatal units shared their staff sickness data for the 2020/21 financial year. They reported 811 staff days lost to mental health related sickness during this period, which based on 7.5-hour days (this may be a conservative estimate given 12.5-hour days are more standard) at the lowest AfC Band 5 pay point equates to £77,491. What this doesn't reflect is the additional pressure on other staff, managers and families which are likely to result in later costs of their own.



A Clinical Psychology led staff support service was piloted on the Addenbrookes Neonatal Unit (53) in response to similarly raised sickness rates. Over a six-month period, they offered a structured staff support intervention which included reflective practice groups, team away days, staff drop-in sessions and teaching on managing difficult conversations. They found that this led to a 40% reduction in absence relating to stress-related sickness.

In our example NWC neonatal unit, a **40% reduction in sickness absence** over the last 12 months would equate to a **financial saving of £30,966**, in itself equivalent to approximately 0.6wte of a Band 8a Clinical Psychologist who would have capacity to provide a range of additional interventions alongside this model.

3. Cost of litigation

A substantial proportion of litigation costs within the NHS relate to maternity and neonatal care. There is a consensus within the research literature that good communication, patients or families feeling listened to, and strong working relationships between patients and staff and within the staff team significantly reduce the likelihood and therefore the costs of litigation (54).

We heard many stories relating to breakdowns in communication during the NFaST project. Staff are under immense pressure and as such can feel they have limited capacity to respond with curiosity and empathy to parents who present as angry or critical. Several parents described feeling that staff didn't always have the time to hear their concerns. Several staff reported that if they felt that they had a space to feel heard and make sense of their emotional reactions to difficult events, they might feel better equipped to support families at these very challenging times.

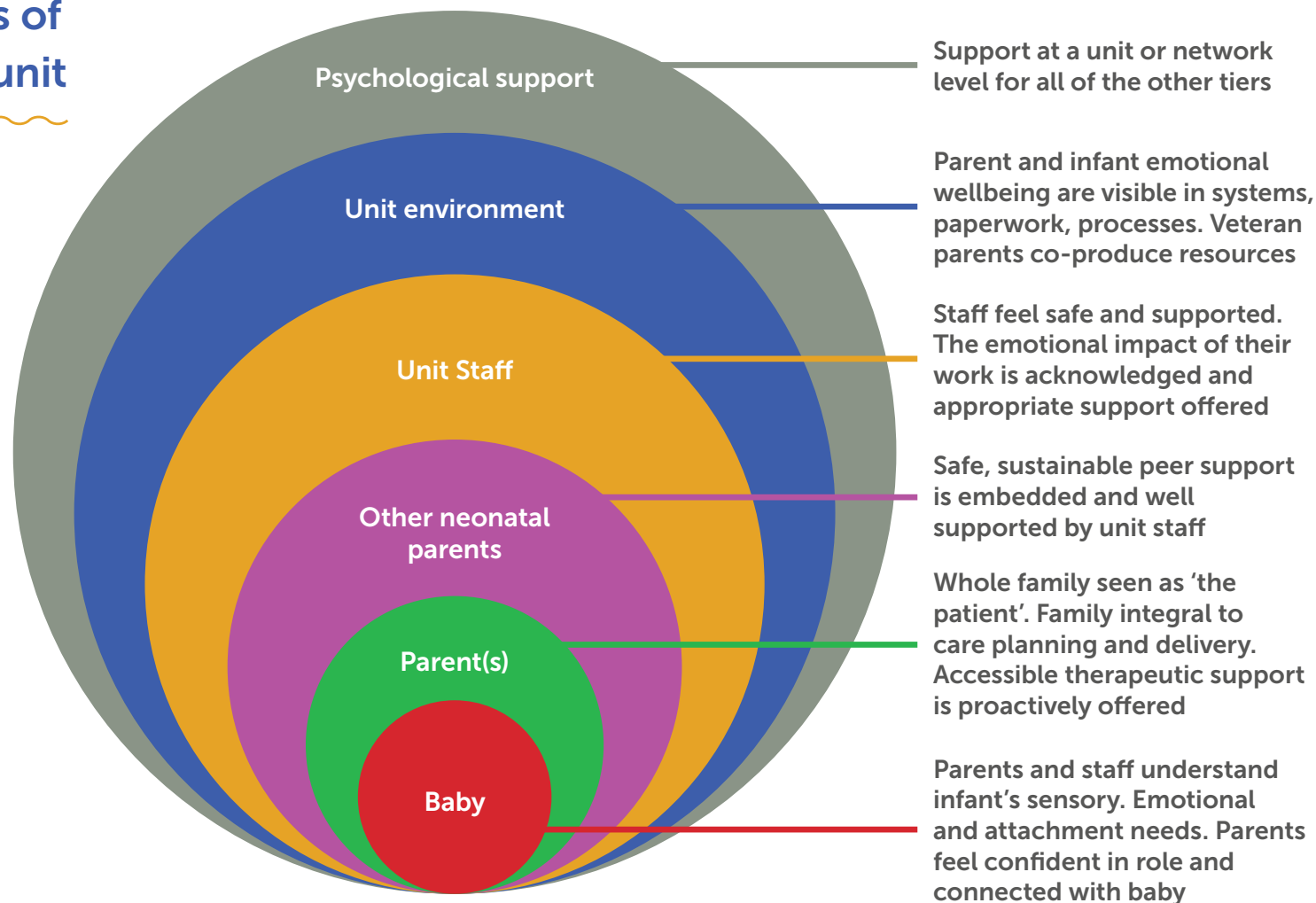
Staff on one unit also hypothesised that having a clinical psychologist's support to identify what might be happening for a parent from a psychological perspective, and to mediate relationships at an earlier stage, might reduce conflict before it has the opportunity to escalate.

While it is impossible to put a value on the cost of hypothetical litigation, we suggest that it is reasonable for both staff and families to receive support to improve relationships, communication and collaborative care planning at an exceptionally vulnerable time.

7. RECOMMENDATIONS FOR PRACTICE

Throughout this document we have highlighted recommendations for ways in which changes in practice might positively impact on emotional wellbeing. Figure 1 illustrates how intervening at all levels of the neonatal system might contribute to a holistic sense of emotional wellbeing for all those involved.

7.1 Figure 1: Key features of an emotionally healthy unit



7.2 Table 2: Tasks involved in promoting family wellbeing

We used the data from this project to operationalise what 'Tasks' are involved in creating a more emotionally healthy system.

	Task	Function	Intended Outcome
Peer support between current parents	<p>Create spaces for parents to come together in mutual support</p> <ul style="list-style-type: none"> Physical space (e.g. pleasant family room) Ringfenced time (e.g. 'information' sessions) 	<p>Parents have the opportunity to share experiences and connect with each other</p>	<ul style="list-style-type: none"> Parents feel less alone, reducing emotional distress Peers can make time to listen in a way that reduces burden on staff
Veteran peer support	<p>Establish and maintain safe, effective veteran led peer support into the unit</p>	<p>Current parents can hear from past parents and experience empathy, hear hope in their stories, feel understood and feelings validated</p>	<ul style="list-style-type: none"> Parents feel less alone, reducing emotional distress Peer supporters can listen in a way that reduces burden on staff Helps communication between staff and parents when things are challenging and can help reduce conflict Reduces parents' stress and anxiety, improves their capacity to tune in to their baby and the impact of their physiological arousal when holding baby
Emotional wellbeing champions	<p>Members of staff are identified as champions and given appropriate time and resources to develop peer support and emotional wellbeing initiatives</p>	<p>Helps to ensure that parent, infant and family emotional wellbeing is seen as a priority and influences decision making</p> <p>Ensures that the work is safe and sustainable</p>	<ul style="list-style-type: none"> Mitigates the traumatic experiences associated with neonatal care, reducing stress and anxiety and ensuring that babies are discharged into an optimal family environment, thereby promoting longer term outcomes

Task

Function

Intended Outcome

Co-production of wellbeing pathways and resources	Developing parent involvement (directly or via the Parent Advisory Groups (PAG)) into service development	Veteran and current parents are actively involved in identifying gaps and needs and helping develop resources and pathways to meet these	<ul style="list-style-type: none"> • New initiatives to support parents are based on what parents see as being most important • Reduces 'change for change's sake' • Improves staff engagement and relationships with families
Counselling / psychological therapy on the unit	Unit has a dedicated offer of therapeutic support for parents	Parents have a safe place to express and make sense of their feelings	<ul style="list-style-type: none"> • Parents feel less anxious, mitigates the impact of traumatic events on later wellbeing • Parents understanding their feelings improves communication between them and staff • Containing parents' stress and anxiety improves their capacity to tune in to their baby and the impact of their physiological arousal when holding baby • Supports parents to process their experiences of becoming a parent to promote the development of secure attachment relationships
Counselling / therapy following discharge	Unit counsellor / therapist is able to offer follow up in the community	Parents are offered or made aware of how to access therapy at the point where we know they may struggle most, by someone who is familiar from the unit (and therefore who might feel more accessible / approachable)	<ul style="list-style-type: none"> • Parents are more likely to seek help from someone they know and trust • Parents receive timely therapeutic support from someone who understands their neonatal experience • This helps to reduce distress and enhance coping in order to provide optimal conditions for parents and child(ren) to grow and develop together

Task

Function

Intended Outcome

Access to specialist mental health support	Clear pathways and access to specialist mental health advice / support are established – ideally with dedicated unit time	Where parents have more complex mental health needs and / or there are more significant parent-infant or parent-parent relationship challenges there is a clear pathway to accessing support	<ul style="list-style-type: none">• Parents' needs are responded to effectively• This improves their ability to engage with their baby and with unit staff• Staff have a better understanding of parents' needs and so can offer more effective support while on the unit
Improved discharge pathways	Preparing families more fully for the process of discharge and how this might feel Working more closely with primary care teams	Reduces parent anxiety around discharge Prepares them for the potential wave of emotional processing post-discharge Ensures ongoing support once the family are home Ensures that the primary care team are aware of and able to respond to the family's individual needs	<ul style="list-style-type: none">• Reduces blocks in the system so families can access appropriate support once home• Contains and reduces the distress and anxiety of this period and therefore promotes positive longer-term outcomes for babies and families

7.3 Table 3: Tasks involved in promoting staff wellbeing

	Task	Function	Intended Outcome
Staff wellbeing champions	Staff wellbeing champions are identified and given appropriate time or resources to promote staff wellbeing	<p>Indicates that staff wellbeing is a priority</p> <p>Meaningful initiatives can be developed that are directly responsive to the needs of the staff team</p>	<ul style="list-style-type: none"> • Staff burnout and moral injury is reduced • Staff feel more 'held' and able to 'hold' parents' and babies' emotional experiences in turn • Sickness absence rates are improved • This promotes continuity of care for families as the staff team remains more stable
Supervision and reflective practice	<p>Developing a systematic approach to clinical supervision</p> <p>Offering reflective practice groups to share and reflect on experiences and learning</p>	<p>Staff have regular planned space to talk about their work and how it is impacting them. This helps them to learn and develop professionally and feel supported, 'seen' and validated in their very challenging roles</p>	<ul style="list-style-type: none"> • The leadership team can pick up on issues of wellbeing at an earlier point and offer appropriate support • Staff are more likely to thrive and perform to the best of their abilities • Interpersonal issues can be aired and resolved • Staff retention is improved
Training	Staff receive regular formal and informal training in recognising and responding to the emotional and psychological needs of parents, babies and families	Staff confidence is improved both in promoting parent, infant and family wellbeing and identifying when additional support might be required	<ul style="list-style-type: none"> • Parents and babies (and the wider family) have their emotional needs met in a timelier way, reducing the extent to which difficult feelings escalate or become more entrenched

Task

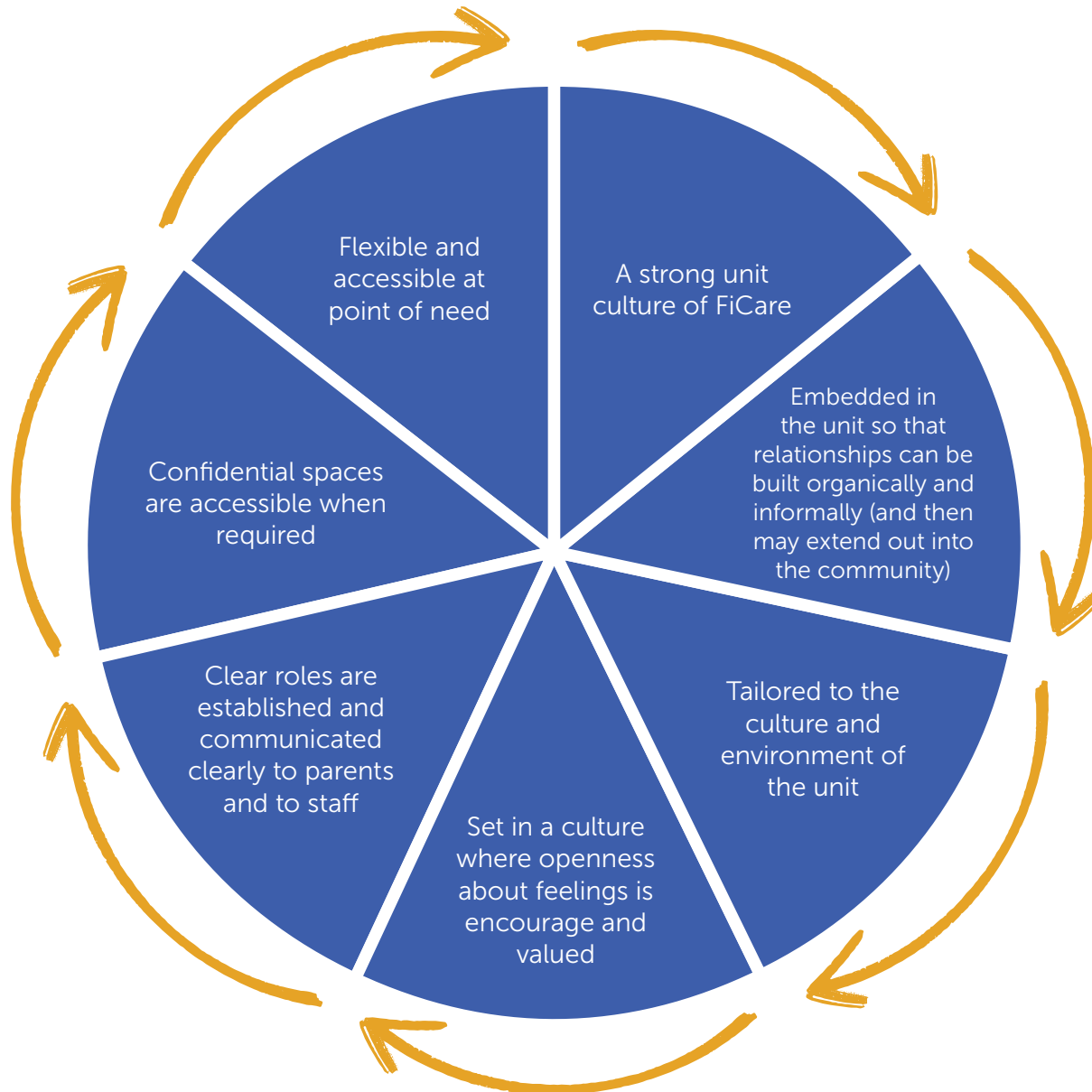
Function

Intended Outcome

Consultation / 'Psychosocial meeting'	Staff have access to consultation from psychological professional(s) where there are concerns about the needs or presentation of a family on the unit	Psychological support is offered to make sense of the needs of the individual or family and to develop a holistic plan to meet those needs	<ul style="list-style-type: none">• Parents feel better understood and have their needs met, reducing their distress and the impact on family functioning• Parent-staff communication is improved, improving the wellbeing of both and the atmosphere on the unit• The likelihood of serious disputes around care planning or complaints from parents is reduced
Debriefs	Psychological input is offered either as part of or alongside existing debriefing mechanisms	The emotional needs of staff are recognised and contained following challenging events	<ul style="list-style-type: none">• Staff wellbeing and sickness levels are improved• Staff feel taken care of, improving morale and unit culture
Counselling / therapy offer	Staff have access to on-unit support and accessible referral pathways	Staff are able to access informal support from a member of therapeutic staff on the unit and then be supported into longer term or more intensive therapeutic support (e.g., within the trust / local services as needed).	<ul style="list-style-type: none">• Staff access support in a timely way, rather than waiting until they reach crisis point• This positively impacts on direct patient care and staff members' capacity to respond to families• Reduce sickness absence and improve staff retention

7.1 Figure 2: Conditions for success

A number of features were identified that improve the likelihood that an emotional support offer will prove to be successful, whether this is peer support or provided by psychological professionals.



These conditions for success also underpin the benefit of 'specialist' neonatal support. Although there are valuable perinatal peer support and therapeutic services available, many parents and staff described that these sometimes felt inaccessible as they lack the features shown in figure 2, above. Having someone to talk to who understands the neonatal culture and environment can aid accessibility of support, particularly for those who might otherwise be reticent. This may well, in turn, allow for a supported transition to mainstream services as needed.

8. WHAT GOOD LOOKS LIKE

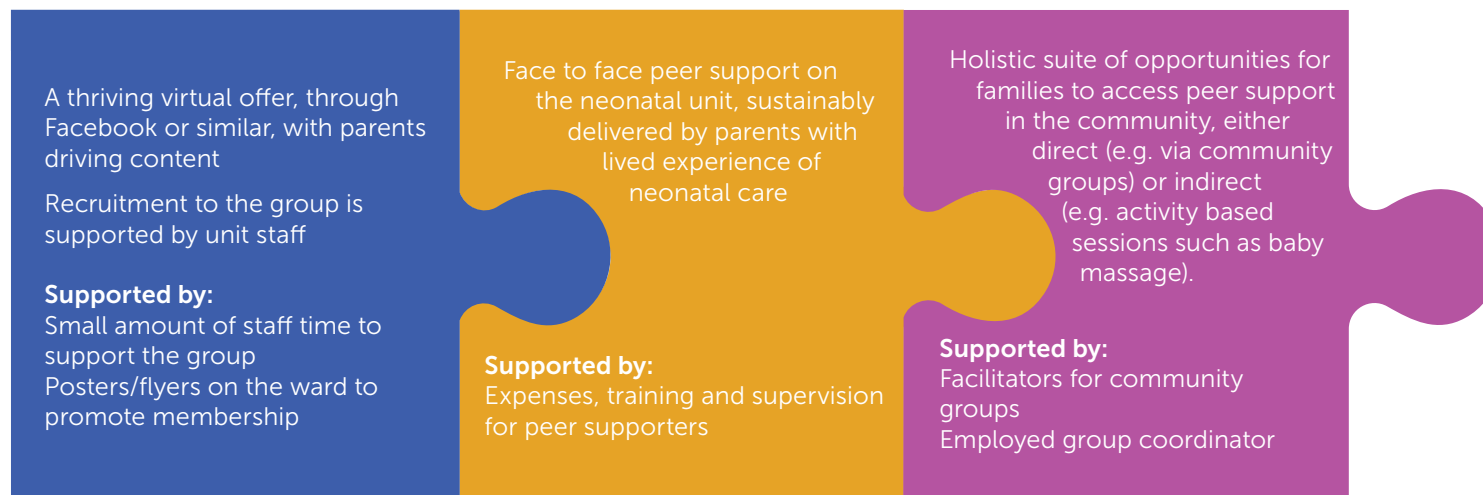
What is clear from this project is that expecting core unit staff to make the changes identified without additional support is unrealistic and unfair. They are carrying a great deal in their day-to-day roles and while they are integral to the emotional wellbeing of families on the unit, they need and deserve additional resources to support this offer.

The jigsaw pieces in this section demonstrate how you can build up a successful emotional support offer. However, context is everything. Some parts of the puzzle work well in some areas, others may not. Each piece of the puzzle represents best practice and no piece is more or less valuable than another. Working in partnership with local neonatal families is vital, to ensure you put the pieces together in the way that works best for your neonatal community.

8.1 What good looks like: Peer Support

Peer support thrives on responsiveness to the local environment. A one-size fits all approach is neither effective nor appropriate, any offer needs to be tailored to the context of each parent community. As such, the jigsaw pieces below represent different offers that can exist independently or build on each other to create a broader offer.

Figure 3: Building up your peer support offer



CASE STUDY: SPOONS NEONATAL FAMILY SUPPORT

Spoons is a North West Charity offering an example of all three jigsaw pieces in one. Here, Operations Manager, Kirsten gives us an overview of how they became established and what the offer to families consists of;

"Spoons was founded in 2015 by a group of parents who had met on the neonatal unit. We all had very different NICU experiences, but we had shared a strong bond on the unit and supported each other. We all struggled with the transition from hospital to home, particularly without each other. We all found it difficult to adjust to life beyond discharge from neonatal care. Each having experienced our own trauma, we all described feeling a little removed from life pre NICU. We wanted to create a space for parents to continue relationships with those they had met on the unit as we understood the value in having them once at home.

Spoons initially ran as a closed Facebook support group for families on NICU at Royal Oldham Hospital – Spoons being an acronym for 'Supporting Parents of Oldham Neonates'. We also set up a monthly community support group at one of the local children's centres with the aim of providing a safe and supportive space for families to keep in touch with their peers and "feel normal" in the company of those who understood.

Spoons worked in partnership with Royal Oldham NICU to promote the groups. I registered as a Trust volunteer to provide weekly peer support on the unit, to encourage parents to access the groups.

The groups were a huge success and we later expanded into North Manchester General Hospital NNU. The more parents and staff invested, the more parents wanted to become involved post discharge and become peer support volunteers. In 2016 Spoons became a registered charity and we now have volunteers linked to four of the eight neonatal units in Greater Manchester. Our services are accessible to any Greater Manchester family who has experienced neonatal care. We are working towards establishing a

unit peer support offer on all eight Greater Manchester neonatal units and are working in partnership with various NHS and third sector organisations to ensure that families have access to appropriate support throughout their neonatal journey and beyond."



The Spoons offer consists of:

- Peer to peer support by lived experience on the neonatal unit – all peer support volunteers are veteran parents and have access to full peer support training and regular supervision.
 - Professional mental health support including EMDR, counselling and trauma therapy – providing parents with access to therapeutic support when universal services are unable to meet their needs.
 - Facilitating community sessions, including baby massage, play sessions, peer support groups and weaning support – creating a space for families to do “normal things” with their baby in a way that feels safe and supportive.
- Working with neonatal teams to promote Family Integrated Care, parent engagement and supporting parents to be actively involved in their baby’s care.
 - Working with Greater Manchester Perinatal Mental Health Teams and Parent Infant Mental Teams to promote understanding of the challenges linked to neonatal care and the impact on the family.

Spoons is now a recognised model of good practice nationally.



Taking this forward

Peer support by lived experience, delivered by trained and supported veteran neonatal parents is a powerful tool within a unit’s emotional wellbeing offer. The opportunity to engage with a peer supporter who has been through, and come out the other side of, the neonatal experience affords families a safe space to explore their emotions and provides them with much needed hope for the future. However, best practice peer support, of the kind delivered by Spoons, does not happen organically. Through our work to develop peer support we have identified a number of quality standards that need to be met. In order to achieve these resourcing is required, through designated staff time to prioritise peer support and a third-party coordinator to manage the offer.

Figure 4: Conditions required to achieve quality peer support



8.2 What good looks like: Psychological support

There are numerous ways of developing a psychological offer that meets the needs of an individual unit. The jigsaw pieces below could be offered in various combinations or as stand-alone provision.

Figure 5: Elements of a best practice psychological support offer



CASE STUDY: THE ROLE OF CLINICAL PSYCHOLOGISTS AND OTHER PSYCHOLOGICAL PROFESSIONALS ON A NEONATAL UNIT

To our knowledge there is no single 'standout' offer in terms of providing psychological / therapeutic input to a neonatal unit in the UK. Given the Tasks identified by this project we wanted to demonstrate the breadth in the types of offer nationally and begin to contribute to the conversation around staffing numbers.

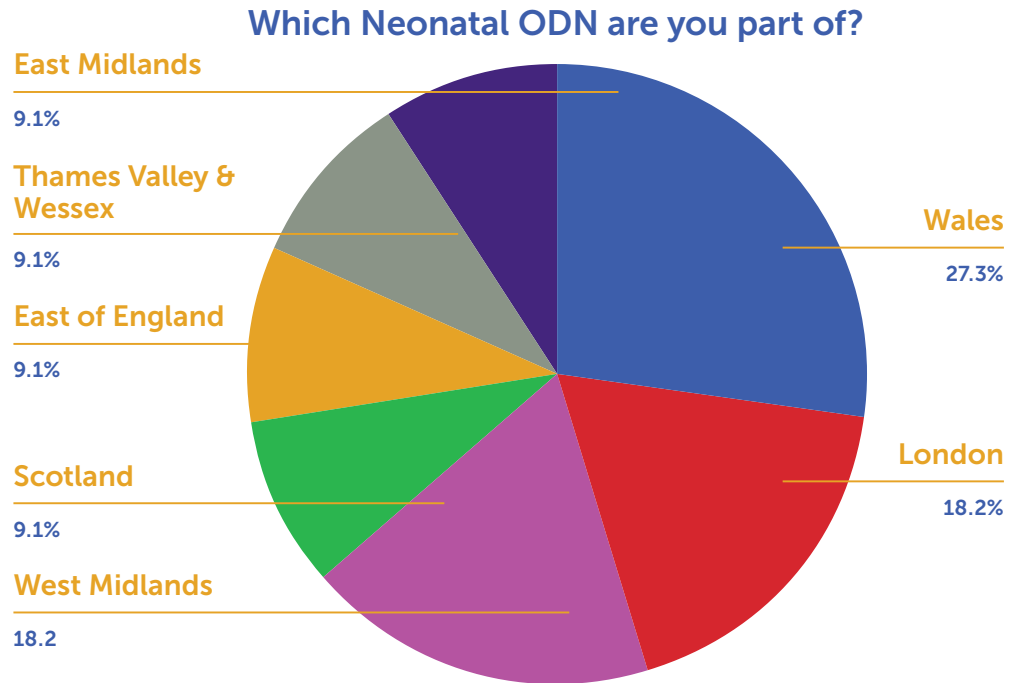
We partnered with the "Clinical Psychologists in Neonatal Care" Special Interest Group to develop a Benchmarking survey for psychosocial support nationally. This is now being circulated via all ODNs but we are able to offer a snapshot of early responses ¹.



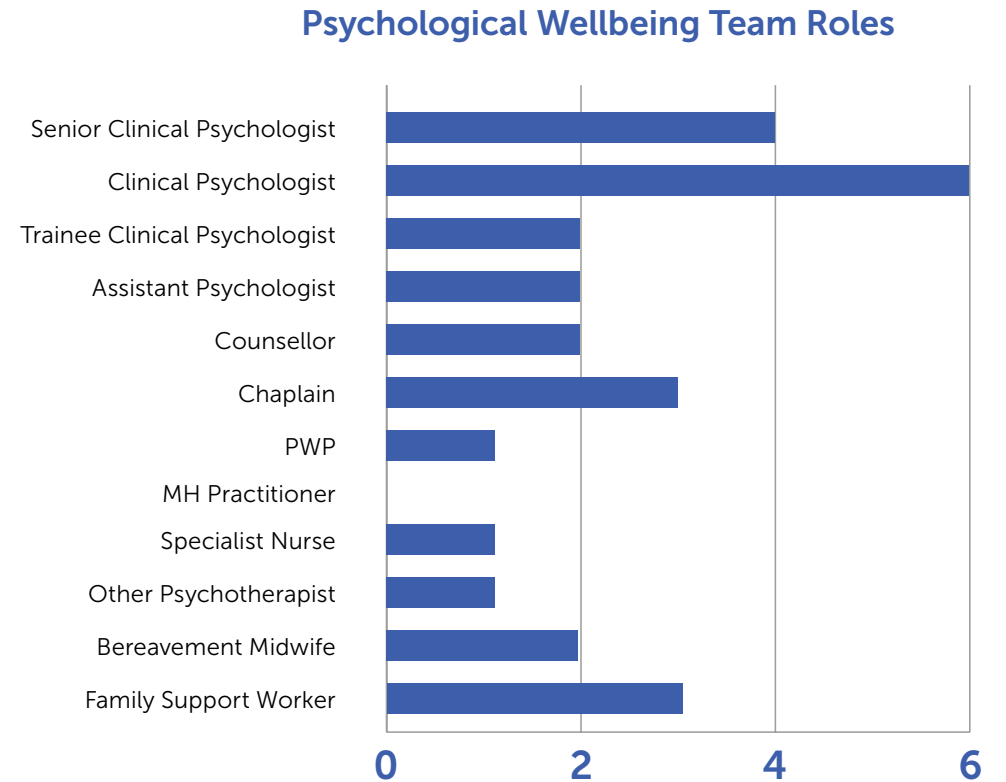
¹Given that the survey was initially circulated by the SIG, the responses predominantly focus on units which have some psychology time – we are aware of brilliant counselling offers on many units and hope these will be reflected in the final benchmarking survey data.

Table 4: Using the available data to extrapolate psychological staff numbers

1. Data was collected from 11 units across 7 ODNs

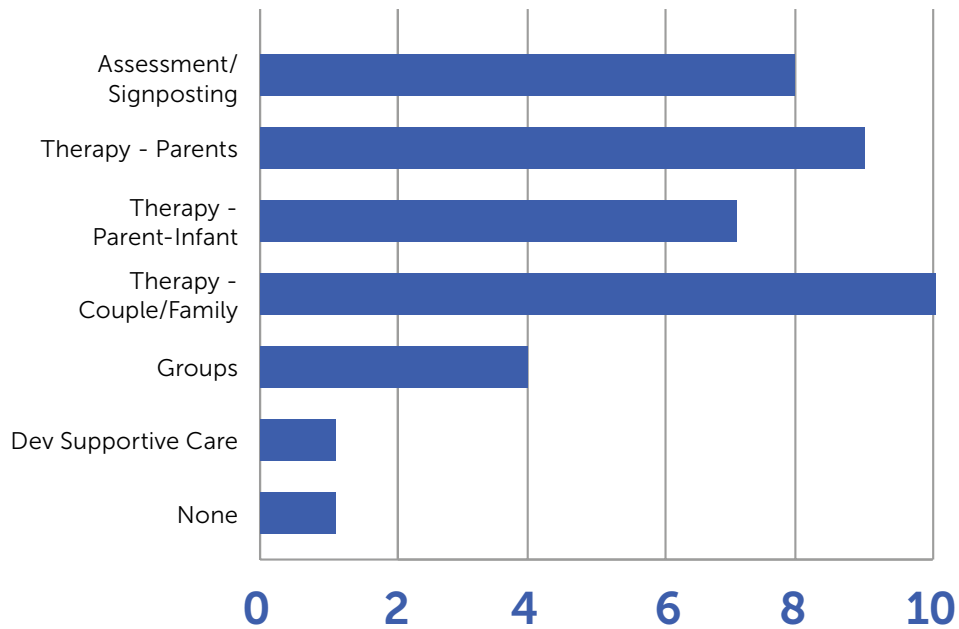


2. A range of different team roles were identified



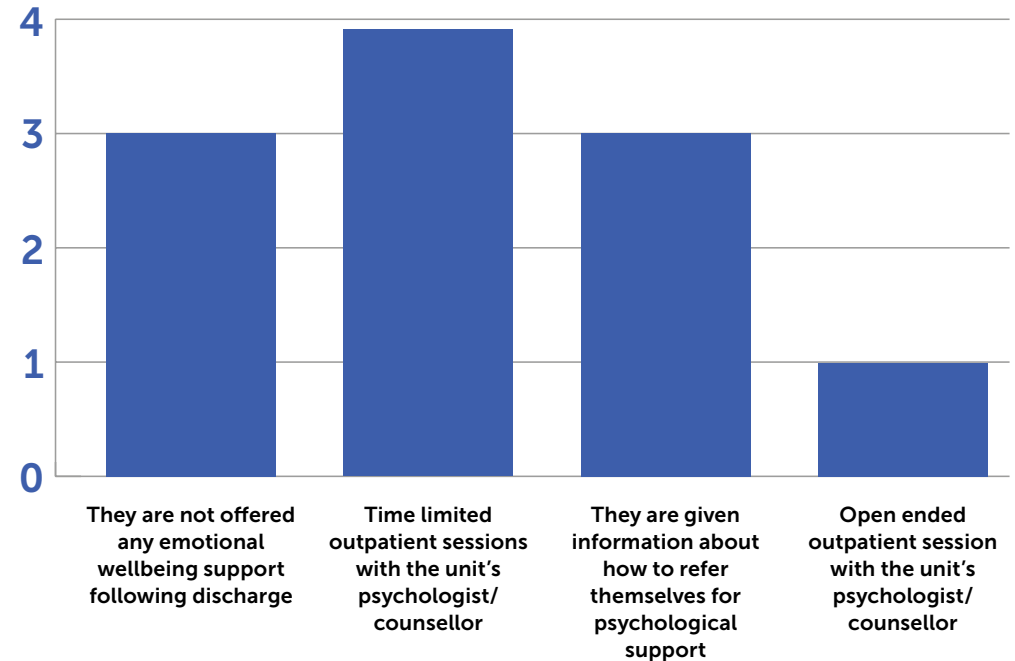
3. A variety of activities were on offer to support family wellbeing

What types of activities do your Psychological Wellbeing Team offer regularly for families?



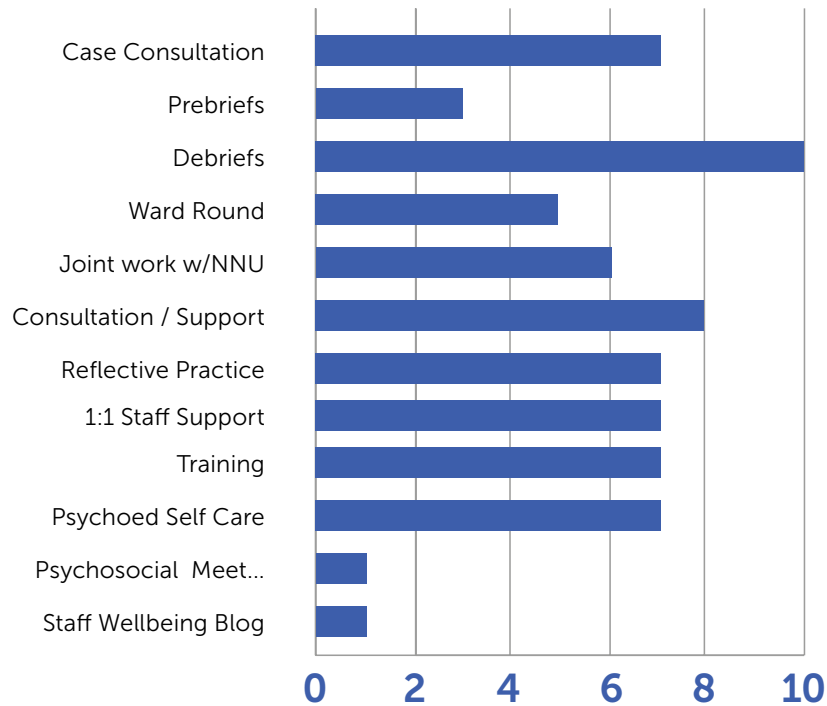
4. And on some units this continues post-discharge

What emotional wellbeing support do families leaving the NNU receive when discharged?



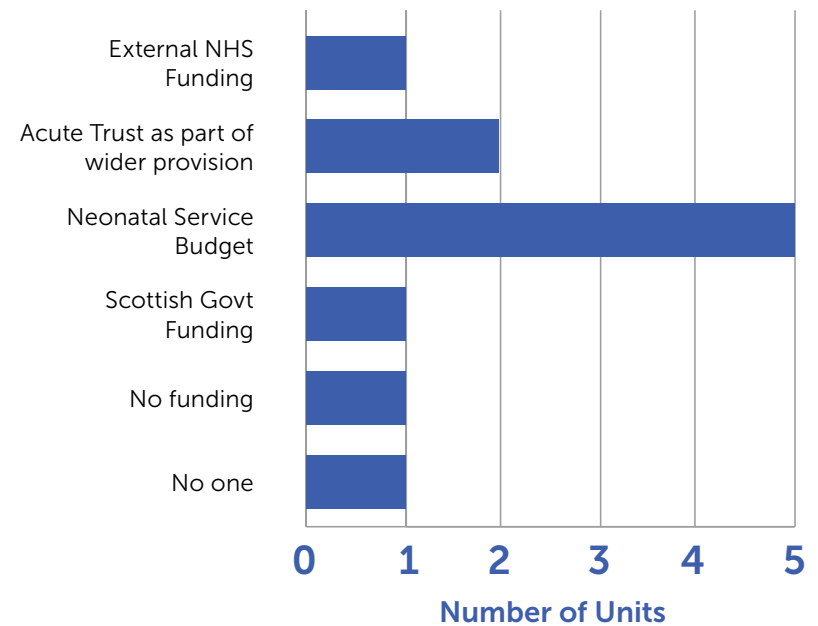
5. Most Units also had provision for staff learning and wellbeing

What support do your Psychological Wellbeing Team offer regularly for NNU Staff?



6. In most cases, the funding came from the Neonatal unit budget

Who funds the Psychological Wellbeing Posts?

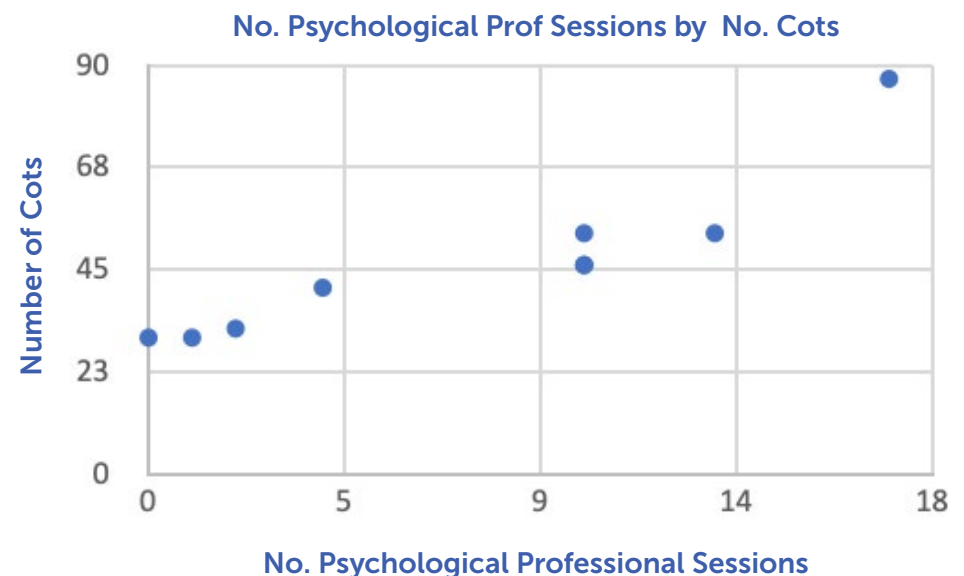


In the absence of clear national or international guidance about the ratio of psychological professionals required on the NNU, we have attempted to draw together the available evidence as follows:

- Both NHS Scotland's (2019) 'Delivery Effective Services' Perinatal Strategy and the British Psychological Society's (2018) Position Paper on Perinatal services suggest that adequate psychological support for a Maternity and Neonatal setting which sees 3000 births per annum requires:
 - 0.6wte senior (Band 8b or 8c) Clinical Psychology Provision
 - 1wte Band 6-8a Psychological Therapist or Clinical Psychologist provision.
- It is difficult to extrapolate exactly what proportion of the provision should be available for neonates. This is further complicated by the fact that the new Maternal Mental Health Services in England are commissioned according to specific maternal experiences (e.g., PTSD, Baby Loss) and as such there is wide variation both in terms of access criteria and in the proportion of therapy vs systemic support available.
- In the only reference we were able to find in the wider literature, Hynan et al (2015, in the USA) suggest that every unit of more than 20 cots should have one wte social worker and one full or part time psychologist in order to meet the therapeutic needs of families.
- In the Benchmarking Survey described above, broadly speaking the number of sessions provided increased with the number of cots on units (all units covered NICU, HDU and SCBU). ('Psychological Professionals' here refers to qualified clinical psychologists, counsellors, psychotherapists and Psychological Wellbeing Practitioners).
- Only one service identified itself as having sufficient provision for families (the top right service on the graph). However, the provision for all those with funded posts was within a reasonably small band of 0.19 – 0.25 (half day) clinical sessions per cot, with an average of 0.22 sessions per cot. Interestingly, the service identifying itself as having sufficient provision, while not having a significantly higher staffing ratio, was a much larger service serving a collection of 3 sites. This

may point to the benefits of having collaborative provision across units in order to make best use of the resources available.

- We asked our clinical psychologists and unit managers for their perspectives on what is needed. For the two larger units who responded, both managers and psychologists reported independently that in order to have capacity to work with the whole staff team and across the week with families, at least 1wte post would be needed. On the smaller units, there was a consensus that 0.2-0.6wte staffing might be sufficient. This will reflect:
 - The size and culture of the staff team and existing resources.
 - The need to consider how families' needs could be met across the week where only very part time sessions were available.



Taking this forward

There is still limited evidence for what an optimal staffing level for psychosocial professionals with the neonatal setting might look like. The benchmarking survey that is underway should, however, result in a minimum proposed staffing level for UK Neonatal units. Given the size of the deficit identified by 'Getting it right first time' (55) there is a strong case to be made for starting with a minimum recommendation and developing a robust approach to evaluating impact on a national level.

Provisional recommendation

Based on the data obtained within the project and from the national data and best practice evidence reviewed, we would recommend a minimum of 50 minutes (0.22 half day sessions) of qualified Clinical Psychology time per cot, per week - which for a 40-cot unit would equate to 33 hours (or 0.88 wte)². Given Hynan's proposed figure and the feedback from Clinical Psychologists nationally this should be seen as the very minimum required and a means by which local need can be better established and quantified.

The national feedback also suggests that a multidisciplinary mix of psychological professionals works well. Some professionals (often Counsellors or Psychological Wellbeing Practitioners) can focus primarily on therapeutic support for families and others (often Clinical Psychologists) on providing assessment and care planning for those with more complex needs, alongside indirect work via the wider MDT and staff training, supervision and support.

Given the complexity of the work and the likelihood of being the lone psychologist on the unit, these posts should be a Principal Clinical Psychologist role (Band 8a or above). It will be crucial to embed support for any posts within other systems, such as the Maternal Mental Health, Perinatal and Infant Mental Health services, to ensure both effective pathways for families and support (and therefore retention) of staff in what will be clinically and emotionally demanding posts. It may also be beneficial for smaller units to collaborate with these services and / or with each other to facilitate recruitment to part time posts.

Clinical Psychologist and other Psychological Wellbeing posts will also benefit from a robust neonatal leadership and support structure. We would suggest that this may be effectively provided by the Clinical Psychology Network Role proposed within the "Implementing the Recommendations of the Neonatal Critical Care Review" report (56). Given that very few units currently have access to Clinical Psychology, this role should initially focus on developing the workforce model and gradually move to being more focused on clinical leadership and supervision.

²The 50 minutes per cot are not meant to indicate the amount of time per family as this role is likely to involve a significant degree of non patient-facing time. Rather, this is a method of calculation based on the different forms of evidence collected in the report.

9. NEXT STEPS AND PROJECT LEGACY

We are grateful for the energy and commitment of parents and unit staff over the course of this project. It is clear that 'the time is now' – many units are ready for change and well placed to start making it happen.

In terms of project legacy, as well as the ideas generated and conversations started, we are handing over a number of outputs from the work:

Five training presentations:

- "Welcome to peer support" (for veteran parents)
- "Working in partnership with parents" (for unit staff)
- "Understanding the needs of families" (for unit staff)
- "Staff wellbeing" (for unit staff)
- "Understanding the neonatal experience" (for Health Visitors and other MDT members)
- **A map of current provision** in the North West Coast area to help the process of 'joining the dots'.
- Our **"Neonatal Volunteering Toolkit"** resource for staff and parents, outlining the many ways in which veteran parents can volunteer their time in a neonatal context.
- A wealth of **digital resources and materials** for units and peer supporters to use with parents on units.

"All of the presentations etc – they're not going to go anywhere; we've got relationships now and more resources and ideas to take forward" (Unit Manager)

In addition, we are delighted to confirm that the NWNODN will be taking forward our recommendation to establish an **Emotional Wellbeing Special Interest Group** for wellbeing champions to network and share ideas and good practice.

"We have special interest groups for FiCare and feeding but perinatal mental health, family wellbeing is definitely something that should be right up there. This [NFaST] has helped to light some fires in people to think 'what can WE do on our unit?'" (Unit Manager)

And finally, thanks to continued funding from the NWNODN, we will be continuing to recruit, train and support veteran parents to become peer supporters across the North West Region for a further 12-months, through the development of a bespoke **'Neonatal Peer Support Volunteering' training and development programme.**

10. THANKS, AND RECOGNITION

We have been grateful to the support and dedication of so many people during the course of this project, far too many to be able to individually name here.

Our sincere gratitude goes to all the neonatal unit staff, veteran parents, current parents, peer supporters, psychologists, health visitors and other frontline staff who attended our presentations, completed our surveys, answered our interview questions, contributed to our Facebook forums and joined our task and finish group.

We could not have achieved the NFaST project without you, your support has been instrumental in making this overwhelming case for change.

NFaST Project Team

Kirsten Mitchell; Operations Manager, Spoons Charity

Dr Ruth Butterworth; Clinical Psychologist

Kaisu Fagan; NFaST Project Manager



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APPENDICES

Appendix 1: Data collection methods

Surveys

Surveys were conducted with three groups; past parents, current or recent parents and neonatal staff.

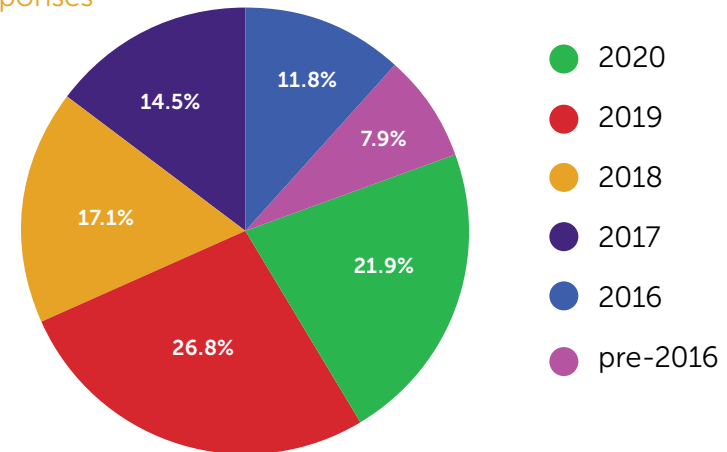
Parents

Parents were approached via existing social media support groups across the region. 238 completed our broadest survey looking at the experiences and needs of neonatal families who have been discharged from a neonatal unit over the last 5 years. Of those who provided this information:

- 94% were mums that had carried the baby (rather than dads or partners).
- The spread of births over the five-year period was reasonably even, as was the time spent on the unit.
- 70% of respondents were aged 30-40, 94.7% described themselves as White British and 95% as heterosexual.
- The majority of parents were living with a partner (60.5%) or married (36.8%) when they had their baby and over 60% had been educated to undergraduate degree level or higher.
- While the demographics of respondents within these results are not unusual for a survey of this type, it does mean we need to employ caution when making generalisations.

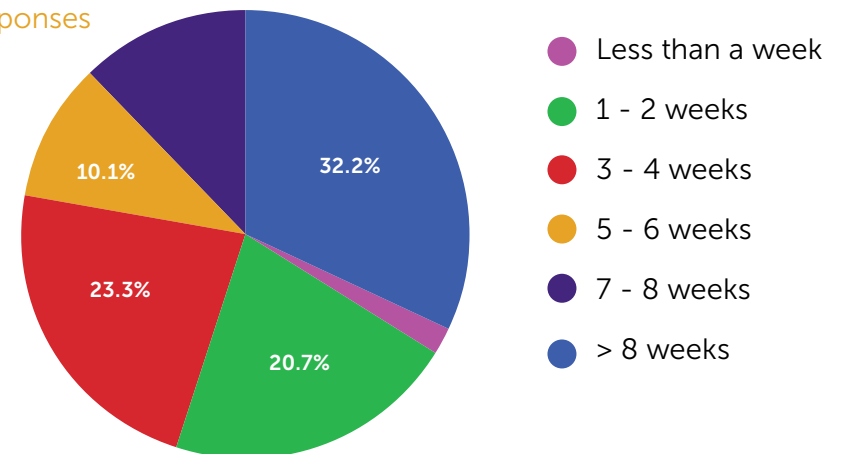
In what year was your baby in neonatal care?

228 responses



How long did you baby spend in neonatal care?

227 responses



Survey respondents were asked to rate their experiences on a measure designed to 'take the temperature' of emotional wellbeing on the unit, as well as asked qualitatively about their experiences. The latter data were thematically analysed.

Staff

Three different surveys were completed by staff – a general survey aimed at staff on all of the regional units (102 members of staff) and surveys specifically looking at the hopes for, and experiences of having had a clinical psychologist based on the unit (129 members of staff). 69.8% of respondents were nurses and 9.5% doctors, with a range of other practitioners making up the remaining 20%.

Staff were asked to ‘take the temperature’ of emotional wellbeing on the unit (using the same measure as parents) and then comment qualitatively on both the experiences of parents and of themselves as staff.

Facebook group

A Facebook group was established involving parents who were either currently on the unit with their baby or who had recently been discharged.

- Flyers were distributed via all of the units in the region with a QR code inviting parents to join the group
- 28 Parents engaged with the group and were involved in weekly facilitated discussions exploring a theme related to their experience of neonatal care
- Weekly surveys were completed to further explore these experiences

Parent focus group

Towards the end of the data collection period, a focus group of parents was held to hear their stories and to allow us to share some themes from our other data sources, exploring whether these felt representative and thereby adding to the strength of the data.

Interviews with dads

As only 5% of our survey respondents were dads or partners, interviews with three of these dads were completed to gather richer data about their experiences and whether these were similar or different to their partners’. Key themes were extracted to complement the survey data.

Interview with a Consultant Neonatologist

As only 9.5% of our survey respondents were doctors, we offered the opportunity to be interviewed to ensure that our learning represented the perspectives of this group. Two Consultant Neonatologists responded but only one was ultimately available for interview.

Interviews with unit leads

Unit Leads had the best overview of the NFaST project within their setting. To gain a broader sense of the learning achieved, we interviewed three managers and one FiCare lead at the conclusion of the project.

Action research with clinical psychologists placed on units

In addition to exploring the role of a clinical psychologist within neonatal care, having our psychologists placed on units was an invaluable source of data collection. They were able to connect with staff and parents informally and hear their stories, collecting rich data about the ways in which unit life was a source of struggle and what helped to mitigate this. The clinical psychologists completed a survey each week documenting their learning in relation to the experiences of parents and babies, staff members’ perceptions of their own and families’ needs, and the psychologists own reflections on what was working well and where the challenges lay. At the end of the project the psychologists were also engaged in a focus group to reflect on their learning. All of these reflections were then thematically analysed.

Benchmarking – national neonatal clinical psychology offer

We contributed to a national benchmarking process via the ‘Neonatal Clinical Psychologists’ WhatsApp group, collecting data around how units’ psychosocial needs are met in other regions.

Appendix 2: Feedback from veteran parents “Welcome to Peer Support” session

Examples of aims for the session:

- “To better understand the role of peer support and how to do it”
- “To decide if peer supporting is suitable for myself”
- “An overview of what peer support can do for those receiving and guidance on how to achieve this”

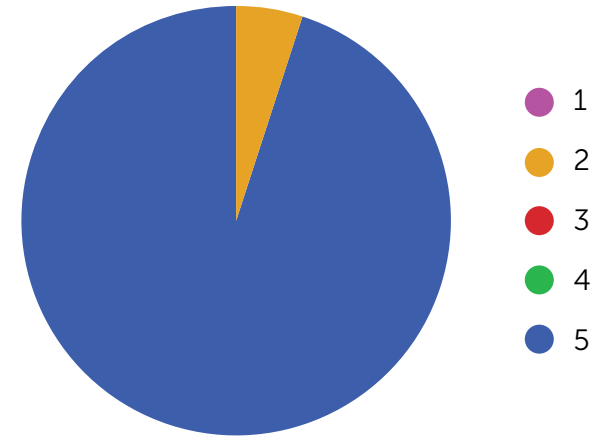
The feedback was overwhelmingly positive with reported strengths of the session including:

“Clear and concise information, delivered with clear presentation slides. Friendly and warm hosts who were supportive and inclusive of everyone in the group. Opportunity and encouragement for everyone to be involved without being pushy or forcing anyone to contribute who didn’t want to or feel able to.”

“Friendly, open, approachable and supportive setting.”

“The training was clear, informative and well presented. I learnt a lot of things that I may not of thought about previously... I thought it was very friendly and has made me excited to explore what’s to come. Each section was broken down in to clear messages and I’ve come away knowing what will be expected of me.”

To what extent did the training meet this need?

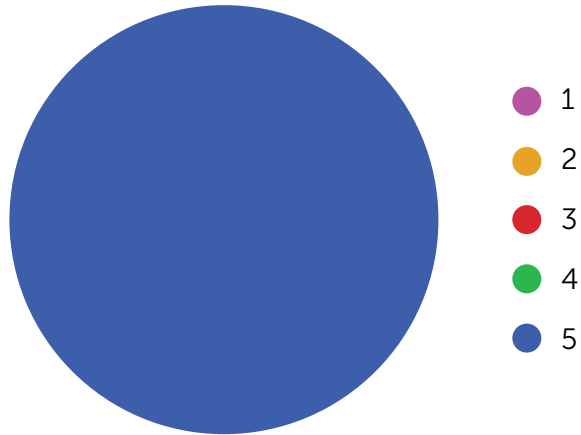


Where there were areas to improve upon, these mostly related to a desire for follow-up training on specific skills.

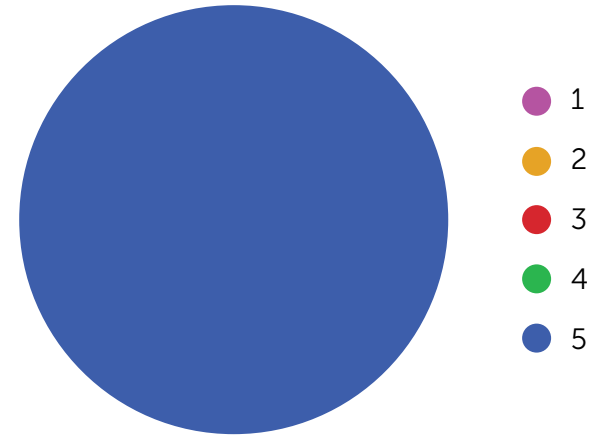
“Role play scenarios as to how to deal with difficult conversations”

“It would be great to have formal peer supporter training lined up ready on offer for people who know which neonatal unit/community they want to support and are in a position to move forward with this - this was an excellent information session to provide interested parents with the information they need to be fully informed of what peer support is (and is not) and the space to evaluate whether this is something that they wish to pursue - but a follow up course of more practical skills based sessions to prepare and train future peer supporters in good quality active listening skills etc would be a fantastic next step to keep the momentum started by this fantastic first session moving.”

The quality of the information provided



Method of delivery



There was a lot of enthusiasm for taking the learning forward:

"I will join the NFaST Facebook group and continue to build links with other volunteers."

"I actually thought about this last night, it stuck with me that this isn't about telling our story it's about listening to others and supporting them in what they might want to talk about, I think I will take that into day-to-day life. It's easy with friends who have babies to say 'oh with [baby] he did this....' and I think I'm really going to just let others lead the conversation and realise I don't have to give my personal advice each time."

"Thank you so much for such an informative and inspirational session."



Appendix 3: Feedback from staff “Working in Partnership with Parents” session

Examples of aims for the session:

- “To gain an insight into how to engage with parents to improve partnerships with in the NNU environment”
- “Understanding the scope of working with parents”
- “To learn how we can better support parents through their neonatal journey”

Again, the feedback was very positive, with particular strengths including:

“Really informative and gave me lots of ideas which I hadn’t thought of”

“Good points across on the power point and good to get a sense of what’s happening in other units.”

“The opportunity to hear others thoughts, ideas who work in different NNU’s. The delivery from the speakers who managed to encourage participants to engage (not an easy task over Microsoft teams)”

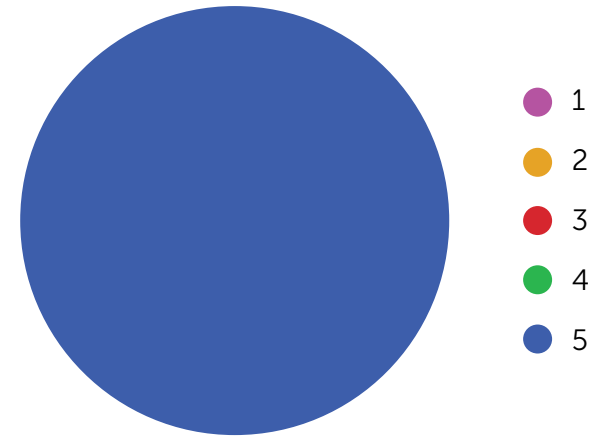
“First-hand experience, enthusiasm, knowledge and credibility.”

There were few areas of improvement, beyond the limitations of remote learning!

“Face to Face training when covid restrictions allows! (Only due to technical problems)”

“Maybe more examples of where working in partnership with parents has worked well in different units.”

To what extent did the training meet this need?



The staff in attendance were keen to take the learning back to their units to influence the way they work with veteran parents.

“NFaST mental health training starts in [unit] tomorrow, peer support will link in well with this and I’m excited to get to know the parents in our area who can offer support in [unit]. Thank you.”

“I will share the training with other staff and ensure we continue to work in a culture that encourages working relationships between staff and parents ensuring any changes in practice/projects involve a parent perspective.”

“This training will help with the implementation of a peer support network on the unit so we can get volunteer parents to support current parents. Hopefully I can also pass this new knowledge on to other members of the team”

Appendix 4: Feedback from staff “Emotionally Healthy Units” session

Examples of aims for the session:

- “A better understanding how we can better support parents and develop secure attachments”
- “Awareness of the feelings of families and how they can be better supported in the neonatal environment”
- “Knowledge and skills to support families emotionally”

Feedback was very positive, with reported strengths including:

“Reflecting on my own feelings/stress, as well as the parents.”

“Very clear explanation and lots of good examples.”

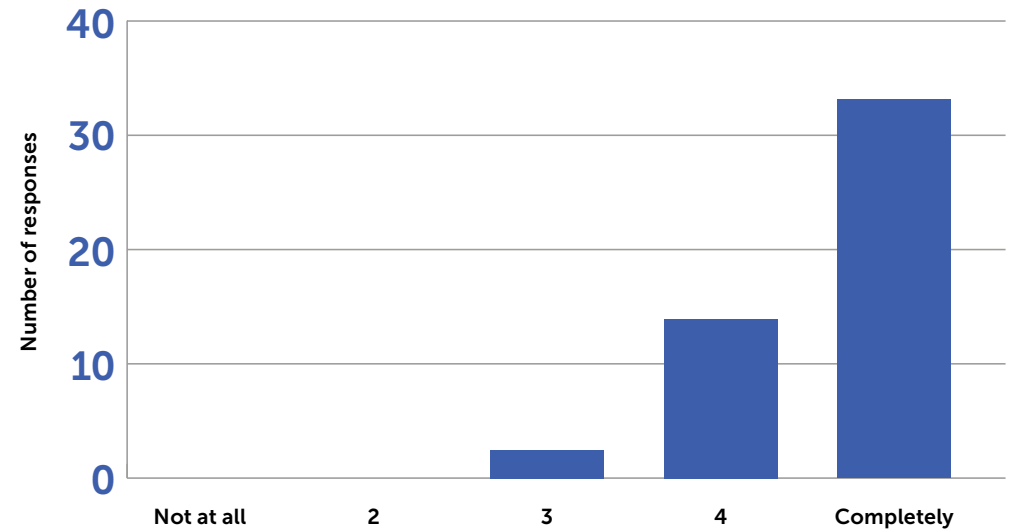
“The breakdown of the emotional aspects of new parents on the nicu”

In general, the areas to improve focused on wanting more time and additional information, e.g.:

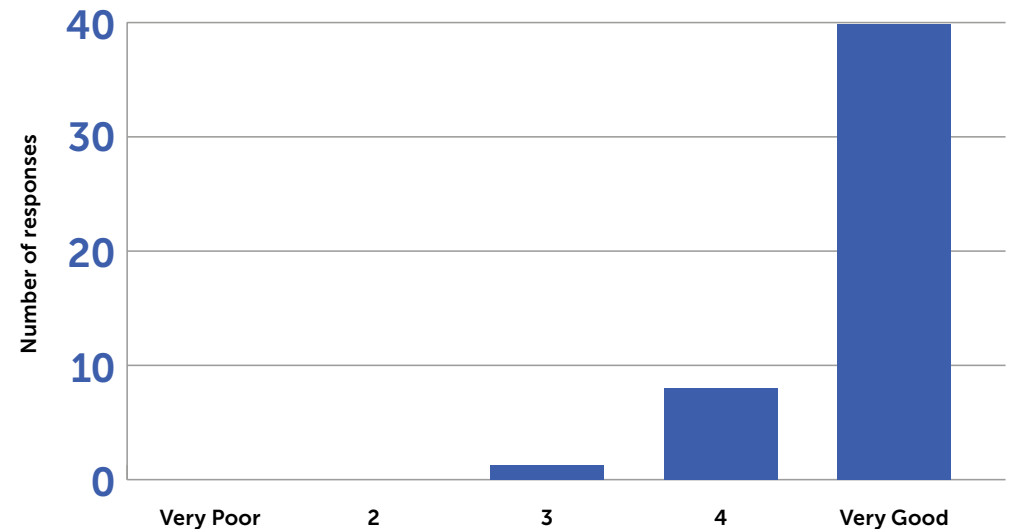
“More time ideally to develop and continue conversations”

“More on strategies to help parents.”

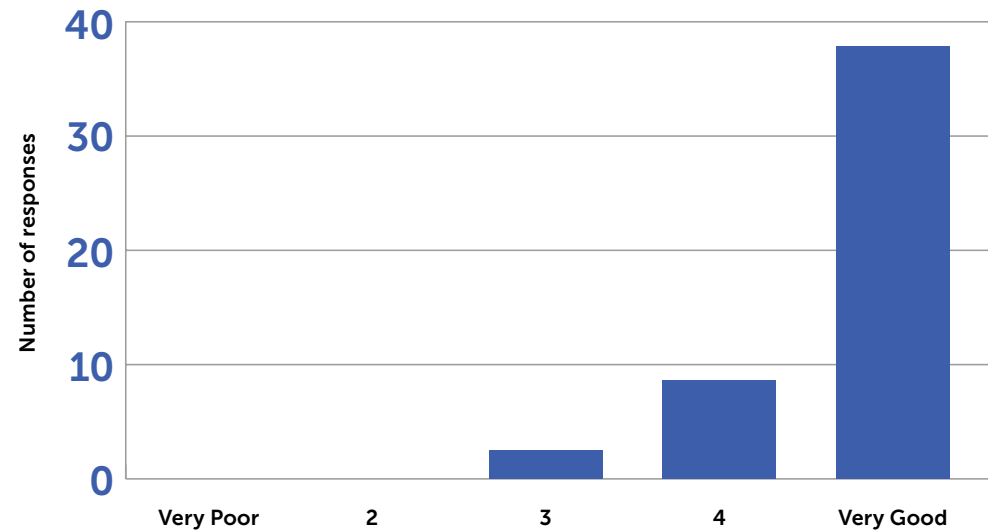
To what extent did the training meet this need?



Quality of information presented



Method of delivery



For those attending the sessions online, there seemed to be a relatively even mix of those preferring the flexibility of online training and those reporting that they would have preferred to have the session in person.

When asked how the training would influence practice there were again some strong themes that emerged:

“Making time to listen and (observe)”

“Give parents the opportunity to talk, and to try to follow up.”

“I feel I have a better/different awareness for how parents feel and more confident to approach difficult subjects.”

“Will hopefully allow me to think about the parent journey and the traumatic event that they are dealing with”

“It has given me a greater awareness of the feelings and emotions families face and the potential barriers. Understanding why reactions influence engagement and what can help improve this. I feel more confident in supporting families on the unit”



Appendix 5: Feedback from staff “Staff Wellbeing” session

Examples of aims for the session:

“Methods to improve staff stress levels and communication between staff”

“How to support colleagues mentally during an acute situation of stress”

“Awareness of own wellbeing and useful tools to support the team.”

The reported strengths of the session included:

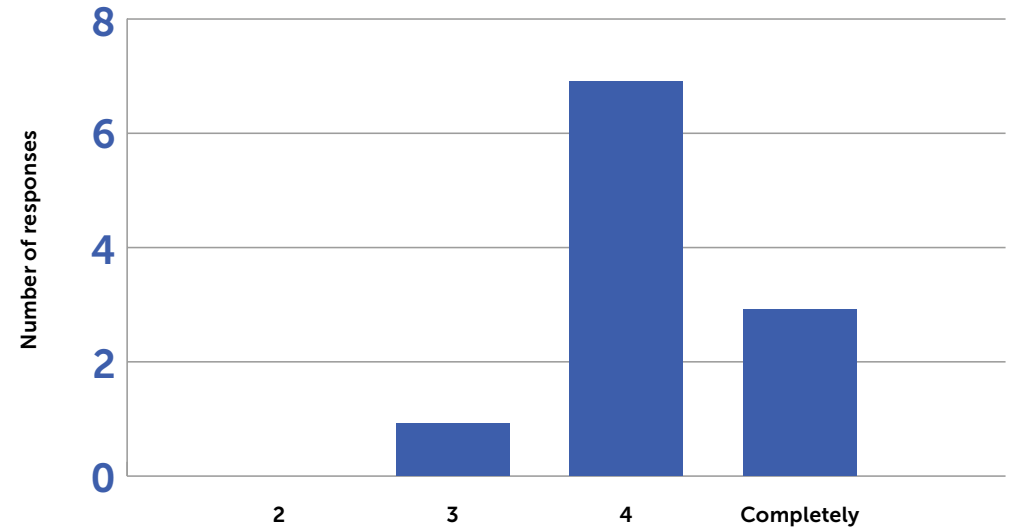
“The group chat was really good. [psychologist]’s slides were fab for describing why people behave/feel the way they do”

“I felt it was a safe space to speak openly”

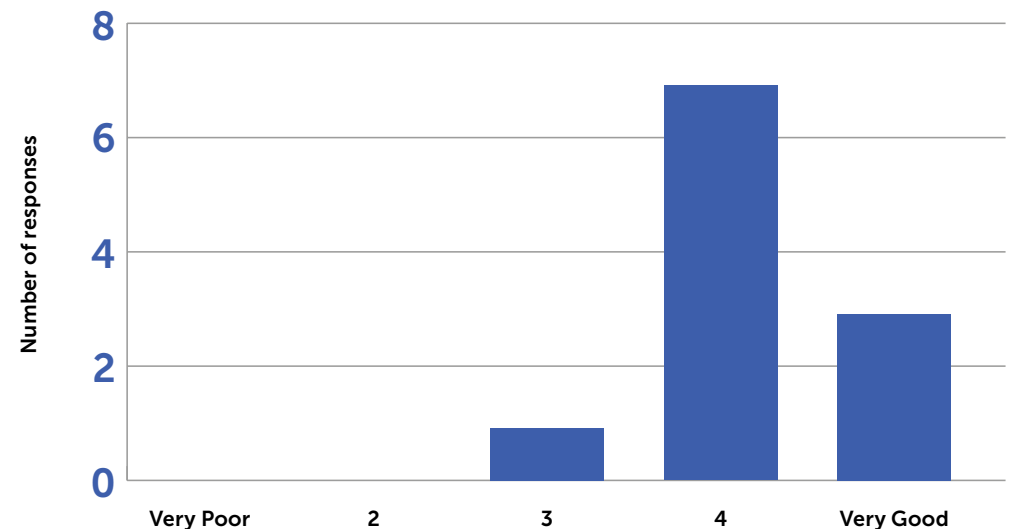
“Very informative, good delivery of information, knowledgeable trainer”

Again, the areas for improvement largely focused on practicalities, including having longer to share experiences and having more people attending, including medical staff. All those who commented would have preferred this session to be face to face rather than online.

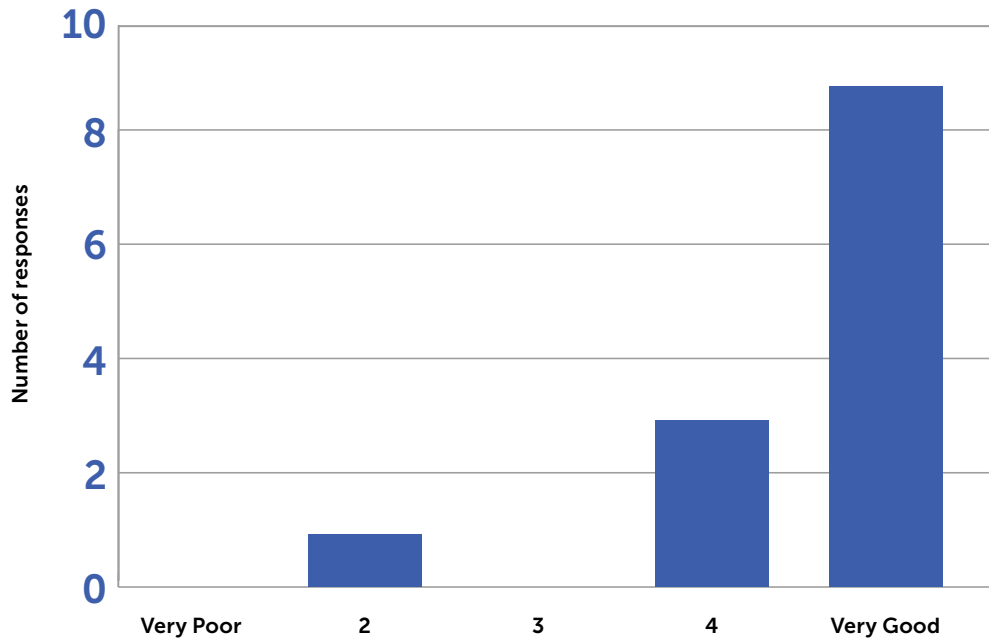
To what extent did the training meet this need?



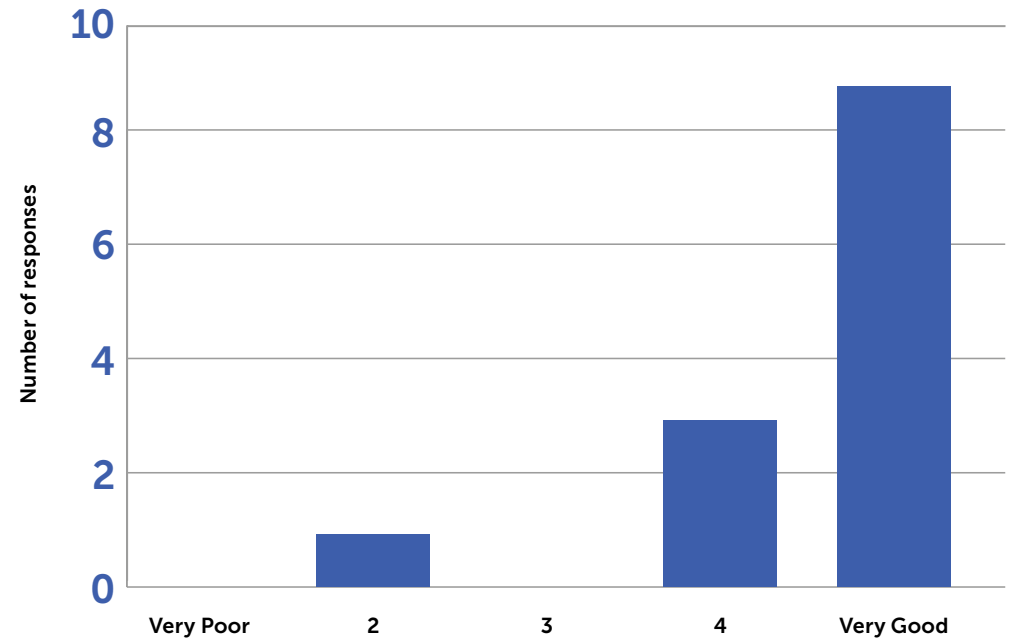
Quality of information presented



Quality of information presented



Method of delivery



In terms of how this training was expected to translate into practice, these included:

“More mindful of others, handling stress better, try to switch off more at home”

“To think of your own self-care as this will impact on the care you deliver”

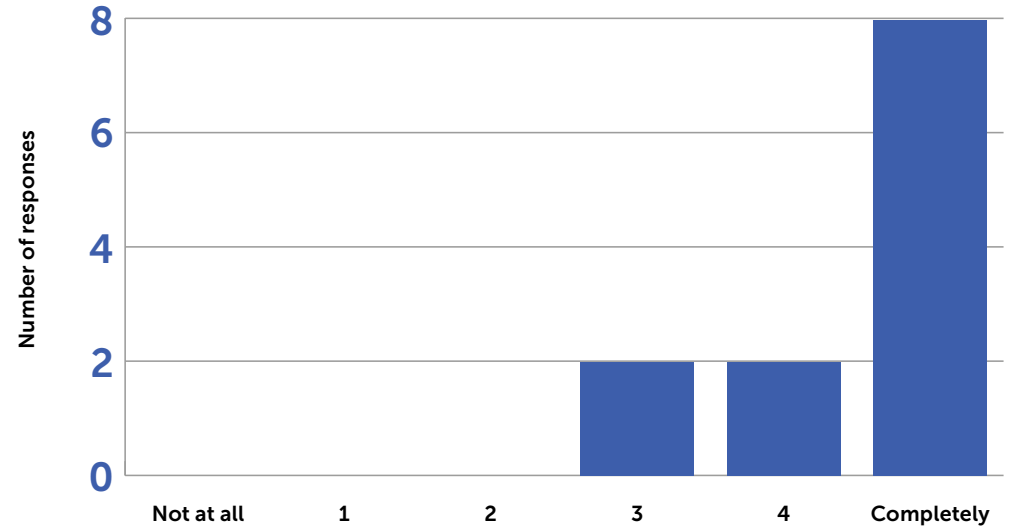


Appendix 6: Feedback from staff “Consultation and Reflective Practice” session

Examples of aims for the session:

- “Discussing difficult situations on the unit”
- “Never been involved in sessions like this before so wanted to experience it. I found it to be useful and something I would like to continue”
- “Air views in a safe space and feel supported”

To what extent did the discussion meet this need?



Staff reported a number of helpful things about the meetings, including:

“Able to address feelings and realise others feel the same.”

“We discussed different ways of communicating with challenging parents in the form of curious questioning”.

“[Psychologist] was very knowledgeable whilst also allowing us to have a great input into the session, leading and building upon what we discussed.”

The only improvements they could identify were for more frequent sessions and for more staff to be involved.

All staff identified ways in which the session would influence their practice, including:

“Going to implement changes in practice - videos/live streams for parents to answer any questions/concerns.”

“It will make me think more of why the parents are negative or noncompliant with necessary medications/treatments for their baby. I feel using curious questioning will help identify this.”

“Have been given tools to deal with difficult situations.”



Creating emotionally healthy neonatal units

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