

# UNICEF UK BABY FRIENDLY INITIATIVE INFANT FEEDING SURVEY 2022



December 2022

## OVERVIEW

### Aims and background

This paper summarises findings from a survey distributed by the UK Committee for UNICEF (UNICEF UK) Baby Friendly Initiative in February 2022 via the National Infant Feeding Network (NIFN) ( $n=161$  infant feeding specialists). Findings explore practice in infant feeding across UK maternity, neonatal, health visiting, children's centre and university settings, and highlight the successes and challenges experienced by NIFN members in implementing the Baby Friendly standards. Results offer valuable insight into current practice and the application of NIFN across the UK, and illuminate the strength of NIFN as a support mechanism for infant feeding leads to:

- share evidence-based information around infant feeding and very early childhood development
- facilitate effective communication across regional networks
- provide practical and emotional support
- share Baby Friendly news and updates.

**It is hoped that the findings from this paper will lay the foundation for strengthening the National Infant Feeding Network (NIFN) as a support mechanism to positively influence local, regional and national infant feeding policy in the UK in order to ensure optimum health and wellbeing outcomes for all babies, their mothers and families.**

### About The National Infant Feeding Network

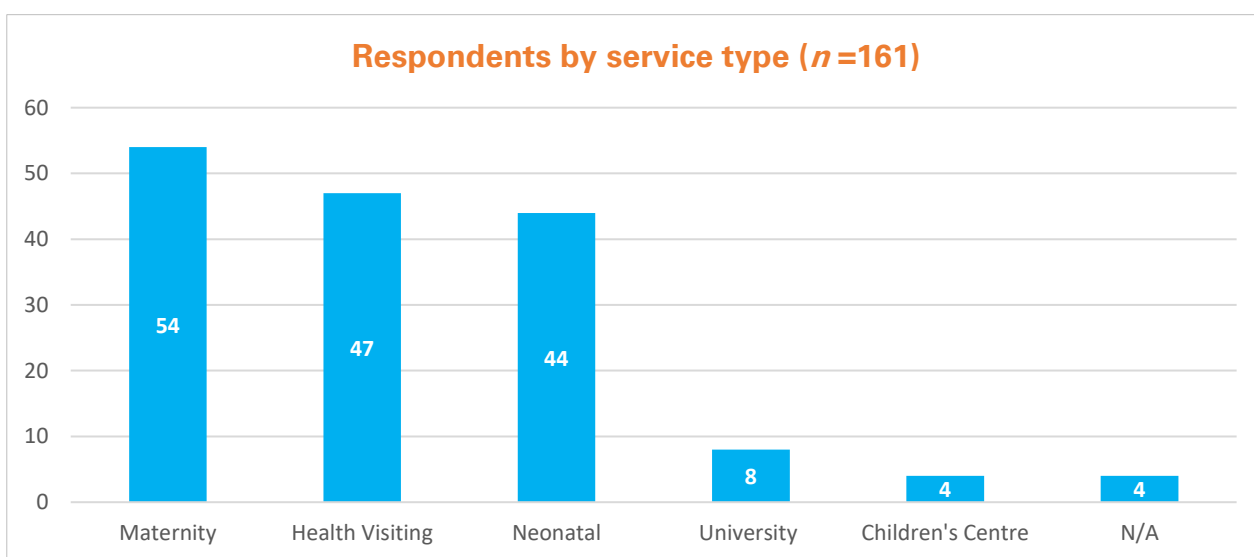
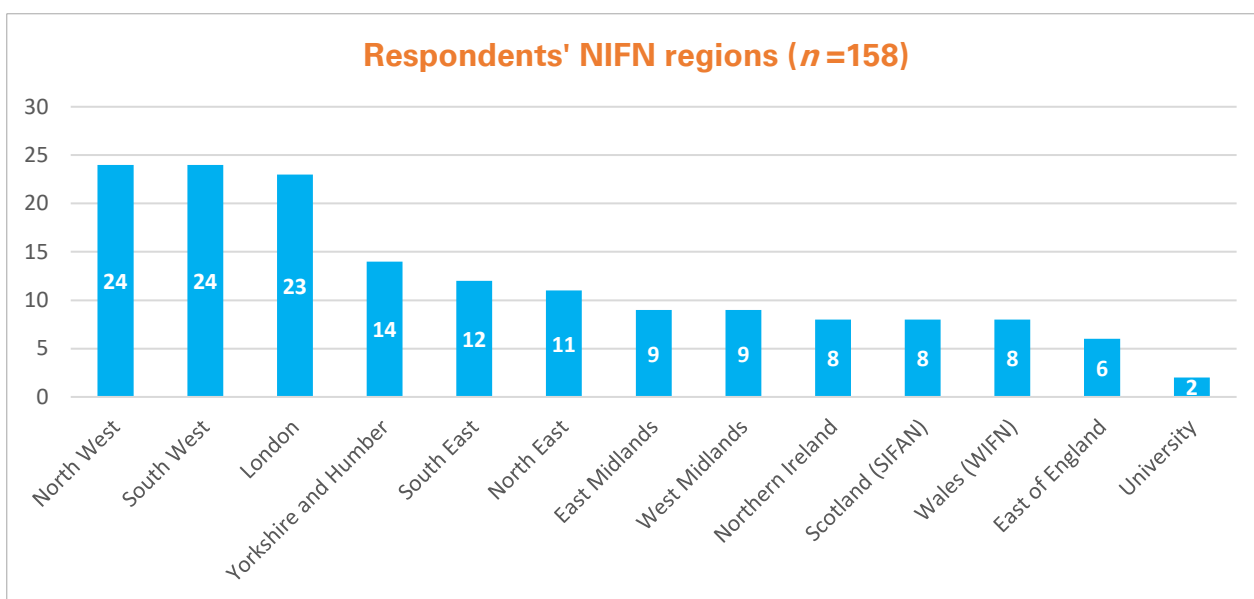
The National Infant Feeding Network (NIFN)<sup>1</sup> is a network of around 800 infant feeding specialists and academics responsible for the support and education of health professionals and students across the UK who in turn are responsible for caring for babies, mothers and their families every year. Supported by UNICEF UK, the network shares and promotes evidence-based practice around infant feeding and very early childhood development in order to deliver optimum health and wellbeing outcomes for babies, their mothers and families. Network communication is facilitated by local leads who provide representation of their members' views at a national, strategic level. Learn more: [unicef.org.uk/bf-nifn](https://unicef.org.uk/bf-nifn)

*N.B. A total of 161 people responded to the survey out of an approximate 800 NIFN members, giving around a 20% response rate. This is considered typical for an online survey. Self-selected sample bias limits scope of some of the findings, which may not be reflective of the entire population.*

<sup>1</sup> NIFN includes nine regional groups in England; the Scottish Infant Feeding Network (SIFAN); the Welsh Infant Feeding Network (WIFN); Neonatal NIFN and University NIFN.

## Representation: Ethnicity, regions and service types

Survey feedback was captured from all NIFN regions and service types, with a higher response rate identified in the North West, South West and London areas and across maternity, health visiting and neonatal settings. Nearly all respondents (97%) work in a setting currently implementing Baby Friendly, with a further half (53%) currently engaged in a Baby Friendly project such as the NHS Long Term Plan or the National Neonatal Project. Most respondents completing the survey (96%) described themselves as 'White' and just 1% described themselves as 'Black' or 'Black British', indicating a significant underrepresentation of Black and Black British and Minority Ethnic staff completing this survey. We therefore intend to undertake further analysis of this issue to explore how we can ensure that access to these roles becomes more inclusive.



## Professional background and length of time in current role

Respondents were asked to provide details on their experience and professional background:

- 17% of respondents had been in their role for less than one year
- 13% had been in their role for 1-2 years
- 23% had been in their role for 3-5 years
- 47% had been in their role for 6+ years
- The majority of respondents indicated that their Band type was 6 (24%) or 7 (67%).

Results reflect a range of professional backgrounds, including in midwifery (55%), as a neonatal nurse (31%) or health visitor (26%). In addition:

- A significant proportion of **health visitors** also described themselves as midwives (46%), lactation consultants (24%) and having experience in public health (24%)
- Some **neonatal nurses** indicated that they had experience as midwives (22%), lactation consultants (16%) and health visitors (10%)
- A proportion of **midwives** shared experience as lactation consultants (36%), health visitors (21%), neonatal nurses (13%) or university lecturers (10%).

## THE JOURNEY TO BECOMING AN INFANT FEEDING LEAD

**Key drivers:** We were interested in understanding more about individual journeys and drivers to becoming an infant feeding lead. Analysis of qualitative feedback reflected four major categories: passion for the role and for Baby Friendly, lived experience as parents, and career opportunities:

### 1. Passion for the role:

*"I had a passion to support breastfeeding mothers in my area; **nobody else was doing it.**"*

*"I **developed a passion for feeding support.** I was a registered nurse on the neonatal unit and the opportunity arose. I am now the Baby Friendly Lead working towards Stage 3."*

### 2. Passion for Baby Friendly:

*"I love breastfeeding and **believe implementation of Baby Friendly will bring cultural change.**"*

*"I learnt about Baby Friendly from a fellow student...and **never looked back.**"*

### 3. Lived experience as parents:

*"I had two infants with tongue tie and **there was very little knowledge or support at that time.**"*

*"**My experience feeding** three kids and **poor support on neonatal units** for mums."*

### 4. Career opportunity:

*"Opportunity for **career development.**"*

*"The opportunity came up to **merge my passion in the community with my career.**"*

**Key barriers:** Around 42% of respondents indicated that they had faced barriers in becoming an infant feeding lead. These broadly related to cultural, resource and educational factors:

### 1. Cultural barriers:

*"I am working to change the **predominantly bottle feeding culture** in staff/service users."*

*"**Cultural issues with longstanding practices.**"*

### 2. Resource barriers:

*"Initially, funding for training was problematic; **now the fight is getting protected hours.**"*

*"It is difficult to **maintain the role/meet standards** in the current climate with **staff shortages.**"*

### 3. Educational barriers:

*"A non-clinical background was previously a barrier; now I **feel it's a valuable skill mix in my area.**"*

*"My role was required to be NMC registered until the **IBCLC qualification** was a recognised alternative."*

## Training and qualifications

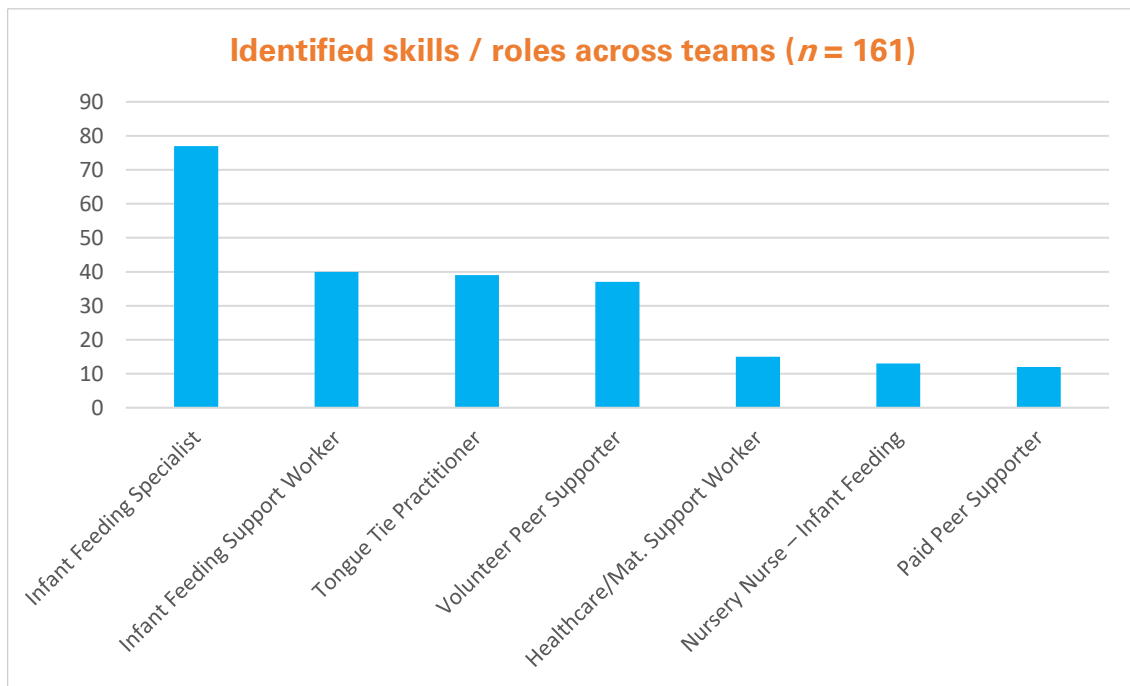
Over half of respondents held a formal infant feeding qualification. This varied significantly across different professional groups. For example, 41% of health visitors and midwives held an IBCLC (International Board of Lactation Consultant) qualification, compared to 16% of neonatal nurses. Additionally, 14% of health visitors, 13% of neonatal nurses and 6% of midwives held a UNICEF UK Baby Friendly Initiative [Qualifications Framework Programme](#) qualification.

Around 27% of health visitors, 39% of midwives and 60% in neonatal units indicated that they did not hold an infant feeding qualification, with some citing funding as a barrier. However, around 60% indicated that they planned to undertake a qualification – around 30% plan to undertake the Baby Friendly Leader qualification and a further 30% plan to undertake the IBCLC.

## WHAT DO INFANT FEEDING TEAMS LOOK LIKE ACROSS THE UK?

### Roles and skills across service types

To paint a more detailed picture of what infant feeding teams look like across the UK, respondents were asked a range of questions related to skills mix of infant feeding teams and proportion of time allocated to their infant feeding role. Most respondents (77%) shared that they had an infant feeding specialist on their team, with 40% specifying an infant feeding support worker. Additionally, 39% had a tongue tie specialist and 12% of respondents had paid peer support workers.



*“Tongue-tie services are delivered by the max fax team. **All staff are trained and deliver infant feeding within their role, but they aren’t feeding-specific (e.g. MSW / nursery nurses).**”*

There was considerable variation in skills mix in different teams. Health visiting services commonly reported a team that included a range of infant feeding roles such as infant feeding coordinators, specialist practitioners, paid peer supporters and breastfeeding counsellors. Maternity services were more likely to have one or two infant feeding clinical advisors, midwives or assistants. Neonatal settings typically reported a much smaller staff team which included an infant feeding specialist.

### Proportion of time allocated for infant feeding

We were interested in understanding how much time was allocated to infant feeding in respondents’ various roles:

- **33% worked full time** in an infant feeding role, and this varied for different services. For example, 46% of maternity, 39% health visiting and 13% in neonatal settings indicated that they worked full time on this role. This increased to 45% for those working in Baby Friendly accredited or re-accredited services.
- **53% spent at least half their time** undertaking this role.
- **10% had no time allocated** and were fulfilling this role voluntarily or when timing allowed.

*“Our service has a **full time Baby Friendly project lead, plus two breastfeeding volunteers** at three hours per week each.”*

*“I am a health visitor and **I do what I can** within that role to lead on infant feeding, **but I have no protected hours and no team around me.**”*

Whilst a significant proportion of infant feeding leads (46%) had been in their role for more than six years, there is a relatively high role turnover, with 29% undertaking the role for two or less years.

## Sources of motivation and frustration

We were interested in understanding more about sources of motivation, support, frustration and challenges for infant feeding leads, as well as the impact of Covid-19 on service provision. Respondents consistently ranked other infant feeding leads, line management and staff they manage as key sources of support in their role. The table below includes a summary of quantitative responses to questions linked to support. We can see that 58% of respondents felt supported by colleagues, 60% felt supported by staff, and 57% felt that the culture in their service values Baby Friendly.

When asked to describe their role in one word, many used descriptors such as 'struggling', 'challenged', 'overwhelmed' and 'undervalued'. Whilst many infant feeding leads reflected positive feelings such as 'passionate' and 'excited', they also felt 'stretched' and 'deflated'.



Analysis of qualitative feedback combined with quantitative data suggests high levels of career satisfaction and opportunities to influence culture and practice to create long-lasting, positive change:

*"I am motivated and inspired by **infant feeding leads, UNICEF UK and NIFN groups**. I'm passionate about making a difference for women, their families and their journeys."*

*"I was extremely supported by senior leadership. Key elements in overcoming challenges were **attendance at University NIFN and staff undertaking training/working towards accreditation**."*

*"Support from being in the **NHS Long Term Plan and Baby Friendly**. Our organisation's **culture of UNICEF UK Baby Friendly Achieving Sustainability Gold is so well embedded in curriculum**."*

When identifying sources of frustration and challenges, respondents consistently cited factors such as Covid-19, organisational priorities and staff capacity. Just 14% of neonatal staff felt that they had adequate capacity and could do their job well, with 81% indicating that reduced staff capacity had made their job difficult. This increased to 88% for those in maternity services.

*"There is a massive bottle feeding culture; **just as we seem to be getting somewhere, there is an influx of new medical staff with the old ideas**. In a big hospital, teams don't know each other."*

*"I want to get the service back to what I know it can be and what families need it to be – better than before. I wish **Baby Friendly Achieving Sustainability had come along earlier in the Trust's journey**."*

*"We have a **good basis for the UNICEF UK Baby Friendly Initiative standards in terms of culture, but a shift is still needed**."*

| Sources of frustration and challenges  |          |
|--|----------|
| Statement  | % agreed |
| I feel my team has adequate capacity   | 20%      |
| I feel I have adequate capacity to do my job well  | 26%      |
| Reduced staff capacity across the service has made my role difficult                                   | 75%      |
| I am often asked to support other parts of the service which takes me away from my infant feeding role | 44%      |
| Changes due to Covid-19 across my service have made my role difficult                                  | 55%      |
| I feel supported by colleagues   | 58%      |
| I feel supported by staff  | 60%      |
| The culture in my unit/service values Baby Friendly  | 57%      |

## The impact of Covid-19 on job roles and service provision

Analysis of qualitative feedback relating to the impact of Covid-19 on infant feeding provides comparative detail across three main categories: staff shortages/redeployment, service delivery and priority given to infant feeding and implementation of Baby Friendly. Findings reinforce results from the [2020-21 UNICEF UK Baby Friendly Initiative Covid-19 infant feeding surveys](#) which explored the impact of the pandemic on job roles, service provision and innovations gained from hybrid working.

### 1. Staff shortages and redeployment:

*“Low staffing levels and staff sick with Covid-19 led to reduced support for the postnatal ward, meaning **families were discharged home with poor feeding support.**”*

*“Not feeling able to support them and not able to work alongside in clinic to embed skills (especially new starters) has led to **long-term impact on staff morale and keeping them motivated.**”*

*“The number of mums with gestational diabetes and high blood pressure has massively increased and **there is a larger population with more health issues.**”*

### 2. Changes to service delivery:

*“**Our population value face-to-face.** They did not engage in virtual classes.”*

*“**Cessation of groups, technology difficulties for clients and Zoom fatigue.**”*

*“**Less opportunity for antenatal education** and less opportunity to work with parents. **Phone calls don't teach skills as well as direct care**”*

### 3. Priority given to infant feeding and implementation of Baby Friendly:

*“Staff shortages have made infant feeding less prioritised. This has been **allowed to become the norm.**”*

*“Midwives were redeployed, so I had to pick up the work. **Baby Friendly was left behind.**”*

*“**Staff are so stretched and infant feeding seems to have been de-prioritised.** Staff with dedicated Baby Friendly hours were pulled. Shortages impacted on Baby Friendly implementation.”*

Feedback also highlighted lessons learnt from the pandemic which continue to contribute to innovations across services. These mainly relate to digital transformation and time management:

### Lessons learnt and innovations implemented:

*“Home working has given me **more time to focus on strategic work and service developments.**”*

*“Using a video call platform works well in rural areas. Online staff training has worked well and is easier than booking venues. Online practical skills training allows for **more individual training than would've occurred.** Less travel also increases efficiency.”*



# THE IMPACT OF THE NATIONAL INFANT FEEDING NETWORK (NIFN)

## The value of participating in NIFN

Feedback on the value of NIFN was overwhelmingly positive. Around 90% of respondents indicated feeling supported by their organisation to attend meetings, with 82% having joined at least one meeting in the last year. Respondents highlighted the motivation, shared sense of purpose and tangible support gained, e.g. professional guidance from accurate sources, signposting to updates, and support with Baby Friendly accreditation. Two respondents commented on the “*sense of shared endeavour!*” and “*a community who just get it!*”

Around half of respondents said that cessation of NIFN meetings would somewhat or significantly impact their local infant feeding strategy, implementation of Baby Friendly, and/or their mental and emotional wellbeing.

*“I rely on this network – otherwise I am working alone!”*

*“I would manage without meetings, but I find them extremely useful and would be disappointed if they stopped.”*

### Feedback on the value of NIFN:

- 92% agreed that it enabled them to share **ideas and learning with colleagues**
- 89% agreed it provided **opportunities for networking**
- 85% agreed it provided opportunities to **hear Baby Friendly updates**
- 82% agreed it enabled them to **connect with like-minded colleagues**
- 80% agreed it enabled them to gain wider **awareness of infant feeding current issues**
- 79% agreed it enabled them to feel **motivated to continue in their role**
- 76% agreed it **stopped them feeling alone**
- 75% agreed that it **provided peer support**
- 65% agreed it helped with planning for **Baby Friendly assessment**
- 53% agreed it helped with their role of **becoming an infant feeding lead**
- On a scale of 1-10, respondents rated an 8/10 on the extent to which NIFN **benefits their role.**

Qualitative comments expanded upon the benefits derived from participation in NIFN:

### The benefits of NIFN:

*“The range of experience is something you won’t find anywhere else. Without NIFN, infant feeding leads (especially new in post) would miss out on access to a wealth of experience and support.”*

*“NIFN meetings are **the best meetings I have been to on infant feeding.**”*

*“NIFN is needed to not feel isolated – it’s a safe space and **reassuring to have these in my diary.**”*

*“A depth of expertise, knowledge and understanding from truly informed colleagues. Friends and allies who understand the importance of supporting relationship building and breastfeeding **in pursuit of developing a loving and caring society, and a better world for children and their families.**”*

*“This role is very isolating and infant feeding uniquely can generate a lot of negativities which can knock your confidence. **The peer support and approaches to problems is incredibly helpful.**”*

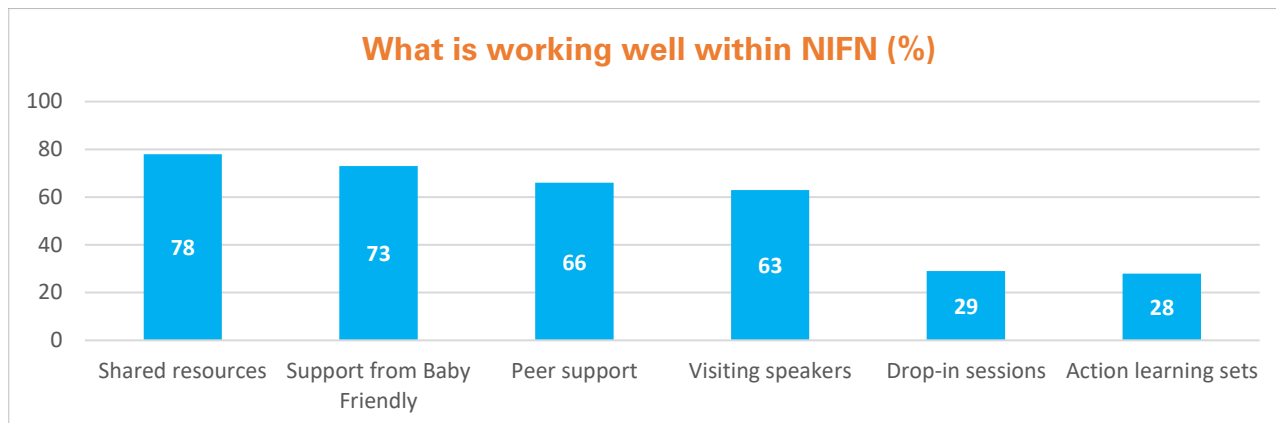
*“NIFN gives me the **strength to persevere and the confidence to speak up for the hours I need.**”*

*“Like-minded people with similar insights. **I don’t have to explain myself at a NIFN meeting.**”*

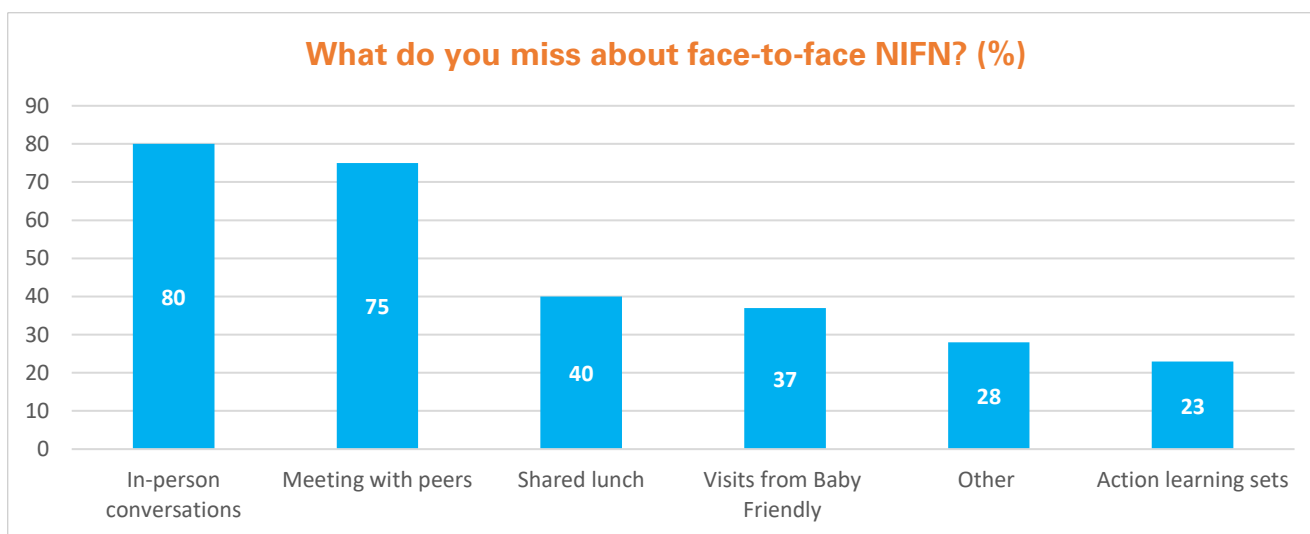


## The future of NIFN: What works well and overcoming challenges

To understand the growing needs of NIFN, we asked infant feeding leads what currently works well within the network. Responses highlight the value of shared resources, the UNICEF UK Baby Friendly Initiative, peer support and talks from visiting speakers.



Preferences on online vs face-to-face NIFN remained heavily polarised. Respondents identified a range of benefits of a virtual format, including accessibility and convenience, cost and time savings, and reduced impact on the environment due to cessation of travel. However, many expressed a desire to return to in-person, pointing out challenges such as a lack of networking, impersonal social connection, reduced participation, fatigue and technical difficulties. One respondent shared that they had been pulled from a virtual NIFN meeting and redeployed elsewhere on the unit due to staffing shortages, and that this could have been avoided had the meeting occurred off-site and in-person.



*“Online is great, but **face-to-face is more valuable for networking, wellbeing and sharing ideas.** Perhaps we could move to alternating which would then **make it accessible to all.**”*

*“Discussions are easier in-person, plus opportunities to meet & build support networks. With virtual you are **tempted to carry on with emails/work** if busy and miss some of the session.”*

*“It is **more convenient not to travel long distances.** There were longstanding colleagues who had become friends...but many have now retired. **Now I wouldn't feel motivated to travel to a NIFN group.**”*

*“There's **no excitement or buzz** of being in the room with like-minded people. No spontaneous interaction, getting to know people...or **ease of conversation.**”*

*“I wouldn't like to travel to **London and back in one day.** I can't see it being sanctioned. Who would pay for travel?”  
“I hear better on Teams than in a big room. For me it is a no-brainer. **Virtual all the way.**”*

*“**Unable to talk informally,** not so easy to develop relationships that would be beneficial. I don't get a break from office work, and **I miss face-to-face discussions.**”*

## Strengthening NIFN's voice

To gauge the strengths and weaknesses of NIFN, infant feeding leads were asked in what areas they thought NIFN held a strategic voice. Around half of respondents thought this voice was strong across national policy and research, and less strong in areas of commissioning and social media. Many fed back anecdotally that there is the potential to be more influential:

### Strengthening NIFN's voice:

*"It would be good to have a more strategic influence on policies at **government and public health level**. Setting it up as a professional body with membership and a vision statement."*

*"I think NIFN should have a greater voice in contributing to raising **awareness and policy-shaping**."*

*"To have a more **recognised and valued collective voice**. We need to shape **higher-level strategic change**, e.g. in national resource development. We need to be able to communicate with places like the British Journal of Midwifery about sponsorship and be seen as a separate voice to Baby Friendly, whilst seen as a representative of our Trust and specialist practitioners/advisors. We need to be **a trusted group of advisors to any services that are linked with feeding**."*

*"I wonder about a **more formal group linked to our region**, like Local Maternity Service, Local Authority, commissioners and HIFN. Not just the infant feeding leads, but everybody who has a role in issues relating to the first 1000 days and infant feeding, **so that we could have a more strategic role but still have a support and educational function**."*

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## CONCLUSION

By exploring respondents' journeys to becoming infant feeding specialists, the findings make clear that a highly skilled, reflective, passionate and driven infant feeding workforce exists across the UK.

Infant feeding roles and services continue to be impacted by the pandemic, staff shortages and ongoing challenges within maternity services. This has resulted in difficulties in prioritising infant feeding and relationship building care for families, as well as the implementation of the Baby Friendly standards within services.

However, new innovations stimulated by the pandemic are helping to meet a range of needs. Across maternity, neonatal, health visiting, children's centre and university settings, infant feeding leads and supporters are largely engaged with and strongly value Baby Friendly and the impact it can have on the short- and long-term health and wellbeing of babies, their mothers and families.

As services continue to deliver care in these unprecedented times, the value of the National Infant Feeding Network (NIFN) is strong. Respondents fed back overwhelmingly that the network is a key source of motivation, information and support in their infant feeding roles, and that the network provides much-needed comfort, reassurance, expertise and friendship.

Continued evaluation, adaptation and investment in NIFN will be vital to create a resilient and sustainable network that is well-placed to influence local, regional, national and global infant feeding policy. Next steps will be to work with NIFN members to strengthen and broaden the network to ensure that infant feeding and relationship building remain everybody's business.

### **Limitation:**

A total of 161 people responded to the survey out of an approximate 800 NIFN members, giving around a 20% response rate. This is considered typical for an online survey. Self-selected sample bias limits scope of some of the findings, which may not be reflective of the entire population.

### **Key recommendations**

- To monitor the impact of the pandemic and ongoing crisis within maternity care on the roles of the infant feeding leads/teams, as well as the implementation of the Baby Friendly standards within services.
- To further analyse the significant underrepresentation of Black and Black British and Minority Ethnic staff completing this survey in order to explore how we can act to ensure that we are supporting an inclusive and diverse NIFN.
- To use the findings within this report along with conversations with regional leads to plan 'What next for NIFN', including how the network could become more inclusive to all those working alongside infant feeding leads in infant feeding support roles or within infant feeding teams to support families.
- To gather case studies and/or stories in order to showcase good practice and so reduce the inequity of care provided across the UK.