Nadia Leake, Dr Liz McKechnie – Written evidence (PRT0069)

A neonatal intensive care unit is a very technical, high acuity, intense environment that few people get to experience. However, they are the place that up too 10% of babies born in the UK may spend their first hours, days or weeks. These babies are our future and so we have a responsibility ensure that they are nurtured and healed in the most appropriate environment we can give them, by families that are not scarred by their neonatal experience.

Family Integrated Care (FICare) can go some way to supporting this goal. FICare is a holistic model of care that supports, educates and mentors families to become competent and confident caregivers. There is evidence to support this model of care and shows significant benefit in length of stay, parental mental health, breastfeeding and weight gain. There is unpublished data (from my own unit in Leeds) that demonstrates families that have received FICare access emergency and primary healthcare significantly less than standard care families. Emerging data shows improvement in neurodevelopmental outcomes for FICare babies. The 2023 World Health Organisation global positioning statement on Kangaroo Mother Care (KMC), where a mother holds her premature baby for prolonged periods in skin to skin contact, describes KMC as a "high-impact intervention that significantly reduces the risk of neonatal mortality and morbidity".

FICare encourages parents to be with their baby as much as possible. Ideally this would be 24/7 but our UK infrastructure does not allow this. During the time they are with the baby there should be access to facilities to allow them to eat, drink and relax. There should be psychosocial support e.g. psychologists to help with the trauma of a NICU journey, signposting to financial support, childcare etc. There should be an education programme for staff to teach them how best to educate and

support families. There must be education and support for parents in caring for their newborn child.

FICare works, but undoubtedly needs thoughtful introduction. As pointed out by Prf. D Edwards (on 26/2/23 parliamentary session) accessing the FICare support and education is easier for mothers that have the support of care for other children or financial support, than families from lower socio-economic groups that cannot access childcare/finances to support spending long periods at the hospital. This inequality must be addressed and supported.

Neonatal staff play a vital part in the implementation of FICare and the realisation of its benefits to babies and their families. Their needs must also be addressed. A systematic review (yet to be published) of healthcare professionals (HCPs) views on FICare, highlights several factors influencing the practice of FICare and KMC. Suggestions to facilitate consistent practice of FICare include the modernisation of neonatal units; a lack of space is often prohibitive of prolonged parental presence. An achievable recommendation is protected or planned time for staff to participate in education on FICare. I am happy to share further findings from this systematic review to support this enquiry.

Implementation of FICare does not have to cost a lot of money – but the allied services to underpin FICare e.g. childcare, benefits, may need investment and careful thought. Investment in staff, both in terms of numbers and their education must be a priority to allow FICare, and it's benefits to flourish. Ideally, this support and investment would continue after NICU discharge into the early years to ensure that this group of children continue to develop.

We have no doubt that ourselves, or UK colleagues that also sit on the International FICare Steering Group would be happy to share more of our experience, at any time.

UK research into the views of neonatal HCPs will be conducted this year via Newcastle university, the PhD student (NL) and mother of preterm twins, can provide this data to support the committees ongoing work.

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