



Executive Summary

Keeping mothers and babies together should be the cornerstone of newborn care. Neonatal Transitional Care (NTC) supports resident mothers as primary care providers for their babies with care requirements in excess of normal newborn care, but who do not require to be in a neonatal unit (NNU). Implementation of NTC has the potential to prevent thousands of admissions annually to UK neonatal units, and also to provide additional support for small and/or late preterm babies and their families. NTC also helps to ensure a smooth transition to discharge home from the neonatal unit for sick or preterm babies who have spent time in a neonatal unit, often at some considerable distance from home.

Following consultation with midwifery, nursing, obstetric and neonatal medical staff, and parent representative organisations, BAPM has compiled this Framework for Practice for the provision of NTC in the UK. We have considered those groups of babies for whom NTC should be a standard of care, and how NTC should be provided. NTC is a *service*, rather than a *location*, and thus need not be dictated by building or geographical constraints. We offer recommendations for staffing of NTC services, with consideration of the care needs of both mother and baby. Successful implementation of NTC demands joint working between midwifery and neonatal nursing staff as well as paediatric services.

NTC is integral to the philosophy of family-centred care and services should be designed with the needs of the extended family in mind. NTC should link seamlessly to community care, facilitating early discharge and appropriate post-discharge support for families.

Commissioners and providers should work together to ensure consistent delivery of high quality NTC, always with the best interests of mother and baby in mind. Recent changes to the Neonatal Critical Care Mandatory Dataset (NCCMDS) and Healthcare Resource Groups (HRGs) (2016) provide clarity around tariffs for NTC in NHS England, but do not apply to the devolved nations. Despite differences in commissioning arrangements, NTC should be equitable across the UK, regardless of place of birth. Newborn care covers a wide and continuous spectrum from healthy term babies to the most critically ill, and different families will require differing levels of support; there should therefore be some flexibility in determining which babies can and should best be accommodated with their mother in a NTC facility. Audit and evaluation of NTC is essential and should ideally use a single national data recording system. User feedback should be actively sought by all NTC services, and the results acted upon.

Every newborn baby should be with their mother if at all possible; implementation of NTC within all UK maternity services has the potential to make this happen. The question should not be whether mother and baby can be cared for together, but rather why should they be separated.

Membership

The composition of the group is as follows:

Name	Position	Representing
Dr Helen Mactier (chair)	Consultant Neonatologist, Princess Royal Maternity, Glasgow & Honorary Clinical Associate Professor, University of Glasgow. Honorary Secretary BAPM	BAPM
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Extensive consultation followed publication of a Draft Framework for Practice, and significant amendments were made. We are grateful to all who gave of their time and expertise to facilitate this Framework for Practice. In particular, we acknowledge the input of Dr Eleri Adams, Chair, National Neonatal Pricing Review, NHS England Neonatal CRG.

Introduction:

Neonatal Transitional Care (NTC) supports a resident mother to be or to become the primary care provider for a baby with care requirements in excess of normal newborn care, but which are not sufficient to require admission to a NNU ⁽¹⁻⁴⁾. NTC achieves the overarching principle of keeping mother and baby together and facilitates parenting and attachment and the establishment of infant feeding, whilst enabling safe and effective management of a baby with

additional care needs. The concept of NTC is not new, having been proposed by Whitby over thirty years ago ⁽⁵⁾.

NTC may apply to newborns with moderate additional care needs (e.g. late preterm babies or babies requiring treatment for neonatal abstinence syndrome), or to older babies transitioning from a NNU to home ⁽⁴⁾. NTC is multidisciplinary and should be flexible and responsive to both mother and baby's physical and emotional needs as well as the rest of the family. A recent systematic review concluded that "*transitional care benefits the health outcomes of moderately compromised infants and mothers in terms of de-medicalising care, improving mother and baby attachments, avoiding separation, developing parenting skills for dependent infants and raising the potential for shorter length of hospitalisation*"⁽⁶⁾.

Many maternity and neonatal services already provide elements of NTC, which may or may not be formally recognised. Service provision and appropriate remuneration for services vary widely across the UK ⁽⁷⁾. Some exemplary models of care exist, supported by dedicated and enthusiastic staff; in other areas, progress has been hampered by a variety of real and perceived issues. Barriers to provision of NTC include lack of confidence among midwifery and neonatal staff in delivering NTC, geographical footprint/accommodation constraints and staffing resource. Commissioning and remuneration may also be significant factors in some areas although this should improve with the adoption of changes to the NCCMDS, new neonatal critical care HRGs and national pricing for NHS England ⁽¹⁾ (appendix A). We have aligned this Framework for Practice with the new neonatal critical care HRGs, but we note that tariff structures are not applicable to the devolved nations. Regardless of geographical location, midwives and neonatal staff must work together to support the needs of individual babies and families, and to ensure that a mother and her baby remain together whenever possible. Properly resourced and managed, NTC should improve the maternity and neonatal experience for the mother, her baby and her partner as well as the extended family, resulting in greater parental confidence, improved breast feeding rates and earlier discharge home for babies with moderate additional care needs. NTC should reduce term admissions to NNUs and help to prevent blocking of NNU cots for babies requiring more intensive levels of care ⁽⁸⁾.

NTC may be undertaken in a variety of settings, including a postnatal ward, a designated transitional care unit or a combination of such settings. Wherever the location, the interdisciplinary approach of both midwives and neonatal staff is important in facilitating delivery of high-quality care to both mothers and babies ⁽⁶⁾, and NTC should link seamlessly with community services. On the very rare occasion when it is not possible for a mother to care for her baby, it may be appropriate to designate an alternative resident primary care giver and support them to provide NTC in lieu of the mother.

The aim of this Framework for Practice is to describe standards for NTC care within the UK National Health Service. The document specifies those babies for whom NTC should be the standard of care and describes service delivery, including provision of family-centred care and the need for effective interface with community neonatal and/or paediatric services. The importance of education and training of staff, monitoring and evaluation of the service and the role of neonatal clinical networks is highlighted. We hope that this Framework for Practice will help to keep mothers and babies together, standardise care for babies with moderate additional care needs and their families, and ensure appropriate audit and clinical governance.

Definitions:

In describing standards for NTC, it is important to explore existing definitions of "normal newborn care", and to consider the role of the midwife in helping a mother to care for her newborn. The latter is described by both the International Confederation of Midwives ⁽⁹⁾ and the National Institute for Clinical Excellence ^(10,11) and is summarised below.

Normal newborn care:

Normal newborn care is delivered by a mother with the support and guidance of her midwife, either in a labour suite, a postnatal ward or at home. Normal newborn care includes immediate review of the baby after birth to detect major physical abnormality, establishment of feeding and ongoing assessment of infant well-being, including observation of vital signs. The newborn initial physical examination (or routine examination of the newborn) may be undertaken by the midwife, who will also normally facilitate newborn bloodspot screening. None of these tasks should involve separation of mother and baby.

The following care activities for otherwise healthy “term” ($\geq 36+0$ weeks’ gestation and birth weight >2 kg) babies should be considered part of normal newborn care and should be managed by the midwife in the relevant postnatal setting ⁽¹⁾:

- enhanced monitoring (NEWTT or equivalent⁽¹²⁾) for early detection of deterioration in babies with risk factors in first 12 hours of life
- thermoregulatory management
- monitoring blood glucose and following a management and prevention of hypoglycaemia policy for babies at risk of hypoglycaemia
- supporting establishment of infant feeding
- monitoring serum bilirubin for babies with exaggerated physiological jaundice
- investigation and support for infants with congenital abnormalities who do not otherwise fulfil criteria for higher category of care
- support for babies with social care needs

Additional neonatal care, not fulfilling criteria for HDU or NICU:

Neonatal HRGs 2016 describe criteria for special care and specify that this care can either be given with carer present (XA04Z) or without carer present (XA03Z):

“Any day where a baby does not fulfil the criteria for intensive or high dependency care and requires any of the following:

- presence of an indwelling urethral or suprapubic catheter*
- oxygen by low flow nasal cannulae*
- feeding by orogastric, nasogastric, jejunal or gastrostomy tube*
- care of a stoma*
- intravenous (IV) medication or IV fluids not specified in criteria for intensive or high dependency care*
- drug treatment for neonatal abstinence syndrome, and requiring 4 hourly (or more frequent) monitoring*
- birth weight ≤ 2000 g, for the first 48 hours after birth*
- gestation at birth 35 weeks, for the first 48 hours after birth*
- gestation at birth 34 weeks, for the first 7 days after birth*
- gestation at birth < 34 weeks, until discharge from hospital”*

The various definitions of NTC which exist, including “special care, which occurs alongside the mother but takes place outside a neonatal unit, in a ward setting” and “postnatal neonatal care” ⁽¹²⁻¹⁴⁾, may cause confusion and so we propose the following definition:

“Neonatal Transitional Care (NTC) is care additional to normal infant care, provided in a postnatal clinical environment by the mother or an alternative resident carer, supported by appropriately trained healthcare professionals”.

Potential benefits of transitional care:

For mum and baby:

- Optimised attachment process**
- Maximal opportunities for skin-to-skin contact**
- Facilitation of baby-led feeding and establishment of breast feeding**
- Access to 24 hour practical support with feeding and /or prompt medical review if required**
 - **helping to build self-efficacy and thus confidence in parenting**
- Immediate access to skilled midwifery support for routine postnatal care**
- Family-friendly environment**
- Potentially reduced risk of hospital-acquired infection**

For maternity and neonatal services:

Reduced length of neonatal stay

Improved team working within maternity and neonatal services

Greater parental* confidence, with reduced rates of re-admission

Increased breast feeding rates

Improved neonatal patient flow with potential for more efficient use of NNU cots

Additional professional opportunities for midwives

* All references in this document to parent should be assumed to also mean carer, and references to mother's partner/partner should be assumed to mean any person who is nominated by the mother as her birth partner, or similar.

Implementation of NTC:

NTC can be delivered under several different service models, including within a dedicated transitional care ward and on a postnatal ward, but the primary carer must be resident with the baby and providing care. Whatever the location, NTC should be considered a *service*, rather than a *place* in which care is delivered.

Additional support for the mother in caring for her baby should be provided by a midwife and/or healthcare professional trained in delivering elements of neonatal special care but not necessarily with a specialist neonatal qualification. Maternity care for newly delivered women must be provided by a midwife.

Whenever possible, babies fulfilling the criteria for special care should be cared for in a NTC setting and the mother facilitated to provide resident care for her baby. Arrangements for babies who have been discharged from maternity facilities and who require re-admission currently vary widely. We recommend that such babies and their mothers are admitted to the facility most suitable to their care requirements; within the first two weeks of life, this will most likely (though not exclusively) be a local NTC facility or postnatal ward, rather than a general paediatric ward.

Babies who require NTC must be properly and timeously assessed by an appropriately experienced and trained member of midwifery and/or neonatal staff, according to locally agreed guidelines. Babies may be identified and assessed at several locations and time points:

- Antenatally or immediately after birth**, in the labour ward, midwifery-led birthing suite or at home: babies identified as likely to have moderate additional care needs, e.g. late preterm
- Within a few hours of birth**, on the postnatal ward or at home: babies who are well at birth but subsequently develop problems, e.g. hypoglycaemia requiring nasogastric tube feeds, neonatal abstinence syndrome requiring treatment
- Within a few days of birth**: babies readmitted from the community who have developed additional care needs but are clinically stable, e.g. poor feeding requiring nasogastric feeding. It is noted that some of these babies will have only very modest additional care requirements, e.g. non-haemolytic jaundice, and will most appropriately be treated in a postnatal ward
- Later in the neonatal or post-neonatal period**: babies who were initially cared for on the NNU who are now fit to be cared for by their mother with some extra support (“step down” care, or “rooming in”)

a) Criteria for NTC for babies from birth:

- Gestational age 34⁺⁰ to 35⁺⁶ weeks who do not fulfil criteria for intensive or high dependency care
- Birth weight > 1600 g* and < 2000 g who do not fulfil criteria for intensive or high dependency care (qualified recommendation)
- Risk factors for sepsis requiring IV antibiotics, but clinically stable
- Congenital anomaly likely to require tube feeding
- At risk of haemolytic disease requiring immediate phototherapy**

b) Additional care needs developing on the postnatal ward or at home:

- Inability to maintain temperature following an episode of rewarming and despite skin to skin contact and/or adequate clothing**
- Stable baby who has developed (or been identified as having) risk factors for sepsis, requiring IV antibiotics
- Inability to establish full suck feeds; predicted to require 3 hourly nasogastric tube feeds
- Significant neonatal abstinence syndrome requiring oral medication or additional feeding support
- Haemolytic disease requiring enhanced phototherapy and/or assessment of serum bilirubin 4 – 6 hourly**

c) Babies readmitted from the community:

- Excessive weight loss and/or poor suck feeding requiring complementary nasogastric tube feeds
- Haemolytic disease requiring enhanced phototherapy and/or assessment of serum bilirubin 4 – 6 hourly**

d) Babies “stepping down” from the NNU:

- Corrected gestational age > 33⁺⁰ weeks and clinically stable
- Current weight more than 1600 g and maintaining temperature
- Monitoring of vital signs required no more frequently than 3 hourly***
- Tolerating 3 hourly nasogastric tube feeds and maintaining blood glucose***

- Stable baby with sepsis requiring ongoing IV antibiotics
- Continuing phototherapy when serum bilirubin has stabilised following IV immunoglobulin or exchange transfusion
- Additional needs (e.g. nasogastric feeding, home oxygen) rooming in before discharge
- Palliative care when parent/carer doing most of the care

*It is to be expected that all babies weighing < 1600 g will be admitted initially to a NNU for observation of feeding and temperature control

** In NHS England these babies will not be coded as NTC unless they require additional treatments (e.g. nasogastric feeding), but it may be appropriate in some circumstances to accommodate them in a NTC setting, rather than a postnatal ward. Babies with non-haemolytic jaundice will usually be cared for in a postnatal ward.

***We recommend that larger NTC facilities are considered in when developing or re-organising maternity and neonatal services, with consideration being given to babies requiring more frequent monitoring or feeding to be cared for with their mother resident.

Service delivery:

To fulfil the criteria for NTC, the **primary carer must be resident with the baby** and providing at least some of the baby's care. Consideration needs to be given to the care of both mother and baby, as this is likely to change with time. For example, in the first 24-48 hours after birth the mother may require regular monitoring and/or treatment, whereas in the case of an ex-preterm baby rooming in with his/her mother prior to discharge it is anticipated that the mother will be self-caring. Ability to evaluate and respond to the care needs of both mother and baby in a flexible manner is essential in providing safe and effective NTC and will necessarily involve multidisciplinary collaborative working. In the rare situation in which the mother is too unwell to provide care for her baby, every effort should be made to keep mother and baby together, but there should be an additional named, primary carer resident with the baby.

A designated transitional care ward with its own staffing structure may facilitate delivery of NTC, but this will not be feasible in many existing services, and should not exclude the development of a NTC service. Within the Department of Health Building Note 09-03 – Neonatal Units (2013) ⁽¹⁵⁾ it is recognised that “transitional care” may take place either in multi-bed bays generally associated with postnatal beds, or in single rooms, generally associated with the NNU. We recommend that a designated NTC area is considered in the planning of all new maternity and neonatal building projects and/or reorganisation or redesign of services. This area should be large enough to accommodate future developments in NTC (e.g. babies requiring more frequent monitoring than is currently considered appropriate for NTC)

Staffing requirements for NTC:

Staffing for NTC will include midwifery, neonatal nursing, medical and ancillary staff.

Midwifery:

Appropriate midwifery staffing for care of the postnatal woman is outlined in 'Birthrate Plus®', NICE guidance and the Scottish Workload and Workforce Tool ⁽¹⁶⁻¹⁸⁾. The recommended staffing ratio for women receiving standard postnatal care is between 1:5 and 1:8 (1 midwife to every 5 to 8 women) depending on complexity, although this is currently under review. Maternity complexity is likely to be higher for mothers of newborns requiring NTC, but this may be offset in part by healthy, self-caring “rooming-in” mothers of babies readmitted from home, or graduates from the NNU. If a designated NTC ward has only a small number of beds, there must be a mechanism in place to cover breaks if there is only 1 qualified midwife on a shift.

Neonatal Nursing:

There should be a designated neonatal nursing lead (Band 7) for NTC but it is not necessary for all neonatal nursing staff providing NTC to be qualified in specialty. Different staffing models may be applied, but consideration should be given to rotation of all neonatal nursing and ancillary staff through NTC. A core team, including neonatal staff dedicated to discharge planning and community outreach may better ensure continuity of service. Collaboration with the midwifery team, health visitor and (where appropriate) paediatric and/or safeguarding teams is also essential. *In addition* to midwifery input, the ratio of nursing staff for babies receiving NTC should be at least 1:4.

The Head of Midwifery will normally be responsible for midwifery staff working in a NTC environment and there must be joint working between midwifery and neonatal nursing management within organisations to determine appropriate staffing for the NTC service. Overall clinical responsibility for a mother who is not fit for discharge will rest with the senior midwife on shift, in collaboration with the obstetric team as indicated. There must be clear and agreed processes for recording when a mother is fit to be discharged from inpatient and/or community midwifery care. All staff working within a NTC service should be adequately trained and working under a framework of sound leadership and locally agreed policies and guidelines, with clear lines of responsibility.

Ancillary nursing staff:

Suitably trained nursery nurses and/or maternity care assistants (MCA) offer invaluable support within NTC. Following completion of appropriate training and assessment, either a nursery nurse or MCA may take responsibility for an individual baby (nursery nurse) or mother and baby (MCA), reporting to the midwife or neonatal lead for NTC.

Medical:

All babies receiving NTC must have a named paediatric or neonatal consultant. Clear and agreed local arrangements must be in place for allocation of the named consultant, and there should be direct clinical input on a day to day basis, at the same level of seniority as for babies receiving special care within the NNU. Daily review of babies receiving NTC may be undertaken by appropriately supervised trainee medical staff or advanced nurse practitioners.

Family-centred care:

NTC is integral to the philosophy of family-centred care, where the baby is placed at the heart of the family, with parents as partners in their baby's care. By keeping mother and baby together, NTC facilitates kangaroo mother care, breast feeding and comfort holding, and helps to support parents as the primary care giver for their baby. The benefits of NTC include: reduced length of hospital stay and readmission rates; enhanced parental confidence and bonding with their baby; support for baby's development with improved chances of a healthier future ⁽¹⁹⁾.

The Bliss Baby Charter ⁽²⁰⁾ provides a clear framework for units to audit and benchmark their current family-centred practice and to make meaningful plans for improvement. In order to facilitate a high quality family-centred approach to care within NTC, we recommend that certain key elements are in place:

Engaging the whole family:

The parent(s) are the most constant influence on a baby's development and should be inputting fully into care decisions for their baby. Parents should have unrestricted access to their baby and should be supported fully to have uninterrupted visits for as long as they wish.

Parental presence and participation in all ward rounds and/or consultations in NTC should be encouraged, and ward rounds scheduled to suit parents' availability whenever practical. Clear and consistent visiting policies should be available for siblings and for extended family members ⁽²¹⁾.

Facilities:

In order to keep families together and remove any barriers that may interfere with them playing a part in their baby's care, families receiving NTC should have access to the following:

- 24 hour access to nutritious food and drink without charge for the resident carer, and ideally for both parents
- clean and adequate kitchen facilities with provision to prepare hot meals
- access to an overnight bed for the partner to stay by the cot-side with the mother and baby, when appropriate
- shower facilities for resident parents
- areas for siblings to be kept occupied, with consideration given to providing periods of supervision
- a family room that is comfortably furnished and provides access to relevant hospital and local support information
- financial support, including free parking for partners

NTC should be additional to, and ideally separate from, overnight accommodation for parents of babies nursed on the NNU

Emotional support for the family:

The experience of having a premature or sick baby can have adverse effects on the emotional well-being of family members. Units should provide access to dedicated psychosocial support, establishing a clear referral process to this support and/or be able to signpost families to local support services.

Information:

Clear and consistent information about their baby's condition and the care they require should be shared regularly with parent(s). This information should be consistent across the neonatal network and should be given in a supportive and nurturing environment in order to encourage and empower parents to take the lead role in their baby's care and make informed decisions. Care plans should be drawn up in partnership with parents, and parents encouraged to ask questions and to input their own suggestions for their baby's care. Translation services should be offered as appropriate. Parents should be signposted to relevant local and national organisations, both for condition specific and emotional and/or financial support.

Equipping and supporting staff:

All NNUs and networks should promote access to training courses in order to help both neonatal and midwifery staff to develop their skills, and to ensure that they understand the benefits of, and are confident in delivering, a family-centred approach to neonatal care. Family-centred care must be flexible, and able continually to adapt to emerging family needs.

Discharge from NTC and interface with community services:

Extending care into the community in the initial period after hospital discharge is an essential component of a high quality, effective neonatal service. The service specification for Neonatal Critical Care for NHS England promotes such service integration, recommending that "by

working closely with community services, neonatal services support babies and their families in the transition and adjustment from an in-patient stay on a neonatal unit to restored family life in the community” ⁽¹⁴⁾. Availability of appropriate community neonatal liaison/outreach (hereafter described simply as “community neonatal services”) support following discharge is also recommended within NHS Scotland’s Neonatal Care in Scotland, A Quality Framework and The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland ^(22,23).

For a majority of babies with moderate additional care needs, discharge home should follow a period of NTC, but for some babies and their families this may not be possible or appropriate (e.g. when alternative care arrangements for older siblings are impractical). No matter the baby’s level of care immediately prior to discharge, NTC and NNU inpatient services should link seamlessly with community neonatal services and the Health Visitor, as well as with both inpatient and (where relevant) community maternity teams. Robust guidelines to promote early facilitated discharge and on-going care pathways for babies from neonatal and maternity services should be developed in order to guide service delivery, and shared-care services developed with existing paediatric community care teams and health visitors.

Community neonatal services should be available seven days per week, with out-of-hours support to families available from members of the NTC team when required. This should be underpinned by the principle that parents will have been educated and supported by the wider neonatal and midwifery team prior to discharge to become the primary care giver, and will be equipped to deliver the required care for their baby at home.

Full description of a community neonatal service is out with the remit of this document, but the team should include a composite of registered and non-registered neonatal and paediatric nursing staff with knowledge and skills appropriate to their role and seniority within the team. Periodic rotation of community neonatal service team staff into the NTC team and/or local NNU will help to facilitate integration between hospital and community services. For some facilities, services will best be delivered by a fully combined NTC/community neonatal team.

Parents must be given appropriate information, including contact details for out of hours support. Technology solutions, including tele-health, may be utilised to complement phone calls and help to promote safe, efficient and effective care, particularly in remote and rural settings.

Monitoring and evaluation:

There should be a consistent national approach towards audit and evaluation of NTC; ideally this would utilise a single national data recording system capturing standard data items. Practical and cost implications of such data collection require to be explored, particularly for those babies who receive NTC within a postnatal ward and are never formally admitted to a NNU. There will also be a need to monitor any impact upon maternity beds of delivering NTC within the maternity facility.

Data collection should assess the impact of NTC and community neonatal service development on acute inpatient neonatal cot occupancy as well as readmissions to neonatal or paediatric services.

User feedback should be actively sought by all NTC services and the results acted upon, to ensure a truly family-centred care model which is acceptable to parents and families.

Commissioning services:

A recent survey of 140 units in England undertaken on behalf of the Neonatal CRG demonstrated huge variation in relation to delivery, classification and commissioning of NTC⁽⁷⁾, but this variance in service provision and funding should be addressed by the new Neonatal Critical Care HRGs 2016. It must be recognised that individual babies and their mothers at similar gestations may differ in their care requirements and so NTC must be flexible and individualised. The basic tenet should be that mother and baby are together whenever possible. The question should not be whether mother and baby can be cared for together, rather why should they be separated.

Role of Neonatal Networks:

Networks throughout the UK play a vital role in improving the delivery of NTC, and should focus on facilitating, coordinating and monitoring NTC activity across the network. This will help to ensure all families and babies receive a similar high standard of care, with consistent and clear messages about when, and for which babies, NTC is appropriate. Networks must also support training and education for staff to help to equip them with skills and knowledge to facilitate delivery of family-centred care.

Vignettes:

“My husband could come and go with my other daughter which was nice especially when I was put in my own room, **it felt like we could be a family of 4 for the first time**. My husband would come up each day and would be totally involved with all aspects of care. We were trained in paediatric first aid before being able to leave with her. It started to feel like a home from home after a while...”

“I went into transitional care with my son who had spent the previous 10 weeks in NICU after being born at 25 weeks. It was invaluable after watching such a tiny vulnerable baby who was so reliant on machines and nurses. **Obviously it made us nervous to take the care on ourselves but TCW made sure they were there for me if I needed it but gave me the confidence and assurance that I could do it myself**. My husband always got involved when not at work. **It felt like we were in entirely in charge of looking after our son with support should we need it**. Kitchen facilities were disappointing, there was no opportunity to make a drink or anything throughout the day, although there were regular tea rounds - just at set times. Otherwise it was great.”

“As a mum, I wanted nothing more than to be under the same roof as my babies and to be able to care for them myself. It wasn't normal to go home without them every day and as a mum this is the most painful thing to go through. Whilst I appreciated my girls still needed input from medical and midwifery staff, they needed their mum and dad equally as much. The TCU enabled us to be together and **allowed me to fulfil my role as a mum**. It was the closest thing we could get to being home as a family and it was **vital for my mental wellbeing in those early weeks**. Our 10 day stay in the TCU allowed our babies to get ready for home and **allowed us to properly bond with them** in the privacy of our own room, and with the help of the TCU staff **we gained confidence in caring for our tiny babies ready for when we got home**. I only have happy memories of my time in the TCU, we were together and the staff were amazing in their support to us. My husband was able to stay with us at weekends when he was off and the staff made him so welcome - that too was so important to me. We were able to be a family.”

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