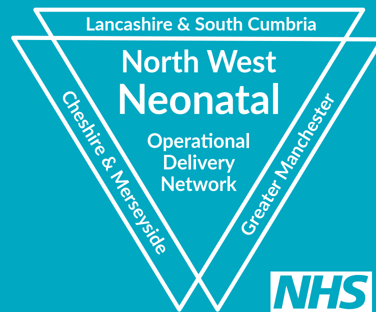
NORTH WEST NEONATAL OPERATIONAL DELIVERY NETWORK



A workforce strategy for North West Neonatal Units 2021-2026

Working together to provide the highest standard of care for babies and families

CONTENTS

EXECUTIVE SUMMARY 5

INTRODUCTION 6

WHERE ARE WE NOW 7

OUR VISION 15

MOVING FORWARD – MAKING THE CHANGE: 28

CONCLUSION 29

Acknowledgements: 30

References 31

Glossary 34

A Workforce Strategy for North West Neonatal Units

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Acknowledgements

This report would not have been possible without the contributions of our north west nursing, medical and allied health professional colleagues who have freely given their expertise and their time to bring this strategy into being.

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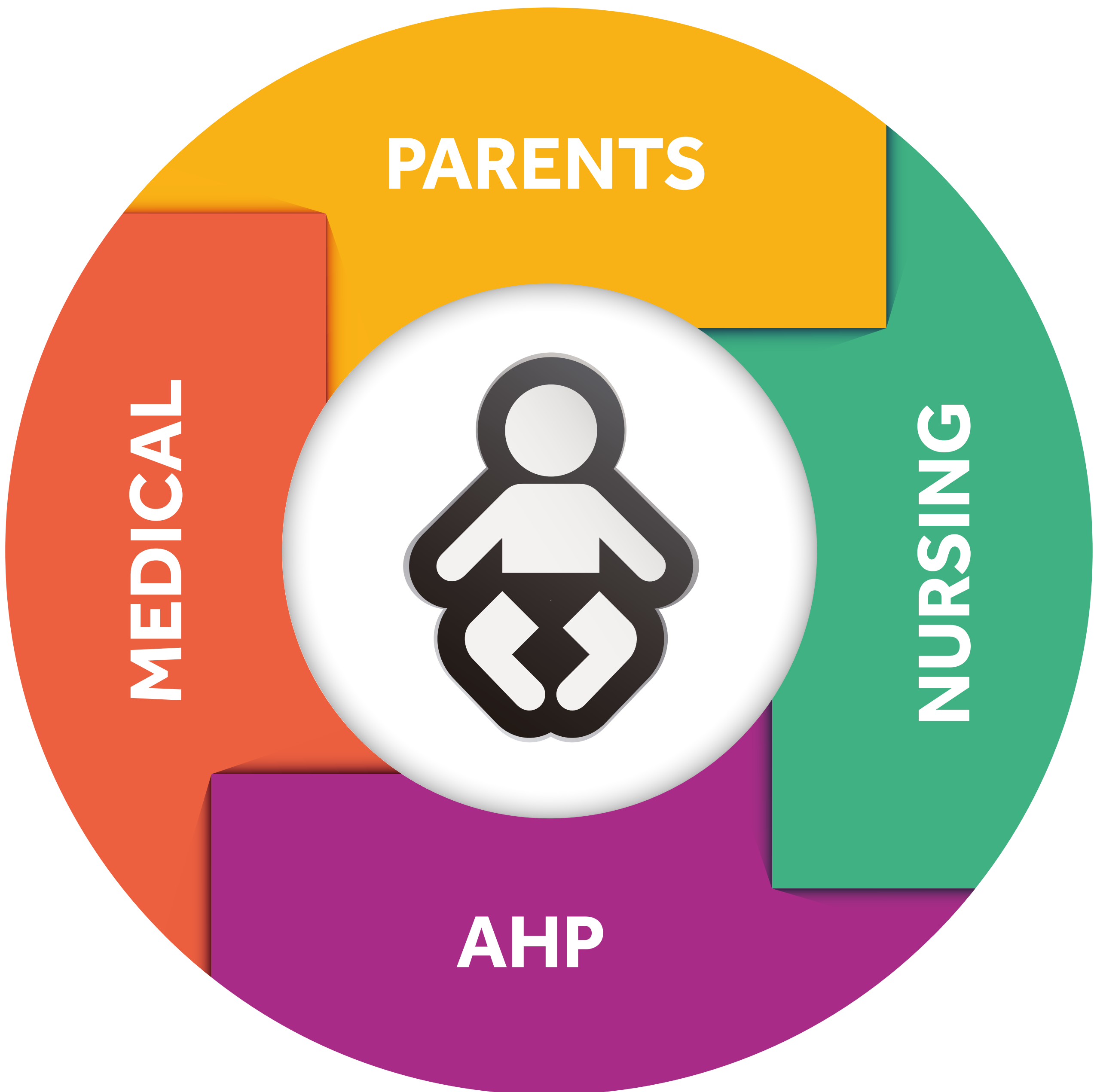
OUR VISION

is for neonatal care to be delivered by an integrated, multi-disciplinary team which makes the best use of the skills available and is focussed on care by parents and families



EXECUTIVE SUMMARY

Introduction

Since the publication of the NHS Long Term Plan there has been a national focus on developing the workforce across the NHS. The impetus of the Long Term Plan was closely followed by specific recommendations in relation to neonatal workforce development within Implementing the Neonatal Critical Care Transformation Review (NCCR), which recognised that delivery of its vision is dependent on having a highly skilled, multidisciplinary and expert workforce in place. This strategy is not intended to supercede locally developed strategies, but to provide support for neonatal service leads and managers to make best use of the opportunities provided by the national drivers.

Where are we now

It is vital to understand some of the complexities which face neonatal services in today's world. This strategy identifies increasing complexity of care, current high vacancies levels, changes in medical training, consistency in quantifying workforce across the ODN footprint, an ageing workforce, the emergence of non-standardised new roles and difficulties in attracting and retaining staff in neonatal as some of the obstacles to overcome. Added to this, across the north west there is a lack of consistency in how neonatal services are integrating Allied Health Professionals and families to help to transcend these obstacles.

Our vision

is clear - it is for "neonatal care to be delivered by an integrated, multi-disciplinary team which makes the best use of the skills available and is focussed on care by parents and families".

In proposing a way forward to achieve this we have introduced the concept of the Ideal Team. That is not to say we are proposing a 'one size fits all' approach. We recognize that each unit across the North West has its own issues in providing care through multi-disciplinary teams, and these will look different dependent on a number of factors including unit designation, estate, staffing and activity levels. What this strategy offers to neonatal care providers is options to support them in building the most appropriately skilled multi-disciplinary team for their unit.

In developing this strategy, it was felt important that time was given to understand what the core 'ideal' neonatal care team should look like in today's world. What we then go on to envision is a further suite of roles which would effectively provide a 'menu of options' from which units could create the team most appropriate for their service needs. These roles may be enhancements or extensions of existing roles; or introduce entirely new roles for that unit. We expect that each team will look different based on size, activity, specialism and population yet in that process we expect a degree of consistency across the roles and competencies in place across the North West.

Integral in the multi-disciplinary team is our families. We see the Family Integrated Care model as enabling families to become part of the care team, with the NWNODN FiCare Accreditation scheme being integral in achieving this integration.

Moving Forward – Making the Change

It is accepted that changing the workforce structure will not happen overnight but will need time to make a cultural shift to a different team dynamic, supporting new ways of working and fully developing the capabilities of newly created roles. To support units to determine the most appropriate team for their workplace, the supplemental document Workforce Strategy for North West Neonatal Units Toolkit – Building a Sustainable Neonatal Team provides a toolkit for NICUs and LNUs to use.

Conclusion

Through the provisions of the NHS Long Term Plan and the NCCR, neonatal care is well placed to undergo transformation. Key to the success of that transformation is a sustainable neonatal workforce, unique to units but consistent across the north west, with the knowledge, skills and competence to ensure optimal quality outcomes for babies and families.

INTRODUCTION

Through the introduction of the NHS Long Term Plan[1] which includes a commitment to expanding neonatal critical care services, and the publication of We Are The NHS People Plan[2] there is an increasing focus on workforce across the health service nationally and as the impact of COVID 19 pandemic is being realised "… our people (staff) must remain at the heart of our NHS, and the nation, as we rebuild."[2] It is vital that we have the right workforce to meet the challenges of the future and to optimise outcomes[3].

This is perhaps more evident within the highly specialised area of neonatal care, with the Implementing the Recommendations of the Neonatal Critical Care Transformation Review (NCCR)[4] recognising that the delivery of its vision is "dependent on a highly skilled, multidisciplinary and expert workforce, working in a network of teams, each contributing different expertise in supporting the baby and their family"

There were 100,000 staffing vacancies in the NHS in 2018, with 40,000 of those being nurse vacancies[5]. There is no doubt that these shortfalls affect every area of the NHS, including neonatal critical care. The Neonatal Critical Care Transformation Review[4] highlights that in 2016-17 there were 2263 fewer nurses in post than the BAPM standard recommends[6]. The NHS Long Term Plan sets out its commitment to improve neonatal care by expanding neonatal critical care services and developing the expert nursing workforce.

There are clearly opportunities to address the gap which neonatal care should take advantage of given; the commitments made in the Long Term Plan and the People Plan for a national increase in the number of nursing clinical placements along with a growth in the number of nurses by 40,000 by 2024, medical school places increasing and the knowledge that since COVID-19 there has been "…an unprecedented interest in careers in the NHS"[2]. The implementation of the Neonatal Critical Care Transformation Review[4], states that actions will be in place to address the gaps in staffing across the neonatal workforce over the next 5 years. We therefore need to consider how we can make best use of these opportunities and of our existing workforce to provide the right care for babies and their families.

This document and the supplemental Workforce Strategy for North West Neonatal Units Toolkit – Building a Sustainable Neonatal Team are intended to support neonatal service leads/managers and their Trust executives, in their own workforce planning. They are not intended to supersede any locally developed strategies, but to provide a framework to support their response to the recommendations of the Neonatal Critical Care Transformation Review which will be considered at local, regional and national level. By putting forward options to enable the introduction and development of the right roles for service provision, this strategy should support local workforce planning and business cases within the neonatal setting.

It is accepted that the issues facing Trusts in attracting, recruiting, training and retaining their neonatal workforce are complex and subject to a multiplicity of influences. What this document proposes is not a 'one size fits all' approach but rather a framework within which Trusts can develop the team which suits their demands and workforce profiles within the neonatal setting.

This strategy has been developed by drawing on established research, current national initiatives and the personal expertise of nursing, medical, allied health professionals, parents and workforce management experts. In approaching the strategy development, two working groups were established; one to look at today's workforce and what the core ideal team should look like, the other to consider how the workforce could be shaped for the future. What follows is the output of their labour.

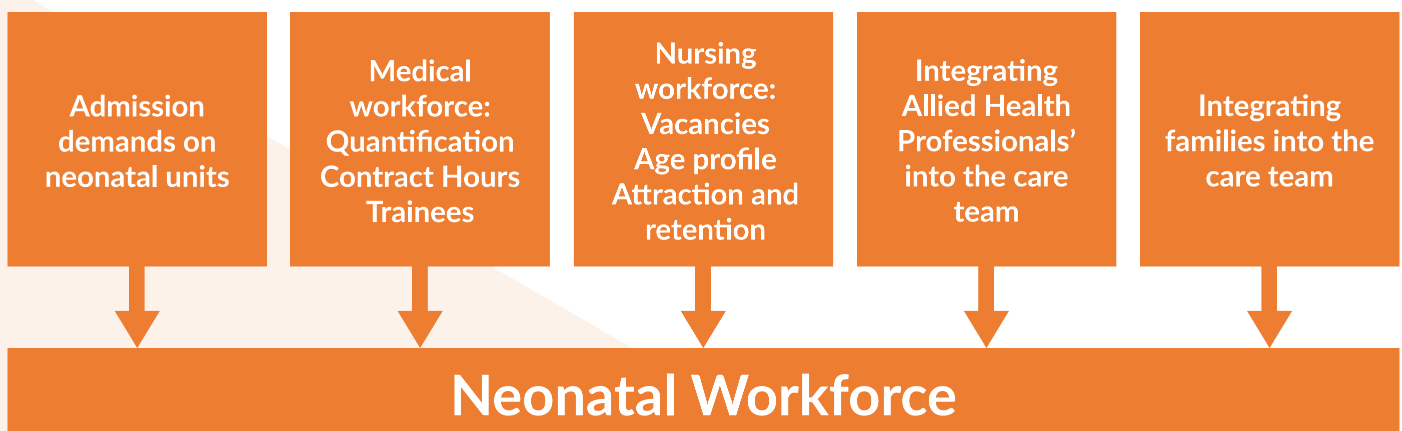
WHERE ARE WE NOW

The medical and nursing workforce delivering neonatal care today within the north west totals over 1500 whole time equivalents (WTE)[7] but there are significant vacancies across all disciplines. The NWNODN's annual analysis of nurse staffing, according to the Dinning Tool[8], highlights that there were 90 WTE nursing vacancies in 2019/20. This does not demonstrate the true gap in nurses delivering direct patient care which increases to 180 WTE when activity is measured against the national staffing standard[6] and rises again when quality/link roles[9] are included.

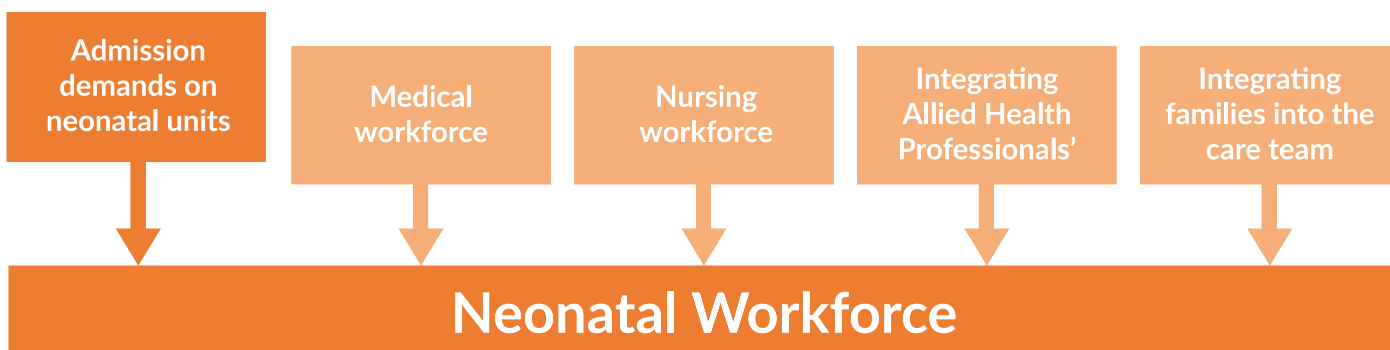
Medical and nurse staffing standards have been described by BAPM* across a number of papers in recent years and have been the benchmark NHSE have measured against in the National Neonatal Critical Care Transformation review[4] and described within the Neonatal Critical Care Service Specification[10] with the most recent documents being Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021)[11] and Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing (2018)[12]

The neonatal team consists of a wide range of staff to deliver high quality neonatal care which include but is not limited to doctors, nurses and allied health professionals along with a number of other supportive roles.

The pressures on the neonatal workforce are multiple and complex and a number of these are discussed below:



* BAPM is a nationally recognised neonatal expert group of neonatologists, paediatricians, obstetricians, nurses, midwives, trainees, network managers and other health professionals who, amongst other things set national neonatal standards that the neonatal community bench mark against and works towards



Term Admissions

Alongside the gaps in staffing numbers, there are a number of factors which need to be accounted for when considering today's neonatal critical care workforce within the North West:

We have seen a relatively consistent picture of neonatal admissions at 10% of the birth rate. However this is set against a relative downward trend in birth rate.

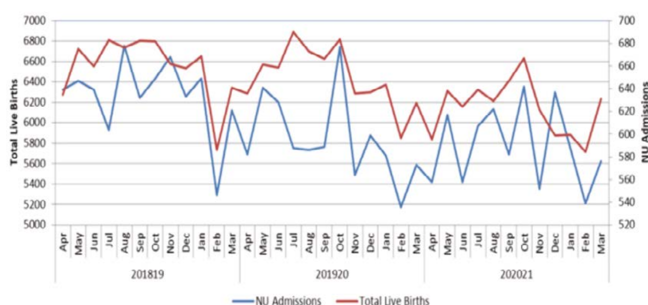


Fig 1: North West Birth Rate v Neonatal Unit Admissions Apr 2018 – Mar 2021 (NWNODN Activity, Capacity and Demand Report 2020-21)

There have been national initiatives implemented which are likely to influence neonatal unit activity over the coming years.

The work undertaken on behalf of NHS Improvement, "Reducing harm leading to avoidable admission of full-term babies into neonatal units"[13] found that, nationally, between 2011–2015, the number of care days for term admissions across all levels of care rose by over 30% and in the summary suggested that between 2011-2013 30% of those term admissions were potentially avoidable. Work has been ongoing within the North West through various interventions to address avoidable neonatal unit admissions.

Whilst 2020-21 showed average term admission rates to neonatal care in the NW at 5.5%, which is favourable to the 6% national average, this still equates to over 3,750 babies admitted at greater than 37 weeks gestation (NWNODN Activity, Capacity and Demand Report 2020-21). A number of maternity/neonatal units within the North West have introduced Transitional Care (TC) services to support a reduction in the unnecessary separation of mothers and babies. There is work ongoing with our LMS, maternity and neonatal services, aligned to Maternity incentive scheme 314, to ensure TC provision is embedded across all services in the North West which will over time reduce the number of term and near term babies admitted to neonatal care, although on current trajectories it is unlikely to see this reduce below 4%. It is important to identify these TC facilities require neonatal input and therefore should be part of the neonatal staffing plans for both nursing and medical workforce[15] (BAPM 2017)

Preterm Admissions

In 2019, NHS England (NHSE) published version 2 of the Saving Babies' Lives Care Bundle (SCLCBv2)[16] which saw the addition of a fifth element "reducing pre-term birth" to support the ambition of Safer Maternity Care[17] by reducing preterm birth from 8% to 6%. This element focusses on prediction, prevention and preparation when optimising the outcomes of those born prematurely, a theme picked up as part of the Maternity and Neonatal Safety Improvement Programme.

Whilst these interventions should have the outcome of reducing demands on neonatal care, the last few years have seen increasing admissions to NNUs of babies at the lower limits of viability with increased acuity. These cases have created greater demands on those working within neonatal care. This will be impacted further given the publication of the BAPM framework for decision making on extreme preterm births[18], which considers the management of babies born at 22 weeks gestation.

Surgical/speciality

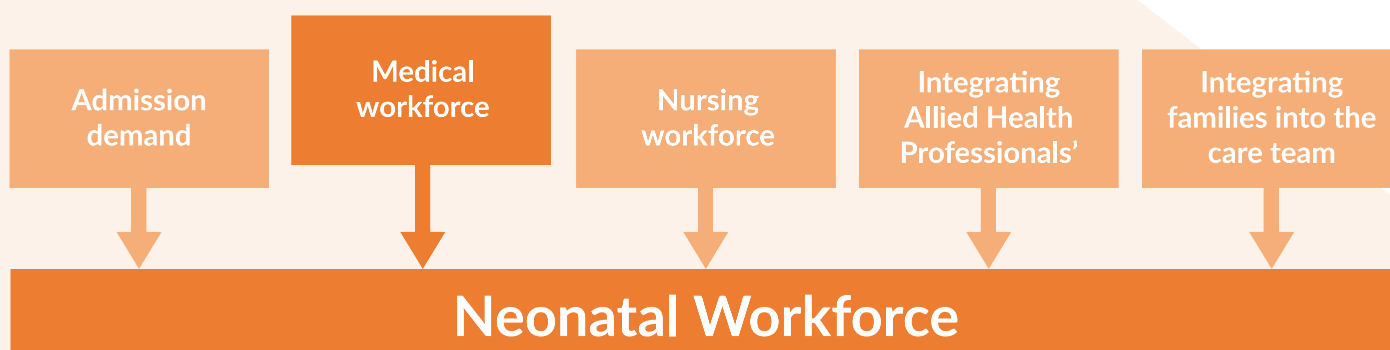
NWNODN has seen a year on year growth in activity through its 2 neonatal surgical centres providing surgical and subspecialty care to those in need of its services from across the North West and beyond. To care for this group of babies the neonatal workforce needs additional skills and competence and work in collaboration with neonatal surgeons and other speciality leads.

Complexity

It is widely accepted[19] that the complexity of neonatal care has increased in recent years with improved outcomes to discharge for both the extremely sick and extremely preterm babies. More babies survive than ever before but, given the above, for some this will involve months of highly specialised multidisciplinary care.

COVID-19

Full data of the impact of COVID 19 on neonatal care is still being gathered, however anecdotal evidence and our experience suggests that it does not appear to have had the profound impact on outcomes seen in other populations; the ONS provisional review of births in England and Wales 2020[20] noted that for Jan to Sept while the proportion of preterm live births in England and Wales fell slightly compared with 2019, this was in line with recent trends.



Quantification

There is limited data to support understanding of medical workforce levels against the BAPM standard within North West neonatal units. Given that in many units joint medical rotas exist with Paediatrics, this makes quantification of the exact WTE resource dedicated to neonatal care difficult to calculate. It goes without saying that there are vacancies and gaps across the board in medical staffing. Nationally, at present, around 15-18% of posts (excluding Consultant posts) are unfilled according to the NCCR[4]

This is corroborated in a Royal College of Paediatrics and Child Health (RCPCH) Survey[21] which found that in the general/paediatric and neonatal categories, vacancy and rota gaps were 17% at Tier 1 and 26% at Tier 2.

The national Neonatology Getting It Right First Time (GIRFT) project, full report due September 2021, found that the majority of NWNODN neonatal units were non-compliant with national standards with respect to medical/Advanced Neonatal Nurse Practitioner (ANNP) workforce and identified NWNODN to have the highest Consultant vacancy rate compared to the other 12 ODNs.

Contract Hours

In June 2019, the British Medical Association Junior Doctors Committee endorsed an improved contract affecting the hours junior doctors work, consequently working no more than 1 in 3 weekends. The impact of this is the need for an increase to rotas of an additional 2 WTE at Tier 1 & Tier 2, effectively widening the gaps in resources.

Trainees

In considering the existing gaps in medical resources, the picture for trainee staff is unlikely to alleviate in the short to medium term.

At national level the NCCR[4] describes a challenging medical staffing picture with a 28% fall in paediatric training applications, some areas of sub-speciality training posts frequently unfilled and 6% of consultant posts unfilled. Locally, according to the North West Head of School, there has been a 10% fall in applications to Paediatrics over the last 4 years with increasing numbers of trainees leaving the training programme completely and a trend for trainees to work less than full time hours. The results of a bespoke survey[22] showed that, as well as 15% of trainees already working less than full time hours, two thirds of trainees (66%) have considered this option. The latter has implications for the completion of specific skills required during training with more part time workers meaning more physical people competing for skill development.

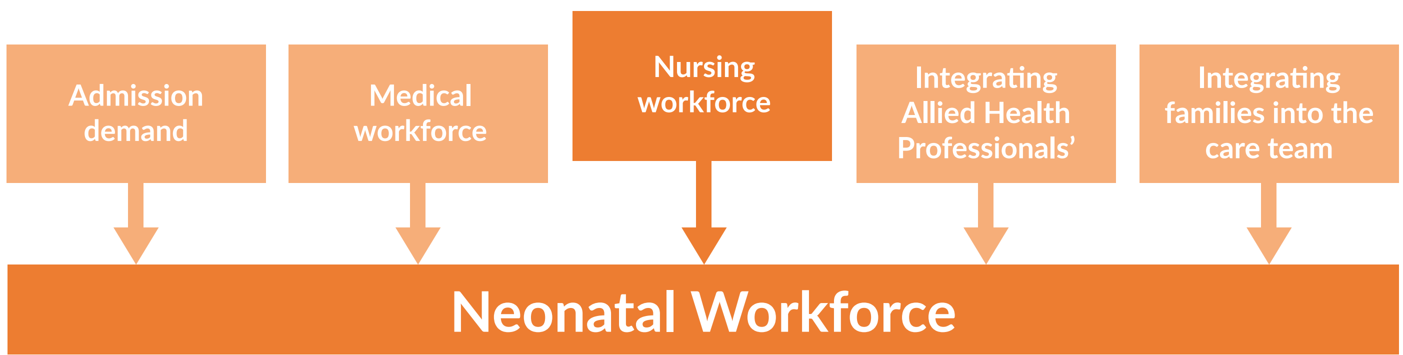
The "Shape of Training Review"[23] is changing medical training through the reduction in training by 1 year meaning decisions regarding specialty training need to be made by ST4 which is a year earlier than current training. The impact of this may be a potential reduction in the selection of neonates as a subspecialty depending on exposure/experience up to ST4. This reduction in length of training will have an impact on clinical exposure to procedures / clinical skills, but it is anticipated this will be balanced by increased expertise in clinical decision making particularly in less invasive therapies such as delivery room CPAP.

As a result of the medical resourcing difficulties which neonatal units are faced with, there has been an increasing trend for Advanced Neonatal Nurse Practitioners to support the medical workforce on the Tier 1, and in some cases Tier 2, medical rotas.

A number of Trusts have taken advantage of the Medical Training Initiatives (MTI) scheme, which provides a route of entry into the NHS for doctors from outside the UK / European Economic Area offering two years of postgraduate training in the NHS. It should be noted that progression from ST3 to ST4 is dependent on an individual's clinical ability and completion of appropriate competencies therefore it may not be realised during their 2 years in post.

The Interim People Plan[5] offers a commitment to improving the future medical workforce through reforming education and supporting progression, although as yet there are no details published on how this will be enacted. More specific to neonatal care, Implementing the Recommendations of the Neonatal Critical Care Transformation Review[4] states that the RCPCH & Health Education England (HEE) are working together to ensure that medical cover for neonatal care is improved.

Whilst these commitments are brought into being, the challenge is for Trusts to demonstrate effective workforce and succession planning to ensure rota coverage maintains consistent without negatively impacting staff wellbeing and retention.



Vacancies

There are more than 41,000 registered nursing posts reported vacant in the NHS in England – more than 1 in 10 posts[24]. Patterson et al[25] calculated that there are 2263 whole time equivalent nurse vacancies across all units in England.

The NWNODN reports annually on nursing staffing vacancies and the North West's ability to achieve the BAPM standards[11], using the Neonatal Nursing Workforce Tool (previously Dinning Tool). This tool, approved by National Quality Board[24] and the neonatal Clinical Reference Group, calculates the number of nurses that would have been required to deliver that care to BAPM[11] standard, based on the actual neonatal activity delivered over a year by level of care. It then quantifies the difference between the number of nurses available within the nursing budgeted establishment and the number that were needed to achieve BAPM standard. Whilst in NWNODN there has been improvement in staffing levels in 2019/20, there has remained a shortfall of almost 8% in nursing budgeted establishment, which means that to meet the national BAPM standard for actual activity delivered there needs to be an increase in nursing budgeted establishment by 91WTE, rising to 15% (181 WTE) when the vacancy gap is included.

This has been corroborated by the National Neonatal GIRFT project which found in the North West that the percentage difference between the calculated Neonatal Nursing Workforce Tool (NNWT) nursing requirement and budgeted establishment was 9% in NICUs and 11% in LNUs and SCBUs, which rose to 18% in NICUs, 14% in LNUs and 7% in SCBUs when the vacancy gap was added.

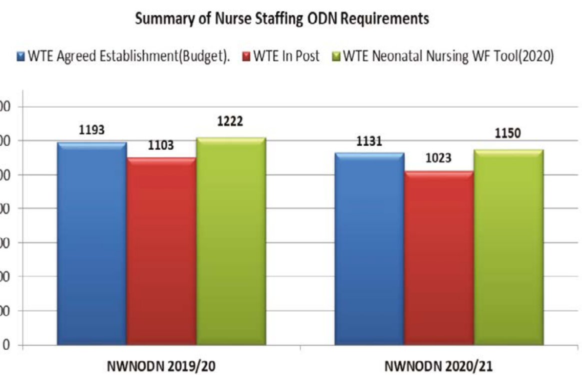


Fig 2 Summary of Nurse Staffing ODN Requirements (NWNODN Activity, Capacity and Demand Report 2020-21)

Age Profile

There are a number of factors which exacerbate the shortage of staffing, now and for the future. From a recent survey of units undertaken on behalf of the NWNODN[7], the top 10 populated roles are shown broken down by age profile:

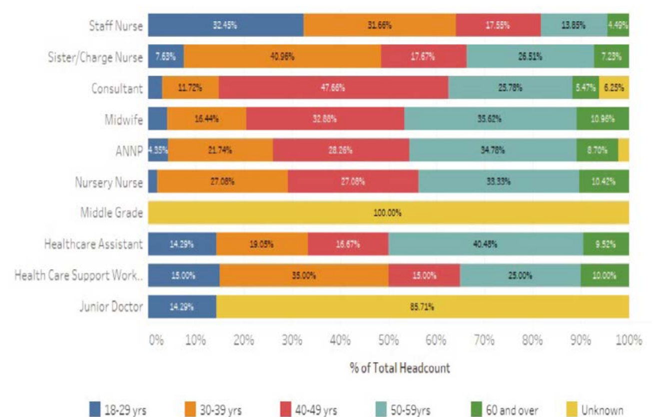


Fig 3: Top 10 Populated Roles by Age Profile (NW Neonatal ODN Baseline - WRaPT)

This shows a significant proportion of the workforce over the age of 40. A survey of neonatal nursing undertaken in 2017 by Patterson et al (2019)[25] highlights at that time 27% of nurses were 50 years or older. With the exception of the consultant role, all others show a higher proportion in the age range of 50-59 years showing in the next ten years a large proportion of the neonatal nursing workforce are likely to retire taking with them their experience and expertise. This has significant implications for the maintenance of an experienced workforce, along with the need to succession plan and recruit.

Attraction and Retention

The retention of staff is an important factor in workforce planning and maintaining the stability of the workforce. The chart above shows a potential loss of up to 50% of staff in specific roles as staff reach either early or state retirement age. NHS Improvement commissioned research in March 2019 into the perspective of older nurses (50+) working in acute hospital trusts[26]. The research found a complexity of factors involved in retaining nurses in this age group including the effects of biological ageing on health, changing life circumstances and age stereotyping as factors for leaving; with financial instability, opportunity to transfer knowledge and a sense of belonging as factors for staying. The study also found that whilst organizational policies such as flexible working and 'wind down' opportunities were supportive, lack of planning and difficulties with 'retire and return' schemes were unsupportive to retention. Across the health sector, trusts are being supported to address these factors although it may take some time before changes to policies, and to attitudes, alter the balance.

In 2002 the North West responded to the need to improve recruitment and retention with the introduction of the Neonatal Induction Programme (NIP) which is specifically designed to provide a supportive learning package for nurses and midwives with no previous neonatal experience and for many years continues to demonstrate a positive impact. Across the NWNODN the NIP is the first part of the pathway for achievement of QiS and is accessed by all those new to neonatal care from our 22 neonatal services.

At the very start of a nurse's journey, the Interim People Plan has identified application rates for nursing courses decreased by 31% between 2016-18. In 2018 the acceptance rate for nursing was 55% compared to an average for all UCAS undergraduate courses of 76%[5]. It is anticipated that this picture will improve following the Government's announcement in December 2019 that "All nursing students on courses from September 2020 will receive a payment of at least £5,000 a year which they will not need to pay back."[27]. Across the UK, almost a quarter (24%) of those starting a nursing degree either did not graduate or failed to do so within the expected timeframe[28] and neonatal nursing in the North West reflects a similar picture where we are seeing significant attrition rates with 15% of nurses not completing the NIP and 20% leaving the neonates to work in other areas of care.

The below chart sets out data collected in relation to 8 cohorts of nurses on the NIP:

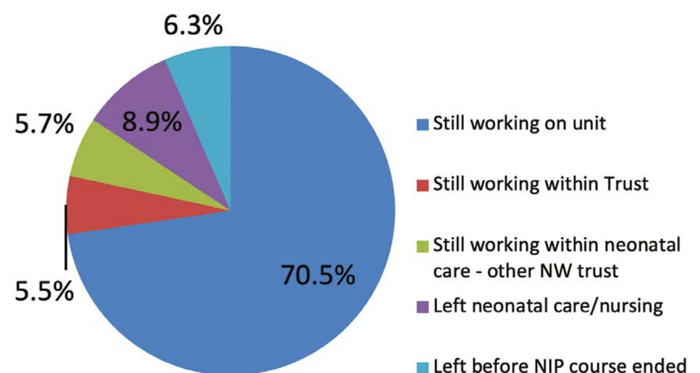


Fig 4: Retention of Neonatal Nurses
(NWNODN NIP Retention 2017-2020)

Within the national survey undertaken by Patterson et al[25], of the staff leaving neonatal units over 22% moved to a different career within nursing, which correlates with the findings of the NIP. A literature review by Ingram School of Nursing McGill University[29] found that 30% to 60% of newly registered nurses changed jobs in their first year and that one third of nurses under 26 years plan to change jobs within 2 years. The review describes the fact that these nurses experience more job stress than their older counterparts with 66% having signs of burnout, exhaustion due to lack of confidence or competence, new situations, high workloads leading to errors and having inconsistent expectations from preceptors.

With the Interim People Plan[5] pledging to expand clinical placements at the same time as developing a national recruitment campaign, an increase in nursing students is likely to follow. This poses a significant question for universities and NHS Trusts of how to attract recruits into neonatal nursing in sufficient numbers to meet both workforce shortages and potential attrition challenges.

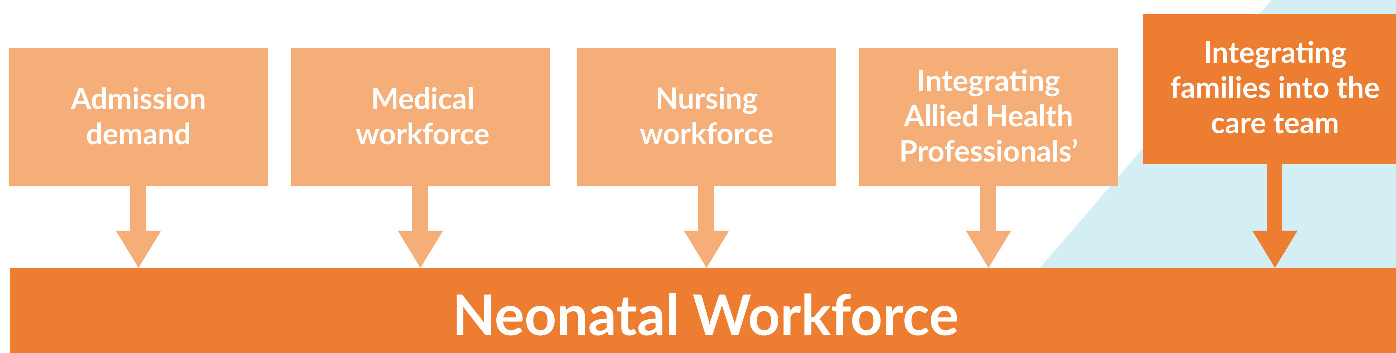
The success of recruitment and retention is further complicated through recognition of generational differences. For the first time in history four different generations will be working together in the same employment environment. New entrants to the workplace – Millennials and Generation Z – seek flexibility and greater work life balance as well has having a portfolio based rather than 'lifelong' career-based plan than previous generations[30].

(See the supplemental document Workforce Strategy for North West Neonatal Units Toolkit – Building a Sustainable Neonatal Team S4.1) This has implications for recruitment, retention and for career paths within healthcare. Anecdotally, through the views of North West neonatal unit managers and educators alike, neonatal nursing is reflecting this global change. The above, fig 4, may illustrate the challenges being faced now and in the future in retaining newly trained nurses.

Allied Health Professionals (AHPs) play a vital role in the quality of care babies receive whilst on a neonatal unit which supports their development and quality of life, AHPs support parents during their time on the neonatal unit to understand their babies' needs thus ensuring healthy long term relationships this in turn should have a positive impact on the long term outcome of the neonatal population.

For each of the disciplines, their level of input into babies' care varies from unit to unit across the North West. Guidelines are set within the DoH Toolkit[9] and BAPM service standards11 that AHPs should have protected time within their job plan to provide support and advice to the neonatal population. In 2015 Bliss[31] identified that 12% of units could not access Speech and & Language Therapists (SLTs) and 43% did not have access to Occupational Therapists (OTs).

More recent work through a national peer review[32] in March 2018 found 'serious concerns' and 'areas for improvement' around the use of AHPs, with the North of England only achieving 18% compliance against the category: "there is a multidisciplinary team of specialist AHPs". Comments within the North West review centred around professionals having insufficient protected time on neonatal units and anecdotally there is a view that AHPs are not integrated as part of the multi-disciplinary teams providing neonatal care. National Neonatal GIRFT project data helps to quantify the gap showing NWNODN to be in the lowest 3rd of ODNs for AHP provision in all but physiotherapy input. The NCCR[4] recognises that AHPs are central to the implementation and embedding of developmentally sensitive care into neonatal practice and requires Trusts to develop an AHP strategy as part of workforce planning.

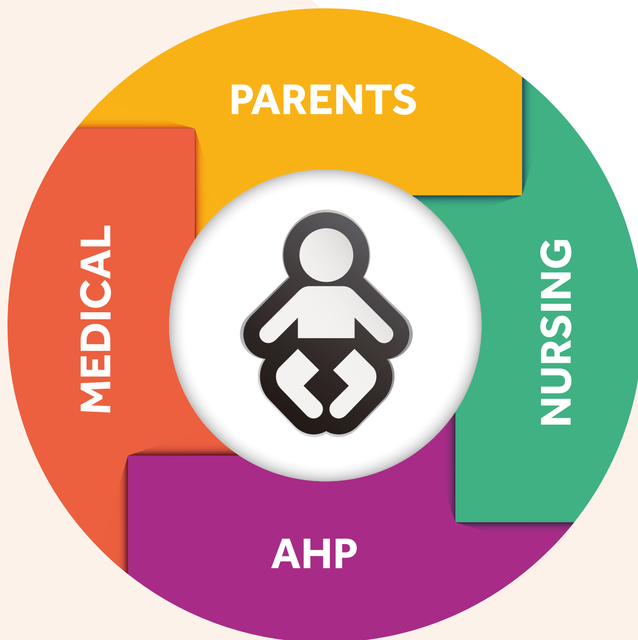


The previous sub sections set out the most significant factors which are facing the current workforce and act as the foundation against which this strategy is set. The Implementation of the NCCR[4] identifies high quality neonatal care must include a substantive role for parents in the care of their baby. In 2017, North West neonatal units committed to developing a Family Integrated Care (FiCare) approach to care within their units. To support this, the NWNODN introduced an accreditation process in December 2019 with the aim of achieving a consistent approach to the development and provision of this model of care.

Trained and supported by healthcare staff, families will be more 'hands on' in caring for their babies. This is a significant cultural change in the neonatal world, where care has traditionally been the responsibility of professionals. Whilst this change will take some time to establish as consistent service provision across the network, it is having an effect on fundamental ways of working in neonatal units.

OUR VISION

Our vision is for neonatal care to be delivered by an integrated, multi-disciplinary, team which makes best use of the skills available and is focused on care by parents and families.



Achieving our vision

At the start of the journey to produce this strategy, it was recognised that each unit across the North West had its own set of specific issues in being able to provide care through a multi-disciplinary team. Many were unable to achieve the guidelines set by the DoH Toolkit[9] and BAPM[11&12], in resourcing their teams, but this looked different dependent on their unit's designation, estate, staffing and activity levels.

As a result of this, it was felt important that time was given to understand what the core neonatal care team should look like in today's world. By bringing together a group of clinical representatives, managers, educators, and a parent representative, they worked through the current standards and job roles to determine the core requirements for NICU and LNU workforce. The real strength of this work was the bringing together of clinical experts and clinicians from across the NW to agree and quantify the WTE for the Quality/Link roles specified in the DOH Toolkit 2010[9] in a way that can be adapted in relation to individual NNUs activity or staffing appropriate for that role.

NWNODN NNU service leads have shared their experience of nursing quality/link roles with particular reference to the increased impact on quality and outcomes when given protected time to undertake these roles. **Inserted below is a case study to evidence this:**

CASE STUDY 1: Quality Roles

The Feeding team
The role of the Neonatal feeding lead ensures that parents are offered the best quality of breastfeeding suport possible by promoting best practice and implementing the UNICEF baby Friendly Intiative standards. The Neonatal feeding lead oversees a team of 6 link nurse/nursery nurses with a special interest in breastfeeding. The current feeding lead is undergoing training with BFI to become a trainer and is also studying to become an IBCLC and a tongue tie practitioner.

The Neonatal breastfeeding leads key responsibilities are:

- Offering support to families and advice to staff with complex feeding and breastfeeding issues
- Working closely with the midwifery infant feeding team to share best practice and to provide training to all staff
- Leading the unit to BFI accreditation through joint project with Cheshire and Merseyside and training all staff once training the trainer is complete
- Work closely with the Cheshire and Merseyside Local Maternity System (LMS)
- Work closely with the North West Neonatal Operational Delivery Network (NWNODN)
- Assisting link nurses/nursery nurses to gain access to further breastfeeding education, running a phone-based breastfeeding clinic to follow up with families on discharge from NNU, this will hopefully move to a clinic, run alongside the neonatal clinc
- Liaising with the multidisciplinary team to ensure babies that are discharged from NNU have breastfeeding support in the community, including breastfeeding specialist health visitors to provide support with more complex breastfeeding issues
- Helping to update and create feeding policies
- Overseeing donor milk usage, audit and liaising with the human milk bank
- Taking on QI projects to help improve/maximise breastfeeding support on the neonatal unit
- Ensure responsive bottle feeding is used and that staff and parents are educated in the reasons why this is used
- Share knowledge and good practice on correct sterilising techniques

Participation in a QI project looking at the Golden hour and importance of hand expressing within an hour of birth - this is being led by the BF team. Monthly statistics shared on the unit displaying babies going home with some breastmilk at discharge - with action plans attached on how to improve services.

Countess of Chester Hospital
Yvonne Griffiths - Ward Manager
Jo Williams - Practice Development Nurse & Senior Neonatal Practioner

Through the actions set out in Implementing the Recommendations of the NCCR[4], Maternity Workforce Strategy[3] National Quality Board[32], and the Maternity Incentive Scheme year 3[14], Trusts are required to draw up plans to address shortfalls in staffing requirements and share these with Operational Delivery Networks. To support the development of these plans, this strategy aims to put Trusts in a position to be best placed to take advantage of the transformation opportunities this creates in workforce planning and the recruitment and training of medical, nursing and AHP roles.

This is not a 'one size fits all' approach; it is set out with the intention of offering Trusts options which support them in building the most appropriately skilled multi-disciplinary team for their unit, while maintaining a degree of consistency across the roles and competencies in place across the North West. To compliment the information provided within in this document NWNODN has produced an additional document, Workforce Strategy for North West Neonatal Units Toolkit – Building a Sustainable Neonatal Team, which provides a helpful suite of resources and information to support neonatal units achieving and sustaining their ideal neonatal team.

Core Team

Workforce Strategy for North West Neonatal Units Toolkit – Building a Sustainable Neonatal Team sets out the core ideal team excluding medical roles, for NICU and LNU/SCBU. This ideal team tool is included to enable units to assess their own workforce complement against.

The ideal team proposes the core workforce, consistent across the region with core role requirements and competencies established; the latter will be described in the NWNODN Education Strategy.

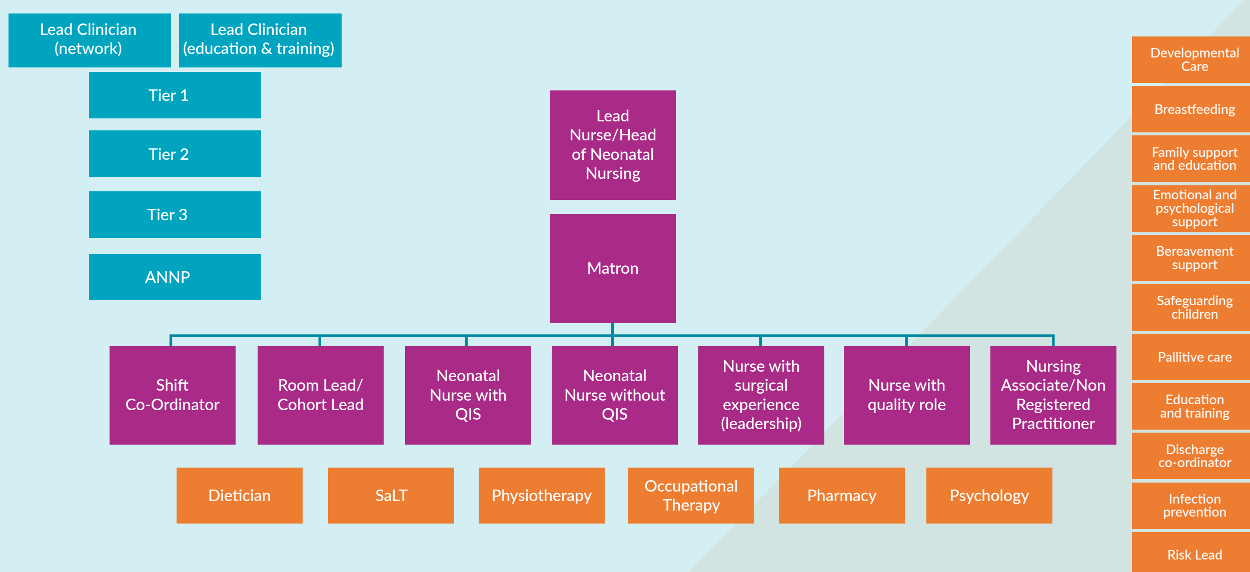


Fig 5: Ideal Core Team

Enhancing the Core Team

This strategy is not aimed purely at increasing the workforce size, it is about finding the right skill mix. It is clear that multi-disciplinary teams with appropriate levels of clinical expertise, offer the best outcomes for babies. Alongside capacity, the NCCR[3] considered having a well-trained workforce in sufficient numbers and with appropriate skills to be the most important development needed in neonatal care. The NWNODN is committed to achieving this and the BAPM nurse staffing standard, as multiple sources of evidence describe mortality, other lifelong outcomes and quality of care are improved when care is delivered at or close to BAPM Nurse Staffing standard[33,34]

In moving forward, we are not starting with a blank page but building on the multi-disciplinary teams already in place in each neonatal unit. This strategy is about enhancing established roles as well as offering an understanding of newly developed roles and how they can fit into existing teams. Building on the core team, we propose a further suite of roles which would effectively provide a 'menu of options' from which units could create the team most appropriate for their service needs. Those roles, summarized below, will each be supported by their own competencies, as per the NWNODN Education Strategy, and where utilised will provide a level of consistency across the network. Each team will look different based on size, activity, specialism and population but should build on the core base ensuring that both cot side care and extended roles cover those outlined by BAPM and the Toolkit. Where WTE was not described within the Toolkit this strategy should be used as a guide to requirements.

Integrating the family into the care team

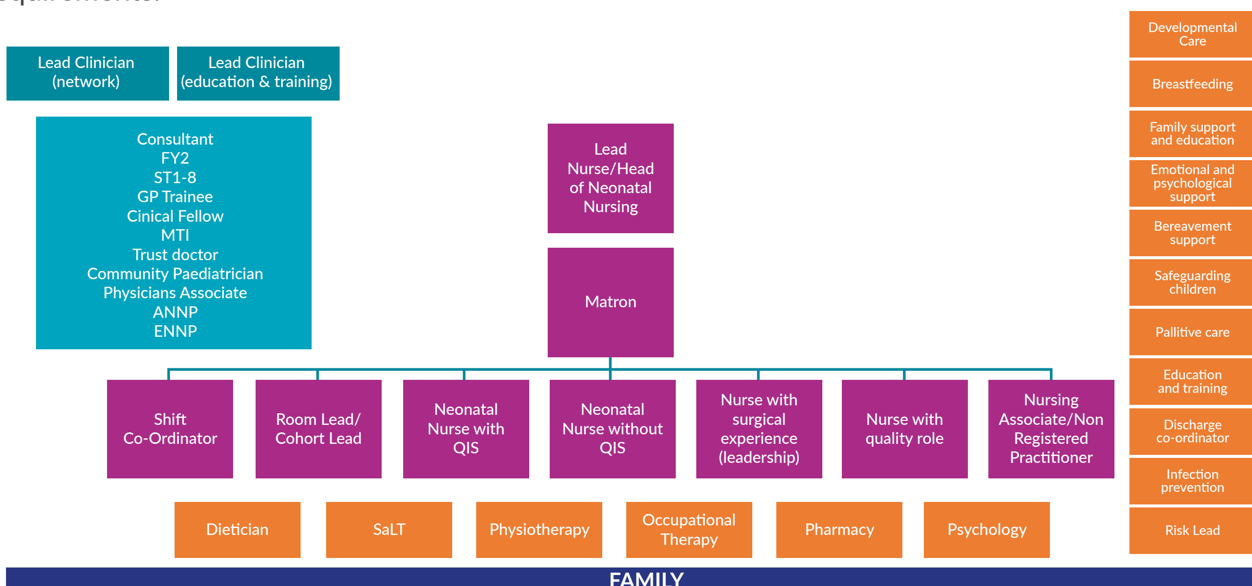
We must not exclude the role of the family within the multi-disciplinary team on the neonatal unit as they are an integral part of the team wrapping care around their babies. The Family Integrated Care (FiCare) model of care enables families to become part of the care team. The NWNODN FiCare Accreditation defines the activities which families can undertake in caring for their baby to enable this integration. Whilst the greater involvement of families in the hands-on care of their babies may on the face of it appear to reduce demands on nursing, this is not borne out by research[35] which found that more resource is required to support parents in caregiving as nurses became educators and coaches for the parents while maintaining responsibility for "more technical aspects of the infant's care"[36] The same study reported that nurses were satisfied with FiCare as a model of care with over 50% noting they had a closer connection with parents as a result.

The Long Term Plan set out its commitment to targeted funding from 2020/21 to ensure that there are Care Coordinators within each of the Neonatal Operational Delivery Networks across England to support families to become more involved in the care of their baby. Work is ongoing to develop and implement this role nationally. Within the NWNODN this role will be in place by Summer 2021

Enhancing and Extending Roles

Figure 6 below outlines an example of a team embracing both core and extended roles.

Fig 6: Ideal Team with Enhanced Roles



In addition to the summary of enhanced and newly developed roles below, the Workforce Strategy for North West Neonatal Units Toolkit – Building a Sustainable Neonatal Team details typical activities and considerations to be for each of the roles below.

Nursing Associate (NA)

A Nursing Associate can provide care and support for patients and service users and bridge the skills gap between clinical support workers and registered nurses. Nursing Associates are members of the nursing team, who have gained a Foundation Degree, typically involving two years of higher education. The Nursing Associate is a stand-alone role regulated by NMC since January 2019 and can provide a progression route into graduate level nursing. The realisation of the Interim People Plan of having 7500 nursing associate trainees by the end of 2019 has led to a number of Nursing Associates practicing in neonatal care, there is recognition that once in post, Nursing Associates need to be supported to develop skill and competencies appropriate to their role.

CASE STUDY 2: Nursing Associate

On the Neonatal Unit at the Royal Oldham hospital we currently have two Nursing Associates forming part of our team that focuses mainly on the care of special care babies. There are many parts to their role which include Family Integrated Care, discharge planning and safeguarding. In addition to this they also form the Home NGT feeding team that aims to enhance parental experience. We are in the process of finalising our trust guidelines to enable our nursing associates to administer medications enabling them to expand on their knowledge and skill set. In recent times we have started to expand our Transitional care service and our Nursing associates have worked closely with the maternity team to work collaboratively in keeping mums and babies together and reducing separation.

'Working on the Neonatal Intensive Care Unit as a Registered Nursing Associate has been the best professional experience I have had. Coming straight from training to this role I have been empowered to continue with my learning and have been supported through my transition from student to qualified member of staff. I have been able to use these skills to provide care and support to neonates and their families as they begin their new journey as a family unit.'

The Royal Oldham Hospital, NICU

CASE STUDY 3: Nursing Associate

Nursing Associates have been welcomed onto the Newborn Services MCS, MFT. The role of the Nurse Associate has been developed with a bespoke education package, to support their integration into the service and yet maintain their unique distinction as a Nursing Associate. As part of this development the Nursing Associates have been supported to develop their competencies in order to undertake and deliver care for an independent cohort of infants in the Special Care and High Dependency areas of the Newborn Intensive Care Unit.

They have been able to develop their proficiency in the care of infants who are receiving CPAP and HiFlow Oxygen therapy and can continue the care for an infant who is receiving Intravenous Fluids with additives. To support them in their role, we have worked very closely with both the Newborn services and the Trust Education teams, who have supported and guided the medicines management and administration by nursing associates which includes Pharmacy, to generate a list of oral medications that the Nursing Associates are able to administer.

The Nursing Associates deliver care to infants overnight as part of the Inreach Cover (the NICU TC model) and are going to be working as a float within the Intensive Care environment following appropriate education and competencies, to be able to enhance their skills and provide support to the registered nurses caring for those infants. The educational package that is provided for the Nursing Associate is bespoke and is tailored to their individual needs.

We currently have 1x Band 4 Nurse Associate. Our NA was one of the first NAs in country having been part of the initial pilot. We are very proud of this. Following qualification they attended further Neonatal specific training to aid consolidation of skills which has proved beneficial and has enticed them to undertake more advanced duties such as administration of medicines. Secondments are being offered to NAs to support Nurse training this is something we hope to invest in in the coming months.

Manchester Foundation Trust – Newborn Services.
(2 sites – NICU and LNU)

Enhanced Neonatal Nurse Practitioner (ENNP)

The ENNP provides a key role in ongoing care of the preterm and term infant as part of the multidisciplinary team. BAPM[11] has acknowledged this role as one of a group of roles appropriate for Tier 1 medical staffing. In neonatal care the role includes undertaking history taking and interpretation of common x-ray findings, learning enhanced clinical practical skills including Newborn Infant Physical Examination (NIPE) and supporting

medical teams in newborn resuscitation within the maternity and neonatal departments. While the original intention for the role may have been to deliver a holistic approach to nursing care, it is being used effectively in differing ways including to support Advanced Neonatal Nurse Practitioners with the more medical management of babies in the high dependency and special care areas of NICU[37].

CASE STUDY 4: Enhanced Neonatal Nurse Practitioner

The service has traditionally supported staff to undertake the Enhanced Neonatal Nurse Practice course to order to support a holistic approach to care of the infant. From this grew the idea that those skills could be harnessed to further improve the care to babies requiring Special Care and High Dependency. The role was and still is to support the medical workforce in the care delivery to this cohort of babies, following the medical model of care. The role offered different opportunities to nursing staff that bridged the role between nursing and medicine whilst supporting the well-established role of the Advanced Neonatal Nurse Practitioner (ANNP).

Nurses working within the now very well established ENNP team need to have undertaken both the enhanced neonatal nursing course and the examination of the Newborn course to ensure they have sufficient background and skills to carry out the role. They work as part of the team in the high dependency and special care areas of the NICU and undertake daily ward rounds alongside the medical team and are overseen by a consultant neonatologist. Many of the team have progressed further to undertake their ANNP training to work on the Tier 1 rota and have found the transition they made as ENNP's working to the medical model, into an ANNP role very beneficial.

Manchester Foundation Trust – Newborn Services - NICU

Specialist Pharmacy Technician

Pharmacy Technicians are professionals, registered with the General Pharmaceutical Council (GPhC). They are members of pharmacy teams with a broad role of preparing, dispensing, supplying and issuing a wide range of medicines to patients, working under the supervision of a pharmacist. Their role can include the provision of a dispensing service; a second checker, relieving the burden on nursing staff; parental education and support around all aspects of medications storage and administration, supporting the family integrated care agenda; and arranging supplies of patient drugs while in hospital and on discharge liaising with GPs and community services to ensure appropriate, timely availability of medication in the community. Our Parent Advisory Groups (PAGs) describe the latter as a real challenge when leaving hospital services.

CASE STUDY 5: Pharmacy technician

Innovations and advances in neonatal care mean the role of the neonatal nurse is continuing to expand and it is essential we consider ways in which the nurse can be better supported to provide high quality cot side care.

Newborn Services are exploring the role of a Pharmacy technician who would be able to support the nursing staff in relation to medications. In a large and busy Neonatal Service, a considerable amount of time each day is spent with the administration of medications which require two registered nurses to check each time. For example, in a busy ICU room this can have an impact on the other patient requirements and demands. A Pharmacy technician would not have the clinical responsibility that a nurse has and as such would be able to fully focus on being the second checker in the process of medicine administration. This would in turn facilitate the nursing staff in the clinical room where the Pharmacy technician was working, to focus on their nursing responsibilities. This role is envisaged to improve safety and increase time the nurse gives to the baby they are caring for.

Manchester Foundation Trust - Newborn Services

Physician Associate

The Physician Associate (PA) role supports doctors and the medical team in the diagnosis and management of patients, offering continuity within the team as they are not subject to rotation through different specialities[39]. PAs have to meet nationally approved standards of training and practice. There is no statutory regulation of the role although work towards this is underway. In the interim period, the Faculty of Physician Associates (FPA) encourages qualified Physician Associates to join their voluntary register as an assurance of qualification.

The role has been developed into the Paediatrics field in recent years, but as yet has limited reach into neonatal care. As such, there will be a requirement to develop a competency framework to suit the requirements of those working within a neonatal unit. The Physician Associate role works with appropriate medical supervision, with mentors to support their career progression[38] and currently is not able to prescribe or request X-rays or CT scans. They have no role in decision making for a patient's treatment.

It has been recognised that there is a need to facilitate staff development for PAs such as non-medical prescribing which could be supported by The Interim People Plan as it is seeking a consultation on introducing prescribing rights after 24 months experience in the role.

CASE STUDY 6: Physician Associate

2021 has seen the first appointments of Physicians associates (PA) with in the Newborn Intensive Care Unit at Oxford Road. Physician Associates (PAs) are an addition to our workforce which help fulfil requirements to staff the neonatal unit other than doctors or nurses and they are being trained to undertake medical roles in HDU and SCBU which are much needed and which they are undoubtedly capable of. They fulfil these roles well and have found them appropriately challenging. They also provide a fresh perspective having not come from a clinical background, which benefits the whole team and especially our babies and families.

By creating opportunities for PAs we have a resource to draw on which does not involve depleting our nursing workforce and at the same time has made our unit a popular place to work by having such a blended workforce which encompasses a number of roles working alongside and providing support for each other.

Although this role is very much in its infancy it is hoped that this blended workforce will continue to support the diversity and sustainability of the medical team. The PA role within other areas of medicine is now well established. It is envisaged that the knowledge and skills the PA's have from their training combined with support and training provided by the medical team in neonatal care will enable our PA's to support both ENNP's and ANNP's in the high dependency and special care areas in their respective roles.

Manchester Foundation Trust – Newborn Services

Advanced Neonatal Nurse Practitioners (ANNPs)

The ANNP role is well recognised in neonatal teams and ANNPs are valued for their clinical experience, expertise, flexibility and the stability they bring to what is by definition a changing medical workforce. This has allowed innovative ways of working to be developed in response to local service need. This has resulted in a wide variance in ANNPs workforce models across the country with ANNPs working in increasingly senior medical roles resulting in a more robust and sustainable medical workforce which provides neonatal nurse progression when supported by a clear framework [39]

In addition to the above it is helpful to consider the potential for ANNPs cross site working and their potential to support all levels of NNUs as they develop in their roles and expertise.

CASE STUDY 7: Advanced Neonatal Nurse Practitioner

"The role of the Advanced Neonatal Nurse Practitioner (ANNP) has become an integral part of the strategy to bridge the gap in the medical workforce while offering opportunities for nursing staff to further develop their role and evolve in their neonatal career path. This role not only brings development opportunities for nursing staff but also helps to support the principle of consistency of care for infants and their families.

ANNP team at Wythenshawe is an experienced cohort of professionals who have been involved in providing high quality care to babies admitted on the neonatal unit. They also provide care to babies on postnatal wards, TCU (in reach) and attend deliveries.

We have 6 ANNP's who provide cover on medical tier 1 rota. As part of permanent staff this helps to maintain a sustained tier 1 cover on the neonatal unit. ANNP's do take various management roles in the form of rota coordination, NNAP data monitoring, FiCare and neonatal governance. Their experience is invaluable and they also provide support to new junior doctors who come for a placement on the unit. ANNP's actively undertake teaching sessions during weekly grand rounds. Stable ANNP workforce definitely helps in an LNU and we at Wythenshawe have been lucky to have them"

Dr. Abhijeet Godhamgaonkar, Consultant and Neonatology Lead,
LNU Wythenshawe Hospital
Manchester Foundation Trust – Newborn Services

Allied Health Professionals

The importance of the use of AHPs as part of a multi-disciplinary team is well recognised and relevant roles have been incorporated into the ideal team. However there is currently a marked disparity of service provision and use of AHPs. It is clear from the work undertaken to develop this strategy that there is a lack of understanding of the role and skills which these professionals can bring, as an integral part of holistic early intervention from day one.
By way of adding to the voice of early introduction of AHPs, our PAGs tell us that they are suspicious of staff who are introduced to them towards the end of their baby's care supporting the case for early involvement of AHPs in a neonate's care.

As the GIRFT data below demonstrates there is currently no equity of access to AHP care for babies across the NWNODN and when compared to other ODNs it is seen to be in the bottom half for "% of units with consistent service" for 6 out of the 8 described AHP roles.

Both the Long Term Plan[1] and the NCCR[4] have recognised the key contributions made to neonatal care by Allied Health Professionals, with individuals Trusts now charged with developing the appropriate resource to support their neonatal service.

Each unit will have a capacity and need for dedicated AHP provision to ensure equity of service for all babies born within our network. These roles can be set against a background of education and training, clinical support and supervision and specialist 1:1 assessment and advice. Each of the professional associations (The Association of UK Dieticians (BDA), Royal College of Occupational Therapists (RCOT), Royal College of Speech & Language Therapists (RCSLT), Neonatal & Paediatric Pharmacists Group (NPPG), Chartered Society of Physiotherapy (CSP), British Psychological Society (BDP)) have proposed recommendations for staffing of roles40 within neonatal ICUs, HDUs and SCBUs. It is recognised that this is a significant step forward in establishing a baseline requirement. These recommendations have been incorporated into the ideal team calculations (see Workforce Strategy for North West Neonatal Units Toolkit – Building a Sustainable Neonatal Team s1.6). This will support the requirement, through the NCCR, for Trusts to develop an AHP strategy as part of workforce planning which sets out the level and expertise of pharmacy and AHP required, the level currently available, and how any gaps will be filled.

An outline of the relevant AHP roles is set out below, with details of their clinical competencies within Workforce Strategy for North West Neonatal Units Toolkit – Building a Sustainable Neonatal Team.

Metric	Source and Year	Number of units in network with highest level of AHP training	Number of units providing unfunded support to network	% of units with consis-tent service	England	Position	Score % (0–10% | 10–25% | 25–75% | 75–90% | 90–100%)
Pharmacy	AHP Questionnaire 2019	3	2	90%	96%	10/12	
Physio - Resp.	AHP Questionnaire 2019	10	3	24%	21%	5/12	
Physio - MSK	AHP Questionnaire 2019			48%	39%	3/12	
Physio - Neurodev.	AHP Questionnaire 2019			43%	46%	7/12	
Occupational therapy	AHP Questionnaire 2019	1	0	5%	12%	10/12	
SLT	AHP Questionnaire 2019	3	4	52%	55%	8/12	
Dietetics	AHP Questionnaire 2019	5	3	62%	67%	7/12	
Psychology	AHP Questionnaire 2019	0	0	14%	27%	10/12	

* Physio is denoted as one group regarding training and funding.

(Fig 7: AHP Staffing GIRFT review of NWNODN March 2020)

Dietitian

The last 20 years have seen a huge number of research studies on the nutritional needs and feeding methods of critically ill infants. The importance of avoiding nutritional deficits by early effective feeding using parenteral nutrition and mother's own milk cannot be underestimated. During prolonged periods of critical care, optimal nutrition is the key to recovery and long-term outcomes. Nutrition is one area where the neonatal team needs to be supported by expert dietitians as a critical member of the team. The main dietetic goal in critical illness is "to prevent the deterioration in nutritional status associated with the stress response" where poor nutrition will add to mortality and morbidity. By enhancing clinical effectiveness and avoiding clinical complications the specialist dietetic role can lead to a reduced length of hospital stay with associated cost saving implications.

In neonatal intensive care units nutrient requirements are difficult to achieve and exacerbated by premature delivery at a time of massive nutrient accretion, low nutrient reserves and a decreased capacity to handle nutrition. The need for optimum nutritional support is paramount as evidence points to short and long term consequences of poor nutrient intake and growth. The National Audit Office report 'Caring for Vulnerable Babies' highlights improved nutrition as one of the improvements that has led to the increased survival rate of preterm infants.

VIGNETTE 1: Dietitian

"Prior to having a dedicated neonatal dietetic service, our paediatric team received very ad hoc requests for advice and support for individual babies on NICU. This usually occurred when the babies had become quite nutritionally compromised and the medical team had exhausted their management ideas. We got many referrals for babies with faltering growth or feeding difficulties post NICU discharge.

Following dedicated funding for a 0.5wte neonatal dietitian our referral pattern has completely changed. Infants are proactively assessed and managed throughout their neonatal journey with improved growth outcomes at discharge and fewer infants being discharged on specialist paediatric formulas. Having protected dietetic time for NICU has allowed us to audit nutritional related practices on the unit and work collaboratively with the MDT to standardise practice and develop guidelines. This has helped to embed the importance of nutrition within the MDT and ensures that both the quantity and quality of nutrition is considered, thus optimising the nutritional intake of all our premature infants."

Carol Pinder, Advanced Paediatric Team Leader Dietitian – NICU
Lancashire Teaching Hospitals – Preston

Occupational Therapist

Occupational therapists form an integral part of the multi-disciplinary team on the Neonatal unit; making a significant contribution to the delivery of developmentally supportive care.

The key elements for successful implementation of the Occupational Therapist role are addressing the underlying need from the Nursing staff, education on developmental care, collaboration and communication with NNU staff, MDT, and families.

VIGNETTE 2: Occupational Therapy

"There is only the one Paediatric OT here at Preston (NICU) and protected time of one day a week currently on Neonates .The value of an OT however is immense and considers the holistic approach to developmental care in particular the consideration of the mental health of the parents/carers. This is vital and forming a relationship with parents to consider the needs of them and their premature baby"

Claire Goulden – Occupational Therapist
NICU - Lancashire Teaching Hospitals

Speech and Language Therapist (SLT)

Neonatal Speech and Language Therapists play an important role in supporting and optimising neonatal feeding. This work begins before suck feeding develops through to the establishment of successful oral feeding wherever possible.

The role of the Neonatal Speech and Language Therapist in enabling interaction and communication between the parent and the infant is integral not only to attachment but to later neurodevelopmental outcomes of this vulnerable neonatal population. Premature infants and those with other diagnoses requiring special care are more at risk of later speech and language and communication impairments. Neonatal units require the regular dedicated presence of a Neonatal Speech and Language Therapist to support staff education, provide timely assessment and management to infants and be an active member of MDT.

Physiotherapist

In recent years we have seen the physiotherapist's role in neonatal units develop from one that had been mainly associated with respiratory care to include advice for staff and parents, assessing development, musculoskeletal and neuromuscular conditions, positioning and handling support and neurodevelopmental input for babies with complex medical needs who need longer stays in hospital.

The neonatal physiotherapist, working closely with the parents and the wider multi-disciplinary team provides early assessment and intervention for babies both born prematurely and for those who have reached full term.

They provide a wide variety of care including neuro developmental assessment and support, respiratory assessment and treatment and, musculoskeletal and neuromuscular assessment and treatment and; offering early support to those babies at risk of developmental delay.

The physiotherapist is involved with all stages on the neonatal unit, from the most vulnerable infants in intensive care to those who are ready for discharge home, facilitating onward referral to community colleagues for home assessment and ongoing developmental needs.

VIGNETTE 3: Speech & Language Therapist

Over the past number of years, we have met as a group of Speech & Language Therapists working across the network. This has identified the significant disparity of SALT services across the units in relation to access, type of service delivered & allocated funded time. SLTs work collaboratively within the neonatal team to support early infant feeding and communication skills. It is recognised that early Speech and Language Therapy intervention on the neonatal unit plays an important role in assessment & management of oral feeding skills, supporting transition from tube to suck feeding and developing early communication skills, thus impacting overall long term outcomes. Developmentally supportive MDT care enables parents to identify and respond to their own infant's individual cues in relation to feeding and communication. Evidence of 'best' practice within the network has identified the funded SALT service in Wythenshawe NNU where historically the service was developed from receiving 0.05wte/week to 0.4wte/week of funded Speech & Language Therapy. Having increased allocated funded sessions has been significant in relation to the timeliness of Assessment & Intervention, promoting & supporting models of practice on unit e.g. FiCare & training of all levels of staff. MDT working has improved patient's care & journey both through the unit & in relation to longer term outcomes.

Jo Marks
Professional Lead Speech & Language Therapy
St Mary's NICU/Wythenshawe NNU

Parent comment on Physiotherapy input

Oscar has global delayed development as well as PVL and ventriculomegaly, so him having physio was crucial in his care! Physio in neonatal is so important and the work the physio team do is amazing and without the hard work they put in I guarantee Oscars development would of been a lot worse!

Sarah Oscar's mum who was born at 29 weeks 2lbs/900g

Psychological Support

The journey from pregnancy to neonatal care and beyond is frequently an extremely traumatic one for families. The impact can be far reaching, affecting attachment security and family relationships and often having a significant longer-term impact on the psychological wellbeing and development of children and parents alike. The demands of work on the neonatal unit can also bring a number of challenges for the clinical team who are then also required to provide a supportive and emotionally safe environment for families, sometimes at cost to their own wellbeing.

Neonatal Clinical Psychologists play an important role in supporting the psychological wellbeing of infants, their parents and the clinical team. They work best as an integrated member of the unit team, providing training, reflective space, supervision and staff support as well as direct work with infants and their parents. Clinical Psychologists are trained to work with individuals and families across the lifespan as well as to provide training and indirect work through other professionals.

Pharmacist – Specialist for Neonatology

This role will act as the lead pharmacist for Neonatology, providing highly specialist pharmaceutical care of babies and supporting healthcare professional in the use of medicines in this area.

VIGNETTE 4: Pharmacist

I love working as a pharmacist on the neonatal unit at the Royal Oldham hospital and I am proud to be part of a fantastic team.

My days are varied and what I set out to do often changes but it means I have to be flexible and no day is ever the same.

The face to face contact allows me to answer questions that crop up as well as making suggestions that can be actioned.

Every day I review all the patients and spend any other time working on projects such as reviewing policies, putting together training, participating in audits and of course some dispensary commitments for pharmacy.

Ruth Hawkins, Senior Clinical Pharmacist - Neonatal, Royal Oldham Hospital

NETWORK ROLES

Whilst network roles exist outside of the North West, this would be a first for the NWNODN. As such there are a number of factors, including funding, which would need to be addressed before progressing these into post.

The NHS LTP committed to new investment to support delivery of the NCCR until March 2024. In 2020 and 2021/22 ODNs received funding to support recruitment into new network-based roles for, Education and Workforce Lead, Care Coordinator and a team of Allied Health Professionals.

Education and Workforce Lead

It is envisaged that Education and Workforce Leads from across the country will come together to support improvements in recruitment and retention, describe and quantify a quality neonatal nursing team, generate and deliver a national standardised approach to neonatal workforce reporting and support their neonatal service providers in completing national workforce submissions.

In addition to the above the NWNODN Education and Workforce lead will work with key stakeholders to implement the NWNODN Workforce and Education Strategies in collaboration with neonatal service leads and educators across the NW.

Care Coordinator

This role is very much key to ensuring that the baby and family are at the heart of neonatal care, ensuring that the parent voice is heard and is integral in developing neonatal care by establishing (if not already present) and maturing Parent Advisory Groups (PAGs). The Care Coordinators will work with PAGs, ODN teams, neonatal service providers and third sector partners to improve outcomes for babies and their families with a focus on embedding FiCare across all neonatal units and quality improvements identified e.g. infant feeding, psychological support, Transitional Care, 2 year follow up etc. A strength of this role will be their linkage and learning from other Care Coordinators as they come together to form a national group.

Network Allied Health Professionals (AHP) Network Teams

In 2021/22, following the commitment in the LTP to develop neonatal AHP support, funding has been released to introduce network level AHP roles within each neonatal ODN, though it is acknowledged that this funding will not support recruitment to the WTE standard for each discipline. It is envisaged that these roles will support the development of Allied Health Professional working. The roles will offer a consistent approach to strategic and operational development of these roles within and across organisational boundaries, reducing inequity and raising standards through education and competency acquisition, generation of standardised guidelines and resources and specialist assessment for complex cases across the network.

A Network AHP Team model has been delivered successfully in South West Midlands Operational Delivery Network. In essence the core role requirement would be the same across the AHP disciplines.

Through collaboration with local neonatal specialist AHPs and the West Midlands Neonatal Operational Delivery Network, who have a well-established and functioning AHP team, the NWNODN has generated a service model and ways of working which can be evaluated and adapted over time. However current funding (for 2021-22) will not support recruitment to the full service requirement for NWNODN which, in line with the national standards and based on live births of around 79000/year, would be 1.6WTE for each of the following: Physiotherapy, Dietetics, and Occupational Therapy & Speech & Language Therapy. That being the case work is underway with the NWNODN AHP group to ensure effective use of the financial resource provided.

The West Midlands Neonatal Operational Delivery Network Model as described by Sara Clarke, Senior Specialist Neonatal Network Dietitian

"Our role sees us heavily invested into Network-wide projects and planning systems such as Family Integrated Care (FIC), Nutrition, and BFI accreditation groups. We have a portfolio of resources which we review/ update and add to as the need arises –all of which support standardised practice and care across the Network. We are looking to standardise our teaching to nurse education embedding our sessions into the Foundation Courses and QIS courses etc. run by Universities and individual units across the Network.

We have become integral members of network-wide managers/education groups/Neonatal LMS's/ Governance Board etc. to advise on AHP staffing, support implementation of FIC and improvements in care not only within our own professions but supporting and advocating for our AHP colleagues such as OT and psychology.

Staffing model: 0.2WTE per 10,000 live births. (We have spilt that as 0.1 WTE developmental care physio and 0.1WTE respiratory physio). All staffing documents recognise this role to be banded at 8a, and this is something we have developed a case for my colleagues to have their roles recognised in this way."

Surgical Nurse Network Role

Locally, through an internal report on pathways evidence has shown that significant delays occur in repatriating babies to their local neonatal unit following care at one of the surgical centres in the North West. This is predominantly due to the limited experience of caring for babies post-surgery at local units, resulting in babies staying at surgical centres for longer than may be necessary and impeding patient flows. Work is ongoing as part of the review of patient flows to consider how a networked role could be developed to aid this situation, alongside improved education on surgical care.

Yorkshire and Humberside have benefited from the recently appointed Lead Nurse for Neonatal Surgery in the Neonatal Services at Leeds Teaching Hospital whose role it is to maintain patient flow for surgical, specialty and cardiac babies. Workforce Strategy for North West Neonatal Units Toolkit – Building a Sustainable Neonatal Team provides access to a job description for Leeds Lead Nurse for Neonatal Surgery.

CASE STUDY 7: Surgical Nurse

"Incorporated within my role, I have developed what the role looks like with some key drivers for safe, high quality care that is equitable. The aim to support early repatriation as soon as safe to do so and ensure care provided is of a high standard with excellent evidence base;

Surgical speciality patients needing paediatric surgery for congenital anomalies, NEC, ENT- airway, Tracheostomies, Neurosurgery- Spina bifida, Hydrocephalus and Urology. I do not specifically follow up cardiac surgical patients. But some of my patients will have a cardiac defect also."

Key Benefits include:

1. Earlier repatriation to DGH. Result is significant reduction in bed days at Leeds for some patients.
2. Patients with stomas for NEC etc can go back to local DGH to grow and develop until big enough to come back to Leeds for stoma closure. This had a big impact on reduced bed days in Leeds.
3. Improved patient flow which ensures availability of tertiary surgical cots
4. Education programme still has on-going developments. But essential for improving practice and standards and. Local teams feel more confident, competent and more knowledgeable in caring for specific surgical neonates. Along with local medical and surgical team, I risk assess the appropriateness for repatriation. I have good links and know the skill set and training for the different level units.
5. Staff at DGHs feel supported in caring for this patient group and have clear links to the tertiary centre and myself if there are and issues. I can visit the local DGH as required to support care or trouble shoot.
6. Written guidance provided
7. Parents can be closer to home- better for finances, visiting, close to their support networks.
8. Financial benefits because of reduction of bed days at the tertiary centre- ICU/HDU and special care bed days.
9. Parents feel confident in the support they are receiving locally and have direct access to myself for advice or if need a clinical consultation if they have any concerns. I can easily link with the paediatric surgeons if there are concerns or we need to readmit to Leeds for specialist care if their condition needs specialist input. We will arrange re admission to Leeds as required.
10. Medical teams can link easily with myself or the surgical on call team

Fiona Metcalfe - Lead Nurse for Neonatal Surgery
Leeds Children's Hospital

MOVING FORWARD – MAKING THE CHANGE

Building the Neonatal Unit Team

It is accepted that changing the workforce structure will not happen overnight but will need time to make a cultural shift to a different team dynamic, supporting different ways of working and fully developing the capabilities of newly created roles.

Each change that a Trust/Unit makes to the structure of its neonatal team will need to consider the impact of that change, understanding that where new roles are considered changes in finance are often required which may result in difficult decisions around exchange of posts. An example of this may be in the employment of a Pharmacy Technician (see page 19).

In helping units to determine the most appropriate team for their workplace, the document Workforce Strategy for North West Neonatal Units Toolkit – Building a Sustainable Neonatal Team provides a toolkit which describes possible options for NICUs and LNUs and highlights examples and areas of good practice both locally and nationally.

It is essential that all units develop an action plan to ensure their workforce is sustainable. In light of the NCCR and Maternity Incentive Scheme[14] these action plans will need to be shared with the NWNODN to ensure system wide workforce plans are in place. An example action plan is included in Workforce Strategy for North West Neonatal Units Toolkit – Building a Sustainable Neonatal Team.

The NWNODN has heard from Providers that there are challenges around clinical competence and the need for a network wide structured approach to the acquisition, maintenance and measurement of clinical competence appropriate to roles and seniority/ responsibility. The NWNODN are committed to supporting the above through the generation of an education strategy.

Although there is a clear recognition from providers that workforce and education gaps exist, plans to address these gaps are in their infancy. With funding granted by HEE, the NWNODN will continue to engage with providers to deliver education programmes to support development and competency acquisition for both nursing and medical staff. At the core of this is the Neonatal Induction Programme which equips the newly qualified nurse, or nurse with no previous neonatal experience, with the necessary knowledge and skills to deliver safe, evidence-based care that meets the needs of the compromised neonate and family.

To continue to deliver the above during 2021 the NWNODN are working closely with Health Education England on a project to develop an Education Strategy describing a sustainable education framework which will ensure all providers and staff delivering neonatal care in the North West have access to standardised, specialist education and training to ensure the competency of the neonatal workforce.

CONCLUSION

It is difficult to imagine a time when neonatal care has been so well placed to undergo transformation as it is currently being afforded through the NHS Long Term Plan, the Neonatal Critical Care Review and the National Neonatal GIRFT review.

Key to the success of that transformation is a sustainable neonatal workforce with the knowledge, skills and competence to ensure optimal quality outcomes for babies and families.

It is the view of those who have contributed to this strategy that it can be used within Providers and across the NWNODN to support innovative ways of working to meet current and future service need in addressing workforce challenges over the next five years.

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(Note: A number of colleagues have since changed roles and/or hospitals. For the purpose of this document, their role and hospital at the time of their involvement in this work is stated)

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GLOSSARY

AHP	Allied Health Profession
ANNP	Advanced Neonatal Nurse Practitioner
BAPM	British Association of Perinatal Medicine
BDA	British Dietetics Associations
BDP	British Psychological Society
CSP	Chartered Society of Physiotherapy
ENNP	Enhanced Neonatal Nurse Practitioner
LNU	Local Neonatal Unit
NHSE	NHS England
NHSI	NHS Improvement
NICU	Neonatal Intensive Care Unit
NPPG	Neonatal & Paediatric Pharmacists Group
PA	Physician's Associate
PAG	Parent Advisory Group
WTE	Whole Time Equivalent
RCOT	Royal College of Occupational Therapists
RCPCH	Royal College of Paediatrics and Child Health
RCSLT	Royal College of Speech & Language Therapists

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