NORTH WEST NEONATAL OPERATIONAL DELIVERY NETWORK

WORKFORCE STRATEGY - TOOLKIT - BUILDING A SUSTAINABLE NEONATAL TEAM

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

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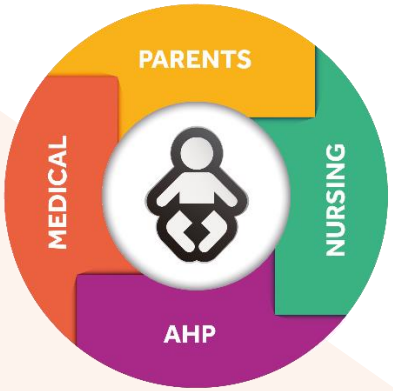
INTRODUCTION

The NWNODN Workforce Strategy sets out the vision:

"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"



This document is intended to assist neonatal units in planning and implementing this vision. It also offers detail of the support available from the NWNODN

It proposes a step by step approach to:

- Quantify
- Build
- Generate
- Move forward

1. Quantify

Quantifying and identifying gaps in the workforce is the first stage to ensuring that the foundations of your workforce mix are understood, and to provide a consistent way in which WTE workforce is measured. The sub sections below set out ways in which quantification can be achieved for the different workforce groupings.

1.1 Nursing workforce:

To quantify the nursing WTE needed for your unit, based on cot base and the National Neonatal Workforce Tool for direct patient care roles – https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/08/Neonatal-Nursing-Workforce-Tool.xlsx

Use the ideal core team to quantify individual roles such as leadership, quality/link roles and AHP roles.
(A tool for calculating quality/link roles is under trial [Sept 2021] and will be published when available)

Identify the gap in roles and WTE between the current and the required nursing workforce

1.2 Medical workforce:

Quantify the medical workforce WTE needed for your unit, based on the BAPM standards:-
Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021) | British Association of Perinatal Medicine (bapm.org)
Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018) | British Association of Perinatal Medicine (bapm.org)

Identify the gap between the current and required medical workforce after allocation of trainees

1.3 Allied Health Professional workforce:

Use the ideal core team to quantify the need relevant to your unit

Consider NWNODN AHP Team when understanding your gaps.

The NWNODN will; work collaboratively with neonatal based AHPs, unit leads and senior management teams to agree both Network-wide and unit based clinical priorities for enhancing and maximising care. They will also support the implementation of up to date, standardised, collaborative guidelines.

1.4 Administrative support team

Use the ideal core team to quantify the need relevant to your unit

1.5 The National Neonatal Nursing Workforce Tool

https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/08/Neonatal-Nursing-Workforce-Tool.xlsx
https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/08/Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf

This tool and its accompanying narrative document have been generated by the National Neonatal Lead Nurse Forum. The final version was presented to the CRG in September 2020 when it was agreed that it should replace the previous version, Dinning Tool. Subsequently it is the tool that the Neonatal Implementation Board are using in their work to support increased funding for neonatal nurses and will be described in the updated neonatal service specification and will replace the Dinning Tool for NHS Resolutions Maternity Incentive Scheme, CNST.

As it is a nationally recognised tool the NWNODN use this tool to support the generation of nurse staffing data as part of their annual Activity, Capacity and Demand Report.

It is noteworthy that in addition to generating the number of WTE nurses required for activity inputted this tool provides WTE nurses required for the cot base.

N.B. This tool is for nurses providing direct patient/cot side care only; it includes a supernumerary shift co-ordinator and excludes leadership and quality/link roles

A calculation for nurse workforce against cot base, direct patient care only

Calculations for nurse staffing are often done in different ways it is key to adhere to the national standards i.e. BAPM and the DOH Toolkit
Below describes the steps for one approach to calculating direct patient care nursing establishment against cot base.

1. Calculate the number of nurses needed per shift
    a. (No. IC x 1) + (No. HD/2) + (no SC/4) +1 shift coordinator = Total number of nurses needed per shift
2. Calculate the number of hours per shift - covering 24 hours
3. Calculate the number of direct patient care nursing hours required per week
4. Calculate the number of additional hours to facilitate an uplift of 25% (DOH)
    a. DOH toolkit identifies neonatal care as a specialist area and as such a higher uplift than other areas i.e. 25%
5. Calculate the total number of direct nursing care hours needed per week including uplift
6. Divide by 37.5 to give WTE nursing establishment for direct patient care only.

Example:_- NNU cot base 2 IC, 2 HD, 15 SC

1. Each shift needs the following number of nurses per shift:
    a. 2 IC cots = 2.00 WTE
    b. 2 HD cots = 1.00 WTE
    c. 15 SC cots = 3.75 WTE
    d. Supernumerary shift co-ordinator = 1.00 WTE
    Total number of nurses required each shift = **7.75** WTE

2. Hours per shift:
    a. Early = 8 hours
    b. Late = 8 hours
    c. Night = 10 hours

3. No. hours per shift x staff needed per week (7 days)
    a. Early = 8 x 7.75 x 7 = 434 hours
    b. Late = 8 x 7.75 x 7 = 434 hours
    c. Night = 10 x 7.75 x 7 = 542.5 hours
    Total = **1410.5 hours**

4. Uplift 25% of 1410.5 hours = **352 hours**

5. Total number of direct nursing care hours needed per week including uplift:
    a. 1410.5 + 352 = **1763 hours**

6. Each WTE nurse give 37.5 hours therefore:
    a. Divide 1763 by 37.5 = **47 WTE**

Number of nurses needed for direct patient care for an NNU with a cot base 2 IC, 2 HD, 15 SC = **47 WTE** which is in line with the national standards.

National Neonatal Nursing Workforce Tool describes a multiplier of 6.07 WTE which for this example would give **47.04 WTE**

N.B.

1. This excludes leadership and quality/link roles
2. Cots should be staffed to 100% as the above calculations demonstrate
    a. Cot occupancy should be at an average of 80% occupancy allowing for variance in demand

1.6 Ideal Team

The ideal team proposes the core workforce; consistent across the region with core role requirements and competencies established (see NWNODN Education Strategy for details of competencies). The core ideal team is included to enable units to assess their own workforce complement against. The WTE figures are based where possible on BAPM standards and guidance from the Neonatal Toolkit[1] AHP services WTE are based on professional associations (BDA, RCOT, RCSLT, NPPG, CSP, BDP) proposed recommendations for staffing of roles[2] within NICUs, LNUs and SCBUs.

Where no whole-time equivalents are described in these sources, consensus was taken from the expert working group who have also suggested indicative banding for each role to reflect the level of knowledge/experience required to undertake each role. It should be noted that due to some service configurations, unit size or high level of activity banding may increase from these described here. Where there is a description of 1 per shift according to Neonatal Nursing Workforce Tool that would equate to 6.07WTE

Note: In developing the Ideal Team, it was felt important to align banding to each of these core roles, matched against Agenda for Change job descriptions.

NICU Ideal Core Team

NICU Ideal Team – Medical Roles

Role Title	WTE required			Additional information
	Day Post	Per shift x 2 shifts	Per shift x 3 shifts	
Lead clinician - Network	These roles should follow the BAPM standard description as outlined in: As per BAPM Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021)			Lead Clinician whose job plan contain identified capacity for their role within the network. As a minimum to include attendance at; Quarterly Neonatal Steering Group, Clinical Effectiveness Group and Safety Champions, the latter 2 roles can be delegated.
Lead clinician – Education & Training				Lead clinician - to ensure appropriate education, training and development for medical staff
Tiers 1 - 3				
ANNP Band 8a/8b				Before acting on Tier 2 rota, ANNP should be able to meet the competencies described in BAPM Service Standards consider using the Cheshire and Merseyside governance framework for advanced clinical practitioner: Paediatrics and Neonates. Career Development Pathway and Assessment tool https://www.improvingme.org.uk/media/1108/cheshire-and-merseyside-governance-framework-for-advanced-clinical-practice-paediatric-and-neonatal.pdf Individuals need to be supported to achieve all 4 Pillars of Advanced clinical Practice, contributing to service development.

NICU Ideal Team - Nursing Roles

Role Title	Band	WTE required			Additional information
		Day Post	Per shift x 2 shifts	Per shift x 3 shifts	
Lead Nurse/Head of Nursing	8c	1			A consideration for large/multisite services and may be Lead over additional services within the Organisation
Lead Nurse	8b	1			
Matron	8a	1			Covering NNU only, potential to have <1 in post dependant on service size/configuration
Shift- Co-ordinator	7		1	1	Supernumerary in line with national standards[1, 3, 4, 5]
Nurse with surgical experience - Leadership (surgical centres)	7	1			Neonatal units providing surgical services have a nurse/midwife with neonatal surgical experience who has clinical leadership responsibility for nursing care of babies needing surgery[6]
Room Lead (Cohort/Area lead)	6		1	1	Accountable for room coordination, nursing care and supervision Requires a level of seniority higher than entry level band 5
Nurse with surgical experience - Advice	6				There must be a surgically experienced nurse on every shift if surgical babies are present, able to give nursing surgical advice to other units in the Network[10]
Neonatal nurse with QIS	5			70% QIS	70% of nurses providing direct patient care should hold QiS - this 70% made up of: Band 5 QiS, and higher bands who are delivering direct patient/cot side care.[1,3,4,5]
Neonatal nurse - no QIS	5				
Non-registered practitioner / Clinical Support worker/Nursing Associate	4			30% SC	No more than 30 % of those delivering direct patient/cot side special care[1,3,4,5]

NICU Ideal Team - Nursing Quality Roles:

These can be development roles and as such the banding can range from 5-7 dependant on a number of factors including level of leadership, responsibility and autonomy as part of a career pathway described in the Education Strategy. (A tool for calculating quality/link roles is under trial [Sept 2021] and will be published when available)

Role Title	Band	WTE required			Additional information
		Day Post	Per shift x 2 shifts	Per shift x 3 shifts	
Breastfeeding/infant feeding support	NNU cover for these roles should be described in local workforce strategies/plans and will vary across services dependant on service need and can change over time e.g. a service with poor breastfeeding rates may have a greater presence of an Infant Feeding Co-ordinator to support QI				0.3 WTE /100 admissions
Developmental care					0.1 WTE / 100 admissions
Family support and education					0.15 WTE / 100 admissions
Emotional and psychological support to families					0.1 WTE / 100 admissions
Safeguarding children					1 link role working with maternity

Palliative care /Bereavement support					0.05 WTE / 10 deaths/year
Education and training					1.3 WTE / 50 staff – with a minimum of 1WTE
Discharge co-ordinator			1	1	0.15 WTE/100 admissions/year
Infection Prevention					0.5 WTE / 30 cots
Risk Lead / Governance					0.3 WTE/100 admissions

NICU Ideal Team - AHP Roles

Role Title	Whole Time Equivalent (WTE)	Professional Body Reference for staffing requirement
Dietetics	0.05-0.1WTE per IC cot 0.025-0.05 x 2 HD cots 0.017-0.033 x 3 SC cots	British Dietetic Association https://www.bda.uk.com/uploads/assets/ab614d3e-e095-4e4f-96ae1458204e8810/BDA-Formatted-Staffing-Recc.pdf
Physiotherapy	0.03-0.05 WTE per IC/HD/SC cot	Chartered Society of Physiotherapy https://www.csp.org.uk/system/files/documents/2018-11/apcp_physiotherapy_staffing_recommendations_for_neonatal_units_in_england_2018_0.pdf
SLT	0.04 x 1 cot +0.02 TC cot	Royal College of Speech & Language Therapists https://www.rcslt.org/-/media/Project/RCSLT/neonatal-speech-and-language-therapy-staffing-level-recommendations.pdf
Occupational Therapy	0.05-0.1 WTE x 1 IC cot 0.025-0.05 x 1 HD cot 0.025-0.05 x 2 SC cots	Royal College of Occupational Therapists https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/neonatal-services
Pharmacy	0.1 x 1 IC cot 0.1 x 2 HD cots	Neonatal & Paediatric Pharmacists Group http://nppg.org.uk/wp-content/uploads/2018/10/NPPG-Neonatal-Pharmacistsstaffing-recommendations-published-with-RPS-Oct-2018.pdf
Psychology	0.6 WTE + 1 per 3000 births	British Psychological Society https://www.bps.org.uk/sites/bps.org.uk/files/Member%20Networks/Faculties/Perinatal/Briefing%20Paper%208%20-%20Perinatal%20Service%20Provision%20The%20role%20of%20Perinatal%20Clinical%20Psychology%202016.pdf

NICU Ideal Team - Administrative/Support Roles

Role Title	Band	WTE required			Additional information
		Day Post	Per shift x 2 shifts	Per shift x 3 shifts	
Housekeeping	2				0.25 WTE / 100 admissions
Data entry and validation					This will be dependent on systems used in individual trusts.
Administration	4		1	1	Minimum requirement 1 x 12 hours/5 days
Business management					As required
Technical support					Daily access/by request

LNU Ideal Core Team

LNU Ideal Team - Medical Roles:

Role Title	WTE required			Additional information
	Day Post	Per shift x 2 shifts	Per shift x 3 shifts	
Lead clinician - Network	These roles should follow the BAPM standard description as described in: As per BAPM Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021)			Lead Clinician whose job plan contain identified capacity for their role within the network. As a minimum to include attendance at; Quarterly Neonatal Steering Group, Clinical Effectiveness Group and Safety Champions, the latter 2 roles can be delegated.
Lead clinician – Education & Training				Lead clinician - to ensure appropriate education, training and development for medical staff
Tiers 1 - 3				
ANNP Band 8a/8b				Before acting on Tier 2 rota, ANNP should be able to meet the competencies described in BAPM Service Standards consider using the Cheshire and Merseyside governance framework for advanced clinical practitioner: Paediatrics and Neonates. Career Development Pathway and Assessment tool https://www.improvingme.org.uk/media/1108/cheshire-and-merseyside-governance-framework-for-advanced-clinical-practice-paediatric-and-neonatal.pdf Individuals need to be supported to achieve all 4 Pillars of Advanced clinical Practice, contributing to service development.

LNU Ideal Team - Nursing Roles

Role Title	Band	WTE required			Additional information
		Day Post	Per shift x 2 shifts	Per shift x 3 shifts	
Matron	8a	1			With responsibility for neonatal services.
Ward Manager	7	1			All neonatal units should be led by a supernumerary senior nurse who is responsible for the unit and who can ensure that it is safely staffed and that workforce planning is effective NQB[8]
Shift- Co-ordinator	7		1	1	These senior members of the nursing team should have additional roles e.g. team leadership/quality roles
Area/Room Lead)	6		1	1	In larger LNUs accountable for area/room coordination of nursing care and supervision An unlikely requirement for Special Care Units
Neonatal nurse with QIS	5			70% QIS	70% of nurses providing direct patient care should hold QiS – this 70% made up of: Band 5 QIS, and higher bands who are delivering direct patient care. [1,3,4,5]
Neonatal nurse - no QIS	5				
Non-registered practitioner / Clinical Support worker/Nursing Associate	4			30% SC	No more than 30 % of those delivering direct patient special care [1,3,4,5]

LNU Ideal Team - Nursing Quality Roles:

These can be development roles and as such the banding can range from 5-7 dependant on a number of factors including level of leadership, responsibility and autonomy as part of a career pathway described in the Education Strategy. (A tool for calculating quality/link roles is under trial [Sept 2021] and will be published when available)

Role Title	Band	WTE required			Additional information
		Day Post	Per shift x 2 shifts	Per shift x 3 shifts	
Breastfeeding/infant feeding support	NNU cover for these roles should be described in local workforce strategies/plans and will vary across services dependant on service need and can change over time e.g. a service with poor breastfeeding rates may have a greater presence of an Infant Feeding Co-ordinator to support QI				0.3 WTE /100 admissions
Developmental care					0.1 WTE / 100 admissions
Family support and education					0.15 WTE / 100 admissions
Emotional and psychological support to families					0.1 WTE / 100 admissions
Safeguarding children					1 link role working with maternity
Palliative care /Bereavement support					0.05 WTE / 10 deaths/year
Education and training					1.3 WTE / 50 staff - with a minimum of 1WTE
Discharge co-ordinator			1	1	0.15 WTE/100 admissions/year
Infection Prevention					0.5 WTE / 30 cots
Risk Lead / Governance					0.3 WTE/100 admissions
Safeguarding children					1 link role working with maternity

LNU Ideal Team - AHP Roles

Role Title	Whole Time Equivalent (WTE)	Professional Body Reference for staffing requirement
Dietetics	0.05-0.1WTE per IC cot 0.025-0.05 x 2 HD cots 0.017-0.033 x 3 SC cots	British Dietetic Association https://www.bda.uk.com/uploads/assets/ab614d3e-e095-4e4f-96ae1458204e8810/BDA-Formatted-Staffing-Recc.pdf
Physiotherapy	0.03-0.05 WTE per IC/HD/SC cot	Chartered Society of Physiotherapy https://www.csp.org.uk/system/files/documents/2018-11/apcp_physiotherapy_staffing_recommendations_for_neonatal_units_in_england_2018_0.pdf
SLT	0.03 x 1 cot +0.02 TC cot	Royal College of Speech & Language Therapists https://www.rcslt.org/-/media/Project/RCSLT/neonatal-speech-and-language-therapy-staffing-level-recommendations.pdf
Occupational Therapy	0.05-0.1 WTE x 1 IC cot 0.025-0.05 x 1 HD cot 0.025-0.05 x 2 SC cots	Royal College of Occupational Therapists https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/neonatal-services

Pharmacy	0.1 x 1 IC cot 0.1 x 2 HD cots	Neonatal & Paediatric Pharmacists Group http://nppg.org.uk/wp-content/uploads/2018/10/NPPG-Neonatal-Pharmacistsstaffing-recommendations-published-with-RPS-Oct-2018.pdf
Psychology	0.6 WTE + 1 per 3000 births	British Psychological Society https://www.bps.org.uk/sites/bps.org.uk/files/Member%20Networks/Faculties/Perinatal/Briefing%20Paper%208%20-%20Perinatal%20Service%20Provision%20The%20role%20of%20Perinatal%20Clinical%20Psychology%202016.pdf

LNU Ideal Team - Administrative/Support Roles

Role Title	Band	WTE required			Additional information
		Day Post	Per shift x 2 shifts	Per shift x 3 shifts	
Housekeeping	2				1 x 7 days
Data entry and validation					This will be dependent on systems used in individual trusts.
Administration	4	1			1 x 12 hours/5 days
Business management					As required
Technical support					Daily access/by request

Note (1): The WTE figures are based where possible on BAPM standards and guidance from the Neonatal Toolkit[1] AHP services WTE are based on professional associations (BDA, RCOT, RCSLT, NPPG, CSP, BDP) proposed recommendations for staffing of roles[2] within neonatal ICUs, HDUs and SCBUs

Note (2): Since the compilation of the Ideal Team there has been increased prevalence of recruiting to Nurse Associate roles at Band 4.

2. Build

Building the right workforce mix for your neonatal unit (NNU) is not solely a matter of identifying the gap in WTE for nursing, medical, AHP and administrative functions. Your action plan will require reflection and consideration of the mix of staffing roles which you believe are the most appropriate for your service. This should include consideration of roles which may not currently exist within your (NNU) as well as those which you have not yet integrated from the ideal team. To assist you in this consideration, the below sets out typical activities of those enhanced roles as well as providing a number of job descriptions.
Another aspect to consider when building your ideal team is not just the roles, but the potential for flexible use of those roles.

2.1 Mobile Workforce

In a number of larger Trusts, where multiple sites fall under an umbrella organisation, there have been moves to introduce a 'mobile' workforce which can be rostered across sites according to resourcing need.

This concept offers the opportunity to address not just immediate resourcing needs but some of the challenges described earlier around:

- Making jobs attractive, especially for post millennials considered in the Workforce Strategy with their tendency to change roles, need to be exposed to different environments and ways of working to understand their career opportunities.
  - to improve recruitment and retention across generational differences
- Achieve/maintain competence
  - A challenge for LNU and SCBU services across all staff disciplines
- Workforce follows activity
  - Improving patient flows and supporting care closer to home
- Reduced variance in practice supports staff and family experience

There is the potential to extend 'mobile' working across neonatal medical, nursing and AHP roles. The success of this way of working is dependent on a number of issues being addressed, which would include; standardised ways of working and equipment as well as an agreed understanding between Trusts on working practices, which could be addressed through a Memorandum Of Understanding or staff passport in a similar to that being embedded across the Lancashire and South Cumbria system in 2021.

2.2 Typical Activities of Enhanced Roles

As described in the Workforce Strategy, the Ideal Team task and finish group generated the lists below of skills/activities some of the enhanced roles can undertake to support the development of hospital specific Ideal Team based on individual neonatal service need.

Nursing Associate

Intensive Care (IC) area

- Allocated to work within the Intensive Care environment but will not be allocated as primary carer
- Assist in nursing care which will include assisting in infant cares under direct supervision of the Registered Nurse. This care may include the administration of Naso/Oro Gastric Tube feeds (this does not include passing the tube in an infant with an ET)
- Assisting in positional changes of the infant up to and including assisting parent with Kangaroo Care under direct supervision of the Registered Nurse.
- Provide support for families
- Seconding checking infusions following training packager
- Undertaking monitoring of blood glucose under instruction of the Registered Nurse

High Dependency (HD) area

- Allocated to work within the High Dependency environment but will work under the supervision of a Registered Nurse in a similar way as is described above in IC

Special Care (SC) area:

- Indirect supervision. A Registered Nurse will be allocated to the same room and will oversee all care. It is reasonable to understand that in SC NAs will have a more autonomous role, planning and evaluating care they have been assessed as competent to undertake under indirect supervision of a Registered Nurse.

Considerations for introducing this role:

In some areas the introduction of a Nurse Associate role will alter the skill mix between the Registered Nurse and the Nurse Associate.

Careful consideration should be given to ensure adequate supervision of Nursing Associates and the DOH[6] recommendations around the minimum % of the workforce establishment who are required to hold a current Nursing and Midwifery registration, which at the time of writing registration related to RNs and RMs.

Enhanced Neonatal Nurse Practitioner (ENNP)	Delivery • Attend high risk delivery as nurse lead Admission • Cannulation • Take venous bloods/culture • Prescribe agreed medication via Patient Group Directive During stay • Cannulation • Sampling of arterial line Arterial bloods • Basic respiratory management – blood gases • Removal of lines (UVC/UAC/Long Line) • Feeding management • Manage Retinopathy of Prematurity screening Discharge Preparation • Newborn Infant Physical Examination (NIPE) • Family support • Paperwork • Organisation of MDT Suggestion of additional roles • Shift Coordinator • Manage Retinopathy of Prematurity clinic for Out Patient • Outreach lead
Advanced Neonatal Nurse Practitioner (ANNP)	Pre Admission ○ Antenatal Counselling Delivery ○ Carry bleep ○ Lead resus whilst awaiting senior ○ Intubate ○ Give surfactant ○ Site Lines ○ Give resus drugs ○ Give blood if needed ○ Assess and support in decision making ○ Communicate with family Admission ○ Cannulate ○ Venous Bloods/Culture ○ Site lines (UAC/UVC) ○ Order and interpret x-rays

	○ Prescribe drugs/fluids ○ Set ventilation ○ Make management plan ○ Admission paperwork – Badger admissions ○ Communicate with family **During stay** ○ Lead daily ward round in HD/SC, support in IC – documentation; examination (NIPE); management plan (Resp, CVS, feeding, sepsis, rationalisation of meds) ○ Ventilation management – gas interpretation; treatment decision making; appropriate escalation; reintubation; extubation; step down – CPAP-High Flow ○ Site lines – longline; PAL; PVL ○ Order and interpret X-rays ○ Bloods (Venous/Arterial/Heel prick) – interpret; make treatment decisions ○ Review of unwell baby - make management plan; order investigations; interpret; escalate appropriately; prescribe ○ Cruss ○ Lumbar Puncture – obtain consent; undertake procedure; order tests; interpret results; make management plan ○ Daily update to family ○ Liaise with MDT – referral to AHP and outside speciality services ○ Prescribe drugs as required ○ Immunisation – prescribe; administer ○ Support Fi Care – communication with families; involve on ward round **Discharge Planning** ○ NIPE – complete check; order additional tests (hip scan, renal scan); arrange follow up ○ Follow up – bloods; appointment ○ Referral – Outpatient referral letters ○ Badger letter ○ Take part in MDT meetings **Additional roles** ○ Education ○ Audit ○ Research ○ Clinics – BCG; Outpatient reviews ○

Specialist Pharmacy Technician	Providing medicines information to staff and parents • Medicines management • Training, supervising and assessing junior staff and trainee • Dispensing and arranging clinical trial medicines • Second checker, attend Deliver suite for drug preparation, support parents giving medication (FiCare), stock control, medicines recourse with pharmacist, prep for discharge – link with GP and community pharmacist assurance correct drugs available etc. *Considerations for introducing this role:* This role would offer no material change to any other roles but would: • Enhance service to parents in relation to understanding medications. • Assist in medicines management to ensure safety
Physician's Associate	In considering the role which a Physician Associate can undertake will differ between the NICU and LNU care settings. **NICU:** Pre-delivery: equipment checking Delivery: Part of the delivery team, attending as 2nd person with senior support Can communicate with family (supportive, not discussing prognosis) Site lines – for specific gestations as per local policy. Admission: Cannulation Venous Bloods/Culture Site lines (UAC/UVC) Admission paperwork plus Badger admission During stay: Contribute to daily ward round - complete documentation; examination; NIPE Site lines: Longline / PAL / PVL Bloods (Venous/Arterial/Heel prick) Interpretation of results Cruss - additional training (images, not to interpret) Lumbar Puncture: obtain consent; undertake procedure; order tests Daily update to family Discharge: NIPE Escalate if abnormalities Follow up Bloods Appointment Badger letter Additional: NIPE clinic Audit Research

	LNU Within an LNU, a Physician Associate role could encapsulate the majority of activities set out above. However it is envisaged that there would be limited activity around the following: 1. Communication with families 2. Interpretation of bloods results (clear pathways would need to be developed) 3. Lumbar puncture – obtaining consent would be the extent of involvement 4. Siting of central lines *Considerations for introducing this role:* • It is a task based role which needs to offer a sufficient range of tasks to create a meaningful role • Clarity between PA and Enhanced Nurse role may need to be established • There is potential for the role to expand given training and competency achievement, on a par with an ANNP role, with inclusion on the Tier 1 rota, it should be noted that this would be over time to allow for the acquisition of experience knowledge and competence to the level of an ANNP. Development of role versus horizontal career path
Dietitian	The Dietitian can have a significant impact on the care of sick and premature babies as part of the neonatal team:- • Provision of consistent nutritional care to each infant • Designing nutrition practice protocols and monitoring tools • A nutritional assessment and intervention for those babies with complex aetiologies and feeding difficulties that compromises their nutritional intake. • Involvement throughout the admission in terms of family integrated care. Education with regards to feeding, nutritional intake, support and preparation for discharge. • Provision of education and training for all HCP's on neonatal nutrition • Lead on nutrition audits, projects and research • In extended practice within role, Dietitians with a non-medical prescribing qualification are • prescribing TPN, specialist feeds, vitamin and mineral supplements
Occupational Therapists	The role aims to provide- • Appropriate assessment of the infants' Neurobehavioral states • Enhance functional participation of the infant within the Neonatal unit environment • Focused neonatal assessment of active and passive range of motion and evaluation • Treatment – to promote postural alignment and enhance positive infant /parent interaction. • Education to staff and parents with regards to developmental milestones. • Positioning through play to promote self- regulation and facilitate the infant's participation in normal sensorimotor experiences such as bringing hands to face • Family support to promote optimal infant development • Advice re. positioning when baby is home including any appropriate seating or equipment • Discharge planning and decision making with MDT • Onward referral to community colleagues for home assessment and ongoing developmental care needs

Speech & Language Therapist	Through early intervention, the Speech and Language Therapist can positively influence the baby's early sensory and motor development which in turn can positively shape the precursors to a successful oral feeding outcome. • Co-ordination of sucking, swallowing and breathing for effective feeding develops as the infant matures and may not reflect gestational age. This requires awareness and support to establish this safely and effectively. • Proactive input to maximise the potential for successful oral feeding & reduce potential development of later feeding difficulties. • Some babies with complex aetiologies will have more specific swallowing difficulties putting them at increased risk of aspiration. This requires specialist assessment and intervention to support safe feeding and provide positive oral experiences. It requires the SLT to assess these risks and ensure effective transfer for ongoing support from community based SLT services. • In extended practice within role, SLTs can undertake ▪ Lactation Consultant role & qualification ▪ Developmental Care Lead on unit with further qualifications at FINE level 2 or NIDCAP ▪ Infant feeding Lead supported by BFI training ▪ NANT Neonatal Therapy Qualification
Physiotherapist	• Neurodevelopmental assessment of babies who meeting referral criteria, in line with NICE follow up guidelines; to optimise early intervention. • Following assessment to provide advice and intervention, including gestational related developmental care and positioning guidance, play time ideas (once term) and head moulding advice if indicated. • Work as part of the IDT teaching parents about developmental care from day one on, to optimise long term developmental outcomes. These should include neuromotor, musculoskeletal, sensory and cognitive; through positioning, handing and wakeful play time ideas; with FiCare as core practice. • Working as part of the education team where appropriate, teaching new staff and enhancing existing staff's knowledge about developmental care and the importance of developmental positioning, handling and the environment from admission to discharge, to optimise developmental outcomes • Providing self-competencies for staff to complete post training to declare they are self-competent.
Psychological Support	• Providing emotional support and/or therapy for parents to make sense of their feelings and experiences and to address the symptoms of trauma. Ideally, this would be available in a responsive way from a psychologist based on the unit who is also able to offer follow up as parents return home (as this is when symptoms of trauma often become more apparent). • Providing psychological support for infants on the unit – supporting parents and staff to attune to each baby and to respond to their individual needs, thereby promoting secure attachment relationships • Providing training, supervision and ongoing consultation to support the wider MDT in understanding infants' and parents' needs and presentation and how to respond effectively (particularly if parents are challenging to engage - e.g. struggling with mental health difficulties / hostile / withdrawn) • Providing emotional support for staff to manage the intensity of this work - e.g. 'debriefing' after challenging events, individual or group reflective practice, embedding wellbeing initiatives etc
Pharmacist – Specialist for Neonates	• Undertaking a daily ward round to clinical review individual babies' prescriptions and management plans to ensure the most appropriate use of medicines • Formulating and updating individual pharmaceutical care plans depending on therapeutic response, results of investigation and adverse effects • Ensuring appropriate therapeutic drug monitoring is performed and results are actioned in a timely manner

	• Acting as an expert source of information about medicines to all ward staff, in areas such as the correct calculation of doses and administration of intravenous medication, clinical interpretation of potential drug interactions and dose adjustments to be made for babies with complex medical problems • Promote breastfeeding of babies in this hospital where the mother is prescribed medications by providing up to date evidence and relevant education to colleague, both in pharmacy and across the hospital, on the safety of breastfeeding to support the mother in making an informed decision about whether to breastfeed • Advising clinical staff of all levels to influence treatment decisions that will lead to improvements in patient care • Educating parents, guardians and carers on the safe use of medicines needed after discharge, particularly in situations with complex dosing regimens or preparations that require manipulation to administer • Attendance on consultant or registrar-led ward rounds • The construction of neonatal data sheets to ensure safe prescribing, administration and monitoring of medicines commonly used in the neonatal setting to support the safe and effective use of medicines • Developing evidence-based treatment protocols for use either within the directorate or for use across the Trust where appropriate • Facilitating the implementation of national guidelines appropriate to neonatal medicine • Supporting the directorate in reporting, investigating and learning from medication incidents • Provide highly specialist pharmaceutical and legal information concerning medicines management and pharmacy issues to trust's healthcare professionals, patients and their carers and general practitioners and other community-based healthcare professional
Allied Health Professionals Network Role	• Review of clinical practice across network • Oversight of service delivery within network • Support in business cases for units with no AHP services • Consistent training to all units • Development of standardised guidelines/protocols • Role within mandatory training across network • Offer specialist assessment for complex cases across network • Develop clinical supervision & skill mix within units to ensure professional competencies are met • Lead in development of network referral criteria • Lead in development of network policies/audits within specialist professional field • AHP representative within wider network projects/ research • Maintain a complex caseload to maintain professional competencies • Represent the NWNODN at national level
Network Surgical Nurse	• Ensuring the highest standard of clinical care and evidence-based practice for surgical neonates and infants. • Ensuring continuous provision of integrated care across organisational boundaries • Review patient pathways and facilitate early discharge of patients • Support for repatriations and safe on-going care at Neonatal Units within the Network • A proactive role in the education and training of the multidisciplinary team(s), providing on-going supervision and support as an expert resource for all disciplines where neonates and infants have had specialist /tertiary surgery. • Act as a resource for colleagues, patients and the public in relation to neonatal surgical care • Forge alliances with local user groups in order to provide an outreach information service

2.3 Job Descriptions

The following job descriptions and person specifications are available on request to the NWNODN (nwnodn@alderhey.nhs.uk)

Nurse Associate	(Royal Oldham Hospital)
Ward Clerk	Manchester FT
Neonatal Support Worker	Kettering General Hospital
Nursing Associate	Royal Oldham Hospital, Manchester FT, University Hospitals Sussex
Nursery Nurse	Ashford & St Peters Hospitals
Senior Nursery Nurse for Neonatal Outreach	University Hospitals Coventry & Warwickshire
Neonatal Staff Nurse	Royal Bolton FT, Walsall Health Care NHS Trust, Torbay and South Devon
Neonatal Outreach Nurse	University Hospitals Coventry & Warwickshire
Band 6 Neonatal Critical Care Outreach Coordinator Specialist	Imperial College Healthcare
Neonatal Senior Staff Nurse	University Hospitals Sussex
QIS Neonatal Sister	Warrington & Halton NHS Teaching Trust, University Hospitals Coventry & Warwickshire
Neonatal Clinical Practice Educator	University Hospitals Sussex
Neonatal Senior Sister	Barts Health Trust
Neonatal Unit Ward Manager	Warrington & Halton FT
Neonatal Matron	London Free Hospital

Enhanced Neonatal Nurse Practitioner	Manchester University FT
Advanced Neonatal Nurse Practitioner	Royal Cornwall Hospital
Network Surgical Lead Nurse	The Leeds Teaching Hospitals
Junior Clinical Fellow	Barking, Havering & Redbridge
NICU Clinical Research Fellow	Ashford & St Peters Hospitals
Neonatal Transport Fellowship	University Hospital of Leicester
Consultant in Neonates	South Tees Hospitals , Imperial College Hospitals
Physician Associate	University Hospital of Leicester
Pharmacy Technician	Liverpool Women's NHS FT
Medicines Administration Technician	Bradford District Care NHS FT
Specialist Pharmacy Technician	Manchester University FT
Neonatal Pharmacist	Liverpool Women's NHS FT
Clinical Lead Specialist Dietitian: Neonates	Imperial College Healthcare
Service Specification: Allied Health Professionals	West Midlands Operational Delivery Network
Clinical Psychologist Neonatal	Guy's & St Thomas' FT
Clinical Psychologist (Neonatal/Bereavement)	St George's University Hospitals
ODN Care Co-Ordinator: Engagement and Evaluation Lead	South West Neonatal ODN

3 Generate

3.1 Generating an action plan

- Generate a workforce action plan:
  - Sample action plan (see below)
  - Refer to NWNODN Education Strategy to develop “ideal team”/competence/confidence etc.

- Share Workforce action plan with NWNODN team

NWNODN Sample Workforce Action Plan 2021

	Aims/ Targets/ Objectives	How this will be achieved	What expected outcome will be	What evidence will support this	Lead	Timescales	Monitoring/ Update
1	Achievement of National Neonatal Nursing Standards: NHSI (2018); NHSE Neonatal Service Specification e08 (2015); DH (2009); BAPM (2010); NICE (2010)	a) Accurate data collection using: - National Nurse Workfoce Tool (NNWT) for direct Paitent/Cotside Care - NWNODN Quality Nursing Roles Calculator (QNRC)- For Quality Roles b)Ongoing discussion with appropriate Organisational leads e.g. Service & Finance Leads c) Ensure Neonatal Safety Champion is aware of ongoing challenges/risks due nurse staffing shortages	a) Identification of total nursing gap/deficity against cotbase, activity & quality roles b) Organisational awareness of nurse staffing position, Generation of Action Plan for achievement of national standards c) Any challenges are escalated to Trust Board for information/action				
2	Share Nurse staffing information, workforce strategy and action plans with NWNODN as stated in Neonatal Critical Care Review and CNST	a) Work with NWNODN team to complete NNWT and QNRC b) Workforce Strategy & Action Plan shared with NWNODN	a) Completed tools to be held locally and by NWNODN b) NWNODN will use data, W/F Strategy and Action Plans to: - Identify gaps for NCCR funding - Inform ODN W/F and Education Strategy				
3	Recruitmentof registered nurses in line with BAPM recommendations with regards to safe staffing levels against patient ratios	a)Current on-going recruitment campaign to recruit to establishments b)Ensuring applications shortlisted in timely way and assessment panels and interview panels set up in advance and to keep to weekly timetable schedule	a) Staffing levels to reflect these required fror accuity.	a) Reflected in compliance recorded by local system			
4	Ensure the recruitment process minimises the time to hire	a).Regular meetings with recruitment team b)Review Assessment Selection tools to assist with recruitment to ensure right calibre of candidates c)Implement Values based assessment centres c) Regular Workforce meetings to discuss all issues.	a) Recruitment in line with Trust standard recruitment time.	a)Staff in post within timeframe.			
5	Develop a recruitment media strategy in order to attract a broader range of candidates	a) Work with recruitment and HR colleagues to develp brand. b)Continue to develop innovative Recruitment Solutions such as use of Social Media e.g. Twitter,	a) Brand reflects Divisional vision and values	a) recruit campaigns. b) minutes of workforce meeting			
6	Review of roles to manage skill mix and encourage inavitive roles.	a) Introduction of New roles b) Review of AHP services and how these support the nursing workforce.	a) Implementation of new roles and asociated competencies.	a) Role diversity			
7	Monitoring of Staffing levels to ensure levels are in line with accuity	a)Weekly review	a) Clear review of staffing on a weekly basis. b) Report of staffing to workforce group. c) Weekly monitoring of data on the Clevemed nursing data.	a) Monthly Reports b) Clevemed Satffing data			
8	Review of Exit Interview process and understanding of why staff stay	a)Review of current Exit Process and Leavers Policy b)Review to be conducted and recommendations on how returns can be improved c)Action plan to ensure feedback is acted on.	a)Improved positive feedback from staff through exit interviews, questionnaires and staff survey.	a) All staff complete exit interview b) Positive exeriances reported by all staff			
9	Retention Rate	a)To listen to staff and understand the key drivers that retain staff and how staff would value being recognized. b)Improvement in staff engagement scores and staff reporting positive experiences at work	a) Improved retention .	a)over 89% Target for retension Staff report positive experiences of their membership of the workforce b) Score of over 3.8 in staff survey.			
10	Training and development opportunities are taken up and positively evaluated by all staff	a)To promote ascending and aspiring Talent b) Review funding for coninuing education. c) Ensure all staff are facilitated to maintain mandatory competencies and monitor compliance.	a) Yearly Training Needs anaysis completed and training delivered.	a) Service specification of 70% staff QIS maintained. b)compliance maintained across all areas of mandatory training			
11	Attendance to be monitored and in line with Trust traget	a)Weekly absence monitoring meetings.	a) Absence below the target	a) Absence levels below target			
12	Robust and effective roster approval process	a) Review of current process against targets	a) Roster standards Met	a)Roster produced in correct time frame. b) Roster meet all Trust Standards			
13	Strengthen, simplify and unify processes throughout the pathway of authorising and approving temporary staff	a) Reduce use of temporary staffing to improve standards and reduce cost	a) reduced temporary staff	a) Temporary staff does not exceed vacancy rate.			

4 Move forward

Having identified your Ideal Team there are there are a number of factors that can influence the development and sustainability of it. The following section looks to outline these providing information and resources to support success.

4.1 Attracting and Recruiting Staff

The Interim People Plan sets out its ambition to grow the nursing workforce by 40,000 by 2024 and the national recruitment campaign to attract potential candidates has been underway since 2020. Furthermore the government has made a commitment to introduce a £5,000-a-year maintenance grant for all nursing students in England starting in September 2020[7,8]. These initiatives should have a positive impact on attracting candidates into nursing where student nurses should then be introduced to wide variety of nursing roles including neonatal nursing. With around 350 nursing careers on offer, neonatal services should work with Practice Education Facilitators and Universities to maintain clinical placements opportunities in neonatal care so that aspirant nurses develop insight into the career pathways within neonatal care.

Case study – Aspirant Nurses

During Covid-19. Newborn Services welcomed Band 4 Aspirants who had answered the NMC Call to Action, to support the NHS. Newborn Services developed a bespoke Special Care and HDU Float role, for the aspirant nurses to be able to work with the infants and develop key skills in neonatology. Newborn services have collaborated with the MFT PEF team in ensuring that the role met their educational needs. This exposure to the role has been instrumental in enhancing the aspirant nurse's skills and proficiencies in the care of the neonate, before they commence their employment as Band 5 nurses.

Phil Colwell, Matron for Continuing Care NICU, St Mary's, Oxford Road, Manchester Foundation Trust – Newborn Services

Case study – University support

"Here at the University of Manchester we have tried to increase exposure to the area of neonatal care in order to encourage career choices. As part of the new BNurs curriculum new additional discovery units were integrated into the curriculum one of which was a 2nd yr introduction to neonatal care. This unit has been chosen by over 120 2nd year students where they will be taught a variety of topics linked to neonatal special care. As part of this learning they will complete an open book assessment. We believe that this will encourage more child health nurses to choose neonatal nursing as they career path both increasing the workforce of the future and preparing the new recruits with underpinning knowledge."

Tracey Jones - Senior Lecturer in Neonatal Nurse Education University of Manchester

Trusts will have their own initiatives for recruiting into neonatal units, however it is important that they are cognisant of the impact of Millennials and Generations Z on recruitment and consider ways to attract those generations. The below sets out descriptions of each generation's characteristics which may assist Trusts in defining their attraction and recruitment policies.

Generation	Characteristics	Values	Work Ethic	Healthy Workplace Environment
Baby Boomers 1943-1964	Optimism, team orientation, work for personal fulfilment	Professional growth, promotions, titles, company loyalty, status	Hard workers, value performance. Work to make a difference, workaholics, live to work, team player	Professional opportunities, praise, recognition, control, good workplace relationships
Generation X 1965-1980	Sceptical, cynical, independent, nonconformist, informal, mistrust, institutions, self-reliant, questions the rules	Worklife balance, autonomy, independence	Work must match reward, no loyalty to employer (committed to career over organisation), shorter employment tenures, work to live, self-directed/independent, change jobs if unhappy, teamwork that encourages individual contributions	Work environments that value their creativity, expertise and talents, informal workplaces, make work fun, value laughing and joking with staff
Generation Y (Millenials) 1981-1996	Technically savvy/cyber-literacy, lifelong learners, confident, demanding, impatient, social, diverse, see challenge, embrace change, multi-tasking	Work/life balance, access to information, collaboration, civic and community involvement, accepting of divergent values, training, mentoring	Team player, shorter employment tenures, lack of job loyalty, seek meaningful work, job portability, lateral career movement, education	Team work, recognising accomplishments, seek coaching, effective and regular communication with leadership, inofrmal workplaces with humour and connectedness. Manageable nurse-patient ratios and working hours (no mandatory overtime)
Generation Z 1997-2012	Curious, compassionate, willing to pursue non traditional options, open-minded, technology savvy	Education, inclusivity, diversity	Loyal	Advocate for patients

Understanding Generational Differences
Nursing Generations (CIHI 2016, Lyons, 2014 Hampton, 2017, Hendricks, 2013, Sherman, 2009 Sudheimer, 2009 Weingarten, 2009 Wieck 2010, Wilson 2008)

4.2 Examples of good practice

4.2.1 Branding

In light of the above there has been a shift in nurse recruitment in recent years which has seen an increase of marketing tools such as branding to attract nurses into organizations/roles some of which have been documented as having big successes such as Norfolk and Norwich University Hospitals who "… created a strong, identifiable recruitment brand that could be utilised for all departments across the Trust. The team are now standing apart from competitor organisations."

4.2.2 Recruitment Events

Neonatal teams should ensure that they are part of the hospital based nursing recruitment events providing an opportunity for registered nurses looking to advance their nursing career, students soon to qualify, or nurses hoping to return to practice. It is a unique opportunity for nurses not only to understand what the organization has to offer but also for neonatal nurses/nurse leaders to promote neonatal nursing, describe the development and training offered and answer any questions.

Case study 1 – Recruitment event

The Neonatal Unit have attended Trust wide recruitments events for the last 2 consecutive years. The event provides the Unit to interview applicants on the same day without prior arrangement, as the event is usually held on a weekend, this allows for the Neonatal education team to be actively involved in the recruitment and able to assess any potential learning needs. As such the NNU have been able to devise a robust" New starter" package which we feel has been successful in our staff retention figures

Cath Bainbridge - Matron – Neonatal services
Bolton NHS Foundation Trust

4.2.3 Retaining Staff

In July 2019 NHS England began to roll out its new scheme which successfully improved attrition rates by just under 2% in its pilot sites. The National Retention Programme[9,10] describes a number of new incentives such as a 'transfer window' which allows staff to move within the NHS between areas while developing new skill; and rewards from local businesses like discount gym membership and targeted mentoring for new joiners. This is in addition to a key themes flowchart which describes where Trusts should focus their efforts, including supporting both new and experienced staff, career progression, flexible working patterns and promoting health and wellbeing. The collection of data to understand why staff are leaving is an important factor, and units are encouraged to review their data and taken action where appropriate. Work is ongoing by the NWNODN Neonatal Induction Programme team to review and understand the reasons why students leave the induction programme or within 2 years of completion. The National Retention programme rolled out to all Trusts in September 2019 and is a useful source of support in improving retention.

4.2.4 Mentoring

Following a literature review Stewart-Lord et al (2017)[11] coaching and mentoring programmers that were open to all staff groups irrespective of seniority not only increases the skills of the mentees and coaches but also of those of the mentors and coaches helping them to feel valued and recognise career development opportunities with their organisation reducing staff movement and supporting retention.

For example, the role of Physicians Associate will need support and development to be effective before being fully able to work within a Tier 1 rota. Research undertaken locally looked at year 2 physicians associate students working on a paediatric rota and found that students were less confident in interpreting test results and developing management plans, and therefore will need supervision and mentoring in the workplace.

- Supervision and mentorship for nurses

Examples
Peer to peer coaching and mentoring scheme for trainee doctors – Cornwall 2017
https://improvement.nhs.uk/documents/1305/Case_study.Cornwall_yo1AXrG.pdf

4.2.5 Wellbeing

As well as mentoring support for staff in their roles, ensuring staff feel valued has been found to be a key component of retention, NHSI[12]. Prioritising staff health and wellbeing will enhance this feeling and help to retain staff in work if they feel comfortable and that their mental health needs are being met.

The NHSI[12] provide a wealth of information which can support units in developing their wellbeing support for staff, which include leadership, policies such as reward and recognition and supporting staff with outside demands such as working carers

Case study 2 – Wellbeing

In 2019 the RBH launched VIVUP – an Employee assistance Provision which provides information on practical support for such things as the following: Stress, work issues, family support, relationships, anxiety, bereavement, health and finances. (The list is not limited to these) The VIVUP portal offers salary sacrifice offers on electronic good and home appliances, low rate loans to support financial difficulties and a 24 hour counselling service with no wait times and ability to signpost for further intervention if required.

Cath Bainbridge - Matron – Neonatal services
Bolton NHS Foundation Trust

Case study 3 – Wellbeing

Counselling service and support

The Counselling service provides support to new staff throughout their probationary period which in turn aims to positively impact on staff retention. The counselling team on Newborn Services have developed wellbeing strategies of support for staff particularly looking at the needs of new staff being able to manage the stressful environment of the neonatal units. The work on Newborn Services is multi-faceted and as such can create many challenges for the nursing staff and the counselling and education team work collaboratively to support all new starters to manage the demands of their new role. This includes wellbeing days, psycho educational sessions, exploring stress management strategies, mental health awareness, the impact of vicarious trauma and more general aspects of staff wellbeing. These strategies are very well received and have had a significant impact on retention of the nursing workforce.

Phil Colwell, Matron for Continuing Care
Manchester Foundation Trust – Newborn Services

4.3 Career Progression/ Succession planning

A significant factor for successful retention is defining career progression. The introduction of new roles and service delivery models will have an impact on the traditional progression routes.

Through its education Strategy NWNODN will describe clear career progression/pathways for nurses along with education and development programmes beyond neonatal Qualification in Specialty (QiS) which will meet both the needs of younger generations around their aspirations and support development into senior nursing roles which is currently threatened with positions in these roles being difficult to recruit to across the country.

Case Study 4 - Creation of Band 6 Neonatal Nurse Talent Pool

Historically, on the NICU at Liverpool Women's Hospital, staff who wished to progress to a Band 6 post needed minimum of 3 years clinical experience, a post-graduate qualification in speciality and a mentorship course. We also used OSCE assessment is as a pre-interview technique aiming to allow candidates to demonstrate their clinical proficiency in areas such as equipment competence, leadership and conflict management. However, we found that it was particularly difficult for some staff to excel in this high pressure simulated environment. A failure to proceed through the interview process, due to poor performance in OSCE assessment, led to reluctance to enter the process again and in turn reduced staff morale and threatened staff retention.
In 2019, we developed the concept of a talent pool, consisting of staff with the required knowledge and skills to apply for a Band 6 post that is not yet vacant. Talent pools originate in the business arena, with the intention of increasing staff retention and speeding up the recruitment process. The theory focuses upon promotion being something you 'achieve' rather than are 'given'. Talent management is a proactive approach, developing staff from the beginning of their neonatal career along a talent pipeline as opposed to the more traditional approach focusing on developing staff who were unsuccessful in promotion.

Charlotte Boddie- Neonatal Matron
Liverpool Women's Hospital

5. Support Available from the NWNON

5.1 Nursing Workforce

- New NWNODN Workforce and Education Lead will work with local workforce leads to support achievement of workforce transformation in line with national initiative standards.
- NWNODN to support neonatal managers to utilise this strategy to understand their own workforce challenges and potential long term solutions
- NWNODN to work with neonatal service unit managers to describe the required competencies and skills of the nursing workforce through an education strategy to support this workforce strategy.
- Map nursing recruitment and retention across NWNODN

5.2 Medical Workforce

- NWNODN to include medical staffing data in 2020/21 Activity Capacity and Demand report.
- NWNODN to lobby BAPM to develop the description of medical staffing requirement with specific reference to Local Neonatal and Special Care Units.

5.3 Allied Health Professionals

- Develop an AHP Service Model that satisfies the needs of NWNODN and fulfils the Neonatal Critical Care Review (NCCR) and Long Term Plan requirements.
- Support the implementation of network AHP roles and understand how they can support local implementation for the AHP elements of this strategy

5.4 NWNODN Surgical Nurse

- Work with Specialised Commissioning to realise the benefits of a network surgical nurse role

Neonatal service Providers to develop and share their Workforce Strategy with NWNODN in line with NCCR and CNST requirements.
NWNODN to develop an Education Strategy to support development of new roles and to enhance/maintain clinical skills/comp

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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
NHSEI	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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