

Workforce Strategy for Thames Valley & Wessex Neonatal Units

2024 - 2029

AUTHOR

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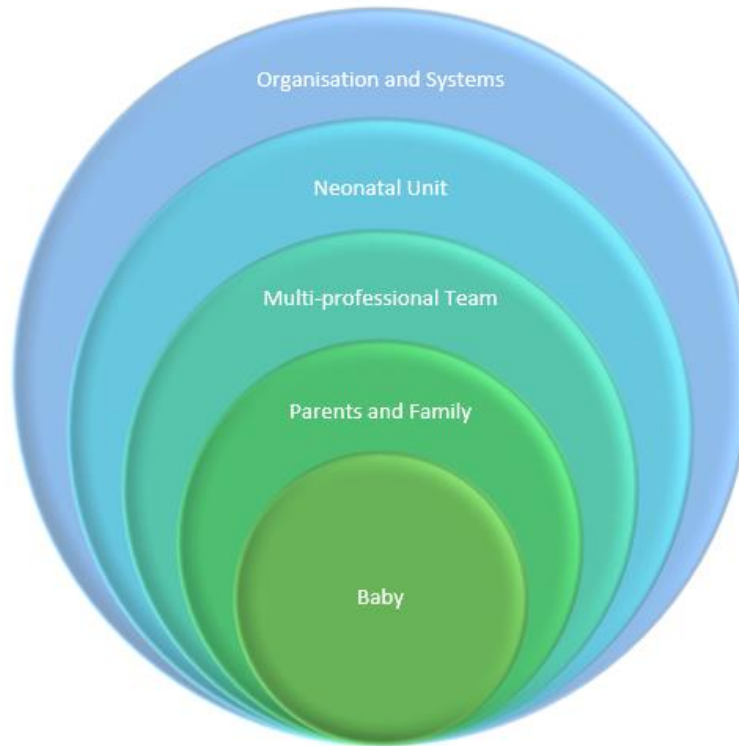
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Our vision

Is for neonatal care to be focussed on care by parents and families delivered by an integrated, multi-professional team underpinned by the best use of skills and knowledge available.



Acknowledgements

Thank you to the Thames Valley and Wessex nursing, medical, Allied Health Professional colleagues and the parents who have been within neonatal care for their contribution and time in the production of the Workforce and Education strategies.
Thank you also to the Northwest Neonatal ODN for sharing their strategies.

Glossary

AHP	Allied health professional
ANNP	Advanced neonatal nurse practitioner
ARCP	Annual Review of Competency Progression
BAPM	British Association of Perinatal Medicine
CP	Clinical Psychologist
CNST	Clinical negligence scheme for trusts
ENNP	Enhanced neonatal nurse practitioner
HD	High dependency
HEE	Health Education England (a Non-Departmental Public Body. It supports the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place)
ICS	Integrated care system (NHS organisations that, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS care, and improving the health of the population they serve)
LMNS	Local Maternity Neonatal System
LNU	Local Neonatal Units provide short-term intensive care (1-2 days); and high dependency/special care and transitional care services for their local populations
MDT	Multidisciplinary team - a team of healthcare professionals from different disciplines
NCCR	NHS England Neonatal Critical Care Transformation Review published December 2019
NIB	Neonatal Implementation Board NHS England
NICU	Neonatal Intensive Care Units (NICUs) provide intensive care for the smallest and sickest babies across the whole region, in addition to high dependency, special care and transitional care for their local population
NIPE	Newborn and infant physical examination – a screening programme that screens newborn babies within 72 hours of birth, and then once again between 6 and 8 weeks for conditions relating to their heart, hips, eyes and testes
NNA	Neonatal Nurses Association
NNAP	National Neonatal Audit Programme
NPPG	Neonatal Paediatric Pharmacy Group
ODN	Operational delivery networks, which are focused on coordinating patient pathways between providers over a wide area to ensure access to specialist resources and expertise
QIS	Qualification in specialty
RCN	Royal College of Nursing
RCPCH	Royal College of Paediatrics and Child Health
SCU	Special Care Units (SCUs) provide special care and transitional care for their local population
TVW	Thames Valley and Wessex
WTE	Whole time equivalent
WTE Directorate NHS E	Workforce Training Education Directorate (formerly HEE)

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Executive Summary

Introduction

Since the introduction of the NHS Long Term Plan (LTP), (2019), there has been a national focus on recruitment, developing and retention of the workforce across the NHS. The impetus of the LTP was closely followed by specific recommendations through the Neonatal Critical Care Review (NCCR), (2019) in relation to neonatal workforce developments and expanding neonatal critical care services. It recognised that delivery of its vision is dependent on having a highly skilled, multidisciplinary expert workforce in place. Therefore, it is vital that we have the right workforce to meet future challenges and to optimise outcomes (2019). This strategy is not intended to supersede local strategies but to provide support and guidance for neonatal service leads to make best use of funding and opportunities provided by regional and national drivers.

TVW Vision

Is for neonatal care to be focussed on care provision by parents and their families supported by a highly skilled expert multidisciplinary workforce.

One way to achieve this is by the introduction of an Exemplar team, while we are not proposing that one size fits all approach. We recognise that each unit will have its own ideas with how the MDT will look depending on designation, estates and space configuration, activity and staffing now including AHP and Psychology integration into the units. The aim of this strategy is to support neonatal care providers with options to build the most appropriate MDT for their unit.

Integral to the MDT is our families. Our vision of the Family Integrated Care model is as an enabler of families to become part of that core team with the Network Care Coordinators, Parent Engagement Lead and Parent Advisory Group being integral in achieving this integration.

With the introduction of recurring funding for both nursing, AHP, Psychology, and some medical funding, time has been given to understanding what the exemplar team will look like over the next five years with existing traditional roles being expanded or enhanced. This may also be the introduction of transformative or new roles such as the Family Care role and psychology support roles. It is the expectation that each unit will look different dependent on activity, size, specialism and their population, although there should be some consistency and standardisation across the roles and competencies across TVW ODN.

Transformation

Since the introduction of NCCR/Ockenden from December 2021 funding, the workforce structure has started to make slow changes and progress into new ways of working. The introduction of new roles such as link nurse roles for repatriation, safety roles, parents involved in co-design and co-production with an awareness that this cultural shift will take time with different team dynamics and realising the expectations and capabilities of newly created roles both at Network level and within the neonatal units. To support units in building the most appropriate team the Education strategy and a workforce toolkit will supplement this document.

Conclusion

Neonatal care is now well placed for continuation of transformation with NCCR and Ockenden funding in place. Pivotal to the success of transformation is a consistent, sustainable, highly skilled, competent workforce across the TVW ODN to ensure optimal quality care and outcomes for babies and families.

Introduction and context

Through the introduction of the NHS Long Term Plan (LTP), (2019), which includes a commitment to expanding neonatal critical care services, the publication of We Are the NHS People Plan (2020), Getting It Right First Time (GIRFT) (2022), Ockenden (2022), Kirkup (2023), and the Three-Year Delivery Plan (2023). There is an increasing focus on workforce, training, education, and workforce shortages across the NHS nationally and within neonatal services, now exacerbated by the impact of Brexit and the Covid-19 pandemic. It is vital that we have the right workforce to meet future challenges and to optimise outcomes (NCCR, 2019)

Shortages of nurses is a global problem projected to worsen until at least 2030 (Scheffler and Arnold, 2019). In England, workforce shortages and inadequate numbers of nursing staff have dominated headlines for several years and have been the basis of recent research as to why (The Kings Fund, 2022; Ball et al., 2019; Griffiths et al., 2019, Ejebu and Turnbull et al 2024). However, within this it is primarily adult services that have been highlighted.

The pre-existing nursing workforce vacancies across the UK now face increased risk to recruitment and retention. Insufficient sustainable nursing supply to meet the needs of the population will undoubtedly lead to risks in service quality, and to patient care and outcomes. Any recent increases in nursing staff working in health services anywhere in the UK will include registrants who have joined or returned to the NHS since the start of the COVID-19 pandemic as part of the response needed during this time, and there is a high risk that this will not be sustained. The people who work in the NHS are its greatest asset and are key to delivering high-quality care. This has been evident throughout the Covid-19 pandemic with staff demonstrating considerable commitment and resilience. However, a prolonged funding squeeze between 2008 and 2018 combined with years of inadequate workforce planning and weak policy mean that staff shortages have become endemic (Kings Fund 2022). This is perhaps more evident within the highly specialised area of neonatal care, with the implementation of the Neonatal recommendations of the Neonatal Critical Care Transformation Review (NCCR), (2019) 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 are currently 110,192 vacancies in the NHS (Kings Fund 2022) this includes 39,652 nurses and 8,158 doctors. There is no doubt that these shortages affect every area of the

NHS workforce and that this significant shortfall of registered nurses relative to societal demand require urgent intervention (Buchan et al, 2020). The House of Commons Committee Report (2023) states that the Government's current target of recruiting 50,000 NHS nurses N50k Programme (2019), (not including Nurse Associates) and an increase in places in medical schools is not having any meaningful impact on the true scale of nursing/medical shortages. Following the publication of the Three-Year Plan the Government from September 2023 has increased financial support to make more health care studies affordable. There will be a 50% raise to support travel to clinical placements and accommodation, raising the threshold for the [NHS Bursary Scheme](#) and an uplift for childcare support. In addition, there will be made available an additional 24,000 adult and midwifery training places. However, this does potentially impact on the quality and safety of support, safety and experience for undergraduates, patients and staff.

Significant gaps in the neonatal workforce provision were identified by the Neonatal Critical Care Review (NCCR), published in December 2019. The NCCR (2019) highlighted that in 2016/17 there were 2263 fewer neonatal nurses in post than the BAPM standard recommends (BAPM, 2012). Improving the morbidity and mortality for newborn infants has been a key national ambition since 2015, alongside reductions in maternal mortality and stillbirth. Therefore, the neonatal workforce is fundamental to the safety and effectiveness of care offered to neonates and their families and ultimately improving outcomes in neonatal care (Watson et al, 2015). In response to this the NHS Long Term Plan has committed to new investment until March 2024 to support the delivery of the Neonatal Critical Care Review (NCCR). This will be achieved by expanding neonatal critical care services to develop the expert nursing workforce but also to include the medical workforce, Allied Health Professionals and Clinical Psychology. Neonatal workforce shortages have not perhaps been emphasised in the same manner as this population is not quite so large and its impact has not been felt by the wider population. However, as approximately 300 000 babies are born in England and Wales each year and one in eight of these may require some form of neonatal care, staffing can have a profound effect on the ability to deliver suitable quality care.

Since 2021 NHSE have invested over £29m to enable recruitment of over 500 WTE neonatal nurses providing cot side care as well as supporting recruitment and retention by investing in Practice Development Nurses and Neonatal Operational Delivery Network (ODN) Education, Workforce Lead Nurses and Quality roles for practice educators, risk/governance, and family care roles. In addition, Ockenden funding was allocated for AHPs, clinical psychology and medical workforce including ANNPs for 2022 and 2023/24.

The workforce, recruitment and education strategy for the Thames Valley and Wessex ODN is intended to support neonatal service leads/managers and their Trust executive teams, in their own workforce planning. The aim is to provide a framework to support their response to the recommendations in the Neonatal Critical Care Review, Ockenden and The Three-Year Delivery Plan, which will be considered at local, regional, and national level. This is not intended to supersede any locally developed strategies. By proposing options to enable the introduction and implementation of both transformative and right roles for service provision, this strategy should support local workforce, growth, recruitment, education planning and business cases within the neonatal setting.

We know from the findings of the Thames Valley and Wessex Workforce Report (2022), and nationally that there are complex issues, subject to a multiplicity of influences facing Trusts in growing, recruiting, training, and retaining their neonatal workforce. What this document proposes is not a 'one size fits all' approach but a framework within which each neonatal setting/Trust can implement and develop their team to fit their workforce requirements and profiles.

Where we are now

The nursing, AHP and Psychology workforce currently delivering neonatal care within TVW ODN totals 623 WTE but despite NCCR and Ockenden funding there are still significant vacancies (funded and unfunded) gaps across all disciplines.

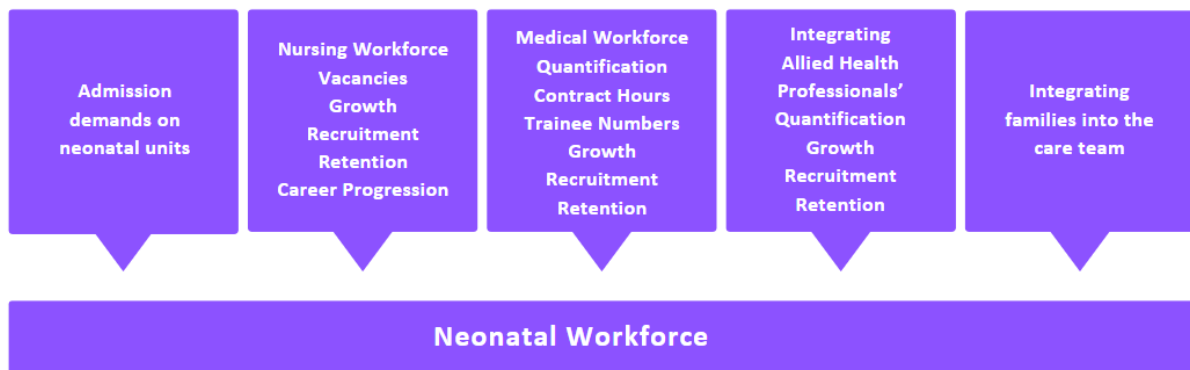
The TVW annual analysis of nurse staffing Quarter 3 December 2023 according to the Neonatal Nurse staffing Tool (2020) identified that there were 132.76 WTE nursing vacancies. However, this does not demonstrate the true gap in Qualified in Specialty (QIS) nurses delivering direct nursing care and rises again with the implementation of new transformation roles, Quality roles and introduction of the Nurse Associate.

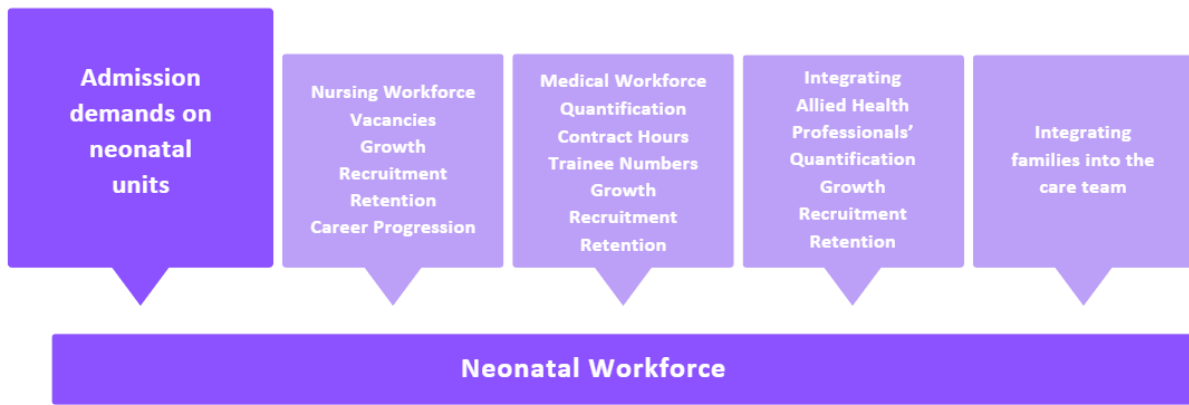
Both medical and nursing staffing standards have been described by BAPM and across several papers and have been the benchmark that NHSE and GIRFT have measured against the NCCR and Neonatal Critical Care service specification. The more recent documents on staffing guidance in Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021) and Optimal Arrangements for Local Neonatal Units and Special Care Units in the UK, have included staffing guidance (2018).

In addition, the neonatal team consists of a wide range of staff to deliver a high-quality neonatal service which include the AHP and Clinical Psychology workforce, who have been working on producing their own discipline specific national staffing and education standards. This has highlighted both funded and unfunded gaps in service and education provision.

The neonatal team also consists of staff in other numerous supportive roles such as data analysts, technician, equipment leads and milk kitchen support staff amongst others.

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



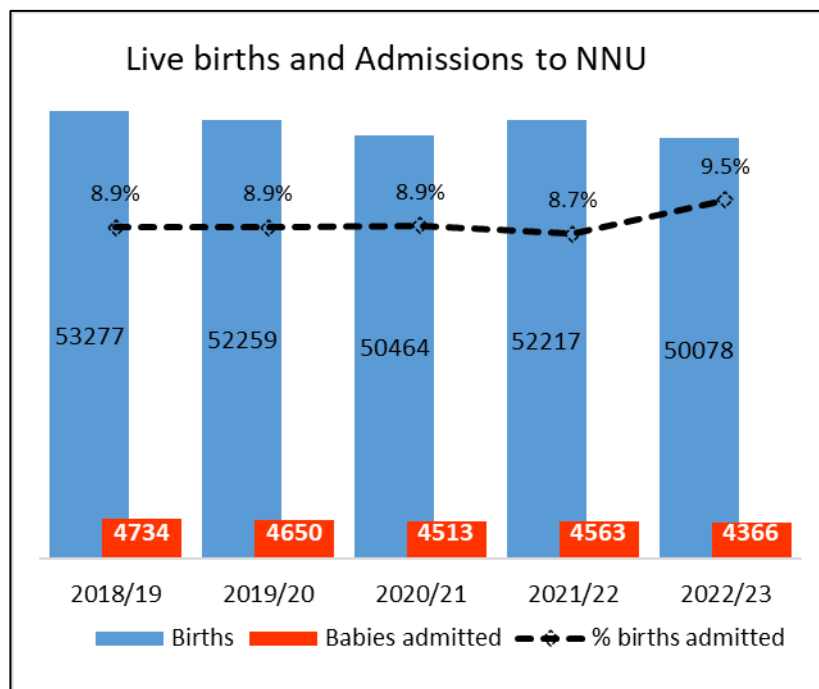


Admission Demands

Alongside the gaps in neonatal workforce, there are several factors which need to be accounted for when considering the neonatal workforce across the TVW ODN.

As a Network we have seen a relatively consistent picture of neonatal admission rates at under 10%. However, this is set, against a relative trend downwards in the birth rate.

Live births and Admissions to TVW Neonatal Units (*figure 1*)



Preterm Admissions

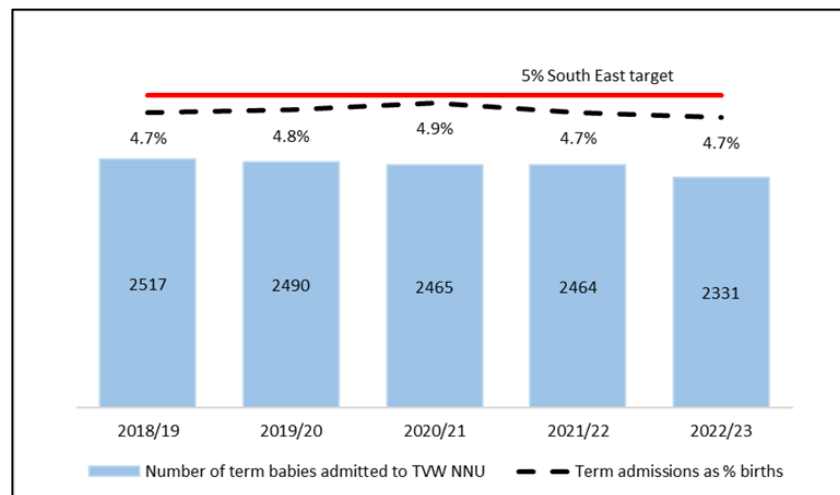
In 2019, NHS England (NHSE) published version 2 of the 'Saving Babies Live Care Bundle' which saw the addition of a fifth element 'reducing preterm birth' to support the national ambition of Safer Maternity Care (2017,) by reducing pre-term birth from 8% to 6%. This element focusses on prediction, prevention and optimisation the outcomes of babies born premature, a theme identified as part of the Maternity and Neonatal Safety Improvement Plan.

Despite this optimisation interventions reducing admissions to neonatal care for the last few years and with the publication of the BAPM framework for decision making on extreme preterm births (2019) which considers the management of babies born at 22 weeks' gestation. Neonatal units have seen increasing babies admitted at the lower threshold of viability with increased complexity and acuity and this has created greater demands on the neonatal workforce caring for them.

Term Admissions

Several initiatives have been implemented which have influenced neonatal activity. The work undertaken by "Reducing harm leading to avoidable admission of full-term babies into neonatal units" (2017) identified that, nationally, between 2011-2015, the number of care days for term admissions across all levels of care rose by 30%, the summary suggested that between 2011-2013 30% of those admissions were potentially avoidable term admissions. Work continues both nationally and at ODN/Provider level through various interventions to address avoidable term admissions. Since the implementation of these interventions term admission rates across the ODN have been below the national target of 5%, which is favourable to the 6% national average. Work is ongoing with the introduction of Transitional Care Units (TCU) to support a reduction in unnecessary separation of mother and baby. Work continues with our LMNSs to ensure TC provision is embedded across our services which in time should reduce further the number of babies who are late preterm, or term admitted to neonatal units. It is important to recognise that TC facilities require both maternity and neonatal input and therefore, should be part of a perinatal collaborative approach to nursing/midwifery/medical staff workforce and education planning (BAPM, 2017).

Number of Term babies admitted to TVW Neonatal Units (figure 2)



Surgical/Specialty

TVW has two surgical centres at University Hospital Southampton UHS (Princess Anne) and Oxford University Hospital (OUH) providing surgical and sub- specialty to those that require its services across the TVW region and beyond. UHS has seen since 2018 to date December 2023, 1049, infants with 780 operations performed. The neonatal workforce caring for these babies do require additional skills and training and collaborative working with neonatal surgeons, AHPs and other specialty leads. This should also ensure provision for Outreach training and education for those babies repatriated back to non- surgical NICUs, LNU and SCUs

Covid -19 Pandemic

Although there is data and evidence published of the impact of COVID-19 on neonatal services, this data does suggest that the impact does not appear to have the profound impact as in other populations. However, Yong, (2021) and Atkins et al (2022) papers discuss the experience of threat for both parents and staff in neonatal services. Such experiences of threat such as criticism, loss of status and reputation for staff have been amplified in recent years through the physical and psychological aftermath of COVID-19 and in a wider culture that is suspicious of and often hostile towards public sector workers. Experiences of threat and threat-based drive likely account for much of the increased risk of trauma and mental health difficulties in parents of preterm infants, and of burnout and trauma in staff.

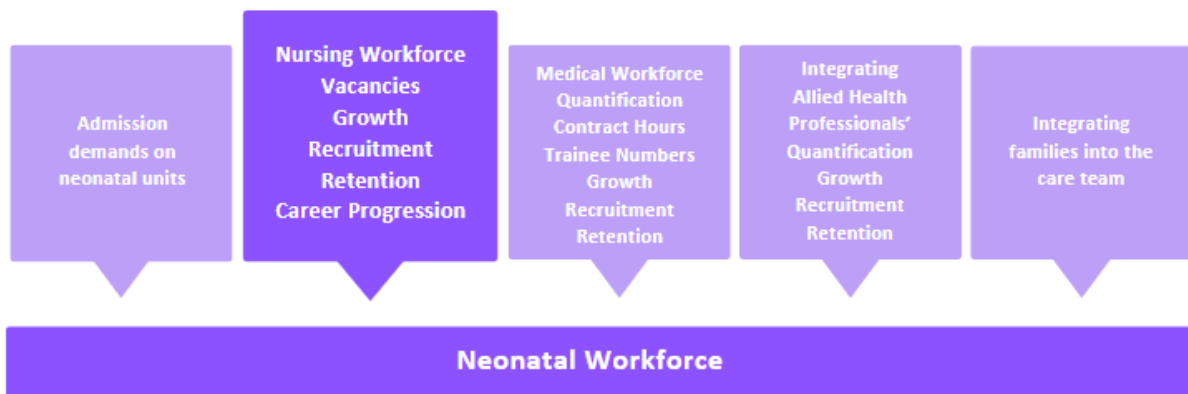
Complexity

The Best Start five year forward plan for maternity and neonatal care (2017) discusses that outcomes for preterm and sick neonates have improved significantly over the last 20 years with enormous advances in care. More babies are surviving than ever before but for some of these babies and families will involve months of highly specialised medical and nursing care. In addition, an effective AHP service can improve outcomes for neonates, in particular the high-risk neonate, and should be universally available, including but not exclusively, physiotherapy, psychology, occupational therapy, pharmacists and speech and language/dietetic services.

Neonatal Outreach

There are large gaps in neonatal outreach services provision across the TVW ODN. Only 7 of 14 units have a dedicated service, currently no service offers a 7 day a week cover. This is compounded by no national guidance or national service specification; therefore, services have evolved over many years according to local demand. There is both a TVW Neonatal Outreach and an MDT Networks Neonatal Outreach group (NNOG) representative of all ODNs, benchmarking services and offering supervision. Other key aims are to develop joint guidelines to standardise care, role descriptors for staff and education pathways.

It is expected that this work also in collaboration with BAPM will reduce inequalities in service provision and support with the development of new outreach services and models of provision. This will be moving away from a paediatric model and working closely with local maternity services/systems will enable these services to provide integrated care for neonates across the whole ODN. This will support the best outcomes for babies and their families both on the neonatal unit and in transitional care. With ODN oversight and awareness of these services we can provide an additional level of governance and support



Neonatal Nursing: Funding and Vacancies

Within the ODN there are currently 132.76 direct care vacancies quarter 3 December nurse staffing data collection. The TVW ODN now reports quarterly on nurse staffing and vacancies, QIS numbers to gain in depth insights into vacancies, recruitment, attrition and staff absences.

In November 2021 the Neonatal Implementation Board (NIB) NCCR, agreed to allocate funding for direct patient care in accordance with the BAPM nurse staffing standards utilising the 2020 Nursing Workforce Calculator see appendix (1). However, the NIB also recognised the value of Practice Education Nurses to support recruitment and retention of the workforce. Where funding had been allocated to a unit, the Trust, Neonatal ODN, and Regional Specialised Commissioning Team agreed to utilise some of the funding to support recruitment and uplift of Practice Education Nurses. The Education and Workforce Lead Nurse group recommend that one whole time equivalent (WTE) quantifier Practice Education Nurse for every 50 nurses (head count) on the neonatal unit. This recommendation is based on “Quality Standards for the Care of Critically Ill or Injured Children”. However, going forward and thinking about the needs of all units such as small LNUs and SCUs the workforce Lead Nurses recommend a minimum standard of 0.5WTE in these units.

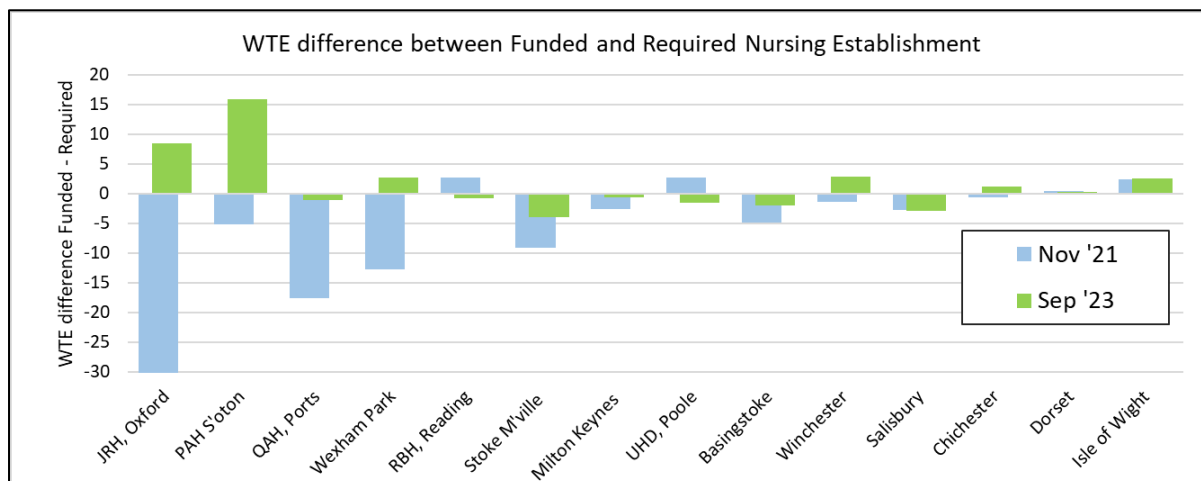
NCCR Direct Care Nurse Funding

NCCR

Unit (Trust)	2022/23 new funding allocation (£)	Planned recruitment WTE	WTE in post Q2
Salisbury	£125,809	2.48	2.48
Milton Keynes	£86,467	1.60	1.6
Wexham Park	£264,589	8.77	8.77
Oxford OUH	£413,861	13.00	13.00
Portsmouth	£684,176	16.92	16.92
Basingstoke	£228,705	5.90	5.90
Stoke Mandeville	£439,252	10.50	10.50
Dorchester	£17,176	0.40	0.40
IOW	£11,450	0.30	0.30
Total	£2,271,485	59.87	59.87

In total 60 nurses were recruited for direct care roles across 7 neonatal units, which also included uplift of Practice Educators to meet the agreed standard of 1 WTE per 50 head count of staff and some uplift of staff to more senior roles. It also included the recruitment of 2 new post educators in 2 of the SCUs.

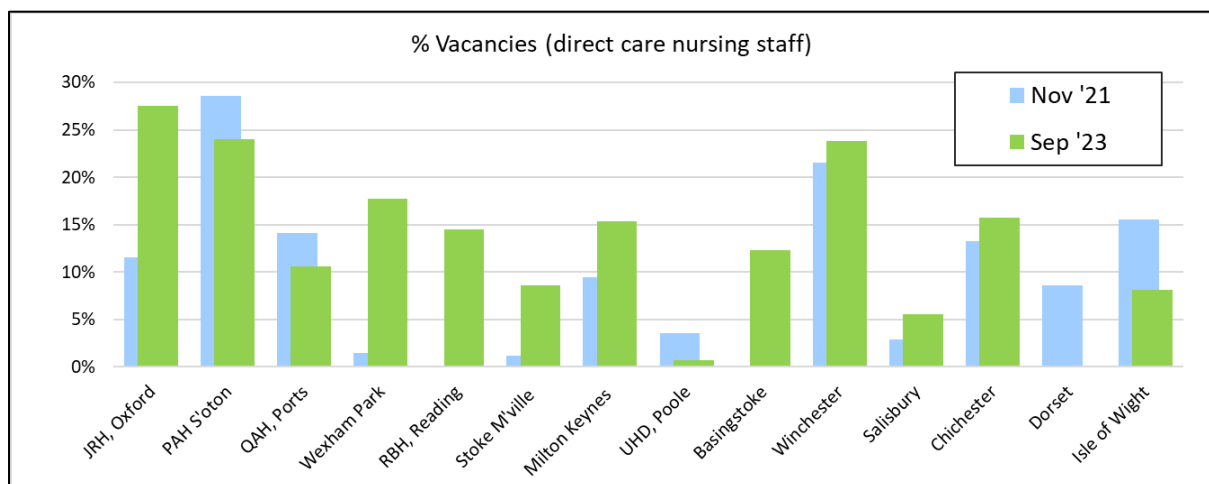
WTE difference between funded and required nursing establishment (figure 3)



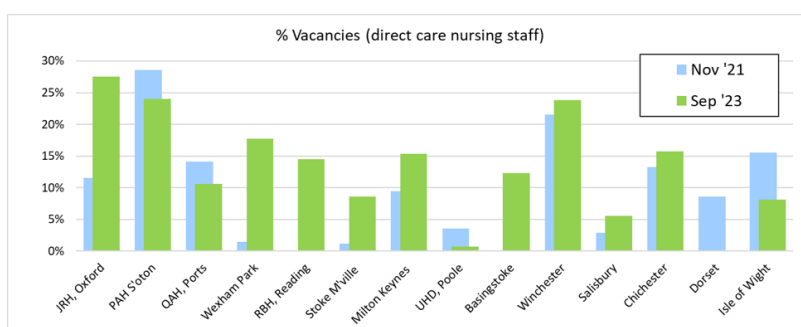
NCCR funding for direct care nurses has addressed the gaps in funding and we now have sufficient nurses for the unit's activity. The only exception to this is the LNU at Stoke

Mandeville, identified as the Trust's high on- costs resulting in a reduction of funding for 4 nurses. Although not an issue in the other units in TVW it was identified in other ODN's Provider Trusts. Despite the addressing of funding gaps there is still a high vacancy rate across TVW at 17.4%. There are several reasons why this is happening. The increase in funding led to nurses moving into supernumerary non direct care roles and quality roles. Recruitment is an ongoing challenge for many of the units chiefly those units in Thames Valley and in the three NICUs where the high cost of living and proximity to London has an impact. Many of these units were heavily reliant on international nurse recruitment, where some have moved to areas where there is a lower cost of living for themselves and families.

Percentage Vacancies (Direct Care nursing staff) (figure 4)



Have we got enough nurses for our activity? 2. In post



Despite Units have funding for posts, many units have a high vacancy rate

The vacancy rate across the ODN has increased from 12.4% in November 2021 to 17.4% now

	ODN total	JRH, Oxford	PAH Soton	QAH, Ports	Wexham Park	RBH, Reading	Stoke M'ville	Milton Keynes	UHD, Poole	Basingstoke	Winchester	Salisbury	Chichester	Dorset	Isle of Wight
Nov-21															
Funded WTE	641.1	129.7	124.6	87.9	25.7	42.9	31.2	40.3	43.8	19.6	24.1	19.3	23.4	14.1	14.5
In post	561.8	114.8	89.1	75.5	25.3	44.5	30.8	36.5	42.2	20.1	18.9	18.8	20.3	12.9	12.3
% vacancies	12.4%	11.5%	28.5%	14.1%	1.4%	-3.7%	1.2%	9.5%	3.5%	-2.3%	21.5%	2.8%	13.3%	8.6%	15.5%
Funded WTE	745.0	178.9	140.0	102.6	34.0	46.7	38.2	39.7	43.4	22.3	25.9	21.7	22.1	14.9	14.7
Sep-23															
In post	615.4	129.6	106.4	91.7	28.0	39.9	34.9	33.6	43.1	19.6	19.8	20.5	18.6	16.2	13.5
% vacancies	17.4%	27.6%	24.0%	10.6%	17.7%	14.5%	8.6%	15.3%	0.7%	12.3%	23.8%	5.6%	15.7%	-8.5%	8.1%

The role of practice educators in neonatal nursing

TVW recognise the importance of supporting neonatal nursing education with dedicated supernumerary practice educator role/s. They are pivotal to supporting the neonatal workforce for the following reasons:

- The need for professional and practical support for all learners which includes our students, newly qualified nurses, new to specialty, international nurses and AHP.
- Robust training and education plans and training needs analysis for all staff to include simulation around essential skills.
- Supporting those staff that supervise and assess all learners which includes our Preceptorship and QIS learners.
- A need to ensure that principles of robust governance and professional decision-making are supported and evidenced.
- NICU/LNU education teams supporting and working collaboratively with the smaller LNUs and SCUs.

Vignette 1: Practice Educator Role Special Care Unit Dorchester

Appointed Educator through NCCR Funding

We have an MDT approach to education and training as we are a small team in Dorchester. The maintenance of skills in resuscitation and stabilisation are pivotal in safe practice. We have joint monthly study days for both medical and nursing team which includes Consultant's. The curriculum includes simulated clinical and human factors practice, resuscitation, calculating and preparation of complex drugs and recognition of the deteriorating infant, this also includes any new procedures/equipment/ideas.

Some other examples of simulation are deferred cord clamping (DCC) of a preterm in theatres, LISA (theory and practical). Our afternoon sessions comprise of skills stations (rarely used skills). Other sessions will include updates on the five principles of Family Integrated Care(FIC), safeguarding delivered by the safeguarding lead, be-spoke blood transfusion update (with blood transfusion practitioner) - to include a simulation. This is mandated attendance and allocated study time for all staff and rostered into the off-duty planner.

In addition, staff make requests around current neonatal topics they wish to learn more about.

Case Study – Lead Practice Educator, John Radcliffe Hospital Oxford University Hospitals NHS FT (uplift in role and team through NCCR funding)

Practice Development and Education Lead Jo Dias, Nursing BSc (Hons), PGDIP Midwifery

Timeline:

2010 - Completed Nursing Degree in Portugal
2011 - First Nursing Job in the UK
2015 - Completed PGDip Midwifery in London
2016 - First contact with Neonatal Nursing
2020 - Position Offered as Clinical Educator
2022 - Practice Development and Education Lead

My main goal as a PDEL is to provide the Clinical Educators and wider team with the support and training that they require to feel empowered, safe, engaged and excellent practitioners.

“ Thank you for your continues commitment and profiling of education. (...) I am grateful for your professionalism and organisation of the education team.
Your passion and commitment shine through. “

Senior Sister, NICU 2023

My PDEL Role(s)

- Education Team Coordinator
- QIS Course Lead
- Preceptorship overseer
- Non-registered staff
 - Students and Nursery Nurses
- New starters and International recruits
- Study days/ Clinical teaching/ Simulations
- CPD Budget Holder
- E-Learning Course Creator/Editor
- Recruitment Lead

Education is everyone’s responsibility

Be the facilitator, not the fixer

Getting the basics right

On a daily-basis, I strive to create an environment that encourages learning and supports personal and professional development. This includes regularly identifying and re-evaluating training and education needs, as well as ways to address them efficiently. It demands organisation, adaptability, kindness, and commitment. By having safe, included and engaged staff, I am reassured that our babies and families are receiving high standards of care. I am proud to be part of the Neonatal Family at the John Radcliffe Hospital, Oxford.

Education is the best way to train ourselves that we will secure our own wellbeing by concerning ourselves with others (Dalai Lama)

Qualified in Specialty (QIS) (Neonatal)

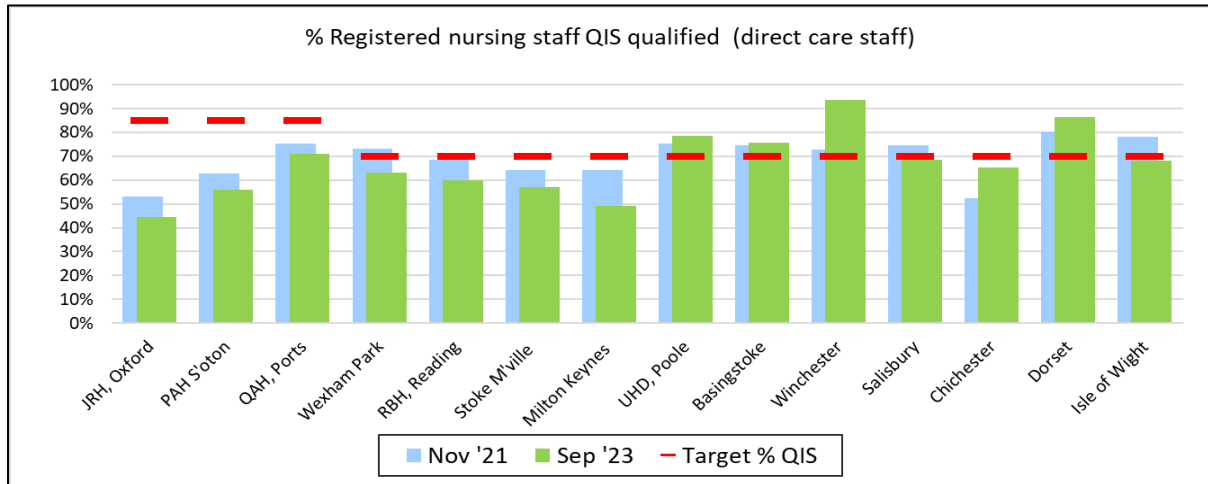
Neonatal Qualified in Specialty QIS is a role essential qualification for all neonatal nurses. Most Lead Nurses report difficulty in attaining the Neonatal Toolkit (2009) minimal recommendation that per shift 70% neonatal nurses should be QIS and above this in neonatal units delivering more complex care.

It is two of the NICUs, Southampton and Oxford, who have the largest QIS gaps. Following on from the NCCR, key findings from the Health Education England (HEE) (now Workforce Training Education (WTE)) review of the neonatal QIS training published in June 2021 highlighted a lack of standardisation, provision, quality and price. Currently in England there is still no professional regulation or monitoring of the content, curriculum, consistency, and transferability of the neonatal QIS. However, there has been a national focus in 2023 to find sustainable solutions and reach consensus for this qualification with a national steering group of representatives from Higher Education Institutions (HEIs), ODNs, NNA, Provider Trusts and the RCN. This work is ongoing and now being overseen by the Workforce and education leads and a small expertise core group. The aim of this work is to meet the recommendations from WTE QIS Standards recommendations (2023).

In 2014 the TVW network responded to the need to improve recruitment and retention with the implementation of the Network Neonatal Preceptorship/Foundation Programme, which is specially designed to provide both an education curriculum and supportive learning package for nurses and now newly qualified Nurses Associates, and midwives with no previous neonatal experience. This continues to demonstrate a positive impact with an 80% retention rate at the end of the Preceptorship Programme (2023). In 2019 the network, following on from the successful Preceptorship Programme model and driven by a lack of QIS standardisation and high HEI funding costs, developed and implemented a network delivered QIS programme. This consists of 3 elements:

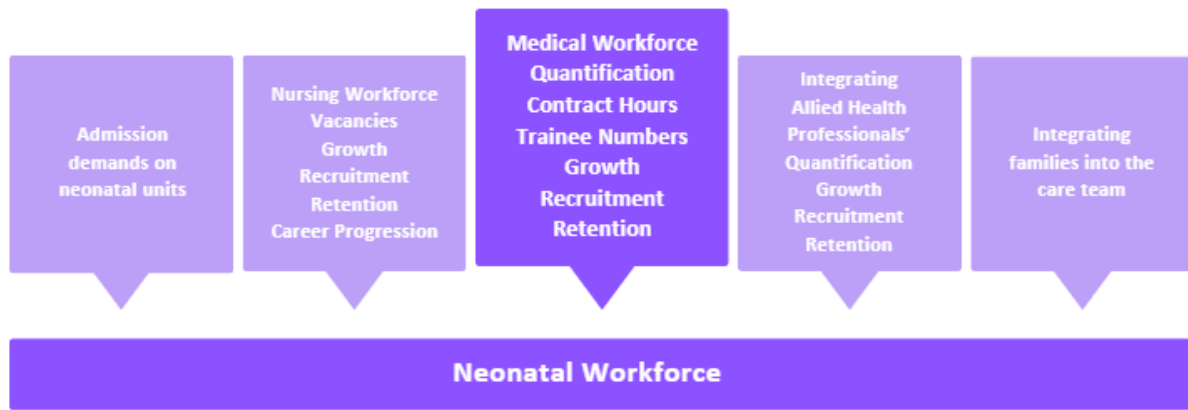
- Completion of Network Preceptorship/Foundation Programme
- 20-40 credit Module at an HEI
- Assessment of clinical competence

QIS Nurses 2021 and 2023 (figure 5)



As a Network there are currently 61% (66% in November 21) of nurses who are QIS, despite strategies to increase this such as the Network QIS Programme there are still large gaps in QIS nurses in some units. Prior to the implementation of the Network delivered QIS Programme in 2019 and allocation of NCCR funding we were not achieving the minimum standard of 70%. In part this was due to a reduction of HEIs delivering the Programme as no longer seen as viable due to small numbers, one local HEI Provider no longer able to fulfil the more complex demands of the role and service. Included in this was the financial burden of the Programme for QIS students and the cost of backfilling staff at unit level. Alongside this recruitment into newly funded posts has been newly qualified nurses/midwives, new to specialty nurses and internationally recruited nurses who although have skills and competence are not recognised as QIS. In addition, QIS nurses moved into education and some quality roles therefore diluting direct care QIS nurses.

Since 2020, 118 nurses have achieved Neonatal qualification in specialty. We aim to train as a Network 50-60 nurses a year with the potential options of shortening the programme/and or delivering the Programme twice a year.



Medical Workforce

Quantification

There is limited data both nationally and locally to support understanding of the complexity of medical workforce compliance against BAPM standards within the TVW neonatal units. Alongside this complexity is that many of the LNUs/SCUs have joint rotas with paediatrics which makes the quantification of WTE number difficult to calculate.

BAPM Medical Standards

Medical staffing standards are set by the British Association of Perinatal Medicine (BAPM) for neonatal intensive care units (NICUs), local neonatal units (LNUs) and special care units (SCUs). These standards are endorsed by national reports and service specifications.

Staffing is divided into three tiers:

Tier 1:	Pre-MRCPCH doctor or Advanced Neonatal Nurse Practitioner (ANNP)
Tier 2:	Post-MRCPCH doctor or ANNP
Tier 3:	Consultant

We know from a recent medical staffing gap analysis in TVW, and Getting it Right First Time (GIRFT), most units were non-compliant to national standards across the 3 Tiers in medical staffing. According to the NCCR, nationally, at present, around 15-18% of posts excluding Consultant posts are unfilled. This is corroborated in a Royal College of Paediatrics and

Child Health (RCPCH) Survey which found that in the general/paediatric and neonatal categories, vacancy and rota gaps were 17% at Tier 1 and 26% at Tier 2.

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 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 Thames Valley and Wessex Post Graduate Deaneries, there has been a small number of trainees changing specialty training, but no change from previous years, an increase in part-time trainees. Although no reduction in trainee places, arguably trainee numbers have not increased in keeping with population. The results of a Trainee bespoke survey (2022) identified that, as well as 15% of trainees already working less than full time hours, two thirds of trainees (75%) have considered this option. The latter has implications for the completion of specific skills required during training with more part time workers and trainee ANNPs meaning an increase in head count competing for skill development and competence.

The “Shape of Training Review” (2013) has changed 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 of trainees up to ST4 depending on experience and exposure in the selection of neonates as a subspecialty. This reduction in length of training will have an impact on clinical exposure to clinical skills/ procedures such as intubation, 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.

There are differences in the staffing between NICUs, who will have ST 2 and 3 trainees and LNU/SCU who have ST 1 trainees. This reflects the different training needs of doctors at each stage of their training. In some of our SCUs, rotas are covered by trainee in General Practice.

To address the medical resourcing difficulties which neonatal units are faced with, there has been the development workforce model for Advanced Neonatal Nurse Practitioners across this Network to support the medical workforce on the Tier 1, and in some cases Tier 2, medical rotas. The ANNP workforce model across this network is well embedded in most units and is to fulfil the gaps in the medical rota and working at a high clinical level with all working on Tier 1 and 2 medical rotas.

However, whilst at times this can be seen as career progression that moves experienced neonatal nurses from the nursing discipline to a more medical role, it is important to recognise and develop the MDT benefits of this experienced and stable workforce, supporting all the four career pillars of clinical expertise, research, education, and leadership/management to enhance the wider quality and safety of the service.

Several 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.

Vignette from Dr Regina Nalliannan, Consultant Neonatologist, Princess Anne Hospital, University Hospital Southampton

MTI Training Experience

Regina grew up in Chennai, South India after qualifying in medicine and initially chose to specialise in paediatrics.

In 2014, while working as a postgraduate doctor in neonates in paediatric hospitals in India, Regina spotted an advert for the Medical Training Initiative (MTI) (paediatrics programme) run by the Royal College of Paediatrics and Child Health in the UK.

Regina says that during her two on the programme working on the Princess Anne Unit, Southampton she learnt a lot from the Consultants in particular the importance of effective communication skills, including the importance of explaining to parents and families about choices and options with care and support. It is important to remember that parents are the baby's advocate as they don't have a voice.

Regina returned to the Princess Anne in 2019 taking up a locum post and was appointed into her current Consultant role in 2021.

As MTI lead for neonates, Regina supports and shares her experiences with new recruits to the programme in Southampton. In addition, Regina is passionate about the new generation of trainees and allowing them to have opportunities to gain and maintain new skills and knowledge, they are like our nursing and AHP learners the medical workforce of the future.

One innovative model to support the gaps in medical staffing within their neonatal transport team is the Southwest ODN staffing for their transport service with Paramedics working in Advanced Practice across the Tier 1 and 2 rotas.

The Interim People Plan (2019) offers a commitment to improving the future medical workforce through reforming education and supporting progression, although 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 states that the RCPCH & Workforce, Training and Education (WTE) NHSE, directorate formerly known as Health Education England (HEE) are working together to ensure that medical cover for neonatal care is improved.

NHS England has already increased funding to establish more midwifery and obstetrics posts (part of the £165m invested in response to the Ockenden and East Kent reviews), and the Three-Year Delivery Plan for Maternity and Neonatal services set out the next steps to further increase staffing into maternity and neonatal services.

To support this, NHS England have provided £10m in 2023/24 on the basis that new staff will be employed from 1 October 2023, and this will rise to £21m recurrently from 24/25 to pay for those posts in each subsequent year. The purpose of this funding is to support the permanent establishment of additional obstetric and neonatal medical posts and to support objectives in the Three-Year Delivery Plan for Maternity and Neonatal Services. This builds on recent additional investment in obstetricians, neonatal nurses, AHPs and midwives and work to boost substantive employment through recruitment and retention initiatives.

The additional investment for neonatal medical establishment is £3m in 23/24 rising to £6m 24/25 onwards. The additional funding is intended for neonatal units:

- To support increasing compliance against BAPM workforce standards and
- To support core safety activities in relation to safety governance, clinical leadership and the Perinatal Mortality Review Tool. This is even more imperative following the outcome of the recent Lucy Letby verdict.

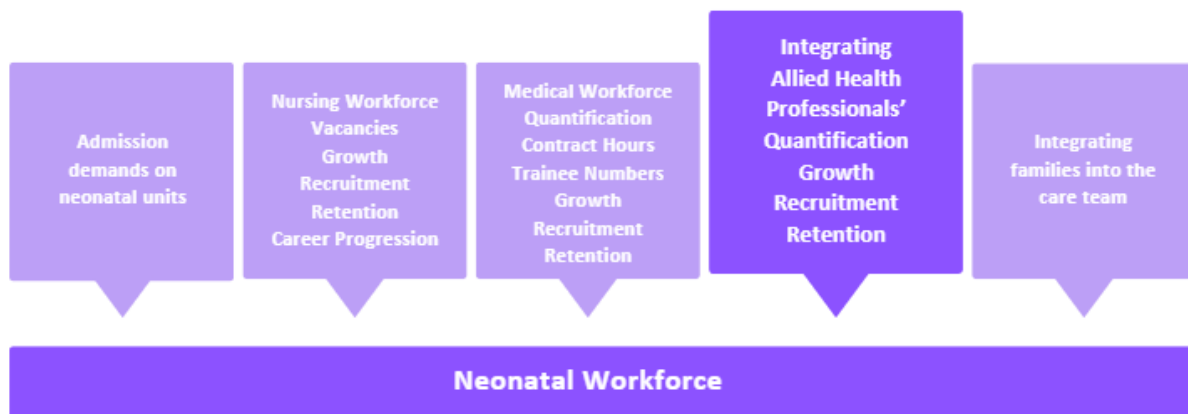
Medical Funding to Support Compliance against BAPM Workforce Standards

Provider Name	Provider Code (select from dropdown)	Neonatal unit type (NICU/LNU)	If NICU - meets the activity standard of 2000+ ICU bed does not meet the BAPM medical staffing standards in England	If LNU - meets the activity standard of 1000+ ICU/HDN bed days activity but does not meet the BAPM staffing standards in England.	ODN have reviewed the provider's CNST MIS returns and the proposal is consistent with the CNST submission	By exception - rationale if allocating funding to a Provider, who does not meet the set criteria (please refer to notes tab)	Workforce group	Role title	AFC Grade/Medical Grade	WTE/PAs	Estimated spend in 2023/24 £
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	RTH	NICU	Yes	N/A	Yes	safety : Support for tier cover	Medical	Support for tier cover	consultant	3.5 PAs	£23,625
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	RHM	NICU	Yes	N/A	Yes	safety : Support for tier cover	Medical	Support for tier cover	consultant	2.5 PAs	£16,875
PORTSMOUTH HOSPITALS NHS TRUST	RHU	NICU	Yes	N/A	Yes	safety : Support for tier cover	Medical	Support for tier cover	consultant	1 PA	£6,750
ROYAL BERKSHIRE NHS FOUNDATION TRUST	RHW	LNU	N/A	Yes	Yes	safety : Support for tier cover	Medical	Support for tier cover	consultant	0.5 PA	£3,375
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	RXQ	LNU	N/A	Yes	Yes	safety : Support for tier cover	Medical	Support for tier cover	consultant	0.5 PA	£3,375
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	RDB	LNU	N/A	Yes	Yes	safety : Support for tier cover	Medical	Support for tier cover	consultant	0.5 PA	£3,375
FRIMLEY HEALTH NHS FOUNDATION TRUST	RDU	LNU	N/A	Yes	Yes	safety : Support for tier cover	Medical	Support for tier cover	consultant	0.5 PA	£3,375
UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	R0D	LNU	N/A	Yes	Yes	safety : Support for tier cover	Medical	Support for tier cover	consultant	0.5 PA	£3,375
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	RNS	LNU	N/A	No	Yes	safety : Support for tier cover	Medical	Support for tier cover	consultant	1 PA (2 units)	£6,750
SALISBURY NHS FOUNDATION TRUST	RNZ	LNU	N/A	No	Yes	safety : Support for tier cover	Medical	Support for tier cover	consultant	0.5 PA	£3,375
ISLE OF WIGHT NHS TRUST	R1F	SCU	N/A	N/A	Yes	safety : Support for tier cover	Medical	Support for tier cover	consultant	0.5 PA	£3,375
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	RBD	SCU	N/A	N/A	Yes	safety : Support for tier cover	Medical	Support for tier cover	consultant	0.5 PA	£3,375
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	RBD	SCU	N/A	N/A	Yes	safety :	Medical	ANNP	8a	1 WTE	£35,198
UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	RYR	SCU	N/A	N/A	Yes	safety : Support for tier cover	Medical	Support for tier cover	consultant	0.5 PA	£3,375
										0	£119,573

Medical Funding to Support Core Safety Initiatives

Provider Name	Provider Code (select from dropdown)	Neonatal unit type (NICU/LNU/SCU)	Description of Activity	Expected benefits	Workforce group	Role title	AFC Grade/Medical Grade	WTE/PAs	Estimated spend in 2023/24 £
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	RTH	NICU	Yes	Yes	Medical		consultant	4 PAs	£27,000
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	RHM	NICU	Yes	Yes	Medical		consultant	2 PAs	£13,500
PORTSMOUTH HOSPITALS NHS TRUST	RHU	NICU	Yes	Yes	Medical		consultant	2 PAs	£13,500
ROYAL BERKSHIRE NHS FOUNDATION TRUST	RHW	LNU	Yes	Yes	Medical		consultant	2 PAs	£13,500
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	RXQ	LNU	Yes	Yes	Medical		consultant	2 PAs	£13,500
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	RDB	LNU	Yes	Yes	Medical		consultant	2 PAs	£13,500
FRIMLEY HEALTH NHS FOUNDATION TRUST	RDU	LNU	Yes	Yes	Medical		consultant	2 PAs	£13,500
UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	R0D	LNU	Yes	Yes	Medical		consultant	2 PAs	£13,500
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	RNS	LNU	Yes	Yes	Medical		consultant	2.5 PAs (2 units)	£16,875
SALISBURY NHS FOUNDATION TRUST	RNZ	LNU	Yes	Yes	Medical		consultant	1 PA	£6,750
ISLE OF WIGHT NHS TRUST	R1F	SCU	Yes	Yes	Medical		consultant	1 PA	£6,750
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	RBD	SCU	Yes	Yes	Medical		consultant	1 PA	£6,750
UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	RYR	SCU	Yes	Yes	Medical		consultant	1 PA	£6,750
								0	£165,375

Total estimated network spend 23/24	£284,948
Available funding	£283,695



AHP Workforce

The Neonatal Critical Care Review (NCCR) recognised that in addition to medical and nursing staff, neonatal units require key contributions from an essential group of Allied Health Professionals (AHPs), many of whom develop special expertise in their discipline as it applies to new-born babies. These disciplines include dietitians, occupational therapists, physiotherapists, speech and language therapists and psychologists.

AHPs and Clinical Psychologists have been central to the implementation and embedding of developmentally sensitive care into neonatal practice in many neonatal units throughout England and the UK, and champion the need to view neonatal care that looks forward to improving longer-term outcomes for babies and their families (NCCR 2019).

Recent workforce benchmarking and scoping has highlighted the significant shortfall and inequity of service of AHP and Psychology provision across England against professional staffing recommendations (GIRFT, 2022). Many services which were in place, are being provided in a 'good will', ad hoc and unfunded capacity, are not ring-fenced for neonatal units and easily pulled away into other competing clinical areas.

As part of the NCCR funding, between January and April 2022, the TVW ODN appointed strategic lead roles for Clinical Psychology, Speech and Language Therapy, Occupational Therapy, Physiotherapy and Dietetics. These roles had 4 overarching key objectives, (as outlined in figure 6) working to improve the care and provision of good quality care to babies, families, and staff across all units in TVW ODN.

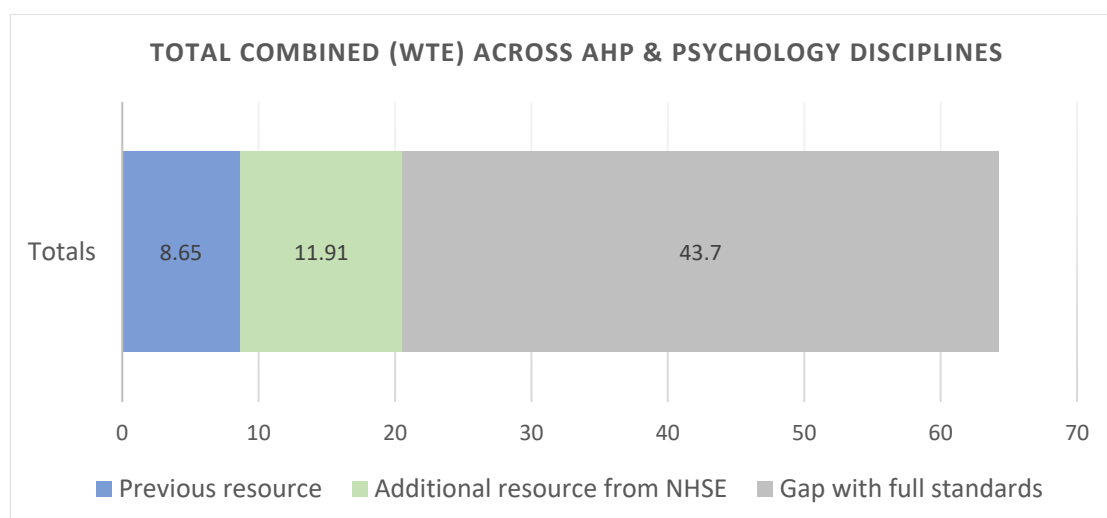
AHP & Psychology Overarching Key Objectives (figure 6)



An initial focus of these roles was in undertaking a more in-depth scoping review of workforce across each discipline during August/September 2022. Much like the national scoping by GIRFT, this review found very limited provision across all disciplines within TVW ODN.

With the publication of the Ockenden Review in March 2022 and the availability of additional funds that came from this to support maternity and neonatal workforce development nationally, a further focus for AHP and Psychology Leads has been on developing and building the AHP and Psychology workforce, which is detailed further in this strategy. Whilst the additional monies have supported workforce growth across each of the disciplines, there remains a significant gap between current provision and the national standards as highlighted in bar graph below:

Total combined WTE across AHP and Psychology disciplines in TVW ODN (figure 7)



Considerable funding is still needed to continue to grow the AHP and Psychology workforce to meet the standards set by each discipline. Supporting units to write business cases will be an important step, but also will national recognition of the ongoing need for AHP and Psychology posts and funding to support this. The AHP and Psychology Leads within TVW all have strong positions nationally, representing and advocating for their respective disciplines so that this is thought about and worked on at every level of the system. Recruitment into some of these posts is also challenging with some posts vacant or partially filled.

Workforce Developments

Psychology

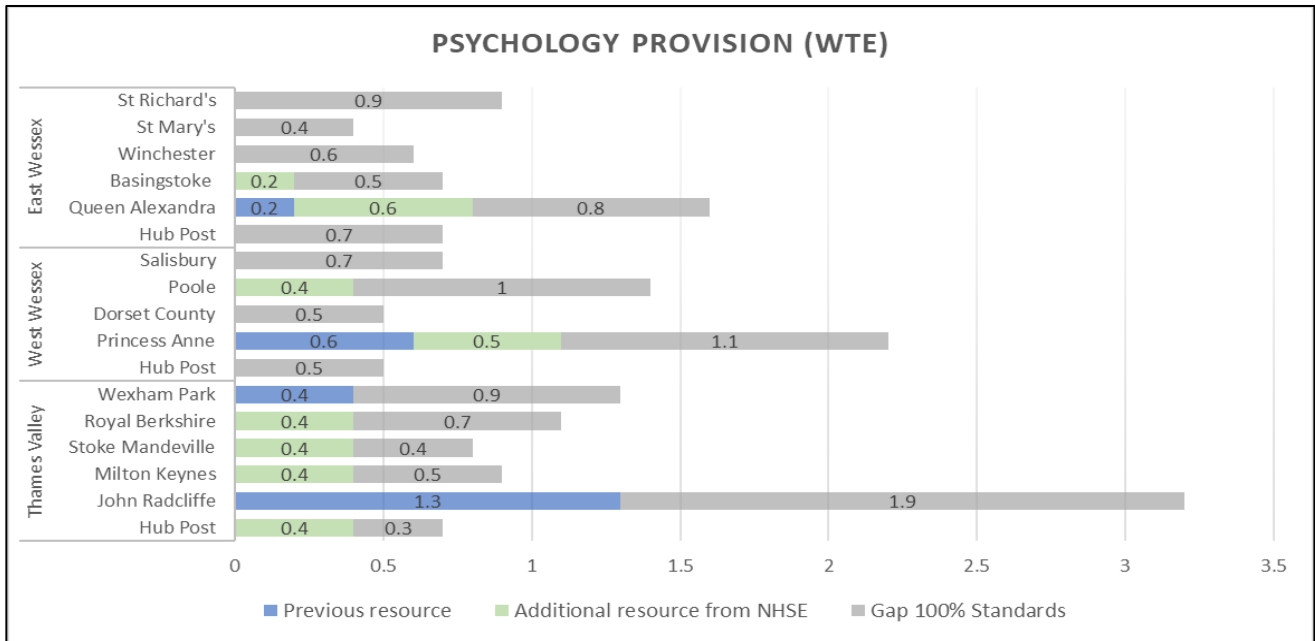
The journey from pregnancy to neonatal care and beyond is frequently an extremely traumatic one for families. The impact can be far reaching, affecting security, attachment, and family relationships, and often having a significant longer-term impact on the psychological wellbeing and development of children and parents alike.

The demands of work on the neonatal unit can also bring several 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.

With the recent allocation of funding from the Ockenden review this has enabled further development of the psychology workforce. As detailed in the table below, this has increased provision from 2.5wte to 5.8wte, reducing the gap compared to the staffing standards from 85-67% for spoke roles and 100-79% for hub lead roles.

		Staffing Standards		Previous resource (WTE)		NHSE Ockendon funds (WTE)		New resource (WTE)		Gap against Standards	
		Spoke	Hub	Spoke	Hub	Spoke	Hub	Spoke	Hub	Spoke	Hub
Psychology	WTE	16.3	1.9	2.5	0	2.9	0.4	5.4	0.4	10.9	1.5
	%	100	100	15%	0	18%	21%	33%	21%	67%	79%



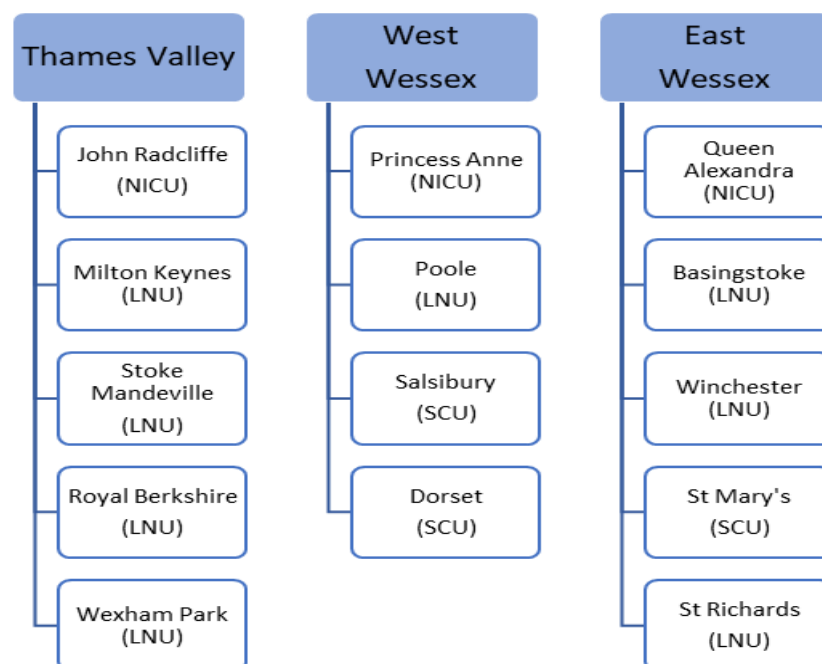
- Prioritisation was given to bringing each of the 3 NICUs and 5 of the LNU's up to 50% of the staffing standards. This was to ensure provision was at a level that could provide a safe service, but also were recruitable posts, as most units did not have posts to uplift.
- Although some units remain without dedicated provision, joint working across the network by the psychological professionals, should allow for shared teaching and sharing of resources which will benefit all. A focus will be on developing business cases to support further development of the workforce.
- Whilst additional funding has been very welcome and will make a significant difference to the units that have dedicated funding, provision for psychology remains significantly below the national standards.

Hub and Spoke Model Development

Aligning with the Neonatal Psychology Standards for neonatal units, a hub and spoke model was developed across the Network. Three hubs were developed around the 3 NICUs, and spokes allocated according to geographical location.

Important to the process of developing the psychology workforce, was the development of robust clinical governance and supervision frameworks.

Each hub will over time, with additional funding, have a Hub Lead Psychologist as outlined in the staffing standards to provide clinical supervision, complex case consultation, working with units within and across the hub to develop services that provide good quality, equitable care for all families and those that move between units.



Neonatal Clinical Psychologist, UHS

As a Clinical Psychologist working in neonatal care, I offer psychological support to the families and staff on the unit.

As a psychologist, I have always been interested in the impact of early experiences on later life, and the power of relationships – and this is something that feels particularly pertinent to me now, working with families at the very beginnings of their journeys into life.

Working in a hospital context really highlighted for me the challenges faced by families living their lives in amongst appointments, admissions and physical health problems – as well as their incredible creativity, determination and courage. It also taught me that those working in health care settings do more than health care, they show witness to and join in a family's developmental life cycle.

A Typical Day

No two days are the same, I try to do regular 'walk arounds' on the unit, introducing myself to new families and checking in with those who have been on the unit a while. I do this to provide an opportunity to demonstrate that psychology is an integral part of their baby's admission, not something reserved for those not 'coping well enough'. Often the conversations I share with families cover a whole range of topics, including acknowledging and empathising with the understandable feelings around for families, letting them know they are not alone, that this was not their fault. Together we explore ways for families to connect with their baby in amongst the uncertainty, wires and beeps, we think about ways for them to be parents, to advocate for their baby and to take care of themselves. We think about their whole experience, including their roles outside of the hospital – with older siblings, work, extended family, and consider ways I might offer additional support (e.g., a letter to an employer, a referral for increased support, an invitation to meet with siblings or share ideas or books). In addition, I facilitate regular trainings for nursing staff, to help them think about ways to support families, understand and respond to distress, find ways for parents to connect with their baby in amongst the busy neonatal unit. We also think about the importance of self-care and if and how to access additional support, this also involves facilitating medical/ nursing groups, to provide a confidential space to reflect, pre/debrief together on the challenging experience working in neonatal care and explore ways to take care of themselves.

My job really does give me so much value, a place where I feel I can use all my professional knowledge and experiences and where I can continue to learn from and with the families and teams I support. I honestly believe it is a true privilege to work in neonatal care.

Dietician

Role of the neonatal dietitian

Dietitians have a specialist role in the complex nutritional care of neonates and specialist knowledge of the potential barriers for managing nutritional interventions. The need for optimum nutritional support is paramount as evidence identifies to short- and long-term adverse consequences of poor nutrient intake and growth in this population.

Neonatal Dietitians are highly skilled at assessing, diagnosing, and managing the nutritional needs of neonates. They understand and interpret current clinical evidence and guidelines for neonatal parenteral and enteral feeding and can apply strategies to both individualised and standardised practice to meet the complex nutritional needs of preterm infants.

As a member of the neonatal team and by working collaboratively with families, dietitians can have a significant impact on the care of sick and premature infants, providing consistent nutritional care to each infant. This contributes to the reduction of nutrition related clinical complications which helps lead to improvements in short term outcomes, long term outcomes and quality of care.

Dietitians play a key role in the wider multi-disciplinary team, supporting the team to make clinically effective feeding decisions, particularly regarding the management of feed choices, feeding methods, the transition from parenteral to enteral feeding and the nutritional management of infants with gastro/surgical conditions. Dietitians have extensive knowledge of the use of breast milk in preterm infants and support establishing and maintenance of lactation and the transition to breastfeeding. They understand the composition and use of breast milk fortifier (BMF), specialist preterm and term formula to supplement nutrition as needed.

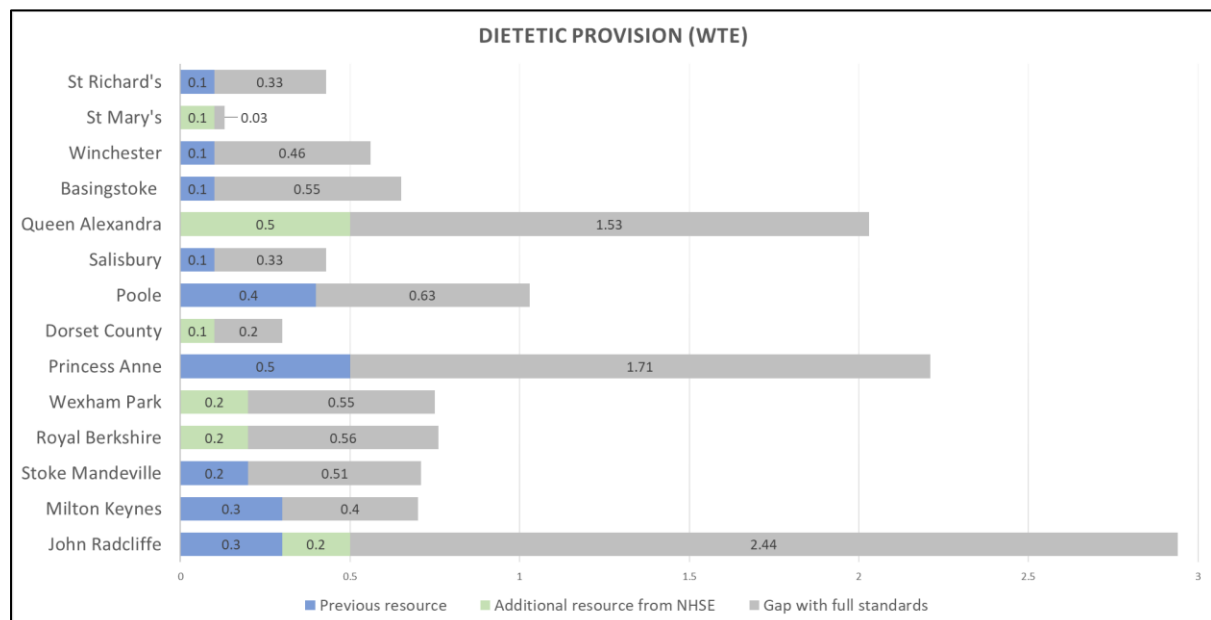
They provide nutrition focused training and support to the wider multidisciplinary team and are integral in embedding UNICEF Baby Friendly Initiative neonatal standards, Family Integrated Care, and the Bliss Baby Charter.

Workforce Developments

Throughout the scoping period, and further to the publication of the Ockendon report, Ockendon funding enabled the allocation of additional funds to dietetic services within the

network. This has reduced the gap in dietetic provision compared to staffing recommendations to 75% (previously 85%).

	Staffing rec's (WTE)	Previous resource (WTE)	NHSE Ockendon funds (WTE)	New resource (WTE)	Gap against rec's %
Dietetics	13.63 WTE	2.1	1.3	3.4	75



- Some level of dietetic provision will now be available to all NICUs within the network. Improved dietitian input should enable focused optimisation of nutrition, including involvement with PN as per NICE recommendations.
- Scoping identified that input to LNU's across the network is variable and would benefit from a consistent, regular dietetic service initially focusing on the establishment of regular nutrition focused sessions to start to embed standardised practice and continually highlight the importance of nutrition and growth. For those Trusts where services were identified as ad hoc only, a resource was allocated.
- Funding was allocated to SCUs which will help embed nutritional practices and support the units for those babies that require specialist dietetic input.

Occupational Therapist

Occupational Therapists form an integral part of the MDT on the Neonatal unit, making 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 neonatal staff and the new Family Care role, MDT, and families.

Baseline Workforce Overview

A scoping review of the Occupational Therapy service provision baseline across the Thames Valley and Wessex network, including workforce development challenges, was carried out in early 2022. The review identified the following:

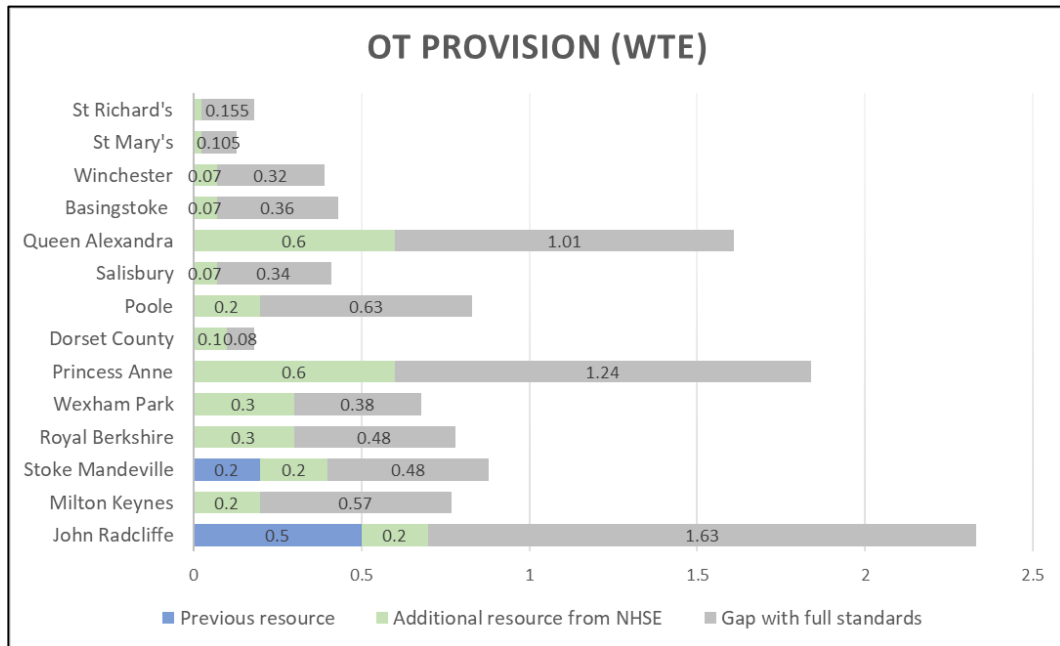
1. Occupational Therapy is poorly and disproportionately represented in the TVW network and amongst the AHP and MDT team, with only two neonatal units funding an embedded, neonatal funded OT service. Of these two services – one NICU and one LNU in the Thames Valley area – both only meet 33% of recommended Royal College of Occupational Therapists (RCOT) staffing standards.
2. There was a sparse goodwill community-based service being provided in 3 LNUs, however, referrals are limited in number (max 5 per year) and reflected an extremely narrow view of the contribution of OT in this setting.
3. There is a general lack of awareness and understanding of the role of Occupational Therapy in the neonatal units throughout the network, with the service often perceived as solely supporting developmental care.
4. There are significantly limited opportunities for OTs to work in this specialist clinical area in TVW network, and as a result, there is a shortage of experienced clinicians.

Workforce Developments

With the recent allocation of funds resulting from the Ockenden review, Occupational Therapy services have increased to provide some level of support across the whole network, giving all units a degree of service access, albeit in reduced and varied models of service delivery.

In summary:

- There has been an increase from 0.9 to 3.7 WTE OT positions covering TVW – all at Band 7.
- Increase from 3 to 9 OTs in terms of practising therapists.
- Gap now at 68% against RCOT Staffing Recommendations (previously 94%).



Models of Service Delivery

Three 'hubs' have been created to provide a level of OT services to all units, balancing best use of staffing options and unit need.

1. HUB 1 Oxford: NICU with x4 larger LNUs
2. HUB 2 Southampton: NICU with x1 larger LNU, x1 SCU and in-reach to x3 smaller LNUs
3. HUB 3 Portsmouth: NICU with in-reach to x2 SCUs

Models of service delivery are dependent on unit size, using in-reach education from the larger NICUs into their respective smaller LNUs and SCUs. This provides nursing education and opportunities for development of an understanding of the OT scope of practice through specific targeted and measurable interventions.

Case Study Neonatal Occupational Therapy Angela Storey

What is my story?

I am a Paediatric Advanced Level Occupational Therapist (OT). Over the past 15 years I have worked in neonatal care unfunded now with Ockenden funding 7.5 hours)0.2WTE
The unit at Poole is a Level 2 LNU . I am part of therapy team alongside my 2 physiotherapy colleagues, with a more developmental therapist approach. We offer support to babies under 32+6 weeks' gestation/ 1500g / other neurological / genetic difficulties and NAS predominately. We offer a named therapist approach enabling us to get to know and provide continuity of support to our named family through the unit, into the community and until they are discharged at 2 years. We support regular training and education opportunities. I work collaboratively with the network and nationally through various forums including Allied Health Professionals, Family Integrated Care and Perinatal Mental Health and the Royal College of Occupational Therapists specialist section.

What do I bring to the team?

Occupational Therapy (OT) is focused around supporting occupations (day to day activities) from a physical, mental health and developmental perspective. We provide added value to the wider MDT with our holistic, occupation focus and dual (physical & mental health) training.

In the neonatal world our skills support parent infant co-occupations, infant neuro-behavioural regulation, and sensory development. We apply specialist knowledge of infant neuro- behavioural and neuro- motor development and analysis of the impact of the physical, sensory, and psychosocial environment, to optimise the infant development and co occupation performance; helping parents be parents and infants have the best start.

Physiotherapy

The role of the physiotherapists in recent years has developed from a role that had been mainly associated with respiratory care to now assessing development, musculoskeletal and neuromuscular conditions, positioning and handling support and neurodevelopmental input for babies with complex medical needs who may stay longer in hospital and require long term follow up. The Neonatal physiotherapist will offer support and advice to both parents and staff, working in collaboration with them and the wider MDT. They will provide a variety of assessment and care including respiratory assessment, musculoskeletal and neuromuscular assessment, and treatment. The neonatal physiotherapist is involved in all stages of the infant and family neonatal care from the most vulnerable intensive care baby to those requiring follow up due to complex developmental care needs.

Baseline Workforce Overview

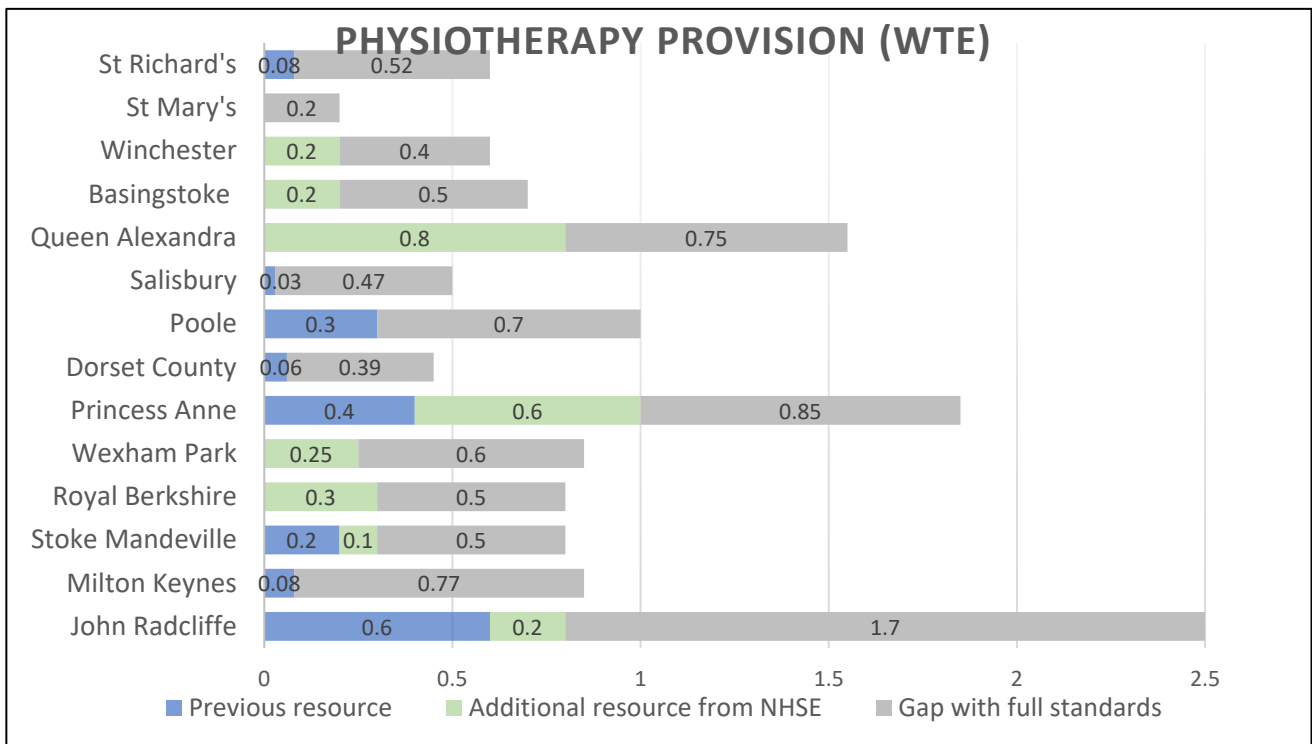
There were no units within the TVW neonatal network that were meeting staffing recommendations for Physiotherapy. The lack of sufficient Physiotherapy provision, funding and neonatal physiotherapy experience for neonatal units impacts on the ability for Physiotherapists to embed their service on Neonatal units.

There is recognition and enthusiasm from Provider Trusts, Therapy Managers and unit clinical leads to embed physiotherapy services in neonatal units.

In the NICUs only two out of the three had identified dedicated funding for neonatal physiotherapists. There was also an 83% gap against staffing standards.

In the LNUs although they all had some access to physiotherapy services, this was well below recommended standards and often associated with a community paediatric good will/ad hoc service.

One of the three SCUs had a funded service and ad hoc referrals to paediatric physiotherapy in the other SCU's.



Workforce Developments

	Staffing rec's (WTE)	Previous resource (WTE)	NHSE Ockendon funds (WTE)	New resource (WTE)	Gap against rec's %
Physiotherapy	13.25	1.75	2.65	4.4	67

All NICUs will have some neonatal physiotherapy provision. Where there were identified gaps and ad hoc provision in LNU's to initially focus on identifying those infants at highest risk of future neurodevelopmental problems, a resource has been allocated.

Despite additional Ockendon funding, Physiotherapy provision across TVW remains significantly below staffing recommendations. However, this funding will allow units to benefit from a more consistent, regular Physiotherapy service and the ability to start to embed standardised practice whilst continually highlighting, educating, and supporting babies' development along with their family.

Speech and Language Therapist (SLT)

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

The role of the Neonatal Speech and Language Therapist is to enable communication and interaction between the parent/caregiver and infant is integral to neurodevelopmental outcomes and attachment and to future outcomes for this vulnerable population.

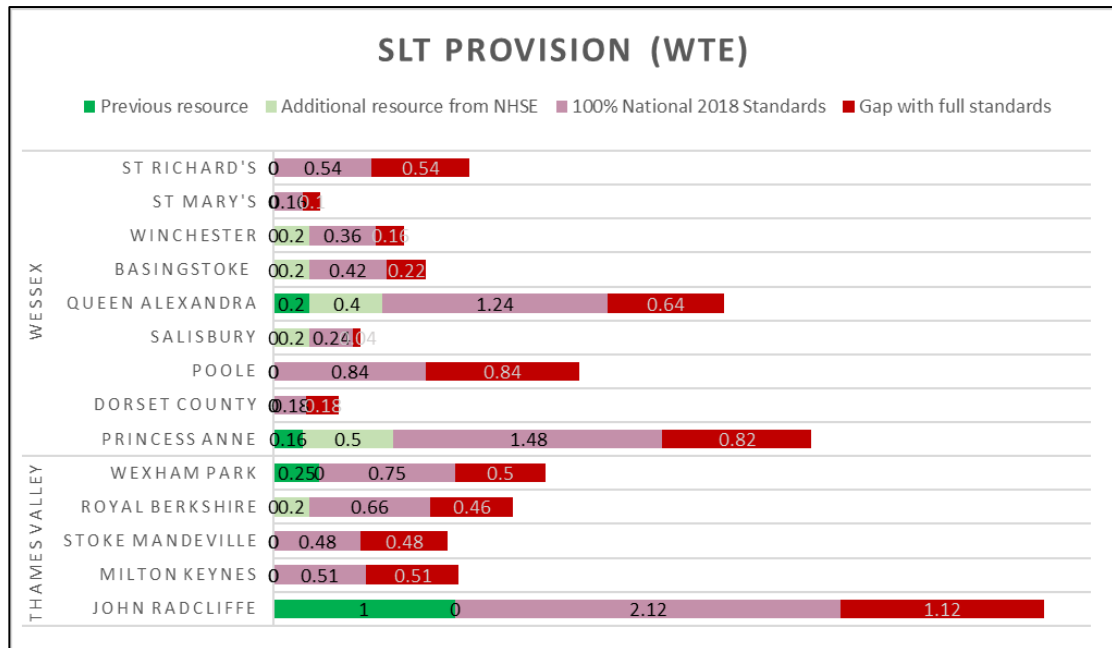
Neonatal units require dedicated regular neonatal speech and language therapists for several key reasons premature infants and those with other diagnoses are more at risk of later speech, language, and communication impairments. There is also a requirement to support MDT staff education, timely assessment and management to infants and their families.

Workforce Developments

There has been an increase in neonatal SLT staffing across the TVW NODN because of the Ockenden report and subsequent NHSE funding.

	Staffing rec's (WTE)	Previous resource (WTE)	NHSE Ockendon funds (WTE)	New total SLT resource (WTE)	Gap against rec's %
Speech & Language Therapy	9.98	1.6 wte	1.7 wte	3.3	6.7 wte (66%)

Prioritisation of Ockenden funds was given to units where there was no access to any SLT which was resulting in families being moved further from home to tertiary units for SLT assessment and planning or not receiving timely or appropriate care balancing SLT provision across Thames Valley and Wessex uplifting Wessex NICU SLT staffing in order to support a future vision of hub-spoke models of care.



Each unit now has 'access to' SLT provision within the TVW ODN.

There has been a levelling up of SLT resource across the ODN- previously 0.4 wte in Wessex vs 1.25 wte TV, now 1.8 wte Wessex and 1.4 TV.

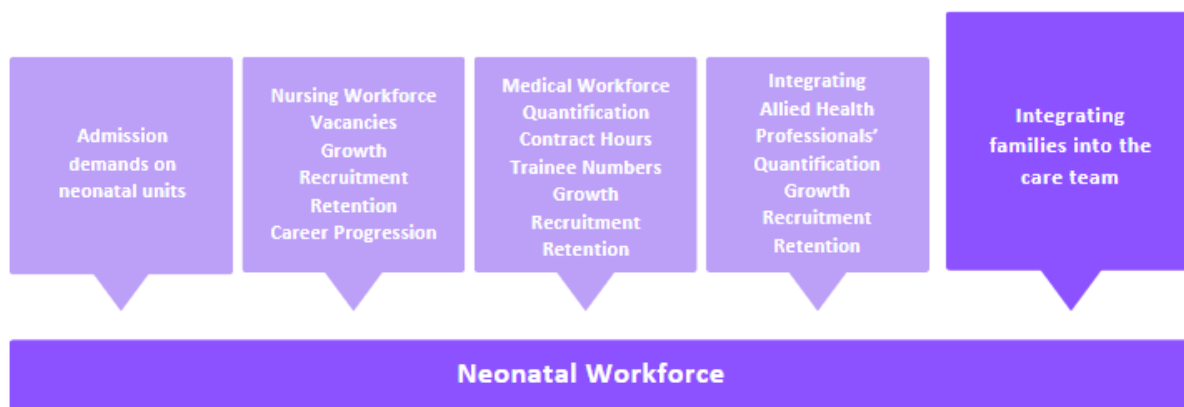
Recruitment to the NICUs is further challenged due to a shortage of appropriate trained/competent neonatal SLTs. This often involves lone working and a national shortage in speech and language graduates.

Network Consultant Neonatal Pharmacist

Pharmacy

This role will act as a Lead pharmacist for Neonatology, providing specialist pharmaceutical care of babies and supporting the MDT in the use of medicines. Therefore, it is important to note the role of the pharmacist as essential to ensure safe use of medicines in neonates. They do play a major role in the prevention of drug errors, supporting electronic prescribing systems and developing guidelines both at unit level and network. A network pharmacist would be able to co-ordinate standardised approaches to medicines optimisation within a region and support training around neonatal medicines for pharmacists working in neonatal units and other neonatal health care professionals.

Following through from the recommendations of GIRFT (2022) TVW ODN have successfully written a job description for a network Consultant Pharmacist and have funding for this role.



Integrating families into the care team

The previous sub sections set out the most significant factors which are facing the current workforce and act as a foundation for this strategy. With the implementation of the NCCR which identifies that neonatal care must include a substantial role for parents in the care of their baby. The introduction of Network Care Coordinators, Parent Advisory Group, Parent Engagement Lead and AHP and funding for Family Integrated Care leads in each unit has led to the beginning of units committing to developing Family Integrated Care (FIC) in their units. The aim of this workforce is to achieve a consistent approach to the development and provision of this model of care by training and supporting healthcare staff and families to be the carers of their babies. This is a significant cultural change in the world of neonates, where care has traditionally been the responsibility of healthcare staff. Whilst this cultural change will take time to establish a consistent service provision across the units, it is already influencing fundamental ways of working.

Network roles

With the allocation of LTP funding through the NCCR it was evident that major workforce transformation was required with the consideration of new roles and ways of working at ODN level with AHP and Clinical Psychology Lead roles, Care Coordinator roles, parent engagement role and Workforce and Education Leads. In addition, funding through Ockenden (2022) created an out of training recruitment and role for a Neonatal Grid /Paediatric trainee (ST5 minimum) 0.4 WTE working within the Thames Valley & Wessex ODN footprint opportunity. This role is primarily to engage in perinatal optimisation of the preterm baby and neonatal quality and safety initiatives across the Wessex region and linking with the Thames Valley.

Parents & Family Engagement Lead

Parent & Family Engagement across the Thames Valley & Wessex Neonatal ODN will ensure the development of partnership working that puts babies, parents and families at the centre of everything we do.

The Parents & Family Engagement Lead, on behalf of the ODN, will develop and lead on parent and family engagement initiatives across the TVW Network to support the development and implementation of Family Integrated Care, meeting the aims and key deliverables of the National Neonatal Critical Care Review (NCCR) (2019), the NHS Long Term Plan (2019), and corresponding neonatal commitments and recommendations from both the Ockenden (2022) and Kirkup (2023) reviews.

Key to this role is the partnership working with the PAG, ODN Care Co-ordinators, Allied Healthcare Professionals and Psychology Lead, to develop, improve and enhance Family Integrated Care in all neonatal units, working creatively, respectfully, and collaboratively to co-design and co-produce solutions together. This role will ensure that parents and families lived experiences will have a 'voice' in the provision and development of neonatal services across the region.

Supporting the network team in aiding units to foster a culture where family integrated care is embedded in everyday practice, so that parents are fully involved, trained, supported and coached in providing their baby's care, leading ward rounds as their baby's experts.

Acting in an advisory capacity assisting provider, and third-party organisations, in the improvement of the accommodation, facilities and support available to parents and families during their baby's time on the unit, in reducing variability of neonatal services across the network when repatriated back to local units, and in preparation for the transition to home, neonatal outreach and/or paediatric services.

Care Co-ordinators (CC)

The CC role is to support the implementation of the NCCR, to enhance the experience of families through their neonatal journey. The CCs will be working alongside local Family Integrated Care and education teams to establish and embed the philosophy of FIC into practice. A key element of their role is to support teams with developing and delivering education to staff on neonatal units. Therefore, ensuring equity of care and FIC provision

across the ODN. Following initial scoping of all 14 units and aligned with parent engagement priorities within the transformation plan the initial areas of focus were:

- Developing a TVW parent/passport/journey log with the aim of standardization of parental participation in their baby's care across the Network.
- Timely repatriation of babies and families between neonatal units.
- To support parent participation in ward rounds and develop training packages to support this.
- To support the development of both TCU and Outreach services to enable timely/safe discharge home.

Workforce and Education Leads

Each ODN was allocated recurring funding for the Education and Workforce Leads. Its objective is to support improvements in growth, recruitment and retention and innovative ways of working. In addition to describe and quantify quality nurse roles as described by the Neonatal Toolkit, BAPM and new transformation roles.

The role will also deliver a national standardised approach to the neonatal workforce reporting and support our neonatal service providers in completing national workforce metric submissions.

Network AHP /Clinical Psychology Leads

The neonatal Network AHP/Clinical Psychology roles have been developing links across the ODN therapy and Psychology services to support service and workforce transformation building on early workforce scoping.

These strategic roles have encompassed development of baseline workforce scoping, identifying where risk assessments need to be put into place, developing neonatal AHP/Clinical Psychology staffing competencies, education packages in conjunction with other ODN Leads and Workforce Training Education Directorate (NHSE) and reviewing the current governing body recommendations. A focus has been on ensuring consistent messages that encompass FIC, psychologically informed care and neurodevelopmental practice across the ODN and identifying risk where this exists. There has been additional funding for all 4 disciplines and psychology across the ODN which has been prioritised in

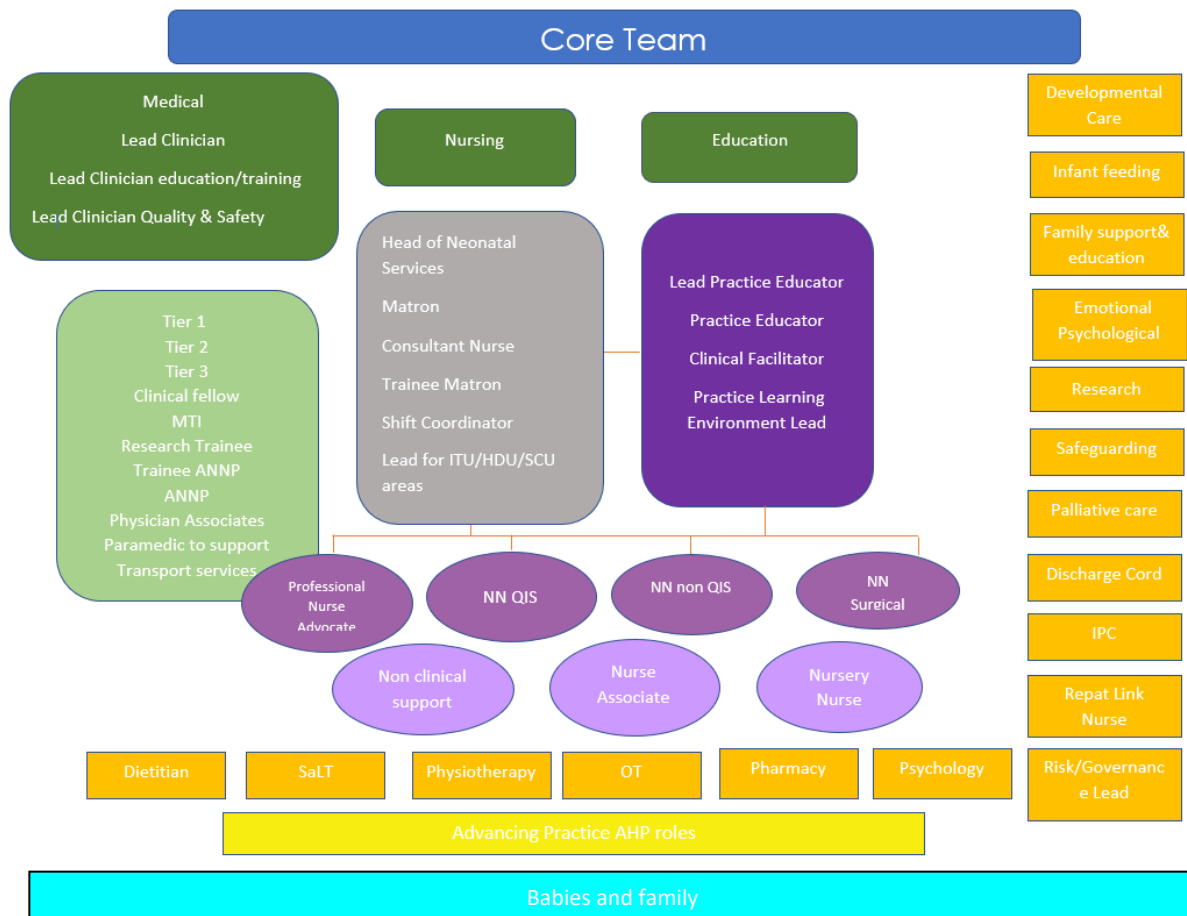
areas where there has been no access to therapists at all and some uplift to services where only good will unfunded provision existed.

Achieving our vision

In the production of this strategy, it was recognised that each unit across TVW had its own set of specific issues in being able to provide care through a multidisciplinary workforce. Some of the units despite funding were unable to achieve the guidelines set by the Neonatal Toolkit and BAPM staffing standards 2012 in resourcing their teams, but this looked very different in the units depending on their unit's designation, estate, capacity, staffing and activity levels.

By working with clinical representatives, managers, ODN teams, educators, Care Coordinators, and parent engagement lead, we were able to work through what the current staffing situation and job roles were. Through this, the scoping review and gap analysis undertaken for Ockenden funding (AHPs, Clinical Psychologists and medical) roles we were able to identify some of the gaps in service and roles. It helped us to understand what the contemporary core neonatal team should look like in the current world.

Multi-professional Neonatal Core Team



Quality roles

The TVW workforce report (2022) and GIRFT (2020) identified that nurse staffing data and narrative concentrates on direct cot-side care nursing and does not consider other important quality/link roles as outlined in the Department of Health's Toolkit for High Quality Neonatal Services (2009), BAPM (2022). Like the Practice Educator role there had been no workforce quality role standard/ calculator to determine WTE and funding to describe, support and underpin these roles.

As part of the LTP commitment to support delivery of the National Critical NCCR, funding was made available in 2023/24 to establish neonatal nurse quality roles within units. These quality roles are listed in the Neonatal Toolkit (2009) and Service and Quality Standards for Provision of Neonatal Care in the UK (BAPM,2022).

In the absence of any national recommendations for the quality role requirements the ODN Education & Workforce group worked to develop standards and quantification for some of these roles determined by staffing and or activity Appendix (2) TVW Quality Role Indicator Tool.

Quality role scoping undertaken in February 2023 had identified significant gaps and inequity of nurse quality roles across TVW as described by the Neonatal Toolkit (2009) and against the Workforce/Education Quality role quantification tool standard.

The initial funding was insufficient to meet all the gaps in roles so initial priorities were agreed in Education, Governance and Family Care based on national drivers NCCR (2019) and maternity and neonatal safety reports Ockenden (2022), Kirkup (2023). All units allocated funding have successfully recruited into post.

Recommendations were developed based on any existing equivalent standards, a review of comparable job descriptions, assessment of the Key Performance Indicators (KPIs) for each role and the hours required to deliver these.

The recommendations agreed are:

- Neonatal Education: 1 WTE per 50 headcounts of staff. Based on the PICU standards for Educators

- Neonatal Risk/ Governance Lead: 0.1 WTE per 1000 delivered care days. A NICU delivering 10,000 care days per year would therefore require 1 WTE.
- Family care: 0.2WTE per 1000 delivered care days. A NICU delivering 10,000 care days per year would therefore require 2 WTE. This recommendation was agreed because of the many aspects to family care that are incorporated into the role.

Role descriptors have been produced to inform and support the writing of Neonatal specific Job Descriptions for the roles at unit level. See Appendix (3 a,b,c.) Role Descriptors

The group continues to work on the development of standards for other quality roles.

Allocation of Funding for Quality roles across TVW ODN (figure 8)

Provider Name	Neonatal unit type (NICU/LNU/SCBU)	Role title	WTE	Estimated spend in 2023/24 £
Oxford John Radcliffe NHS Foundation Trust	NICU	Fi Care Lead	0.20	£12,306
Portsmouth Hospitals NHS Trust	NICU	Risk Governance	1.00	£61,530
Portsmouth Hospitals NHS Trust	NICU	Fi Care Lead	0.20	£12,306
University Hospitals Sussex NHS Foundation Trust (St Richards Hospital)	SCU	Risk Gov	0.50	£30,765
University Hospitals Sussex NHS Foundation Trust (St Richards Hospital)	SCU	Practice Educator	0.50	£30,765
University Hospitals Sussex NHS Foundation Trust (St Richards Hospital)	SCU	Fi Care Lead	0.20	£12,306
St Mary's Isle of Wight NHS Trust	SCU	Risk Gov	0.50	£30,765
St Mary's Isle of Wight NHS Trust	SCU	Practice Educator	0.20	£12,306
St Mary's Isle of Wight NHS Trust	SCU	Fi Care Lead	0.20	£12,306
Dorset County NHS Trust	SCU	Risk Gov	0.50	£30,765
Dorset County NHS Trust	SCU	Fi Care Lead	0.20	£12,306
University Hospitals Dorset NHS Foundation Trust	LNU	Risk Gov	0.50	£30,765
University Hospitals Dorset NHS Foundation Trust	LNU	Practice Educator	0.50	£30,765
University Hospitals Dorset NHS Foundation Trust	LNU	Fi Care Lead	0.20	£12,306
Salisbury NHS Foundation Trust	LNU	Fi Care Lead	0.20	£12,306
Hampshire Hospitals NHS Foundation Trust (Basingstoke)	LNU	Risk Gov	0.20	£12,306
Hampshire Hospitals NHS Foundation Trust (Winchester)	LNU	Risk Gov	0.20	£12,306
Royal Berkshire NHS Foundation Trust	LNU	Risk Gov	0.50	£30,765
Royal Berkshire NHS Foundation Trust	LNU	Practice Educator	0.50	£30,765
Royal Berkshire NHS Foundation Trust	LNU	Fi Care Lead	0.20	£12,306
Milton Keynes University Hospital NHS Foundation Trust	LNU	Risk Gov	0.50	£30,765
Milton Keynes University Hospital NHS Foundation Trust	LNU	Fi Care Lead	0.20	£12,306
Buckinghamshire Healthcare NHS Foundation Trust	LNU	Risk Gov	0.20	£12,306
Buckinghamshire Healthcare NHS Foundation Trust	LNU	Fi Care Lead	0.20	£12,306
Frimley Health NHS Foundation Trust Wexham	LNU	Risk Gov	0.50	£30,765
Frimley Health NHS Foundation Trust Wexham	LNU	Fi Care Lead	0.20	£12,306
THAMES VALLEY & WESSEX Total			9.00	£553,770

Neonatal Feeding Specialist; Intensive Care Unit.
Qualifications:
BSc Sociology; Health Improvement.
Post Graduate Diploma in Nursing
Qualified in Speciality Neonates
International Board-Certified Lactation Consultant

My background is high dependency nursing; where I fostered an interest in family focussed care.

I did a lot of training around motivational interviewing and supporting families in difficult situations.

I moved to Neonates as I was looking for a new challenge and wanted to make a difference and build my career.

After having my own children, feeding became a particular interest of mine. I appreciated the magnitude of expressing and breastfeeding a baby who was in Neonatal care.

I did lots of training around breastfeeding and nutrition for preterm infants gaining lactation specific training via Breastfeeding London Course and then completed my lactation Consultant exam.

My job as Neonatal Feeding Specialist is varied. A typical day: Monday begins with checking in with the feeding team, emails, and referrals from parents answering any urgent queries and checking my diary. I also check the latest evidence and sources surrounding feeding, updates and any public health notices and network meetings I need to attend. I am to ensure all communications are passed on to the team. I will have a quick meeting with either the medical team or Nurse in Charge to discuss any priorities for the day or Consultant on service who highlights anything that is of issue.

Then is ward round, supporting the MDT with babies who are more complex feeding close to discharge. I will answer queries, support breastfeeding of complex babies and suggesting ways to maximize breastmilk if possible

Once this is done every parent on NICU is supported ensuring that initiating lactation or maintaining milk production is going smoothly. I then will see specific parents who perhaps need a feed observed. I will ensure that parents express/feeding plans are up to date and suggest ways to boost lactation/ support feeding and the transition to breastfeeding for those on the unit.

Continued

I am currently working on several projects, including UNICEF baby Friendly and locally driven initiatives to support long term health. I will spend some time working on these. If time allows, I will do some education sessions on the unit, such as trolley dashes to support these projects. Feeding rotations are always open to the team and I will spend some time supporting and coaching staff to gain skills in complex feeding, breastfeeding and parental involvement in cares.

I then see inpatient parents on NICU babies and liase with maternity colleagues to support successful feeding. I liase closely with Perinatal Mental Health and family charities who can support parents on going needs. I facilitate breastmilk donation and work closely with local hospitals to support this provision.

I am absolutely privileged to work in NICU. I love making a difference and seeing families overcome any difficulties to breastfeed successfully from NICU. Or support them to provide expressed breastmilk or bottle feed. I urge anyone with a passion for providing the best care to choose a career in Neonates. I have been fully supported every step of my career and am looking forward to the next challenge ahead.

What Inspired Zita to follow a research career:

"I have always enjoyed research and think that evidence based practice is pivotal in advancing nursing care. My interest in research developed when I undertook a secondment role as a nurse researcher for one year to support a study at the University of Brighton, on nursing burnout. It is was there that I found the work really interesting and it inspired me to support ward teams to be involved in everyday, practical research. This means getting teams involved in huddles, discussing how we solved problems through audit, looking at evidence and encouraging the use of the Clinical Librarian as well as testing out ideas.

It is rewarding to see research being discussed at ward levels and teams acknowledging how evidence based practice can shape improvement in the care we provide to our patients."

What research means to Zita:

Makes a difference

Hannah Wells, Neonatal Surgical Specialist Nurse

I have always known surgical nursing was for me. I worked as a health care assistant on a children's surgical ward for a year prior to undertaking my nurse training. My first job as a newly qualified nurse was on a children's surgical ward. I then moved to the Neonatal unit, and I have been here ever since. I enjoyed taking care of a variety of neonatal patients but still found I had a particular interest in the infants with surgical pathology.

A secondment into the surgical nursing team opened and I applied. 12 years later I am still part of the team!

The role of the Neonatal Surgical Nurse Specialist (NSNS) team is to work collaboratively within the wider surgical and Neonatal Multi-Disciplinary team (MDT). The team support the care of families from antenatal/postnatal diagnosis to discharge home or transition into paediatric services. We provide specialist advice, education, and support to health care professionals in UHS and the wider Thames Valley and Wessex Network, and for parents/carers of the neonates in our care, both on the Neonatal Unit and immediately after discharge.

We work 7 days a week to provide both continuity and expert care for infants and their families. This starts with supporting prenatal counselling and continues through an infant's inpatient stay and during the early outpatient phase prior to their transfer to paediatric care. We work collaboratively with the Paediatric surgical team. Working 7 days a week also allows for complex discharges to not be delayed as we often facilitate sending a family home over a weekend as we are here to support that to happen smoothly. Part of our role requires us to work autonomously, with the ability to undertake a surgical ward round or clinic independently if the clinical need arises. We utilise advanced clinical, analytical, and decision-making skills to prioritise our workload and make clinical plans for the surgical infants.

We support the neonatal team in setting up for surgery on the NNU or transporting infants to theatre at the general hospital and support the family through the whole process.

We provide teaching day to day on the Neonatal unit, the wider Trust and the Thames Valley and Wessex Network for the multi-disciplinary team. We have a virtual learning platform on neonatal surgical conditions and procedures to support the teams in local units.

Jo Nash Consumables and Equipment Lead NICU QAH

My role on NICU consists of day-to-day trouble shooting of any equipment and stock issues. If there are any issues ordering a consumable through materials management, I will liaise with our supply chain coordinator and try to source an alternative product this also involves asking the Network to see if anyone has stock and then to enquire on what other alternative products units are using.

I work collaboratively with sales teams and procurement regarding new products, obtaining quotes, preparing correct paperwork for medical engineering and sign off for procurement from Managers.

.I submit all small works requests required for any works on NICU and then meet with our Matron for sign off of quotes for work to be completed.

As Equipment lead, I attend both monthly procurement and consumables meeting with the Trust as well as NICU governance meetings where I will update the team on stock issues, actions to be decided and future equipment orders.

As a Charitable Funds champion which involves producing fundraising ideas for NICU alongside this I prepare all charitable funds requests and once authorised raise the Purchase orders to buy the products.

All Non-Stock purchase orders which can range from uniforms, badges, stationery, Developmental Care aids and any orders required for the milk kitchen and breast-feeding item are undertaken within this role.

There is a training requirement to the role involving being one of the trainers for medical and nursing staff induction training, for example demonstrating the blood gas machine, arranging barcodes, explaining how the consumables and emergency packs are prepared.

I work also with Sophie's Legacy (we top up the parent's kitchen with snacks, drinks, breakfast cereals) to place orders for this valuable resource of food for parents.

Nurse Associates (NA)

A Nursing Associate (NA) can provide care and support for patients and service users and bridge the skills gap between clinical support workers and registered nurses. NAs are members of the nursing team, who have gained a Foundation degree typically involving 2 years of higher education. The NA role is a stand-alone role regulated by the Nursing and Midwifery Council (NMC) since January 2019 and can provide a progression route into graduate nursing programmes. The realisation of the Interim People Plan of having 7500 NA trainees by the end of 2019 has led to several NAs practicing in neonatal care. However, there is a recognition that once in post the Nursing Associate needs to be supported to develop skills and competencies appropriate to their role.

Since the publication of the TVW Getting It Right First Time (GRIFT) 2020, where only one unit, Wexham Park LNU, had employed/ trained their own Nursing Associates in collaboration with their Trust education team. Most units now will offer a placement for a trainee Nurse Associate usually from paediatrics and have and are considering employing newly qualified NAs or training their own. If employing newly registered NAs all agreed that they would participate in the Network Foundation Programme.

To embed Nursing Associates in practice ideally, a 5.2 WTE is required. There have been challenges in the embedding of Nurse Associates for some units. One of the challenges have been an established Nursery Nurse workforce, who are negatively financially impacted if undertaking Nurse Associate training.

The underpinning aspiration of this work is to develop system-wide workforce planning and transformation to address challenges associated with recruitment, retention, development and growth of the Trainee Nursing Associate and Nursing Associate workforce in neonatal services. It is hoped that by adopting a focussed, Network approach we can support sustainable long-term solutions which have a tangible impact upon the Trainee Nursing Associate and Nursing Associate workforce in neonatal services.

Growth, Recruitment, Retention of the Workforce

The growth, recruitment and retention of staff is an important factor in workforce planning and maintaining a stable workforce. Within Thames Valley and Wessex, we identified potential losses of staff in the nursing and medical workforce, as not only in staff reaching either early retirement or state retirement age but the demographic group of nurses who

start having their families, maternity leave and requesting different ways of working. This has been further compounded by the exit of European nurses due to Brexit and the Covid-19 pandemic with staff citing lack of emotional support. In March 2019 NHS Improvement commissioned research into the perspective of older nurses (50+) working in acute hospital Trusts. The research identified a complexity of factors involved in retaining nurses in this age group including the effects of biological aging on both physical and mental health, age stereotyping and for many changing life circumstances as factors for leaving. This group also identified that opportunity to transfer knowledge, a sense of belonging and financial instability as valid reasons for staying. This study and the TVW workforce report (2022) also identified that most provider Trusts had policies in place such as flexible working and 'wind down' opportunities were supportive, however, lack of planning and difficulties with 'retire and return' schemes translated into working clinically for many were not conducive to support retention. The conundrum we need to overcome is how neonatal nurses/nursery nurses on limited hours can work within neonatal units. The benefits of retaining these staff are huge, we just need to think imaginatively and utilise these staff in supporting staff who are transitioning into the specialty. In midwifery experienced midwives are encouraged to retire and return in supportive, legacy roles and are focusing on supporting newly qualified/recruited colleagues.

The success of recruitment and retention is further complicated through recognition of generational differences. It is important in workforce planning to recognise these generational concepts if we are to appropriately support individuals as they begin their professional careers. For the first time working and in the same employment environment are 4 different generations There are generational differences in values, expectations, perceptions and motivation and therefore, that new entrants to the workplace Millennials and Generation Z seek greater work/life balance and greater flexibility with a portfolio-based career plan rather than 'lifelong learning' (Jones et al, 2015). The TVW workforce report identified that the Covid-19 pandemic had highlighted and raised awareness how critical staff wellbeing is to create a safe and sustainable workforce. A model of Psychologically Informed Environments (PIE) can meet both the fundamental needs of babies, families and staff and has the potential to prevent this challenging environment having a negative impact on those exposed to it. Atkins and Syed-Sabir (2022) explorative paper on the importance of Psychologically Informed Environments providing a whole systems approach to improving psychological wellbeing in all those in the neonatal environment, babies, children, parents, and staff.

In addition, D'Urso et al, 2019 identified the benefits of having psychological support for staff with a mean reduction of 22% WTE days due to stress-related sickness, which resulted overall in a decrease of 40% in the overall cost of sickness. Some of the Lead Nurses reported that staff mental health had deteriorated since the start of the pandemic compounded by chronic understaffing, workload and dealing with traumatic events. When staff feel supported, it can have a significant effect on sickness, absence, and retention.

With the allocation of Ockenden funding to fund Clinical Psychologists in the NICUs and LNUs and to utilise the underspend on psychological training and education. In addition, the offer to fund Professional Nurse Advocate training. The Professional Nurse Advocate (PNA) Training Programme is an accredited virtual Level 7 clinical professional development programme for registered nurses to equip them with the skills and knowledge to support the mental health and wellbeing of fellow colleagues and improvement of patient care. Link to a [day in the life of a PNA](#). This is particularly important as part of a suite of measures to improve retention, and the impact it has on the support for women and families who journey through maternity and neonatal services. The training will focus on the four functions of the Advocating for Education and Quality and Improvement (A-Equip) Model. The four functions of the A-Equip Model are as follows.

- Clinical Supervision (Restorative)
- Monitoring, Evaluation and Quality Control (Normative)
- Personal Action for Quality Improvement
- Education and Development (Formative)

NHS England have currently allocated £11,000 per neonatal unit to be used in two ways:

- To support backfill to accommodate protected capacity for early, mid and late career neonatal nurses/midwives to access expertise including wellbeing support and restorative clinical supervision.
- Support backfills for the continued development of PNAs to enhance their development to accelerate the service to deliver consistent high quality safe maternity and neonatal care.

It is hoped with these initiatives a Psychological Informed Environment (PIE) framework will start to be developed and implemented across all units within the Network.

Workforce inflexibility was cited as a reason why some nurses leave the speciality, although all Lead Nurses reported supporting staff to take sabbaticals, to go travelling or volunteer in different countries. Most reported this cohort of staff returned to the neonatal workforce. Flexible working patterns can be difficult to accommodate to fulfil the requirements of nursing rotas and unit/ individual staff competing priorities, with only two units offering term time contracts. Although, some units in TVW have effectively implemented self-rostering for staff which has supported staff feeling recognised and valued.

The scoping review identified that all units have recruitment strategies in post, most units worked with their Trusts and Human Resources (HR) departments to hold quarterly recruitment open days and some of the NICUs would hold recruitment events in local shopping malls. However, due to the Covid-19 pandemic much of this effective recruitment was postponed. Most Trusts and units have now again initiated both face-to-face and virtual recruitment fairs and produced videos of their units and scope of work. For these units the reinstatement of face-to-face recruitment days is pivotal to successful recruitment across all bands of staff. There has been successful recruitment from advertising in targeted nursing journals such as Nursing Times, Infant and Journal of Neonatal Nursing. Other innovative recruitment strategies are the use of social media platforms such as TikTok, X formerly known as Twitter, nationally there is a national X campaign #beaneonatalnurse aired with links to Neonatal Nursing Association (NNA) neonatal nursing and vacancies across each ODN. This will be supported by the commissioned TVW and KSS ODN [advertising campaign for neonatal nursing “Could you”](#).

In 2014 the TVW network responded to the need to improve recruitment and retention with the implementation of the Network Neonatal Preceptorship/Foundation Programme, which is specially designed to provide both an education curriculum and supportive learning package for nurses and now newly qualified Nurses Associates, and midwives with no previous neonatal experience. This continues to demonstrate a positive impact with an 86% retention rate at the end of the Preceptorship Programme end of 2022.

In 2019 the network, following on from the successful Preceptorship Programme model and driven by a lack of QIS standardisation and high HEI funding costs, developed and implemented a network delivered QIS programme.

All units agreed that the network education programmes both Foundation and QIS were a successful recruitment and as important, retention strategy. All units now access the network

Foundation and QIS Programme and 150 QIS students from 4 different cohorts have completed the QIS programme end of 2023.

Other innovative ideas around recruitment were the production of YouTube videos such as Poole LNU '[Careers in nursing on our neonatal unit](#)'. A short 2-minute snapshot into neonatal nursing and the local area.

The ODN team worked collaboratively with Kent, Surrey & Sussex (KSS) ODN to develop a [website](#) with a recruitment/careers page with very short video/vignettes into all professions/workforce who work within neonatal services and short videos of each unit and local area.

All the LNU/SCU Lead Nurses reported that rotational placements/opportunities to a NICU/LNU to maintain skill acquisition and understanding of the workplace culture and parent experience would be of benefit to staff post QIS. They also reported recognition of this to be part of the units TNA.

International Nurse Recruitment (INR)

Nationally across the general nursing workforce, recruitment of internationally trained nurses has been a strategy to mitigate workforce gaps. Most of the units have actively recruited from this population.

Although there has been success with international recruitment, some challenges have been identified. The time from recruitment of international nurses until they reach the unit did take months. Although many of these nurses are experienced with competent skill acquisition there are issues around cultural awareness and adaptation to life and work in the United Kingdom. In addition, a recent commentary by (Ford 2022) reflects on the impact of Covid-19 on the global workforce both professionally such as retention of this cohort and personally, while flagging concerns around worsening staff shortages and the reliance on international recruitment by high-income countries. An exemplar from practice has been the work the NICU at Southampton have done in supporting their international recruits to integrate and stay. This has successfully supported further recruitment of staff by 'tell a friend' who apply for roles on the unit.

A slight contentious issue both locally and nationally is adaptation programmes and access to Preceptorship/Foundation/QIS Programmes for this cohort of nurses. The units which were early adapters to international recruitment initially sent all new international nurses on the Preceptorship programme. Feedback from both the nurses and lead nurses identified that elements such as neonatal skills, resuscitation, and recognition of the deteriorating infant was not needed but other elements of the programme such as developmental care, FIC, communication, and cultural differences such as the philosophy of FIC were of value to them. In TVW a bespoke programme for the INR was produced to meet their individual learning requirements.

International Recruit Staff Nurse Harshgeet Kaur OUH

I came from India to the UK in 2021 to work. After graduation from nursing school I started working on a large neonatal unit and stayed for over eight years. The advanced skills and knowledge I gained prepared me to work in the UK. I moved to the UK to work for career advancement.

. There were many differences both working for the NHS and living in the UK. The main difference was a high nurse to patient ratio, in India, this was not the case. There appears to be more opportunities for nurses to progress in their career by having different career and speciality options which are not available for nurses in India .

Here at OUH everyone works as a team, and I feel more supported when learning new things.

The experience here is different from my previous one as OUH has evidence- based guidelines and policies to guide and inform clinical practice such as feeding and administration of complex drugs. This helped with the transition into my new workplace. Another difference is that care here is family oriented where families are involved in decision making. There are other also differences such as Psychologists who are available for parents and staff who need psychological support.

With new experiences and opportunities, there were different challenges as well, one of the challenges I faced was the language barrier, compounded by local accents, slangs and dialects. It took me about six months to understand their meanings with help from colleagues. Long working hours and patterns of working were an additional challenge as I was used to working 6-hour shifts but with time I have got used to it.

Despite these challenges there were some encouraging things that helped me to settle on the unit. The orientation package and study book provided us with information and resources. There was also support from my manager, team and other colleagues to answer queries and to transition into the team. As international recruits we also attended a bespoke programme for overseas nurses 'The Bridging Program', which helped with understanding the NHS culture.

Finally, after working one year and 9 months with OUH , I can say that I have grown personally and professionally in ways I never imagined. Working in UK has given me confidence and knowledge . I work with people from different backgrounds and cultures. There is also an opportunity for career progression with access to education and training I am happy and proud to be a part of this Healthcare system.

Undergraduate Workforce Our future workforce (Pipeline)

The pre-existing nursing workforce vacancies across the UK now face increased risk to recruitment and retention. Laying aside the issue of how to retain staff, which does require urgent attention (Darbyshire et al, 2019). One 'supply' side solution is to increase the numbers of student numbers beginning their education (Williamson et al, 2020).

One of the ambitions of the NHS Long Term Plan is to develop sustainable growth in the NHS workforce and scale up the number of people in higher education health care programmes. If employers are to meet this ambition and support the recruitment drive for roles in nursing, midwifery and the allied health professions, then undergraduate placement capacity will need to increase, while maintaining the required quality and level of educational support. Clinical placements are a pivotal element of all healthcare education and in the training of our next generation of health care professionals.

Clinical practice is a time of stress for nursing students with impact in academic outcomes. When compared to other students the level of anxiety experienced by nursing students is considered higher than in other student populations (Bartlett et al, 2016) and is also higher in clinical practice than in a classroom setting (Lei et al, 2015). However, specific clinical locations such as Neonatal Intensive Care Units (NICUs) and Neonatal Units are a distinct and multifaceted context that offer complex experiences to nursing students (Barreira et al, 2022).

Historically, the ability to take on learners for whom practice-based learning is a requirement of their programme has been limited by two main factors, the number of placements available to host them and having experienced staff who can teach and assess. There is ever increasing demand and competition for undergraduate neonatal placements, from child branch, midwifery, and some adult undergraduates which includes Nurse Associates. With the increase in government funding to increase the number of both nursing and midwifery students in training this will increase the supervisory burden on registered nurses and postulate may be unsafe if they dilute students' supervision (Williamson et al, 2020).

Responses from a national survey recognised the importance of the ambition and motivation to meet the proposed increase in students, as our future workforce, however, there is some apprehension about how further capacity for placements can be generated (Edwards et al, 2023)

Recommendations from this report include utilising Collaborative Learning in Practice (CLiP) or other supervision models for undergraduates on neonatal placements to support an increase in placement capacity, rotational placements across maternity, Outreach, Transport teams and AHP workforce, input into child branch curriculum and Neonatal Masterclasses at university/Provider level for all undergraduates.

Maternity/Neonatal Placement Collaboration Project

Case Study: Maternity/Neonatal Placement Collaboration Pilot Utilising A Coaching Supervision Model

A clinical placement coaching model where the student midwife would work with the CYP student nurse and a practice supervisor while on their neonatal placement and then the CYP student nurse would have the opportunity to work on the postnatal ward with the student midwife and midwifery practice supervisor.

The aim of the pilot is to;

- Increase education collaboration between maternity and neonatal services
 - Utilise a coaching model of supervision to enhance peer learning
 - Enable interprofessional education for pre-registration learners
- Enhance understanding of different professionals working within maternity and neonatal services

Growth/Recruitment/Retention Strategy for Neonatal Healthcare Workforce

Demographics	Action	Owners	Timescale
Raise awareness of Neonatal health care careers to 15–18-year-old school/college students	<ul style="list-style-type: none"> • ODN Workforce Lead Nurse to engage with Workforce, Training and Education Directorate and Career enterprise services to gain access to schools and colleges Tutor groups/ career days. • Offer taster/mentorship sessions on the unit. • Placements for T level students in neonatal units 	ODN Workforce & Education Leads ODN AHP and Clinical Psychology Leads Unit Practice Educators Neonatal Recruitment Leads	2 years

	<ul style="list-style-type: none"> • Work with Neonatal Educators and Health and social care tutors to facilitate this. • Development with NHS England of a Neonatal Digital Virtual Learning work experience • Explore interactive learning experiences in collaboration with the wider Trust 		
<p>Increase undergraduate child branch student capacity to neonatal units and undertake placements in maternity services</p> <p>Increase AHP undergraduate capacity into paediatric units</p>	Work with national team to engage with HEI's and LMNS teams to inform curriculum and plan placement opportunities and apply different models of coaching and supervision	<p>NHSE Maternity and Neonatal Programme team</p> <p>Workforce & Education Leads</p> <p>AHP Network Leads</p> <p>ICB Clinical Placement Capacity Leads</p>	Ongoing
Increase adult undergraduate placement to neonatal units	<ul style="list-style-type: none"> • Work with national team to engage with HEI's Adult nursing teams to inform curriculum and plan placement opportunities and apply different models of coaching and supervision. • Input into adult/child and mental health curriculum 	<p>NHSE Maternity and Neonatal Programme, Adult Education Leads at HEI</p> <p>Provider Unit Senior nurses</p>	Ongoing
Planning and production of marketing materials to support recruitment strategy at ODN level and Provider Trust level	<ul style="list-style-type: none"> • Production of marketing materials such as branding posters flyers, use of digital technology such as QR codes to signpost to TVW ODN website, X and other social media platforms. • To be used across all 14 units 	<p>ODN</p> <p>Provider Trusts/units</p>	Ongoing
Ensure all units meet the minimum standard of a supernumerary Practice Educator to support staff	ODN Workforce Lead and Education Leads	<p>ODN</p> <p>Provider Trusts/units</p>	In place
All staff to have annual appraisal, offer of coaching, supervision and support for career progression	<p>Senior Nurses</p> <p>Practice Educators</p>	<p>ODN</p> <p>Provider Trusts/units</p>	In place

The Perinatal Workforce

Role of the Nurse in maternity care

In recent years adult registered nurses have been introduced into maternity theatres. Scrub nurses and recovery nurses have been accepted as part of the maternity team. This is in part, due to the increasing caesarean section rate, which currently stands at one third of all births (NHS Digital, 2022). Their expertise as theatre nurses has been recognised and welcomed by maternity units, as this supports midwives to focus on providing midwifery care. The Royal College of Midwives (RCM) Position statement fully endorses nurses working in theatres and recovery as they have the expertise and knowledge to provide skilled competent care within their scope of practice. Likewise adult and paediatric nurses are working across high dependency units, post-natal, TCU with the neonatal care focus or leading the service. In addition, some essential (education), quality roles such as retention leads in maternity, palliative care and infant feeding roles could have a more perinatal focus.

Conclusion

We have come a long way since the publication of the NCCR in the building foundations for a sustainable MDT neonatal workforce. We need to focus on new ways of working, integration of the AHP workforce, new roles and delivering education with a focus on family partnership in care to ensure a more holistic, high quality, safe neonatal service. Education and training are the lynchpin to support new models of delivering neonatal care for nurses, AHP, Clinical Psychologists, medical staff and parents. Access for all teams to contemporary, relevant education and training is pivotal to support recruitment and retention of all staff, in addition, it should be recognised by all Trusts to provide protected time to enable this to happen. Furthermore, the evolution of existing and creation of new innovative roles such as Nurse Associate, FIC leads will be required as well as more fully integrating the family within the MDT. ODN workforce leads will need to work with units and trusts to ensure that workforce models are tailored to provide the best fit for each unit. This should also include education and training that gives LNU and SCU staff competence and confidence to manage situations that occur infrequently outside the NICUs.

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Neonatal Nursing Workforce Tool (*Appendix 1*)

Neonatal Nursing Workforce Tool (2020)

1. Introduction

The Neonatal Nursing Workforce Tool (2020) has been adapted from the CRG Workforce Calculator (Dinning) Tool (2013) and has been developed with the National Lead Nurses Group. It is intended to support neonatal nurse managers and their colleagues by providing a consistent method for the calculation of nursing establishment requirements which meet national standards i.e., NHSI (2018); NHSE Neonatal Service Specification e08 (2015); DH (2009); BAPM (2010); NICE (2010).

2. Definitions

Declared Cots:	The number of cots, by care level, which a unit are operating.
Required Cots:	The number of cots, by HRG, required to deliver the activity undertaken in the reporting period at an average occupancy of 80%.
HRG 1 / IC:	Intensive Care as per HRG 2016
HRG 2 / HD:	High Dependency as per HRG 2016
HRG 3-5 / SC:	Special Care, and any other care HRG 3-5 that takes place on NNU, as per HRG 2016
WTE:	Whole time equivalent. This will differ from headcount according to the number of staff working part time.

3. Using the Calculator

3.1. Inputs

Yellow boxes are for the input of local Trust / unit level data.

3.1.1. Unit details:

- Enter local unit details for reference.
- The designation of unit should be selected from the drop-down box.

3.1.2. Activity:

- Activity data for a full year (365 days) should be used but can be for a calendar or financial year. (This data may be provided from the Neonatal ODN).
- Intensive Care is HRG 1, High Dependency Care is HRG 2 and Special care is any activity which takes place on NNU HRGs 3-5.
- Data for Transitional Care activity should be excluded as the calculations are for the neonatal unit only.

- The calculator can be used to model workforce requirements for service developments or changes. For example, use activity data which includes 'lost' activity to model cot-base requirements, or subtract activity from NNU where that activity will be delivered on a Transitional Care Unit.

3.1.3. Staffing Numbers:

- Enter numbers of WTE funded establishment and WTE actually in post by qualification i.e. Nurse/Midwife with QIS, Nurse/Midwife without QIS and Nursing Associates/Non-registered staff.
- The WTE numbers should be for nursing workforce providing **direct patient care only**. Time allocated for additional roles, such as management, education, outreach etc. should be excluded.
- A supernumerary nurse in charge will be included in the calculations for all units.
- Transitional Care staffing numbers should not be included.

4. Outputs

Once all yellow boxes have been filled the calculator will generate figures for the following:

4.1. Activity

- The number of cots required (by HRG) to deliver the activity undertaken in the reporting period declared at an average of 80% occupancy.
- Where the cot requirements include a decimal fraction, it is assumed that cots can be flexed down to a lower level of care but not up i.e., a cot designated for Intensive Care can be used to provide High Dependency care, but a cot designated for High Dependency cannot be used to provide Intensive Care. Therefore, the number of critical care cots required is rounded up to the higher level of care. For Special Care the number is rounded to the next whole number. For example:

HRG	Level of Care	No. of cots to deliver activity	Rounded to
1	Intensive care	1.3	2
2	High dependency	4.4	4
3-5	Special care/other care	12.7	13
Critical Care	TOTAL	5.7	6
ALL	TOTAL	18.8	19

4.2. Nursing Workforce

- The total number of WTE staff required to staff the declared cots will be shown in the Nursing Workforce output table.
- The total number of WTE QIS required to staff the declared cots will be shown in the Nursing Workforce output table.
- A multiplier of 6.07 WTE has been used to provide 1 nurse per shift:

Calculation of multiplier									
	No. weeks	No. days	No. hours	Uplift for shift handover & supervision @ 2 hrs / day	Total No. hours required	No. hours 1 WTE will provide	No. WTE reqd to cover all hours i.e., 9490/1955	Uplift for leave @ 25%	Total WTE establishment required to give 1 nurse per shift
Per day			24						
Per week		7	168			37.5			
Per year	52.14	365	8760	730	9490	1955	4.85	1.21	6.07

- In line with the recommendations in the DH Toolkit for Neonatal Care (2009) the multiplier includes an uplift of 25% for annual leave, study leave, maternity/paternity leave and sick leave.
- The multiplier is based on a 26-hour day to include two hours per day for shift handover and supervision (such as appraisals).
- Nursing workforce requirements are calculated to meet BAPM nurse: baby ratios i.e., HRG 1 (IC) 1:1. HRG 2 (HD) 1:2, HRG 3 – 5 (SC/TC) 1:4
- The calculator will give the actual WTE staff requirements based on the number of cots needed to deliver the activity for each level of care, at an **average** of 80% occupancy across the year.
- Calculations are made for an average of 80% occupancy because evidence shows that outcomes, mortality and morbidity are not as good when occupancy exceeds this level.
- Unit nurse staffing should be established to 100% to ensure that peaks in activity can be managed without an adverse effect on outcomes, mortality and morbidity.
- In all units, at least 70% of Registered Nurse/Midwifery staff should hold a post registration qualification in neonatal care i.e., Qualified in Specialty (QIS). This does not include nurses in training for QIS (NHSi, 2018)
- All intensive and high dependency care should be provided by QIS staff, so where a unit has a high proportion of critical care activity, the percentage of QIS staff required will be greater than the 70% minimum.
- A minimum of 2 registered nurses are required per shift to meet National Toolkit standards. Therefore, the minimum number of registered nurses required per shift is 12.14 WTE (6.07 x 2). The calculator allows for this.

5. Limitations

The calculator cannot accommodate every variation within local nursing workforce provision. However, it can be used to provide a standardised method for calculating nursing workforce requirements which can then be supplemented with local detail and any additional requirements. For example:

- The calculator does not allow for services which require more than one supernumerary nurse in charge per shift, for example those that are delivered across separate sites. However, the multiplier of 6.07 can be used to calculate the number of extra nurses needed and this can be added into the calculations at individual service level.
- The calculator does not allow for units where there are multiple small rooms which may "...necessitate staffing above the minimum recommendation to ensure that no room and no babies are left unsupervised at any time" (NQB 2018).
- The calculator does not include recommendations for nursing workforce requirements for non-direct patient care roles. This will be added to the calculator when available.

6. References

- **Department of Health (2009)** Toolkit for High-Quality Neonatal Services. Available at: https://webarchive.nationalarchives.gov.uk/20130123200735/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107845
- **National Institute for Health and Care Excellence (2010)**. Specialist Neonatal Care Quality Standard. Available at: <http://publications.nice.org.uk/specialist-neonatal-care-quality-standard-gs4>
- **NHS Improvement (2018)** Safe, Sustainable and Productive Staffing. An Improvement Resource for Neonatal Care. Available at: https://improvement.nhs.uk/documents/2978/Safe_Staffing_Neonatal_FINAL_PROOF_27_June_2018.pdf
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- **NHS England Neonatal Service specification [e08] (2015)**. Available at: <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/e08-serv-spec-neonatal-critical.pdf>

7. Further information

- For any further information or queries please contact: judith.foxon@nhs.net

Role Descriptors for Educators, Risk Governance and Family Integrated Care (*Appendix 3*)

National Neonatal Lead Nurses supported Band 7 Lead Neonatal Clinical Educator job role and responsibilities:

<https://neonatalnetworkssoutheast.nhs.uk/wp-content/uploads/2024/05/National-Neonatal-Lead-Nurses-supported-Band-7-Lead-Neonatal-Clinical-Educator-Job-role-and-responsibilities.docx>

National Neonatal Lead Nurses supported Band 7 Neonatal Governance Nurse job role and responsibilities:

<https://neonatalnetworkssoutheast.nhs.uk/wp-content/uploads/2024/05/National-Neonatal-Lead-Nurses-supported-Band-7-Neonatal-Governance-Nurse-Job-role-and-responsibilities.docx>

National Neonatal ODN role outline for Band 7 Neonatal Family Integrated Care (FIC) Lead and Family Care Quality Role job role and responsibilities:

<https://neonatalnetworkssoutheast.nhs.uk/wp-content/uploads/2024/05/National-Neonatal-ODN-Role-Outline-for-Band-7-Family-Integrated-Care-FIC-Lead-and-Family-Care-Quality-Role.docx>