Neonatal Nurses Association – Written evidence (PRT0074)

There are 200 NNUs in the UK including NICUs (Level 3), LNUs (Level 2), SCUs (Level 3) and surgical units caring for 90,000 babies born preterm annually.

The NNA would like to bring to your attention the current challenges with the neonatal nursing workforce across the UK. National reports continue to recognise concerns with the neonatal nursing workforce: Neonatal Critical Care Review (2019), National Neonatal GIRFT report (2022), and most recently the National Neonatal Audit Programme report (2023).

In 2019 across England there was a gap in neonatal nursing posts of approximately 2000 nurses excluding vacancies. This was recognised in the NHS Long Term Plan and funding was made available to all neonatal services in England with an aim to support nurse staffing closer to the national standards (please see the National Quality Board, DOH Toolkit & BAPM). This funding was not replicated in the devolved nations.

Whilst clearly this funding is welcomed by all services in England this potentially increased inequity in staffing provision nationally. In addition, this funding does not solve current challenges with neonatal nursing recruitment and retention. According to NNAP (2023) in 2022 an average of only 71.1% of neonatal rotas were staffed to the recommended staffing levels (these are minimum staffing levels). This figure has dropped consistently over the past 3 years. In 2022 the average was 71.1% but this ranged from 56.8% to 85.3% - showing the inequity of provision across the country.

The NNA is calling for a mandated policy around staffing to ensure it is commissioned beyond "cot side" only minimum standards. The existing standards are written by the charity sector and adopted by NHSE.

Safe staffing levels impact outcomes for the most vulnerable population – premature and sick term babies requiring neonatal care. They also impact on staff well-being and retention.

As stated in the GIRFT report, 'staff wellbeing is a critical part of creating a safe and sustainable workforce. When staff feel supported it can have a significant impact on sickness and retention. Research by Bliss in 2019 highlighted the significant impact of the neonatal environment on the mental health and wellbeing of neonatal staff. It found that support for staff who need it is inconsistent and often inadequate. Based on the survey of neonatal staff, over half of respondents said their mental health deteriorated over the previous 12 months, highlighting understaffing, workload and dealing with traumatic events as contributory factors.

There is a paucity of psychologists and Allied Health Professionals (AHP) at Trust level. There has been some funding, but it has been insufficient to enable adherence to recommendations from BAPM.

The NNA is calling for commissioning for AHPs and Psychologists. Currently neonatal nurses fill that void in care but they are not the experts. These specialists will optimise the outcomes for preterm and sick newborn babies.

The purpose of the NNA is to support neonatal staff to deliver optimal care to babies and families. We acknowledge the increasing number of NNU shifts not staffed to recommended levels according to the service specification, the Neonatal Critical Care Review and BAPM, as highlighted in consecutive NNAP reports.

We are committed to supporting neonatal nurses to provide safe, consistent and equitable access to expert neonatal care for all babies and families and are co-creating a well-being offer to support our members. This well-being offer does need to be provided consistently and equitably by NHSE nationally.

Neonatal nurse recruitment initiatives are high on the NNA agenda, and we have been working with the Chief Nursing Officers to raise awareness of the neonatal nursing discipline and encourage recruitment into current and future nursing vacancies. Additionally, the NNA have offered free membership to all students to support awareness raising and recruitment to neonatal units.

The GIRFT (Get It Right First Time) Neonatal Workforce report must be approved by NHSE so it can be published across NHS websites and widely available. The co-produced (with the NNA) career framework can then be promoted, highlighting the range of quality-enhancing roles to support safe sustainable care for babies, families and staff, improving recruitment and retention.

Recruitment is not the only solution to this paucity of neonatal nursing staff as attrition rates are high, we have an ageing workforce and challenges attracting nurses into senior nursing roles. Work must focus on the retention of current and new neonatal nurses to create a sustainable highly skilled neonatal nursing workforce.

At present the neonatal workforce is commissioned for 'cot side' nurses only. Quality nursing roles such as education, governance, family care (including bereavement and palliative care), quality improvement, infant feeding and research must be seen as essential to support quality care and improved outcomes (please see the reports above). Transitional care and Outreach must also be commissioned. Supporting nurses to take ownership of these additional roles with protected time as part of a clear career pathway acknowledges their expertise and encourages development and in turn retention and facilitates succession planning reducing burnout and dissatisfaction and increased turnover of staff, particularly in bigger cities.

There is recognition of the need to support workforce development and clinical competence within the Ockenden report (2022).

We have a depleted workforce. Currently, nurses are not supported with protected time or backfill/cover to attend or deliver training or further education. Nurses are not supported financially to complete further training or education. Currently, nurses must self-fund and attend training or education in their own time.

The NNA is calling for nurses to be given protected time to complete training and quality improvement (QI) projects, bringing them in line with their medical colleagues and enabling the workforce to deliver on centralised plans and standards. If you do not give nurses the tools to lead QI projects to improve care, it cannot be done.

To support recruitment and retention there is a need for career progression within neonatal nursing. This is an expert workforce who must be nurtured and encouraged to develop. The National GIRFT report in conjunction with the NNA set out a clear career structure for neonatal nurses from qualification onwards and we must raise awareness of this nationally and commit to supporting the development of the neonatal nursing workforce to provide consistently safe and equitable access to expert neonatal care for all families. The NNA believes neonatal care would become more attractive as a career and retain more staff if the increased level of expertise and responsibility of neonatal nurses were recognised in a similar way to that of midwives, that is, on completion of their qualification in speciality (QiS) they should progress from an Agenda for Change band 5 to band 6 following a period of consolidation as per recommendation 3 in HEE's Neonatal Qualified in Specialty (QIS) Education and Training Review. Currently, there is inequity and nurses will move to other specialties where they are appropriately recognised.

To deliver on national guidance we need the right (and enough) staff in the right roles (mandated by policy and commissioned) to make a difference to outcomes. If we do not have enough staff, or the right staff in the right places then national guidance and benchmarking cannot be achieved.

The NNA believes that the commissioning for neonatal services needs to be restructured to include transitional and outreach services. This will ensure babies are cared for in the right place (including at home through virtual wards) by the right people, including commissioned transitional care and outreach staff. This would reduce separation between babies and parents, improve outcomes for the preterm baby, reduce separation anxiety and post-traumatic stress in parents and reduce length of stay in hospital and reduce cot days as demonstrated by the data below kindly shared by the South West Neonatal Operational Delivery Network (please see Appendix 1).

The BAPM Transitional Care Framework 2017 supports mothers to be the primary caregiver for babies born 33 -37 weeks gestation, reducing cot blocking in the neonatal unit. Perinatal units must have an infrastructure to support both the clinical care and the additional care/benchmarking for staff and families.

Transitional care must be in place to support the mother to be the primary carer for the preterm infant as per the Maternity Incentive Scheme action 3.

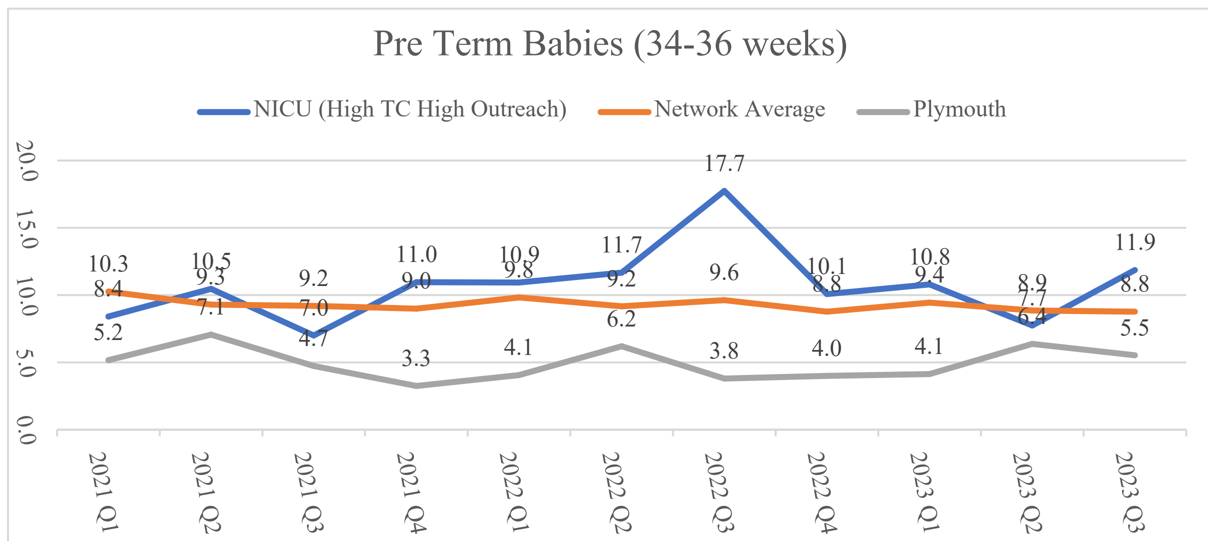
7 day Outreach services should be in place to support reduced length of hospital stay and safe transition to home for preterm infants.

The NNA is calling for the commissioning of Transitional Care & Outreach services to facilitate the flow from NNUs to home 'right baby, right cot, right time', which supports the NHSE ATAIN strategy to prevent admission of term babies to NNUs.

APPENDIX 1

This section shows the data around Transitional Care. Data from South-West Operational Network including length of stay and separation for Early Preterm (32-34/40) and Late Preterm Infants (34-36/40).

Graph represents length of hospital stay days for 'late preterm babies' (born 3-6 weeks preterm) born in the South-West Operational Delivery Network, demonstrating Plymouth has a shorter length of hospital stay for this cohort, compared to another NICU with limited Transitional Care and outreach services and against the regional average. This clearly demonstrates that having a dedicated Transitional Care and 7-day Outreach Service reduces NNU hospital cot days and supports early safe discharge home from hospital with mother/family. **y-axis = number of days x-axis = years**



Graph represents length of hospital stay days for 'early preterm babies' (born 6-8 weeks preterm) born in the South-West Operational Delivery Network, demonstrating Plymouth has a shorter length of hospital stay for this cohort, compared to another NICU with limited Transitional Care and outreach services and against the regional average. This clearly demonstrates that having a dedicated Transitional Care and 7-day Outreach Service reduces NNU hospital cot days and supports early safe discharge home from hospital with mother/family.

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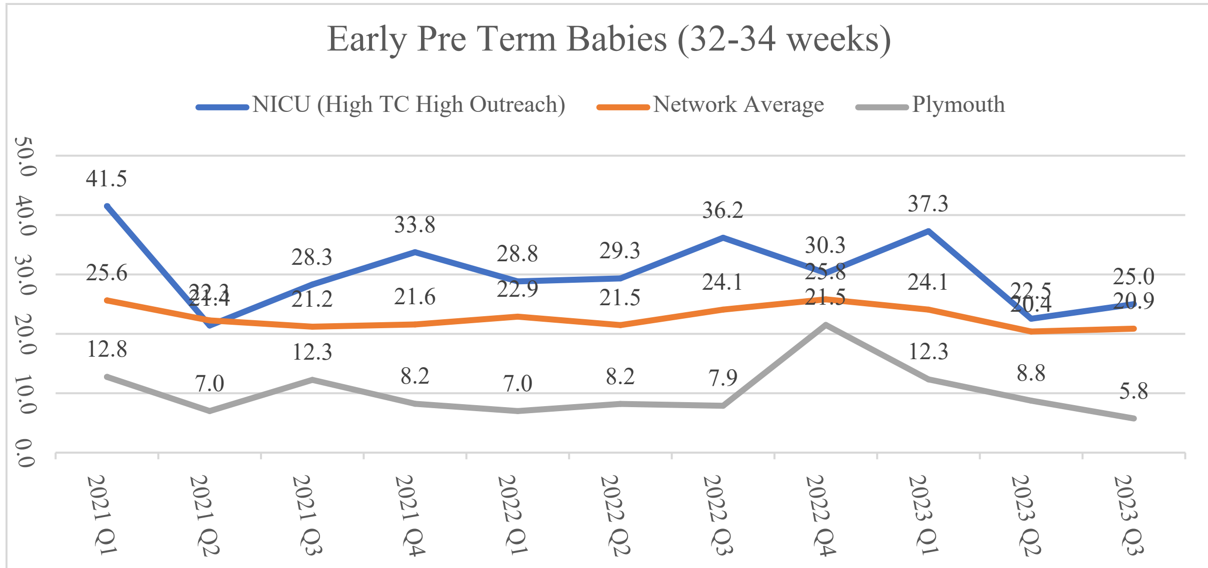
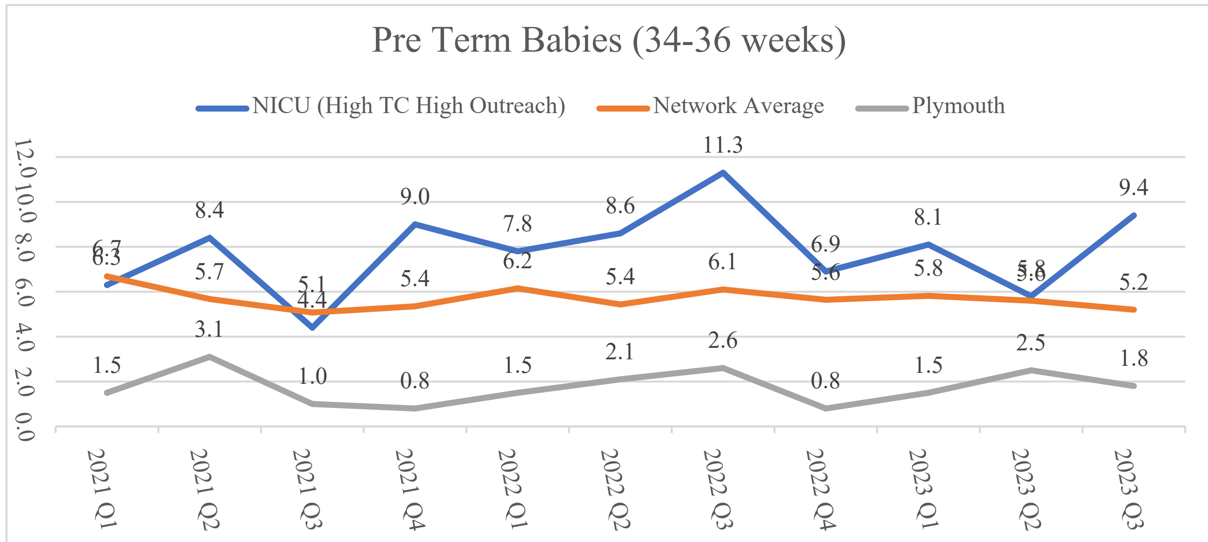


Graph represents separation from mother at birth for 'late preterm babies' (born 3-6 weeks preterm) born in the South-West Operational Delivery Network, demonstrating Plymouth has a shorter length of separation from mother at birth for this cohort, compared to another NICU with limited Transitional Care services and against the regional average. This clearly demonstrates that having a dedicated Transitional Care prevents separation of baby from mother and there is a reduction of cost of NNU cot days, prevention of separation anxiety for mother and baby and increased breast-feeding rates.

y-axis = number of days x-axis = years



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