Neonatal Nurses Association submission to NHS Change

What does your organisation want to see included in the 10-Year Health Plan and why?

Workforce

The NNA is calling for a mandated policy around staffing to ensure it is commissioned beyond "cot side" only minimum standards.

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.

With the Thirlwell inquiry continuing, challenges will also continue. Nurses will need psychological support to provide complex care in challenging circumstances. There must also be provision of psychological support available to parents. We know this is essential for the parents, families and staff.

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 care, quality improvement, specialist neonatal surgical nurses/surgical outreach and research must be seen as essential to delivering safe care. Quality roles support optimal care and improved outcomes for babies and their families.

Transitional Care & Neonatal Outreach

The NNA is calling for the commissioning of neonatal services to be restructured to include transitional and outreach services. 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. Nurse Specialist roles are necessary to implement these services, including Specialist Surgical Nurses.

Commissioning transitional and outreach services 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 South West Neonatal Operational Delivery Network.

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.

The inclusion of neonatal surgical special nurses/ outreach nurses would facilitate improved patient flow, in and out of tertiary centres and improved patient pathways- from fetal medicine counselling through to complex discharge planning. They would support the timely transition of some of our sickest babies, to be discharged home or cared for closer to home in local hospitals with support from neonatal surgical outreach. They can also facilitate parental and staff training to ensure successful discharge/repatriation with ongoing expert support available eg stoma care, specialist feeding tubes dressings etc. Specialist nurse roles enhance care standards, clinical outcomes, parental experiences, care pathways, education provision and leadership and integrated care across trust and regional community boundaries and teams.

Neonatal Surgery

Neonatal Nurses need protected time within specific roles to deliver transitional care and outreach services, including Specialist Neonatal Surgical Nurses.

Babies that require surgery, in the neonatal period, can be the sickest and most complex babies cared for on neonatal units. They can often need extended periods in hospital- months. Specialist neonatal surgical nurses facilitating integrated, discharge planning or transition to their local hospital can be a positive step towards discharge preparation for families.

These services require adequate funding, appropriate staffing, protected time, a multidisciplinary approach and a workplace environment that promotes psychological safety. There will need to be national standards and guidance to support national implementation.

Palliative & Bereavement Care

We are also calling for a National Strategic Plan which focuses on Neonatal Palliative & Bereavement Care, and is fundamental to the NHSE agenda.

Neonatal Palliative Care is the responsibility of the whole perinatal team. Dedicated and funded time for lead roles is essential to provide personalised, equitable, consistent, safe and effective Core Perinatal Palliative and Bereavement Care.

This must include commissioned perinatal palliative care regionally (within each of the 10 neonatal networks) and locally with neonatal nursing leads for neonatal intensive care units to provide leadership, management, family support and training for the team.

Priority must be given to the specific needs of babies, their families and the complexity of this growing population.

Family Integrated Care

There must be protected time and the right infrastructure for staff to promote FICare and co-production with parents. FICare improves outcomes for babies. Currently, neonatal nurses are not supported through estates, structures, commissioning and time to embed and promote FICare.

The importance of the first 1001 critical days of a baby's life for their longer term outcomes are well documented, as are the economic benefits of offering effective support during this period. For babies in neonatal care and their families, these days are characterised by vulnerability, pain and trauma which can have a profound, lifelong impact.

The staff teams supporting them also experience higher levels of trauma, burnout and moral distress. This is particularly marked for neonatal nurses who spend long shifts physically and emotionally supporting babies and families. In the context of high profile perinatal inquires and the conviction of a neonatal nurse for murdering babies in her care, the level of work-based stress, anxiety and conflict for neonatal nurses has been amplified even further without a corresponding increase in support. There is a pressing need to provide robust, embedded, evidence based psychological care for babies, families and staff in the neonatal environment which is currently significantly lacking.

Neonatal Transport

The structure and support of neonatal transport services need to be reviewed. Neonatal transport services are set up in very different ways around the nation. In some regions, they are closely integrated into their host NICUs, sharing staffing, resources, guidelines etc, and others are entirely independent. However these are set up, and there are pros and cons to each, they should all have appropriate funding and resources to provide quality roles such as education (internal and external), governance, parent experience, staff well-being, infection control and such like. It should be recognised that delivering each of these quality roles is significantly different, and has unique challenges when working in a transport context. This comes down to the different physical environment we work within, the restrictions and limitations of the transport workforce, the different psychological burden that transport places on families and staff, and the reduced opportunity for peer support. The level of training, confidence and competence of transport staff needs to be different to staff working in a hospital setting due to the increased autonomy required, the unpredictability and uncertainty that transport teams face, and the exposed nature of operating outside of a hospital premises.

Transport Services also have different roles and relationships with their Neonatal ODNs and Stakeholders within different regions. They often play a key role in supporting patient flow around the region, ensuring appropriate cot capacity in the right places, and keeping babies and their extended families as close together as possible. They are often linked into key educational support for the regions they are hosted in, using their comms pathways, roadshows and feedback loops to monitor and support changes in clinical and operational guidelines across the regions. They are also fundamental in supporting regional escalation

pathways operationally and strategically, as well as during fluxes in capacity for example around major incident planning.

Accountability

As above, plus, there must be accountability. Currently, NHSE and other groups consider certain roles or services to be 'funded', but the money approved for roles or services is not allocated to the intended purpose. Someone must hold budget holders and decision makers to account. There must be processes in place that track approved spend and monitor where it is actually being spent and then measure the impact of that spend.

Currently, what is officially happening does not always reflect what is actually happening on the ground. For example, shift coordinators are notionally supernumerary. In practice, they are not – but need to be. There needs to be a process by which we can understand, why the funding for this role to be supernumerary is not reaching the shop floor. Or, if it is, the blocks that exist that mean that shift coordinators are being pulled to clinical work, when they shouldn't be.

Disjointed and duplication

There is a lot of disjointed work happening across services and areas. Therefore, there is a lot of duplication, causing inefficiency. There needs to be a centrally run and supported neonatal programme, as there used to be within HEE to coordinate work and push projects forward.

Workforce development

Nurses must be supported with protected time to complete QI and further education. They are not currently supported with protected time for this safety critical element of their role.

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 career progression within neonatal nursing is key. This is an expert workforce who must be nurtured and encouraged to develop through structured succession planning from undergraduate, post-graduate, QIS, Clinical Nurse Specialist roles (including neonatal surgery), ENNP, ANNP and Consultant Practitioners, alongside the quality roles (including bereavement and palliative care). The National GIRFT report in collaboration with the NNA set out a clear career framework for neonatal nurses. This career framework for neonatal nurses must now be funded and supported.

Neonatal care would be a more attractive career path 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.

What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Commissioning

Transitional Care and Outreach (medical and surgical) services are not currently commissioned.

Quality roles, including palliative and bereavement care roles, and Specialist Surgical Nurse roles are not commissioned. They need to be. There are currently excellent examples of transitional care and neonatal outreach services, but these are not centrally commissioned or supported with national guidance.

If nurses are not given the tools to meet national standards and benchmarks, they cannot be achieved.

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

There needs to be one electronic system that nurses are trained and supported to use, including with time for data entry, or commissioned digital roles. Fragmented IT systems cause inefficiency and duplication of work within an already stretched workforce.

There needs to equity in terms of digital resource. Some units will have access to digital tools to support FICare. Some units will have a Digital Lead nurse. Some units will have support and training to use technology to support data input, collection and analysis. Some units will care for more parents facing digital poverty.

There needs to be equity of access for parents and staff. Currently there is no parity.

The integration of data is vital to capturing the impact and outcomes of neonatal care, and the impact of changes made to commissioning and services. This data should be an integral part of the accountability piece (see above, Q1)

Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

a.Quick to do, that is in the next year or so

b.In the middle, that is in the next 2 to 5 years

c.Long term change, that will take more than 5 years

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. Recruitment and retention need to be addressed urgently.

a) When looking at routes into neonatal nursing the Nursing Apprenticeships need to be funded. This will support current ancillary staff to progress to registration and will support succession and retention of staff.

a) 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. 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.

a) Currently, neonatal nurses are not supported with protected time or 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.

a) To support recruitment and retention career progression within neonatal nursing is key. This is an expert workforce who must be nurtured and encouraged to develop through structured succession planning from undergraduate, post-graduate, QIS, Clinical Nurse Specialist roles (including neonatal surgery), ENNP, ANNP and Consultant Practitioners, alongside the quality roles (including bereavement and palliative care). The National GIRFT report in collaboration with the NNA set out a clear career framework for neonatal nurses. This career framework for neonatal nurses must now be funded and supported.

a) Neonatal care would be a more attractive career path 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.

If we do not have enough staff, or the right staff in the right places, with the right support and structures then national guidance and benchmarking cannot be achieved.

a) Introduce a National Neonatal Safety Champion inline with maternity services.

b) A full NHS bursary is key to increasing registration onto university nursing degree courses (and lessening attrition). Trainee nurses can be eligible for £5k but it is means tested. These trainee nurses must work more hours to achieve their clinical expectation, therefore they are unable to work outside of their course to support their degree.

b) Overview of commissioning across maternity and neonates.

b) Continue to work in partnership to reduce the discrimination and poor culture in the NHS

b) Publish and act on the NHS Estates Survey and reinstate staff rooms and private spaces for staff to debrief. These areas are an ideal place to develop inter professional bonds and reduce silo working.