London Neonatal Operational Delivery Network

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Workforce Strategy 2016/17

Report of the London neonatal nursing workforce survey and associated workforce strategy

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1. Nursing Workforce Report

1.1 Background

Nursing requirements for neonatal care has been well documented over the years, with various organisations and governing boards endorsing the basic requirement for safe, effective and quality driven care (DH 2009, BAPM 2001 & 2010, RCN 2013, NICE Quality Standard 2010). In 2013 the Francis Report made strong links between staffing levels, skill mix and patient safety.

Back in 2009 the Department of Health (DH) published the Toolkit for High Quality Neonatal Services, this document built on the previous recommendations by BAPM's 2001 "standards for neonatal care" whereby specific workforce recommendations where laid out. Since 2009 many Trusts continue to struggle to achieve the Toolkit recommendations especially in accordance with the nurse-to-baby ratio and qualified in speciality requirements. In times of financial constraints, and the requirement for the NHS to achieve ever increasing efficiency savings, seemingly make the DH's recommendations increasing difficult to achieve. A recent national report by Bliss (2015) validates the lack of investment in neonatal care and highlights an insufficient nursing and medical work force to sustain the increasing critical care required. Across London 14 out of 21 LNU's and NICU units are reported to not currently meet the recommended 1:1 nursing staff ratio for intensive care (source: NHSE 2015).

1.2 Aims

In view of consistent previously published reports of insufficient staffing levels on many neonatal units, and on the back of the Bliss report, the London Operational Delivery Network (ODN) undertook a London based workforce survey towards the end of 2015. The aim of the survey was to firstly obtain detailed nursing statistics that reflected the current staffing situation across London, identifying those units that have been able to achieve and sustain

aspects of the Toolkit standards and those units who are still striving to towards them.

The findings from the workforce survey would be presented to various stakeholders and would ultimately be utilised to form the basis of the London wide ODN workforce strategy.

1.3 Process

In November 2015 the workforce survey was circulated to all twenty six London based neonatal units. The survey was largely based on previous questionnaires used from 2010 available from NHSE but certain elements were up-dated to bring in components of the DH Toolkit (2009) recommendations and also to include questions regarding access to qualified in speciality (QIS) training and recruitment issues.

Each units' senior nurse was given the opportunity to share staffing, recruitment and retention challenges as well as recruitment strategies they had implemented in a bid to fill gaps in the establishment.

The survey was distributed via the sector ODN lead nurses with a six week deadline. The deadline was then extended in order to facilitate additional submissions, in a bid to try and achieve a 100% return rate.

2. Work force survey findings

Twenty four surveys were eventually returned, giving a 92% return rate. There was missing data from one NICU within NWLODN and one LNU in SLODN. There was also some inconsistencies with the completeness of the data submitted; some questions were not answered, presumably due to the level of detail required regarding staffing profiles. It is acknowledged that some of the data requested was time consuming to collate and a few units either had new

Matrons/Senior Nurses in post or no Matron available, making data collection even more onerous.

2.1 Overview

This was the first workforce survey carried out since 2013 and relates to 2015 staffing data, with activity data submitted for a full financial year for 14/15. The findings for the 2013 survey were not publicised due to changes within the ODN and local Network structures, therefore this survey's results will be the first available since 2012.

When drawing comparison on previous data available, is it important to note that the historic data should be compared with caution as completeness and return rate of previous surveys is unknown. That said, general trends can be derived from the current data analysed.

2.2 Staffing establishments

Across the 24 London units that responded there are a total of 1513.58 *funded* whole time equivalent (wte) clinical nursing posts at bands 3-7. These are posts whose main role is to deliver cot side hands on clinical care. It excludes additional nursing roles such as Practice Development Nurses, Senior Nurses/Matrons, ANNP's and Community roles.

The *actual* number of nurses in post within the funded establishment and within these bands is 1265.68 wte, leaving a shortfall of 247.90 wte clinical nurses. This equates to a total 16% vacancy rate across London.

The majority of vacant posts can be seen within the band 6 posts with 158.2 wte unfilled posts, accounting for 64% of all vacant posts at a clinical level. This will undoubtedly have a significant impact on the qualified in specialty (QIS) skilled nurses available to care for one of the most vulnerable groups of the

population. Many senior nurses commented that it was particularly difficult to recruit to band 6 posts, with many units resorting to over recruiting to band 5 positions in a bid to 'fast track' them through speciality courses to counteract the short fall.

With that said, there is still a significant short fall of band 5 nurses, with their vacancy rates accounting for 24% of all vacant clinical posts.

There is strong evidence that the current situation across the London units shows no improvement. Through earlier surveys carried out since 2009/2010, the average fill rate of posts stays around the 86% mark - this figure is for all neonatal staff not just clinical based staff, but shows there has been little or no improvement in the nursing workforce since the publication of the DH's Toolkit for High-Quality Neonatal Services in 2009.

Furthermore, individual unit's existing funded establishments do not meet the recommended standards for the activity or cot base they are delivering, highlighting a sustained lack of investment in funded establishments, despite the more recent launch of the NHS England's (2014) 'Safer Staffing' programme.

The situation is compounded with the level of vacancies across London and beyond, clearly evidenced by the recent Bliss baby report 2015: hanging in the balance.

The required nursing workforce for London, to meet the Toolkit's recommendations against activity and cot occupancy, accounts for almost 30% of the nursing workforce shortfall highlighted in the Bliss report for England. The Bliss report highlighted that even if all funded nursing posts were filled, 60% of units would *still* not be able to meet national standards due to the deficiency of financial investment.

Fourteen LNU or NICU's are currently under NHS England derogation for not meeting DH staffing requirement against the one-to-one nurse-to-baby ratio recommendation for intensive care. This is unsurprising given the vacancy factor for staff in post at band 6 level and the overall continued funding gap.

The Clinical Reference Group (CRG) in response to indications that derogation was primarily around nursing staff levels, undertook a national survey of occupancy and staffing levels in 2014. The CRG analysis similarly highlighted a deficit in nursing numbers to meet cot capacity and occupancy. The majority of the nursing deficit was in the most expert units (NICU), in which there was a 27% deficit in nursing staff against the activity they undertook. There were smaller numbers required in Local and Special Care Units, both of which operated with a 21% deficit of the nurses required to meet DH standards. The survey also found considerable inequity in the distribution of these deficits between networks.

This is reflected in London's workforce survey where there is an apparent 20% average shortfall in funded establishments compared to the DH standards. This figure increases to 33% when taking into account the actual wte in posts/vacancy factor.

The activity data for 2014/2015, according to the Toolkit recommendation of an 80% occupancy rate, shows the need for 1878.81 wte clinical nurses band 4-7. The current London funded establishment is 376.36 wte nursing posts *short* of this overall figure and when taking in to consideration the actual nurses in post there is a shortfall of 619.13 wte clinical nurses.

The staffing figures, for the purpose of comparison, are calculated on the recommended 5.75 wte which achieves 1:1 / 1:2 / 1:4 nursing ratios plus 25% uplift in the establishment to allow for annual leave/study leave etc. However anecdotally it is apparent that even the 25% uplift recommendation is not met by individual Trusts, with senior nurses citing their uplift being anything from 19% to 23%.

Is it therefore any wonder that some neonatal units are grossly underfunded with regard to nursing establishments and will never achieve the recommended staffing levels?

In addition to clinical hands on care many units stated that their nursing staff took on additional roles with no extra funding, these included; breast feeding lead, infection control lead, discharge planning, developmental care, palliative care and safeguarding. Most units did have additional roles separate from the day-to-day hands on clinical care for practice education & development, however some units did not have this role in place at all. The additional roles taken on by nurses will undoubtedly impact on the availability of direct clinical care and add pressure to the individuals who undertake these roles.

Furthermore, fourteen units stated they provided a neonatal community/outreach service. Of those fourteen, only seven units stated that this service was funded separately to the nursing establishment for 'direct clinical care' suggesting that this service, where provide, was depleting the availability of clinical nurses even further.

2.3 Qualified in Specialty

One of the key recommendations within the Toolkit is the achievement of specialty trained nursing staff to the number of NMC registered workforce. The toolkit recommendation is that 70% of the registered workforce should hold a QIS qualification. Less than half of all the twenty four units who responded met this recommendation.

The average percentage of wte registered staff who hold a QIS qualification across London is 68%. There is a notable disparity across the units ranging from 49% to 92% attainment.

Only 10 out of the 24 units meet the minimum recommendation; 1 SCBU, 5 LNUs & 4 NICU's. Some units reported additional staff holding either or both the special care and high dependency course and therefore holding a QIS within this level of care. The Toolkit does not define 'qualified in speciality' to this degree and therefore it could be argued that the QIS percentage for some units may indeed be higher. It is recommended that a more detailed analysis of QIS data is included in the next workforce survey, in order to distinguish between full ITU QIS and SC/HDU QIS.

Common themes were highlighted in regard to difficulties in accessing QIS training; the most common was releasing staff from their clinical duties for undertaking training, given that the majority of units had significant vacancies already, this further depleted the workforce. The requirement for QIS students to also undertake a practice placement within a NICU adds further pressure. In addition there is rising concern regarding the length of these placements, and what 'time frame' constitutes sufficient practice placement time. Although consideration should be given to the individual nurses experience and capability, where 'one glove may not always fit all'.

This gives rise to review the quality of the training offered, not only from clinical placements but also the courses on offer from Higher Educational Institutes (HEI).

The disparity of the quality of HEI delivering QIS courses has been highlighted in various forums, anecdotally key issues include: the number of study sessions to deliver the course varies between 4 to 12 days; course content is not governed by a core set of standards; length of HDU/ITU practice placement varies between units from 2 weeks to 3 months; modules may run separately i.e. SC, HDU & ITU or combined as either SC & HDU, ITU or SC, HDU/ITU.

The Shape of Caring Review (Willis, 2015) aimed to ensure that throughout a nurses career they receive consistent high quality education and training, which in turn supports high quality care. Part of this review focused on neonatal

nurses QIS education. Since the demise of the English National Board (ENB) in 2002, post registration education standard has been left to individual HEI's to quality assure their academic courses. These are monitored through the Quality Assurance Agency (QAA) for Higher Education, an independent body who monitor and advise on standards and quality throughout UK higher education. However these academic committees are entirely educationally focused and do not necessarily safe guard against clinical competency requirement. It was out of this shape of caring review that the toolkit for the provision of education leading to QIS was devised (Turrill, 2015). This toolkit sets out standards for HEI, individual Trust's and Networks to audit their provision for delivering and supporting QIS education. This toolkit however has yet to make an impact in higher education institutes, due to the seeming enormity of the proposed work this standard may take to implement. This standard has to be nationally driven and ultimately led by NHSE in order for the toolkit to be implemented and regulated across the country. Nurses and babies move around the country and across local sectors, the standard of education has to be congruent wherever a neonatal nurse may practice or where a baby may be cared for.

The Royal College of Nursing (RCN) similarly in 2014 published their document 'Career, education and competence framework for neonatal nursing in the UK', detailing the career and educational pathways from unregistered novice to a registered expert neonatal nurse. This framework aimed to achieve equity in the career and educational opportunities available to meet the needs of the neonatal nurse and their employing organisations. The RCN recommended that the framework was used throughout the UK to "inform workforce development and educational plans on practice environments" and that the "associated competencies, core clinical skill set and matched educational requirements should be used at practice level and by higher education institutes to underpin and benchmark local provision".

This framework, in conjunction with the RCN endorsed the BAPM, NNA & SNNG (Turrill et al, 2012) joint publication 'matching knowledge and skills for

QIS neonatal nurses', greatly informed the Pan London Band 5 competency document which was produced in 2015 by a working group of London hospital based neonatal practice development nurses/facilitators. This document was produced in order to guide band 5 nurses through the expected level of knowledge, skills and competency prior to their undertaking of the QIS course. This document predisposes nurses to the core syllabus for clinical competency as set out in the 'matching knowledge and skills for qualified in speciality neonatal nurses: core syllabus for clinical competency' document.

The band 5 document is an excellent tool, funded by the London ODN, and may go some way in helping to retain junior staff, offering them an educational and clinical focus during their first year, whilst ultimately defining the career pathway within the specialty. Neighbouring ODN's have since shown great interest in this competency document in a bid to progress to unified pre-course standards.

It was identified in the survey that some units have experienced reduced funding for training purposes, which has resulted in less band 5's being able to access QIS courses. The survey shows that 20 out of the 24 units that responded were able to access some kind of specialist training during 14/15. The training was across the board from the special care module to the ANNP course. Nineteen units were able to send staff on the special care module; seventeen units accessed the high dependency module and 16 units the intensive care module. Enhanced and advanced nurse practitioner courses were also accessed by four and eight units respectively. However these figures do not of course reflect the actual number of staff who underwent training and whether this was deemed sufficient for need. It also does not reflect the success rate of staff passing the individual modules, where staff may be sent on to the course but unfortunately, for whatever reason, fail. The introduction of the band 5 competency document in 2015 should however inevitably help in preparing band 5 nurses for the QIS course.

2.4 Age profile

Unsurprisingly the majority of the workforce at band 5 are aged between 21-39 years. The more experienced staff at band 6 and 7 expectedly feature in the upper age brackets of 40-65+ years. There appears to be significantly less nurses across the bands that feature in the 55 years and above bracket. It may be reasonable to consider that more nurses are retiring earlier from the profession.

Unit's need to be prepared for succession planning for replacement of experienced band 7 senior staff where 30% of these nurses are reported to be 55 years and over.

2.5 Recruitment

Many units highlighted difficulty in recruiting staff mainly at band 6 level, this would undoubtedly account for the under achievement of QIS percentage recommendations. Some units reported that they intentionally over recruited into lower bands with a view to 'growing their own', fast tracking band 5's through development programmes and QIS courses. This tactic would go some way in achieving an experienced workforce eventually, although initially this may result in a particularly lower skill mix and/or experience, requiring greater supervision and training.

Many units stated they had taken part in overseas recruitment strategies including Spain, Philippines, Ireland, Greece, Portugal, Italy and Hungary. Although overseas recruitment appears to be successful, some units highlighted that there was a high turnover of overseas recruited staff, many either leaving the specialty or returning home. Overseas nurses also require a period of supervision and completion of the NMC's 'overseas nursing programme' before they can be entered on to the NMC register. During this period the nurses are unable to fully take on the responsibility of a band 5 nurse, which in turn may add additional pressures due to supervision requirements.

Other comments from units stated that it was not always possible to recruit good paediatric nurses at band 5 as they have such a wide choice of job offers across the sector, and felt they were in ‘competition’ with each other.

Various units stated they regularly held joint recruitment days with paediatrics colleagues, some as often as monthly. Most units also stated they had rolling adverts in order to maintain momentum with attracting staff.

A few units commented on an increase in recruitment of adult RN nurses from critical care areas who wish to make the transition in to neonatal intensive care.

It may be prudent to highlight that from the survey, it is evident that the neonatal QIS workforce accounts for 65% holding a general/adult RN NMC registration, with only 35% being registered children’s nurses.

Anecdotally, some years ago, there were rumours that suggested all nurses working in neonatal units should be paediatric trained. The data from the survey clearly highlights that this requirement would be completely unsustainable and thankfully never came to fruition.

Back then there was an even more mix of staffing, with registered midwives (RM) also making up a percentage of the workforce. RM’s have since declined from working in neonatal units, probably due to the fast track programmes available for midwives into band 6 posts following their initial foundation year. RN’s working in units may however be dual qualified but let their RM qualification lapse due to pressures of keeping up with revalidation and associated hours of practice requirements.

One factor in the high percentage of RN nurses, may be due to the increase of overseas recruitment. The majority of other countries only offer a combined nurse training and do not differentiate between specialist children’s nurse training and general training; hence overseas nurses would automatically only

be entered on to the RN section of the NMC register when they commence work in the UK.

Taking this into consideration, are there missed opportunities to attract nursing staff of all domains at an earlier stage?

General nurses do not receive any exposure to a neonatal unit during their training, and potentially a large percentage may never consider a career in neonates because they probably think they cannot work within this environment. Similarly is there enough exposure for paediatric nursing students? These and midwifery students do undertake placements on a neonatal unit but it has been cited that there is limited theoretical exposure in the class room. Consideration should be given to including a specific neonatal module within their training, thereby encouraging greater knowledge and skills in neonatal nursing at an early stage, potentially attracting more junior nurses in to the service.

Many Trusts offer open days to help recruit nurses. These are often successful in attracting nurses but clearly do not go far enough given the number of vacant posts across London. Higher education institutes similarly hold open days to attract students into their programmes; consideration should be given for Networks and Trusts to engage with the HEI's to promote neonatal nursing at an early stage in order to raise awareness of the specialty, not just for children's nurses and midwives, who will have some exposure to a neonatal unit during their training, but also for general nurses, who may have not have even considered a career in neonates as an option.

The availability of rotational posts within Trusts also seems to go some way in attracting staff, especially newly qualified nurses who perhaps wish to consolidate and gain experience in their first 18 months of qualifying. The offer of rotational posts will increase exposure to different areas and may entice staff. Although, there may be logistical issues with the length of rotation, along with the investment in education, training, supervision and competency in each area.

While the data presented offers average results for the nursing workforce figures, there are inevitably units with effective recruitment programmes and low vacancy rates. These may be attributed to specific factors such as support systems offered to new/junior staff, training opportunities or the nature of experience offered by the unit, for example cardiac and/or surgical treatment. Good transport links may also play an important role in successful recruitment.

One area to exam in future, as part of a yearly workforce analysis, may be to review the retention and turnover rates of the workforce, which may also give an indication on the impact of support and training available.

This report, as with many others before it, consistently highlights the apparent need for an urgent increase in investment in the nursing workforce within neonatal care; be it training and development or funded establishments. The birth rate is rising year on year with an inevitable increase in care required, and yet the nursing workforce is already significantly understaffed, underfunded and under pressure.

The ODN endeavours to work collaboratively with stakeholders in order to engage with the national agenda and share successful recruitment and retention strategies and training programmes. It is essential the workforce for one of the most vulnerable group of patients is highly skilled, competent and knowledgeable across the board, attracting nurses in to the profession to ensure the service is sustainable for the future.

3. Workforce Strategy: Where the London Operational Delivery Network can support and add value

Area of Work:	ODN's Strategy:
National service review	To support this review due to take place in 2017. Neonatal services across the country will be involved in the transformation review, where the provision of services, capacity, activity, medical and nursing staffing, and compliance with the service specification will be reviewed nationally.
ODN demand and capacity modelling	Neonatal services need to meet the needs of the predicted rise in birth rates over the coming years, providing services that meet the need of the population. Regular capacity and demand reviews and assessment will be undertaken to ensure the services are accessible and appropriate to demand in accordance with the national neonatal service specification.

Maternity national service review	Neonatal services need to be organised to support critical care in accordance with the maternity service review undertaken in 2015.
Close working with maternity services	Through joint workshops such as 'Nobody's patient/whose shoes' events, the ODN will work with maternity and obstetric colleagues to increase engagement and improve patient experience. A multidisciplinary approach to the workshops will be delivered along with other stakeholders depending on the workshop focus i.e. adult critical care and paediatric services.
Neonatal Service Specification delivery	The ODN will support the implementation and monitoring of units complying with the national service specification, taking into consideration agreed pathways and patient flow. Exception reporting to be monitored via the ODN governance leads.
Annual workforce review	To ensure a yearly nursing workforce review is undertaken to allow for

	direct comparative data across London. The on-going data will inform the ODN and associated stakeholders of improvements, or decline, in the numbers of clinical nurses and essentially QIS trained nurses in accordance with BAPM (2010) and Toolkit (2009) recommendations. The tool used will be revised as necessary to ensure it remains relevant and captures the appropriate data. To scope national roll out of the tool.
Maintain links with HEI/HEE	To improve communication and unify work programmes with post graduate nurse training commissioning. To support a national review of QIS courses and implementation of the educational toolkit for QIS.
Badgernet daily nursing numbers	For every London unit to input daily nursing number data on the Badgernet system, in order to monitor its usefulness and accuracy in capturing the 'real' picture on a day-to-day basis regarding nurses

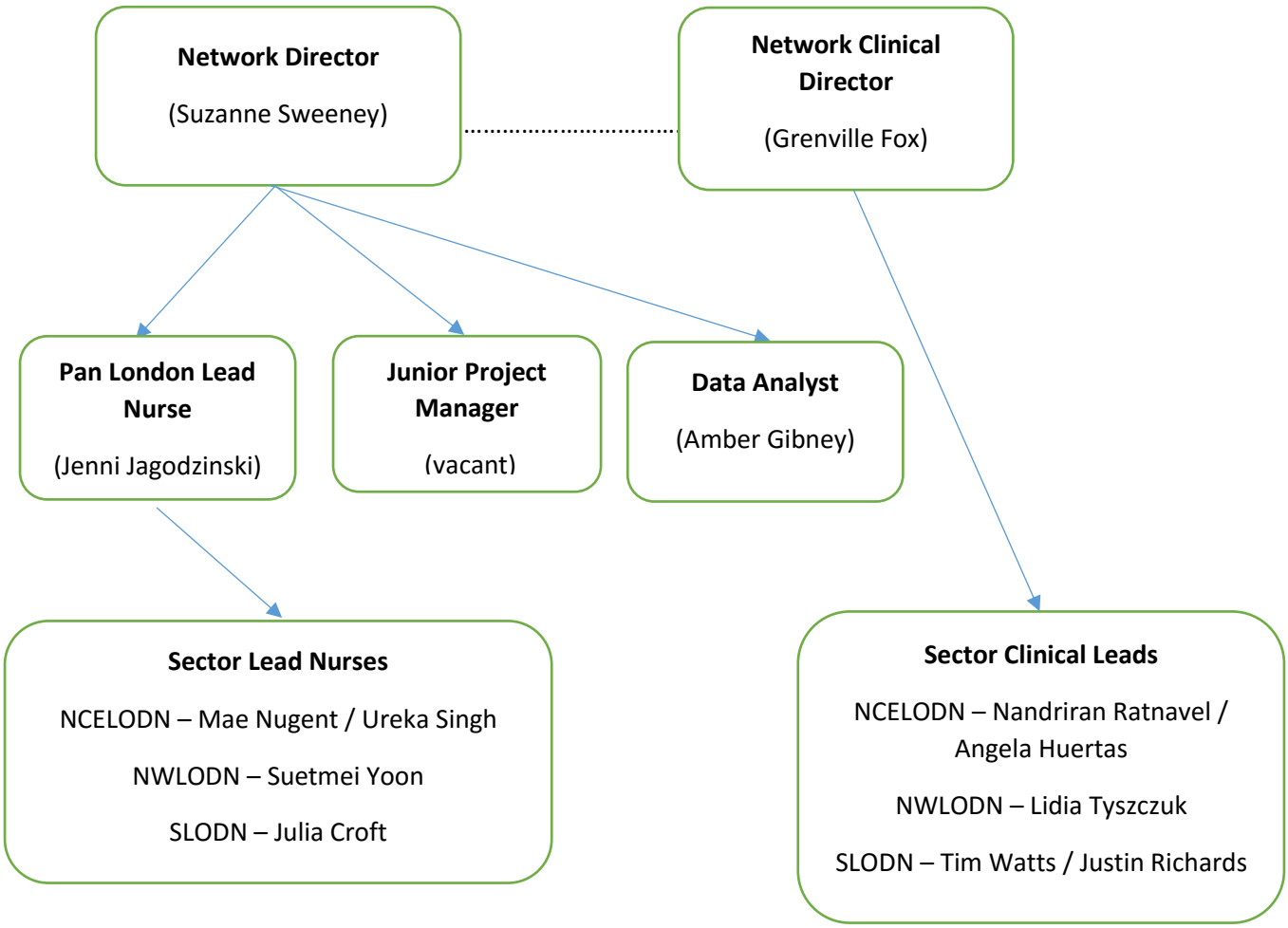
	required against daily activity. To offer feedback to Badgernet regarding improvements that can be made to ensure the system is utilised to its full potential.
Band 5 Development days	To provide further development days, which have proven to be extremely successful and valuable for new staff starting in the speciality. These need to be funded accordingly within a network education budget and to potentially offer further days for band 6 and 7 senior nurses. Sustained funding is required for staff development and training needs.
Support Trusts in working towards achieving BAPM/Toolkit staffing recommendations	Through supporting individual units/Trusts the Lead Nurses should work with the Matron's/Senior Nurses to engage Senior Management Teams/Heads of Nursing to establish and implement workforce plans in a bid to reduce variance and improve resources available.

	To support derogation action plans for Trusts and share successful recruitment and retention plans.
ODN recruitment days/advertising	In order to promote neonatal nursing and in a bid to attract staff across London, the ODN will scope the provision of a rolling programme of open days, held centrally, where representation from each clinical ODN would be able to discuss career opportunities for their local units and promote a career in this speciality. To scope the possibility of an advertising campaign across London, similar to current Trust/HEI campaigns i.e. the use of buses, banners on nursing websites etc. To consider a web link with all advertised neonatal posts, sign posting the candidate to the ODN website, where information on the ODN and each hospital is available.
Resources	Continued development and expansion of information available on the ODN website. For the website to act as a single point of information for network wide guidelines, educational

	information including study days and up-coming events.
Work programme for lead nurses	The sector lead nurses will undertake a pan London infection control survey to establish current practice and precautions undertaken for colonisation of micro-organism, with the aim to establish variances across units. This scoping work will ultimately inform the ODN of isolation and infection control restrictions that may need to be managed and escalated from time to time. This work will link in to an ODN infection control escalation policy. To undertake a 'visiting policy' review across each sector in order to inform Clinical Oversight Groups of the variance in policy, with the potential to lessen the disparity where possible; offering consistency for parents when moving between units. A structure chart for the London ODN is shown in section 4.

Educationally funded practice educators	Review of the northwest project which is currently funded via HENWEL. To scope further roll out across London ODN's. The project offers support to units without practice educators in post and acts as an additional resource to educators on individual units. However the project requires continued funding commitment.
National group for ODN Lead Nurses	Proposal for a national group to bring together best practice, benchmarking, national programmes of work and a roll out of a national workforce review tool.

4. Structure Chart



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