# Filling the gaps:

## A Spotlight on Allied Health Professional, Psychological and Pharmacy Roles in Neonatal Care

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Bliss

for babies born premature or sick

## Contents

## About Bliss

Bliss was founded in 1979 by a group of concerned parents who discovered that no hospital had all the equipment nor the trained staff it needed to safely care for premature and sick babies.

Determined to do something, these volunteers formed a charity to give vulnerable babies the care they deserve. More than 45 years later Bliss has grown into the UK's leading charity for babies born premature or sick, and our vision is that every baby born premature or sick has the best chance of survival and quality of life.

## Acknowledgements

Bliss would like to thank the hard-working neonatal Allied Health Professionals (comprising dietitians, occupational therapists, speech and language therapists, and physiotherapists), psychological professionals and pharmacists who took the time to provide us with information for this report, which would not be possible without them.

We would also like to thank the parents who responded to our survey and shared their stories with us in our focus groups.

Thank you to all those who provided help and guidance with carrying out this work, developing our research methods and interpreting the results. In particular, we would like to thank our Advisory Group members: Sara Clarke, Ben Harris, Maria Furtado, Katy Parnell, Zoe Gordon, Ruth Butterworth and Sian Gaze. We would also like to thank Eleri Adams, Michelle Sweeting and Mary Leighton for their invaluable advice in the development of this project.

This report was written by Shaun Odili, edited by Beth McCleverty, Caroline Lee-Davey and Peter Bradley, and designed by Joana Águas.

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## Glossary/Terminology

| | |
|---|---|
| **Allied Health Professional (AHP)** | Allied Health Professional (encompassing physiotherapists, dietitians, speech and language therapists, and occupational therapists) |
| **AHPPP** | Allied Health Professional, Psychological professional, Pharmacist |
| **Developmental care** | Developmental care includes a broad range of interventions that are designed to maximise neurological development and minimise long-term cognitive and behavioural problems for babies |
| **Developmental post** | Jobs providing learning and development opportunities that the postholder can undertake to enhance their skills and expertise |
| **Family Integrated Care (FICare)** | FICare is a model of neonatal care, which promotes a culture of partnership between parents / carers and healthcare professionals working to care for babies on the neonatal unit. |
| **Getting It Right First Time (GIRFT)** | GIRFT is an NHS England programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. |
| **Multidisciplinary team (MDT)** | An MDT is a group of health and care staff who are members of different professions that work together to make decisions regarding the treatment of individual patients. |
| **NICU** | Neonatal Intensive Care Unit |
| **Operational Delivery Network (ODN)** | ODNs are established across England and focus on coordinating patient pathways between providers over a specified regional area to ensure equitable access to high-quality care for babies born across a region. There are ten neonatal ODNs in England. |
| **WTE** | Whole Time Equivalent. WTE is a unit used to measure the workload of an employed person, where an WTE of 1.0 equates to a full-time worker, and an WTE of 0.5 indicates a half-time worker. |

## Methodology

This report brings together the findings from a workforce survey covering all six professions included in our research: dietitians, occupational therapists, speech and language therapists and physiotherapists, known collectively as Allied Health Professionals (AHPs); psychological professionals; and pharmacists. Throughout this report we refer to all six professional groups together as AHPPP(s). We also draw on findings from two focus groups and a survey of parents with experience of caring for a baby who received support and care from neonatal AHPPP services.

### Workforce survey

We circulated a survey to 10 Neonatal Operational Delivery Networks (ODNs) in England and to key AHPPP contacts in Scotland, Wales and Northern Ireland (13 areas in total). We received responses between July and November 2024. The survey asked about the shortfall in the workforce currently available in comparison to the respective staffing level recommendations for each profession and the recruitment and retention challenges that each profession was facing.

We received 62 responses out of a total possible 78 responses (13 areas x 6 professions), giving us a response rate of 79 per cent. We received data from all 10 ODNs in England and from each of the other nations: Scotland, Wales and Northern Ireland. We received similarly high levels of data across 5 of the 6 professions, however for pharmacy this was notably lower, at less than a third of possible responses. In England, the survey was sent to AHPPP leads at ODNs and where we did not receive responses this was usually because there were vacancies in lead roles. This was particularly significant for pharmacy.

The response breakdown by profession is as follows:

| Professional Group | Responses (out of 13) |
|---|---|
| **Dietetics** | 12 |
| **Occupational therapy** | 12 |
| **Pharmacy** | 4 |
| **Physiotherapy** | 11 |
| **Psychology** | 11 |
| **Speech and language therapy** | 12 |

### Focus groups

We conducted two parent focus groups in July 2024 with parents of babies born premature or sick that received support from neonatal AHPPP services. Parents were recruited via Bliss' social media channels and Bliss' Insight and Involvement Group. Six parents attended in total, 3 parents per focus group, who were all mothers.

The first focus group explored the AHP and pharmacist support that families and their babies received during their neonatal journey. The second focus group explored the psychological support that they

received. The focus groups explored the themes of support and resources provided by AHPPPs, involvement in their baby's care, and individualised care.

## Parent survey

Based on the findings gathered during the focus groups, we conducted a survey to understand parents' experiences of the care they and their baby received from AHPPPs, and the impact this had on them and their baby. We advertised the survey on social media, and through our Insight and Involvement Group and Bliss' newsletters throughout October and November 2024. We received a total of 90 responses to the survey.

## Summary of key findings and recommendations

Neonatal Allied Health Professionals, psychological and pharmacy professionals are an integral part of neonatal care in the UK. These professional groups are core to the multidisciplinary teams (MDTs) that babies born premature or sick need in order to have the best chance of survival and quality of life. Where units are fully staffed across these professional groups, these team members add up to more than the sum of their parts, providing support to the whole MDT. They play a vital role in improving short- and long-term outcomes for babies and are an essential part of delivering good Family Integrated Care (FICare) and developmental care. AHPPPs can provide both direct care for babies and families as well as wider support to the MDT, to ensure every baby receives the highest quality care.

Despite the benefits these professional groups bring to a neonatal unit, our research has found:

### There are not enough AHPPP staff in post

- On average, there is a 67 per cent shortfall across the UK between the recommended AHPPP staffing levels for units and the staffing levels currently being achieved. In our data, the average shortfall for each nation is as follows:
    - Scotland - 88 per cent
    - Northern Ireland - 69 per cent
    - England - 66 per cent
    - Wales - 62 per cent
- On average, there is also a 60 per cent shortfall between the recommended staffing levels for roles at network level in England and the staff in place.

### There are significant challenges to recruiting and retaining staff

- Funding is the key barrier to recruitment.
- There are multiple challenges in retention including: lack of career progression, supervision, unit and team dynamics, inadequate space and resources (for example, poor access to appropriate desk space and computers/laptops) and Trust / Health Board infrastructure.

### The value of AHPPP services is recognised by parents

- 9 in 10 parents surveyed say support from neonatal AHPPPs had a positive or very positive impact on their baby.
- 8 in 10 parents surveyed say the AHPPP professionals they received support from listened to them and advocated for them and their baby.

Our research shows that access to AHPPP services varies across the UK, and between professions, and the lack of funding to embed these services within neonatal teams is negatively impacting staff and the care that they can provide to families. To ensure that the staffing recommendations for each profession are met and that more babies and their families benefit from these services, we call on governments and NHS bodies across the UK to:

1. Ensure that funding is made available for services to recruit to sufficient posts to meet the recommended staffing levels for each profession at unit and network level.
2. Ensure all areas of the UK have plans in place to work towards full staffing levels for all six professional groups detailed in this report.

3. Ensure that national workforce planning considers retention alongside recruitment. Plans should take into consideration the specific challenges and circumstances that different regions face and the concerns we have heard about retention challenges, which include:
    - Lack of career progression
    - Unit and team dynamics
    - Supervision
    - Trust / Health Board infrastructure
    - Inadequate space and resources

4. Develop and improve AHPPP leadership in all UK nations through a model of neonatal AHPPP lead roles.

Neonatal allied health professionals (dietitians, occupational therapists, physiotherapists, and speech and language therapists) and pharmacy and psychological professionals are an integral part of neonatal care in the UK.

These professional groups are an essential part of the multidisciplinary teams that babies born premature or sick need to have the best chance of survival and quality of life. Our research has found:

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**88%** shortfall in Scotland

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**66%** shortfall in England

**60%** shortfall between recommended staffing levels for roles at network level in England and the staff in place

Funding is the key barrier to recruitment

There are multiple challenges in retention including: lack of career progression, supervision and infrastructure

**9 in 10 parents** say support from neonatal AHPPPs had a positive or very positive impact

**8 in 10 parents** say the professionals they received support from listened to them and advocated for them and their baby

## Bliss calls on governments and NHS bodies to:

- Ensure funding is available to meet staffing recommendations
- Develop workforce plans to work towards full staffing levels and resolve local and national retention issues
- Develop and improve leadership roles in all UK nations

## Introduction

1 in 7 babies in the UK is born needing neonatal care. Neonatal care is the type of hospital care that a baby receives if they are born unwell. Babies are admitted to neonatal care shortly after birth, either because they have been born prematurely (before 37 weeks of pregnancy) or at full term and sick. For example, they might have an infection, difficulty breathing or a genetic condition.

These babies are among the most vulnerable patients cared for in the NHS: they may spend days, weeks, and in some cases months in hospital. For the parents of these babies, the experience is life changing. Rather than taking their baby, or babies, home shortly after birth, they are admitted to a specialist hospital unit to receive lifesaving care.

For these babies to have the best possible chance of survival and quality of life they need to be cared for by a fully staffed multidisciplinary team (MDT) of neonatal professionals. Having a fully staffed neonatal MDT, where each professional group is embedded properly on the unit, means that each of the different specialist professionals has more time to provide focused and dedicated support to babies and their families. A fully embedded approach means that the whole team's knowledge and capacity is improved and professionals are able to learn from each other. In this environment, neonatal AHPPPs can be more than the sum of their parts and can improve the care that all babies on a unit receive, not just those that they see personally. This can help improve the overall care that babies and families receive, as well as boost staff morale and confidence.

Currently, significant numbers of babies are not benefitting from a fully embedded MDT approach which includes the appropriate AHPPPs for their care. Bliss has conducted research to assess the current provision of neonatal AHPPPs across the UK, and the challenges that services face in improving provision. We have also gathered the experiences of parents who have had a baby in neonatal care who was cared for by one or more of these professional groups. Based on this evidence we have produced recommendations for UK governments and NHS bodies that aim to ensure that more babies, and their parents, have access to the care they need from AHPPPs.

# Background

## Policy context

The importance of AHPPP services in delivering high quality neonatal care is highlighted in a number of national reports and service specifications.

In England, the service specification for the provision of neonatal critical care emphasises the importance of AHPPPs as part of a shift towards ensuring that neonatal care supports the improvement of longer-term outcomes for babies[1]. NHS England's three-year delivery plan for maternity and neonatal care recognises the need to grow the AHPPP workforce, alongside other maternity and neonatal professions[2].

The Getting It Right First Time (GIRFT) review of neonatology highlighted significant shortfalls in staffing, and recommended that the development of the wider MDT, including AHPPP services, would be essential to delivering a holistic, safe and high-quality neonatal service for the future[3]. The Neonatal Critical Care Transformation Review, which set out how the NHS would improve neonatal care, also recognised that neonatal units require key contributions from AHPPPs and acknowledged their importance in embedding developmentally sensitive care into neonatal practice[4].

The Scottish Government Best Start report, which provides a forward plan for maternity and neonatal services, set out that an effective AHPPP service can improve outcomes for neonates, in particular high-risk neonates, and should be universally available[5]. A recent report produced by the Scottish Perinatal Network, commissioned by the Scottish Government, has identified significant shortfalls in AHP provision and makes recommendations for further development and investment in neonatal AHP roles[6].

In Wales, the service specification for neonatal services recognises the essential role that the AHPPP professions play in the MDT and the positive impacts they have on length of stay, family experiences, neurodevelopmental outcomes and health outcomes[7]. Additionally, in a report exploring the landscape of maternity and neonatal services in Wales, one of the key priorities for action focused on convening AHPPPs with other expert groups to drive improvements in care[8].

Following the publications of the Neonatal Critical Care Transformation review and the GIRFT review there has been some investment into neonatal care and AHPPP services since 2021, particularly into network level roles in England. However, AHPPP provision remains patchy at best.

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[1] NHS England (2024). Service specification: neonatal critical care.
[2] NHS England (2023). Three year delivery plan for maternity and neonatal services.
[3] Adams, E., Harvey, K., and Sweeting, M. (2022). Neonatology, GIRFT Programme National Specialty Report.
[4] NHS England (2019). Implementing the Recommendations of the Neonatal Critical Care Transformation Review.
[5] Scottish Government (2017). The Best Start, A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland.
[6] Cruickshank, H., Blair, H., and Whyte Z. (2024). Neonatal Allied Health Professionals in Scotland, Building the future workforce.
[7] NHS Wales (2024). Neonatal Services (Intensive Care, High Dependency and Special Care)
[8] Public Health Wales (2023). Improving Together for Wales: Maternity Neonatal Safety Support Programme Cymru, Discovery Phase Report.

## AHPPPs at the heart of Family Integrated Care

Family Integrated Care (FICare) is a model of care for babies born premature or sick which promotes a culture of partnership between parents and healthcare professionals working to care for babies on the neonatal unit[9]. FICare is recognised as crucial to improving neonatal care across all nations of the UK. In England, FICare is recommended as part of the Neonatal Critical Care Transformation Review, which highlights how parents being able to play an active role in their baby's neonatal care leads to better neurodevelopmental outcomes for the baby and promotes long-term quality of life and family cohesion[10]. In Scotland, the Best Start report[11] includes a strong focus on parent involvement in care and in Wales, the *Quality statement for maternity and neonatal services* makes clear the expectation for neonatal services to deliver a family integrated model of care.[12]

AHPPPs play a crucial role in delivering the best care and ensuring optimal long-term outcomes for babies born premature or sick and their families. They are critical to the implementation and embedding of developmentally sensitive care and FICare into practice across neonatal units including supporting parents to be involved in hands on care, decision making, feeding and medicines administration. Neonatal AHPPPs play a key role in improving the confidence of parents in these areas and support them to be partners in their baby's care. There are many positive outcomes for both babies and families that are linked to FICare, including reducing parental anxiety and stress, improved breast feeding rates, and reduced risk of infection; as well as reduced length of stay on the unit, reduced readmission rates, and improved patient and staff satisfaction[13]. These factors can contribute to improvements in the long-term neurodevelopmental and behavioural outcomes for babies.

The significant role that AHPPPs play in delivering FICare is clear in the findings from our research with parents for this report. We heard parent experiences of receiving support from AHPPPs which contributed to many of the essential pillars of FICare, such as parental involvement, participation and empowerment.

## Professional groups covered in this report

Each AHPPP staff group is governed by a professional body, and these bodies have each published a set of guidance and staffing recommendations for their respective professions. The aim of this is to provide clear information and staffing standards that units and neonatal networks can follow in order to ensure that they provide a safe, high-quality service.

### Physiotherapy

Physiotherapists play an essential role in identifying and assessing babies who are at risk of movement and developmental issues that can be caused by prematurity, birth complications, and conditions affecting joints or muscles. They provide specialist care relating to movement, posture, motor skills and the positioning of a baby to promote healthy growth and neurodevelopment. Physiotherapists can also provide advice and support to help a baby with their breathing.

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[9] Bliss. What is FICare?: https://www.bliss.org.uk/health-professionals/family-integrated-care/what-is-ficare
[10] NHS England (2019). Implementing the Recommendations of the Neonatal Critical Care Transformation Review.
[11] Scottish Government (2017) The best start: five-year plan for maternity and neonatal care
[12] Welsh Government (2025) Quality Statement for maternity and neonatal services
[13] O'Brien K et al (2018) Effectiveness of Family Integrated Care in neonatal intensive care units on infant and parent outcomes: a multicentre, multinational, cluster-randomised controlled trial. Lancet Child Adolesc Health. 2018 Apr;2(4):245-254..

Neonatal physiotherapists ensure parents and caregivers have the tools they need to support their baby's development[14]. For example, this could be through working with parents to help them better understand correct positioning and handling of their baby, or providing specialist positioning aids to use on the neonatal unit.

Evidence shows that early intervention from a physiotherapist can improve babies' long-term outcomes, support early diagnosis of motor problems allowing for early intervention, help to prevent ongoing complications, promote better motor and cognitive outcomes, and mitigate longer-term care costs[15]. Neonatal physiotherapists may provide care on the neonatal unit and into neurodevelopmental follow up clinics, where assessment and advice will continue after discharge home to support babies' developmental needs[16].

*"I went home feeling supported and more confident with new knowledge of ways to support and promote my baby's physical development in a comfortable manner for them, from the physiotherapist." - Parent survey respondent*

A neonatal network physiotherapist offers support for complex clinical decision making, facilitating peer supervision, education, research and workforce planning across a network area, but doesn't provide a direct clinical service as a part of this role. They play a strategic part in the Neonatal Operational Delivery Networks across England[17].

Staffing standards for neonatal units in the UK, developed by the Neonatal Committee of the Association of Paediatric Chartered Physiotherapists, recommend that the minimum Whole Time Equivalent (WTE) for physiotherapists working in neonatal units should be 0.05 WTE per cot. It is also recommended that the WTE for a network lead physiotherapist should be 0.2 per 10,000 births within the network[18].

**Speech and Language Therapy (SLT)**

Speech and language therapists (SLTs) play a vital role in the early identification and management of feeding, swallowing, and early communication challenges for babies needing neonatal care. They can enable positive feeding experiences for the baby and facilitate feeding development from the start of the baby's feeding journey, to reduce the risks of prolonged feeding difficulties. They also promote effective early communication and interactions between parent and baby which are essential in developing early attachment and bonding in addition to improving speech, language and communication outcomes in the years post discharge[19]. Feeding and communication are key elements of FICare which parents play an important role in delivering, with skilled support and education from SLTs.

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[14] APCP Guidance for Good Practice for Physiotherapists Working in Neonatal Care 2020
[15] South West Neonatal Network. Evidence repository to support the development of Allied Health Professions and Clinical Psychology services in Neonatal Units within the South West.
[16] NICE (2017) NICE Guideline NG72: Developmental follow-up of children and young people born preterm
[17] Chartered Society of Physiotherapy (2023). Physiotherapy Staffing Recommendations for Neonatal Units in the United Kingdom.
[18] Chartered Society of Physiotherapy (2023). Physiotherapy Staffing Recommendations for Neonatal Units in the United Kingdom.
[19] Royal College of Speech and Language Therapists (2023). Speech and language therapy staffing recommendations for neonatal units.

*"I went home with new knowledge learned from the speech and language therapist regarding the importance of feeding with premature babies, learning how to feed them using the side lying position and how much safer it is using this way. [I also learned] to watch for my baby's cues, how much they can tolerate, learning not to rush the feeding process, what bottle sized teats to use that were the safest." - Parent survey respondent*

The role of a neonatal network lead SLT is to bring a strategic overview to progress workforce growth and sustainability across a network area, raise awareness of the value that SLTs bring to neonatal care, and reduce inequalities of speech and language therapy care experienced by babies and families[20].

Staffing standards developed by the Royal College of Speech and Language Therapists (RCSLT) and endorsed by the British Association of Perinatal Medicine (BAPM) recommend that the workforce calculations for SLTs working in neonatal units are based on the total annual cot activity of units (at 80% cot occupancy) multiplied by a sliding scale WTE (0.04-0.055 WTE) depending on the level of neonatal unit. Additional staffing is required for units with transitional care facilities and for neonatal SLT outreach and neurodevelopmental follow up. A simple calculator is available online to support with these calculations[21]. The RCSLT also recommends that the minimum WTE for a network SLT should be 0.3 per 10,000 births within the network[22].

**Occupational Therapy**

Occupational therapists work collaboratively with parents and the MDT to facilitate a care environment that is developmentally supportive, which minimises the potential for harm on the baby's developing brain and fosters their growth and development to encourage early engagement with their parents. Through supporting parenting and baby activities they can help cultivate the parent-baby relationship. Moreover, occupational therapists can provide ongoing intervention and anticipatory guidance to support long-term development outcomes, in areas such as self-regulation, learning and play[23].

Behavioural and environmental interventions form part of non-pharmacological interventions that support stress and pain management in neonatal care. Occupational therapists use these, in collaboration with parents, to support the baby during their neonatal stay[24]. A range of evidence also shows that support for parents from occupational therapists, both on the unit and post-discharge, has helped to decrease parent stress, improve parent-baby relationships and parent involvement[25].

*"When our son was born he was very, very ill and I wasn't able to hold him for the first month. When the OT heard I had not held him she advocated and ensured this happened ASAP. It took a lot of staff*

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[20] Royal College of Speech and Language Therapists (2023). Speech and language therapy staffing recommendations for neonatal units.

[21] Calculator can be accessed here: https://360.articulate.com/review/content/51f1d7e4-baf9-4c62-b677-6adf5db9c70f/review

[22] Royal College of Speech and Language Therapists (2023). Speech and language therapy staffing recommendations for neonatal units.

[23] Royal College of Occupational Therapists (2022). Occupational therapy in neonatal services and early intervention: practice guideline

[24] Hatfield, L., Murphy, N., Karp, K. and Polomano, R. (2019) 'A Systematic Review of Behavioral and Environmental Interventions for Procedural Pain Management in Preterm Infants', Journal of Paediatric Nursing, 44, pp. 22-30. doi: 10.1016/j.pedn.2018.10.004.

[25] South West Neonatal Network. Evidence respistory to support the development of Allied Health Professions and Clinical Psychology services in Neonatal Units within the South West.

*and was not easy to get him out of the incubator, but the OT kept pointing out the benefits and how the effort of the nursing staff would be so worth it for both mum and baby." - Parent survey respondent*

The neonatal network lead occupational therapist roles in England support service coordination and development across a network area through their focus on workforce expansion, facilitation of training and education, and coordinating opportunities for clinical support and development for unit-based neonatal occupational therapists[26].

Staffing standards for neonatal units in the UK, developed by the Royal College of Occupational Therapists (RCOT), recommend that the minimum WTE for occupational therapists working in neonatal units should be 0.05 per cot. The RCOT also recommends that the WTE for a network occupational therapist should be 0.2 per 10,000 births within the network[27].

**Dietetics**

Dietitians provide specialist advice and support to facilitate improved outcomes by helping meet the complex nutritional needs for babies born premature or sick. They assess nutritional requirements, monitor and evaluate growth and develop feeding plans that meet the needs of each baby. Improving the nutritional care of babies can reduce their risk of developing co-morbidities of prematurity such as necrotising enterocolitis (NEC), retinopathy of prematurity (ROP) and bronchopulmonary dysplasia (BPD). Dietetic-led protocols can also reduce the impact of nutrition-related complications such as vitamin deficiencies and metabolic bone disease. This is beneficial for babies' short- and long-term outcomes[28] [29] [30] [31].

Neonatal units that receive input from dietitians are more likely to monitor growth and implement optimum nutrition practices for very low birth weight babies in the early stages of their lives, which can help improve their outcomes in the neonatal intensive care unit (NICU)[32]. Evidence shows that the inclusion of a dietitian in a NICU team can improve nutrition care and growth rates for high-risk babies, which leads to shorter hospital stays[33].

*"My baby had very complicated nutritional needs due to having a stoma and struggling to absorb nutrients. Her dietitian was very helpful and she reassured us. She helped us try various prescription baby formulas until we found the right balance." - Parent survey respondent*

The role of a neonatal network lead dietitian is to carry out policy development and implementation, training and education, service evaluation and workforce development across a network area. They

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[26] Royal College of Occupational Therapists (2023). Occupational therapy staffing on neonatal units
[27] Royal College of Occupational Therapists (2023). Occupational therapy staffing on neonatal units
[28] British Dietetic Association (2022). Dietitian Staffing on Neonatal Units.
[29] Smith M, Mustapha M, The evolving role of dietitians in neonatal units and beyond, Paediatrics and Child Health, https://doi.org/10.1016/j.paed.2024.02.002
[30] Mustapha M et al., Nutrition of preterm and term infants in the neonatal unit, Paediatrics and Child Health, https:// doi.org/10.1016/j.paed.2024.10.002
[31] Mustapha M, Blair H, Leake N, Johnson V, van den Akker CHP, Embleton ND. The evolution of nutritional care in preterm infants with a focus on the extreme preterm infant. J Hum Nutr Diet. 2024;1–12. https://doi.org/10.1111/jhn.13353
[32] Olsen, I., Richardson. D., Schmid, C., Ausman, L. and Dwyer, J. (2005). 'Dietitian Involvement in the Neonatal Intensive Care Unit: More Is Better', Journal of the Academy of Nutrition and Dietetics, 105(8), pp. 1224-1230.
[33] Barr., S., Hand, K., Fenton, T. and Wargo, S. (2023). 'The Role of the Neonatal Registered Dietitian Nutritionist: Past, Present, and Future', Clinics in Perinatology, 50(3), pp. 743-762. doi: 10.1016/j.clp.2023.04.010.

also engage in research, partner with parents and families, provide professional leadership and act as a clinical point of reference across the units in their network[34].

Staffing standards for neonatal units in the UK, developed by the British Dietetic Association (BDA), recommend that the minimum WTE for dietitians working in neonatal units should be 0.1 per intensive care cot, 0.05 per high dependency cot and 0.033 per special care cot. The BDA also recommends that the WTE for a network dietitian should be 0.2 per 10,000 births within the network[35].

Dietitians working in neonatal care require a specific level of knowledge and skills to provide a safe, effective and high quality neonatal dietetic service. The BDA document *Knowledge and Skills Framework for Dietitians Working within Neonatal Services* recommends core skill sets required for each level of neonatal care[36].

**Psychology**

Due to the significant impact on parents' mental health and wellbeing of having their baby admitted to neonatal care, parents need access to psychological support from the time of admission and during the entirety of their stay on the neonatal unit. The support that psychological professionals can provide for parents includes, but is not limited to, supporting parental bonding, aiding adjustment to bad news, providing specialist bereavement counselling and making difficult treatment decisions. Psychological support for parents is essential to ensure that the impact on their emotional and mental health does not become a barrier to them being involved in their baby's care.

Psychological professionals can also enable a smoother transfer for the family, whether that's to the paediatric ward, another hospital or home, particularly if the baby has ongoing medical needs and/or disabilities[37]. They play a significant role in creating a culture of psychological safety within neonatal care by providing care to parents and facilitating a compassionate, psychologically safe workplace for the MDT[38].

Evidence shows that psychological support for parents with babies that have been admitted into neonatal care is essential. The prevalence of mental health issues is significantly higher in parents who have babies in neonatal care in comparison to the general perinatal population[39]. The importance of psychological support for staff on the neonatal unit is also significant; in a study on the prevalence and severity of secondary traumatic stress in NICU nurses, 49 per cent of nurses reported moderate to high

[34] British Dietetic Association (2022). Dietitian Staffing on Neonatal Units.
[35] British Dietetic Association (2022). Dietitian Staffing on Neonatal Units.
[36] British Dietetic Association (2023), Knowledge and Skills Framework for Dietitians Working within Neonatal Services Neonatal Sub-Group Recommendations
[37] The British Psychological Society (2016). Perinatal Service Provision: The role of Perinatal Clinical Psychology.
[38] Evans D., Butterworth R., Atkins E., Chilvers R., Marsh A., Barr K., Cole S., Cordwell J., D'Urso A., Higgins S. (2023). 'The anatomy of compassion: courage, connection and safeness in perinatal practice', Infant,19(3), pp. 88-92
[39] South West Neonatal Network. Evidence repository to support the development of Allied Health Professions and Clinical Psychology services in Neonatal Units within the South West.

levels of secondary traumatic stress[40]. In a similar study, 55 per cent of staff members reported experiencing burnout[41].

*"They (psychology team) helped during our time in NICU but also arranged for care to be in place after discharge. Fought for us to be able to take [our babies] outside the unit for 30 mins, fought for our discharge to coincide with the end of a lockdown so we would have more support, fought for us to be more involved in their care. Incredible team who really supported and advocated for us as a family." - Parent survey respondent*

In England, psychological professionals operate under a 'hub and spoke' model where units (spokes) have psychological professionals being supervised by an experienced professional working across the local area (hub). A hub is comprised of 3 units. The role of a neonatal network psychological professional is to supervise hub leads and promote the psychological perspective in the network team[42].

Staffing standards for neonatal units in the UK, developed by the Association of Clinical Psychologists UK (ACPUK), recommend that the WTE per 20 cots for psychological professionals working in neonatal units should be 1-1.2 (0.05-0.06 per cot). Staffing levels are recommended per 20 cots to underline the importance of the service that psychological professionals provide that is not at the cot-side or with individual families. The ACPUK also recommends that the WTE for a hub practitioner should be 0.4-0.6 per hub and that there should be a band 8c or 8d network psychology Lead to supervise hub leads[43].

**Pharmacy**

Neonatal pharmacists play a crucial role in the optimisation of drug therapy for the baby. The expertise of pharmacists is fundamental in supporting appropriate dosing and administration of medicines where often the evidence base for use of medicines in neonates is unclear or limited.

The role of neonatal pharmacists includes prescription monitoring, provision of advice on the use of off-label and unlicensed medicines, therapeutic drug monitoring, and general monitoring of medicine efficacy. In addition, many neonatal pharmacists work as independent prescribers to optimise therapy and provide improved access to prescriptions, avoiding possible delays in administration. Neonatal pharmacy expertise is critical for adverse drug reaction prevention, treatment, monitoring and reporting as well as minimising the potential for medication errors. Neonatal pharmacists are usually part of the clinical governance team involved with review of any medication incidents, and support improvements in practice to prevent reoccurrence.

Neonatal pharmacists also educate other healthcare professionals and parents on how to correctly administer medication, provide medicines information and support parent medicine administration schemes[44]. It is particularly vital that parents are empowered and provided with the necessary information to be able to administer medication at home, as appropriate, and it is crucial that this

[40] Beck, C., Cusson, R. and Gable, R. (2017). 'Secondary Traumatic Stress in NICU Nurses: A Mixed-Methods Study', Adv Neonatal Care, 17(6), pp. 478-488. doi: 10.1097/ANC.0000000000000428

[41] Scott, Z., O'Curry, S., and Mastroyannopoulou, K. (2021). 'Factors associated with secondary traumatic stress and burnout in neonatal care staff: A cross-sectional survey study', Infant Mental Health Journal, 42(2), pp. 299-309.

[42] Association of Clinical Psychologists UK (2022). Psychology Staffing on the Neonatal Unit.

[43] Association of Clinical Psychologists UK (2022). Psychology Staffing on the Neonatal Unit.

[44] Neonatal and Paediatric Pharmacists Group (2022). Pharmacy Staffing Standards for Neonatal Services.

process starts from the point of admission into neonatal intensive care. Neonatal pharmacists are therefore integral to supporting FICare on neonatal units and are able to provide this support as part of the wider MDT.

*"The pharmacists helped me understand all the medications my daughter needed and even after discharge they helped me get the medication my daughter needed after our local pharmacy failed." - Parent survey respondent*

Research shows that pharmacist-led interventions, such as daily bedside reviews of medication orders, parenteral nutrition (PN) regimens and delivering education programmes, improve medication management in the NICU and reduce medication errors[45].

The role of a neonatal network lead pharmacist is to support standardisation of best practice across a network area, in addition to working collaboratively at a national level to ensure seamless transfer of care across networks where needed, and to coordinate implementation of recommendations from national reports regarding pharmacy and medicines use. This role also oversees the development and review of network guidelines and regional/national audits of practice, and provides support to pharmacists and the wider MDT working in their network[46].

Staffing standards for neonatal units in the UK, developed by the Neonatal and Paediatric Pharmacists Group (NPPG), recommend that the minimum WTE for pharmacists working in neonatal units should be 0.12 for a 5-day service (and 0.168 for a 7-day service) for each intensive care cot, for every two high dependency cots and for every four special care cots. In the NPPG's staffing standards there is a strong recommendation to created dedicated network pharmacist posts, however they don't set out recommended WTE levels for these roles[47].

[45] Krzyżaniak N, Pawłowska I, Bajorek B. (2018). 'The role of the clinical pharmacist in the NICU: a cross-sectional survey of Australian and Polish pharmacy practice', European Journal of Hospital Pharmacy, 25, pp. 7-16. doi: 10.1136/ejhpharm-2017-001432

[46] Neonatal and Paediatric Pharmacists Group (2022). Pharmacy Staffing Standards for Neonatal Services.

[47] Neonatal and Paediatric Pharmacists Group (2022). Pharmacy Staffing Standards for Neonatal Services.

**Case study: Pharmacy led project to empower parents- PADDINGToN**

Parents of babies who have received neonatal care may have to administer multiple medicines after their baby is discharged home from a neonatal unit. Medication regimens for babies can be complex and the wrong administration can pose a potential risk. There is also variation, and sometimes gaps, in the information supplied to parents before discharge and the support given to parents in the administration of medicines.

In collaboration with parents, pharmacists, neonatologists, nurses and the wider multi-disciplinary team from five hospitals: Alder Hey Children's Hospital, Liverpool Women's Hospital, Leeds Children's Hospital, Wirral Teaching Hospital and The Rotunda Hospital in Dublin, the PADDINGToN project explored parents' experiences of managing their babies' medicines following discharge from a neonatal unit and used this information to develop suitable resources for future families.

The PADDINGToN resources provide comprehensive guidance to support parents of neonates to give medicines safely and include an extensive frequently asked questions section and a medication administration record which parents can use to record medicines given at home.

Parents were central to the study co-design process and research methods, which included surveys, interviews, focus groups and workshops which found that less than half of parents who needed it received information on medication prior to discharge and that this was causing stress to a quarter of parents. Parents were scared to make a mistake when administrating medication, worried about their capacity and being able to find the time to adequately administer medication, and they struggled to find reliable information resources to support them.

The evidence and analysis that was generated from the research led to the development of the PADDINGToN booklet, which was launched in September 2023 and is available on the MedicinesForChildren.org.uk.

The PADDINGToN resources are an example of the importance of specialist neonatal pharmacists playing a unique role in improving parent confidence through education. Through their involvement on neonatal units parents are given the tools they need to safely and reliably administer medicines for their baby, at home.

## What do parents say about neonatal AHPPP services?

### Overall impact

Neonatal AHPPPs play a key role in delivering Family Integrated Care by supporting parents to be partners in their baby's care in a myriad of ways. This includes by providing parents with the information and support they need to understand how they can play an active part in care, including parents in decision making, and as a result improving bonding and emotional wellbeing.

In our parent survey:

- 89 per cent of parents said that the support they received from these professional groups had a positive or very positive impact on how able they felt to be involved in their baby's care.
- 61 per cent said their ability to take part in decision making about their baby was improved
- 51 per cent said the emotional and mental wellbeing of them and their family was improved
- 59 per cent said their ability to bond with their baby was improved

### Listening to parents

84 per cent of parents told us they felt that they were being listened to and heard during their interactions with AHPPP professionals.

*"They were paramount in ensuring our baby made it home from hospital, they encouraged bonding between me (mum) and baby and dad and baby. They listened in the hard times and celebrated the good times. They helped us feel like parents, when we felt so far from parenthood. Having a psychologist on the unit helped us process what happened to us."* - Parent

*"All staff were fantastic, friendly, and easy to talk to. No question went unanswered, and they definitely gave me and my husband a sense of confidence through our time on the neonatal unit."* – Parent

*"I always felt they listened to us and they encouraged us to ask questions and when they were doing the ward round and stuff they would ask us questions."* - Parent

### Advocating for parents

84 per cent of parents said that they felt the AHPPP professionals they interacted with advocated for them and their baby. Many parents expressed very positive sentiments in terms of how the professionals who supported them advocated for them, encouraged them and enabled them in turn to advocate for their baby.

*"I am more knowledgeable about my son's conditions and can advocate for him for the care he needs thanks to all the excellent health care professionals we met with, and my son has the best possible chances to lead a healthy and full life."* - Parent

*"The AHPP team not only cared for my baby, but they cared [for] and supported us. I always felt they had time to check in how we were doing throughout our stay. As our daughter was full-term, the AHPP advocated that she needed stimulation suitable for her gestation and supported me to show staff she needed care that was different to pre-term babies."* – Parent

*"We were quite well supported in an emotional way... they reminded me that I had to advocate for my baby and I could, you know, I had the power to ask questions and I could, if I wasn't happy with something, ask questions or, you know, ask them to stop."* - Parent

### Validating feelings and emotions

In our focus groups, participants shared their struggles with trying to process the experience of having their baby admitted to neonatal care and coming to terms with the emotions and feelings that they were experiencing. One parent expressed how the support she received from her psychologist helped her acknowledge that the emotions and feelings she experienced were normal and true.

*"[The psychologist] was like, in one sense, it doesn't matter if that is true or not, that is what your brain has decided. And that is your truth. That is how you are processing that information. And I actually found that really helpful."* - Parent

### Providing individualised care

Participants had generally positive experiences regarding how individualised their psychological support and care was. It can be beneficial to parents for psychological professionals to take a reflective approach in their care and seek to understand them on a more personal level.

*"I saw [the psychologist] for about six months. That was well past leaving hospital time…..We talked about relationships and identity as a person, stuff that felt way off topic...One of the things I remember is in our last session, she actually wrote a letter for me that was kind of a summary of this is what we've done and this is the progress you have made... She always asked me, what if you went back to when your son had first been born, what would be the things you would want to say to yourself, I want you to remember these things... it (the support) did feel very, very tailored to me"* - Parent

### Bonding

Focus group participants also expressed how AHPPP support helped them to bond with their baby by aiding pain management, demonstrating how to hold their baby and facilitating play between parent and child. By encouraging bonding, AHPPPs can help parents to do activities with their child which can help manage the difficulties that they have experienced while in hospital.

*"When she'd moved more into the nursery room, so she was getting ready to come home early, the physio came to us and encouraged us to do some tummy time and use the blankets as positioning aids and things like that, which I found really good, I thought it just kind of normalised things for us. It's not just about having to do your cares and all the medical side of things. The physio brought us a mat. She got us on the floor with the baby. She said, don't worry about the wires, position her on her tummy and used the blankets for us to be able to do that. And it does really help with that bonding, being able to just play and just do normal things with her. It helped us lots when we got home as well, not to be too scared to put her on her tummy and do those kind of play experiences with her"* - Parent

### Signposting between AHPPPs

One focus group participant spoke of the ability of the AHPPPs she interacted with to signpost to other professional groups. It is important that AHPPPs are fully embedded on the unit so that babies and their families can receive a more holistic service. AHPPPs being well embedded means that they can provide support in different ways, including signposting to other professionals available on the unit and referring parents and/or babies where they require specialist intervention.

*"They actually referred us to SLT at one point. That was through the physio and the OT because they're classed as developmental therapists in our hospital. So they seem to be able to help signpost."* - Parent

**Case study: Aberdeen Neonatal Unit Developmental Therapy service– impact of embedded service**

The Developmental Therapy team at Aberdeen Neonatal unit work with babies on the unit that have been identified as "high risk" and comprise two posts (OT and physiotherapy) dedicated to the neonatal unit.

The team is well embedded on the unit and as a result are able to provide a consistent presence for families and have been able to improve care for every baby cared for at Aberdeen, not just those babies that they see face-to-face.

When establishing these roles the service initially focused on developing a consistent approach to postural support for the babies. Over time cot-side education for specific parents and staff became more formal staff training across the unit which allowed them to build relationships and establish their role in the MDT. Now their remit has expanded to include:

- Support for parents, carers and staff, particularly through education and training
- Support for developmental care, FiCare, Bliss & UNICEF accreditation
- Support for sensory development i.e. hearing, visual skills, touch
- Support for pain & stress management, particularly non pharmacological interventions.
- Support for activities of daily activities such as eating, bathing, sleeping and play
- Emotional support
- Postural support
- Neurodevelopmental assessment
- Referrals and liaising with other AHPs when babies are transferring to other units, children's hospitals or community teams
- Support for outreach team & community coffee mornings
- Follow up services up until two years of age.

They provide a familiar face and consistent presence throughout the whole neonatal journey for families, both on the unit and in follow-up sessions up to 2 years post discharge. There are plans to extend their follow-up services to 4 years post discharge, when resources allow.

The team have been able to demonstrate their value and impact for parents and babies to the wider multidisciplinary team and gain buy-in for their approach and the importance of MDT working.

## Shortfall in the neonatal AHPPP workforce

Our research found that in the UK, on average, there is a **67 per cent** overall shortfall between the recommended AHPPP staffing levels for neonatal units and the staffing levels currently being provided. This means that across the UK we have only **33 per cent** of the staff needed to meet staffing recommendations which are designed to ensure that every baby benefits from a full MDT approach to neonatal care. As a result, too many babies are missing out on the vital support that they need, both in terms of the direct care they receive from neonatal AHPPPs, but also in the wider practice of the whole MDT.

Table 1 shows that there is some variation between nations, with the largest shortfall in Scotland (88 per cent). There is still a considerable shortfall in Northern Ireland (69 per cent), England (66 per cent) and Wales (62 per cent) however, indicating a significant need for action across all four nations of the UK.

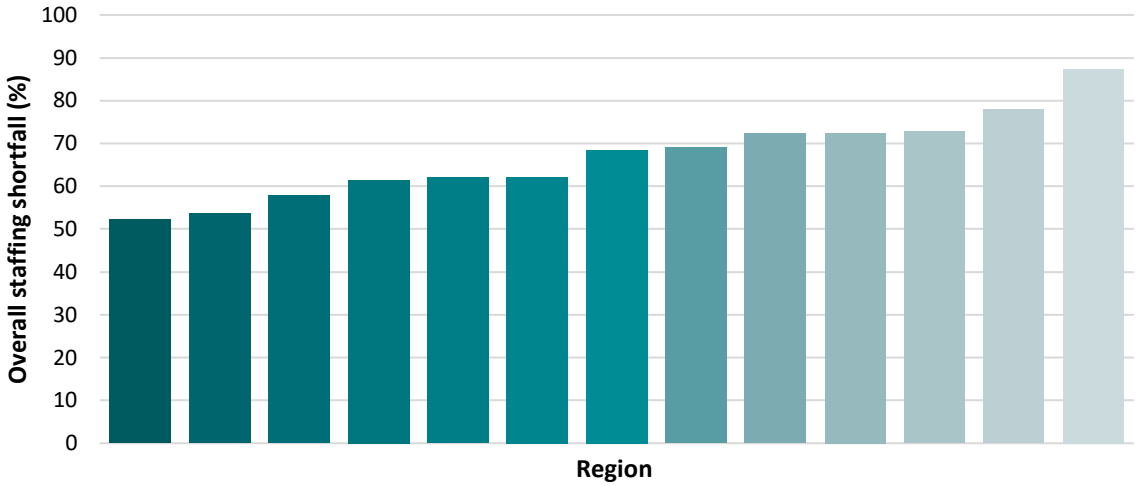
Table 1 also demonstrates that there are variations in workforce shortfall between professions. The shortfall in capacity is particularly high for psychology (77 per cent) and occupational therapy (75 per cent), which is concerning given the mental health support that psychological professionals provide, the interventions that occupational therapists provide to introduce a developmentally supportive environment for babies, and the importance to bonding of both professional groups. Even though the shortfall is lowest for pharmacy (56 per cent), this still means that we have less than half of the staffing provision needed to meet staffing recommendations within the pharmacy workforce, which is concerning for the safety of babies across the UK. While we do not have complete data for pharmacy in Northern Ireland, we do know that the Intensive Care Unit is fully staffed for pharmacy.

**Table 1. Average staffing shortfall**

| Profession | England | Scotland | Wales | Northern Ireland | UK |
|---|---|---|---|---|---|
| **Physiotherapy** | 58% | 87% | 69% | 68% | 68% |
| **Speech and language therapy** | 62% | 90% | missing | 64% | 64% |
| **Occupational therapy** | 76% | 94% | 56% | 65% | 75% |
| **Dietetics** | 60% | 79% | 40% | 50% | 59% |
| **Psychology** | 73% | missing | 90% | 100% | 77% |
| **Pharmacy** | 57% | missing | 55% | missing | 56% |
| **Overall** | **66%** | **88%** | **62%** | **69%** | **67%** |

Below, Chart 1 shows that there are also notable regional variations in the shortfall in the required workforce. The shortfall ranges from 52 per cent to 88 per cent across the networks and devolved nations in the UK. This demonstrates that there is highly unequal access to, and availability of, funded neonatal AHPPP services across the UK.

## Chart 1: regional variation in overall staffing shortfall




We collected data on the AHPPP Lead roles at network level in England. **In England,** there are AHPPP network leads currently in post across all 10 ODNs. Most ODNs now have network leads from the AHP and psychology professions, and recent investment and development following the Neonatal Critical Care Review has helped expand this number. For pharmacy, we only received data from three networks in England, and since receiving that data three new network level positions have been recently filled. This shows that there is ongoing progress with the development of pharmacy network level roles, which is positive, as they are starting from a low base compared to the other professions - however, it does mean that we have less data on neonatal pharmacy provision than within other professional groups.

However, Table 2 illustrates that there is still significant room for improvement to develop network lead roles in England, showing that there remains on average a **60 per cent** shortfall between the recommended network staffing levels and the roles currently in place. Our data shows that while generally Networks have AHPPP Lead roles in place, they are only meeting **40 per cent** of resource required.

**Table 2. Average shortfall in network roles in England**

| Profession | England |
|---|---|
| **Physiotherapy** | 56% |
| **Speech and language therapy** | 65% |
| **Occupational therapy** | 57% |
| **Dietetics** | 63% |
| **Psychology** | 65% |
| **Pharmacy** | 45% |
| **Overall** | **60%** |

## Challenges to recruiting and retaining staff

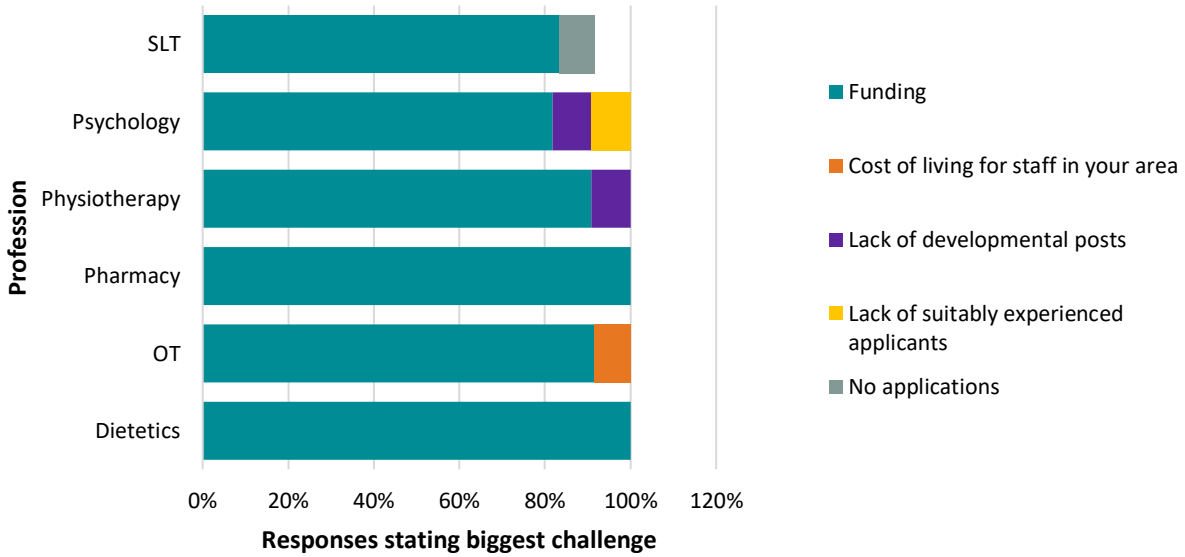
We asked respondents to tell us about the biggest challenges they were facing in their region / nation relating to recruitment and retention of neonatal AHPPPs. We developed a list of challenges with the help of our project advisory group and asked respondents to rank these challenges from most to least significant. We also provided a free text option for respondents to expand on their answers or cover topics not mentioned in the options given.

### Recruitment

Chart 2 shows that by far the most significant challenge facing services is that they don't have funding to recruit to the required roles. **90 per cent (55 out of 61 respondents) reported that funding is the biggest challenge** to recruiting staff in their area and professional group. This is consistent across the UK and the six different professional groups.

Funding is not the only challenge that services are facing to recruitment, however, although it is currently by far the most significant. Other answers indicated issues with the workforce pipeline and availability of training posts, with some professions and geographies unable to recruit because there are no qualified applicants applying for posts or because of a lack of training posts.

**Chart 2: Biggest recruitment challenge**




*"Sub-optimal funding can impact the service model provided, meaning an SLT doesn't always feel as integrated within the team. This limits opportunities for service development and limits the provision of a gold standard service with parents as partners in care, feeling as empowered as they should be around the care of their baby or babies with the appropriate expertise."* - Speech and Language

While services remain chronically underfunded and therefore significantly short staffed, this has a significant impact on retention of the staff already in place. The funding of services cannot be seen in isolation and currently the inadequate funding of neonatal AHPPP services is a downward spiral in terms of recruitment, staff experience and the care of babies. Where services are overstretched there is poor morale, higher vacancies, fewer applications and overall, a more unstable service.

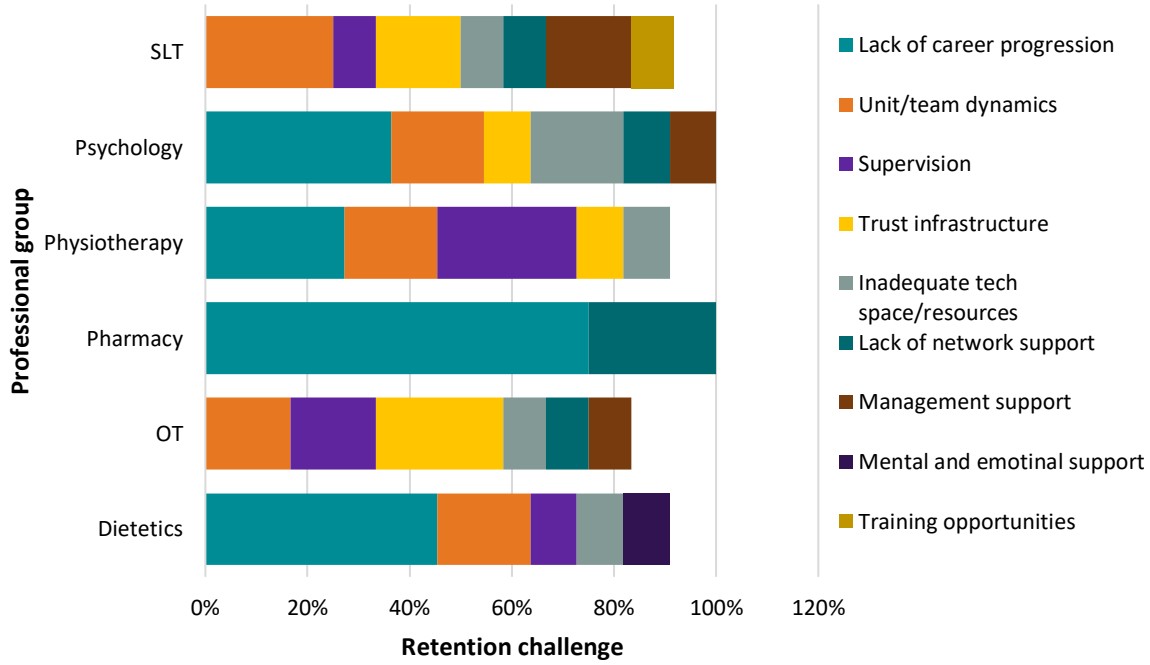
## Retention

Retention issues are, inevitably, closely related to the existing funding and staffing shortfall in neonatal AHPPP services. Chart 3 illustrates that the challenges facing services to retain those staff who are in post are myriad and include: lack of career progression, unit and team dynamics, supervision, and Trust / Health Board infrastructure. From the qualitative answers to our survey, it was clear that many, or most, of these nuances around retention relate to the funding of services.

*"Dietitians are often funded for such small amounts of WTE that they never spend enough time on the unit to feel part of the team, gain sufficient expertise, see parents, or have any time or monies allocated for CPD when neonates is such a small part of their role. This is professional risk and risk to babies. Dietitians feel unsafe and are often working outside their scope of expertise due to the lack of investment in services. This is especially true in smaller units, but this poor funding exists in larger units and can increase stress on individuals."* – Dietitian

There was some variation between professions; for example, as shown in chart 3 lack of career progression was regarded as the biggest challenge for several of the professional groups: psychology, pharmacy, dietetics and physiotherapy. By contrast, responses from SLT and occupational therapy indicate more of a mixed picture, and highlighted team dynamics, Trust / Health Board infrastructure, supervision, and support from management as key issues in retention for their staff groups.

**Chart 3. Biggest retention challenges by profession**



**Training and career development**

Where there is a lack of funding for roles on neonatal units, this does not mean that no AHPPP staff provide care to babies on that unit. On units where there are no, or very low levels of, funded posts for these professional groups, the care for babies depends on "good-will" services where staff from another part of the hospital (usually paediatrics, but also maternity in some professions) are effectively "lent" to the neonatal unit when they are required. This is an unsustainable way to run services for both staff and the babies and families they care for.

Staff who lack dedicated time on the neonatal unit or are funded for a very low number of hours per week on the unit, often will not have protected time for CPD related activities that are specific to neonatal care. Junior staff in this position do not get the exposure to complex cases and are therefore unable to develop their skills. There is also a significant shortfall in developmental posts, which give staff the training and experience they need to progress in their careers.

*"I think there is lack of career progression within neonatal pharmacy, which I think could lead to pharmacists moving for better opportunities and/or pay. Neonatal pharmacists are also rarely funded for neonates only and are spread quite thinly across paediatrics and/or maternity - neonatal cover is often then not prioritised due to more urgent nature of other wards (i.e. timely discharge medications often needed for paediatric and maternity wards). Having a dedicated neonatal pharmacist would certainly help with this, particularly having desk-space allocated for them on the neonatal unit to fully embed into the team."*

This impact on training and development compounds the issues with recruitment and retention as the pool of staff who could take on roles, particularly more senior ones, becomes limited. If there is no clear career path for staff considering roles in neonatal care, the specialty becomes less attractive to staff early in their career. This clearly impacts succession planning and creates instability in the service as if someone leaves or retires there is no one who could be recruited to their role.

*"Hosting neonatal physiotherapy services varies and understanding how to navigate this is challenging. Lack of suitable training posts (e.g. band 6 rotations) means poor exposure of junior staff and lack of training opportunities which leaves services unsustainable. Staffing standards that recommend minimum levels are often not achieved - which leaves isolated posts with no resilience. Making posts viable - especially in smaller units - is a huge challenge."*

*"There is also a limited pool of OTs with neonatal experience. Although there are national training [programmes] to raise awareness of role and core training for OTs starting on a neonatal OT role, there is still some work needed around supporting transition of paediatric OTs into neonatal roles and/or progression of OTs into a neonatal role."*

**Trust or Health Board infrastructure and supervision**

Staff highlighted that to develop a service takes time and capacity. These are often new roles in a unit and there may not be understanding or support from everywhere.

*"These are hard jobs, especially when setting up a new service, from scratch, in a unit which may or may not understand the role. There's a lot of early work which needs to be done, and the time funded currently is totally inadequate to meet this challenge."*

*"Business cases for more time are time consuming and the trusts themselves have a poor understanding of the role. Expectations are very high on post holders to do a lot more than is possible in their hours."*

ODN level Lead roles should be able to improve the sustainability of the service and support staff coming into new roles. But in England only 40 per cent of the capacity needed is currently in place. Qualitative responses to our survey showed that this means that Leads aren't always able to provide the support that they want to because of capacity restraints, which in turn impacts retention for services locally.

*"OTs are trying to deliver a service in only a fraction of the recommended staffing level e.g. 0.4WTE to cover a 2.2 WTE requirement, this leads to frustration on both the OT and the unit team and then to burn out. This is also reflected in the network role, plus also [being] unable to provide supervision for new staff at their request due to limited ODN [Operational Delivery network] WTE. Feeling unwelcome or not wanted are also reported as causes of concern and stress and reasons of possible resignation."*

*"Developmental posts simply do not exist, so post holder development and support falls to the network lead dietitian. The majority of new post holders come into role with no experience of neonatal care at all so require considerable support, training and supervision. This is very challenging to provide from the network level, where workforce provision is also minimal."*

**Wellbeing and team dynamics**

The pressures placed on neonatal staff by the significant shortfall in staffing is a key driver of poor retention as a result of the impact on overall team dynamics and staff wellbeing. Staff are overburdened with work, in an environment where they do not get the structural support needed and are unable to complete training or find posts that give them the career progression they need.

This combines to leave us with a picture of moral injury, overwhelm, poor team dynamics, burnout and consequently high sickness rates, poor retention, and difficulties recruiting even where there is funding to do so. Staff told us:

*"In those units with a proportion of physiotherapy staffing there is high risk of staff burnout - the demand outstrips capacity by well over 50%-70% in most cases. There is a high risk of moral injury associated with recognising the needs and the impact on the patient and family and being unable to meet the therapy needs."*

*"SLTs have reduced time and funding for appropriate CPD to support the development of individual SLTs and services. SLTs can be part of the team but are not able to provide the most optimum service to babies, families and the neonatal team that is required. This can also impact on the time available to provide education and training to support understanding of communication and feeding development to parents/carers and the neonatal team and reinforces the rationale behind assessment and management provided by an SLT. This can impact how an SLT may feel about their role and how effective and safe they feel. All of these points can impact resilience and retention to roles (leading to sick leave or SLTs leaving their roles)."*

*"The need on units can overwhelm post holders with limited hours. They feel they cannot meet it, and this results in moral distress, leading to burn out in some cases. They have no time to attend CPD (or*

*they do and cannot do any clinical work for that week), they have little to no cover when ill or on holiday, and the broad scope of their role is unrecognised- therefore job satisfaction can decrease over time as they are not utilising their skills."*

**Case study: Kings College Hospital NHS Foundation Trust: the benefit to babies of a full MDT**

Kings College Hospital NHS Foundation Trust has a surgical and neurosurgical NICU and a Local Neonatal Unit which is supported by **speech and language therapy (SLT), occupational therapy (OT) and physiotherapy (PT).** As a skilled multidisciplinary team (MDT) their inpatient services offer a weekly Developmental Care ward round and parent-led ward round, parent education group and a neonatal book club to encourage language development and bonding.

The MDT meet on a weekly basis to plan and assess their support for the babies and families that are in their care and work closely together to provide this support. The support that they provide is not only focused on immediate care for babies, the SLT, OT and PT neonatal therapy services also provide MDT out-patient developmental surveillance for infants at high risk of neurodevelopmental difficulties. This team carries out developmental assessments for early identification of difficulties and makes onward referrals to community services and a single point of contact for parents.

The dedicated **pharmacist** supports parenteral nutrition and they attend the weekly MDT nutritional rounds, to ensure that babies receive optimal nutrition for growth in a safe way. The team work alongside the MDT to optimise medicines use, including input to ward rounds, governance, research, education via team "druggles" (medication safety huddles). They support the supervision of medication audits and service evaluations to improve prescribing. The recent implementation of standardised drug infusions has also significantly improved medication safety and the team is currently working with the nurse education team to improve the information they provide to families on discharge in relation to medicines.

**Dietetic services** on the unit provide individualised advice and counselling on both parenteral and enteral nutrition in collaboration with the medical team. They also develop protocols and guidelines, undertake audits of practice and provide education to the wider team. In collaboration with the pharmacy team they support a multidisciplinary nutrition team advising on the nutritional management of all infants on the unit.

The service has recently expanded to include **psychology services** who are able to offer individual therapy, parent-infant relationship support and staff support.

This comprehensive approach ensures that both families and staff receive the emotional and psychological support they need, enhancing the overall care environment in the neonatal unit.

## Conclusions and recommendations

Neonatal AHPPP services are an integral part of neonatal care in the UK. The professionals delivering these services need to be recognised as essential to the multidisciplinary teams that deliver high quality care to babies born premature or sick, and their parents. National policy recognises the need for AHPPP services, including in guidance and service specifications, and each professional group has guidance on the minimum staffing standards for their profession on units and at network level.

Neonatal AHPPPs also play a vital role in supporting the delivery of Family Integrated Care for babies and their parents, and are key to ensuring that parents are treated as partners in their baby's care. This involves enabling parents to bond with their babies and be active care givers both on the unit and at home; as well as empowering them to advocate for their, and their baby's, needs. These professional groups are instrumental in ensuring that every baby and family can receive the individualised care they need. Parents tell Bliss that the support they receive from the whole MDT had a positive impact on their experience of neonatal care and how able they were to be partners in their baby's care.

However, our research has found that, across the UK, there is a 67 per cent shortfall in the neonatal AHPPP capacity needed compared to what is currently available. Funding is clearly, and overwhelmingly, the biggest challenge to meeting staffing recommendations in every nation across the UK and across all six professions.

Where some funding is available, a key concern should be around the recruitment and retention of staff. While services remain chronically underfunded and therefore significantly short staffed, this has a significant impact on retention of the staff already in place. The issues facing services around retention are multiple, but include lack of career progression, unit and team dynamics, supervision, and Trust / Health Board infrastructure.

AHPPPS are not currently receiving the funding, or overall support, required to properly embed services and ensure that every baby has the best possible care. It is vital that these issues are addressed to ensure that every baby born premature or sick in the UK is given the best chance of survival and quality of life.

Bliss recommends that governments and NHS bodies across the UK:

1. Ensure that funding is made available for services to recruit to sufficient posts to meet the recommended staffing levels at unit and network level.
2. Put plans in place to work towards full staffing levels for all six professional groups detailed in this report.
3. Undertake national workforce planning which considers retention alongside recruitment. We recommend taking into consideration the specific challenges and circumstances that different regions face and the concerns we have heard about retention challenges which include:
    - Lack of career progression
    - Unit and team dynamics
    - Supervision
    - Trust / Health Board infrastructure
    - Inadequate space and resources
4. Develop and improve AHPPP leadership in all UK nations through a model of network AHPPP Lead roles.

## What is Bliss doing to support neonatal AHPPPs?

**Bliss MDT Spotlight Webinar series**

We have created a six-part webinar series exploring the role of neonatal Allied Health Professionals, psychological professionals and pharmacists within the neonatal unit. Find out more at www.bliss.org.uk/webinars

**Bliss Baby Charter**

This Bliss Baby Charter is an audit and accreditation tool that helps examine the procedures, practices and environment of a neonatal unit. The Baby Charter standards define good practice, and using this, the Bliss team encourages and supports healthcare professionals to empower parents to be primary caregivers through joint decision-making and hands on care, as well as understanding families' needs and availability in order to provide individualised care. This facilitates a solid foundation for Family Integrated Care.

The Baby Charter helps facilitate the development of the multi-disciplinary team by including embedded AHPPP roles within standards relating to staffing and service provision. The Baby Charter also reflects standards of practice for which AHPPP roles are critical, such as the importance of developmental care, the provision of psychological support for the whole family, and discharge planning.

**Bliss policy activity**

Bliss advocates for allied health professionals and those in psychological and pharmacy roles through a range of policy and influencing work, ensuring their vital role within the multidisciplinary team is recognised and their value reflected in national policymaking. This includes engaging with national consultations and guidelines, across the UK, to embed best practice that supports these neonatal staff groups. We hope that this report adds to these efforts.