SOS

save our special care babies
save our specialist nurses

A Bliss report on cuts to
frontline care for vulnerable babies

Bliss

for babies born too soon,
too small, too sick

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Foreword

This report throws into stark relief the state of specialist neonatal services in the NHS. We already know that, despite claims that the NHS is 'protected', many of its services are subject to deep cuts and significant change. The RCN has uncovered that around 40,000 posts are ear-marked for cuts, something that will have a real impact on the quality of care for all patients, even the very young.

In 2009, the Department of Health worked with Bliss to release the *Toolkit for high quality neonatal services* which set out very positive steps for ensuring that care is able to meet the needs of patients. It would seem that now, much of this good work is being undone.

Bliss has led the way on the issue of staffing levels in neonatal care settings. Most recently, they've highlighted that we need more than a thousand additional neonatal nurses in the UK. This is on top of the fact that one in three units are making cuts through down-banding or freezing of posts. The NHS cannot adequately deliver the care patients need if its workforce and services are being systematically eroded – it just can't be done.

Short-sighted decisions will have long-term consequences; we must ensure that neonatal units are adequately staffed with specialist staff. Not only do specialist nurses save money, they save lives. This report shows that increasing the number of specialist nurses in a unit reduces infant mortality by around 48 per cent. Driving patient-focused care and guiding innovation, specialist nurses are rich in the knowledge and experience that is essential for delivering high standards of care.

This publication shows that nurses and the babies they care for are being put at risk by deep cuts. Our priority must be to not only defend the posts that already exist, but also ensure continued investment in services which make a huge difference to thousands of babies across the UK.

Dr Peter Carter

Chief Executive & General Secretary,
Royal College of Nursing

Key findings

Cuts to frontline nursing staff are putting the lives of England's sickest babies at risk.
A Bliss survey carried out in July 2011 of all England's neonatal units has found the following:

Cuts to the neonatal nursing workforce

- One in three hospital units caring for premature and sick babies have made or will be making cuts to their nursing workforce over the past year or in the coming 12 months. This is through redundancies, recruitment freezes or downgrading nursing posts (demoting nurses or replacing experienced nurses who leave with less experienced or less qualified nurses).
- One in every eight units are either making redundancies or freezing nursing posts when they become vacant.
- In a report published last year Bliss found that 1,150 extra neonatal nurses were needed to provide care for premature and sick babies. Yet, since then units have made redundant, frozen and downgraded a total of almost 140 nursing posts.
- Of additional concern to the 140 posts affected this year, our survey found that 32 neonatal units are also intending to cut their nursing workforce in the coming year. This, if followed through, will lead to an even greater shortage of neonatal nurses to care for babies born too soon, too small or too sick.

Cuts to nurses qualified in specialised neonatal care

- More than half of units are not meeting the Department of Health and NHS's *Toolkit for high quality neonatal services (Toolkit)* standard which states that 70 per cent of their registered nursing workforce should be qualified in specialised neonatal care (qualified in specialty[ii]) – referred to as 'specialist nurses' in this report.
- There is considerable variation across England in the percentage of the registered nursing workforce that are qualified in specialty. While some units are a long way off this standard, with only around 45 per cent of their registered nurses holding this specialist qualification, other units have 100 per cent of their registered workforce qualified in specialty.
- One unit in every nine is cutting their specialist nursing workforce despite not meeting this *Toolkit* standard in the first place. This means units will fall even further short of this minimum standard which will, in turn, affect the care provided to premature and sick babies.

Cuts to training and education

- For every neonatal unit to meet the *Toolkit* standard for the appropriate proportion of specialist nurses, nearly 450 nurses from the existing workforce need to complete a qualification in specialist neonatal care.
- Yet nearly one in ten units reported to us, unprompted, that either their training and education budgets were being cut or that they did not have enough staff available to care for babies on their unit to be able to release nurses for training.

Other cuts to neonatal services

- Spending on transitional care and community care is being reduced or cut completely in some trusts in order to make immediate and short-sighted savings. Yet other trusts are increasing investment into these services as an efficiency measure in order to reduce length of stay and reduce readmissions.
- Bliss welcomed the Government's recent commitment that networks will be retained under the new NHS structures being introduced in the health service reforms. However, the excellent work undertaken since 2003 to establish neonatal managed clinical networks risks being undermined in the drive to reach efficiency saving targets.

Introduction

Every year 70,000 premature and sick babies are admitted to specialist units in England where they receive critical and often life-saving care from neonatal nurses. Bliss has become highly concerned by reports from frontline neonatal staff that their services are being negatively affected in the NHS's drive to make large scale efficiency savings. We therefore decided to investigate further.

In July 2011, Bliss sent a survey to all 145 hospital trusts with a neonatal unit in England as a Freedom of Information request. The survey asked whether trusts had made, or were making changes to their nursing workforce over the past year or in the coming 12 months. We were shocked to find that one in every three units have made or will be making redundancies, freezing vacant posts[iii] or downgrading[iv] their nursing staff.

In 2009, the Department of Health and NHS's *Toolkit*[v] was published. This was in response to a report by the National Audit Office which found serious capacity and staffing problems in services for premature and sick babies. Outlined in the *Toolkit* is a comprehensive set of standards covering: staffing levels and training requirements; how units should be organised and governed; and the facilities and support that should be available for families. The two standards most referenced in this report are:

- Nursing standards which state the number of nurses needed to look after babies within each level of neonatal care: one specialist nurse to care for every baby in neonatal intensive care, one specialist nurse to care for two babies in high dependency and one registered nurse to care for every four babies in special care[vi].
- The standard for appropriate proportion of specialist nurses which states that at least 70 per cent of the registered nursing and midwifery workforce hold an accredited post-registration qualification in specialised neonatal care (qualified in specialty).[vii]

Trusts and commissioners are required to use the *Toolkit* standards along with the NICE *Specialist neonatal care quality standard*, which also outlines that units should have a sufficient, skilled and multi-disciplinary workforce, to ensure babies born premature or sick receive high-quality care. Yet, two years on, not enough nurses are employed, or even funded in the first place, by the NHS to meet these minimum standards. Cuts to the neonatal nursing workforce therefore mean that neonatal units are moving even further away from providing a high-quality, safe service in the drive to reduce spending and meet cost saving targets.

Inevitably, units are becoming even more overstretched through these changes to the nursing workforce which must be having a major impact on the care of babies born too soon, too small and too sick. There is strong evidence, outlined in more detail in this report, which states that increasing the number of specialist nurses to care for England's sickest babies will mean their chance of dying decreases significantly.

The cuts outlined in this report are not only impacting on the care babies receive today, they are also having a damaging impact on services in the longer term. A number of survey responses stated that their nurses are working overtime or taking on more shifts in order to cover the shortfall. This, combined with nurses witnessing first hand the redundancies, vacancy freezes and downgrading occurring amongst their colleagues, is likely to have a detrimental effect on nurse morale, sickness and turnover and exacerbate the shortage of nurses further.

We understand that the NHS is currently facing considerable challenges in the drive to create the four per cent year-on-year efficiency savings required by the Chief Executive of the NHS, Sir David Nicholson. We therefore recognise the need for the quality, innovation, productivity and prevention (QIPP) programme. The focus must, however, be on finding ways to make genuine quality improvements rather than short-sighted cuts to essential frontline care. If trusts and commissioners implement the *Toolkit* and NICE *Quality standard*, this will, in turn, generate long-term savings, as the Department of Health itself calculated[viii].

We know many trusts and NHS commissioners do recognise the benefit of investing in this vital service, even in these difficult times, and we have included examples of best practice around England in this report. These areas of best practice set the standard of care which we expect all others to follow.

Neonatal nursing cuts

One in every three neonatal units have or will cut their neonatal nursing workforce over the past year or in the coming 12 months through a combination of redundancies, freezes or downgrading. This is a significant proportion of units, considering the Government made a commitment that frontline services would not be affected in the drive to create efficiency savings.

> "I will protect frontline services. I will do the right thing."
>
> David Cameron MP, 23 July 2009

The Department of Health and NHS *Toolkit for high-quality neonatal services* nursing standards are based on British Association of Perinatal Medicine (BAPM) standards[ix] that have been in place for over a decade and were updated in 2011 to take the *Toolkit* into account. Yet, year-on-year, Bliss has found that there are not enough nurses employed by the NHS to provide this level of care[x]. In fact, last year Bliss found that 1,150 extra neonatal nurses were needed to meet this standard[xi] and, since then, units have made redundant, frozen or downgraded a total of almost 140 whole time equivalent nursing posts. Further cuts to the neonatal nursing workforce are planned, with at least 32 units either making posts redundant, freezing, downgrading posts, or a combination of all three, over the coming 12 months (Appendix – Table 1). This will lead to an even more acute shortage of neonatal nurses to care for premature and sick babies in the future.

A third of neonatal units are making cuts to their nursing workforce

Bliss is highly concerned that these short-sighted cuts will have a major impact on care provided to England's sickest babies and their chances of survival and long-term health. There is strong evidence to support the *Toolkit* standards for nursing. For example, one study confirmed that increasing the ratio of specialist neonatal nurses to babies in intensive care and high-dependency care is associated with a 48 per cent decrease in risk-adjusted mortality[xii].

Further research, which observed nurses working in neonatal intensive care units, revealed that a nurse spends on average 56 minutes in every hour providing direct care for the baby[xiii]. It has also been found that understaffing leads to serious problems including delays to essential treatment and reduced clinical care[xiv]. This study's conclusion was that these standards should be regarded as a minimum standard, not just something to aspire to in the future.

The correct number of nurses on a unit can also mean that they have more time to spend with parents explaining medical procedures and equipment and generally supporting families during such a difficult and emotional time. They will also have more time to help provide skin-to-skin care which, among other developmental care techniques, has been proven to have a positive effect on the health of a premature or sick baby and reduce their length of stay in hospital[xv].

However our findings demonstrate that many trusts do not appear to see the *Toolkit* or NICE *Quality standard* as a priority when trying to generate cost savings, and commissioners are not doing enough to ensure that the services that they are funding are meeting the standards.

Hospital trusts are currently implementing Cost Improvement Programmes (CIP) in order to meet Sir David Nicholson's target to create four per cent year-on-year efficiency savings and balance their budgets. Alongside these CIPs, trusts should also be publishing a quality impact assessment showing how their cost saving measures will affect their future performance. However, we believe that trusts are overlooking the

* The term 'whole time equivalent' refers to the number of full-time filled posts. All staffing figures in this report relate to whole time equivalent posts.

impact that these cuts will have on their performance. As the evidence highlighted above shows, specialist nursing levels are linked to babies' outcomes – which is surely the most important indicator of a trust's performance in this area of care. Bliss is therefore urging the following:

- Neonatal networks and NHS commissioners must work with these trusts to ensure only genuine, quality improvements are made to already overstretched neonatal services.
- Commissioners should provide incentives to trusts to meet the minimum standards outlined in the NICE *Quality standard* and *Toolkit* in order to improve babies' outcomes.
- The Secretary of State for Health must ensure improving babies' outcomes is a key priority for the NHS.

Removing or freezing posts

One in every eight units have made or will be making immediate cuts to their salary costs through redundancies or freezing nursing posts when they become vacant (Appendix – Table 2). This totals nearly 60 nursing posts, 25 of which are nurses qualified in specialty. These cuts will have a major impact on care for premature and sick babies as it means trusts are moving even further away from *Toolkit* nursing standards. The shortfall of nurses is so critical that units are reporting to Bliss that their staff are having to work overtime or extra shifts, which is unsustainable in the long term.

One in every eight units is making immediate cuts to their salary costs through removing or freezing posts

Best practice

One neonatal intensive care unit has invested over £1 million in order to expand to meet the needs of their patients and meet the *Toolkit* standards. In order to create efficiency savings they have focussed on reducing costs of medicine by comparing prices and negotiating with their suppliers.

Case study

One local neonatal unit does not meet the *Toolkit* standard for the correct proportion of specialist nurses to non-specialist nurses and yet a qualified in specialty nursing post has been frozen and will remain frozen throughout the coming year. Their response to our survey also states that they are working significantly above the recommended occupancy level of 80 per cent due to a shortage of staffed cots, with their high dependency cots running at over 110 per cent on average last year. Ensuring there is additional capacity provides a safety net so that if there are sudden peaks in the number of babies admitted to the unit, all babies will get the care and attention they need[xvi].

Downgrading

The NHS has a pay system for staff called Agenda for Change. It includes eight bands that outline NHS staff's pay, roles and responsibilities. For example, an administrator may be on Band 1 whereas a senior nurse may be on Band 8a. Posts can be downgraded in two ways: either a nurse's job description will be revised against Agenda for Change criteria to have less responsibility, and therefore the nurse will be demoted to a lower band; or, when a nursing post becomes vacant, it is filled by a less experienced nurse on a lower band without the specialist knowledge and skills. There are a number of serious implications associated with both types of downgrading.

Nearly one in every five units have downgraded or will be downgrading nurse posts through demotion over the past year or during the coming 12 months. Demoting nurses in post will inevitably have a negative impact on morale as established staff feel devalued and their career progression is stalled. This is particularly the case in units that are downgrading not just one or two nurses but dozens all at one time, such as one unit which downgraded more than 45 nurses in one year. Retention of these nurses over the coming months and years is therefore likely to be seriously affected. In a service where there is already a critical shortage of nurses, and in which some areas of the country face particular difficulties recruiting more experienced nurses, this approach to managing the workforce balance sheets is likely to be extremely counterproductive. Ultimately, this approach will exacerbate the nurse shortfall over the long term.

Downgrading through demotion can also have an effect on babies' outcomes. There is strong evidence to show that when NHS staff are enabled to grow and develop in their roles, patient satisfaction, patient mortality rates and trust financial performance improves[xvii]. Yet downgrading stalls any development and career opportunities and therefore leads to nurses becoming less motivated and engaged in their work, having a subsequent impact on patient care.

Downgrading the level of posts as they become vacant can also result in a serious loss of the more experienced and specialist nurses to the workforce. We recognise that it can be appropriate for individual units to re-evaluate the level at which posts are advertised when vacancies arise to ensure they have the right mix of staff with different levels of skills and experience. However our findings show that some units are downgrading vacancies in this way despite not having enough senior nurses.

> "Morale of staff has fallen."
>
> Nurse Manager

In this area of care where tiny and fragile babies often have multiple complex conditions, it is vital that the correct proportion of experienced, qualified nurses are available to provide hands-on care as well as advice and supervision to other, less experienced nurses. As the research on page 10 outlined, increasing the proportion of specialist nurses to babies decreases their risk of mortality by 48 per cent. The Department of Health recognised this strong evidence for improving premature and sick babies' outcomes when including the minimum standard for the appropriate proportion of qualified in specialty nurses in the *Toolkit*.

Three units told Bliss that they are replacing one senior nurse who has left with two or more nurses not qualified in specialty, consequently increasing the overall number of nursing staff in the workforce but reducing the availability of specialist nurses with the specialist knowledge and skills. While this way of reconfiguring the workforce means units are better placed to meet the *Toolkit* nursing standards on the ratio of nurses to babies, it also means they are moving further away from meeting the standard on the proportion of their nursing workforce with a specialist qualification in neonatal care. It is vital that units work towards meeting both of these standards at the same time.

In summary, downgrading is a damaging change to the workforce that will affect both the staff and the care provided to premature and sick babies, therefore affecting their outcomes.

Looking at the data from the past 12 months we can see where units have downgraded from and to. As Figure 1 demonstrates there has been a significant shift in the nursing workforce from higher to lower grades. All Band 6 to 8 nurses are qualified in specialty with some Band 5s also being qualified in specialty (if they have received a specialist neonatal qualification). This table therefore shows us that it is the qualified in specialty nurses who are most affected by downgrading.

"With all due respect to the role of non-registered nurses, I am concerned that some networks seem to be considering increasing the numbers on neonatal units and reducing the numbers of nurses trained in speciality... this concerns me greatly."

Senior Nurse

Figure 1: Salary bands nurses have been downgraded from and to over the past 12 months

= 2 whole time equivalent nurses

Salary Bands

	Downgraded from	Downgraded to
High Salary		
Band 8	-28	1
Band 7	0	2
Band 6	-58	15
Band 5	-6	49
Band 4	0	30
Band 3	-1	4
Band 2	-0.3	2
Band 1	0	1
Low Salary		

Case study

One trust has used the funding from a Band 6 and a Band 7 vacancy to hire one nursery nurse (Band 3 or 4). However, this unit also does not meet the *Toolkit* standard for appropriate proportion of qualified in specialty nurses meaning they should be making plans to recruit more specialist nurses not replacing them with unregistered nursing staff who do not have the appropriate skills to provide specialist care to premature and sick babies.

"We are able to recruit Band 5 nurses, but because these nurses are either newly qualified, or inexperienced in the neonatal field, they have to go through a long period of training and orientation before being able to work to their full potential. It is difficult to recruit staff that are qualified in speciality."

Matron

Cuts to specialist nurses

The *Toolkit* outlines that a minimum of 70 per cent of the registered nursing and midwifery workforce in each unit should have an accredited post-registration qualification in specialised neonatal care. This is to ensure there are a sufficient number of trained, experienced nurses to provide complex care to babies born too soon, too small or too sick[xviii]. Table 3 shows that 55 per cent of the units who responded to this question do not meet this standard across all levels of units.

There is a wide variation in units meeting this standard. For example, only 40 per cent of one unit's registered workforce is appropriately skilled whereas 100 per cent of another unit's registered workforce is qualified in specialty. Bliss is particularly concerned that around half of all neonatal intensive care units and local neonatal units (which provide short term intensive care) do not have the appropriate proportion of specialist nurses. Yet these are the units which provide the most complex care to England's critically ill babies.

Despite this critical shortfall, qualified specialist nurses are still being cut. We have found that one in every nine units are cutting their specialist nursing workforce through redundancies, freezes or downgrading, regardless of the fact that they are not meeting this *Toolkit* standard in the first place. This is highly concerning as a shortfall of qualified nurses has been proven to have serious implications on the outcomes

One in nine units are cutting their specialist nursing workforce despite not meeting the *Toolkit* standard for appropriate proportion of specialist nurses in the first place

> "Less QIS [qualified in specialty] nurses will lead to suboptimal quality of care and a lack of experienced registered nurses to deliver best, safest, quality care to vulnerable neonates."
>
> Ward Manager

of premature and sick babies who require complex, specialist care from nurses with the right knowledge and skills that can only be obtained through additional education and training. For example, a qualified in specialty nurse has the proven level of competence to recognise and take appropriate action when a baby's condition is becoming unstable or is deteriorating and initiate emergency interventions[xix]. A nurse who is not qualified in specialty is only reliant on previous experiences, rather than specific knowledge and training, and may not recognise situations where intervention is required, or know what intervention would be most appropriate.

The identified shortages of qualified nurses, through no fault of individual nurses, could therefore have a negative long-term impact on the baby's health. Bliss is urging trusts to look at whether they have the right proportion of qualified in specialty nurses before making short-sighted cuts to these crucial nurses. It is also essential that commissioners provide trusts with adequate resources to employ the correct proportion of specialist nurses in the first place.

Table 3: Units meeting *Toolkit* standard on appropriate proportion of qualified in specialty nurses

Responses	Numbers of units not meeting standard	Percentage
Special care baby units (26)	18	69%
Local neonatal units (54)	29	54%
Neonatal intensive care units (39)	19	48%
Total (119)	**66**	**55%**

Case study

One local neonatal unit has made two specialist nursing posts redundant and frozen one specialist nursing vacancy over the past 12 months. This cut to specialist nurses has taken place despite the fact that only 60 per cent of their registered workforce is qualified in specialty. The Trust has stated that they do not intend to try to meet this standard until next year. In the meantime babies born premature and sick will be at risk by being treated by staff without the necessary qualifications to provide such specialised care.

Best Practice

One local neonatal unit has nearly 90 per cent of their registered workforce qualified in specialty. They are also not making any cuts to their nursing workforce and are instead putting forward a case to their Trust to increase the number of staff for the next financial year based on the *Toolkit*.

Training and education

We estimate that a further 310 nurses from units' existing workforces would need to complete a specialist post-registration nurse education programme to become qualified in specialty. Only then will all 119 units who responded to the relevant questions meet *Toolkit* standards for appropriate proportion of qualified in specialty nurses. While not all units responded to this question, if you were to extrapolate this to all the 172 units across England, another 450 nurses need to be trained up if all units are to meet the *Toolkit* standard.

This is a considerable number and yet 14 units (nearly one in ten units) reported, unprompted, that either their training and education budgets were being cut or that they do not have enough staff in post to be able to release nurses for training, or both. However, this number is likely to be higher as we did not ask a specific question about education and training. We have also heard anecdotal evidence that specialist neonatal post-registration nursing education programmes are not being commissioned in the first place in some areas.

It is vital that skills are maintained and improved to deliver high quality care[xx], especially considering the complex and specialist service provided by neonatal nurses. In fact, according to Royal College of Nursing guidance, neonatal nurses should "commit to lifelong learning and activities that enhance knowledge, skills, values and attitudes required for safe and effective neonatal nursing practice"[xxi]. Bliss is therefore urging trusts, commissioners and the Government to ensure babies born too soon, too small or too sick receive the highest-quality care possible by investing in training and education for nurses. This will in turn improve babies' outcomes including mortality and long-term health in the future.

One in ten units reported that either their training and education budgets were being cut or that they do not have enough staff to be able to release for training

Case study

One trust has asked their neonatal intensive care unit to implement a Cost Improvement Programme (CIP). As part of this trust's CIP a review of their education provision was undertaken and all external course attendance has now been stopped in work time. Many nurses already work well over their paid hours and yet they will now have to attend courses during their own time or not at all. As the lead neonatal intensive care unit in its network, it is concerning that nurses may not receive the training they need to maintain and improve their skills in this complex area of care. It may also result in a decrease in the proportion of the registered workforce qualified in specialty over time.

Best Practice

One local neonatal unit has been unable to recruit qualified in specialty nurses despite many attempts at advertising these vacancies. They have therefore begun recruiting Band 5 nurses and training them to become qualified in specialty. During their course they attend college days and also gain hands-on experience on a placement at a neonatal intensive care unit.

Case study

Training for a qualification in specialised neonatal care at one neonatal intensive care unit was funded by the Strategic Health Authority as e-learning. However, the e-learning package was not fit for purpose so further training had to be found and funded out of the nursing budget. This is a clear example of waste and inefficiency in the NHS that could have been avoided.

Other cuts to services

Community and transitional care services

As well as trusts making cuts to their neonatal units' nursing workforce, cuts are also being made to other aspects of neonatal services, including transitional care and community care, in order to create immediate savings. Yet other units are investing in these services in order to increase efficiency and quality.

Transitional care is a service which provides the baby with a level of hospital-based treatment or observation alongside their mother. This service, for babies born late, preterm or less sick than others, has been proven to reduce length of stay[xxii] as the mother can breastfeed and bond with her baby while still having the safety net of nurses to turn to if they have any questions or concerns. Community care is provided by nurses outside of the unit once the baby has been discharged and has been proven to reduce readmissions[xxiii]. This is because, even when premature or sick babies are discharged from hospital, they may still need treatment such as being kept on oxygen due to breathing problems. Having a community nurse trained in neonatal care to turn to, or visit the family's home, if parents have any questions or concerns can hugely benefit the parent as well as the baby and therefore reduces readmissions.

Twenty units have recognised these benefits and reported to us that they are increasing or introducing these transitional care and community services as efficiency measures. Yet seven units told us, unprompted, that they are cutting their community services or closing their transitional care services in order to make immediate savings.

> "Evidence is now available that length of stay is reducing [since] development of neonatal outreach services."
>
> Children's Services Manager

Case study

The discharge coordinator at one local neonatal unit was not replaced on retirement, despite this role being able to provide crucial responsibilities outlined in the *Toolkit*[xxiv]. The coordinator's responsibilities, including making arrangements for going home, providing parents with key information about how to care for their baby at home and ensuring support for families by other professionals in the community is arranged, are now undertaken by all staff. This has diluted the effect of robust communication at the point of discharge. In addition the unit is considerably understaffed meaning the nurses that are employed have even less time to spend on discharge responsibilities.

Best practice

One hospital trust is reducing the length of stay on their special care baby unit and local neonatal unit by introducing the role of a designated neonatal community sister. They report that feedback from a parents' survey states that because of this new post, parents felt well supported during discharge. The unit has also employed a neonatal liaison sister who is working with paediatricians and nursery nurses on the postnatal ward to prevent unnecessary admissions onto the unit.

Neonatal managed clinical networks

Neonatal services are organised into 22 neonatal managed clinical networks across England. These networks co-ordinate the care of babies across a group of provider organisations (the neonatal units) to ensure that babies receive the care they need, as close to home as possible. The units within each network provide a range of levels of neonatal care.

Bliss welcomed the Government's response to the Future Forum in June which stated that networks are to be retained under the new NHS structures being introduced in the health service reforms. However we are concerned that their role could be undermined in the current turmoil facing the NHS.

We have particular concerns that the excellent work undertaken since 2003 to establish neonatal networks could be unintentionally reversed in the drive to cut management and administration costs and therefore reach efficiency saving targets. This is leading to network posts, including some network managers, lead nurses, data analysts and administrative posts, being removed. We now understand that the Department of Health's review into clinical networks is being delayed, meaning uncertainty over network posts is likely to continue as the NHS waits to receive the review's recommendations before making plans for next year.

Managed clinical neonatal networks have led to demonstrable improvements to babies' survival rates and care pathways. A recent study[xxv] found that since neonatal services were re-organised into networks in 2003, survival rates of babies have risen by six per cent. In addition there has been a marked increase in the proportion of women and babies being cared for in the right place at the right time, with the proportion of births at 27–28 weeks gestation taking place in the most experienced neonatal units rising from 18.5 per cent to 50.1 per cent. It is therefore essential that managed clinical neonatal networks are maintained and properly resourced, as well as given sufficient authority to hold trusts to account if they do not meet key standards.

Conclusions

In July 2009, Andrew Lansley, the Secretary of State for Health, made a speech saying: "Our commitment to the NHS is clear. We have made tough choices on public spending so that we can protect the NHS and ensure that the sick do not pay for Labour's debt crisis". Yet, as our survey shows, sick babies are paying.

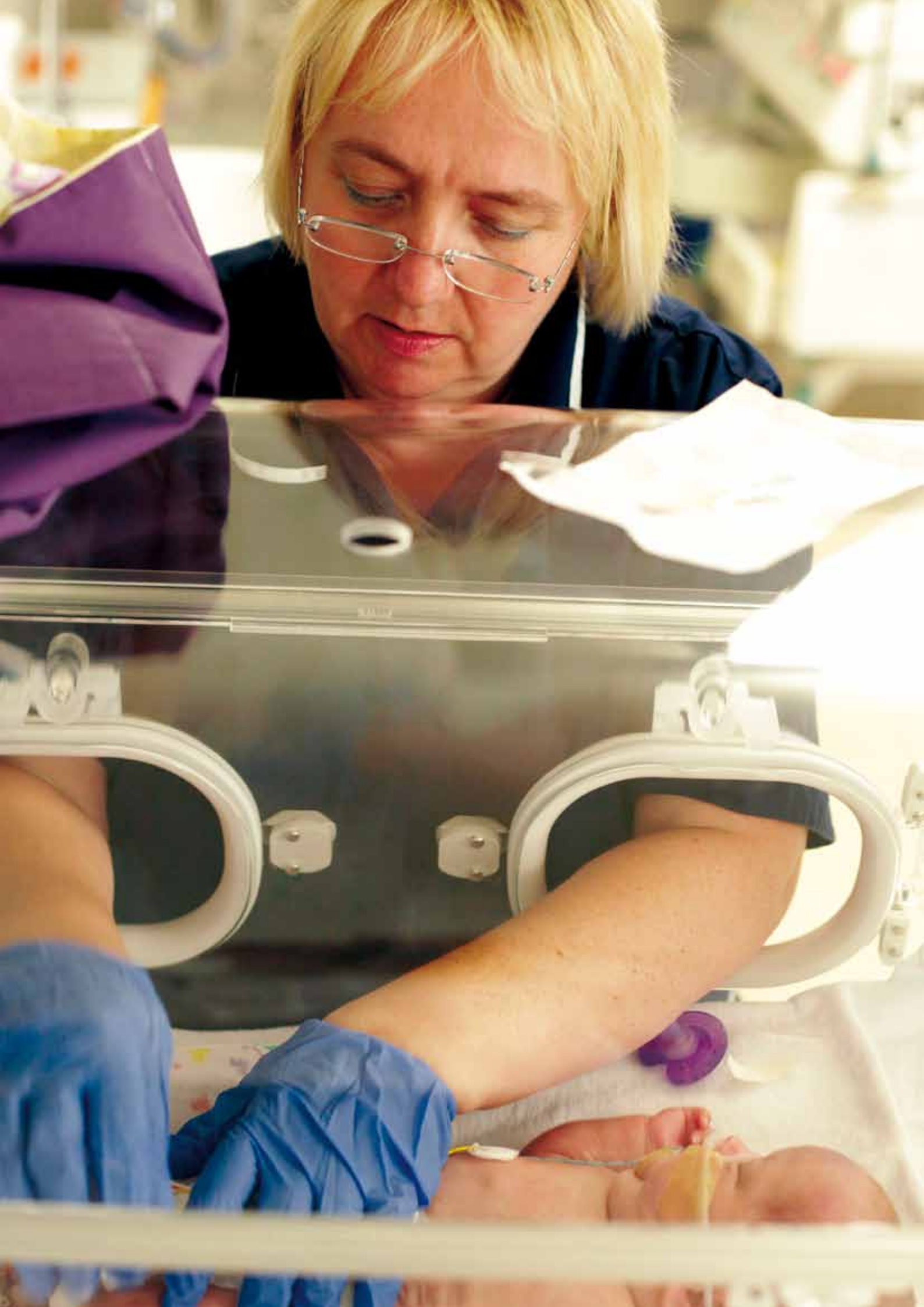
Frontline neonatal services are being cut in the drive to meet the steep efficiency targets set by the NHS and the Government. In fact many trusts just do not see the *Toolkit* or NICE *Quality standard on specialised neonatal care* as a priority and are instead making immediate and short-sighted savings rather than focussing on quality, innovation, productivity and prevention that will create efficiency savings and protect this crucial service in the long term. Commissioners are also failing to ensure that the services they fund are meeting these standards.

Neonatal care is already significantly understaffed and overstretched, putting neonatal nurses and doctors under unbearable pressure. This can no longer be acceptable. If trusts persist in cutting their nursing workforce and are not held to account by those commissioning services then babies born too soon, too small and too sick will continue to be put at risk and outcomes will worsen.

As the Secretary of State for Health himself said at the Conservative Party Conference in 2011: "We must support nurses to raise standards". Bliss is urging the Government, NHS commissioners and trusts to recognise the importance of the *Toolkit* and its evidence for improving quality care for premature and sick babies. Investment into the service is urgently required. This will then reap considerable economic savings over the medium term, as the Department of Health itself recognises[xxvi].

Recommendations

- Trusts must take immediate action to halt programmes that are cutting nurses or other crucial services outlined in the *Toolkit*. Instead they should use the *Toolkit* as a means for finding ways to make services run more efficiently.
- Trusts must invest in training and education to ensure nurses have the right skills and experience to care for such critically ill babies. Commissioners should also ensure that appropriate training programmes are funded so that units meet the *Toolkit* standards.
- NHS commissioners must ensure trusts and neonatal networks develop comprehensive plans without delay outlining how they will implement and fully meet the standards set out in the Department of Health and NHS's *Toolkit* by 2020. This should include clear short-term goals that support trusts and neonatal staff with local implementation – prioritising increasing specialist and non-specialist registered nursing posts.
- Commissioners must provide sufficient investment and incentives, such as Commissioning for Quality and Innovation (CQUIN) payments, to trusts to ensure they are able to provide a high-quality service that meets *Toolkit* standards.
- The Government must set out in its mandate to the NHS Commissioning Board and the NHS Outcomes Framework that implementing the *Toolkit* and NICE *Quality standard on specialised neonatal care* is an NHS priority. By doing so this will improve premature and sick babies' outcomes by reducing mortality and potentially avoidable life-long conditions and disabilities that may result as a consequence of inadequate staffing levels and inappropriate proportion of specialist nurses.
- The current Department of Health review into clinical networks must ensure that networks have the authority to hold trusts to account if they do not meet standards.
- An announcement should be made without delay stating that adequate funding arrangements will be provided to ensure existing neonatal networks are not unintentionally undermined in the drive to cut management and administration costs.



Methodology

In July 2011 Bliss sent a survey to all 172 hospitals with a neonatal unit in England as a Freedom of Information request. We received a response from 158 units in total. This is a response rate of 92 per cent.

We asked 16 questions about each unit's funded nursing establishment broken down by band and qualification. We then asked whether nursing posts were or are being made redundant, frozen or re-banded over the 12 months prior to 1 June 2011 or during the 12 month period after, also broken down by band and qualification. Comment questions were also asked about what impact on care the cuts to their workforce would have and whether any changes to neonatal services are being made in order to create efficiency savings and their effect on implementing the *Toolkit*.

The number of nurses needed to train up from the existing workforce for all units to meet the *Toolkit* standard for appropriate proportion of qualified in specialty nurses was worked out by the following calculation:

((number of nurses needed to train up + current QIS workforce)/current registered workforce)x100 = 70

The 'number of nurses needed to train up' is the variable that was altered until the calculation equalled 70, as this is the *Toolkit* standard. The denominator stays the same, as the 'number of nurses needed to train up' will come from the existing pool of registered workforce.

All posts in this report refer to whole time equivalent positions.

Percentages given are calculated using the total number of responses received to each specific question and are rounded up or down to the closest whole number.

Appendix

Table 1: Summary of cuts to the neonatal nursing workforce

Cuts to the neonatal nursing workforce	Past 12 months		Future 12 months		Past & Future 12 months (no duplicates†)	
	number of units	percentage	number of units	percentage	number of units	percentage
Redundancies	1	1%	1	1%	2	1%
Vacancy freezes	18	11%	5	3%	20	13%
Downgrading in post	16	10%	20	13%	29	18%
Downgrading when post becomes vacant	11	7%	11	7%	18	11%
Total (no duplicates‡)	**37**	**23%**	**32**	**20%**	**50**	**32%**

Table 2: Number of units removing or freezing posts

Cuts to the neonatal nursing workforce	Past 12 months		Future 12 months		Past & Future 12 months (no duplicates)	
	number of units	percentage	number of units	percentage	number of units	percentage
Special care baby units (41)	5	12%	2	5%	6	15%
Local neonatal units (67)	8	12%	2	5%	8	12%
Neonatal intensive care units (50)	5	10%	1	2%	6	12%
Total (158)	**18**	**11%**	**5**	**3%**	**20**	**13%**

† This column is not the sum of the other columns as some units have made cuts both over the past year and will be in the coming 12 months.

‡ This row is not the sum of the 'number of units' column as some units are cutting through a combination of redundancies, freezes and downgrading.

References

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iii A decision has been made by trusts not to refill posts that become vacant.

iv The NHS operates a nationally-agreed pay system that allocates the pay of nursing staff according to various pay bands. Re-banding is the process by which nurses' job descriptions are reassessed. Downgrading refers to the reassignment of nurses to a lower grade following this re-banding process.

v Department of Health and NHS, *Toolkit for high-quality neonatal services*, 2009

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xx Department of Health and NHS, *Toolkit for high-quality neonatal services*, 2009, p53

xxi Royal College of Nursing, *Competence, education and careers in neonatal nursing: RCN guidance*, 2011, p13

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