Medical and nurse staffing for newborn care

P M DUNN

University of Bristol Department of Child Health, Southmead Hospital, Bristol

In the July issue three distinguished neonatal nurses, P Hale, J Boxall, and M Hunt, explored the suggestion that has been made, and discussed in an Annotation,¹ that the current shortage of junior medical staff in neonatal intensive care units might be solved by the creation of a new grade of neonatal nurse practitioners with clinical skills and responsibilities. In their letter they pointed out the fact that the shortfall in neonatal nurses is just as great as that for doctors and the authors warned that the introduction of this new role was likely to create many problems in terms of training, financing, in lines of command, and so on. They urged great caution and careful study to ensure that the present unsatisfactory level of newborn care was not further compromised. I agree with them. We should first examine the reasons for the present situation and attempt to put them right.

Neonatal intensive care developed in the United Kingdom in the 1970s against a background of steadily increasing financial difficulty. In one sense the development created its own problems in that babies that had previously been stillborn or had died soon after birth were now delivered alive and survived, often after weeks or months of intensive care. In my own hospital the perinatal mortality fell between 1968 and 1985 from 46 to seven deaths per 1000 births. The Sheldon report² estimated a need for 0.5 intensive care costs per 1000 deliveries per year in 1971; by 1978 this requirement had doubled. Since that time the greatly improved prognosis of very tiny babies has increased the need to its present level of 1.5 cots per 1000 deliveries in 1987. Hopefully, now that neonatal care has reached down to the lower limits of viability (22–24 weeks' gestation) this represents the near maximum demand likely to be made for further resources.

At the time of the Sheldon report there were practically no facilities for neonatal intensive care in this country. In the ensuing years progress has been slow because of the economic climate and only very recently have the 1971 recommendations been broadly implemented. In the meantime the workload has tripled and the need for increased staffing and facilities remains as acute as ever. The impact of

an unsustainable workload and the stress it engenders has fallen particularly heavily on the nursing staff and has predictably led to a recruitment problem, thus creating a vicious circle. The situation is very serious and must be tackled at once if the service is not to founder. Care of the newborn should be very attractive to nurses. That this is not so underlies the astonishing shortsightedness of those responsible for the present state of affairs whether in government, in NHS management, or in the hierarchy of the nursing profession.

What can be done? First and foremost, every neonatal intensive care unit should have the appropriate number of intensive care cots and the minimum nursing establishment of four nurses per cot to go with them.³ Second, there should be a major expansion in neonatal training courses and the provision of funds to enable nurses to be seconded to them. Third, the talents, experience, and responsibilities carried by senior neonatal nurses should be recognised in terms of added remuneration and also in career prospects within a clinical setting. Fourth, skilled nurses should be relieved of the non-nursing duties that they often have to undertake, such as acting as ward clerks and receptionists. Fifth, each neonatal intensive care unit should examine ways of making working conditions more attractive and less onerous—for example, by improving rest facilities, rotating nurses between the unit and the transitional care nursery or postnatal wards, improving inservice training and, where appropriate, increasing the nurse's technical responsibilities in the care of the baby.

The situation regarding medical staffing is as serious as that for neonatal nursing. Although a steady expansion has taken place over the last 15 years, it has not kept pace with the growth of the service. Furthermore, for reasons of economic expediency, there has been an imbalance in the expansion favouring the creation of resident junior doctors rather than the more expensive non-resident consultant staff. Thus, in Bristol with two major maternity units catering for 11 000 births each year and providing a regional neonatal referral service, there are 12 whole time paediatric residents and just

two consultant whole time equivalents. Now manpower and training considerations require that the shape of this pyramid be changed and, indeed, be turned upside down. Any attempt, however, to reduce the number of junior residents without first greatly expanding the senior staff would have a catastrophic effect. In countries with consultant led neonatal services (including resident duties) it is usual to have roughly one consultant per 1000 deliveries per year. In the United Kingdom this would require a five to six fold increase in neonatal consultant posts. Needless to say this would be very expensive. Such an expansion, however, would at the same time go some way towards justifying the training of the present number of junior neonatal doctors. Further scope for compromise would be possible if those shaping our manpower needs came to appreciate that neonatal posts, and especially when these are combined with obstetrics in the district general hospital, provide ideal professional training for doctors seeking careers in general practice and community medicine. With most babies

returning home within two to three days of delivery a sound knowledge of the newborn is essential to the primary health team. The relatively small number of posts required to staff regional neonatal intensive care units might then be, for the most part, reserved for doctors training for careers in paediatrics, perinatal medicine, or obstetrics.

References

- ¹ Chiswick ML, Robertson NC. Doctors and nurses in neonatal intensive care: towards integration. *Arch Dis Child* 1987;**62**:653-5.
- ² Report of the expert group on special care for babies. *Reports on Public Health and Medical Subjects* 1971;127. London: HMSO. (Sheldon report.)
- ³ Midwife and Nurse Staffing and Training for Special Care and Intensive Care of the Newborn. A consultative document prepared by the Standing Joint Committee of the British Paediatric Association/Royal College of Obstetricians and Gynaecologists, 1983:1-11.

Correspondence to Professor PM Dunn, University of Bristol Department of Child Health, Southmead Hospital, Bristol BS10 5NB.