The ANNP investigated…

Róisín McKeon-Carter
Service Line Clinical Director Neonatology/Senior ANNP
Derriford Hospital, Plymouth

Florence Nightingale Leadership Scholar 2013

roisin.mckeon-carter@nhs.net

The advanced neonatal nurse practitioner (ANNP) role has evolved since its introduction in 1992 through a pilot study in Southampton[1]. Initially offered as a certification course (ENBA19), then as a bachelor's degree and now mainly as a master's level qualification, many ANNPs continue their academic education through to PhD level.

The popularity of the ANNP post increased year-on-year, exacerbated by the neonatal services review in 2003[2] and subsequent development of neonatal networks in 2004. Specialist commissioning in 2006 led to the evolution of neonatal transport teams, which increased the popularity of the ANNP, as many teams were ANNP led. Changes to the training of junior doctors in the UK resulted in senior house officers (SHOs) being replaced by foundation doctors (FY1/2) and specialist trainees. Clinical governance in hospital trusts dictated that there was much more rigor around junior doctors gaining their clinical skills, therefore ANNPs became instrumental in supporting clinical junior medical training in many hospitals[3,4].

In 2006, nurses were given independent prescribing rights if they undertook training and were registered with the Nursing and Midwifery Council (NMC) as a prescriber. Practising ANNPs then became more autonomous, in what was historically a medical role.

The European Working Time Directive (EWTD) had to be fully implemented in 2007[5]. Consequently, lead neonatologists, senior nurses and midwives were investigating strategies to ensure the service for neonates was not compromised and many centres advertised for ANNPs; however posts were difficult to fill and remained vacant.

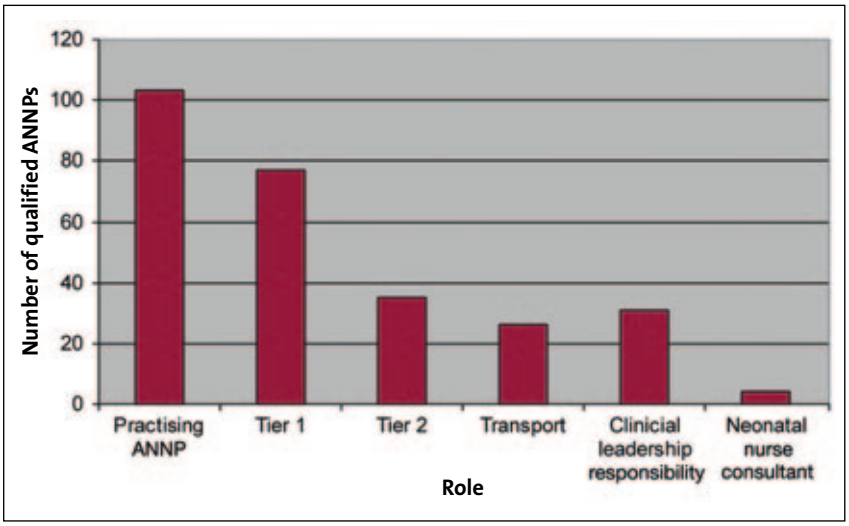

FIGURE 1 Roles of ANNPs, as revealed in the 2012 survey.

The number of both qualified and practising ANNPs throughout the UK is unknown. Several educational institutions commenced delivery of the programmes but, as yet, the NMC have not formally recognised nor recorded the qualification, despite this being planned since 2005[6]. ANNPs in the UK are working in a variety of roles with varying levels of responsibility. Many government/Department of Health documents suggest sustainability and provision of quality neonatal care is dependent on the ANNP role yet it is impossible to identify ANNP numbers accurately.

ANNP survey

In 2012, in conjunction with ANNP colleagues in Plymouth, a survey of ANNPs in the UK was instigated. Initially a covering letter and questionnaire was developed that was cascaded to ANNPs through neonatal network managers and lead network nurses in the UK. The British Association of Perinatal Medicine supported the initiative by emailing their members and the Neonatal Nurses Association published a letter in the *Journal of Neonatal Nursing* to raise awareness of the survey.

The survey addressed the working practices of ANNPs and asked if they worked on the Tier 1 neonatal rota (historically SHO), Tier 2 (registrar) rota or within transport teams (**FIGURE 1**). Of the 111 surveys returned, 103 (93%) of qualified ANNPs were still practising and many worked on hybrid rotas that included neonatal/paediatric trainees. Many also worked within neonatal transport teams as the medical lead and some had clinical leadership and managerial commitments.

Seventy-seven ANNPs (70%) worked at Tier 1 level and 35 (30%) at Tier 2. Twenty-six ANNPs (23%) took medical lead on transport, 31 (28%) had clinical leadership responsibilities and four (3.5%) were neonatal nurse consultants. The ANNPs who responded had attended 12 different universities with 68 (61%) having qualified from Southampton University.

The most salient finding from the survey was the age profile – 36% of ANNPs who completed the survey were >53 years of age and could retire soon. Fifty-six per cent were >48 years old and only 22% of the ANNPs surveyed were 40 years or younger. The conundrum for those managing neonatal care is to develop teams to support the service. ANNP training takes a long time; it is expensive for hospital Trusts, especially if travel and accommodation are necessary, and challenging in the current NHS economy. In addition, the physical nature of the role can be a challenge for ANNPs who are nearing retirement.

Ensuring longevity and momentum of advancing practice in neonatal nursing

The neonatal service anticipates that every neonate, having been safely delivered at birth, may need stabilisation and/or resuscitation. Therefore there must be effective assessment of their medical and nursing needs. All neonates, including those born requiring normal, intensive or special care, must have their first examination (the newborn and infant physical examination, NIPE) within 72 hours of birth. Hospitals must have competent staff to undertake procedures and deliver optimal care in hospital and those offering tertiary services must ensure safe and effective care when transporting. ANNPs working in a hybrid role are often sought to perform these tasks and fulfil such roles.

However, could some of these tasks – historically the remit of the junior doctor/SHO and increasingly the ANNP – be undertaken by others[7]? For example, midwives who have completed training and assessment could undertake routine NIPE screening. This model has been successfully implemented in Plymouth, where there has been a midwife-led service since June 2012. This has enabled greater availability of ANNPs and junior doctors for the neonatal medical rota in the NICU and transitional care ward.

Experienced qualified in specialty (QIS) neonatal nurses could undertake further education and competency packages to become enhanced neonatal nurse practitioners (ENNPs). The ENNP could insert intravenous cannulae; manage ventilation; act as first attendee at low risk deliveries (having undertaken newborn life support, NLS, training); and lead on some infant transfers. This strategy would facilitate a gradual increase in the skills and knowledge of neonatal nurses and allow further progression to ANNP.

To ensure longevity of the neonatal service, a 'mapping exercise' to identify national QIS, ENNP and ANNP staffing requirements would be useful. This would inform academic institutions offering the training and facilitate succession planning and commissioning of neonatal services.

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