Introducing the new neonatal Operational Delivery Network speech and language therapists

The lack of appropriate allied health professional (AHP) expertise within neonatal care has been formally recognised in recent years. This article reviews the background to the new neonatal Operational Delivery Network AHP and psychology strategic roles and how they are working to support neonatal workforce transformation plans. We explore how an expert neonatal speech and language therapist (SLT) workforce will complement the existing medical and nursing teams' expertise and review some of the challenges of current models of SLT provision.

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Key points

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1. SLTs deliver proactive, evidence-based neuroprotective care.
2. Current access to specialist neonatal SLT is extremely variable.
3. Where SLT provision does exist, some services are not clearly funded by or embedded in neonatal services resulting in inequitable service delivery.
4. AHPs and psychology lead roles are now integrated into each neonatal ODN to support workforce and education transformation plans

Background

Over the past two decades there has been increasing acknowledgement that infant outcomes following admission to a neonatal unit need to extend beyond survival and discharge.[1] Our expertise as SLTs in supporting early communication and feeding through skilled observation, assessment, collaborative management planning and education is well suited to the neonatal setting. Current understanding of the role of the SLT, and other AHPs, in neonatal settings remains limited and the AHP workforce is currently underrepresented in neonatal care.[2,3] The lack of appropriate AHP expertise within neonatal care has been formally recognised within the Neonatal Critical Care Review (NCCR, 2019)[4] and neonatal Getting it Right First Time (GIRFT, 2022) reports.[2,3]

Murphy et al (2021)[5] describe the extensive work carried out by the Royal College of Speech and Language Therapists (RCSLT) Neonatal Clinical Excellence Network (CEN) members over the past few years. The CEN is committed to developing a competent SLT neonatal workforce ensuring evidence-based intervention, providing education to achieve this, and developing outcome measures to evidence the impact of SLT interventions. SLTs work in collaboration with parents, families and with members of the neonatal team in the areas of early communication, feeding and swallowing.[5] SLTs play a core role in the delivery of proactive, evidence-based neuroprotective care, which can support families and the neonatal workforce through direct interventions and education. **TABLE 1** summarises the breadth of the neonatal SLT role.

National drivers for neonatal change

The Toolkit for High Quality Neonatal Services (2009)[9] and the British Association of Perinatal Medicine (BAPM) *Service Standards for Hospitals Providing Neonatal Care* (2010)[10] recognised the need for AHPs within the neonatal unit. In 2018, the RCSLT Neonatal CEN developed SLT whole time equivalent (WTE) staffing recommendations based on national benchmarking[11] to clearly identify the SLT workforce short fall with an aim to consider the development of business plans to increase service provision. These staffing recommendations are supported by professional competency documents to ensure SLTs reach the required standard to practise in neonatology. Similar developments have been made by our neonatal AHP and psychology colleagues.

The NCCR[4] set out to review neonatal care resulting in a specific action plan for regional commissioning teams with the neonatal ODNs to bring about a service change. These recommendations have been recently supported by the GIRFT programme (2021/2022)[2,3] and the Ockenden report (2022).[12]

As a consequence of the NCCR recommendations, each neonatal ODN

was commissioned to establish an AHP and psychology team working at a strategic level to contribute to neonatal service development and workforce transformation plans. The aim is to ensure a holistic, equitable and cohesive approach to the delivery of neonatal care for infants, families and the neonatal workforce (**FIGURE 1**).

Neonatal ODN AHP roles in England

Neonatal ODN AHP roles have been in place in the West Midlands since 2009. These AHP roles consisted of a respiratory physiotherapist, a dietitian and an SLT. The Southern West Midlands Newborn Network (SWMNN) employed ODN AHPs with the aim to fulfil the recommendations of the Neonatal Toolkit[9] and the BAPM Service Standards.[10] This established team has provided an example of the implementation of these new AHP and psychology roles.

Each neonatal ODN in England now has AHP and psychology teams established, consisting of dietetics, occupational therapy, physiotherapy, SLT and psychology. There are 12 SLTs in post within the ODNs across England, all of whom also continue to carry neonatal clinical specialist roles and are active members of the RCSLT Neonatal CEN. These SLTs are working alongside their neonatal ODN clinical and strategic leads, other neonatal ODN AHPs and psychologists, and local neonatal AHPs to scope and support the neonatal workforce, quality, and education workstreams, highlighting the value of increased AHP and psychology services in neonatal care.

Models of SLT service delivery to neonatal care

Access to specialist neonatal SLT is extremely variable. Access to therapists can be limited and with differing levels of experience. Where SLT provision does exist, some of these services are not clearly funded by or embedded in neonatal services resulting in inequitable service delivery within and between neonatal ODNs. ODN SLTs are currently mapping the myriad of different sources of funding, models of service provision, SLT competency and skill mix. For example, in-reach services from community providers versus funded embedded services that currently exist nationally. Early involvement of SLT embedded in the care for our neonatal infants and families enables individualised and family-centred care, supports therapeutic interventions and improves longer-term outcomes. **TABLE 2** compares some of the risks versus benefits related to service delivery models.

SLT roles in neonatal care	Examples of areas of specific expertise and training
Collaboration with families, medical, nursing, AHP and psychology teams to support and improve communication and feeding outcomes within FiCare and developmental care frameworks[6-8]	• Supporting parents' interaction, responsiveness and involvement in their infant's neonatal care • Early communication development • Early feeding development • Responsive breastfeeding • Responsive bottle feeding • Weaning from the tube to responsive suck feeding • Neonatal MDT and parent education and training
Direct assessment and management of feeding and swallowing difficulties	• Observing feeding alertness/readiness, quality/success of feeding and therapeutic interventions • Close collaboration with medical, surgical and other AHPs to ensure joined up goals and management plans • Work may be supporting either a universal level of staff and parental education and skill, ensuring a quality baseline of evidence-based care or more targeted, specialist interventions for cohorts of infants • Management of persistent feeding difficulties and/or dysphagia to improve longer term outcomes
Support of parents and infants with their transition to home, collaboratively with the neonatal MDT, neonatal community outreach teams and community healthcare teams	• Providing education on the specific areas of communication and feeding development associated with prematurity/neonatal health conditions to help guide parents after discharge • Collaborative working with the neonatal MDT to counsel parents around taking their infant home using alternative supplemental feeding methods if needed • Post-discharge developmental support bringing the unique SLT 'lens' of the impact of prematurity and/or health challenges on brain development, communication, feeding and weaning • Providing support to the MDT management of ongoing feeding issues, including weaning and sensory-based feeding issues
Use of outcome measures to demonstrate effective patient care and improve quality of care	• A tool is currently in development and being trialled by RCSLT Neonatal CEN that considers domains of neonatal SLT input and outcomes

TABLE 1 Summary and examples of the range of SLT roles and skills relating to neonatal care. Key: MDT=multidisciplinary team; FiCare=family-integrated care.

"AHPs have been central to the implementation and embedding of developmentally sensitive care into neonatal practice in many neonatal units and champion the need to view neonatal care that looks forward to improving longer term outcomes for babies and their families" (NCCR, 2019)

FIGURE 1 The 2019 NCCR report[4] recognised the valuable role that SLTs play in neonatal care.

Conclusions

Recent reports into service provision and staffing in neonatal care have emphasised the value of AHPs and psychologists. This has led to more SLTs in neonatal care and for the first time SLTs in strategic neonatal ODN roles, enabling them to begin to highlight the SLT role, address service inequalities and consider staffing provision.

It is important that SLTs, together with neonatal medical, nursing, AHP and psychology colleagues, continue to raise

their profile at a national and local strategic level to influence change and demonstrate the skills and expertise brought to the neonatal workforce and the benefits in improving infant and family outcomes throughout their neonatal care journey. Key relationships built between neonatal ODN SLTs and local SLTs within neonatal units will further support specific workstreams and service developments while continuing to develop a robust and resilient workforce for the future.

SLTs working in neonatal care can access resources from the RCSLT Neonatal CEN[5] and local and national neonatal ODN teams. These include the recent Health Education for England (HEE) e-learning for healthcare (e-lfh) foundation modules, including *Introduction to Allied Health Professionals in Neonatal Care* and a further two profession-specific modules focused on the role of the SLT within neonatal care and development of clinical skills and knowledge.[13]

The AHP and psychology neonatal ODN roles are not only a resource for unit neonatal AHPs and psychologists, but are also an excellent resource for the wider neonatal MDT including medical and nursing teams. We recommend multi-disciplinary engagement across neonatal teams with the neonatal ODN AHP and psychology teams. Information on local neonatal ODN AHP and psychology teams and available supporting resources are available on each neonatal ODN website.

If you are an SLT working within a neonatal unit we would encourage you to reach out and contact your ODN SLT to access support, education and share best practice within your network.

Funded SLT provision embedded in neonatal care	In-reach SLT provision
Dedicated and ring-fenced neonatal time to establish and maintain a responsive and proactive service	Ad hoc service delivery unfunded and based on goodwill taken from other clinical areas of SLT provision. Lack of responsiveness of service due to multiple service demands
Enabling timely intervention that protects development and prevents problems occurring	'Last resort' referral culture leading to a reactive service and potentially avoidable feeding difficulties, prolonged tube feeding and delayed discharge
Recognition of the holistic needs of the neonate as a complex and neuro-developmentally immature and at-risk infant with consideration for communication, feeding and brain development	Reactive referral service for dysphagia/swallowing only assessment referrals, missing SLT role and expertise in early communication and supporting feeding development
Integration into and understanding of neonatal unit practice, structure and ethos enables implementation of effective SLT care recommendations	SLT role not well understood, utilised or valued
SLT is part of the neonatal MDT with opportunities to build effective working relationships, trust and credibility with other staff	Opportunities for more SLTs to have some limited experience/exposure to neonatal units however lack of opportunity to develop expertise
Accessible training for SLT while on the unit at ward rounds and meetings Able to provide training for MDT and parents Dedicated time for follow-up post-discharge from the neonatal unit as part of wider AHP team	Difficulty accessing neonatal training and supervision for competency development Limited opportunity or capacity to be part of integrated training programmes within the unit No neurodevelopmental follow up by SLT

TABLE 2 The risks versus benefits of the two different service delivery models.

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