# nhe

# Prioritising staff wellbeing

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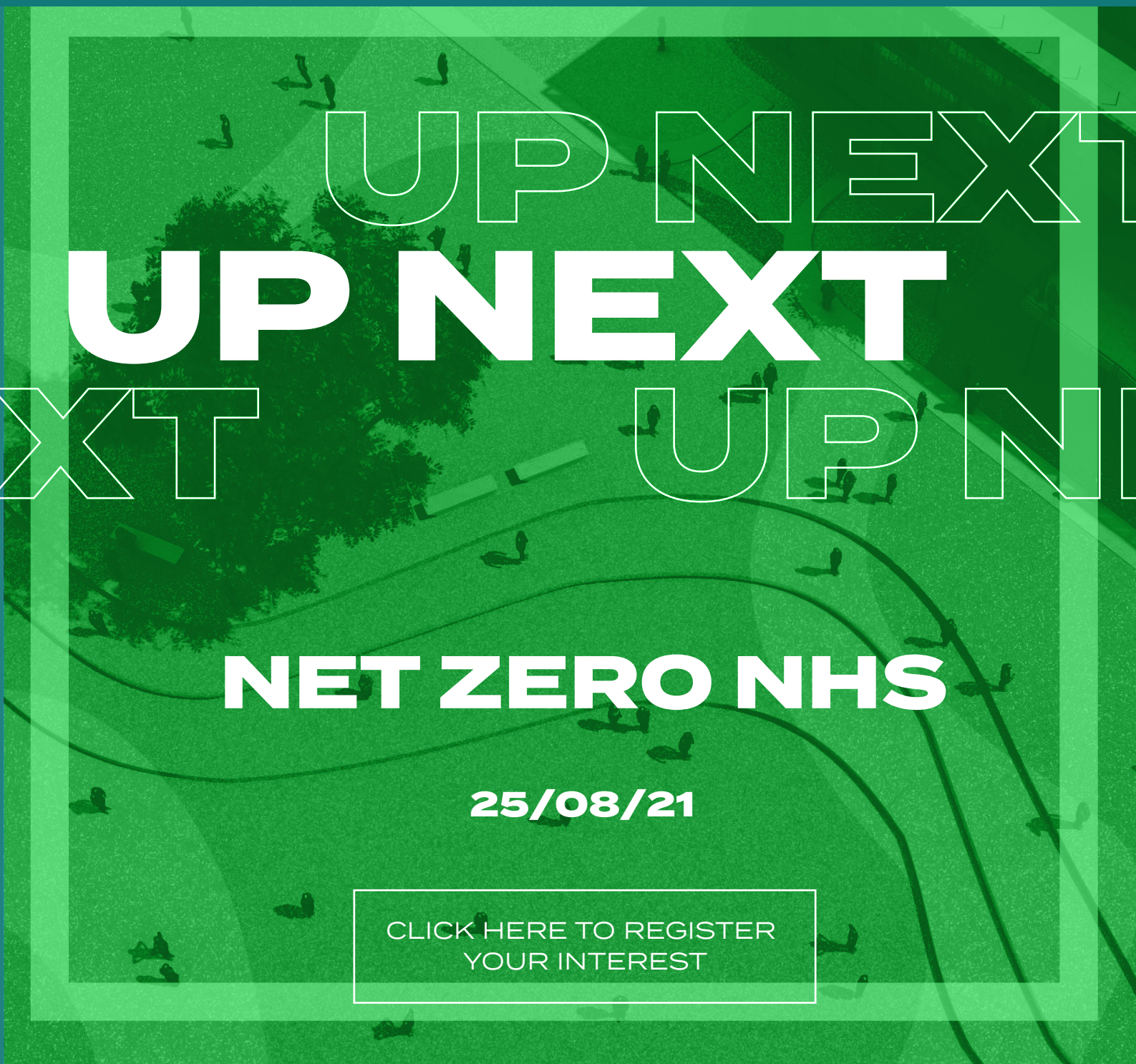

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# Supporting continued success

After nearly 18 months of disruption and immense challenges, we appear as a society in the UK to be heading out of the pandemic with some of the final restrictions set to be lifted over the coming weeks. However, as some aspects of normal life return, our health service is by no means back into the clear.

Patient safety must still remain paramount, while a growing treatment backlog needs to still be tackled - with significant work already underway to overcome these delays. Within this edition, we preview a new report the team at National Health Executive have conducted with industry partners on this patient capacity backlog (page 16).

Elsewhere, we have a focus on Infection Prevention (page 21) which sees us discuss some of the successes and necessary future steps to maintain our highest standards of care and safety throughout our hospitals.

And all of this work would not be achievable without our incredible staff, who have gone above and beyond through this past year and a half, and may need to continue to do so in addressing that backlog.

Our Workforce feature (page 47) discusses some of the different innovative ways we can support them, while protecting staff's mental wellbeing is equally key. In our Mental Health focus, NHE's Jasmine Jackson delves into the mental health impact on those working in our ambulance service (page 33).

Read these and much more in this July/August 2021 edition of the NHE magazine...

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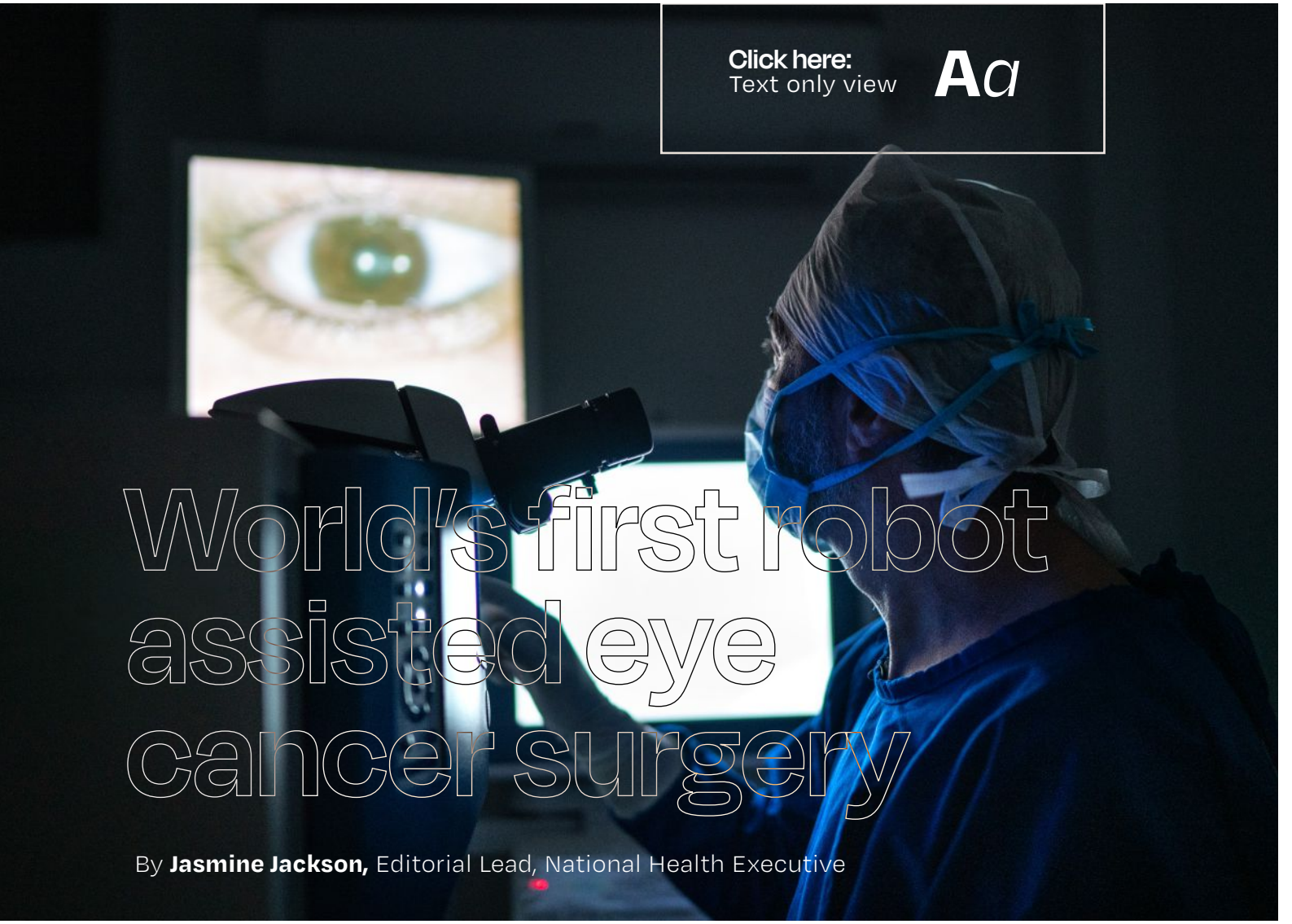

# World's first robot assisted eye cancer surgery

By **Jasmine Jackson,** Editorial Lead, National Health Executive

The world's first robot assisted eye cancer surgery, was carried out by surgeons at Moorfields Eye Hospital NHS Foundation Trust, and Guy's and St Thomas' NHS Foundation Trust in March.

Guy's and St Thomas' decided to become a centre of excellence for robotics, and is the largest robotic centres in the UK, with four robots already at the trust. Having had more than 15 years of experience in urology initially, it has expanded its use into thoracic, head & neck, gynaecology, transplant and lower GI surgery. Consultant Head and Neck Surgeon, and Associate Professor of surgery at Guy's and St Thomas', Jean-Pierre Jeannon, said the trust's management has been hugely supportive of innovative robotic surgery, including robotic orbital surgery.

The potential patient benefits of robotic surgery are huge, in terms of being able to reduce the length of stay in hospitals, faster recovery and more conservation of normal tissue.

Mr Jeannon's patient, 85-year-old Irene Milton, was the first to receive this treatment, which managed to save her eye and eyesight. The grandmother-of-seven had a recurrent basal cell carcinoma on the inner corner of her right eye, and was previously advised that her eye would have to be removed to treat the cancer.

Tumours on the eye are rare, and this type of cancer is known to destroy the skin and soft tissues, growing slowly.


## KUGA PLUG-IN HYBRID

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Model shown is an All-New Kuga ST-Line 2.5 PHEV Auto with optional Lucid Red Exclusive Body Colour Paint. Weighted fuel economy mpg (l/100km) (Combined): 201.8 (1.4). Weighted combined electricity consumption: 26.88 kWh/100miles. Weighted $CO_2$ emissions: 32g/km. Equivalent all-electric range: 35 miles.

These figures were obtained using a combination of battery power and fuel. The Kuga Plug-in Hybrid is a plug-in hybrid vehicle requiring mains electricity for charging. Figures shown are for comparability purposes. Only compare fuel consumption, $CO_2$ and electric range figures with other cars tested to the same technical procedures. These figures may not reflect real life driving results, which will depend upon a number of factors including, accessories fitted, variations in weather, driving styles and vehicle load.

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The two-hour operation now means Ms Milton doesn't have to go through radiotherapy treatment. Without this type of technological advancement, she would have had to undergo six months of radiotherapy, resulting in blindness.

Mr Jeannon commented: "It's the first time in the world that the robot has been used in this way for orbital surgery, and we hope we can treat more patients in the same way. The success of this procedure is testament to the collaboration between our team and our colleagues at Moorfields."

There can of course still be a risk of accidental damage to the eye and surrounding tissues for Robotic Assisted Orbital Surgery (RAOS), but Mr Jeannon explained that surgeons are trained to manage risk, and balance it against the benefits for patients.

The main benefits of robotic surgery are that the robotic arms provide tremor free, scaled down movement and enhanced optics, thereby reducing a surgeon's hand movement to a ratio of 3:1. This enhances precision and allows a surgeon to work in a very small and tight space, carrying out procedures in a minimally invasive way.

The 3D HD visual optics also increase the surgeon's view of the operative field. Robot systems are able to be fitted into existing operating theatres, and once installed and the relevant teams are trained, they are easy to run.

Guy's and St Thomas' currently carry out around 1,100 robotic procedures per year, making it the most in the UK. With their recent addition of a new surgical robot, they will be able to increase the number of procedures by more than 300. The trust typically uses robotic surgery for prostate, bladder and kidney tumour removal.

Mr Jeannon spoke of what to expect moving forward: "We expect to see a significant expansion of the use of robotics in all fields of surgery. Currently in the UK urology, thoracic, head and neck and gynaecology are the leading specialities involved in robotics. This is because robotic surgery is a development technology from endoscopic and laproscopic surgery (minimal access surgery). "

Claire Daniel, Consultant Oculoplastic Surgeon and Lid Oncology Lead, at Moorfields, said: "Irene has done really well after her surgery and it's very exciting to be able to provide such a great service for our patients affected by cancer. This is truly a world-leading advance in orbital surgery, which we will build on in the future.

"We have developed a highly specialised periocular cancer unit thanks to our excellent collaboration with Guy's and St Thomas', enabling us to share our expertise in treating these very difficult cases."

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# The journey to Veteran Aware status

**Sophie Ayre**, Partnership and Inclusion Development Worker, Gloucestershire Health and Care NHS Foundation Trust

Gloucestershire Health and Care NHS Foundation Trust (GHC) is delighted to have achieved Veteran Aware status this May, in recognition of our commitment to driving improvements in NHS care for veterans, reservists, members of the armed forces, and their families.

We officially received our accreditation in June's Armed Forces Week, during a brief ceremony and visit from Colonel Andy Hodson, who presented the accreditation on behalf of the Veterans Covenant Healthcare Alliance (VCHA).


This is a significant accolade that demonstrates our intent and commitment to the best possible care for veterans. Veterans make up a significant part of the local population and it is important we consider their specific needs.

As well as this accreditation, we were granted a Bronze Award in the Defence Employer Recognition Scheme (ERS) in March this year. We are looking to progress this to a higher level, to show our ongoing support by ensuring we have enough pathways into employment, support deployment and training for our reservists.

Over the last four years our trust has focused on four key areas of development, so that we can provide a service that is understanding, responsive and well-educated in the needs of serving military personnel, veterans and their families. This aligned closely with many of the things that the VCHA look for in Veteran Aware Trusts.


The first key area for us was bringing together organisations who support veterans within our county on a regular basis, so that knowledge and understanding can be shared with ourselves, local councils, and voluntary and community sector groups.

Our second focus was to educate our workforce on the need for veterans, and understand their experiences with NHS services. This has included organising network meetings, recruiting staff to be veteran champions in their localities, and making educational videos inviting veterans to share their story.

The third was to identify veterans using our services, so we can be responsive and ensure support is provided. This has been achieved via our initial assessment process. And the fourth was to work with other areas of the NHS, such as our acute colleagues and regional specialist services like Op Courage, to promote the fact that all aspects of the NHS are veteran aware.

The opportunity to work on these areas has been a great honour and has provided us with a foundation for further developments. It is very clear that serving personnel and veterans have had unique experiences and training.

It is vital for NHS staff to appreciate this, and have the ability to adapt and provide understanding and care that is meaningful. It is fundamental that NHS staff are skilled in supporting veterans and have the ability to recognise and understand these needs. Chief Executive, Paul Roberts at GHC, said: " We strive to provide the best possible care for veterans and their families. We actively encourage all patients and colleagues to let us know if they currently serve, or have ever served in the UK armed forces, so that we can best support their needs.

"At times this year, the NHS has felt like the frontline, and this has given us a real and deep appreciation of the contribution our veterans have made to our society and communities over many decades."

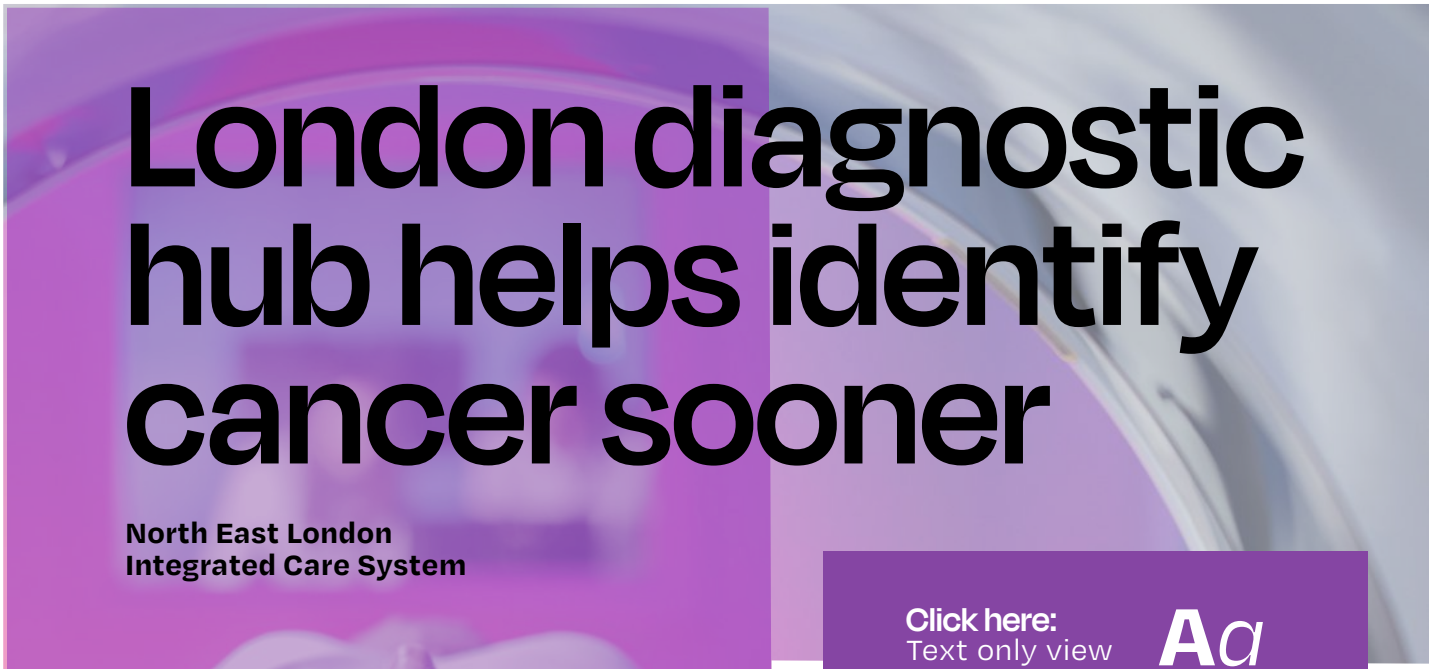
One of the things that will help us keep progressing and improving, is meaningful involvement from experts by experience, in shaping and developing what we do.

These are people who have personal knowledge of our services in Gloucestershire - either through their own use of those services, or through caring for someone who has.

We have a number of serving personnel, veterans and people from forces families involved in a range of ways; whether that is sitting on recruitment panels, being part of project groups, or making training videos for staff.

As well as the expertise they bring, their insight helps us to see things through their eyes.

# London diagnostic hub helps identify cancer sooner



**North East London Integrated Care System**

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People in north east London at risk of developing cancer can now benefit from a ground-breaking NHS service dedicated to spotting the disease early. Located at Mile End Hospital NHS Trust, the Early Diagnosis Centre (EDC) is a joint initiative with Barts Health (BH), Barking, Havering and Redbridge University Trust (BHRU), and Homerton University Hospital FT, and is one of the first of its kind in the country.

Patients living with conditions that could increase their risk of cancer, such as gastric ulcers and inflammatory bowel disease, are being invited to attend regular screenings, to help detect the disease sooner and boost survival rates. The EDC will also closely monitor patients with early-stage cancer who don't need treatment right away.

Specialist cancer clinicians will staff the centre, which will be equipped with two endoscopy suites, two ultrasound rooms and a CT scanner. An MRI suite is also planned for 2022.

It is expected to carry out around 16,500 additional procedures annually on patients from seven London boroughs – Barking and Dagenham, Hackney, Havering, Newham, Redbridge, Tower Hamlets, Waltham Forest – as well as the city of London.

The centre is open from 8am to 6pm, Monday to Friday, freeing up diagnostic capacity at local hospitals for those unable to travel to Mile End. It also offers patients greater choice when booking their appointments, following referral by their GP.

Angela Wong, Consultant Gastroenterologist at BH, and Clinical Lead for the service, said: "The Mile End Early Diagnosis Centre has been specifically designed to undertake scans, tests and surveillance safely and efficiently under one roof, completely separate to A&E and urgent care services.

"More people are being diagnosed with cancer following a visit to A&E, and many of these cancers are at a later stage, reducing the chance of survival. Our aim is to reduce variation in how cancers are diagnosed across north east London and ultimately speed up the path to treatment, potentially saving thousands of lives every year."

Key to making the project a success was involving patients at every step of our journey to help make sure the services met patient requirements.

Noel Judge, a patient representative, said: "This new, modern facility is a big step forward for cancer patients in north east London. By bringing together diagnostic services in one place, it will be quicker and easier to get an appointment, helping us to spot and treat this deadly disease before it has the chance to spread.

"I'm proud to have been involved in this project and would continue to urge patients worried about cancer symptoms to seek help from the NHS as soon as possible."

In order to keep everyone safe during the Covid-19 pandemic, we have introduced a number of checks, including testing patients prior to their appointments and temperature checks on arrival.

Speaking about its success, Sas Banerjee, Colorectal Surgeon and Endoscopy Lead at BHRU, and the Endoscopy Clinical Director for NHSE/I London, added: "The EDC is a great example of colleagues coming together across north east London as an integrated care system. The centre is all about early diagnosis, collaboration and research.

"As we focus on improving early diagnosis and reducing waiting lists, I'm delighted that we can invite those living with conditions that increase their risk of cancer, to attend regular screenings. The EDC is one of the first of its kind in the country and I'm proud that we are part of it."

We are already receiving positive feedback from patients. One of the first patients to use the facilities, 84-year-old Ann visited the EDC for a colonoscopy, and shared her experience: "The facilities were great and it felt very luxurious. It was spotlessly clean, felt very relaxed and I even had my own room. The staff were also brilliant. They fell over backwards just to make sure I was okay".

# How the National Autistic Society developed Saint Helena's autism support service

The National Autistic Society

Aa

The National Autistic Society specialises in working with healthcare providers, with experience across the UK and internationally. We helped to develop a sustainable support service for autistic people in Saint Helena, one of the remotest inhabited islands on the planet.

Saint Helena is an island of 47 square miles located in the South Atlantic Ocean, with a population of roughly 4,500. The Education and Safeguarding Directorates on Saint Helena contacted the National Autistic Society in 2018 requesting support to develop daytime provision for children and young adults with complex needs, including autism.

Our specialists supported social care and education staff on Saint Helena to develop a needs-led service for autistic children and adults, taking account of local culture, environment and staffing limitations. The staff on the island are working towards a clear process and structure for lifelong planning and transitions from childhood to adulthood, and services are now equipped to meet the needs of autistic people.

Social care and education staff have been trained to deliver our Essential Autism training course to others on the island. This ensures an ongoing legacy of learning and improved practice as more staff achieve an understanding of autism and supportive strategies.

Whether you're a remote island or a big city, our consultancy services could help your organisation to develop, maintain and continually improve your existing autism provision.

Click here to find out more

# Building a City of Research in Bradford

**Dr Tracy Watson**, Director of Research Operations, and **Professor John Wright**, Director of Research, Bradford Teaching Hospitals NHS Foundation Trust

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**WHY A CITY OF RESEARCH?** Bradford is the fifth biggest city in the UK with a population of over half a million, including some of the most deprived areas and worst health profiles. Healthy life expectancy is significantly lower than the rest of the UK and the city has some of the highest rates of childhood obesity, diabetes and heart disease in the UK.

If health and social care research aspires to make a difference, then a city like Bradford is a good place to investigate new approaches to tackling ill-health, poor educational attainment and increasing inequalities.

**STRONG RESEARCH FOUNDATIONS** In contrast to the high levels of ill-health, medical research was virtually absent in Bradford. To address this inverse research law, the Bradford Institute for Health Research (BIHR) was established at Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) in 2007, in partnership with primary and secondary care NHS trusts in Bradford and Airedale, and its local universities. Since then, a number of unique academic, practice and community strengths have coalesced, *(see box on the next page).*

Research is not about glass temples to science, but about people. Over the last 14 years, over 50,000 citizens have become actively involved in clinical and health research in Bradford – probably the highest levels of research engagement of any city in the world.

**THE LANDSCAPE IS CHANGING – THE NEED FOR NEW RESEARCH ARCHITECTURE** The pandemic has heightened people's interest in science and research. When we ran vaccine trials in Bradford we were overwhelmed by support, with nearly 4,000 people volunteered and signed up to our local vaccine registry. The Covid-19 pandemic has also highlighted the importance of science and research in leading policy and practice.

Building on the local population's altruism, increased recognition of the importance of research, and also the formal implementation of Integrated Care Systems, we felt it was important to formalise our synergistic research working, and create the 'City of Research' concept.

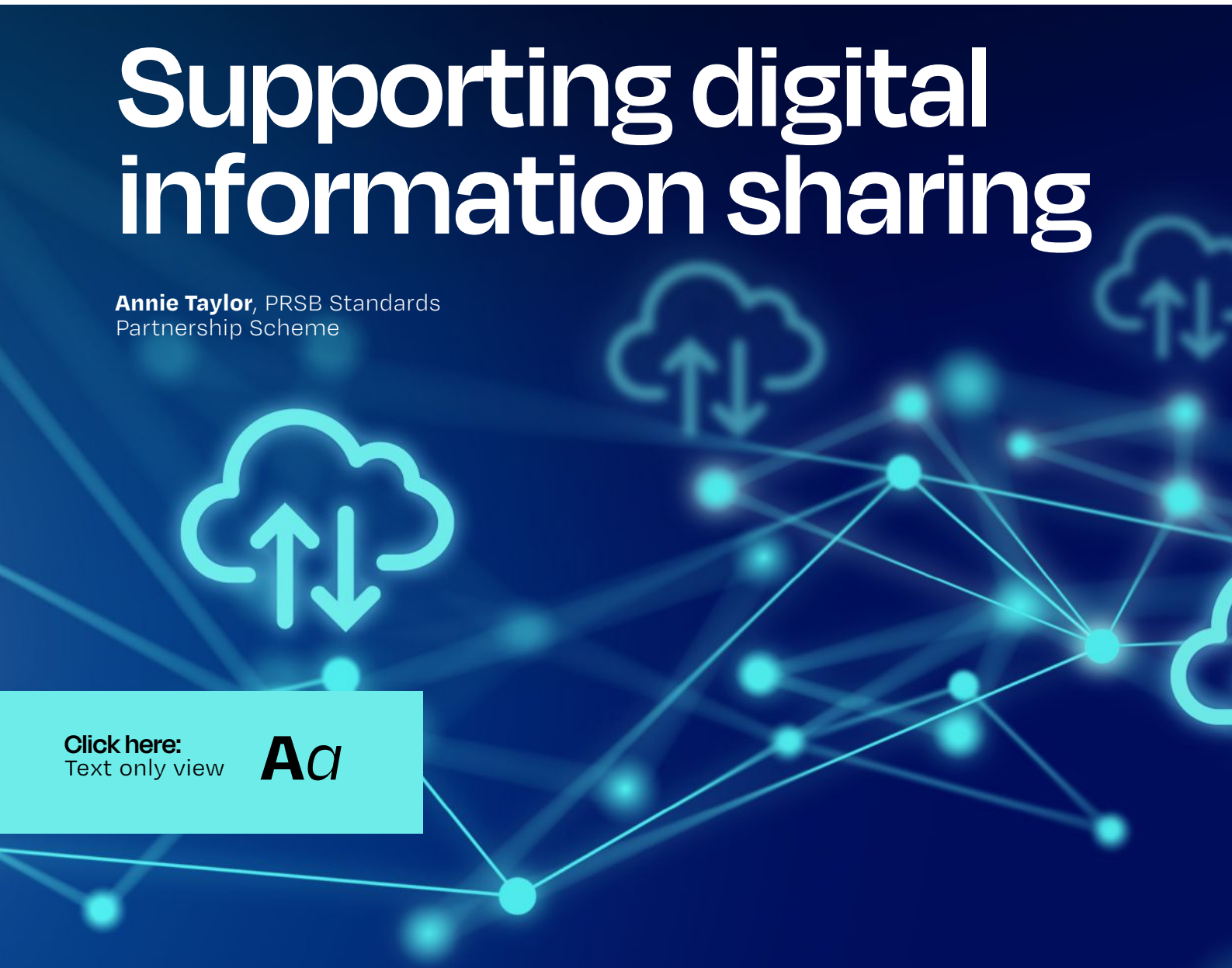
- An international reputation in applied research with a particular focus on child health, older people and quality and safety of health care, involving the Wolfson Centre for Applied Health Research, and the NIHR Applied Research Collaboration Yorkshire and Humber.
- A strong track record in clinical research with the ability to recruit patients quickly (global and national firsts) and deliver recruitment targets. BTHFT hosts one of five NIHR National Patient Recruitment Centres.
- World class community research cohorts - The global-first experimental birth cohort study Born in Bradford's Better Start, and the CARE 75+ frail elderly cohort, are leading the world in community engagement in research and translation of research into policy and practice.
- One of the leading improvement agencies, the Yorkshire and Humber Improvement Academy, and one of the top patient safety teams the Yorkshire Quality and Safety Research Group.
- Whole system research - Bradford has an excellent track record of collaboration across health and education sectors and close co-production with patients and communities. In 2019 it was awarded a UK Prevention Research Consortium to establish an ActEarly 'City Collaboratory' to tackle the wider determinants of health.
- Connected data - Bradford also hosts the Connected Yorkshire programme that is working to enable safe and secure sharing and analysis of data to redesign pathways of care.

The formal launch of the City of Research campaign took place in May to mark International Clinical Trials Day, and the City of Research Registry website launched. This is an 'umbrella' website initially for all our NHS organisations' research activity, and is a digital doorway into all the opportunities and studies that the district's home-grown research talent is leading, and encourages our population to register their interest in taking part in this.

**THE FUTURE CITYSCAPE** The pandemic has shown how policy and practice should be led by science and research. We have a second, silent pandemic of non-communicable disease in the UK. Our City of Research aims to work together across our communities, the wider NHS, local authorities, and the education sector, to embed research and innovation into everything we do, and promote research activity. In our people-powered, data-driven 'City Collaboratory', we aspire to have a research ethos where our population is at the heart of prioritising and producing research, as well as having the opportunity to take part – and want to take part- in research for the benefit of Bradford and District and its future generations.

# Supporting digital information sharing

**Annie Taylor**, PRSB Standards Partnership Scheme



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Professionals working for NHS and social care in the UK are striving towards the delivery of more integrated care. To offer joined-up support for patients, up-to-date information needs to be available to professionals through the computer software system they are using at any point of care. While people continue to use a wider range of services and support than ever before, standardised records are essential for ensuring that information can be securely saved and shared between those who need access.

The Professional Record Standards Body (PRSB), the organisation responsible for developing these standards, is now expanding its Standards Partnership Scheme to support the implementation and adoption of their standards. The scheme, which was initially launched in February this year as a pilot, is now an important part of PRSB's work and is helping digital software providers to implement information standards into their software. This change will ensure health and care professionals can access the right information about an individual in the right place, at the right time, helping them deliver the integrated care that is needed.

The scheme, now fully off the ground, has attracted leading health and care software providers. The goal of the Quality Partner Scheme is to develop collaborative working relationships with partners which will impact standards development and priorities for the future. Among other benefits to partners, they have access to an extensive programme of workshops and learning opportunities. Following the first of these events, feedback has been extremely positive and the PRSB will be listening to partners to shape future work and activities.

**TYPES OF QUALITY PARTNER** Software providers can join the scheme as Partners, where they have access to help and support for implementing standards or they can join as a Quality Partner, where the PRSB assess their software conformance to one or more of the standards.

Speaking about joining the scheme as a partner, Managing Director of RIVIAM, Paul Targett, says: "By ensuring RIVIAM's care coordination and collaboration services conform to PRSB's nationally agreed information standards, we have a robust and solid foundation on which our services can be configured to meet our customer's individual needs."

Nourish Care has become the scheme's first Quality Partner, after achieving conformance following assessment for the digital care and support plan standard. This standard is designed to help people with long-term and complex conditions, including mental health conditions, to receive more personalised support, by ensuring information is available to all those involved in their care.

The standard includes an About Me section, where individuals share crucial, personal information they want their care providers to know about them, such as how they wish to be communicated with in a crisis, or what personal items they need to bring to hospital in an emergency. Its implementation into systems will help professionals support a person's overall wellbeing and encourage them to get involved in their own health and care.

**GETTING INVOLVED** The PRSB currently develops all its standards with professionals, patients, carers and vendors. As the Partner Scheme continues to develop, it will offer more opportunities for vendors to be involved in building the standards, as well as feeding back on gaps or areas of future interest. In the coming months, the PRSB aims to expand its Quality Partner Scheme, encouraging more software providers to join and learn with our team of experts and others we work with.

By creating a platform to share ideas, experiences and best practice, we can break down the siloed ways of working that often exist within health and care, working together towards the goal of fully integrated services. This will not only help vendors to succeed with their clients, but it will also support a future of better connected and more personalised and health and care for people and their families.

Click here to visit the website

Click here to email

# Overcoming elective capacity backlog

**Matt Roberts**, Editor, National Health Executive
**Dr Jean Challiner**, Medical Director, Medinet

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Our healthcare services are facing a significant and mounting patient treatment backlog, which is likely to extend over the coming months and years. It is going to require administrative, policy and service delivery changes to overcome. But what are some of the specific challenges faced and the solutions which can help us overcome them?

At National Health Executive, our team has worked with industry partners to better understand how the elective capacity backlog is affecting our health sector workforce, and some of the innovative approaches both being put in place - and suggested - as potential solutions.

As Dr Jean Challiner, Medical Director at Medinet, explains: "There's a big task ahead, but maybe a different task too."

We have a duty to build back service capacity and resiliency after the pandemic, but that doesn't necessary mean needing to return to the existing status quo. There are opportunities to redesign the way services are delivered which, due to the magnitude or type of change required, simply haven't been possible up until now without extreme disruption.

**"There's a big task ahead, but maybe a different task too."**

However, faced with this disruption already, the shackles are off the health service in terms of dramatic, transformational change. It is just now important that any alterations introduced are considered, practical and sustainable.

That requires conversations, differing viewpoints and inputs, and open, honest conversations. Alongside our own NHE reflection and that of Dr Challiner, we speak with Adam Brimelow, Director of Communications at NHS Providers, and Tim Mitchell, Vice President of the Royal College of Surgeons.

Offering rich and vastly different experiences, each offers their own inputs as to how we can reimagine the new-look health service post-pandemic.

For Tim, with his surgical considerations, this includes creating dedicated spaces to reduce the amount of postponement to routine surgical procedures that we've so often seen in the NHS, both during Covid-19 and typical winter pressures.

He explains: ""One of the College's main focuses has been around the concept of having sites that are dedicated from surgery which can be kept free - in the context of the pandemic - from people with Covid.

"But, as we move out of the pandemic, we should also look to keep these free from people with other medical issues.

"Having facilities that are ring-fenced for elective surgery is one way of protecting that activity, so you don't find that during the winter months, you've got a huge influx of people with medical conditions needing to be in hospital beds, [where] we use elective surgical beds."

There are many ideas and a steely determination to overcome this treatment backlog, but it will take time and innovative thinking. From the clutches of adversity, the health sector has been presented with an opportunity - now, it is important that the chance is not allowed to pass.

The full NHE report on elective capacity backlog can be downloaded by clicking below.

## Download the full whitepaper report:


## How do we overcome elective capacity backlog?

Click here:
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# Angels and Demons

*[Editorial Board Member]*
**Glenn Smith**, Advanced Nurse Practitioner,
St Helen's Medical Centre

Very few people can deny that the pandemic has exposed how frail the relationship is between the public and those who work in health and social care. The NHS has swung from angelic to demonised in weeks as several waves of Covid lockdown has fundamentally changed in the way health and social care operate, with the prospect of full recovery being measured in years. Sadly, in too many cases the need to protect the public has been misunderstood as a desire to keep the public at bay. Those in care are not immune to these misunderstandings either, setting the public and those who care on the frontline line on collision course.

At the start of the pandemic, fear gripped the public. Super spreader was the term many used to describe health and social care workers, and this led to keeping professionals at arms' length. People who laboured under the misapprehension that healthcare professionals were the source of spreading infection deprived themselves of essential healthcare through fear. The very precautions that sought to protect, in some cases, conspired to heighten risk.

# Protect the Nurse
# Protect the Practice

## 6 Ways to Help Keep Nurses Safe

**No one becomes a nurse because they think it will be easy.** But they'd never expect to feel alone and unsafe. Discover tangible solutions in the latest CNO Perspective report from Rhonda Collins, DNP, RN, FAAN.


# DOWNLOAD at:
**vocera.com/int/2021-cno-report**

vocera

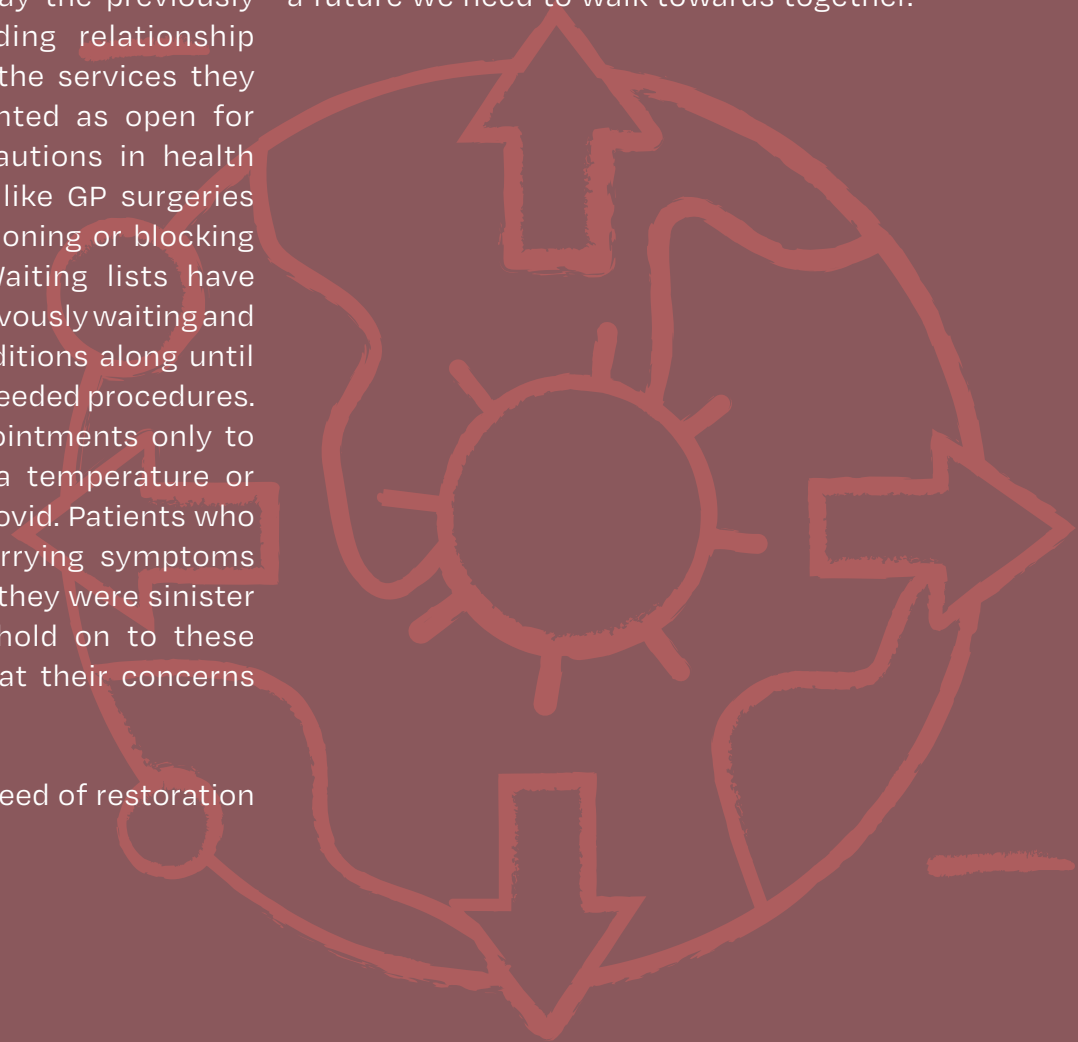
The pendulum swung the opposite way with Clap for Carers; the ubiquitous 8pm call which made people feel that they were really showing appreciation for essential frontline workers. Shops, when they were able to open, threw discounts at frontline staff and gave gifts of food and other items to show how they were valued, and many understood with what personal sacrifice and risk frontline staff were serving their communities. For some, the risk became more than rhetoric. Lives were lost and frontline workers harmed by catching the virus whilst undertaking their duties to others.

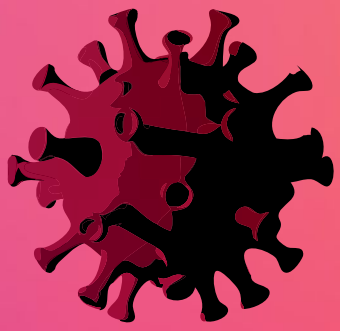
Now we are on the other side of the waves, we watch the tide go out again nervous that it might again rise and sweep away the norms of our society. More importantly, the turning tide may have swept away the previously trusting and understanding relationship between the public and the services they have long taken for granted as open for business. Essential precautions in health and social care settings like GP surgeries are misinterpreted as rationing or blocking access to healthcare. Waiting lists have soared and patients sit nervously waiting and nursing their painful conditions along until they are called for much needed procedures. Patients turn up for appointments only to be turned away due to a temperature or symptoms unrelated to Covid. Patients who once presented with worrying symptoms anxious to learn whether they were sinister or not have elected to hold on to these symptoms, distrustful that their concerns will be addressed.

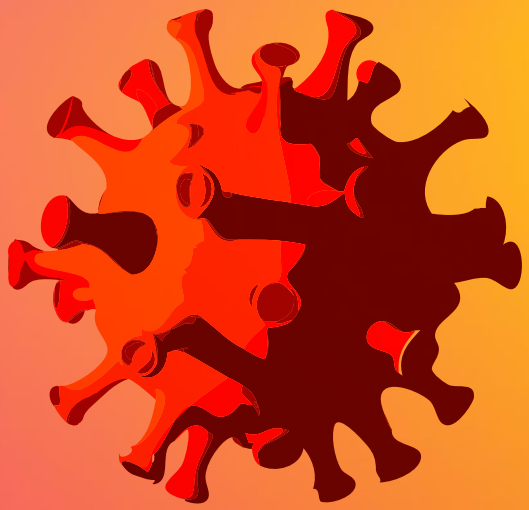
The commodity most in need of restoration it appears is trust.

Waiting lists can be reduced with resources and focus. Precautions will ease eventually. Trust however is a more intractable problem. The hands that cared and the hands that clapped need to reach out to each other again with patience and understanding on both sides. Nothing less will secure the future of the health and social care in the minds and hearts of the public. No one would pretend that this is easy. It is however essential. No one wants frontline workers they cannot trust. No one wants to work for a public who does not trust them.

So, when you hear the cries of fear and distrust, take a breath and listen. Acknowledge the pain and fear that everyone has felt, yourselves included. Those in need of care are not the only ones in need of healing. We all are. This is a future we need to walk towards together.

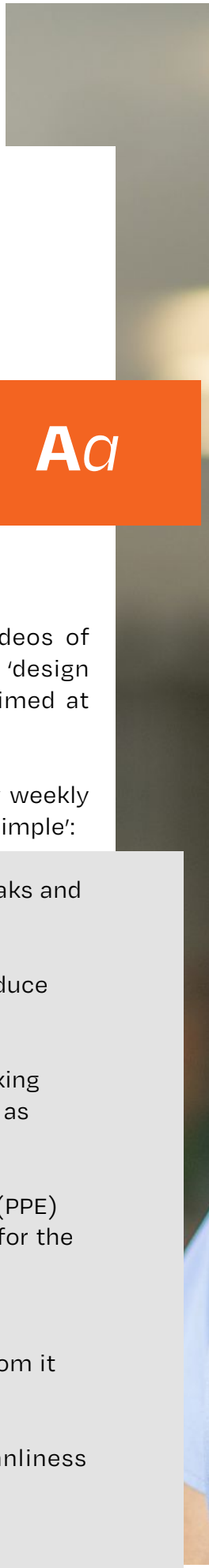






# Infection Prevention

# Wirral University Teaching Hospital 'Keep it Simple'



**Hazel Richards**, Chief Nurse and Director of Infection Prevention and Control, and **Jay Turner-Gardner**, Associate Director of Nursing for Infection Prevention and Control, and Deputy DIPC, Wirral University Teaching Hospital NHS Foundation Trust

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Staff at Wirral University Teaching Hospital (WUTH), have worked hard over the past year to protect patients and colleagues by preventing the spread of infection across the trust's hospitals.

An unannounced CQC focused inspection at the trust in February 2021 found outstanding areas of practice. The inspection focused purely on IPC at the trust's Arrowe Park Hospital site.

Inspectors praised the trust's IPC Campaign, titled 'Keep it Simple', which was a strong clinically-led campaign, explaining all aspects of IPC not just focused on Covid-19. We earned the accolade of 'outstanding practice' as a result of this work.

The six-week campaign, which ran across the trust's sites including Arrowe Park Hospital, Clatterbridge Hospital, and Wirral Women and Children's Hospital, used simple messages to communicate information about IPC to staff, patients and visitors. This included brightly coloured posters, information leaflets, pull-up banners at hospital entrances, videos of hospital staff, and an interactive 'design a bug' competition for staff, all aimed at articulating key IPC priorities.

It focused on the following six key weekly themes that spelled out the word 'simple':

- **Surveillance** – Detecting outbreaks and increased infection
- **Invasive devices** – Helping to reduce bacteraemia and infection
- **Multi-disciplinary groups** – Working together to provide patient care as everyone has a part to play
- **Personal protective equipment** (PPE) – Wearing the right level of PPE for the right task
- **Lessons learnt** – Reflecting on a patient's journey and learning from it
- **Environmental cleanliness** – Maintaining a high level of cleanliness across the hospitals.

While there has been a significant reduction in the rates of reportable organisms, to the Public Health England (PHE) Mandatory Healthcare Associated Infection Surveillance System in 2020/21, staff are aware there is a need to continue to be proactive to maintain this improvement. It identified a 30% (27) reduction in *Clostridium difficile* infection, 25% (6) reduction in Meticillin sensitive *staphylococcus aureus* bacteraemia, and an overall reduction of 35% (32) of reportable Gram-negative bacteraemia, compared to 2019/20.

During their visit, CQC inspectors found that there was an improvement in healthcare associated infections. The CQC report highlighted that the trust had a clear vision and plan for continuously improving practices related to IPC, and it had an annual plan that was aligned with the wider healthcare system. It found that staff felt respected, supported and valued. The trust was viewed as having an open culture where staff felt safe to raise concerns with a variety of ways in doing so, all with a focus on the needs of the patients. Inspectors also found that leaders understood and managed priorities well, and that they were visible and approachable to staff and patients alike.

Staff were clear about their roles and who was accountable for patient safety. Communication and learning, supported patient safety across the trust. Improved IPC measures implemented at the trust included separate staff and patient entrances to allow for social distancing; volunteers at entrances to direct people to hand sanitiser and fluid repellent surgical face masks, which are mandatory on entering the hospital, as well as social distancing signage on floors and walls.

The CQC report found that the trust collected reliable data and staff could easily access the information they needed. Its IT systems worked well and were secure. Patient records were clear and accurate with regards to Covid-19 tests and results. Leaders collaborated with partner organisations to improve services for patients. Trust staff were committed to continually learning and improving services. It had processes in place to achieve this and promoted a continuous improvement culture around IPC.

Delivering excellent IPC has enhanced a really difficult experience for patients and has helped to keep both patients and families safe.

There were areas highlighted by inspectors to help the trust improve and are currently being worked upon. These included the need to finalise its draft IPC strategy; a requirement for staff to assess the risk of infection transmission for patients nursed in single rooms that have other risk factors other than IPC, and ensuring all staff are aware of personal protective requirements regarding eye protection in specific settings. All of these issues have now been addressed.

The trust aims to embed IPC in everything it does and will continue to campaign to promote behavioural change with an awareness of the evolving landscape of Covid-19. To support and protect staff and patients, a Covid-19 vaccination programme was launched across the trust. Twice weekly Lateral Flow Device (LFD) testing has now been re-placed with a more accurate weekly LAMP test for asymptomatic staff, which is a saliva test completed at home. The importance of vaccinations and weekly testing to prevent transmission continue to be promoted.

Staff have worked hard over the past year to develop and apply IPC measures to protect patients and staff. IPC has been a key focus as we have adapted our working during the pandemic.

It has been important for us to have an open culture where we continue to learn and IPC has been a constant focus.

While we are extremely proud of all the work we have achieved we know we still have a lot to do. As we learn more about nosocomial infection and asymptomatic transmission of Covid-19, we will continue to adapt and develop our processes.

# A multifaceted approach

NHE's **Jasmine Jackson** spoke with **Dr Sara Mumford**, Director of IPC, Deputy Medical Director, and Consultant Microbiologist at Maidstone and Tunbridge Wells NHS Trust (MTW)

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In April 2021, the CQC published a report, following the March 2021 inspection of IPC measures at East Kent Hospitals University NHS Foundation Trust, finding some outstanding examples of practice.

Inspectors visited the Queen Elizabeth the Queen Mother Hospital, and the William Harvey Hospital to look at IPC procedures in place across both hospitals. Due to it being a focused inspection, the overall rating of Requires Improvement for the trust, remains unchanged.

A previous inspection resulted in the CQC putting forward a set of conditions on the trust for them to improve IPC practices, last August. The most recent report praised how the trust improved IPC practices, given the added pressure Covid-19 posed on the NHS, where the trust – like so many others – were under extreme pressure.

Dr Sara Mumford spoke to NHE, where she detailed the immediate action that the trust took around the issues raised, which resulted in the lifting of these conditions.

"It was a multifaceted approach I think it's only fair to say. When I first went to East Kent, they were in a difficult position with respect to infection control. I joined them a few days prior to the CQC inspection in August.

"The first thing we did really was focus on better educating staff on PPE and get all of the staff doing the same thing consistently." Dr Mumford has worked for MTW for 13 years and was seconded into East Kent to help support the trust to make improvements. She worked there for nine months, working half of the time in East Kent, and half in MTW, where she also very much led the Covid response.

Part of the changes at East Kent included the development of a video, showing staff how to put on and take off PPE properly, making it very specific to East Kent so that it was most relevant to those using the PPE at the trust. It became mandatory for every member of staff to watch the video, with some people watching it several times.

"We did one for all staff and then we looked again at the facilities staff, because they're a special group, and some didn't have English as their first language. We also made separate videos for the cleaning staff on the wards, the portering staff, and all the various groups of facilities staff, and made special videos for them, which were task dependent.

**"They were all really keen to improve, they were all up for the challenge, but they needed to be told what to do.**

"So, for instance, for porters, there was a video about transporting a patient, but then there was also a video about taking specimens to the laboratory, and what PPE they needed, and that worked really well.
"We also did a second version which was overdubbed in Nepali because we have a high number of Nepali staff, and we made it more accessible for all the staff.

"The most important thing I think was just getting hold of the hearts and minds of the staff. So, going on to the wards, talking to the staff, making them enthusiastic, whilst putting it right, giving them positive feedback when they did something well, and really supporting them, was key.

"The staff were all really keen to improve, they were all up for the challenge, but they needed to be told what to do initially, and they needed to be encouraged and shown and have it repeated, and have a little bit more education, and a little bit more training."

The infection control team were under a lot of pressure at the trust, and were short staffed, as everywhere else was during Covid. But they really needed to be supported, and having availability and good communication, was crucial in the recovery process, according to Dr Mumford.

"My availability wasn't just for the infection control team, that was basically anybody who needed to ask a question. It was a huge part of just enabling people to find out an answer quickly, but also then, empowering them to make decisions themselves. So, when things were improving, I started not just answering a question but saying more, what do you think? What do you think you need to do?

"This was part of coaching them into coming to the right decision, and if they found that difficult, explaining my thought processes, so that you give people the confidence to start making decisions for themselves."

At the same time as improving PPE and putting out tailored messages staff, the trust also started decluttering a lot of the wards. Dr Mumford did a lot of work with the facilities team to streamline what they were doing, including using UVC light decontamination rather than hydrogen peroxide fogging, which enabled improvements in patient flow and turnaround.

Clear curtains were introduced in between patients as a physical barrier, but which could also be pushed out of the way when patients needed privacy.

"We maintained that line of sight for the nurses to all of the patients in a bay, and through the clear curtains, but, also providing that physical barrier was very successful, and gave the staff confidence."

East Kent was particularly hard hit in both of the waves of Covid. During the second wave almost all of the wards were Covid wards. With so many patients visiting the hospital, it meant it was even more challenging for the trust to ensure that the patients who didn't have Covid were very much protected.

"At the end of the first wave of Covid, we had a C.difficile outbreak in one of the hospitals, so we had to do a big deep clean exercise as well, and that of course has lots of operational challenges associated with it. But, we did it and we stopped the outbreak in its tracks, and that was very motivating and empowering for the teams that were doing that, because they could see that they were doing something really positive. So we gradually built up this cultural change, with encouragement and positive feedback.

"Every time the numbers improved, or the audit results improved, we would feed that back and make sure that the teams on the wards knew that they were being praised. And when they didn't do so well, we were completely honest with them, but we did help them. So, with honesty and support, the staff knew that we had their back."

Learnings were taken on-board from other trusts and NHS Improvement, leading to the development of a detailed IPC improvement plan that started in September, which was fully implemented and closed down by the end of February.

This involved setting up an improvement group - which was a separate group outside of the infection control committee - to implement the actions outlined in the plan and review internal audit data.

prevention committee really working much better, so that we had senior nurses from every care group in the trust attending, reporting back, being responsible for their own reporting, and making sure they owned their audit results.

"If the matrons, the senior nurses, and heads of nursing own the results that come back out of audit, and have a clear understanding of where an area has gone wrong in their audit, and knows what the reasons are for low scores, then they can go back and put them right.

"If you just see an audit number on a piece of paper, it doesn't mean anything to anybody. So, making them own those results, and doing that work to find out what the issues were, reaps huge benefits in improvement.

"It was just a fantastic piece of team working because everybody was energised and motivated to make the change, and started to see that change was happening.

"Over and above all else, I think empowering staff to learn, to make those educated decisions, taking responsibility, and make change happen was vital, because I couldn't have gone in and forced change, I had to have everybody buying into it. Change just doesn't happen by itself, and it's not just one person, it's everybody wanting to change, making improvements, and feeling responsible for it.

"There is always something more to be done in infection control. I don't think you can ever find somewhere that is completely perfect, it's all work in progress. The team who are in place now are continuing the work, making further changes and consolidating the work that's already been done."

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# Using domestic air purifiers to reduce Covid-19 transmission

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**South Tyneside and Sunderland NHS Foundation Trust**


Clinicians at South Tyneside and Sunderland NHS Foundation Trust (STSFT) have developed an innovative way to reduce the time it takes to clear infectious particles in the air.

We know that there is an increased risk of transmission of Covid-19 in enclosed spaces with poor ventilation. Small infectious droplets and particles can remain suspended in the air over long periods of time.

Ear Nose and Throat (ENT) clinicians at STSFT identified that the time it took for particles to disperse following an aerosol generating procedure (AGP), was directly linked to a substantial increase in waiting times.

In ENT and Maxillofacial surgery, the downtime period was notably reducing the number of patients that clinicians could treat. A wait of up to 60 minutes between each patient to allow 99% of aerosol particles to clear, meant that a substantial amount of time was being wasted between patients.

National guidance recommends a baseline of 10 to 60 minutes between patients, dependent on air changes per hour and other mitigating factors such as ventilation or air cleaning.

As AGPs are common place in ENT and Maxillofacial surgery, the team realised the potential scale of the problem and began researching solutions in March 2020.

The ENT team, working with Medical Physics, IPC and the trust's lead microbiologist, brought together a range of multidisciplinary experts in fluid dynamics, filtration, aerosol science and microbiology.

Their research found that 99% of airborne viruses could be eradicated using domestic air purifiers. In a large treatment room, domestic air purifiers cleared 99% of infectious particles in 9 minutes. In a standard clinical examination room, this reduced further to 5.5 minutes. Previously, it took 60 minutes to achieve 99% clearance.

The team developed a safe and effective method for testing aerosol clearance using domestic air purifiers and were able to significantly improve ENT waiting times. On average 280 more patients are now being seen monthly.

The average 'downtime' required between AGPs for minor dental procedures has also been reduced from 60 to 12 minutes. This means that four extra local anaesthetic dental operations can be carried out per weekday, leading to a 100% increase in activity. Previously, only four of these types of procedure could be carried out each day.

Productivity within endoscopy has also improved, with 10 additional ENT procedures being carried out every weekday, representing a 250% increase in activity.

By reducing waiting times, STSFT has been able to see and treat more patients in a timely way. This is vital for cancer patients accessing ENT services at the trust to ensure that they receive timely diagnosis and treatment.

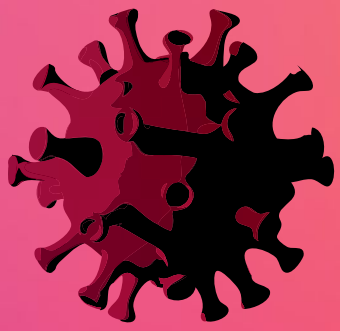
Mr Leon Lindsey, ENT Surgeon at STSFT, said that the air purifiers 'have given a visible reassurance that both staff and patient safety is the trust's main priority'.

He explained: "Our staff have said that they felt much safer knowing the trust had taken these additional precautions. Our junior medical staff also said they felt more valued, protected and confident whilst performing exposure prone procedures in outpatient, ward and emergency settings."

In March 2021, the CQC carried out a focussed IPC inspection at STSFT, where they highlighted the work of the ENT and IPC team as outstanding practice:

*"Following the success of using equipment in ENT, the trust is investing in the purchase of air purifying equipment for other areas of the hospital where ventilation is poor. The aim is to reduce the risk of transmission of Covid-19 or other viruses from asymptomatic patients to other patients and reduce the risk of nosocomial infection."*

Throughout the pandemic STSFT has sustained the best performance across the region's ICS for the 62-day cancer wait standard. ENT referral to treatment times have also remained amongst the best nationally with no patients waiting over 52 weeks.



# Mental Health



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# Improving employee mental health in ambulance services

NHE's J**asmine Jackson** spoke with **Anna Parry**, Deputy Managing Director and lead for employee mental health, Association of Ambulance Chief Executives (AACE)

It's no secret that all areas of the NHS have been immensely affected by Covid-19, whether that's the increased demand, added pressure on workloads, or managing mental health and wellbeing during such a difficult period. But the national NHS Staff Survey 2020 results showed that the ambulance sector was hit particularly hard in terms of how to deal with their own mental health and wellbeing.

This comes as no surprise given the emotive situations ambulance staff are faced with day in and out, sometimes not knowing what their next job will entail or when they will get a break. But how can this be better managed, and what are some of the reasonings behind some of the figures?

NHE spoke to Anna Parry, Deputy Managing Director and lead for employee mental health, Association of Ambulance Chief Executives (AACE), about what AACE already has in place, what the challenges are, as well as breaking down some of the survey results. Ambulance trusts were also keen to share how staff are being supported when struggling with their mental health, and where we go moving forward.

**RESOURCING** The recent Health and Social Care Committee report reiterated the stress and burnout staff were experiencing, highlighting the challenges surrounding funding pressures, and staff morale.

When it came to staff shortages in the survey, although this is regarded as an issue across the whole of the NHS, only 36% of ambulance staff felt there was enough staff, whereas other sectors reported slightly higher.

One of the main reasons behind this primarily comes down to resourcing and funding issues, but there are many layers to this, and it isn't as straight forward as that. As pointed out in a report published by AACE and NHS Providers last autumn, during the first wave of Covid-19, ambulance services received additional funding to help them deal with the increased capacity and challenges.

But there have been calls for this to be adequately funded in ambulance services on a regular basis, for capacity to be able to respond safely to predicted demand and be fully and appropriately resourced all year round.

"Ambulance trusts do capacity and demand analyses, and there's a mismatch. Trusts are not paid to meet the demand placed upon their services. And those independent reviews are generally commissioned by commissioners and trusts.

"If trusts were resourced to the level that we know they need to be to meet their demand, then that would be the best possible thing to improve mental health and wellbeing because the pressure on existing staff wouldn't be so intense.

"There's a great reliance on ambulance services at a societal level, so it's absolutely

essential that ambulance service staff are looked after, and that their health and wellbeing is prioritised too; finding the best way of doing that in an evidence based sustainable way is the best method."

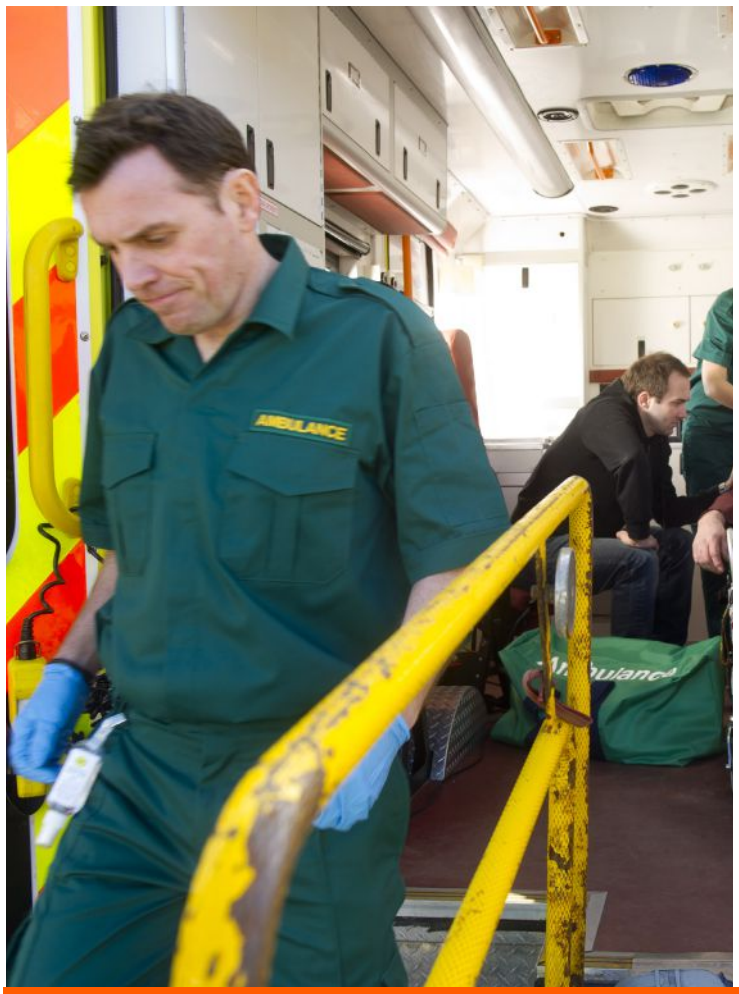
This poses a problem for trusts to be resourced to the correct level when the demand continues to increase. Many initiatives have been brought in at a local trust level and by organisations such as The Ambulance Staff Charity (TASC) to support staff 'but addressing the inadequacy of current resourcing levels is essential as a root cause.'

**DEMAND AND CAPACITY** The AACE and NHS Providers report underpins much of what is needed to turn this around, such as recommendations in the latest combined independent demand and capacity review modelling, commissioned for ambulance trusts in England. It forecasts an annual funding gap of £237.5m.

Despite the increased demand however, for the first time in the last decade, during the initial months of the Covid pandemic, ambulance services were able to meet national targets and standards, which is likely down to there being a closer alignment between capacity and demand during this time.

"If you do a route cause analysis of what the underlying issue is that affects ambulance staff mental health, it's the mismatch of resourcing and demand.

"But funding is required to address this, and obviously in the context of where we're at now, things are more stretched than ever." Patients waiting in ambulances outside emergency departments has emphasised the truly extraordinary conditions staff have been faced with, only giving a glimpse of capacity pressures in hospitals.




During the height of the pandemic, handover delays reduced significantly. But they have proved to be an obstacle for ambulance services to overcome. An average of 27,164 hours were lost each month for handovers over the standard 15-minutes. This is now increasing again to similar figures to those in Q2 last year (40,000 hours lost in September 2020).

Capacity pressures have intensified when it comes to managing the safety of Covid and non-Covid patients. This has meant that capacity has been reduced by 10 to 30%, dependant on the trusts concerned.

"Some staff have spent a whole shift waiting on the back of an ambulance with a patient outside A&E. So, there's the mental impact of that as well. If you lose the ability to do your job well, which has really been compromised even more in Covid, wellbeing is impacted considerably.

"Many ambulance service staff work on their own or alongside one colleague, so there's that element as well. Belonging to and feeling part of a team is so important for good mental health.

"That core thing that makes people feel better and helps ensure that you don't get to the burn out point, is much more practically harder to achieve in the ambulance sector."

**OVERTIME CULTURE** There is a well-known culture of working overtime in the ambulance sector, with 72% working additional paid hours in the staff survey, which was the highest compared to other sectors. Some of this is likely to be higher during the year of the pandemic than others, with many shielding, or isolating and being unwell.

"It's not ideal is it, from a health and wellbeing perspective, with staff working long shifts anyway. But the sector is trying to move away from long shifts, which is something that trusts are doing, with some further ahead than others."

For example, South Central Ambulance Service have removed 12-hour night shifts, showing that there is positive action being taken to help with the operational arrangements that affect employee mental health and wellbeing.

**WORK-RELATED STRESS** In the last 12 months the survey showed that 49.7% felt unwell as a result of work-related stress, which was the highest out of the sectors. Of course, one aspect will be dealing with more emergency calls around Covid, but this demonstrates the need to ensure ambulance staff are able to cope with their work once the day's over.

Ambulance staff (53.7%) also said in the survey that they still came to work in the last three months even though they didn't feel up to carrying out their duties. This was the highest out of the sectors, but has started to decline when compared with results from previous years.

On the other hand, at the Isle of Wight NHS Trust, Head of Ambulance Service, Victoria White, had seen "a 15% increase in the number of ambulance staff who claimed that over the previous three months, they did not feel pressured to come to work if they were not well enough to perform their duties.

"Over 90% said they feel trusted to do their job and able to report unsafe clinical practice. In two categories of this survey, line management and teamwork, we have exceeded the average benchmark score when compared to other trusts.

"It is our priority to support our staff and we have strived towards creating an open and honest, supportive environment by encouraging our colleagues to feel they can open up and talk about their wellbeing concerns."

There are many elements when it comes to managing staff's mental health in the most appropriate way, which will be different for each trust.

But an important factor to all of this is that, nationally staff have experienced many more cases of patients dying at home, so there were inevitably more conversations relating to end-of-life care. This exacerbated the pressures faced by frontline ambulance service staff.

Anna added: "To support staff with this, we invited Kathryn Mannix, a palliative care consultant, to talk to some of our staff about how to compassionately manage end of life conversations in such difficult situations.
"Obviously the difference last year, and in an ongoing way, but to a much lesser degree, is the number of those. So, it's multiple times a day having to take somebody very, very sick


away from their family, the accumulation of which has a massive emotional impact on staff."

**SUICIDE PREVENTION** AACE have expressed its desire to do more for the benefit of ambulance staff, involving a lot of work around suicide prevention. The rate of suicide amongst male paramedics is significantly higher than police, fire, and other health professions, based on Office of National Statistics data. AACE commissioned a study in 2016, looking at data from staff suicides in 2014 and 2015 to identify trends and common themes. Recently, Samaritans was commissioned to produce some bespoke suicide postvention guidance, which is available here:

Click here Suicide Prevention in Ambulance Services

"This is so in the event of a suicide, trusts know what to do, and how to deal with the aftermath in the most effective way, in an effort to prevent further suicides and to support staff. In the case of a suicide, it's never attributable to one sole factor, it's a lot of compounding things."

**INITIATIVES MOVING FORWARD** The staff survey also showed that only 25.7% of ambulance staff thought organisations took positive action with their health and wellbeing, which was the lowest out of the sectors. Ambulance services have recognised the importance of putting health and wellbeing, and mental health at the top of the trajectory.

The London Ambulance Service NHS Trust has developed a station created by staff, known as the 'Wellbeing Garden', aimed at providing a peaceful space for staff after busy shifts. Other initiatives include the 'Tea

Trucks', delivering hot snacks and drinks to crews in control rooms and hospital bays, during the closure of canteens in lockdown. Wellbeing hubs were also created to bring awareness to a variety of resources and counselling services, as well as a strong peer support network and an independent support line for anyone concerned about their wellbeing.

West Midlands Ambulance Service University NHS Foundation Trust (WMAS) has also followed suit to try and support staff through their Staff Advice and Liaison Service, which provides peer support 24/7. They now employ three dedicated mental wellbeing practitioners to ensure staff requiring assistance receive it as quickly as possible. This is in addition to the trust's occupational health provision. Hundreds of their staff have also been trained as mental health first aiders. Each ambulance hub has a 'quiet room', and last year they increased the level of management support for all of their hubs.

People Director, Carla Beechey at WMAS, said: "As a service we fully recognise the pressure staff are under during the current pandemic, which is why helping them to maintain both their physical and mental health is so important.

"Our ever-expanding and varied support initiatives cover preventative and responsive care, right from the recruitment and training stage, all the way through to colleagues entering their retirement.

"We recognise all of our staff are people with full and busy lives, so to support the workforce both in and out of work, we've built links with numerous support services who can offer specialised advice about a wide range of personal difficulties. Colleagues who need more personalised support can quickly access psychological therapies via our Employee Assistance Programme.

"One area we are making great strides in is in reducing mental health stigma. In previous years staff may have felt uncomfortable saying they were away from work due to mental health challenges, but now through active encouragement we are pleased that increasing numbers of staff are now comfortable having open and honest conversations at work about their mental health experiences. From those conversations, we are now more accurately able to record mental health challenges as the reason for time away from work. This enables us to get the right support in place as early as possible."

Mental health and wellbeing has also been recognised as a priority by South Western Ambulance Service NHS Foundation Trust. They introduced their Staying Well Service in 2015 as a way to ensure external partners had the right access to counselling, physiotherapy and specialist mental wellbeing support; as well as promoting self-help, resilience tools, and a range of different techniques; including meditation and mindfulness, and physical activities and healthily eating.

A SWAS spokesperson explained: "The health and wellbeing of our people is a key priority for our trust, and we have an ongoing programme of work across the organisation.

"The Staying Well Service is also supported by a team of over 100 Peer Support Guardians who volunteer their time to provide first line support to their colleagues. We have also trained our Peer Support Guardians, and a number of our leaders specifically in mental health first aid to enable them to be better able to support colleagues who are in need.

"We recently introduced dog therapy and virtual reality therapy in areas of our trust, and we are exploring alternatives such as equestrian therapy and blue water therapy. Additionally, we have also developed a Menopause Café, Carers' Café and Cancer Support network, as we look to engage with colleagues about issues many people find hard to discuss, and become a more compassionate workplace."

Victoria, said: "We recognise that there has been an impact on staff wellbeing. The role of our ambulance staff has always been physically and mentally demanding, and the traumatic incidents they respond to can be extremely challenging.

"There are several helpful measures in place to support staff's mental health and wellbeing, including a mental health hotline, clear guidance on how to raise concerns, access to specialist bereavement and psychological support, and an online hub, packed with wellbeing resources.

"As part of our staff wellbeing framework, we gave staff an extra day of 'wellbeing' leave, and we also encourage anyone struggling, to come forward for a confidential conversation with one of our colleague wellbeing champions and our occupational health team.

"We recognise that ambulance staff require bespoke support, so we provide time for staff to reflect on work experiences such as paediatric cardiac arrest; we have a well-developed integrated debriefing tool to ensure staff get the support they need.

"As part of making further improvements, we have invested in additional training for staff; namely mental health first aid and trauma risk management (TRiM) as well as the provision of a well-being lounge, both to enhance staff safety and wellbeing."

AACE are focusing on where there's an increase surrounding improvements and how they are moving forward, rather than where they are in comparison to sectors, because of the message that sends.

**MENTAL HEALTH AWARENESS: GETTING STAFF TO TALK** In November last year AACE produced its 2020-2023 strategy, after consultation on AACE's governance structure and priorities. This included conversations with chief executives, chairs and national director group leads.

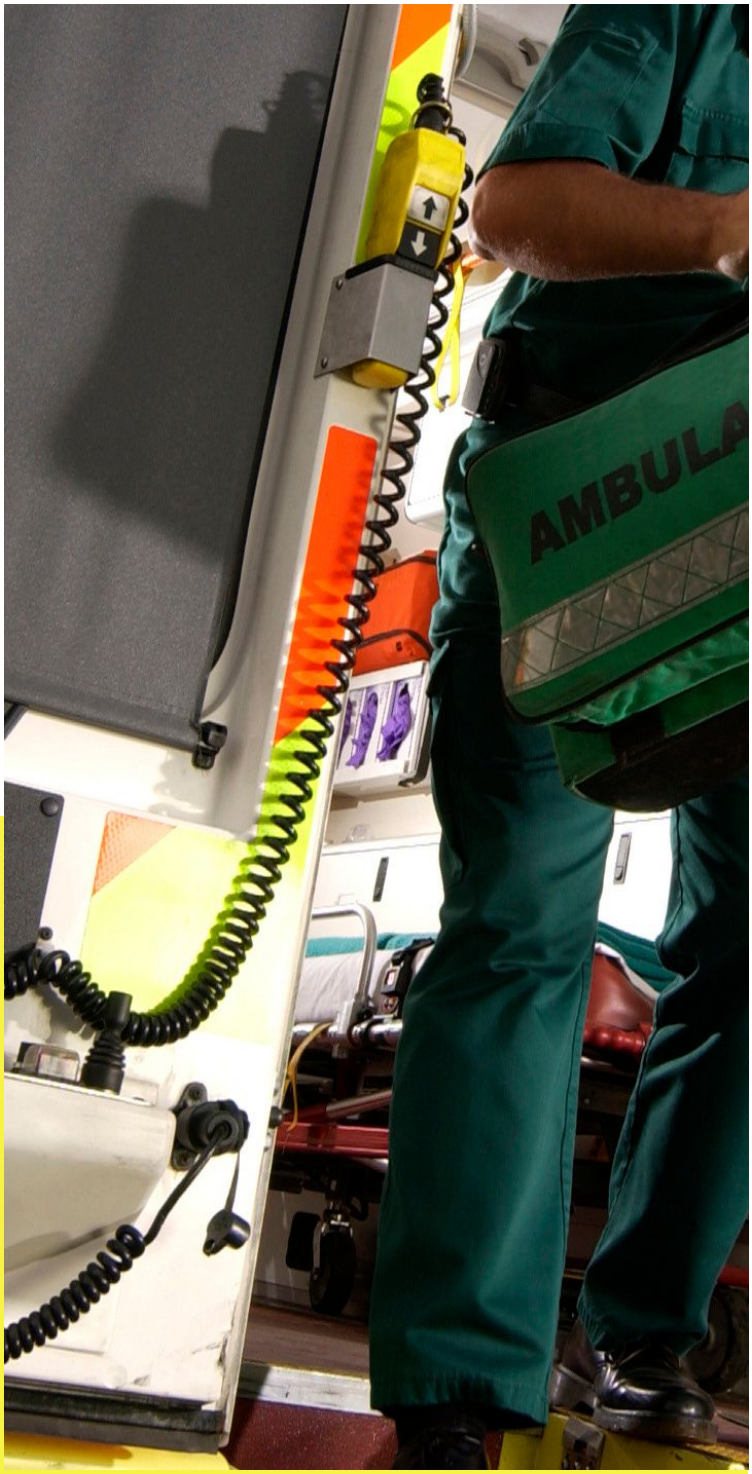
"Employee wellbeing is a priority for our members – this has been heightened during Covid-19 because of the mental health impact upon staff. Our national employee wellbeing and suicide prevention group oversees the development of products where there is a clear evidence base for specific interventions.

"One such intervention that one trust will be piloting imminently, will be making proactive contact with 500 staff from one division to ask how they are, mental health wise by an external provider. Because one of the issues we have as well is people acknowledging that they have got a mental health issue, and they're looking for help."

As part of their work to prioritise staff wellbeing and mental health, AACE produced a film, aiming to remove the stigma, encouraging staff to talk about their mental health, wherever they are, and whoever they are. In this footage, ambulance staff shared their own experiences of mental health issues, and how having the right support available made a difference in their working life and home life. It raised awareness surrounding how the work culture has shifter around this, and the benefits of being able to get the right support:

Click here visit the support website

"Ambulance services all have their own, specific approaches; what we seek to do at AACE is to work together where it makes sense to work together at a national level. We are acutely aware that different services and supports will suit different people when it comes to mental health. Our ultimate aim is to ensure that staff know where they can access help and feel able to do so at their time of need."



# Prioritising staff wellbeing and leading the way through mindfulness

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**Sarah Fereday MSc**, Acting Health and Wellbeing Manager, Kettering General Hospital NHS Foundation Trust

Staff wellbeing has always been important at Kettering General Hospital (KGH), but particularly since the Covid-19 pandemic. I started providing wellbeing services shortly after joining the NHS in December 2013 as PA to the Director of Nursing at Kettering. Prior to joining, I had a very stressful job in publishing, and when my publishing job moved to Hong Kong I decided not to go and change career.

After joining KGH, I did an eight-week Mindfulness-Based Stress Reduction course, which I enjoyed. I ran a few short mindfulness sessions for clinical staff at the hospital, which were well received.

I went on to do an MSc in Mindfulness & Compassion at Coventry University part-time. My assignments all focused on mindfulness in the workplace, and after mentioning this at a Staff Health & Wellbeing meeting, I was invited to meet with the HR Director to discuss providing mindfulness sessions to staff more formally.

After providing evidence of the benefits of mindfulness on mental wellbeing, funding was agreed for me to deliver mindfulness sessions for a three-month trial period, one day a week. The sessions were held in clinical and non-clinical areas so staff could just pop along for a short 15-minute session.

As much as 70% of staff reported feeling calmer and less stressed, and when I presented the results to our executive team, funding was approved for my role to become full-time.

I developed a framework and pathway for staff to be referred for one-to-one mindfulness sessions and continued with group sessions. I also recorded videos and developed other resources staff could use outside these sessions.

Staff who attended sessions reported reduced stress levels. While they still worked in challenging situations, they could use healthy coping mechanisms to manage stress.

**WELLBEING INITIATIVES DURING COVID** When the pandemic hit it, it had a profound effect on the mental wellbeing of clinical and non-clinical staff on a professional and personal level.

In response, we set up the WeCare Café to provide a place for staff to have a break, as well as share some of the donations made by local businesses and the public.

We are an acute hospital that never closes, so we opened the WeCare Café initially for seven days a week. It has been hugely popular and viewed as a cosy place people can go and have a free cup of tea, relax, and have a break.

We also set up the 'Open Office' listening service where colleagues can talk to someone privately and confidently in a safe space. It is located centrally and easily accessible and visible. If colleagues need to speak to someone they can drop in, with no appointment needed.

The service is managed by a core team, including myself, and people with a spiritual, pastoral care or counselling background. Our service is not therapeutic; but we listen and signpost people to other services.

We provide immediate support and onward signposting to services as appropriate, including Employee Assistance Programmes (EAP), Improving Access to Psychological Therapies (IAPT), Stronger Together, national NHS offers, and apps that can help with mindfulness or sleep.

**BEYOND THE PANDEMIC** When we measured the impact of the WeCafe and Open Office – we found they were having a positive impact. What surprised us is the service is accessed by staff of different ages and both men and women.

We have seen over 1,800 attendances in the Open Office. Attendance is changing as we move out of the pandemic peak, and colleagues are processing what they have been through. However, the length of time colleagues spend in the Open Office has increased.

During the early days of the pandemic, colleagues were running on adrenalin and just getting on with the job because they had to. However, we imagine the long-term effects on their mental wellbeing are just starting to show, and they could be feeling the impact of it for some time.

Therefore, it is so important we keep these services going and continue developing our wellbeing strategy. We have received funding from NHS Charities to continue these services and to recruit a wellbeing co-coordinator on secondment for six months. Following a successful bid to our Investment Management Committee, the trust has approved these services to continue.

My role has changed too, and I am now working strategically across the county, including with Northampton General Hospital NHS Trust. We are collaborating and sharing information on our successes to shape the future of wellbeing at both hospitals.

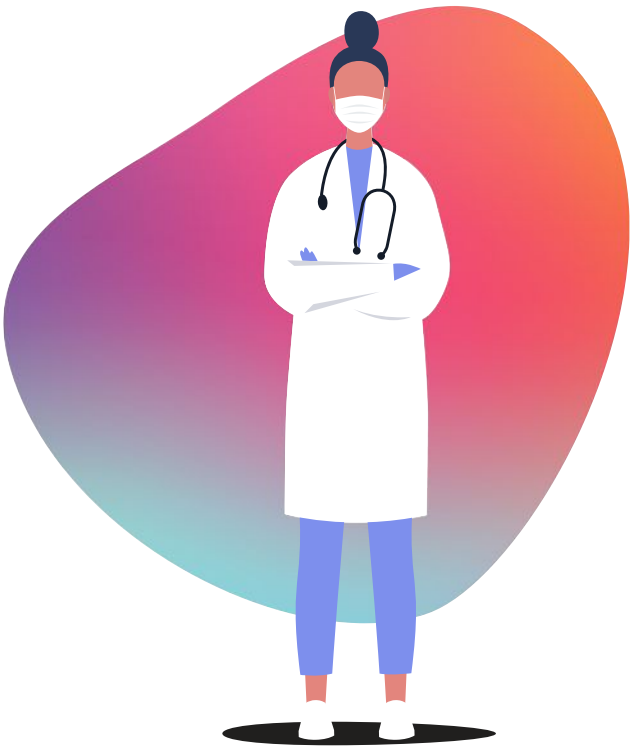
I am also working with the Stronger Together team to roll out face-to-face psychological support for intensive care staff. My mindfulness sessions have also been an important part of our wellbeing services.

**KEY LEARNING** These initiatives were very well received, and colleagues have valued the fact that the trust cares about their wellbeing. Offering a face-to-face service seven days a week, when so many other services for mental wellbeing went online, was key to the success as I don't think other hospitals did this.

Measuring the benefits on staff wellbeing enabled us to present the business case to secure funding. We also tracked themes around wellbeing such as relationship difficulties, Covid stress, long Covid, anxiety around restrictions easing, amongst other issues. This meant we understood the issues colleagues were experiencing and tailored our services accordingly.

Very often these were different from the national picture. For example, issues around finances and furlough have not been a major concern for NHS staff as they have been employed throughout. However, we saw people struggling with finances because they were helping family members who had been made redundant or earning less. Tracking themes has given us valuable, tangible data and enabled us to target our support.

Personally, it has been a real journey and my role has changed enormously, but I have had the opportunity to play a key role in supporting my colleagues' wellbeing. Although my role is not clinical, I have worked hard to support colleagues' mental wellbeing, and knowing it has been valued and made a big difference, gives me a great sense of pride.



# Military style mental health support is the way forward for NHS staff

**Professor Dame Jane Dacre**, President,
Medical Protection Society

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In March this year the NHS established dedicated veterans' mental health services, which provide rapidly accessed, occupationally informed, care for veterans who have been psychologically injured because of their service. More than 13,000 former troops have benefited from specialist care for issues such as anxiety and depression, and almost 2,000 more have received help for more complex problems such as Post Traumatic Stress Disorder (PTSD). Similar veterans' mental health services exist in Scotland and Wales, and following its success there are plans to develop services specifically for veterans in Northern Ireland.

This is an excellent and fitting initiative and MPS, alongside 12 other healthcare organisations, have written to the government to urge them to learn from it when designing specialist physician-led occupational health services for NHS staff, whose work during the Covid-19 pandemic has caused or exacerbated mental health difficulties.

Despite the difference in context between the military on deployment and healthcare staff working during the pandemic, there are key similarities in terms of the exposure to trauma and risk to psychological and physical health. While we do not yet know the real long-term mental health legacy of the pandemic, the available evidence suggests that it will be substantial. Indeed, a study by Professor Neil Greenberg on staff working in critical care during the pandemic, showed staff reported more than twice the rate of PTSD found in military veterans who have recently experienced combat.

The duration and severity of the Covid-19 pandemic has had a huge impact on an already stretched workforce. While most healthcare workers will be used to dealing with illness and death, many have been dealing with extremely high numbers of critically ill and dying patients, made more challenging by restrictions on family visits. An October 2020 MPS survey of 1,251 doctors, showed that 1 in 4 doctors had witnessed the death of a patient with no family member present. More than 1 in 10 (11%) had lost a colleague due to Covid-19 at that point.

Other healthcare workers have been unable to deliver essential care for non-Covid-19 patients, which has the potential to cause moral injury - psychological distress caused by actions which violate your moral or ethical code – and mental health disorders. In addition, support and facilities

management staff have also been under significant pressure to keep healthcare services functioning.

The government has made some positive steps to address this issue in the NHS People Plan, including piloting wellbeing hubs around the country and creating a national support service for critical care staff who, according to research, are most vulnerable to severe trauma. However, the concern is that when the crisis is over, some of the local services may not continue, and longer-term treatment for conditions, including but not limited to PTSD, will not be prioritised.

We believe a dedicated mental health support service similar to that established for former troops, is needed. The NHS has been at the frontline of our nation's battle against this virus, and staff have risked their health in performing their duties with great dedication. This is analogous to the way that military personnel perform when they put their health on the line when the nation requires them to do so.

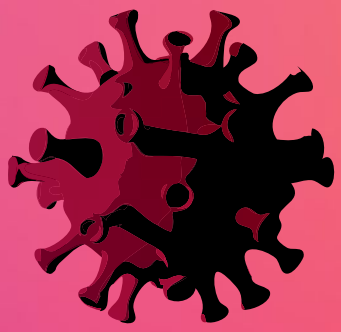
Establishing a dedicated, rapid access, occupationally focused service for healthcare workers feels, morally, like the right thing to do, just as establishing specific veterans' mental health services is morally right.

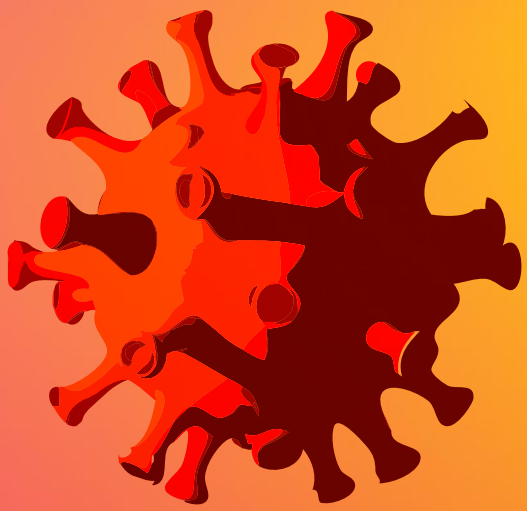
There are both social and financial imperatives. If appropriate support is not offered, sadly we may lose staff from the workforce temporarily, placing even more pressure on stretched resources, or even permanently.

In a recent British Medical Association survey, thousands of exhausted doctors said they are considering leaving the NHS in the next year, as many continue to battle mental wellbeing conditions without adequate respite from the demands of the pandemic.

Many are in a desperate situation, and this is not something that can wait. This is a pressing issue which we feel has a rapid and clear solution.

The letter to the Health Secretary was signed by Medical Protection Society, Royal College of Psychiatrists, The Doctors' Association UK, Hospital Consultants and Specialists Association, British Medical Association, Royal College of Surgeons of England, Royal College of Surgeons of Edinburgh, British Association of Critical Care Nurses, Association of Anaesthetists, Society of Occupational Medicine, Faculty of Intensive Care Medicine, British Association of Physicians of Indian Origin, and Medical Defence Shield.





# Workforce



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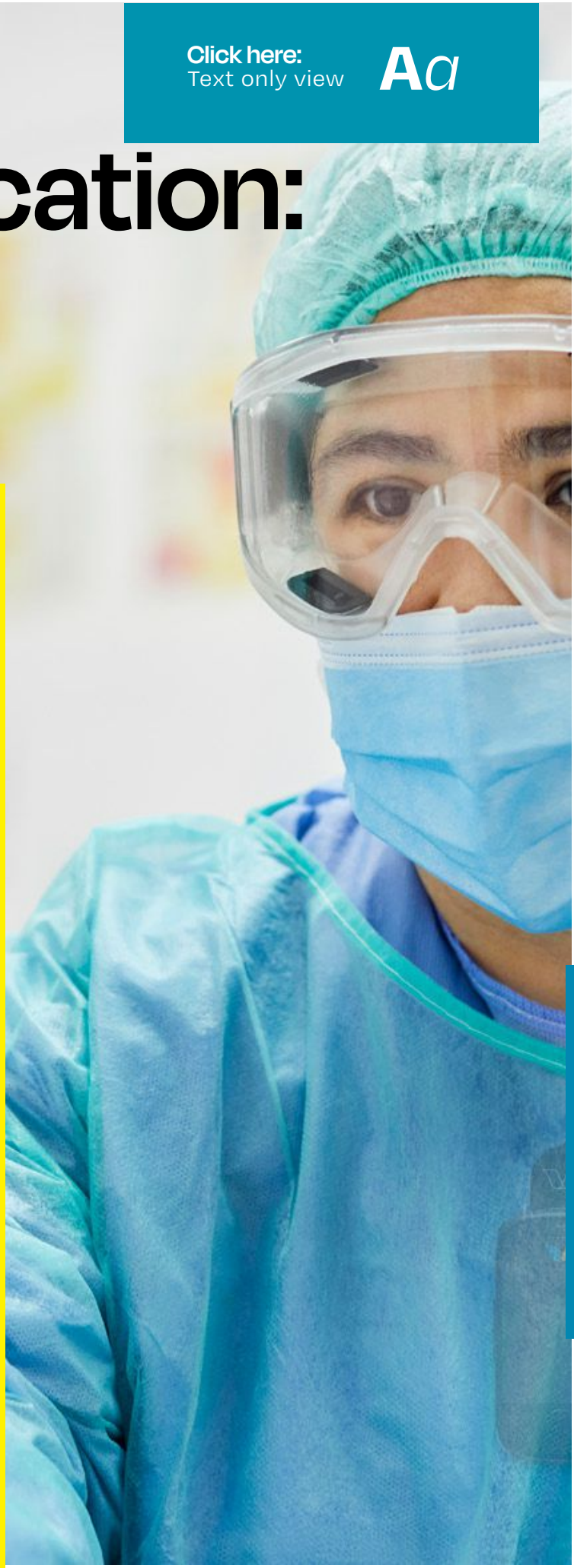
# Effective communication:

## the foundation for nurse safety

**Rhonda Collins, DNP, RN, FAAN**,
Chief Nursing Officer, Vocera



Over the past year, as we've all seen how nurses impact the health and healing of our world, we've also seen them embrace the mantra "Never Again" and leave the profession at unprecedented rate.

The need for change is clear. We must heed the call from all corners to listen to, support, and protect nurses. We must envision new ways of staffing and new ways of communicating and engaging, and focus on changing complex work environments and workflows – the source of most workplace fatigue and burnout.

I have been researching, writing, and speaking on the topic of nurses' cognitive burden for more than two years. I continue to be invited to talk about cognitive burden and how it affects nurse safety. At every CNO roundtable I attend, I meet nurse leaders who are perplexed and frustrated over how to fix what's wrong. They are experiencing everything their staff is suffering and more, and they are asking for workable solutions.

Often, nurse leaders focus primarily on building nurse resiliency. While resiliency is important, we also need to address the mental fatigue and moral injury this pandemic has wrought on our healthcare workers. It's helpful to give people a safe

place to go or a dedicated expert to talk to. There is nothing wrong with offering nurses space to meditate or listen to a mindfulness recording. But if nurses take five minutes every hour to go collect themselves and they come out of that space and the work environment is still chaotic, newfound serenity can't be sustained.

It's not the nurse that needs to change. It's the work environment. Nurses need tools to minimize the stress and make it easier to do their job. To this end, there are tangible actions nurse leaders can take to improve the work environment and strengthen nurse safety.

**SIX SOLUTIONS FOR STRENGTHENING NURSE SAFETY** Communication is the underpinning of everything that happens in a hospital, and effective communication is the primary foundation of a safe and effective work environment. In my 2021 CNO Perspective report, "Protect the Nurse, Protect the Practice," I propose six solutions to help nurse leaders create a safe and effective work environment, all rooted in strengthening communication. These solutions factor in lessons learned from the COVID-19 pandemic and include:

- Keeping nurses protected and safe
- Empowering nurses with control over patient-family communication
- Reducing the stress of crisis care
- Enabling smooth movement from novice to expert and back
- Protecting nurses from workplace violence
- Measuring and solving for communication task load

I invite nurse leaders to make their nurses' voices heard as part of an unprecedented study that aims to measure how the effort involved in communicating affects nurses mentally, physically, and emotionally. The study will provide insight and a body of knowledge to solve for the task burden of communicating more effectively going forward.

**LET'S PARTNER TO MEASURE AND SOLVE FOR COMMUNICATION** My plan is to measure nurse communication in hospitals using the NASA Task Load Index (TLX).

The NASA TLX has been used to measure the task load of workers in high-intensity jobs, such as pilots and air traffic controllers. It's been used to measure the task load of ICU nurses– and this is the first time it will be used to measure the task load involved in clinical communication. Nurses will be able to anonymously answer seven questions while thinking about a clinical communication task or effort during their most recent 12-hour shift. For example, trying to reach a physician or obtain a lab result.

- The NASA Task Load Index (TLX) measures on 6 dimensions:
- How mentally demanding was the task?
- How physically demanding was the task?
- How hurried or rushed was the pace of the task?
- How successful were you in accomplishing what you set out to do?
- How hard did you have to work?
- How insecure, discouraged, stressed, or annoyed were you?

The more we listen to nurses' voices, the better we can support and protect them, and the better we can engage the creative thought process of nurse leaders. Join me in this conversation. Work with me as we ask the questions and look for answers to improve communication, facilitates nurse safety, and ease the work of nurses caring for patients and families.

# Responding to the pandemic

The NHS Workforce Alliance

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Every NHS body and prospective workforce supplier understands that the staffing challenges the NHS face today have been magnified and complicated by the demands put on the system by Covid-19.

At the same time, the NHS is undergoing a new and fundamental organisational change, with the introduction of integrated care systems (ICS). The aim is to increase efficiencies through more collaborative working at a local level, while also improving the connectivity with local authority social care provision to ensure effective and timely patient care.

Right now, getting all parts of the system to work effectively together to reduce waiting lists is the most pressing priority for the NHS, as we emerge from the peak of the pandemic. It is essential that the NHS has access to the right workforce. That means boosting not only capacity, but also flexibility, and ensuring that the right strategies and action plans are in place to meet the current challenges - and plan for the future.

**A WORKFORCE FOR THE FUTURE** There is an urgent need for NHS bodies to be able to quickly access additional staff, while maintaining a focus on quality by ensuring they are appropriately trained and vetted. They are also under pressure to eradicate off-framework spend, and reduce spend on agency staff.

Temporary clinical and non-clinical staff, international recruitment and the creation and management of staff banks are all options for NHS bodies who need a flexible solution. Collaboration between procurement/commercial teams and workforce/HR teams, and building partnerships with NHS England and NHS Improvement approved workforce

providers, will help NHS organisations meet their workforce goals - and, importantly, make sure the best commercial value is achieved.

It is also important to remember that a successful workforce strategy needs to have the proper support structures and technology in place to manage and retain a healthy workforce. This typically includes occupational health services and enterprise resource planning systems.

And whatever the requirement, commercial partnerships need to work at a local NHS trust or ICS level. That could mean shared, collaborative banks of staff, multi-agency recruitment campaigns, and different vendor models.

**NHS WORKFORCE ALLIANCE** The NHS Workforce Alliance is a team of experts from the NHS Procurement in Partnership – which brings together the four NHS Procurement Hubs, owned and operated by the NHS – and Crown Commercial Service, the UK's largest public procurement organisation.

We are motivated by a genuine desire to make the NHS better. You can trust us to act in the best interests of the NHS – never losing sight of your primary focus on patient care, nor the need to adapt your workforce to the specific conditions and challenges of your local health economy.

We support acute hospital providers, mental health trusts, community health trusts, clinical commissioning groups, sustainability and transformation partnerships, ICS groups and ambulance services across the UK, to develop and implement successful workforce Strategies.

Our primary focus at the moment is building our connectivity across the health sector, and developing the communication networks that will enable us to respond to the drivers and influencers at a local level, as the NHS moves toward a new national infrastructure.

**THE IMPORTANCE OF INTEGRATION** As the development of the ICS structure gathers pace and the structure of our health systems change, the solutions the alliance provides will evolve to ensure we can always meet your needs. We know that this is likely to impact workforce strategies, and we are currently setting up a new approach to how we work with our customers.

The aim of the alliance is to make sure we can provide each ICS with a dedicated account management team to help you manage your transition, respond to your strategic priorities, and ensure that you get the workforce service you need.

Find out more about the NHS Workforce Alliance and how we can help you achieve your workforce goals by clicking here

# The potential benefits of hybrid working in health

**Matt Roberts**, Editor, National Health Executive
**Jane Craven**, UK & Ireland Sales Director Enterprise, EPOS

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Workforce shortages are nothing new in the health service, and for many years it's been a head-scratcher as to how to best sustainably solve the problem. More funding, more accessible training and better support to retain existing staff have all been key drivers of positive change, but for an organisation with a headcount of 1.35 million employees in England alone, according to March 2021 workforce statistics from NHS Digital, there are still vacancies in the many thousands.

But then came the pandemic and a shift for some roles, particularly in administrative and general practice positions, to remote working, and an opportunity has spawned.

Presented with greater flexibility than ever before, many people have been able to find a greater balance between work and life commitments. Recruiters have equally found a wider, less geographically-constrained talent pool suddenly available to them, due to less on-site requirements for some roles. There is the potential to close some particularly long-standing staff shortages.

Jane Craven, UK & Ireland Sales Director Enterprise at EPOS explains: "For hiring managers in healthcare, remote working has provided access to a more diverse talent pool.

"Healthcare organisations are no longer limited to a small proportion of the population, based on their geographic location or ability to work within the traditional 9-5 working day.

"Instead, they have the opportunity to increase diversity in the workplace and reach talent pools which were once inaccessible."

However, with the move to remote working also comes challenges which must be overcome; particularly around ensuring a continued quality of service, for patients, end users and staff alike.

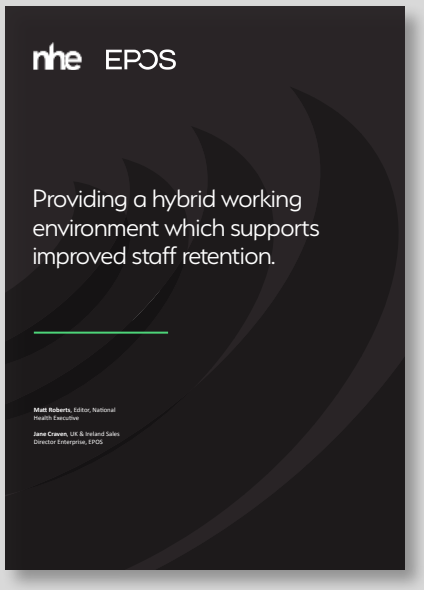
At National Health Executive, we have worked with industry partners to better understand these challenges and what the potential solutions to them might be.

In particular, one of the core, underlying aspects which must be addressed when remote working is access to high quality audio technology. A remote or hybrid worker can operate without the greatest quality video hardware. Internet connections are important, but don't need to necessarily be the fastest, instant fibre optic connections. While potentially disruptive, these are surmountable challenges.

Poor audio, particularly in healthcare, is not the same. The consequences of mishearing information can lead to a significant number of issues, from a frustrating experience for the patient right through to potential misdiagnosis or misunderstanding around a treatment.

The full NHE report on health sector hybrid working and the challenges to overcome can be downloaded by clicking below.

## Download the full whitepaper report:




## Providing a hybrid working environment which supports improved staff retention

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# Supporting staff remotely:

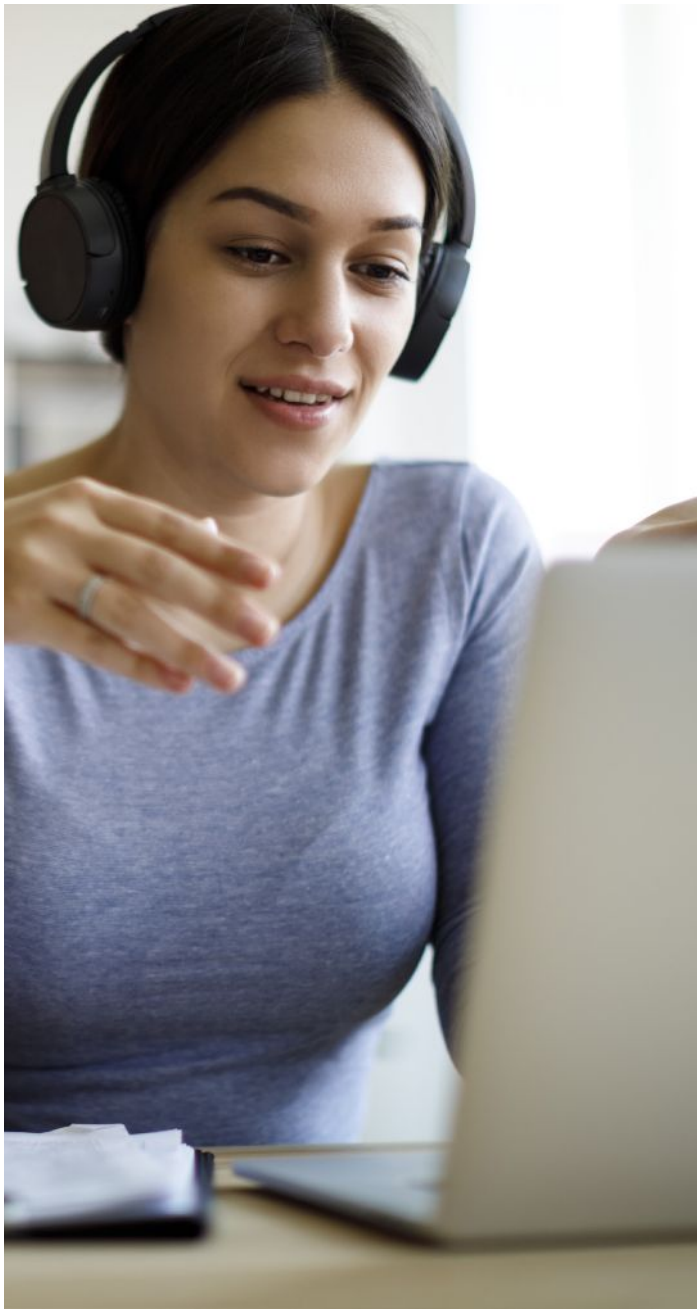
## implementing a successful wellbeing strategy in lockdown

**Mike Walker**, Director of Business Services at NHS Arden & GEM CSU

The value of investing in initiatives that support the physical and mental health of staff is well documented, both in terms of attracting and retaining great people as well as improving productivity. But the changes in work practices forced upon us by the Covid-19 pandemic shifted the goalposts. Many of the softer support initiatives we'd taken for granted were lost overnight, just as we all had to grapple with a significant threat to our wellbeing.

At NHS Arden & GEM CSU, we had a People Plan in place prior to Covid-19, with an associated health and wellbeing strategy to support our staff based across 15 office locations. But it hadn't been designed with over 900 different work locations in mind, all with varying levels of IT infrastructure, and little or no 'in person' interaction. Alongside employers across the globe, we had to act quickly to support our staff through such an unprecedented challenge – many of whom were working long hours on emergency response projects, while isolated from friends, family and colleagues.

**FIVE ELEMENTS OF A SUCCESSFUL WELLBEING STRATEGY** Arden & GEM has been on a steep but successful learning curve, reengineering some aspects of our strategy to meet the challenges of lockdown. In doing so, we have found the following aspects to be key in supporting staff through change and maintaining social connections amid remote working.



*Arden & GEM recently achieved gold award level in the 'We invest in wellbeing' accreditation – part of the internationally recognised Investors in People framework.*

**TAKE A HOLISTIC APPROACH.** Building a wellbeing strategy is about more than physical and mental health. In the past year in particular, the lines between home and work have become increasingly blurred, and financial and social pressures have impacted day-to-day work and home life. For wellbeing support to be successful, it needs to reflect this range of needs and support employees through every aspect of their lives, encompassing physical, financial, emotional, social and psychological needs. We have found that some of the simpler initiatives such as staff newsletters and competitive health challenges have proved as valuable as more structured initiatives such as access to counselling or financial advice.

**RECOGNISE AND PLAN FOR TECHNOLOGY LIMITATIONS.** The pandemic has given us little choice but to rely on technology to communicate with colleagues. However, as with any new initiative, it's important to make time to ensure people know how to use it and to flesh out any issues that may prevent people from accessing the information and support they need. Regularly reviewing IT infrastructure, providing quick access to technical support and offering alternatives such as phone-based services can all help reduce barriers.

**LEAD BY EXAMPLE.** Working remotely can make it harder to spot when people may be struggling and need support. Leaders have an important role to play in creating a safe space for colleagues to share their experiences – good and bad – and ask for help when they need it. This is partly about creating opportunities to engage with different leaders – our regular virtual 'coffee with directors' sessions have given staff at all levels the chance to raise issues and catch up with colleagues in a semi-structured but informal setting. But it's also about leaders getting involved with the initiatives they have helped to create, whether that's joining in with a physical challenge or adding to the social discourse on the community chat channel.

**BUILD IN FLEXIBILITY.** A diverse workforce inevitably means there will be some initiatives that appeal more to some than others. Likewise, some people will be more inclined to engage with initiatives than their colleagues. A multi-layered approach, where some activities, such as homeworking assessments, are mandatory; some are centrally-led but optional; and some are staff-led and socially focused; gives enough scope to enable your entire team to get involved in some way.

Building in regular opportunities for staff to recognise and log how they feel also provides multiple opportunities to check-in with team wellbeing and signpost staff to specific areas of support when they are most needed.

**LISTEN, LEARN AND ADAPT.** Engaging with staff and seeking input on different initiatives has perhaps never been more important. Staff surveys have always been a key part of our people strategy, but both formal and anecdotal feedback has proved invaluable as we've implemented new ideas. For example, the value of giving people time and space to join non-work-related discussions via our community chat channel has proved extremely popular, with 95% staff saying the channel had made them smile. By contrast, setting up virtual informal catchups at lunchtime didn't work for our staff, despite the social focus. With people adjusting to spending most of their day at a screen, lunchtimes have become a vital opportunity to step away from the computer and do something different.

Supporting staff is an ongoing priority. Whether frontline or back office, NHS staff work incredibly hard to do their bit to support excellent patient care. As human beings, we can achieve so much more when we are healthy, active and engaged, so it is in everyone's interests for organisations to continue to invest in initiatives that give teams the tools and guidance they need to achieve their goals.

# What's in a name

NHE's **Matt Roberts** looks at a recent petition to the UK Government, asking for the legal protection of the title 'nurse'

With comment from:
**Dave Dawes**, Chair, RCN Council

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Nurses provide a duty of care to patients across the country, with confidence drawn partly from their integrity, experience and qualifications. There is often an expectation of quality and regulation involved with it; but currently in the UK anyone can use the term nurse to describe themselves. There is no current legal requirement to be described as a 'nurse' - allowing people to use to the term to offer professional advice and services, even if they have no nursing qualifications, experience or have been struck off a professional register.

Instead, UK law currently protects instead the terms 'registered nurse' and 'dental nurse' to only those registered with professional regulators.

Now, a petition has been lodged with the UK Government to amend this and make the more basic, root 'nurse' title protected under the same rules - bringing it in line with the likes of titles 'paramedic' and 'physiotherapist' which are both limited to those on the professional register.

Brought by RCN Professional Nursing Committee member Alison Leary, the petition has recorded more than 20,000 signatures within a month, with signatories from all across the UK.

The principles behind the initiative have also been backed by the Royal College of Nursing (RCN), with Chair of the RCN Council, Dave Dawes, saying: "The Council meeting covered every angle on this topic and there was widespread support for the principle behind the petition.

"The debate in our meeting proved that this is such a crucial issue for our members that we need the wider membership to have their say on the best way to protect our professionals and those they care for."

On July 1, 2021, the Department of Health and Social Care (DHSC) responded to the petition, highlighting the Government's awareness of concerns caused by the lack of 'nurse' being a protected title. It did however also raise the complications associated with protecting the title, due to it's use in multiple professions (i.e., registered nurses, dental nurses, school nurses, and veterinary nurses) with some using only some using professional registers.

Proposals are also planned to further explore the issue of protected titles, as part of the ongoing government review of professional regulation, with DHSC working in collaboration with policy colleagues from the professional regulators, including the Nursing and Midwifery Council (NMC), as the regulator of nurses and midwives in the UK, and nursing associates in England, including officials from the DHSC and the Office of the Chief Nursing Officer for England.

DHSC will also consider in detail whether the protection of title offences relating to registered nurses, midwives and nursing associates are the right ones when bringing forward reform of the NMC's legal framework, following our consultation on the reform of all healthcare professional regulation.

# Going beyond ticking boxes and building inclusive workplace cultures

**Mohamed Jogi,** National Programme Manager for Diversity & Inclusion, NHS Employers

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We are at a critical juncture in history, nationally, globally, and within the NHS. Now more than ever, it is imperative that embedding equality, diversity and inclusion (EDI) in the NHS workplace, moves beyond ticking box intervention and becomes an integral part of the core business of the NHS.

It is well-established, for example, that people from Black, Asian and Minority Ethnic (BAME) backgrounds are at much greater risk of serious illness and death as a result of Covid-19. At the same time, the BME Leadership Network, which is delivered by the NHS Confederation, found staff from BME backgrounds were more likely to take high-risk roles, including working in frontline Covid-19 wards, for fear their contract may not be renewed or shifts reduced, especially if they were agency staff or had a vulnerable immigration status.

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Furthermore, looking beyond Covid-19, the findings of the most recent NHS Staff Survey showed, on almost all questions, that people who self-described or who preferred not to report their gender, experienced much worse levels of wellbeing and lower satisfaction in relation to work. This demonstrates the need to make improvements in NHS workplaces so that people of all genders have an equally positive experience, strengthening retention and reducing the risk of burnout.

There is room for optimism, however, and change is already underway across the sector to strengthen EDI and improve staff and patient experience. For example, at West Hertfordshire Hospitals NHS Trust — which has a workforce that is 40% BAME — the trust and its chief executive worked with colleagues from the Connect BAME Employee Network to talk about how to manage the impact of Covid-19. Together, they agreed on actions including staff risk assessments, admissions to the 'virtual hospital' and the creation of a helpline. The 'virtual hospital' was the first of its kind in the UK, and allows patients to recover at home, while updating the respiratory team looking after them via an app.

Also, Coventry and Warwick Partnership NHS Trust are now working with the University of Essex and ACAS to review and capture the impact of Covid-19 and its work with its BAME network, as part of a case study that will be published later this year.

Of course, good work was already underway even before the pandemic struck. For example, North East London NHS Foundation Trust worked to create an inclusive culture, based on the understanding that staff are less likely to feel engaged if they have a disability, come from a BAME background, or identify as LGBTQ+. To support this, it took on measures including organising specialist training sessions; introducing an employee assistance programme; and introducing a health passport system to allow effective provision of workplace adjustments for staff with disabilities or long-term health conditions.

But this kind of action must now become business as usual. Once this crisis passes, EDI must remain at the centre of NHS decision-making and the deep-rooted issues of inequality and discrimination must no longer be tolerated or ignored.

For its part, NHS Employers, which is part of the NHS Confederation, is working to provide organisations with support to embed EDI. For example, our Diversity and Inclusion Partners Programme is run on an annual basis and supports participating NHS trusts to progress and develop their equality performance, and build capacity in this area. The programme has now been running for more than 10 years and has worked with about 300 organisations.

Many of the organisations who have been through the programme have subsequently been recognised for their work on equality, diversity and inclusion. The University Hospitals of Morecambe Bay NHS Trust was ranked number 1 in the 2020/21 Inclusive Top 50 UK Employers List, and Leeds Community Heath, Northern Care Alliance, and Avon Wiltshire Mental Health Partnership NHS Trust all made the top 50 UK.

Moreover, at the NHS Confederation, there are networks available to health leaders, including the BME Leadership Network, as well as the Health and Care Women Leaders Network, and the Health and Care LGBTQ+ Leaders Network. All of these exist to support and strengthen the voices of people working in health and care who face inequality, underrepresentation and discrimination.

Health leaders continue to work hard to reverse inequalities, especially in the face of the disproportionate impact of Covid-19. The NHS Confederation and NHS Employers will continue to support them to work towards ending inequalities for both staff and patients.

Beyond action on the ground, it must also be for national policymakers to make sure they understand and follow their duties under the Equality Act 2010. They must view equality impact analysis as an integral part of decision making. It must not be seen as a chore, but instead a task requiring insight, imagination and a deep understanding of the way different communities use and benefit from services.

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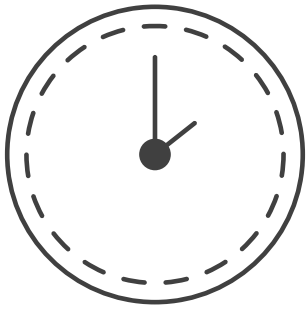
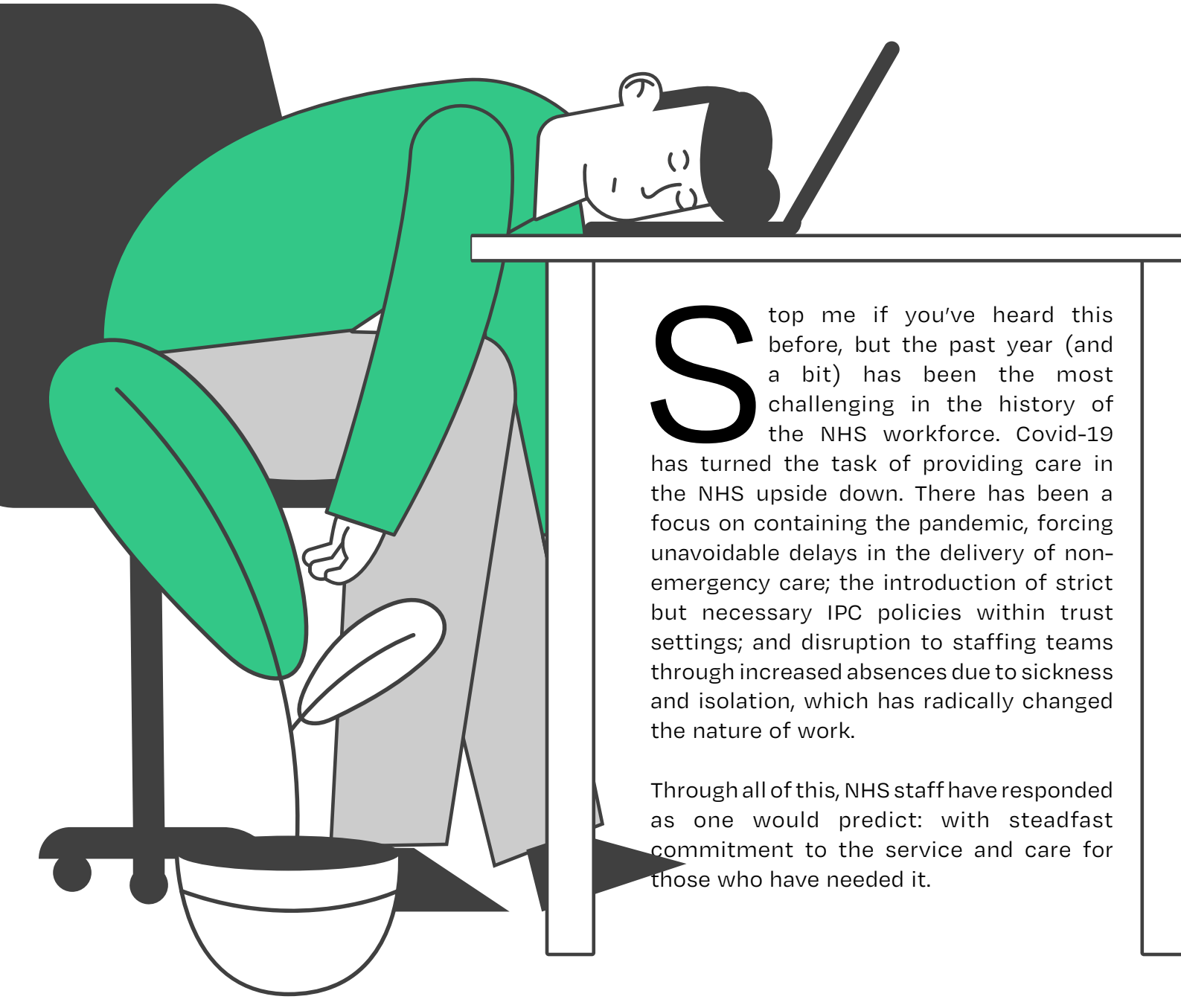
# Sustainable and national commitment needed to tackle staff burnout



**Finn O'Dwyer-Cunliffe,**
Policy Advisor, NHS Providers



Stop me if you've heard this before, but the past year (and a bit) has been the most challenging in the history of the NHS workforce. Covid-19 has turned the task of providing care in the NHS upside down. There has been a focus on containing the pandemic, forcing unavoidable delays in the delivery of non-emergency care; the introduction of strict but necessary IPC policies within trust settings; and disruption to staffing teams through increased absences due to sickness and isolation, which has radically changed the nature of work.

Through all of this, NHS staff have responded as one would predict: with steadfast commitment to the service and care for those who have needed it.

But the pandemic – and its impact on the workforce as it enveloped society in the early months of 2020 – has taken a toll. In our State of the Provider Sector survey last autumn, 99% of trust leaders said they were concerned about staff burnout within their organisations. This month, 48% said they have seen evidence of staff leaving their organisation due to early retirement, Covid-19 burnout, or other effects from working in the pandemic. This is a hugely concerning finding, supported by similar warnings in polls carried out by the BMA and IPPR, among others.

The NHS entered the pandemic in March last year with over 100,000 vacancies in the trust sector alone and – as we have consistently emphasised in comments to the media and in evidence to parliamentary inquiries – staff have for too long been asked to provide a level of discretionary effort to counteract workforce gaps.

Trusts are working hard to support their workforce and have prioritised staff wellbeing throughout the pandemic. As my colleague Sarah White wrote in May, trusts have been creative with the limited funds at their disposal to invest in staff wellbeing in recent months. They have focused specifically on the provision of additional counselling services to support staff both now and in preparation for the longer-term effects of work-related trauma; the development of wellbeing teams and organisation wide listening exercises, to ensure that leaders are addressing the most pressing issues for their workforce; and the repurposing of empty spaces into places where staff can rest and access free hot drinks and food.

It's a cliché, but in evaluating the impact of these programmes on staff, trust leaders have emphasised that 'every little helps', and have told us that dedicated support has indeed been appreciated. However, they have also been clear that sustained effort and investment is needed to support the workforce and address burnout beyond the immediate term. A commitment to recurrent funding from the government to support the continuation of these initiatives and deliver the NHS People Plan is a priority, alongside the announcement of a meaningful, real-terms pay rise for staff this summer, going beyond the insufficient 1% proposal submitted by DHSC earlier this year.

The most important action the government can take is to finally commit to a long-term, fully costed and funded NHS workforce plan – focusing both on recruitment of new staff and investing in key retention tools like CPD – to build flexibility into the system and give staff confidence that their workloads will be more realistic. As Professor Michael West stated last year, staff shortages are "the most important factor in determining chronic excessive workload" and burnout.

There are some signs of encouragement though. The NHS workforce has been growing, albeit gradually, but we've seen a significant increase in applications to healthcare degree courses over the past year. While this has likely been driven in large part by the introduction of financial assistance to students, public appreciation for the NHS and its workforce has been palpable throughout the pandemic, inspiring a heightened national commitment to its preservation and ongoing success.

Following the celebration of the NHS's 73rd birthday, and the welcoming of a new secretary of state and head of the service to the helm, we must not lose sight of the scale of effort required at all levels to address staff burnout in a sustainable and comprehensive manner which will be of benefit to us all.

# Increase in NMC registration doesn't mean the work stops

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**Andrea Sutcliffe CBE**, Chief Executive and Registrar, Nursing and Midwifery Council (NMC)

Our latest annual registration data report and leavers' survey for the past year, paints a cautiously optimistic picture. Even after a year of unprecedented challenge and uncertainty, we've still seen over 15,000 more nursing and midwifery professionals join our register.

**KEY FINDINGS** We now have almost 732,000 (731,918) nurses, midwives and nursing associates on our register, the highest number ever. We saw over 11,000 more nurses and 1,100 more midwives join in the previous year. We also saw the number of people leaving our register at its lowest ever, with fewer than 24,000 people leaving in 2020-21, compared to a peak of almost 35,000 in 2016-17.

Given the impact of the pandemic, I'm really glad to see this continued growth but there are reasons to remain cautious:

- Nursing and midwifery are global professions, and the UK benefits from the diversity of experiences and knowledge that those on our register bring to our services. But the pandemic and Brexit have highlighted just how vulnerable we can be to world events. In the five years since the EU referendum, recruitment from the European Economic Area (EEA) has dropped significantly, and the total number of EEA trained nurses on the register continues to decline.
- We've also seen significant growth in international recruitment outside the EEA - there are now 92,260 overseas trained professionals on our register. But in the past year, pandemic travel restrictions and pauses in international recruitment affected the number of overseas trained professionals joining our register.
- This makes it even more important for us to have a sustainable and balanced approach to developing our health and care workforce.

**REASONS TO BE HOPEFUL** The impact of Covid on the perception of nursing and midwifery has been hugely positive and that's inspired more people than ever before to apply for nursing courses (UCAS). That bodes well for the future.

It's not just recruitment we need to be mindful of though. We have a nursing and midwifery workforce of nearly 732,000 people, so we need to think about what we do to keep them. For example, the rise in the number of retirement age professionals on our register (6.2%) suggests (though we don't know for sure) that people may have stayed on to help tackle the pandemic. That's a tremendous testament to their commitment, but it could lead to increasing numbers leaving in the months and years to come.

We need people to have roles that are fulfilling and rewarding, with chances to develop their skills as their careers progress, including the flexibility they need at different stages in their lives.

**MOVING FORWARD** One of my favourite reads last year was the King's Fund 'Courage of Compassion' report, which I thoroughly recommend. It's a great guide to the steps individual employers and the wider system can take to transform workplaces, so nurses and midwives can thrive and focus on providing the high-quality care they want to.

We can't be complacent. We have to recognise the immense pressure colleagues have experienced and the challenges of the future. Professionals will now be turning their attention toward the restoration of elective services, and supporting the mental and physical health issues in the community that may have been exacerbated during the pandemic, as well as the impact of long Covid.

All of us, working across health and care, have a role to play in rising to this challenge. At the NMC, we will continue to play our part to support professionals to deliver the kind of care we all want to receive: safe, effective and kind.

# CQC Strategy 2021:

## Ground for optimism but much still to be learned

**Carl May-Smith**, Partner and Barrister,
health law firm Browne Jacobson

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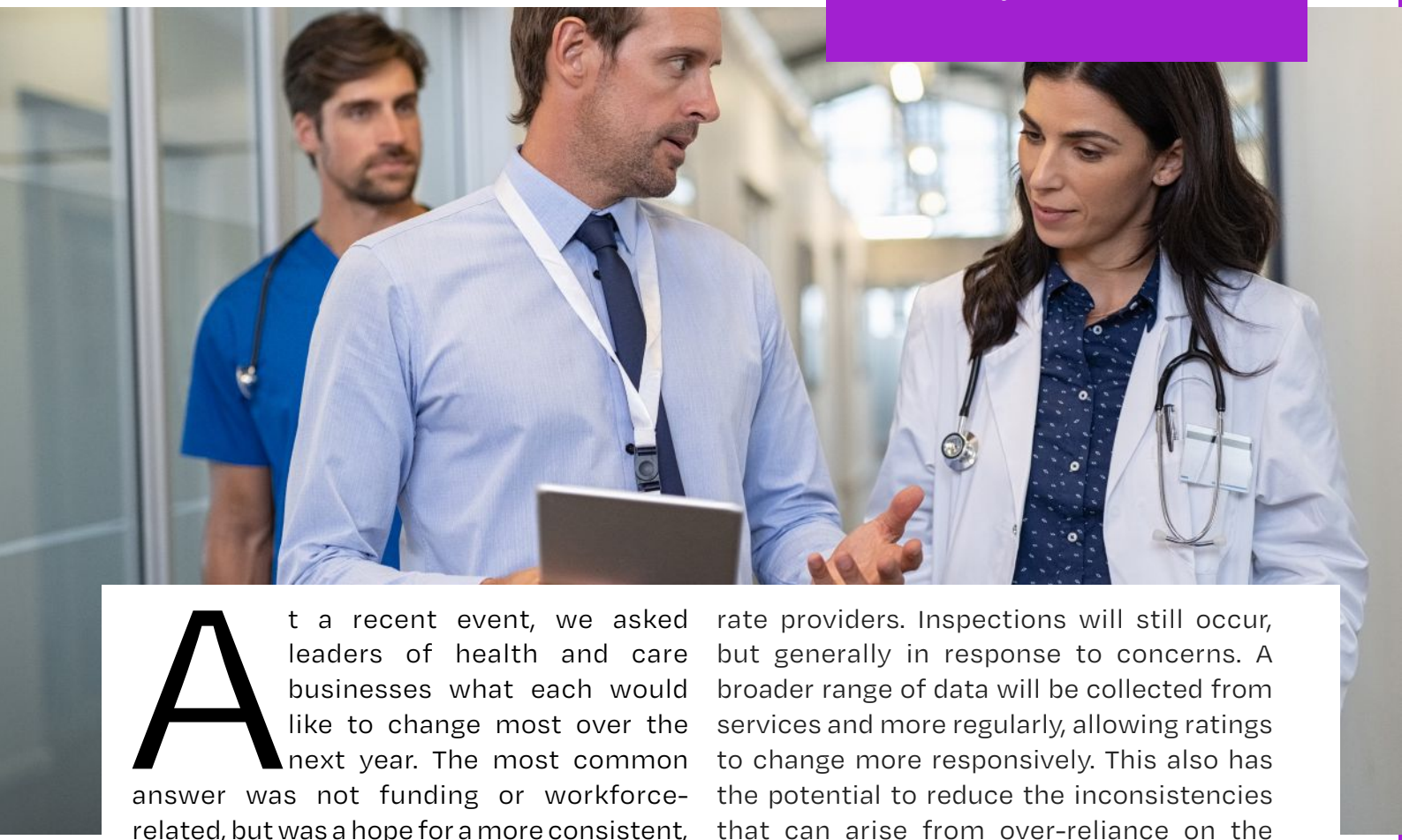


At a recent event, we asked leaders of health and care businesses what each would like to change most over the next year. The most common answer was not funding or workforce-related, but was a hope for a more consistent, collaborative regulator that truly understood their businesses.

With the CQC having launched its new strategy in June, will that hope be fulfilled? The truth is, we don't know. There is much still to learn about how the strategy will be implemented and those details will play a huge part in determining the final outcome. However, there are grounds for optimism.

**INSPECTIONS** One of the key changes in the strategy is the move away from reliance only on set-piece inspections to regulate and rate providers. Inspections will still occur, but generally in response to concerns. A broader range of data will be collected from services and more regularly, allowing ratings to change more responsively. This also has the potential to reduce the inconsistencies that can arise from over-reliance on the view of a lead inspector on a single day.

Where inspections are carried out, generally in response to concerns, providers should expect that they will be challenging and prepare accordingly. It is often said that a CQC inspector's first impression can set the stage for a whole inspection process. Increasingly, that first impression will have been formed before the inspection even commences as most inspections will be prompted by identified risks.

**RELATIONSHIPS** The CQC is talking about changing its relationship with providers, being more accessible and transparent. Understanding those it regulates better. Setting clearer expectations and benchmarks. Providing advice or signposting to reliable sources of guidance as part of meaningful engagement.

If realised, that ambition could be revolutionary for the sector. The development of mutual respect, trust and transparency has the potential to encourage innovation and investment. Providers should certainly seek to engage with their local inspectors.

The CQC as a leader in the sector, including in its new role regulating Integrated Care Systems, could play a vital role in sharing best practice and ensuring local systems work more effectively.

**SYSTEM-LEVEL REGULATION** The CQC's new 'core ambitions' are 'Assessing local systems' and 'Tackling inequalities in health and care'. This emphasises how much they are aiming to move beyond just provider-by-provider regulation to play a role in making the whole health and care system work better and work for everyone. Much of this will come from the powers due to be bestowed on CQC in the Health and Social Care Bill. This should be welcomed by those who have said that CQC's decisions over recent years have demonstrated a lack of a 'big picture' view.

**CQC INVESTMENT** Crucially the CQC acknowledges the need to recruit and upskill its own staff and to invest in technology as well as working with stakeholders to fundamentally change how it collects data and service user experiences.

**PROVIDER RISKS** Of course, there are risks for providers. There is reason to be wary of the CQC's drive to publish more data about services, including action plans agreed following difficult inspections, given the potential effect on their reputations. The CQC has a history of prioritising timely publication over providing an effective route to challenge.

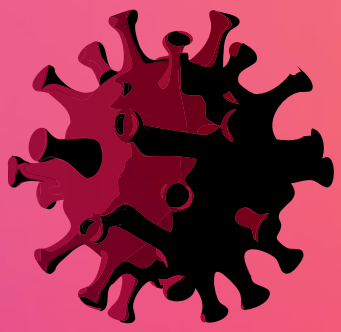
Clearer expectations and benchmarking, absent the time and expertise to fully understand specialist and innovative models of care, and can lead to a one-size-fits-all approach that stifles innovation. We have seen previous examples of CQC insisting on rigid compliance with certain guidelines, even when clinical practice has developed alternatives.

**ACTIONS FOR PROVIDERS NOW** Providers will need to adapt to data-led regulation, ensuring that they are equipped to and proactive in providing and analysing required data. It will be vital to provide data in a way consistent with similar providers, to avoid appearing as an outlier. Where data does suggest a concern, providers will need to identify this proactively and be able to provide an explanation and action plan. There is a risk that the regular provision of data will become burdensome and this will need to be factored in to resource-planning.

Continual, meaningful engagement with service users will be even more important than ever as otherwise the CQC will be reliant on feedback they collect themselves, which may be less balanced.

**STAYING UP TO DATE** There will be many changes to come in how the CQC operates. It is due to start with development of a new inspection and rating framework over the next year or less. A new scope of registration document may need to follow, as will new expectations on the provision of data and collection of service user feedback.

Providers that are to thrive under the new system will respond quickly to these changes, understanding how they feed into to the CQC's thinking and how they can adapt to ensure the best result for their services.



# Pharma



# Covid-19 vaccine equity:

## Five steps to a fairer future

**Andy Powrie-Smith,** Executive Director of Communications and Partnerships, European Federation of Pharmaceutical Industries and Associations (EFPIA)

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*The global nature of the pandemic demands strong, international action. Vaccine equity must be at the heart of this collective response.*

Innovative vaccine manufacturers and biotech companies are playing a key role in tackling the crisis by developing and delivering billions of vaccine doses.

From the outset, vaccine producers have supported fair and equitable access, playing an active role in the ACT-Accelerator partnership launched by the World Health Organization (WHO) and partners, and working with COVAX, the World Trade Organization (WTO) and the Coalition for Epidemic Preparedness Innovations (CEPI).

These intensive efforts are bearing fruit. After more than 200 clinical trials and nearly 300 partnerships and collaborations among manufacturers worldwide, production has increased in just a few months from zero to 2.2 billion Covid-19 vaccine doses by the end of May. It is estimated 11 billion doses will be delivered by the end of 2021 – enough to vaccinate the world's adult population.

Despite the progress to date, further immediate action is needed to support responsible dose sharing and further boost production without compromising quality or safety. In collaboration with companies and trade associations, the European Federation of Pharmaceutical Industries and Associations (EFPIA) and Vaccines Europe have set out a five-point plan for achieving vaccine equity as quickly as possible.

1

**STEP ONE: DOSE SHARING** We are working with governments that have significant domestic supplies of Covid-19 vaccine doses to share a meaningful proportion of their doses with low- and lower-middle-income countries. Additional uncommitted Covid-19 vaccine doses could also be made available. These goals can be achieved in a responsible and timely way through COVAX or other efficient established mechanisms.

2

**STEP TWO: OPTIMISE PRODUCTION** Vaccine producers will continue to maximise Covid-19 vaccine output without compromising safety and quality, including through additional collaborations with partners that can produce significant quantities. Together, manufacturers, governments, and suppliers of raw materials and components can find effective ways to scale up production.

3

**STEP THREE: TACKLE TRADE BARRIERS** As production capacity continues to expand, attention must turn to trade barriers and access to raw materials. I urge governments, in coordination with the WTO, to eliminate all trade and regulatory barriers to export, and to adopt policies that facilitate the cross-border supply of key raw materials, essential manufacturing materials, and vaccines along with the prioritised movement of skilled workers needed for Covid-19 vaccine manufacturing.

We must also support CEPI's effort to create an independent platform that would identify and address gaps in these inputs and facilitate voluntary matchmaking for fill and finish capacity through the newly established COVAX Supply Chain and Manufacturing Task Force.

4

**TEP FOUR: SUPPORT COUNTRY READINESS** While vaccines are essential, it is vaccination that will make or break the global drive to protect people. Companies are committed to partnering with governments

on Covid-19 vaccine deployment, particularly in low- and lower-middle income countries, to ensure that they are ready and able to deploy available doses within their shelf life. In so doing, we must take care not to disrupt the production and deployment of other vaccines that remain vital to public health worldwide.

5

**STEP FIVE: DRIVE INNOVATION** We won't rest until the world has the tools to end the pandemic. Innovative companies will continue to develop new Covid-19 vaccines and treatments, including vaccines effective against variants of concern. To facilitate this, governments must guarantee unhindered access to virus samples and sequences of any Covid-19 variants.

Political momentum is building behind vaccine equity. At the G7, G20 and international organisations there is a growing focus on fairness. Our industry will continue to play a central role in solving this crisis. After all, no one is safe until everyone is safe.

# A win for patients

## Why broader access to treatments for rheumatoid arthritis can benefit patients and the NHS

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**Professor Ernest Choy,** Clinical Professor, Cardiff University, School of Medicine

NICE has recommended the use of biologics, including adalimumab, etanercept, and infliximab for rheumatoid arthritis patients who have not responded to conventional therapies, following a review of their guidelines.

Biological treatments were previously only recommended for severe rheumatoid arthritis. Since biosimilars have become available, the NHS can provide these treatments to a broader group in a way that is financially viable, without compromising the quality of treatment and effectiveness.

Rheumatoid arthritis is an incurable chronic systemic inflammatory autoimmune disease in which the synovial joints (such as those in the hands and feet) become inflamed, causing pain, swelling and stiffness.

The expansion of the guidelines is welcomed news for approximately 25,000 people who have moderate rheumatoid arthritis, where conventional therapies have been unsuccessful. They will now be able to access these transformative treatments at an earlier stage in their disease, which will mean real long-term remission is possible before joint damage has occurred. Furthermore, this decision provides more choice to clinicians, as well as an overall lower cost of treatment for the NHS.

To qualify, patients must have an active disease with a score of 3.2 to 5.1. It is approximated that 15% of people with rheumatoid arthritis will now be eligible for these newly recommended treatments.

Rheumatoid arthritis can develop at any age but the peak age of onset in the UK is about 40–70 years. As the onset of the disease often occurs whilst people are still at the working age, managing flare ups can be extremely difficult. Back pain, arthritis and other conditions of musculoskeletal pain are some of the main causes of work disability in the UK, accounting for the loss of 10 million working days per year, at a cost of £7bn.

The treatments approved fall into the biological Disease-modifying antirheumatic drug (DMARD) category and act by altering the underlying disease rather than treating symptoms.

What makes biological treatments different to conventional DMARDs is their mechanism and point of usage in the disease pathway. Conventional DMARDs are the first therapy prescribed for patients. If these fail to improve symptoms, then biological DMARDs are recommended. There is strong data to support these being used in combination therapy with conventional DMARDs.

DMARDs work by interacting within the inflammatory cascade, reducing the excessive antibody response. Biological DMARDs differ in being highly specific and targeting pathways of the immune system.

Following the update of the guidance, it will be another three to four weeks before patients can benefit from the treatments. This decision is a great step forward for people with moderate rheumatoid arthritis and will help thousands of people live a fuller life, both physically and mentally.

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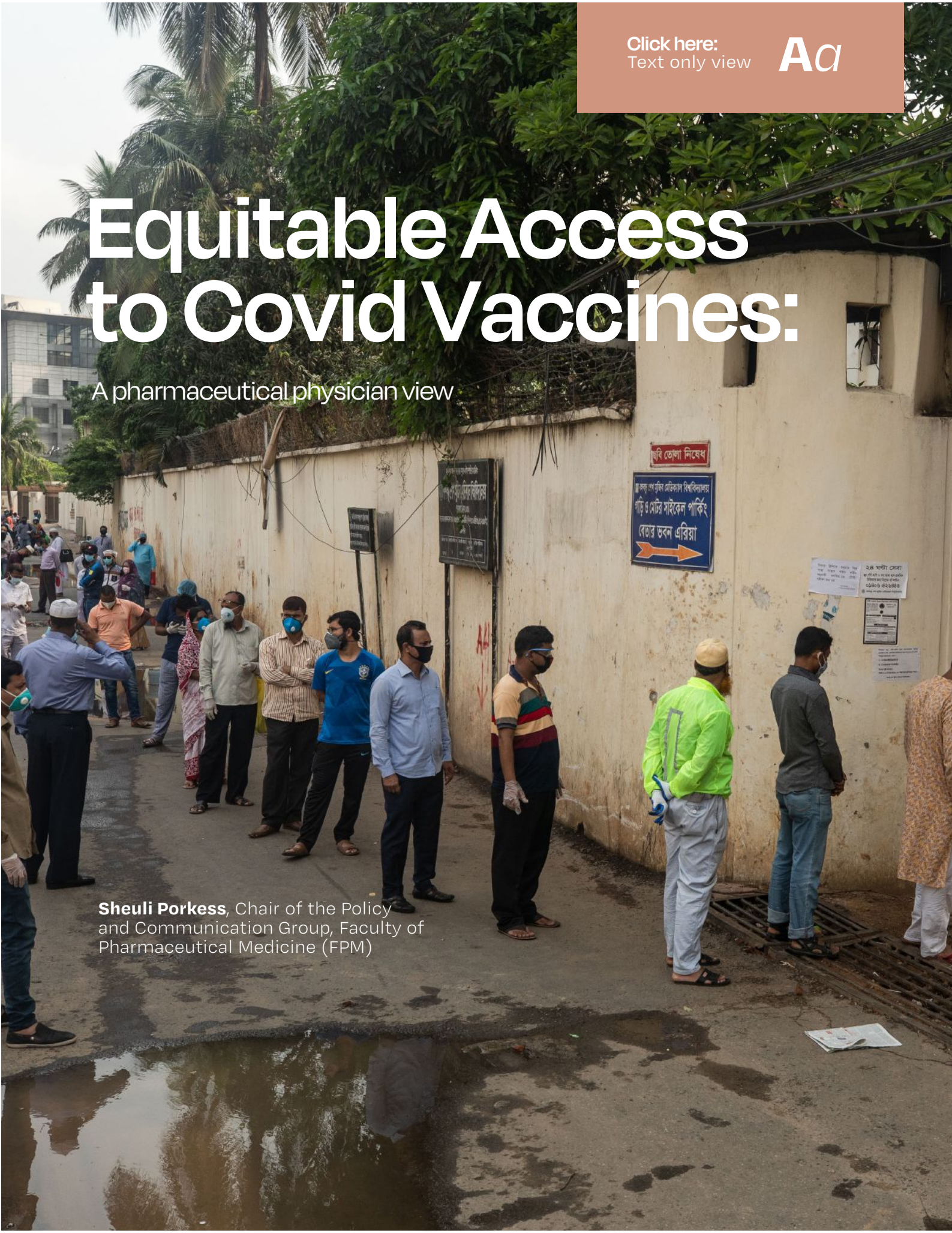
# Equitable Access to Covid Vaccines:

## A pharmaceutical physician view




**Sheuli Porkess**, Chair of the Policy and Communication Group, Faculty of Pharmaceutical Medicine (FPM)

The research and development and pharmaceutical medicine communities have delivered an incredible response to the pandemic with multiple vaccines being available within 18 months of the emergence of SARS-COV2. However, vaccines are not reaching the global population in an equitable way and this blog looks at three aspects of working towards equitable access.

**WHY IS RESEARCH METHODOLOGY IMPORTANT WHEN THINKING ABOUT EQUITY?** One of the things we've seen over the year is the challenge of getting research up and running quickly to provide the evidence to be reviewed by the regulators. The FPM has been very active in providing expert commentary for our members and the public as the situation has unfolded.

One of the important collaborations was, and will continue to be, the regulatory agreement on what information needs to be collected. The International Coalition of Medicines Regulatory Agencies, with 22 members including the US, UK, Japan and EU, published guidance in July 2020 on preclinical and clinical data required to support proceeding to Phase 3 clinical trials and considerations for study design for Phase 3 clinical trials. This was important to ensure no regulatory issues and enable any regulatory review to be as rapid as possible. However, regulatory assessments are based on the evidence or data collected so it's important that the data reflect the population the vaccine is intended for.

We saw trials recruiting rapidly. In the UK, this was made possible by the designation of some Covid trials as Urgent Public Health trials, which provided priority status and focus as well as the development of an NHS Covid-19 vaccine research registry where people could sign up so they can be contacted to enter trials. It was seen that there were differences in the profile of people signing up. In October 270,000 people had signed up but Black, Asian, minority ethnic groups, those with chronic diseases and overs 65s were underrepresented.

The regulators undertook rolling reviews of the data as it emerged, rather than waiting until the end, to enable them to issue emergency approvals as soon as possible and in the UK, the first person received a Covid vaccine on December 8, 2020.

One particular population that is worth us considering is that of pregnant and breastfeeding women. The advice from the JCVI (Joint Committee on Vaccination and Immunisation) in December 2020 was that there is insufficient evidence to recommend routine use of Covid-19 vaccines during pregnancy, that vaccination in pregnancy should be considered where the risk of exposure to SARS-CoV2 infection or serious complications is high and then, clinicians should discuss the risks and benefits of vaccination with the woman, who should be told about the absence of safety data for the vaccine in pregnant women.

This was updated in April 2021 to say that it's preferable for pregnant women in the UK to be offered the Pfizer-BioNTech or Moderna vaccines where available, based on real-world data from the US on around 90,000 pregnant women. There is ongoing research into the safety, tolerability and immunogenicity of the Pfizer-BioNTech Covid-19 vaccine in healthy pregnant women with the UK joining the study this week which has been ongoing in the UK since February.

The overall theme of women's health and the role of research is one that we're looking at within the FPM.

And if we think about children, the FDA has now given emergency authorisation for the Pfizer/BioNTech vaccine based on a trial involving 2,260 young people between 12 and 15 years old.

However, the need to collect information hasn't stopped. These are new vaccines and the need to monitor their effects is critical. The WHO has issued a safety surveillance manual and recommends that infrastructure and capacity for surveillance of the safety of Covid-19 vaccines should be in place in all countries and existing infrastructure be reactivated and engaged before a vaccine is introduced, requiring local, national, regional and global collaboration.

And there is more research needed into the emerging variants and how this is managed over time.

**HOW CAN MANUFACTURING BE UPSCALED?** Manufacture of vaccines is a critical step and whilst it needs to be done quickly, this must not compromise quality and safety standards. Manufacture of vaccines is a complex process, requiring skills and technical know-how and so effective manufacturing capacity expansion needs to address this as well as providing for highly specialised equipment, technology transfers, and management of complex international supply chains. For example, the BioNTech/Pfizer vaccine contains 280 ingredients sourced from 19 countries.

Before Covid-19, annual global vaccine production, including seasonal flu vaccines, totalled 5bn doses. During the pandemic, vaccine manufacturers have continue to produce those whilst adding capacity to aim to make more than 10bn Covid-19 doses.

The challenge of scaling up manufacturing was identified as early as March 2020. At this time pharmaceutical companies identified that collaborations would be needed and they made a commitment to "increase industry's manufacturing capabilities and willingly share available capacity to ramp up production once a successful vaccine or treatment is developed".

Examples of this include Sanofi announcing an agreement to help manufacture the Moderna Covid-19 vaccine, in addition to their commitment to provide manufacturing support for the BioNTech and J&J vaccines. Another example was Novartis announcing an agreement to support the production of the Pfizer-BioNTech Covid-19 vaccine.

However, there are challenges which were discussed at a meeting in March 2021, COVAX, IFPMA, the Developing Countries Vaccines Manufacturer Network and the Biotechnology Innovation Organization reviewed the situation, and the supply chain challenges which are emerging due to the unprecedented upscaling. All stakeholders agreed there is a need to expand capacity in a way that promotes equitable access. However, more needs to be done and in May 2021 manufacturers and biotech companies announced commitments to step up dose sharing; continue to optimise production; call out trade barriers to be eliminated; support country readiness; and drive further innovation.

The FPM have issued a statement on Covid Vaccine Supply, emphasising that new collaborations are essential to increase supply without compromising safety and quality. One example of a collaboration is COVAX, the vaccines pillar of the Access to Covid-19 Tools (ACT) Accelerator. The aim of COVAX is to accelerate the development and manufacture of Covid-19 vaccines, and to guarantee fair and equitable access for every country in the world aiming to have 2 billion doses available by the end of 2021, which should be enough to protect high risk and vulnerable people, as well as frontline healthcare workers.

Are vaccines being distributed to ensure equitable uptake?

**Even with sufficient quantities of Covid-19 vaccines available, there are significant challenges in upscaling delivery of vaccines. These include vaccine hesitancy, storage and transportation hurdles, and coordination of a large immunisation program across multiple communities.**

Within the UK, we're seeing disparities in uptake of vaccines: the open safely study showed that in the first month of vaccination in England there was a substantial divergence in vaccination by ethnicity within the group (White 42.5% vaccinated, Black 20.5%). And this has persisted – by May 2021, for the 80 years and older population, around 97% of those with White ethnicity have been vaccinated compared to 75% of with Black ethnicity and this difference is seen across the age groups. And we need to find ways to address this as we discussed at a recent FPM event.

In summary, equitable access is needed urgently and we must find innovative solutions. Achieving equity of access requires finding ways to design and conduct research for all populations, manufacturing quickly and safely and then ensuring equity of delivery and uptake across populations.

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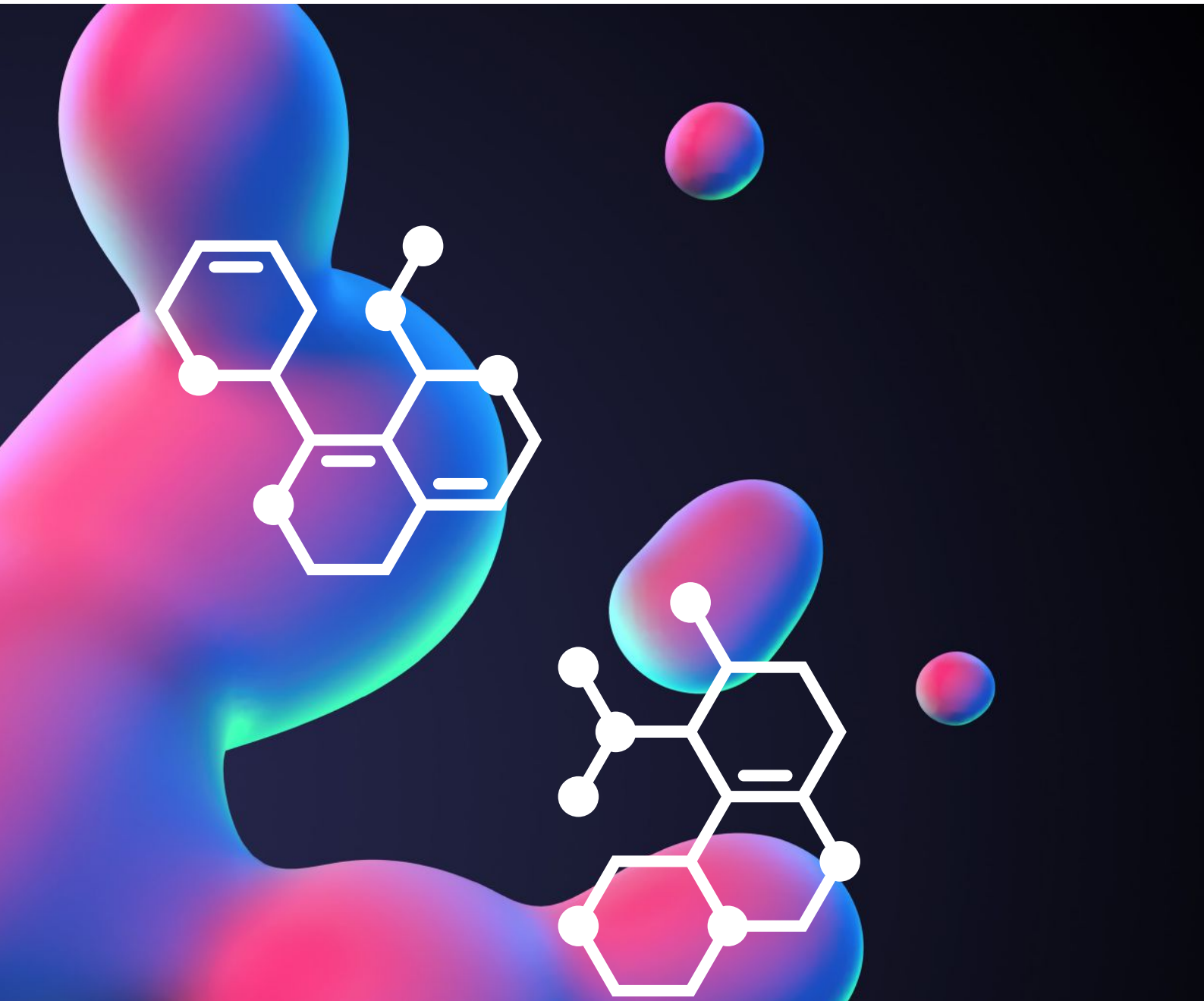
# Build back better:

## What does this mean for the development of medicinal products in the UK?

**Marcia Philbin**, Chief Executive, Faculty of Pharmaceutical Medicine (FPM)

The global pandemic caused by Covid-19 has dominated our lives for the last 18 months. We have witnessed unprecedented collaboration between governments, industry, academia and healthcare providers to develop vaccines, and diagnostic as well as therapeutic treatments.

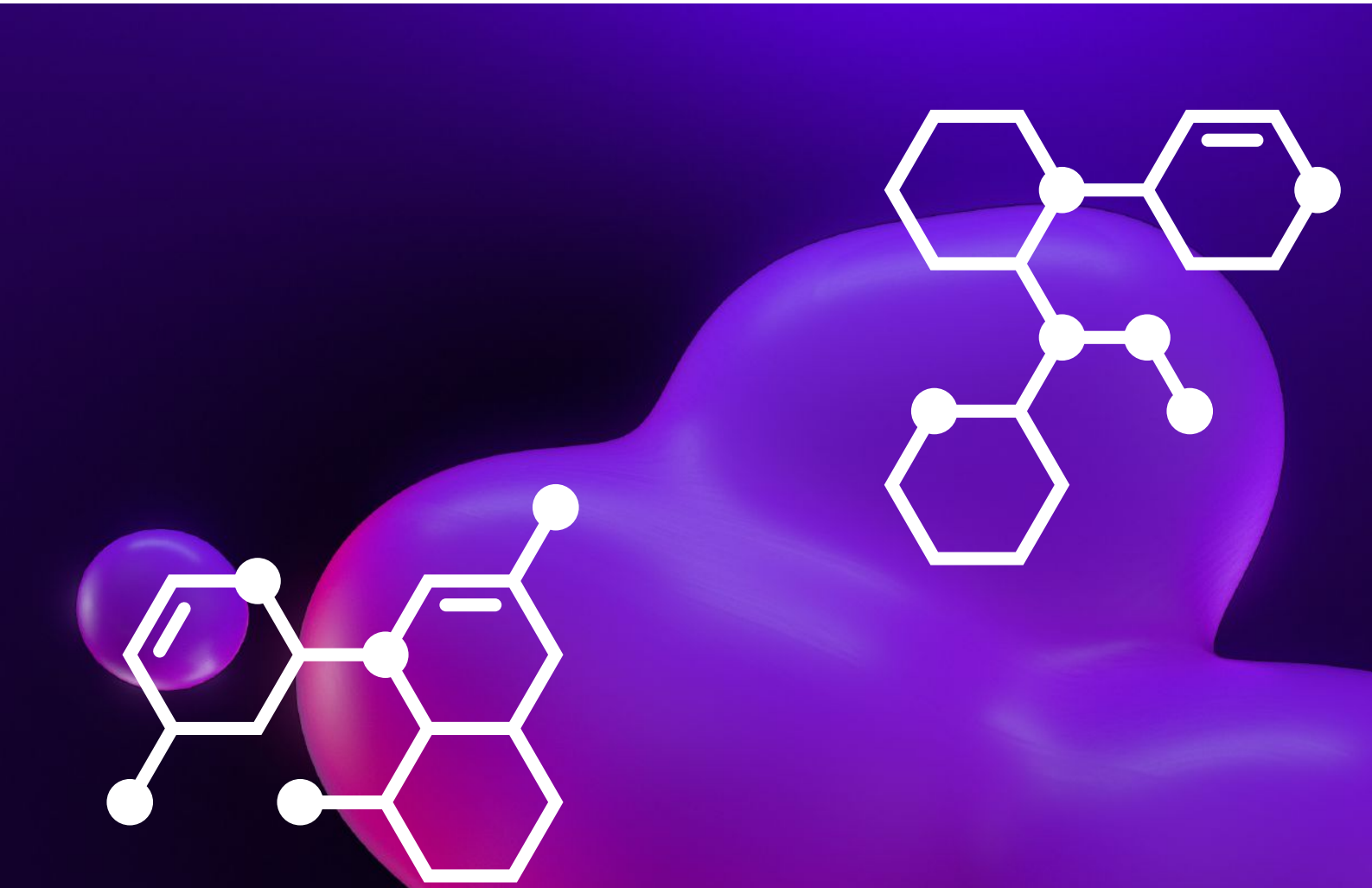
Members of the Faculty of Pharmaceutical Medicine (FPM) have been directly or indirectly involved in this global effort with many involved in clinical trial programmes across the world in various capacity such as safety consultants, regulators or clinical trial investigators. As we start to emerge from the pandemic, how can FPM support the national effort to build back better?



**CLINICAL TRIALS** The pandemic has disrupted or stopped non-Covid 19 clinical trials in the UK as resources were redeployed to support Covid-19 programmes. In 2020, FPM surveyed its members to understand how the pandemic had affected the work of pharmaceutical physicians on clinical trial programmes. Respondents reported amendments to the ethics process to speed up approvals for clinical studies, the challenge in recruiting as well as maintaining patients and the revision to the registration process for new medicinal products.

A key development was the adoption of remote monitoring of trial participants in terms of source data verification and remote data collection. This adaption is likely to continue in some form as it provides more flexibility for trial participants.

Another noted success was the greater collaboration between research teams and the improved communication with regulatory bodies which helped to expedite approvals for new clinical trials.



An important recommendation resulting from the survey is that FPM members should be invited to contribute to discussions with key stakeholders such as the Department of Health and Social Care to inform decisions and priorities with national clinical trial programmes. Pharmaceutical physicians are experts in all aspects of medicine development, have acquired practical research skills in industry and have real world experience in designing and leading clinical studies. This gives them a unique perspective which will be invaluable in responding to future pandemics as part of the build back better agenda.

**CLINICAL RESEARCH SKILLS** In building back better, it has been accepted that clinical research capacity must be built into the NHS. FPM is the UK standard setting body for pharmaceutical medicine and offers examinations and training programmes based on these standards. FPM coordinates the Pharmaceutical Medicine Specialty Training (PMST), which is a four-year specialty training programme for physicians to gain accreditation and apply to be on the GMC's specialist register for pharmaceutical medicine.

FPM currently offers specific training in human pharmacology enabling physicians working within Phase I units to be credited as first in human investigators by the MHRA via the Diploma in Human Pharmacology examination. The training enables clinical investigators to ask the right questions and anticipate and address potential issues that may arise prior to and during conduct of first in human studies.

In addition, FPM offers specific training for experimental medicine as well as a recognised qualification, the Diploma of Experimental Therapeutics. The certificate qualification in both pharmaceutical medicine and human pharmacology can be undertaken by non-physicians with an interest in acquiring knowledge about medicine development.

**DIVERSITY IN CLINICAL TRIALS PROGRAMME** The Covid-19 pandemic highlighted some of the potentially disproportionate barriers faced by black, Asian and ethnic people to participate in clinical trials. Fortunately, several initiatives focused on increasing diversity in clinical trial participants are currently underway:

The Pharmaceutical Research and Manufacturers of America has produced a resource for increasing racial diversity in clinical trials with a particular focus on the importance of building trust.

The Centre for Black and Minority Ethnic Health (CBMEH) based in Leicester is advocating for education in cultural competency amongst researchers.

The Equality, Diversity, and Inclusion in Science and Health (EDIS) Group is a coalition of health organisations that support the expansion of diversity in research design.

The National Institute for Health Research (NIHR) has commissioned the INCLUDE project to examine how to improve inclusion of underrepresented groups into clinical research.

In summary, the Covid-19 pandemic has disrupted everyone, regardless of professional status, socio-economic background, ethnicity or gender. It has exposed divisions and structural inequalities in society.

However, there has been unprecedented national and global collaboration to solve a world-wide problem. Post-pandemic, FPM will advocate for greater diversity in clinical trial programmes, the adoption of new technology to support delivery of clinical trials, and increase investment in clinical research skills so that the UK is better prepared for the next global pandemic. Then we can confidently say we have built back better.