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Abortion and the world post Roe vs Wade: protecting human rights in the UK

This editorial was originally written as an overview of this issue of the *British Journal of Healthcare Management*, with some additional commentary on this month's clinical focus on malnutrition and gastrointestinal conditions. These widespread and often overlapping conditions have been discussed with excellent insight and expertise by our authors. However, on Friday 24 June, a political event occurred that was of such significance to health and human rights that I believe the journal could not be published without commentary on it.

The overturning of Roe vs Wade by the United States (US) Supreme Court removes the constitutional right of women and other persons who can become pregnant to legal and safe abortions in the US. While the ruling does not, in itself, ban abortion, it allows individual states to place heavy restrictions or bans on this medical procedure. Overall, severely restrictive laws against abortion are expected in around half of US states, many of which will be upheld even in cases of rape or incest (The Associated Press, 2022).

Debates regarding abortion are often centred around human rights, economic factors and gender equality. However, as a procedure, abortion is a medical treatment, so any legislation around it has legal and ethical implications for healthcare services. An inevitable consequence of banning or restricting abortions is that many women will be forced to continue with pregnancies, even when doing so is a risk to their health. Although state laws do provide an exemption to abortion restrictions in medical emergencies, an amicus brief to the Supreme Court, created by over 20 US medical groups, reported that the definition of a medical emergency is often too narrow (American College of Obstetricians and Gynecologists et al, 2021). The brief highlights that, under new laws in states such as Mississippi, clinicians may have to withhold treatment from patients who are at high risk of complications until their condition deteriorates to a life-threatening level. Not only does this put the mother at greater risk of serious complications, it also puts healthcare professionals in an 'impossible position' whereby they must choose between allowing a patient to become seriously ill or breaking the law (American College of Obstetricians and Gynecologists et al, 2021). The amicus brief also points out that many common conditions that can pose a substantial risk to a pregnant individual's wellbeing are not covered by such exemptions, including diabetes, pulmonary hypertension and valvular heart disease, as well as mental ill health (American College of Obstetricians and Gynecologists et al, 2021).

The overturning of Roe vs Wade, and the subsequent introduction of bans and restrictions on abortions, thus represents a barrier to medical treatment. There are many mental and physical health risks associated with pregnancy, particularly for Black women and those from poorer backgrounds (American College of Obstetricians and Gynecologists et al, 2021). The Supreme Court's decision does not come with any measures to mitigate these risks, thus it is likely that maternal morbidity and mortality rates will increase once the option of abortion has been removed. It is also likely that these measures will lead to more people undergoing abortions illegally, putting them at greater risk of harm; the risk of abortion-related death is 34 times higher in countries with restrictive abortion laws (Smith, 2022).

These effects are likely to be felt in the short term, both by people who face an unwanted and/or non-viable pregnancy and the healthcare services that could previously have treated them. However, the restriction of abortion also has longer-term public health implications. Around 75% of those who seek abortions in the US live below the poverty line (American College of Obstetricians and Gynecologists et al, 2021). Lack of access to safe abortion leads to more women having to exit the labour market and increases the likelihood of families living in poverty (Corbett, 2022). Therefore, restricting reproductive rights may exacerbate existing socioeconomic health inequalities, particularly among those from marginalised groups.

It is easy to see the Supreme Court's decision and the inevitable fallout as something that is happening far away. It is true that opposition to abortion is far less prominent in the UK overall, and the principles of shared decision making and patient autonomy are upheld

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across medical institutions, including the NHS and the royal colleges. However, although the right to abortion up to 24 weeks is protected in UK law, many still face significant barriers. In Northern Ireland, abortion was only decriminalised in 2019; although abortion services are now legal, political opposition means that none have been centrally commissioned (Connolly, 2022). Meanwhile, none of the health boards in Scotland offer abortions up to the 24-week limit (Connolly, 2022).

Following the removal of the constitutional right to abortion in the US, it is crucial for UK institutions to speak out for reproductive rights and improve access to legal and safe abortions in the NHS. The US is a major political, economic and cultural power, so there are concerns that the Supreme Court's decision could provide fuel for anti-abortion groups in the UK (Connolly, 2022). So far, many leading UK politicians, including Prime Minister Boris Johnson, have denounced the overturning of *Roe vs Wade* (Woodcock, 2022). Efforts have also been increased to establish 'buffer zones' around abortion clinics to prevent the harassment of patients and staff attempting to enter (British Pregnancy Advisory Service, 2022). These steps, plus an expansion of abortion services across the UK, could provide reassurance to women and others who can become pregnant.

Yet, events in the US still cast a heavy shadow over health rights in the western world. The overturning of *Roe vs Wade* removes the constitutional right to bodily autonomy from over half the US population. Not only does this have myriad public health implications, it is also a major step backwards for gender equality. US law now holds pregnancy as the only situation in which a person must use their body to sustain the life of another—in no other circumstance is this the case; explicit consent is needed to use an individual's blood or organs to save the life of another, even if that individual is dead. Exactly where that ethical code places the rights of a pregnant woman in a world post *Roe vs Wade* is difficult to comprehend.

The decision of the Supreme Court on 24 June serves as a stark reminder of the need to defend human rights; it is not enough to assume that, once granted, they cannot be taken away, nor is it appropriate to look abroad and simply say 'that would never happen here'. Currently, the UK government is drafting a national Bill of Rights to replace the 1998 UK Human Rights Bill. Healthcare leaders and professional bodies should review this bill, and particularly any amendments to human rights related to health, with the utmost scrutiny and ensure that their voices are heard.

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The mental health crisis breathing space: what healthcare managers need to know

Laura Peters, head of mental health and money advice at Rethink Mental Illness, shares her insights into the mental health crisis breathing space scheme, how it can improve mental health crisis treatment and how healthcare professionals can help more patients to access this support.

Mental health conditions can impact an individual's ability to manage their money. This can happen for various reasons, such as impulsive spending caused by bipolar disorder, an anxiety disorder causing difficulties in contacting the bank, or problems with focusing and remembering important information because of schizophrenia. As a result, people who have experienced a mental health problem over the last 3 years are four times more likely to be behind on their bills and to be borrowing money to pay off their debts (Money and Pensions Service, 2022).

When someone with debt spirals into a mental health crisis, managing money can be nearly impossible, and having to worry about potentially losing their home and possessions can impede recovery. However, support is available for those experiencing both debt and a mental health crisis and healthcare professionals can play a key role in helping these individuals to access this support.

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The mental health crisis breathing space

In May 2021, the UK government introduced the mental health crisis breathing space (MHCBS) service to England and Wales (Mental Health and Money Advice, 2022). The MHCBS gives people who are experiencing an acute mental health crisis legal protection from creditors who may be requesting payments from them and, for the duration of their treatment, provides a freeze on most interest and charges on their debts. This protection lasts for the length of the individual's mental health crisis, plus an additional 30 days.

To be eligible for the MHCBS, an individual must be in crisis treatment, whether this is delivered by a crisis house, a crisis home treatment team or a community mental health team. Those who have been detained under the Mental Health Act are also eligible for the scheme.

The mental health charity Rethink Mental Illness is running a bespoke service, funded by the Money and Pensions Service, for people who wish to access the MHCBS scheme in England, with Citizens Advice Cymru providing a similar service in Wales. The aim of this is to address debt issues and help with the patient's long-term recovery. However, to ensure that this service is accessible to all who are eligible, it is crucial for healthcare professionals to be aware of the MHCBS scheme and refer patients accordingly.

The benefits of a financial breathing space

There is a clear link between money worries and mental health, with the former often exacerbating the latter (Mental Health Foundation, 2022). Therefore, having a break from financial concerns may be very beneficial for a patient experiencing a mental health crisis, as it can give them the time and space they need to focus on recovery without worrying about money. The protection provided by the MHCBS scheme can also prevent evictions, bailiff action and deductions from wages or benefits.

One of the most important benefits of the MHCBS service is that it provides a route towards debt advice as, once an individual is under the scheme, debt advisers at Rethink Mental Illness reach out to them to provide advice and support with debt. The charity also engages with carers, healthcare professionals and other third parties in cases where the

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patient does not have the capacity to manage their debts. In the author's experience, people who have used the MHCBS service have been able to better manage their debt problems with the support of their debt adviser, finding ways to write off their debts, receive charitable payments or renegotiate debt payments.

Being in debt can be overwhelming for someone with mental ill health and/or issues with their mental capacity. To address this, the debt advice services under the MHCBS scheme in England can be split into several shorter sessions to help the patient retain focus and manage their anxiety. Meetings are usually planned for later in the day, as some medications for mental health conditions can make patients feel lethargic and less able to focus in the mornings. Sessions are delivered in plain English, with information given in manageable 'chunks'. Both verbal and written communication is used, with emphasis placed on key points to act on.

The ability to engage with people through the MHCBS before they leave crisis care presents a unique opportunity to reach patients at a particularly vulnerable time and help to ensure their long-term recovery. The pro-active approach of the scheme allows holistic care to be delivered, with debt advisers who are equipped with both mental health and financial knowledge.

How healthcare professionals can help

Frontline healthcare professionals can look out for signs that their patients may be experiencing serious debt problems and take action to prevent this from further impacting their mental health by referring them to the MHCBS scheme. This can be done via the online portal: <https://www.maps.org.uk/mental-health-crisis-breathing-space/>. The MHCBS referral process has been designed to be as simple as possible, and can be completed by a mental health professional, a care coordinator, a mental health nurse, a social worker, an advocate, an attorney or a deputy. The patient themselves (or their carer) can also make the referral.

After an individual has been referred, a nominated point of contact (a healthcare professional involved in the patient's care) must confirm their continued eligibility for the MHCBS scheme every 30 days. It is important that this is done in a timely manner to ensure that the patient does not lose access to this support.

Healthcare managers can support the MHCBS scheme by sharing information about why it exists and how to refer patients with their staff in team meetings and around their practice. Rethink Mental Illness can also provide materials such as posters or leaflets to leave in patient waiting areas to raise awareness of the scheme among service users; this may make the initial conversation with the patient about debt easier.

There can be a vicious cycle when it comes to mental health and money. Living with a mental illness can make it difficult to manage finances, leading to money issues, which in turn cause stress and can push the individual into a mental health crisis. The MHCBS service can give patients the time and tools to get their finances back on track, which can ultimately help them reach and maintain recovery.

Rethink Mental Illness are running regular webinars aimed at healthcare professionals to help optimise the scheme. These can be accessed at <https://www.rethink.org/aboutus/what-we-do/mental-health-breathing-space/>

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A holistic approach to the treatment of Crohn's disease and ulcerative colitis

Inflammatory bowel disease, including Crohn's disease and ulcerative colitis, is common, chronic and sometimes debilitating. Lucy Williamson explores the barriers to diagnosis and treatment, highlighting the importance of holistic, specialist care for this patient group.

Crohn's disease and ulcerative colitis, the main forms of inflammatory bowel disease (IBD), are chronic diseases that cause inflammation in the wall of the gastrointestinal tract. They are life-long, complex conditions that follow an unpredictable pattern of relapse and remission (NHS, 2020). The causes of IBD are widely debated, but are likely to involve a combination of genetic factors and environmental factors (such as smoking) that cause the immune system to react inappropriately to external triggers, such as bacteria (Hlavaty et al, 2013; Centers for Disease Control and Prevention, 2022). The diagnosis of IBD is confirmed by clinical evaluation, as well as haematological, endoscopic, histological or imaging-based investigations.

There is currently no cure for IBD, so treatments largely focus on symptom relief. These interventions can be highly invasive, with 25% of people with ulcerative colitis requiring a colectomy and approximately 80% of people with Crohn's disease requiring some form of surgery (Mowat et al, 2011).

An estimated half a million people live with IBD in the UK. Approximately 20% of patients with Crohn's disease and 12% of patients with ulcerative colitis develop the condition before the age of 20 years, meaning that many patients will be of school or working age (Rosen et al, 2015). Developments in care mean that most patients will be able to lead active lives. However, a shift is still needed to deliver care that is more personalised, preventative and proactive.

Challenges in diagnosing inflammatory bowel disease

People diagnosed with IBD may be affected by loss of income, absenteeism and loss of work opportunities, as well as strains on familial relationships (Purc-Stephenson et al, 2014). Both ulcerative colitis and Crohn's disease can cause diarrhoea and an urgent need to go to the toilet. This can lead to accidents, which can leave patients feeling embarrassed, uncomfortable and anxious about socialising or being active, particularly as there is still societal stigma around IBD and bowel problems (Crohn's and Colitis UK, 2022).

Diagnosing IBD can also be challenging, as the symptoms and the patterns of relapse and remittance can overlap with irritable bowel syndrome (Nazarko, 2019), thus it may take time for IBD to be recognised. To differentiate between the two phenomena, faecal calprotectin testing should be performed (National Institute for Health and Care Excellence, 2013). This is a relatively straightforward test, but many patients still struggle to get a timely diagnosis for their symptoms. A survey of over 10 000 patients with IBD found that 26% waited for over 1 year from symptom onset for their IBD diagnosis, while 41% visited the accident and emergency department at least once before getting their diagnosis and 12% visited three times (IBD UK, 2021). This is distressing for patients, who may experience debilitating symptoms without having an understanding of their condition or access to effective treatment. This may also increase their risk of complications from IBD affecting other parts of the body, including the joints, kidneys, liver and bones (Crohn's and Colitis Foundation, 2022).

Meanwhile, delayed diagnosis has cost implications for healthcare providers, as it increases the likelihood that the patient will require surgery and more expensive treatments,

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as well as leading to a poorer prognosis (Mozdiak et al, 2015). In 2006, the annual average cost to the NHS per patient with IBD was estimated to be as high as £3000, meaning that, based on estimates of prevalence, the condition may cost as much as £900 million per year (Lucas and Bodger, 2006). However, these costs are likely to be considerably higher now, given inflation, the increased use of biological drugs and the increased prevalence of IBD (Royal College of Physicians, 2014).

The need for more holistic care

Once a diagnosis has been given, care for patients with IBD can be reductionist, focusing on medication, rather than the wider impact of the condition. To induce remission, the pharmacological approach usually involves medications such as corticosteroids, which can have side effects, especially in the long term (Todorovic, 2013). To maintain remission, immunosuppressant drugs can be effective, but require close monitoring (Todorovic, 2013). Furthermore, many patients find that some of their pain symptoms persist even once their inflammation is under control (Bakshi et al, 2021).

The nature of IBD means it affects each individual differently, meaning that a trial-and-error approach is often required to achieve optimal care. This should ideally involve a multidisciplinary team, including radiologists, pathologists, surgeons, nutritionists and mental health professionals, as well as a gastroenterologist. Mental health support is particularly important for patients with IBD, as the incidence of depression in this group is double that of the general population (Goodhand and Rampton, 2009). This can then lead to a vicious circle, as psychological stress can exacerbate the inflammatory process (Goodhand et al, 2009).

However, despite clear evidence of the impact IBD can have on an individual's psychological wellbeing, relationships, education and employment, only one in 10 patients with IBD reported being asked about how they were coping emotionally with their condition (IBD UK, 2021). This suggests that a greater emphasis on holistic care is needed in IBD services. Patients should be signposted to suitable psychological therapies if necessary, and it is important to manage their expectations of those who have been newly diagnosed so that they have a clear understanding of how their condition may affect them in the long term.

Malnutrition is also a common complication of IBD as a result of inflammation, diarrhoea, corticosteroid use and difficulty eating. Approximately half of patients with IBD show signs of malnutrition, often lacking vitamin A, iron and calcium in particular. Malnutrition can have severe consequences on physical health and quality of life, as well as increasing healthcare costs (Balestrieri et al, 2020). However, qualitative research by Prince et al (2011) found that less than half of the 72 patients with IBD included in their study had seen a nutritionist for tailored nutritional advice, despite rating it as extremely important to their personal experience of care. It has also been estimated that 100 000 patients with IBD in the UK do not have access to a specialist nurse, with care varying widely depending on where the patient lives (Nursing in Practice, 2016).

The role of specialist care

Research suggests that specialist IBD clinics could allow more timely diagnostics and better outcomes for patients (Mawdsley et al, 2006). These 'one-stop shops' mean that patients can interact with different specialisms within one cohesive service, while also allowing smoother collaboration between healthcare professionals. For example, St Mark's Hospital (2014) in London covers all aspects of IBD care, including medical treatments, nursing, surgery, psychological services, nutritional support and patient education. There is also a weekly rapid access clinic for patients experiencing an acute flare up or those who require urgent medical attention, with the aim of preventing hospital admissions where possible.

Self-management is also a key part of a holistic care pathway for patients with IBD, as lifestyle changes (particularly those that reduce stress) can help them to reach and maintain remission (Todorovic, 2013). For example, the 'patient flare card' sent to patients with IBD by Crohn's and Colitis UK in Scotland is designed to help patients to recognise the signs of an IBD flare up, with simple steps to follow to prevent escalation. Squires et al

(2017) found that this supported self-management intervention helped patients to feel more in control of their IBD, as well as improving medication adherence and reducing symptoms. This demonstrates the potential effectiveness of patient education and supported self-management, which could be further delivered through specialist IBD services aiming to provide holistic care.

Conclusions

IBD can be a challenging condition to diagnose and treat, which means that optimal management requires holistic care, with strong multidisciplinary working. By designing and working towards this type of service, healthcare providers can both improve patient outcomes and reduce costs. The high rate of hospital admissions and delays in diagnosis experienced by patients with IBD in the UK indicate that improvements are needed. It is important for patients to be empowered to take control of their own care, but this must be done with support from clinicians and built on an understanding of the multi-faceted nature of IBD.

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Key points

- Diagnosing inflammatory bowel disease can be challenging, with many patients experiencing delayed diagnosis which can lead to worse outcomes and increased costs for healthcare services.
- There are several pharmacological treatment options for inflammatory bowel disease, but it is also important for holistic care plans to address pain management and emotional wellbeing.
- Specialist services for inflammatory bowel disease can provide 'one-stop shops', allowing patients to access multiple different care specialisms in one visit and facilitating more holistic, joined-up care to be delivered.

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Optimising stoma care through effective pathways: an overview

Jennie Burch, head of gastrointestinal nurse education at St Mark's Hospital, discusses stoma pathways, emphasising the need for regular review post discharge to avoid readmission and achieve optimal outcomes.

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The formation of a stoma can be difficult for patients to cope with physically and emotionally, especially as there may have been a long or a life-threatening illness that led to it. The care pathway following stoma formation is usually provided by specialist nurses for the duration of the patient's time with a stoma. The care pathway begins before surgery and lasts throughout the postoperative pathway in the hospital and after discharge into the community. With over 200 000 people in the UK having a stoma, and an NHS spend of over £400 million on stoma care products (Hodges, 2022), it is essential to ensure that the care of these patients is optimised so that they have the best outcomes and quality of life possible.

What is a stoma?

A stoma can be formed during surgery to re-route the passage of faeces or, less commonly, urine from its usual passage, usually as part of treatment for conditions such as bowel cancer. The stoma is formed when a hole is made through the abdominal wall and part of the bowel is brought through that hole and stitched onto the abdominal wall. There are three main types of output stoma: through a urostomy (also called an ileal conduit) the patient will pass urine, while those with a colostomy or ileostomy will pass flatus and faeces through the stoma. The different operations and parts of bowel involved determine which stoma will be formed.

A stoma can be permanent or temporary, with the latter often being designed to last months or longer and requiring another operation to reverse or close the stoma later. To collect and contain the output of either faeces and flatus or urine, a stoma appliance, often termed a stoma bag or stoma pouch, is necessary. The appliance adheres to the abdomen around the stoma. The appliance needs to be changed by the patient, either daily or multiple times a week; people with a urostomy or ileostomy will need to empty their appliance several times a day to release the contents into the toilet.

The stoma care pathway

There is no standardised care pathway for stoma care, with no National Institute of Health and Care Excellence guidance available. However, it is generally accepted in the UK that the stoma care pathways used by NHS services should aim to empower patients to become independent with their stoma care. Having a stoma is associated with many potential complications, such as skin damage, which can prevent the appliance from adhering properly to the abdominal wall. Davenport (2014) explored the stoma pathway, but recognised that it needed to be altered for patients with greater needs, such as cognitive impairment or skin issues.

Preoperative nursing care usually begins soon after the patient is informed that surgery is needed. This part of the care pathway involves the patient spending time with a specialist stoma care nurse to receive information about the operation, the stoma, how to care for the stoma and, often, a practical demonstration of an appliance change. It is also important for the stoma site to be marked on the abdomen to guide the surgeon as to where to place the stoma; good stoma positioning on the abdominal wall has been shown to reduce appliance management issues, such as appliance leakage (Kim et al, 2021). A well-sited stoma is also

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linked to greater independence for the patient in the long term (Slater, 2014). Furthermore, preoperative stoma education reduces the rate of skin problems and readmission in the first month after stoma formation (Stokes et al, 2017).

Postoperative stoma care in hospital includes reconfirming information and training the patient to be independent with their stoma. In hospitals that use the enhanced recovery pathway, the length of stay for someone with a stoma is 5–6 days (Chaudhri et al, 2005). During this time, the patient begins to recover physically from the operation by resuming eating, drinking and mobilising. The patient is also taught to care for their newly formed stoma, as well as how to recognise complications and know who to contact to resolve any issues. The stoma will become active in hospital, passing either urine or faeces and flatus. Acceptance of the stoma psychologically often takes longer.

Post-discharge stoma care may be undertaken by staff who work both in the hospital and the community, or just by the community nurse. Different care pathways have been described in the literature (Nagle et al, 2012; Davenport, 2014) and the chosen pathway may need to be revised if complications occur. Skin-related complications can occur in one-third of patients in the first 3 months after the stoma is formed (Salvadaleña, 2013), with skin damage increasing the likelihood of readmission and the costs associated with a longer hospital stay (Taneja et al, 2019). A planned care pathway involves several contacts with the specialist stoma care nurse within the first year to ensure that skin health is maintained, as this is essential to ensure a leak-free stoma appliance. Ideally, the specialist stoma care nurse should review the patient annually, including assessment of the stoma, the skin around the stoma and the stoma products used by the patient to ensure that they are appropriate. For example, those with problem-free stomas will likely only require a stoma appliance, while patients with more problematic stomas may need to use products that aid adhesion, such as stoma adhesive paste, seals or flange extenders. Patients with sensitive skin may also require products to help them to remove the stoma adhesive when needed, such as an adhesive remover. Assessment by a specialist stoma care nurse enables the effective use of budgets to ensure that these (often costly) stoma products are used efficiently, with optimal benefit for the patient. Timely assessment also allows any issues that have arisen to be identified and addressed, such as changes to the abdominal surface associated with weight change or aging.

It is important for patients to have rapid access to stoma clinics in case problems arise. About one in five patients will need to be readmitted within 1 month of their stoma formation, with dehydration being the leading cause of readmission (Vogel et al, 2022). There is also a high chance of readmission within the first 60 days (Liu et al, 2021). Patients at risk of readmission for dehydration include older people and those with comorbidities such as diabetes (Liu et al, 2021). As cancer is the most common reason to have a stoma formation, and cancer is more common in older people, many patients with a stoma are at a reasonably high risk of being readmitted to hospital. Nagle et al (2012) found that use of a care pathway that included education and planned nursing visits reduced the likelihood of readmission for dehydration among patients with a stoma. Therefore, it is important for the patient to have regular reviews with the specialist stoma care nurse within the first month after formation; these reviews can be administered via telephone or in person, depending on the nursing assessment.

Emergency stoma formation: key challenges

One challenge that is regularly encountered with the stoma pathway is emergency surgery. As stoma preparation begins as soon as it is determined that a person needs to have a stoma formed, the likelihood that there will be sufficient preoperative nursing input in an emergency setting is greatly diminished. Additionally, emergency stoma-forming surgery will usually result in prolonged hospital stay, as it is more likely that the patient will not be in an optimal state for surgery and thus recovery may take longer. Emergency surgery also means that there has been no planning and appropriate setting of expectations for the patient and their family. In the non-emergency stoma pathway, preoperative stoma care involves educating the patient about the stoma and how to manage it, as well as siting the mark for the surgeon to place the stoma; all this is missing in the emergency setting.

Improving patient outcomes

Having a stoma can affect a person's quality of life, particularly if a stoma appliance leaks (Pittman et al 2008), as this can result in skin damage and a perpetuating cycling of more leaks. To reduce the risk of appliance leakage, it is important to ensure that patients are carefully taught how to care for their stoma independently before they are discharged from hospital. Additionally, several reviews are needed within the first year to ensure that the patient maintains a good change technique of their appliance. If issues do occur, they need to be quickly addressed, as leaking appliances are distressing for the patient and can reduce the patient's ability to fulfil activities of daily living. Because of this, it is crucial that patients have open access to stoma care nurses, with provision for long-term care to enable annual assessment of the stoma and necessary care products.

Conclusions

Specialist stoma care nurses are pivotal to quickly enable a patient to be independent with their stoma in the days that they spend in hospital. However, to ensure that patients remain in a position to appropriately care for their stoma, it is important for the patient to be regularly reviewed by the specialist stoma care nurse.

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The role of nutrition in the management of inflammatory bowel disease

Health writer Francesca Ramadan discusses the importance of appropriate nutritional management in patients with inflammatory bowel disease, highlighting the need for evidence-based dietary recommendations.

Introduction

Inflammatory bowel disease is an umbrella term that encompasses both Crohn's disease and ulcerative colitis, which are both characterised by chronic inflammation of the gastrointestinal tract (Centers for Disease Control and Prevention, 2022). Crohn's disease can affect any part of the gastrointestinal tract, but most commonly affects the portion of the small intestine before the colon and the colon itself; any inflicted damage may be intermittent, with affected tissue interspersed with healthy tissue, and the inflammation can manifest throughout multiple layers of the walls of the gastrointestinal tract (Centers for Disease Control and Prevention, 2022). Meanwhile, ulcerative colitis is restricted to the colon and the rectum, with damage inflicted continuously and inflammation being present only in the innermost layer of the lining of the colon (Centers for Disease Control and Prevention, 2022).

Crohn's disease and ulcerative colitis are both chronic, lifelong conditions, with no cure currently available. Symptoms include persistent diarrhoea, abdominal pain, rectal bleeding, bloody stools, weight loss and fatigue (Centers for Disease Control and Prevention, 2022). Mouth ulcers, swollen joints, inflamed eyes and anaemia have also been reported (Crohn's and Colitis UK, 2019). Symptom severity is on a spectrum, with some patients experiencing debilitating symptoms that can significantly impact their quality of life and their ability to perform activities of daily living, while others may demonstrate relatively normal functionality and require minimal intervention. The prevalence of inflammatory bowel disease is on the rise, increasing from 3.7 million persons affected worldwide in 1990 to 6.8 million in 2017 (Alatab et al, 2020). In the UK, an estimated 500 000 people have either Crohn's disease or ulcerative colitis (Crohn's and Colitis UK, 2019). Therefore, it is crucial that healthcare services are well-equipped to support patients with inflammatory bowel disease in their care.

Nutritional challenges in inflammatory bowel disease

Although there is no cure for inflammatory bowel disease, there are several treatment options available, which mainly include anti-inflammatory medications and surgery to remove damaged portions of the gastrointestinal tract (Centers for Disease Control and Prevention, 2022). Nutritional care and therapy have also become more prevalent in the management of inflammatory bowel disease, as an interaction between environmental factors, including diet, and gut microbiota in genetically susceptible individuals may cause the immune response dysregulation underlying these conditions (de Castro et al, 2021). Numerous dietary factors may influence the development and maintenance of inflammatory bowel disease, while others seem to play a protective role (Sahu et al, 2021). For instance, high intake of animal fat and cholesterol is associated with ulcerative colitis risk, while a high long-term intake of food that is rich in fat and sugars, such as fast food, is a risk factor for Crohn's disease (Reif et al, 1997; Burisch et al, 2014). Meanwhile, a diet high in fibre has been shown to substantially reduce the risk of Crohn's disease (Liu et al, 2015), while the consumption of a variety of nutrient-dense foods, including fruits, vegetables, nuts, seeds and whole grains, has been linked to lower levels of gut inflammation (Strisciuglio et al, 2020).

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Because of this relationship between dietary patterns and inflammatory bowel disease, nutrition is key in the reduction of complications caused by chronic inflammation and active disease, including malnutrition, growth failure, osteoporosis, lower bone mineral density and colorectal cancer (Strisciuglio et al, 2020). Nutritional deficiencies are common among those with inflammatory bowel disease, affecting as many as 85% (Roncoroni et al, 2022), because of reduced oral intake, malabsorption, side effects of medication and systemic inflammation (Donnellan et al, 2013). This is exacerbated by the lack of medical consensus regarding nutritional guidelines for these patients (de Castro et al, 2021; Roncoroni et al, 2022), which often leads to them seeking alternative sources of information and support, including the internet and other forms of media, which are largely unregulated (Roncoroni et al, 2022). It is also common for patients with inflammatory bowel disease to avoid certain foods based on their personal experience of symptom flare ups. However, while consideration of patient choice is an important element of person-centred care, the self-management of elimination diets can increase the risk of malnutrition and restrictive eating disorders (Roncoroni et al, 2022). As well as the physical impact of malnutrition, inflammatory bowel disease can also have psychosocial consequences, with patients avoiding eating outside of their own home or in social settings (Roncoroni et al, 2022). Patients with inflammatory bowel disease who live in the community may be particularly susceptible to malnutrition, as reduced oral intake and any subsequent nutritional deficiencies are less likely to be detected.

Nutritional management approaches

Various approaches have been developed, assessed and implemented to improve nutritional management in patients with inflammatory bowel disease, with differing degrees of efficacy. Any dietary changes implemented as part of inflammatory bowel disease care should be made in conjunction with a trained dietitian and must be tailored to the individual based on their specific nutritional deficiencies and dietary triggers. While oral nutritional supplementation is sufficient for most patients, some may require tube feeding; this has been useful in the treatment of children with inflammatory bowel disease and its use is now expanding into the treatment of adult patients (Sahu et al, 2021).

For patients with inflammatory bowel disease who are malnourished or at risk of malnutrition, oral nutritional supplementation can be a well-tolerated means of allowing individuals to meet their nutritional requirements (Donnellan et al, 2013). The European Society for Clinical Nutrition and Metabolism guidelines recommend up to 600 kcal per day in the form of oral nutritional supplements (Bischoff et al, 2020). However, if daily nutritional requirements are still not adequately met, enteral nutrition (tube feeding) can be used as a supportive therapy, according to standard nutritional practice in patients with severe ulcerative colitis (Bischoff et al, 2020). Parenteral nutrition (the intravenous administration of nutrients) should only be used if enteral nutrition is impossible (such as in cases of severe vomiting or diarrhoea) or contraindicated (such as in cases of intestinal obstructions or ileus, severe shock or intestinal ischaemia) (Bischoff et al, 2020). Enteral nutrition should always be preferred over the parenteral route, but combinations of enteral and parenteral nutrition should be considered in patients requiring nutritional support and in whom >60% of energy needs cannot be met via the enteral route (Bischoff et al, 2020). It is important that most patients should be allowed to continue oral intake if possible, despite the use of parenteral nutrition. In practice, a mixture of oral, enteral and parenteral routes may be used together to achieve the best nutritional status (Donnellan et al, 2013).

For patients with inflammatory bowel disease who do not have active disease, the efficacy of various types of dietary change have been researched, as shown in **Table 1**. It should be noted that most of these diets do not have sufficient evidence to be recommended in clinical guidelines for patients with inflammatory bowel disease (Roncoroni et al, 2022). However, individual food intolerances are common in this patient group, with lactose, dairy, spices, herbs, gas-generating and fibre-rich products often being poorly tolerated; therefore, their removal is likely to be helpful in prolonging remission (Bischoff et al, 2020).

Table 1. Proposed dietary changes for inflammatory bowel disease remission

Diet	Components of diet	Recommendations
Specific carbohydrate diet	Removal of grains, including wheat, barley, corn and rice. Removal of added sugar, honey and most milk products. Fully fermented yogurts can be consumed	There have been several studies showing the potential benefits of this diet in improving the course of disease, but there is not yet enough evidence to recommend this diet
Gluten-free diet	Elimination of gluten	This appears to lead to symptomatic improvement in those with IBD, but there is not yet enough evidence to recommend this diet to this patient group
Low-FODMAP diet	Elimination of short-chain carbohydrates (oligosaccharides), disaccharides, monosaccharides and related alcohols	A low-FODMAP diet may have some positive effects in patients whose IBD symptoms are similar to those of irritable bowel syndrome
Autoimmune diet	Modified 'paleolithic' diet, which excludes gluten and dairy	Some preliminary efficacy in patients with active IBD, but lacking significant studies
Vitamin C and E supplementation	Dose not specified	Has effects on biomarkers of oxidative stress, but has not yet been shown to have significant clinical efficacy and is not currently recommended
Vitamin D supplementation	Dose not specified	Vitamin D deficiency may affect the cause and progression of IBD, particularly Crohn's disease, so low-dose vitamin D supplementation seems reasonable in these patients
Omega-3 supplementation	3–4 g daily	Currently not recommended
Curcumin supplementation	2–3 g daily	Curcumin shows promise as a dietary supplement as part of adjunctive therapy for ulcerative colitis, but data are inconclusive; currently not recommended

Adapted from Roncoroni et al (2022). FODMAP= fermentable oligosaccharides, disaccharides, monosaccharides and polyols; IBD=inflammatory bowel disease

Conclusions

Neither enteral nutrition nor parenteral nutrition is recommended as primary therapy for maintaining remission in inflammatory bowel disease, but these interventions may be of value as supplementary measures in many instances of malnutrition or as an exclusive treatment in cases of active disease. Oral nutritional supplementation is often the first step in the medical management of malnutrition, but is only effective if the patient is able to manage an oral intake of food, so regular follow up is essential to ensure that the patient's nutritional status does not deteriorate. Whichever pathway or intervention is used, individualisation must be at the core of any care provided. Consideration of patient preferences is paramount in optimal nutritional management of patients with inflammatory bowel disease, which will ultimately help them to achieve a good quality of life and prevent further morbidity from this chronic condition.

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Key points

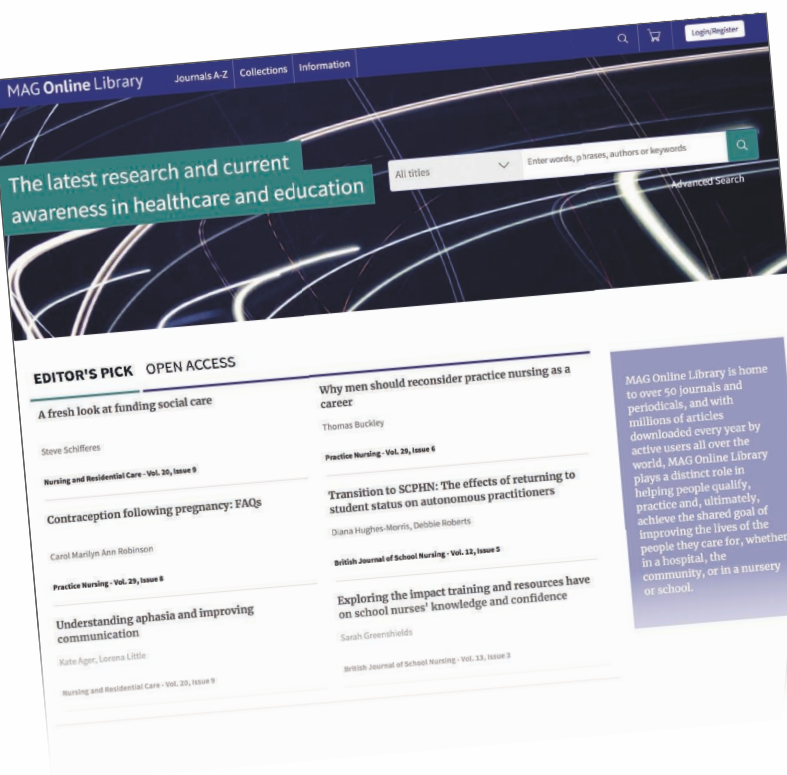
- Research suggests that certain dietary factors can increase the risk of inflammatory bowel disease, and that nutrition is key to the management of these conditions.
- Patients with active inflammatory bowel disease may need nutritional interventions to prevent malnutrition, such as oral supplements, enteral or parenteral feeding.
- Patients with inactive inflammatory bowel disease may benefit from dietary modifications to reduce or remove foods that may aggravate their condition, but these should be recommended with caution, as many popular 'anti-inflammatory' diets lack empirical evidence.
- Care for inflammatory bowel disease should always be patient-centred, with shared decision making being key to successful nutritional management.

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Managing malnutrition in the community setting

Registered dietitian Natalie Taylor discusses the burden of malnutrition on patients and healthcare services, outlining strategies to improve nutrition in the community setting.

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Malnutrition is widespread in the UK, affecting an estimated 3 million people at any one time (British Association for Parenteral and Enteral Nutrition (BAPEN), 2022). Around 30–40% of patients admitted to hospital or to a care home are already malnourished or are at risk of developing malnutrition, and the cost of treating a malnourished patient is 2–3 times higher than treating a well-nourished patient. Malnutrition can also lead to an increased likelihood of hospital admission, length of hospital stay and increasing risk of pressure ulcers, as well as more frequent exacerbations of respiratory conditions. Because of this, an estimated £200 million could be saved by health and social care services each year if simple changes to manage malnutrition were implemented (BAPEN, 2022).

The British Dietetic Association's (2018) position statement on malnutrition is of particular relevance to healthcare providers, as it outlines the key evidence and guidelines for managing malnutrition in the UK. This incorporated work from the BAPEN, the National Institute for Health and Care Excellence, the NHS and the Department of Health and Social Care. The statement emphasises that good nutrition can improve the health of vulnerable individuals, making four key recommendations:

- Everyone should have access to a nutritious, high-quality diet. Systems must be in place in community health and social care settings to identify and support those at risk of having a sub-optimal diet and/or hydration
- Dietitians should lead a coordinated and integrated approach to addressing the nutritional care of vulnerable populations in community health and social care settings
- Commissioners must recognise the value and potential cost savings of preventing malnutrition, and commission services that ensure that all people identified as being at risk of malnutrition are offered nutritional support interventions that aim to meet their personalised nutritional requirements
- All public sector catering specifications, including in the NHS and care homes, are required to meet nutritional standards suitable for the setting and the population that they serve. This should be supported by appropriate expertise from dietitians, caterers and procurement professionals (British Dietetic Association, 2018).

Identifying malnutrition

The identification of malnutrition risk should be completed using a validated screening tool; increased use of screening could help to identify more vulnerable individuals early and subsequently reduce the cost of treating malnutrition. The Malnutrition Universal Screening Tool (MUST) is commonly used in a range of health and care settings, and can be accessed through BAPEN (2015). The COVID-19 pandemic and the increased use of virtual consultations led to some difficulties in using the MUST, as it largely focuses on the patient's height, weight and appearance. To mitigate this, BAPEN (2020) produced an update on the use of the MUST, including a malnutrition self-assessment that patients can complete online before their consultation.

However, a potential problem with the MUST is that malnourished individuals are not always underweight and many do not experience significant weight loss. On the contrary, malnutrition often occurs in individuals who would be classified as overweight or obese on a body mass index scale (Roubin et al, 2020). It is important that healthcare professionals are aware of this so that malnutrition is not overlooked in these patients because of their weight and/or lack of weight loss. Other ways of screening for malnutrition without relying

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on weight or appearance include asking patients about their energy levels, their mood, if they are experiencing muscle weakness or dizziness, or if they have had more infections than usual (NHS Inform, 2021).

Improving nutritional intake

A range of strategies can be used to improve patients' nutritional intake, including oral nutritional support, enteral nutrition (delivered as liquid) and parenteral nutrition (delivered intravenously) (National Institute for Health and Care Excellence, 2017). In patients who are able to swallow safely, prescribed nutritional supplementation can be considered. In primary care, the appropriate prescription of supplements is guided by the Advisory Committee for Borderline Substances criteria (BAPEN, 2016). In some areas of the UK, the prescription of supplements is managed by GPs, while in other areas dietitians oversee prescribing. The supplement manufacturer (such as Nutricia, Abbott, Fresenius or Aymes) usually depends on the location of the service.

Evidence for the use of prescribed nutritional supplements and dietary advice is somewhat problematic, as studies are often small, with differences in research type making it difficult to compare outcomes (Baldwin et al, 2021). Prescribing supplements alone does not always mean that the patient's condition will improve in the long-term, particularly if the underlying cause of their malnutrition is not addressed. Moreover, if a patient does not like the supplements or finds them difficult to drink, they are unlikely to take them for long enough to see a positive outcome. Therefore, scheduling timely reviews to check on the patient's progress and establish or re-establish their nutritional goals is important. It may be that supplements are not indicated initially, but may later be deemed appropriate, such as if the patient is struggling to achieve their nutritional goals with dietary change alone. Dietetic advice, both with and without oral nutritional supplements, has been shown to support weight gain in malnourished individuals (Baldwin et al, 2021). Setting dietetic outcome measures in the form of nutritional goals has also been shown to prevent premature death, enhance quality of life and help with recovery from illness (Parenteral and Enteral Nutrition Group, 2016).

The British Dietetic Association has a range of publicly-accessible factsheets have been designed to be user-friendly for patients and clinicians (<https://www.bda.uk.com/food-health/food-facts.html>). As well as dietary advice, these factsheets also cover issues such as the link between malnutrition and pressure injuries. While online resources are not a substitute for tailored advice from a healthcare professional, it may be helpful to signpost patients to reliable sources of information.

Food poverty

For many, struggling to afford food is not a new concept. At present, several factors are converging to make managing finances more difficult, not least of which is the energy crisis, which may make paying for gas or electricity for cooking more daunting and force some to sacrifice food to pay for other expenses (Taylor, 2022). Those recovering from COVID-19, who may already be in a nutritionally compromised state, may find themselves struggling to return to work, bringing an unexpected decline in their income. Increased fatigue may also act as a barrier to cooking in these individuals (NHS England, 2021).

It is important to remember that these problems may be encountered by fellow health and care staff, as well as patients. As a health service that is dedicated to improving standards for all, signposting for staff is just as important; a pro-active approach to staff wellbeing may allow staff to gain support without having to come forward and discuss this sensitive issue. Useful resources include the British Dietetic Association's (2022) factsheet on eating well while spending less, which provides practical ideas for making a food budget go further and reducing cooking costs. It may also be helpful to signpost staff to local foodbanks and organisations such as the Trussell Trust (<https://www.trusselltrust.org>), who can assist in a crisis. Although healthcare managers may not be able to change the root causes of these problems, they can help to make the workplace a supportive and empathetic environment for staff facing financial difficulties.

Conclusions

Malnutrition is widespread in the UK and may increase in times of crisis and raised food poverty levels. Commissioning dietetic services can help to facilitate the implementation of national guidance across health and social care to improve patient outcomes and bring significant financial savings. Prescribed nutritional supplements can help to treat malnutrition in certain circumstances, but these are best used alongside individualised dietary advice. There are a range of online resources that patients and staff can access to prevent and treat malnutrition, but the impact of environmental factors such as financial difficulties should not be underestimated. Healthcare managers can help to support good nutritional health among staff by signposting them to practical resources and creating a supportive work environment.

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Conflicts of interest

The author declares that there are no conflicts of interest.

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Virtual cancer multidisciplinary team meetings: outcomes of a two-phased survey from a tertiary NHS hospital

Abstract

Background/Aim Multidisciplinary team meetings have been an integral part of comprehensive cancer services in the UK for over 20 years. The COVID-19 pandemic led to the adoption of virtual platforms to allow these meetings to continue with minimal in-person contact. This study assessed multidisciplinary team members' perspectives regarding the efficacy of the virtual platform, with the view of continuing this mode of delivery in the post-pandemic world.

Methods A two-phased survey study was conducted among all members of the cancer multidisciplinary team in one UK hospital. Respondents completed a four-part questionnaire 6 months ($n=108$) and 1 year ($n=120$) after the implementation of the virtual platform in March 2020 to determine their perceptions of its effectiveness and safety.

Results There was a statistically significant ($P<0.05$) improvement between the 6-month and 1-year survey responses in terms of overall satisfaction with the virtual platform, ease of use and efficiency of collective decision making using the virtual format. After 1 year, 80.5% of respondents preferred either continuing to use the virtual platform exclusively or switching to a hybrid model.

Conclusions Staff experiences of using a virtual platform for cancer multidisciplinary team meetings may improve over time, with many respondents preferring this mode of delivery. Virtual meetings can provide greater flexibility and allow wider participation, potentially including specialists from across the globe.

Key words: Cancer; COVID-19; Multidisciplinary team; Virtual meetings

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Introduction

Cancer remains a major cause of morbidity and mortality in the UK and worldwide. Multidisciplinary teams were introduced to NHS cancer services based on the recommendations of the report by Calman and Hine (1995) and have since become the gold standard for treatment planning for patients with complex conditions (Prades et al, 2015; NHS, 2016; European Union, 2017). Traditionally, multidisciplinary team meetings involve a predetermined membership of clinicians, who meet regularly in person at a recurring fixed time to discuss patients (Munro and Swartzman, 2013).

Given the risks associated with cancer, sustained, coordinated and innovative efforts were required to maintain reasonably uninterrupted services during the COVID-19 pandemic. One such innovation was the investment in infrastructure and technology to support virtual consultations and multidisciplinary team meetings (Butler et al, 2020). A survey by Rimmer (2020) found that 90% of surgeons had resorted to virtual service delivery during the first year of the pandemic, at which point it was already expected that remote working and telemedicine would likely remain a feature of healthcare after the crisis.

Like many other hospitals in the UK, the cancer services at the University Hospitals of North Midlands NHS Trust started to use a virtual format to ensure seamless continuity of cancer multidisciplinary team meetings during the pandemic. This study explored the perspectives of team members regarding virtual meetings over time with the view of determining the ideal format of multidisciplinary team meetings in the future.

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Methods

Cancer services at the University Hospitals of North Midlands NHS Trust run 13 specialist multidisciplinary team meetings each week, including brain cancer, breast cancer (core and main), cancer of unknown primary, colorectal cancer, gynaecology, haematology, head and neck cancer, hepatobiliary cancer, lung cancer, skin cancer, upper gastrointestinal cancer and urology. Following the start of the COVID-19 pandemic, virtual multidisciplinary team meetings were held using the Microsoft Teams software. A designated organiser was assigned to each meeting to coordinate and oversee its smooth functioning.

A structured online survey was conducted among core and extended members of the oncology multidisciplinary teams on two different occasions, at 6 months (September 2020) and 12 months (March 2021) after the virtual platform came into use. In the first phase of the survey, the questionnaire was emailed to 186 core multidisciplinary team members and extended to committee members through the cloud-based software SurveyMonkey. In the second phase, the same questionnaire was sent to 190 core members. Two separate email reminders were sent out by the multidisciplinary team coordinators in each phase, with an interval of 1 week between reminders.

The online questionnaire comprised four sections. The first section asked respondents to state their role in the multidisciplinary team, as well as which cancer multidisciplinary team meetings they attended and most regularly contributed to. The second section asked respondents about their experience of virtual multidisciplinary team meetings in comparison with in-person meetings, using the following questions (answered in a yes/no format):

- Overall, are you satisfied with the current virtual multidisciplinary team format?
- Do you feel cases are given sufficient time for discussion?
- Do you feel the virtual delivery allows you to appreciate clinical images/ radiological plates/ histological slides as it is discussed?
- Do you feel patient management options can be adequately discussed in the virtual format?
- Do you feel the whole team can get involved in making a collective decision?
- Do you find the Microsoft Teams platform easy to use?
- Do you have adequate access to necessary gadgets to participate in the virtual meetings (computers/ headphones/ cameras)?
- Do you feel data security and patient confidentiality can be maintained in virtual platform discussions?

The third section of the questionnaire asked participants whether they would prefer to continue with virtual multidisciplinary team meetings, revert back to in-person meetings or use a hybrid model of meeting delivery (partly virtual, partly in-person). Part four provided a space for respondents to make any further comments about the virtual multidisciplinary team meetings. Overall, the questionnaire was designed to evaluate the extent to which multidisciplinary team members considered the virtual platform to be a safe and effective alternative to in-person meetings.

All responses were analysed and compared using the Chi-square test and paired Student's *t* test. A *P* value of <0.05 was considered statistically significant.

This study was registered with the University Hospitals of North Midlands NHS Trust clinical governance team (reference number: CA20421). Responses were collected via the SurveyMonkey questionnaire, which included a section for respondents to give informed consent and ensured their anonymity.

Results

For the 6-month survey, 108 individuals responded (58% response rate), while 120 individuals responded to the 12-month survey (63% response rate). **Table 1** shows the job roles and specialisms of respondents to both surveys—it was quite common for respondents to be members of more than one multidisciplinary team.

Responses to the 12-month survey showed significantly more positive perceptions of virtual multidisciplinary team meetings than the 6-month survey (**Table 2**). In the 6-month survey, only 23.0% of respondents stated that they would prefer multidisciplinary team meetings to remain virtual in the future, while 52.0% preferred a hybrid model and 25.0%

Table 1. Job roles and specialisms of respondents

Variables	6-month survey (n=108)	12-month survey (n=120)
Cancer specialism		
Brain/central nervous system	18	18
Breast	14	16
Cancer of unknown primary	7	8
Colorectal	13	10
Gynaecology	9	10
Haematology	15	15
Head and neck	15	14
Lung	18	16
Paediatrics	1	3
Skin	12	4
Upper gastrointestinal (hepatobiliary)	17	18
Upper gastrointestinal (oesophagogastric)	14	14
Urology	11	12
Job role		
Allied health professionals	3	3
Cancer nurse specialist	19	21
Multidisciplinary team coordinator	10	11
Oncologist	6	7
Pathologist	7	8
Physician	14	16
Radiologist	10	12
Surgeon	29	30
Restorative dentists	2	2
Clinical trial nurses	4	4
Palliative care specialists	4	6

preferred to switch back to exclusively in-person meetings. In contrast, in the 12-month survey, a slight majority (53.0%) preferred multidisciplinary team meetings to remain entirely virtual, 27.5% preferred a hybrid model and only 19.5% favoured returning to exclusively in-person multidisciplinary team meetings. This changing trend for choice of multidisciplinary team platform was statistically significant ($P<0.05$).

Discussion

The role of multidisciplinary team meetings in improving outcomes for patients with cancer has been widely evidenced (Fleissig et al, 2006; Taylor et al, 2010; Prabhu Das et al, 2018). Effective multidisciplinary team working enables better inter-specialty coordination and communication, leading to better decision making (Fleming, 1989; Siegel et al, 2015). This may be particularly useful in developing countries, where many healthcare professionals struggle to regularly access in-person multidisciplinary tumour board meetings (Abbasi et al, 2020). Virtual multidisciplinary teams may help clinicians in

Table 2. Responses to the 6- and 12-month surveys regarding effectiveness and safety of virtual multidisciplinary team meetings

Respondent view	6-month survey (n=108)	12-month survey (n=120)	P value
Satisfied overall with the virtual format	65.7%	85.0%	<0.05
Possess required gadgets to participate effectively	61.1%	85.0%	<0.05
Find Microsoft Teams software easy to use	85.0%	95.0%	<0.05
Data security and patient confidentiality is adequately maintained	91.7%	92.5%	0.5
Adequate time is assigned to each case	79.6%	81.7%	0.5
Clinical images and slides can be displayed appropriately	75.0%	85.0%	0.75
Patient management options can be adequately discussed	70.4%	77.5%	0.68
Whole team can be involved in decision making	68.5%	82.5%	<0.05

these locations to access these meetings, which could substantially improve cancer care in low- and middle-income countries (Fabian et al, 2021). However, one of the main hindrances to optimal multidisciplinary team discussion is inconsistent attendance at meetings, which can compromise the decision-making processes and delay care (Lamprell et al, 2019). Munro and Swartzman (2013) suggested that the advantages of virtual multidisciplinary team meetings could include increased participation of specialists without geographical limitations, greater flexibility of scheduling and more consistent participation of members. As a result, virtual platforms and teleconferencing had been proposed even before the COVID-19 pandemic, but had rarely been implemented consistently (Augestad and Lindsetmo, 2009; Saini et al, 2020).

Since the pandemic was declared in March 2020, various studies have reported on the use of virtual platforms for team meetings. For example, Jalaeefar et al (2020) reported their experience of virtual tumour board meetings, initially using a Whatsapp group with 26 participants to discuss the management of patients with complex head and neck cancer. Meanwhile, Mercantini et al (2020) carried out virtual gastrointestinal cancer multidisciplinary team meetings using a dedicated oncology platform known as the NAVIFY Tumour Board (F Hoffmann-La Roche AG, Basel, Switzerland), which was originally described by Krupinski et al (2018). Experiences of virtual platforms have generally been positive, with a survey of 50 clinicians by Sidpra et al (2020) finding that 83.3% agreed that virtual multidisciplinary team meetings provided the same standard of care as in-person meetings and two-thirds supported the use of virtual platforms after the pandemic. This is similar to the results of the present study, although the majority (53%) of respondents to Sidpra et al's (2020) survey used Zoom rather than Microsoft Teams. Another survey study conducted in the UK among members of a bone and soft tissue tumours multidisciplinary team found that 72.2% of respondents were satisfied with the depth of discussion possible through virtual meetings, 75% were satisfied with their overall experience and 77.8% predicted that virtual multidisciplinary team meetings would become part of modern cancer care. Interestingly, 91.7% believed that the experience of using virtual platforms during the pandemic could pave the way towards global multidisciplinary teams in the future (Rajasekaran et al, 2021).

This study adds to this body of literature, as it took a two-phase approach to allow changes in perceptions to be tracked over time and included multidisciplinary team members from various cancer specialisms and job roles. The first survey was conducted 6 months after the virtual platform was initiated to allow ample time for any initial teething issues to be settled. The follow-up survey at 12 months demonstrated increased positivity in terms of respondents' perspectives about the efficiency and ease of use of the virtual multidisciplinary team meeting platform. The reasons for this change could not be assessed in this study, but could be attributed to team members becoming more accustomed to virtual meetings over

Key points

- The increased use of technology in healthcare seen during the COVID-19 pandemic is likely to shape the way cancer care is structured in future.
- Surveys taken at 6 and 12 months following the introduction of virtual multidisciplinary team meetings showed that the majority of oncology clinicians preferred either an entirely virtual or hybrid model of meeting delivery by the end of the year.
- Providing virtual multidisciplinary team meetings could improve access and attendance, particularly for those working in remote areas and/or in developing countries.

time, as well as the ability for the trust to ensure that staff had access to the technology and skills required to use the platform effectively. The 12-month survey showed significant improvements in overall satisfaction, ease of use of the platform and involvement of the entire multidisciplinary team in collective decision making. As a result, the proportion of respondents who chose the virtual platform as their preferred method of delivering multidisciplinary team meetings increased from 23% in the 6-month survey to 53% in the 12-month survey.

Limitations

This study was conducted in a single institution and used a simple binary response format. This was done to help ensure adequate participation and to facilitate clear and simple statistical interpretation, but may have limited the scope and detail of responses.

Conclusions

After 1 year of experience with the virtual multidisciplinary team meeting format, the majority (80.5%) of respondents preferred to either continue with the virtual model exclusively or to switch to a hybrid model, including some virtual meetings. This opens up the possibility of exercising more flexibility in the scheduling of multidisciplinary team meetings, which could ensure more consistent attendance and improve access for clinicians working in remote areas or those who are unable to travel to in-person meetings.

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Conflicts of interest

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What can healthcare managers learn from marketing managers? Marketing theory concepts with implications for healthcare

Abstract

Healthcare managers are increasingly relying on advances in management science to improve service organisation, operations and delivery, with the aim of better serving patients. Acknowledging the unique and specific nature of healthcare, and the associated constraints, this article argues that healthcare managers can learn from recent developments in the field of marketing in order to better understand and serve patients. Theories and concepts in the service marketing and consumer behaviour literature emphasise the need to take the perspective of consumers and co-construct meaningful experiences with them. In addition, marketing theories and concepts such as service-dominant logic, the 'jobs-to-be-done' approach and the duality of mind carry implications both in terms of understanding how to interact with patients and how to approach healthcare management in the modern world. Adopting these principles in healthcare management practices can result in a better understanding of the patient journey throughout their healthcare experience.

Key words: Duality of mind; Jobs-to-be-done approach; Marketing; Patient focus; Service-dominant logic

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Introduction

The marketing discipline arguably does not have a particularly favourable image. When thinking about marketing, especially in a healthcare context, ideas that come to mind include dubious claims about health supplements and the rise of consumerism in the health and wellbeing industry. Overall, the image that most healthcare managers will have of marketing is likely not a flattering one, and certainly not one of a discipline and practice that can be useful to the running of public healthcare services.

However, marketing has evolved significantly as a discipline over the last 20 years. It has now moved away from pure sales and a crude mercantile focus to embrace a more comprehensive study of consumption practices and culture, with the concepts of value-in-use (Karababa and Kjeldgaard, 2014) and co-construction (Edvardsson et al, 2011) at its core. As a discipline, marketing has also pushed for a more ethical approach to its principles and practices (Laczniak and Murphy, 2019). As a result, learning from the marketing discipline, and especially its developments over the last two decades, could be highly relevant for healthcare managers, particularly in terms of patient experiences and satisfaction.

Marketing has traditionally been defined as identifying and satisfying human wants and needs. Its roots can be traced back to the post-industrial revolution period, when companies realised that producing quality products and services was not enough to achieve high sales. This was the start of the 'sales era' in marketing. Gradually, the imperative to understand consumers became stronger and marketers started to focus on what consumers wanted before production time. More recently, the field has begun to develop long-term relationships with consumers in what is now called the 'customer relationship era' of marketing, with a focus on the customer lifetime value concept (Gupta et al, 2006). This is not too far from the priorities of healthcare managers, who aim to understand how to satisfy patient needs and optimise the efficiency of healthcare services, which requires a deep understanding of patients and their psychology. There have been previous attempts to infuse healthcare

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management with marketing principles; Dickinson (1995) suggested that healthcare could benefit from adopting a broad marketing approach. The growing popularity of behavioural economics over the last 10 years has highlighted how more theoretical academic fields can help to improve healthcare management practices. For example, the Behavioural Insight Team (Nesta, UK) highlighted the potential applications of nudges drawing from marketing and consumer psychology principles to healthcare (Voyer, 2015).

Drawing from the last 15 years of advances in marketing and consumer research, this article introduces and discusses a series of concepts that can help healthcare managers to improve the overall healthcare experience, from the design of the patient journey to operational efficiency and patient satisfaction. The core aspects of marketing theory evolution over the last 20 years reflect the shift experienced in healthcare management: a transition from being transaction-oriented to becoming increasingly centred on the service user.

Service-dominant logic

Introduced by Vargo and Lusch (2004), service-dominant logic represents one of the most important paradigm shifts in the discipline of marketing. Service-dominant logic follows from the work of Pine and Gilmore (1998), which suggested that economic value has evolved from being about goods and service delivery, to being about experience staging. The premise of service-dominant logic is that any product needs to be conceived as a service that addresses or fulfills a particular need. Such an approach is especially relevant for drug and hardware product makers, as it would allow the proposed vision to be shifted from alleviating symptoms to enabling a good quality of life. Adopting a service-dominant logic approach also has implications in terms of communication strategies, such as preferring the use of storytelling rather than traditional fact-based messages and campaigns (Wieczerzycki and Deszczyński, 2022). Thinking of healthcare management as the provision of a medical experience thus offers a way to reconceptualise the patient experience around concepts that are much more likely to lead to satisfaction.

Value co-creation: treating patients as actors

The concept of value co-creation emerged in the marketing literature over 10 years ago (Grönroos, 2011). Value co-creation refers to the idea that the perceived value that consumers' experience is co-constructed with the company offering the products or services being purchased. Following this theory, healthcare managers should encourage patients to realise that the value from a treatment or operation does not come solely from their service provider. Instead, patients should be actors and co-creators of their healthcare service experience. For instance, patients need to understand that the outcome of a medical consultation does not only rely on the knowledge and competencies of the clinician, but also on their openness and preparedness. Taking preliminary steps such as listing concerns or writing a diary detailing the evolution of symptoms before the consultation can help the clinician with both the diagnostic stage and the consideration of treatment options. This adds value to the service by allowing the patient to shape the outcome in a positive way. Understanding that value is ultimately co-created can lead healthcare managers to facilitate the increased involvement of patients in their overall healthcare experience. This could be done by offering consultation guides to patients that explain how they can best prepare for a consultation, including questions answer before the appointment.

Co-construction theories echo healthcare research that has shown how an active patient role is instrumental to full success of operations and medical outcomes (Roberts, 1999). In recent years, technology has enabled many patients to draw from community knowledge and support (Osei-Frimpong et al, 2018). The involvement of a patient in the co-constructed patient–practitioner–service experience does not need to be extensive; the positive effects of co-construction can occur through small, symbolic choices which can contribute to making patients actors in their recovery or condition management. Small-scale acts of creativity can contribute to the creation of value (Taillard et al, 2014). In healthcare management, this can mean involving consumers to customise or comment on aspects of services that are of direct concern to them.

The jobs-to-be-done approach: framing the bigger picture

Introduced by Christensen et al (2007), the jobs-to-be-done approach focuses on thinking about products and services not just in terms of who they target and what their consumers' characteristics are, but also in terms of the job that they perform or, in other words, the 'fundamental problem a customer needs to resolve in a given situation'. The jobs-to-be-done theory represents another paradigm shift away from traditional theories of innovation and marketing. These traditional theories focus on offering a product or service that has been conceived, developed and designed from the point of view of a manager, rather than the end user. Christensen et al (2007) gave the real-world example of a fast-food chain that managed to improve their sales of milkshakes, not by asking consumers which flavour they wanted to buy, but by observing why and how consumers were buying milkshakes. This showed that a significant proportion of the sales occurred in the morning, with consumers essentially buying the product as a substitute for breakfast or a snack before driving to work. The 'job' performed by the product was thus that of a breakfast alternative.

Christensen et al (2007) also discussed the case of a medical equipment company based in the United States of America, which improved its market share in hospital beds by understanding that the job of a hospital bed is to satisfy its customers more than the competition. The company observed that nurses were spending much of their time on non-nursing related tasks, such as helping patients who were experiencing issues with their audio-visual equipment or bringing them objects that had been dropped on the floor. The company adapted its products to include functions that would make nurses' jobs easier which, in turn, increased sales.

In healthcare management, the jobs-to-be-done approach can be applied to a wide range of areas, from outpatient infrastructure design to post-operation services. From appointment taking to waiting rooms, understanding the core motivations of patients can enable small initiatives to positively reshape the patient experience.

Persuasion and communication: the role of the duality of mind

Another important stream of research in consumer psychology in the last 20 years has been around the duality of mind concept (Samson and Voyer, 2012). Often labelled the 'system one' and 'system two' thinking systems, this stream of research can help healthcare managers to communicate in a more efficient way. System one, a high-capacity information processing system, is used by individuals who have the motivation, capacity or resources to process information consciously, and thus rely on heuristics to make decisions. Heuristics are mental shortcuts that are used to speed up the evaluation and/or decision-making process, such as relying on expert or user ratings. This has also been referred to as 'fast thinking'. System two, a low-capacity information processing system, is used when individuals can engage deeply with information. This has also been referred to as 'slow thinking'. The core premise of fast vs slow thinking is that, depending on which route an individual takes to process information, they will be looking at very different types of information and be persuaded by different types of arguments.

Understanding what makes an individual fully engaged in processing information and what makes them only remotely engaged and thus drawing from heuristics is critical for healthcare managers who need to design any kind of communication material. By ensuring that such materials reflect this duality of mind, managers can provide information in ways that can be easily assimilated, regardless of the way in which the information is being processed.

Work on the duality of mind has also been extended to reflect decision making during an emergency (Samson and Voyer, 2014). For example, designing persuasive messages that promote a responsible use of the accident and emergency department requires an understanding of the way in which individuals will process these messages in a context that they perceive as an emergency.

The rise of data analytics in customer relationship management

Big data has transformed marketing practices over the last 10 years by allowing a better understanding of consumer habits and the building of sophisticated models to predict behaviours such as purchases, repurchases or referrals (Erevelles et al, 2016). Healthcare has traditionally been a field in which data are collected and stored to satisfy regulation and patient care requirements, whether in paper form or, more recently, in digital form (Raghupathi and Raghupathi, 2014). Big data in healthcare refers to 'electronic health data sets so large and complex that they are difficult (or impossible) to manage with traditional software and/or hardware; nor can they be easily managed with traditional or common data management tools and method' (Raghupathi and Raghupathi, 2014). For healthcare managers, this means improved tracking, higher accuracy of the data and potential improvements in care, particularly for those with chronic conditions (Raghupathi and Raghupathi, 2014). Big data can also play an important role in disease prevention, as long as there are data managers who can interpret it. In a management context, this could lead to benefits such as better prediction of peak time and anticipation of issues. In this area, the marketing literature can serve as a source of best practice (eg Chintagunta et al, 2016).

The field of marketing is still moving forward in directions that may benefit healthcare management. For instance, research on virtual reality, virtual communities and metaverses may be useful to the field of healthcare, such as in creating support communities for patients with chronic conditions. Given the growing body of research looking into the patient journey (Trebble et al, 2010; McCarthy et al, 2016), healthcare managers can benefit from decades of research on customer experience and the customer journey (Lemon and Verhoef, 2016; Rosenbaum et al, 2017) to understand the critical stages of the patient journey.

Conclusions

A recurrent criticism of healthcare management is that patients are increasingly being treated as consumers throughout their care journey. However, much can be learned from developments in the field of marketing over the last 20 years that could improve the patient experience. The adoption of a jobs-to-be-done approach can lead to more patient-centredness, which in turn can result in greater patient satisfaction. Moreover, building an understanding of how patients can be persuaded to adopt healthier lifestyles, adhere to treatment or attend health screenings could result in a more streamlined healthcare experience. In sum, healthcare managers can learn from adopting a patient perspective and the tools associated with it, just as marketers aim to adopt a consumer perspective when designing their products and services. Altogether, healthcare managers can benefit from the knowledge of a discipline that excels at understanding what people want and need.

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Conflicts of interest

The author declares that there are no conflicts of interest.

Key points

- Recent developments in marketing theory and consumer psychology can improve the efficiency of healthcare management.
- A patient focus can be adopted by taking a job-to-be-done approach and envisioning the patient experience as being co-constructed.
- Health communication campaigns need to be designed by considering the duality of mind concept and adapting to slow and fast ways of processing information.

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Implementing the care aims approach in children's services: a quality improvement pilot study

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Abstract

Background/Aims Care aims is a population-based, person-centred approach which provides a strategy encompassing the management of a service, informing the population, empowering the workforce around the service user and supporting the person and their family to manage their own lives wherever possible. This pilot study implemented the care aims framework into children's services using quality improvement methods.

Methods An audit of baseline data identified the referral process as an area for improvement in the service. Quality improvement techniques were used to design and test small cycles of change.

Results The results of the audit showed up to 25% of 'requests for help' received from various referrers were not appropriate for several reasons, including old forms and incomplete information. Five tests of change were implemented, which had a mixed impact.

Conclusions This pilot study can help other multidisciplinary teams who are implementing the care aims approach and looking to improve their referral processes in order to improve access to care.

Key words: Care aims; Children services; Multidisciplinary team; Plan-do-study-act; Quality improvement

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Introduction

The care aims approach is a population-based, person-centred way of providing care, based on the principal that all public services have a duty to do the most good and the least harm for the highest number of people possible within the populations that they serve, given the resources available (Malcomess, 2005a, 2005b). This approach is used increasingly as a model of care in NHS services, particularly by allied health professionals, but has traditionally been used in uniprofessional teams (Waterworth et al, 2015). The care aims framework provides a strategy that encompasses the management of a service, the education of the population and the empowerment of the workforce around the service user, as well supporting the patient and their family to manage their own lives wherever possible (Malcomess, 2005a, 2005b).

The care aims approach focuses on the impact and outcomes of care, encouraging evidence-based decision making and health professionals to identify their main reason for intervening (Waterworth et al, 2015). This would, for example, encourage the multiple professionals to work together with their patients and families to agree what support is required and when. The care aims framework has been described in various ways since it was developed by Malcomess (2005a, 2005b). For example, John (2011) described care aims as a mechanism to capture the reason to treat, which can be used alongside therapy outcome measures as a framework for managing workloads based on identifying impact and intended outcomes in planning an intervention. Meanwhile, Waterworth et al (2015) saw care aims as a model of practice to support clinicians to demonstrate evidence-based practice through systematic reflection, ensuring that specialist services are targeted at those in most need of their expertise, while signposting others to non-specialist services that can help to manage their needs.

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Previous research on care aims has largely focused on uniprofessional teams, usually looking at allied health professionals (Mowles et al, 2010; Stansfield, 2012; Waterworth et al, 2015). For example, McCarthy et al (2001) presented an audit that was implemented to ensure uniformity of the definition of care aims across speech and language therapies in the south west Thames region of the UK. The outcome of the audit showed that the care aims approach had been adopted in a flexible way to meet the needs of patients in the locality, and provided speech and language therapists with a tool to reflect on the types of interventions provided to clients. More recently, Waterworth et al's (2015) case research examined the impact of implementing care aims in an integrated community health team. The results indicated that the care aims approach can support teamworking and provision of integrated care. However, they also emphasised that this framework may be more challenging to implement in some professional groups than others, and that ongoing training and support is required to fully realise its potential (Waterworth et al, 2015). Further study into the effect of culture and context on staff in integrated teams showed that the implementation of the care aims approach is more likely to be successful in a team that is already highly integrated (Waterworth, 2016). However, there is still a dearth of literature regarding the care aims framework (Waterworth et al, 2015) and particularly how it links to service or quality improvement. There are clear similarities between the quality improvement and care aims approaches, as highlighted in **Table 1**.

In 2018, the children's services at Hywel Dda University Health Board, Wales, started to implement training regarding the care aims approach. This article reports on the findings of a pilot study that explored how quality improvement methods could assist in the implementation of the care aims approach in a children's services.

Methods

The pilot study focused on the implementation of the care aims approach in the delivery of children's therapy and nursing services at one health board in Wales. The health board provides acute, primary, community, mental health and learning disability services via general and community hospitals, health centres and other sites, located across three local authority areas. A 9-month quality improvement collaborative programme was run by the health board from June 2019 to February 2020, which allowed the authors' team to pilot the use of quality improvement techniques to improve the referral process. The team included service leads and colleagues from physiotherapy ($n=1$), occupational therapy ($n=1$), nursing ($n=2$), speech and language therapy ($n=2$) and dietetics ($n=2$), as well as quality improvement facilitators ($n=2$).

The health board's quality improvement collaborative provided a structured education programme to the authors (as one of the teams on the collaborative), covering quality improvement tools and techniques. Between the education sessions, the team undertook action research to test the feasibility, acceptability, effectiveness and sustainability of their quality improvement learning. Action research is commonly used to improve conditions

Table 1. Similarities between care aims and quality improvement

Care aims framework	Quality improvement
Person-centred approach	Understanding value from user perspective
Evidence-based decision making	Evidence based and data driven
Reduce variability of outcome	Reduction of non-value adding activity
Common language for communicating professional reasoning	Standardisation where appropriate
Promoting transparency	Visualising the process/pathway
Continual evaluation	Continuous improvement
Improve effectiveness of services	Improve efficiency and effectiveness

and practices in healthcare (Lingard et al, 2008) and allows healthcare staff to play a key role in bringing about change in their work environment (Parkin, 2009).

The authors drew on the Model for Improvement (Langley et al, 2009), the care aims framework and key improvement tools to develop a roadmap for care aims implementation, with various quality improvement techniques to help with problem definition, problem solving, data gathering and analysis. This was then used to provide a structured framework to test plan-do-study-act cycles of change and encourage interdisciplinary teams to consider what they were trying to accomplish, how they would know when a change is an improvement and what changes they could make that would result in improvement.

Results

Initial data collection

A high-level process map was developed by the multi-professional team, which visualised the child's journey and interactions with each of the services. It was evident from this review that the demand for these specialist services was greater than the clinical capacity, resulting in long waiting times for patients. Staff felt that they were not making the best use of their specialisms or optimising the impact of the community-based services. A need to improve and integrate existing services and processes across the health board was also recognised.

A cause-and-effect (fishbone) diagram was used to capture possible reasons as to why capacity was not meeting demand, which led to the identification of the referral process as an area for improvement, with some of the delays to care being associated with poor quality or inappropriate referrals being made to the service. Information from across the service were collated by the authors, including:

- The longest waiting times
- The number of patients experiencing the longest waiting times
- The total number of patients on the waiting list and the case load number at the end of the month
- The proportion of referrals that were not appropriate for the service
- The main reasons for inappropriate referrals
- The professional groups that were sending referrals and the proportion of those that were inappropriate for the service
- The type of referral (such as email, letter etc)
- The quality of referrals (such as their completeness).

Before the study, a 'request for help' referral model had been implemented at the service, moving away from the traditional system whereby referrals are made by an educator or a healthcare professional, and towards a request for help that is coproduced by the patient's family. The vision for this was that most families would be supported to identify what help they required and make their own request for help following an appointment with a health professional. For other patients, this would be undertaken collaboratively with the referring health professional and their parents during the consultation. Ultimately, the requests for help system aims to move towards members of the public being able to articulate their needs and directly raise a request for help with the service. This is in line with the care aims approach ethos, which aims to increase family involvement in care. However, the authors' analysis showed that up to 25% of requests for help received were not appropriate for several reasons, including the use of old forms and incomplete information. Therefore, the team set the aim of reducing inappropriate referrals by 25% over 6 months. A driver diagram was created to help visualise the authors' theory of what would drive and contribute to achieving this aim.

Interventions

There were five professional groups involved in the programme: community children's nursing, specialist paediatric dietetics, physiotherapy, occupational therapy, and speech and language therapy. Each team undertook a test of change, focused on using different ways of engaging their key referrers using plan-do-study-act cycles. The target referring groups were paediatric doctors, GPs, health visitors and tertiary centres. The tests of change each

involved introducing the care aims way of working and implementing the request for help pro-forma, using a different method of engagement, including:

- Engaging with the most frequent referrers through in-person awareness sessions to educate them on using the new proforma in the context of the care aims approach
- Writing to referrers to advise them of the correct proforma when an incorrect proforma was submitted to the service
- Liaising with tertiary centre referrers to provide patient transfer information on the new proforma.

Run charts were used to monitor the number of 'requests for help' inappropriate and incomplete referrals (missing information, not clear what is required or wrong service) received for each test of change.

Regular team meetings were held to review the monthly data and to assess the impact of the plan-do-study-act cycles undertaken by the specialist services. Unfortunately, the study was disrupted by the onset of the COVID-19 pandemic, which caused difficulties with the continued monitoring of the data. However, the paediatric speech and language therapy team did manage to collect sufficient data to demonstrate a reduction of 8% in poor-quality requests for help over 4 months. Despite this, the team did not see a substantial increase in the use of the request for help proforma. A second plan-do-study-act cycle was designed in which families were involved in the co-creation of the request for help pro-forma. Unfortunately, this project was interrupted again by the COVID-19 pandemic, but the authors intend to resume data collection as soon as possible.

Discussion

The quality of referrals can have direct consequences for patient care, but poor referral practice is commonly reported both anecdotally and in the literature (Bright et al, 2019). There are a number of factors that determine the quality of a referral, including completeness of the referral information, where the referral is directed, timeliness and whether the patient and their family are involved in the decision to refer and understand why the referral is being made. The referral pathway or process in place for the service is also an important factor (Bright et al, 2019).

Problem definition and baseline data helped to identify the issues surrounding the referral process and the need to integrate request for help referral method, in line with the care aims approach. It was evident from the baseline data that referrals and requests for help were received from different stakeholders in each of the services. Therefore, a one-size-fits all solution was not appropriate, so each service piloted different plan-do-study-act cycles of change, guided by the analysis of the referral data.

The multi-professional nature of the authors supported a systems approach, where the patient's journey could be mapped across the various services and professions. This is integral to both quality improvement and the care aims approach, and supports the family-centredness of the requests for help referral method, which was fundamental to this pilot study. However, as the multi-professional team are not located in the same facilities, communication was critical to ensure that the learning from the different plan-do-study-act cycles was shared and incorporated into the next cycle of change. As different information technology systems are used in different services, a shared drive was used as a portal for data and quality improvement outputs. Greater integration across the teams and services would have made this process simpler.

This pilot study aimed to develop a roadmap that could support the implementation of the care aims approach to service improvement. Unfortunately, the study was interrupted by the COVID-19 pandemic, so the aim of reducing inappropriate referrals by 25% over 6 months was not met. However, in one service, there was an 8% reduction in the number of poor-quality requests for help received in a 4-month period, suggesting that this method has the potential to have some impact on the referral process. The authors recommend that other services aiming to implement the care aims approach test and adapt the method used in this pilot study. The authors also intend to extend the use of quality improvement techniques to other parts of the service, such as assessments and discharge.

Key points

- The care aims framework is a population-based, person-centred approach that aims to empower the workforce around the service user and support the patient and their family to manage their own lives wherever possible.
- The implementation of the care aims framework was supported by multi-professional working and the use of quality improvement techniques.
- Use of the Model for Improvement and plan-do-study-act cycles allowed small scale changes to be tested to improve the referral process for children's services.

Limitations

This pilot study is limited to one organisation and focused largely on one element of the care pathway (referrals), so the results may not be generalisable. Further research is needed on a larger scale and to explore how this learning can be extended to other parts of the care pathway, as well as other services. This pilot study was also limited to a selection of improvement techniques and the Model for Improvement. There are other approaches to improvement, such as lean and six sigma, which could also be used for the future development and integration of improvement approaches within healthcare.

Conclusions

This pilot study provides insight into how quality improvement techniques can assist with the implementation of the care aims approach. The main aim of the improvement in this study was to integrate and improve the request for help referral method. The multi-professional approach taken by the team was essential in allowing a systems approach to improving the quality of referrals to be followed. Although this study was interrupted by the COVID-19 pandemic, the authors intend to continue to test the road map produced here in other parts of the care pathway.

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Conflicts of interest

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Learning from the professional midwifery advocate role to revise clinical supervision in nursing

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Abstract

Nursing has lacked a professional voice in the workplace, which contributes to delays in recognising and addressing patient safety concerns, as identified by national reviews into patient care failings. Nurses often lack structured or consistent approaches to clinical supervision, with poor access to real-time professional and personal support and development. In 2017, midwifery reformed its supervision model, with the change from supervisors of midwives to professional midwifery advocates. This new model links continuous quality improvement, staff wellbeing, patient experience and education to improve care. Adopting this approach of professional advocacy in nursing under national leadership to continuously develop self-learning, professional confidence and communication skills in a structured way could benefit nursing. This article discusses the potential advantages of this model over the current nursing clinical supervision approach.

Key words: Advocacy; Clinical supervision; Nursing; Patient safety; Professional; Quality improvement

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Introduction

Successive reviews of NHS service failures (Francis, 2013; Keogh, 2013; Kirkup, 2015, 2019; Gosport Independent Panel, 2018; Department of Health and Social Care, 2022) have criticised nursing or midwifery professionals and their leaders for accepting poor standards of patient care, highlighting a lack of professional leadership. Common themes across these reviews include the voices of nurses or midwives not being heard, the status quo being accepted and low standards of education and training, emphasising the need to instil a culture of honesty, lifelong learning and quality improvement into NHS organisations (Berwick, 2013).

These reviews have exposed extensive patient safety concerns and harm to patients, and the subsequent recommendations have led to widespread change in the NHS. Changes have had a particularly strong impact on the nursing and midwifery professions, including the introduction of revalidation (Nursing and Midwifery Council, 2013), education reforms (Nursing and Midwifery Council, 2018) and strengthening the nursing and midwifery voice (Kirkup, 2015; Department of Health and Social Care, 2018). In midwifery, the national maternity review (NHS England, 2016) resulted in the removal of statutory midwifery supervision (Baird et al, 2015), which in turn led to the development of a new model of supervision, known as advocating and educating for quality improvement (A-EQUIP) model (NHS England, 2017). The professional midwifery advocate role was developed to facilitate the new model (Martin et al, 2018), recognising that midwives require restorative self-care and can benefit from learning from their experiences. Recently, there have been comparable recommendations to strengthen or reform clinical supervision in nursing (May, 2021) and a contractual requirement to implement professional nurse advocates in the NHS contract (NHS England, 2022).

This article explores the potential benefits of the professional nursing advocate role as a strategy to address some of the safety concerns raised from historical care failings in the NHS.

Clinical supervision in nursing

When clinical supervision emerged as a nursing concept in the 1990s (Butterworth et al, 1996), it was underpinned by Proctor's (1986) three-function model of modern clinical

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supervision: normative functions (managerial aspects of practice, eg core mandatory training), formative functions (educative aspect of developing skills and self-reflection) and restorative functions (supportive aspects for personal development eg stress management). This also meant the introduction of the roles of supervisor and supervisee. This was in contrast to previous supervision models, which had been largely based on counselling relationships in the field of psychology or practitioner reflection (Basa, 2017). At the time, the clinical supervision approach offered a potential means of improving safety through a restorative approach (Snowdon et al, 2017). A number of systematic reviews supported this, reporting beneficial effects such as stress relief, improved professional accountability and knowledge development (Brunero and Stein-Parbury, 2008). However, subsequent research regarding clinical supervision has mainly focused on the restorative functions and have been largely conducted in mental health environments (Snowdon et al, 2017), with results linked to general nursing practice, despite the obvious differences in the context. A rare review of the effect of clinical supervision on patient outcomes found no association with improved patient outcomes or patient experience when clinical supervision was used, although a significant improvement in nurses' compliance with processes of care was reported (Snowdon et al, 2017).

There has been criticism of clinical supervision in nursing. Pollock et al (2017) examined the effectiveness of clinical supervision and how it was implemented in a systematic review, concluding that there was insufficient evidence with which to develop a framework. They also found a lack of agreement on the nature of clinical supervision, as well as variation in the delivered interventions. This problem was also found by Sawbridge and Hewison (2013), whose focus group of nurse executives from acute NHS trusts found no widespread system of clinical supervision or support for the emotional wellbeing of nurses, concluding that this lack of professional support contributed to poor care. A further challenge is that, while clinical supervision is challenging to implement, consistency in practice requires further skill and leadership to prevent the outcomes being steered towards the agenda of the supervisor or organisational policies (Sloan and Watson, 2001).

However, there have also been positive reports of clinical supervision. Wallbank and Hatton (2011) identified substantial benefits from restorative clinical supervision in health visitors and school nurses, who were found to be at risk of burnout and stress because of their close exposure to safeguarding issues. Providing regular opportunities to discuss clinical cases with a supervisor led to the study's participant group being able to make professional decisions with more clarity, resulting in safer decision making and care. Wallbank and Hatton (2011) used an initial questionnaire to evaluate the 22 participants' professional quality of life, including compassion satisfaction, compassion fatigue and burnout, before delivering six clinical supervision sessions. After the introduction of the supervision sessions, the repeated questionnaire demonstrated a 36% reduction in burnout symptoms and a 59% reduction in stress, although compassion satisfaction remained unchanged. Research by Macdonald (2019) concurred with this research, concluding that supporting and valuing midwives increases their positive contributions to care and the workplace.

Literature relating to both professional nurse advocate roles and restorative clinical supervision in nursing is limited and often confined to accounts rather than research. One chief nurse who instigated restorative clinical supervision to build resilience in ward leaders reported positive outcomes (Foster, 2015), while Mahachi (2020) found improved resilience and self-awareness among nurses working in an endoscopy department following the introduction of restorative clinical supervision combined with the A-EQUIP model. Therefore, the challenge appears to be in the implementation and support of clinical supervision, and also in connecting it with quality improvement and education so that patient outcomes are improved.

Moving to the professional nurse advocate and a new model of clinical supervision

The professional midwifery advocate role is carried out by a midwife who is specially trained to take on the position, and will usually be responsible for 5–20 midwives. Training

for the professional nursing advocate role is now available and operational models are emerging (NHS England 2021a), with recommendations of one professional nursing advocate to 20 registered nurses (NHS England 2021b).

The reported success of the professional midwifery advocate role (Ariss et al, 2017; Hopper et al, 2017) has been in its ability to facilitate the implementation of the A-EQUIP model. This model was developed by an NHS England (2017) task group and is made up of four distinct functions: normative supervision, restorative supervision, personal action for quality improvement, and education and development. It differs from the traditional clinical supervision model by including the more recent concept of quality improvement. Although quality improvement is widely advocated, it can become problematic through overstated simplicity and lack of fidelity to original models, producing mixed results (Dixon-Woods and Martin, 2016). However, quality improvement had produced several examples of reduction in harmful variation of healthcare (Moen et al, 1999; Fisher et al, 2013; Conaty et al, 2018; Hill et al, 2020). Strong leadership and the engagement of clinical teams, including nurses, health visitors and midwives, is essential to the success of quality improvement initiatives (Ham, 2014). Because of their close links to the workforce, professional midwifery advocates have been in an ideal position to engage individuals in improvement. This could pave the way for similar outcomes in nursing.

The A-EQUIP model is designed to provide employer-led supervision, which joins its elements to promote a strong emphasis on the personal action that is required for personal development, quality improvement and enhanced quality of care (NHS England, 2017). The inclusion of restorative clinical supervision, a process which Wallbank and Robertson (2008) demonstrated can both protect clinicians from the detrimental effects of stress and reduce of compassion fatigue, is a key element to maintaining the wellbeing and voice of midwives. The combination of the professional midwifery advocate and A-EQUIP supports the midwife to practice both patient-centred care and self-care through a structured approach to supervision (Pettit and Stephen, 2015).

The professional midwifery advocate fulfils a leadership role for midwifery in an era of increased pressure and expectations on this staff group (Rouse, 2019). Using the A-EQUIP allows discussions to be fed back into the local system and individual practitioners are encouraged to take part in improvement studies to inform future practice and development. Although the A-EQUIP model is largely tactical in nature, the restorative element serves to support the emotional needs of the midwife, with restorative clinical supervision aiming to reduce burnout and increase compassion satisfaction (Wallbank, 2007), and instil a sense of joy and fulfilment in professional lives (Coetzee and Kloppe, 2010). This model could support resilience in other healthcare professions, including nursing, especially if modified to meet their specific needs (NHS England, 2017).

Conclusions

The emotional demand on nurses is often taken for granted and efforts to identify methods to support them are not always systematically implemented, although this is now changing in the wake of the COVID-19 pandemic and the chief nursing officer's efforts to establish a system of professional nurse advocates, which is now gathering momentum through a programme of education and positive examples of operational deployment and feedback.

The midwifery profession has developed a model that seems to be of benefit to nursing, and has potential for other health and care professionals. The A-EQUIP model addresses many of the concerns and criticism of clinical supervision models and draws on the current desire for improvement and learning, all while supporting staff with the emotional and physical demands of caring roles. However, strong leadership is required to support consistent implementation of any supervision model, and fidelity to the model will require persistent reinforcement to prevent it from becoming merely a vehicle for organisational messages. The professional nurse advocate may be able to provide this reinforcement, as a novel, professionally-dedicated role.

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Conflicts of interest

The author declares that there are no conflicts of interest.

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The experience of non-clinical research staff during the COVID-19 pandemic: key learning points

Abstract

The COVID-19 pandemic has created and exacerbated many challenges and difficulties, but research departments across the UK were able to adapt and delivery research at an unparalleled rate. This article discusses the work of a large research department and the role that non-clinical staff played in coordinating a considerable research response to the pandemic. The outputs of the team during this time will be discussed, as well as discussion of how individuals adapted and how change management can be used to identify key recommendations and learning points. These learning points should be considered in any future crisis situations when managing non-clinical healthcare teams, both in research and the wider NHS.

Key words: Change management; COVID-19; Leadership; Project management; Research

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Introduction

Within most NHS trusts, there is a research and development department, which focuses mainly on delivering innovation, new therapies and technologies, as well as providing new pathways to help improve and transform services and patient care (NHS England, 2021). Research-active hospitals typically have better patient outcomes, which is thought to be because a research-positive culture gives patients and the public greater access to a better range of treatments and therapeutic options (National Institute for Health and Care Research, 2022).

In the day-to-day running of the NHS, delivering research across many busy NHS services often comes with its own challenges, including lack of space and funding, limited resources and the need for additional tests as part of the research protocol (Dimova et al, 2020). During the COVID-19 pandemic, research departments reached new levels of forward thinking and innovation in order to accelerate the delivery of public health research, including the clinical drug trials and vaccination trials that allowed the UK to become world leading in treatment and prevention of COVID-19 (University of Oxford, 2021).

Staff roles within each research and development department vary between trusts, and can include clinicians, research fellows, research nurses and senior managers, as well as data managers, project managers and a number of other non-clinical administrative staff. The non-clinical workforce assists with a number of duties, such as the set up and management of research trials, the completion of funding applications, data input, data analysis and metrics. Additional tasks include interacting with patients to ensure accurate data capture and building relationships with commercial companies on a variety of research trials. Therefore, non-clinical staff play a vital role in the delivery of research.

The non-clinical NHS workforce has received little attention in research. Official NHS workforce statistics showed that there are approximately 1 189 345 NHS staff, of which 52.7% are qualified clinical staff. The number of administrative or research staff is unclear, as there is no specific identifier for this staff group (NHS Digital, 2021). An inquiry in 2016 found that non-clinical staff often feel 'invisible' and undervalued in discussions about the NHS, with their work often going unrecognised, despite the crucial contributions they make to the service (Cowper, 2016).

This article explores the role of non-clinical research staff during the establishment of a COVID-19 administrative research team. This team had the ability to change and facilitate a rapidly transforming work environment during the pandemic. The experiences

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and learning of the team are summarised for use in other practices, and recommendations made regarding future NHS research teams. Crucially, this article highlights the substantial contribution of NHS non-clinical staff to the effective running of the NHS, during the COVID-19 pandemic and beyond.

Creating the COVID-19 research administration team

The authors' research and development department is part of one of the largest NHS foundation trusts in the UK, which had one of the highest numbers of patients admitted with COVID-19 in the first year of the pandemic (UK Government, 2021). In March 2020, when the first UK national lockdown was announced, the trust admitted 883 patients to hospital with COVID-19, of which 134 required intensive care. At the end of that month, all NHS trusts were told by the National Institute for Health and Care Research to pause the majority of research trials that were not related to COVID-19 in order to support the government's urgent public health research response (National Institute for Health and Care Research, 2020). This led to a rapid reduction in research activity; in the authors' research and development department, 75% of clinical staff were redeployed to other areas of the hospital. This left the department significantly understaffed, with most remaining staff being non-clinical.

Between March and July 2020, the trust had been sent 180 requests to investigate, participate in or set up COVID-19 trials. These proposed trials ranged from a large multi-armed clinical trial of an investigational medicinal product and vaccination trials, to audits and data trials, as well as observational studies. Of the 180 enquiries, 129 were clinical trials that were applying for or had already received approval from the Health Research Authority, while the remaining 51 were data trials or audit requests. Between April and July 2020, the trust set up, approved and opened 26 projects, of which 23 were academic trials and 3 were commercial trials. This meant that the department needed to change their ways of working rapidly to keep up with this demand. Effective solutions were needed to support and manage the setting up of trials, recruitment of patients to act as participants, entry of time-sensitive data and analysis feeding directly into government statistics. One specific trial required extensive data entry for every patient admitted to the hospital with COVID-19 for longer than 24 hours which, during the peak of infections, required a large workforce.

To keep up with this demand, a large COVID-19 research administrative team was created, with 15 whole-time equivalent non-clinical staff being pooled from specialties across the research and development department. Within 2 days, the team had been established. It comprised a mix of clinical and non-clinical expertise, including 10 data managers with varying levels of knowledge and experience in disease areas such as hepatology, oncology, clinical research, general surgery and respiratory conditions. Staff members were invited to join the team based on several factors, including non-clinical status, ability to get to work safely and not having any carer issues.

The teams worked together systematically to manage the data regarding patients with COVID-19. Three sub-teams were created who worked alongside the research nurses to cover trials that involved the delivery of monoclonal antibodies, trials that were delivered on the intensive care unit and trials delivered on other wards. A junior administrative leader was assigned to each sub-team, which consisted of two supporting data managers. Staff members' working hours changed so that cover was provided 24 hours a day, 7 days a week, to ensure that support for the clinical and nursing teams was available at all times. In addition to this main team of data managers, there were three other senior non-clinical research and development staff members who helped to develop a process for reviewing new proposals for trials.

Developing the team

In May 2020, as hospital and intensive care unit admission rates for COVID-19 were falling, the National Institute for Health and Care Research (2020) published the restart framework, which led to the reopening of research portfolios and thus the natural expiration of the

COVID-19 research administration team. The creation of this team and the experience the staff had gained in the delivery of trials meant that the department was better prepared when the January 2021 national lockdown was announced.

Between December 2020 and February 2021, the trust saw a total of 11 747 hospital admissions and 490 intensive care unit admissions of patients with COVID-19. This led to mass redeployment to support the clinical areas that were facing particularly high pressures and, once again, most research that was not related to COVID-19 was paused. By the end of February 2021, the trust had recruited over 14 250 patients to COVID-19 research trials, which required varying amounts of datasets, electronic data entry, data queries, site file management, preparation of test kits for specific trials and even urgent safety monitoring visits. The department was also responsible for ensuring that all research activities met international ethical, scientific and practical standards.

Another result of the high patient admission rate was the high administrative workload for the recruitment of patients to research studies. To meet this demand, the COVID-19 research administration team was reformed, this time on a more substantial scale. Four project managers (including the two who were involved in the original team) rapidly brought together 22 research administrators, project assistants, data managers and trial coordinators. These staff members were from a wide range of specialties, including oncology, hepatology, trauma care, bioresources and National Institute for Health and Care Research infrastructures. Staff members who had been part of the original team were contacted for the reformed team initially, with further staff requested from other teams. Once the team had been briefed and a suitable rota implemented, the team began to work together on 18 January 2021. A dynamic management structure helped to support the administrative workload for the COVID-19 portfolio of research trials. Having clear objectives and using specific, measurable, achievable, relevant and time-bound (SMART) criteria was key to completing this.

The aim of the reformed team was to provide strong administrative support to the portfolio of COVID-19 research studies being performed in the trust. Careful consideration was given to fair allocation of work, ensuring that all staff were informed and felt comfortable with their new workloads. Rotas were created in a way that was accommodating and flexible to all staff needs. An inclusive culture within the team was aspired to, with communication and the building of good rapport within the team being prioritised.

It was also important to address key practical issues. The pragmatic elements of any new team should never be underestimated, as they are pivotal in ensuring a cohesive start to a role. In this instance, such aspects included access to information technology systems and seating plans to adhere to social distancing practices. All members of the team were offered a one-to-one meeting with a project manager within the first 2 weeks. Communication between the project managers and members of the team was seen as crucial to provide updates, maintain motivation and show a supportive presence. This was in line with research by Walton et al (2020), who emphasised the importance of communication for the mental health of NHS staff during the pandemic, stating:

‘It is often impossible for leaders to communicate too much. The challenge in this pandemic is what to communicate. A key principle behind communication in this setting is to be open and honest: say what you know are facts, say what you do not know but what you are going to do to find out.’ (Walton et al, 2020).

Communication is a dynamic process that requires a multifaceted skillset and involves more than just talking to staff. The reformed team was an opportunity to develop communication skills further, including understanding and empathising with individuals needs, and learning motivations behind staff behaviours. Taking into account individual perspectives and how staff felt about the situation meant the team could be managed more effectively. For example, working on site full time caused some staff anxiety and a few individuals struggled to adapt to the new working environment, particularly if they had not been working on site during the first wave of the pandemic. Empathetically supporting these staff members to help to ease these anxieties was vital, as was following procedures and using risk assessments to reassure staff.

Staff experiences

Staff experiences of the 2021 reformed COVID-19 research administration team varied from those of the original 2020 team. In the original team, staff initially felt overwhelmed by the rapid changes, so flexible working was supported and regular one-to-one meetings were set. This helped to ease concerns, while also supporting a positive work-life balance, which was particularly important during such a challenging and unpredictable time. Daily morning briefings were also introduced to deliver updates quickly and efficiently, and give staff the opportunity to ask questions. Throughout the time the team was active in 2020, all staff remained on site and, as a result of effective social distancing policies in the department, there were no sickness absences.

However, in the reformed 2021 team it quickly became clear that different staff coped with the change in different ways. These differences were often connected to how long they had been in their current role, the teams and specialties that they had been based in before the pandemic, and individual factors such as their level of enthusiasm and passion for the work. Some staff were more anxious about the pandemic than others, which was sometimes linked to their perceived level of risk and personal experiences of COVID-19. As a result, a culture of increased consideration for the thoughts, feelings and mindsets of others was needed, as these could change rapidly in times of stress. In their review of NHS staff experiences during the pandemic, NHS Employers (2021) highlighted similar findings about the varied ways in which staff adapted, emphasising the need to promote a culture of wellbeing, staff engagement and equality, with strong leadership through the crisis.

With reassurance and problem-solving strategies in place, the reformed COVID-19 research administration team were able to settle into their roles. Overall, there was a positive, conscientious attitude from staff, who showed willingness to contribute. From the authors' perspective, most staff seemed comfortable seeking support when they needed it and approaching the project managers with any queries. There were many staff who had never worked together before, so all communication techniques discussed in this article were essential.

The success of this workforce structure was demonstrated through the high level of recruitment into COVID-19 trials achieved. The urgent public health COVID-19 research studies took a median of 7 days each to set up at the trust, which was 63% quicker than before the pandemic. By the end of March 2021, 39 COVID-19 studies had been set up and opened, with the trust recruiting 17986 participants to COVID-19 and vaccination studies. Data from these studies have contributed substantially to understandings of the virus and public health measures put in place to mitigate it.

Key learning points

The key learning points from the team's experience are summarised in **Table 1**. These points have been generated via feedback from staff, discussions with senior management and reflections from team leaders.

It quickly became evident that individuals came into the COVID-19 research administration team with different levels of experience. Tasks such as using standard hospital systems were difficult for some staff, while others were already very proficient. Staff understandings of the hospital and department also varied widely, with some team members having no understanding of the structure of the research and development department at first. There was no standardised induction or training plan in place for non-clinical research and development staff, which the authors believe was the main reason for the disparate skillsets within the newly formed team. Some of the key learning points shown in **Table 1**, such as consistent management and training and strong leadership, would help the department to work towards a clear education model for the non-clinical research and development workforce.

The team's experience also highlighted the need to maximise the contribution of non-clinical NHS staff (Cowper, 2016). Group training, working in the same office and exposure to clinical areas offered a great opportunity to create a generic training structure

Table 1. Key learning points for the experience of the COVID-19 research administration team	
Learning point	Details
Consistent management and training for non-clinical staff	<ul style="list-style-type: none"> By reviewing current policies and procedures, departments can develop workforces with transferable, adaptable and flexible skills Roles should have certain goals and these should be managed consistently across managers Departments would benefit from the creation of induction packs for staff, training for line managers to be consistent in relation to style and boundaries and a training matrix for non-clinical staff Staff should be involved in a skills mix review, with the opportunity to be involved in recruitment or interview panels
Communication	<ul style="list-style-type: none"> Communication should be structured, honest, factual and include all staff If a manager does not know the answer to a query or concern, they should admit that they do not know and give clear timeframes for when staff can expect to receive that communication Regular, organised communication channels are useful, such as webinars and email distribution channels Senior management need an approachable ethos, with an open-door policy for all managers Staff should be given clear messages and instructions as announcements There should be trust-wide access to staff training modules on NHS Elect (https://www.nhselect.nhs.uk/)
Leadership	<ul style="list-style-type: none"> Staff require clear direction from senior management, with clear expectations for all roles within the team Leaders should be supportive, approachable and trustworthy; demonstrate clear responsibility and delegate appropriately; and take accountability for their actions Managers must be decisive and confident, but also listen to their team It is important for leaders to be present and develop mentoring skills A project management forum can help managers to develop their leadership skills Managers should aim to build resilience in their teams and develop the strengths of team members
Staff morale	<ul style="list-style-type: none"> Staff morale can be improved through incentives and positive reinforcement, as well as regular check ins and structured one-to-one meetings with leaders Managers should aim to build a constructive environment by encouraging feedback and providing training and learning opportunities Trusts can facilitate career progression by encouraging staff to take leadership roles where possible, such as lead coordinator on research studies Leaders should encourage a positive team 'can do' attitude, with regular praise and acknowledgement of work and achievements
Major incident readiness	<ul style="list-style-type: none"> In emergency situations, close proximity of working is desirable Staff can be prepared for major incidents through training for readiness, resilience and action Promoting the mindset of readiness to change and adaptability can help staff cope with a crisis Completion of any mandatory training in line with the trust to support management of major incidents in the future
Clear roles and objectives in teams	<ul style="list-style-type: none"> Highlighting the key aims and objectives to staff can make them more relatable Conducting a skills mix review or staff structure review can be beneficial Staff can benefit from a training matrix SMART objectives can be used for the team as a whole Showing the positives of learning from the experience of COVID-19 is important Staff should be involved in system development, piloting new programmes, such as the EGDE intelligent research management programme and Microsoft PowerBI

SMART=specific, measurable, achievable, relevant, time-bound

to allow non-clinical staff to develop transferable skills. Developing working relationships, networking and sharing knowledge and expertise would mean that, in future, it may be possible to redeploy non-clinical staff to areas of need during times of crisis in order to optimise their potential. These experiences may also inspire more junior staff regarding how they could potentially progress through their careers, either within research or in other NHS departments.

Conclusions

The COVID-19 pandemic brought unprecedented levels of pressure to NHS services, but it has also presented the opportunity to change for the better. The experience of the COVID-19 research administration team shows the potential of non-clinical research staff and their role in the research and development department. The success of the department could not have been achieved without the help and expertise of clinical research staff and other research peers. However, the COVID-19 pandemic forced the non-clinical team to review working structures and gave them the opportunity to implement change. The effective leadership of the team also led to increased staff morale, a positive team ethic and a supportive working environment, in which staff felt safe and comfortable to raise concerns and suggest ideas for improvement.

Having consistent roles, management styles and exposure to other roles in the wider healthcare team can help the workforce to grow and, in turn, to support clinical academics as they develop their research. Implementing improvement tools, such as generic training programmes and competencies for non-clinical research staff, can give trusts the opportunity to measure outcomes through staff feedback, job retention rates and the ability to redeploy staff when needed. Effective communication is essential to the day-to-day running of any service, including clear direction from senior leadership and a defined management structure. It is important to be aware of possible factors that could hinder communication, such as staff anxiety, and to have a clear support mechanism and reporting structure. This can enable more efficient working, improved productivity and better staff wellbeing.

The experiences from the COVID-19 pandemic have provided the authors' team with the motivation to drive change forward. Reviewing working processes and developing standardised staff training, encouraging interworking and networking of specialties, and promoting shared knowledge will help to continue the development of the workforce. The recommendations made in this article can allow new pathways and procedures to be created. In the authors' experience with the COVID-19 research administration team, these developments have helped to create a large and effective team who are able confidently support and facilitate a rapidly changing work environment.

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Conflicts of interest

The authors declare that there are no conflicts of interest.

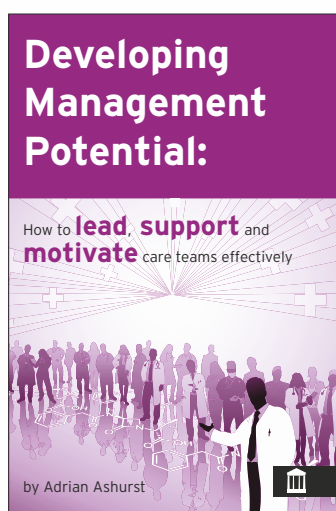
Key points

- The lessons learnt from the experiences of these authors can be used to review staff skillsets and ensure consistency of jobs, management styles and exposure to other areas.
- By reviewing current policies and procedures, departments can develop workforces with transferable, adaptable and flexible skills.
- The main aspect for effective leadership during a rapidly changing work environment is communication and clear direction from senior management.

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