NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC

BOARD OF DIRECTORS IN PUBLIC

2 October 2024

09:00 GMT+1 Europe/London

AGENDA

1. BOARD OF DIRECTORS IN PUBLIC

REFERENCES

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- 9.1 CFO BAF.pdf
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- 9.4 Monthly Maternity Neonatal Report Oct 2024.pdf
- 9.4.1 Appendix 1 - Perinatal Clinical Surveillance Quality Assurance Report August 2024.pdf
- 9.4.2 Appendix 2 - MIS-Year-6-audit-tool V3 September 2024.pdf
- 9.4.3 Appendix 3 - SBLCBv3 Wirral Q2 2425 FINAL REVIEW.pdf
- 9.4.4 Appendix 4 - WUTH Claims Balanced Score Card.pdf
- 9.4.5 Appendix 5 - National-review-maternity-services-england-2022-2024.pdf
- 10 Organ Donation Annual Report.pdf
- 11 Complaints Annual Report 2023-24.pdf
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- 12 Safeguarding Annual Report.pdf
- 13 Managing Conflicts of Interest Update.pdf
- 14 Fit and Proper Persons Policy.pdf
- 14.1 Appendix 1 Fit and Proper Persons Policy - 2023a.pdf
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- 15.1 Refreshed CMAST Joint Working Agreement v1 0924 _ track.pdf
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Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 2 October 2024
Time	09:00 – 11:00
Location	Hybrid

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		Items for Decision and Discussion		
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	6.	Chair's Business and Strategic Issues – **Verbal**	Sir David Henshaw	
24	7.	Chief Executive Officer Report	Janelle Holmes	
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Committee Chair's Reports

	16.	16.1)	Audit and Risk Committee - **Verbal**	Steve Igoe
464		16.2)	People Committee	Lesley Davies
466		16.3)	Research and Innovation Committee	Steve Ryan
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Closing Business

17.	Questions from Governors and Public	Sir David Henshaw
18.	Meeting Review	Sir David Henshaw
19.	Any other Business	Sir David Henshaw

Date and Time of Next Meeting

Wednesday 6 November 2024, 09:00 – 11:00

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 4 September 2024
Location	Hybrid

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
SI	Steve Igoe	SID & Deputy Chair
CC	Chris Clarkson	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
RM	Dr Rajan Madhok	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Dr Nikki Stevenson	Medical Director & Deputy Chief Executive
HK	Hayley Kendall	Chief Operating Officer
DS	Debs Smith	Chief People Officer
MS	Matthew Swanborough	Chief Strategy Officer
MC	Mark Chidgey	Chief Finance Officer

In attendance:

DM	David McGovern	Director of Corporate Affairs
JJE	James Jackson-Ellis	Corporate Governance Officer
CM	Chris Mason	Chief Information Officer
JC	Jo Chwalko	Director of Integration and Delivery
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 8.5
RMe	Dr Ranj Mehra	Deputy Medical Director – item 8.6
AA	Alice Arch	Guardian of Safe Working – item 8.7
SLa	Sharon Landrum	Head of People Experience – item 9
TC	Tony Cragg	Public Governor

Apologies:

SR	Dr Steve Ryan	Non-Executive Director
SH	Sheila Hillhouse	Lead Public Governor
EH	Eileen Hume	Deputy Lead Public Governor
RT	Robert Thompson	Public Governor
GB	Gary Bennett	Appointed Governor

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH welcomed everyone to the meeting. Apologies are noted above.	

2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 3 July were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story from a patient who had been diagnosed with autism and suffered a food allergy. The video story described the challenges she experienced eating hospital food as an inpatient. The video story also described the improvements that had been implemented following her feedback. SW stated ward folders had recently been implemented and included information on how to request an allergy free menu. SW added mandatory training had also been rolled out recently, specifically the Oliver McGowan Mandatory Training on learning disability and autism. MS reported a business case was in development and expected early next year to revise the approach to patient catering and suppliers for the patient meal service across the hospitals. The Board **NOTED** the video story.	
6	**Chairs Business and Strategic Issues** DH provided an update on recent matters and highlighted it was positive the Trust had been shortlisted for Trust of the Year. DH added financial challenges continued and the Trust was engaged with the process being led by the ICB. DH stated breakfast with the staff network co-chairs earlier in the morning had been positive and commented staff continue to embody the Trust values. DH thanked all the staff for their continued hard work. DH reported that an allegation had been made towards him by the Governor for Bidston and Claughton regarding plagiarism of his dissertation from 1974. DH added this allegation had also been circulated to other Governors and because of this wanted to raise the matter publicly.	

	DH explained because of the allegation and investigation he would not Chair future Council of Governors meetings and instead SI as Deputy Chair would chair instead until the matter had been resolved. DH requested members agree with this approach and stated SI would also seek agreement from the Council of Governors. Members agreed with the approach as outlined above. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** JH highlighted in July there were no Patient Safety Incident Investigations opened under the Patient Safety Incident Response Framework and two Reporting of Injuries, Diseases and Dangerous Occurrences were reported to the Health and Safety Executive. JH updated members on the Wirral system review, highlighting phase 1 was complete and identified opportunities for improving service delivery and productivity. JH added phase 2 was expected to be finalised and presented to the ICB in October. JH explained the Cheshire and Merseyside Surgical Centre had now treated over 5000 patients and that phase 1 of the Urgent and Emergency Care Upgrade Programme (UECUP) had officially opened. JH referenced that the Trust had been shortlisted as finalists in the Health Service Journal Award for Trust of the Year and the winners would be announced at the HSJ Awards on 21 November. JH highlighted ward 20, 54, 26, 14 and 17 achieved green level 3 WISE accreditation. JH summarised the recent meetings of the Cheshire and Merseyside Acute and Specialist Trust Board (CMAST) on 2 August, noting a key area of discussion was on the system financial challenges and a federated data platform. JH also summarised the recent meeting of the Place Based Partnership Board (PBPB) on 25 July, noting the Wirral Place Workforce Group were developing a Wirral People Strategy to support the delivery of the Wirral Health and Care Plan. DH queried about the Cheshire and Merseyside Surgical Centre business case and the estimated number of patients being treated. HK stated in a year, for phase 1 this was 3000 patients and 2000 patients for phase 2.	

	CC queried about the Trust of the Year Award. JH stated the Trust submitted a nomination and the submission detailed the improvement journey the Trust has been on during the last 5 years and various other achievements. JH added the next step included a presentation in October and the results would be announced in November. SI commented about the importance of the Trust being an Anchor institution and communicating to the Wirral population about the role the Trust plays in the community. The Board **NOTED** the report.	
8	**Board Assurance Reports** **8.1) Chief Finance Officer Report** MC reported at the end of July, month 4 the Trust was reporting a deficit of £12.3m, an adverse variance against plan of £3.4m and the Trust was forecasting a risk adjusted deficit of £31.7m, a potential variance to plan of £15.4m. MC set out the key drivers of this forecasted variance and the internal risks to achievement, including full delivery of elective activity, CIP, maintaining expenditure on urgent care within planned levels and delivering planned integration benefits. MC highlighted the Trust has fully engaged with the NHSE and ICB finance review to plan actions to reduce expenditure to mitigate against these risks. MC provided an update on the statutory key financial risks for month 4, noting the RAG rating for each, highlighting that financial stability and financial sustainability were red, agency spend, financial efficiency and cash were amber, and capital was green. The amber rating for cash relates to the current cash balance and assumes that cash support will be made available. MC explained at the end of month 4 the cash balance had reduced to £3.8m. Maintaining a positive balance had only been achieved through management of working balances with a significant negative impact on the metrics for payment of suppliers. The Trust planned to submit a request for additional cash support from October 2024, which would result in additional scrutiny and require a cash recovery plan. MC confirmed that the Trust was still awaiting confirmation from the ICB as to when it would receive additional income as part of the original financial planning exercise to support the planned deficit position. SL queried about income support that was going to be provided to Trusts in Cheshire and Merseyside reflecting the £150 deficit	

	position. SL commented there was a reputational risk if the Trust was unable to pay suppliers in line with the Public Sector Payment Policy. MC stated that the commitment to additional income was based upon delivery of plans and NHSE/ICB continued to seek assurances from Trusts on this. MC added that no guidance had been published to confirm when income support would be provided, and this delay was one of the drivers requiring the Trust to apply for cash support sooner than would otherwise be the case. SI queried if the Trust's capital programme could reduce as part of a condition for applying for cash support. MC stated the Trust may face challenge on the capital programme and other areas. However, there was very limited scope to reduce capital as the Trust was already legally committed to many schemes and only operationally essential schemes had been prioritised. The Board: • **NOTED** the report including engagement with NHSE and the ICB on the management of financial risk through the review process; and • **NOTED** that the Trust will be submitting a request for additional cash support in Q3 (October to December 2024) **8.2) Chief Operating Officer Report** HK highlighted in July the Trust attained an overall performance of 98.03% against plan for outpatients and an overall performance of 97.56% against plan for elective admissions. HK summarised referral to treatment target, noting the Trust has a delivery plan to eliminate all 65 week waiters by the end of September excluding Gynaecology. HK added the Trust continues to support other Trusts across the region by offering mutual aid. HK explained the cancer performance against the trajectory, noting the Trust met the faster diagnosis standard for Q1 and continued to make good progress for 62 day treatment/waiters. HK reported the DM01 performance standard was 96.1% in July and highlighted there were challenges regarding increases for endoscopy and Dexa scanning. HK reported in July type 1 unscheduled care performance was 42.68% and remains a significant challenge. HK stated the Trust was working with Wirral system partners to agree out of hospital responses to support the achievement of the national target. HK added the review carried out by Aqua would be shared with the Finance Business Performance Committee in October.	

HK stated ambulance handover performance continues to be an area of focus, specifically 12 hour DTAs, and a new pilot was being tested to improve performance.

HK reported the number of patients not meeting the criteria to reside at the hospital remained low, however, the demand for patients attending the ED with mental health conditions remains high.

The Board **NOTED** the report.

8.3) Integrated Performance Report

SW reported C Diff continued to be a key area of focus and remained above the target of 6 cases per month with an average of 9 cases per month. SW explained a dedicated improvement plan had been developed with high incident areas to reduce the number of cases.

SW reported, following the NHSE review into C Diff on the Wirral, a Wirral Place wide improvement plan is in development in partnership with Wirral system partners.

DH queried how the improvement plan could be accelerated to reduce the number of C Diff cases.

SW stated it was important to work with Wirral system partners to reduce the use of antimicrobial drugs in the community. SW set out the number of C Diff cases in the community vs health care associated.

SW reported the Friends and Family Test for ED in July scored 74.9% against a target of 95%. SW added the main concerns related to waiting times, delays and communication.

DS highlighted staff turnover in month and mandatory training compliance continued to meet Trust target. DS explained appraisal compliance was below Trust target and each Division had an improvement trajectory in place which was being overseen by Workforce Steering Board.

DS added sickness absence continued to increase and was an area of concern. DS highlighted that once the updated Attendance Management Policy had been in place for 6 months, a review will be carried out to ensure the triggers remained appropriate. DS also explained the flu and COVID vaccine programme would start in October and reduce increased incidents of colds and flu.

SL commented about the high sickness absence rate and stated this would have an impact on the financial position of the Trust.

	DS agreed and stated it does have an impact not only on finances but potentially also on patient care experience and employee experience. DS stated the Trust was not an outlier in the increased rates of sickness absence. SL also queried if there were any specific staff groups who had high sickness absence. DS stated Clinical Support Workers had a higher rate of sickness absence, but this was not unusual. DS added another area was estates and auxiliary staff. NS reported the number of informal complaints was above threshold, however the number of formal complaints remained below. NS added this means patient concerns were being addressed before a formal complaint was made and this was positive. NS explained the number of patients recruited to NIHR studies was low, however the new Research and Innovation Hub at Clatterbridge would open in September and a number of research studies was already planned. CM reported the priority 2 calls to the IT helpdesk closed outside of SLA was above Trust threshold and work was underway with teams to agree the qualifying criteria for call priority categorisation to ensure it reflects the needs of the organisation. CM highlighted subject access requests completed in month was marginally below target and requests continued to be above the planned trajectory. CM added the backlog of subject access remained higher than trajectory due to the complexity and number of requests. CM explained the trajectory would be reviewed and the reallocation of staff would be considered to reduce the backlog. LD queried if there were any process improvements which could be made to reduce the waiting list of subject access requests. CM stated there was technology available to process requests, but this had not been fully developed. CM added there were opportunities to make process efficiencies to respond more promptly and these were being explored. LD also queried if subject access requests were analysed to understand if there were any trends. CM stated subject access requests followed the trend in the media, specifically in response to key topics effecting patients. JH suggest it may be beneficial to understand if the increase in requests was due to patients or staff. JH also suggested the	

	Service Improvement Team could provide support to identify process improvements. The Board **NOTED** the report. **8.4) Productivity and Efficiency Update** HK summarised the 2024/25 Cost Improvement Programme position for Trust, highlighting the target for the year was £28.8m and the forecast delivery in year so far was £20.1m. HK added the amount transacted as at month 4 was £11m. HK also gave an update on the nine transformation workstreams and summarised the RAG delivery status for each. HK highlighted the productivity workstream was being fast tracked in line with the Cheshire and Merseyside financial recovery request. Members noted the good progress so far this year. The Board **NOTED** the report. **8.5) Quarterly Maternity and Neonatal Services Report** JL provided the perinatal clinical surveillance data linked to quality and safety of maternity services and highlighted there were no areas of concern to raise for July. JL added there were no Patient Safety Investigation Incidents (PSII's) declared in June or July for maternity services. JL gave an update on MIS Year 6, explaining compliance was being monitored monthly via the Women and Children's Divisional Quality Assurance meeting and that an updated gap analysis had been produced in line with the revised updates to the scheme published in July 2024. JL referenced the Perinatal Mortality Reviews Summary Report indicating there were no reviews of perinatal deaths in the period April to June. JL also gave an update on Saving Babies Lives, noting the Trust achieved 96% compliance against the 6 elements based on evidence submitted in June 2024. JL also referenced the Ockenden gap analysis and the 15 immediate and essential actions, noting the Trust remained in the same RAG rated position as fully compliant. JL also gave an update on progress regarding implementing a Continuity of Carer Model with an update on Trust's position regarding the British Association of Perinatal Medicine and Maternity Self-Assessment Tool, as required by NHSE and the CQC.	

Members thanked JL for their continued hard work.

The Board:

- **NOTED** the report.
- **NOTED** the Perinatal Clinical Surveillance Assurance report.
- **NOTED** the position of Patient Safety Incident Investigations (PSSI's) & Maternity and Newborn Safety Incidents (MNSI)
- **NOTED** the progress of the Trust's position with Maternity Incentive Scheme and Saving Babies Lives v3.
- **NOTED** the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals."
- **NOTED** the position of the neonatal medical and nursing workforce.
- **NOTED** the position of the maternity workforce.
- **NOTED** the updates within the maternity self-assessment tool; and
- **NOTED** the PMRT reports.

8.6) Learning from Deaths Report

RMe summarised the report, highlighting the Trust's Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) remained within the expected range of mortality data.

RMe explained from September the Medical Examiner Service will be required to scrutinise deaths in the community and plans are in place to ensure sufficient capacity to undertake this work.

RMe noted there had been a rise in sudden infant deaths from the community during the reporting period. RM added the Trust was unable to benchmark this data following the system data changes which took place last year.

RMe also noted next year the HSMR indicator would increase because of coding changes, however Trust would remain within the expected ranges.

LD queried the external benchmarking data, specifically the complications arising from device implants and the 16 cases identified had been reviewed.

RMe stated this had been completed and primarily related to devices implanted at other hospitals. RM added two areas of focus for the Trust following the reviews were catheters and sepsis.

	RM queried about the cases relating to carcinoma of bronchus and the delay in fast-track discharge and commented about the dignity between dying at home vs in the hospital. RMe stated in some instances a committee care package could not be put in place in time to allow patients to return home to die. RMe added further work needed to be done to improve this. DH queried if this situation would be included as an integration opportunity as part of the Wirral Review. JC agreed and stated there were opportunities to improve this in the short, medium and long term. JC added an example of this was changing the criteria during winter to admit end of life patients into the integrated care beds to prevent them from dying in hospital but also not at home. DH requested JC provide an update on the operational aspects of end of life care. NS stated the Trust had good palliative care in place at the hospital and allowed patients to die in this setting with dignity, should patients choose to do this. HK highlighted she and the Place Director had contacted the ICB regarding a commissioning decision stop top up funding to care homes which would allow patients to die in this environment. The Board **NOTED** the mortality indicators, ongoing Medical Examiner input and ongoing scrutiny of mortality through the Mortality Review Group. **8.7) Guardian of Safe Working Report** AA summarised the number of exception reports during the period, noting the number of reports raised by F1s had reduced compared to previous periods. AA explained this was expected as junior doctors gain the time management and essential non-clinical skills to complete their role. AA stated General Medicine continued to have the highest number of exception reports raised. AA highlighted the Doctors' Mess had now been refurbished and had already received positive feedback from junior doctors. LD thanked AA for providing the additional data in the report which included the duration of time claimed on the exception reports, and this provided more assurance to the People Committee that these were not excessive.	Jo Chwalko

	NS explained one of the areas of good practice recently implemented was exception reports, which were now provided to the Educational Supervisor and which provided further opportunities to provide support to junior doctors. The Board **NOTED** the report. **8.8) Board Assurance Framework (BAF)** DM summarised the key changes to the BAF, noting additional controls had been included for several strategic risks and the risk score regarding finance sustainability had increased to 16. DM added the risk appetite and risk maturity positions had been changed. DM highlighted an internal audit review of the risk maturity was being undertaken. The Board: • **NOTED** the current version of the BAF; and • **NOTED** current position regarding Risk Appetite and Risk Maturity.	
9	**Equality Diversity and Inclusion Bi-Annual Report** DS gave an overview of the bi-annual report, noting that this report focusses specifically on workforce demographic data and gives a summary of activities that demonstrate the advancement of the EDI agenda. DS also gave an overview of the WRES and WDNES reports, noting there were individual action plans in place to address areas of concern. DS noted there was a decrease in the some of race equality data outcomes and reminded members there was a dedicated Board Seminar to focus on this in the afternoon. DH queried how the Trust compared regarding ethnicity data and if a general trend was available for this. SLa stated comparative data did exist to compare with other Trusts and added 4% of Wirral community identified as non-white. DS stated two years ago the Trust employed 7% non-white staff, and this was now 14%, which was significantly higher than the ethnic diversity of Wirral. SI queried about the progress regarding the Equality Diversity and Inclusion Strategic Commitment and embedding the culture of diversity. DS stated this was challenging and the Trust was not an outlier. DS highlighted one of the biggest challenges was how staff were	

	treating each other and understanding each other's differences. DS explained a key area of focus was raising awareness and embedding a zero-tolerance approach. The Board **NOTED** the report.	
10	**2023/24 Annual Submission to NHS England North West: Appraisal and Revalidation** NS presented the report and explained the requirements set out by NHS England and provided a summary of the appraisal and revalidation data for the period year April 2023 – March 2024. NS summarised the plans for the 2024/25 period, noting this would include a self-assessment on the Trust's processes and carry out a medical engagement survey. NS added following approval the report would be signed by the Chief Executive and returned to NHS North West before the specified deadline. The Board **APPROVED** the report.	
11	**Board of Directors' Terms of Reference** DM highlighted the Terms of Reference were created last year as part of the wider corporate governance review and consolidates information already set out in the Trust Constitution. DM added no amends have been proposed this year and the Terms of Reference remain unchanged. DM explained the Terms of Reference would be reviewed again following any recommendations arising from the Wirral Review. The Board **NOTED** the Terms of Reference.	
12	**Committee Chairs Reports** **12.1) People Committee** LD reported the Committee discussed the Equality Diversity and Inclusion Bi-Annual Report, noting there was a range of activity being undertaken but a key area of focus was improving the employee experience of Black, Asian and Minority Ethnic Staff. LD added the Committee also received good assurance in relation to the Guardian of Safe Working Report and Safe Staffing Report. LD highlighted the Committee also discussed the 2023/24 Annual Submission to NHS England North West: Appraisal and Revalidation, noting this was comprehensive and identified areas of focus for 2024/25.	

	The Board **NOTED** the report. **12.2) Charitable Funds Committee** SL provided a verbal update on the most recent meeting and highlighted the Committee received a presentation on the neonatal unit redevelopment options and looked forward to receiving a final proposal in due course. SL added the Committee also considered the budget for the financial year and received the draft Charity Annual Report and Accounts for 2023/24. Members thanked the Charity team for their ongoing hard work and Finance team for their support. The Board **NOTED** the report. **12.3) Quality Committee** NS reported the Committee received an update on progress against the Wirral Place commissioned report into C Diff, Committee noted the Trust had completed several actions already and further work was required with Wirral system partners to complete the remaining ones. Several actions were agreed by the Committee and a further update would be provided in the autumn. NS explained the Trust had benchmarked negatively against a national clinical audit on dementia, specifically in relation to the frequency of screening for delirium. Actions were already underway to address this. The Board **NOTED** the report. **12.4) Finance Business Performance Committee** SL provided a verbal update on the most recent meeting and highlighted most of the business had already been discussed in this meeting. SL added the Committee received a presentation form the Diagnostics and Clinical Support Division on their Cost Improvement Programme and Committee were also provided with assurance in relation to consultant agency spend. The Board **NOTED** the report.	
13	**Questions from Governors and Public** TC commented about the patient story and suggested the patient passport may have helped prevent some of the issues this patient	

	experienced. TC also congratulated the Trust on being shortlisted for Trust of the Year in the Health Service Journal Awards.	
14	**Meeting Review** No comments were made.	
15	**Any other Business** No other business was raised.	

Action Log
Board of Directors in Public
2 October 2024

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	4 September 2024	8.6	To provide an update on the operational aspects of end of life care	Jo Chwalko	The Director of Integration and Delivery has liaised with Primary Care, Wirral Borough Council, Wirral Community Health & Care Trust and the Voluntary Community & Faith Sector. Feedback has highlighted numerous Health and Care Community Services that support End of Life Care. There are also various governance meetings across Wirral that review End of Life Health and Care provision. However, there is an opportunity to review the interdependences and criteria between those services. More specifically, how the pathways align to supporting hospital discharge for End-of-Life Care patients in a timely manner. The Director of Integration and Delivery will progress this workstream with system partners.	October 2024

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
2 October 2024

Title	Chief Executive Officer Report
Area Lead	Janelle Holmes, Chief Executive
Author	Janelle Holmes, Chief Executive
Report for	Information

Executive Summary and Report Recommendations
The purpose of this report is to provide Board with an update on strategic activity undertaken since the last meeting and draws the Board's attention to any local and national developments. It is recommended that the Board of Directors: • Note the report

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
This is a standing report to the Board of Directors			

1	**Narrative**
1.1	**Industrial Action Update** No update
1.2	**Health and Safety**

	There were no Patient Safety Incident Investigations (PSII) opened in August under the Patient Safety Incident Response Framework (PSIRF). The Patient Safety Response Meeting report and investigate under the PSIRF to identify learning and improve patient safety. There was one Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported in August. All RIDDORs reportable events are subject to a Health and Safety Local Review investigation to ensure causes are identified and to ensure improvements are made to reduce the risk of a similar event occurring.
1.3	**News and Developments** **Wirral System Review Update** The Phase 2 report of the Wirral System Review has now been released. A detailed paper has been included in the agenda for the Private Board. **Tier 1 Unscheduled Care Support** In August, the Trust was informed that it was one of five Trusts in Cheshire and Merseyside to be classified as Tier 1 (of particular concern). This related specifically to the number of patients waiting more than 12 hours in A&E for admission. The Tier 1 classification will result in external support, likely to be provided by the Emergency Care Improvement Support Team (ECSIT) before the winter. To date the Trust has had a meeting with the System Command and Control lead who is coordinating the response for the ICB and NHS England. The Trust has been asked to identify the areas that it believes would benefit most from a review and potentially improve the position. **PWC Financial Support** Cheshire and Merseyside ICS have agreed with NHS England, that the system is at high risk of overspending against the financial plan submitted for the year. PWC were engaged by the ICB and have completed a review of the financial position of each organisation within the ICS. The Board has agreed a number of actions that can be taken to reduce the current rate of expenditure, all such decisions are subject to governance and oversight, to make sure that service delivery, quality and patient safety are not adversely impacted. We are now exploring with PWC and the ICB options of additional support to ensure that mitigation plans are fully implemented at the earliest opportunity. **Women's and Childrens Vaccination Programme update** In line with guidance from JCVI from mid-September 2024 all women/birthing people will be offered Pertussis (whooping cough) following their 20-week scan, Respiratory Syncytial Virus (RSV) from 28 weeks via an appointment. Both immunisations will be available for any patient attending ANC for appointments or scans.

	The RSV and Pertussis vaccines will be offered throughout the year as this is a year-round programme. The immunisations give babies best protection, including if they are born early and will be offered in Antenatal Clinic along with seasonal immunisations including Flu and Covid. A designated vaccinator is in the progress of being recruited to deliver the programme along with the support of midwifery champions and a designated treatment room to deliver during ANC hours 08:30 – 16:30 hours. **Wirral Research and Innovation Centre launched** On 12 September staff and guests gathered to celebrate the much-anticipated launch of the Wirral Research and Innovation Centre at Clatterbridge, which has been made possible with funding from North-West Coast Clinical Research Network (NWC CRN). The purpose-built facilities will be an attractive offering for life sciences companies looking to place research studies. The Centre also provides a further opportunity to undertake research in combination with GPs and Wirral system partners, enabling the Trust to expand the volume and breadth of study types carried out. **The Darzi Review: Independent investigation of the NHS in England** In September, the Rt Hon. Professor the Lord Darzi of Denham published the findings of his investigation of the NHS in England. The investigation was commissioned by Wes Streeting, Secretary of State for Health and Social Care, in July. The investigation draws on evidence from a wide range of stakeholders, along with insights from an expert reference group comprising over 75 organisations contributing to the health service today. The report focuses on 'diagnosing' the problems facing the NHS, and provides an assessment of access to care, quality of care, and the overall performance of the health system. While specific policy recommendations are outside of the scope of the investigation, Lord Darzi sets out the major themes to be explored in the upcoming ten-year plan for the NHS, led by the Department of Health and Social Care. These include re-engaging staff and empowering patients, shifting care closer to home, driving productivity, invest in technology, and contribute to economic prosperity. A detailed report is provided on the agenda for this meeting.
1.4	**System Working** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** CMAST Leadership Board met on 6th September, including Trust Chairs, and discussed four substantive items as follows.

	Ann Marr presented a summary of CMAST's Annual Plan, as she had presented to the ICB in July, and which included highlights of a number of the main achievements for 23/24. Thereafter CMAST Programme Directors provided an outline of programme plans for 24/25, as well as updates on delivery progress year to date. Claire Wilson, ICB Chief Finance Officer, provided an update on the system financial position, NHSE and partner scrutiny and the current areas of focus. Correspondence outlining initial recommendations from Simon Worthington, the NHSE partner placed with the ICB, had been circulated to CEOs recommending a number of measures to increase grip and control across organisations, highlighting the need for a rapid adjustment in trajectory and approach. Tony Mayer, Director MHLDC Provider Collaborative updated on Virtual Wards, the variance in performance against planned occupancy rates was noted, as well as the increased challenge for Trusts with multiple community/Place partners. A review of the CMAST Joint Working Agreement and committees in common terms of reference was presented to the Board with a request for review and support in commending this documentation to Trust Boards for adoption. The changes were summarised as mainly relating to updates to circumstantial commentary. The updated documentation will now be recommended to Trust Boards following CMAST Leadership Board support and is included on the agenda for this meeting.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 8**

02 October 2024

Title	Lord Darzi Independent investigation of the NHS in England Report
Area Lead	M Swanborough, Chief Strategy Officer
Author	M Swanborough, Chief Strategy Officer
Report for	Information

Executive Summary and Report Recommendations

On 12 September 2024, the Rt Hon. Professor the Lord Darzi of Denham published the findings of his investigation of the NHS in England.

The investigation was commissioned by Wes Streeting, Secretary of State for Health and Social Care, on 11 July 2024, with a request to undertake a rapid investigation of the state of the NHS, assessing patient access, quality of care and the overall performance of the health system.

The attached report details Lord Darzi's findings and key drivers of performance. The report also contains a conclusion and provides a number of themes of how to repair the NHS.

It is recommended that the Board/Committee:

- Note the Lord Darzi Independent investigation of the NHS in England Report

Key Risks

This report relates to these key risks:

- BAF Risk 12: Failure to work with local partners to address and reduce health inequalities across the Wirral population.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes

Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
24th September 2024	Executive Committee	Lord Darzi Independent investigation of the NHS in England Report	Noting

1	Narrative
1.1	**Background** On 12 September 2024, the Rt Hon. Professor the Lord Darzi of Denham published the findings of his investigation of the NHS in England. The investigation was commissioned by Wes Streeting, Secretary of State for Health and Social Care, on 11 July 2024, and included the following areas of focus: • Provide an independent and expert understanding of the current performance of the NHS across England and the challenges facing the healthcare system • Ensure that a new 10-year plan for health focuses on these challenges • Stimulate and support an honest conversation with the public and staff about the level of improvement that is required, what is realistic and by when
1.2	**Report Findings** The attached report details Lord Darzi's findings and key drivers of performance. These include: • The National Health Service is in serious trouble. • The first step to rebuilding public trust and confidence in the NHS is to be completely honest about where it stands. • The state of the NHS is not due entirely to what has happened within the health service. The health of the nation has deteriorated and that impacts its performance. • How long people wait, and the quality of treatment, are at the heart of the social contract between the NHS and the people. The NHS has not been able to meet the most important promises made to the people since 2015. • People are struggling to see their GP. • Waiting lists for community services and mental health have surged. • A&E is in an awful state. • Waiting times for hospital procedures have ballooned • Cancer care still lags behind other countries. • Care for cardiovascular conditions is going in the wrong direction. • The picture on quality of care is mixed. • The NHS budget is not being spent where it should be—too great a share is being spent in hospitals, too little in the community, and productivity is too low.

	• The NHS is not contributing to national prosperity as it could. *Drivers of Performance* • Austerity. The 2010s were the most austere decade since the NHS was founded, with spending growing at around 1 per cent in real terms. • Capital. The NHS has been starved of capital and the capital budget was repeatedly raided to plug holes in day-to-day spending. On top of that, there is a shortfall of £37 billion of capital investment. • The pandemic. The impact of the pandemic and its aftermath: a bigger backlog than other health systems. • Patient engagement. The patient voice is not loud enough. • Staff engagement. Too many staff are disengaged. • Management structures and systems. Still reeling from a turbulent decade and the growth in oversight • A further effect of the 2012 Act has been a costly and distracting process of almost constant reorganisation of the 'headquarters' and 'regulatory' functions of the NHS.
1.3	**Conclusion** The report also contains a conclusion and provides a number of themes of how to repair the NHS. • It is apparent from this report and from the accompanying analysis that the NHS is in critical condition. Some have suggested that this is primarily a failure of NHS management. They are wrong. • Despite the challenges, the NHS's vital signs remain strong. • Nothing that I have found draws into question the principles of a health service that is taxpayer funded, free at the point of use, and based on need not ability to pay. • It has taken more than a decade for the NHS to fall into disrepair so improving it will take time. • There are some important themes that have emerged for how to repair the NHS, which will need to be considered alongside strategies to improve the nation's health and reforms to social care. The Report findings and conclusions will be used to form the NHS 10 Year Plan, which is due to be finalised in 2025.

Independent Investigation of the National Health Service in England

The Rt Hon. Professor the Lord Darzi of Denham OM KBE FRS FMedSci HonFREng

September 2024

This publication is available on www.gov.uk

ISBN 978-1-916594-05-0

E03202445 09/24

Any enquiries regarding this publication should be sent to us at darzi2024evidence@dhsc.gov.uk.

Independent investigation of the National Health Service in England

Contents

Summary letter from Lord Darzi to the Secretary of State for Health & Social Care

Dear Secretary of State,

You asked me to undertake a rapid investigation of the state of the NHS, assessing patient access, quality of care and the overall performance of the health system. I have examined areas such as the health of the nation and social care system in so far as they impact on the NHS, although these were outside the formal scope of the Investigation. My attention has also been drawn to some worrying health inequalities that will require further examination than has been possible in the time available, although I do highlight some particular areas of concern.

This report contains my findings, which are summarised as follows:

1. **The National Health Service is in serious trouble.**

   The British people rely on it for the moments of greatest joy – when a new life comes into being – and those of deepest sorrow. We need it when we are suffering from mental distress or hurting from physical pain and for all the times when care and compassion matter most. Yet public satisfaction – which stood at a record high in 2009 – is now at its lowest ever.

2. **The first step to rebuilding public trust and confidence in the NHS is to be completely honest about where it stands**.

   Everyone knows that the health service is in trouble and that NHS staff are doing their best to cope with the enormous challenges. The sheer scope of issues facing the health service, however, has been hard to quantify or articulate. That is why this

report has not held back, even if it has been a rapid assessment over just nine weeks. Although I have worked in the NHS for more than 30 years, I have been shocked by what I have found during this investigation—not just in the health service but in the state of the nation's health.

3. **The state of the NHS is not due entirely to what has happened within the health service. The health of the nation has deteriorated and that impacts its performance.**

   Overall life expectancy increased in the 2000s, but plateaued during the 2010s, before decreasing during the Covid-19 pandemic. It has started to rise again now, but the absolute and relative proportion of our lives spent in ill-health has increased.

   Many of the social determinants of health – such as poor quality housing, low income, insecure employment – have moved in the wrong direction over the past 15 years with the result that the NHS has faced rising demand for healthcare from a society in distress.

   There has been a surge in multiple long-term conditions, and, particularly among children and young people, in mental health needs. Fewer children are getting the immunisations they need to protect their health and fewer adults are participating in some of the key screening programmes, such as for breast cancer. The public health grant has been slashed by more than 25 per cent in real terms since 2015 and the country's main public health institution was abolished – split into two new bodies – in the middle of the pandemic.

4. **This report sets out where the NHS stands now, how we arrived at this point, and some of the key remedies.**

   My terms of reference preclude me from making specific policy recommendations. But I would note that the NHS has been through very difficult times in the past and has emerged stronger, and that many of the measures needed to tackle the current malaise are already well known. So, without providing policy detail, I do, as requested, set out the major themes for the forthcoming 10-year health plan. These are the steps that I believe are needed to turn the NHS around.

Performance of the NHS

5. **How long people wait, and the quality of treatment, are at the heart of the social contract between the NHS and the people. The NHS has not been able to meet the most important promises made to the people since 2015.**

   From access to GPs and to community and mental health services, on to accident and emergency, and then to waits not just for more routine surgery and treatment but for cancer and cardiac services, waiting time targets are being missed. It is inevitable that public trust and confidence will have been damaged by the inability of the NHS to meet the promises of the NHS constitution for the reasons that this report describes.

6. **People are struggling to see their GP.**

   GPs are seeing more patients than ever before, but with the number of fully qualified GPs relative to the population falling, waiting times are rising and patient satisfaction is at its lowest ever level. There are huge and unwarranted variations in the number of patients per GP, and shortages are particularly acute in deprived communities.

7. **Waiting lists for community services and mental health have surged.**

   As of June 2024, more than 1 million people were waiting for community services, including more than 50,000 people who had been waiting for over a year, 80 per cent of whom are children and young people. By April 2024, about 1 million people were waiting for mental health services.

   Long waits have become normalised: there were 345,000 referrals where people are waiting more than a year for first contact with mental health services—more than the entire population of Leicester—and 109,000 of those were for children and young people under the age of 18.

8. **A&E is in an awful state.**

   There are three types of A&E department. Type 1 are what most people think of as A&E—they are major departments and able to deal with the full range of emergencies. Type 2 are for specific conditions such as dental or ophthalmology and type 3 are for minor injuries and illnesses.

In 2010, 94 per cent of people attending a type 1 or type 2 A&E were seen within four hours; by May 2024 that figure had dropped to just over 60 per cent (and for all three types of A&E combined, performance is now at 74 per cent). More than 100,000 infants waited more than 6 hours last year and nearly 10 per cent of all patients are now waiting for 12 hours or more.

According to the Royal College of Emergency Medicine, these long waits are likely to be causing an additional 14,000 more deaths a year—more than double all British armed forces' combat deaths since the health service was founded in 1948.

9. **Waiting times for hospital procedures have ballooned.**

The promise is that for most procedures, treatment will start within 18 weeks. In March 2010, there were just over 2.4m on the waiting list, of whom 200,000 had been waiting longer than 18 weeks. Of those, 20,000 had waited more than a year. By contrast, in June 2024, more than 300,000—fifteen times as many—had waited for over a year, and 1.75 million had been waiting for between 6 and 12 months. One recent improvement is that only some 10,000 people are still waiting longer than 18 months, a sharp fall from 123,000 in September 2021.

10. **Cancer care still lags behind other countries.**

While survival rates at 1-year, 5-years and 10-years have all improved, the rate of improvement slowed substantially during the 2010s. The UK has appreciably higher cancer mortality rates than other countries. No progress whatsoever was made in diagnosing cancer at stage I and II between 2013 and 2021. Since then, rates have risen from 54 per cent to 58 per cent in 2023, with notable improvements in the early detection of lung cancer due to the targeted lung check programme.

In 2024, more than 35,000 genomic tests are being completed each month but only around 60 per cent on time. Recent research from the Tessa Jowell Brain Cancer Mission found that in practice, only around 5 per cent of eligible patients with brain cancer are able to access whole genome sequencing, which is important for treatment selection.

The 62-day target for referral to first treatment has not been met since 2015 and in May 2024, performance was just 65.8 per cent. More than 30 per cent of patients are waiting longer than 31 days for radical radiotherapy.

11. **Care for cardiovascular conditions is going in the wrong direction.**

    Once adjusted for age, the cardiovascular disease mortality rate for people aged under 75 dropped significantly between 2001 and 2010. But improvements have stalled since then and the mortality rate started rising again during the Covid-19 pandemic. Rapid access to treatment has deteriorated—the time for the highest risk heart attack patients to have a rapid intervention to unblock an artery has risen by 28 per cent from an average of 114 minutes in 2013-14 to 146 minutes in 2022-23. The percentage of suspected stroke patients who receive the necessary brain scan within an hour of arrival at hospital varies from 80 per cent in Kent to only around 40 per cent in Shropshire.

12. **The picture on quality of care is mixed.**

    For the most part, once people are in the system, they receive high quality care. But there are some important areas of concerns, such as maternity care, where there have been a succession of scandals and inquiries. There have been improvements in patient safety, with more error-free care in hospitals and a reduction in the number of suicides in inpatient mental health facilities, partly as a result of sustained political attention. The power of prevention is illustrated through the impressive achievements of the Diabetes Prevention Programme, which reduces the risk of type II diabetes by nearly 40 per cent.

13. **The NHS budget is not being spent where it should be—too great a share is being spent in hospitals, too little in the community, and productivity is too low.**

    Hospitals are where most waiting list procedures take place. But they present an apparent paradox. Growth in hospital staff numbers has increased sharply since the pandemic—rising 17 per cent between 2019 and 2023. There are 35 per cent more nurses working with adults and 75 per cent more with children than 15 years ago. The number of appointments, operations and procedures, however, has not increased at the same pace and so productivity has fallen.

    The key reason for this is that patients no longer flow through hospitals as they should. A desperate shortage of capital prevents hospitals being productive. And the dire state of social care means 13 per cent of NHS beds are occupied by people waiting for social care support or care in more appropriate settings. The result is there are 7 per cent fewer daily outpatient appointments for each consultant, 12 per cent less surgical activity for each surgeon, and 18 per cent less activity for each clinician working in emergency medicine.

It needs to be stressed that falling productivity doesn't reduce the workload for staff. Rather, it crushes their enjoyment of work. Instead of putting their time and talents into achieving better outcomes, clinicians' efforts are wasted on solving process problems, such as ringing around wards desperately trying to find available beds.

Too many people end up in hospital, because too little is spent in the community. Many people will have experienced congested A&E departments themselves. If you had arrived at a typical A&E on a typical evening in 2009, there would have been just under 40 people ahead of you in the queue. By 2024, that had swelled to more than 100 people.

This is because we have underinvested in the community. We have almost 16 per cent fewer fully qualified GPs than other high income countries (OECD 19) relative to our population. After years of cuts, the number of mental health nurses has just returned to its 2010 level. Between 2009 and 2023 the number of nurses working in the community actually fell by 5 per cent, while the number of health visitors, who can be crucial to development in the first five years of life, dropped by nearly 20 per cent between 2019 and 2023.

Since at least 2006, and arguably for much longer, successive governments have promised to shift care away from hospitals and into the community. In practice, the reverse has happened. Both hospital expenditure and hospital staffing numbers have grown faster than the other parts of the NHS, while numbers in some of the key out-of-hospital components have declined. Between 2006 and 2022, the share of the NHS budget spent on hospitals increased from 47 per cent to 58 per cent.

This distribution is perpetually reinforced: performance standards are focused on hospitals, not on primary care, community services or mental health. Single-year budgets necessarily reinforce the status quo—and when things go wrong the knee-jerk response from ministers has been to throw more money at hospitals where the pressure is most apparent as waiting areas fill up and ambulances queue outside.

The result is that NHS has implemented the inverse of its stated strategy, with the system producing precisely the result that its current design drives. The problems are systemic. In the current paradigm, patients have a poorer experience, and everybody loses—patients, staff and taxpayers alike.

14. **The NHS is not contributing to national prosperity as it could.**

At the start of 2024, 2.8m people were economically inactive due to long-term sickness. That is an 800,000 increase on pre-pandemic levels with most of the rise accounted for by mental health conditions. Being in work is good for wellbeing. Having more people in work grows the economy and creates more tax receipts to fund public services. There is therefore a virtuous circle if the NHS can help more people back into work.

More than half of the current waiting lists for inpatient treatment are working age adults. And there are long waits for mental health and musculoskeletal services, too, which are the biggest causes of long-term sickness. Improving access to care is a crucial contribution the NHS can make to national prosperity.

There are still wide variations in performance, so my findings may be explanations, but they are not excuses. So, the real question is how such a situation has arisen in the system as a whole: what has caused it? Why has it happened?

Drivers of performance

Four heavily inter-related factors have contributed to the current dire state of the NHS. They are austerity in funding and capital starvation; the impact of the Covid-19 pandemic and its aftermath; lack of patient voice and staff engagement; and management structures and systems.

15. **Austerity. The 2010s were the most austere decade since the NHS was founded, with spending growing at around 1 per cent in real terms.**

Until 2018, spending grew at around 1 per cent a year in real terms, against a long-term average of 3.4 per cent. Adjusted for population growth and changes in age structure, spending virtually flatlined.

In 2018, for the service's 70th birthday, a more realistic promise was made of a 3.4 per cent a year real terms increase for five years in revenue spending. The promise did not include capital spending, medical training, nor any increase in public health expenditure.

The 2018 funding promise was broken. Spending actually increased at just under 3 per cent a year in real terms between 2019 and 2024—below both the 2018 promise and the historic rate on which it had been based.

16. **Capital. The NHS has been starved of capital and the capital budget was repeatedly raided to plug holes in day-to-day spending.**

    The result has been crumbling buildings that hit productivity – services were disrupted at 13 hospitals a day in 2022-23. The backlog maintenance bill now stands at more than £11.6 billion and a lack of capital means that there are too many outdated scanners, too little automation, and parts of the NHS are yet to enter the digital era.

    Over the past 15 years, many sectors of the economy have been radically reshaped by digital technologies. Yet the NHS is in the foothills of digital transformation. The last decade was a missed opportunity to prepare the NHS for the future and to embrace the technologies that would enable a shift in the model from 'diagnose and treat' to 'predict and prevent'—a shift I called for in *High Quality Care for All*, more than 15 years ago.

    Some £4.3 billion was raided from capital budgets between 2014-15 and 2018-19 to cover in-year deficits that were themselves caused by unrealistically low spending settlements.

17. **On top of that, there is a shortfall of £37 billion of capital investment.**

    These missing billions are what would have been invested if the NHS had matched peer countries' levels of capital investment in the 2010s. That sum could have prevented the backlog maintenance, modernised technology and equipment, and paid for the 40 new hospitals that were promised but which have yet to materialise. It could have rebuilt or refurbished every GP practice in the country.

    Instead, we have crumbling buildings, mental health patients being accommodated in Victoria-era cells infested with vermin with 17 men sharing two showers, and parts of the NHS operating in decrepit portacabins. Twenty per cent of the primary care estate predates the founding of the health service in 1948.

18. **The pandemic. The impact of the pandemic and its aftermath: a bigger backlog than other health systems**

    The combination of austerity and capital starvation helped define the NHS's response to the pandemic. It is impossible to understand the current state of the NHS without understanding what happened during it.

The decade of austerity preceding Covid-19, along with the prolonged capital drought, saw the NHS enter the pandemic with higher bed occupancy rates and fewer doctors, nurses, beds and capital assets than most other high-income health systems. The NHS's resilience was at a low ebb.

What is less widely known, is that **the NHS delayed, cancelled or postponed far more routine care during the pandemic than any comparable health system.** Between 2019 and 2020, hip replacements in the UK fell by 46 per cent compared to the OECD average of 13 per cent. Knee replacements crashed a staggering 68 per cent compared to an average fall of 20 per cent. Across the board, the number of discharges from UK hospitals fell by 18 per cent between 2019 and 2020, the biggest drop across comparable countries.

19. **Patient engagement. The patient voice is not loud enough.**

The NHS should aspire to deliver high quality care for all, all of the time. That not only means care that is safe and effective but that treats people with dignity, compassion and respect, making their experiences as positive as they can be. Yet patient satisfaction with services has declined and the number of complaints has increased, while patients are less empowered to make choices about their care. A familiar theme in inquiries into care failings has been patients' concerns not being heard or acted upon. The NHS is paying out record sums in compensation payments for care failures, which now amount to nearly £3 billion or 1.7 per cent of the entire NHS budget.

20. **Staff engagement. Too many staff are disengaged.**

There is also compelling evidence that, post-pandemic, too many staff have become disengaged, and there are distressingly high-levels of sickness absence – as much as one working month a year for each nurse and each midwife working in the NHS.

The experience of the pandemic was exhausting for many and its aftermath continues to reverberate. NHS staff not only mourned deaths of their colleagues on the frontline but were at the sharp end of the Covid rules. They had to insist that mothers gave birth alone and that elderly and other patients had to die without the comforting touch of their loved ones. The result has been a marked reduction in discretionary effort across all staff groups.

21. **Management structures and systems. Still reeling from a turbulent decade and the growth in oversight.**

The Health and Social Care Act of 2012 was a calamity without international precedent. It proved disastrous. By dissolving the NHS management line, it took a "scorched earth" approach to health reform, the effects of which are still felt to this day. It has taken more than 10 years to get back to a sensible structure. And management capability is still behind where it was in 2011.

Some sanity has been restored by the 2022 Act which put integrated care systems on a statutory basis. This has the makings of a sensible management structure, consisting of a headquarters, seven regions and 42 integrated care boards (ICBs) whose strategy to tackle inequalities, and to improve population health, is set by an Integrated Care Partnership (ICP) that includes local government and the third sector alongside the NHS itself.

Across ICBs, there are differing understanding of their roles and responsibilities, including how far they are responsible for the performance management of providers, and quite how and at what level they should tackle population health. The NHS in England has emulated Wales and Scotland and changed its improvement philosophy from competition to collaboration. The framework of national standards, financial incentives and earned autonomy as part of a mutually reinforcing approach is no longer as effective as it once was, and needs to be reinvigorated.

22. **A further effect of the 2012 Act has been a costly and distracting process of almost constant reorganisation of the 'headquarters' and 'regulatory' functions of the NHS.**

Although there are ongoing reductions in management spend and headcount numbers continue to fall, some 19,000 people are employed between NHS England and the Department of Health and Social Care (having peaked at 23,000 in 2022). Some 5,200 of the 16,000 employed by NHS England provide shared services to the NHS such as IT infrastructure and 3,500 are in its seven regions. The Department of Health and Social Care has increased in size by more than 50 per cent in the past 10 years, employing fewer than 2,000 people in 2013 compared to more than 3,000 in 2024, as it reabsorbed staff following the abolition of Public Health England.

Accountability is important. But too many people holding people to account, rather than doing the job, can be counterproductive. Regulatory type organisations now employ some 7,000 staff, or 35 per provider trust, having doubled in size over the past 20 years. Taken together, there are nearly 80 people employed in regulatory and headquarters functions for each NHS provider trust. And there are a multitude of other organisations that produce guidance, recommendations and standards. NHS organisations should focus on the patients and communities they serve, but

the sheer number of national organisations that can 'instruct' the NHS encourages too many to look upwards rather than to those they are there to serve.

The Care Quality Commission – which inspects the NHS – is not fit for purpose, as the recent independent review made clear. Its focus on inputs rather than outcomes has played a major role in driving up the numbers of clinicians in hospitals to unprecedented levels.

Conclusion: the NHS is in critical condition, but its vital signs are strong

23. **It is apparent from this report and from the accompanying analysis that the NHS is in critical condition**.

    It continues to struggle with the aftershocks of the pandemic. Its managerial capacity and capability have been degraded, and the trust and goodwill of many frontline staff has been lost. The service has been chronically weakened by a lack of capital investment which has lagged other similar countries by tens of billions of pounds. All of this has occurred while the demands placed upon the health service have grown as the nation's health has deteriorated.

24. **Some have suggested that this is primarily a failure of NHS management. They are wrong.**

    The NHS is the essential public service and so managers have focused on "keeping the show on the road". Some fantasise about an imaginary alternative world where heroic NHS managers were able to defy the odds and deliver great performance in a system that had been broken. Better management decisions might have been taken along the way, but I am convinced that they would have only made a marginal difference to the state that the NHS is in today.

25. **Despite the challenges, the NHS's vital signs remain strong.**

    The NHS has extraordinary depth of clinical talent, and our clinicians are widely admired for their skill and the strength of their clinical reasoning. Our staff in roles at every level are bound by a deep and abiding belief in NHS values and there is a shared passion and determination to make the NHS better for our patients. They are the beating heart of the NHS. Despite the massive gap in capital investment, the NHS has more resources than ever before, even if there is an urgent need to boost productivity.

26. **Nothing that I have found draws into question the principles of a health service that is taxpayer funded, free at the point of use, and based on need not ability to pay.**

    With the prominent exception of the United States, every advanced country has universal health coverage—and the rest of the world are striving towards it. But other health system models—those where user charges, social or private insurance play a bigger role—are more expensive, even if their funding tends to be more stable. It is not a question, therefore, of whether we can afford the NHS. Rather, we cannot afford not to have the NHS, so it is imperative that we turn the situation around.

27. **It has taken more than a decade for the NHS to fall into disrepair so improving it will take time.**

    Waiting times can and must improve quickly. But it will take years rather than months to get the health service back to peak performance. I have no doubt that significant progress will be possible, but it is unlikely that waiting lists can be cleared and other performance standards restored in one parliamentary term. Just as we in the NHS have turned around performance before, we can do so again.

28. **There are some important themes that have emerged for how to repair the NHS, which will need to be considered alongside strategies to improve the nation's health and reforms to social care.**

    You asked me to identify the major themes for the forthcoming 10-year health plan. These include the following:

    - *Re-engage staff and re-empower patients*. Despite all the challenges and low morale, NHS staff are profoundly passionate and motivated to raise the quality of care for patients. Their talents must be harnessed to make positive change. The best change empowers patients to take as much control of their care as possible.

    - *Lock in the shift of care closer to home by hardwiring financial flows*. General practice, mental health and community services will need to expand and adapt to the needs of those with long-term conditions whose prevalence is growing rapidly as the population age. Financial flows must lock-in this change irreversibly or it will not happen.

    - *Simplify and innovate care delivery for a neighbourhood NHS*. The best way to work *as* a team is to work *in* a team: we need to embrace new multidisciplinary

models of care that bring together primary, community and mental health services.

- *Drive productivity in hospitals*. Acute care providers will need to bring down waiting lists by radically improving their productivity. That means fixing flow through better operational management, capital investment in modern buildings and equipment, and re-engaging and empowering staff.

- *Tilt towards technology*. There must be a major tilt towards technology to unlock productivity. In particular, the hundreds of thousands of NHS staff working outside hospitals urgently need the benefits of digital systems. There is enormous potential in AI to transform care and for life sciences breakthroughs to create new treatments.

- *Contribute to the nation's prosperity*. With the NHS budget at £165 billion this year, the health service's productivity is vital for national prosperity. Moreover, the NHS must rebuild its capacity to get more people off waiting lists and back into work. At the same time, it should better support British biopharmaceutical companies.

- *Reform to make the structure deliver*. While a top-down reorganisation of NHS England and Integrated Care Boards is neither necessary nor desirable, there is more work to be done to clarify roles and accountabilities, ensure the right balance of management resources in different parts of the structure, and strengthen key processes such as capital approvals. Change will only be successful if the NHS can recover its capacity to deliver plans and strategies as well as to make them.

* * *

In an unprecedented act of transparency, my report is being published with an accompanying technical annex containing over 330 analyses that my team and I have commissioned for this investigation. These have been completed by NHS England and the Department of Health and Social Care at remarkable speed.

At my insistence, every piece of analysis includes all available data going back to 2001 or from the first creation of datasets thereafter. It is my hope that this will mark the start of a more open and honest conversation between ministers, the NHS and the public about performance.

In addition, I have examined more than 500 pages of analysis from charities, professional bodies, and other organisations that have a shared passion for the NHS, its values, and its future.

I have also benefitted enormously from the advice and wisdom of the Expert Reference Group. This comprised of the leadership of more than 75 of the most important organisations contributing to the health service today (listed at annex A). I would like to express my sincere thanks to all contributors and to the team that has delivered this report at such speed. I am also grateful to those organisations that hosted me for my programme of visits.

The NHS is now an open book. The issues are laid bare for all to see. And from this shared starting point, I look forward to our collective endeavour to turn it around for the people of this country, and to secure its future for generations to come.

ARA DARZI
Paul Hamlyn Chair of Surgery, Imperial College London
Consultant Surgeon, Imperial College Healthcare NHS Trust
and the Royal Marsden NHS Foundation Trust
Independent Member of the House of Lords

Part I

Performance of the NHS

Introduction

The purpose of the National Health Service

1. We can only understand the performance of the NHS if we understand what it is there to do. The goal of this rapid review is to establish whether the NHS is fulfilling its promise to the people, and if it is not, setting out how and why this is the case.

2. The NHS Constitution—its contract with the people implied from its creation and codified since 2009—describes the purpose of the health service. It is worth restating it here:

> *"The NHS belongs to the people.*
>
> *It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives.*
>
> *It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health.*
>
> *It touches our lives at times of basic human need, when care and compassion are what matter most."*

3. The NHS Constitution describes the values and principles of the health service and the rights and responsibilities of those that use it as well as those that work in it. It sets out pledges to patients and the public on the standards of access and quality that they can expect and to staff on ways in which the NHS will work.

4. In this review, we examine how well the NHS is living up to its promises to patients and the public and to its staff. To understand how well the NHS is doing, it is important to begin by understanding what challenges it faces. We now explore how demand for healthcare has changed and the reasons why it has risen.

1

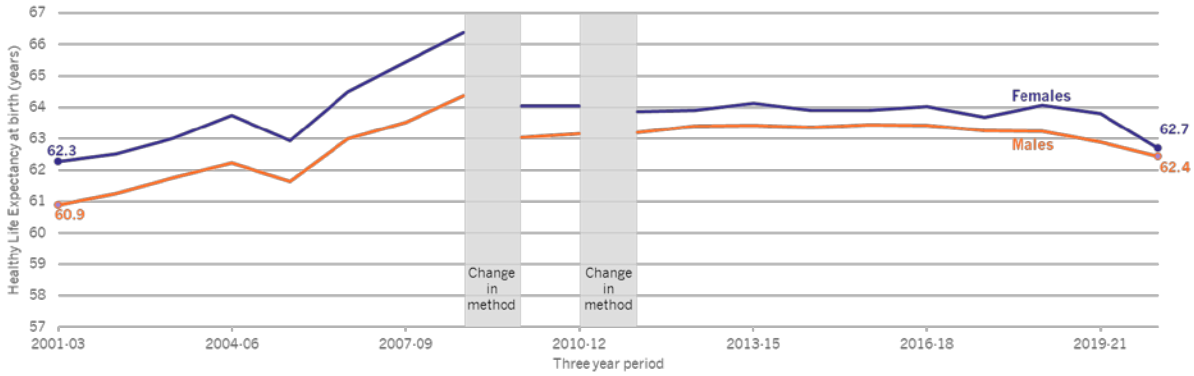
Health of the nation

1. To understand how well the NHS is performing, we first must understand how and why the demands placed upon it have changed. In this chapter, we briefly survey the health of the nation and the implications that it has for the health service. We also touch on other important contextual factors including advances in technology and the state of the social care system.

Life expectancy, preventable and treatable mortality

2. The health of the nation has deteriorated. Overall life expectancy improved in the first decade of the century, plateaued during the 2010s, fell during the Covid-19 pandemic and is now starting to increase again[1]. The picture is even worse for healthy life expectancy, where the absolute and relative proportion of our lives spent in ill-health has increased. As healthy life expectancy for both men and women has fallen, the gap between the two has narrowed. People in England can now expect to live until their early-60s in good health[2].

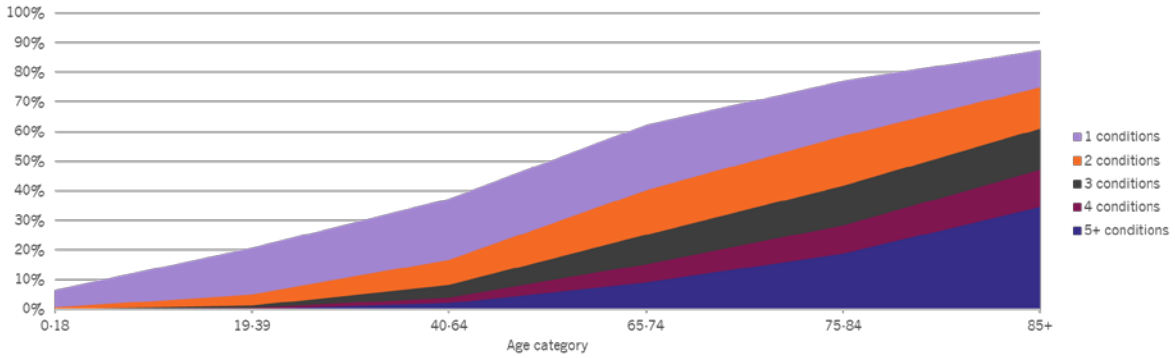
Figure I.2: Trends in Healthy Life Expectancy at birth in England, between 2001 to 2003 and 2020 to 2022



Rising demand for healthcare

3. When national health systems were first conceived, it was imagined that health would be a diminishing part of the economy. This was rooted in the belief that as society became wealthier it would become healthier, and so the demands placed upon the health system would fall over time. Instead across all advanced countries, the healthcare sector has tended to expand more quickly than the rest of the economy, meaning an increasing share of national income is devoted to health[3].

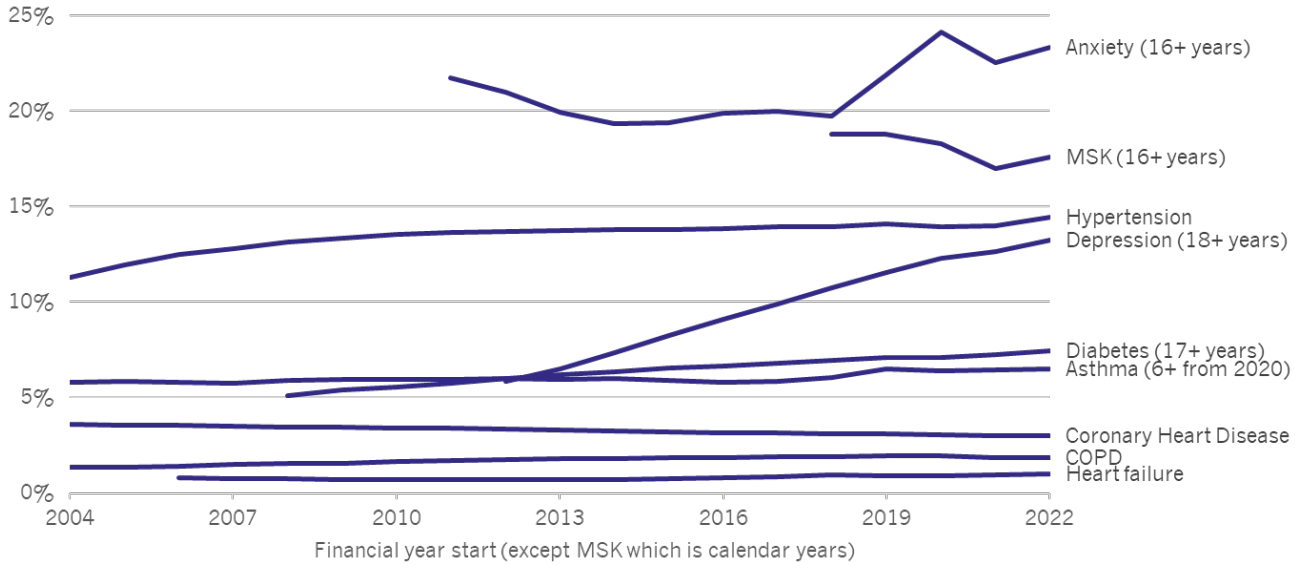
Figure I.5: Share of patients with no, one, or multiple long-term conditions by age



4. An ageing population is the most significant driver of increased healthcare needs since it is associated with the development of long-term conditions such as diabetes, breathing difficulties, or depression[4]. The analysis above is based on NHS England's patient level data. It shows that by the time people are aged 65-74, a majority will have at least one long-term condition and some 40 per cent will have two or more. By the time people are aged 75-84, this rises to nearly 60 per cent having two or more, and by the time people are aged 85 or above, 9 out of 10 will have at least one long-term condition[5].

5. As we can see below, the prevalence of some long-term conditions appears to be rising inexorably. Take diabetes, for example, which has increased from 5.1 per cent prevalence in 2008 to 7.5 per cent in 2022[6]. While the prevalence of high blood pressure (and its associated risks) was 11.3 per cent in 2004, by 2022 it has risen to 14.4 per cent[7].

Figure I.6: Recorded prevalence of health conditions by year (financial or calendar) for all ages (except where indicated) in England, 2004 and 2022



6. But it is our mental health that appears to have deteriorated most significantly in the past decade. The prevalence of depression has shot up from 5.8 per cent in 2012 to 13.2 per cent a decade later in 2022[8]. But the rise in need for mental health services is not evenly distributed in the population. For adults, mental health referrals have been increasing at a rate of 3.3 per cent a year[9]. But for children and young people, the rate of referrals has increased by 11.7 per cent a year from around 40,000 a month in 2016 to almost 120,000 a month in 2024[10]. And referrals for perinatal services for mothers has risen by 23 per cent a year since 2016, rising from around 1,400 a month in 2016 to more than 7,600 a month in 2024[11].

7. While ageing may be the most significant driver of increased healthcare needs, the health of the nation is affected by many other factors too. The wider determinants[12] such as income, education, work, housing, relationships, families and our natural and physical environment can have enormous impacts on our health. Many of these are moving in the wrong direction.

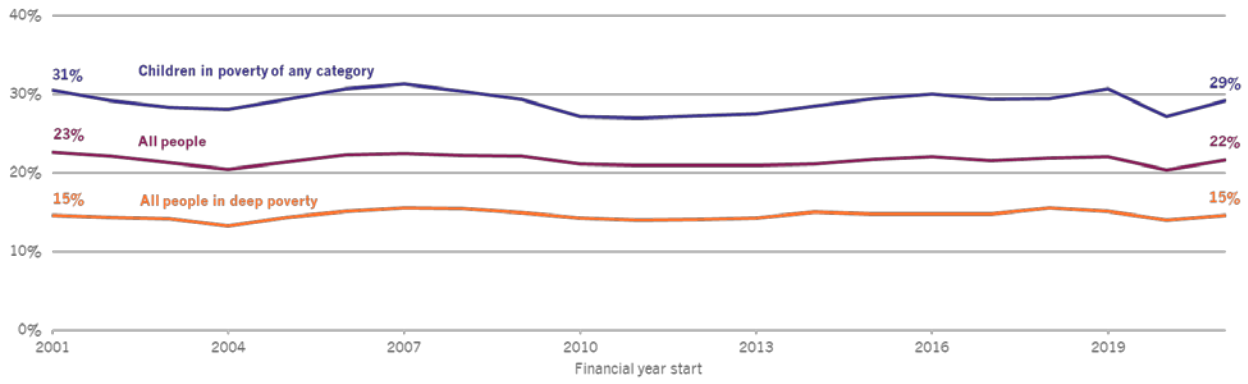
An economy and society in distress

8. The NHS has been impacted by wider changes beyond the health system. Our health is the result of our genetic inheritance, our lifestyle and behaviours, and our social and economic circumstances which shape our lives. These include income, housing and access to healthy food, amongst others. It has a particular impact for the most deprived and disadvantaged in society.

9. While the poorest households saw their income increase by 2.3 per cent a year in real terms during the 2000s, this plummeted to just 0.0 per cent real income growth in the 2010s for the bottom quintile. This compares to 0.9 per cent and 0.6 per cent real income growth across for these decades respectively for the top income quintile[13]. This has, of course, impacted poverty rates, particularly for children. The proportion of children living in poverty fell from 31 per cent to 27 per cent between 2007 and 2010. But it steadily rose from then, so that by 2019, all the progress had been reversed and 31 per cent of children were living in poverty, and the latest data shows that this is now 29 per cent[14].

10. According to the Joseph Rowntree Foundation (JRF), around 3.8 million people have experienced destitution in a year, one million of whom are children – nearly triple the number of children since 2017[15]. And in their submission to the Investigation, the Child Poverty Action Group pointed out that the UK had the largest rise in relative child poverty of any advanced nation between 2014 and 2021.

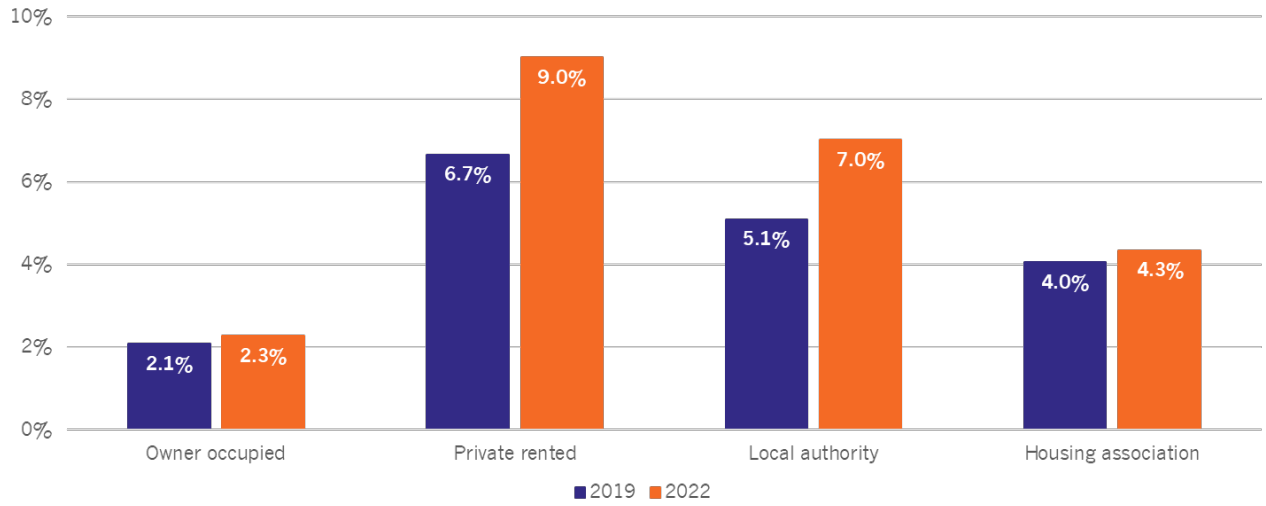
Figure I.9: Poverty rates



11. With worsening poverty, there has been an upward trend in food insecurity. Data from the Trussell Trust shows an increase in the number of food supply parcels from 1.4 million in 2017-18 to the highest recorded level of 3.1 million in 2023-24[16]. Healthy and nutritious food is comparatively expensive; cheap food is associated with higher obesity levels, which has many different health impacts. The Office for National Statistics (ONS) reported that between 18 October 2023 and 1 January 2024, 20 per cent of households in the most deprived quintile reported eating less fruit and fewer vegetables because of cost-of-living increases[17], compared to 8 per cent of the least deprived quintile. Almost half of primary care providers are running foodbanks, according to the JRF.

12. The housing crisis has continued to get worse, with the UK having the highest rates of homelessness in the OECD when measured by the proportion of the population in temporary accommodation[18]. Housing quality impacts health outcomes: poor housing is associated with increases in respiratory conditions and communicable diseases. The number of homes with damp problems has increased between 2019 and 2022[19]. While this rose across all sectors, the starkest increases were in private and local authority rentals. People in privately rented homes are nearly four times as likely to experience damp issues as those who own their homes.

Figure I.11: Dwellings with any damp problems, England, 2019 and 2022



13. It is not just our material conditions that impact our health and therefore the NHS. The rise in social media use has reshaped our lives. While there have been many benefits, there are harms, too. Studies are split on the impact on our physical and mental health. But it seems highly unlikely that the dramatic rise in mental health needs is wholly unconnected from social media. Studies have found 14-year olds that use social media excessively (more than five hours a day) were more likely to be depressed[20]. But it is unclear whether it was the cause or the consequence of depression.

Expanding possibilities

14. A further reason for the growth in healthcare expenditure should be celebrated: medical and scientific advances means that disease can be better diagnosed and treated than ever before. The scope of what is possible continues to expand: at the start of the century, nearly 1,500 diseases had a known molecular basis, and some 1,000 gene mutations were understood to cause disease[21]. By 2024, that had

increased to nearly 7,500 diseases with a known molecular basis and around 5,000 identified gene mutations that caused or contributed to disease[22].

15. Over the past decade, NHS spending on drugs for specialised services has grown at 8.9 per cent a year, while for devices it has increased at 10.2 per cent annually[23]. This far outpaces the rate of growth of the total NHS budget, meaning that specialised services account for a growing share of expenditure. While it means more diseases and conditions can be treated—such as putting England on a trajectory to eliminate hepatitis C ahead of the rest of the world[24]—it creates an inexorable pressure on costs.

Overall impact

16. Analysis commissioned for this report found that NHS activity has increased, notably for primary care and mental health services; that complexity has risen, with the proportion of NHS patients with disabilities notably increasing at more than 9 per cent a year between 2017 and 2023[25]; and that spending on specialised services has increased at a much faster rate than routine care[26].

17. On every front, the demands placed upon the NHS have accelerated. This means that we are much closer to the 'slow uptake' scenario than the 'fully engaged' scenario described by Derek Wanless in his 2002 review of long-term health financing[27] that looked at expenditure to 2022. Indeed, the 'slow uptake' scenario was defined as:

    "Life expectancy rises, but by the smallest amount in all three scenarios. The health status of the population is constant or deteriorates. The health service is relatively unresponsive with low rates of technology uptake and low productivity."[28]

    This seems to rather presciently capture the situation we are in today. The consequence is a very significant mismatch between the demands placed upon the NHS and the resources available to it.

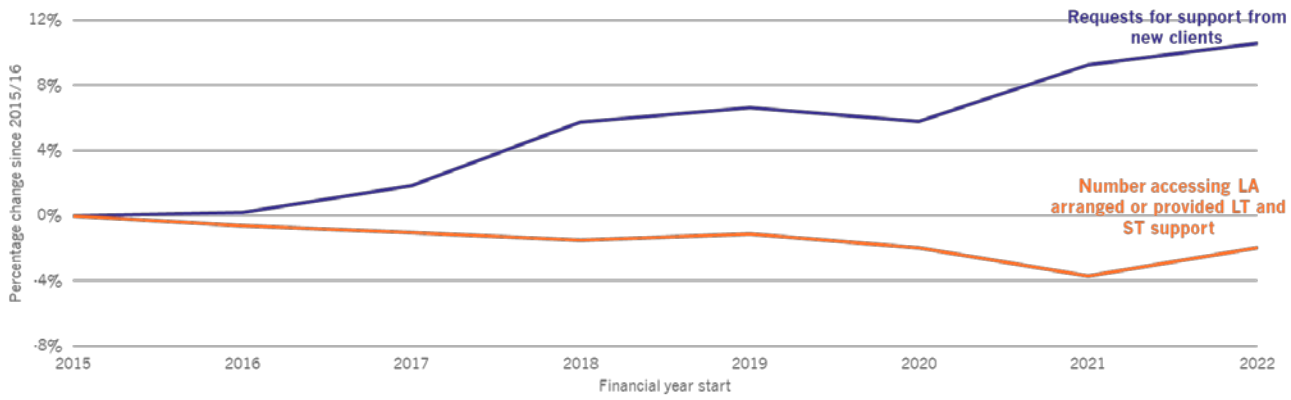
Social care challenges impacting the NHS

18. It is impossible to understand what has been happening in the NHS without understanding what has happened to social care, although social care itself is outside the remit of this Investigation.

19. Social care is a vital service in its own right, helping people with disabilities, and all of us as we age, to lead full and independent lives for as long as possible. While public debate on social care tends to focus on the needs of older people, there are very significant needs for many children and working age adults with disabilities. According to a submission from the Royal College of Occupational Therapists, 30 per cent of their members surveyed in 2023 said they could not provide equipment or adaptations for children who needed it. Social care has not been valued or resourced sufficiently, which has both a profound human cost and economic consequences.

20. While the health service endured a significant slowdown in funding during the 2010s, local government had real-terms cuts to its expenditure[29]. The result is that publicly funded social care is provided for fewer and fewer people while the demand for it has risen, largely as the result of an ageing population. Analysis by The King's Fund shows how a colossal gap has opened up between resources and need, as the chart below shows. In their submission to the Investigation, the Local Government Association highlighted that the vacancy rate in adult social care is nearly three times that of the economy as a whole.

Figure I.17: Changes to requests for support and user of long-term and short-term care to maximise independence support arranged or provided by local authorities in England, 2015-16 to 2022-23



21. Whereas the NHS is funded by taxpayers and free at the point of need, social care is means-tested and only provided to those with the greatest need and least ability to pay. With each passing year, the gap grows between those in need and those receiving publicly funded care[30]. This places an increasingly large burden on families and on the NHS. The impact on the NHS has been more people staying in hospital for longer than their medical needs require them to be there[31]. This means older people have been stuck in acute hospital wards rather than in facilities better suited to their needs (so-called delayed discharges[32]).

22. It is apparent that the different economic models between the NHS and social care is driving the most expensive outcome—people spending time in hospital when there is no medical reason for them to be there—that is also a poorer experience for elderly people and their families. The impact of delayed discharges is equivalent to 13 per cent of all NHS beds[33].

* * *

23. Rising demand from a society where people have become older and sicker alongside a social care system that is far from supporting the scale of needs of the population, are the crucial context in which NHS performance must be understood. We now turn to how well the NHS is fulfilling its commitments to the people.

2

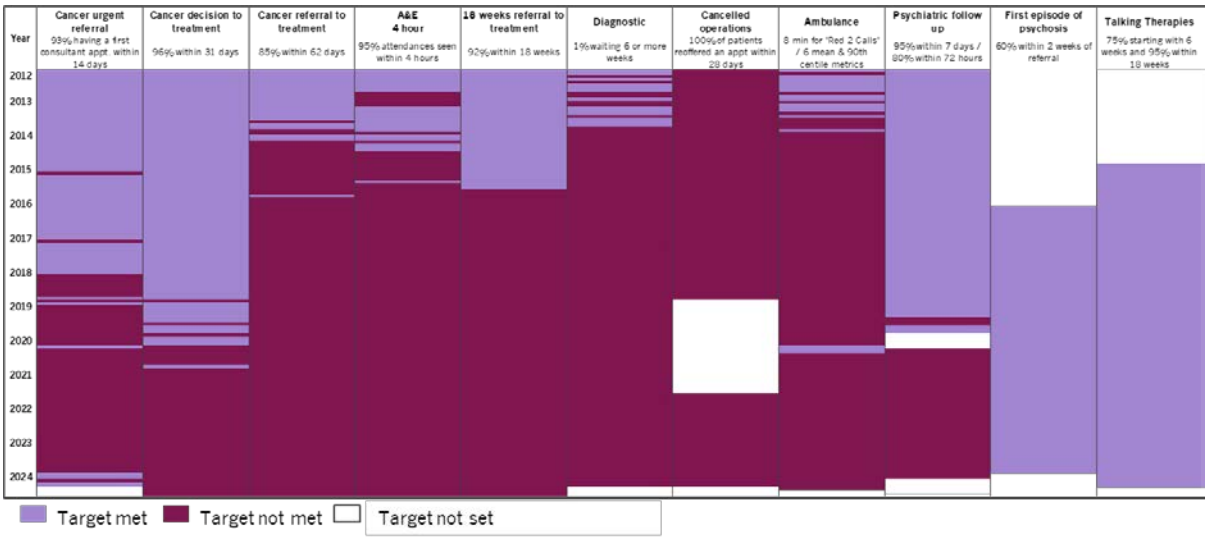
Access to NHS services

1. In this chapter, we explore speed of access to services. An essential promise between the NHS and the people is that the health service should deliver timely access to care when it is needed. While many people know that it is harder to access care, what may be less well understood—and more worrying—is the depth and breadth of access problems in the health service today.

NHS Constitutional standards

2. The majority of the NHS's most important promises to the people were no longer being met by 2015[34]. These are at the heart of the social contract between the NHS and the people. It is inevitable that public trust and confidence will have been damaged by the inability of the NHS to meet its promises.

Figure II.1.1: NHS constitutional targets and whether they are being met



3. The NHS's constitutional standards include some of the most important aspects of what the health service delivers. They include speed of access when cancer is suspected, waiting times for operations, and consistent follow up by psychiatric

services. It is striking that the NHS was unable to meet most of these promises since well before the pandemic.

Access to the front door of the NHS

NHS 111

4. The goal of NHS 111 is to enable patients to access the right care, in the right place. In the last decade, NHS 111 has grown in usage from around a million calls a month to well over 1.5 million[35]. The service has struggled to keep up with demand: as we can see from the charts below, the rate of calls that are abandoned has increased as have calls that have taken more than a minute to answer. While NHS England mandates that abandoned calls should be 3 per cent or less, the average proportion of calls abandoned every month between August 2022 and May 2024 has been 11.3 per cent – or nearly four times the acceptable level[36].

Figure II.2.1A: NHS 111 Calls Received (numbers)

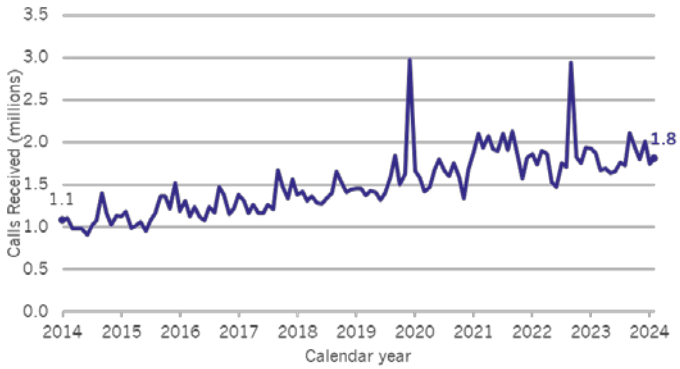
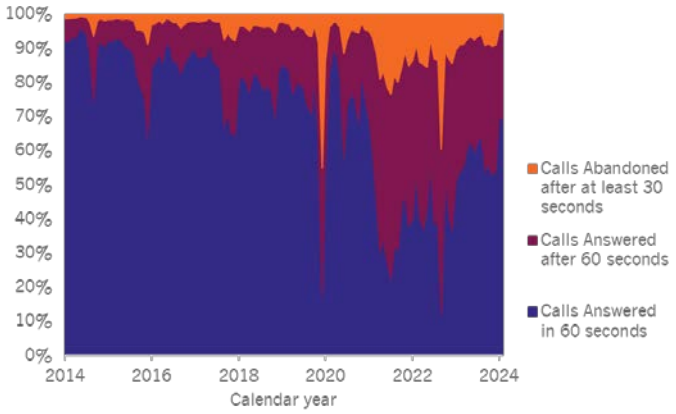


Figure II.2.1B: Call volumes split by answered in under and over 60 seconds and abandoned in over 30 seconds (percentage)



5. Where 111 callers are advised to go for help has been broadly stable over time, with 43 per cent told to contact their General Practice, 12 per cent advised to attend A&E or other urgent care and 12 per cent given an ambulance response. Self-care remains a relatively small proportion at less than 1 in 10 callers[37].

Digital front door

6. The Covid-19 pandemic led to a rapid increase in registrations for the NHS App, with nearly 80 per cent of adults now registered. But less than 20 per cent use it monthly[38]. The NHS App is not delivering a 'digital-first' experience similar to that found in many aspects of daily life, although there is huge potential. While there has

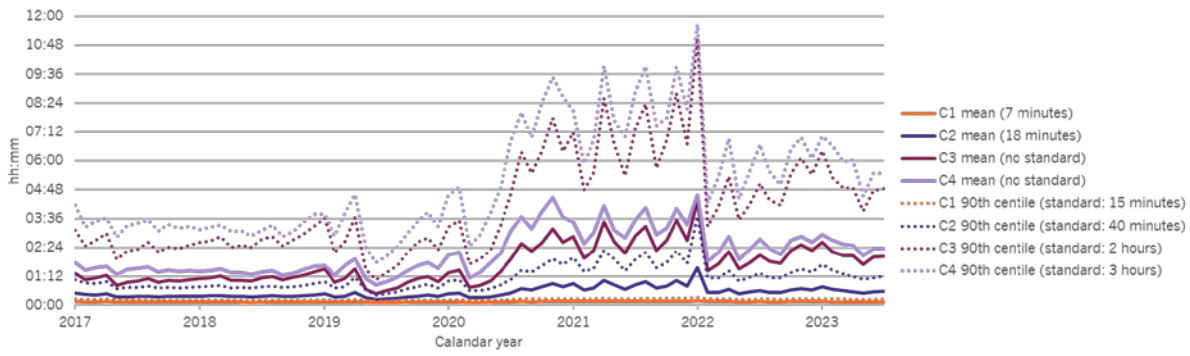
been growth in ordering repeat prescriptions and managing hospital appointments, just 1 per cent of GP appointments are managed via the App (although many book their GP appointments through other online systems)[39]. With the huge success in registrations, an important opportunity is being missed to improve both efficiency and patient experience.

Ambulance services

7. The ambulance service is there for those times when we need immediate, emergency help from the NHS. The way in which the NHS categorises ambulance responses changed in 2017. As we can see in the chart below, response times increased very sharply during the pandemic and have remained stubbornly high since then. NHS England has responded by promising to increase capacity: more than 800 new ambulances were promised by 2023-24, but only 300 new ambulances were reported to be operational by February 2024[40] and these were replacements of those in the existing fleet.

8. Calls are triaged into four categories according to the patient's need. Category one calls are those where there is an immediate threat to life, such as cardiac arrest; response times should be 7 minutes on average with 90 per cent responded to within 15 minutes. As the chart below shows, since 2021, response times for the category one 90th centile initially deteriorated before improving and nearly meeting the targets by May 2024. This trend is not reflected in the category one mean response times, which have shown a steady improvement but have not yet recovered, with the June 2024 figure recorded at 8:21 minutes[41].

Figure II.8.2: Category 1 to 4 ambulance response times, England



9. Category 2 calls include serious conditions such as stroke, sepsis, heart attack or major burns. The response time is set to be 18 minutes on average with 90 per cent responded to within 40 minutes. Response times were at their worst in December

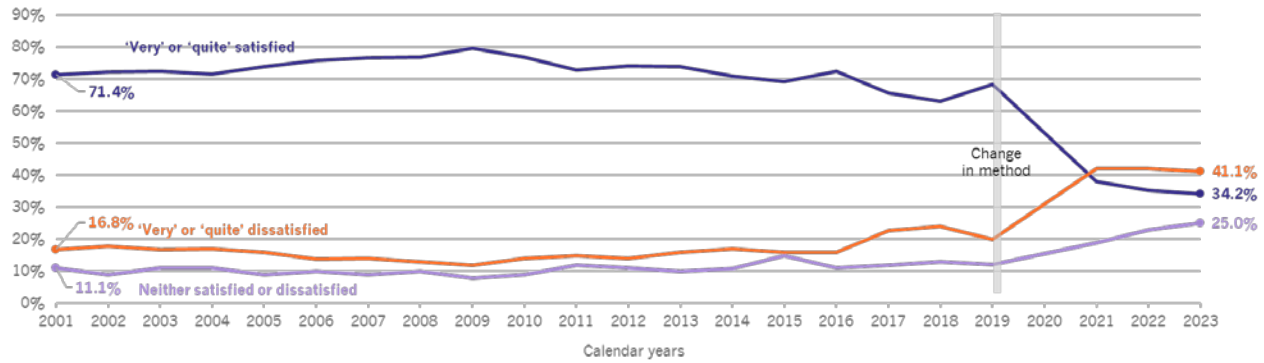
2022 (as we can see from the chart above), when there was an average response time of just over an hour-and-a-half, with the 90th centile standing at nearly 4 hours. By May this year, responses had improved to an average of 32 minutes and 90 per cent responded to within 1 hour and 8 minutes[42].

10. While there has been a sharp focus on these waits for category 2, the position for other patient groups is likely to be causing as much harm. Category 3 incidents include some of the most vulnerable in society, such as those for frail older people who have fallen and people in mental health crisis, which each make up 10 per cent of the total call volume to 999. By May 2024, the 90th centile of category 3 calls waited up to 4 hours 45 minutes (or 2 hours on average) for a response[43].

Access to General Practice

11. For most people, their GP practice remains their most common interaction with the NHS. The overall trend is for more GP appointments than ever before[44], with GPs working harder and seeing more patients. Yet there is still a struggle to meet patient demand, as the percentage of respondents to the GP patient survey who said they had to wait a week or more for a GP appointment increased from 16 per cent in 2021 to 33 per cent in 2024[45]. Satisfaction with GP services dramatically reduced during the Covid-19 pandemic, accelerating a decade in decline in satisfaction since 2009[46].

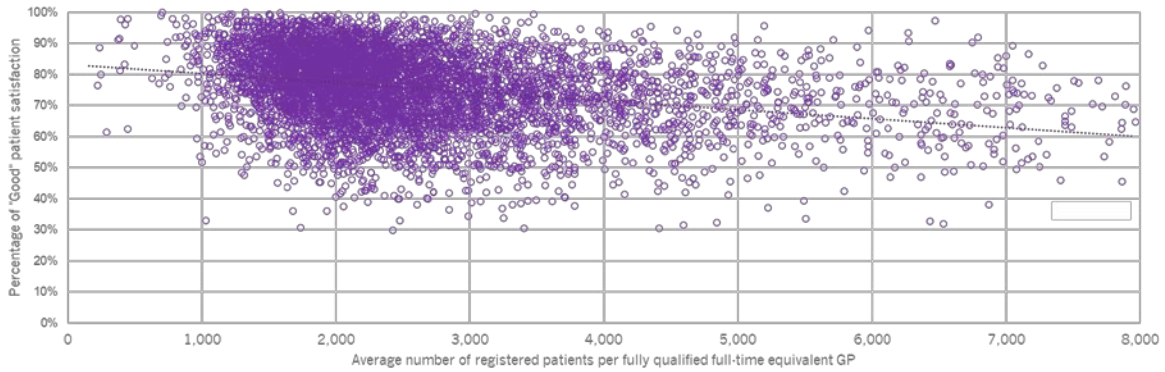
Figure II.3.3: Question asked: 'From your own experience, or from what you have heard, please say how satisfied or dissatisfied you are with the way in which each of the parts of the NHS runs nowadays: Local doctors or GPs



12. GPs are spread unevenly across the country. There are 1,467 patients per GP in Devon, compared to 2,261 patients per GP in North West London[47], a 54 per cent difference. Moreover, there are wide variations in the numbers of patient per GP within Integrated Care Boards (ICBs) as well as across them. This is important as a

smaller number of patients per GP is associated with higher satisfaction (see chart below)[48]:

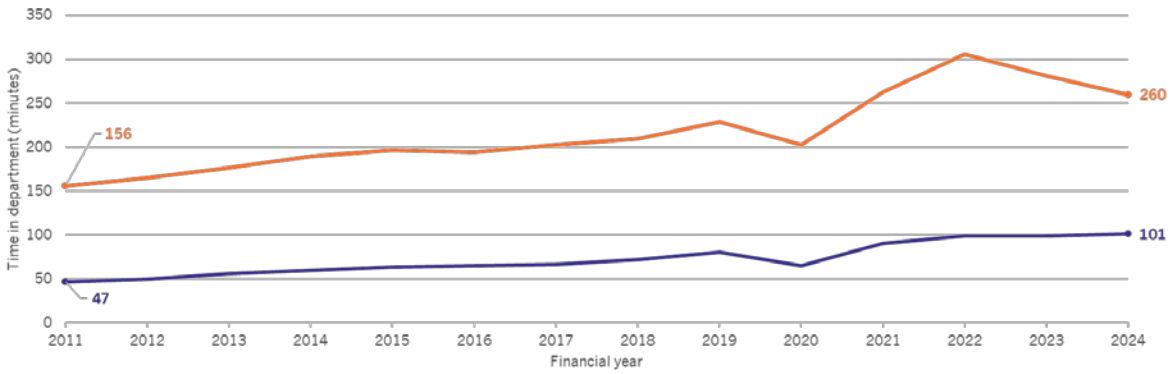
Figure II.3.7: Reported patient satisfaction by average numbers of registered patients per GP, June 2024



13. There have been positive developments in growing the wider workforce in general practice such as clinical pharmacists and occupational therapists. These should be supplements, rather than substitutes to GPs though and more GP time is required to coordinate multidisciplinary working. In particular, more GPs are needed in under-doctored areas.

14. Many, although not all, urgent treatment centres and walk-in centres are GP-led. They too have faced significant increases in demand that have resulted in longer waits. As we can see in the chart below, waiting times have increased significantly, more than doubling between 2012 and 2024 from around 50 minutes to more than an hour-and-a-half. There are also now some long waits, with the 95th centile waiting 4 hours and 20 minutes[49].

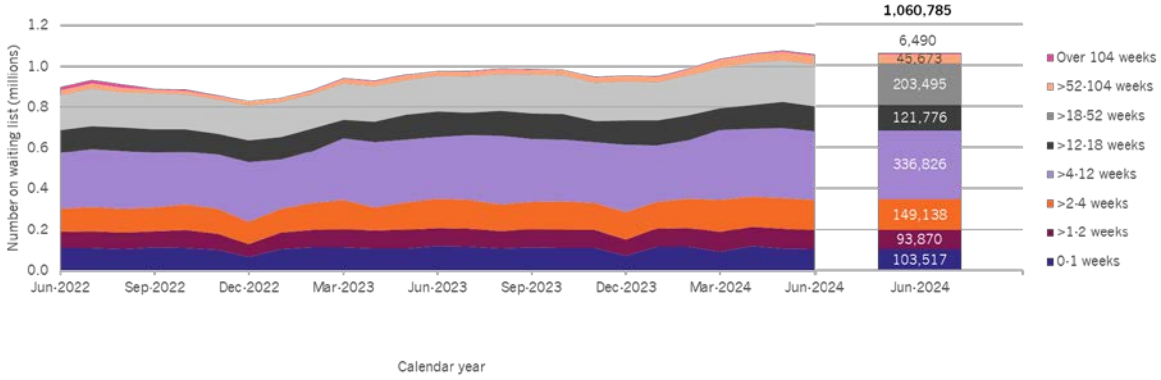
Figure II.3.8: Total time in department from arrival to admission, transfer or discharge, UTCs and WICs



Access to community services

15. High quality community services are essential to create a sustainable NHS and have been highlighted by national strategies to shift care closer to home for decades. Yet properly assessing access in NHS community services is hampered by the lack of data. Data on the total waiting list size is only available from 2022. As of June this year, more than 1 million people were waiting for community services, including more than 50,000 people who had been waiting for over a year, 80 per cent of whom are children and young people (see chart below)[50]:

Figure II.7.1: Total community health services waits by waiting times, June 2022- June 2024

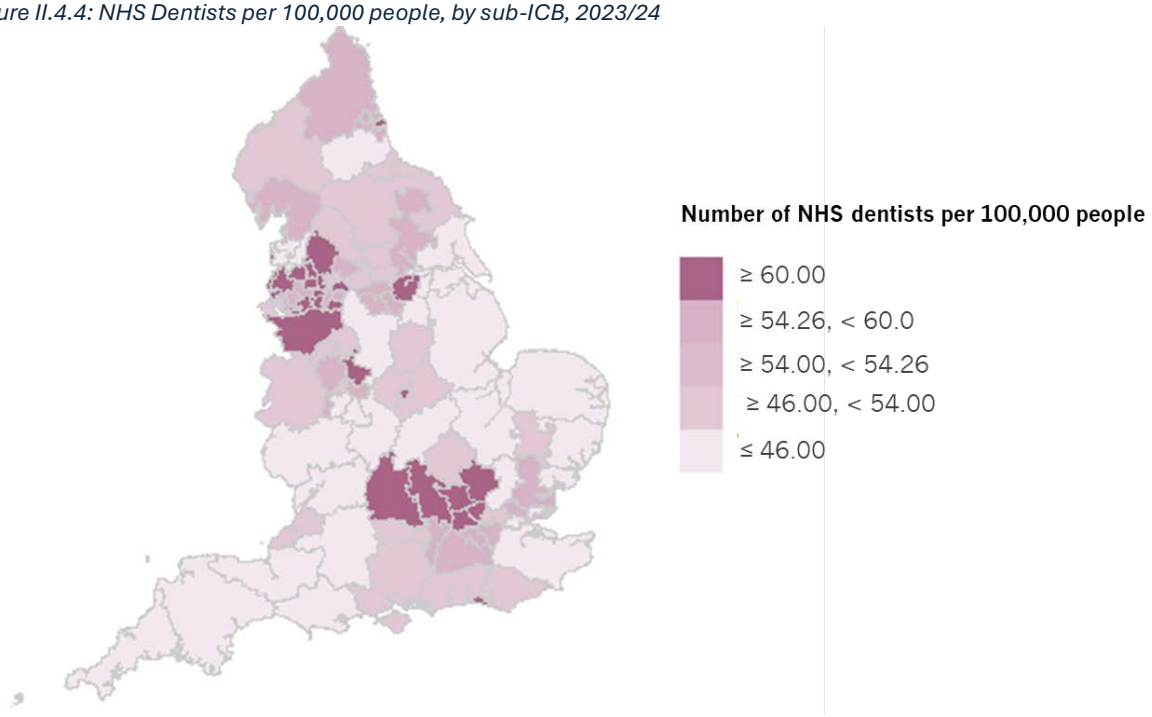


16. Set against a backdrop of growing need, the overall numbers of community nurses have held steady since 2016[51], whilst the number of district nurses (nurses who have completed additional training to become specialist community practitioners) has actually declined[52]. There has been a worrying reduction in the number of health visitors between 2019 and 2023[53] – a crucial role given the extensive evidence base on the importance of getting a good start to life. Community services need to be more visible and have a higher priority given to them.

Access to dentistry

17. Good dental health is essential for adults and children alike. Yet only about 30 and 40 per cent of NHS dental practices are accepting new child and adult registrations respectively[54]. And as this chart from the Nuffield Trust shows[55], there are wide variations in the number of NHS dentists per population in different areas of the country. Rural and coastal communities particularly lack access to NHS dentistry.

Figure II.4.4: NHS Dentists per 100,000 people, by sub-ICB, 2023/24



18. Dental access was particularly badly hit by the Covid-19 pandemic and is still recovering. If dentistry is to continue as a core NHS service, urgent action is needed to develop a contract that balances activity and prevention, is attractive to dentists and rewards those dentists who practice in less served areas. There are enough dentists in England, just not enough dentists willing to do enough NHS work, which impacts provision for the poorest in society.

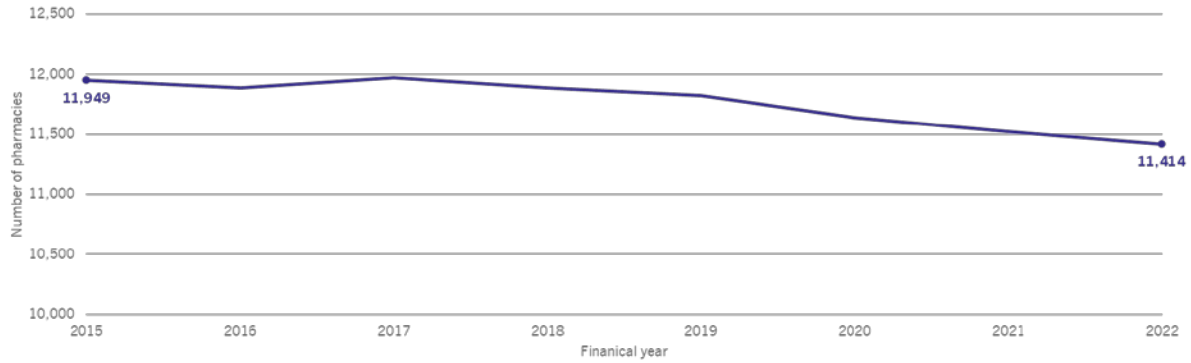
Access to community pharmacy

19. One of the great strengths of the health service in England has been the accessibility of community pharmacy. Historically, the contract promoted a highly efficient distribution of pharmacies. Indeed, in contrast to many aspects of care, deprived communities are better served. More than 93 per cent of patients living in areas of highest deprivation live within 1 mile of a pharmacy compared to 71 per cent in areas of the lowest deprivation[56]. While access has started to deteriorate in recent years, more than 85 per cent of people live within one mile of a community pharmacy[57].

20. Yet pharmacies are now closing in significant numbers. As the chart below shows, around 1,200 pharmacies have shut their doors since 2017[58]. While pharmacies have expanded the range of clinical services that they provide – such as blood

pressure checks, prescription contraception, and minor illnesses – the total level of spending on the community pharmacy contract has fallen by 8 per cent[59].

Figure II.5.1: Number of pharmacies in England from 2017 to 2024



21. There is the potential for community pharmacy to provide even more value-added services for the NHS and there have been notable successes already, such as the Pharmacy First programme. As the Royal Pharmaceutical Society pointed out in their submission to the Investigation, nearly 30 per cent of existing pharmacists are independent prescribers and changes to pharmacy education mean that from 2026 all newly-qualified pharmacists will be[60].

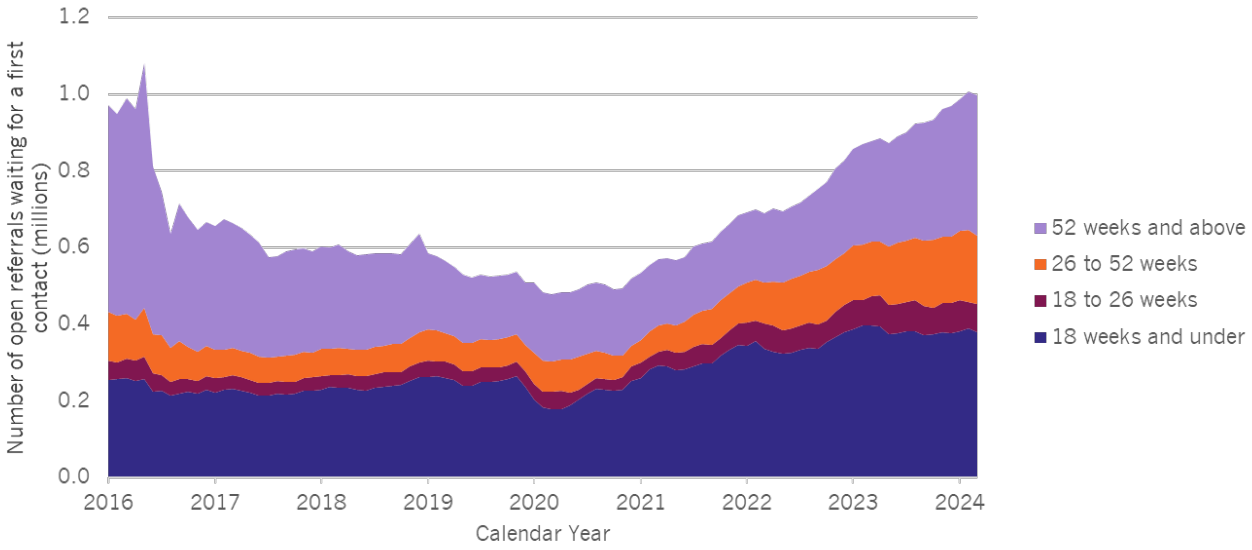
22. There is huge potential for a step change in the clinical role of pharmacists within the NHS. Expanded community pharmacy services are likely to include greater treatment of common conditions and supporting active management of hypertension. But there is a very real risk that on current trajectory, community pharmacy will face similar access problems to general practice, with too few resources in the places where it is needed most.

Access to mental health services

23. The need for mental health services has been growing rapidly. In 2016, around 2.6 million people were in contact with mental health services; by 2024, this had increased to 3.6 million people[61].

24. By April 2024, around 1 million people were waiting for mental health services[62]. Long waits have become normalised: there were 345,000[63] referrals where people are waiting more than a year for first contact with mental health services— a figure higher than the entire population of Leicester[64].

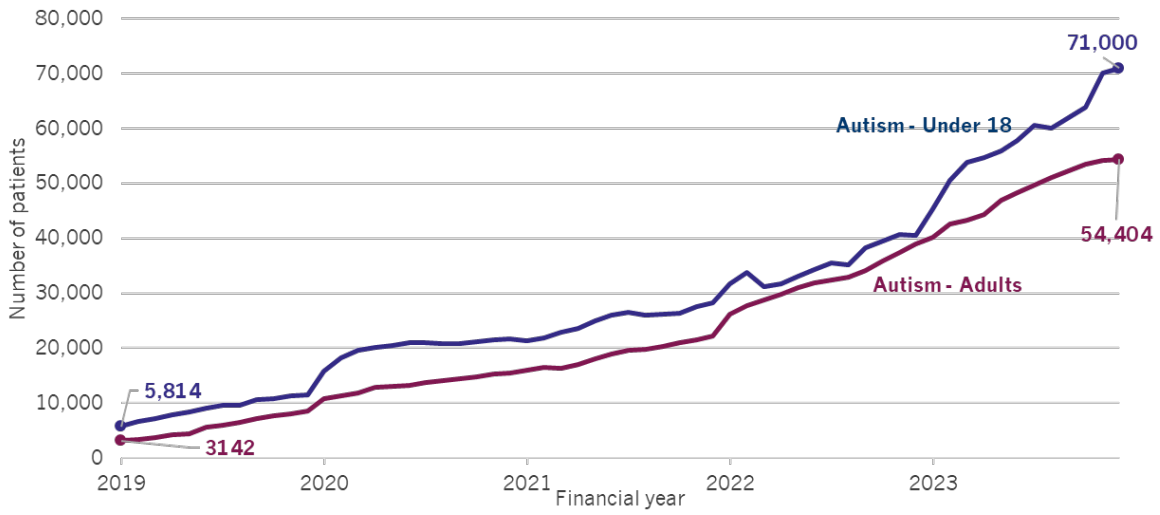
Figure II.6.5: Number of Open Referrals for people of all ages at the time of referral to Mental Health, Learning Disability and Autism services by time waiting for first contact



25. Some 343,000 referrals for children and young people under the age of 18 are waiting for mental health services, including around 109,000 referrals waiting for more than a year[65] (equivalent to the population of Maidstone[66]). For any person, a year wait is far too long. But for young people who are going through profound life changes, this is particularly concerning.

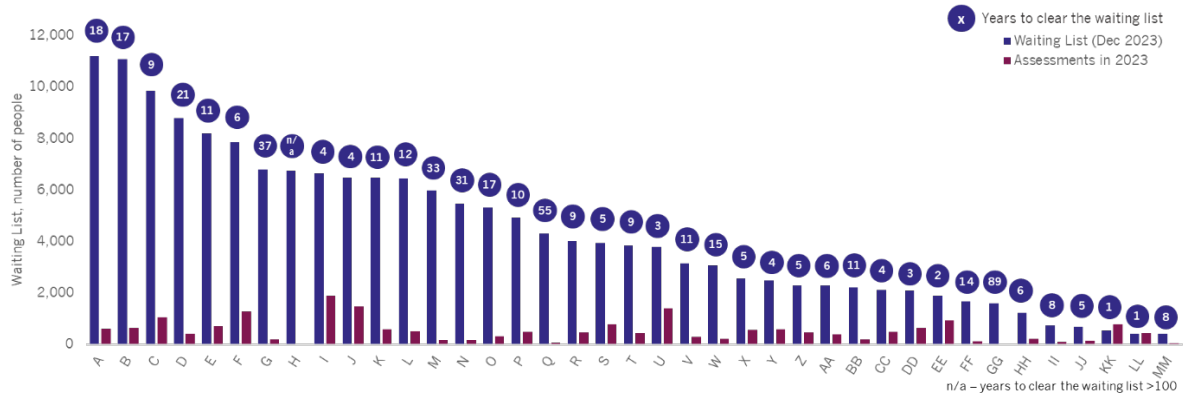
26. Demand for assessments for ADHD and Autism have grown exponentially in recent years. Since 2019, the number of children waiting at least 13 weeks for an assessment for Autism has increased at a rate of 65 per cent a year, while for adults the increase has been 77 per cent a year[67]. Activity has risen too, with services now seeing 33,000 people a month[68]. But as of March 2024, there were still more than 70,000 children and young people under 18 and more than 50,000 adults waiting at least 13 weeks for an assessment for Autism[69].

Figure II.6.12: Number of patients with a referral for suspected autism, open for at least 13 weeks, who were still waiting for a first contact, April 2019 to March 2024



27. The growth in demand for ADHD assessments has been so significant that it risks completely overwhelming the available resource. As the chart below sets out, there is a huge mismatch between demand for assessment and their availability. The result is that, at current rates, it would take an average of 8 years to clear the backlog in adult ADHD assessments – and for many trusts, at current rates, the backlog would not be cleared for decades.

Figure II.6.10: Implied clearance time for adult ADHD assessments based on activity and wait list size (based on 44 providers, in England, Wales and Scotland)



28. There is no consensus around what explains the dramatic increase in demand for assessment for ADHD and autism. Some believe that it is the conversion of unmet need into demand for assessment as stigma has reduced and awareness has increased. Others argue that is the result of self-diagnosis induced by misleading

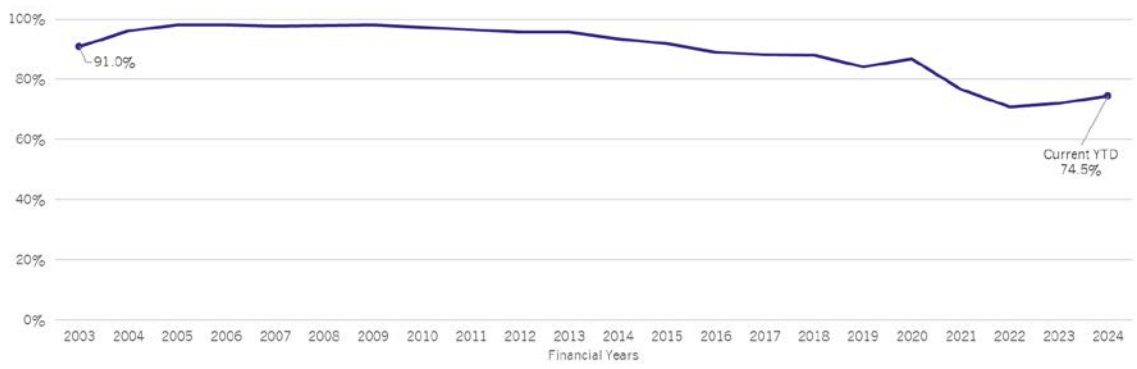
discussion on social media. No matter the cause, it is clear that with services overwhelmed, many people who need help will be missing out. NHS England's taskforce on ADHD[70] will have important recommendations to make.

Access to acute hospital services

Waiting times for A&E departments

29. In 2022, for the first time since the start of the century, more of the public were unhappy with how A&E departments are run than were satisfied. In 2023, nearly 40 per cent of people were dissatisfied, with just over 30 per cent satisfied[71]. This is not surprising. As the chart below shows, in 2011, 96.6 per cent of people attending A&E were seen within four hours; by 2024 that figure had dropped to just 74.5 per cent[72]. Between 2011 and 2023, the number of people attending A&E increased by 22.5 per cent to some 26.3 million[73].

Figure II.8.6: Percentage of attendances admitted, transferred or discharged within 4 hours of arrival at A&E



30. The poor state of the headline figures can obscure some of the important nuances that sit beneath. The average waiting time for infants has increased by around 60 per cent over the last 15 years. But it is particularly concerning that nearly 250,000 infants (aged 0-2) were left waiting for more than four hours and more than 100,000 infants waited more than six hours in 2023-24[74]. There is a similar picture for children aged three to 17, with almost 500,000 waiting more than four hours and 225,000 waiting for more than six hours in A&E[75].

31. Older people have endured particularly long waits. The average waits for people over the age of 65 have nearly doubled over the past 15 years from just over three hours to nearly seven[76]. But some have had particularly appalling experiences: at

the 95th percentile, people have been waiting for more than 24 hours in A&E[77]. Analysis from the Royal College of Emergency Medicine (RCEM), submitted to the Investigation, found that in December 2023, almost a third of people over 80 waited for 12 hours or more. The RCEM also found that people who were over the age of 90 were five times more likely to wait 12 hours or more than people aged 18 to 29[78].

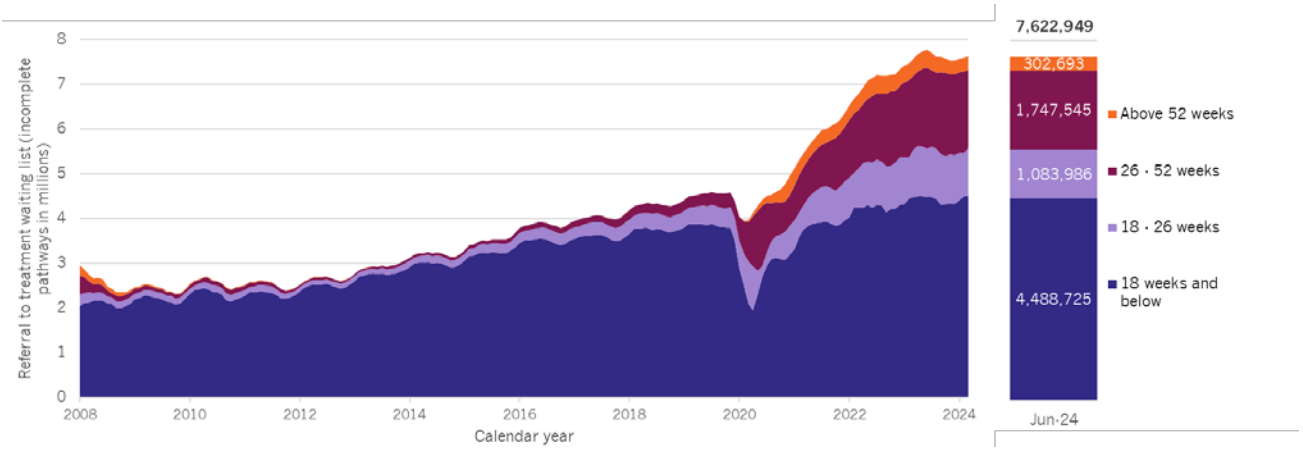
32. There has been a similar experience for people coming to A&E in a mental health crisis. People with a mental health flag tend to experience wait times that are approximately 25 per cent longer than those without[79]. For the 95th percentile, these waits have been getting worse and worse since the pandemic, such that in May 2024, waits were nearly 30 hours[80] and one patient with complex mental health needs spent more than 18 days in an A&E department in August 2024. In 2023-24, more than 80,000 people with mental health crises waited more than 12 hours and more than 26,000 waited for more than 24 hours in A&E departments[81]. Analysis from the RCEM showed that patients in 2022 with a primary diagnosis of mental illness were twice as likely to wait for 12 hours or more than the rest of the population[82]. Bright, busy and noisy A&E departments are completely inappropriate places for someone in mental distress.

Waiting times for consultant-led treatment of non-urgent conditions

33. In March 2010, the NHS Constitution, published in 2009 following the recommendation of *High Quality Care for All*, was amended with a new right for patients to start consultant-led treatment for non-urgent conditions within a maximum of 18 weeks from referral by their GP. In that month, just over 2.4 million people were waiting for NHS treatment. This included 2.21 million people waiting for treatment within 18 weeks; 200,000 waiting between 18 weeks and a year; and 20,000 waiting for more than a year[83]. In 2012, it became a statutory requirement that at least 92 per cent of patients should have a referral-to-treatment time of less than 18 weeks.

34. As we can see in the chart overleaf, in June 2024, the total waiting list stood at 7.6 million people. More than 300,000 people had waited for over a year, and some 1.75 million people had waited for between 6 and 12 months[84]. More than 10,000 people are still waiting longer than 18 months (although this has fallen sharply from its peak of 123,000 people waiting that long in September 2021)[85]. By far the largest group waiting were working age adults – some 4.2 million people[86]. As we will explore in the next chapter, the Covid-19 pandemic saw the most rapid rise in waiting lists. But in February 2020, waiting list already stood at some 4.6 million people, over 2 million more than 10 years earlier[87].

Figure II.8.15: Referral to treatment waiting list over time by weeks waiting



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35. In almost all NHS services, performance on access to care has declined. Long waits have become normalised across the NHS and public satisfaction has declined as a result. Turning the situation around will take time, but it cannot come soon enough. Too many people are waiting too long for the care that they need.

3

Quality of Care in the NHS

1. In my 2008 report, *High Quality Care for All*, I made the case that raising the quality of care should be the organising principle of the NHS. In this chapter, we examine how the NHS is performing in terms of the quality of care that it provides. It is structured around the main pathways, examining the quality of care from the start of life to its end. We then explore three key areas that cause the most avoidable deaths: cancer, cardiovascular conditions, and suicide. We conclude by looking at complaints and clinical negligence – what happens when things go wrong.

Maternity and newborn

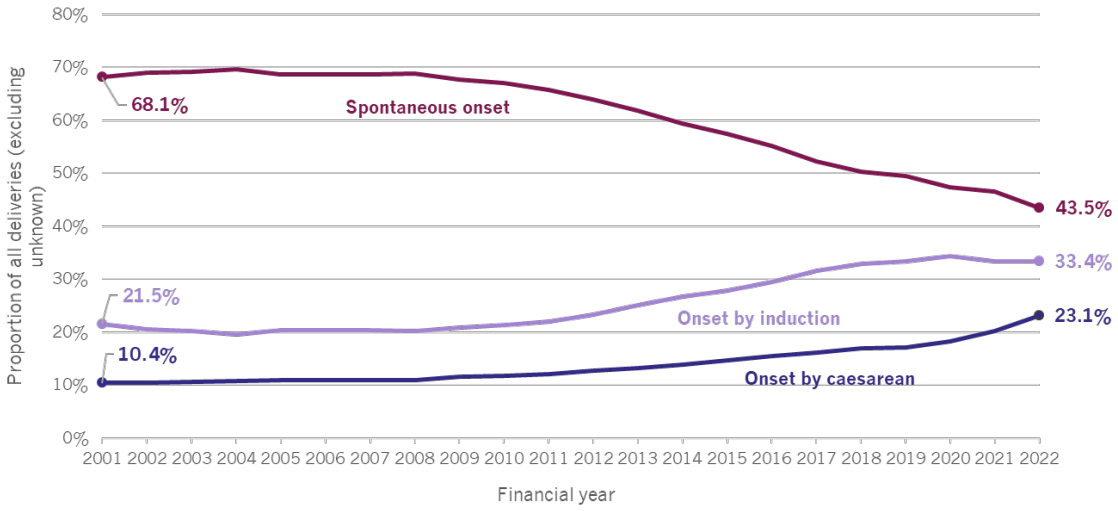
2. There have been positive developments in reductions of stillbirths and a small decrease in neonatal mortality and serious brain injuries. Yet maternal deaths have increased since the pandemic[88], including when adjusted for the direct impact of Covid-19. Most worrying are the huge inequalities that exist in maternity care. For instance, black women are almost three times as likely as white women to die in childbirth. And neonatal mortality of the most deprived quintile is more than double that of the least deprived[89].

3. The lack of progress in some areas occurs at a time when we have had a succession of scandals and subsequent inquiries into maternal care, such as in East Kent, Shrewsbury and Morecambe Bay. A recurring theme is that the recommendations of previous reviews have not been universally adopted.

4. Complexity continues to steadily rise as the age that women become pregnant increases and more expectant mothers have other conditions such as obesity[90] or diabetes[91], whose prevalence is increasing in the population (and also increases with age). This is also reflected in trends in the onset of labour. As the chart below shows, fewer than half of women now go into labour spontaneously, compared to around 70 per cent in the early 2000s[92]. Births by caesarean section are now much

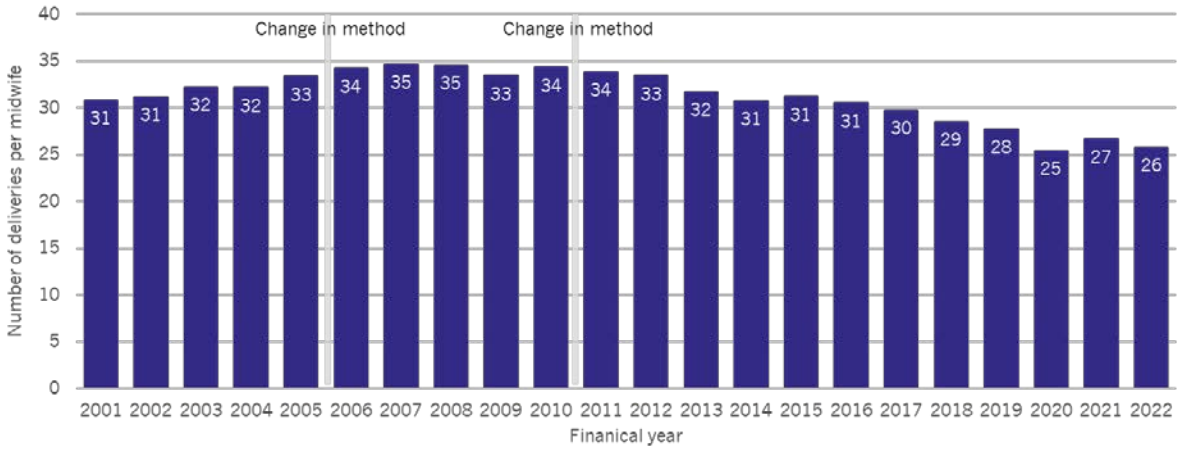
more common, having risen at annual rate of 4.6 per cent since 2005 while inductions have risen at an annual rate of 2.9 per cent over the same period[93].

Figure III.2.1: Rates of onset of labour by induction, spontaneous and caesarean section as a percentage of all deliveries of known onset method



5. While complexity has increased, it has occurred at a time when births have been falling and the number of midwives has risen. The overall result is that the number of deliveries per midwife each year has fallen from a peak of 34.7 in 2007 to 25.8 in 2022, as the chart below shows[94]. This was a notably better ratio than France (31.3 births per midwife in 2021), Germany (31.8 births per midwife in 2021) and Spain (34.3 births per midwife in 2021) and similar to Italy (23.7 births per midwife in 2021)[95].

Figure III.2.10: Deliveries per midwife



6. High rates of sickness absence – equivalent to one working month (22 days) per midwife per year across the NHS as a whole – are likely having an impact[96]. But even

when this is considered, capacity alone does not appear to be the constraint on improvement. This suggests that a deeper conversation needs to be had on skills, staffing mix, clinical models, leadership and culture in maternity services.

7. The Investigation received an important submission from Dr Bill Kirkup, former Associate Chief Medical Officer for England, who most recently led the review into the quality of care at East Kent. Dr Kirkup describes the issues that are supported by published evidence:
    a. Pressure and stress are at high levels which contributes to poor morale. This leads to burnout, absenteeism, high turnover, and the loss of trained staff. This dynamic impairs patient safety.
    b. Training in silos impairs teamwork which compromises patient safety. This is partly a result of divergent curricula for different staff groups that damage attitudes and a lack of focus on learning the skills for teamwork.
    c. Unstable working patterns and the lack of rest space impair teamworking and morale. Having dedicated space and refreshments benefits staff and improves patient safety.
    d. Leadership is crucial particularly Clinical Directors, but the Clinical Director role is poorly developed, supported and managed.
    e. Capacity for compassion is variable, sensitive to environment and pressure, but can be systematically improved.
    f. Transgressive behaviour is more common than admitted, which is very difficult to deal with, and damaging to morale and patient safety.
    g. Response to safety incidents is dominated by personal reactions; fear of blame by colleagues and others is a significant disincentive to investigation and learning; a culture of openness is essential to patient safety, but often lacking.

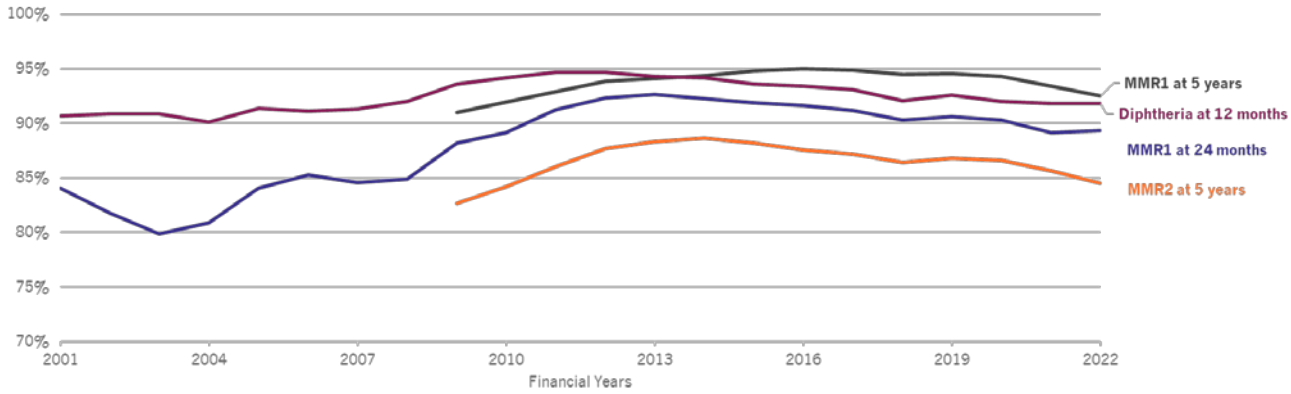
8. Today, too many women, babies and families are being let down. None of the issues described by Dr Kirkup are insurmountable. Each can be solved with sufficient time, attention and focus. The first step is to acknowledge that the problems are complex and that the data suggests that adding more staff will not by itself address them.

Children and Young People

9. Children and young people are 24 per cent of the population and account for 11 per cent of NHS expenditure. Their mental and physical health appears to have been deteriorating in recent years. Since 2019/20, for example, there has been an 82 per cent increase in hospital admissions for eating disorders[97]. Between 2001 and 2018, there was a 250 per cent increase in the prevalence of life-limiting and life-threatening conditions in children and young people[98]. This may reflect an increase in survival in this population as well as an increase in recording of diagnoses. Such children are increasingly likely to have lengthy hospital stays, as the Children's Hospital Alliance (CHA) highlighted in their submission to the investigation. Similarly, the Royal College of Paediatrics and Child Health pointed out that the number of children with eight or more chronic conditions nearly doubled from 7.6 per cent in 2012-13 to 14.0 per cent in 2018-19 and the number of children receiving long-term ventilation more than doubled between 2013 and 2020[99].

10. There are multiple challenges in delivering high-quality care for children and young people. Vaccinations are one of the safest and most cost-effective health interventions. Yet in England, childhood vaccination rates have been declining since 2013-14[100]. This needs to be addressed.

Figure III.3.7A: Vaccine coverage of children aged 24 months with the MMR vaccine (dose 1) and aged 5 years with the MMR (dose 1 and dose 2) and diphtheria vaccines, in England

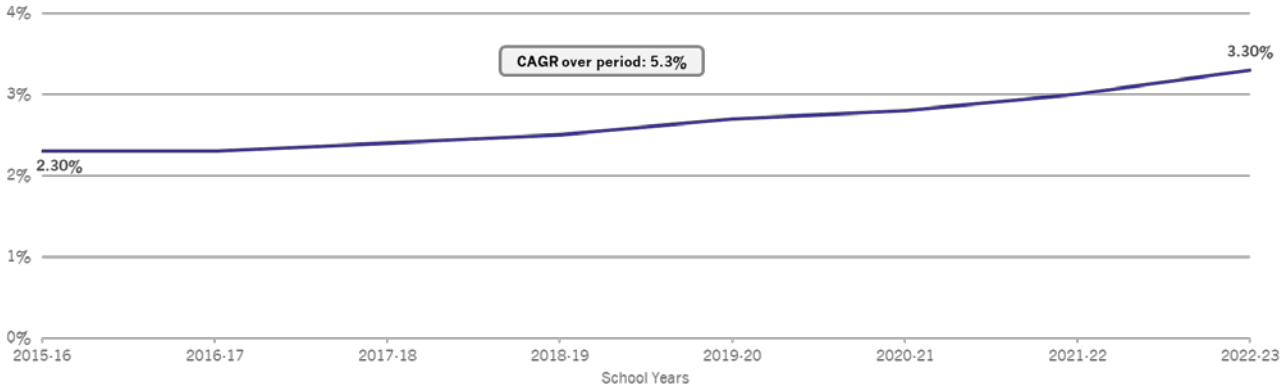


11. It is also clear that health inequalities begin at a very young age. Children from the most deprived decile are 2.1 times as likely to be obese in Reception than children from the least deprived decile, and this extends to 2.3 times by Year 6[101]. It is utterly shocking that in the poorest communities, nearly one-in-three children are obese by year 6[102]. Moreover, according to a submission from the Royal College of Paediatrics and Child Health (RCPCH), 2.5 million children and young people in England are affected by excess weight or obesity, with 1.2 million living with obesity-related complications[103].

12. Under-18 smoking rates continue to fall, and it is unequivocally good news that the government intends to proceed with legislation to create a smoke free generation. But there has been a worrying rise in vaping by children[104]. While vaping is substantially less harmful than smoking, it is not risk free. Given that the long-term health implications are not known, this is a cause for concern.

13. There is a significant rise in mental health needs amongst children, as analysis from the charity Young Minds shows. The percentage of school pupils with social, emotional and mental health needs increased from 2.3 per cent in 2015-16 to 3.3 per cent in 2022/23[105]. Between 2004 and 2023 the number of patients on ADHD medication has been increasing by just over 10 per cent each year[106]. And as we have seen, access to mental health services is a huge problem for children and young people.

Figure III.3.6: Percentage of school pupils who have educational support for social, emotional and mental health needs (school age)



14. Paediatric services for physical health are under pressure, too. As we have seen, waiting list size and duration of waits have grown more rapidly for children than for adults. And according to the RCPCH, children are 13 times more likely than adults to wait over a year for access to community services[107].

15. As the Children's Hospital Alliance (CHA) points out, paediatric intensive care unit (PICU) beds are regularly over 90 per cent occupancy with some units at 100 per cent. Length of stay is also increasing (notably, with more 100+ day patients), leading to cancellations of cardiac and cancer elective operations[108]. More children are attending A&E, but the emergency admission rate has not increased, suggesting that they could be cared for elsewhere.

16. There are real concerns about the NHS' capacity and capability to deliver high-quality care for children. Only 25 per cent of GPs now receive paediatric training[109]. The centralisation of paediatric surgery to specialist centres during the pandemic means some surgeons and anaesthetists in non-specialist acute hospitals are more reluctant to operate on children[110]. Paediatrics is not a requirement of doctors' training at foundation level, and for many specialties only happens after full adult training (such as for pathology and radiology)[111].

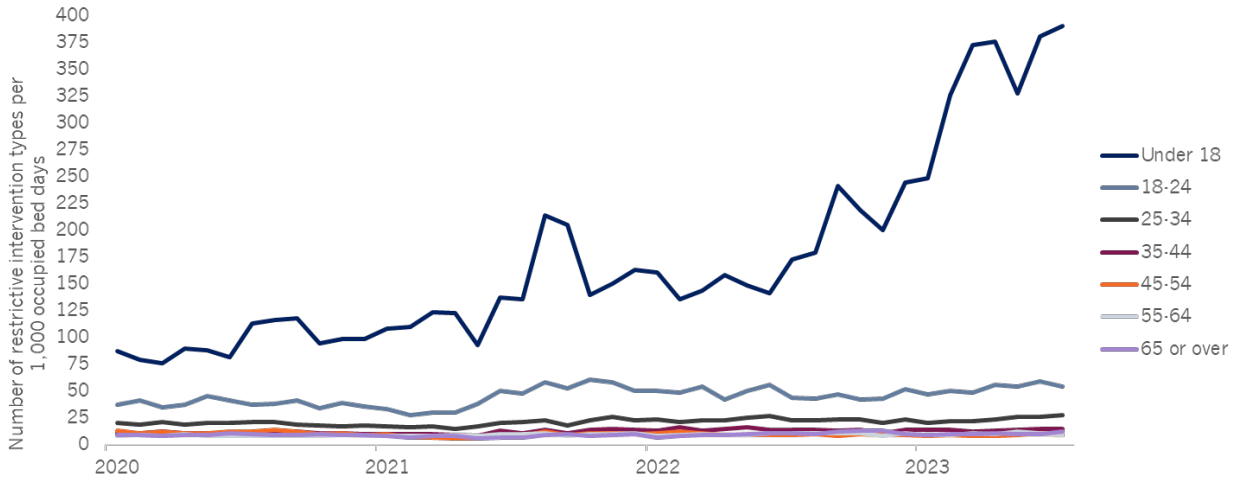
17. The problems faced by all NHS patients are similarly encountered by children and young people. At the moment, too many are being let down. Childhood is precious because it is brief; too many children are spending too much of it waiting for care. It is apparent that the NHS must do better and that national policymaking on care for children and young people needs to be more joined up.

Mental health

18. There has been a notable success in the Improving Access to Psychological Therapies programme. The proportion of people with anxiety or depression who have been able to access Talking Therapies has increased from 6.1 per cent in 2013/14 to 15.9 per cent in 2022/23[112]. The recovery rate for those who complete a course of talking therapies has remained steady at approximately 50 per cent[113].

19. For those receiving inpatient mental health care there has been an increase in restrictive interventions, such as physically restraining patients to administer medication or gastro-nasal feeding, over the last four years. As this chart shows, that increase is being driven by a dramatic and concerning surge in restrictive interventions for children under 18[114]. This goes alongside a dramatic rise in admissions, which have increased by 82 per cent since 2019, according to analysis done using NHS data, though changes in reporting practices as well as an increase in the number of organisations reporting may account for some of this increase[115].

Figure III.5.4: Number of restrictive intervention types per 1,000 occupied bed days (Sep 2020 - Mar 2024)



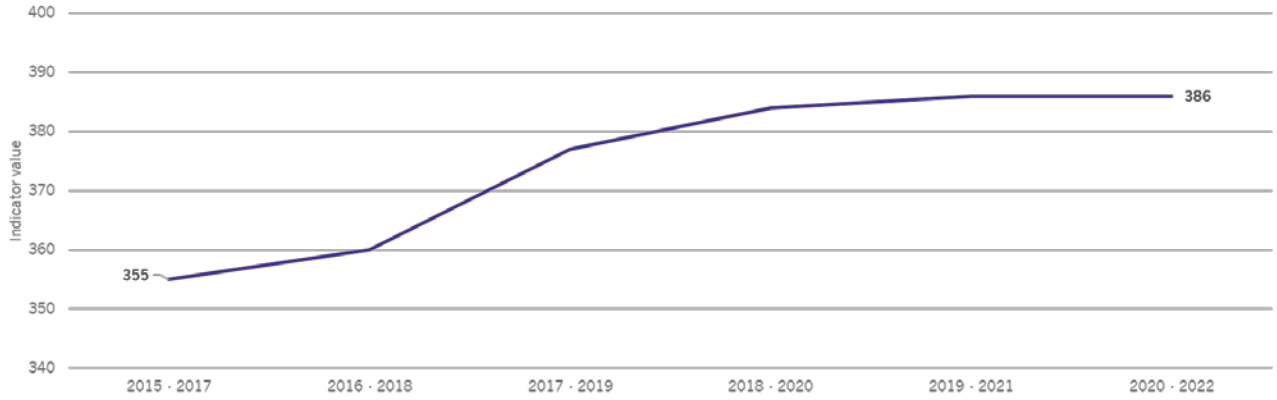
20. There has been a significant expansion in access to perinatal mental health services. Despite the significant impact of the pandemic, between 2019-20 and 2023-24, the numbers of women accessing care grew by two thirds[116]. The aim is to expand it further so that 66,000 mothers are helped this year.

21. People living with serious mental illnesses have significantly lower life expectancy than the rest of the population, typically dying 15 to 20 years earlier[117]. This problem is well-documented. Yet while psychiatric liaison exists in acute physical hospitals, there is no physical health liaison in mental health wards.

22. There have been positive developments with more mental health patients receiving physical health checks. In their submission to the Investigation, the Royal College of Psychiatrists pointed out that there had been an annual increase in physical health checks of 127 per cent, rising from nearly 160,000 to more than 360,000[118]. This is close to, but still below, the ambition set in the 2019 NHS Long Term Plan.

23. Yet excess mortality for those with serious mental illnesses has been going in the wrong direction, as the chart below shows. According to the RCPsych, there were an estimated 130,400 premature deaths among adults with severe mental illness during 2020-2022, compared to an estimated 100,476 in 2015-2017.

Figure III.5.7: Excess Under 75 mortality rates in adults with serious mental illness, 2015-17 to 2020-22, England



24. The NHS has a special responsibility to those that it treats while they are detained under the Mental Health Act. During visits as part of this investigation I saw some high-quality, modern facilities that are world-leading. But I was appalled to uncover that mental health patients continue to be accommodated in rooms that were constructed for a Victorian asylum. In one ward that I visited, patients' rooms were 7' x 8'6" with a fixed bunk that measured 6'6" by 3', occupying more than a third of the room.

> "We shouldn't be living like this. We're human beings at the end of the day. How are we supposed to recover from our mental illness when we have to live like this? We shouldn't be living with leaks and floods and cockroaches and mice. We have two showers for 17 men. It's totally wrong."
> *A patient speaking to Lord Darzi during a service visit*

25. Patients told me how nearly 20 men were expected to share just two showers, how the laundry facilities often broke down, and how they struggled to maintain their personal hygiene and dignity. They spoke of infestations of mice and cockroaches

which no amount of pest control had managed to eradicate from the decrepit estate. Under the current capital rules, even if the Trust concerned raised the capital from disposals of other assets, they would not have the discretion to spend it on replacing or rebuilding the unit.

26. According to a submission from the Royal College of Psychiatrists, more than a third of single rooms across mental health and learning disability sites in 2022-23 lacked ensuite facilities, amounting to more than 6,600 patient rooms. Many patients stay in these facilities for months at a time, and some for many years. If the measure of a society's humanity is how it treats its most vulnerable, then we are falling far short.

27. I was therefore particularly concerned to discover that a decision was taken to remove three out of five of the mental health schemes in the new hospitals programme, as part of the review of the programme by HM Treasury. NHS England's prioritisation, based on objective assessment of the merits of the schemes, was overruled.

28. The lack of sufficient good quality facilities contributes to mental health inpatients being accommodated far from their family, friends and loved ones. Inappropriate out-of-area placements of mental health service users have decreased at a rate of 8 per cent a year since 2018 but while they fell from their 2019 peak through to 2022, they began to rise again in 2023 and stood at nearly 6,000 in that year[119]. Being far from a support network hinders recovery and makes it harder for people to get back to daily life. And as we have seen, bed capacity and management problems mean that all-too-often patients are waiting for excessively long times in hospital accident and emergency departments as no mental health beds can be found[120].

29. There has been a steady decline in suicides completed by people with diagnosed mental illnesses, both those who are living in the community and those who are inpatients. The numbers of mental health inpatients that have completed suicide have reduced from 100 in 2009 to fewer than 60 in each year since 2017[121]. This reflects sustained efforts to reduce ligature risk and to improve observations. But

there is still further to go to ensure inpatient wards are as safe as possible for people in mental distress.

30. At the same time, there are also concerns about the rigor with which patients who have serious mental illnesses are followed up in the community and how effectively risk is managed. There are a number of cases, high profile and not, where people with serious mental illness have not had appropriate risk assessments or sufficiently assertive follow up[122]. There is significant scope for improvement in the quality, safety and consistency of care.

Long-term conditions

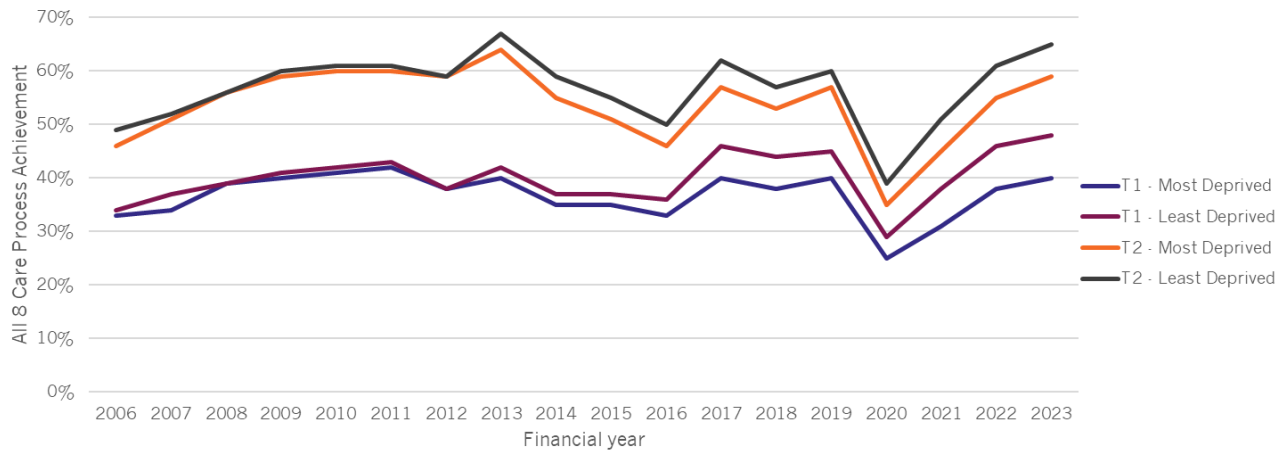
31. As we saw in chapter 1, there has been a substantial rise in the prevalence of some long-term conditions. Perhaps more significantly, more people now have multiple long-term conditions: between 2017 and 2022, the number of people with two or more long-term conditions increased at an annual rate of 6.1 per cent[123]. This matters because multiple conditions can interact with each other, which increases complexity and makes their management more challenging. Many long-term conditions are caused or exacerbated by lifestyle factors, such as tobacco or alcohol consumption, and obesity.

32. As the disease burden has shifted towards long-term conditions, multidisciplinary team working has become more important. Yet NHS structures have not kept pace. GPs are expected to manage and coordinate increasingly complex care, but do not have the resources, infrastructure and authority that this requires.

33. As we saw in chapter 1, the probability of having one or more long-term conditions rises substantial with age. In their submission to the Investigation, Age UK analysis of the GP patient survey found significant declines in the proportion of older people who feel supported to manage their long-term conditions in the community. Rates fell by around 10 per cent across all older adult age cohorts between 2018 and 2023.

34. For many long-term conditions, there is a strong evidence base about what interventions are required. People with diabetes, for example, should have eight care processes that are well-defined and evidence-based. Yet while there has been some progress, there are wide disparities between the most and least deprived communities, with the least deprived 5 per cent more likely to receive all eight than the most deprived, as we can see in the chart below[124].

Figure III.7.3: Percentage of patients with all 8 Care Process achieved, by diabetes type and deprivation quintile (most and least deprived)

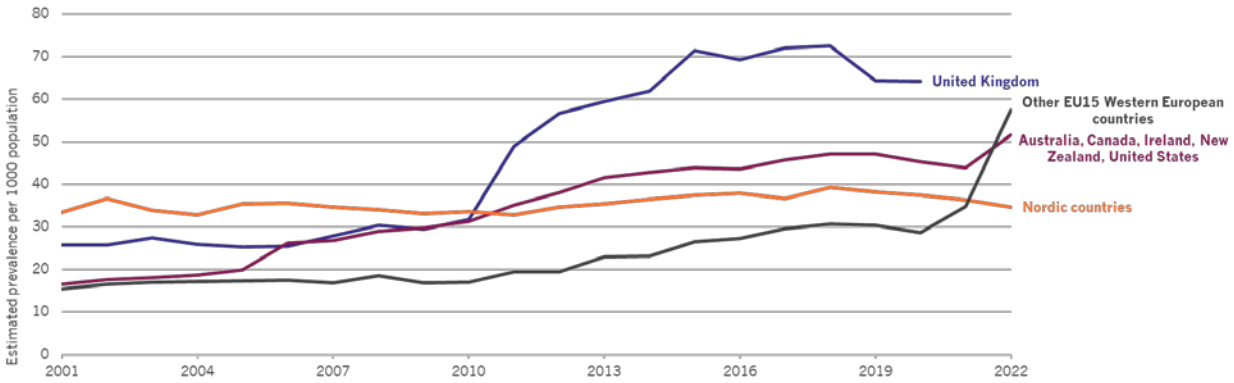


35. A similar picture is true for other long-term conditions, such as chronic breathing difficulties. Moreover, 35 per cent of patients with long-term conditions still do not have a care plan, which is one of the most important tools to coordinate and manage care[125].

Dementia

36. The number of people aged 65 years and over increased from 9.2 million in 2011 to over 11 million in 2021 and the proportion of people aged 65 years and over rose from 16.4 per cent to 18.6 per cent[126]. The Alzheimer's Society estimates that there are approximately 982,000 people living with dementia[127]. Analysis of OECD data finds that prevalence of dementia is 19 per cent below the OECD20 but that the UK has a substantially higher rate of dementia deaths, which have been above 60 per 100,000 patients since 2014 (though this may reflect difference in recording)[128].

Figure III.9.2: Dementia deaths per 100,000 patients (standardised rates)



37. In addition, dementia diagnosis rates have not improved in recent years. The dementia diagnosis rate for people aged 65 and over has only recovered to around 65 per cent compared to 68 per cent before the Covid-19 pandemic[129]. Concerningly, the proportion of patients with dementia receiving a care plan or care plan review in the preceding 12 months dropped to less than 40 per cent during the Covid-19 pandemic[130].

38. In their submission to the Investigation, the Alzheimer's Society argued that there are "high levels of unwarranted variation in access to diagnosis and treatment [and] insufficient adherence to clinical guidelines". As society continues to age, there is an important challenge to improve both the quality and quantity of care for people with dementia.

Planned care

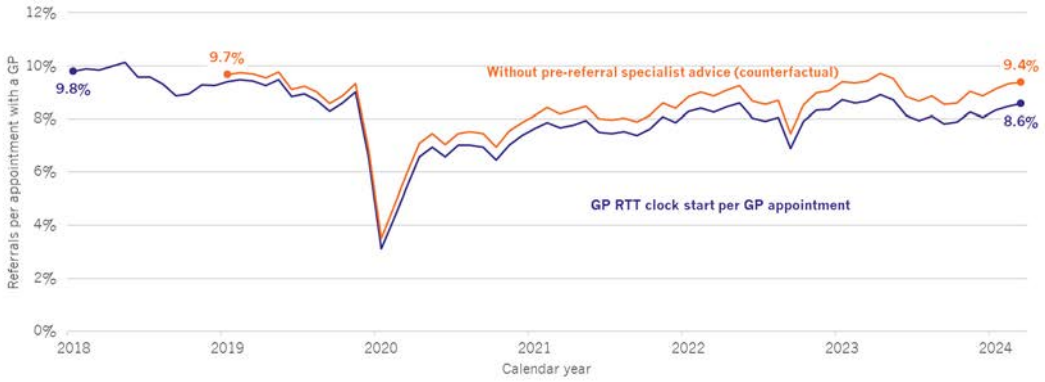
39. As we have seen above, there have been large increases in waiting times for planned procedures. Long waits for treatment have a significant impact on patients. For some, it means waiting for longer periods in discomfort or with limited mobility. For others it can limit their ability to work or to enjoy leisure time with family. From a clinical perspective, it can mean a worse prognosis, more complex interventions, more powerful medications, and longer recovery times.

40. There has been a significant increase of 2.3 per cent a year in outpatient referrals from 2008 to 2023[131]. Progress has been made in reducing the number of follow-ups to first outpatient appointments[132]. This has a quality and efficiency benefit: it

focuses on resolving issues the first time while also freeing up clinician time to see new cases.

41. There has also been important progress in expanding the role of specialist advice. As the chart below shows[133], this has helped to slow the rate of consultant-led treatment, as more patients can be managed by their GP, with appropriate specialist input.

Figure III.4.6: Estimated impact of pre-referral specialist advice on the GP referral rate for consultant-led treatment per appointment

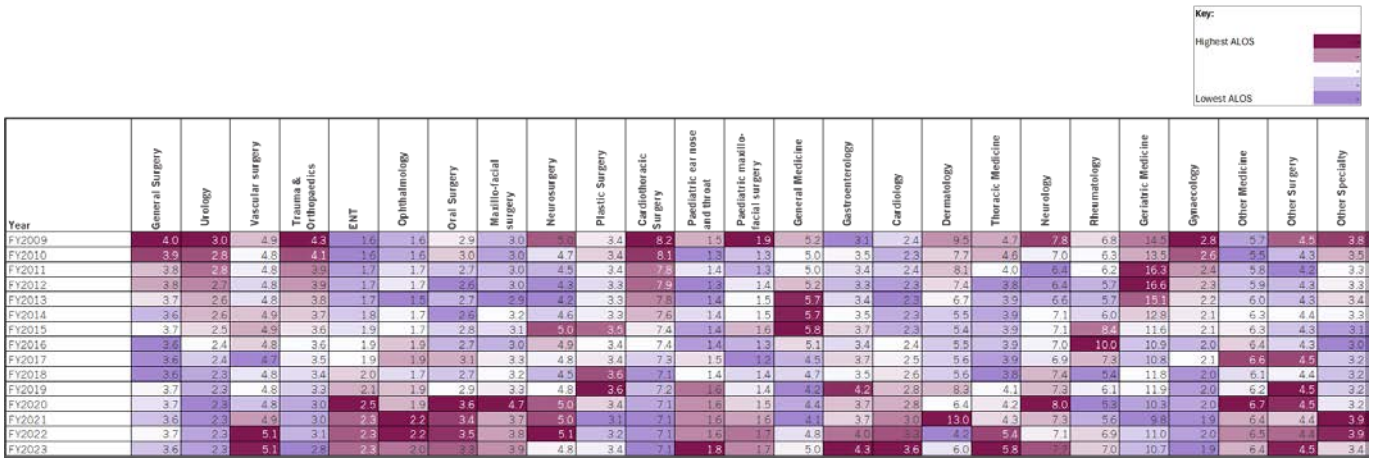


42. Other innovations include "virtual wards". A virtual ward (also known as hospital at home) is an acute clinical service with staff, equipment, technologies, medication and skills usually provided in hospitals delivered to selected people in their usual place of residence, including care homes. It is a substitute for acute inpatient hospital care. Since the national programme was launched in April 2022, virtual wards have been established in all integrated care systems in England with 12,365 'beds' in place in July 2024[134] and the ambition to be able to be able to admit 50,000 patients a month[135].

43. Where effective, virtual wards have the potential to support two key areas of system impact: reducing attendances and admissions to hospital for 'step up' virtual wards and secondly to support reductions in length of stay in hospital through 'step down' virtual wards where the acute episode of care is completed in the home setting.

44. Another measure of greater efficiency and quality is reducing length of stay for planned care. Here the overall progress in reducing length of stay masks significant variation by specialty, as the chart below shows. This may reflect a shift to day-cases, which means that only the most complex patients stay in hospital. The precise reasons why some specialities have reduced their length of stay, whilst others have increased, is worth closer examination.

Figure III.4.3: Variation in elective overnight average length of stay by treatment function



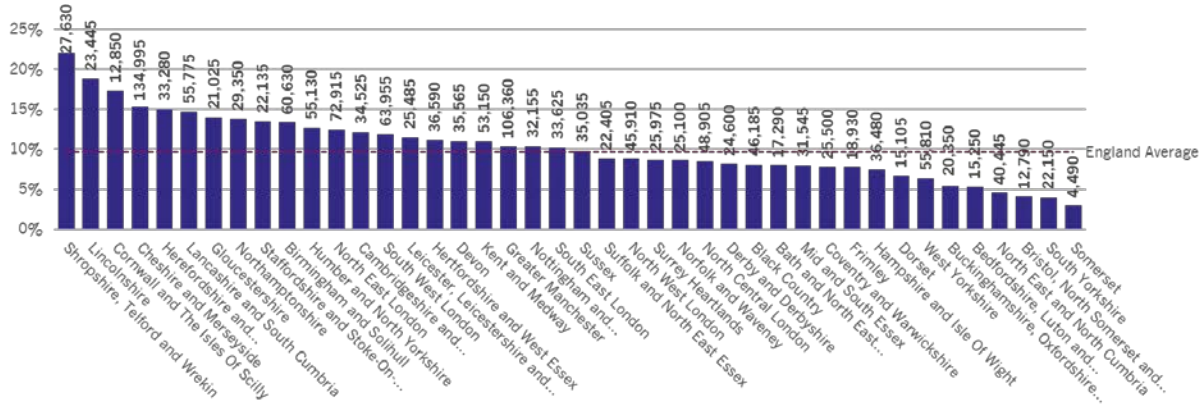
Year	General Surgery	Urology	Vascular surgery	Trauma & Orthopaedics	ENT	Ophthalmology	Oral Surgery	Maxillo-facial surgery	Neurosurgery	Plastic Surgery	Cardiothoracic Surgery	Paediatric ear nose and throat	Paediatric maxillo-facial surgery	General Medicine	Gastroenterology	Cardiology	Dermatology	Thoracic Medicine	Neurology	Rheumatology	Geriatric Medicine	Gynaecology	Other Medicine	Other Surgery	Other Specialty
FY2009	4.0	3.0	4.9	4.3	1.6	1.6	2.9	3.0	5.0	3.4	8.2	1.3	1.9	5.2	3.1	2.4	9.5	4.7	7.8	6.8	14.5	2.8	5.7	4.5	3.8
FY2010	3.9	2.8	4.8	4.1	1.6	1.6	3.0	3.0	4.7	3.4	8.1	1.3	1.3	5.0	3.5	2.3	7.7	4.6	7.0	6.3	13.5	2.6	5.5	4.3	3.5
FY2011	3.8	2.8	4.8	3.9	1.7	1.7	2.7	3.0	4.5	3.4	7.8	1.4	1.3	5.0	3.4	2.4	8.1	4.0	6.4	6.2	16.3	2.4	5.8	4.2	3.3
FY2012	3.8	2.7	4.8	3.9	1.7	1.7	2.6	3.0	4.3	3.3	7.9	1.3	1.4	5.2	3.3	2.3	7.4	3.8	6.4	5.7	16.6	2.3	5.9	4.3	3.3
FY2013	3.7	2.6	4.8	3.8	1.7	1.5	2.7	2.9	4.2	3.3	7.8	1.4	1.5	5.7	3.4	2.3	6.7	3.9	6.6	5.7	15.1	2.2	6.0	4.3	3.4
FY2014	3.6	2.6	4.9	3.7	1.8	1.7	2.6	3.2	4.6	3.3	7.6	1.4	1.5	5.7	3.5	2.3	5.5	3.9	7.1	6.0	12.8	2.1	6.3	4.4	3.3
FY2015	3.7	2.5	4.9	3.6	1.9	1.7	2.8	3.1	5.0	3.5	7.4	1.4	1.6	5.8	3.7	2.3	5.4	3.9	7.1	8.4	11.6	2.1	6.3	4.3	3.1
FY2016	3.6	2.4	4.8	3.6	1.9	1.9	2.7	3.0	4.9	3.4	7.4	1.4	1.3	5.1	3.4	2.4	5.5	3.9	7.0	10.0	10.9	2.0	6.4	4.3	3.0
FY2017	3.6	2.4	4.7	3.5	1.9	1.9	3.1	3.3	4.8	3.4	7.3	1.5	1.3	4.5	3.7	2.5	5.6	3.9	6.9	7.3	10.8	2.1	6.6	4.5	3.2
FY2018	3.6	2.3	4.8	3.4	2.0	1.7	2.7	3.2	4.5	3.6	7.1	1.4	1.4	4.7	3.5	2.6	5.6	3.8	7.4	5.4	11.8	2.0	6.1	4.4	3.2
FY2019	3.7	2.3	4.8	3.3	2.1	1.9	2.9	3.3	4.8	3.6	7.2	1.6	1.4	4.2	4.2	2.8	8.3	4.1	7.3	6.1	11.9	2.0	6.2	4.5	3.2
FY2020	3.7	2.3	4.8	3.0	2.5	1.9	3.6	4.7	5.0	3.4	7.1	1.6	1.5	4.4	3.7	2.8	6.4	4.2	8.0	8.3	10.3	2.0	6.7	4.5	3.2
FY2021	3.6	2.3	4.9	3.0	2.3	2.2	3.4	3.7	5.0	3.1	7.1	1.6	1.6	4.1	3.7	3.0	13.0	4.3	7.3	5.6	9.8	1.9	6.4	4.4	3.9
FY2022	3.7	2.3	5.1	3.1	2.3	2.2	3.5	3.8	5.1	3.2	7.1	1.5	1.7	4.8	4.0	3.3	4.3	5.4	7.1	6.9	11.0	2.0	6.5	4.4	3.9
FY2023	3.6	2.3	5.1	2.8	2.3	2.0	3.3	3.9	4.8	3.4	7.1	1.8	1.7	5.0	4.3	3.6	6.0	5.8	7.3	7.0	10.7	1.9	6.4	4.5	3.4

45. There has been good progress in improving patient safety, partly as a result of sustained focus and political attention, notably from the Rt Hon. Jeremy Hunt MP who was the longest serving health secretary and a passionate advocate for improvement. The proportion of care that is error-free has increased, while avoidable harms like pressure ulcers have fallen[136]. Good progress was made in reducing healthcare acquired infections from 2007-08 to 2011-12, though since then progress has plateaued[137]. Deaths from venous thromboembolism (blood clots in the veins, which can result from hospital stays) spiked during the Covid-19 pandemic and have not yet returned to pre-pandemic levels[138].

Urgent and emergency care

46. Very long waits in A&E have become all too common, and they are a quality of care issue as well as an access problem. While around 60 per cent are seen within four hours and 30 per cent within 12 hours, some 10 per cent of people are now waiting for 12 hours or more[139]. As the chart below shows[140], in some parts of the country, more than one-in-five people are now waiting for 12 hours or more.

Figure II.8.14: ICB A&E waiting times, 12+ hour waits from time of arrival



47. The Royal College of Emergency Medicine has highlighted that very long waits are associated with an increase in deaths. Their analysis shows that this may have resulted in as many as 268 additional death per week in 2023, or nearly 14,000 over the year as a whole[141]. The first priority in addressing issues in A&E should be to eliminate very long waits.

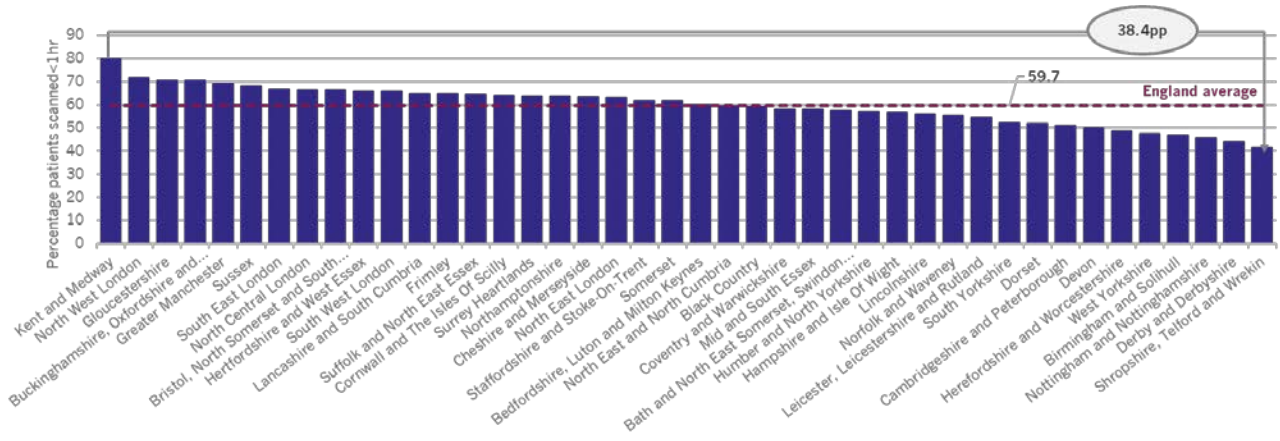
48. Unsurprisingly patient satisfaction has declined with longer waits. In 2010, 60 per cent of the public were very or quite satisfied with Accident and Emergency Services. This had declined to 54 per cent by 2019 and then fell sharply to just 30 per cent by 2022[142]. It remains at historically low levels.

49. Analysis by Age UK, submitted to the Investigation, found that there were more than a million admissions or readmissions to hospital per year from conditions that should not normally require hospital treatment. On any given day, over 2,000 people aged over 65 are admitted to hospital in an emergency for a condition that could have been treated earlier in the community or prevented altogether (such as a fall). Moreover, Age UK found that one-in-six emergency admissions of those aged over 75 were people that had been discharged from hospital within the previous 30 days.

50. Rapid access to treatment for cardiovascular conditions has deteriorated and varies dramatically across the country. For example, the 'call-to-balloon' time for higher risk STEMI heart attack patients in England, Wales and Northern Ireland has risen by 28 per cent from an average of 114 minutes in 2013-14 to 146 minutes in 2022-23[143]. The rise has the greatest impact on the 25 per cent of patients who are now waiting more than 130 minutes for this emergency procedure. Moreover, there is a more than two-fold difference between ICB areas: patients in Surrey are likely to receive the procedure in less than 90 minutes while those in Bedfordshire, Luton and Milton Keynes must wait around four hours[144].

51. There is a similar picture with stroke care. Rapid access to brain imaging is required when patients arrive in hospital to confirm stroke diagnosis and the right course of treatment. But the percentage of patients who receive the necessary brain scan within an hour of arrival at hospital is hugely variable. As the chart below shows, in Kent, 80 per cent of patients will receive that standard of care; while in Shropshire, only around 40 per cent will do so[145].

Figure III.8.6: Percentage of patients scanned within one hour of arrival, by ICB (England) / LHB (Wales) 2023/24

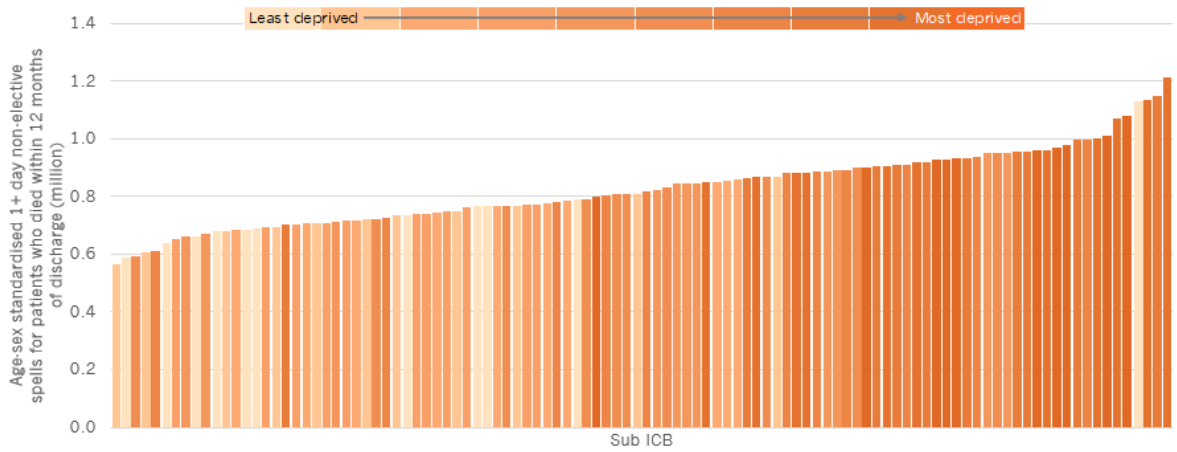


End of life care

52. Dignity, compassion and respect are important at the end of life. According to polling by YouGov commissioned by the charity Compassion in Dying and submitted to the investigation, 83 per cent of adults would prioritise quality of life over living longer in the last years of life[146]. As the Chief Medical Officer has said, better quality at the end of life may require "less medicine, not more"[147]. Yet as the Nuffield Trust has found, one in four people in the last year of life have three or more unplanned hospital admissions[148].

53. New analysis prepared for this report highlights some important disparities. People in the most deprived communities are far more likely to have multiple emergency admissions to hospital in the last year of their lives, as we can see in the chart below. There are likely to be complex reasons for this: people in poorer communities are more likely to die of treatable conditions; GP access is less good, so there are less likely to be end of life plans; and there may be cultural factors[149]. This should be examined more closely, especially in light of Compassion in Dying's findings that many bereaved people believe their loved ones had medical treatment they would not have wanted[150].

Figure III.10.3: Sub-ICB age-sex standardised rates of 1+ day non-elective spells in the last year of life, shaded by proportion of population living in more deprived areas



54. Many people express a preference to die at home. While there are major data limitations, analysis of those countries submitting data to the OECD found that the UK performs in the middle of the pack[151]. There may be lessons to be learned from the Netherlands' consistently low rates and from Ireland's steep reductions. Analysis of primary care data found that the proportion of people with a recorded preference increased substantially from just over 10 per cent in 2009 to nearly 50 per cent in 2019. Since then, it has plateaued[152]. Society needs to restart the conversation about how to die well: with dignity, compassion, and preferences respected.

Avoidable deaths

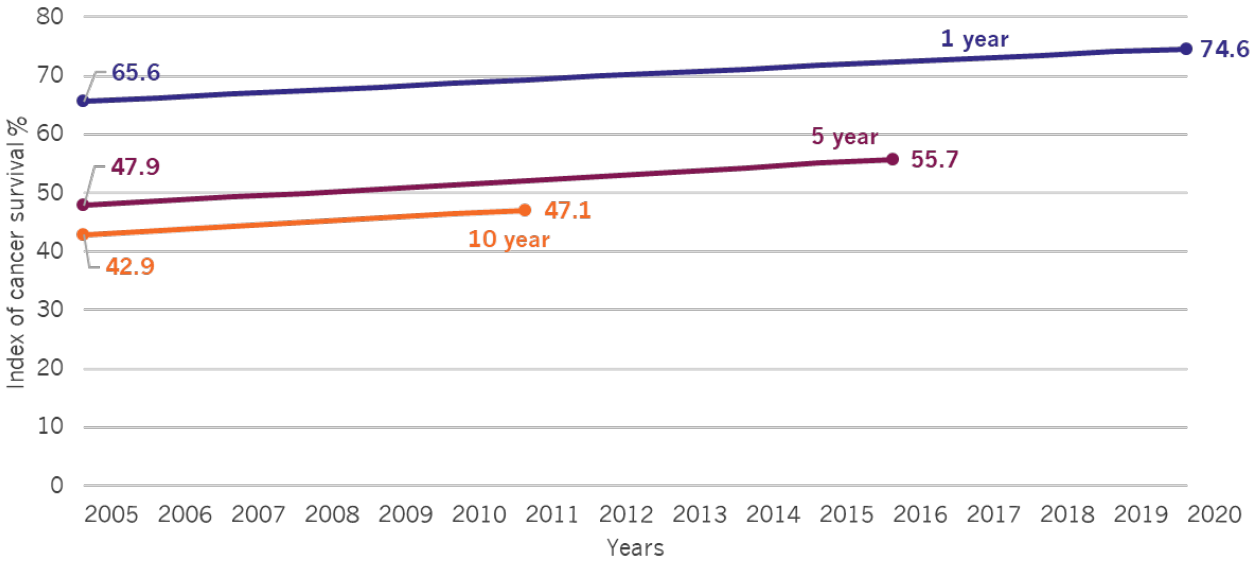
55. Far too many lives are lost to avoidable causes, meaning that they are either preventable or treatable. There is significant scope to improve the performance of the NHS and to save lives. Here, we examine three of the most significant areas: cancer, cardiovascular disease, and suicide.

Cancer

The number of cancer cases in England has risen at a rate of 1.7 per cent a year from 2001 to 2021. When standardised for age, it has still risen at 0.6 per cent annually[153]. The result is that there were around 96,000 more cases of cancer in 2019 than in 2001. While survival rates at 1-year, 5-year and 10-year have all

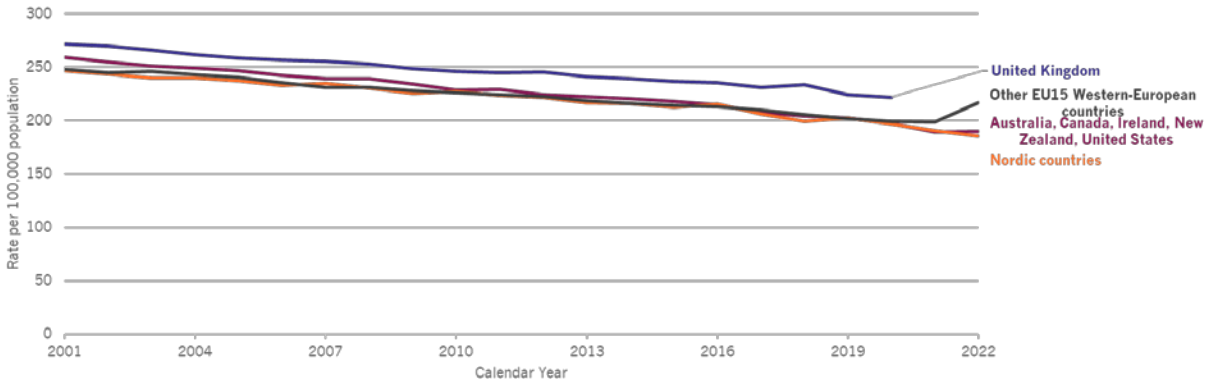
improved, the rate of improvement slowed substantially during the 2010s, as the chart below sets out[154]:

Figure III.12.2: Index of cancer survival by calendar year of diagnosis in England, Persons aged 15 to 99 years, diagnoses 2005 to 2020



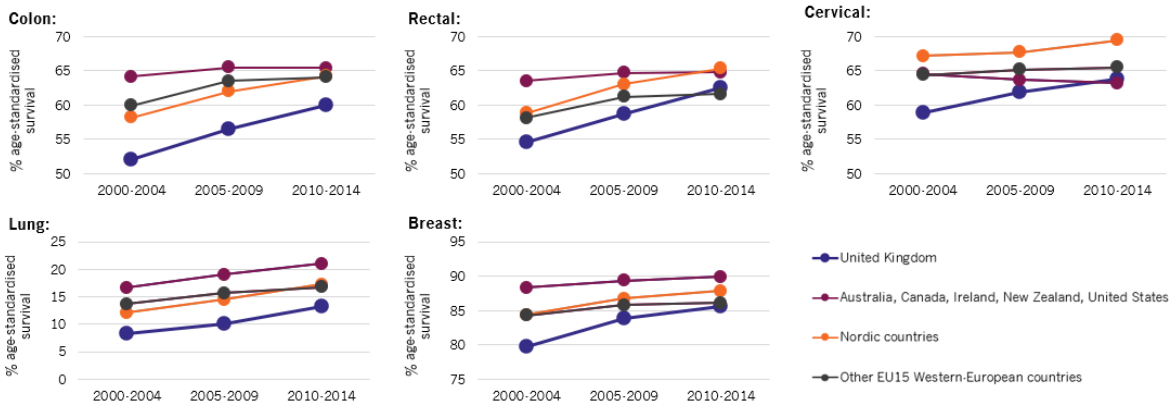
56. International comparisons of cancer mortality find that the UK has substantially higher rates than our European neighbours, Nordic countries, and countries that predominantly speak English (see chart below)[155].

Figure III.12.4: Standardised rate of malignant neoplasms deaths per 100,000 patients, 2001 to 2022 (or nearest year)



57. While cancer survival rates have improved more quickly than many peer countries, they have done so from a low base. This means that the UK is still behind the Nordic countries for all major cancers and behind other European countries and other predominantly English-speaking countries for three out of five cancer sites analysed, as the chart below shows[156]:

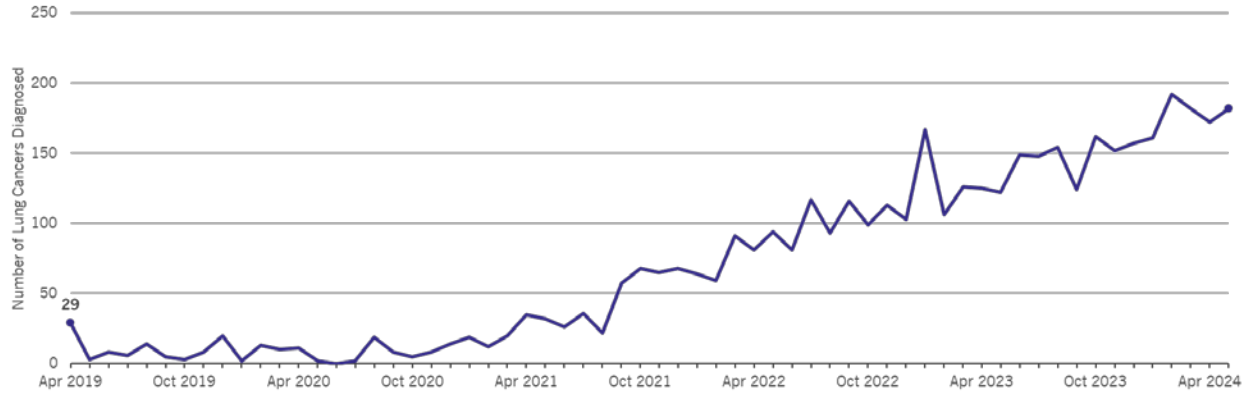
Figure III.12.5: % age-standardised five-year net cancer survival, 15 years and above, 2000 to 2014



58. The route to diagnosis has changed over time, in particular with the uptake of the urgent suspected cancer pathway. Important progress has been made in reducing the number of cancers diagnosed as result of an emergency presentation, with the proportion falling from nearly 25 per cent in 2006 to below 20 per cent in 2018 and 2019[157]. There are important inequalities, with the most deprived more likely to present as an emergency.

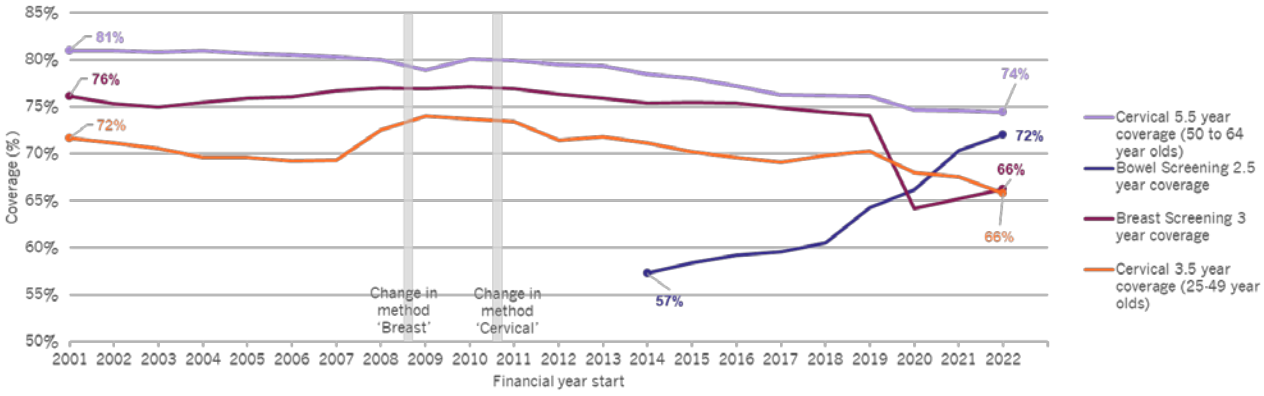
59. Early diagnosis is an important priority since it is associated with higher survival rates. Yet despite its importance, no progress whatsoever was made in diagnosing cancer at stage I and II between 2013 and 2021. Since then, there have been some signs of hope as rates of early-stage diagnosis have improved from around 54 per cent to 58 per cent in 2023[158]. This is likely to be in significant measure due to the Targeted Lung Health Check programme which has identified more than 4,000 cases of lung cancer since 2019, with 76.7 per cent at stage I or II[159]. This important success should be celebrated and the transferable lessons applied to other areas.

Figure III.12.11: The number of Lung Cancers Diagnosed each month through the TLHC Programme April 2019 – May 2024 (TLHC Management Information Return)



60. One contributor to the early diagnosis challenge may be declining participation in screening programmes. Screening coverage rates for breast and cervical screening have both been going in the wrong direction since around 2010, as the chart below shows[160]. Rates of bowel screening have increased at an impressive rate since the programme was started but still have further to go.

Figure III.1.10: National Cancer Screening Programmes Coverage (%) 2002 - 2023

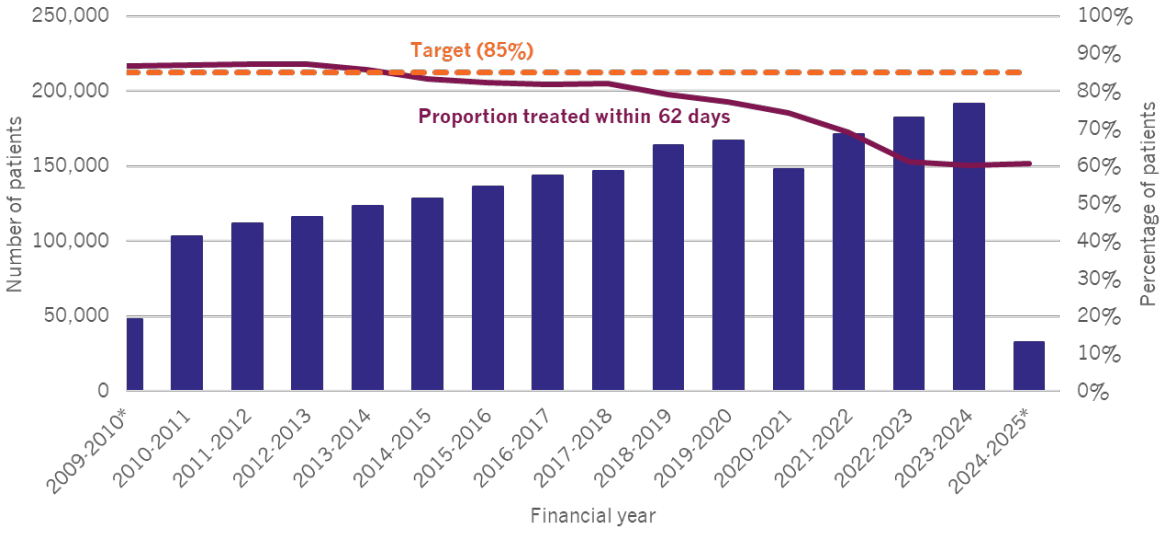


61. Treatments are becoming more sophisticated, but less timely. In 2024, more than 35,000 genomic tests are being completed each month. But the turnaround times are poor, with only around 60 per cent of test being performed to the agreed timeframes[161]. This can delay the start of treatment which often depends on the result. Genomic testing is routinely commissioned across 7000 rare diseases and 200 cancer indications. And the NHS is the first in the world to offer whole genome sequencing as part of routine care. However, there is more to do to ensure access for everyone who could benefit. Research shared with the investigation by the Tessa Jowell Brain Cancer Mission found that 72 per cent of UK neuro-oncology centres

were able to deliver whole genome sequencing to at least some of their patients but that no centre was able to offer it to all eligible patients. Moreover, the authors estimated that in 2023, on average, less than five per cent of eligible adult brain tumour patients were having whole genome sequencing through NHS commissioned pathways[162].

62. Waiting times for treatment have been deteriorating, too. As Cancer Research UK pointed out in their submission to the investigation, the 62-day target for referral to first definitive treatment for cancer has not been met since December 2015[163]. Since the pandemic, the backlog of long waiters has been prioritised, and partly as a result in May 2024, performance was just 65.8 per cent[164]. If the target had been met, around 5,200 additional patients would have been treated on time. Similarly, more than 30 per cent of patients are waiting longer than 31 days for radical radiotherapy[165].

Figure III.12.16: Number of patients receiving a first definitive treatment for cancer and proportion treated within 62 days, England (USCR routes only)



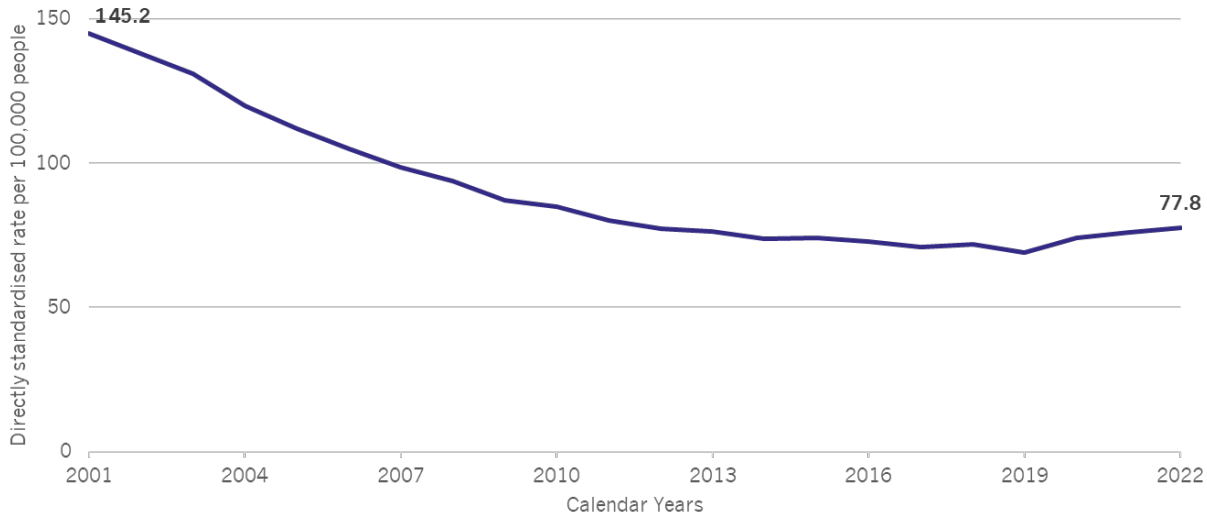
63. When it comes to systemic anti-cancer therapies, there continue to be significant disparities in how quickly patients are able to access new treatments. The time from approval by NICE to adoption of new cancer drugs such as alpelisib and fulvestrant varied from less than a month in nine provider trusts to more than a year in nine other organisations[166]. There is no excuse for such wide variation, which is fundamentally unfair to patients and goes against the principles of a universal service. Overall, the UK ranks ninth out of 37 OECD countries for the adoption of medicines.

Cardiovascular health

64. Cardiovascular disease remains a leading cause of death in England. Once adjusted for age, the cardiovascular disease mortality rate for people aged under 75 dropped significantly between 2001 and 2010. But improvements have stalled since then, and the mortality rate started rising again during the Covid-19 pandemic[167].

65. Cardiovascular disease is strongly linked to health inequalities. In 2022, people under the age of 75 living in the most deprived areas of England were more than twice as likely to die from heart disease than people living in the least deprived areas[168].

Figure III.13.1: Directly standardised mortality rate from all circulatory disease, persons under 75s, England, 2001 to 2022



66. Cardiac rehabilitation is a programme of exercise, education and psychological support that is proven to reduce hospital readmissions, deliver better outcomes and is cost effective. For patients who have experienced myocardial infarction (MI) and/or coronary revascularisation, attending and completing the exercise-based component of cardiac rehabilitation is associated with an absolute risk reduction in cardiovascular mortality from 10.4 per cent to 7.6 per cent when compared to those who do not participate, as well as a significant reduction in acute hospital admissions. Yet despite the compelling evidence, there is wide variation. In one ICB

area, more than 80 per cent of eligible patients participate, whereas in four ICBs, fewer than 20 per cent do so[169].

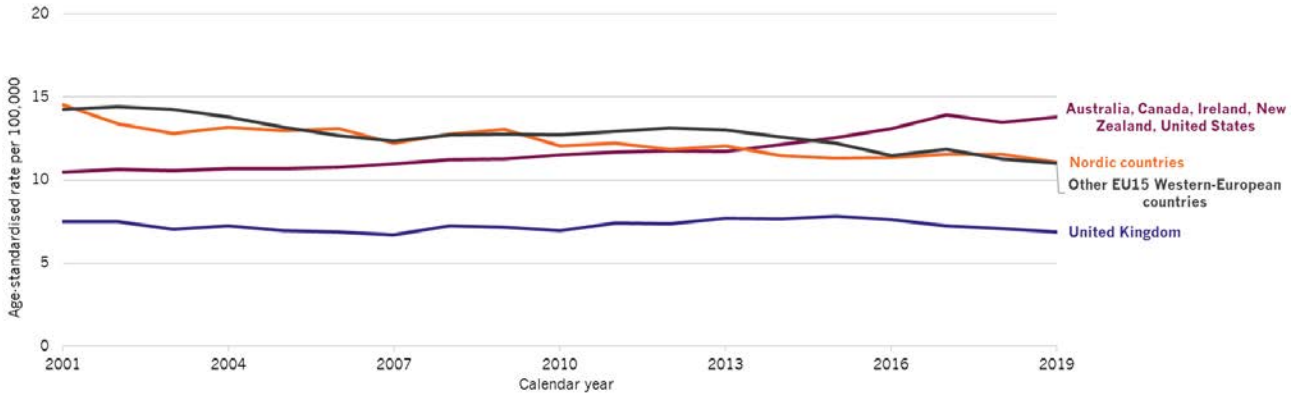
67. Lipid lowering therapies are an important tool in preventing cardiovascular disease. In March 2024, 62.1 per cent of people at high risk of cardiovascular disease were treated in this way (in line with the NHS Long Term Plan target of 60 per cent)[170]. There has also been good progress towards the objective to treat 95 per cent of people with cardiovascular disease with lipid lowering therapies, with 85.1 per cent receiving this treatment in March 2024[171].

> "We are extremely concerned that the significant progress made on heart disease and circulatory diseases (CVD) in the last 50 years is beginning to reverse. The number of people dying before the age of 75 in England from CVD has risen to the highest level in 14 years"
> *British Heart Foundation submission to the Investigation*

Suicide

68. Overall suicide rates in the UK are significantly below many other countries and relatively stable over time as shown below[172]. Analysis shows that while rates have been declining in European countries, they start from a much higher point, meaning that there is still a large gap between the UK and the EU15. Suicide rates in other predominantly English-speaking countries have steadily increased such that by 2019, they were nearly double those of the UK.

Figure III.14.1: Age-standardised suicide rates per 100,000 population, 2001 to 2019



69. While the suicide rate among adolescents aged 15 to 19 was 44 per cent below the OECD in 2019, there has been a worrying increase in suicides of young people[173]. There was a particularly large increase during the years running up to the pandemic, with the number of young women and girls (10-24) completing suicide rising 6.9 per

cent a year between 2015 and 2019, while the numbers of young men and boys increased by 3.2 per cent a year[174]. Suicide rates are now at their highest levels this century, and this is an area where close attention will need to be paid in the years ahead[175].

Figure III.14.4: CAGR change in suicide rates for males and females by age group, England, 2001 to 2021

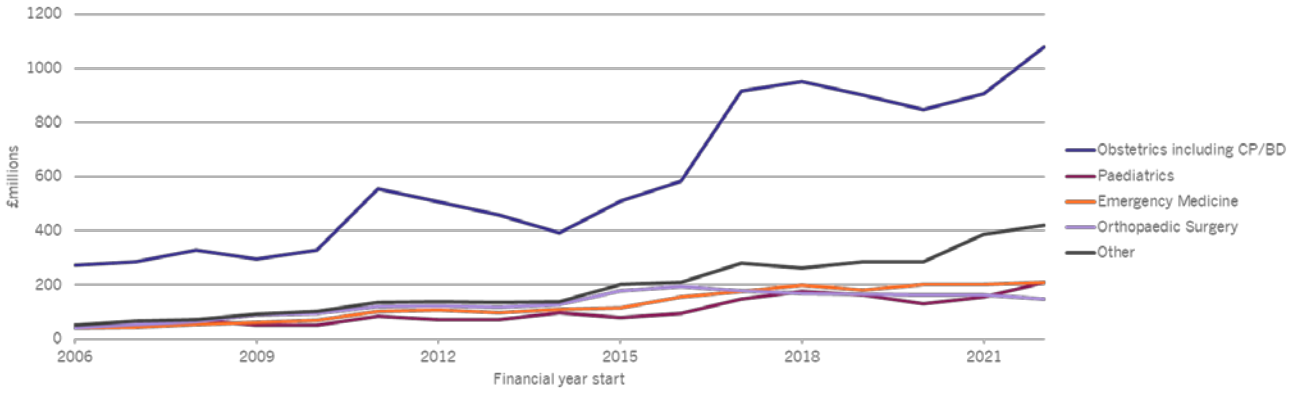
	10 to 24 years		25 to 44 years		45 to 44 years		65 years and over	
	Males	Females	Males	Females	Males	Females	Males	Females
2001-2005	-6.4%	0.9%	-1.5%	-0.1%	-1.1%	1.9%	-2.1%	-3.6%
2005-2010	-2.0%	-0.7%	-2.4%	-3.5%	0.8%	-2.7%	-2.8%	-2.8%
2010-2015	4.6%	1.9%	0.5%	1.2%	2.3%	2.8%	1.5%	3.4%
2015-2019	3.2%	6.9%	3.1%	4.2%	2.0%	-1.1%	-0.6%	-3.9%
2019-2022	-4.7%	2.6%	-0.4%	2.0%	-1.8%	0.5%	-0.1%	0.0%

Complaints and clinical negligence

70. The number of formal complaints raised about NHS services has changed over time as awareness of the complaints process has risen. But it is still striking that complaints have nearly doubled in a little over a decade, according to data shared with the Investigation by the Parliamentary and Health Service Ombudsman. As the highest level to which complaints about the NHS can be directed, they received 14,615 formal complaints in 2011-12, rising to 28,780 complaints by 2023-24[176].

71. As a Health Select Committee report points out[177], the NHS in England is an outlier in clinical negligence payments, devoting double the share of total health spending as New Zealand, ten times the level of Australia, and twenty times as much as Canada. In the year 2023/24, clinical negligence payments increased to £2.9 billion or 1.7 per cent of the entire NHS budget[178]. To put this in context, that amounts to more than the combined budget of every GP practice for the whole of the Midlands[179] serving more than 10 million people, and is the same as the NHS spending on 1.2 billion pathology tests each year. Aside from pensions and nuclear decommissioning, NHS clinical negligence claims are the largest liability on the Government's balance sheet[180].

Figure III.15.3: Cost of clinical negligence claims settled each year in clinical specialties with the highest costs of claims



72. As we can see from the chart above, while cost of claims has been rising across all specialties, they have risen much more quickly in obstetrics over the past two decades, amounting to around £1 billion in 2023-24[181].

* * *

73. On balance, the picture on quality of care is mixed. There are some notable improvements, such as the targeted lung check or the increase in specialist advice and virtual wards. But in too many areas, we have been going in the wrong direction. Complaints have doubled, and clinical negligence claims are at record levels. There is much work to be done if quality of care is to become the organising principle of the NHS once more.

4

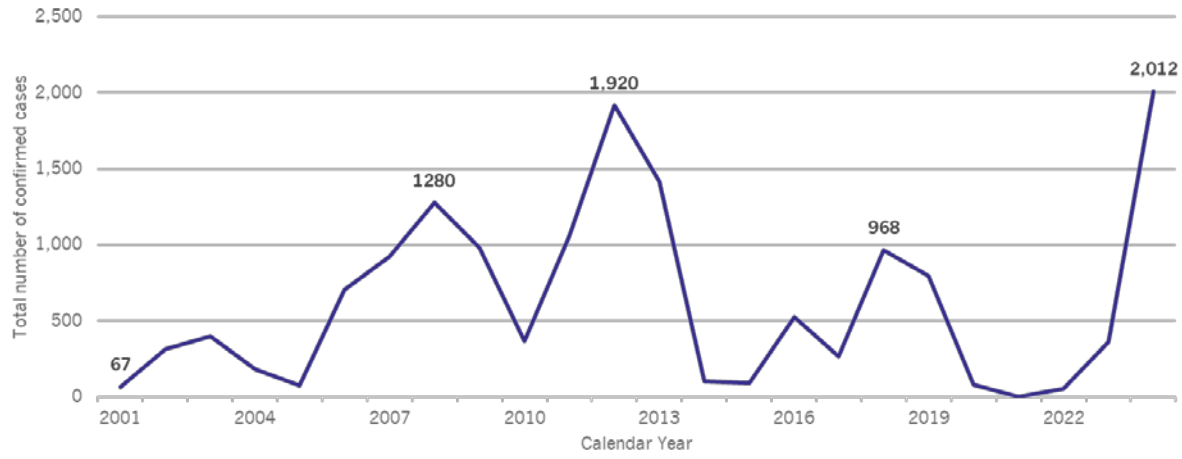
Health protection, promotion and inequalities

1. We now turn to three themes that cut across all aspects of the NHS. How well our health is protected from infectious disease in the wake of the pandemic, how effectively good health is promoted, and the inequalities experienced by people in health and care services.

Health protection

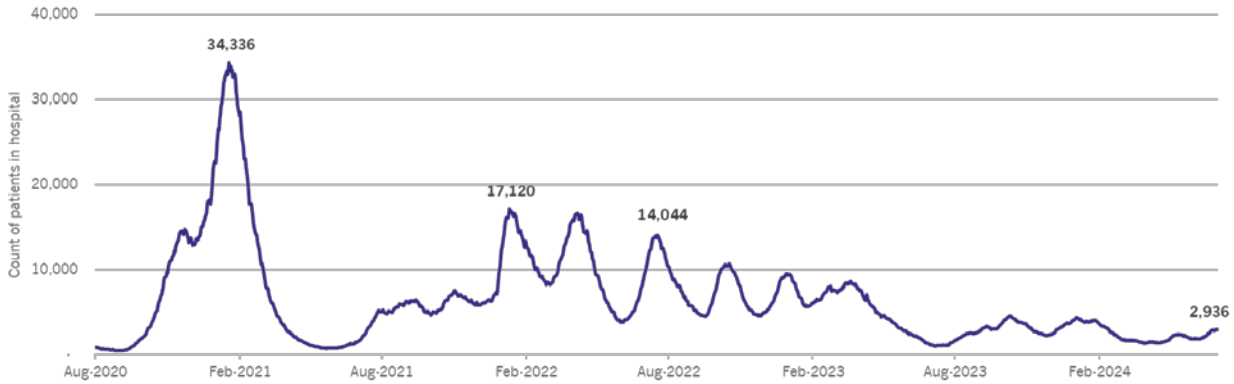
2. In the wake of the Covid-19 pandemic, it is apparent that infectious diseases remain a major challenge for all health systems. Well known infectious diseases could be on the rise as vaccination rates fall: measles cases in 2024 have been the highest this century as shown below[182]. It is too early to tell if this is a temporary spike like in 2012, or a new sustained level.

Figure III.6.5: Confirmed cases of measles in England, 2001 to 2024



3. Covid-19 remains an ongoing challenge for the NHS. While it has receded from public discussion, it continues to affect significant numbers of people. In the summer 2024 wave, Covid-19 has caused around 200 deaths per week between mid-July and mid-August[183]. There will continue to be patients who require hospital care and there may be periodic spikes as illustrated in this chart[184].

Figure III.6.1: Daily count of confirmed COVID-19 patients in hospital at 8am, England, August 2020 to June 2024



4. The Covid-19 pandemic had a very significant negative impact on the NHS and health outcomes, as is evident throughout this report and explored further in Chapter 8. However, there were some benefits of the public health interventions from the pandemic, including emphasising the importance of flu vaccinations (seasonal flu vaccination rates did increase during the pandemic for 65+ year olds and remain above pre-pandemic levels)[185]. Social distancing, meanwhile, contributed to rates of sexually transmitted disease falling and these have remained below pre-pandemic levels[186].

5. A looming threat is Anti-Microbial Resistance (AMR), which by 2050 could kill 10 million people globally every year—that is more than cancer[187]. AMR occurs where microbes are becoming resistant to the drugs meant to kill them and is particularly a challenge for keeping antibiotics working. Thanks to the championing of Dame Sally Davies, the UK Special Envoy on Antimicrobial Resistance, this country has been leading the way in tackling AMR and this year published a new five year action plan[188]. The Fleming Initiative, which I chair, looks to share solutions globally, often drawing from UK success—including the forthcoming centenary of Fleming's world-changing discovery[189]. Yet there is still more the UK needs to do to decrease inappropriate antibiotic usage and accelerate the development of new diagnostics and drugs.

Health Promotion

6. It is apparent that where bold action has been taken, health has improved. This is notably the case for smoking where a succession of interventions have driven smoking rates down[190], with consequential positive impacts on cardiovascular disease and cancer incidence and survival.

7. In contrast, bold action has been sorely lacking on obesity and regulation of the food industry. This means that childhood obesity rates for 10-11 year olds have risen[191] and inactivity rates in adults have remained constant[192]. As we have seen, the prevalence of diabetes has increased from 5.1 per cent prevalence in 2008 to 7.5 per cent in 2022 as a result of this inaction[193]. Similarly, when tough action was taken on the harm caused by alcohol, deaths attributed to it stabilised. As the chart below shows, alcohol is becoming more affordable over time, and deaths are rising at an alarming rate. In the pandemic, there was an 10.8 per cent annual increase between 2019 and 2022[194]:

Figure III.1.3A: Age-standardised alcohol-specific mortality rate per 100,000 in the United Kingdom, 2001 to 2022

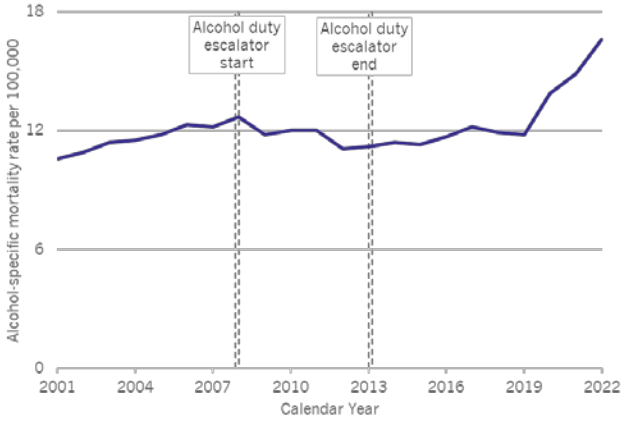
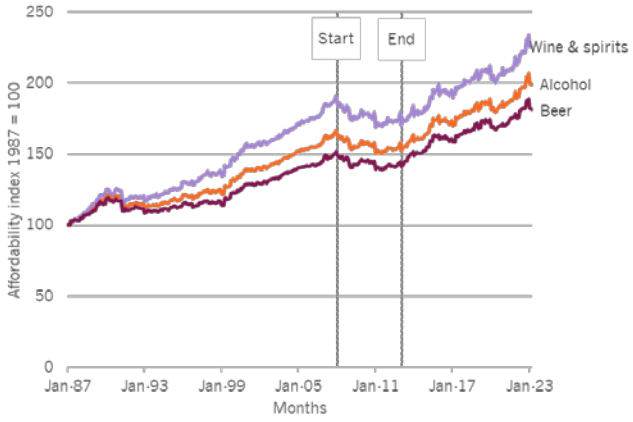
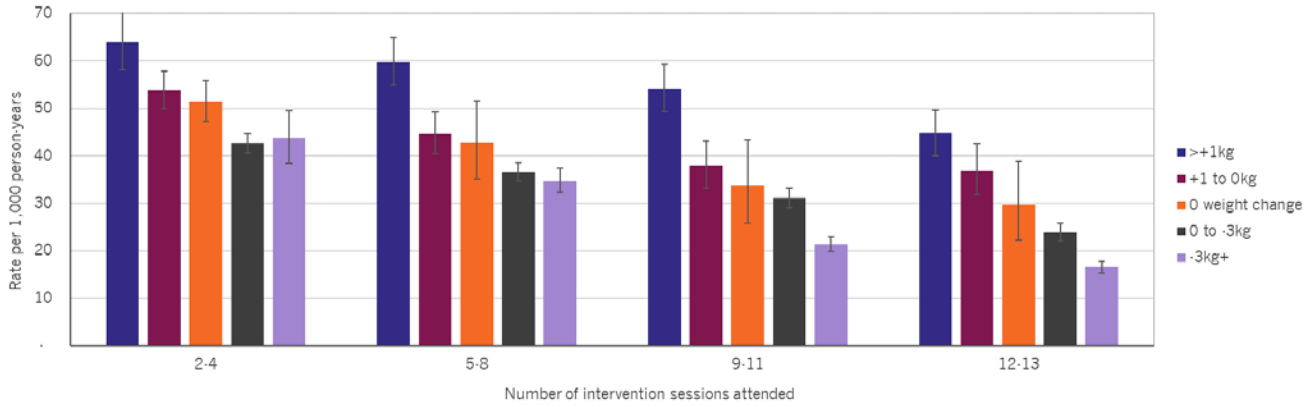


Figure III.1.3B: Alcohol affordability in the United Kingdom, January 1987 to March 2023



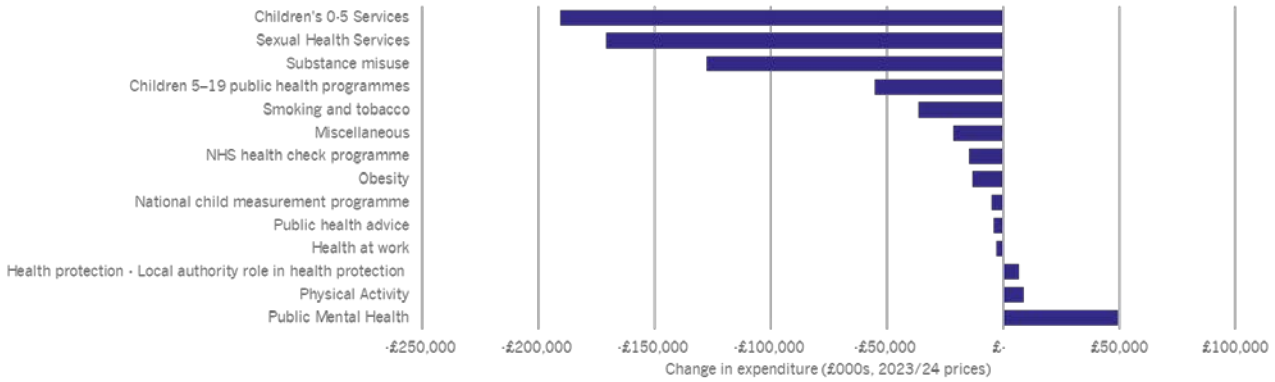
8. Everybody knows that prevention is better than cure. Interventions that protect health tend to be far less costly than dealing with the consequences of illness. Take the NHS-funded Diabetes Prevention Programme which reduces the risk for type II diabetes by nearly 40 per cent[195]. Given the potential power of preventative interventions, it is perverse that the public health grant to local authorities has been cut so substantially. Analysis from the Health Foundation shows that the public health grant was cut by more than a quarter between 2015-16 and this year[196]. Moreover, cuts to public health allocations have tended to be greater in cash terms in more deprived areas.

Figure III.7.6: Incidence of type 2 diabetes between April 2018 and March 2023 for individuals referred to the NHS DPP



9. The consequences are felt by individuals and families across the country in a reduction in the services that are offered to them. Spending on NHS health checks, for example, has dropped by £15 million[197]; participation rates in the programme have fallen by 20 per cent[198]. The £171 million reduction in sexual health services spending[199] comes at a time when there are concerns about the rise in cases of mpox[200]. It is particularly saddening to see the £191 million cuts to services for young children[201].

Figure III.1.8: Change in reported local authority spend on public health services from 2016/17 to 2022/23, 2023/24 prices



10. People in the most deprived areas die much earlier on average; this is well recognised and deeply entrenched[202]. It is preventable. It is often assumed that if we reduce premature mortality, we will extend the period in ill health. But this is wrong. Those in less deprived areas live substantially less time in ill health as well as having longer lives[203]. Prevention which reduces premature mortality leads to less time spent in ill health.

11. There is extraordinary power in getting public health right. We can reduce premature mortality, reduce social disparities, and reduce the absolute time in ill health. This

in turn reduces the burden on the NHS and social care while enabling us to be more productive in our working lives so strengthening the economy. This is the desired outcome for individuals, families, the public purse. But it takes the political will and willingness to invest to achieve it, with the skills to successfully engage the public.

Inequalities in health and care

12. The impact of the deterioration in access and the challenges around quality of care have not been felt equally. As we have seen, there are important disparities in almost all aspects of care. The 'inverse care law' seems to apply: that those in greatest need tend to have the poorest access to care[204]. In this section, we draw from the expertise of a number of charities and campaigners who have informed this report.

The impact of poverty

13. In their submission to the Investigation, the Joseph Rowntree Foundation (JRF) pointed out that people living in poverty are getting sicker and accessing services later. For the most deprived groups, A&E attendances are nearly twice as high and emergency admissions 68 per cent higher that the least deprived. People who live in the most deprived areas of England are twice as likely to wait more than a year for non-urgent treatment. In 2021 the undiagnosed diabetes rate was double for those in the bottom Indexed of Multiple Deprivation (IMD) quintile compared to the top.

14. A recent JRF survey found that of those in the bottom income quintile whose health has been negatively impacted by the cost-of-living crisis, only 33 per cent had accessed mental health services, and 39 per cent physical health services[205]. This presents a challenge for the NHS in finding those with an unmet need for healthcare.

15. Greater illness and poorer access to care contribute to worse health outcomes[206]. The result is that the mortality rate in the lowest Index of Multiple Deprivation (IMD) decile is almost double that of the highest[207]. Analysis by the JRF and The King's Fund described the impact of deprivation on mental health: in the poorest communities, the depression rate was twice as high, double the number of people were in contact with mental health services, and nearly four times as many were sectioned under the mental health act[208] as in the least deprived. There are similar findings for bowel cancer, where fewer people take part in screening at 64 per cent

for the most deprived compared to 75 per cent for the least deprived, diagnoses are 36 per cent lower, and the mortality rate is 25 per cent higher[209].

Homelessness is a health catastrophe

16. Between 2010 and 2023, the number of people in temporary accommodation doubled from around 90,000 to 180,000[210]. In the same time period, the number of people sleeping rough more than doubled from 1,768 to 3,898 (although this was down from a pre-pandemic peak of 4,751 in 2017)[211].

17. People experiencing homelessness are far more likely to have asthma or other breathing problems, heart disease, or epilepsy[212]. A study of homeless hospital inpatients found that 64 per cent had three or more physical health co-morbidities, while a survey of people experiencing homelessness found that 82 per cent had a mental health diagnosis[213]. Poor health can precipitate homelessness and homelessness creates poor health[214].

18. According to a submission to the Investigation from Pathway's Lived Experience Programme, people facing homelessness do not receive the same level of care as those who have a safe place to call home. They experience stigma and discrimination as negative social attitudes in society are also present in the NHS. The result is that services are harder to access than they should be.

19. A survey of Faculty for Homeless and Inclusion Health members found health services are very difficult for inclusion health patients to access. Given the population's high rates of mental health need, difficulties accessing mental health services are of pressing concern, which respondents felt was due to poor service accessibility, digital exclusion, and stigma[215]. In primary care, lack of identity documents or proof of address is a major problem. Indeed, a mystery shopper exercise found that only 31 per cent of people with no ID/address were able to register with a GP, despite this not being a legal requirement[216].

20. The result of poor access to primary and community care is a costly overreliance on urgent and emergency care: people experiencing homelessness attend A&E four times as often as the general population and are eight times as likely to need inpatient care[217].

21. The outcomes are tragic. According to the ONS, the average age of death for homeless men was 45 years and for women it was 43 years[218]. There were seven times as many deaths of men as of women. As of 2021, the death rate had increased in every region of England since 2013.

Disparities by ethnicity

22. Data from the NHS Race and Health Observatory that was submitted to the investigation finds widespread disparities[219]. Minority ethnic groups, particularly Asian people, experienced disproportionally longer waits for elective care after the pandemic than those from white backgrounds. Asian people experienced an 8 per cent overall fall relative to White groups in elective procedure rates—with this as high as 23 per cent in therapeutic cardiac appointments[220]. Black people also experienced a large drop in some areas, with a 19 per cent drop in cataracts procedures relative to the white population[221].

23. Similarly, in mental health, people from minority ethnic groups experienced worse outcomes; waited longer for assessment; and were less likely to receive a course of treatment following assessment in the NHS Talking Therapies Programme[222]. There is a substantial evidence base that shows that people from minority backgrounds are more likely to be sectioned under the Mental Health Act. Indeed, as the RCPsych point out, in the latest annual data for 2022-23, the standardised rate of detention under the Mental Health Act for Black or Black British people was more than 3.5 times higher than the rate for White people[223]. As Mind described in their submission to the Investigation, black people are more than ten times as likely as white people to be subject to a community treatment order, where they can be recalled to hospital if they do not comply with treatment protocols[224].

24. Analysis from the NHS Race and Health Observatory, set out in the chart below, finds that the median age at death was 62 years for people from white backgrounds, whereas it was 40 years for Black people, 33 years for Asian people, and just 30 years for those from a mixed background[225]. It is vitally important that the reasons for this are better understood so that these extraordinary differences can be addressed.

People with learning disabilities

25. There are particularly severe disparities in learning disabilities. According to a submission from Mencap to the Investigation, only four-in-10 people with a learning disability will live to see their 65th birthday[226]. People with a learning disability are twice as likely to die from preventable causes[227] and four times as likely to die from treatable causes[228]—with areas such as respiratory care and cancer care of

particular concern. There are multiple barriers that prevent people with learning disabilities from accessing the care that they need.

26. There are important variations in access to care. Around three-quarters of people with a learning disability are not on the GP learning disability register[229]. Mencap points out that there is no target for registration but that there is a target to provide health checks for 75 per cent of those on it. This may be disincentivising adding people to the register.

27. More than 2,000 people with severe learning disabilities and/or autism continue to be detained in inpatient mental health settings. The 2024-25 NHS Planning Guidance re-states the target to reduce inpatient numbers by 50 per cent, but this is in the context of failure to meet 2014, 2019, 2020 and 2024 targets. Current estimates suggest that it may not be achieved until 2030—and Mencap believes it will be later than that[230].

Carers

28. In 2024, 4.7 million people were unpaid carers in England, 1.4 million of whom provided more than 50 hours of care each week[231]. Nearly 60 per cent of carers are women, and the largest group are in their late 50s[232]. There are more very elderly carers, including 6.3 per cent of women aged over 85 and 2.9 per cent of women aged over 90[233]. Many carers struggle with their own health, with 28 per cent having a disability and 7 per cent reporting that their health was bad or very bad, according to Carers UK. One-third of all NHS staff are carers themselves[234].

29. The *State of Caring 2023* report by Carers UK found that 30 per cent of carers who were waiting for hospital treatment or assessment for themselves, had been waiting for over a year. More than 40 per cent said they needed more support from the NHS, while 60 per cent said they were not involved in hospital discharge[235]. In particular, carers were often not asked about either their willingness or ability to care. A striking 14 per cent said they had accompanied the person they cared for to hospital appointments more than 20 times in the previous 12 months[236].

30. Carers UK points out that all too often, unpaid carers do not receive the recognition and support that they need and deserve from the NHS. Instead, they feel invisible, misunderstood and unsupported despite their huge contribution. A fresh approach is needed which regards unpaid carers both as people with their own needs where caring is a significant factor in their lives, but also as a provider of care who should be treated as an equal partner. The current paradigm leads to poorer outcomes for

people needing care, for carers, and for the health service. A different approach is needed.

5

Where and how the money is spent

1. In this chapter, we explore where and how the NHS has sought to spend its budget. This is both an aspect of NHS performance, and a driver of it. We look at its major priorities—providing care that is more joined-up and delivered in the communities where people live—and how and whether resources are distributed to match. From there, we provide a high-level examination of the resources and productivity in each of the different main settings of care: general practice, community services, mental health, and acute hospitals.

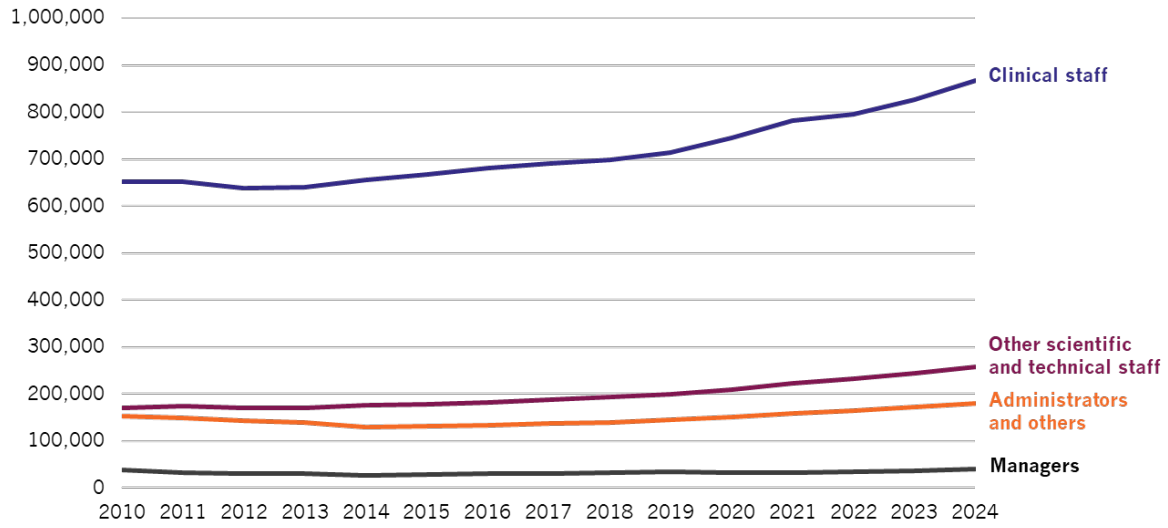
2. At the highest level, the NHS has had the strategic intention to shift spending from reactive care in hospitals to more proactive care in the community setting – but care has in fact moved in the other direction. Hospitals have attracted a greater share of NHS spending, meaning that other settings have received a smaller share. Accordingly, there has been a significant boost in hospital-based staff[237].

3. Regrettably, productivity in the NHS has all-too-often become associated with simply spending less or working harder. Neither is correct. Narrowly, productivity is the output, in terms of quantity and quality, produced relative to input. What it is really about is how much healthcare value can be created with the resources available. This encompasses everything from detecting disease earlier so that it is more amenable to treatment, embracing new innovations at the frontiers of scientific possibility, through to making care more planned and more consistent. It means using healthcare resources to provide the highest quality care, at the right time, and in the right place. Above all, it means using the full talents of NHS staff to help patients to get better outcomes. Not only is it possible to be smarter, not to just work faster, it is better for patients' outcomes and experiences and for staff and their enjoyment of work.

The big picture: workforce and productivity

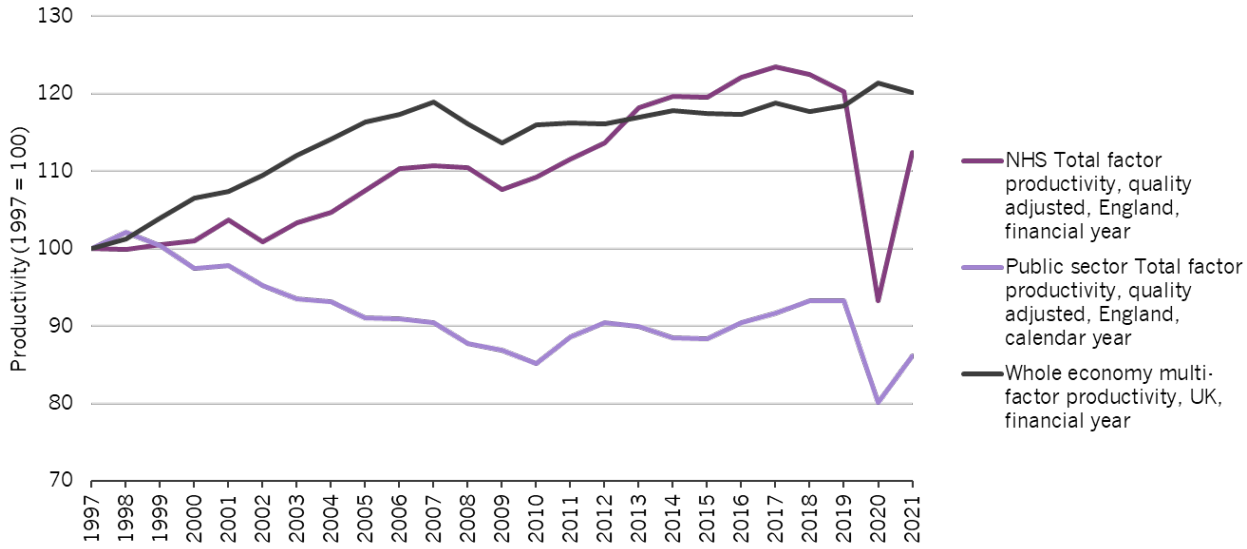
4. Overall staff numbers increased gradually during the 2010s, in line with the slow-down in funding increases over the same period[238]. Staff numbers have since increased more rapidly, as funding has risen[239], as we can see in the chart below[240]. Between 2022 and 2024, the rate of clinical staff growth has been 4.5 per cent compared to just 0.7 per cent between 2010 and 2016 and 3.3 per cent a year during the pandemic years from 2020 to 2022[241]. Other scientific and technical staff (who support clinicians) have increased at more than 5 per cent a year since 2020[242]. The number of managers fell at an annual rate of 4 per cent in the first half of the 2010s, and from that lower base, it has since grown again, rising at 5.8 per cent a year in the past two years[243].

Figure VIII.2.1: Hospital and Community Health Services (HCHS) staff by staff group, in NHS Trusts and other core organisations, March 2010 to 2024



5. During the 2010s, NHS productivity increased more quickly than the wider public sector and in a number of years it rose faster than the economy as a whole. But there was a deep drop in NHS productivity during the pandemic, when NHS productivity declined far more significantly than the economy as a whole or the wider public sector, as the chart below shows. It still remains below its 2019 level[244].

Figure VIII.2.3: Total factor productivity level for the NHS in England, wider public sector in England and the whole UK economy



6. Understanding productivity requires us to look at both where and how resources are spent. We now turn to where the resources the NHS receives are spent and the NHS's main strategic imperatives. From there, we examine how well they are spent in each of the main settings of care.

Changes in the population and strategic priorities for service change in the NHS

7. The fundamental driver of change in healthcare provision is change in the needs of the population. As we saw in chapter one, as people age, they tend to have more long-term conditions such as diabetes, breathing difficulties, or heart failure. There is a strong evidence base about what interventions help people to manage their conditions and to maintain their independence. This means that care can and should be more planned – such as the eight care processes for diabetes that were described in chapter three – and typically requires a multidisciplinary team of professionals to provide it.

8. To respond to this change in the needs of the population, the NHS has embraced two main strategic ideas, in common with many international health systems. The first is that care should be more joined up, or more "integrated". This is to reflect the fact the people living with long-term conditions need the help of a variety of different physical and mental health professionals and often rely on social care too. The frequency of their interactions with the health service mean that their care is more complex and therefore requires coordination. This is particularly true for people with two or more conditions (whose prevalence is growing over 6 per cent

annually), who may require care from different specialists and the expertise of GPs and others to understand the interactions between their conditions, treatments, and medicines. Since healthcare is organised around groups of professionals with similar skills (such as GP practices, mental health or community trusts, and hospitals), it requires organisations to work well together.

9. The second idea is that care should be delivered in the community, closer to where people live and work, and that hospitals should be reserved for specialist care. This is more convenient for patients – especially for those with long-term conditions who will need contact with the NHS more frequently. It builds on the fact that General Practice is how most people commonly interact with the health service and GPs' expertise as generalists. Indeed, research by the NHS Confederation has demonstrated that spending in primary and community settings had a superior return on investment when compared with acute hospital services[245]. It therefore makes sense that this should be the fundamental strategic shift that the NHS aspires to make.

10. The problem is that to provide high-quality, multidisciplinary care in the community requires resources that often are not there. These include the right professionals with the right skills—and the modern facilities, digital infrastructure, and diagnostics to support them. Over time, then, there must be a shift in the distribution of resources towards community-based primary, community and mental health services. Research from the NHS Confederation found that, on average, systems that invested more in community care saw 15 per cent lower non-elective admission rates and 10 per cent lower ambulance conveyance rates together with lower average activity for elective admissions and A&E attendances[246].

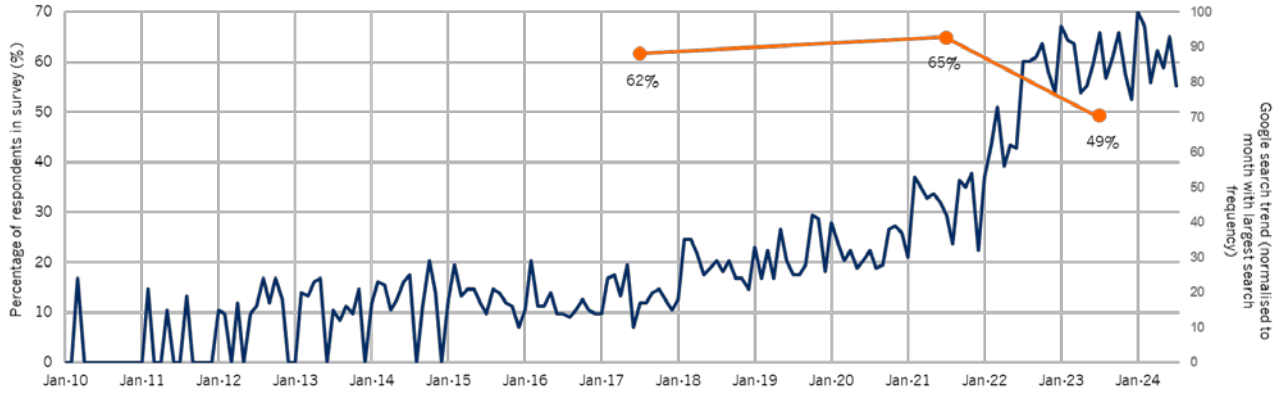
11. In the NHS, this goal of rebalancing care towards the community is sometimes described as the "left shift". Since at least the *Our Health, Our Care, Our Say* White Paper of 2006, and arguably before, the NHS has been committed to this change in the pattern of services. Similarly, pilots of integrated care were well underway in 2010, the 2014 Five Year Forward View described the NHS' commitment to integrated care, and integrated care systems have existed in one form or another since at least 2016. And integrated care boards and integrated care partnerships have been on a statutory footing since 2022.

12. So, if integrated care and the "left shift" have been the core of the NHS's service strategy, how far has the NHS progressed towards them?

Integrated care

13. While we heard—and indeed, saw—various examples of brilliant integrated care around the country, there has not yet been a systematic shift at scale. Indeed, the more the NHS has talked about integration, the less satisfied patients have become with the coordination of their care[247], as the analysis below shows:

Figure VIII.1.3: Google Trends for 'NHS integrated care' compared patient responses to "How often does your regular doctor or someone in your doctor's practice help coordinate or arrange the care you receive from other doctors and places?" (% of respondents 'always' and 'often')



14. There are three essential steps for delivery of integrated care[248]. First, it requires an understanding of the population and their needs using integrated datasets. Second, it requires the creation of multidisciplinary teams of health and care professionals. Third, it requires the whole team to work to a shared care plan that is developed in partnership with individuals and their carers and families and includes preventative interventions to keep people well.

15. If there are not population insights, multidisciplinary teams, and shared care plans, then integrated care is not happening. Where new multidisciplinary teams have formed, for example, around primary care networks, they report significant positive impact. The proportion of people with long-term conditions that report having an agreed a care plan with a health or care professional has been stuck at about 60 per cent from 2018 to 2023 (indeed, it slightly declined over the period). So, there is still much further to go.

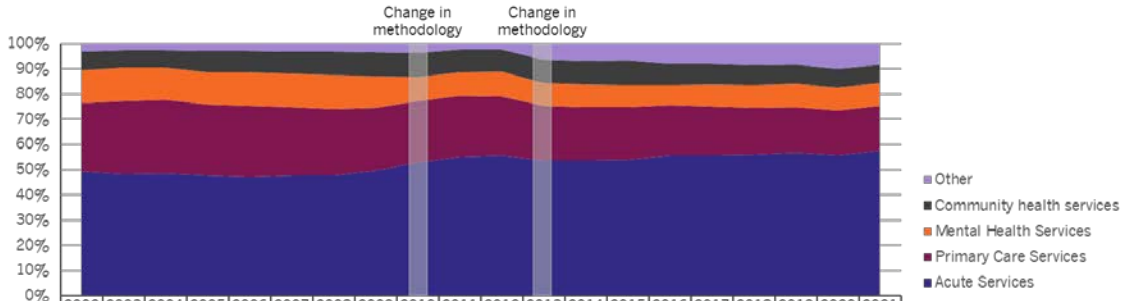
The "left shift"

16. So how far has the NHS come in meeting its stated strategy to shift care closer to home? As the chart below shows, since the NHS stated its intention to move care closer to home in the 2006 white paper, spending has drifted towards the acute hospital sector. The data suggests that this happened in broadly three phases: between 2002 and 2009, it was fairly stable changing from 49 per cent to 50 per

cent from beginning to end. It then rose to 53 per cent in 2010 and stood at 56 per cent by 2012. It then remained relatively stable, hovering between 54 and 56 per cent, before rising again during the pandemic years.

17. The overall result is that since the 2006 commitment to shift care towards the community, the share of NHS spending on hospitals increased from 47 per cent to 58 per cent in 2021 (the most recent year of data available)[249]. The "left shift" could, in fact, be characterised as a "right drift", when the whole period is examined. This means that the NHS has implemented the inverse of its stated strategy. Moreover, it is notable that the biggest rises occurred when the NHS's commissioning structure was at its most distracted: from the publication of the *Liberating the NHS* white paper in 2010 and the passing of the Health and Social Care Act of 2012. It seems unlikely that this is merely a coincidence.

Figure VIII.1.1: Estimation of NHS group spend by healthcare service



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Other	3%	3%	2%	3%	3%	3%	3%	3%	4%	2%	2%	6%	7%	7%	8%	8%	8%	8%	10%	8%
Community health services	7%	7%	7%	8%	9%	9%	9%	10%	10%	9%	9%	9%	9%	10%	8%	8%	8%	8%	8%	7%
Mental Health Services	13%	13%	13%	13%	13%	14%	14%	13%	10%	9%	10%	9%	9%	9%	8%	9%	9%	9%	9%	9%
Primary Care Services	27%	29%	29%	28%	28%	27%	26%	25%	24%	24%	24%	22%	21%	21%	20%	19%	19%	18%	18%	18%
Acute Services	49%	48%	49%	48%	47%	48%	48%	50%	53%	55%	56%	54%	54%	54%	56%	56%	56%	57%	56%	58%

18. In 2011, the Coalition Government published its mental health strategy, *No health without mental health*, in which it stated "we are clear that we expect parity of esteem between mental and physical health services"[250]. Yet in the year of publication, the number of mental health nurses fell and would continue to fall for each of the following five years[251]. The 2023 National Audit Office report *Progress in improving mental health services in England*[252] omits this vital context by only examining what had happened from 2016-17 to 2022-23.

19. Since 2016, the NHS has applied the "mental health investment standard". This important intervention has helped by protecting mental health budgets and so keeping it share of NHS spending constant at 9 per cent[253]. This has enabled much of the mental health capacity that was cut in the first part of the 2010s to be rebuilt. Nonetheless, it took until 2023 for the number of mental health nurses to return to their 2009 levels[254], while both prevalence and referrals rose steadily throughout the

period. The result is a much larger treatment gap for mental health than for physical health[255], while people with severe mental illnesses die nearly two decades earlier than others in society and the gap is widening[256].

20. There is no question that rebalancing healthcare resources is complex and challenging. But the "right drift" is not an accidental outcome. It is the result of financial flows that have funded hospitals for their activity and much of the rest of the NHS for their efforts. It was the choice of successive governments to exclude primary care, mental health and community services waiting times from NHS constitutional standards, which are instead focus on hospital care. This has been reinforced by the failure to invest in the measurement of primary, community and mental health services, which has obscured the real consequences of cuts to block budgets.

21. Changing both the distribution of resources and the operating model to deliver integrated, preventative care closer to home will be strategic priorities of the NHS in the future because they are derived from the changing needs of the population. Getting them right requires as strong a focus on strategy as much as performance; to invest in the quality and capacity of management as well as clinicians; and on the skills and capabilities to commission care wisely as much as to provide it well.

22. So, if there has been limited progress on integrated care and the left shift of resources has drifted in the opposite direction, why is that? What has been the focus and the challenges for integrated care boards?

Where have ICBs focused

23. As the NHS has made this move to formalise integrated care systems, it has invested significant effort in forming new collaborations between NHS organisations. Collaboration and integration are often conflated, but they are not the same. Service or clinical integration[257] is about a fundamental change in the way health services are organised for patients rather than the degree to which NHS organisations cooperate with one another as institutions.

24. NHS organisations are certainly working more collaboratively together now than in the past, with many formally joining group or collaborative structures[258]. We can see this in the increasing consolidation of NHS providers over time. This allows for scale economies to be captured and to concentrate managerial talent on solving difficult problems once rather than many times over. But the benefits of ever larger provider trusts for frontline patient care are yet to be proven, and there is a risk that

underlying performance is obscured in averages, while the distance from board to ward may become too great.

25. Collaboratives should be a means to deliver more integrated care and to spread good practice that raises the quality and consistency of care—but it is not obvious that this is the case. Simplifying governance from the top-down and capturing scale benefits are not good enough reasons in themselves. If collaboratives prove unable to change the way care is delivered, then there is a real risk that they amount to displacement activity from the strategic priorities of delivering integrated, preventative care closer to home.

26. Part of the challenge for ICBs comes from their conception. The Health and Care Act 2022 put integrated care systems on to a statutory footing, establishing integrated care boards and integrated care partnerships, and set out their four aims in legislation. The NHS Confederation's most recent *State of the ICSs*[259] report describes how local ICSs have found it challenging to fulfil their aims on population health and on the wider contribution to social and economic development. In the call for evidence, we heard conflicting accounts of the definition of population health and the ways in which Integrated Care Boards interpret their duty to improve it. NHS England has aimed not to be prescriptive in the way in which ICBs have formed and how they fulfil their aims. Including "integrated care" in the title of organisations does not make it thus.

27. Some ICBs interpret their population health duties as requiring them to act upstream of healthcare needs on the social determinants of health, where the NHS has few direct levers[260]. Other ICBs interpret their population health duties as requiring them to understand and adjust healthcare services to match the needs of the population that they serve, in line with the NHS Operating Framework[261]. Some interpret it as both and others as neither, preferring to focus on what they see as their "traditional" role of performance managing providers. The roles and responsibilities of ICBs need to be clarified.

28. Having examined the distribution of resources and the integration of care, we now turn to the productivity of services in the main care settings. We examine each of general practice, community services, mental health services, and acute services in turn. Given the short time frame for this investigation and the lack of readily accessible data, we have not examined productivity in dentistry, community pharmacy, ambulances or NHS 111.

Resources and productivity of services by setting

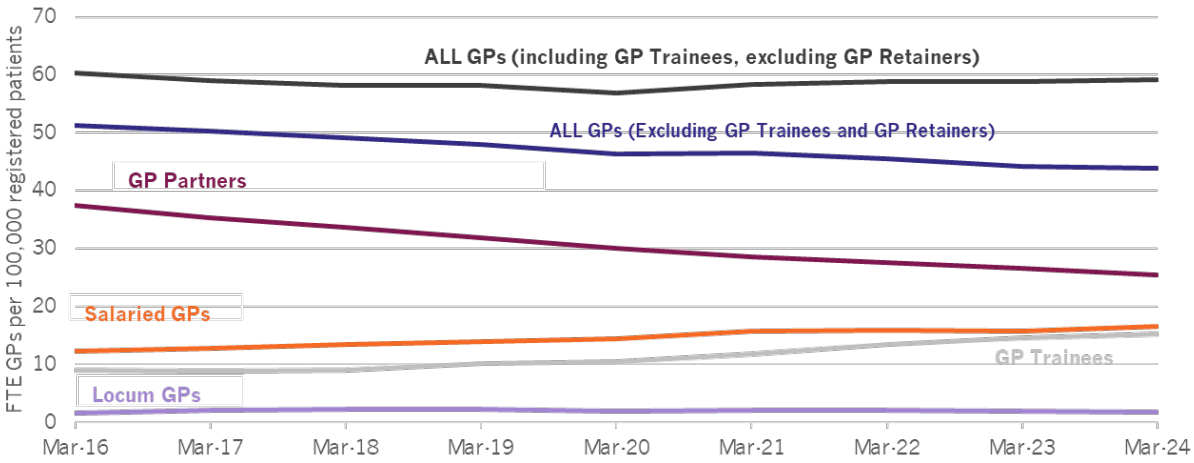
29. As we turn to resources and productivity of services, one thing that stands out is the degree of detail that is available for acute hospitals services versus other settings of care. This reflects the availability of data—and in itself demonstrates the need to invest in measurement and transparency across all areas of the NHS.

General Practice

30. It has long been said that General Practice is the "jewel in the Crown of the NHS"[262]. However, our analysis finds that the UK has 15.8 per cent fewer GPs per 1,000 population than the OECD average[263]. The number of GPs per 100,000 population declined by 1.9 per cent a year between 2016 and 2024, with the number of GP partners falling sharply, as we can see in the chart below[264]. It is a complex picture, however, since the absolute number of qualified GPs increased by 6 per cent between 2015 and 2022. Since in the same time period, the numbers of GPs choosing to work part-time has increased, and the population has expanded, the overall result is that there has been a decline in the numbers of whole-time equivalent GPs per 100,000 population[265].

31. As we have seen, there are wide variations in the numbers of GPs in different parts of the country, while patient satisfaction is better when there are fewer patients per GP. Moreover, more and more demands are being placed upon GPs who are expected to deliver an ever-wider range of services and to integrate care for more and more complex patients.

Figure VIII.3.2: Number of GPs FTE per 100,000 registered patients, by GP type – March 2016 to March 2024

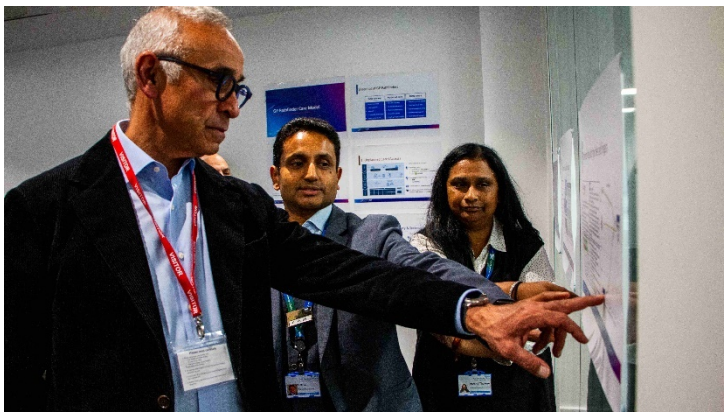


32. At present, multiple disincentives conspire against allocating additional funding to match known higher primary care workload in deprived areas. Primary care workforce recruitment is more challenging; consultation workload is progressively higher for each additional deprivation quintile; deprived area additional funding areas allocated according to the Carr-Hill formula does not take account of factors such as the social dimension of health and higher consultation rates[266]. Taken together, the Health Foundation estimated that current funding results in a 7 per cent shortfall in funding for practices serving more deprived populations per 'need adjusted' patient than those serving less deprived populations[267].

33. As independent businesses, General Practices have the best financial discipline in the health service family as they cannot run up large deficits in the belief that they will be bailed out. Despite rising productivity, an expanding role, and evident capacity constraints, the relative share of NHS expenditure towards primary care fell by a quarter in just over a decade, from 24 per cent in 2009 to just 18 per cent by 2021, continuing a downward trajectory from their peak in 2004[268].

34. With primary care doing more work for a lesser share of the NHS budget, we heard significant irritation felt by GPs who perceive that more and more tasks are being shifted from secondary care back to primary care, with a never-ending flow of letters demanding follow-ups and further investigations. This frustration is understandable when the hospital workforce appears to have expanded to the amongst the highest levels in the world.

35. In the face of such difficult challenges, some GP practices have embraced extraordinary innovations. GPs have made significant shifts towards a digital model for those patients who want it, they have introduced impressive approaches to triage, and have boosted their responsiveness to patients. During visits as part of the investigation, I saw some remarkable examples of local innovations that were improving access and quality of care, while also relieving pressures on acute hospitals.



36. While there have been some impressive programmes to support GP innovation, such as the GP Pathfinders, I also heard how the current GP standard contracts are complex and can mean that doing the right thing for patients can require doing the wrong thing for GP income. That cannot be right.

37. The primary care estate is plainly not fit for purpose. Indeed, 20 per cent of the GP estate pre-dates the founding of the NHS in 1948 and 53 per cent is more than 30 years old[269]. More recent buildings are bedevilled by problems with the management of LIFT (PFI-type) schemes that give GPs too little control over their space and that some GPs described as having charges that are unreasonably high during visits to the frontline as part of the investigation. It is just as urgent to reform the capital framework for primary care as for the rest of the NHS.

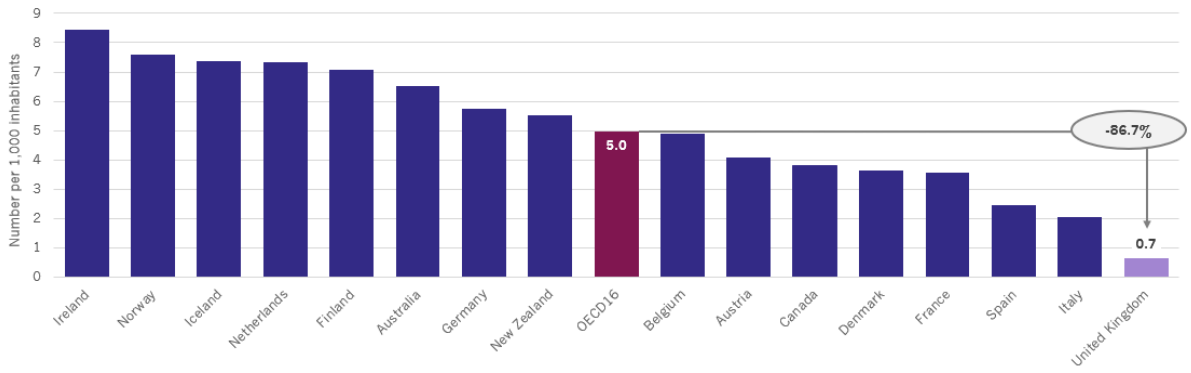
Community services

38. The poor quality of data means it is difficult to establish how well or how poorly community services are performing. In the NHS, what gets measured, gets funded. The community services dataset was only recently established. It contains nearly four times as many metrics as acute services[270], even though the NHS spends eight times as much on acute services as on community. It is little surprise, then, that completion rates are poor. The overall result is that there are tens of thousands of NHS staff working in community settings[271] and far too little is known about their performance and productivity. It even proved impossible to get precise headcount figures.

39. Community services are significant outliers in international comparisons of resources. We believe the UK has far fewer nurses working outside of hospital compared to other countries. Analysis seems to suggest that the UK may be as much as 86.7per cent below the OECD average in the numbers of nurses and midwives working outside of hospital, as the chart below shows.

40. While we treat this with caution—we speculate that it might exclude, for example, GP practice nurses or maybe acute hospital staff that are community based. If the data under-reported by a factor or four, we would still have the lowest level of resource among comparable countries. This therefore suggests that we may have too few resources in the community, compared to other health systems. Indeed, the Nuffield Trust has observed that, despite pledges to increase spending on care outside hospital, community services spending was cut in real terms in three out of the six years between 2016-17 and 2022-23[272]. What is clear is that it requires further investigation and that the first step to giving greater priority to community services is to properly count the number of people working in them.

Figure VIII.4.1: Practicing nurses and midwives per 1,000 inhabitants outside of hospital, 2023 (or nearest year)

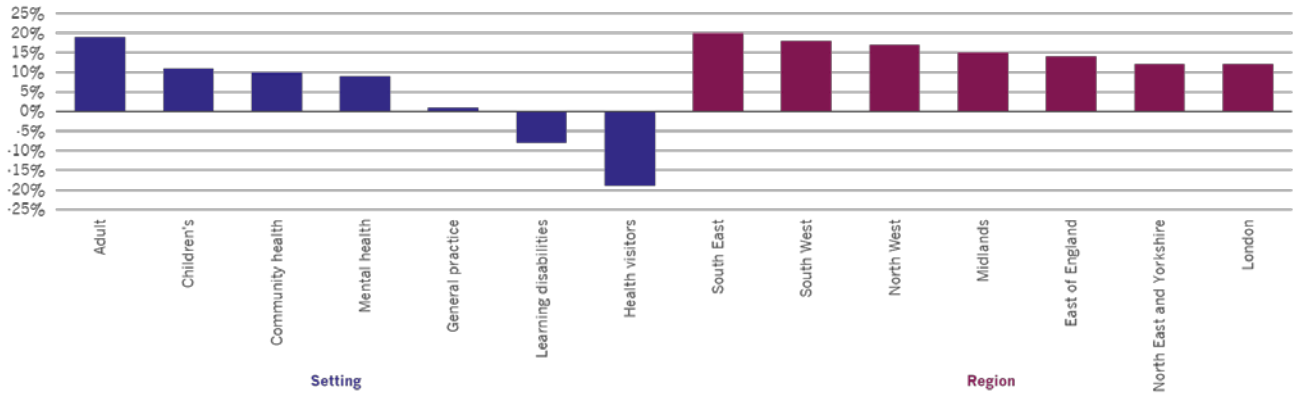


41. Despite rising demand, there were 5 per cent fewer nurses working in the community in September 2023 than September 2009[273]. During the same period, hospital nurses working with adults increased by 35 per cent and for children's hospitals, there has been a 75 per cent increase in nurses[274]. Analysis published by the NHS Confederation shows that for community services, spend is not correlated with needs (in a way that it is for primary care, mental health services, and acute hospital services)[275]. There is, therefore, an unfair postcode lottery in community services.

42. The Health and Social Care Act moved the commissioning of public health services to local authorities. As we have seen, the public health grant has fallen by more than 25 per cent in real terms. This has had a particular impact on Health Visiting,

where numbers of health visitors have fallen by nearly 20 per cent since 2019, as the chart below shows. Given the extensive evidence base on the importance of the first 1,000 days of life[276]; it is clear the NHS is missing an opportunity to intervene early.

Figure VIII.4.5: Change in the number of nurses in hospital, community and general practice settings, December 2019 – September 2023

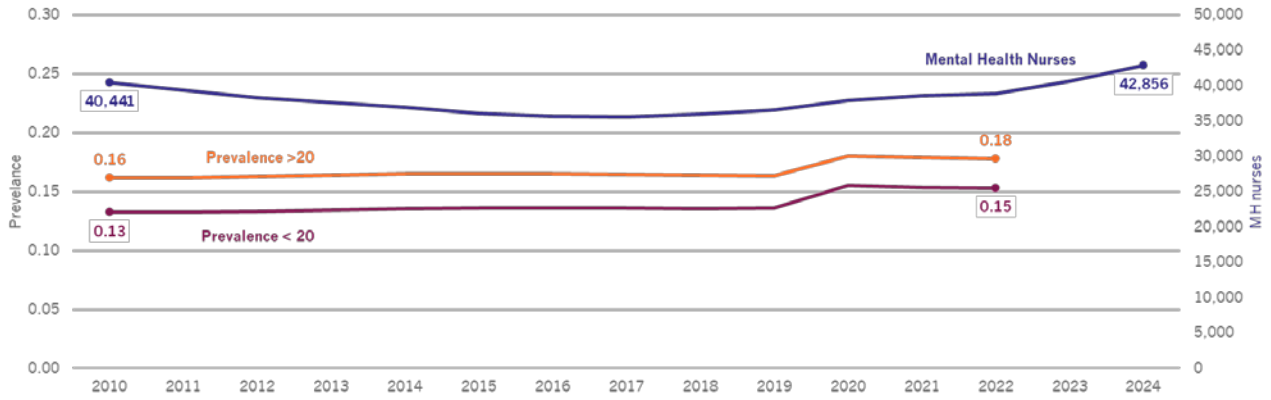


43. The lack of data makes it difficult to assess the productivity of community services. It means the unit costs and minimum efficient scale are poorly understood. This is particularly true with assumptions that subscale outpatient clinics are cheaper when delivered out of hospital. A modest reduction in capital costs is dwarfed by an increase in operational costs since scale efficiencies cannot be achieved. Simply shifting the setting of care without changing the care model will have a poor return on investment[277].

Mental Health services

44. Despite rapidly rising mental health needs of children and young people and working age adults, the overall mental health workforce reduced by 9.4 per cent between 2010-11 and 2016-17[278]. The number of mental health nurses dropped by 13 per cent between 2009-10 and 2016-17[279]. The workforce then expanded by 26.5 per cent between the start of 2017-18 and the end of 2023-24[280]. But the number of mental health nurses only returned to their 2009-10 level by 2023-24[281]. There remains a wide gap between need and resources[282], which explains the problems for people who need access to services.

Figure VIII.5.2: Prevalence of mental disorders by age group – England vs Mental Health Nurses



45. There has been a particularly concerning drop in the number of learning disabilities nurses. Since 2010-11, the number has declined by 44.1 per cent on average, and by even more in some regions, as we can see in the following chart[283]. As we have seen, there are serious concerns about very wide disparities in life expectancy for people with learning disabilities. This deserves further investigation.

Figure VIII.5.3A: NHS Hospital & Community Health Service (HCHS) Mental Health Nursing staff in post (FTE) percentage change 2010/11 to 2023/24 by region

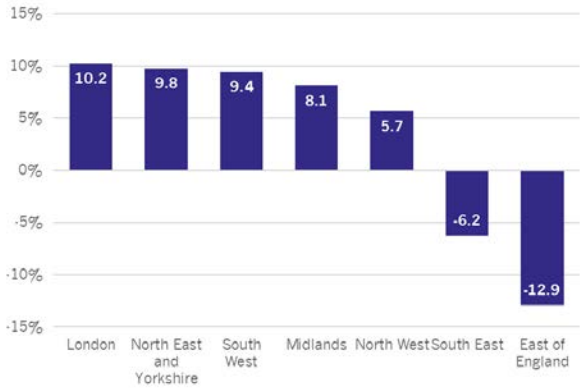
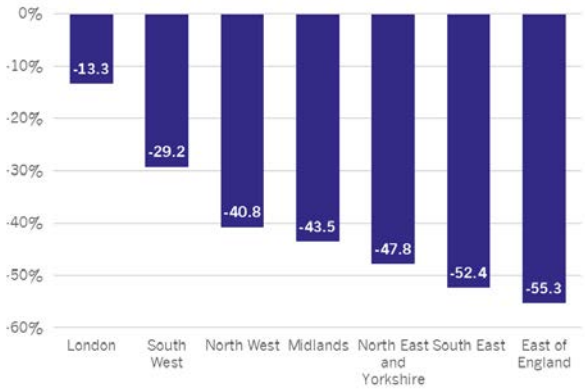


Figure VIII.5.3.B: NHS Hospital & Community Health Service (HCHS) Learning Disability Nursing staff in post (FTE) percentage change 2010/11 to 2023/24 by region



46. More comprehensive mental health data has only been recorded since 2016, and insufficient data is recorded to make definitively assessments of productivity. Nonetheless, a number of local estimates of productivity have been shared from different areas of the country. These seem to suggest that productivity has remained broadly constant, meaning that the increase in resources has resulted in a similar rise in activity.

47. In common with community services, there has been chronic underinvestment in technologies that could improve the efficiency of mental health community teams. Technology platforms that allow for automated route planning and easy-to-use data recording have existed for at least 15 years but are still a novelty in the NHS. It is

said that productivity has not dropped—but neither was it likely to be high to begin with, given the poor use of technology and the absence of sufficient management information to drive up performance.

48. There are perpetual access problems for inpatient services. As we have seen above, difficulties in finding mental health beds contribute to long waits for patients with a mental health flag at acute hospital emergency departments[284]. This means patients are kept waiting in an environment that is not suitable to their needs and as high-stress places, could exacerbate a mental health crisis. Moreover, the data shows that having brought down the number of inappropriate out-of-area placements between 2019 and 2002, numbers have started to rise again, reaching nearly 6,000 in 2023[285]. This is a worse result for the patient and a higher cost for the NHS, meaning a significant hit to productivity.

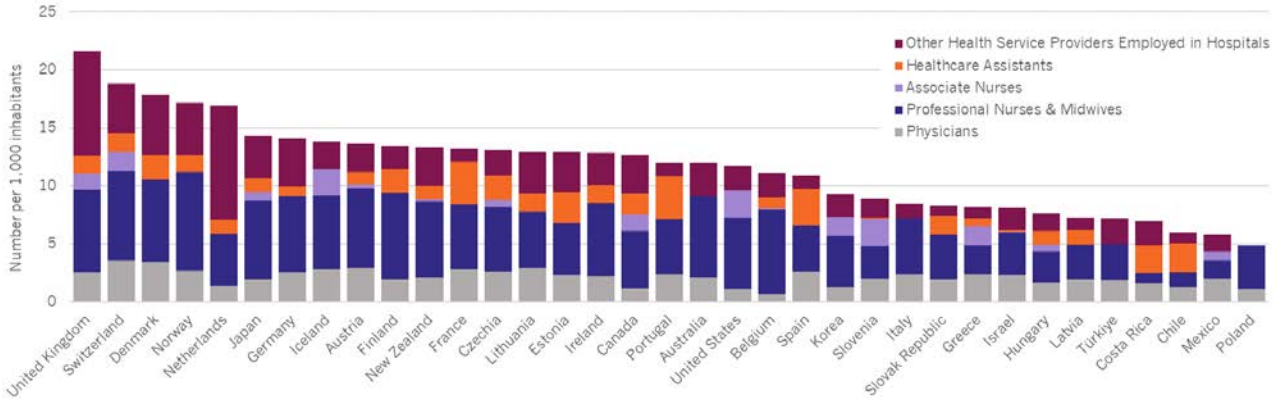
49. There is a fundamental problem in the distribution of resources between mental health and physical health. Mental health accounts for more than 20 per cent of the disease burden[286] but less than 10 per cent of NHS expenditure[287]. This is not new. But the combination of chronic underspending with low productivity results in a treatment gap that affects nearly every family and all communities across the country[288].

Acute hospital services

50. The hospital workforce has expanded very significantly in recent years, rising 17 per cent between 2019 and 2023[289]. On first examination, the UK appears to have the highest level of hospital employment in the world[290], and when looking at a narrower part of the healthcare team—doctors, nurses, and midwives—the UK is ranked fourth highest among OECD countries[291].

51. We treat this data with caution, even though it is taken from official statistics. The Office for National Statistics (ONS) submits data on behalf of HM Government to the Paris-based, intergovernmental Organisation for Economic Cooperation and Development (OECD). The NHS provides the source data to the ONS. We speculate that it may include staff working in the community but employed by acute hospital trusts. Should this be the case, then the inability to even distinguish community staff in official statistics suggests that insufficient priority has been given to them. Without accurate and frequent measurement and recording, it is surely impossible for the NHS to know whether or not its strategy is succeeding.

Figure VIII.6.1: All healthcare workers employed in hospitals per 1,000 inhabitants, 2022 (or nearest year)



52. This dramatic expansion of the hospital workforce, rising by 17 per cent between 2019 and 2023[292], has come at the expense of other settings of care, as the proportion of the total NHS budget dedicated to acute hospitals has continued to rise, partly driven by costs incurred by the pandemic[293], even as the NHS's stated strategy has been for resources to shift to the community.

53. Despite this significant flow of resources into hospitals, output has not risen at nearly the same rate. The result is that a large productivity gap has opened up. Overall, hospital productivity is at least 11.4 per cent lower now than it was in 2019[294], which is a reason why it is taking longer to tackle the big increase in waiting times in recent years (alongside the decisions to cancel more hospital activity than any other comparable health system during the pandemic[295].
Looking across clinical workforce crude productivity metrics, a pattern is readily apparent: productivity has fallen (see the chart below)[296]. The number of clinicians for each bed has increased by 13 per cent, while key measures have declined. A&E attendances per emergency medicine clinician are down 23 per cent; outpatient appointments per consultant are down 10 per cent; and surgical activity is down 15 per cent.

54. At the same time, many frontline clinicians say they are working harder than ever. This appears to present a paradox. But it is possible for both to be true at the same time: productivity is not a measure of effort, but of value creation. And, as we shall see, the central problem is that patients are not flowing efficiently through hospitals anymore and neither have we upgraded the infrastructure – diagnostic scanners, operating theatres and so on – with which they work. That slowdown in flow generates more non-value adding work and less output.

Figure VIII.6.11A: Clinical WTEs per G&A bed

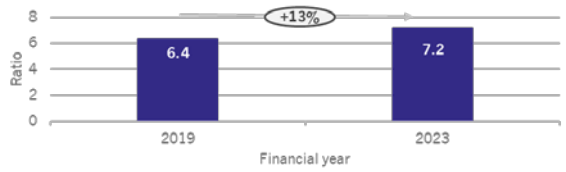


Figure VIII.6.11B: Non-admitted emergency activity (per calendar day) per medical emergency medicine WTE.

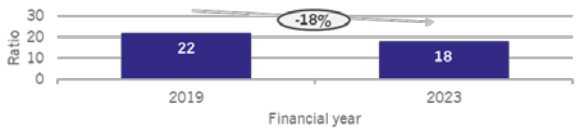


Figure VIII.6.11C: Outpatient attendances (price-weighted, per working day) per consultant WTE

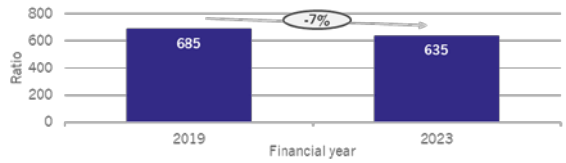
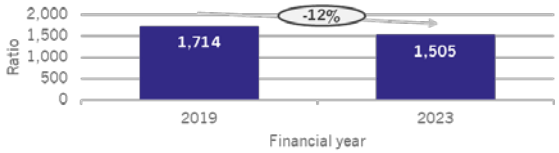


Figure VIII.6.11D: Surgical specialty spells per medical WTE in surgical specialties

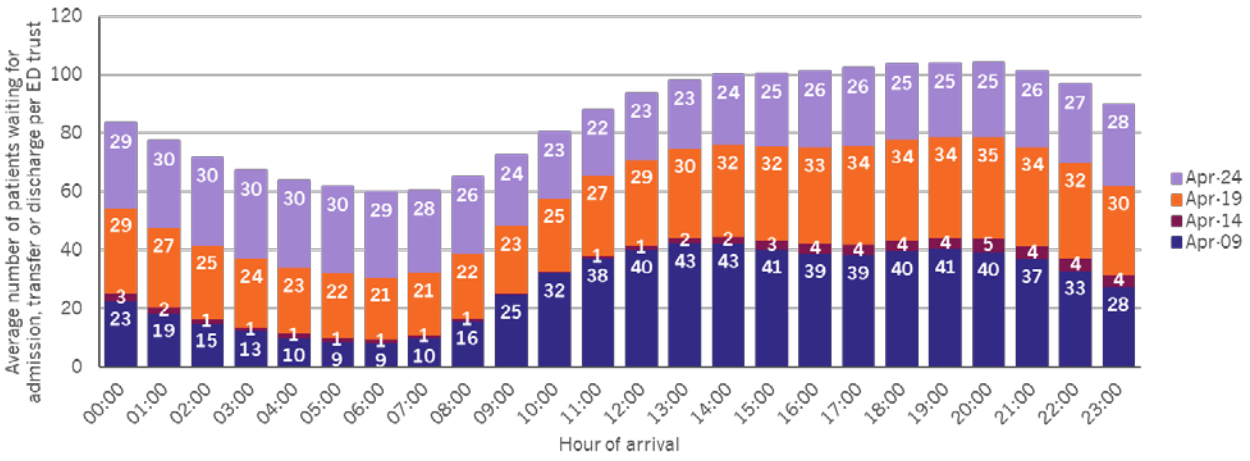


Congested hospital emergency departments

55. The data shows a significant rise in attendances at hospital emergency departments[297]. This is the result of push and pull factors: the failure to invest in primary, community and mental health services outside of hospital has pushed people towards them. Patients flocking to hospitals is also the inevitable consequence of concentrating resources within them that creates a pull of its own.

56. New analysis prepared for this report shows that had a patient arrived at a typical A&E on an average evening in 2009 (when sufficiently detailed data began to be collected to make this analysis possible) there would have been 39 people waiting in the queue. By 2024, this had increased to more than 100 people waiting at an average A&E department on a typical evening, as shown in the chart below[298].

Figure VIII.6.12: Average number of patients arrived but not admitted, transferred or discharged per A&E Trust, A&E CDS & ECDS

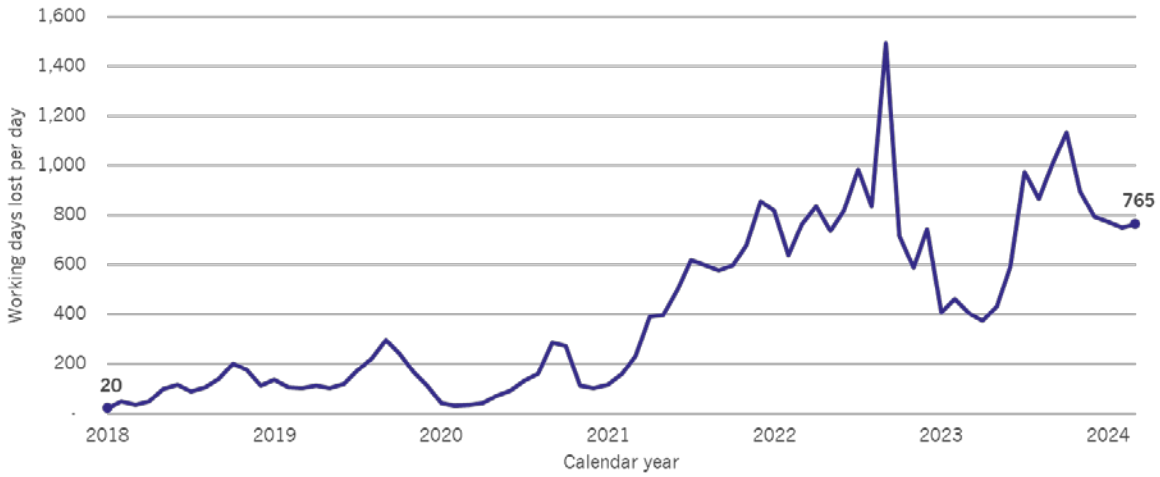


57. A significant proportion of people presenting at emergency departments are those that say they were unable to get a GP appointment[299]—or perhaps they *believed* that they could not and so did not try. The number of GP appointments has increased significantly[300], even as the number of GPs on a population basis has declined. This appears, therefore, to be a capacity rather than a performance issue.

58. As attendances have risen and emergency departments have become more congested, waiting time performance and productivity have declined. The rate of attendance at emergency departments in the UK is double that of the Netherlands, and the second highest in a group of comparator countries[301]. As we have set out above, the Royal College of Emergency Medicine has shown that very long waits are a serious quality of care issue, since they appear to lead to higher mortality[302]. They also lower productivity, as they necessitate clinical activities that would never have occurred without the wait, for example, providing pain relief to patients stuck waiting in corridors.

59. Congested emergency departments also reduce the productivity of ambulance services. A huge amount of time is lost to handover delays[303] where ambulances arrive at emergency departments but there is no space for their patients. In 2024, around 800 working days, each day, have been lost to these delays[304], which are only counted when they exceed 30 minutes. In aggregate, it is the full-time equivalent of nearly 1,400 paramedics over the course of a year[305]. By tying up paramedics and their vehicles, it contributes to the significant increase in ambulance waiting times.

Figure VIII.6.13: Working days lost per day due to ambulance handover delays, England (assumes 7.5 hours lost is equivalent to a working day lost for two staff)



Slow flow of patients through hospitals

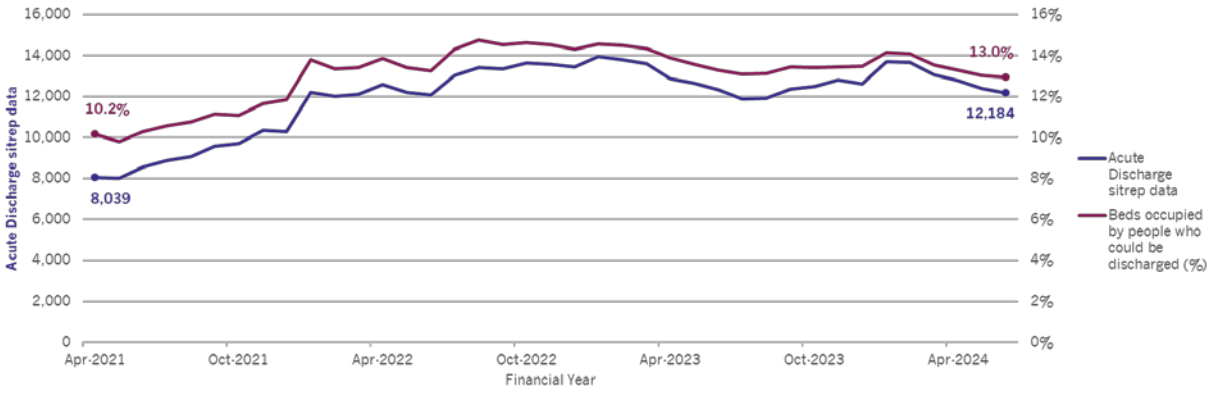
60. The inability of patients to flow through emergency departments results from the capacity of the departments themselves, both workforce and physical space, as well as from elsewhere in the hospital, such as the availability and speed of diagnostics and the availability of beds for admission[306]. At its core, this is a result of the intersection of high levels of demand (caused by the lack of investment in the community[307]), chronic capital underinvestment in both facilities and technology[308], combined with operational planning and management issues.

61. Underinvestment in diagnostics extends the stay of patients in hospital, as we have seen[309]. Despite the first clinical use of MRI taking place in an NHS hospital, the health service has far fewer MRI and CT scanners than comparable countries[310]. Moreover, many of the machines are old[311]: this means that they are less powerful and so take longer for each scan and that more time is lost due to breakdown and maintenance.

62. The chronic lack of capital investment and cost-improvement targets set alongside imperatives to increase clinical staffing levels means that hospital managers are always under pressure to reduce beds. The result is that the number of beds has fallen more quickly than length of stay, putting many hospitals into a perpetual bed crisis, and damaging productivity. National planning guidance required hospitals to reduce occupancy from 94 per cent to 92 per cent[312], but even at the reduced level it will inevitably cause occupancy to exceed 100 per cent during peak periods such as a particularly cold snap during winter.

The most immediate solution to hospital capacity issues is to address delayed discharges. This would free up beds and get patients flowing through hospitals again. As the chart shows[313], up to 13 per cent of hospital beds could be freed up if patients could be transferred to appropriate nursing homes or other care facilities.

Figure VIII.6.18: Beds occupied by people who no longer meet the criteria to reside, April 2021 to June 2024



63. Falling productivity doesn't reduce the workload for staff. Rather, it crushes their enjoyment of work. Instead of putting their time and talents into achieving better outcomes, clinicians' efforts are wasted on solving process problems, such as ringing around wards desperately trying to find available beds. A low productivity system creates a worse experience of work for staff, as well as increasing waiting times for patients.

Systems

64. Wide variations in performance by providers within the same settings, in similar as well as different areas of the country, shows that there is plenty of scope for improvement for many organisations[314]. At the same time, many of the productivity problems in the NHS are caused by the interaction between different parts of the system. The only sustainable solution to congestion in acute hospitals, for example, is to build up the capacity, capability, infrastructure and technology base of care that is delivered in the community, including general practice, community services, and mental health services. By keeping people well for longer, they are less likely to need hospital treatment.

65. Yet the current distribution of resources is perpetually reinforced: performance standards are focused on hospitals, not on primary care, community services or mental health, as is measurement. Single-year budgets necessarily reinforce the status quo—and when things go wrong the knee-jerk response is to throw more money at hospitals where the pressure is most apparent as waiting areas fill up and

ambulances queue outside. Indeed, the system produces precisely the result that its current design drives. And in the current paradigm, patients have a poorer experience, and everybody loses—patients, staff and taxpayers alike.

66. Given the very significant increase in resources in acute hospitals[315], it is implausible to believe that simply adding more resource will address performance. One large hospital trust I visited had expanded its workforce by nearly a fifth from before the pandemic to after it, while its yearly elective care activity (routine operations such as knee replacements) was up by just 0.3 per cent. Low productivity is both a provider and a system problem that will require a systemic solution.

* * *

67. There are no easy solutions. Fundamental reform will be needed to improve where and how the NHS budget is spent so that the highest quality care can be delivered in the most timely and efficient way to all people who need it, all of the time.

68. A starting point, however, would be to increase transparency into the activity, workforce, spending and therefore productivity in each setting of care. By making this information freely available to all in an easy-to-access format, it would empower clinicians and managers to create insights that allow action. But it will require a step-change improvement in data quality for community and mental health services in particular.

69. As a Nobel prize winning economist once observed, productivity isn't everything, but in the long-run, productivity is almost everything[316]. And that's because a productive NHS can mean high quality care for all—and right now, too many are waiting too long for its help.

6

Health and prosperity

1. The NHS is an important part of the national economy, so its performance and productivity directly impacts economic performance. Health and care is one of the most important sectors of the economy. It has increased as a share of gross value added from 6 per cent in 2001 to 8 per cent in 2023, a 33 per cent rise in just over 20 years[317]. And the NHS accounted for 43 per cent of all-departmental government spending in 2023, up from 26 per cent in 1998-99[318] so it is an important destination for tax receipts.

2. The Commission on Health and Prosperity, which I co-chair, describes how health and prosperity are mutually reinforcing[319]. Healthier workers are more productive, and the UK has a strong life sciences sector which drives innovation and exports. We now explore how well the NHS is supporting the nation's prosperity.

Work and health

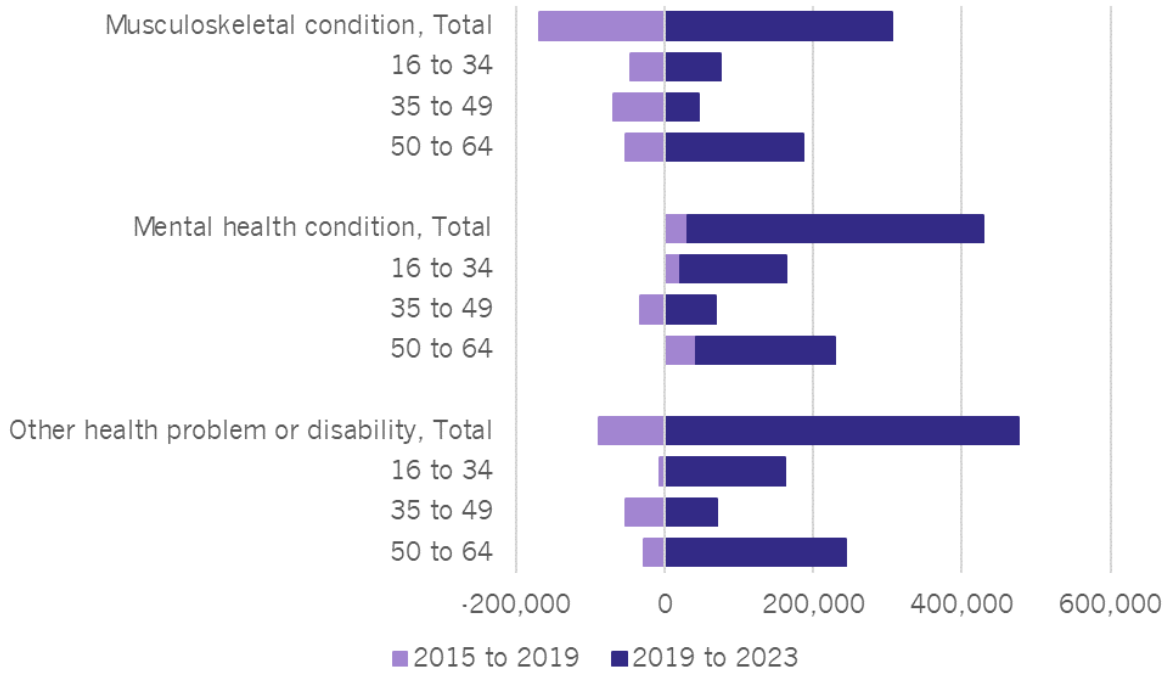
3. The health of our economy is dependent on a healthy workforce. There are many reasons why people are economically inactive, including education, retirement, disability or caring responsibilities. The number of people who are economically inactive because of long-term sickness has risen to record highs[320]. Long-term sickness as a proportion of those who are economically inactive decreased during the 2000s, stayed constant in the 2010s and then increased sharply during and after the COVID-19 pandemic (2020-24)[321].

4. At the start of this year, long-term sickness was the most common reason why people were out of the workforce, accounting for 30 per cent of the total or some 2.8 million people[322].

5. Most of the recent rise in long-term sickness is being driven by mental health conditions, especially for two main age groups: 16 to 34 year olds and 50 to 64 year olds. The fastest growth in long-term sickness absence was for 16 to 34 year olds, with growth of 9.5 per cent between 2015 and 2019, rising to a staggering 57.1 per cent between 2019 and 2023[323].

6. For musculoskeletal conditions and other health problems or disabilities, the previous downward trend in long-term sickness absence between 2015 to 2019 was replaced with significant growth between 2019 to 2023[324]. Worryingly, younger people are most adversely affected; long term sickness absence for people aged 16 to 34 with musculoskeletal conditions declined at an annual rate of 9.7 per cent in 2015 to 2019 before growing 16.4 per cent between 2019 to 2023[325].

Figure IV.2: Change in the number of people aged 16-64 in the UK who are economically inactive due to long-term sickness by age and main or secondary health condition, 2015 to 2019 and 2019 to 2023



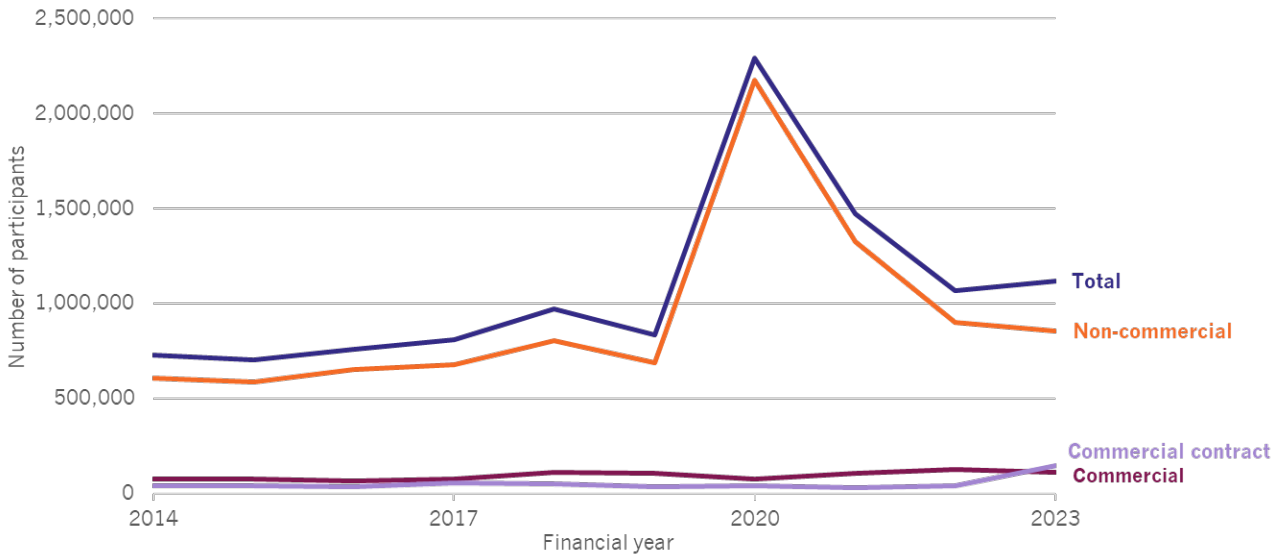
7. Being in work is good for wellbeing[326] and having more people in work grows the economy and creates more tax receipts to fund public services. There is therefore a virtuous circle if the NHS can help more people back into work. As we have seen, however, there are long waiting lists for both mental health services and for musculoskeletal (MSK) services. Improving access to care is a crucial contribution the NHS can make to national prosperity.

A scientific superpower

8. The NHS and the life sciences sector make important contributions to one another that benefit both: innovations improve the effectiveness of treatments and offer hope where treatments have not existed before. During the pandemic, it was the Recovery trial in the NHS that discovered the benefits of dexamethasone for patients with severe Covid—that discovery went on to save one million lives globally[327]. From the first clinical use of MRI to the Oxford-AstraZeneca vaccine to dexamethasone, there is much in the past and present to celebrate in the NHS' rich history of collaboration with life sciences.

9. The number of participants recruited into studies held fairly steady between 2015 and 2019, followed by a sharp spike during the Covid-19 pandemic. Yet this decreased dramatically in 2021 and in 2024 the number of participants recruited to studies dropped although remained slightly above the pre-pandemic baseline[328].

Figure IV.3: Number of participants recruited into studies in the UK held on the National Institute for Health and Care Research (NIHR) Clinical Research Network's Central Portfolio Management System (CPMS), 2014/15 to 2023/24



10. Commercial clinical trials are the lifeblood of the life sciences industry. As life sciences is a globally competitive industry, how the UK compares to others is vitally important. The UK ranked fourth in the number of industry clinical trials initiated in 2021 behind the USA, China and Australia[329]. This position is under threat as countries like Spain increase their clinical trials capacity. Lord O'Shaughnessy's review of commercial clinical trials found that the process for establishing trials in the UK needs to be made simpler and faster to maintain competitiveness.[330]

11. What's more, there are declining numbers of clinical academics practising in the NHS. This is a worrying trend. Clinical academics bring together research and practice and have a vital role in delivering each. They are an essential resource in bridging the gap between research and clinical practice so that research focuses on the areas of greatest need and patients in the clinic benefit from breakthroughs faster.

12. For the NHS, partnerships with the life science sector for research or treatment too often fall into the category of 'important but not urgent'. It is doubtful that there is an NHS leader in the country who would not recognise that research and innovation are important. It has simply not been a high enough priority in a world where waiting lists are long, and finances are tight. But in the medium term, it is innovation that can make the NHS more sustainable.

A Greener NHS

13. The World Health Organisation has described the climate crisis as the "single biggest threat facing humanity"[331]. The NHS is a large contributor to England's carbon footprint (4 per cent) and we must play a part in our national drive to net zero[332]. The NHS has set ambitious targets of reaching net zero by 2040 for its direct emissions and 2045 for wider emissions such as those of suppliers. The impact of climate breakdown will be felt more directly, such as the health impacts of heatwaves.

14. Important progress on carbon reduction has been made in recent years, through reducing emissions across the NHS estate, reducing the carbon footprint of clinical care, and decarbonising the supply chain, but it will become more challenging as easier reductions are made first. Through its participation in the public sector decarbonisation scheme, projects in the NHS are set to reduce the energy bill for the health service by £260 million a year and cut nearly 3 million tonnes of carbon over the lifetime of the programme. According to polls, there is public support for this agenda. But that support has declined recently, most likely due to concern over problems with access to care[333].

15. Given the global health imperatives, the NHS must stick to its net zero ambitions. There is no trade-off between climate responsibilities and reducing waiting lists. Indeed, often health and climate are mutually reinforcing goals: cleaner air is good for the environment and good for respiratory health. The NHS has the second largest fleet (after Royal Mail), in the country, consisting of over 20,000 vehicles travelling over 460 million miles every year—and electrifying the NHS fleet is set to

save the NHS over £59 million annually[334] while cleaning up the air. Active travel reduces emissions and improves cardiovascular health.[335]

* * *

16. In part I, we have seen how the NHS is performing in terms of access to services, quality of care, public health and inequalities, its distribution and use of resources and its contributions to national prosperity. These have been examined in the context of the health of the nation. We now turn to the drivers of performance, in an attempt to understand why the NHS is so far from peak performance.

Part II

Drivers of performance

7

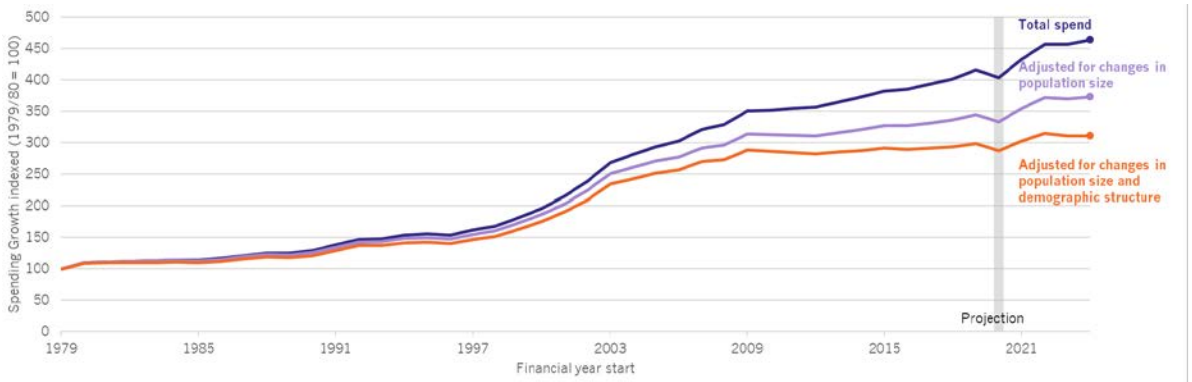
Funding, investment and technology

1. In this chapter, we explore whether the NHS has had the resources it needs. We look at the revenue funding that pays for things like wages, medicines, and all the other day-to-day expenses of the NHS. We then turn to capital investment – examining spending on diagnostic scanners or modern buildings – that is the engine of a more efficient NHS. We then turn to digital technology and explore how well prepared the health service is for the future.

NHS revenue funding

2. Apart from the exceptional funding boost in the Covid period, since 2010, NHS funding has increased by just over 1 per cent in real terms each year. This compares to the long run average annual increase of around 3.4 per cent, and a per person increase of 5.8 per cent a year in the first decade of this century[336]. The 2010s, in the run up to the pandemic, were the most austere decade since the NHS was founded in 1948. Such increases have essentially left funding flatlining, once adjusted for changes in population numbers and changes in population age structure.

Figure V.1.1: Real Terms spending on the NHS in England adjusted for population size and demographic profile

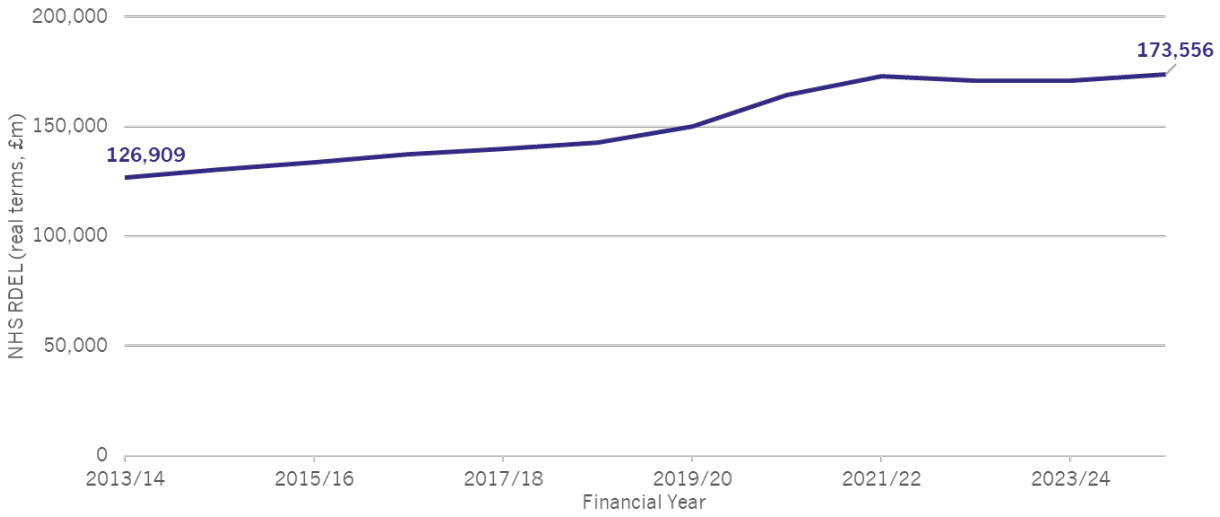


3. It was not until 2018, with a new prime minister, that the then health secretary and NHS chief executive were able to negotiate for a return to the NHS' long-term

average spending increases of 3.4 per cent[337]. When it was announced, the prime minister noted that "increases in health funding have often been inconsistent and short-term – creating uncertainty over what the funding position will be in as little as two years' time. This has led to a system of planning from one year to the next, preventing much needed investments in technology, buildings and workforce"[338].

4. In common with other advanced countries, health system funding surged dramatically during the pandemic. This meant that whereas in 2019 the UK was spending a similar share of GDP on health as EU15 and Nordic countries (approximately 10 per cent[339]), by 2022, it was spending relatively more (amounting to some 11 per cent of GDP[340]), and its comparators were other countries where English is predominantly spoken[341]. But the funding promised in 2018 did not materialise, and between 2019 and 2024 funding actually increased just under 3 per cent a year in real terms between 2019-20 and 2024-25[342].

Figure V.1.2: Resource DEL (exc. depreciation) NHS England – real terms (£m), 2013/14 to 2024/25

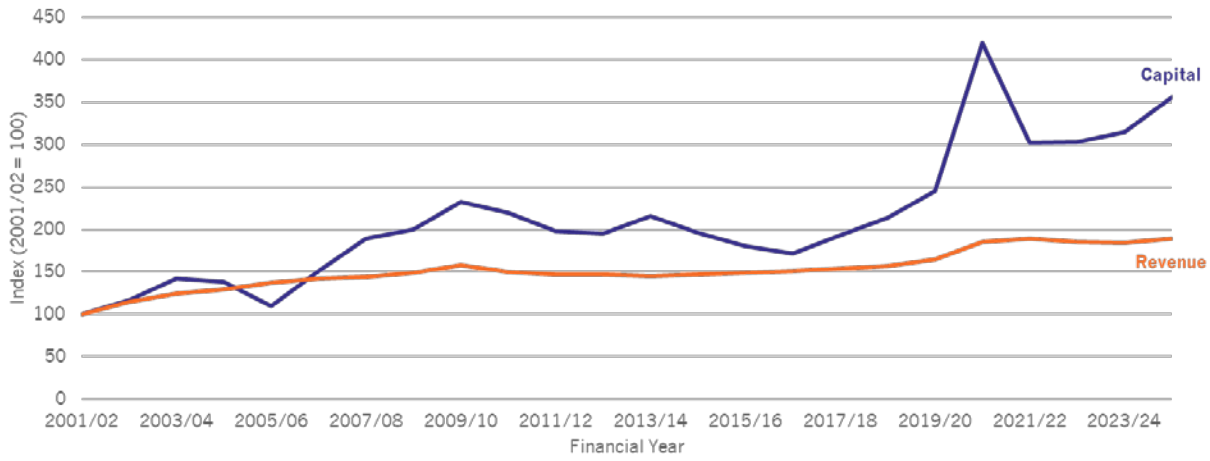


5. When analysed per person at purchasing parity, the UK spends about the same as other European countries ($5,600 compared to an EU15 average of $5,800). But we spend substantially below both countries where English is predominantly spoken and the Nordic countries, which spend about $1,900 and $900 per person more respectively[343]. This reflects differences in the performance of the economy overall (in those countries, GDP per capita is higher[344], so the same percentage share translates into higher spending).

The shortfall in capital investment in the NHS

6. During the 2000s, capital investment increased markedly, such that by 2007, the UK was investing more than the average of the EU15 and continued to do so until 2010[345]. Investment peaked in 2009 at 0.54 per cent of GDP. From then onwards, capital investment sharply declined[346]. By 2013, it stood at just 0.26 per cent of GDP, less than half of its 2009 high and well below peer countries. It then increased incrementally until the Covid-19 pandemic[347]. In the NHS, capital spending per person increased at 9.1 per cent a year in the first decade of the century, falling to 1.2 per cent in the 2010s, before rising to 7.8 per cent per year during the pandemic, as shown below[348].

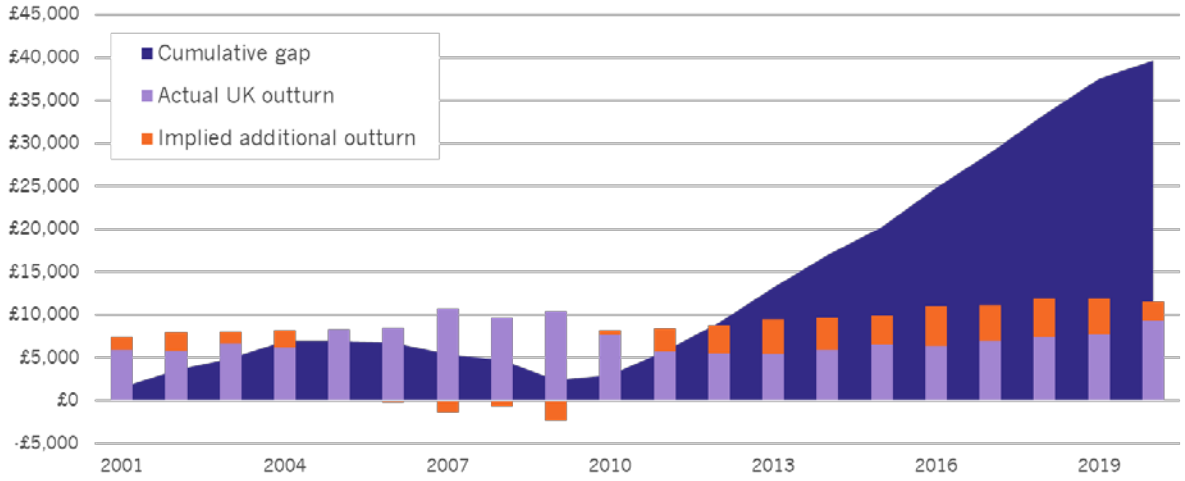
Figure V.2.4: Total NHS spend per person – revenue and capital, 2001/02 to 2024/25



7. New analysis prepared for this investigation has looked at what we would have invested, had the UK matched international benchmarks in the two decades since 2001 (shown in the chart below, in 2020 prices)[349]. Had the UK matched EU15 or Nordic levels of capital investment from 2001 to 2010, it would have actually invested slightly less; had it matched levels of investment in predominantly English-speaking countries, it would have invested substantially more[1]. So, capital investment was somewhere in the middle – similar to the Nordics, more than the EU15 and less than countries such as Australia or the United States.

[1] OECD capital investment data across countries relates to 'gross fixed capital formation' – that is, the purchase of assets (for example, buildings and scanners) minus the sale of assets in that year. Research and development spending may be counted if it involves the purchase or sale of an asset or leads to intellectual property. Private Finance Initiatives and all other private capital spending in health care may be included.

Figure V.2.5: Cumulative capital gap UK vs peers, £ millions, constant 2020 prices

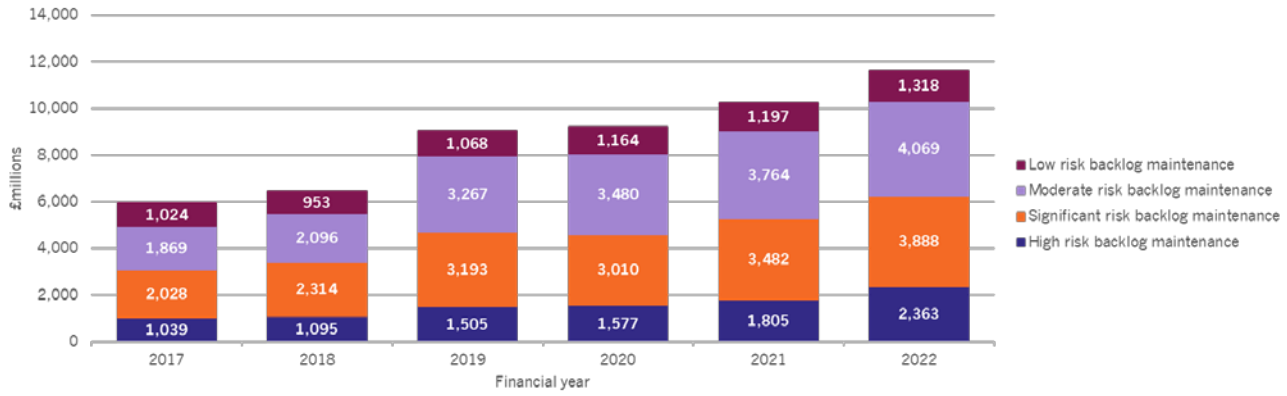


8. During the 2010s, a staggering capital gap opened up between the UK and other countries. There would have been £27 billion more capital investment, had we matched the EU15, £35 billion more had we matched the Nordic countries, and £46 billion more had we matched the investment levels of predominantly English-speaking countries[350]. Had we matched the average of all peers, this would have amounted to an additional £37 billion[351].

9. This could have eliminated all backlog maintenance (now standing at £11.6 billion in 2022)[352] and have already funded the 40 new hospitals announced in 2019 before the pandemic hit[353]. The £37 billion to match the all-peers' average alternatively amounts to some £4.9 million for every GP practice[354], so it could have paid for every community in the country to have a purpose-built, modern GP practice complete with diagnostics, space for specialist input, and a base for mental health and community services.

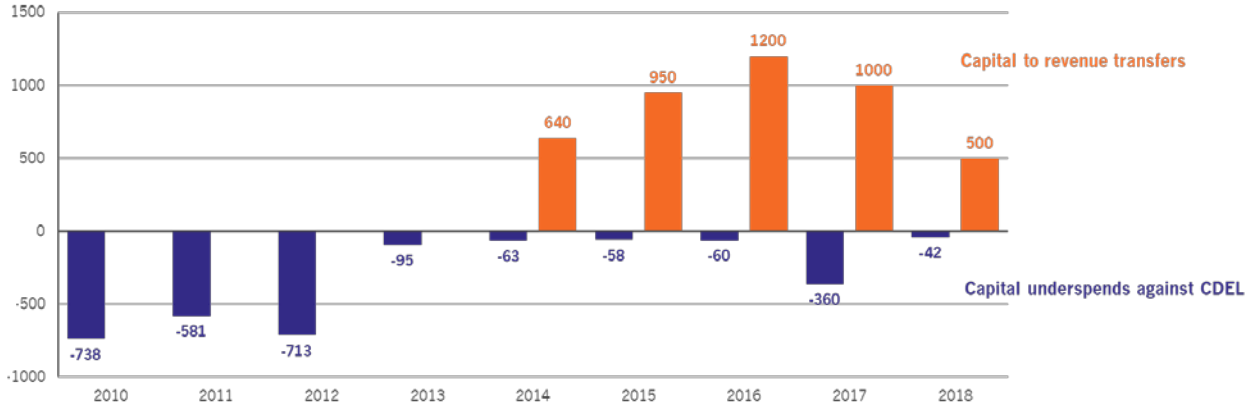
10. From HM Treasury to NHS provider trust, the capital regime is widely recognised to be dysfunctional; the Hewitt Review was the most recent call for it to be overhauled[355]. Capital expenditure limits are imposed on NHS trusts by HM Treasury that cannot be exceeded, even if the funds to make such investments are available. And the capital approvals process is so byzantine that it is hard to find an NHS senior manager who understands it. It has left much of the NHS estate crumbling, notably in primary care, with a backlog of maintenance across the service that amounted to £11.6 billion in 2022, as the chart below shows.

Figure V.2.13: Backlog Maintenance - Actual



11. The result is that the NHS routinely underspends its capital allocation, despite it being insufficient to begin with. These underspends have been used to plug deficits in day-to-day expenditure, by switching from capital to revenue. The chart below shows that between 2014-15 and 2018-19, £4.3 billion was transferred from capital to revenue[356]. The Department of Health and Social Care and HM Treasury have effectively used the NHS capital budget as an informal reserve to protect against NHS deficits. This is obviously dysfunctional and stores up problems for the future.

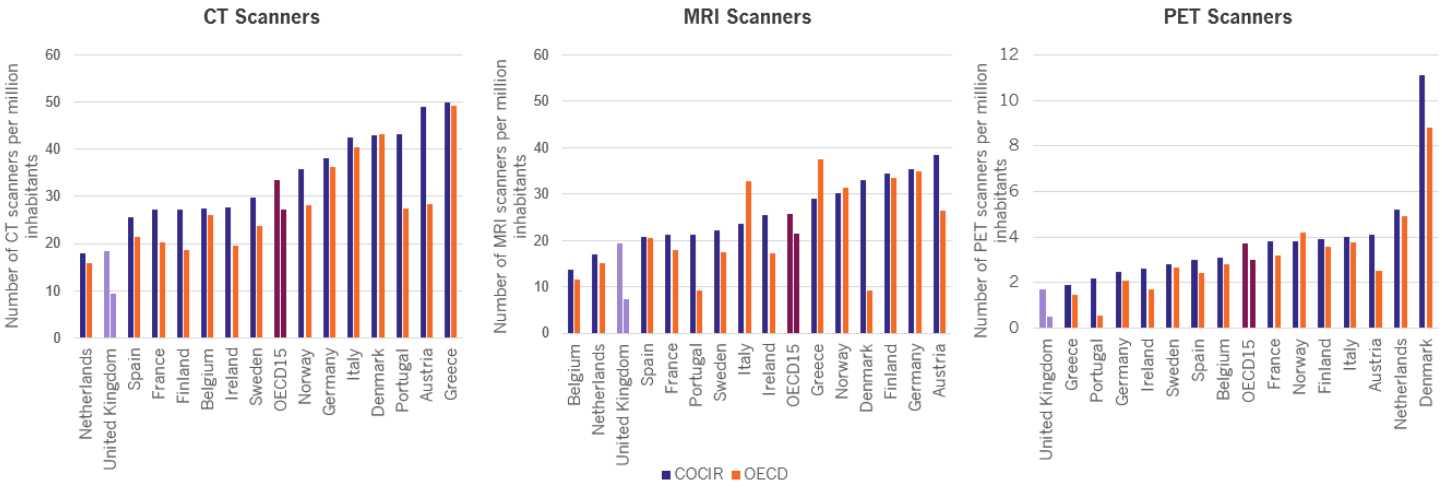
Figure V.2.6: Annual transfers from capital spending to revenue spending, and underspends against the capital limit, 2010-11 to 2018-19 (£ millions)



12. The outcome is that the NHS has been starved of capital, so the service has too few scanners, too little investment in digital automation in laboratories and pharmacy, and too little digital technology to support its workforce. One hospital chief executive described to us how his organisation had to reduce the number of operating shifts for MRI scanners from three daily to two daily, since the aged

machines would break down if used too intensively. Using both OECD and industry benchmarks, the UK is far behind other countries in the levels of CT, MRI and PET scanners for its population[357].

Figure V.3.1: Number of CT, MRI and PET scanners per million inhabitants, 2023 (or nearest year)

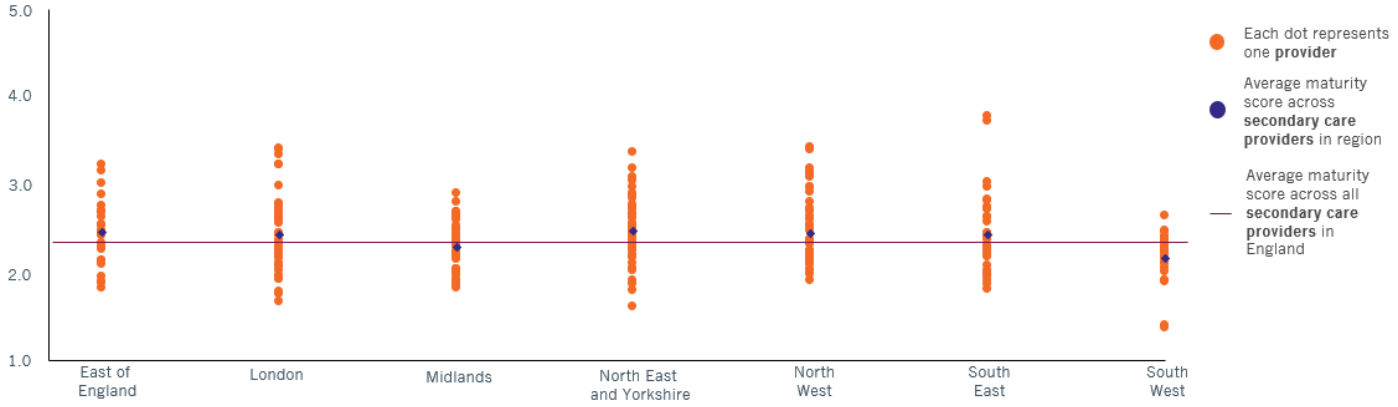


Technology

13. Over the past 15 years, many sectors of the economy, in this country and internationally, have been radically reshaped by platform technologies. From the way we shop, to the way we socialise and how our politics is conducted, technology has transformed daily life. By contrast, while there are many excellent examples of technology having an important impact in the NHS—from virtual wards to remote dermatology consultations—it has not radically reshaped services. The NHS remains in the foothills of digital transformation. Indeed, the last decade was a missed opportunity to prepare the NHS for the future and to embrace the technologies that would enable a shift in the model from 'diagnose and treat' to 'predict and prevent'—a case that I made in my report *High Quality Care for All*, more than 15 years ago.

14. The NHS, in common with most health systems, continues to struggle to fully realise the benefits of information technology. It always seems to add to the workload of clinicians rather than releasing more time to care by simplifying the inevitable administrative tasks that arise. The extraordinary richness of NHS datasets is largely untapped either in clinical care, service planning, or research. As the chart below shows, digital maturity is still low across much of the NHS.

Figure V.3.5: Digital Maturity Assessment secondary care provider scores (out of 5)



15. The NHS has made some significant investments, such as the Federated Data Platform, which have great promise and have started to show some impact locally[358]. Similarly, there are dozens of examples of start-ups that have created apps that improve the quality and efficiency of care[359]. But too many of these remain subscale. And as we have seen, the NHS App is not currently living up to its potential impact given the vast scale of its registered user base.

16. Investment in information technology continues to focus on acute hospitals, rather than other providers, as shown in the chart below[360]. Take community-based services such as district nursing or mental health home treatment. Technology platforms that have existed in the private sector—such as automated route planning—for more than 15 years are rarely found in the NHS. There are many possible technologies that would support more efficient, higher quality, safer care in the community. But they are largely absent. Given the shift in the disease burden towards long-term conditions, there is a greater need for information systems that work across different settings.

Figure V.3.4: IT capital investment per clinical FTE by NHS provider type (cash terms), England

17. While there are some examples of breakthroughs, the NHS has struggled with data-sharing to support higher quality care. The Whole Systems Integrated Care dataset in north-west London is one example that integrates data at the patient level from all settings of care since 2013[361]. More recently, the OpenSAFELY programme[362], created in 2020, has built an extraordinary platform that integrates general practice data from across the country. Yet its enormous potential to transform care is largely untapped.

18. Similarly, we are on the precipice of an artificial intelligence (AI) revolution that could transform care for patients. A submission from the Royal College of Radiologists to the Investigation reported that 56 per cent of NHS trusts are already using AI tools within radiology[363]. From the discovery of new treatments to novel diagnostics and biomarkers to routine process automation, there are a multitude of ways in which the health service could see extraordinary change. With its deep and broad datasets, and the global AI hub that has emerged in the UK, the NHS could be at the forefront of this revolution with NHS patients the first to see the benefits. But to capture those opportunities, there will need to be a fundamental tilt towards technology.

* * *

19. A core tenet of industrialisation that transformed our prosperity in the 19th and 20th centuries was increased use of capital relative to labour to drive up productivity. In recent years, it appears that the NHS has been subjected to a kind of capitalism-in-reverse: forced to increase labour relative to capital, rather than the other way round.

    The workforce has been rapidly expanded while its capital base has been artificially constrained, since the health service as a whole—as well as individual trusts—lacks the authority to decide how the NHS budget is divided between day-to-day spending on wages and consumables versus capital investment in digital technology, diagnostic scanners, or modern buildings.

    It is little wonder, then, that productivity has declined when capital per worker fell year-on-year during the 2010s[364]. But the period of capital starvation was to have a far more costly impact during the pandemic, as we shall see in the next chapter.

8

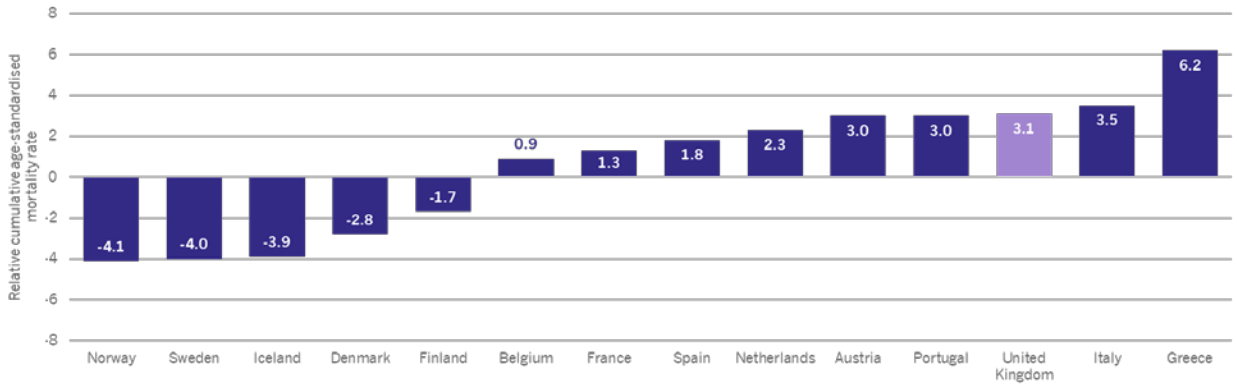
The impact of the Covid-19 pandemic

1. As we have seen, the NHS entered the pandemic after the most austere decade of funding in its history with chronic underinvestment in its infrastructure. In this chapter, we explore the impact of the Covid-19 pandemic on the NHS, and how its aftermath continues to affect the service today.

The impact of the Covid-19 pandemic

2. The Covid-19 global pandemic strained societies, economies, and health systems of every country on earth. Many lives were lost, including those of clinicians who were working at the frontline. It upended daily life for all of us. It was an unprecedented challenge in the modern era, that policymakers all over the world struggled to respond to. Analysis from the Health Foundation shows that, when measured by excess mortality, the UK did worse than many other comparable countries[365]. Indeed, as we can see in the chart below, cumulative excess mortality was amongst the highest of selected comparator countries[366].

Figure VI.2: Cumulative excess mortality, relative to the 2015 to 2019 average mortality rate, week ending 3 January 2020 to week ending 1 July 2022



3. One part of the explanation is the adequacy of the public health measures that were the direct response of the Government to the pandemic, which is the subject of the Covid-19 public inquiry. Yet as we have seen in chapter 1, the health of the

population had also deteriorated in the years preceding the pandemic. The population was, therefore, less resilient to infectious disease precisely because it was less healthy going into the pandemic. For instance, people with conditions such as obesity[367] or type II diabetes[368] were more likely to die from Covid-19.

The impact on the NHS

4. The resilience of the NHS was at a low ebb at the start of the pandemic. Analysis from the Nuffield Trust (updated with more recent data from the OECD and World Bank) shows that the NHS went into the pandemic with higher bed occupancy rates and fewer doctors, nurses, beds and capital assets than most other high-income health systems[369], as shown in the chart below.

Figure VI.3: International comparison of health system capacity going into the Covid-19 pandemic

	Practising physicians per 1,000, 2019	Practising nurses per 1,000, 2019	Hospital beds per 1,000, 2019	Occupancy rate of curative (acute) care beds, 2019	Total health spending, US dollars per capita, 2019	Average length of stay in hospital, 2019	Capital expenditure on health as share of GDP, average over 2015–19
UK	**3.0**	**8.2**	**2.5**	**89.1**	**4,268.7**	**6.7**	**0.4**
Australia	3.8	12.2			5,545.9	5.3	0.8
Austria	5.3	10.4	7.2	73.0	5,263.0	8.3	0.9
Belgium	3.4	11.6	5.6	72.5	5,049.6	6.0	1.0
Canada	2.7	10.0	2.5	91.6	5,116.0	7.6	0.5
Denmark	4.3	10.1	2.6		6,059.0		0.8
Finland	3.6	13.5	3.4		4,460.0	7.7	0.7
France	3.2	8.8	5.8	75.9	4,504.5	8.8	0.6
Germany	4.4	11.8	7.9	78.9	5,487.0	8.8	1.1
Ireland	3.3	13.4	2.9	89.9	5,462.7	5.9	0.4
Israel	3.3	5.1	3.0	91.6	3,354.0	6.7	0.6
Italy	4.1	6.2	3.2	78.1	2,911.0	8.0	0.4
Netherlands	3.8	10.8	3.0	63.7	5,341.0	4.4	0.9
Portugal	5.3	7.0	3.5	82.0	2,222.0	8.0	0.7
Spain	4.4	5.9	3.0	75.9	2,716.8	8.1	0.6
Sweden	4.3	10.9	2.1		5,653.0	5.6	0.6

Bottom third
Middle third
Top third

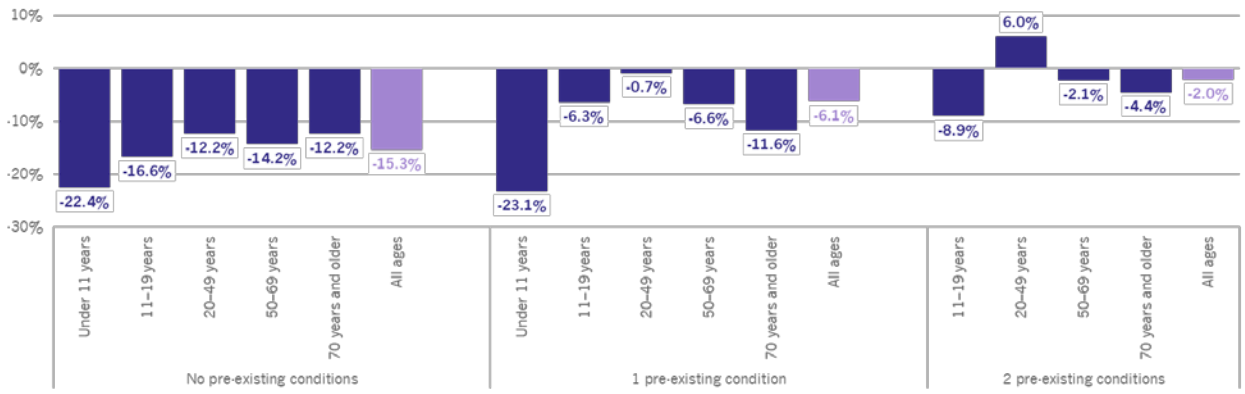
5. Countries with greater pre-existing capacity, and that more effectively contained coronavirus, were in a better position to cope with care backlogs arising from the pandemic and recover from its consequences. It is impossible to understand the state of the NHS today without understanding what happened to routine care during the pandemic as a result.

6. It is widely recognised that lockdowns caused a significant drop in the number of people accessing healthcare, both in this country and around the world. But what is not commonly understood is how much harder the NHS was hit than other comparable health systems.

7. Figures from the Health Foundation show that this impact was felt by people without health conditions as well as those with existing health conditions, as we

can see in the chart below[370]. Reductions in interactions with primary care meant fewer physical and mental health problems could be identified earlier[371] as the consultation rate fell by around 15 per cent for those with no preexisting conditions[372]. Moreover, for people with preexisting conditions it may well have meant a reduction in the early detection of deterioration and poorer adherence to medication. As we all know, the pandemic also led to a very significant increase in the need for mental health services[373].

Figure VI.4: Percentage change in consultation rate in 2020 compared to 2019, by number of pre-existing conditions and age



8. International comparisons show that the impact on the NHS appears far more severe than elsewhere. While almost all health systems that reported data saw significant falls in activity, the reductions were far greater in the UK than in almost all other similar countries with available data. Moreover, it is striking that the UK was an outlier, reducing its routine healthcare activity by a far greater percentage than any other health systems that recorded comparable data for areas such as hip or knee replacements, which fell 46 per cent and 68 per cent respectively[374] between 2019 and 2020. The UK also had the second greatest reductions in mastectomies which fell by 15 per cent compared to an OECD average of 9 per cent[375], which suggests that cancer treatment was also more significantly disrupted than other countries in the same time period.

Figure VI.6A: Hip replacement, percentage change between 2019 and 2020

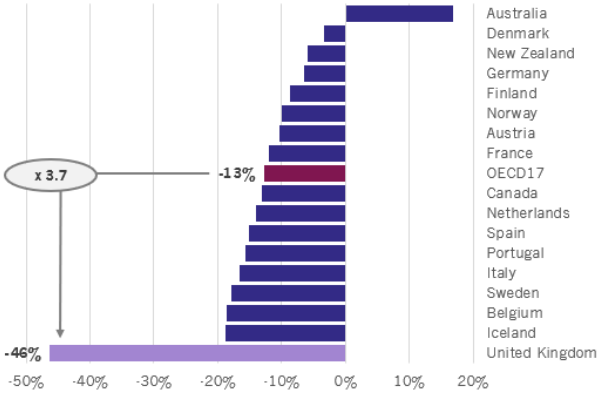


Figure VI.6B: Knee replacement, percentage change between 2019 and 2020

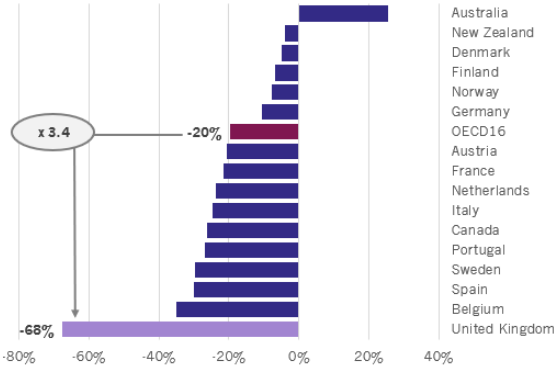


Figure VI.7A: Cataract replacement, percentage change between 2019 and 2020

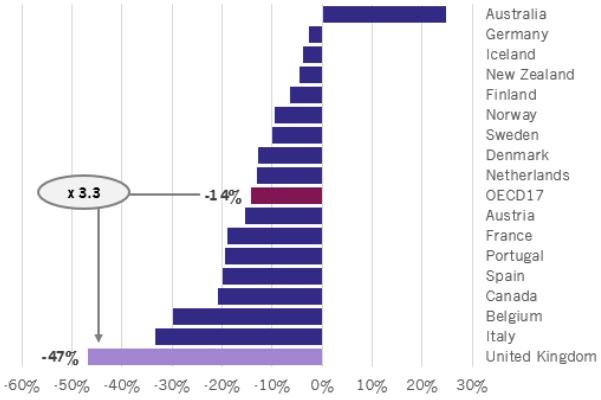
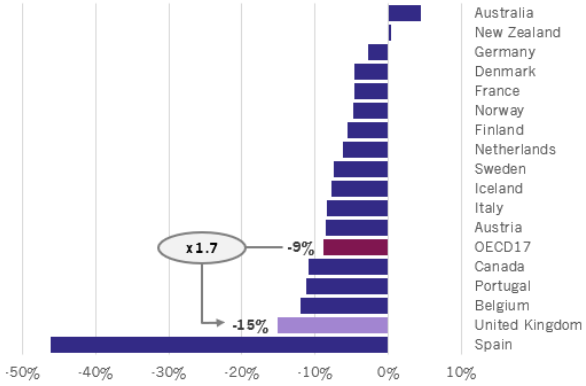
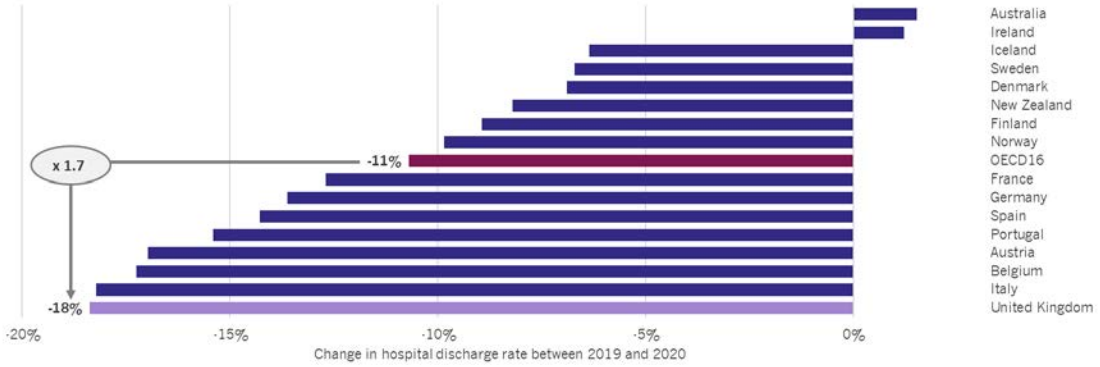


Figure VI.7B: Mastectomy, percentage change between 2019 and 2020



9. Although the OECD datasets only include a relatively small number of specific procedures, they also record changes in the hospital discharge rate per 1,000 inhabitants. By this metric, too, the UK reduced hospital activity by a larger percentage when compared to similar countries with available data. In the chart below, we can see that hospital discharges fell by 18 per cent between 2019 and 2020 in the UK, compared to the OECD16 average of 10 per cent[376].

Figure VI.8: Change in hospital discharge rate per 100,000 population, percentage change between 2019 and 2020



10. The state of the NHS today cannot be understood without recognising quite how much care was cancelled, discontinued or postponed during the pandemic. The pandemic's impact was magnified because the NHS had been seriously weakened in the decade preceding its onset. It will be for the Covid-19 public inquiry to consider the decisions which were made in the management of the pandemic. I do, however, want to highlight one unusual organisational decision which was taken at the time.

The public health system was reorganised in the middle of the pandemic

11. In 2021, in the midst of the pandemic, the Government took the decision to reorganise the public health system. Public Health England, which had been established by the Health and Social Care Act 2012, was abolished and its functions split into two[377]. Health improvement was moved to the Office for Health Improvement and Disparities in the Department of Health and Social Care while health protection was put into a new UK Health Security Agency.

12. Other countries have sought to strengthen their institutional arrangements in the wake of the pandemic[378]. Yet perhaps unsurprisingly, we could find no example of any other country abolishing its main public health institution in the middle of the Covid-19 pandemic. This, combined with the substantial real terms cuts to the public health grant[379], illustrate the turmoil in the public health system.

9

Patient voice and staff engagement

1. At its heart, the NHS is about people: staff, patients, carers and partners working together to treat sickness and to achieve better health. The NHS is not just a health system: it is a social movement of more than 1.5 million people who are bound by a common set of values that start with kindness and compassion. Understanding the state of the NHS means understanding where things stand with the people who it serves and those who work in it.

The patient and public voice is not loud enough

2. Patients rightly expect the NHS to deliver high quality care for all, all of the time. That not only means care that is safe and effective but that treats people with dignity, compassion and respect, making their experiences as positive as they can be.

3. The overwhelming majority of NHS staff passionately want to deliver high quality care for all their patients, all of the time. Every day, there are millions of moments of kindness and compassion—which is why the health service is held in such deep affection by so many people. There are many examples of excellent practice.

4. But in some respects, particularly in its decision-making and systems, the patient voice is simply not loud enough. There are real problems in responsiveness of services to the people they are intended to serve. The recent report from the All-Party Parliamentary Group on Birth Trauma[380], for example, highlights the important ways in which women's voices have not been heard. Similar stories are also true of other services.

5. As well as examples where patients and their carers have not felt listened to their care, there is potential for people to be more involved in designing and developing how services work. National Voices brought together 50 people with lived experience of using NHS services ahead of the NHS's 75th birthday. The

overwhelming view was that the NHS could do better at involving real experts (those living with an ongoing health condition) in how care was provided[381].

6. Listening to patients about what's important to them would help the NHS deliver tangible improvements to people's experience of the NHS. For example, communication with the people the NHS serves is sometimes lacking and despite patients saying this is a priority for them improving administrative processes for patient benefit is rarely prioritised[382]. A report by Demos for The Patients Association found that 55 per cent of those polled had experienced a communication issue with the NHS in the last five years[383]. Disabled people, those with long-term conditions and women were disproportionately affected by poor communication[384]. Research from Healthwatch England highlighted that 45 per cent of those on lists received none or not enough information while waiting. 82 per cent received no help at all with pain relief, physiotherapy or mental health support while waiting.[385]

7. The NHS could look to make data more publicly available by local authority area. More co-production could be done with the local population and patients on the NHS's priorities. A good example is how East London Foundation Trust is working with the people it serves to be a Marmot Trust, seeking to tackle health inequalities in all it does[386]. A strong voice for patients and local communities would promote more responsive services, while making it easier for the NHS to fulfil its promises to promote population health and to narrow health inequalities.

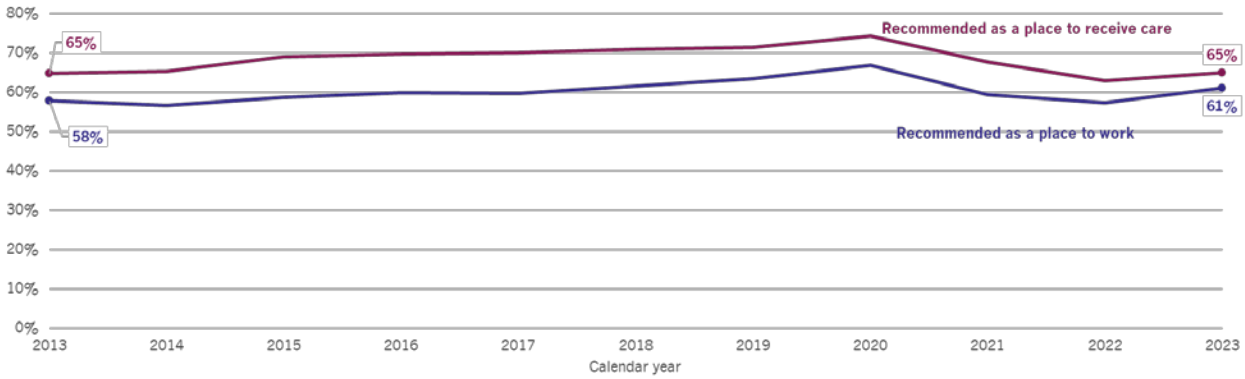
8. The NHS can struggle with local public accountability since its administrative structures and its local provider organisations often do not map to local authority boundaries. Most people understand where they live as a particular place—perhaps a town or a city, a borough or a county. Yet despite this, the NHS still does not routinely report on access, quality nor spending according to the places where people live.

Many staff feel disempowered and disengaged

9. Every day, more than a million NHS staff start their shifts ready to do their best for their patients. All too often, they end their shift frustrated and exhausted. Through focus groups, surveys, visits and contributions in writing, staff told us about their feelings of being disempowered and overwhelmed. In research for this Investigation commissioned from Thinks[387], the top three words NHS staff used to describe their experiences were "challenging", "tiring" and "frustrating". Around 60 per cent of

NHS staff would recommend their organisation as a place to work, while 65 per cent would recommend it as a place to receive care, as shown in the chart below[388].

Figure VII.2: Recommend as place to work or receive care, 2013 to 2023



10. It is hard to capture the essence of people's emotions. But there seems to be a deeply held belief that NHS institutions are not inclusive in the sense that many staff do not feel that their work is part of a common endeavour. One senior clinician described it to us this way: "there's no sense of ownership—you just want to move the patient on [to someone else], so they are no longer your problem". Given the shift away from activity-based funding, the reward for working harder is more work, not more resources.

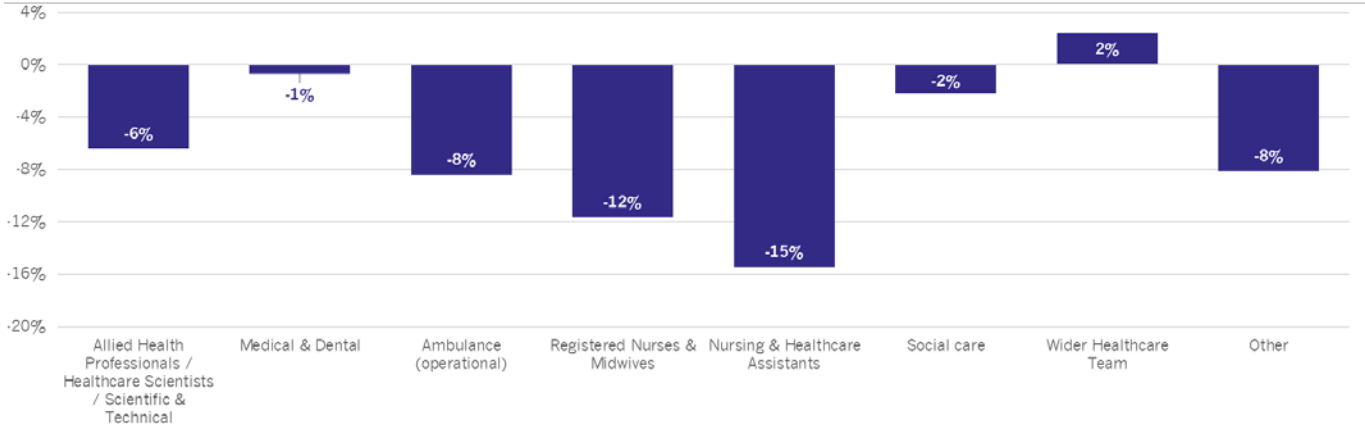
11. Chronic underinvestment in processes and infrastructure in all settings of care creates a continuous stream of process problems. While the evidence shows that health information technology improves care[389], the National Audit Office found that the NHS track record on digital transformation had been poor[390]. Focus groups for the Investigation found a strong perception among NHS staff that information technology created an additional burden. This intersects with the poor definition of operational processes, as the *Getting it right first time* programme has identified in multiple aspects of services. These types of problems are intensely frustrating precisely because frontline staff lack the power to fix them and because they distract from caring for patients. It is our belief that they therefore are at the heart of feelings of disempowerment and disengagement.

12. Relationships between different settings of care are particularly frayed. GPs, for example, voted for industrial action because of a proposed real-terms cut to practice incomes. But many GPs also shared with us or have written about their frustrations with the expanding workload[391]. While the number of fully-qualified GPs has been falling[392], the number of hospital-based doctors has risen[393]. Given that

most patients are discharged back to their GPs, this necessarily means that the GP workload increases.

13. Overall, there has been a reduction in discretionary effort across the health service. Analysis of the NHS staff survey shows fewer staff working beyond their contracted hours. This is not to suggest that they should be expected to; but it is a barometer of how many feel about their work[394].

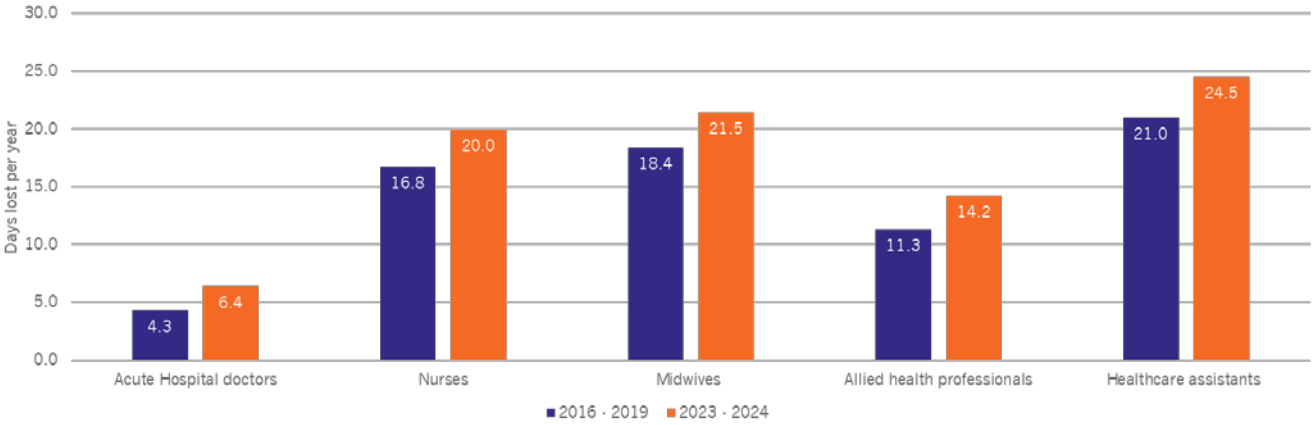
Figure VII.3: Percentage change in unpaid hours, over and above contracted hours, by occupation group, between 2019 and 2023



14. Underinvestment in the estate not only has consequences for patients, as the number of incidents that disrupt clinical care illustrates[395]. It also has an impact on staff morale. During one of my visits to inform this report, I saw a staff meeting room where the ceiling had collapsed. It was sheer good fortune that this took place at night so there were no injuries. Neither patients nor staff should be in crumbling buildings.

15. Rates of sickness absence have also increased, when comparing the situation before and after the pandemic, with sickness absence rising 29 per cent between 2019 and 2022[396]. In hospitals, there are 6.4 days lost per doctor per year to sickness absence. This rises to 20 days per nurse per year, 21.5 days per midwife per year, and 24.5 days per healthcare assistant per year[397].

Figure VII.4: Total days lost per year to sickness absence by staff group, 2016 to 2019 and 2023 to 2024

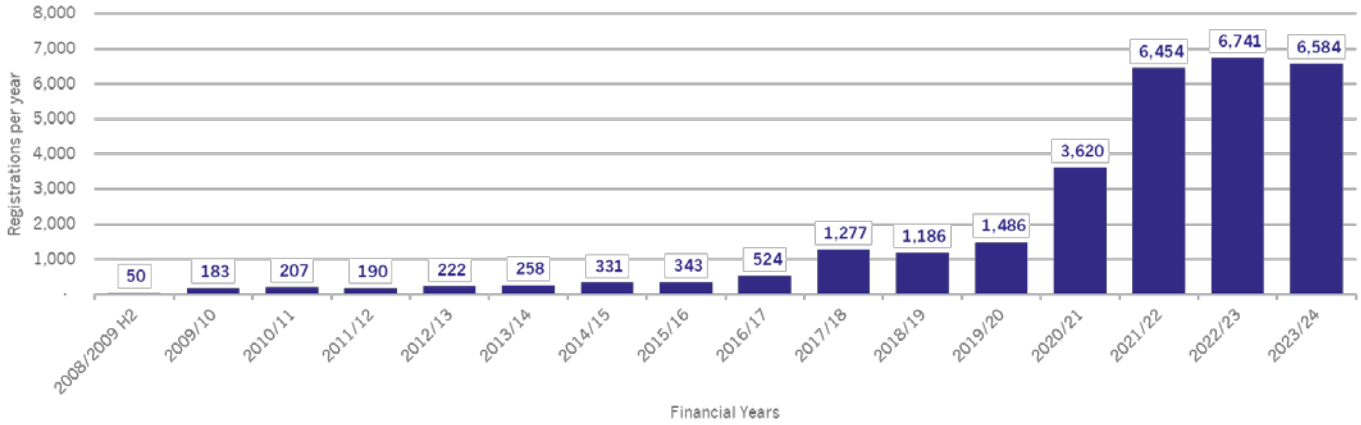


16. Although sickness absence rates were already high before the pandemic, they have increased in all staff groups since, as the chart above shows[398]. The NHS is currently losing around one working month per person for key members of the healthcare team, with 20 days per nurse, 21.5 days per midwife, and 24.5 days per healthcare assistant lost each year. This is well above the public sector average of 10.6 days per employee[399]. The most common reason cited for sickness absence was anxiety, stress or depression or other psychiatric illnesses[400].

Psychological impact of the pandemic and its aftermath

17. It is my belief that there has been a very significant impact on the psychological wellbeing of NHS staff from the pandemic and its aftermath. NHS Practitioner Health was founded in 2008 to treat health and social care professionals with mental health and addiction problems. Since its inception, it has treated some 30,000 staff, amounting to some 20 per cent of the medical workforce that it covers[401]. As the chart below shows, registration shot up during the pandemic[402]. Depression/low mood is the most common diagnosis for those presenting to the service, with 71.3 per cent of patients reaching the level for moderately severe and severe depression based on the PHQ9 questionnaire[403].

Figure VII.6: NHS Practitioner Health registrations by financial year



18. The effects continue to reverberate in the NHS today. The shadow of the pandemic has had a major impact on industrial relations and the significant number of strikes that have taken place. Many NHS staff were particularly angry about being valorised during the pandemic only to be presented with what they believed were unsatisfactory pay settlements.

Cultural challenges in the NHS

19. There are many wonderful aspects of being a part of the NHS family. But there are some very serious issues too. As the outgoing Parliamentary and Health Service Ombudsman Rob Behrens made plain[404], there are some deep cultural issues in the NHS that must be addressed. These include concealing problems and taking retaliatory action against clinicians who raise concerns. He cited a "cover-up culture" that included "the altering of care plans and the disappearance of crucial documents after patients have died and robust denial in the face of documentary evidence". More than a decade after the Francis Inquiry[405], the NHS still appears to struggle with the duty of candour.

Leadership

20. Getting the best from people requires great leadership. Leadership is not about individuals who stand tall, but about communities who raise people up, and the NHS has been an extraordinary engine of leadership development and social mobility. Healthcare leadership is a particularly challenging task precisely because the stakes cannot be higher – people rely on vital NHS services – and there is

seemingly unending complexity. And it requires leadership at every level of the system and within and across all different staff groups.

21. The NHS has many strong and capable leaders. It needs more. Fortunately, leadership is not a quality that is simply endowed; it is a skill that can be learned. For the NHS to have more and better leaders, it needs to continue to invest in them.

22. The independent report from General Sir Gordon Messenger and Dame Linda Pollard published in 2022 offered a powerful analysis of the challenge[406]. It described institutional inadequacy in the way that leadership and management is trained, developed and valued. It highlighted stress in the workplace and the sense of constant demands from above that creates "an institutional instinct…to look upwards to furnish the needs of the hierarchy" rather than outwards to patients and communities that the NHS exists to serve. It recognised that there were "too many reports to ignore of poor behavioural cultures and incidences of discrimination, bullying, blame cultures and responsibility avoidance".

23. The report made important recommendations, too, which NHS England has begun to implement. Alongside targeted interventions, it highlighted the importance of inclusion, more consistent training, standardised appraisal systems, better talent management of managers and non-executives, and the encouragement of top leaders into challenged parts of the system.

10

NHS structures and systems

1. Over the past 15 years, the structure of the NHS has changed radically. There has been a decisive shift in the improvement philosophy away from competition and towards collaboration. The NHS in England now has structures that are more similar to those in Wales and Scotland. Structures and systems are not an end in themselves, but a means to an end. Their ultimate purpose is to deliver better performance by ensuring resources are deployed in the right places and used as well as possible. As we have seen, performance is poor on access, mixed on quality, and the NHS has not been able to implement its two main strategic priorities. Here, we examine how the structures and systems have contributed to that outcome.

The Health and Social Care Act and its aftermath

2. The Health and Social Care Act of 2012 was without international precedent. It was a uniquely complicated piece of legislation, comprising more than 280 clauses plus 22 schedules, amounting to some 550 pages[407]. Indeed, it was three times the size of the 1946 Act that founded the NHS[408]. During the chaotic parliamentary process, more than 2,000 amendments were submitted[409].

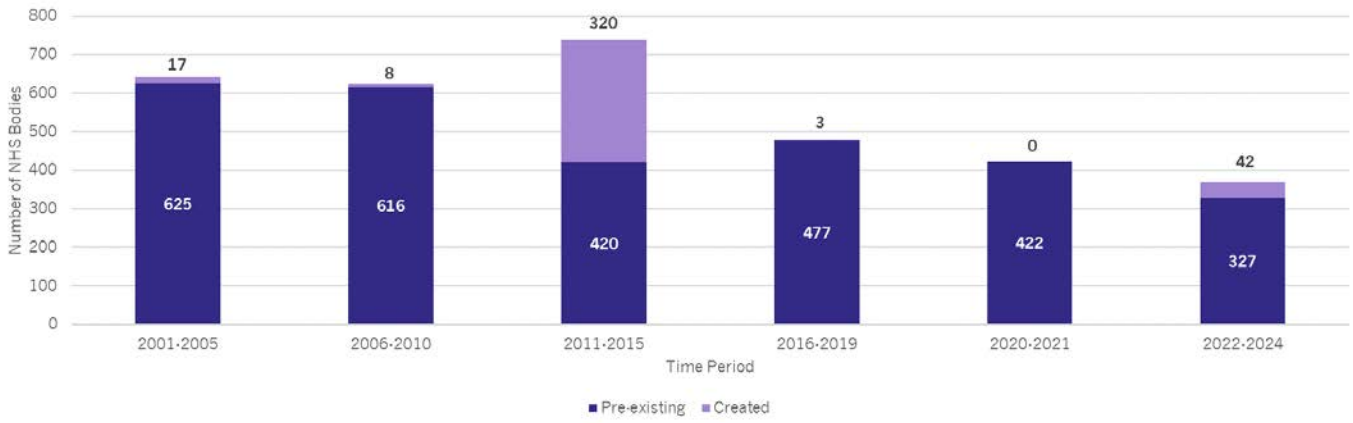
3. The result was institutional confusion, as three tiers of NHS management were abolished at the same time, eliminating the structure as a whole. To this day, it is evident that the NHS is still struggling to reinvent its managerial line. It is therefore impossible to understand the state of the NHS in 2024 without understanding why its managerial structures are so challenged.

4. The reforms were intended to dissolve the management line of the NHS, a move that the white paper framed as "liberating the NHS"[410]. If the goal was to increase the role of GPs in commissioning, a single sentence of legislation—requiring a majority of the board of directors and the chair of a primary care trust to be registered with the GMC as general practitioners—would have accomplished it.

Instead, every commissioning organisation in the health service was abolished and entirely new clinical commissioning groups had to be constructed from scratch. It was a hitherto unprecedented 'scorched earth' approach to health system reform.

5. As analysis below sets out, the reforms established more than 300 new NHS organisations between 2010/11 and 2015/16. No health system, even with the most talented managers in the world, could be expected to build such a large number of organisations and for them to be high-performing in less than five years. Such huge change in commissioning and regulatory structures also has an opportunity cost: just imagine if all the effort and resource that had been poured into dissolving and reconstituting management structures had been invested in improving the delivery of services.

Figure IX.1.1: Number of NHS Bodies existing and created across time periods



6. The seminal *World Health Report 2000* focused on health system performance and set out the four core functions of health systems[411]. Namely, *stewardship*, including policy-setting and regulation; *financing*, including funding, pooling, and commissioning (also called paying or purchasing in private systems); *resource creation*, including investment and workforce education and training; and *provision of healthcare services*, including primary, community, mental health and acute services.

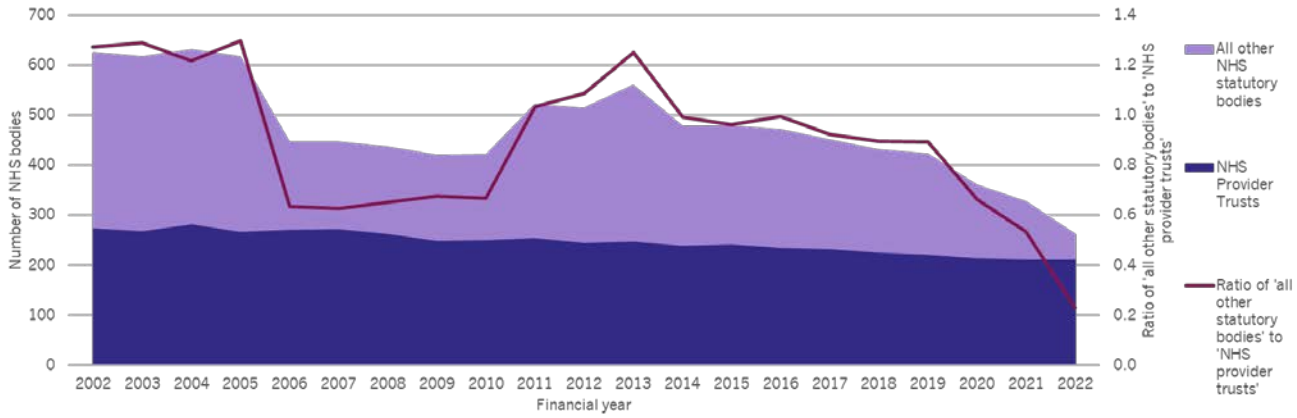
7. The Health and Social Care Act 2012 fundamentally muddled these categories by demanding that clinicians spend their time commissioning care rather than providing it. Despite the name "clinical" commissioning groups, these were in fact dominated by GPs who were not equipped with the training or resources to succeed, and who had no functional organisations that they could inherit. Indeed, the opposite was true: by dissolving the old structures rather than reforming them, GPs were to all intents and purposes set up to fail.

8. An analysis of international health systems prepared for this report could find no example in any advanced country of the top-down reorganisation of a health system that deliberately fragmented commissioners (variously known as payors, purchasers, or insurers). For example, Germany consolidated from 420 sickness funds in 2000 to fewer than 100 by 2022,[412] while in 2007, Denmark reduced the number of healthcare regions from 13 to five.[413]

9. Even reforms underpinned by the same philosophy of regulated market competition sought to consolidate and strengthen institutions rather than to fragment and weaken them. The Netherlands market-based reforms of 2006, for example, nearly halved the number of insurance companies[414] from nearly sixty to a little over thirty.

10. Analysis shows that NHS management and administrative organisations exceeded the number of care-providing organisations until the 2006 consolidation, partly because prior to that year primary care trusts both commissioned acute services and primary medical care and provided community services[415]. As the chart shows, the fragmentation introduced by the Health and Social Care Act 2012 was not reversed until 2020.

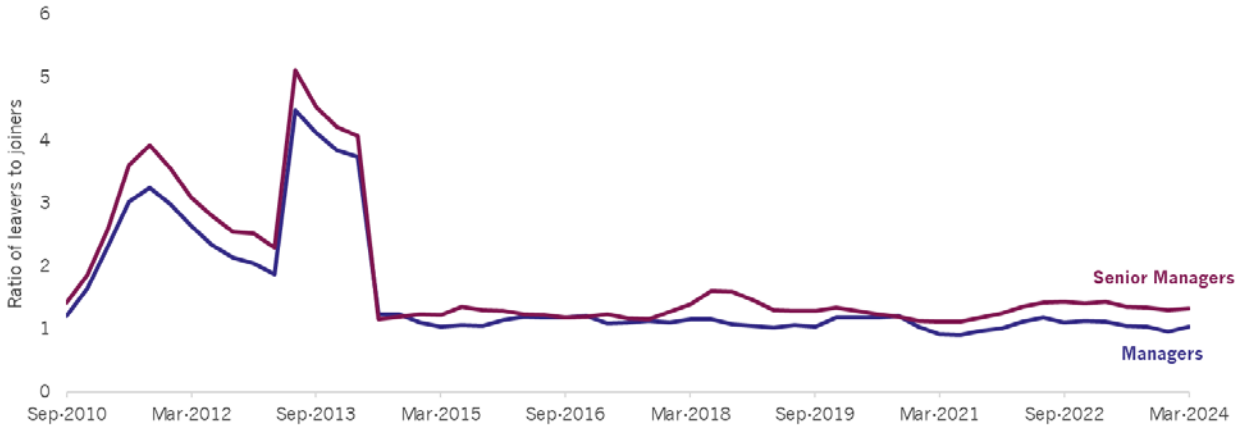
Figure IX.1.3: Number of NHS bodies, 2002 to 2022



11. It had quickly become apparent that the new system was dysfunctional, but the political space to confront the mistakes was absent. By 2015, both ministers, the Department of Health and NHS England were already putting in place "workarounds and sticking plasters" to bypass the legislation from 2012[416]. But the problems would not be directly addressed for a decade, during which NHS management structures had to be cobbled together as best they could.

12. The result of the disruption was a permanent loss of capability from the NHS. Experienced managers left meaning the NHS lost their skills, relationships and institutional memory, as the chart below shows[417]. New teams had to be formed, reporting to GPs, most of whom had no prior experience in NHS administrative structures and were independent contractors to the health service. Many health service managers believe strategic commissioning capabilities—the skills to deliver the priorities to redistribute resources out of hospital and integrate care —are weaker today than they were 15 years ago. This is an important part of the explanation for the deterioration in performance of the NHS as a whole.

Figure IX.1.4: Turnover of managers and senior managers: ratio of leavers to joiners, September 2010 to March 2024



13. Rather than liberating the NHS, as it had promised, the Health and Social Care Act 2012 imprisoned more than a million NHS staff in a broken system for the best part of a decade.

Recent reforms

14. The Health and Care Act 2022 formally addressed the problem of subscale clinical commissioning groups by consolidating into much larger integrated care systems. The result is that the basic structure of a headquarters, regions, and integrated care boards (ICBs) is fit for purpose. Each ICB on average is responsible for 1.4 million people[418] which is typical by international standards.

15. There are significant implementation challenges for the 2022 Act. The function and authority of ICBs remains unclear in some important respects. The 2023 Hewitt Review was unable to clearly define the relationship between providers and ICBs, and the ambiguity persists[419]. There are duplications of functions between ICBs and

providers, such as in infection prevention and control, where trust boards should be held accountable. More consistency is now needed in the way ICBs are organised and their functions should be more standardised.

Oversight and regulation

16. Constant reorganisations are costly and distracting. They stop the NHS structures from focusing on their primary responsibility to raise the quality and efficiency of care in providers.

17. Between 2013 and 2022 the number of staff working in NHS England (including its predecessor organisations) increased from 11,300 to 19,500. At the direction of ministers, over the last two years NHS England has merged with NHS Digital and Health Education England. NHS England has since implemented a 35 per cent management cost reduction programme such that it now employs around 16,000 staff[420] and the headcount continues to fall. Some 5,200 staff are employed in national shared services, such as education and training and IT infrastructure[421]. Around 3,400 work in national programmes and improvement support, such as for cancer, mental health, or urgent and emergency care, while 3,500 staff are based in its seven regions[422]. Excluding those in national shared services or the back office of NHS England itself, this equates to 45 people for each of the 212 provider Trusts.

18. At the same time, the Department of Health and Social Care has grown by around 50 per cent from 1,920 in 2013 to 3,185 in 2024[423]. While the Department has a broader range of responsibilities that the NHS, it continues to be involved in policy making that impacts NHS providers. This is compounded by dozens of other organisations that exert some degree of regulatory or policy influence on providers, from regulators of the professions to Royal Colleges to the Health and Safety Executive. Research from 2019 found 126 organisations exerting some influence over NHS providers[424].

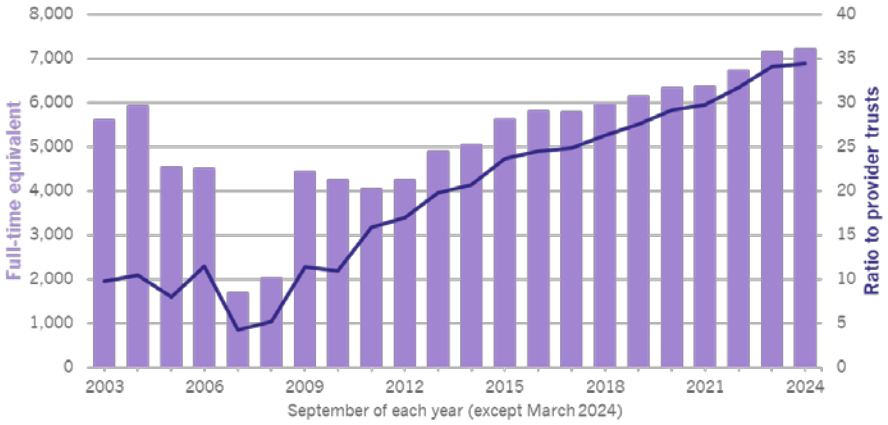
19. Nonetheless, the expansion at the top presents some challenges. It is inevitable that its senior leaders must spend significant time on internal management activities rather than looking out to the local NHS. It is hard to have clear accountability because tasks are distributed across such a large group of people. And many people at the top of the organisation encourages local NHS organisations to look upwards to them, as well as outwards to the communities that they serve.

Figure IX.3.7: Employment in the NHS England, DHSC and NHS Provider Trusts

Payroll Period	NHS England Total	DHSC Total	NHS England & DHSC Total	NHS Provider Trust	Headcount per trust
2013/14	11,331	1,920	13,251	249	53.2
2014/15	11,771	2,028	13,799	240	57.5
2015/16	11,321	2,001	13,322	243	54.8
2016/17	11,889	1,355	13,244	236	56.1
2017/18	13,189	1,519	14,708	234	62.9
2018/19	13,474	1,622	15,096	227	66.5
2019/20	13,471	1,770	15,241	223	68.3
2020/21	15,492	3,530	19,022	216	88.1
2021/22	18,606	4,075	22,681	213	106.5
2022/23	19,481	3,670	23,151	212	109.2
2023/24	15,857	3,185	19,042	212	89.8
CAGR (%)	27.5%	2.3%	15.1%		21.1%

20. The expansion of NHS England is compounded by the growth in the numbers of people employed in regulatory type functions[425]. As we can see from the chart below[426], the numbers of people employed in regulatory type bodies has increased from just over 2,000 in 2008 to more than 7,000 in 2024, and the number of people in regulatory roles for each provider trust has gone from 5 per provider to more than 35, as trusts have consolidated over the same period. This imposes a burden on Boards and management teams of care-providing organisations. Taken together, there are some 80 people in organisations at the top of the system for each NHS provider trust.

Figure IX.3.8: The full-time equivalent number of staff in NHS statutory bodies with 'regulatory' type functions, and the ratio of staff to provider trusts, 2003 to 2024



Statutory bodies in scope:
NHS Resolution
National Institute for Health and Clinical Excellence
National Patient Safety Agency
NHS Counter Fraud Authority
Appointments Commission
Health Development Agency
NHS Information Authority
NHS Litigation Authority
National Treatment Agency
Prescription Pricing Authority
Family Health Services Appeal Authority
Dental Practice Board
Human Fertilisation and Embryology Authority
Health Research Authority
Human Tissue Authority
Care Quality Commission
Medicines and Healthcare products Regulatory Agency
Health Services Safety Investigations Body

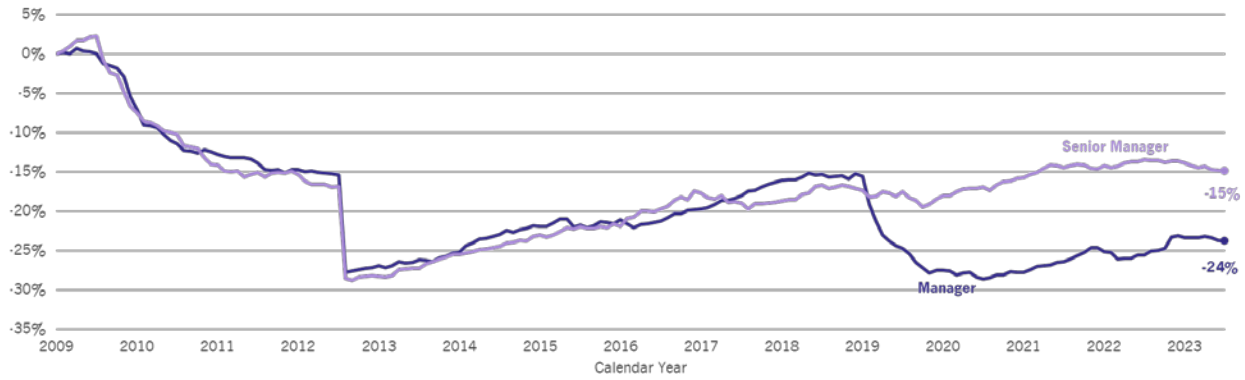
21. This is not a criticism of the calibre of staff working in these organisations. If anything, it is the opposite: intrinsically-motivated, highly-qualified and capable people tend to want to have impact through their work—but while each initiative may have value on its own terms, ultimately their output lands on the same management teams. The result is an ever-lengthening list of demands on providers.

Management capacity and capability

22. Despite what some media commentators may say[427], good management has a vital role in healthcare: it exists to ensure that the maximum healthcare value is created with the resources that are available. In providers, managers are there to ensure efficient organisation and process so that clinicians can deliver high quality care to meet the needs of patients.

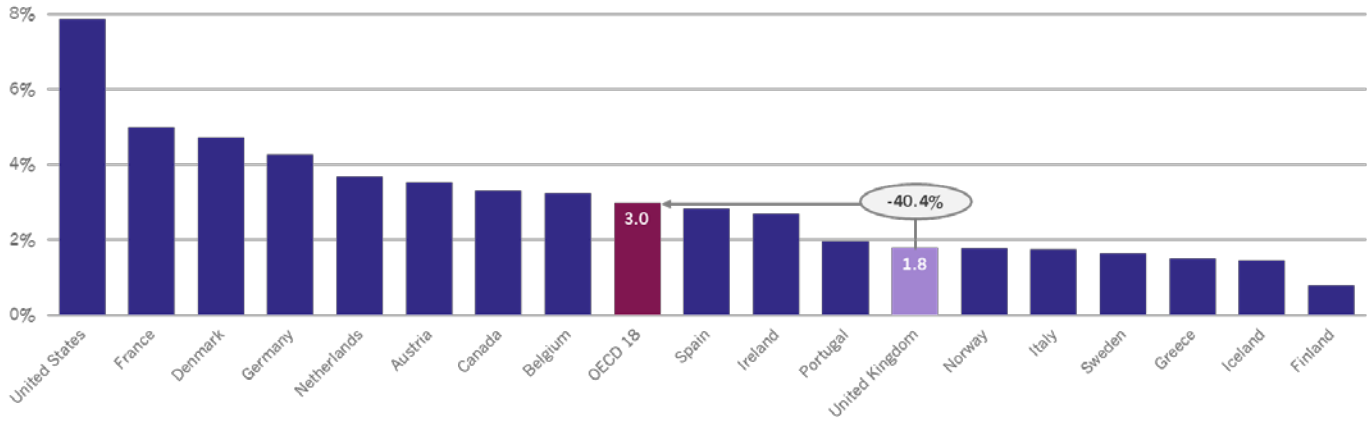
23. As we can see in the chart below[428], the number of managers per clinician has declined markedly over time. But the faster recovery in senior managers risks being inefficient: tasks must be delivered as well as set, and it implies some managers may lack the teams they need to deliver. Moreover, many clinicians take on managerial responsibilities, such as service directors. They find themselves lauded in one capacity and demonised in another. This is counterproductive.

Figure IX.2.3: Change in managers per NHS employee since September 2009



24. The problem is not too many managers but too few with the right skills and capabilities. International comparisons of management spend show that the NHS spends less than other systems[429]. This has often been observed as source of pride; but it may well be a failing, since it suggests that the NHS is not employing enough people whose primary responsibility is that its resources are used well, and the talents of its clinicians are focused on delivering high quality care. We need to invest in developing managerial talent and creating the conditions for success.

Figure IX.2.1: Administration and overall governance spend as a percentage of total health expenditure, 2023 (or nearest year)



Systems, incentives and regulation

25. The performance of the NHS reflects the way its internal systems and processes operate as well as the resources and structures that it has to deliver care. Here, we briefly examine some of the key themes.

Planning blight

26. The Health and Social Care Act deepened the "planning blight" already afflicting the NHS, such as when the plans for stroke reconfiguration in London were called in by the Secretary of State. More recently, the lack of alignment between the Department of Health and Social Care and HM Treasury caused delays to the planning guidance for the financial year 2024-25. It was not issued until after the financial year had begun, so organisations across the health service started the year without a finalised financial plan.

27. The instability of NHS structures and the multitude of workarounds and sticking plasters that became necessary as a result of the dysfunction of the Health and Social Care Act meant that NHS processes became fiendishly complicated. The Health and Social Care Act divided up functions among a multiplicity of new institutions. In a single decade, NHS Improvement, NHS Trust Development Authority, Health Education England, NHS X, and NHS Digital were all created and abolished, with their functions and staff rolled into NHS England.

28. This has created an unenviable task of attempting to bring coherence and cultural cohesion to an organisation whose role and functions have been in constant flux. The result of such institutional upheaval at a national level is that almost every

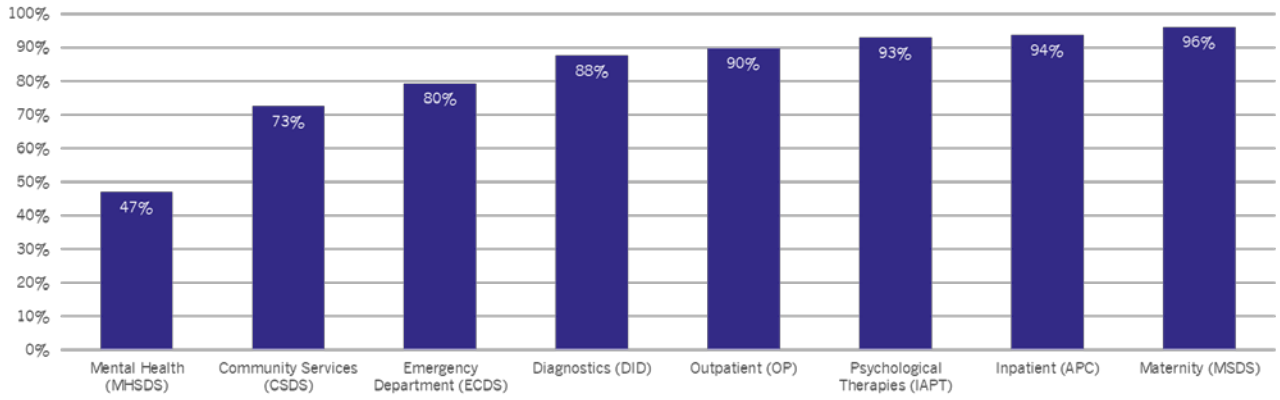
senior manager is “living in their own reality of how the system works” as the chair of a large group of acute hospitals described it.

29. During stakeholder discussions, we found managers routinely had differing understandings about how decisions were made, particular around capital and service change. Much of the frustration with NHS England appears to be the direct consequence of the dysfunctional capital regime. While the rules are defined by HM Treasury, NHS England is the face of those decisions in the NHS.

Data and performance management

30. In healthcare, as in all organisations, what gets measured gets managed. The NHS has focused its data collection and analysis on the acute hospital sector. Patient-level information has been collected centrally for hospitals since 2007, with aggregate data preceding that. In contrast, there is almost no centrally held data for mental health before 2016 and virtually nothing for community services until 2021. Community settings employ hundreds of thousands of people, and too little is known about the work that they do, the impact that they have, and the productivity that they achieve.

Figure IX.4.1: Data Quality Maturity Index, March 2024



31. As the Hewitt Review pointed out, there are too many targets set for the NHS which makes it hard for local systems to prioritise their actions or to be held properly accountable[430]. The Review recommends that the NHS prioritise a small number of important targets and seeks to make progress on them, such as referral to treatment times across all settings of care.

32. There are some important ways in which the performance management framework needs to change, in particular to clarify the role of ICBs with regards to provider trusts. Given the scale of the performance challenge, it will be essential that this is resolved at pace.

Incentives for performance

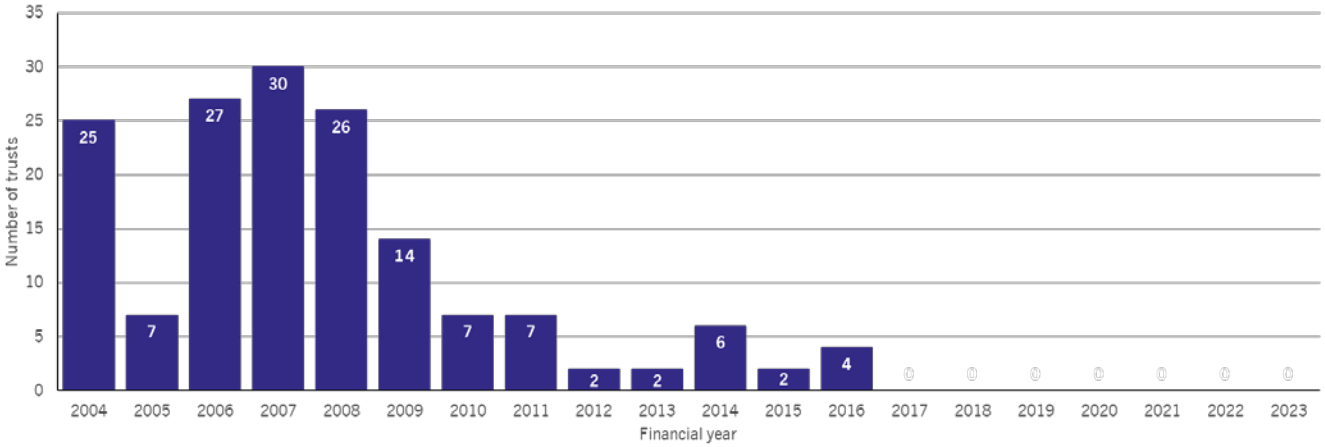
33. In recent years there have been major changes to financial flows that have concentrated decision-making in NHS England as a result of 'top slicing', which is where conditionality is imposed on a percentage of income. While the NHS's most local services—primary care, dentistry, and optometry—had been shifted to national commissioning by the 2012 Act, following the 2022 Act, NHS England rightly returned these to ICBs. There is a tension between being more directive—protecting funding for primary, community, and mental health services—and being more devolved. The balance will shift further with the recent announcement by NHS England that specialised commissioning budgets are to be devolved to ICBs.

34. Over the past decade, there has been a significant shift in payments away from activity-based mechanisms, although they remain in place for elective care. By doing so, funds have become more consolidated and less transparent. National pricing has been replaced with block contracts where providers are funded for their efforts rather than their outputs. It is perhaps not a coincidence that the drop in clinical productivity metrics for the urgent and emergency pathway is nearly double that for outpatients and elective surgery[431], since it remains on block contracts. There are international examples of payment innovations that incentivise activity while containing costs[432].

35. As the number of organisations in deficit has risen, the amount of funds held centrally has increased in order to balance the system as a whole. While there can be no doubt about the expediency of this approach, over the longer-term it risks complacency in providers who may begin to believe they will always be bailed out.

36. At the institutional level, trusts no longer advance to foundation trust status, since a policy decision was taken to cease the foundation trust pipeline in 2016, and the status itself has been diminished as they have lost their freedom to determine capital spending. This was imposed in response to the overall capital constraints set by HM Treasury but reduces the incentives for Boards to develop their organisations. It drives intense frustration when organisations have the cash available to fund investment but are not permitted to spend it.

Figure IX.4.5: Numbers of NHS organisations authorised as Foundation Trusts for the first time



37. The incentives for individual trust leaders are blunt. The only criteria by which trust chief executive pay is set is the turnover of the organisation. Neither the timeliness of access nor the quality of care are routinely factored into pay. This encourages organisations to grow their revenue rather than to improve operational performance. Our analysis found that the revenue per NHS provider trust had more than doubled between 2011 and 2022, reflecting increasing budgets and the consolidation of trusts[433].

38. Ultimately, the incentives for organisations and their senior leaders work their way through to the frontline. In recent years, there have been few incentives for teams to change how they work, since neither their organisations nor their departments would be rewarded for doing so, since income was largely fixed through block contracts and the earned autonomy framework of foundation trusts was discontinued.

39. The recent introduction of volume incentives for elective recovery have had a powerful, galvanising effect that shows how much performance can be unlocked by the combination of resources and incentives. For-profit insourcing companies are offering to do NHS work for 20-30 per cent below the national tariff[434]. They use NHS facilities, clinicians, and consumables. One of the crucial differences between insourcing companies and the NHS provider trusts in which they work is their fundamentally different approach to individual and team incentives[435].

Regulation of quality of care

40. The interim findings of the review of the Care Quality Commission (CQC) by Penny Dash found "significant failings in the internal workings of CQC which have led to a substantial loss of credibility within the health and social care sectors, a deterioration in the ability of CQC to identify poor performance and support a drive to improve quality - and a direct impact on the capacity and capability of both the social care and the healthcare sectors to deliver much needed improvements in care"[436].

41. Many clinicians and managers believe the CQC to be excessively focused on staff numbers and paperwork, at the expense of patient experiences and clinical outcomes. For reasons that are unclear, in recent years the CQC abandoned the specialised inspection model that it moved to from 2014 onwards in the wake of the inquiry into care failings at Mid-Staffordshire Trust in 2013[437].

42. Despite the highest level of hospital employment in the world, there appears to be no problem for which the CQC believes the solution is something other than to add more staff. One Trust described how it had been issued with a warning notice by the CQC on the grounds that inspectors had been told a ward was so short of staff that it was "unsafe", only for it to emerge that the general ward had better than a one-to-one ratio of staff to patients. The CQC had made no effort to establish the facts prior to issuing the warning notice which was subsequently withdrawn. It is this type of behaviour that has contributed to the sharp increases in staffing and falling productivity.

Competition and quasi-markets

43. Since the 1980s and the creation of the internal market, the NHS has used quasi-markets to promote efficiency improvements. In acute hospital services, this saw funding shift from being based on inputs to being linked to activity and ultimately to following patients according to their choices. The idea was that this would create competition *in* the market for elective services which would encourage providers to reduce waiting times and improve patient experience. This was part of the way in which the NHS got to peak performance during the first decade of this century[438].

44. Under the NHS Constitution, patients continue to have the right to choose their provider[439]. But in practice, patients are not routinely asked where they would like to receive their care[440]; to exercise their rights, they must demand them of their own volition, and nearly half of adults are unaware that they have a legal right to choose[441]. The practical effect has been that the quasi-market for elective care

services has been weakened. This is despite the fact that choice remains popular, with 75 per cent of the public agreeing that they should have a right to choose their provider, in opinion polls[442].

45. A different approach was taken for community and mental health services. With community-based staff highly distributed and often working in people's own homes, these services have the characteristics of natural monopolies, such as railways or water. The Health and Social Care Act 2012 therefore aimed to introduce competition *for* the market by requiring community and mental health services to be put out to tender.

46. Just as this approach failed in railways and water[443], the introduction of quasi-markets for natural monopolies such as out-of-hospital services has produced perverse results[444]. Some community and mental health trusts now operate services in four or more ICBs, for example, and tender processes continue to create needless recruitment and retention crises[445].

47. Precisely because this form of competition appeared to generate no benefit, the requirement for competitive tendering was removed by the Health and Care Act 2022. Yet the legacy is an incoherent pattern of service delivery that further exacerbates the challenges of raising the quality and efficiency of out-of-hospital services.

48. Yet despite all-but eliminating the role of markets, the NHS is yet to fully embrace the planned alternative. The NHS Long Term Plan was published in 2019, but was quickly superseded by events with the outbreak of the pandemic the following year. Since then, political demands have pushed the NHS to a short-term operational focus and the priority has been to recover performance.

Conclusion

The NHS is in critical condition, but its vital signs are strong

1. It is apparent from this report and from the accompanying analysis that the NHS is in critical condition. It continues to struggle with the aftershocks of the pandemic. Its managerial capacity and capability have been degraded by disastrous management reforms, and the trust and goodwill of many frontline staff has been lost. The service has been chronically weakened by a lack of capital investment which has lagged other similar countries by tens of billions of pounds. All of this has occurred while the demands placed upon the health service have grown as the nation's health has deteriorated.

2. Some have suggested that this is a failure of NHS managers. The NHS is the essential public service and so managers have focused on "keeping the show on the road". Some fantasise about an imaginary alternative world where heroic NHS managers were able to defy the odds and deliver great performance in a system that had been broken. They are wrong. Better management decisions might have been taken along the way, but I am convinced that they would have only made a marginal difference to the state that the NHS is in today.

3. Despite the challenges set out in this report, the NHS' vital signs remain strong. The NHS has extraordinary depth of clinical talent, and our clinicians are widely admired for their skill and the strength of their clinical reasoning. Our staff in roles at every level are bound by a deep and abiding belief in NHS values and there is a shared passion and determination to make the NHS better for our patients. They are the beating heart of the NHS. Despite the massive gap in capital investment, the NHS has more resources than ever before, even if productivity is far from where it should be.

4. Nothing that I have found draws into question the principles of a health service that is taxpayer funded, free at the point of use, and based on need not ability to pay. With the prominent exception of the United States, every advanced country has universal health coverage—and the rest of the world are striving towards it. But other health system models—those where user charges, social or private insurance

play a bigger role—are more expensive. It is not a question, therefore, of whether we can afford the NHS. Rather, we cannot afford *not* to have the NHS, so it is imperative that we turn the situation around.

5. It has taken more than a decade for the NHS to fall into disrepair so improving it will take time. Waiting times can and must improve quickly. But it will take years rather than months to get the health service back to peak performance. I have no doubt that significant progress will be possible, but it is unlikely that waiting lists can be cleared and other performance standards restored in one parliamentary term. Just as we in the NHS have turned around performance before, we can do so again.

6. There are some important themes that have emerged for how to repair the NHS. These include the following:

    - *Re-engage staff and re-empower patients*. Despite all the challenges and low morale, NHS staff are profoundly passionate and motivated to raise the quality of care for patients. Their talents must be harnessed to make positive change. The best change empowers patients to take as much control of their care as possible.

    - *Lock in the shift of care closer to home by hardwiring financial flows*. General practice, mental health and community services will need to expand and adapt to the needs of those with long-term conditions whose prevalence is growing rapidly as the population age. Financial flows must lock-in this change irreversibly or it will not happen.

    - *Simplify and innovate care delivery for a neighbourhood NHS*. The best way to work *as* a team is to work *in* a team: we need to embrace new multidisciplinary models of care that bring together primary, community and mental health services.

    - *Drive productivity in hospitals*. Acute care providers will need to bring down waiting lists by radically improving their productivity. That means fixing flow through better operational management, capital investment in modern buildings and equipment, and reengaging and empowering staff.

    - *Tilt towards technology*. There must be a major tilt towards technology to unlock productivity. In particular, the hundreds of thousands of NHS staff working outside hospitals urgently need the benefits of digital systems. There is enormous potential in AI to transform care and for life sciences breakthroughs to create new treatments.

- *Contribute to the nation's prosperity*. With the NHS budget at £165 billion this year, the health service's productivity is vital for national prosperity. Moreover, the NHS must rebuild its capacity to get more people off waiting lists and back into work. At the same time, it should better support British biopharmaceutical companies.

- *Reform to make the structure deliver*. While a top-down reorganisation of NHS England and Integrated Care Boards is neither necessary nor desirable, there is more work to be done to clarify roles and accountabilities, ensure the right balance of management resources in different parts of the structure, and strengthen key processes such as capital approvals. Change will only be successful if the NHS can recover its capacity to deliver plans and strategies as well as to make them.

7. Many of the solutions can be found in parts of the NHS today. The vast array of good practice that already exists in the health service should be the starting point for the plan to reform it. The NHS is a wonderful and precious institution. And no matter the challenges it faces, I am convinced it can return to peak performance once again.

Annex A

Expert Reference Group Membership

I would like to extend my thanks to all members of the expert reference group, and particularly to Jennifer Dixon of the Health Foundation and Matthew Taylor of the NHS Confederation for their assistance in moderating the meetings.

1. The Academy of Medical Royal Colleges
2. Age UK
3. The Allied Health Professions Federation
4. Alzheimer's Society
5. The Association of Ambulance Chief Executives
6. The Association of British HealthTech Industries
7. The Association of Directors of Adult Social Services
8. The Association of Medical Research Charities
9. The Association of the British Pharmaceutical Industry
10. The British Dental Association
11. The British Generic Manufacturers Association
12. The British Heart Foundation
13. The British In Vitro Diagnostics Association
14. The British Red Cross
15. Cancer Research UK
16. The Care Provider Alliance
17. Carers UK
18. Central London Community Healthcare Trust
19. Child Poverty Action Group
20. Diabetes UK
21. Disability Rights UK
22. Faculty of Pharmaceutical Medicine
23. The Faculty of Public Health
24. Family Action
25. The Foundation Group of NHS Trusts
26. Groundswell
27. The Health Foundation
28. Health Innovation Yorkshire and Humber
29. Healthwatch England

30. Hertfordshire Partnership University NHS Foundation Trust
31. The Independent Health Providers Network
32. The Institute for Fiscal Studies
33. The Institute for Government
34. The Institute for Public Policy Research
35. The Joseph Rowntree Foundation
36. The King's Fund
37. The Local Government Association
38. Locala
39. MacMillan Cancer Support
40. Mind
41. Mums Aid
42. The National Association of Primary Care
43. The National Autistic Society
44. National Voices
45. NHS Confederation
46. NHS Cornwall and Isles of Scilly Integrated Care Board
47. NHS Dorset
48. NHS Employers
49. NHS Providers
50. NHS Race and Health Observatory
51. North East and North Cumbria Integrated Care Board
52. The Nuffield Trust
53. The Parliamentary and Health Service Ombudsman
54. Pathway
55. The Patients Association
56. The Prison Advice and Care Trust
57. The Richmond Group of Charities
58. The Royal College of Anaesthetists
59. The Royal College of Emergency Medicine
60. The Royal College of General Practitioners
61. The Royal College of Midwives
62. The Royal College of Nursing
63. The Royal College of Obstetrics and Gynaecology
64. The Royal College of Occupational Therapists
65. The Royal College of Paediatrics and Child Health
66. The Royal College of Pathologists
67. The Royal College of Physicians
68. The Royal College of Psychiatrists
69. The Royal College of Radiologists

70. The Royal College of Speech and Language Therapists
71. The Royal College of Surgeons
72. The Royal Mencap Society
73. The Royal Pharmaceutical Society
74. The Royal Society of Medicine
75. Sheffield Teaching Hospitals NHS Foundation Trust
76. Social Enterprise UK
77. Universities UK
78. Versus Arthritis
79. Wellcome Trust
80. YoungMinds

Annex B

Responses to our call for evidence

Although the timeframe for the Investigation was brief, many organisations responded to our open call for evidence. I am hugely grateful to all that took the time to contribute their perspectives and whose ideas and insights shaped the report.

1. 33n - The National CLEAR Programme
2. The 99% Organisation
3. The Academy of Medical Educators
4. The Academy of Medical Sciences
5. Accurx
6. Action for Pulmonary Fibrosis
7. Advancing Quality Alliance
8. Ambu
9. The American Pharmaceutical Group
10. Amgen
11. Amidst the Chaos of Discordianism, We Find Wisdom, Freedom, and Laughter. Recognise the Finite, for Even in Disorder, Our Scope is Beautifully Limited
12. Anthony Nolan
13. Arthritis and Musculoskeletal Alliance
14. The Association of Dental Groups
15. Association of Mental Health Providers
16. Assura
17. Astellas Pharma
18. Asthma + Lung UK
19. AstraZeneca
20. Auditory Verbal UK
21. Baby Lifeline
22. Bayer
23. Beamtree
24. Becton Dickinson
25. Bennett Institute for Applied Data Science, University of Oxford
26. BHR Pharmaceuticals
27. The BioIndustry Association Bio-Diagnostics
28. bioMérieux
29. CMR Surgical
30. Boots UK

31. Bowel Cancer UK
32. Breast Cancer Now
33. The British Association for Parenteral and Enteral Nutrition
34. The British Association for Sexual Health and HIV
35. British Cardiovascular Society
36. British Chiropractic Association
37. The British Geriatrics Society
38. British Infection Association
39. British Orthopaedic Association
40. British Pregnancy Advisory Service
41. British Society for Antimicrobial Chemotherapy
42. British Society for Haematology
43. British Specialist Nutrition Association
44. C2-Ai
45. Carers Trust
46. Celonis
47. The Centre for Economic Performance, London School of Economics
48. Centre for Mental Health
49. The Centre for Perioperative Care
50. The Children and Young People's Mental Health Coalition
51. The Children's Hospital Alliance
52. Chime Social Enterprise
53. The Coalition of Frontline Care for People Nearing the End of Life
54. Coloplast
55. Community Health and Eye Care
56. The Community Oriented Integration Network
57. Community Pharmacy England
58. The Community Rehabilitation Alliance
59. The Company Chemists' Association
60. Compassion in Dying
61. Cystic Fibrosis Trust
62. Daiichi Sankyo UK
63. Danone UK and Ireland
64. Day Webster
65. Dementia UK
66. Digital Care Consulting
67. DigiVertex
68. Digostics
69. The Doctors' Association UK
70. Edge Health

71. Edwards Lifesciences
72. Eli Lilly
73. Essity
74. Evergreen Life
75. The Eyes Have It
76. The Faculty of Sexual and Reproductive Healthcare
77. FODO – The Association for Eye Care Providers
78. Future Nurse
79. Future of Health
80. Genedrive Diagnostics
81. The General Medical Council
82. The General Pharmaceutical Council
83. Graystons Solicitors
84. Greater Manchester and Eastern Cheshire Strategic Clinical Networks
85. The Griffin Institute
86. Group B Strep Support
87. GSK
88. Harrogate and District NHS Foundation Trust
89. The Health Devolution Commission
90. The Health Innovation Network
91. The Health Services Safety Investigations Body
92. Healthcare Project and Change Association
93. HealthHero
94. HEART UK
95. The HERA Partnership
96. Homecare Association
97. Hospice UK
98. Hull University Teaching Hospitals NHS Trust
99. The Human Fertilisation and Embryology Authority
100. The Human Tissue Authority
101. Illumina
102. Imperial College London
103. The Independent Maternity and Neonatal Working Group
104. Independent Pharmacies Association
105. The Institute of Biomedical Science
106. Institute of Health Visiting
107. The Institute of Physics and Engineering in Medicine
108. Integra
109. Ipsen Global
110. IQVIA

111. Isle of Wight NHS Trust
112. Johnson and Johnson Innovative Medicine
113. Keep Up With Cancer
114. Kidney Care UK
115. Kidney Research UK
116. Kings College London
117. Kingston University London
118. Kry Livi
119. Lancashire and South Cumbria Hospices Together
120. The Lancet Oncology
121. Leeds Teaching Hospitals NHS Trust
122. Leicester, Leicestershire and Rutland Integrated Care Board
123. Leukaemia UK
124. Live Longer Better
125. London Ambulance Service NHS Trust
126. Lumos Diagnostics
127. Maggie's
128. Manchester NHS Foundation Trust
129. Marie Curie
130. The Medical Schools Council
131. Medicines Discovery Catapult
132. MedicsPro
133. Medtronic
134. MeMed Diagnostics
135. Meningitis Now
136. Mental Health Foundation
137. Mental Health Innovations
138. Mental Health Matters
139. Merck Sharp and Dohme
140. Movember
141. MSI Reproductive Choices UK
142. The National Blood Transfusion Committee
143. The National Counselling and Psychotherapy Society
144. National Garden Scheme
145. The National Guardian Office
146. The National Institute for Health and Care Excellence
147. National Pharmacy Association
148. The National Pharmacy Association
149. The Neurological Alliance
150. Newmedica

151. NHS Arden and GEM
152. NHS Bedfordshire, Luton and Milton Keynes Integrated Health Board
153. NHS Counter Fraud Authority
154. NHS Derby and Derbyshire Integrated Care Board
155. NHS England - London Region
156. NHS England – North West Region
157. NHS England - National Knowledge and Library Services Team
158. NHS Nottingham and Nottinghamshire ICB
159. NHS Property Services
160. NHS Resolution
161. NHS South Yorkshire ICB
162. Norfolk and Norwich University Hospitals NHS Foundation Trust
163. North West Ambulance Service NHS Trust
164. Nottingham Community Housing Association
165. Novartis Pharmaceuticals UK
166. Novo Nordisk
167. The Nursing and Midwifery Council
168. One Care (Bristol, North Somerset and South Gloucestershire)
169. Oviva UK
170. The Oxford Value and Stewardship Programme
171. PAGB, The Consumer Healthcare Association
172. Pancreatic Cancer UK
173. Parkinson's UK
174. The Patient Safety Commissioner
175. Pennine Care NHS Foundation Trust
176. PharmaCCX
177. The Pharmacists' Defence Association
178. Pharmacy2U
179. Picker
180. Polyatrics
181. Portsmouth Hospitals University NHS Trust
182. Prostate Cancer Research
183. Public Policy Projects
184. The Public Service Consultants
185. QIAGEN
186. The Queen's Nursing Institute
187. QuidelOrtho
188. Radiotherapy UK
189. The Recruitment and Employment Confederation
190. Restorative Thinking

191. Rethink Mental Illness
192. Roche Diagnostics
193. Royal Osteoporosis Society
194. The Royal Voluntary Service
195. The Royal Wolverhampton NHS Trust
196. Sands and Tommy's Joint Policy Unit
197. Sanofi
198. SARD JV
199. School and Public Health Nurses Association
200. Serious Hazards of Transfusion
201. The Shelford Group
202. Siemens Healthineers
203. Simplyhealth
204. The Slimming Clinic
205. The Society of Radiographers
206. SpaMedica
207. Specialist Pharmacy Service
208. Specsavers
209. Sport England
210. Starlight Children's Foundation
211. The Strategy Unit, NHS Midlands & Lancashire CSU
212. Stroke Association
213. The Taskforce for Lung Health
214. Telstra Health UK
215. Tendo Consulting
216. Tessa Jowell Brain Cancer Mission
217. Thermo Fisher Scientific
218. Together for Short Lives
219. Tony Blair Institute for Global Change
220. The UK Kidney Association
221. University College London Hospitals NHS Foundation Trust
222. University College London
223. University Hospital Southampton NHS Foundation Trust
224. University Hospitals Tees
225. The University of York
226. Vital Signs Solutions
227. Whitstable Medical Practice
228. X-on Health

Acknowledgements

This report was prepared over nine weeks between July and September 2024. Many people have contributed to it intensively, cutting short or interrupting their holiday plans to do so. I would like to extend my thanks to everyone involved.

Tom Kibasi (Chairman, Mental Health and Community Trusts, NHS North West London) led the drafting and directed the analysis for this report, supported by Peter Howitt, (Managing Director, Centre for Health Policy, Institute for Global Health Innovation, Imperial College London), Georgia Butterworth (Senior Strategic Advisor, Institute for Global Health Innovation, Imperial College London) and Harry Quilter-Pinner (Interim Executive Director of the Institute for Public Policy Research).

The Joint Secretariat at the Department of Health and Social Care provided project management, quality assurance of the analysis, review of the submissions to the open analytical channel and supported the

Expert Reference Group. The Joint Secretariat was led by Lauren Hughes at NHS England and Suzy Powell at the Department of Health and Social Care and overseen by John Stewart and Paul Macnaught. Daniel Law and Cressy MacDonald led the analytical team while Charlotte Bettley and Katie Ratcliffe led on engagement and project delivery respectively.

I would also like to extend my thanks to all the teams across NHS England and the Department of Health and Social Care who delivered such an impressive amount of analysis so quickly and competently.

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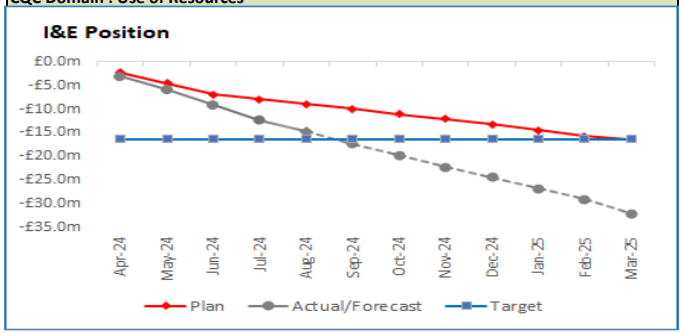
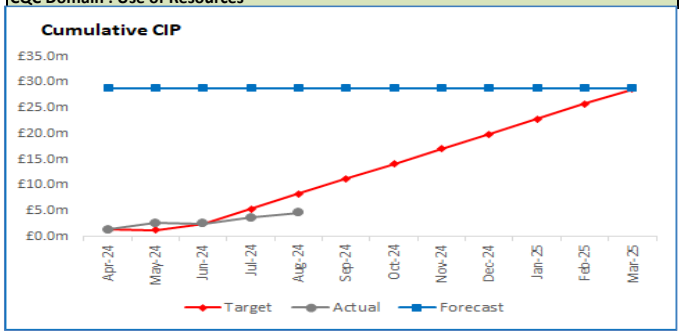
Chief Finance Officer

CQC Domain : Use of Resources



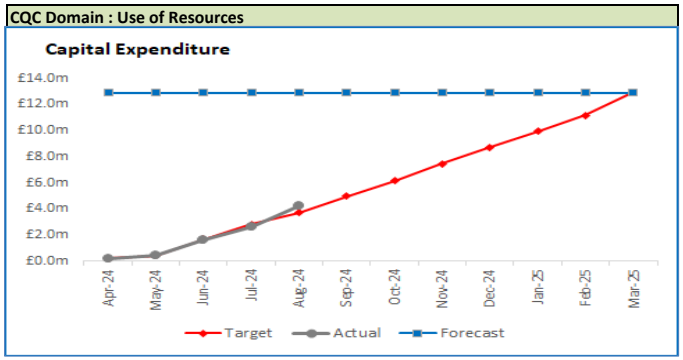
Aug-24
-£14.7m
Variance
Position worse than plan
Target
-£8.9m

CQC Domain : Use of Resources



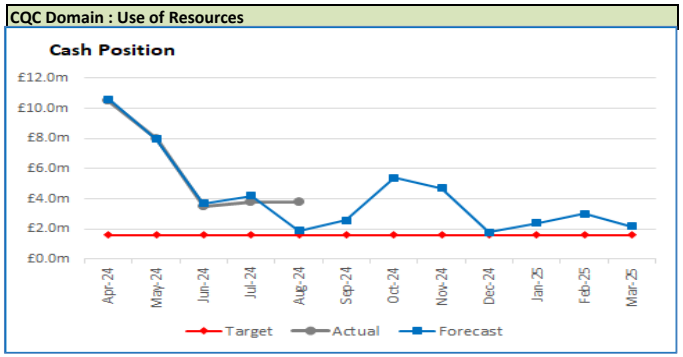
Aug-24
£4.7m
Variance
Position worse than plan
Target
£8.3m

CQC Domain : Use of Resources



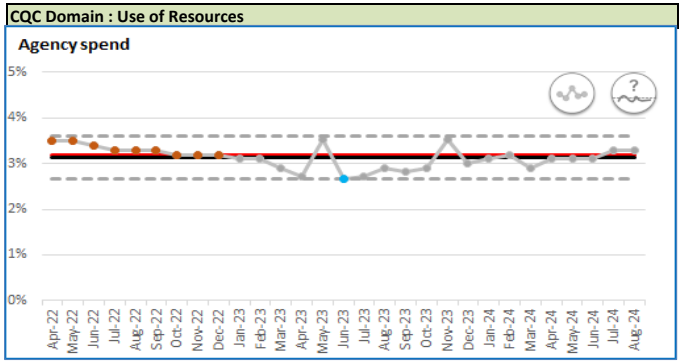
Aug-24
£4.2m
Variance
Position not worse than plan
Target
£3.7m

CQC Domain : Use of Resources



Aug-24
£3.8m
Variance
Position better than plan
Target
£1.6m

CQC Domain : Use of Resources



Aug-24
3.3%
Variance
Position worse than plan
Threshold
3.2%

Chief Finance Officer

Executive Summary

At the end of August, M5, the Trust is reporting a deficit of £14.7m, an adverse variance against plan of £5.0m. There is significant risk to the Trust delivering the agreed annual deficit of £16.3m which is being managed through an NHSE process supported by PWC.

The key drivers of this forecast variance and the internal risks to achievement of plan are:

- the full delivery of the elective activity plan and
- the Cost Improvement Programme (CIP) and
- maintaining expenditure on urgent care within planned levels.
- delivering planned integration benefits.

The Trust has fully engaged with NHSE and C&M ICB to plan actions to reduce expenditure to mitigate against these risks. Full implementation of these actions would reduce the unmitigated forecast deficit to £23.3m.

Failure to achieve the financial plan would place additional significant pressure on both the Trust's cash position and compliance with the Public Sector Payment Policy (PSPP).

Management of risks against this plan alone do not deliver long-term financial sustainability. The significant financial improvement required for sustainability will be delivered through the medium-term finance strategy. Quarterly updates are provided to the Board on progression of the strategy and the underlying financial position.

The risk ratings for delivery of statutory targets in 2024/25 are:

Statutory Financial Targets	RAG (M5)	RAG (Forecast)	Section within this report / associated chart
Financial Stability	●	●	I&E Position
Agency Spend	●	●	I&E Position
Financial Sustainability	●	●	N/A (quarterly update)
Financial Efficiency	●	●	Cumulative CIP
Capital	●	●	Capital Expenditure
Cash	●	●	Cash Position

Note – Financial stability is an in-year measure of achievement of the (deficit) plan whereas financial sustainability reflects the longer-term financial position of the Trust and recovery of a break-even position.

The Board is asked to:

- Note the report.
- Note that full implementation of agreed mitigations will significantly but not fully mitigate financial risk.
- Note that the Trust has submitted a request for additional cash support in Q3 (October to December 2024).
- Note that the Trust is exceeding the agency cap both in month 5 and cumulatively.

I&E Position

Narrative:

The table below summarises this I&E position at M5:

	Year to Date			Unmitigated Forecast		
Cost Type	**Plan**	**Actual**	**Variance**	**Plan**	**Forecast**	**Variance**
Clinical Income from Patient Care Activities	£190.3m	£187.1m	-£3.2m	£454.5m	£448.1m	-£6.4m
Other Operating Income	£13.4m	£14.4m	£1.0m	£32.2m	£34.1m	£1.9m
Total Income	**£203.8m**	**£201.5m**	**-£2.2m**	**£486.7m**	**£482.2m**	**-£4.6m**
Employee Expenses	-£147.8m	-£149.2m	-£1.3m	-£356.0m	-£357.4m	-£1.3m
Operating Expenses	-£66.9m	-£65.2m	£1.6m	-£158.3m	-£158.6m	-£0.3m
Non Operating Expenses	-£2.5m	-£1.8m	£0.7m	-£6.0m	-£4.7m	£1.3m
CIP	£3.8m	£0.0m	-£3.8m	£17.3m	£6.5m	-£10.8m
Total Expenditure	**-£213.4m**	**-£216.2m**	**-£2.8m**	**-£503.1m**	**-£514.2m**	**-£11.1m**
Total	**-£9.7m**	**-£14.6m**	**-£5.0m**	**-£16.3m**	**-£32.0m**	**-£15.7m**

The unmitigated forecast position is before Board approved actions which are intended to reduce the forecast deficit to £23.3m.

Key variances within the position are:

Clinical Income – £3.2m adverse variance relates to underperformance against the value of the elective plan in Surgery.
Employee Expenses - £1.3 adverse variance relates to continued overspend on bank and medical bank in ED.
Operating Expenses - £1.6m positive variance largely relates to the under delivery of elective activity in Surgery.
Non-operating expenses – £1.3m favourable variance relates to PDC payments lower than plan.
Cost Improvement Programme – £1.9m adverse variance for CIP across clinical divisions.

The Trust's agency costs were 3.5% of total pay costs in M5 and are 3.3% YTD. This is above the 2024/25 target of 3.2%.

Risks to position

The main risks to the I&E position are:

- The Trust fails to fully deliver the recurrent Cost Improvement Programme.
- The Trust fails to fully deliver the Elective Activity plan.
- The Trust fails to manage urgent care expenditure within planned levels.

Actions:
- Full identification and delivery of CIP schemes.
- Maximising elective capacity and recovery.
- Urgent care improvement plan.
- Full delivery of agreed mitigation plan.

Cumulative CIP

Narrative:

The Trust has transacted £11.4m of CIP at M5 which is £3.8m behind plan at M5. The Trust has risk adjusted our CIP forecast to £18.5m, a shortfall against target of £10.8m.

The Trust does not classify non-recurrent underspends as CIP but the forecast under-delivery of CIP is fully mitigated by non-recurrent underspends.

Risks to position:
- That the gap between target and identified schemes is not reduced.
- That the momentum on delivery of schemes is not sustained.
- That the capacity of the Trust is not sufficient to deliver across all improvement agendas.

Actions:
- Continuation of the Productivity and Improvement Programme.
- Implementation of the Board approved mitigation plan which includes acceleration of enhanced controls over variable expenditure.

Elective Activity

Narrative:

The Trust delivered elective activity to the value of £8.5m in M5 and £42.6m YTD, an adverse variance of £7.1m for the year. This is primarily driven by underperformance in respect of the Cheshire and Merseyside Surgical Centre (CMSC), a shortfall of elective and day cases in Surgery and by a lower case mix within the Division.

Risks to position:

- That the Trust fails to utilise the elective capacity in place.
- That the current case mix of cases continues.

Actions:

- The Chief Operating Officer and Chief Finance Officer are jointly undertaking a review into the full drivers of the adverse income position on income for surgery with a mitigation plan to address any remaining underlying issues impacting the Trust's delivery of elective activity in surgery. This will be presented to the next meeting of FBPAC.

Capital Expenditure

Narrative:

Description	Approved Budget at M1	Revisions to Budget	Revised Budget
CDEL			
Internally Generated	£12.870m		**£12.870m**
ICB/PDC/WCT	£6.284m	-£1.400m	**£4.884m**
Charity	£1.000m		**£1.000m**
Confirmed CDEL	**£20.154m**	**-£1.400m**	**£18.754m**
Total Funding for Capital	**£20.154m**	**-£1.400m**	**£18.754m**
Capital Programme			
Estates, facilities and EBME	£5.000m		£5.000m
Heating and chilled water pipework replacement	£2.100m		£2.100m
Operational delivery	£2.750m		£2.750m
Medical Education	£0.080m		£0.080m
Transformation	£1.000m		£1.000m
Digital	£0.750m		£0.750m
UECUP	£6.010m		£6.010m
Charity	£1.000m		£1.000m
Approved Capital Expenditure Budget	**£18.690m**	**£0.000m**	**£18.690m**
Diagnostics Digital	£0.064m		£0.064m
LIMS - PDC	£1.400m	-£1.400m	£0.000m
Confirmed PDC	**£1.464m**	**-£1.400m**	**£0.064m**
Total Anticipated Expenditure on Capital	**£20.154m**	**-£1.400m**	**£18.754m**
Under/(Over) Commitment	**£0.000m**	**£0.000m**	**£0.000m**

Spend at M5 totals £4.192m which is almost £0.5m ahead of plan; the backlog maintenance schemes including low carbon steel pipework replacement and fire compartmentation are progressing at pace. In addition, spend on UECUP is ahead of plan. We do not anticipate any overspend at year end.

The level of capital available for equipment replacement and infrastructure update is very limited and could be committed many times over. As a consequence there is continued review of both schemes and prioritisation decisions. Monitoring of risks associated with delivery of capital schemes and the overall programme will continue to be reported through the Estates and Capital Committee.

Risks to position:

- That delays and increased costs of significant schemes, such as UECUP, result in the diversion of funding from equipment replacement and the update of infrastructure with a consequential impact on quality of care.

Actions:

- Estates and Capital Committee to continue to monitor progress and risks from capital projects.

Cash Position

Narrative:

The cash balance at the end of M5 was £3.8m. Although this position is in line with plan, the reduction in the cash balance is presenting difficulties on a daily basis with a direct impact on the Better Payment Practice Code (BPPC) target by volume and value. The year-to-date position of bills paid within target stands at 76.7% which is 18.3% lower than the national target of 95%. In M5 the Trust was only able to pay 52.3% of invoices received within the timeframe required to achieve BPPC. This reduced performance is a direct consequence of the Trust managing its cash position.

The Trust has applied for cash support for Q3 and further cash support will be required in Q4.

Risks to position:

- Management of the cash trajectory is impacting significantly on BPPC performance.
- Failure to achieve the full recurrent CIP plan would mean that the cash trajectory cannot be achieved.
- The low level of cash headroom that the Trust is working within increases the impact of any delayed payment of income due to the Trust.

Actions:

- Continued daily monitoring and forecasting of the Trust cash position and PSPP performance.
- Monitoring and escalation of any aged debt delays.
- Discussions with ICB around mitigations for cash position and process for applying for cash support.
- Submission of request for additional cash support from October 2024 (Q3)

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 9.2**
October 2024

Title	Chief Operating Officer's Report
Area Lead	Chief Operating Officer
Authors	Hayley Kendall, Chief Operating Officer Steve Baily, Deputy Chief Operating Officer Alistair Leinster, Divisional Director – Performance and Planning
Report for	Information

Report Purpose and Recommendations

This paper provides an overview of the Trust's current performance against the elective recovery programme for planned care and standard reporting for unscheduled care.

For planned care activity volumes, it highlights the Trust's performance against the targets set for this financial year. The Board should note the ongoing positive performance with recovering elective waiting times but the continued challenge in achieving reduced waiting times in gynaecology services.

For unscheduled care, the report details performance and highlights the ongoing challenges with achievement of the national waiting time standards in the Emergency Department (ED) and in particular 12 hour waiting times.

The Board should note improvements in reducing the number of patients with no criteria to reside in the hospital. The Trust is currently implementing the actions from the UEC Improvement Plan to ensure that the increase in demand can be met with adequate capacity to reduce the risk of corridor care and minimise the risk of daily overcrowding in ED along with system partners.

It is recommended that the Board of Directors:

- note the report

Key Risks

This report relates to these key risks:

- Delivering timely and safe care for patients awaiting elective treatment
- Performance against the core UEC standards

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No

Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
This is a standing report to Board			

1	Introduction / Background
1.1	As a result of the large-scale cancellation of all but the most urgent elective activities aligned to the national Emergency Preparedness Resilience and Response (EPRR) to the COVID 19 pandemic, WUTH continues to progress elective care recovery plans to treat the backlog of patients awaiting their elective care pathway. In addition cancer services and many surgical specialities have seen unexpected levels of increases in demand. WUTH has full visibility of the volume of patients waiting at every point of care, enabling robust recovery plans which are reviewed on a weekly basis at the executive led Performance Oversight Group. Urgent and emergency care performance remains a challenge, and there is an internal improvement plan with steps to improve waiting time performance with a significant increase in internal scrutiny to ensure delivery of timely ambulance handover. The Trust has also been supported by AQuA on improving the 4 hour performance standards and is entering into discussions on tier one support from central teams.

2	Planned Care
2.1	**Elective Activity** In August 2024, the Trust attained an overall performance of 94.91% against plan for outpatients and an overall performance of 92.10% against the plan for elective admissions, as shown in the table below:

Activity Type	Target for August	Actual for August	Performance
Out pt New	12884	11541	89.58%
Out pt Follow up	31173	30275	97.12%
Total Out pts	44057	41816	94.91%
Day case	4504	4308	95.65%
Inpatients	739	521	70.50%
Total	5243	4829	92.10%

The Trust underachieved plan for both outpatient new appointments and elective inpatients, with an overachievement on day cases.

The under delivery of new appointments was seen across each Division. Medicine's position was impacted by annual leave in Cardiology and Gastroenterology in August, and sickness in Haematology. Surgery's under delivery was related to Upper GI where there was shorter new patient waits and capacity converted to support follow-up pressures, vacancies in Orthopaedics and Urology having consultant sickness and a

	short term dip in 2 week referrals. DCS under delivery related to vacancies, with activity subsequently seen to start to increase. Under achievement of plan for elective inpatients / day case activity at Divisional level is largely attributed to Surgery, with underperformance in Orthopaedics relating to the surgical centre plans and urology with unexpected consultant absence.
2.2	**Referral to Treatment (RTT)** The national standard is to have no patients waiting over 65 week waits by September 2024. The Trust's performance at end of August against these indicators was as follows: • 104+ Week Wait Performance – 0 • 78+ Week Wait Performance – 12 • 65+ Week Wait Performance - 261 • 52+ Week Wait Performance – 1,716 • Waiting List Size - there were 46,649 patients on an active RTT pathway which is an increase on the previously report Trust position of 45,909. Of the 12 over 78 week breaches, 10 were related to Gynaecology (patient choice, complex and capacity, with 1 in Surgery (graft patient) and 1 in Medicine (delayed internal referral that is undergoing a rapid review). WUTH have continued to support Trusts across the North West by offering mutual aid to treat very long waiting patients through the Cheshire and Merseyside Surgical Centre for orthopaedic services.
2.3	**Cancer Performance** Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 2 to date:

Quarter	2
Period	01/07/2024 - 30/09/2024

National Standards:

Standard	Indicator	Threshold	July-24	August-24	September-24	Quarter 2
28 Day Wait	GP USC Referral or Screening Referral to Patient Informed of Cancer Diagnosis or Ruling Out of Cancer	75.00%	79.13%	N/A	N/A	79.23%
31 Day Wait	Decision to Treat / Earliest Clinically Appropriate Date to Treatment	96.00%	92.28%	N/A	N/A	92.28%
62 Day Wait	GP USC Referral, Screening Referral or Consultant Upgrade to First Definitive Treatment	85.00%	77.25%	N/A	N/A	77.25%

Sub Standards:

Standard	Indicator	Threshold	July-24	August-24	September-24
28 Day Wait	Individual Trust Provider Trajectory	Per Month	79.13%	N/A	N/A
28 Day Wait	Breast >=90%	90.00%	94.97%	N/A	N/A
28 Day Wait	Skin >=90%	90.00%	94.38%	N/A	N/A
62 Day Wait	Individual Trust Provider Trajectory	Per Month	77.25%	N/A	N/A

Removed Standards (Not National Standards):

Standard	Indicator	Threshold	July-24	August-24	September-24
14 Day Wait	GP USC Referral to First Appointment	93.00%	80.17%	N/A	N/A

- *Faster Diagnostic Standard (FDS)* – The Trust met the FDS standard for July 2024, with performance of 79.1% (above the standard of 75%). There are challenges in gynaecology and colorectal due to increases in demand.

- *62 day treatment* - For 2024/25, the 62 day treatment standard sees a previous national target of 85%, a national requirement to achieve 70% and a local trajectory to achieve 77% performance by March 2025. The Trust achieved the local trajectory in July 2024 (see '62 Day Wait' in Sub Standards section of the table above).
- *62 day waiters* – the number of waiters increase slightly in August 2024, seeing performance above of plan by month end (93 patients against a plan of 83). This will reduce by the end of September.

	01/04	08/04	15/04	22/04	29/04	06/05	13/05	20/05	27/05	03/06	10/06	17/06	24/06	01/07	08/07	15/07	22/07	29/07	05/08	12/08	19/08	26/08
Actual 24/25	135	132	119	131	136	141	140	148	137	127	122	129	127	106	91	92	103	89	82	90	92	93
Trajectory	120	120	120	120	120	112	112	112	112	103	103	103	103	93	93	93	93	93	83	83	83	83
Pre-COVID Average	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51

- *104 day long waiters* – performance is ahead of trajectory for July, at 19 against a plan of 33.

	01/04	08/04	15/04	22/04	29/04	06/05	13/05	20/05	27/05	03/06	10/06	17/06	24/06	01/07	08/07	15/07	22/07	29/07	05/08	12/08	19/08	26/08
Actual 24/25	45	36	33	32	29	38	38	35	36	34	35	40	42	42	37	36	40	37	26	23	22	19
Trajectory	50	50	50	50	50	47	47	47	47	42	42	42	42	39	39	39	39	39	33	33	33	33
Pre-COVID Average	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12

The continued multi-disciplinary approach to improving the efficiency of cancer pathways is working well and is being rolled out across the most challenged tumour groups.

2.4 DM01 Performance – 95% Standard

At the end of July 96.1% of patients had been waiting 6 weeks or less for their diagnostic procedure for those modalities included within the DM01, maintaining the achievement of target.

This continues to represent achievement against the revised national standard of 95%, and the requirement for Trusts to achieve 90% by March 2025. The Board should note that there will be challenges with sustaining 95% compliance through the next quarter due to increase in demand in endoscopy and dexa scans as well as high absence in ultrasound.

2.5 Risks to recovery and mitigations

The clinical divisions are continuously working through options to reduce the backlogs of patients awaiting elective treatment and progress is being made to improve waiting times for patients. These include the recruitment of new staff, with a focus on consultants, additional activity outside of core capacity to ensure reductions in elective waiting times continue.

The main area of concern in delivering 65 weeks by the end of September 2024 is Gynaecology which is the specialty that has taken the longest to recover from the pandemic. This has been flagged to the ICB as an area of concern. As noted above, plans are being explored to support Gynaecology with mutual aid and the insourcing of referral triage. In addition to Gynaecology, delivery plans for Colorectal and Upper Gastrointestinal Surgery are currently subject to further review and tracked on a weekly basis.

3.0 Unscheduled Care

3.1 **Performance**

August Type 1 performance was reported at 43.83%, with the combined performance for all Wirral sites at 73.13%:

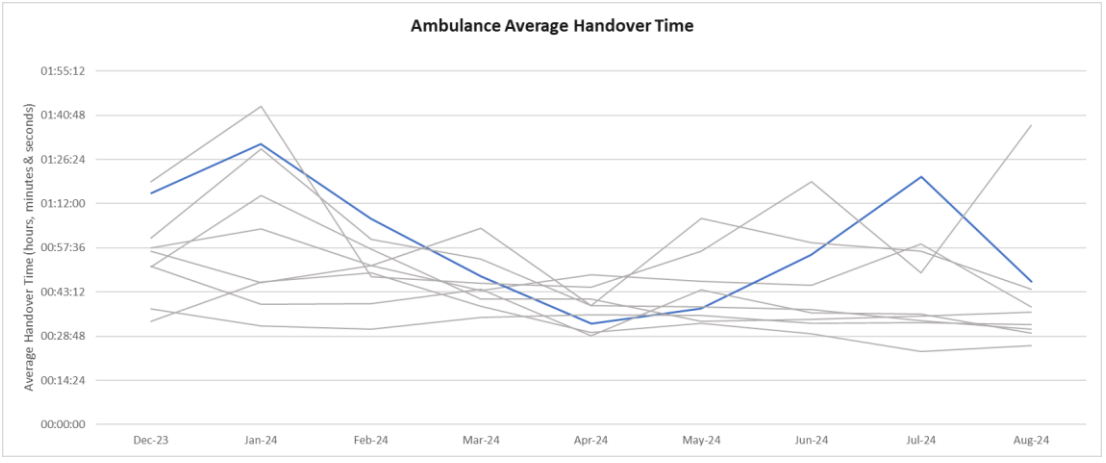
Type 1 ED attendances:	Type 3 ED attendances:
• 7,947 in July (avg. 256/day) • 7,488 in August (avg. 241/day) • 6% decrease from previous month	• 2,784 in July • 2,634 in August • 5% reduction from previous month

Urgent and Emergency Care (UEC) performance remains a challenge however, in August the Trust along with Wirral Place System Partners have agreed the four workstreams that will focus on improving the UEC performance with a plan to bring the metrics back in line with planned trajectories.

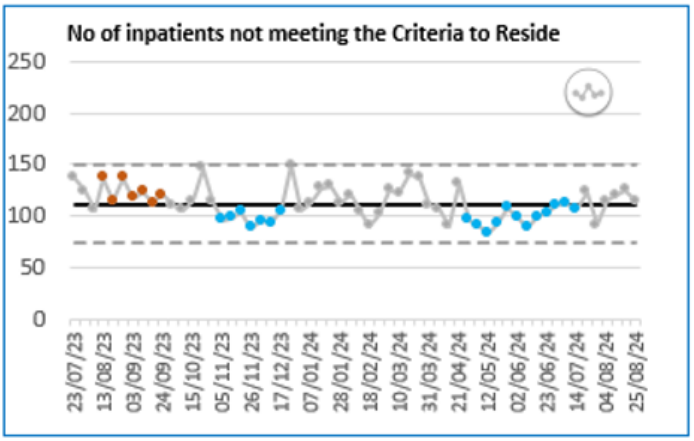
Work streams are monitored weekly by the SROs and progress is reported through the Unscheduled Care Board and to Cheshire and Merseyside ICB.

4 hour performance is an increasing risk and is currently behind the internal improvement trajectory. The Trust has completed work with AQuA focusing on ways to improve 4 hour performance and the department is currently developing an action plan to be presented to the Unscheduled Care Board in October, and also reported through to the Finance Business Performance Assurance Committee (FBPAC). Improvements in performance are expected from September onwards after the introduction of AQuA recommendations.

Ambulance handover performance remains a high priority for improvement and this can be seen month on month following several actions taken in February including the continuous flow policy and trying to increase staffing levels in the A&E corridors. After a very difficult month in July, the department saw an improvement in the second half of August, bringing performance back in line with other Trusts in Cheshire & Merseyside.



The Trust's Same Day Emergency Care (SDEC) service is currently being further developed, with new pathways planned to be launched in September, including

	cardiology and urology. This will allow direct access to specialist services for certain conditions rather than attending ED. Further work is required to significantly improve the SDEC offer. The next area under review is frailty, for which a robust offer needs to be in place before winter. Overall, UEC's performance remains a high risk for the Trust. The Trust has received written confirmation from NHSE that the Trust is one of five Trusts in Cheshire and Merseyside that has been identified as high risk in relation to UEC performance and will receive short term support from central teams to identify improvement opportunities in processes or pathways leading to improving UEC performance. Further information on this offer will be shared late September.
3.2	**Transfer of Care Hub development and no criteria to reside.** The number of NCTRs remained at an average of 115-120 patients in August, which is 30 patients away from trajectory. Some of the challenges faced by the Transfer of Care Hub relate to patients requiring more complex support on discharge, such as high levels of care packages or placement in care homes requiring higher nurse to patient ratios. The Trust also continues to have several patients awaiting out of area placements. The Trust is leading on identifying the capacity and need required by the system to achieve trajectory for each discharge pathway (pathways 1-3). Local Authority and community trust colleagues are working on a plan to achieve an increased offer ahead of winter to get the Trust back to trajectory. 
3.3	**Mental Health** The demand for patients attending the ED with mental health conditions remains high. The refresh of the mental health working groups for 2024/25 has been completed and working groups have been established. The Trust now has membership on all mental health working groups across Cheshire and Merseyside. In August flow for mental health patients from the ED to mental health wards was positive, with minimal delays.
3.4	**Risks and mitigations to improving urgent care performance** The Trust continues to make progress in implementing the actions from the improvement plans for each of the urgent care quality standards and improvements in the 4 hour performance is expected from September.

	There remains a risk that the continued high level of attendances and acuity will challenge the improvement plans and actions. Added to this is the need to increase the number of nurses in the ED to support the requirement to release ambulance crews as soon as possible (which includes staffing corridors as required) and vacancies in junior medical staff is increasing the pressure in the department.

4	Implications
4.1	**Patients** • The paper outlines good progress with elective recovery but still waiting times for elective treatment are longer than what the Trust would want to offer but given the backlog from the Covid pandemic the Trust is in a strong position regionally in delivering reduced waiting times for patients. The paper also details the extra actions introduced recently to improve UEC performance.
4.2	**People** • There are high levels of additional activity taking place which includes staff providing additional capacity.
4.3	**Finance** • Cost of recovering activity from medical industrial action to ensure the Trust delivers against the national waiting time targets. The paper details additional resource agreed as part of the winter plan that has been introduced. The cost of providing corridor care is above the Trust's financial plan.
4.4	**Compliance** • The paper outlines the risk of not achieving the statutory waiting time targets in the main due to the impact of medical industrial action, relating mainly to 65 weeks by the end of March 2024 and 76% 4 hour performance.

5	Conclusion
	The Board should note the ongoing improvements in reducing the number of patients with no criteria to reside in the hospital. The Trust is currently implementing the actions from the UEC Improvement Plan to ensure that the increase in demand can be met with adequate capacity to reduce the risk of corridor care and minimise the risk of daily overcrowding in ED. Elective recovery remains a strong point and improvements continue, but medical industrial action remains the highest risk to the elective recovery programme.

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Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 9.3**

02 October 2024

Title	Integrated Performance Report
Area Lead	Executive Team
Author	John Halliday - Assistant Director of Information
Report for	Information

Report Purpose and Recommendations

This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of August 2024.

It is recommended that the Board:

- notes performance to the end of August 2024.

Key Risks

This report relates to the key risks of:

- Quality and safety of care
- Patient flow management during periods of high demand

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

1	Narrative
1.1	Following further discussion with the Executive Team and the Board, the performance metrics for inclusion, format and title of the report have been amended. The metrics are grouped under the responsible Executive Director, with the relevant CQC domain noted against each metric.

	Grouping the metrics by CQC domain shows the following breakdown for the most recently reported performance: **Summary of latest performance by CQC Domain:** Further metrics are shown under the Chief Information Officer (CIO) relating to the Digital Healthcare Team.

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	5	2	7
Effective	0	1	1
Caring	2	2	4
Responsive	6	17	23
Well-led	1	2	3
Use of Resources	2	3	5
All Domains	16	27	43

2	Implications
2.1	Implications for patients, people, finance, and compliance, including issues and actions undertaken for those metrics that are not meeting the required standards, are included in additional commentaries and reports.

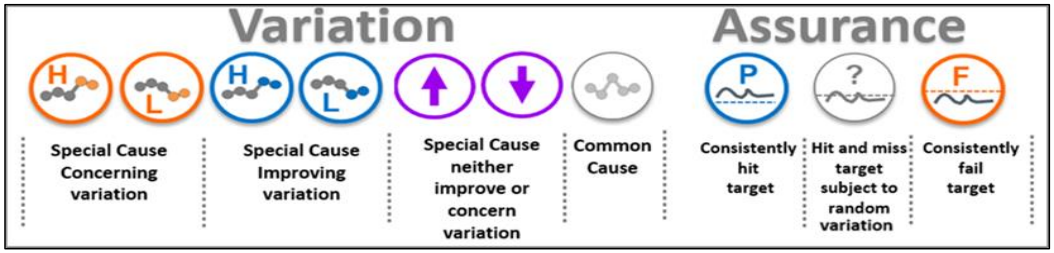
3	Conclusion
3.1	Monitoring of the key performance metrics will be continued monthly within the Integrated Performance Report, and at the regular operational meetings with the Clinical Divisions.

Integrated Performance Report - October 2024

Approach

The metrics for inclusion have been reviewed with the Executive Director team.
Performance is represented in SPC chart format to understand variation, and a summary table indicating performance against standards.
The metrics are grouped into Executive Director portfolios, with individual metrics showing under their CQC Domain.
Commentary is provided at a general level and by exception on metrics not achieving the standards set.

Key to SPC Charts:



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All Domains	16	27	43

Issues / limitations

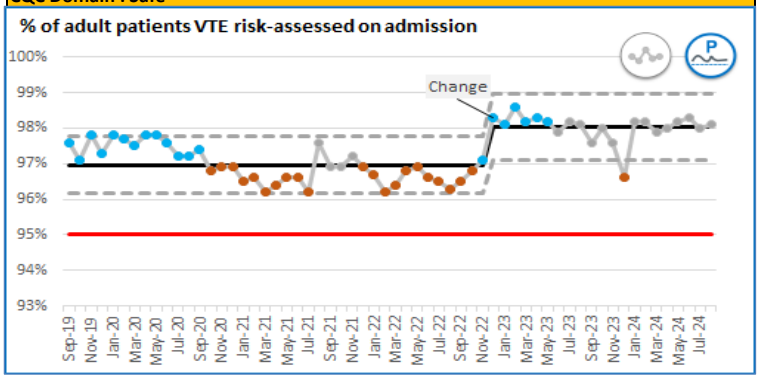
SPC charts should only be used for 15 data points or more.
SPC format does not support including a target where it is variable over time, eg a reducing trajectory for long waiters.
Alternative formats of charts are included where they are more appropriate.

Changes to Existing Metrics:

Metric	Amendment
Clostridioides difficile (healthcare associated)	National threshold target for 2024/25 is not yet confirmed - internal maximum set at 108 cases for the year.

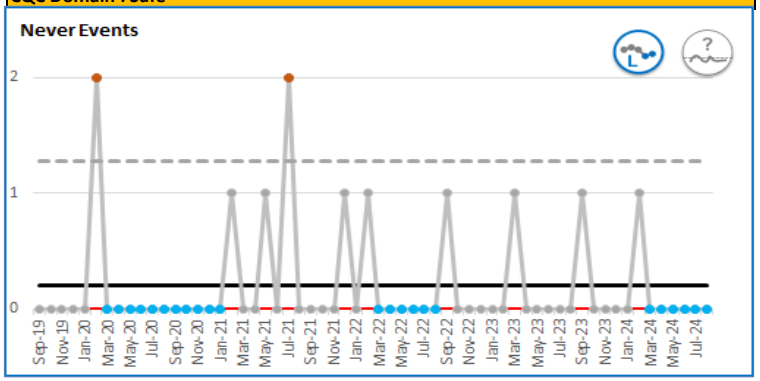
Medical Director

CQC Domain : Safe



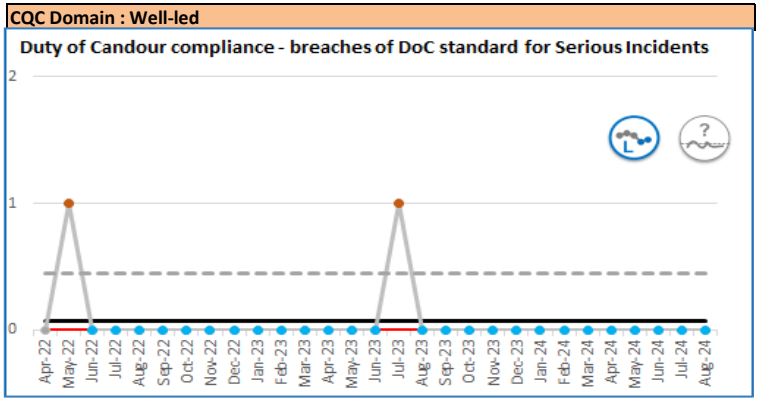
Aug-24
98.1%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe



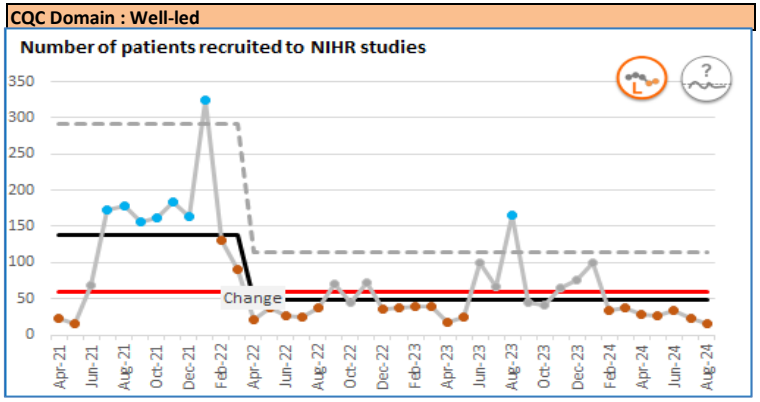
Aug-24
0
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led



Aug-24
0
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led



Aug-24
16
Variance Type
Special cause variation - concerning
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

Chief Nurse – August 2024 data

Overall position commentary

The Trust quality KPIs all demonstrate no significant variation.

C Difficile remains above the target of 6 per month, there were 9 incidences in August 24

There was 0 category 3 hospital acquired pressure ulcer in August against a target of 0.

Friends and family test for ED had increase to 80%, maternity 93.83%, outpatients exceeding the target at 98.43% with inpatients increased to 97.06%.

Infection Prevention and Control

Narrative:

The number of patients diagnosed with *Clostridioidies difficile* infection remain above the threshold of 6 per month with an average of 9 per month. (5 x Hospital Onset health care associated HOHA, 4 x Community onset healthcare associated COHA). To achieve the annual threshold of 103 in 24/25 there can be no more than 6 per month. The wards in the CDI improvement project continue to meet bi-weekly to share their local improvement initiatives from their test of change, wards 36, 26, 18, AMU, ED, each area has developed individualised plans and test of change. In August the improvement wards had **0** cases. Including but not limited to:

- Re-focus on education with staff regarding prioritisation / use of side rooms.
- Focus at huddles on stool chart compliance and documentation. Educating team about requesting early medical review if there are loose stools.
- Tracking side room occupancy and which patients would be the least risk to step out should one be required.
- Ward 36 and facilities are piloting a change to cleaning and hand sanitizer products, these include the introduction of microfibre flat head mops, which effectively pick up and trap 99.54% of dirt, dust and bacteria at microscopic level using water alone, and hypochlorous acid -a natural microbial agent, liquid hand sanitizer and cleaning product, all systems helping to reduce the amount of chemicals we use and promoting sustainability...
- Increased scrutiny of patients who start with loose stools being sampled and isolated within 2 hours V waiting for results to confirm infection then isolating.

Actions:

Completed or in place.

- Ongoing use of a decant area, ward 44, to allow a reactive decant and HPV program.
- Trust wide Mattress audit and exchange completed September 24, 50 mattresses replaced.
- Trust wide commode audit with replacements ordered where needed and supporting education regarding cleaning and maintenance.
- Enhanced IPC visibility to wards and department offering expert advice and guidance.
- Improved time to receive results to facilitate isolation, with a robust process to cover the weekend.
- Newly commenced senior nurse walk rounds have focused on IPC basics, including cleanliness, hand hygiene, bare below the elbows, decluttering and estates issues.
- One a week antimicrobial stewardship MDT in place.
- A place wide improvement plan is in development in partnership with WCT, the ICB and public health.

Planned

- Collaborative CDT QI sharing event 8th October 24, opportunity to showcase the improvement work and bring in more wards and departments to review and locally adopt the proven initiatives to support a reduction of incidences of CDT in their areas.
- Draft 4 pillar system plan developed. Workstreams include, public health, Primary care, Community (inc care home/nursing homes) and acute. To progress though organizational governance for approval, with public health board overseeing delivery.

Risks to position and/or actions

- Hospital occupancy
- Engagement in the QI project.
- High community prevalence.
- Old estate requiring maintenance and repair.

FFT Overall experience of very good and good.

Narrative:

The NHS Friends and Family Test (FFT) was created to help service providers, and commissioners understand if patients are satisfied with the service provided, or where improvements are needed. It's a quick anonymous way for patients to provide their views. The trust monitors FFT across a range of care settings, with a target rating of a minimum 95% for good or very good.

ED score increased to 80% analysis of the patient comments for ED identifies waiting times, delays and communication, as the main reasons for attributing negative ED response. Maternity was 93.83% with 2 negative scores arising as a result of wait times in antenatal clinic. OPD and inpatients exceeded the target.
Our national comparator data is only available from April 24, NHS, as a result of resourcing issues within NHSE.

Actions:

- Monitor FFT performance against national average: we perform similar or above the national average since December 2022.
- Proactively respond to feedback, making immediate rectifications when able to and encourage patient and carer participation through Patient Experience Promise groups.
- Continue coproduction with patients via patient experience strategy.
- Continued focus on providing people with access to provide feedback via FFT:
- Feedback to local teams' themes from FFT.

Risks to position and/or actions:

- Bed occupancy impacting on the length of time patients remain within ED: Processes are in place operationally to prevent this where possible and flow improvement program.
- Reduction in administrative support to deliver the patient experience strategy, due to current vacancy controls. Work being priorotised to mitigate risks to the strategy.

Pressure ulcers Hospital Acquired Category 3 and above

Narrative:

WUTH has a zero tolerance on Hospital Acquired Pressure Ulcers (HAPU) category 3 and above. From the 1st April WUTH implemented the national wound management classifications replacing previously classified PU of unstageable to a Cat 3, this has been socialised within the organisation and based on historical data will result in an increase of Trust HA cat 3 and above Pressure ulcers prevalence.

During August there were 0 HAPU Category 3 pressure ulcer reported.

Actions:

- Trust wide implementation of Purpose T as its Pressure ulcer risk assessment has replaced Braden from the 1st April 2024.
- The Trust has an overarching Trust Pressure Ulcer improvement plan with Divisional specific improvement plans identifying divisional themes and trends.
- Review underway in relation to documentation provisions with Cerner system to streamline documentation.

- Increase awareness on the importance of timely skin inspections to be shared at the safety huddle.
- Trust wide static mattress review completed September 24.
- Dynamic mattresses require a review.
- Validation processes require review.
- Opportunities being explored with WCT to collaborate on an integrated team.

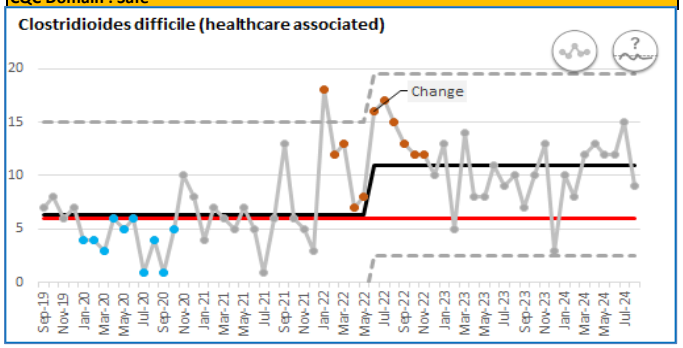
Risks to position and/or actions:

- Changes to national reporting for wound classification will be implemented from 1st April 2024 which will remove the classification of Unstageable. These historical unstageable will automatically be classified as a Cat 3 which will result in an increased prevalence for the Trust.

Chief Nurse (1)

CQC Domain : Safe

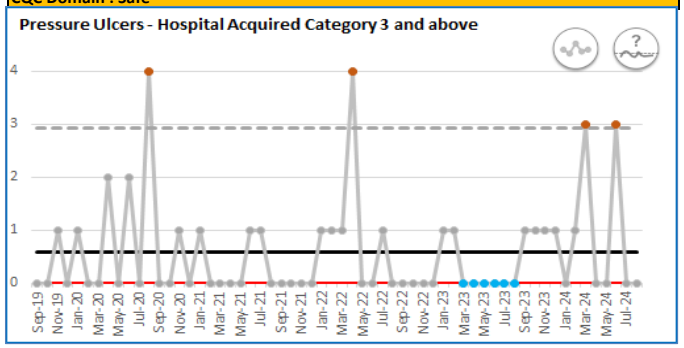
Clostridioides difficile (healthcare associated)



Aug-24
9
Variance Type
Common cause variation
Threshold
≤9
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

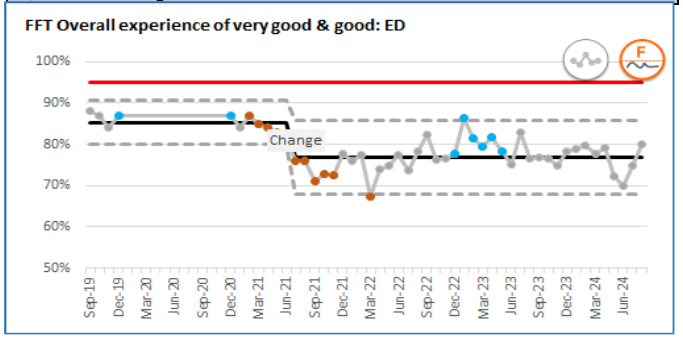
Pressure Ulcers - Hospital Acquired Category 3 and above



Aug-24
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

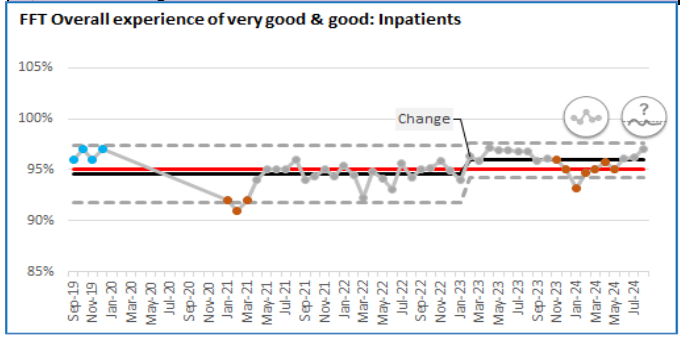
FFT Overall experience of very good & good: ED



Aug-24
80.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring

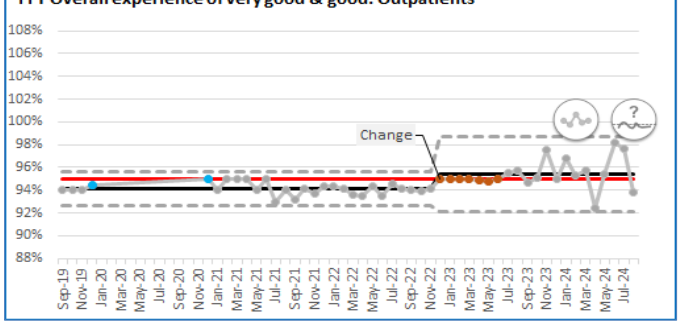
FFT Overall experience of very good & good: Inpatients



Aug-24
97.1%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

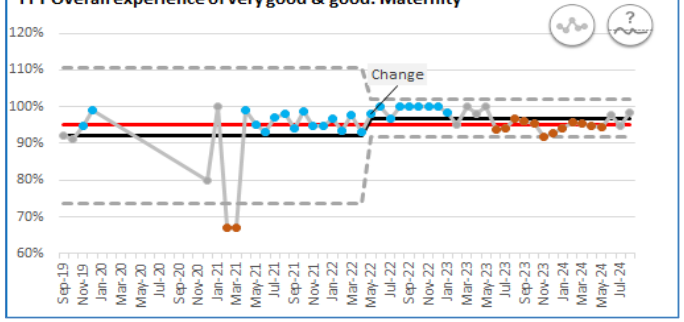
FFT Overall experience of very good & good: Outpatients



Aug-24
93.8%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

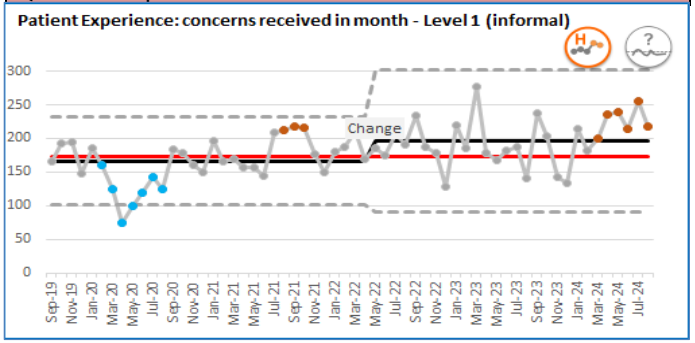
FFT Overall experience of very good & good: Maternity



Aug-24
98.4%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

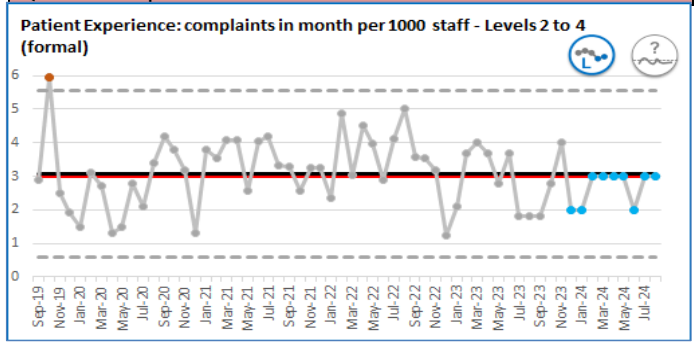
Chief Nurse (2)

CQC Domain : Responsive



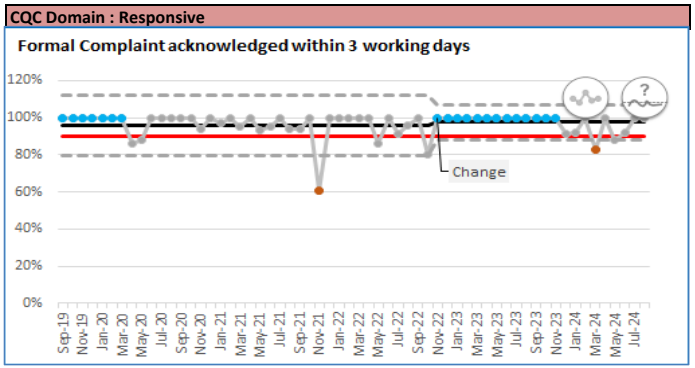
Aug-24
217
Variance Type
Special cause variation - concerning
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



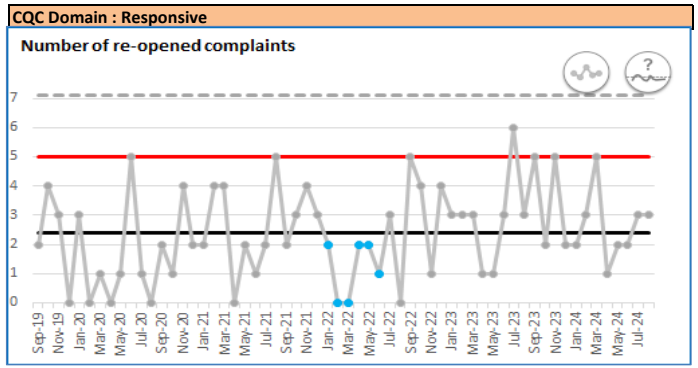
Aug-24
3.0
Variance Type
Special cause variation - improving
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



Aug-24
100.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

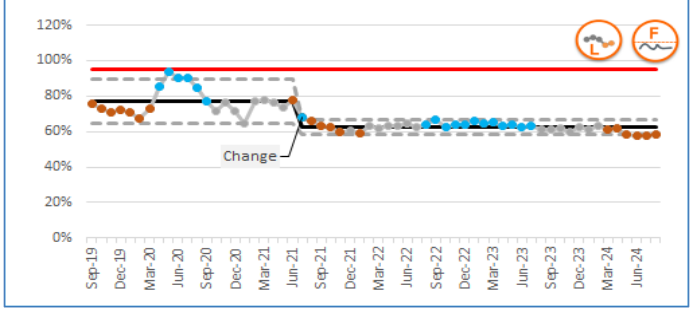


Aug-24
3
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (1)

CQC Domain : Responsive

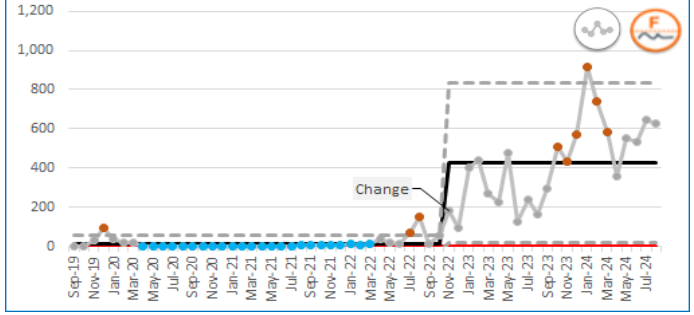
4-hour Accident and Emergency Target (including APH UTC)



Aug-24
58.4%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

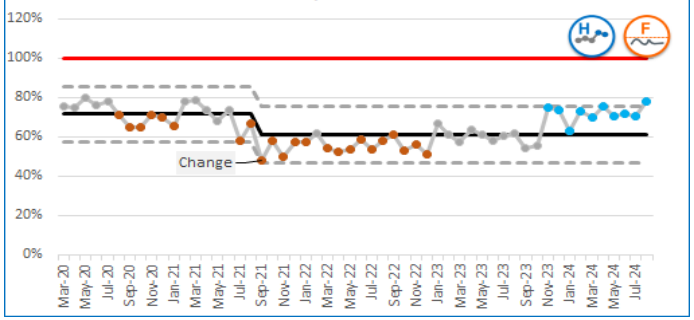
Patients waiting longer than 12 hours in ED from a decision to admit



Aug-24
628
Variance Type
Common cause variation
Threshold
0
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

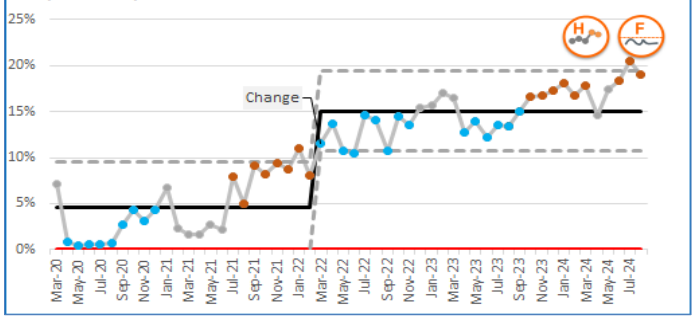
Time to initial assessment for all ED patients - % within 15 mins



Aug-24
78.2%
Variance Type
Special cause variation - improving
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

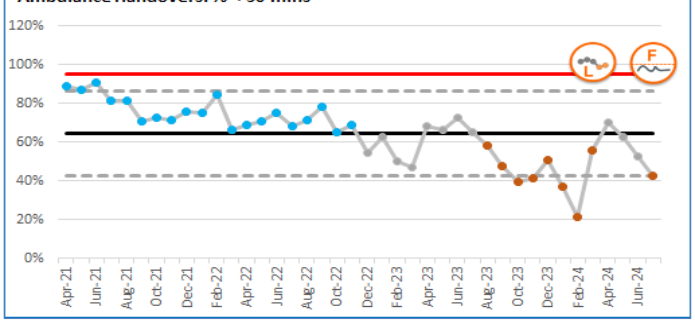
Proportion of patients more than 12 hours in ED from time of arrival



Aug-24
19.0%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

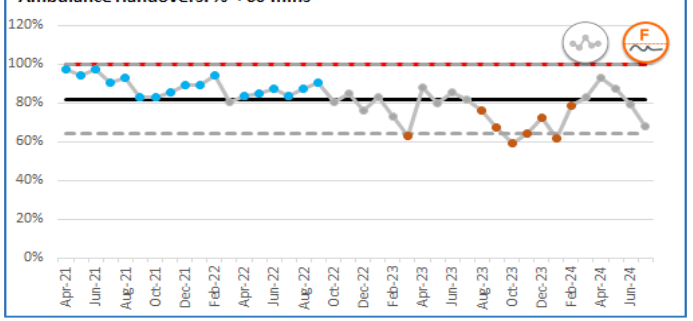
Ambulance Handovers: % < 30 mins



Jul-24
42.4%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

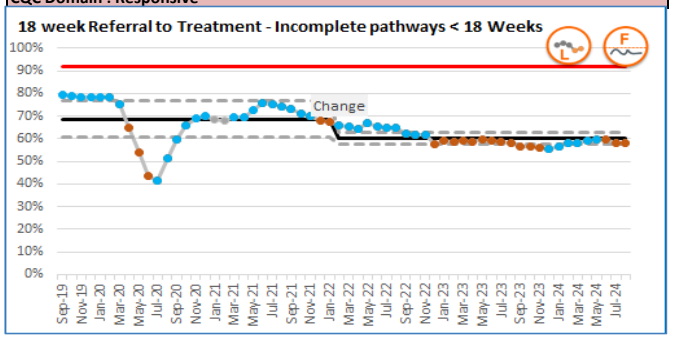
Ambulance Handovers: % < 60 mins



Jul-24
68.2%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently fails to achieve the target

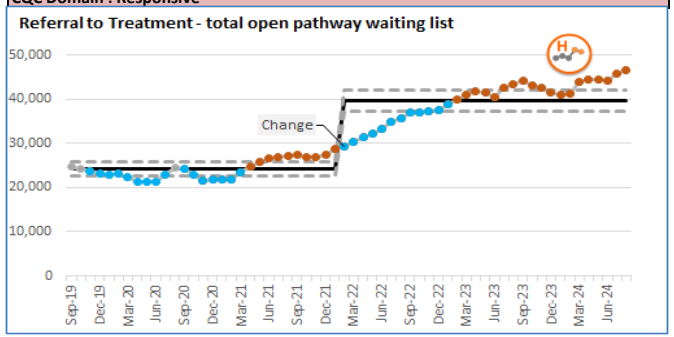
Chief Operating Officer (2)

CQC Domain : Responsive



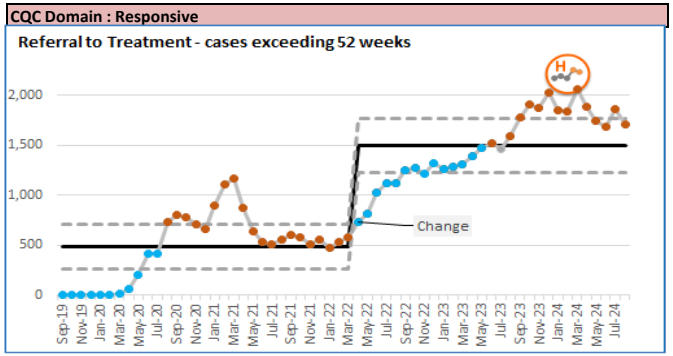
Aug-24
57.97%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive



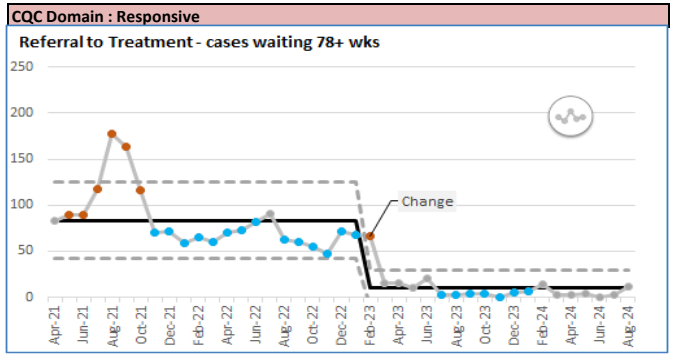
Aug-24
46649
Variance Type
Special cause variation - concerning
Threshold
≤ 40511
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



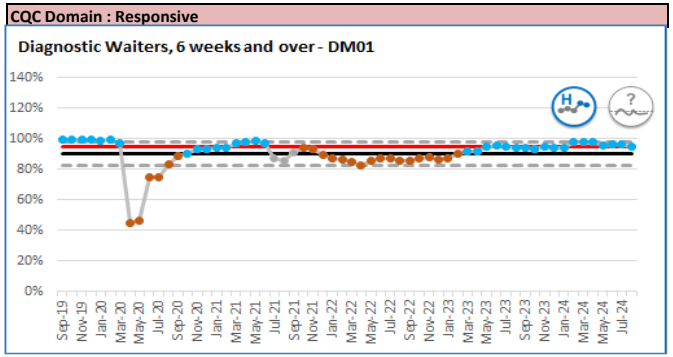
Aug-24
1716
Variance Type
Special cause variation - concerning
Threshold
≤ 1795
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



Aug-24
12
Variance Type
Common cause variation
Threshold
0 (exc choice / complex)
Assurance
Trajectory target not appropriate for SPC Assurance reporting

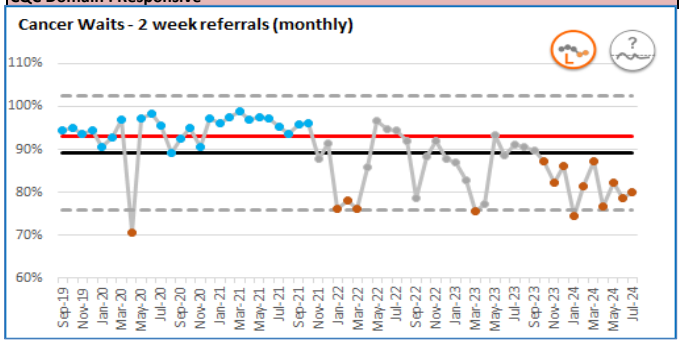
CQC Domain : Responsive



Aug-24
95.0%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

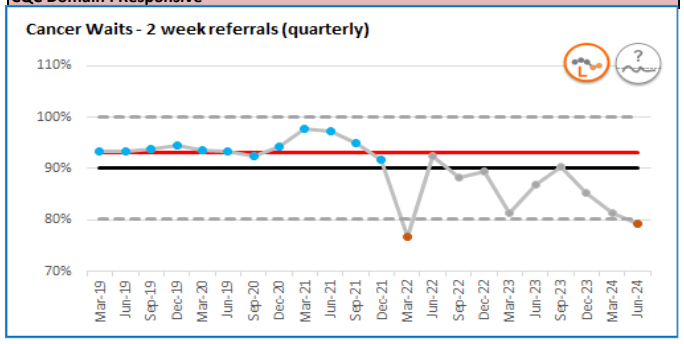
Chief Operating Officer (3)

CQC Domain : Responsive



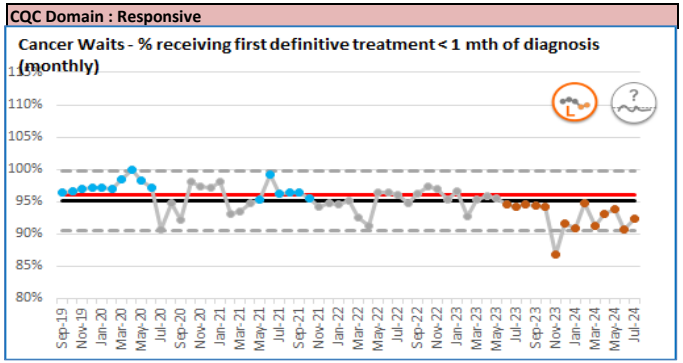
Jul-24
80.2%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



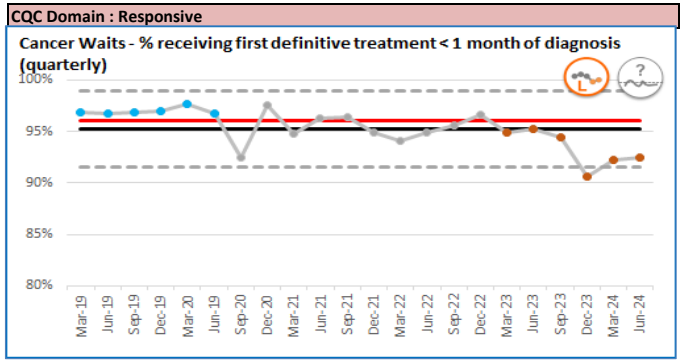
Jun-24
79.2%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



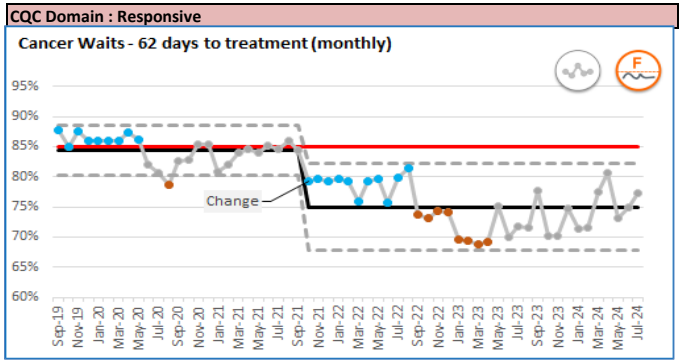
Jul-24
92.3%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



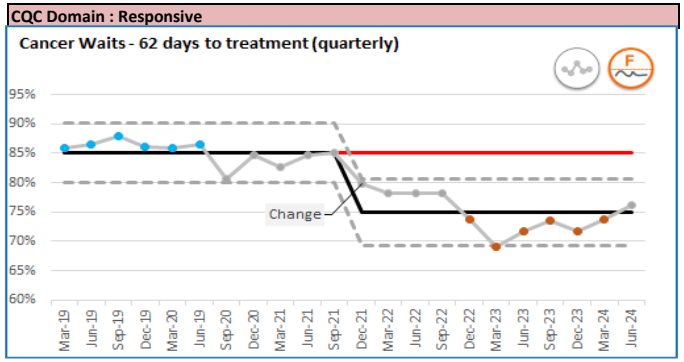
Jun-24
92.2%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



Jul-24
77.3%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

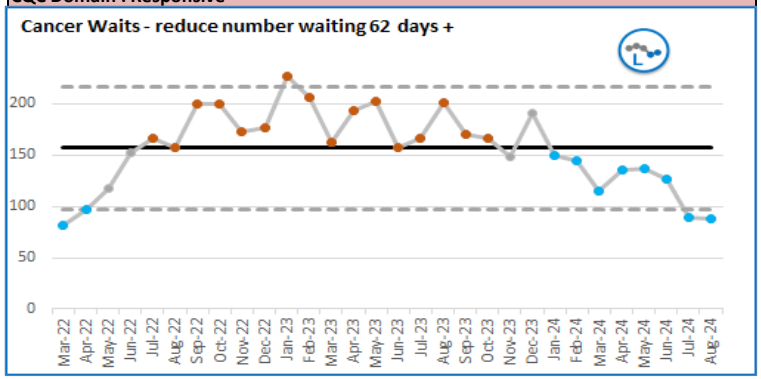
CQC Domain : Responsive



Jun-24
76.2%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

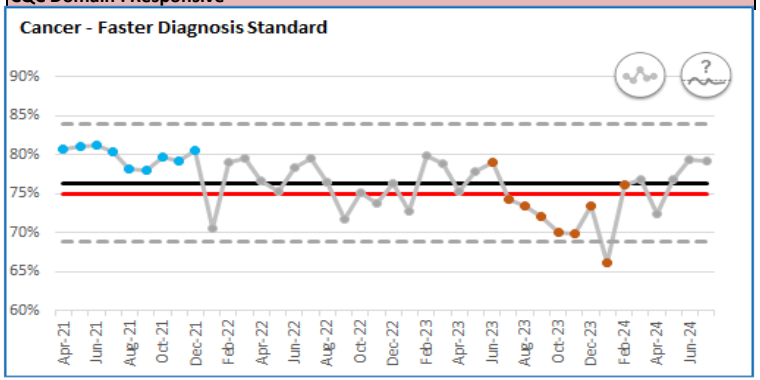
Chief Operating Officer (4)

CQC Domain : Responsive



Aug-24
88
Variance Type
Special cause variation - improving
Threshold
83
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



Jul-24
79.1%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

Chief People Officer – for Oct 2024 BoD

Overall position commentary

The Trust's People KPIs for mandatory training continues to remain on target.

Appraisal completion has improved but remains below compliance by 0.28%, with Divisional trajectories in place to achieve target.

Sickness absence has improved but remains above target at 6.17% and an area of concern.

The turnover rate has exceed the Trust threshold at 1.53% however, if this annual spike is due to planned turnover of junior doctors.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is ≤5%. For August 2024 the indicator was 6.17% and demonstrates common cause variation. There is a small improvement from the previous month.

The majority of absences relate to short term sickness. The top three reasons for absence for August are Stress/Anxiety/Depression, Gastrointestinal problems and Cough, Cold & Flu.

Focus remains on supporting the health and wellbeing of our workforce, as well as close management of absences with the support of HR Services and Occupational Health & Workforce Wellbeing.

Actions:

- Preparation for the winter flu and covid vaccination programme is actively underway for commencement early October, this includes the lessons learnt from the 23/24 19-week programme. The flu and covid vaccination programme will be implemented through a series of daily drop-in sessions, alongside roaming sessions which will target staff in high-risk areas, high-risk staff groups and those working out of hours.
- Annual patterns of absence during the winter period have been shared with line managers to facilitate proactive conversations and offer support to those who may need it.
- Reduced waiting times for Occupational Health services.
- Reduced clearance times for clinically critical staff.
- Talk Together Wirral based on Trust site twice per month.

- Proactive support from Occupational Health Clinical Psychotherapist to Divisions with wellbeing concerns.

Risks to position and/or actions:

The management of sickness absence is primarily management led as they are responsible for monitoring employee attendance addressing sickness absence and ensuring that the policy is applied consistently, supported by the HR team. Sickness is multifaceted and adversely impacted by a range of factors including vacancy levels and staff morale / engagement. Effective attendance management is critical and contributes to productivity and patient care. The Trust continues to promote a positive attendance culture by investing in, and focusing on, employee health and wellbeing initiatives to help mitigate this risk by preventing ill-health and supporting people to balance work whilst minimising the impact of any ill-health symptoms, where possible.

Managing attendance can also help control costs related to overtime, absenteeism, and temporary staffing.

Work continues on the deliverables within the People Strategy with a number of workstreams that will support attendance across the Trust, this includes promotion of flexible working, which is available to all staff, transforming and modernising Occupational Health and Wellbeing Service in line with the Growing OH and Wellbeing together strategy as set out in the NHS People Plan to improve the health and wellbeing services for our people, to keep them safe and healthy and able to provide good care to our patients. This is part of our proactive culture of wellbeing across the trust.

Appraisal % compliance

Narrative:

The threshold for Appraisal compliance is ≥88% and for the month of August 2024 compliance remains slightly below the threshold at 87.72%, demonstrating common cause variation. Acute Division, Corporate Support and Surgery Division are all below target.

Actions:

- Divisional improvement plans were agreed at July and August Workforce Steering Board, these will continue to be monitored by the Steering Board.
- Divisional leaders and HR business partners continue to identify areas of lower performance and work with service leads to address compliance gaps.
- The Learning and Development Team contacts all individuals that are out of compliance and due to become out of compliance with details about the appraisal process.
- Contact is also made with all line managers each month to actively highlight gaps in compliance and provide information and guidance on the process, note this is in addition to ESR automatic messages which are also issued.
- Development for managers continues with online resources and guidance made available together with formal management training.
- The intranet has a comprehensive suite of guidance and ‘on-demand’ learning resources that brief staff and managers on the new process.

- A new appraisal 'portlet' has been developed in collaboration with the national ESR Team. This makes recording appraisal easier for managers with a short step by step video to assist them in recording appraisals.
- The Deputy CPO is writing to all service leads in Corporate Division to request that out of date appraisals are completed by end of September, for those still outstanding; they will be invited to October WSB to present their trajectories in the same way Divisions have presented.
- All managers with outstanding appraisals will be invited to an awareness session outlining the importance of appraisal where support and guidance for completion will be provided.

Risks to position and/or actions:

- Ongoing system pressures continue to be a risk to capacity for managers and staff to have quality appraisal discussions. To help mitigate this, the OD Team will work in collaboration with HR to provide targeted awareness sessions for teams / services that are particularly lower in compliance.

Staff Turnover % compliance

Narrative:

In-Month Turnover

Trust-wide in-month turnover increased to 1.53%, surpassing the threshold of 0.83%. This increase is attributed to the planned junior doctor rotation.

The data highlights an improving trend, particularly for permanent contracts, while acknowledging the short-term impact of seasonal factors like the Doctors Rotation on in-month turnover.

Actions:

Continued development and implementation of the retention programme with enhanced focus upon Nursing and AHPs. Some examples of the work delivered so far include;

- Career clinics within divisions
- Reward & recognition initiatives
- Buddy system for new CSWs

Some examples of the work underway include;

- Staff career stories
- Digitalisation of resignation and exit interviews
- Executive engagement events

- Career shadowing opportunities

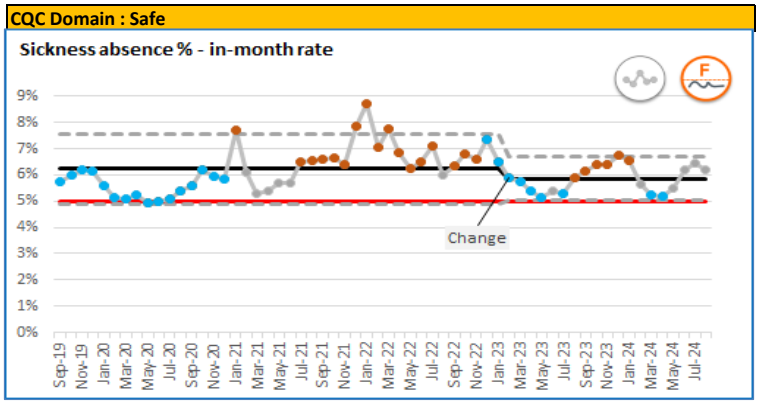
Risks to position and/or actions:

The impact of the work outlined above will continue to help maintain turnover below the Trust threshold. High turnover present risks to the Trust financial management (bank and agency cover), quality, patient safety and operational performance.

Work continues as per the People Strategy Priorities for 24/25 deliverable with ccontinued development and implementation of the retention programme with enhanced focus upon nursing and AHPs. Other workstreams also help support retention across the Trust – such as flexible working, effective workforce planning and efficient deployment of our workforce.

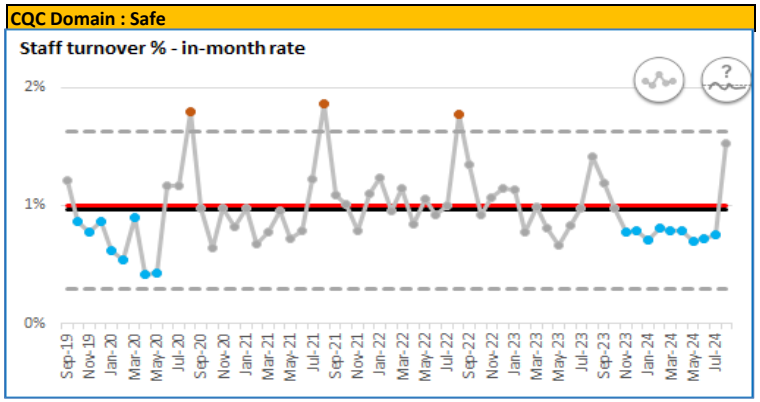
Chief People Officer

CQC Domain : Safe



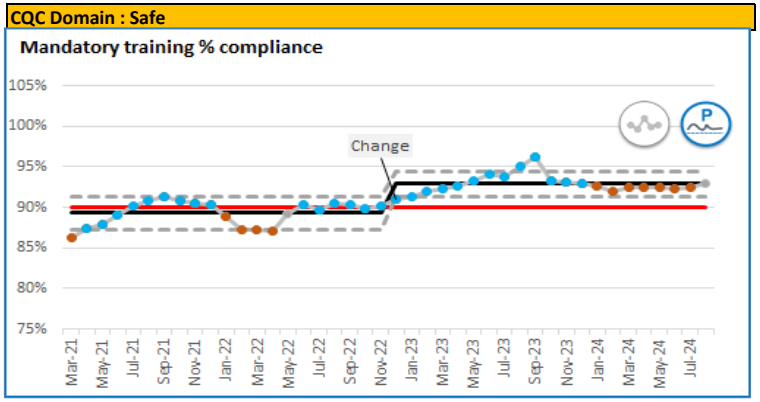
Aug-24
6.17%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe



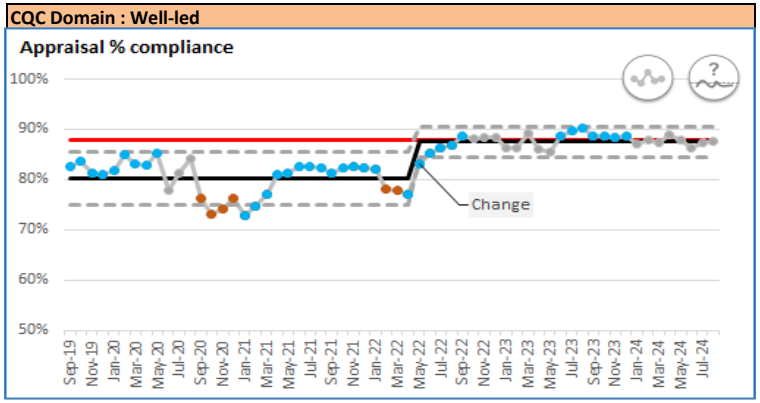
Aug-24
1.53%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



Aug-24
93.00%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led



Aug-24
87.72%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief Information Officer – for September 2024

Overall position commentary
Strong performance is maintained in: • CareCERT alerts at 100% - a key control for cyber-security. • Cyber supported servers continue above the 95% threshold figure. Improvements are highlighted in: • Service desk response time for Priority 2 incidents has increased significantly this month with 0% of calls being closed outside of SLA. Key areas for improvement are: • Subject Access Requests (SARs)– completed requests were significantly below the trajectory which has increased the backlog further. • Staff vacancies are currently at 9.7% of the workforce, a significant increase on previous months which has impacted on SARs capacity.

Service Responsiveness – Subject Access Requests
Narrative: The organisation has experienced a year-on-year increase in volume and complexity of Subject Access Requests (SARs) totaling 41% since 2016. Change in legislation, increase in request numbers, the complexity of the requests and the evolving attitudes towards information rights have had a significant impact on the demand. This combination has led to a significant backlog of requests within the Access to Information department. As at January 2024 there was a backlog of circa 1,000 requests, with approximately 650 of those requests being outside of the regulatory 30 day response target. The improvement trajectory for completing requests was 80 behind target in August with 304 being processed against a target of 384 Total requests waiting increased to 1,395. This was largely due to the departure of 2 experienced staff within a department who are already challenged in meeting the increased demands. The number of new requests received every month remains higher than in 2023 and above the average anticipated. In August, 455 requests were received, which is the largest figure recorded to date. The continued increase in numbers is largely attributable to the heightened profile of Healthcare related media events such as the Cyber attack on the London Pathology services and the recent high profile maternity case at the Countess of Chester Hospital (CoCH) **Actions:** • Implementation of new tracking software to help manage and streamline the process is imminent. • Requested the support of the Service Improvement team for a review of processes to identify opportunities for efficiencies.

- Currently assessing workforce risk in light of vacancy freeze.

Risks to position and/or actions:

- Risk posed by any further increase in demand
- Risk of trajectory slippage depending on any personnel issues such as sickness, staff turnover
- Risk of not being able to appoint to established posts

Operational Capacity – Staff vacancy as a % of workforce.

Narrative:

The last reporting period has seen a significant increase in staff vacancies as a percentage of the workforce, rising from 5% in June to nearing 10% in August. The increase is due to a number of staff departing to accept opportunities at a higher banding at other C&M organisations and the retirement of several long serving senior managers, particularly within the BI & Information department. There are some key areas of risk for the Trust in the areas of BI & Information, Development & Integration, Coding, Cyber Security, Access to Information, and more recently Clinical Analysis (with specialist knowledge of Laboratories)

The team continues to assess its workforce risks together with executive colleagues.

Actions:

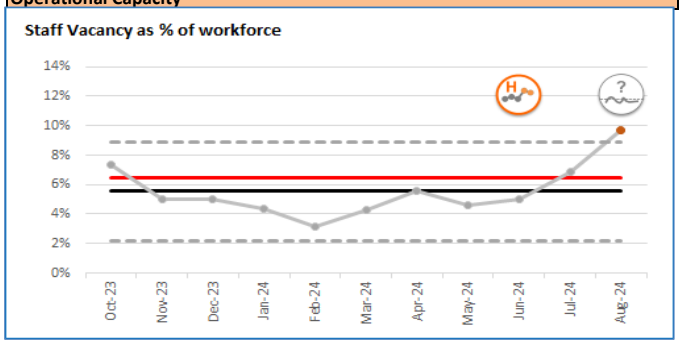
- All departments across DHT have been risk assessed and proposals are being prioritised to address the high risk areas.
- Vacancy freeze exception being progressed for BI & Information Team.
- Benchmarking work conducted for BI provision across C&M.
- Technical Cyber work being actioned by the Technical Infrastructure Team.
- Chief Technology Officer providing backup cover for Integration Team.
- Scoping work ongoing to understand the opportunity of collaboration with Community Trust in problem areas.
- Investigating Artificial Intelligence opportunities within the coding arena.

Risks to position and/or actions:

- Difficulties in recruiting the desired skill sets for vacated positions due to national skills shortages in those areas.
- Chief Technology Officer providing expert cover for Development & Integration is not sustainable.
- Vacancies are not approved at the exception process.
- Performance impacts across the department.

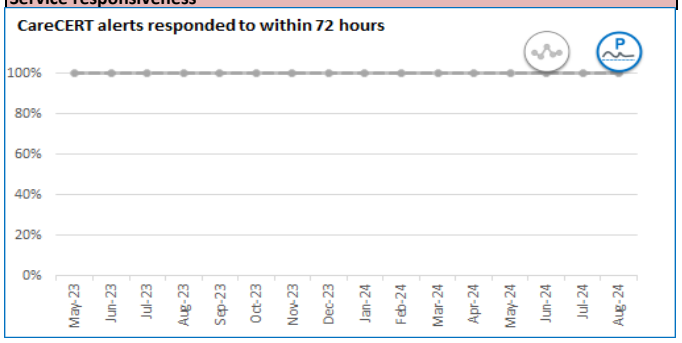
Chief Information Officer

Operational Capacity



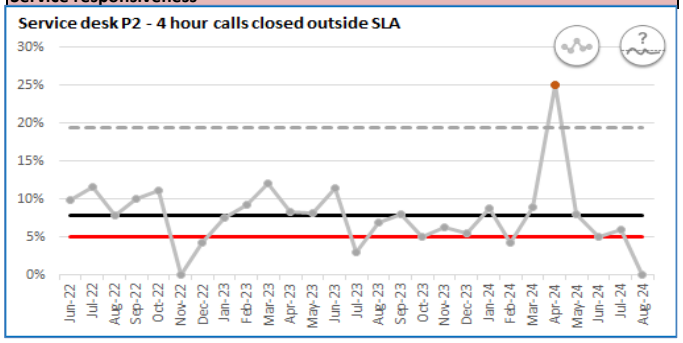
Aug-24
9.7%
Variance Type
Special cause variation - concerning
Threshold
<=6.5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



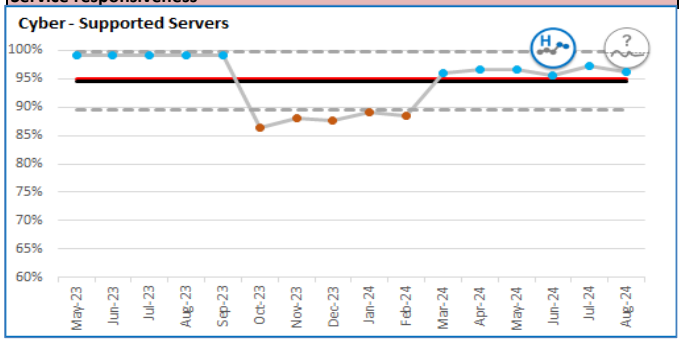
Aug-24
100%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently achieves the target

Service responsiveness



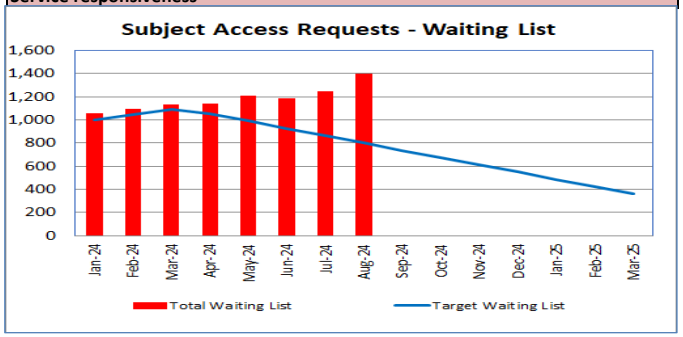
Aug-24
0.0%
Variance Type
Common cause variation
Threshold
<=5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



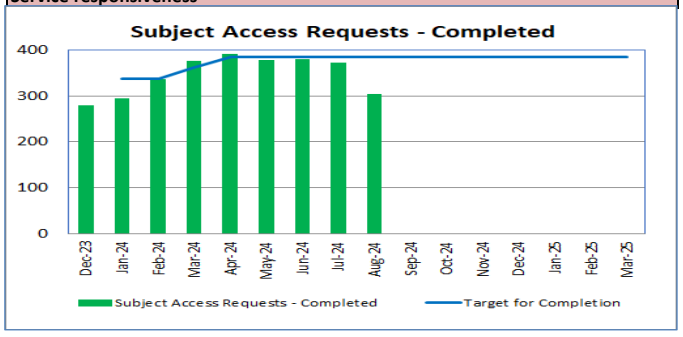
Aug-24
96.1%
Variance Type
Special cause variation - improving
Threshold
>=95%
Assurance
Hit & miss target subject to random variation

Service responsiveness



Aug-24
1395
Variance
Total requests waiting worse than target
Threshold
801

Service responsiveness



Aug-24
304
Variance
Completed requests worse than target
Target
384

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9.4**

02 October 2024

Title	Monthly Maternity and Neonatal Services Report
Area Lead	Sam Westwell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's')
Report for	Approval

Report Purpose and Recommendations

The last Quarterly Maternity Services update report to the Trust Board of Directors was presented in September 2024. The following extended monthly paper provides a further update and oversight of the quality and safety of Maternity and Neonatal Services at Wirral University Teaching Hospital (WUTH).

Included in the paper is the monthly Perinatal Clinical Surveillance Quality Assurance Report providing an overview of the latest (August 2024) key quality and safety metrics and the position of patient safety incidents.

This paper provides a specific update regarding Fi-Care accreditation, MIS Year 6, Saving Babies Lives (SBLv3), National Maternity services review in England published in September 2024, together with an update on the Maternity Claims Scorecard.

It is recommended: -

- Note the report.
- Note the Perinatal Clinical Surveillance Assurance report.
- Note the achievement of the NNU Fi-Care accreditation.
- Note the progress of the Trust's position with Maternity Incentive Scheme and Saving Babies Lives v3.
- Note the contents of the National Review of Maternity Services in England 2022-2024
- Note the Maternity Claims scorecard.

Key Risks

This report relates to these key Risks:

- BAF Risk 1.4, Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes
Which strategic objectives this report provides information about:	

Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
October 2024	Maternity & NNU Assurance Board	Extended Monthly Maternity and Neonatal Services Report	For information
October 2024	Patient Safety and Quality Board	Quarterly Maternity and Neonatal Services Report	For information

1	**Perinatal Clinical Surveillance Quality Assurance Report**
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 1** and provides an overview of the latest (August 2024) key quality and safety metrics. The purpose of this report is to provide a monthly update to BOD of key metrics reported to the Local Maternity and Neonatal System (LMNS) and NHSE/I via the Northwest regional Maternity Dashboard which are linked to the quality and safety metrics of Maternity and Neonatal Services. The dashboard is provided for information and whilst there is no indication to escalate any of the metrics to the Board of Directors, it should be noted since there is no longer a Northwest coast regional report being produced WUTH is no longer able to report on the benchmarking against other providers for rates such as stillbirth and neonatal deaths. Assurance has previously been provided to the Board of Directors this was escalated via the Local Maternity and Neonatal System (LMNS) for a resolution. However, a Northwest Regional Dashboard Tool for use by Regional Maternity and Neonatal Teams is available to provide bespoke reports for Regional Operational Performance reporting. On review of the dashboard the Board of Directors should be aware concerns regarding the accuracy of the data sources have been raised regionally, further escalating regionally it remains WUTH is still unable to benchmark against other providers.

2	**Patient Safety Incident Investigations (PSII's) & Maternity and Newborn Safety Incidents (MNSI)**
	Patient Safety Incident Investigations (PSII's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). PSSI's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity PSSI's across the region.

	There were no Patient Safety Investigation Incidents (PSII's) for Maternity declared in August 2024 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) and to date two cases will undergo the independent safety investigation. There were no Patient Safety Investigation Incidents (PSII's) declared in August 2024 for Neonatal services.

3	Maternity Incentive Scheme (MIS) Year 6
	A detailed MIS update is included to Board of Directors Monthly Maternity Services update, which will further inform Trust declaration with the MIS due for submission before a deadline of 12 noon on 3 March 2025. Now in its sixth year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts' contributions to the Clinical Negligence Scheme for Trusts (CNST). The MIS rewards Trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both Maternity and Neonatal care. The compliance is being monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. An updated gap analysis is provided at **Appendix 2.** Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS and the declaration will also be required to be signed off by the ICB. The compliance will be monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. A further compliance update will be included in the next maternity quarterly update report utilising the audit tool. Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS/ICB.

4	Saving Babies Lives v Three (SBLv3) Safety Action 6 of the MIS year 5 Scheme
	The Saving Babies' Lives Care Bundle (SBLCB) launched in July 2023 provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020 (DHSC 2017). ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there was more to do to achieve the ambition in 2025. Version 3 of the Care Bundle (SBLCBv3) was redeveloped to include a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. On final review of all the evidence as of August 2024 for Quarter 2 the Trust achieved

	97% compliance against the 6 elements included at **Appendix 3**. The Trust continues to work towards full implementation and a further update will be in the next Board of Directors quarterly paper.

5	Family Integrated Care Accreditaion (FI-Care)
	WUTH NNU was first assessed in May 2023 for the Family Integrated Care (FICare) accreditation achieving green status. FICare is a model of neonatal care which promotes a culture of partnership between families and staff. This enables parents to become confident, knowledgeable, and independent primary caregivers. This BAPM framework describes a model of FICare and provides a structure for implementation in UK neonatal units and networks. WUTH is committed to improving patients experience on the NNU and has developed FICare principles and frameworks to improve outcomes and continuity of care for premature babies. The four areas are parental education and support; staff education and support; Neonatal environment and psychosocial support for parents and staff. The neonatal unit at WUTH are striving to attain their Northwest Neonatal Operational Divisional Network (NWNODN) Family integrated care (FICare) accreditation. Following the first accreditation in May 2023, there is a requirement for annual re-assessment which was carried out in August 2024 sustaining green accreditation.

6	Claims Balanced Score Card
	An initial gap analysis outlining compliance against the recommendations is attached at **Appendix 4** and is RAG rated accordingly. The next three years the following four themes will be focused on: - • Listening to and working with women and families, with compassion • Growing, retaining, and supporting our workforce • Developing and sustaining a culture of safety, learning, and support • Standards and structures that underpin safer, more personalised, and more equitable care. Delivering this plan will continue to be a collaboration with maternity and neonatal services to support women and families and improve care. Progress is monitored via the Maternity and Neonatal Quality assurance board and WUTH continues to implement within the timescales. The Equity and equality guidance for local maternity services is the pathway followed to address health equalities and is also part of the three-year delivery plan.

7	National Review of Maternity Services in England 2022-2024
	The report at **Appendix 5** published in September 2024 brings together the findings from inspections of 131 hospital maternity units carried out as part of that programme, setting out the key themes, evidence of good practice and the common areas of concern. It makes recommendations for NHS trusts, the wider system and national bodies.

	Within the report there are a few recommendations for NHS Trusts and a gap analysis will be undertaken and included in the next quarterly Board of Directors report.

8	Conclusion
	The Board of Directors are requested to note the content within the report and progress made within maternity and neonatal services. The next BOD paper will continue to update on the delivery of safe maternity and neonatal services.

9	Implications
9.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
9.2	**People** • Compliance and confirmation via the LMNS/ICB WUTH have that meet all 10 safety standards provides assurance of the improvements to high quality, safe care and the delivery of best practice in both Maternity and Neonatal services. • The outstanding relationship with MNVP demonstrates co-production with service users and patient involvement. • Progress with the three-year delivery plan supports birthing people and their families with quality improvements to deliver safer, more personalised, and more equitable care. • Progress with sustainability of Ockenden. • Progress with Saving Babies Lives v3 supporting better outcomes for women/birthing people and babies.
9.3	**Finance** • In order to meet the continued compliance and sustainability of the Maternity Incentive Scheme (MIS) and continue to deliver Maternity Continuity of Care as for women/birthing people with enhanced care needs, investment into the maternity and neonatal workforce is required and funding options continue to be explored. • To achieve compliance of MIS Year 6 the Statement of case for an additional Neonatal Consultant has been approved to cover Monday to Sunday, recruitment is in process and awaiting all checks to be completed.
9.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Author	Jo Lavery, Director of Midwifery & Nursing - Women and Children's Division
Contact Number	0151 678 5111, Ext 2792
Email	Jo.lavery@nhs.net

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	No	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and NW Regional dashboard now available however discusssed regionally as Data to October 2023 and decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised; external review requested to support rise in still birth rate; no further trends identified as an outlier in 2024
	Outlier for rates of neonatal deaths as a proportion of birth	na	No escalation from SCN / LMNS on outlier report; internal thematic review undertaken and shared with BoD; Decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised.
	Rates of HIE where improvements in care may have made a difference to the outcome	na	Very low rates of HIE, sitting way below the lower control limit for the region. No current cases
	Number of PSII's	na	No PSSI's reported in August 2024
	Progress on SBL care bundle V3	no	SBLv3 launched and continued to be a key safety action of MIS Year 5 which was signed off as complaint meeting 81% (>70% was the requirement); Audits and evidencecontinue to be submitted for LMNS review and achieved complaince as at Q1 (April-June 2024) of 97%; compliance will be monitored by LMNS quarterley and updates provided to BoD quarterley
	Outlier for rates of term admissions to the NNU	na	The rate of avoidable term admissions; regular multi-disciplinary reviews of care take place; NW region outlier report no longer published and awaiting national guidance on monitoring processes
Service user and st	MNVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints; to date all complaints have been addressed for maternity in the target timeframesand there is nil to escalate
	Trainee survey	no	No update this month
	Staff survey	no	Trust Staff Survey completed and divisional response has included staff engagement and continuation with the Pulse surveys; Score survey completed for MatNeo and cultural conversations commencing over x 4 sessions; Requirement to report to BOD Feb 2024
	CQC National survey	no	Published Feb 2024 and included within BoD report March 2024; action plan progressing; Sample provided for 2024 survey to be pulished early 2025
	Feedback via Deanery, GMC, NMC	no	Nil to esclate
	Poor staffing levels	no	Current vacancy rate is >2%; all new qualified midwives commenced in Sept 2024
	Delivery Suite Coordinator not super nummary	no	Super nummary status is maintained for all shifts
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	Nil of note; full establishment; governance structure review and revised structure implemented to meet requirements and maternity self assessment tool and continue to meet Ockenden Part 1
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams /Directorates
	False declaration of CNST MIS	no	MIS Year 5 submission and declaration submitted by 12 noon on 1st February 2024 - complaince met; MIS Year 6 publication published April 2024 included within BoD report updates.
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil to report this month; funding options explored; 5 teams in total and two approach model in place; comparison data / research underway; one team disbanded in July 2024
Safety and learning culture	Lack of engagement in MNSI or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead. Quarterly regional meetings arranged with excellent MDT attendance. Quarterley meetings held with MNSI
	Lack of transparency	no	Being open conversations are regularly had and 100% compliance with duty of candour evident
	Learning from PSII's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all PSSI's, local reviews, rapid evaluations of care, complaints and compliments. Engagement with staff to assess and improve how learning is shared. Patient experience strategy in progress.
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations. No exceptions to report. Three year single delivery plan for maternity and neonatal services published 31th March 2023 - gap analysis in progress and will monitored via WUTH CG structure and BoD
Incident reporting	Low patient safety or serious incident reporting rates	no	Consistent rates of reporting across the speciality groups. Regular training takes places on the importance of incident reporting, underpinning the Trust stance of safe reporting and non-punitive culture
	Delays in reporting a PSSI where criteria have been met	no	Robust PSIRF framework followed with timely reporting of all cases that meet the PSSI framework; PSIRF with effect from 1/9/2023
	Never Events which are not reported	no	No maternity or neonatal never events in July 2024
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales
Governance processes	Unclear governance processes		Clear governance processes in place that follow the PSIRF framework - Within division there is maternity and neonatal review of governance processes: 3 separate meetings. Staff are informed of top risks and incident themes. Governance notice boards updated and newsletters disseminated. Additional quality assurance framework agreed with effect from June 2023 to give the BoD addiitonal assurances in monitoring of MIS, Three year delivery plan etc. Governance structure strengthened
	Business continuity plans not in place	no	Business continuity plans in place
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	Nil to report this month
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Nil to report this month
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	CQC reports published for maternity sites Seacombe Birth Centre and APH site for the domains Safe and Well led; both sites were rated 'GOOD'
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

Safety action 10:
Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

Safety action Lead(s):

Jo Lavery (JKL); Mustafa Sadiq (MS), Katherin

Link to SA10 Guidance

Reporting period: 8 December 2023 until 30 November 2024

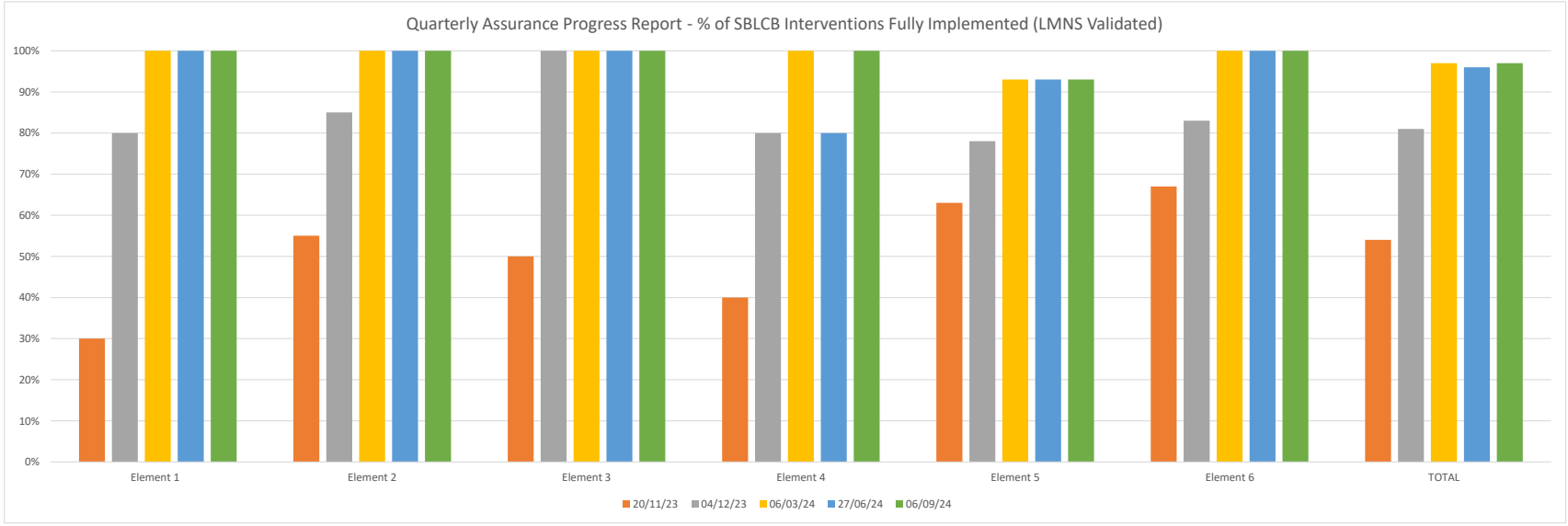
	Requirement	Lead	Actions/progress	Update due	Compliance status	Supporting evidence	Location of evidence	Evidence signed off by	Date of sign-off
10.1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	*DC*	*At review 31/3/2024 all cases reported*	*Quarterley*		*Compliant at Q1 (Jan - March 2024)*	*CG working folder*		
10.2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.	DC	At review 31/3/2024 all cases reported	Quarterley		Compliant at Q1 (Jan - March 2024)	CG working folder		
10.3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme	DC	At review 31/3/2024 all eligible families have received DOC	Quarterley		Compliant at Q1 (Jan - March 2024)	CG working folder		
10.4	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	DC	At review 31/3/2024 all eligible families have received information	Quarterley		Compliant at Q1 (Jan - March 2024)	CG working folder		
10.5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	DC	Updates provided at monthly reports	Monthly		Compliant at Q1 (Jan - March 2024)	CG working folder		
10.6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	DC	Provided to BoD at final sign off	31/12/24		Compliant at Q1 (Jan - March 2024)	CG working folder		
10.7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	DC	Provided to BoD at final sign off	31/12/24		Compliant at Q1 (Jan - March 2024)	CG working folder		
10.8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	JL		31/12/24					

LMNS Quarterly Assurance Meeting Record on Implementation of the Saving Babies Lives Care Bundle (Version 3)

Trust: **Wirral University Teaching Hospital NHS Foundation Trust**

ICB: **North West**

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5	Assessment 6	Assessment 7	Assessment 8	Assessment 9	Assessment 10	Assessment 11
Review Quarter	**Q2**	**Q3**	**Q4**	**Q1 24/25**	**Q2 24/25**							
Assurance Review Date	**20/11/23**	**04/12/23**	**06/03/24**	**27/06/24**	**06/09/24**							
Element 1	30%	80%	100%	100%	100%							
Element 2	55%	85%	100%	100%	100%							
Element 3	50%	100%	100%	100%	100%							
Element 4	40%	80%	100%	80%	100%							
Element 5	63%	78%	93%	93%	93%							
Element 6	67%	83%	100%	100%	100%							
TOTAL	54%	81%	97%	96%	97%							

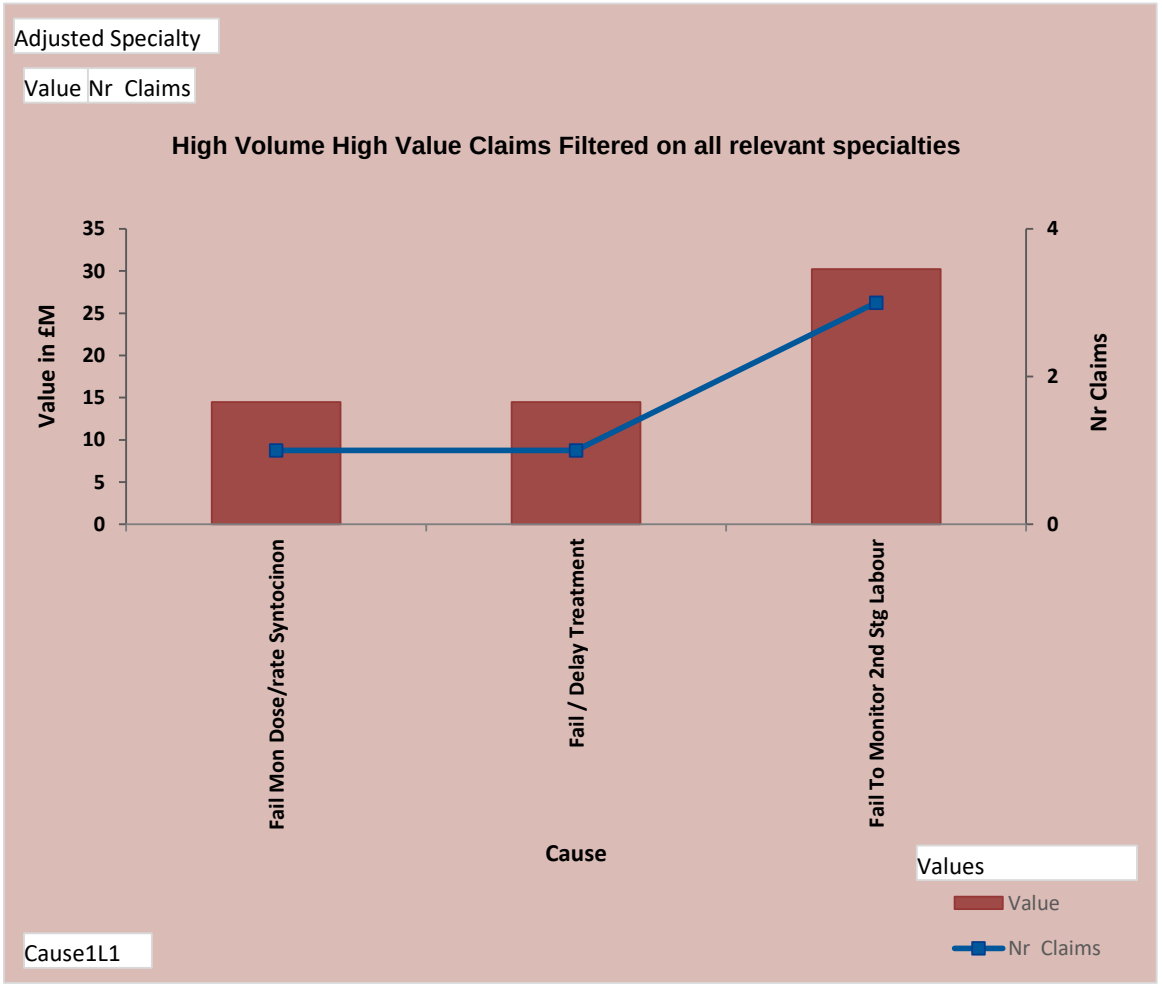


Scorecard - Red Zone Analyses

Wirral University Teaching Hospital NHS Foundation Trust

Adjusted Specialty	(All)

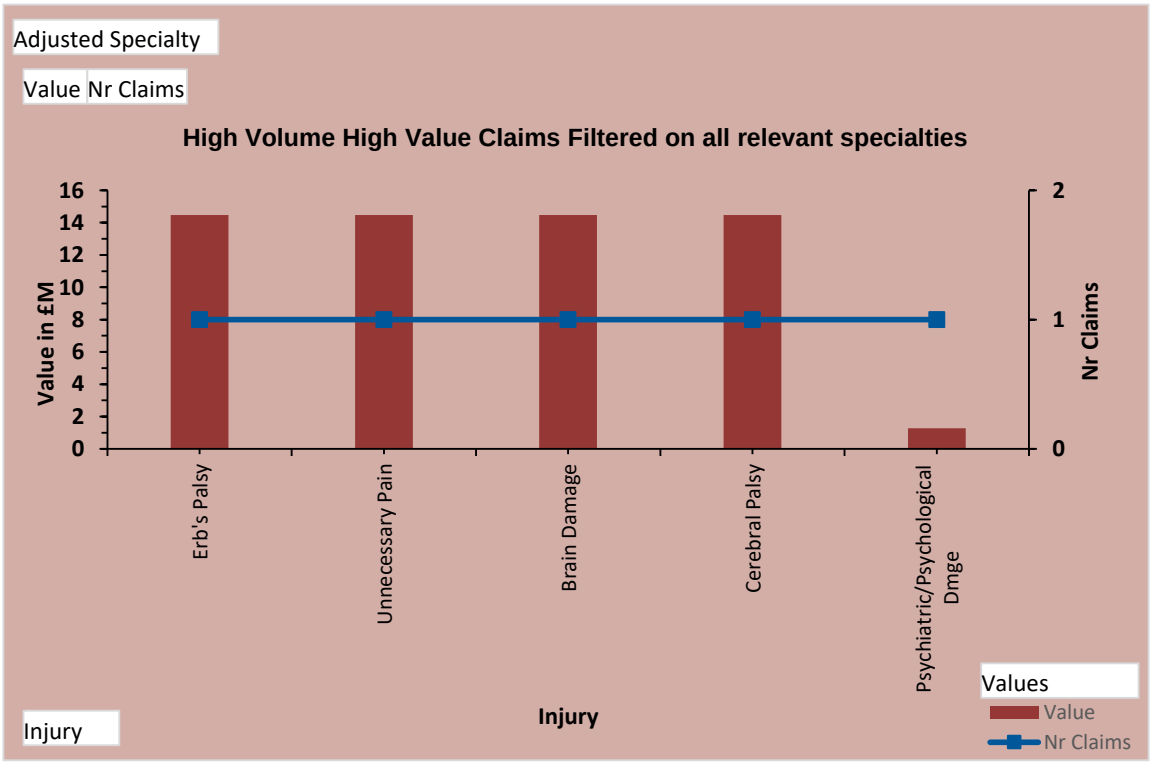
Cause	Value	Nr Claims
Fail Mon Dose/rate Syntocinon	£14,470,000.00	1
Fail / Delay Treatment	£14,470,000.00	1
Fail To Monitor 2nd Stg Labour	£30,220,000.00	3
Grand Total	£59,160,000.00	5



Selection Criteria: CNST claims received with an Incident Date between 01/04/2014 and 31/03/2024
Total number of claims for this Trust: 454. Total value of claims for this Trust £140,091,283
Data correct at: 30/06/2024

Adjusted Specialty	(All)

Injury	Value	Nr Claims
Erb's Palsy	£14,470,000.00	1
Unnecessary Pain	£14,470,000.00	1
Brain Damage	£14,470,000.00	1
Cerebral Palsy	£14,470,000.00	1
Psychiatric/Psychological Dmge	£1,280,000.00	1
Grand Total	£59,160,000.00	5



Selection Criteria: CNST claims received with an Incident Date between 01/04/2014 and 31/03/2024
Total number of claims for this Trust: 454. Total value of claims for this Trust £140,091,283
Data correct at: 30/06/2024

National review of maternity services in England 2022 to 2024

Our national review of maternity services in England, 2022 to 2024.

Download an easy read version of this report

What maternity services are like in England - September 2024 (Easy Read)
20240919-NationalMaternityReport-EasyRead.pdf
File title
What maternity services are like in England - September 2024 (Easy Read)
Keywords
easy read

Summary

The quality and safety of maternity services have remained under scrutiny in recent years. While a series of high-profile investigations identified key failings at specific NHS trusts, our National maternity inspection programme – an inspection of all hospital maternity locations that had not been inspected since before March 2021 – has shown many of the issues raised are widespread across England.

While we identified pockets of excellent practice, we are concerned that too many women and babies are not receiving the high-quality maternity care they deserve. Of the 131 locations we inspected between August 2022 and December 2023, almost half were rated as requires improvement (36%) or inadequate (12%). Only 4% of services were rated as outstanding and 48% were rated as good. At 12 locations, ratings for being well-led dropped by 2 ratings levels and at 11 locations, ratings for being safe dropped by 2 levels.

The safety of maternity services remains a key concern, with no services inspected as part of our inspection programme rated as outstanding for being safe. Almost half (47%) were rated as requires improvement for the safe key question, while 35% were rated as good and 18% were rated as inadequate. Where we had the most concerns, we used our enforcement powers to require trusts to make significant improvements to protect people from risk of harm.

While many of the issues we highlight in this report are systemic, with the right culture, services can improve and learn from one another. Alongside this report, we have worked with providers, maternity staff and stakeholder organisations to develop some additional resource materials which can be implemented at trust-level. These resources are available on our website and are aimed at maternity service staff at all levels to help support their efforts to deliver high-quality care and make improvements where needed.

In this report we refer to 'women', but we recognise that some transgender men, non-binary people and people with variations in sex characteristics or who are intersex may also use maternity services and experience some of the same issues.

Responding and learning from incidents

More work is needed to improve the way services report, learn and communicate with women following patient safety incidents. Although most services managed patient safety incidents well, we are concerned about the potential normalising of serious harm in maternity. For maternity staff, well recognised complications such as postpartum haemorrhages may be common and do not always constitute a patient safety event. However, the impact on women can be significant. We are concerned that women do not always receive the information they need to process what has happened to them and make informed decisions about future pregnancies.

Risk assessment and triage

We found significant variation for maternity triage as there are no national targets or standards for this area, and many of our inspections were carried out before the Royal College of Obstetricians and Gynaecologists (RCOG) released its Good Practice Paper on Maternity Triage in December 2023. Research by the Sands and Tommy's Joint Policy Unit supports this, showing that "guidance on how and when to contact triage is not clear and consistent between services". While a 'one size fits all approach' may not be appropriate across all services, we are concerned that not everyone received a safe and timely assessment. We found instances where the triage phone went unanswered and when people arrived at hospital, issues with staffing and the triage environment meant some women were not assessed in a timely way. In some cases, delays in triage were so severe that women discharged themselves before being seen by a midwife or doctor

Recruitment and retention of staff

Our programme identified chronic issues around recruitment and retention of the maternity workforce as a key issue affecting the quality of care that women receive. It is vital that maternity services can recruit to maintain safe staffing levels in line with national standards. Staff should then be supported to carry out their roles with the appropriate levels of training. With high numbers of midwives being driven away from the profession by current pressures, leaders must prioritise the wellbeing of staff to foster an open and supportive culture. There is also work to be done to future-proof the workforce and attract students to a career in midwifery, as data from UCAS shows midwifery applications for June 2024 were at their lowest for more than 6 years.

Estates and environment

Unsuitable maternity estates emerged as another key barrier to high-quality care. We found some maternity units were not fit for purpose, as they lacked space and facilities and, in a small number of cases, appropriate levels of potentially life-saving equipment. Additional capital investment is needed to ensure women receive safe, timely care in an environment that meets their needs.

Inequalities and racism

We found significant differences in the way trusts collect and use demographic data to address health inequalities in their local populations. Reducing inequalities is imperative in saving lives and preventing harm to people with protected characteristics. Without national guidelines, we are concerned that trusts have no way of effectively evaluating whether initiatives to make maternity care more equitable are driving much-needed change. This is unacceptable given that, according to MBRRACE-UK data published in January 2024, Black women are still 2.8 times more likely to die during or up to 6 weeks after pregnancy compared with women in White ethnic groups. The data also showed that Asian women are 1.7 more times likely to die during the same period. Concerningly, we also found some trusts where both staff and people who were using the service experienced discrimination because of their ethnic background, or issues associated with having English as a second language or not their preferred language.

Communication with women and families

Communication with women and their families is not always good enough, particularly for those with protected equality characteristics. This affects their ability to consent to treatment and can perpetuate levels of fear and anxiety. Through our Give feedback on care service, many women told us that a lack of communication negatively affected their birth experiences. A cultural shift is needed so that all women are given the information they need, in a way they understand it, to make informed decisions and consent to treatment.

Foreword

Every pregnant woman wants a positive birth experience – and every member of staff working in a maternity service wants to provide safe, high-quality care. In most situations that's what happens, but sadly, it's not always the case. For some families who are impacted by poor maternity care, the damage is irrevocable. No family should ever have to suffer in this way and everyone working in the health and care system has a responsibility to do all they can to prevent it happening.

Maternity services have been and continue to be under significant scrutiny. In recent years, several high-profile investigations have highlighted worryingly similar failings - a sobering reminder that efforts to improve have not yet done enough to address the underlying issues preventing safe, high-quality care being delivered every time.

In 2020 we shared our concerns about the variation in quality and safety of maternity services across the country in a briefing paper Getting safer faster: key areas for improvement in maternity services. Those concerns were further evidenced a year later in our thematic report on 'Safety, equity and engagement in maternity services', and more recently CQC State of Care reports have singled out maternity as a service that has seen a marked deterioration in ratings over time.

It was within this context that we introduced a targeted national maternity inspection programme. The programme aimed to provide an up-to-date assessment of maternity care across England – and to explore what lies behind the lack of progress in some services. It began in August 2022 and involved on-site assessments of all hospital maternity locations that had not been inspected and rated since before March 2021.

This report brings together the findings from inspections of 131 hospital maternity units carried out as part of that programme, setting out the key themes, evidence of good practice and the common areas of concern. It makes recommendations for NHS trusts, the wider system and national bodies.

Our programme of inspections has shown that there are hospitals providing good maternity care and we found some excellent practice. However, we also identified some common issues and concerns that too many women and babies are not always receiving the high-quality service they should expect.

Sadly, we found that the failings uncovered by Donna Ockenden and Dr Bill Kirkup following their reviews of maternity in individual trusts are not isolated. Many of the factors apparent at East Kent and Shrewsbury and Telford are more widespread. Key issues continue to impact quality and safety – and disappointingly, none of them are new. Poor management of incidents with limited learning when things go wrong, failure to ensure safe and timely assessment at triage, unsuitable estates and access to essential equipment, a lack of oversight from trust Boards and significant challenges in recruiting and retaining staff.

We know the inequalities in outcome and additional risks experienced by women from Black and ethnic groups are well documented, yet we found huge differences in the way trusts collect and use demographic data to try to address those disparities. Significant concerns also remain regarding the quality of communication with women and their families, and a failure to engage with and listen to their needs.

These findings are all too familiar - so why do they persist and what is stopping us from moving forward? We need to be more honest about the reality of the problem and recognise that we all have a role to play to ensure sustainable improvement. This starts with a robust focus on safety where the culture that prevails does not accept risks as the norm and where staff are supported to deliver the high-quality care they want to provide. The recommendations made in this report aim to help us achieve that goal and to ensure good safe care for mothers and babies of today and in the future.

This report sets out some hard-hitting findings. However, this should not detract either from the positive steps that have already been taken to support change or from recognition of the dedication and commitment of the maternity workforce. Our findings show that the work to help improve safety already underway needs to continue and that there are specific issues that must be tackled as part of NHS England's three-year delivery plan for maternity. The findings also underline why it's so important that we encourage staff and services to take learning from CQC inspections that identify good care. Alongside this report we have published a number of new online resources intended to do just that by sharing what is working well as a source of practical guidance and support.

Without action, the danger is that poor care and preventable harm will become normalised. We cannot and must not let that happen.

We would like to express our sincere thanks to all those who have contributed to this report, In particular, our thanks go to all the families who shared their experiences with us to help ensure safer, better care in the future.

Recommendations

For NHS trusts

We recommend NHS trusts ensure all women leave hospital with the information they need to be able to process their experience and have an opportunity to make arrangements to speak to a member of the multidisciplinary team about their birth within a realistic timeline. Women whose cases are referred to a review panel should have the right to attend the panel and the opportunity to co-produce improvements for future reviews.

For NHS trusts and integrated care boards (ICBs)

We recommend NHS trusts and integrated care boards:

- Improve their collection of demographic data, including information on ethnicity and levels of deprivation, to improve outcomes for women.
- Ensure that demographic data, including ethnicity data, is always considered when reviewing patient safety incidents and action is taken where risks are identified.
- Ensure that there are clear policies and procedures on the collection of demographic information and staff understand the importance of how this data can be used to improve outcomes for women.

For NHS England

We recommend NHS England:

- Develops guidance and definitions of a patient safety event, where something unexpected or unintended happens in maternity services, ensuring reporting in line with Learn from Patient Safety Events (LFPSE), to tackle the issue of inconsistency in interpretation.
- Oversees the performance of maternity triage services to enable trusts to benchmark and improve. This is in line with the Royal College of Obstetricians and Gynaecologists (RCOG) recommendation to introduce "an agreed national standard and reporting tool for maternity triage, similar to that used in emergency medicine." As outlined by RCOG, metrics should include "staffing requirements, agreed audit standards reported nationally, and frameworks for improvement."
- Has oversight of gaps in middle-grade rotas and the proportion of time spent by consultants covering them. This supports recommendations in the Ockenden Review to introduce nationally agreed minimum levels of medical staff to cover the full range of maternity services at all times.
- Works with the Nursing and Midwifery Council and Royal College of Obstetricians and Gynaecologists to establish a minimum national standard for midwives delivering high dependency maternity care.
- Ensures trusts are proactively managing succession planning in midwifery services and, In line with recommendations from Leadership for a collaborative and inclusive future review, supports midwifery and obstetric staff to become effective future leaders.

For the Department of Health and Social Care (DHSC)

We recommend DHSC:

- Provides additional capital investment in maternity services to ensure that women receive safe, timely care in an environment that protects their dignity and promotes recovery.
- Works with NHS England to ensure that this additional investment is ring-fenced and maternity services receive the investment they need.

For the Royal College of Obstetricians and Gynaecologists

We recommend the Royal College of Obstetricians and Gynaecologists takes our findings in relation to the surgical first assistant role in maternity services so that it is in line with the requirements set out by the Royal College of Surgeons.

For the Nursing and Midwifery Council

We recommend that the Nursing and Midwifery Council uses findings from our report to review their proficiency standards for midwives.

Methodology and evidence used

We inspected hospital maternity units that had not been inspected since before 2021, focusing on the safe and well-led key questions. The findings in this report are based on inspections of 92 NHS trusts across 131 locations. Overall ratings were determined using our ratings principles.

Inspectors working on the programme received additional training and structured support to prepare for the role This included briefings on the maternity pathway from midwives and senior specialists in our secondary care team. This covered what to expect when on site and the terminology used, as well as opportunities to shadow other inspectors and work with specialist advisors on site. Inspectors received specific guidance and used standardised templates to promote consistency, and could access additional support from a remote senior specialist at all times.

In 2019/20, we carried out 9 pilot inspections to develop a focused approach to inspecting maternity services. Learning from the pilots informed the National maternity inspection programme.

The aims of the National maternity inspection programme were to:

- show how services are responding to current challenges and what extra help they may need
- give women and their families an up-to-date view of the quality of maternity care at their local hospital trust
- show hospitals an objective assessment of what they are doing well and how they can improve
- help CQC understand what is working well so we can share good practice to help services learn and improve
- show where national action is needed to combat the challenges facing services.

This report explores the findings from our inspection programme to give a national view of the current state of maternity services in England. Evidence used in this report includes:

- inspection reports (thematic analysis of the first 85 published inspection reports alongside engagement with the inspection teams involved in all 131 inspections)

- responses received through our Give feedback on care service (around 10,000 maternity responses analysed for the report)
- open responses to the 2023 Maternity survey (around 1,250 responses)
- interviews with 10 midwives and 10 obstetricians from ethnic minority backgrounds
- focus groups with maternity leaders and frontline staff across 16 trusts to help us understand how trusts were ensuring that women from ethnic minority backgrounds had equitable access to pain relief.

As part of the programme, we commissioned THIS Institute to evaluate how we carried out the inspection programme and identify where we can improve. The final section of this report summarises this evaluation.

Safety

The National maternity inspection programme has identified widespread issues affecting the quality and safety of maternity services in England.

In the programme, we rated 47% of services as requires improvement or inadequate. Many of our concerns are not new – in our Getting safer faster: key areas for improvement in maternity services report, we highlighted that maternity services stood out from other services as not making safety improvements fast enough. Similarly, our Safety, equity and engagement in maternity services report identified that issues such as poor relationships between obstetric and midwifery teams, and failure to engage with and listen to local women, continue to affect the safety of some hospital maternity services.

Throughout the programme, the safety of women using maternity services has remained a key concern. This is reflected in our ratings, as no service was rated outstanding for being safe. In fact, for the safe key question, the majority of services were rated as requires improvement (47%), while 35% were rated as good and 18% were rated as inadequate. Where we had the most concerns, we used our enforcement powers to require trusts to make significant improvements to protect people from risk of harm.

We found a range of issues affected how safe services were. These ranged from compliance with training requirements, particularly in key areas such as measuring babies' heart rates and safeguarding, to how well services identified and managed the risk of deterioration in both women and babies. We also found concerns in relation to infection prevention and control in some services, with poorly maintained estates adding to their inability to provide safe care to women (see the Estates section of this report).

Throughout the programme, our inspection teams received high levels of challenge from some leaders working across the sector, which led to concern that poor care within maternity is being normalised. But all services must recognise the long-term, significant impact that pregnancy and birth can have on women. Many women told us about how their mental health had suffered before, during and after birth. In the UK, 4% to 5% of women develop post-traumatic stress disorder (PTSD) every year after giving birth and data from MBRRACE-UK shows that although extended perinatal mortality rates decreased across the UK in 2022, they remain higher than in both 2019 and 2020.

Many of the issues we highlight in this report present serious risks to safety, such as unacceptable levels of variation in key areas such as triage However, in this section we look specifically at the way services reported, learned from and communicated with women following incidents.

Incident reporting

Although most services managed patient safety incidents well, more work is needed in this area to ensure that where women suffer serious harm in maternity services do not go unreported and are graded correctly. Issues and inconsistencies around incident reporting were identified as concerns in Dr Bill Kirkup's report on maternity services in East Kent.

We are concerned that a lack of reporting – either because of a recognised complication that the trust does not believe meets the definition of a patient safety incident or that staff are overstretched – is leading to harm becoming normalised and opportunities for learning being missed.

For most of the inspection programme, services were reporting incidents to the National Reporting and Learning System (NRLS) – a central database for all patient safety incident reports. NRLS defines a patient safety incident as "any unintended or unexpected incident(s) that could have, or did, lead to harm for one or more person(s) receiving NHS funded healthcare." Towards the end of the programme, NHS England introduced the new Learn from Patient Safety Events (LFPSE) service and guidance, which has replaced the NRLS. This provides clearer definitions and distinguishes between physical and psychological harm.

Recognised complications may be common for staff and may not always meet NHS England's definition of a patient safety incident, which means they do not always need to be reported to NRLS or LFPSE. However, these complications can have a significant and long-lasting impact on women, and trusts have a statutory duty to notify CQC of such events. Trusts can do this through LFPSE and should monitor and respond to trends in these commonly occurring obstetric complications at a local level.

Many services did not have this oversight of commonly occurring obstetric complications. We found that services often had to access several different dashboards to get an overall picture of patient-related outcomes, which could at times be contradictory and unclear. In addition, we found inconsistencies in how trusts managed key metrics such as blood loss. Despite available guidance, not all services were measuring blood loss in all deliveries. This risks potential under-reporting and could mean national dashboard comparisons are less meaningful for oversight and improvement. We also found some services did not report all incidents of delays in care and controls of postpartum haemorrhage.

Not reporting incidents at a local level suggests a tendency for services to accept that maternity incidents are inevitable and that nothing in a woman's care or treatment may have contributed to them. But this is not always the case. Previous successful initiatives have shown that incidents such as shoulder dystocia, where a baby's shoulder becomes stuck, can be preventable. For example, in 2000, North Bristol NHS Trust introduced simulation training to reduce shoulder dystocia. Since training was introduced, the trust believes that no babies have suffered permanent injuries. We also know that the likelihood and impact of postpartum haemorrhages can be effectively reduced with good antenatal monitoring of haemoglobin levels. Our concerns are reinforced by the recent Birth Trauma Inquiry, Ending the Postcode Lottery for Perinatal Care, which described a "maternity system where poor care is all-too-frequently tolerated as normal".

While we recognise that postpartum haemorrhages (PPH) are not entirely preventable, services need to use evidence-based practice and guidance to optimise outcomes for women and acknowledge the impact that it can have on them. In addition, we know that women from Black and Asian backgrounds have an increased risk of PPH. Perinatal care for women from ethnic minority backgrounds should focus on preventative measures to optimise outcomes. However, as highlighted in our section on inequalities, not all services we inspected were monitoring outcomes by ethnicity.

Pressures on staff

When a patient safety incident occurred, most services managed this well in line with national guidance. However, we were concerned to find instances of patient safety incidents going unreported to NRLS because of time constraints. We found a significant number of incidents were not reported as staff were overstretched. Until more action is taken to ensure that incidents are recorded properly, and in a timely way, opportunities for improvement can be missed. Services rated as good and outstanding have a culture where incident reporting is encouraged, and feedback loops and improvement actions are normalised.

Maternity services tend to generate a significant number of incidents compared with other areas within a trust, and our inspection programme found that the size and make-up of governance teams were not always sufficient. Services often did not involve risk and governance managers, meaning midwifery staff were required to review incidents themselves. We were concerned about the impact of this on the quality and speed of reviews and the knock-on effect on staffing levels if midwives do not have protected time to review incidents. We consider this in more detail in the section on staffing.

Grading of incidents

As well as problems with reporting incidents, we are also concerned about variation in the way incidents were graded. The final report of the Ockenden review highlighted the importance of correctly grading patient safety incidents, ensuring the level of harm recorded reflects the actual harm the patient suffered.

NRLS states :

> "Maternity, fetal and neonatal incidents such as intrauterine deaths should be reported to the NRLS, however a degree of harm of death should only be chosen if it is considered that a patient safety incident, such as an omission in care during the antenatal period, has led to or contributed to the death. The degree of harm can be amended and re-uploaded to the NRLS after further investigation."

The way trusts and clinicians interpreted NRLS guidance on reporting incidents varied. While this variation exists, there is room for confusion, loss of learning and potential harm. Grading incidents based on whether omissions in care contributed to them, as outlined by the NRLS, does not take into consideration the actual physical and psychological harms that women experienced.

We saw evidence of this from incidents that are defined as 'major obstetric emergencies' (including uterine inversion and major haemorrhages over 2 litres) regularly being graded as no harm or low harm. Incidents graded as lower harm might mean opportunities to investigate and learn are missed. It could also result in no follow-up care or monitoring being organised, which may harm mothers and their babies. For example, one service used the perinatal mortality review tool, which showed an incident was graded less severely than it should have been. The trust originally highlighted that care issues 'may' have made a difference to the outcome for the baby, but a further review showed these issues were 'likely' to have made a difference.

We know that traumatic birth experiences can have a significant lasting impact on women and their families. Through our review, people told us about their experiences and the impact on them:

> "This experience [was] not one I wish to ever have to go through again, this will be my first and LAST baby. When I think of my birth experience and the aftercare, I cry every time, it was purely awful."

> "I am now undergoing therapy for PTSD... I find it incredibly traumatic to explain what happened in detail."

> "I would love another baby at some point but am emotionally scarred and find the whole ordeal difficult to talk about so this is something I am very concerned about."

LFPSE defines a patient safety incident as “something unexpected or unintended that could have or did lead to harm for one or more patients”. Recording guidance states, “if in doubt, it is always better to record a patient safety incident using the available information and best judgement”.

The guidance advises that where an unintended or unexpected outcome has been observed, but there is any uncertainty about whether an unintended or unexpected incident has occurred, the event should always be recorded to LFPSE to support national learning.

The new Patient Safety Incident Response Framework (PSIRF), introduced during the programme, moves away from the grading of incidents and prioritises compassion and engagement with the people involved in patient safety incidents. It also has a focus on improvement. We will monitor how trusts implement and use PSIRF in future inspections and ensure that harm and trauma are still given the appropriate consideration.

Our inspections found that even in a very defined system such as the previous serious incident framework, there was variation and under-reporting. Under PSIRF, providers should agree their incident response plan with their integrated care board (ICB). We will assess how trusts have done this, looking specifically at plans for maternity and neonatal services.

Investigating and learning from incidents

We expect leaders and staff to have a good understanding of service improvement, using processes to ensure that incidents are learned from. Leaders should encourage reflection and collective problem-solving.

While we found some pockets of good practice, the overall picture of how services investigated incidents was mixed. We were encouraged to find some services with midwives who specialised in learning from incidents and action plans being developed as areas were identified for improvement.

At some services, managers reviewed incidents potentially related to inequalities (see the inequalities section for more information). For example, one trust interrogated data to identify the impact of ethnicity on outcomes. Following this, the service recommended increased scanning for Pakistani women after data revealed they have a higher risk of having babies that are Small for Gestational Age (SGA). At another service, following a baby abduction incident, an abduction policy was implemented and security staff were employed. The service also introduced 2-hourly security rounds and a sign in register.

Our improvement resource provides more information on how services learned from incidents well. However, this good practice was not consistent across services. An investigation by MSNI into one service noted that staff did not acknowledge the needs of people with a learning disability using the maternity service.

We also found that delays in the reviewing process meant learning from incidents was slow-paced and learning was not always shared effectively with staff. Concerningly, in a small number of cases, it was not clear whether the service had produced any ongoing action plans or monitoring. In other instances, action plans were not up to date, or did not fully reflect the findings of the reported incident.

These issues expand beyond maternity services. A study published in the Journal of Patient Safety found that too often hospitals develop action plans with weak or ineffective interventions, which can fail to address key issues and result in significant gaps in translating investigations into meaningful improvement. It found plans typically included individual-focused interventions, even when problems were systemic.

Although we saw pockets of outstanding practice in many areas, there is a need to support trusts to adopt solutions that are working well in other maternity services. The lack of a system-wide approach to sharing learning is preventing maternity services from driving improvement by implementing strategies and interventions that work well elsewhere.

There are opportunities in the Patient Safety Incident Response Framework (PSIRF) to improve the way maternity services identify and embed learning from incidents through directing investigation resources towards incidents that they can learn most from. At one PSIRF early adopter site, we found the trust had created a continuous improvement and learning team that comprised midwives, patient safety and quality improvement practitioners. This team reviewed all incidents reported as moderate or above in the previous serious incident framework and identified learning opportunities. We welcome the increased focus on quality improvement and compassionate involvement of those affected by patient safety incidents.

Some serious events in maternity services have national requirements for reporting, such as intrapartum stillbirths and maternal deaths, which are reportable to the Maternity and Newborn Safety Investigations programme (MNSI). However, additional metrics for serious maternal morbidity outcome would improve oversight. These could include maternal admissions to the intensive therapy unit, returns to theatre, and maternal collapse.

Transparency and accountability

While recognised complications such as postpartum haemorrhages, obstetric anal sphincter injury (OASI), or shoulder dystocia do not always constitute a patient safety incident and may be recognised by staff as complications, it is vitally important to acknowledge the trauma experienced by the woman at the centre of each incident. Women need to understand what has happened to them, their recovery, and any potential impact on future pregnancies, but we are concerned that this does not always happen. Although research has identified improvement in this area, it shows there is still work to be done to make sure families are involved in investigations. Like other national reports, we heard through our Give feedback on care service that women did not always get a timely debrief or explanations of events, and this had had a negative impact on them.

Under the Health and Social Care Act 2008 Regulation 20: duty of candour requires providers to act in an open and transparent way. It aims to protect people's right to openness and transparency from their health or care provider and encourages families to talk about their experiences openly and without fear as they begin healing. This can also help build people's understanding of risk in future pregnancies. But the duty of candour only applies in certain situations, and we are concerned that when incidents are out of scope of the duty of candour, women do not always receive the debrief they need to process what has happened to them.

As well as the statutory duty of candour for all health and care providers, there is also a wider professional duty to be open and honest following incidents where the statutory duty of candour does not apply. The Nursing and Midwifery Council and the General Medical Council issued joint guidance on the professional duty of candour. The guidance is not intended for circumstances where a patient's condition gets worse due to the natural progression of their illness. It applies when something happens with a patient's care, and they suffer harm or distress as a result. There are opportunities to develop the principles of being open and honest with women in all scenarios, including after recognised complications of pregnancy.

We noted that in some trusts, staff can view potential complications as being normal – particularly during the intrapartum phase (during labour). However, we know from speaking to women who have experienced trauma that some of these 'normal' complications can have a significant impact. For example, although a grade 3 perineal tear may not warrant a patient safety incident, nor would it necessarily require the duty of candour to be instigated, it is vital that women still have the opportunity to discuss what happened, why it happened, and what it means for their future.

Through our Give feedback on care service, women told us about the impact of their traumatic birth experiences:

> "I'm still traumatised, developed high level of anxiety and obsessive thoughts..."

> "However after the traumatic time… even now 3 months on I am very upset about this… the first few weeks of my baby's life were marred by flashback."

> "I have been left with trauma. Worst experience of my life."

We also found that potentially serious incidents such as massive obstetric haemorrhage were normalised by many services if they perceived that they had 'managed' everything in line with guidance (generally either the Royal College of Obstetricians and Gynaecologists' Prevention and Management of Postpartum Haemorrhage guidelines or the All Wales Maternity & Neonatal Network Guidelines on Prevention and Management of Postpartum Haemorrhage). Despite a number of services thematically reviewing incidents, we found this did not always translate into learning and improvement, such as a reduction in rates of PPH. In addition, even though services may have 'managed' an episode of haemorrhage well, a review and explanation of events would still be vital to help women to process their experience.

In many cases, managers involved women and their families in the investigation of incidents, which is a key part of incident response under PSIRF. We also heard about the importance of compassionate staff who provide people with clear information in a supportive setting:

> "The team have been incredibly kind with our questions and making the next steps very clear, which makes them less daunting… They've really validated our experience and helped us to feel like what we are going through matters."

We found examples of good practice where services applied duty of candour and issued letters in the first language of the family affected by the incident , but this was not always the case. We found evidence of inequality in how some services reviewed incidents. For example, in one service there were potential delays to the duty of candour process because the women involved did not speak English. It is vital that women are given the opportunity to be involved in investigations concerning their care. Not having English as a first language should not exclude people from being part of this important process.

At another service, we found good practice such as appointing a family liaison midwife to provide continuity of support throughout the process and auditing compliance with the duty of candour. But we also saw in a significant number of services that, although staff apologised following incidents, they were not always open and transparent with women and their families. Moreover, staff did not always provide clear information on the reason why things happened. Similarly, we identified occasions where women and families who were affected by serious incidents had not been involved in the investigation process, or their involvement was delayed. Through our Give feedback on care service, we have heard from women who are still waiting for answers and want to ensure mistakes are not repeated:

> "I had a traumatic labour which resulted in a uterine inversion. I was rushed to theatre to be operated on, could not bond with my new baby and had to have a blood transfusion... We have since been into hospital for a meeting to discuss what happened but I still have no answers and I was meant to be contacted to have another meeting with a midwife and all these months later I am still waiting. I think the service I received was absolutely atrocious in what should have been a wonderful experience. The surgeon was amazing and so were some of the nurses on the ward. I hope something will be done about the care I received as I know I am not the only one and I wouldn't recommend to anyone."

Through our engagement with families who have suffered a bereavement, we heard concerns about the lack of a complaint route, as services like PALS do not look into complaints where a patient has died. Family members also explained that policies and procedures following a loss can be left to staff to interpret, echoing our concerns around variation in the quality of follow up and communication. The families suggested that people affected by maternity failings should be involved in delivering training to midwives to ensure all families receive clear information and appropriate care in the future.

A pilot of Maternity and Neonatal Independent Senior Advocates started recently in England. The role has been introduced to support women and families affected by problems in maternity care. Maternity and Neonatal Independent Senior Advocates will help ensure that the voices of women and families are listened to and acted on. They will play an important part in ensuring women understand what has happened to them.

We recommend NHS trusts ensure all women leave hospital with the information they need to be able to process their experience and have an opportunity to make arrangements to speak to a member of the multidisciplinary team about their birth within a realistic timeline. Women whose cases are referred to a review panel should have the right to attend the panel and the opportunity to co-produce improvements for future reviews.

We recommend NHS England develops guidance and definitions of a patient safety incident, where something unexpected or unintended happens in maternity services, in line with the Patient Safety Incident Response Framework (PSRIF), to tackle the issue of inconsistency in interpretation.

Triage

Maternity triage is an important first step for women who have an emergency or concern during their pregnancy (including early labour) or post-birth, offering advice, assessment and prioritisation.

On contacting the service, midwifery staff will carry out a preliminary assessment of their condition to determine the urgency of the situation and decide what further action is needed. In maternity services, the first assessment is often carried out over the telephone and includes:

- advising when women should make their way to their chosen birthing unit because they are in labour
- suggesting they should call back for further review
- making sure women are seen urgently if they have an obstetric issue that needs assessment, such as bleeding or if they have reduced fetal movements.

Despite being the first point of call when women have concerns, research by the Sands and Tommy's Joint Policy Unit found that guidance about how and when to contact triage is not consistent between services. It found “concerning levels of variation” about key topics including bleeding, waters breaking and reduced fetal movements.

Issues around assessments and the prioritisation of clinical risk have been highlighted in previous national reports, dating back several years. With no national targets or standards for operating maternity triage services, our inspection programme found significant variation. While a ‘one size fits all’ approach may not be appropriate across all services, we are concerned that not everyone received a safe and timely assessment, as many services developed their own tools, processes, and standard operating procedures. We found a lack of consistency across services and many were not able to audit the effectiveness of their triage system.

Consistency in this area would provide frontline staff with clarity when caring for women and babies.

Issues with triage emerged as an early finding from the programme. Following the first 20 inspections, we highlighted concerns around:

- patient prioritisation
- timeliness for initial assessment
- oversight of those waiting
- staff training and competence.

Unsafe practice in maternity triage went on to form the basis of 81% of enforcement actions issued to providers and was recognised as a safety concern in around a third of our inspections overall. Through our Give feedback on care service, we heard that women and babies were exposed to potential harm by delays in triage. Many women told us they had experienced significant delays in triage, even when they had been told they would need an urgent medical review because they had presented with high-risk scenarios.

All the obstetric services we inspected offered a form of triage service. Standalone midwifery-led units offer a limited dedicated triage service, with phone numbers to the main units. One service that did not offer a triage service provided a maternity helpline for women who needed advice.

Triage services also varied in terms of opening hours, with some services open 24 hours a day, 7 days a week , and others operating between a given time, often during daytime hours. Where the dedicated triage service was closed through the night, most services offered telephone triage and/or a triage system operated by a different department within the maternity service, such as the delivery suite.

As there was no national mandate during the programme, we did not apply a single criterion for assessing triage across inspections. Instead, we judged safety against the trust's own declared criteria for time to first triage and best practice guidelines. For example, we expected to see a rapid review by a midwife for a woman attending the service in an unscheduled way. Proactive services had introduced an electronic safety in triage system to enable consistent professional assessment and recording of the assessment to determine the immediate action needed according to clinical urgency.

Many of our inspections were carried out before the Royal College of Obstetricians and Gynaecologists (RCOG) released its Good Practice Paper on Maternity Triage in December 2023. The paper acknowledges that implementing the recommendations will require significant system-level change and investment, and a commitment to multidisciplinary working to improve local pathways.

As RCOG's good practice paper points out, maternity triage systems evolved to mitigate against urgent attendances diverting intrapartum teams from caring for people in labour. It highlights, that "unlike general emergency departments, they have developed without appropriate organisational and clinical systems in place to prioritise the clinical urgency of the women presenting". We found this to still be the case.

Triage attendance is not monitored nationally but trusts have told us, using their own data, that they have seen an increase in the number of women who attend the maternity unit with concerns about their pregnancy. While there are many contributory factors, such as access to primary care, or the increase in women with multiple morbidities who become pregnant , a knock-on effect is the additional pressure on triage in maternity services. Sometimes this means services struggle to keep pace with demand and assess people in a timely way.

There is a need for national data collection and analysis about the number of women attending maternity units for triage to monitor themes and trends.

Telephone triage

In the same way that people use NHS 111 when they need general medical help, the first step for women who have a concern or emergency linked to their pregnancy is often to call a triage phone line. RCOG's Good Practice Paper on Maternity Triage recommends that services should have well-defined pathways and dedicated telephone lines where calls are answered promptly. It highlights that telephone triage is complex as there is no clinical assessment, instead it relies on a person's individual account, which can be affected by the person answering the telephone.

Most services inspected operated a dedicated telephone triage service monitored by midwives. We saw pockets of good practice, such as staff trained in telephone triage and measures to ensure lines were monitored. The improvement resource published along with this report provides more information on the areas of good practice in telephone triage that we identified.

However, as highlighted in the Staffing section, low levels of staffing prevented some services from implementing measures like this. We saw instances where the telephone triage midwife was moved to a busier department, leaving telephone triage unmonitored. This puts women and babies at risk of harm if calls are not answered and means vital early warning signs could be missed. One service did not have a dedicated telephone triage line, which led to a congested main hospital telephone line and delayed women getting through to the telephone triage midwife. On this inspection, we also observed the midwife leaving the phone line unattended and a call was not answered.

We also found services did not always monitor their triage telephone line in terms of the number of calls waiting and call drop-offs to understand the levels of activity. This information could have helped services to gauge the volume of calls to provide enough staff to manage the phone lines accordingly.

At one service that did monitor call numbers and waiting times, we were encouraged to see that data on abandoned calls was reviewed on a weekly basis. More information on this can be found in our improvement resource.

We also saw some services using a paper-based triage prioritisation tool. This was far less reliable, resulting in inconsistencies and confusion between staff while increasing the risk of poor outcomes for women.

Through our Give feedback on care service we heard how issues with the telephone triage line can affect women:

> "The triage phone line was not working properly, but it was not clear whether any staff were available to talk to. Because of this I was delayed in going to the hospital in person. When I arrived at the hospital (I went as I had concerns about my baby) I waited 107 minutes before I was seen. It turned out my baby was in distress so I had to have a cat 1 emergency c section delivering my baby at 34 weeks."

> "The initial phone call was helpful and provided advice and told to ring when contractions closer together. Tried to call at this point when I was scared, worried and also bleeding and not knowing what I was doing. Unable to get through for over 30mins. When I did get through I was told that despite having close together contractions that they didn't sound bad enough and that I needed to wait until they were toe-curling and couldn't talk through them (again as a first time mum you don't know what to expect)."

We know that calls to triage are often time-sensitive and calls going unanswered, or lines being frequently engaged could present a real risk to the safety of mothers and their babies.

In-person triage

On arrival at a maternity unit, face-to-face triage is carried out according to a trust's own policy. RCOG's Good Practice Paper on Maternity Triage recommends that a brief assessment is performed by a midwife within 15 minutes of arrival. Then, staff should determine the urgency in which people need to be seen in a standardised way. This assessment should ensure consistency in the way different midwives assess risk and should include physiological assessment using a modified early obstetric or maternal early warning score.

There are a number of tools available for identifying and monitoring risk including:

- BSOTS – Birmingham Symptom-Specific Obstetric Triage System (recommended in the RCOG's Good Practice Paper)
- MEOWS - Modified Early Obstetric Warning Score
- RAG - Red Amber Green
- SBAR - Situation, Background, Assessment, Recommendation.

Like telephone triage, we found similar variation in how services operated in-person triage services. Some services had effective processes and were able to triage a high rate of women within the RCOG-recommended 15-minute guideline. This usually involved staff using a recognised tool for evaluating risk and prioritisation of women, which was reviewed regularly. As we discuss in the sections on staffing and estates,, services with effective triage systems had adequate staffing levels and space to manage flow of people into the service.

Several services did not routinely complete risk assessments on arrival and did not use formal tools or processes to effectively triage women. In one service, it was not clear how long people had been waiting, and in others, ineffective tools and processes led to delays in accessing care. We frequently found gaps in risk assessments and examples of poor record-keeping, which could pose risks for women.

Another service had a chaotic environment, where triage systems and processes were not well managed, which led to long delays. It was also concerning to visit services where staff had access to a risk assessment tool but did not always use it. On one inspection, staff did not always record a priority score , meaning the service could not be assured that all staff had enough information on high risk women and babies.

In a couple of services a RAG system was used to understand women's immediate needs, but the tool did not give target timescales for medical staff to review. At one of these services, there were no processes or guidelines in place to aid prioritisation and ensure women were seen and treated in a timely way, meaning staff had to use their clinical judgement to do this.

Triage environment

The environment is an important factor in the safe and effective running of a triage service. Health Technical Memorandum guidance outlines that maternity units should be designed to ensure a clear flow of women through triage and onto the labour ward. The location of the triage area should enable quick transfers in an emergency. Good maternity triage areas provide space for people to discuss concerns in private, as well as allowing birthing partners and families to stay while assessments are carried out.

We found that many maternity triage areas had dedicated rooms and areas that gave people privacy for initial assessments, but not all triage environments were designed in a way that kept women safe. While we found one example of a service improving its triage area to ensure safer assessments and improve patient flow (see our improvement resource for more information) , others continued to triage women in areas that were cramped, crowded, and lacked privacy.

At one service, inspectors could hear all information requested and shared during telephone calls. This included identifiable information such as the caller's name and date of birth, and perhaps most worryingly, meant that sensitive information such as safeguarding concerns could not be discussed in confidence. Small triage areas can also cause issues with patient flow. A lack of space for triage had been identified as a risk by many services and was included on their service risk register.

The location of the triage area in the hospital itself was another important factor in being able to provide women with safe, high-quality care . For example, having the triage area close to the labour ward enabled quick transfers in an emergency at one service , which helped reduce the risk of poor outcomes related to deterioration. Another trust relocated its triage service closer to the midwifery unit (see our improvement resource for further information).

We were concerned that in some services, the location of waiting areas posed increased risks to women. Waiting areas out of the direct line of sight of clinical triage staff, for example in a corridor outside a triage unit, meant staff could not carry out continuous observation to identify any deteriorations in condition. We heard how this negatively affected one woman's experience:

> "We were left on the corridor in between triage and the delivery suites for 2 hours with no pain relief and nobody checked on us during this time."

Where women were not in the direct line of sight of clinical staff, we were also concerned about how clinical staff could be summoned in the event of deterioration. At one service, this was compounded by a lack of information for women on how to seek support if their health deteriorated. In another service, while triage was located on the delivery suite, the rapid assessment room was in the midwife-led unit, in a separate area of the maternity unit. This meant the triage midwife would need to leave to go to rapid assessment, leaving other women unattended and increasing their workload.

In some cases, it was extremely concerning to hear about women going into labour and giving birth in maternity triage because of delays in transfer from maternity triage to the delivery suite. As well as putting women in a frightening situation, this poses a safety risk as triage areas may lack appropriate equipment, such as neonatal resuscitation and emergency obstetric equipment. This can be vital if people give birth quickly and experience complications.

Where our inspectors raised concerns about the physical environment and the impact it had on women, leaders in some services acted by submitting improvement plans to try to combat risk and improve the physical triage environment . However, we were also told in some cases there was little more that could be done because of the physical constraints of the estate.

Triage staffing

During our inspections we saw how the availability of staff played a significant role in how well services were able to triage women. The Royal College of Obstetricians and Gynaecologists (RCOG) states that maternity triage should be staffed by "appropriately trained midwifery staff whose primary responsibility is to assess women both by telephone and in-person". In many services, we found a dedicated team of suitably trained and competent midwives. However, issues with workforce management and staffing numbers contributed to delays in women's assessment and treatment, which could put them at risk of harm.

When women arrived at triage, many services did not have enough midwives to carry out initial assessments, which led to an increase in the length of time people waited to be triaged. In some services, this affected the flow of women coming through the triage service, as well as increasing the risk of deterioration.

In some cases, delays in triage were so severe that women discharged themselves before being seen by a midwife or doctor. This is unacceptable – these women clearly had concerns that prompted them to go to hospital, so waiting for long periods (in some cases 6 hours) and leaving before a medical review presents safety risks for both the mother and baby. Concerningly, one service did not have systems and processes in place to follow up women who left the triage unit without a review to ensure they were safe.

We also found that midwives were often re-allocated to different maternity departments during quieter triage periods, which frequently led to delays when triage became busier and they were then a midwife short. At one service, the labour ward co-ordinator was tasked with allocating staff from the delivery suite to work in triage. This meant staffing in triage depended on the activity and acuity on the labour ward. At busy times, the triage service would then be under-staffed, posing a risk to women.

We also found that staffing issues meant that staff who had not received sufficient training in triage filled the roles of experienced and trained staff. For example, at one service staff told us they worked in triage but had not received training on the triage system. We found particular concerns around the availability of appropriately trained doctors. In some cases, the required number of doctors had not been allocated to triage in line with the acuity of patients, and in others, the skills and experience of the doctor on duty did not meet the women's needs (see the staffing section for other examples where staff were covering for roles that are outside of their training).

We found some positive examples where leaders were supportive of triage-specific training. Triage wait times, as well as compliance with national and local guidelines, were better in these services (see our improvement resource for further details.)

Staffing levels also meant that the quality of care in triage varied between day and night. There were often fewer members of staff on shift during the night, meaning those working had higher workloads. Concerningly, this could mean that women receiving care in triage during the night did not always receive the same level of care and attention as those being treated during the day. In some services during the night, delivery suite staff who did not have access to the same training as triage midwives were expected to cover the triage telephone. Staff at one service told us there were times when they were alone during night shifts and their duties included answering the telephone, initial triage assessments and providing ongoing care to women.

Issues with triage are unlikely to be overcome by frontline staff alone and there is also a role for national policy to support trust boards and integrated care systems to address inconsistencies in prioritisation and escalation by implementing standardised systems.

We recommend NHS England oversees the performance of maternity triage services to enable trusts to benchmark and improve. This is in line with the Royal College of Obstetricians and Gynaecologists (RCOG) recommendation to introduce "an agreed national standard and reporting tool for maternity triage, similar to that used in emergency medicine." As outlined by RCOG, metrics should include "staffing requirements, agreed audit standards reported nationally, and frameworks for improvement."

Inequalities and racism

We remain concerned about the inherent inequalities in access to maternity services, experience and outcomes for women, and the safety risks this presents.

We stressed the ongoing inequity in maternity services in both our Safety, equity and engagement in maternity services report and our 2022/23 State of Care report.

The most recent MBRRACE-UK data, published in January 2024, showed that, compared with women from white ethnic groups, Black women were 2.8 times more likely to die during or up to 6 weeks after pregnancy, and Asian women were 1.7 more times likely to die during the same period. The National Maternity and Perinatal Audit's report on inequalities highlighted further disparities. It showed that compared with women in white ethnic groups:

- South Asian or Black women were more likely to have babies born early or small for gestational age (SGA)
- Stillbirth rates were high for babies born to women from South Asian and Black ethnic groups and for those in the most deprived areas
- South Asian women are also at higher risk of perineal tears and major obstetric haemorrhage.

The inspection programme highlighted that while some trusts are taking action to address issues with inequality, much more needs to be done to ensure maternity services are accessible and meet people's needs at all stages of pregnancy and birth. Everyone deserves safe care and the inherent inequalities faced by some groups are unacceptable.

We found some evidence of how different units were attempting to reduce the impact of inequalities, but this was not consistent across services. Examples of good practice often focused on:

- mental health support
- support for women who were living in poverty
- awareness and inclusion of ethnic and cultural diversity .

For example, one service introduced several initiatives to address barriers face by the community it served. These included establishing an antenatal and postnatal clinic in a hotel housing asylum seekers and creating communication cards for women who did not speak English as a first language. More examples can be found in our improvement resource.

However, without the right data, it is difficult for trusts to evaluate whether initiatives are driving much needed change. In addition, many of the issues we raise in this report meant some services were operating in crisis mode. While day-to-day issues are important, services must not lose sight of the ongoing systemic issues such as the inequalities that we know can have a significant and unacceptable effect on people's care. Reducing inequalities is imperative in saving lives and preventing harm to people with protected characteristics.

Concerningly, we also found some trusts where both staff and people using the service experienced discrimination because of their ethnic background, or issues associated with having English as a second language or that was not their preferred language.

Women's experience of racism

In our 2022/23 State of Care report, we found that care for people using maternity services was affected by racial stereotypes. This has also been reported in The FiveXMore Black Maternity Experience Survey. During our inspection programme, it was concerning to hear about incidents of racism experienced by women. We heard from people who felt staff were neglectful and rude towards them:

> "The problems started when I was moved to the postnatal ward. Staff were racist, rude and couldn't care less. They didn't listen to my concerns as a new mum and were desperate to discharge me even when I told them that my baby had only fed once in 36 hours since birth."

> "One nurse even told me I'm over-reacting after having some concerns over my baby knowing full well, I'm a first time mother, my clothes were all over the floor because I couldn't bend. However, another woman who happened to be White across the room got every help she could get. I feel this was very disheartening because I was there suffering. I believe it was racial abuse. A Black woman on the same ward got the same treatment as me. I felt ignored, neglected and ridiculed."

These examples are supported by our interviews with midwives and obstetricians from ethnic minority groups. Staff identified an issue around a lack of respect for women from ethnic minority backgrounds, with 'dismissive', 'disrespectful', and 'patronising' used to describe the tone of interactions.

Through the interviews, we heard about the safety implications when women were not supported to understand information or communicate their feelings, needs or questions. These ranged from not having the information they need about their own or their baby's health, to very serious physical and emotional trauma with long-lasting effects.

Failing to hear concerns and respond appropriately can have devastating consequences. As a result of one inspection, we issued a Warning Notice where we had concerns that a Black African woman had not been assessed appropriately despite attending triage multiple times. Sadly, this case resulted in a stillbirth. In another case, a review by the Healthcare Safety Investigation Branch (HSIB, now known as the Maternity and Newborn Safety Investigations or MNSI) into the death of a baby raised concerns that the mother's ethnicity affected the care she received. The mother asked for help but was dismissed.

Equity in access to pain relief during labour and after birth has also been identified as an issue nationally. During our inspection programme, our Medicines Optimisation team held a series of focus groups with maternity leaders and frontline staff across 16 trusts. The aim was to help us understand what trusts were doing to ensure that women from ethnic minority backgrounds had equitable access to pain relief.

We asked how trusts audited people's outcomes and experiences of pain and pain relief. Most did not audit this at all, and in those that did undertake epidural audits, ethnicity was not recorded as part of this.

A study published in the Journal of the Association of Anaesthetists looked at disparities in the delivery of anaesthetic care between different ethnic groups. A spinal anaesthetic for caesarean birth means the baby is exposed to the lowest amount of medication and the mother can participate in the baby's birth. However, the study found Caribbean (Black or Black British) women were more likely than British White women to be given general anaesthesia for elective and emergency caesarean births (58% and 10% respectively).

Further research is needed to better understand the underlying causes of these disparities to see whether improvements can made to reduce any inequalities in the different types of pain relief and anaesthesia provided.

A recent MBRRACE-UK study reported that identifying and responding to language needs was insufficient among women from all ethnic groups, highlighting inconsistent provision of independent interpreters. The research also advised that family members and healthcare staff (who are not employed for their language skills or as interpreters) were inappropriately used instead. As outlined in the section of this report on communication, this is not in line with guidance from the National Institute for Health and Care Excellence (NICE), which states that interpreters should be independent.

Access to interpreting services

English as a second language was also a noticeable theme throughout our inspections. We found various examples where interpreting and translation services were available, including BSL (British Sign Language) interpreting services. The use of these services meant women had relevant information in their first language, or preferred form of communication, so they could make informed and safe choices about their pregnancies and births. We also found examples of services that sent duty of candour letters in the woman's first language after an incident, ensuring that all women and birthing people were adequately informed and involved in the reviewing process of serious incidents.

However, we inspected some services where leaders had made an active decision to keep hospital signage in English only, despite the wide range of languages spoken and understood by women accessing the service. Limited access to relevant information can potentially result in harm to women and babies. We found a service where incidents that were recorded were linked to poor outcomes due to lack of interpreting services. One report also described instances of discrimination, where staff made "inappropriate comments" about women who did not speak English as a first language.

NHS services have a statutory obligation under the Equality Act 2010 to have "due regard" to eliminating discrimination and advancing equality, and access to interpreting services is an important way to deliver this. Good quality interpreting services are also vital for services to meet the regulations covering person-centred care and consent to care and treatment. Providing high-quality interpretation and translation services is an important part of ensuring that women receive the right care, with informed consent, and have improved health outcomes. All the services we inspected had arrangements to provide interpreting services. However, we have concerns that they had not always considered specific aspects to meet the women's needs.

Staff experiences of racism in maternity services

There is a need for action to proactively support maternity staff from ethnic minority groups to ensure a diverse workforce that is representative of the community it serves. We visited some services where staff felt they were discriminated against because of their race and ethnic backgrounds. Staff at one service told us they felt that they were treated differently because of the colour of their skin and at another service, described episodes of racism.

In this example, even though episodes of racism had been reported, no action had been taken to address the issues, which suggests a poor culture around responding to concerns. Discrimination against staff in minority ethnic groups was linked to episodes of bullying and harassment. At one inspection, this was reflected in the trust-level Workforce Race Equality Standard (WRES) data.

Again, this was supported by our research into the experiences of midwives and obstetricians from ethnic minority groups. Interviewees described feeling "ignored, dismissed or effectively punished by negative treatment" when they spoke up about unfairness. Participants overwhelmingly felt that when they spoke up, issues were "swept under the carpet" or only addressed superficially, with a lack of genuine accountability and organisations adopting a defensive position.

On inspections, we also heard concerns from staff at one trust that job opportunities were not made transparent or equally accessible to all staff, with those from ethnic minority backgrounds feeling less able to access senior and board level roles. Through our research, we heard about midwives from ethnic minority groups whose confidence was undermined when applying for promotions, which is compounded where they do not see people from ethnic minorities in senior roles:

> "Being in interviews – it was always, 'you were very close, you just were not quite there'. If you are having this throughout your career, you start to believe it – you think, maybe I am only suitable for a certain role. And when you lose confidence, you don't perform as well or you stop aspiring."

Although examples of such discriminatory behaviour were limited during our inspections, they are completely unacceptable and raise important concerns about the inclusion, dignity, and safety of staff from ethnic minority groups in the workplace. Through interviewing staff in our research, longer-serving staff told us that things had improved over time for staff from ethnic minority groups. But interviewees described a culture in which it is normalised for people from ethnic minority groups to tolerate discrimination from colleagues, such as microaggressions, and not being made to feel like part of the team.

Using demographic data

Research by THIS Institute confirms that people from ethnic minority backgrounds may have distinctive health needs that maternity services do not consistently meet effectively. It is essential that a maternity service understands the needs of its local population to provide everyone with safe and effective care. Demographic data is vital to achieve this. However, there is currently huge variation in the way trusts collect and use demographic data to address health inequalities and access, experiences and outcomes from using their services and evaluate progress in this area. Having a national-level picture, along with guidance that could be tailored at trust level, would allow services to understand the data they have and use the metrics to improve access and outcomes.

Local systems have an important role to play in addressing unwarranted variations in population health. As discussed in our 2022/23 State of Care report, systems must work to reduce inequalities in people's access to care, their experiences and outcomes. As part of our new responsibilities to assess whether integrated care systems (ICSs) are meeting the needs of their local populations, we will be looking at whether different parts of the system are working together to achieve this.

Through our maternity inspection programme, we were pleased to find evidence at trust level that some leaders understood how various protected equality characteristics may affect treatment and outcomes for women and babies. This awareness was translated into monitoring outcomes and taking action on the findings and even, in some cases, commissioning research , to make services more responsive and appropriate for people's needs. (See more information on these initiatives in our improvement resource.)

But we remain concerned about a data gap at trust-level, which could be preventing trusts from making improvements. We have previously highlighted the need for services to use ethnicity data to review safety outcomes for women from ethnic minority groups. However, during the programme we saw this did not always happen.

Some managers collected information about ethnicity and other protected equality characteristics to identify themes and trends related to inequalities when reviewing incidents. But there are opportunities to review data relating to people with protected characteristics throughout the maternity pathway – not just when patient safety incidents happen.

By looking at other areas, such as the effectiveness of national approaches to improving outcomes, services would be able to gain insight that may not be available from incident data and ultimately improve outcomes. Without this demographic data, many services had no way to analyse whether national approaches, such as NHS England's Saving babies' lives requirements, were reaching those most in need of support in their local communities. Applying a blanket approach may not always be effective. The Marmot review recommends that while action should be universal, the scale and intensity should be proportionate to the level of disadvantage, known as 'proportionate universalism'.

As reported by THIS Institute, clinical guidelines and tools used in maternity services are not always sufficiently sensitive to the needs of different groups. To mitigate the risk of discrimination, there may be a need to adapt guidelines and how they are applied. For example, the NHS Race and Health Observatory recently called for new assessments for newborns from ethnic minority backgrounds. It highlighted that the Apgar score – a scoring system to evaluate the health of newborns – was developed based on white European babies, with some guidance referencing that a baby's skin should be "pink all over." Applying this guidance to babies from ethnic minority backgrounds can lead to inaccurate assessments and poorer outcomes.

We saw some evidence of services adapting guidelines and processes in this way, but this was not always the case. One service amended triage guidelines to have a low-risk threshold to invite women with English as a second language into the unit for face-to-face triage, recognising that language barriers can make telephone triage services less effective.

Engaging with local communities

The role of a maternity and neonatal voices partnership (MNVP) is to ensure the voices of women are heard, and to communicate back to staff and stakeholders to plan, review and improve local services. Where these relationships worked especially well, services built a relationship with the MNVP that allowed people to have their voices heard by their trust, to drive meaningful change and co-produce services or resources.

However, we previously highlighted in our Safey, equity and engagement in maternity services report that MNVPs were not always representative of the local community and we are concerned that in some areas, this issue persists. For the partnership to be successful, services must be proactive in gathering feedback from all women who use services. As stated in NHS England guidance, "effective MNVPs will reflect the ethnic diversity of the local population and reach out to seldom heard groups, including those most at risk of experiencing health inequalities, parents with experience of neonatal care, and bereaved families." It is vital that these services are funded appropriately to enable MNVP chairs to reach those most in need of support.

We also found some examples where the relationships between the MNVP and the maternity service were not as strong as they could have been. To enable the work of the MNVP to be meaningful, there needs to be authentic commitment from leaders within maternity services.

We recommend NHS trusts and integrated care boards:

- Improve their collection of demographic data, including information on ethnicity and levels of deprivation, to improve outcomes for women.
- Ensure that demographic data, including ethnicity data, is always considered when reviewing patient safety incidents and action is taken where risks are identified.
- Ensure that there are clear policies and procedures on the collection of demographic information and staff understand the importance of how this data can be used to improve outcomes for women.

Estates

Many maternity services inspected were appropriate for people's needs and kept them safe in line with national guidance, but this was not always the case. Too many maternity units are currently not fit for purpose, lacking space, facilities, and in a small number of cases, the appropriate levels of potentially life-saving equipment.

We are concerned about the serious safety risks this presents for women and babies. Common issues found on inspections included:

- a lack of space to accommodate necessary equipment and meet people's needs
- generally ageing environment and facilities, including issues with temperature and ventilation
- a lack of capacity in theatres
- a lack of adequate bereavement provision.

As well as presenting risks to women, unsuitable maternity environments can make it difficult for staff to provide the level of care they want to deliver. As highlighted by the Royal College of Midwives, a human factors approach can help improve safety in maternity care and is about "making the right thing to do, the easiest thing to do". It identifies a range of factors that affect safety and performance, such as:

- equipment should be easy to use and staff should receive training on how to use it
- noise levels and distractions should be monitored to help create a productive working environment
- working patterns, breaks, staff access to nutrition and hydration should be considered to prevent fatigue.

Research has also highlighted the benefits of shared social spaces, where staff can debrief and decompress after complex clinical situations.

However, as we highlight in this section, we found issues with equipment and ward environments which affected both staff and women using services.

Access to equipment and theatres

It is vital that maternity services have the right amount of equipment, and that all equipment is kept in good condition to maximise outcomes for women and babies. We were therefore concerned to find that a small number of services were missing required equipment, including a shortage of cardiotocograph machines used to measure babies' heart rates. Worryingly, we also found a lack of resuscitation equipment at several trusts. While there are no national guidelines for the number of standard items of resuscitation equipment that should be available, NICE guidance outlines that all birth settings should have facilities for resuscitation. These issues could have a devastating impact on neonatal and maternal outcomes.

We also issued Warning Notices on some trusts that failed to carry out regular checks on emergency equipment or did not adequately document that equipment had been checked. In addition, at one service we found a lack of clarity among staff about who was responsible for ensuring emergency equipment was safe and ready to use. This meant it was often misplaced or untidy. Conversely, only a few services had invested in replacement programmes for ultrasound scanners, neonatal resuscitaires and cardiotocography equipment to minimise these risks.

We also heard concerns about call bells. Although we found call bells were within easy reach in most maternity services and staff responded quickly when called, in a few services they were not working or only working intermittently. One antenatal ward did not have a call bell system in place. In other instances, we observed staff being slow to respond to buzzers. One person told us about having to verbally call for help when in distress or during an emergency as the call bell had failed and staff did not respond. Another person told us they were not able to reach their call bell with the sides up on their bed.

As well as a lack of equipment in some services, we also found issues with theatre capacity. It is essential that maternity services have access to dedicated operating theatres for planned and emergency caesareans as well as obstetric surgical procedures. All services we inspected had at least one dedicated obstetric theatre located within the maternity department, in line with national guidance. Most services had at least 2 operating theatres dedicated to maternity services, which were available for both planned and emergency caesarean sections as well as obstetric surgical procedures. One service responded to our recommendations made in a previous report by improving and future-proofing its maternity theatre provision.

However, in some cases, maternity theatres were out of use because of concerns about space and infection control. This meant that caesarean sections took place in the main theatre, and women and their partners had to walk through corridors and surgical wards for their procedure.

We found that where services did not have access to at least 2 dedicated maternity theatres, there were significant risks of delays to emergency caesarean sections due to lack of theatre capacity. Some trusts managed this risk by having separate surgical lists in the main hospital theatres for planned caesarean sections, keeping a maternity theatre free for emergencies.

Unsuitable ward environments

Many women told us they were unhappy with the hospital environment. Some concerns related to sensory issues, for example people complained of noisy and sometimes overheated wards. Additionally, we heard about unsuitable spaces for labour and postnatal recovery, as well as a lack of bed space.

Several people told us about uncomfortable ward environments, which were stuffy and unpleasant to be in. Fewer people reported feeling cold, but one person described a negative experience when they were placed in a storage cupboard with their baby because there was no space on the postnatal ward:

After my emergency c-section the ward was full. I was freezing from the operation and me and my baby were wheeled into a storage closet with air conditioning blasting. My baby then became cold and unwell and needed to be put under a lamp once we got into the ward... I became deeply distressed and wanted to leave.

Issues with ventilation or a lack of scavenging systems to remove harmful residual medical gases from the air meant that Entonox (as the trade name for gas and air) could not be used in all birthing rooms at one service. National guidance states that Entonox should be available for pain relief in all settings and our 2022 Maternity survey found it was used by 76% of women.

Through our Give feedback on care service, several women explained how the lack of space on wards affected their experiences. We heard of women in labour being placed in the same ward as postnatal patients, or postnatal patients being placed in a triage area because of a lack of appropriate space:

While being in Ward 9 before having my baby I was on the same ward as women who have had their babies already, which to me is unacceptable. I had bad contractions back then and was in pain which is not ideal for either me or women who've had their babies to be in such an atmosphere. The reason I was there was because there was no space in the labour ward, which is what I was told, and I find that appalling.

Furthermore, like other parts of the NHS, maternity services are under increasing pressure and sometimes there is more demand than a service has capacity for. Maintaining good and efficient flow requires a trust-wide culture of safe and efficient patient care. During some inspections we saw how staff spent time dealing with issues around flow in the maternity service specifically, which were not part of the wider trust's capacity management. We suggest maternity services should be included as part of the whole trust-wide capacity and flow processes so that appropriate skills and support can be obtained, releasing clinical staff to focus on managing clinical risk.

Several maternity services had completed self-harm and ligature assessments within all environments to meet the needs of pregnant women at risk of self-harm. Some services coupled this with further actions aimed at reducing risks that were identified, such as staff training around caring for women at risk of suicide.

National guidance on the design of maternity units stresses the importance of security to protect babies and families. We noted issues related to tailgating, whereby it was possible for people to enter a unit without passing any sort of security clearance by directly following close behind someone who had been admitted, which posed a clear safety risk.

Privacy, dignity and hygiene

The experience of giving birth can leave women feeling at their most vulnerable and it is therefore important that ward environments are set up to protect their privacy and dignity. This includes having easy access to ensuite bathroom facilities. While most services inspected had provision for women to have access to ensuite bathroom facilities during labour and postnatally, we inspected some services with limited access to toilets and showers. Some services lacked ensuite rooms in delivery suites, meaning women had to walk through a ward to use communal toilets and showers during labour.

Issues with ward layouts and a lack of space also meant there was a risk that people could overhear confidential conversations. For example, one service did not have a dedicated space for staff to discuss sensitive issues with women, making it difficult to maintain confidentiality during handovers to the birth centre. As highlighted in the triage section, we found that cramped triage areas also compromised women's privacy.

Women also told us about overcrowded and cramped ward environments, which meant they did not have enough space to get changed or attend to their babies. Some people said that beds were placed very close together on wards, which made it difficult to move around with reduced mobility, and again, made it difficult to have conversations in private. This led us to be concerned that people sometimes found it difficult to get the rest and privacy that they needed during their stay at the hospital.

Many women complained about a lack of hygiene in maternity units. For example, we heard several comments about inadequate toilet and shower facilities. Some of the comments related to unclean and dirty bathrooms, such as blood on the floor that had not been cleaned, or urine samples being left in the toilets. Several people also expressed concern about the hospital's failure to change bed sheets. Some people reported having to lie in blood-stained sheets for hours; in some cases, they said that bed linen was not changed for several days. This is particularly unhygienic, given that they were likely to be still bleeding after giving birth and wished to rest in a clean bed. Lack of bedding was also a concern. In one case, someone was asked to bring their own pillow, as the hospital was under-resourced and could not supply one:

> "I had to take my own pillow into theatre for the operation (they asked me to as they had none). This is NOT a reflection on the staff – more on the under-resourced NHS."

Poor hygiene standards sometimes resulted in a lack of dignity for women, who told us that a hospital's failure to clean facilities meant that partners were sometimes called on to clean up, in the absence of staff, or to help change bed sheets due to understaffing:

> "No-one changed the mat on my bed for hours which was soaked in blood, plus no-one changed my sanitary pad at all the whole time I was there. So my husband had to change it, which shouldn't really happen."

Bereavement provision

Pregnancy loss is devastating for parents. Through the inspection programme, we observed the impact of different ward environments and bereavement provision on this experience. We found a high level of variability in the quality of bereavement suite facilities. Where they were good, refurbishment was often funded by hospital charities or community fundraising.

To reduce the potential for bereaved families encountering or overhearing new and expectant parents, national guidance is clear that families should have a private and comfortable space to grieve their loss. We found that most maternity services had a dedicated space for women and families, often located in a private area away from labour and antenatal wards. Some services had clothing designed for very small babies and cold cots so that parents could spend time with their babies and say goodbye.

However, where bereavement suite facilities were available, they were not always in line with the National Bereavement Pathway recommendations. For example, we inspected several services whose bereavement suites were not soundproofed. In one case, where the bereavement rooms were in the labour ward, bereaved parents experiencing baby loss were being cared for in the middle of a labour ward surrounded by the sights and sounds of newborn babies. In 2 services, the location of bereavement suites was within antenatal and early pregnancy units, with bereaved and grieving families meeting pregnant women in attendance. The location of these facilities was challenging for grieving women and their families and did not adhere to current national guidelines.

Several people in these situations explained how the negative psychosocial impact of antenatal environments made their experience worse. Numerous people described having to sit in waiting areas with other 'happily' pregnant women as a triggering and traumatic experience. Many women felt that these locations were unsupportive of their loss, further highlighting their emotional pain and adding to the difficulties they were yet to face.

We recommend DHSC:

- Provides additional capital investment in maternity services to ensure that women receive safe, timely care in an environment that protects their dignity and promotes recovery.
- Works with NHS England to ensure that this additional investment is ring-fenced and maternity services receive the investment they need.

Communication

Effective communication is vital to ensure women are supported to make informed decisions and feel listened to if they raise concerns.

NICE guidance states that services should use clear language, provide timely information and offer regular opportunities for questions. It also highlights the importance of considering people's individual needs and preferences.

In our 2022/23 State of Care report, we identified poor communication as an emerging theme from our initial inspections. Now that the programme has finished, we remain concerned that communication is not always good enough, particularly for those with protected characteristics under the Equality Act. Communication is also often the subject of formal complaints received by services, who have a responsibility to ensure all women are given the information they need, in a way they understand it, to make informed decisions and consent to treatment.

Communication challenges

In the feedback we received on inspections and through our Give feedback on care service, negative comments about communication during the maternity pathway outweighed positive comments. Many people told us that a lack of information negatively affected their maternity experiences and sometimes resulted in different birth outcomes than they had envisaged or hoped for:

> "Communication should just be better, it would help if the staff remembered that it might be all routine for them, but for patients it's very much a new and potentially traumatic time. And communicating in a sensitive way goes a long way."

> "Nothing was explained to us at all. Everyone we spoke to had traumatic births during this period. We had been warned that they leave you and ignore you completely, which they did. You have to shout to have someone come and look at you, and fight to be heard."

Many people highlighted poor communication during the antenatal pathway, noting they were not given enough time to ask questions. We also heard that staff did not always provide enough information about the harms and risks associated with their pregnancy. Some of these people told us about how they were made to feel like an inconvenience:

> "They honestly made me feel like I was inconveniencing them and they were rushing through patients. They didn't take time to ask if I was OK and explain what ANYTHING meant. One even scared the life out of me by misdiagnosing me, luckily me and my midwife caught the discrepancy and queried it. I feel they speak to me as if I'm incompetent and unable to comprehend and then tell me to forget it and not worry when I ask genuine questions/worries."

In addition, several people told us they felt "fobbed off" and lost trust in the people caring for them:

> "Some of the midwives don't listen to your concerns and you feel like you're always being fobbed off or your concerns aren't being listened to..."

> "I asked several times to be examined, to which I was told there was no need! I couldn't even sit down my baby had dropped so low, at 7ish I had a bad bleed so someone finally come and examined me and was told I was 7cm!! I had been saying for hours I was progressing and was fobbed off."

This feedback is supported by the findings of our 2023 Maternity survey, which found a 5-year downward trend for respondents saying they were 'always' given the information and explanations they needed while in hospital after the birth. This year's results found 60% of respondents reporting that they 'always' received the information and explanations they needed, compared with 65% in 2018.

Communication around induction of labour was a key issue. Inductions are often offered when babies are overdue or if there is a risk to their health. While inductions are becoming more common, it is vital that staff recognise that the process can be difficult for women as some may be disappointed about being induced and the process can be painful. Effective communication therefore plays a key role in shaping the experience.

Inductions are often planned in advance and while it may be medically appropriate for someone to wait to be induced, we found that this is not always explained to women. Some women felt they were given insufficient information to understand the reason for delaying an induction, which increased their anxiety about the consequences for their health and their baby.

On a broader level, a lack of mental health support during the maternity pathway emerged as a theme from our analysis of experiences received through Give feedback on care. Despite a recent focus on perinatal mental health, including in the NHS Long Term Plan, many women felt better communication could have reduced their anxiety. People explained that pregnancy and birth is an overwhelming experience and without clear communication, levels of anxiety can increase. Again, it is important that staff recognise this and care for women in a holistic way to improve the overall experience of having a baby.

Listening to women and families

It is essential that women feel listened to by staff, especially when they are in pain. From April 2024, the first phase of the introduction of Martha's Rule will be implemented in the NHS. This will allow patients and families to request a review if they feel their concerns are not being listened to. In maternity services, it may help women make sure that their concerns are heard, as during the programme, we were concerned to hear about instances where people felt that staff did not listen to their requests for pain relief. In some cases, this resulted in poor pain management during birth.

> "The staff weren't listening to my worry of not having pain relief and managing without an epidural with my mental health as well as my physical health. By the time the midwife took me over to the room, my labour was unbearably painful, and I was told that it was too late for the epidural. I gave birth with no pain relief – not even paracetamol and I was very disappointed and frustrated that they didn't listen to me when I knew what my body was going to do."

> "I was not listened to by the healthcare professionals during my labour and they were not managing my pain. I was left for several hours despite asking for help."

One woman we spoke with felt her concerns about pain may have been dismissed because staff knew she had not given birth before:

> "When I first went into labour I contacted [name of hospital] for advice. I contacted them 4 times as I was in agony with the pain but was told to stay at home because it was my first child. I felt I had been stereotyped because it was my first child and didn't know how much pain I would be in. When I eventually arrived at hospital after deciding just to go in because I was in so much pain I was actually 7cm dilated."

Even when women asked for help to manage their pain, they were sometimes not given the help they asked for. Through our research interviewing midwives and obstetricians from ethnic minority groups, we heard how false beliefs around physical characteristics and symptoms can mean some people are denied pain relief. Interviewees reported hearing racial bias in pain assessment, for example:

> "Black women have thicker skin, so they are less likely have a tear after delivery."

> "You are African, you are tough – you don't need pain relief, get on with it."

Stereotyping and a lack of cultural awareness can significantly affect people's experience of care, as we outline in the section of this report on inequalities.

People whose first language is not English face additional inequalities. Access to and the quality of interpreting services varied and continues to be a theme in patient safety incidents nationally. We found some pockets of good practice, for example in one service, the Non-English-Speaking Team (NEST) hosted an antenatal clinic using translation services with midwifery and consultant support. Home visits could be arranged and information was provided in the woman's first language, allowing people to make the right choice for themselves and their babies.

However, our interviews with midwives and obstetricians from ethnic minority groups highlighted that having poor or no spoken English was associated with worse experiences of care:

> "My summary is, if you are White you will get good care. If you are not White but you speak English, it's OK, you will get what you need. If you have poor English – it's going to be the very basic standard."

This supports the findings of our Safety, equity and engagement in maternity services report. In this, we reported variation in how well maternity services tailored communications and engaged with women whose first language is not English.

NICE guidance is clear that maternity services should ensure that reliable interpreting services are available when needed and that interpreters should be independent, rather than using a family member or friend.

Interviewees also called for staff to do more to ensure that people understand the information they provide:

> "Staff need to be very mindful that you will get people nodding their head but not understanding. And instead of just choosing to accept that, staff need to make sure that they have understood."

Communication between staff

Multiple studies have shown a link between effective communication and safety in maternity services. Teamwork, co-operation and positive working relationships combined with effective co-ordination are also 2 of the 7 features of safe maternity services identified in research by THIS Institute. Where staff communicated effectively, people told us this had a positive impact on their experience.

> "My second midwife [name] was brilliant, I witnessed a team who worked seamlessly together, handing over information about my care which made me feel confident in the continuity of the high standards of care I was receiving."

On all our inspection visits we reviewed the quality of communication and co-ordination at morning multidisciplinary handover meetings on labour wards. These meetings are critical for staff to understand how to manage current risks across the unit. They are also an opportunity for staff to share learning.

A small number of women explained how poor staff handovers had a detrimental impact on their care – notably access to pain relief:

> "The lack of continuity of care was also a contributing factor to my difficult delivery and eventual caesarean. There was little handover between most clinicians during my delivery and no handover between 2 clinicians, this also led to difficulties and unnecessary pain."

> "There was no consistency of care during labour. I had the gel and my contractions were really painful and I could tell that the baby was on the way. The midwife wasn't listening to us and actively put off examination due to a change-over of staff."

We also heard from several people who had to repeat information about their medical history, or preferences about their care because of a disconnect between staff:

> "I saw a different doctor from the diabetic team for every appointment, so I had to tell each one my history."

> "There was also a disconnect between consultants, midwives and obstetricians, all of whom seemed to have a different opinion on induction timings."

NICE published guidance on information sharing during the postnatal period. It states that when women are transferring between services, relevant information should be shared between healthcare professionals to support their care.

Informed choice and consent

It is essential that women are clear about the risks and benefits of different birthing choices and treatment options. Staff also need to ensure the language they use is accessible so that women know what to expect when they consent to procedures and examinations. Everyone has a right to physical autonomy and integrity, and good communication is vital in empowering people to make informed decisions about their care.

When we found good examples of communication and information-sharing, women praised clear and transparent explanations from staff, which meant that they were able to make more informed choices:

> "My husband said that the day my son was born, the maternity department was very busy but I was completely oblivious to this as not one midwife or doctor made me feel like this, I felt like everyone gave me the time I needed and we were able to discuss

> options, ask questions and make plans about our care."

> "I had loads of questions and anxieties regarding pain relief and labour, and they were able to answer all of my questions and made me feel at ease. I felt as though I was in good hands."

However, this was not always the case. For example, one person told us about feeling a lack of choice about being induced:

> "I was induced. It did feel as though I was being 'told' that I had to be induced. When I expressed my reluctance for an induction a consultant was sent to speak to me. It would have been more helpful to understand the clinical rationale and risk vs benefits of induction versus waiting. The only explanation I received was that 'baby is to term and it won't affect baby being born early'. I felt this could have been explained more thoroughly and would help me to make an informed decision rather than feeling 'forced'."

In our interviews with midwives and obstetricians from ethnic minority backgrounds, staff identified other factors, along with language barriers, which can lead to a lack of choice. This included cultural perceptions of authority, where people from some ethnic minority groups may be more inclined (or perceived by staff to be more inclined) to accept the advice of health professionals without questioning it. Concerningly, interviewees also suggested that staff may not always offer choice, because they know they will not be challenged. Perhaps most worryingly, we also heard about perceptions around who is 'entitled' to care, and this sometimes affected the level of choice offered.

In our Safety, equity and engagement in maternity report, we found many services had worked together with the Maternity and Neonatal Voices Partnership (MNVP) to engage their local community, including reviewing communications and online content. We were encouraged to see evidence through our inspection programme that this has continued. We found some services worked with local MNVPs to improve informed choice and consent by co-producing information on induction of labour including leaflets and information videos.

Accessing digital maternity records

In line with recommendations in NHS England's 3-year delivery plan most services have adopted digital records and have maternity records apps to enable women to view their records at home. We heard a few positive comments about the functionality of the maternity records apps and how it contributed positively to the maternity experience as people could access their records, store their birth plan and receive reminders about upcoming appointments.

However, a small number of women discussed their frustration with the maternity records app. For example, we heard that when it was not updated, this meant there was insufficient information about their antenatal care and tests. This could lead to miscommunication and anxiety where test results were only communicated through the app if midwives and nurses remembered to release the information:

> "The [maternity records app] does not update and let patients know about the care and tests they have received. This left me very anxious during my first few appointments and being pregnant for the first time."

The use of digital technology is not always inclusive. In our Safety, equity and engagement in maternity report, and through our engagement with MNVPs, Five X More and National Maternity Voices, we heard concerns that reliance on digital technology to engage women and provide them with the information they needed could exclude women who do not have the access to, or skills to use, digital technology.

Staffing

Concerns around staffing in midwifery are not new and have been well publicised. The additional scrutiny of maternity services following high-profile investigations including Shrewsbury and Telford Hospital and East Kent Hospitals has compounded this, with staff feeling pressured to go the extra mile.

In our 2022/23 State of Care report, we looked at the impact of pressures on staff on both the maternity workforce and people using services. We highlighted that while people using services appreciated that maternity staff were often doing their best despite being very busy, people often felt they were not a priority and did not get the help they needed.

Throughout our national maternity inspection programme, we have seen staff going above and beyond to provide compassionate care for women and their families under difficult circumstances. Despite this, we continued to find that many women were not receiving safe care because of the pressures on staff. Staff also told us that this meant they were not always able to provide the care they wanted to deliver.

Staffing levels

As the demand for maternity services continues to increase, the staffing levels need to keep pace with the changes to keep women and babies safe. Staffing levels depend on the acuity of individuals and the numbers of women needing care. During the programme, services used Birthrate Plus, a midwifery-specific national tool for calculating staffing levels and recommended numbers of midwives.

Delays in improving levels of staff affects the ability to provide safe, effective care. Pressures on staff, who told us they did not always feel respected or supported, meant that care was sometimes task-focused rather than patient-focused.

To keep people safe and ensure that people receive consistently safe, good quality care, we expect services to ensure there are appropriate staffing levels and skill mix. Through our inspection programme, we found variation in this area. Some services had good oversight of staffing levels. Managers in these services reviewed and adjusted staffing levels and skill mix in line with NHS best practice, with services often having enough staff with the right qualifications, skills, and experience to keep women safe.

We found that many services had a clear escalation policy to manage staff shortages and reduced bed capacity. This gave managers an awareness and oversight of staffing needs in each service area, so they could provide appropriate cover as necessary. Where managers identified the need for additional staff, members of staff could be moved between service areas, they could access on-call staff or community midwives could be recalled. However, this could affect women's choices, for example, they may need to suspend homebirth services. At one service, it was incredibly concerning to see how redeploying staff left one midwife caring for 13 mothers and babies on the postnatal ward. Following this inspection, we issued a Warning Notice, requiring the trust to make significant improvements.

Staff who were redeployed told us they were often moved to unfamiliar areas, which they felt affected their ability to care for women and their babies. We also heard that there was not always a sense of teamwork between units, which could make redeployment difficult for staff.

We found care was not always person-centred or dignified because of a lack of staff. For example, we heard from women who felt maternity staff were overstretched and overworked:

> "It was very obvious at times the staff were under pressure to manage all the patients on the labour ward. I noticed staff being pulled from the postnatal ward to work in other areas…. I felt sorry for them. I've heard from friends who have experienced the same as me. Not enough staff but everyone trying hard."

> "The triage midwife also spent a lot of time out of the room, looking for someone to hand over to, but everyone was in theatres. This meant it was just me and my partner left alone in the room, for long stretches during the birth. The triage midwife came back into the room for the final stage of the birth, but the labour midwife missed it entirely, due to being in theatres with other women. I totally understand that there were other women who needed her more than me, but for me, it felt out of control and unsafe."

A few services that struggled to maintain safe staffing levels indicated staffing shortages as a primary risk on the risk register. As highlighted in the section on leadership and culture, board-level oversight of key issues such as staffing is vital in enabling leaders to make effective decisions and drive real improvement for women. The importance of board-level oversight was also highlighted in the final report of the Ockenden review, which found that a lack of understanding by the board of issues and concerns resulted in neither effective change nor the development of accountable implementation.

Not having enough staff affected the quality of care they were able to provide and put women at risk. For example, at one service we heard how it was a normal occurrence for induction of labours to be delayed due to staffing issues. In some services, we found women having to wait for long periods for transfer to a labour ward once the induction process had started, and in some cases, there was a lack of effective monitoring during periods of delay. Trusts should be making sure women and their babies are observed closely and that regular assessments are carried out to identify and prioritise those at greatest risk. Where we have found concerns about delayed treatment – including induction of labour – we were clear with trusts that effective oversight of the issue is vital and that all action possible must be taken to mitigate any risk and keep people using the service safe.

Staff acting beyond the scope of their clinical practice

The complexity of maternity care has increased in recent years, with higher numbers of women needing higher levels of care, including high dependency care. As highlighted by the Royal College of Midwives, this demands more of the maternity workforce. Services need staff with the skills and expertise to look after people at each part of the pathway – from antenatal to triage, labour, and postnatally. At every stage, staff play a critical role in ensuring the safety of both mothers and babies, identifying early warning signs and making sure people understand what is happening to them. We know that the number of women with complex medical histories is increasing, which increases risk. In the UK, 1 in 5 pregnant women have multiple pre-existing long-term conditions. Studies have shown that maternal multiple long-term conditions are associated with adverse outcomes. Modern day maternity services have not always kept up with this change.

We were encouraged to see that a number of services, while recognising that midwives provide specialist care, also opted to provide training in high dependency care, which aligns to the midwifery proficiency standards. This enabled women who needed more intensive levels of observation (for example, those who had a postpartum haemorrhage) to stay close to their baby while being treated on the maternity unit.

There are currently no national training requirements for midwives in providing high dependency maternity care, which is defined by RCOG as "an intermediate level of care for pregnant or recently pregnant women where a higher level of observation, monitoring and interventions can be provided than on a ward but not requiring high dependency care/organ support." This is unlike general nursing, where there are competency packages and recognised training packages to ensure staff are appropriately trained to provide this level of care. While some trusts have intensive care outreach services that can care for women when they have babies, these generally provide advice rather than physical care.

Issues with staffing levels were leading to staff having to perform tasks or cover for roles that are outside of their training and not in line with national guidance. Although services were successful in developing innovative solutions to redeploy staff, in others this put women at risk. For example, we were concerned to see instances of unregistered staff acting as Surgical First Assistant (SFA)or scrub nurses, without proven competency.

We would expect everyone performing the SFA role to have completed training in line with national guidelines. We questioned if this practice was replicated in other NHS inpatient services, but were told it was unique to maternity. This is concerning, given procedures such as a caesarean section require the same level of skill and competence as any other surgery.

We identified staffing issues across the workforce, and problems were not limited to midwifery staffing. Where there were low numbers of staff, one trust used Foundation Year 1 (FY1) doctors interchangeably with more experienced FY2 doctors. It is important that services recognise that the FY1 training year is designed to enable medical graduates to begin to take supervised responsibility for patient care. They are not interchangeable with FY2 doctors who have developed more independence.

There were also some services who diversified their workforce by recruiting registered nurses to carry out tasks which fall outside of the protected function of the midwife role which makes it a criminal offence (other than in an emergency or during training) for any person other than a registered midwife or registered medical practitioner to attend to a woman in childbirth. Service leaders need to be assured that these registered nurses are not working outside their scope of practice, and how service delivery and outcomes are monitored in practice.

Training and development

The Health and Social Care Act states that "staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities."

While we saw evidence of good practice, we were concerned that staffing pressures meant midwives and junior doctors sometimes missed out on mandatory training and other learning and development opportunities because of the intensity and inflexibility of their rota. For example, staff discussed not receiving training to use the triage system.

In a number of services we found compliance levels for mandatory training were below the trusts' targets. Not completing mandatory training can negatively affect the safety of women and babies.

In one service, only 39% of staff had completed the Perinatal Institute's growth assessment protocol training, and 51% of all staff groups had completed the fundal height measurement training. This was against the trust target of 90%. The training supports staff in correctly identifying if babies are the expected size against gestational age. At the trust, we saw a number of incidents that demonstrated missed opportunities to identify babies who were small for gestational age.

Worryingly, we saw varying levels of completion rates of maternal and newborn life support training for midwifery staff, with low rates of completion in immediate life support (53%) and newborn life support (56%). This meant service leaders could not be assured all staff were suitably trained to respond to life-saving emergency situations, putting women and babies in their care at an unacceptable risk. In addition, we found a number of examples when staff were unable to describe the process of a birthing pool evacuation in an emergency or locate the necessary equipment.

Some junior doctors told us the intensity of their rota provided them with little or no learning and development opportunities as caring for women took priority. We also found the current workforce challenges meant supervision meetings and annual appraisal meetings were often postponed due to clinical work taking priority.

Junior medical staff told us that the inflexibility of their rota meant they were not always provided with protected or paid time for teaching, including mandatory training, and they felt expected to complete relevant training in their own time.

Staff wellbeing

As reported in our 2022/23 State of Care report, high demand and more pressure on services is continuing to affect the health and wellbeing of staff across all areas we inspect. In 2022/23, we continued to see high sickness rates for staff, with a high proportion of staff saying they felt sick as a result of work-related stress.

Throughout the maternity inspection programme, staff absence caused by sickness and other reasons such as maternity leave, has been a key barrier preventing services from reaching full staffing capacity. While many factors can contribute to high rates of staff sickness and absence, we identified some themes including stress, COVID-19-related absence, and short and long-term sickness.

Low staffing numbers because of high sickness rates can put additional pressure on staff who are able to work, contributing to low morale, exhaustion, and increasing the risk of burnout. Many members of staff told us that a lack of breaks and meal breaks was common, especially during night shifts. Some staff told us they felt unable to stop for a break due to safety concerns from staffing levels. We also heard about staff working late and/or working additional unpaid hours to support the safety of women. This is supported by a recent survey by the Royal College of Midwives, which showed that midwives and maternity support workers are working 100,000 unpaid hours a week to support maternity services. In addition, 87% of respondents did not feel their workplace had safe staffing levels.

While staff told us they had identified and reported these issues to managers and leaders, some said they felt their concerns were dismissed and ignored. It was concerning to hear from staff who felt that their job had become harder and that they were “pushed to the brink” and “emotionally exhausted”.

We expect providers to care about and promote the wellbeing of staff to enable them to provide, safe, effective, person-centred care. Some services were taking action to improve how they support staff, for example by introducing wellbeing coaches, employee support services and guidance on managing stress. However, it was not clear on the impact of these strategies on staff absence and sickness levels.

Workforce planning and recruitment

Recruitment and retention of staff remains a chronic issue for maternity services and presents a major national concern. It is vital that services can recruit to maintain safe staffing levels. Staff then need to be supported to carry out their roles with the appropriate levels of training on an ongoing basis.

Retaining staff is perhaps an even greater challenge. Sustainable improvement in this area requires further investment to support the wellbeing of staff, enable them to provide the level of care they want to deliver, and prevent them from being driven away by current pressures.

The Royal College of Midwives (RCM) has warned that staffing is the most important issue, which is placing unacceptable levels of pressure on staff and compromising the safety and quality of care for women. These issues extend to recruiting students to join the profession and there is work to be done to future-proof the maternity workforce, with data from UCAS showing that midwifery applications for June 2024 were at their lowest for more than 6 years.

Throughout our inspection programme, we have continued to see high numbers of vacancies. In some cases, services lacked enough maternity staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and provide the right care and treatment.

NHS Resolution's Maternity Incentive Scheme is a financial incentive programme that aims to enhance maternity safety within NHS trusts and encourage them to implement essential safety measures. The scheme has numerous requirements for trusts to ensure effective midwifery workforce planning. However, we found some services had not fulfilled these requirements, for example by not following best practice when calculating the midwifery staffing.

Services identified high staff turnover as being associated with a lack of opportunities to progress to other roles. Although staff were promoted at one service, we still found issues with staffing shortages as the service had not replaced midwives it had promoted.

In an attempt to combat some of these issues, in 2022/23, the government announced that all maternity units would be given additional funds to increase supernumerary capacity and improve support for midwives, with a continued focus on retention and pastoral support activities. The majority of units we visited had a recruitment and retention midwife in post, whose role included:

- providing pastoral support to the workforce
- attracting new staff through proactive succession plans to address shortfalls in staff numbers and skills mix
- working with matrons and midwives to identify where improvements could be made to support staff retention.

Some recruitment and retention midwives collated themes from staff exit interviews to drive improvement. At one service, 18 members of staff who planned to leave had been retained as the recruitment midwife had identified what staff need and ensured the availability of clinical development opportunities.

In contrast to staff shortages, several services were found to have low vacancy rates and limited staff turnover, although no reason was provided as to how the service achieved this.

Reporting red flag events

The National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings' describes a midwifery 'red flag' event as "a warning sign that something may be wrong with midwifery staffing" such as delays in medical reviews and maternity triage difficulties. Nearly all the services we inspected reported maternity red flag staffing incidents in line with these guidelines. However, we saw inconsistencies in how these were recorded, monitored and mitigated. We noted that a few services had no red flag incidents within the reporting timeframe.

In addition, it was not always possible to identify in trusts' board papers whether maternity red flags were presented to the board. This could mean that boards were not fully appraised of the safety concerns women were experiencing.

We saw that maternity red flags were primarily associated with delays in care, with most red flag events identified as delays to induction of labour where one-to-one care was unavailable, or staffing or bed availability that was considered to compromise safe infant delivery for women. Some services aimed to prevent future red flag events through a review of planned admissions, enabling transparent conversations about activities within all units and discussing red flag incidents at safety champion and governance meetings to identify themes and learning.

Medical staffing

Reviews by doctors in triage are often compromised because middle grade rotas are hard to fill. The middle grade cover for triage is often (but not always) from the intrapartum team, who will prioritise intrapartum over triage unless the case is very urgent. Often, these doctors are also covering gynaecology emergencies from the emergency department. There is no dedicated national model of obstetric cover.

All units we inspected had adjusted the level of consultant cover to meet the requirements set out in the Ockenden Review recommendation to have 2 ward rounds in a 24-hour period. However, as we highlighted in our interim blog, we are concerned that the cover model is often fragile, and the rotas rely on every consultant being available and establishing a culture of escalation for support. While funding was provided following the Ockenden report, it was not enough to meet the demand from trusts.

We recommend NHS England:

- Has oversight of gaps in middle-grade rotas and the proportion of time spent by consultants covering them. This supports recommendations in the Ockenden Review to introduce nationally agreed minimum levels of medical staff to cover the full range of maternity services at all times.
- Works with the Nursing and Midwifery Council and Royal College of Obstetricians and Gynaecologists to establish a minimum national standard for midwives delivering high dependency maternity care.

We recommend the Royal College of Obstetricians and Gynaecologists takes our findings in relation to the surgical first assistant role in maternity services so that it is in line with the requirements set out by the Royal College of Surgeons.

We recommend that the Nursing and Midwifery Council uses findings from our report to review their proficiency standards for midwives.

Leadership and culture

Effective leadership, governance and culture can drive and improve the delivery of high-quality, person-centred maternity care and help to drive a culture of safety and improvement.

The first Ockenden review into maternity services at Shrewsbury and Telford Hospital NHS Trust highlighted the need for strengthening leadership and oversight, preventing toxic cultures and fostering more collaborative approaches in maternity services. Similarly, Dr Bill Kirkup identified a culture of denial and described 'a resistance change' in his investigation into maternity failings at East Kent Hospitals University NHS Foundation Trust. To drive meaningful change and address systemic issues, a joined-up approach from organisations, colleges and system leaders is essential.

Our inspection programme supported these findings, demonstrating the importance of strong leadership and an inclusive culture. We found that many of the issues raised in these reviews of individual trusts not only persist but are widespread.

We observed a wide range of maternity service leaders who demonstrated dedication and passion in making their service effective in caring for women and babies, but the quality of leadership remained varied. We identified numerous factors involved in effective leadership, including:

- a stable leadership team, with consideration of succession planning and backfilling to enable seamless provision of services
- leaders with the capacity to support service development, address issues in a timely way and drive continuous improvement
- a detailed understanding of immediate issues and priorities faced by the service to form the basis of an effective management plan
- a leadership team that is accountable for acting on risks identified and making tangible improvements
- supportive and approachable leaders who listen to staff and act on what they hear in a way that the workforce recognises
- regular and clear communication and transparency from leaders.

In his report into failings at East Kent, Dr Bill Kirkup highlighted "the divergence of objectives of different groups" as an issue that is particularly striking in maternity care. He highlighted a "struggle for 'ownership' of maternity care" where "rather than contributing as equal partners, midwives may be encouraged to see themselves as being 'there for women', defending them from the 'medicalisation' of maternity care" and putting them in conflict with obstetricians. We saw one instance of a team not working holistically, which we escalated to the trust leadership team when identified and issued a Warning Notice to drive urgent action.

In maternity services, it is vital that multidisciplinary teams work towards the same aim – safe care for women and babies throughout the maternity pathway. As previously seen in the East Kent report, divisions within professions can place women at a greater risk of harm.

Culture

An open and positive culture can demonstrate examples of teamwork, professionalism, and listening to women. Healthy cultures, where staff feel supported and empowered to thrive, improve staff retention and are crucial to ensuring high-quality, safe care for people.

We expect leaders at all levels to understand the context in which they deliver care, treatment and support, and to embody the cultures and values of their organisation. They should have the skills, knowledge, experience and credibility to lead effectively, with integrity, openness and honesty. Good leadership is vital in creating an inclusive team culture with effective communication, escalation and clear routes of accountability. This is necessary for good clinical care for women and helps to drive a culture of safety and improvement.

In our Safety, equity and engagement in maternity services report, we found variation in the culture of services we inspected. There was evidence of poor working relationships between obstetric and midwifery teams in some services, staff did not always feel valued, and some services could not demonstrate a clear culture of learning.

Throughout our inspection programme, we were encouraged to find examples of leaders taking responsibility for providing a safe service, often seeking external support and guidance and being open to scrutiny at all levels. However, more work is needed to ensure these cultural values are present in every service.

In many maternity services, we observed a positive, just and learning culture of reporting incidents and near-misses, with staff encouraged to raise concerns without fear. For example, one service shared regular newsletters and posters of 'you said we did' with staff and patient feedback from recent visits from non-executive directors. This is vitally important, as a poor culture can mean staff do not feel confident to speak up and issues can become exacerbated. A positive culture is also marked by the quality of interpersonal relationships in a service. We were encouraged to visit multiple services where staff reported feeling respected, supported and valued by their colleagues. More examples can be found in our improvement resource.

Unfortunately, not all services demonstrated these values. For example, at one service, staff spoke of low morale and described a blame culture, where managers did not listen to their concerns. We are concerned that while these cultures persist, services will not be able to address issues raised in reports such as the Ockenden review, and ultimately, families will continue to suffer. We heard that a decline in enthusiasm, burnout and low morale were having a negative impact on culture.

As highlighted in the section of this report on inequalities, staff feeling ignored or dismissed emerged as a theme in our interviews with midwives and obstetricians from ethnic minority backgrounds. When staff do not feel empowered to speak up, or their concerns are dismissed it can be indicative of a closed culture, in which people are more at risk of deliberate or unintentional harm. Any service that delivers care can have a closed culture and we monitor for signs or risk factors associated with closed cultures throughout our inspection activity.

Some trusts recognised that they needed to address cultural issues. For example, one trust that had recently been through significant structure changes made sure staff had a common purpose of providing safe, quality maternity care.

Throughout our inspection programme we came across leaders at all levels who challenged our findings. We heard from some leaders that our inspection reports were contributing to poor morale among maternity staff, making it even more challenging to recruit. In contrast, we heard from staff who wanted to share their experiences, and in some cases thanked us for going into their services and highlighting areas for improvement.

There is no doubt that maternity services receive a great deal of publicity and much of that describes poor experiences and, at times, devastating outcomes. Some women told us they are frightened of what might happen if things go wrong. This is unacceptable.

We heard an overwhelming message from trusts' maternity leaders that they did not want any more recommendations on what they need to do to improve. However, as our report highlights, on a national level there are some fundamentals of care that need systemic improvement. Until these are addressed, women and babies will not consistently receive the level of safe care they should be entitled to and the level of care that staff want to be able to deliver every time.

Visibility of leaders

In our Safety, equity and engagement in maternity services report, we previously raised concerns about a lack of clear, consistent and visible leadership. When we assess whether services are well-led, we expect leaders at every level to be visible and lead by example, modelling inclusive behaviours. This can help make staff feel supported in their role and enable them to escalate concerns promptly to improve outcomes for women and their babies.

We were encouraged to see examples of visible leadership on many inspections, which are outlined in our improvement resource. Several trusts benefitted from the use of maternity safety champions. These were introduced as part of the Safer maternity care action plan, where maternity clinical networks were asked to designate a maternity safety champion to promote learning, seek out best practice and share it across the system. At one service, the board safety champion ran regular open forums both virtually and in the maternity unit to gather feedback from staff and listen to their concerns or queries. They were regularly visible and approachable on the wards, taking a proactive stance in maintaining and improving standards of care.

However, on several occasions, we heard about leaders who were not always visible. At one trust this meant that not being present prevented them from recognising the scale of issues the service faced. Here, safety champions had limited, superficial knowledge of the service and executive leaders failed to recognise the severity of issues faced within maternity. The impact of this lack of oversight and visibility was clear on our inspection – the delivery suite was chaotic and not having clear organisation or leadership hindered a calm and systematic way of working.

Information sharing

Information sharing is paramount for safe and effective care. Without it, leaders may be hampered in their ability to make effective decisions. At ward-level, when caring for women, it is essential that staff communicate well, especially during handovers, to make sure they are aware of potential risks and can deliver compassionate care.

Throughout the programme, we saw examples of good information sharing between staff and managers, but we are concerned that leaders do not always have a full picture of their service and may miss opportunities to learn. At one hospital, there were clear communication systems for sharing information from ward level to service managers, who were routinely available to respond to any issues. In addition, meeting minutes and information on notice boards displayed positive feedback to staff.

Another service had a risk and governance midwife who was responsible for sharing learning from incidents. At a different service, sharing information was an important element in safeguarding training and included examples of harm, how incidents were reported in the trust, and actions that had been taken as a result.

Reporting incidents is key to providing leaders with a clear picture of their service. Although we saw evidence of trust boards being presented with incident data, this was usually limited to incidents graded moderate and above. Given the potential issues with the grading of incidents outlined in the safety section, we are concerned that trust boards may not have the full picture of maternity incidents, themes and trends. This presents a missed opportunity for boards to check and challenge, and limits the ability of services to learn and improve.

In addition, we found no regional or local oversight of incidents reported and graded by perinatal services. NHS England regional midwifery teams, integrated care boards (ICBs) and local maternity and neonatal systems (LMNS) do not have access to the NRLS data set. Again, this could mean a missed opportunity for analysing trends, identifying inequalities and benchmarking at a local or national level.

Leadership decision-making

Clear oversight of challenges enables leaders to identify issues, make effective decisions and drive meaningful change. While we saw evidence of strong leadership and good decision-making at several trusts, we also found examples of poor decision-making and issues with vacancies within leadership teams.

One service exemplified how effective leadership, governance and culture can drive and improve the delivery of high-quality, person-centred care. Here, staff at all levels demonstrated commitment to sharing data and using information proactively to drive internal decision making as well as system-wide working and improvement. Another service had a clearly defined management and leadership structure, led by a triumvirate comprising a divisional director, midwifery director, and associate medical director for obstetrics, gynaecology and neonatology. This helped leaders to make effective decisions based on a clear understanding of the challenges faced by the service.

However, we also saw instances of poor decision-making, which was sometimes compounded by a lack of leadership support and communication. For example, a small number of services did not always collect and analyse reliable data, which meant they were unable to make effective decisions and drive improvements. We also saw evidence of a lack of decision-making where, following a period of instability within the leadership structure across the trust, a number of senior posts remained vacant. This led to delays in implementing improvements.

Leadership vacancies for maternity services are a problem. We saw a high turnover of staff in senior leadership roles in some trusts. We could also correlate this with our ratings of the well-led key question. Maternity services usually have a head of midwifery and/or a separate director of midwifery who reports to the trust's chief nurse. In addition, there are maternity leadership roles in ICBs, NHS England's regional teams and other bodies such as MNSI, and NHS Resolution. Some midwives expressed concern that there was only a finite pool of capable leaders, which makes recruiting for these posts challenging. While there is no doubt maternity services need leaders who understand the complexities of delivering a safe maternity service, there may be a further argument to explore the greater need for effective, strong compassionate leaders, supported by maternity experts.

Leadership response to staff concerns

The final report of the Ockenden review highlighted that many members of staff reported a fear of speaking out as well as a culture of 'them and us' between midwifery and obstetric staff. As we previously raised in our Safety, equity and engagement in maternity services report, the result of this is 'working in a silo', which can have a hugely detrimental impact on women, particularly when concerns need to be escalated. During the inspection programme, although we found some good examples of leaders engaging with staff about their concerns, this was not always the case. Where there was a failure to listen and respond to issues about safety, this put women and babies at risk of preventable harm.

But it was encouraging to see instances of leaders being responsive to concerns.This included holding listening events, displaying 'you said, we did' posters and at one service, having non-executive directors undertake regular safety walkabouts to give staff an opportunity to voice concerns.

A key component of an open culture is creating an environment where staff feel supported to raise concerns. We were pleased to see many members of staff feeling able to speak to leaders about difficult issues and incidents. Issues were raised through a number of routes, including Freedom to Speak Up teams, guardians or ambassadors, who supported staff when they wished to voice their concerns.

However, on a small number of inspections we found that while some staff felt that they could speak up when they needed to, not all of them felt that leaders always listened to them or felt confident that the organisation would address their concerns. This could contribute to a poorer culture where staff are deterred from raising concerns in the future, and ultimately opportunities to improve care may be missed.

At another service, we were concerned to hear that staff had raised issues directly to senior leaders several times regarding safety and staffing levels, but did not see the quick action or improvement they had expected. A similar picture emerged at another service, where we heard there was sometimes unkindness between staff and that following incidents, leaders did not provide compassion and support.

Governance

Effective governance structures support the flow of information from frontline staff to senior managers and trust boards, ensuring leaders have the insight needed to make effective decisions and vital improvements. While some of the services we inspected had clear and established governance processes in place, this varied between trusts. Without effective governance processes, leaders do not have oversight of the risks and issues in maternity services and cannot address them in a timely way.

In a small number of services with limited oversight at board level, opportunities to address issues were missed. This meant, for example, that leaders only heard about the impact of an understaffed triage and delays in medical care when staff raised concerns, rather than regularly monitoring key areas on an ongoing basis using performance metrics. A review of board papers for 7 NHS trusts by the Sands and Tommy's Policy Unit raised questions over the ability of boards to fully understand the performance of maternity units. It highlighted a need to step back and reflect on metrics over a longer timeframe, as well as ensuring sufficient time for meaningful scrutiny.

While some trusts had well-established maternity governance teams, in other services, the teams were under-resourced. This was sometimes because of staffing pressures and the need to redeploy governance teams to provide frontline care. There are further opportunities to explore the skill mix within governance teams and make use of generalist risk and governance expertise when required. At times, we found an over-reliance on using midwives rather than recognising the different benefits that a non-maternity team member who is trained in the fundamentals of governance and risk can contribute.

Many of the concerns we identify in this report are about the fundamentals of safe care and treatment and are similar to the requirements in any other healthcare service.

Vision and strategy

It is vital that leaders ensure there is a shared strategy, and that staff understand and support the vision, values and strategic goals. Staff need to be clear on how their role helps in achieving these goals and be motivated to work towards them. Where staff had the opportunity to develop the strategy at a local level, this resulted in an engaged and motivated workforce, with staff who not only understood the service's vision and how to apply it to their roles, but were also able to explain the vision to women.

In a small number of services, we were concerned to find an absence of a maternity-specific vision and strategy, or that the overall trust vision and values did not include maternity services. The nature of maternity care means that attempting to apply broad visions of principles is likely to be an ineffective approach and could fail to recognise the unique position of women using maternity services. Having a specific maternity strategy helps staff ensure their services are responsive, evidence-based, and sustainable. In a minority of cases, although services had a strategy, they failed to communicate it well to staff, meaning they were prevented from understanding how their work contributed to the wider vision.

Gathering feedback and handling complaints

As a regulator, we believe people using care services, their carers, families, friends and advocates are the best sources of evidence about their lived experiences of care, and we champion this in our work. We are also clear about our expectation of services: providers should make it easy for people to share feedback or raise complaints about their care, treatment and support.

In several services, we were encouraged to see how staff effectively handled feedback from their investigation of incidents, both internal and external to the service. At one service, the governance midwife collated feedback to identify themes or trends related to health inequalities and included these in staff training and feedback sessions. At several other services, staff knew how to acknowledge complaints and women received a response from managers after the investigation into their complaint.

Conversely, in a smaller number of services, feedback was not handled as well. For example, at one service, there was limited evidence that changes had been made following feedback. At a different service, we were concerned to hear that senior staff sometimes took several months to review feedback, with staff reporting limited meaningful action and improvement following feedback. A lack of serious consideration of feedback or delay in taking action presents a missed opportunity for trusts to make vital improvements at an earlier stage of risk of harm and increases the likelihood of mistakes being repeated.

We urge system leaders to prioritise improvements in maternity services, both from a cultural and financial perspective, to drive much-needed change.

> We recommend NHS England ensures trusts are proactively managing succession planning in midwifery services, and, in line with recommendations from Leadership for a collaborative and inclusive future review, supports midwifery and obstetric staff to become effective future leaders.

Evaluation of the programme

As part of our work, we commissioned The Healthcare Improvement Studies Institute (THIS Institute) at University of Cambridge, with RAND Europe to evaluate our inspection programme and to identify where we can improve.

The evaluation had 2 objectives:

- to characterise what good safety culture looks like in maternity services and the factors underpinning it
- to evaluate the national maternity inspection programme to maximise learning.

Here, we look at the findings from the programme evaluation.

THIS Institute interviewed CQC inspectors, staff managing the programme and staff from inspected provider organisations (23 interviews in total). They also reviewed internal and external programme documents, including anonymised inspection notes, and undertook a literature review of the evidence for regulation with a particular focus on inspection.

Key findings from the evaluation include:

- The programme ensured that maternity remains a high priority in NHS trusts and gave greater momentum to current improvement initiatives.
- Our focus on equality and diversity further highlighted these issues in maternity settings. Although inspectors were keen to include these considerations in their inspections, the focus was brought in later in the programme. Therefore, assessment materials were not always designed in a way that made it easy for inspectors to consistently capture relevant information.

- The programme placed demands on maternity services, which sometimes struggled to provide the information we requested at short notice ahead of inspections. Our inspection visits were perceived to add to already high levels of scrutiny from regulatory and quasi-regulatory bodies.
- The scale of issues identified on inspection meant that the process was more involved than had been anticipated – both for services and for CQC colleagues. The programme was planned and delivered very quickly, which also introduced challenges.
- Some staff in maternity services said they were uncertain about the effectiveness of the inspection process, which made them question the consistency and validity of the ratings produced in some cases. Staff told us this was partly because of how they perceived the inspectors used discretion when making judgements, and that they felt the reasoning behind judgements was not always made transparent. Some staff also shared that including inspectors in the programme who had less direct maternity expertise and experience might have resulted in judgements they felt to be less robust.

Following the evaluation and feedback from inspectors, we are exploring what changes we can make to improve inspections of maternity services.

The role of inspection

The National Maternity Inspection Programme used inspection as the primary tool for gathering evidence. The evaluation therefore focused on the role of inspection as an effective regulatory tool.

From the evidence reviewed, the evaluation reported general agreement that inspection is a vital part of effective and accurate regulation, since some aspects of quality, safety, culture and leadership are difficult to assess through secondary sources. To gather enough evidence across the wide range of factors that contribute to high-quality care, inspections need to use methods that look at specific and observable activities as well as more complex features such as culture, vision and innovation.

The evaluation highlights the benefits of principle-based inspection, rather than inspection that is based on the use of strict rules and prescriptive standards. Principle-based inspection allows inspected organisations to respond to regulators in flexible, adaptive, and reasonable ways. It empowers professionals to take ownership while also supporting inspectors to exercise discretion. However, in applying discretion, the consistency of inspections may be challenged.

Going forward, inspections will remain an important part of how we regulate. Since delivering the National Maternity Inspection Programme, we have moved to our new assessment approach. As part of this approach, we'll gather evidence to support our judgements in a variety of ways and at different times – not just through on-site inspections. This means inspections will support this activity, rather than being our primary way to collect evidence. We know that observational methods, such as inspection, have a clear role in capturing evidence about cultures in care settings. The findings from the National Maternity Inspection Programme presented in this report suggest there is a clear need to continue to use inspection as part of our assessment of maternity settings.

The learning from the evaluation has given us helpful principles to consider when delivering inspections. This includes how we might use additional checks and balances to review judgements made by inspectors.

Learning opportunities

In addition to considerations for how we undertake inspection activity well, the evaluation has helped shape the following learning opportunities:

- Improve the alignment with other oversight bodies, including those who provide improvement support, to reduce demands on services. This can include careful consideration of the scheduling of visits and timing of information requests. It could also involve timely data sharing between us and other bodies to enable comprehensive judgements of risk that tell the whole story.
- Identify opportunities to use data that is specific to maternity services and distinct from data at trust level to help us delve deeper into risks and issues in a more targeted way. This will help us with our continuous monitoring of risk and reduce the scale of issues uncovered in inspection.
- Continue to improve how we assess equality and diversity in maternity settings to ensure this remains a central focus and key priority for services. This can include improving internal processes and systems for evidence gathering of specific equality and diversity information.
- Focus on building trust and positive relationships with maternity settings to encourage regulation to be seen as a factor that contributes to improvement. Positive feedback from inspected trusts as part of the programme welcomed kindness from inspectors and a thoughtful and supportive approach.
- Share more information with providers due to be inspected as part of focused programmes to create shared expectations and improved awareness of the information we will be reviewing.
- Improve how we plan focused programmes to ensure there is sufficient time to provide further learning and development opportunities to inspectors who have less experience in specialised settings and to ensure we can secure the involvement of specialist advisors.

Despite the challenges, regulation remains critical in maintaining safe levels of care and driving improvements in sectors like maternity, where we know systemic issues persist. We have a clear role in outlining the quality of care that people should expect and holding services to account if they fail to meet these standards. Learning from this evaluation will help us to carry out this role in the future.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 10**

2 October 2024

Title	Organ Donation Annual Report 2023-24
Area Lead	Dr Nikki Stevenson, Medical Director & Deputy CEO
Author	Dr Rosie Holmes, Clinical Lead for Organ Donation Angela Campion-Sheen, Specialist Nurse Organ Donation
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to provide a detailed account of organ donation activity within Wirral University Teaching Hospital (WUTH) for the period 1st April 2023 – 31st March 2024.

Organ donation activity is monitored via the Potential Donor Audit (PDA) through NHS Blood and Transplant (NHSBT) and overseen locally by the Organ Donation Committee (ODC), which meets quarterly. Lead members of the committee are:

- Dr. Steve Ryan - Chair (Non-Executive Director) WUTH
- Dr. Rosie Holmes - Clinical Lead for Organ Donation (CLOD) WUTH
- Angela Campion-Sheen - Specialist Nurse – Organ Donation (SNOD) NHSBT/WUTH

Organ donation takes place mainly within the Intensive Care Unit (ICU), with some within the Emergency Department (ED) at WUTH. There are two groups of patients who can donate solid organs after death:

1) patients who have been pronounced dead using neurological criteria and are ventilated on a life support machine. This is known as Donation after Brain Stem Death (DBD).
2) patients who are mechanically ventilated with overwhelming single organ failure (usually brain) and a decision has been made to withdraw life-sustaining treatment (WLST). This is known as Donation after Circulatory Death (DCD).

Organ donation is a complex process requiring multi-disciplinary co-operation. Potential organ donors are identified by medical and nursing staff in the above units and subsequently referred to the on-call organ donation team. It is imperative that potential donors are identified and referred to NHSBT in a timely manner.

All organ donor activity, including potential donors, is monitored via the PDA. This national audit commenced in 2003 as part of a series of measures to improve the rates of organ donation. The principal aim of the audit is to determine the number of potential solid organ donors in the UK, and to provide information about the hospital practices surrounding donation and how local teams are contributing to this.

It provides a breakdown of information, including reasons why some potential donors do not go on to become solid organ donors. All deaths in the Critical Care Unit and Emergency Department are included in the audit which is input to the NHSBT databases for analysis.

Performance in organ donation is compliant with CG135 and is within acceptable national targets in many of the key metrics measured.

There continues to be a small number of missed potential donors, however there is no recurrent theme, and the overall referral rate is improved when compared to last year and we hope this will continue to rise.

It is recommended that the Board:

- Note the report

Key Risks
This report relates to these key risks: • Board Assurance Framework risk 3 - Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	No
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
September 2024	Quality Committee	As above	As above
August 2024	Patient Safety Quality Board	As above	As above

1	Narrative
1.1	**Key Issues** This report provides assurance on organ donation activity within WUTH. An update from 1st April 2023 – 31st March 2024. Donation activity data is obtained via the NHSBT PDA. This is collected and collated by our dedicated embedded SNOD who inputs the data into the national audit. The SNOD is essential for the success of the organ donation program.

The following statistics represent data obtained by Angela (SNOD) for the National PDA. It includes all deaths within the ICU and the ED.

The column on the right of the table shows comparator data from the National PDA across the UK. Please note that this data excludes patients over 80 years of age, despite patients aged up to 85 (but not actually 85) being eligible.

Key Figures: Key numbers comparison with National Rates, 1st April 2023 – 31st March 2024

	DBD	DCD	UK wide PDA data 2023 - 2024
Patients meeting OD referral criteria	9	36	6911
Referred to NHSBT	9	31	6522
Referral rate %	100%	86%	94%
Neurological death tested	7 (both had CI to NDT)	-	1534
Testing rate %	78%	-	76%
Eligible donors	7	7	1426
Family approached	7	3 (1 opt out, 1 predicted PTA, 2 missed potentials)	1259
Collaborative approach with SNOD	6	3	1215
% collaborative approaches	86%	100%	97%
Consent ascertained	4	3	858
Consent rate	67%	100%	68%
Actual donors	4	2	788
% of consented that became actual donors	100%	67%	92%
Missed potential	0	2 (1 ICU, 1 ED)	-
Number of patients receiving organ transplants	15		

As can be seen in the table above, 45 patients met the criteria for referral to NHSBT. Considering absolute contraindications, a known expressed decision of opt-out on the organ donation register (ODR), screening out on assessment by the SNOD team and clinical deterioration post consent, meant 14 patients were actual potential donors. Of these, 6 patients had their end-of-life decisions to donate honoured, with a resultant 15 people receiving life-saving transplants:

- 4 people received liver transplants
- 11 people received kidney transplants
- 2 people donated their heart tissue
- 1 person donated their corneas

The figures include all possible patients from the ICU and ED; all referrals came via the critical care team. The numbers highlight the successful collaboration between the ICU team, SNOD and Transplant Teams. The previous introduction of a referral reminder in the ICU morning safety huddle continues to maintain our high referral rate. Local consent rate figures are adjusted to account for known decisions not to donate and identify when deemed consent has been obtained.

	Over the last year there were 2 missed potentials, both DCD, one within ICU and the other in ED. Regarding the patient in ICU, there was no obvious reason for the missed referral other than the decision to withdraw life sustaining treatment was made later in the day, after both the safety huddle and ward round. This missed referral was unusual. Technically the patient in ED was a late referral to the SNOD, but this was after the decision to withdraw life sustaining treatment had been made. The family expressed a wish to explore the option of organ donation and although this was not possible, the patient did successfully donate tissues. Again, there was no clear reason for the missed referral other than the involvement of multiple clinicians. There are no specific learning points identified, other than to continue to promote awareness of OD in both ICU and ED. We are looking at recruiting an ED clinician to join the ODC to champion donation in ED and to strengthen our ties with the ED link nurses.
1.2	**Organ Donation Committee** The Organ Donation Committee meets quarterly and is chaired by Dr Steve Ryan. This gives strategic direction to organ donation activity. Angela has successfully recruited new ICU link nurses who endeavour to attend meetings however it can prove tricky for many of the committee to attend and so we plan to carry out future meetings both face-to-face and via Microsoft Teams to facilitate attendance. We continue to raise the public profile of organ donation at WUTH mainly through the ongoing efforts of Paul Dixon, our volunteer. He has continued to raise awareness, promote discussion and increase the numbers of people signing up to the Organ Donor Register on the Wirral. Organ Donation Week runs from Monday 23rd to Sunday 29th September 2024. There will be a stall in the main entrance for the week, along with an exercise bike for staff and members of the public to log miles for the WUTH Race for Recipients team. Race for Recipients (RfR) is a national OD week challenge in honour of our organ donors, their recipients and those waiting for a lifesaving transplant. Teams and individuals up and down the country will be able to log miles through multiple forms of exercise to achieve targets and compete against other teams. There will be a WUTH team which any member of staff or the public can join. We will be running a ‘Find the Pink’ campaign, a social media-oriented promotion whereby anyone can photograph anything pink and link it to the campaign via multiple social media forums. We will fly the OD flag over the hospital again, as well as having the main entrance lit up pink. We are liaising with Wirral Borough Council to have a council building lit up pink; this will most likely be Wallasey Town Hall. We are continuing to work on the design and creation of the permanent memorial to publicly recognise and acknowledge the patients and families who have generously given the gift of life through organ donation within WUTH. We are working closely with Paul Mason, Director of Estates and Facilities, to pick the location that will best show this memorial off within the setting of the new development at the front of the hospital. This continues to be supported by the Trust’s Chief Executive.

1.3	**Clinical Guidelines** The WUTH Organ Donation Guideline is up for review in November 2024 and will continue to reflect current national guidance.

2	**Implications**
2.1	**Patients** • At the heart of every potential donation there is a patient. Their, and that of their family's journey and care remains the top priority even after referral to the Organ Donation team. The process is clearly explained, and the family are involved from the very start. They receive support not only from the Critical Care team but also the SNOD involved in the case. They are free to change their mind about whether they would like to explore organ donation at any point, and their wishes are always honoured and respected. • A safety huddle occurs every morning on the Intensive Care Unit. It is usually at this point that any patients who may fulfill Brain Stem Death criteria or whom may have treatment withdrawn are identified. Nursing staff as well as doctors are closely involved in the process and if someone requests not to be involved, that is facilitated.
2.2	**People** • Organ donation is acknowledged to be a difficult process for staff to go through. It can be extremely lengthy and is usually highly emotive. As such, support is given throughout the entire process by the SNOD involved in each case. There is an opportunity for a debrief after donation and the SNOD and/or CLOD endeavour to liaise with individual members involved in the process. • It is recognized that from referral to donation can be well over 24 hours. This in itself is a huge resource requirement as it requires a dedicated Critical Care nurse and bed for the duration, as well as time in theatre if the donation proceeds. The Critical Care Unit and Trust support and help facilitate every donation.
2.3	**Finance** • Funding is currently through NHSBT; the SNOD is employed through NHSBT and the CLOD's PAs are funded by NHSBT. The Trust receives a donation from NHSBT for proceeding donors. Funds are currently held in a separate account, spending from which is authorized by the Organ Donation Committee.
2.4	**Compliance** • WUTH continues to follow Best Practice Guidance for organ donation and is audited annually via the NHSBT PDA.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 11**

02 October 2024

Title	Complaints Annual Report 2023/24
Area Lead	Dr Nikki Stevenson, Medical Director & Deputy CEO
Author	John Molyneux, Head of Complaints
Report for	Information

Executive Summary and Report Recommendations

This report summarises concerns and complaints activity and performance at Wirral University Teaching Hospital NHS Trust (WUTH) for the financial year April 2023 to March 2024. The Annual Report has been appended to this report.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key risks:

- Board Assurance Framework risk 3 - Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	No
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**

September 2024	Quality Committee	As above	As above
July 2024	Patient Safety Quality Board	As above	As above

1	Narrative
1.1	**Comparative Performance (Formal Complaints)**

	2022/23	2023/24	% Change Over Previous Year
Formal Complaints Logged[1]	240	201	-16%
Active Caseload (at Year End)	59	65	10%
Ongoing Breaches (at Year End)	20	27	35%
% Acknowledged in 3 Working Days[2]	95%	98%	3%
% Responded to Within Original Timescale Agreed	25% (68/267 responses)	35% (64/184 responses)	10%
Avg. Response Time (Working Days)	70	60	14%
Re-opened Cases[3]	31	45	45%
PHSO Cases Opened	13	8	-38%
PHSO Completed Investigations Upheld or Partially Upheld	3 (21% of closed cases and 60% of detailed investigations)	3 (23% of closed cases and 75% of detailed investigations)	0%

The Trust logged 201 formal complaints, averaging 17 cases per month, and 3 per 1000 staff.

Most complaints involved more than one single division. Acute Care received the most complaints (involved in 74 cases), followed by Medicine (73), Surgery (59), Diagnostics & Clinical Support (42), Women & Children's (38), Corporate Departments (13), and Estates, Facilities & Capital (13).

At department level, the ED was involved in the greatest number of cases (58, with issues around delays and waiting times featuring prominently), followed by the AMU (12), Gynae OPD (12), Ward 19 / OPAU (11), and Colorectal and Upper GI (10).

'Communication' was an aspect of 63% of complaint cases, followed by 'Treatment and Procedure' (53%), 'Access and Admission' (19%), 'Diagnosis' (14%), 'Medication' (17%), and 'Transfer and Discharge' (15%). This was consistent with the previous year.

[1] Trust performance metric is set at </= 3.1 per 1000 staff per calendar month.
[2] Trust performance metric is set at 90% per calendar month.
[3] Trust performance metric is set at </= 5 per calendar month.

	Of the 184 complaints that received a first response, 40% (73) were not upheld, 48% (89) were partially upheld, and 12% (22) were upheld. **Comparative Performance (Level 1 Concerns)** The Trust logged 2190 level 1 concerns, averaging 183 cases per month. The clinical divisions of Surgery (597), Medicine (557), Women & Children's (485), Acute Care (301), and Diagnostics & Clinical Support (195) were involved in the majority of level 1 cases. At department level, the ED was involved in the greatest number of cases (232), followed by Community Child Health (203), Urology (102), Gynae OPD (96), and Colorectal and Upper GI (91). 'Communication' was an aspect of 32% of concerns, followed by 'Access and Admission' (24%), 'Treatment and Procedure' (19%). 'Infrastructure' (14%), and 'Transfer and Discharge' (8%). **Positives** • 98% of complaints were acknowledged and forwarded to divisions within three working days (and on average within one working days). • There was a 16% fall in formal complaints and a 1% fall in informal concerns. • Formal complaints comprised just 0.02% of WUTH patient contacts. • 71% of informal concerns were resolved and closed within three working days, and 89% within ten working days. • Few complaints progressed to PHSO detailed investigation, with PHSO final report findings then largely mirroring the previous Trust investigation. **Gaps** Although response times to formal complaints improved, they remained poor, with responses taking on average sixty working days against a performance metric of 40 working days. The main reason for delays continued to be the time taken for divisions to provide full, detailed, and evidenced responses.

	2022/23	2023/24	% Change Over Previous Year
Level 1 Concerns Logged[4]	2215	2190	-1%

2	Implications
2.1	**Patients** • Analysis of complaints themes and trends, and improvement action taken as a result of complaints, feeds into and supports the Trust's patient safety and patient experience agendas. It also may highlight potential inequalities of service and lack of reasonable adjustments. • This annual report therefore provides assurance of such themes and trends, as well as highlighting any specific and substantive actions or learning resulting from service user (patients and relatives) complaints and poor experience.
2.2	**People**

[4] Trust performance metric is set at </= 173 per calendar month.

	• An effective complaint process should ensures that staff are enabled to give a fair and balanced account of what happened and what conclusions they reached on every complaint. The wellbeing of staff involved in a complaint should be supported via a culture of fairness, openness, and learning, with staff feeling confident to acknowledge when things go wrong, rather than fearing blame. • Equally, where complaints are not upheld, staff should feel supported during the complaints process, the outcome of which should be both timely and fairly explained. • This annual report therefore reflects that not all complaints are fully upheld and that outcomes do not result in blame.
2.3	**Finance** • Although there are no direct financial implications arising from most complaints, where there has been a finding by the PHSO of maladministration or service failure, financial remedy may be recommended. Poor and untimely complaints handling may also be followed by litigation, with associated costs incurred in defense or compensation. • Conversely, service and process improvements made because of learning from complaints may have a positive financial impact.
2.4	**Compliance** • Per The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, healthcare bodies are required to prepare an annual report that must: (a) specify the number of complaints received; (b) specify the number of complaints that were decided to be well-founded; (c) specify the number of complaints referred to the Health Service Commissioner (PHSO) or Local Commissioner (LGSCO); and (d) summarise (i) the subject matter of the complaints received; (ii) any matters of general importance arising out of those complaints, or the way in which the complaints were handled; (iii) any matters where action has been or is to be taken to improve services as a consequence of those complaints. This annual report is therefore in line with those regulations and provides assurance of compliance.

Complaints Annual Report 2023/24

Purpose

This report summarises the concerns and complaints activity and performance at Wirral University Teaching Hospital NHS Trust (WUTH) for the financial year April 2023 to March 2024.

Introduction / Background

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 set out a complaints process with two stages: local resolution (carried out by the NHS body) and, if the complainant remains dissatisfied, referral to the Parliamentary and Health Service Ombudsman (PHSO).

The Trust's Concerns and Complaints Policy places emphasis on local resolution of concerns by frontline staff to avoid concerns escalating to formal complaints unnecessarily. When a formal complaint is raised, a patient experience specialist manages an end-to-end process, acting as a point of contact for the complainant and the investigation lead staff in the divisions.

For every complaint received, as part of the registration process, the Patient Experience Team (PET) clarifies and confirms each concern that the complainant would like us to address, and the period within which the investigation of the complaint is likely to be completed.

National timescales for complaint responses were removed in the 2009 Regulations and replaced with the ability to agree individual response timescales on a case-by-case basis with the complainant; however, to assist in the production of timely responses, WUTH's complaints policy currently grades concerns and complaints on a scale of 1 to 2, with the following timescales.

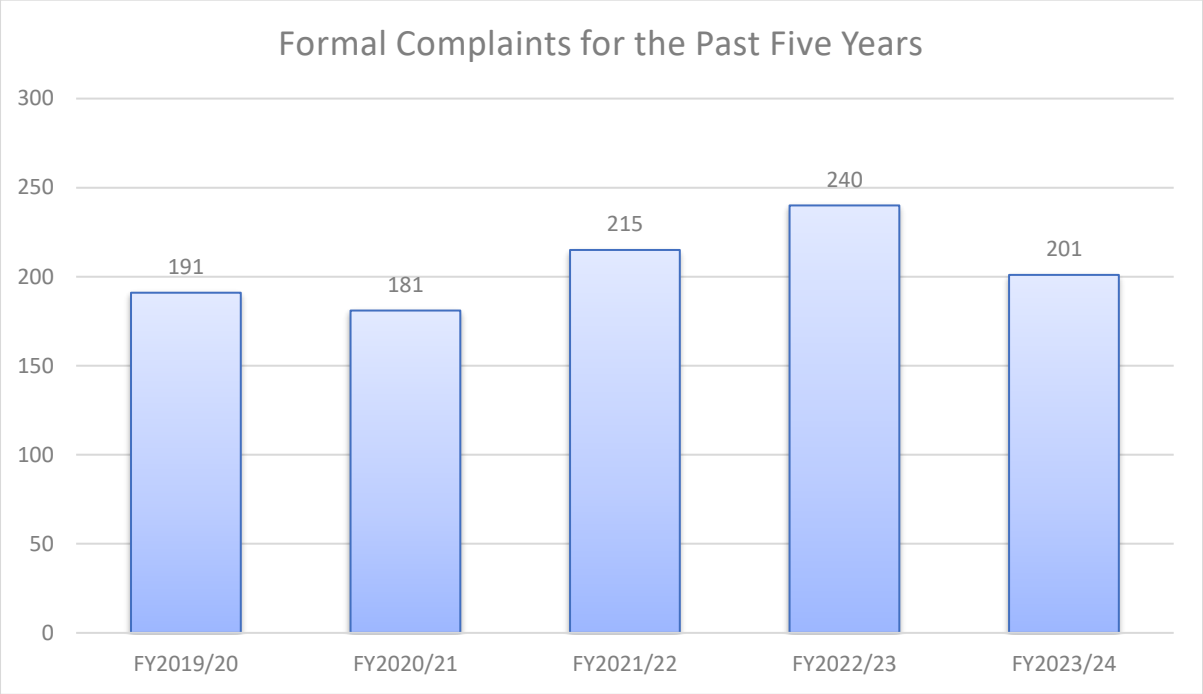
Level 1	Level 2
This will be investigated as an informal concern that has the potential to be resolved quickly by front line staff within three working days. Level 1 concerns may be resolved verbally and do not require a written response unless requested by the enquirer. Any such written response may be signed off at departmental / divisional level.	This is a formal complaint that should be acknowledged within three working days of receipt and responded to within 40 working days via a written response signed off by the Trust's CEO. In the absence of the CEO, level 2 complaint responses may be signed off by the CEO's nominated deputy.

Complaint Activity

There were 201 complaints formally registered in 2023/24, averaging 17 per month. This was a 16% decrease from the 240 registered in 2022/23 but more in line with the previous years.

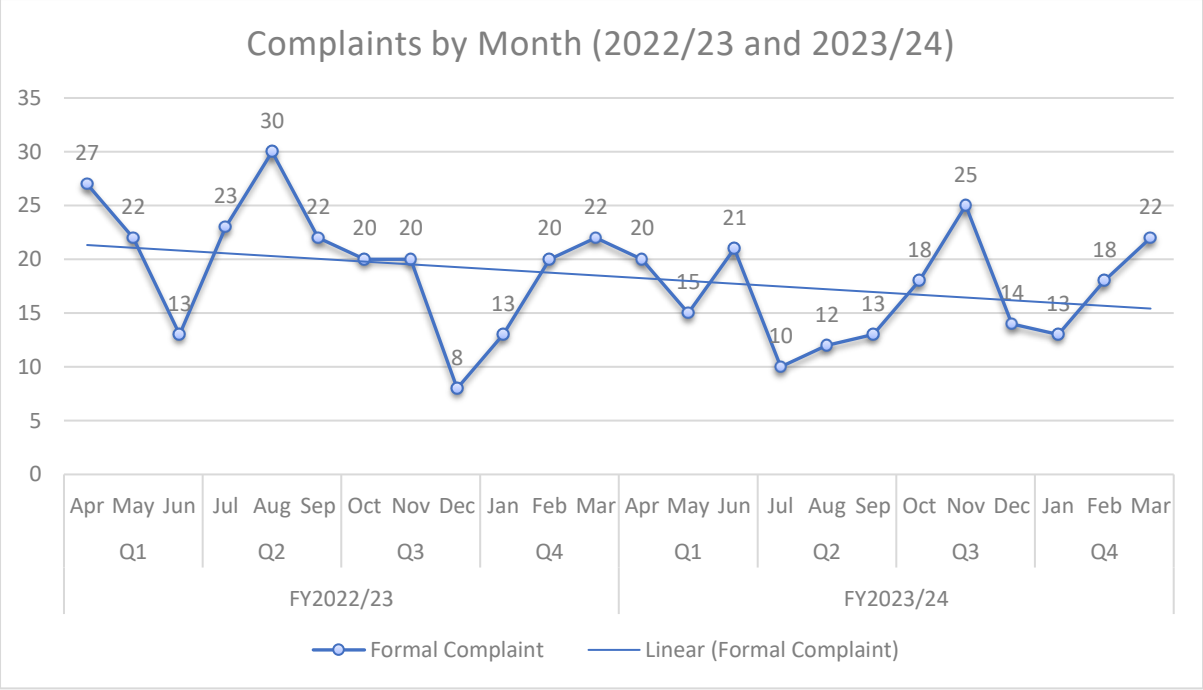
At the time of writing this report, NHS Digital K041 performance data for 2023/24 was not yet available; however, the 2022/23 K041 data showed a decrease of 1.5% in formal complaints to hospital and community health services in England.

For context, as in previous years, WUTH's 240 formal complaints in 2022/23 comprised just 0.02% of patient contacts (1072096) for the year.[1]



[1] The patient contact / activity data for the WUTH's 2022/23 Annual Report, excluding total births and diagnostic orders, were as follows.

New outpatient attendances	**146636**
F/up outpatient attendances	**370074**
Diagnostic examinations performed	**349743**
ED attendances	**96611**
Emergency admissions	**51696**
Elective day case admissions	**49365**
Elective planned admissions	**7971**
Total	**1072096**



'Communication' remained the highest reported thematic category of complaint (per the categories on Ulysses Safeguard, the Trust's Risk Management database), comprising 30% of total themes recorded and featuring in 127 cases (63%). In the main, this sub-divided to a communication failure with a patient or relative, or nursing and medical staff attitude.

'Treatment and Procedure' comprised 27% and featured in 106 cases (53%). These were around delays, but also featured sub-categories such as failure to assist with hygiene or feeding, pressure ulcers, and end-of-life care.

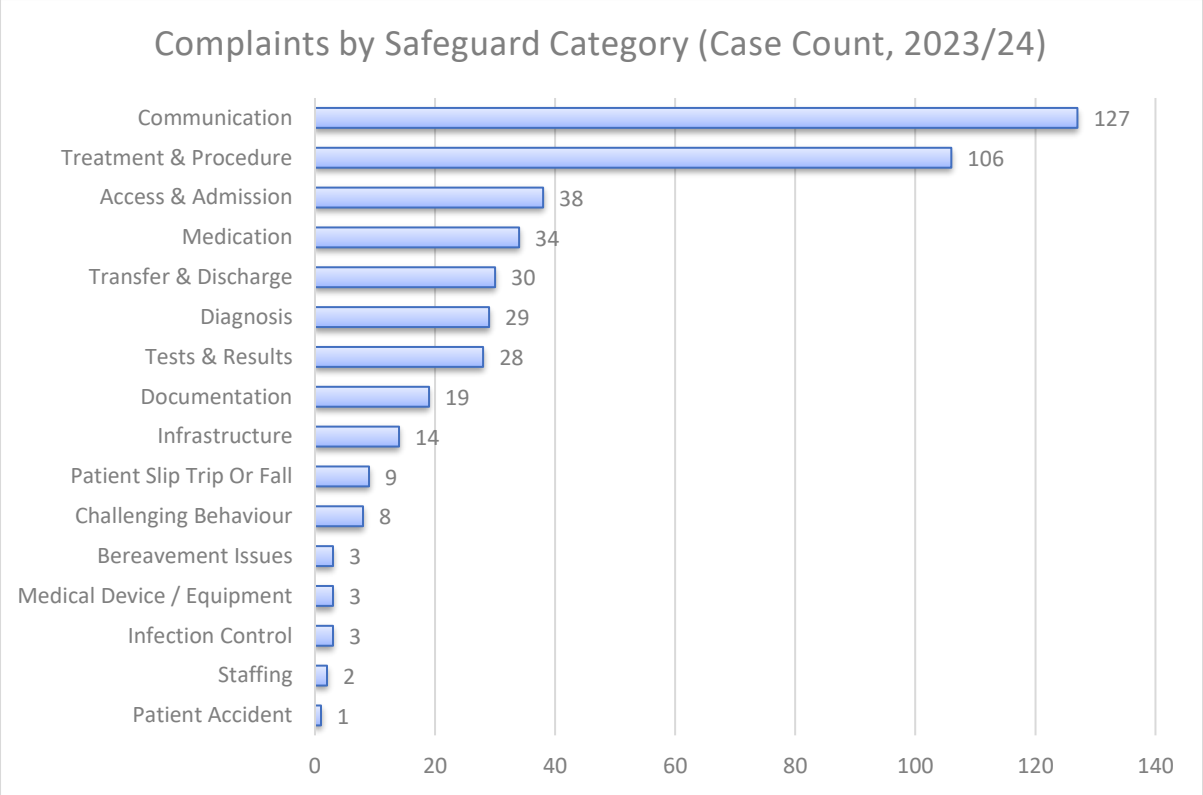
'Access and Admission' comprised 7% and featured in 38 cases (19%). These were sub-categories such as delays in accessing hospital care and cancelled or delayed inpatient and outpatient appointments.

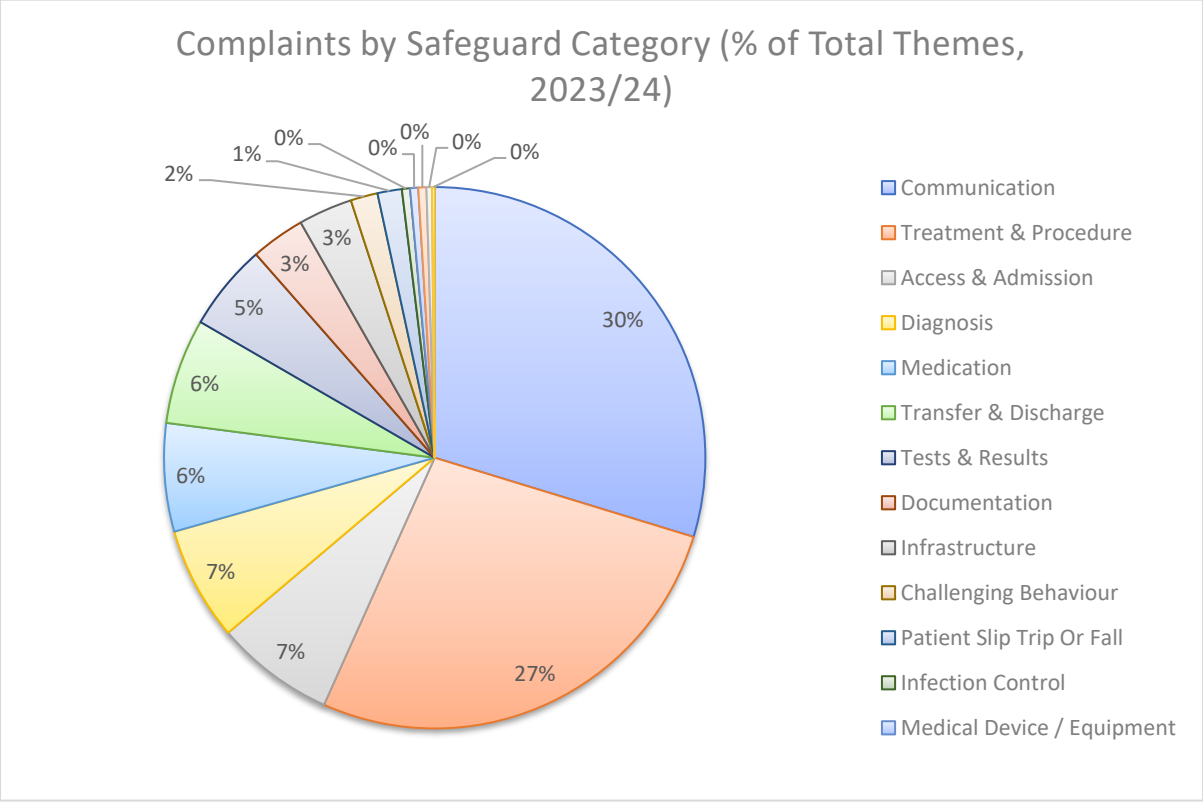
'Diagnosis' (delayed or wrong) also comprised 7% and featured in 29 cases (14%).

'Medication' (delays in prescribing or administering pain relief) comprised 6% and featured in 34 cases (17%).

'Transfer and Discharge' (inappropriate or unsafe) comprised 6% and featured in 30 cases (15%).

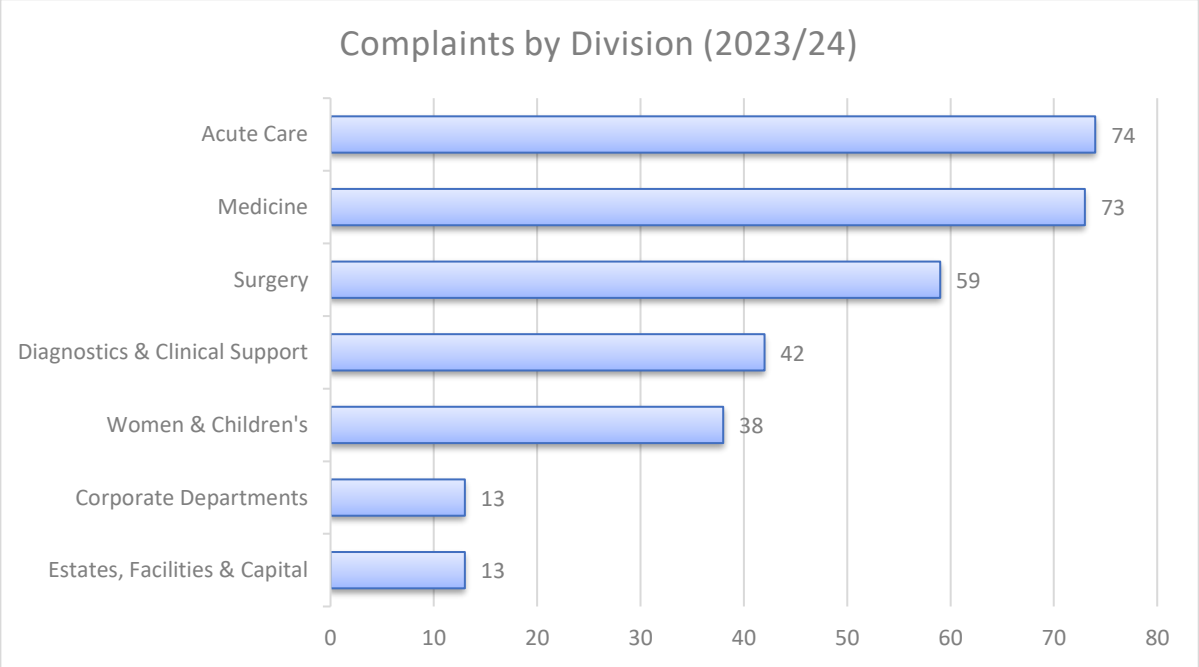
All categories recorded, and a comparison with the previous four years, are shown in the following charts. (N.B. A single complaint may comprise, and usually will comprise, multiple issues).


Complaints by Safeguard Category (Case Count, 2023/24)
Communication 127
Treatment & Procedure 106
Access & Admission 38
Medication 34
Transfer & Discharge 30
Diagnosis 29
Tests & Results 28
Documentation 19
Infrastructure 14
Patient Slip Trip Or Fall 9
Challenging Behaviour 8
Bereavement Issues 3
Medical Device / Equipment 3
Infection Control 3
Staffing 2
Patient Accident 1
0 20 40 60 80 100 120 140

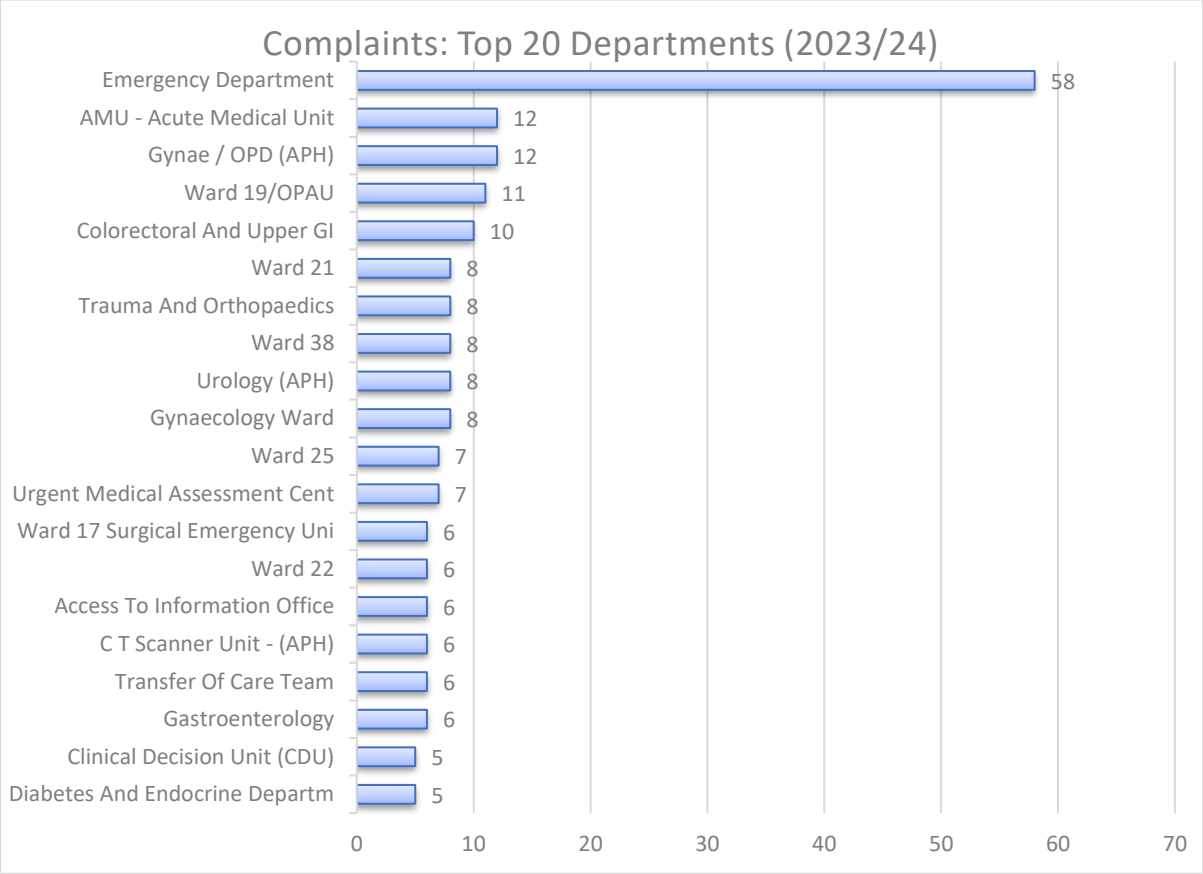

Complaints by Safeguard Category (% of Total Themes, 2023/24)
30%
27%
7%
7%
6%
6%
5%
3%
3%
2%
1%
0%
0%
0%
0%
0%
Communication
Treatment & Procedure
Access & Admission
Diagnosis
Medication
Transfer & Discharge
Tests & Results
Documentation
Infrastructure
Challenging Behaviour
Patient Slip Trip Or Fall
Infection Control
Medical Device / Equipment

Safeguard Category	FY2019/20	FY2020/21	FY2021/22	FY2022/23	FY2023/24
Communication	33%	32%	39%	34%	30%
Treatment & Procedure	36%	24%	28%	25%	27%
Access & Admission	5%	3%	3%	6%	7%
Diagnosis	7%	12%	9%	7%	7%
Medication	5%	4%	3%	7%	6%
Transfer & Discharge	5%	11%	6%	7%	6%
Tests & Results	3%	2%	3%	5%	5%
Infrastructure	2%	3%	3%	3%	3%
Documentation	1%	2%	2%	2%	3%
Challenging Behaviour	1%	1%	1%	1%	2%
Patient Slip Trip or Fall	0%	1%	1%	1%	1%
Bereavement Issues	0%	0%	0%	0%	0%
Infection Control	1%	2%	1%	0%	0%
Medical Device / Equipment	0%	0%	0%	1%	0%
Staffing	0%	1%	1%	1%	0%
Patient Accident	0%	0%	0%	0%	0%
Unexpected Events	0%	0%	0%	0%	0%

Acute Care received the most complaints (the division was involved in 74 cases), followed by Medicine (73), Surgery (59), Diagnostics & Clinical Support (42), Women & Children's (38), Corporate Departments (13), and Estates, Facilities & Capital (13).



The top 20 areas to receive a complaint are shown in the following chart.



For the ED, 'Communication' was an element in 40% of cases, 'Treatment and Procedure' in 32%, 'Access and Admission' in 29%, 'Diagnosis' in 17%, and 'Medication' in 16%.

For the AMU, 'Treatment and Procedure' was an element in 50% of cases, 'Communication' in 8%, 'Medication' in 25%, 'Access and Admission' in 8%, and 'Infrastructure' (delayed bed availability) also in 8%.

For Gynae OPD, 'Communication' featured in 42% of cases, 'Access and Admission' in 25%, 'Diagnosis' also in 25%, 'Treatment and Procedure' in 17%, 'Tests and Results' in 8%, and 'Documentation' also in 8%.

For Ward 19 / OPAU, 'Treatment and Procedure' featured in 64% of cases, 'Communication' in 55%, 'Infrastructure' in 18%, while 'Transfer and Discharge', 'Tests and Results', and 'Patient Slip, Trip or Fall' each totalled 8%.

For Colorectal and Upper GI, 'Treatment and Procedure' featured in 60% of cases, 'Communication' in 50%, and 'Diagnosis' in 40%.

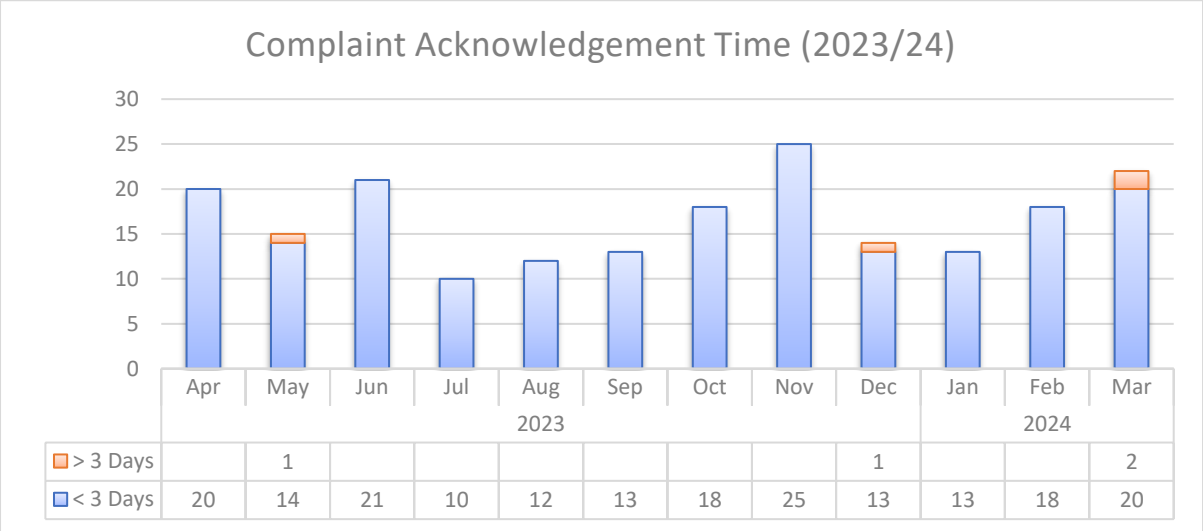
Complaint Response Timeliness

From October 2020, the Trust's Concerns and Complaints Policy set a routine timescale for responding to complainants of 40 working days.

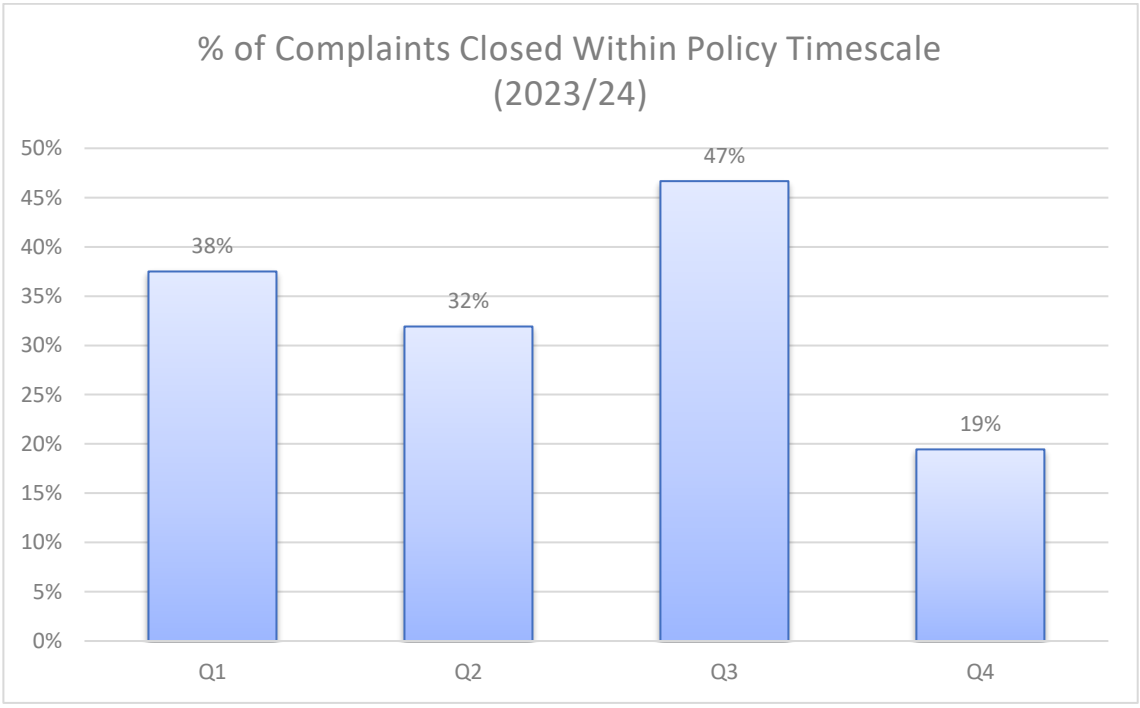
Internal divisional response times are currently set at 23 working days (parallel with an initial acknowledgement target of three working days). The remaining time is then allocated to drafting of the response letter by the PET (following receipt of the divisional investigation)

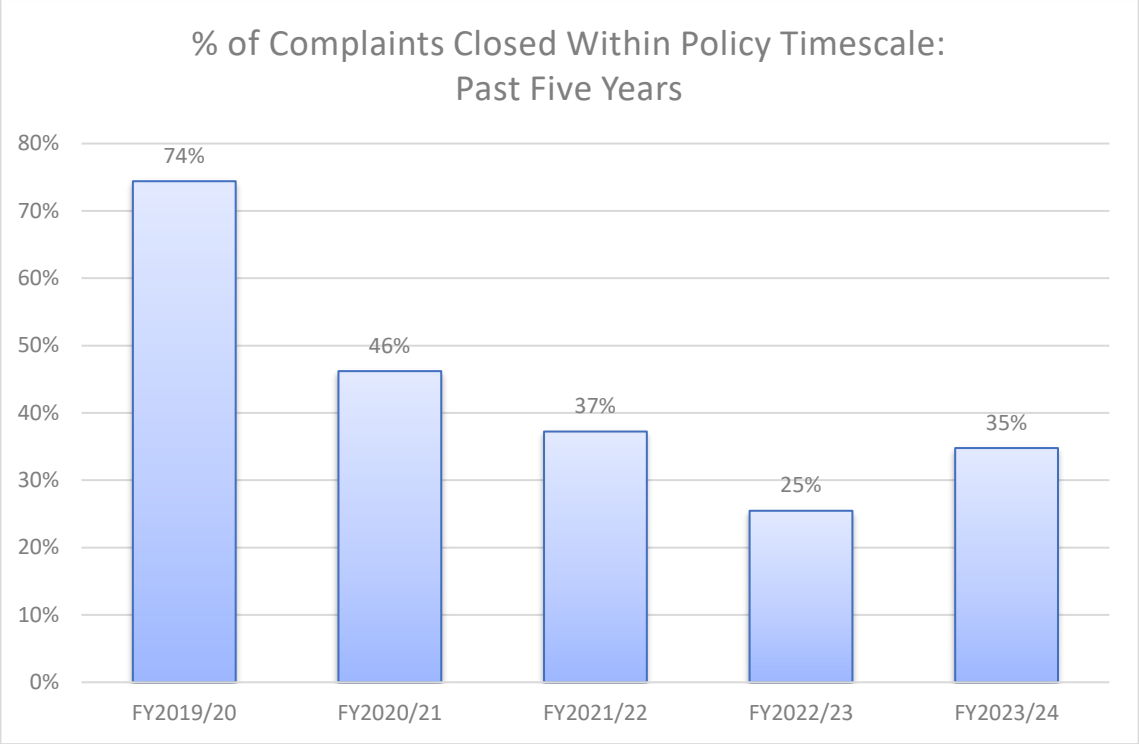
and executive quality assurance and sign-off of that letter by the chief executive officer or deputy.

During 2023/24, 98% of formal complaints were registered and acknowledged within the national target of three-working days, with an average acknowledgement time of one working day.



However, only 35% of complaints then received a response within 40 working days. Also, although this figure was a 10% improvement from 2022/23, and the average response time also improved from 70 to 60 working days, the actual number of completed investigations in 2023/24 was 31% lower.





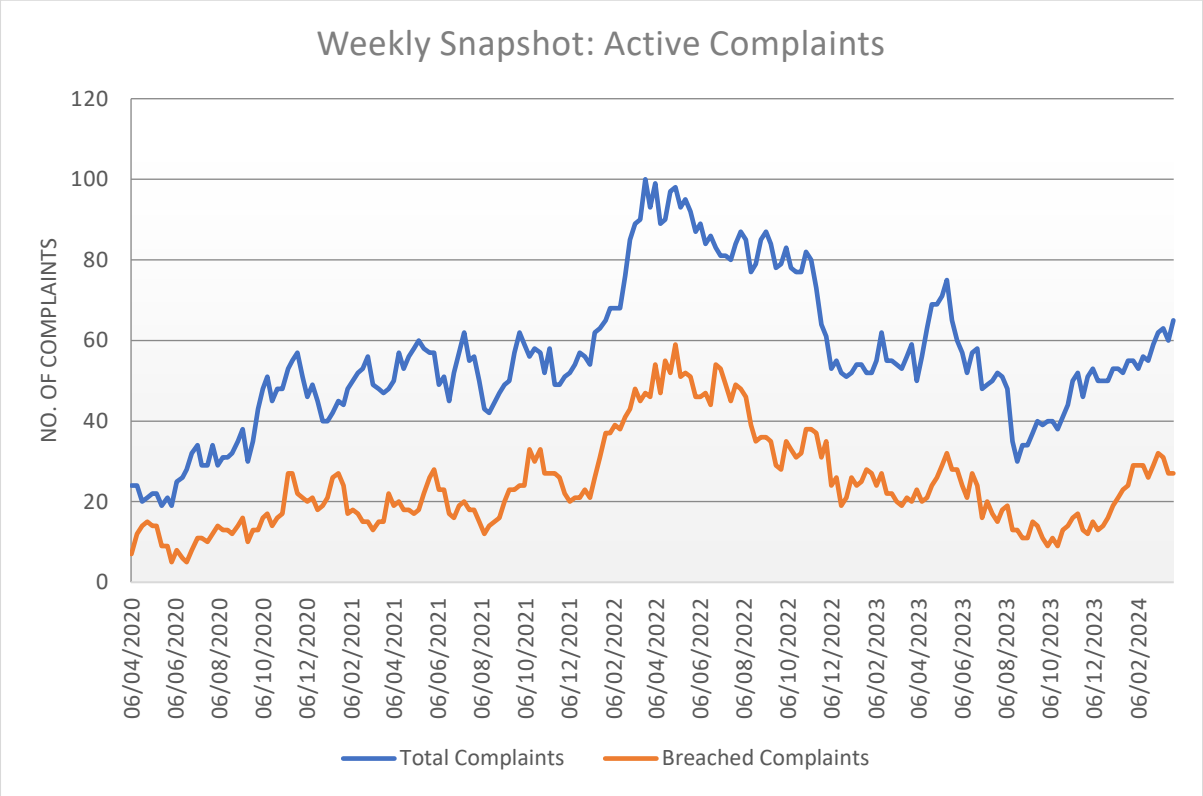
Analysis of the end-to-end process has shown that most of the delays have been with the clinical divisions, which in most cases take longer than the internal deadline of 23 working days to provide their reports/responses. Those responses then often require more work by the divisions, resulting in an extended period of quality assurance. Such delays are partially explicable by continuing operational pressures.

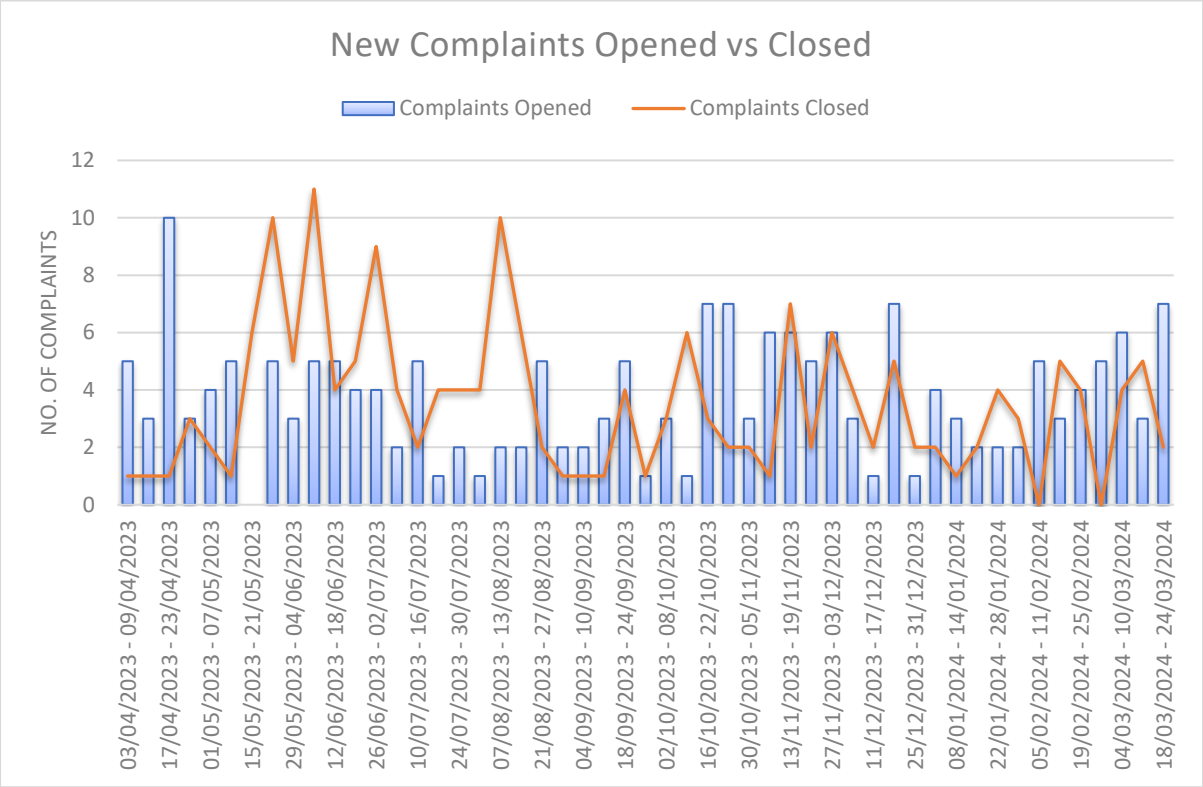
The multi-divisional nature of many complaints, and the iterative nature of the drafting and quality assurance process, makes it difficult to quantify these delays exactly but the following chart provides some comparison. This is a snapshot of the still-open cases at the end of quarter 4 of 2023/24.

Division	All Cases	Cases Breached Internal 23 Working Days Deadline	Cases Breached External 40 Working Days Deadline
Acute Care	24	14	10
Corporate Departments	0	0	0
Diagnostics and Clinical Support	6	4	3
Estates and Facilities	0	0	0
Medicine	13	5	3
Surgery	13	10	6
Women's and Children's	12	6	4

WUTH began 2023/24 with an active caseload of 59 complaints, of which 20 had breached 40 working days. This had represented an improved position from 2022/23, when active complaints had peaked at just over 100.

However, during 2023/24, that improvement was not maintained, and by year-end numbers had risen to 65 active complaints, of which 27 had breached. The following charts show the weekly fluctuations in active caseload over the past four years, as well as a comparison of the complaint numbers opened and closed each week over the past two years.

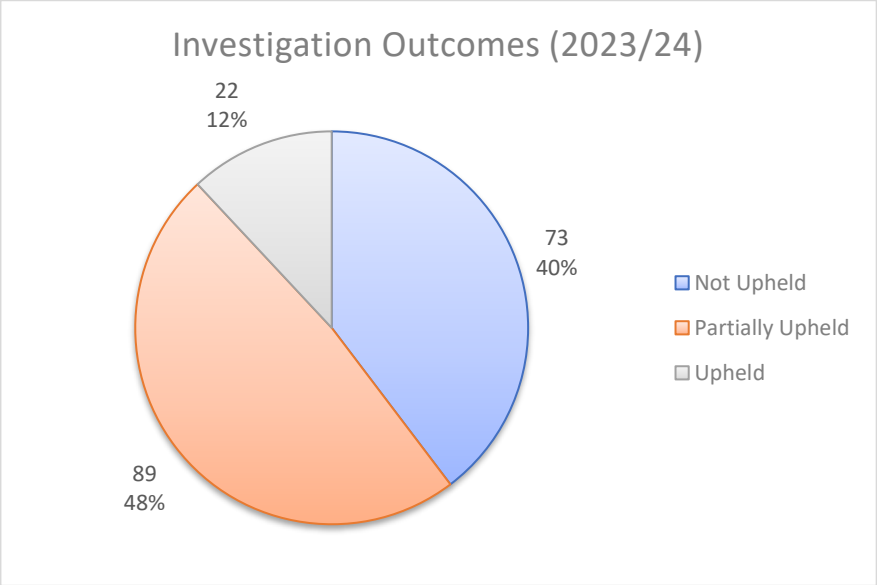

Weekly Snapshot: Active Complaints
NO. OF COMPLAINTS
120
100
80
60
40
20
0
06/04/2020
06/06/2020
06/08/2020
06/10/2020
06/12/2020
06/02/2021
06/04/2021
06/06/2021
06/08/2021
06/10/2021
06/12/2021
06/02/2022
06/04/2022
06/06/2022
06/08/2022
06/10/2022
06/12/2022
06/02/2023
06/04/2023
06/06/2023
06/08/2023
06/10/2023
06/12/2023
06/02/2024
Total Complaints
Breached Complaints


New Complaints Opened vs Closed
Complaints Opened
Complaints Closed
NO. OF COMPLAINTS
12
10
8
6
4
2
0
03/04/2023 - 09/04/2023
17/04/2023 - 23/04/2023
01/05/2023 - 07/05/2023
15/05/2023 - 21/05/2023
29/05/2023 - 04/06/2023
12/06/2023 - 18/06/2023
26/06/2023 - 02/07/2023
10/07/2023 - 16/07/2023
24/07/2023 - 30/07/2023
07/08/2023 - 13/08/2023
21/08/2023 - 27/08/2023
04/09/2023 - 10/09/2023
18/09/2023 - 24/09/2023
02/10/2023 - 08/10/2023
16/10/2023 - 22/10/2023
30/10/2023 - 05/11/2023
13/11/2023 - 19/11/2023
27/11/2023 - 03/12/2023
11/12/2023 - 17/12/2023
25/12/2023 - 31/12/2023
08/01/2024 - 14/01/2024
22/01/2024 - 28/01/2024
05/02/2024 - 11/02/2024
19/02/2024 - 25/02/2024
04/03/2024 - 10/03/2024
18/03/2024 - 24/03/2024

Complaint Outcomes

During 2023/24, 184 complainants received a first response to their concerns (31% fewer than in 2022/23).

Of these, 40% were not upheld, 48% were partially upheld, and 12% were upheld.



There was therefore a 3% decrease in upheld and partially upheld complaints during 2023/24 compared with 2022/23.

For comparison, NHS Digital K041 data for 2022/23 for all hospital and community services in England shows the following outcomes: 33% not upheld, 40% partially upheld, and 28% upheld. WUTH therefore had a 20% higher rate of partially upheld or upheld complaints.

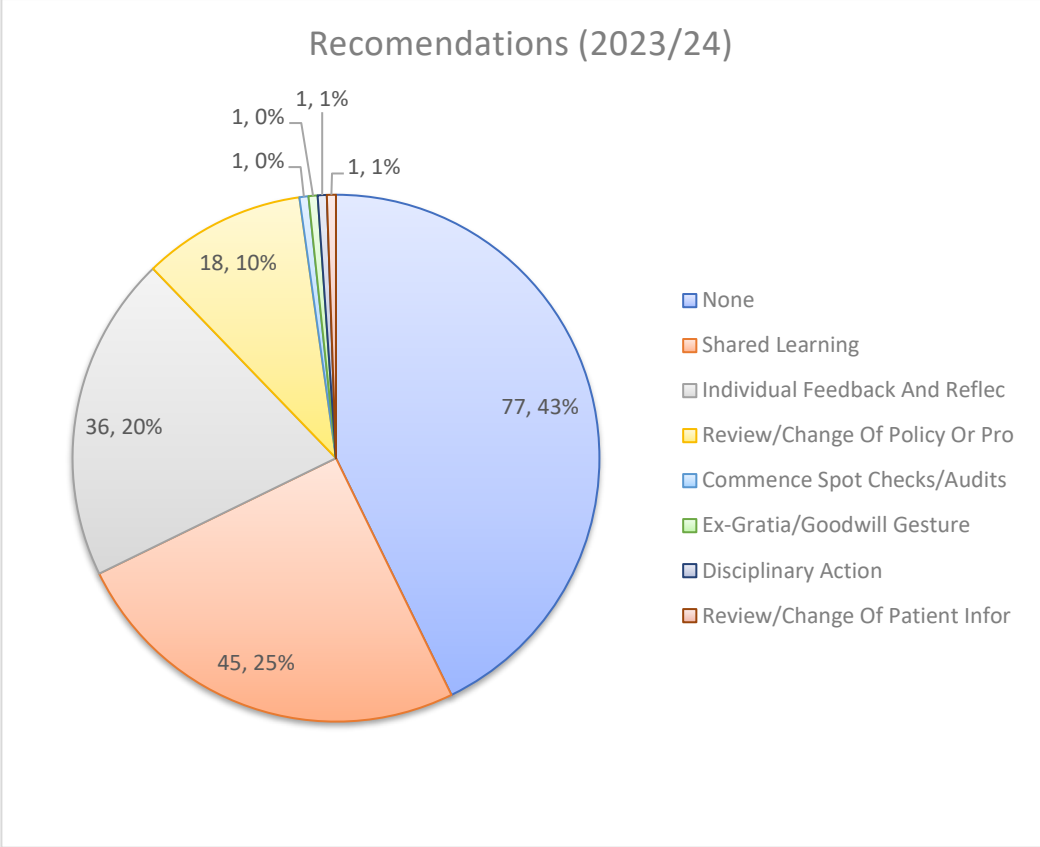
The majority of upheld or partially upheld complaints related to aspects around communication (for which, as communication is subjective, complainants are usually afforded the benefit of the doubt and so that complaint aspect is upheld), and appointment or treatment delay.

Learning from Complaints

From October 2020, all divisions have been required to submit an action plan with each complaint response, including timescales for completion and identified leads, so that these may then be tracked via Ulysses Safeguard.

Of the 184 complaint responses that received a response in 2023/24, 77 cases were judged not to require any actions.

The broad actions/recommendations described in the complaint response are summarised in the following chart.



Examples of specific learning actions and changes in process are as follows.

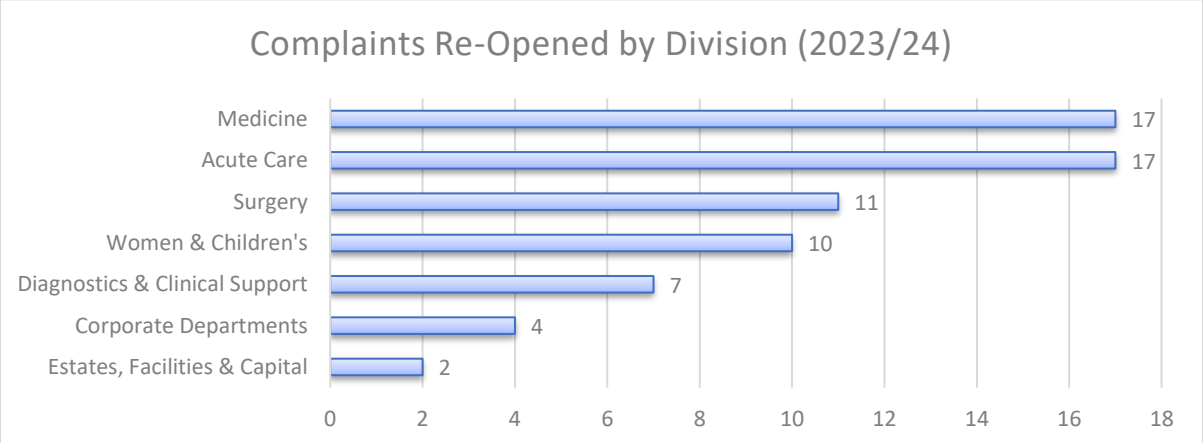
Acute Care	A review of ED processes for patients requiring an appointment following an ED review (following a complaint in which the booking of an appointment was overlooked). Collaboration between the Emergency Medicine and Maxillofacial teams to create a more robust referral system. When patients are discharged from the ED with a plan to return to seek specialist advice, they will instead be given a telephone number to contact during working hours. They will then be given a time to re-present directly to the Maxillofacial Department for wound management, without the necessity first to return to the ED.
Corporate	The Patient Experience Team has reviewed and modified its processes around the sending of response letters to complainants, to reduce the risk of these being misaddressed due to human error.
Medicine	A review of processes around virology screening, to ensure clarity and consistency around who is responsible for discussing virology investigations with ward-based patients.
Surgery	The introduction of weekly meetings between the Business Support Manager for Emergency General Surgery and the Home Therapies team, to avoid administrative errors around the booking of patient surgery. Any patient who has been referred from the renal consultants requiring treatment is discussed in detail, so that plans can be put in place and

	potential delays (such as scans not having taking place yet) can be identified and actioned at an early stage.
Women's and Children's	Amendment of clinical guidelines to reflect that all women with altered or diminished foetal movements are referred to the Maternity Triage Assessment Unit. Devising of an information poster (for the Delivery Suite, Maternity Ward, Triage and Antenatal Clinic) to provide clearer guidance on birth partner/visitor times for each different area. Discussion with the Obstetric Team to ensure that conversations related to the possible outcomes of a high-risk pregnancy are discussed with patients when their families or partners are available for support. Amendment of our guidance on the management of acute appendicitis in pregnant patients, to reflect the learning that conservative management in pregnant patients is not recommended. The division / Trust has recognised the need to revise its chaperone policy, such that when a patient declines the presence of a chaperone the policy is then more balanced in its guidance around the protection of staff. Review of all discharge packs to ensure that they contain the correct information.

Completion of actions may be monitored by divisional clinical governance leads via daily automated reports from Ulysses Safeguard.

Re-opened Complaints and PHSO Cases

In 2023/24, 45 cases were re-opened for further local resolution / comment compared with 31 in 2022/23. Complaints were re-opened due to the complainants disagreeing with the original investigation findings and actions (despite, in 26 cases, the complaint having been upheld or partially upheld), or because they were seeking further clarification.



There were eight complaints opened with Parliamentary and Health Service Ombudsman (PHSO) for consideration of independent investigation, which was a 38% decrease from the 13 opened in 2022/23

However, following the PHSO's consideration of the documentation provided by WUTH, not all complaints for which details are requested then proceed to detailed investigation; thus, five of these cases were later closed. Of the remaining three cases, at the time of writing, one has been confirmed as proceeding to a detailed investigation.

Four cases that had been opened in previous financial years were also, during 2023/24, confirmed by the PHSO to have been closed without detailed investigation.

These low numbers suggest that, despite WUTH's lengthy response times, its final letters are in the main providing comprehensive and fair responses to formal complaints.

Five PHSO cases completed detailed investigation. One of these was not upheld; the other four were partially upheld. The four were as follows.[2] In all cases, the PHSO's recommendations were subsequently completed by the Trust.

Women's and Children's (19/171 – previously partly upheld by WUTH)	The patient had complained that she had been given insufficient information before agreeing to a caesarean section, about poor communication with her and her partner by staff, and that her pain had been insufficiently managed during her labour. She stated that these failings had contributed to post-natal depression, and she wished for an apology and financial remedy. The PHSO upheld WUTH's clinical and complaints management, but a gap in the clinical records meant that the PHSO was unable to

[2] Comparative PHSO data for local NHS trusts are as follows (Source: Complaints about the NHS in England, 2020–21). More recent data is not available.

Organisation	Complaints Received	Accepted for Detailed Investigation	Uphold rate (upheld or partly upheld)
NHS Hospital, Specialist and Teaching Trusts (Acute)	8095	292	59%
Alder Hey Children's NHS Foundation Trust	26	1	0%
Countess of Chester Hospital NHS Foundation Trust	22	3	33%
Liverpool Heart and Chest Hospital NHS Foundation Trust	5	1	100%
Liverpool University Hospitals NHS Foundation Trust	53	3	100%
Liverpool Women's NHS Foundation Trust	8	0	0%
Mid Cheshire Hospitals NHS Foundation Trust	17	1	0%
Southport and Ormskirk Hospital NHS Trust	33	1	100%
St Helens and Knowsley Teaching Hospitals NHS Trust	14	0	100%
The Clatterbridge Cancer Centre NHS Foundation Trust	7	0	0%
The Walton Centre NHS Foundation Trust	19	0	0%
Warrington and Halton Hospitals NHS Foundation Trust	24	0	0%
Wirral University Teaching Hospital NHS Foundation Trust	25	3	100%

	establish whether the patient's pain had been well managed at all times. The PHSO therefore recommended an apology for this gap and a payment of £100 in respect of the patient's distress.
Acute Care (20/048 – previously partially upheld by WUTH)	The patient's daughter had complained that between 31 July 2020 and her father's death on 1 August 2020: • given his cancer diagnosis, clinicians had unnecessarily sent her father for an abdominal X-ray. • Clinicians had transferred her father to another ward, which was not appropriate as he was unfit to transfer; and had transferred him without oxygen, which he needed; • clinicians had not prescribed her father enough fluid, given that he had sepsis; • her mother had needed to beg clinicians for an hour for permission to see her father in the ED; • staff had not allowed the family to visit her father, despite the fact he was deteriorating and likely to die soon; • staff had not communicated her father's deterioration to family and had told them he had a reversible illness; • clinicians were insensitive in the way they approached the issue of a DNACPR with her mother; and • the ED consultant was rude to her when she enquired about her father. Although the PHSO's findings mirrored those of the Trust (the care had also been subject to a rapid review via the Trust's SI Panel), greater assurance was needed around the actions then taken by the Trust in response to those findings. These actions were: • To share the patient/family's story with ED staff, taking a formal approach that sufficiently acknowledged the failings and the impact, to help ensure the staff benefit from its learning. • To engage ED staff in sepsis refresher training, specifically including guidance on fluid administration. • To pay financial redress of £500 to the patient's widow to put right the failures of inadequate visiting access and poor communication that caused the family significant distress because they could not be with the patient when he died.
Medicine (21/037 – previously partially upheld by WUTH)	This case related to a patient's care on Ward 33 in March and April 2021. The patient claimed that he did not receive appropriate post-COVID-19 treatment and raised issues about nursing attitudes and care. He also complained about the way the Trust handled communication with him and his family during his admission. Although the PHSO identified a delay in the patient being administered the prescribed antibiotics, this delay was not considered to have been detrimental to the patient's treatment, and it was considered that the Trust had already acted appropriately via its response to put right this failing. The report also identified a delay in staff actioning the patient's concerns about a chest infection, although the report also concluded

	that had the patient's concerns been escalated, given his clinical observations at that time, an earlier review by a doctor would unlikely have been a priority. However, because the Trust had not specifically apologised for the emotional impact caused by the failure to escalate, a specific apology was recommended and subsequently provided.
Women's and Children's (21/009 – previously not upheld by WUTH)	The patient's mother complained that there had been a delay in diagnosing and treating her son's meningitis, and that the Trust's response to her complaint had been dishonest. The PHSO endorsed the Trust's complaint response that there had been no delay in diagnosis and treatment and found that the clinicians' actions had been in line with the relevant guidance. However, the PHSO's radiology advisor believed there to have been a discrepancy on the child's head MRI scan that had not been acknowledged in the Trust's complaint response. Although this had not impacted management and treatment, the PHSO suggested that there was potential learning. The recommendation on which the complaint was partially upheld was that the Trust should conduct a discrepancy assessment on the MRI scan and the complainant be advised of the outcome. This discrepancy assessment was subsequently undertaken. It was concluded that the scan report had been reasonable, and that the queried finding was in fact normal in children of the patient's age group. As such, the finding would not necessarily receive comment in a paediatric radiology report. Nevertheless, in addition to the discrepancy assessment described above, the patient's mother was advised that the MRI scan would be shown in the Radiology Department's REAL (Radiology Education and Learning) Meeting in July 2024, to allow for shared learning of how fluid may look in paediatric brains.

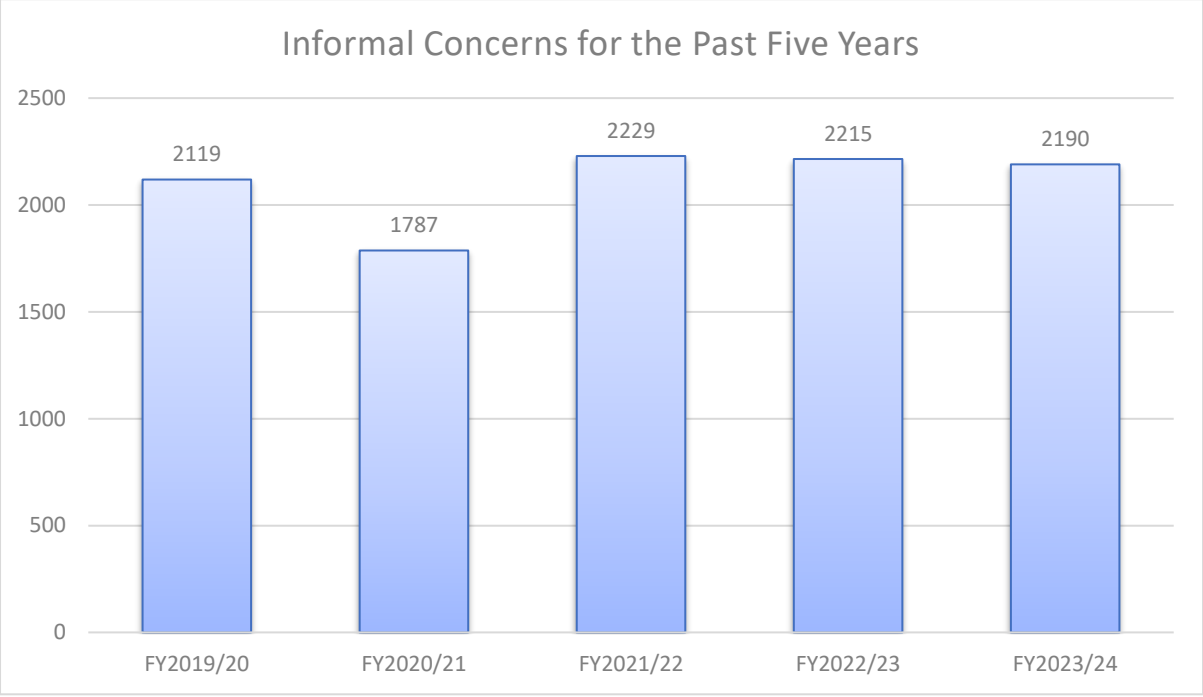
Complaint Demographics

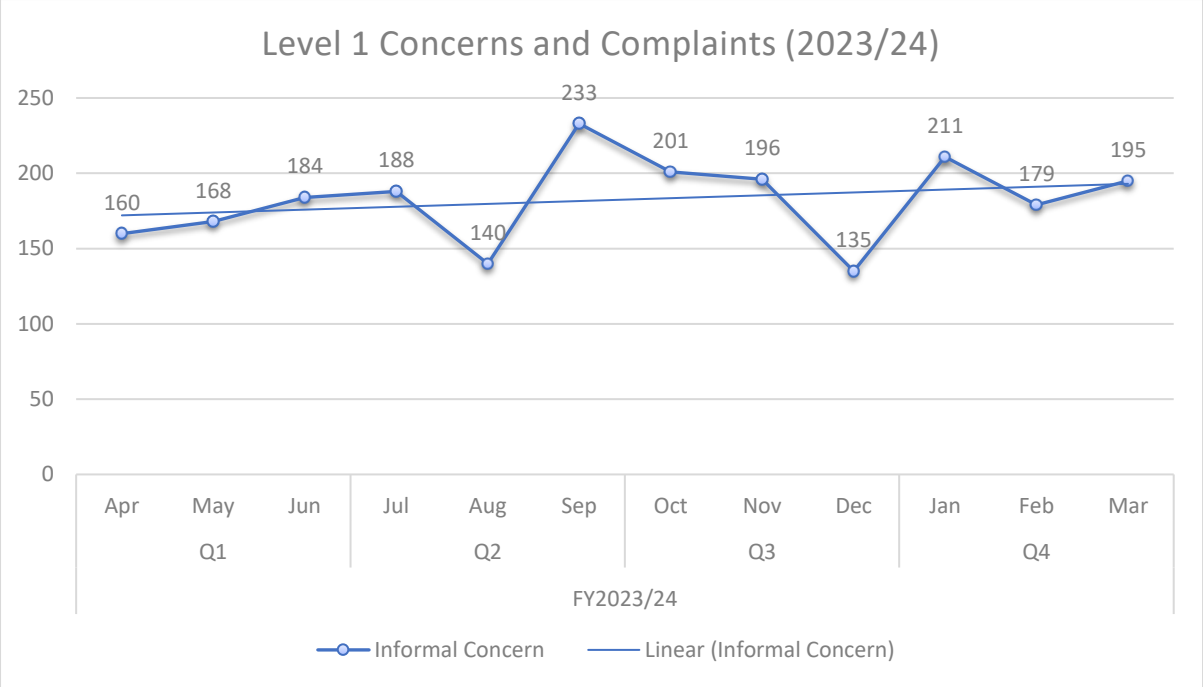
Complaints raised on behalf of another	**55%**	
Ethnic group of patient	**45%**	Not Recorded
	7%	Not Stated
	48%	White – British
Sex of patient	**25%**	Not Recorded
	45%	Female
	30%	Male
Age range of patient	**0–17**	12%
	18–35	4%
	36–53	11%
	54–71	18%
	72–89	29%
	90+	13%

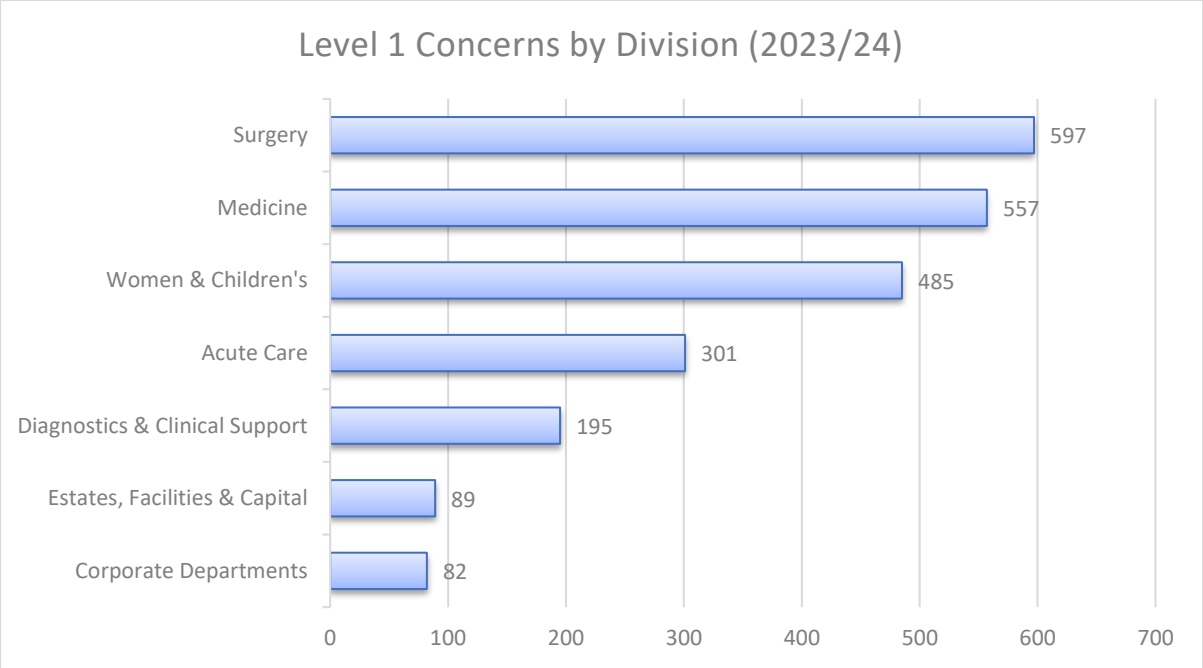
Level 1 (Informal Concerns)

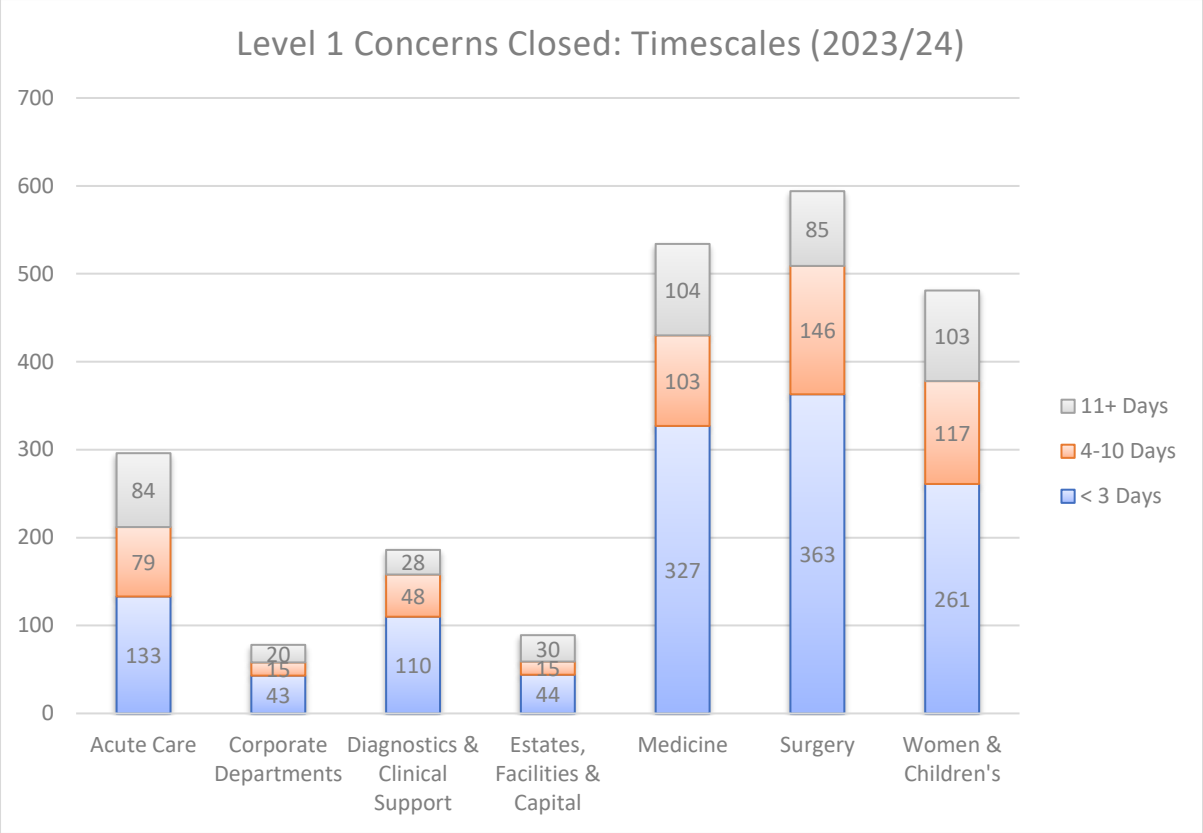
WUTH received a total of 2190 informal concerns relating to its services in the financial year 2023/24. This was a 1% decrease from 2022/23 (when 2215 were received).

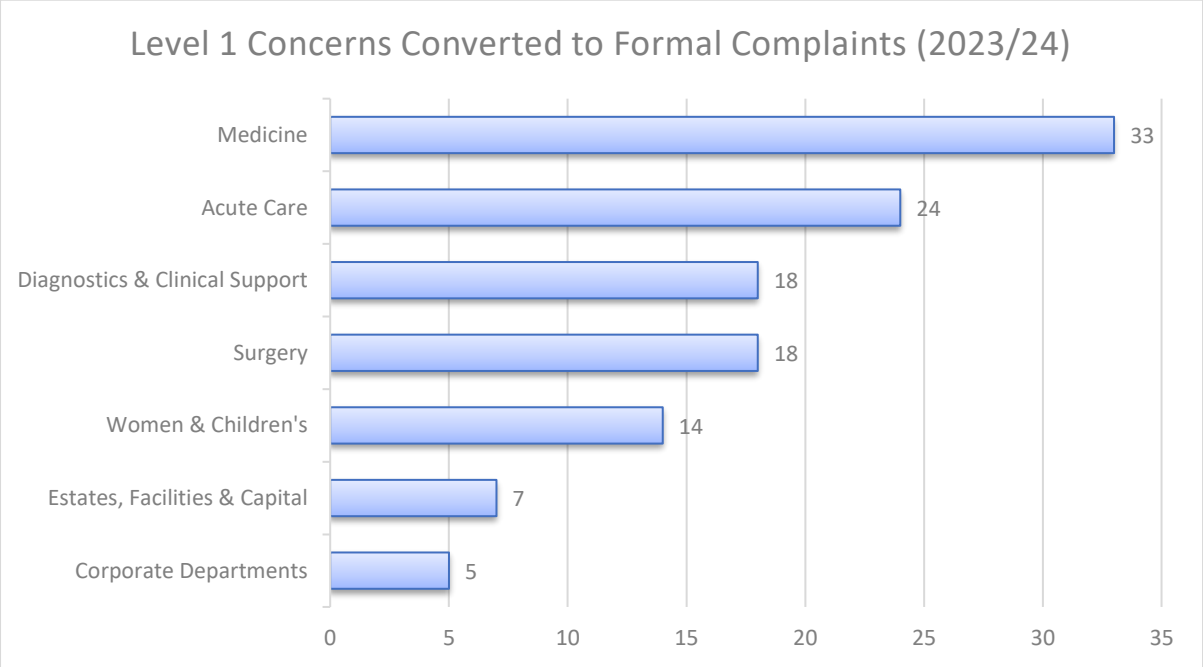
Of these, 71% were resolved within three working days and 89% within ten working days. Average resolution time was five working days, while 42 cases subsequently became formal complaints.

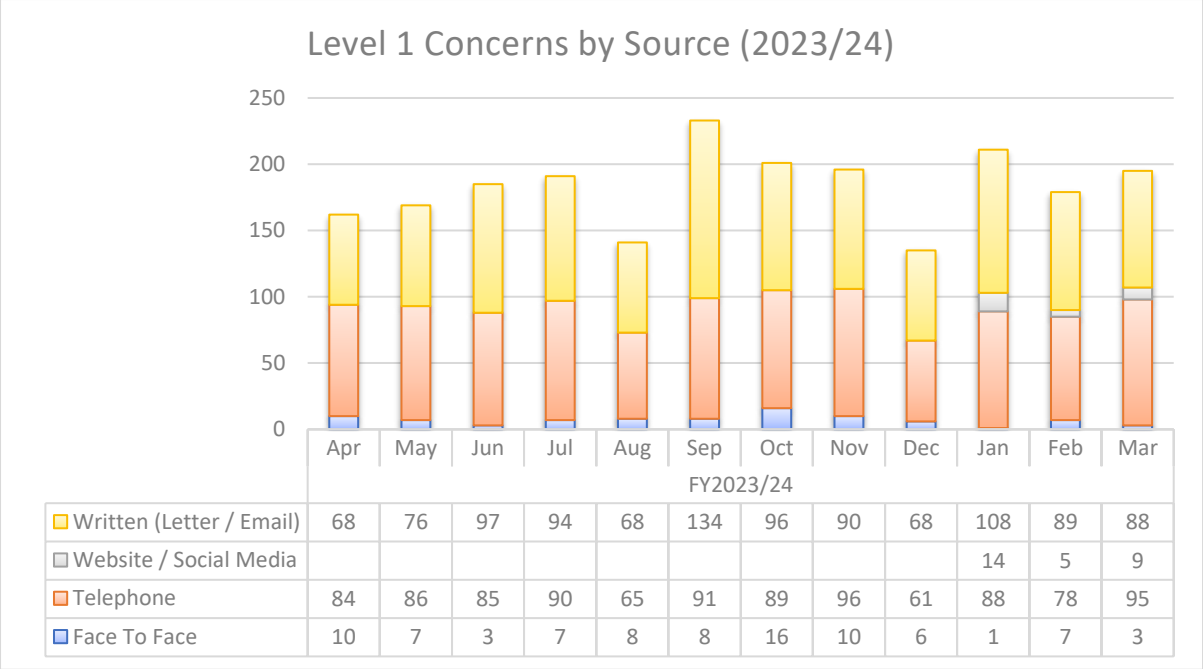



Level 1 Concerns and Complaints (2023/24)
250
200
150
100
50
0
160
168
184
188
140
233
201
196
135
211
179
195
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Q1
Q2
Q3
Q4
FY2023/24
Informal Concern
Linear (Informal Concern)


Level 1 Concerns by Division (2023/24)
Surgery
597
Medicine
557
Women & Children's
485
Acute Care
301
Diagnostics & Clinical Support
195
Estates, Facilities & Capital
89
Corporate Departments
82
0
100
200
300
400
500
600
700


Level 1 Concerns Closed: Timescales (2023/24)
700
600
500
400
300
200
100
0
84
79
133
20
15
43
28
48
110
30
15
44
104
103
327
85
146
363
103
117
261
Acute Care
Corporate Departments
Diagnostics & Clinical Support
Estates, Facilities & Capital
Medicine
Surgery
Women & Children's
11+ Days
4-10 Days
< 3 Days


Level 1 Concerns Converted to Formal Complaints (2023/24)
Medicine
33
Acute Care
24
Diagnostics & Clinical Support
18
Surgery
18
Women & Children's
14
Estates, Facilities & Capital
7
Corporate Departments
5
0
5
10
15
20
25
30
35



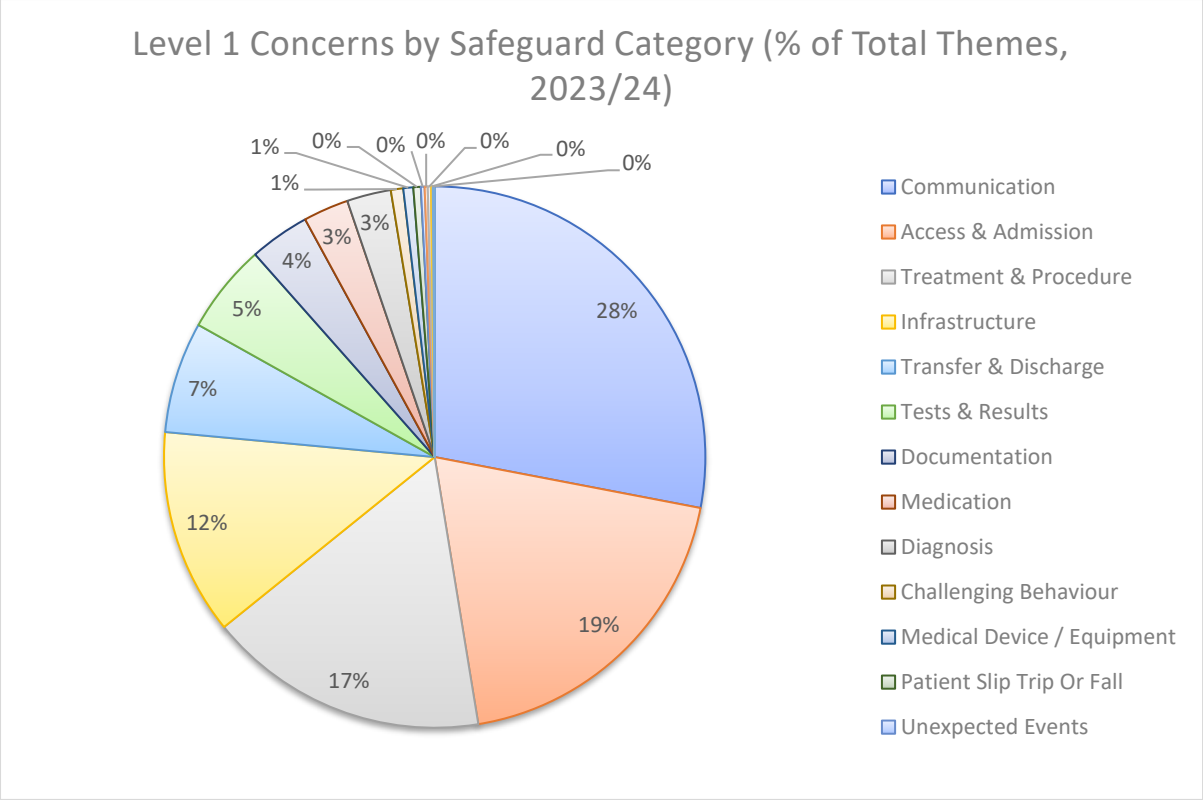
'Communication' remained the highest reported category of concern, comprising 28% of total themes and featuring in 703 cases (32%). In the main, this was a communication failure with a patient or relative, and nursing and medical staff attitude.

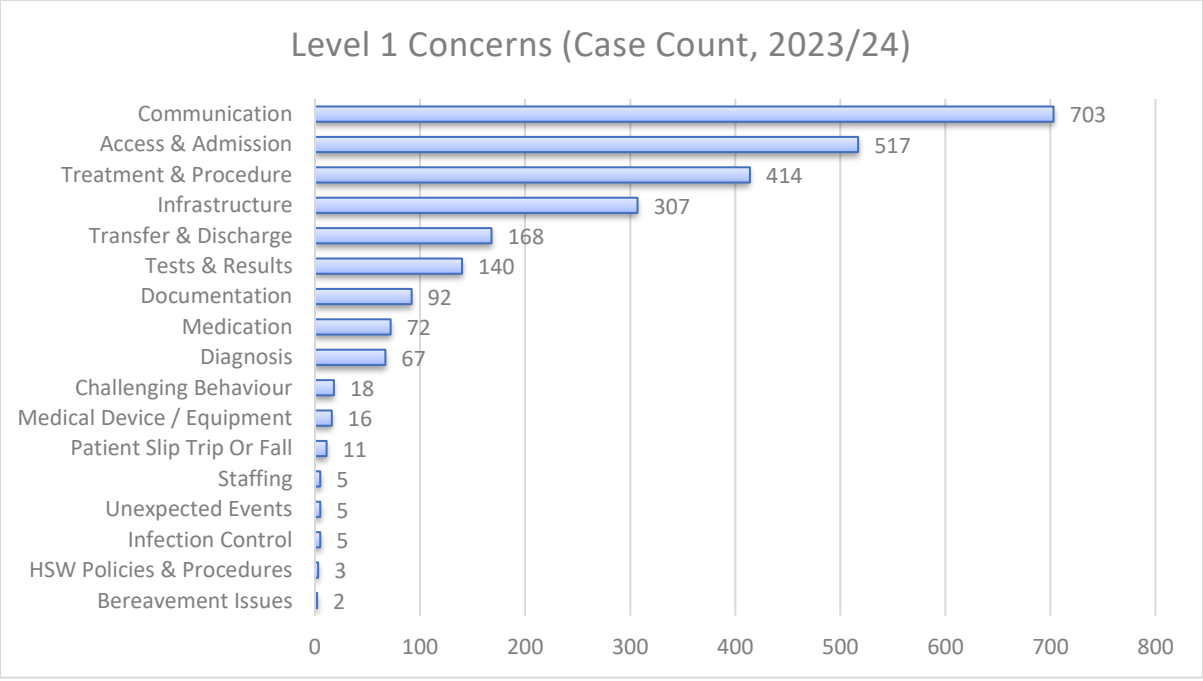
'Access and Admission' comprised 19% and featured in 517 cases (24%). In the main this was cancelled or delayed inpatient and outpatient appointments.

'Treatment and Procedure' comprised 19% and featured in 414 cases (19%). These were around delays, but also featured sub-categories such as failure to assist with hygiene or feeding, pressure ulcers, and end-of-life care).

'Infrastructure' comprised 12% and featured in 307 cases (14%). In the main (37%), this was difficulty contacting departments by telephone and lost property (27%). Car parking (charges and lack of spaces, and lack of disabled spaced) also comprised 17% of this category.

'Transfer and Discharge' (inappropriate or delayed) comprised 8% and featured in 168 cases.

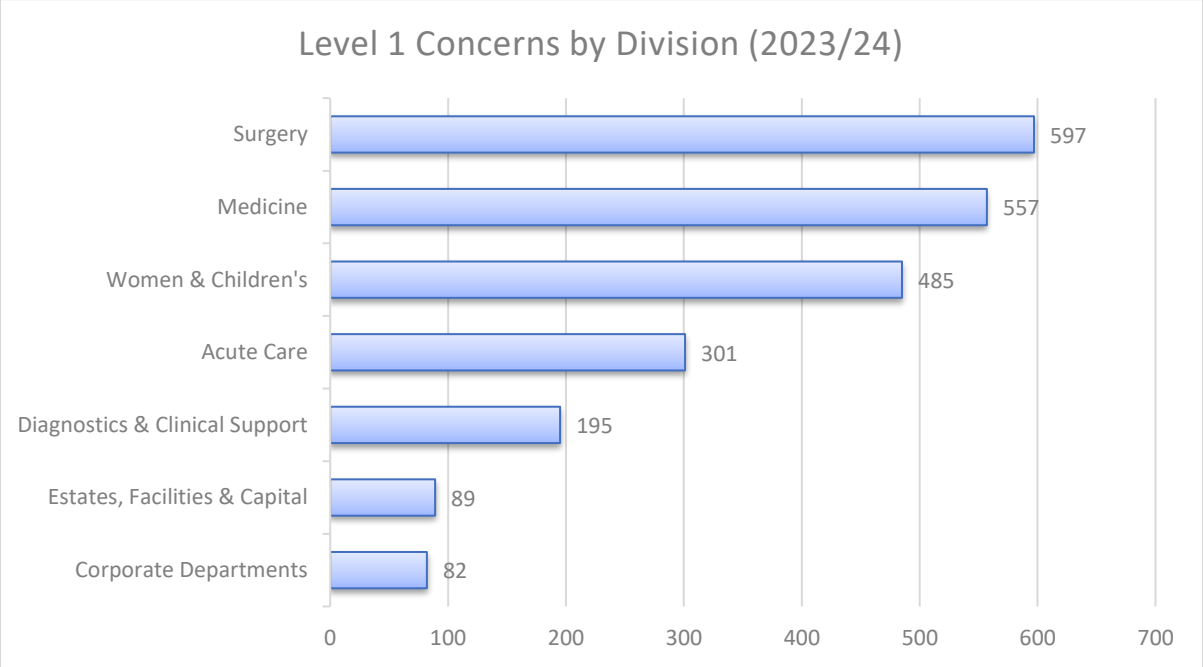




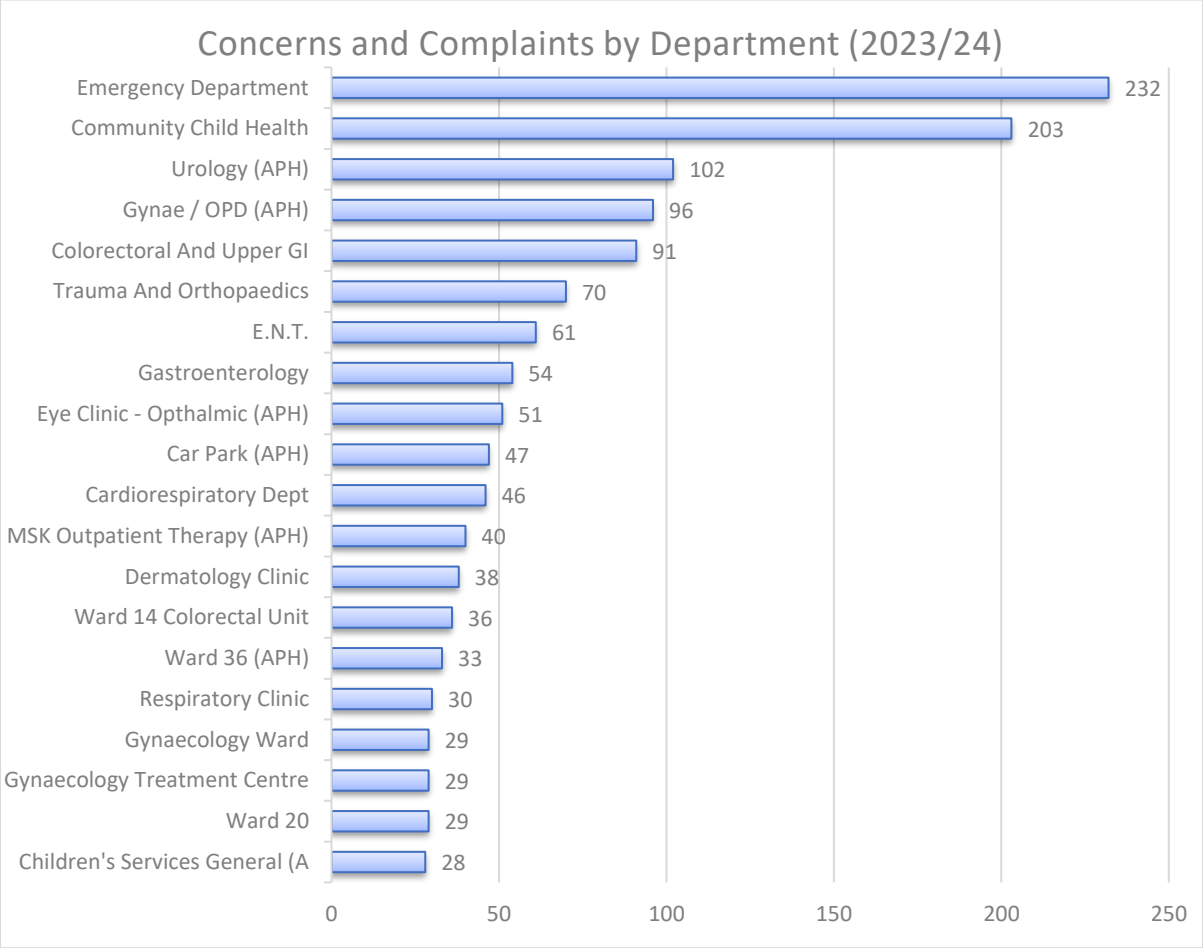
Category	FY2019/20	FY2020/21	FY2021/22	FY2022/23	FY2023/24
Communication	747	708	1229	1126	703
Access & Admission	572	334	266	340	517
Treatment & Procedure	347	257	302	266	414
Infrastructure	215	229	212	254	307
Transfer & Discharge	185	150	104	114	168
Tests & Results	100	107	95	134	140

Category	FY2019/20	FY2020/21	FY2021/22	FY2022/23	FY2023/24
Documentation	90	44	45	58	92
Medication	67	48	50	62	72
Diagnosis	38	27	36	47	67
Challenging Behaviour	20	10	13	18	18
Medical Device / Equipment	14	12	15	16	16
Patient Slip Trip or Fall	13	11	7	9	11
Infection Control	9	41	14	3	5
Unexpected Events	3	1	3	2	5
Staffing	5	6	4	2	5
HSW Policies & Procedures	9	17	7	1	3
Bereavement Issues		1	2	3	2
Patient Accident	4	3	2		

Surgery received the most concerns (involved in 597 cases), followed by Medicine (557), Women and Children's (485), Acute Care (301), Diagnostics and Clinical Support (195), Estates, Facilities and Capital (89), and Corporate Departments (82).



The top 20 areas to receive a concern are shown in the following chart.



For the ED, ‘Communication’ was an element in 32% of cases. ‘Treatment and Procedure’ and ‘Infrastructure’ (mostly lost property) were two other big elements, at 28% and 20% respectively.

‘Access and Admission’ (waiting times) comprised 61% of concerns raised about Community Child Health.

For Urology, 43% of its concerns involved ‘Access and Admission’, and 27% ‘Treatment and Procedure’ – both delays in service access and treatment.

For Gynae OPD, 47% of its concerns involved ‘Access and Admission’, with ‘Communication’ involved in 23%, and ‘Treatment and Procedure’ in 22%.

For Colorectal and Upper GI, 44% of concerns were around ‘Access and Admission’, 21% around ‘Treatment and Procedure’, and similarly 21% around ‘Communication’.

Conclusion

Although the complaints process at WUTH is performing well against those performance indicators that fall to the Patient Experience and Executive teams to fulfil (i.e. acknowledgement and registration of complaints, and drafting, approval and sign-off of final responses), the Trust’s overall performance against its 40-working day response target remains poor. Despite an improved response time (from 70 to 60 working days), the number of complaint investigations completed has fallen during the twelve months.

The bulk of delays remain with the clinical divisions, which are not providing timely responses per the internal deadlines, and the responses then provided in the first instance not always covering all the issues raised in an evidence-based way.

For multi-divisional complaints, despite a push for one division to take the lead and to involve and coordinate the other divisions as stakeholders, this approach remains unadopted. Instead, investigations remain fragmented and 'siloed', with the PET then coordinating the disparate information. Even within a single division, it has not always been apparent that the investigation has been centrally coordinated, with individual responses (i.e. nursing and medical) being returned separately to the PET by several 'leads'. This has then necessitated further work and revision, to ensure an evidenced final response with clear leaning and actions where appropriate. All that said, because of a strong process of quality assurance and review, the final responses are comprehensive and robust, with any subsequent PHSO investigations then tending to mirror the Trust's findings.

Next Steps for 2024/25

- The divisions that consistently received the highest number of concerns and complaints were Surgery, Medicine, Acute Care, and Women and Children's, indicating the need for targeted interventions in these areas.

- The thematic categories of concerns and complaints in 2023/24 remained similar to previous years, with 'Communication' being the most prominent issue. This highlights the importance of addressing communication failures with patients, visitors, and relatives, as well as improving the attitudes of nursing and medical staff.

- Additionally, 'Access and Admission' and 'Treatment and Procedure' delays remained significant areas of concern and complaint, emphasising the need for process improvements and measures to reduce waiting times in most departments, with Community Child Health featuring particularly highly.

- Divisions need to consider how they can provide assurance as to how actions and learning from complaints are being followed up / tracked.

- Divisions need to adhere to policy by appointing single lead investigators who can then coordinate with individual staff.

- Divisions need to clarify and consider staff support processes and provide assurance of the same.

- To improve the quality of divisional investigations and response timeliness, the PET will continue to provide monthly investigation and response training sessions to senior management divisional teams. This were instituted in February 2024, with 15 senior staff having received training before year-end.

- While investigation delays continue, the PET needs to maintain focus on keeping complainants updated during the investigation of their complaints, particularly around anticipated delays.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 12**

02 October 2024

Title	Safeguarding Annual Report 2023/2024
Area Lead	Sam Westwell, Chief Nurse
Author	Karolyn Shaw, Associate Director of Nursing for Safeguarding
Report for	Information

Executive Summary and Report Recommendations

The Safeguarding Annual Report provides an overview of the national and local context of safeguarding and the current Trust position by providing assurance that the Trust is meeting its statutory obligations and national safeguarding standards.

Analysis of the annual safeguarding activity including progress made against the objectives set out in the Safeguarding Annual Report 2022/23 and an overview of the Trust safeguarding priorities for 2024/25.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key risks:

- Trust Risk 612 - PVP mandatory training is a statutory requirement for the organisation and remains under the mandatory 90% compliance rate
- Trust Risk - 0221 - FGM screening Cerner – FGM routine enquiry is currently only asked in Maternity and Gynecology services
- Trust Risk 1366 – Oliver McGowan Mandatory Training (OMMT)

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes

Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
September 2024	Quality Committee	As above	As above
August 2024	Patient Safety Quality Board	As above	As above

1	Narrative
1.1	The report provides an end of year position of compliance against the following areas: 1. Protecting Vulnerable People (PVP) training against the target of 90% 2. Safeguarding Assurance and Accountability Framework Key Performance Indicators 3. Care Quality Commission updates 4. Trust safeguarding activity 5. Learning Disabilities and LeDeR (learning form lives and deaths) **Key successes summary during 2023/24:** • Identification of Child protection Information System (CP-IS) champions within the Women's and Childrens division to support improvements in compliance, inclusive of monthly meetings, re-training and development of competency checklists. • Improved position for CP-IS compliance in Emergency Department, Children's ward and Paediatric Assessment Unit from last year. • Request for the Trust to be part of the 2nd phase of the National pilot for the HOPE boxes (Hold on Pain Eases) which will focus on specialist maternal mental health and wellbeing support. • Improved data collection for safeguarding themes and trends for children attending the Emergency Departments (ED) and sharing to Wirral Safeguarding Childrens Partnership to contribute and support system wide improvements. • Development of a multiagency Microsoft Teams Channel (tracker) in collaboration with Childrens Social Care and Wirral Community Trust to improve completion of timely statutory Initial Health Assessments (IHAs) across the system. This initiative will go live in 2024/25. • Development of a Pre-Birth Liaison tracking system developed in collaboration with Childrens Social Care (CSC) to proactively monitor and provide assurance that timely actions and risk assessments are completed supporting effective plans ahead of baby being born. • Streamlining of processes that now support the divisional ownership to monitor, track safeguarding actions and improvements through the Ulysses system. • Increase in Deprivation of Liberty Safeguards (DoLS) applications, improved quality and timelessness of DoLS applications by staff, this improvement year on year demonstrates that staff have a good understanding of their responsibilities for statutory DoLS applications. (86.5%) of DoLs applications were completed within 3 days of admission or from point of identifying deprivation from last year (79.6%). • Introduction of electronic Independent Mental Capacity Advocate (IMCA) referral within the patient electronic record, this notifies both Wirral Advocacy Hub and the Trust Safeguarding Team to support timely responses and monitoring.

	• Development of 3 Mental Capacity Act (MCA) bit sized Vodcasts as well as several educational resources and bespoke sessions provided for staff to utilse in addition to mandatory training. • The Lead Nurse for MCA undertook a review as the author of the current missing policy to ensure it reflected the requirements for the Right Care Right Place (RCRP), now renamed as 'Patients who walk out of healthcare due to be published in Q1 2024/25. Support has also been provided to the Deputy Chief Operating Officer in the development of a supporting educational package for staff regarding RCRP. • Completion of the outstanding CQC action (2019) to ensure that all children and young people receive care and treatment from suitably trained medical and nursing staff in line with national guidance. The 24hr paediatric Emergency Department was opened 19 February 2024 which also included the recruitment of registered nurses. • Protecting Vulnerable People (PVP) compliance has remained a challenge throughout the year. Progress has been impacted due strikes across all disciplines during the year however the divisions have been able to hold their positions with only minimal decrease in compliance. Q4, below, figures provide overview of each PVP level from end of year position 2022/23 to 2023/24: Level 1 improvement from 94.35% to 90.96% (3.39% decrease) Level 2 improvement from 90.58% to 87.86% (2.27% decrease) Level 3 improvement from 89.64% to 85.05% (4.59% decrease) Level 4 improvement from 90.55% to 82.91% (7.64% decrease) • Review and realignment of safeguarding vacancies within the safeguarding team for 2 combined Safeguarding and Complex Care Practitioners to provide a more robust and flexible service within the Trust. Recruitment to take place during Q1 2024/25. • Full embedment of the new Safeguarding Assurance and Accountability Framework (SAAF) reporting to the ICB inclusive of commissioning standards (Self-assessment) completed in Q3. The Trust received positive feedback from the ICB highlighting it an example of good quality and assurance. • Completion of 16 Structured Judgment Mortality Reviews, 12 identified good care and 2 find excellent care. The remaining cases identified learning that was shared across the Trusts steering groups to steer improvements in identified areas. • Oliver McGowan Mandatory Training (OMMT) proposal presented to Education Governance to roll out training in 2024/25. • Evidence that staff have a good understanding and awareness of 'Think Family Approach' and professional curiosity in the wider context continues to be evidenced through referrals across all areas.

2	**Implications**
2.1	**Patients** • The commitment by the organsation to safeguarding supports patients during those times of need and when unable to raise concerns advocate on their behalf. There is a recognition of equality, diversity and inclusivity and this is recognised as part of making safeguarding personal, inclusion of reasonable adjustments, translation services and capturing the voice and lived experience of patients. • The Annual report provides assurance of steps taken for complex care mainly Learning Disabilities and Autism which also supports trust wide workstreams

	which support mandatory training (Oliver McGowan) and addressing equality, diversity and inclusivity inclusive of reasonable adjustments (Equality Act 2010).
2.2	**People** • The Safeguarding Annual Report demonstrates the commitment from the organisation to the Safeguarding Adults Partnership Board and Wirral Safeguarding Childrens Partnership agendas. These partnerships/boards place statutory duty on all NHS Trusts to ensure organisational policy and practice is in place to safeguard and promote the welfare of vulnerable adults and children. Multiagency partnership working is a driver for all safeguarding work streams and the subgroups of the boards are represented by the statutory named roles within the organisation where there is focus on system wide collaboration which as shared vision to protect and safeguard and support all patients, visitors and staff from harm and abuse.
2.3	**Finance** • Whilst the Safeguarding agenda has no specific financial direct costs outside of cost of staff employment the potential indirect costs that a of breach of contract, failure to comply with statutory requirements or litigation if the organisation fails to discharge its responsibilities could prove significant.
2.4	**Compliance** • The Safeguarding Assurance and Accountability Framework (SAAF) sets out clearly the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations. The responsibilities for safeguarding form part of the core functions for each organisation and therefore assurance regarding compliance of safeguarding responsibilities is provided to Cheshire and Merseyside ICB on a quarterly basis. This includes compliance of Initial Health Assessments for Children Looked After, Safeguarding Mandatory Training, Mental Capacity Act and Prevent (The Counter Terrorism and Security Act (2015) and various other legislative KPIs included within the Care Act 2014 and The Children Act (1989).

Contents

Glossary

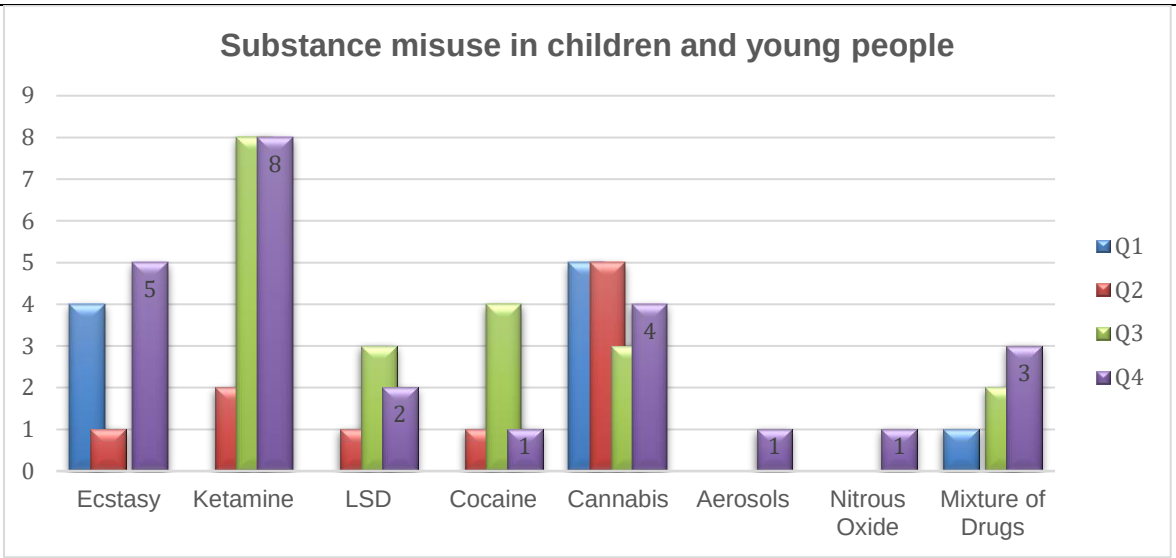
ACE	Adverse Childhood Effects
ADNS	Associate Director of Nursing for Safeguarding
AMA	Adoption Medical Advisor
BI	Best Interests
CDOP	Child Death Overview Panels
CSPR	Child Safeguarding Practice Review
CLA	Children Looked After
CMICB	Cheshire and Merseyside Integrated Care Board
CP-IS	Child Protection information sharing
CQC	Care Quality Commission
DNA	Did Not Attend
DoLS	Deprivation of Liberty Safeguards
ED	Emergency Department
FGM	Female Genital Mutilation
IFD	Integrated front door
IHA	Initial Health Assessments
IDVA	Independent Domestic Violence Advisor
HV	Health visitors
KPI	Key performance indicators
LA	Local Authority
LPS	Liberty Protection Safeguards
MAR	Multi Agency Referral
MARAC	Multi Agency Risk Assessment Conference
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
NOK	Next of Kin
NRLS	National Reporting and Learning System
OPD	Outpatients Department
PBL	Pre-Birth Liaison
PiPoT	People in Positions of Trust

PVP	Protecting Vulnerable People Training
PSQB	Patient Safety Quality Board
RPR	Relevant Persons Representative
RRM	Rapid Response Meeting
SAG	Safeguarding Assurance Group
SARs	Safeguarding Adults Reviews
SIRG	Serious Incident Review Group
SJR	Structured Judgement Review
SOP	standard operating procedure
SUDIC	Sudden Unexpected Deaths of Child
WSAPB	Wirral Safeguarding Adults Partnership Board
WISE	Wirral Individual Safe Care Every Time Accreditation Programme
WLSSG	Wirral Local Safeguarding Strategy Group
WRAP	Workshops to Raise Awareness of Prevent
WSCP	The Wirral Safeguarding Children Partnership

1	Background and Statutory Legislation
1.2	**Introduction** Wirral University Teaching Hospital NHS Foundation Trust, thereafter, referred to as the Trust, is committed to ensuring that the safeguarding of our patients, their families, our staff, and our communities is at the foundation of our 'Together we will' Trust values. We strive to improve and build upon the safeguarding practices we offer by promoting the Trust ethos that safeguarding is everyone's business in the drive to continuously make improvements to the service we provide. The term "safeguarding" covers everything that assists unborn, children, young people, and adults at risk to live a life that is free from abuse and neglect, which enables them to retain independence, wellbeing, dignity, and choice. Safeguarding encompasses prevention of harm, exploitation, and abuse through provision of high-quality care, effective responses to allegations of harm and abuse that are in line with multi-agency procedures. Importantly safeguarding embraces the use of learning to improve services for our patients, their families, and carers. The Trust Safeguarding team continues to provide a range of activities to support key areas of safeguarding work, embrace change and respond to emerging themes both local and nationally and strive to ensure all safeguarding processes are robust and effective. The team safeguarding structure and further definitions have been elaborated on in appendix 1 and 2. Effective safeguarding of adults, young people, children and unborn is heavily reliant on the development of robust professional relationships and multi-agency working arrangements. This can only be effective when all staff are knowledgeable, confident, and equipped with the skills to deal with process and procedures when concerns arise relating to safeguarding and patient safety. There is a culture of 'Think Family' that is embedded throughout the Trust as it is recognised that unborn, children, young people, and adults do not exist or operate in isolation of one another. This report provides assurance that the Trust is fulfilling the duties and responsibilities in relation to promoting the welfare of children, adults and families who come into contact with our services. This report reflects the high level of activity across all work streams to improve internal and multi-agency processes and build on existing systems and procedures. We continue to strive to further improve and achieve strong compliance against all our safeguarding standards internally and externally to safeguard the most vulnerable in our society.
1.3	**Statutory Framework and National Policy Drivers** Whilst safeguarding shares the same agendas and principals for adults and children, there are significant differences in the laws and policies that shape how we safeguard these groups. The legal framework to protect children is contained in Working Together to Safeguard Children (2020) and the Care Act 2014 for adults. However, the overarching objective for both is to enable children and adults to live a life free from harm, abuse, or neglect.

	The Children Act (1989) and Section 11 of the Children Act (2004) places a statutory duty on all NHS Trusts to make arrangements to ensure that it has regard for the need to safeguard and promote the welfare of children when exercising its functions. The statutory guidance 'Working Together to Safeguard Children (2018) supports the multi-agency safeguarding arrangements set out in the Children and Social Work Act (2017). The Care Act 2014 set out a clear legal framework for how local authorities and other agencies should protect adults at risk of abuse or neglect. The focus is on personalised and outcome focused care with an emphasis on making adult safeguarding 'personal', Adults should therefore be seen as experts in their own lives and safeguarding means working 'with the adult' and not a process that is done to or for an adult. Trust Safeguarding policies, procedures and training are up to date with current child and adult safeguarding legislation and includes new LSCP definitions and arrangements and how the Trust discharges its statutory safeguarding duties in relation to: • Children Act (1989, 2004) • Children and Social Work Act (2017) • Working Together to Safeguard Children (2020) • Promoting the Health and Well-being of Looked after Children (2015) • Safeguarding Adults at risk in line with the Care Act (2014) • The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007 • The Domestic Abuse Act (2021) • The Counter Terrorism and Security Act (2015) • CQC Regulation 13: Safeguarding service users from abuse and improper treatment
1.4	**Safeguarding children** **Wirral Safeguarding Children Partnership** The Wirral Safeguarding Children Partnership (WSCP) is led by three statutory partners Local Authority (LA), Police, and Cheshire and Merseyside Integrated Care Board (ICB). Structure can be found in appendix 3. The Children Act (1989) and Section 11 of the Children Act (2004) in conjunction with Working Together to Safeguard Children (2018) places a statutory duty on all NHS Trusts to ensure organisational policy and practice is in place to safeguard and promote the welfare of children. **Section 11 audit** Section 11 audit is monitored through the WSCP and provides evidence of effective safeguarding arrangements by demonstrating compliance with relevant legislation, provides evidence of reflective practice, identifies areas of good practice, and highlights organisational development and improvement. Collectively the review of organisation section 11 and cross triangulation of other areas of intelligence can enable local partnership developments to be identified. **Multi agency reviews** There has been a total of 3 chronology requests for children and their families from WSCP, one Child James met threshold for a Child Safeguarding Practice Review (CSPR). Child James suffered serious harm from one parent following alleged child sexual abuse offences, and concerns about the familial sexual abuse of James. This

	case highlighted the importance of documenting multiagency case recordings of significant safeguarding and family events on all siblings' electronic records. Trust awaits further updates regarding the other 2 chronologies requested to ascertain if they meet threshold for either a local learning review or CSPR. **Trust Position** • The Trust is represented at the WSCP by the Associate Director of Nursing for Safeguarding, Named Nurse for Safeguarding Children and Children Looked After, and the Named Midwife for Safeguarding the unborn. • In 2023/24 19 child deaths were recorded, compared to 12 in the previous year. 15 cases required management via the Sudden Unexpected Death in Infants and Children (SUDIC) process. 4 cases were due to poor health outcome/medical conditions and were expected compared to 5 cases in 2022/23. • The increase in Q3 and Q4 was due to 6 infant deaths that occurred (age from 3 days to 49 days). A thematic review was undertaken by Women and Childrens Division which identified: ➢ six cases 5 were living with some element of socioeconomic deprivation/austerity ➢ 5 of the 6 babies were noted to be found in parents' bed at time of death. ➢ Learning identified a need to standardise and strengthening safer sleeping advice to parents and families, inclusive of documentation of the assessment of home conditions both antenatal and postnatal periods. This includes a visual assessment of the sleeping conditions for babies when advising upon safe sleeping practices. • All deaths are reviewed at Child Death Overview Panel (CDOP), the CDOP lead represents the Trust at this multi-agency panel. • 24,584 children attended the Emergency Department (ED) during 2023/24 which is an increase of 403 children from 2022/23. Consistently 93% of all 16/17yr had status recognised as a child (until their 18th birthday). The outstanding 7% have been identified as those children who have booked into ED and left prior to any assessments of treatment. • 734 of those children attending ED for medical treatment were open to Children's Social Care (CSC) either via a child in Need (CiN) plan, Child Protection (CP) plan or a Child Looked After (CLA) which required information sharing with partner agencies. • Data continues to be collated regarding children attending ED following an assault and is shared via WSCP Quality Assurance Performance Committee and Harm outside the Home Committee (formerly contextual safeguarding). In 2023/24 there had been a total of 131 children who had attended ED following an assault, 93 children were males and 28 females and in 12 cases a weapon was used with knife/machete being the most used weapon on 4 separate occasions. • The total number of children between the ages of 12-17yrs attending ED for substance misuse has increased by 50% in Q3 and Q4 with 45 attendances compared to 20 cases in Q1 and Q2. There has been an increase in the use of ketamine with children and young people due to the availability, and cost of this drug. The health implications of this drug have already been noted throughout the Trust with children attending with ketamine bladder which is irreversible. 75% of the children attending for substance misuse were male.



Children and Young People - Mental Health
Trust Position

- Mental health and well-being of children and families continue to be a focus for all agencies within the WSCP. In 2023/24 615 children attended ED with concerns for their mental health and well-being, information continues to be shared via the ED Liaison Coordinator with agencies to offer further support. A breakdown of themes can be seen below, and a quarterly breakdown can be found in appendix 4:
  - 182 attended following an overdose
  - 101 for self-harm
  - 173 for low mood
  - 159 children expressing feeling suicidal
- Named Nurse Safeguarding Children and CLA represents the Trust at the task and finish group led by the Harm Outside the Home Team and the Missing's Coordinator from Merseyside police, with an aim to develop a notification process which informs police of missing children presenting to the ED with mental health concerns. This will support police to apply appropriate risk assessments when responding to this vulnerable group of children/young people. Moving into 2024/25 representation from the Acute division will be required to embedded processes within ED.
- Further mental health workstreams for children are ongoing both internally and externally including with the LA (Integrated Front Door and Emergency Duty Team), Cheshire and Wirral Partnership (CWP) all with the shared vison to develop standardised processes when a child attends ED on a Section 136 or with mental health concerns.

Child Protection Information Sharing

Trust Position

- Child Protection Information Sharing (CP-IS) compliance continues to remain challenge and a priority requiring improvement. Responsibility for the quarterly monitoring and reporting of CP-IS data was handed over to the divisions (Q4) who are required to provide assurance of CP-IS compliance as part of their divisional reports to the Safeguarding Assurance Group (SAG).
- Below illustrates the annual compliance (%) of those areas who are utilising the system:

Ward/Area	Annual % compliance
Emergency Department (inclusive of CED)	85.5% (improved position)
Children's ward (including Day case)	93% (improved position)
Paediatric Assessment Unit	86% (improved position)
Children's Outpatient Department	98% (no change)
Maternity	26% (data collection commenced Q1)
Gynaecology Ward (inclusive of GAU/EPU/Day case)	26.4% (data collection commenced Q1)
Gynaecology outpatient department	6% (data collection commenced Q1)
Neonatal Ward	35% (data collection commenced in Q3)

- During 2023/24 the Safeguarding Specialist Nurse for Children and Unborn (lead for CP-IS) requested that the Women and Children's division identified CP-IS champions to support training, act as advisors for CP-IS and provision of assurance that CP-IS is embedded within their ward/departments. Quarterly CP-IS Champions meetings are held by the CP-IS lead every quarter to allow for opportunities to discuss progress and or barriers in their areas.
- A refresh of CP-IS training was delivered within the Women and Children's and ED division which included the development of a competency checklist for staff to be signed off as competent.
- Maternity and Gynaecology now have the facility for CP-IS data to be reported via the BI portal ensuring more robust data collection and reporting of compliance.

1.5 **Children Looked After (CLA) and Initial Health Assessments (IHAs)**

Children coming into care must have a high-quality initial health assessment (IHA) within 20 working days of becoming a Child Looked After (CLA). The Trust has a statutory and contractual responsibility to provide this service. Assurance of compliance is monitored via the quarterly Safeguarding Accountability and Assurance Framework (SAAF) data submissions against a set of key performance indicators (KPIs) which cover Adults, Children and CLA.

Trust Position

- Delays continue in receiving referrals from the LA outside of the agreed 48hrs time scale which subsequently impacts on the Trust's ability to complete within the statutory timeframes. Monthly escalation reports are completed to the LA and the Designated Nurse for Children and CLA. As a result of these delays the Trust continues to remain below the statutory compliance rate of 100%.
- Further delays have been identified through the process of quality assurance due to partial or no information regarding the child's birth history or family history being provided by the LA.
- Collaborative work with the LA continues, during 2023/24 work has progressed to a joint health and social care Microsoft team's tracker to monitor and audit the IHA process. This is in final stages and staff obtaining access and will be in place for Q2 2024/25. This tracker will support wider multi agency collaborative improvements and it is hoped to provide significant improvements and better outcomes for those children who are looked after.

1.6	**Unborn** The Wirral Pre Birth Liaison meeting (PBLM) is a pathway to share information to develop a coordinated plan to safeguard children and unborn babies; this multiagency group is chaired by the Trust's Named Midwife. The main purpose is to obtain multiagency information and develop a support plan for the unborn. The threshold and criteria are women who are known to services, for reasons such as safeguarding, mental health issues, substance misuse and those who disclose any form of domestic abuse. • 130 referrals were submitted for consideration to PBLM by midwives (140 in 2022/23), 115 met the criteria/thresholds to progress (130 in 2022/23). The most consistent reasons for referrals into PBLM were previous social care involvement followed by known domestic abuse concerns. • The Trust were invited to partake in the 2nd phase of the 'HOPE (Hold on Pain Eases) Boxes' national pilot in collaboration with Silver Birch, this focuses on specialised maternal mental health and wellbeing support to support mothers with associated trauma of having their baby removed from their care. This is collaboration with midwifery services providing the HOPE boxes and referring the patient to Silver Birch. Phase 1 saw the embedment of the HOPE boxes within maternity and social care within Wirral evidencing innovation and excellent partnership working to support families affected by such separation. • The Named Midwife has been instrumental in working in partnership with Social Services to streamline and create a Pre-Birth tracking system which will monitor and provide assurance that all required actions are completed. This proactive system supports management of risk and ensures robust plans are in place for when the baby is born. This will go live in 2024/25.
1.7	**Safeguarding Adults** The Care Act (2014) states that adult safeguarding is established as a core function of every LA's care and support system. The Care Act sets out the statutory framework for safeguarding adults. The Care Act (2014) requires each LA to have a Safeguarding Adults Board (SAB) with core membership from the LA, police, NHS, alongside members from other emergency services, probation services and the voluntary sector. One of SAB's key functions is to ensure that policies and procedures governing adult safeguarding are fit for purpose and can be translated into effective adult safeguarding practice. The Wirral Safeguarding Adults Partnership Board (WSAPB) has the primary responsibility to ensure that adults in Wirral, who may be at risk, are able to live fulfilling lives, free from abuse and neglect. The WSAPB has a statutory responsibility to monitor and evaluate what is done by partner agencies individually and collectively to safeguard and promote the welfare of adults who live in Wirral (appendix 5). The WSAPB meets quarterly with 2 development days a year with members representatives of agencies across Wirral, including representation from the Trust by the Associate Director of Nursing for Safeguarding. The Named Nurse for Safeguarding Adults represents the Trust at the 4 WSAPB subgroups. The WSAPB works collaboratively with 3 other adult boards across Merseyside to undertake work in relation to Safeguarding Adult Reviews (SARs). During the annual reporting in the year 2023/24 the Trust were requested to provide information for 8 SAR

considerations, none of which met the thresholds as SARS. The Merseyside SAR group has not commissioned any new SARs since March 2023. The Trust has continued to support in 3 MARS commissioned last year. Findings and learning will be shared across agencies to provide assurance of actions taken to improve practice once finalised, any learning for the Trust will be monitored via the SAG.

Trust Position

- During 2023/24 there have been no legislative changes in policy or guidance in respect of safeguarding adults.
- The Safeguarding Team received 590 referrals in 2023/24 which is consistent with previous years, 214 referrals were shared with Adult Social care (ASC) and 78 were progressed to further statutory section 42 enquiry.
- Compliance of staff following correct policy and procedure when referring an adult at risk to ASC has continued throughout the year. Compliance remains low at 53% (113/214), where both adult MAR form and safeguarding notification incident form via Ulysses are required. However, despite this 80% of the concerns were raised directly to ASC at the point concerns were identified. Further work is required to improve the incident reporting internally.
- As a requirement of the SAAF a quality audit of safeguarding referrals was completed during Q4, this highlighted key successes which included: 88% of referrals were raised with ASC at the time concerns were identified, 81% of referrals all contained relevant information and due to the criteria checklist in place the Trust were able to prevent inappropriate referral being sent top ASC. Areas requiring improvement are being monitored through action plans via the Named Nurse.
- External concerns raised against the Trust directly from the ASC continue to be managed through the governance divisional leads using the safeguarding rapid review template. Oversight is provided by the Named Nurse for Safeguarding Adults with any learning identified, and subsequent actions monitored by the divisions involved. Themes and trends are reported through the Quality & Patient Safety Intelligence Report feeding into the Patient Safety and Quality Board (PSQB) for wider learning and assurance.
- In 2023/24 72 externally raised concerns against the Trust were received. 31 (43%) were closed as initial enquiries following review by Safeguarding with no identified concerns. 27 (37.5%) were raised as a clinical incident for the appropriate divisions to review and 14 (19.5%) progressed to a statutory safeguarding section 42 enquiry which is an increase from 15% in 2022/23.
- Themes throughout 2023/24 included discharge and/or poor care concerns. Over 80% of concerns were discharge related issues such as package of care provision/arrangements, general poor communication which also included poor communication of skin condition and/or wound care advice.
- S42 enquiries are required to be completed within 28 days in keeping with statutory framework, therefore divisions are expected to complete reviews within 7 days. During 2023/24 a total of 14 statutory section 42 enquires were initiated and 10 were completed within the required 7-day timeframe. The outstanding reviews were delayed due to a variety of reasons which included coroner involvement, completion of a Rapid Evaluation of Care and finally capacity to identify leads to complete reviews.
- Named Nurse for Safeguarding Adults has worked alongside the Governance Support Unit (GSU) to ensure reports can be created through Ulysses, a standard operating procedure (SOP) was developed and disseminated for this purpose. The reports will assist all divisions in providing and monitoring safeguarding

	performance and addressing areas that require improvement as part of assurance reporting to the SAG.
1.8	**The Mental Capacity Act (2004) and Deprivation of Liberty (2007)** The Mental Capacity Act (2005) (MCA) protects and empowers individuals who are unable to make decisions for themselves. It applies to everyone working in health and social care providing support, care, and treatment to people aged 16 and over who live in England and Wales. The five principles of the MCA are: • Assume a person has the capacity to make a decision themselves, unless it's proved otherwise. • Wherever possible, help people to make their own decisions. • Don't treat a person as lacking the capacity to make a decision just because they make an unwise decision. • If you make a decision for someone who doesn't have capacity, it must be in their best interests. • Treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms. The MCA allows people to express their preferences for care and treatment, and to appoint a trusted person to make a decision on their behalf should they lack capacity in the future. Any individual is deemed to lack capacity to make a decision if they are unable to: • Understand the information relevant to the decision • Retain that information • Use or weigh up that information as part of the process of making the decision The MCA (2005) allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards are needed if restraint and restrictions are used to deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards (DoLS). In April 2023, the Department of Health and Social Care (DHSC) provided an update that the implementation of LPS would be delayed beyond the life of this Parliament, however feedback will be provided of the consultation by DHSC in due course. In the meantime, DoLS remain an important system for authorising deprivations of liberty, and it is vital that the Trust continues to make applications in line with the MCA 2005 to ensure that the rights of those who may lack the relevant capacity are protected. There have been no further updates. **Trust Position** • Trust policy is in place 'Role of the Mental Capacity Act 2005 in Acute Healthcare – policy reference 237' and will be reviewed in February 2025 and amendments have also been made to the electronic MCA template following changes due to case law and are due to go live during 2024/25. • Trust policy for Deprivation of Liberty Safeguards – policy reference 217 is in place and will be reviewed in December 2025, changes have also been made to the DoLS application form via Ulysses supporting easier documentation for staff. • A total of 2695 referrals were received for 2023/24 an increase of 382 compared to 2022/23 (2313).

- 2248 referrals were processed as DoLS 7-day urgent authorisations and standard applications which was an increase of 242 compared to 2022/23 (2006). 216 received an extension to the urgent authorisation. Only 2 standard authorisations were approved and received from the Supervisory Body (LA) 1568 patients DoLS expired prior to DoLS no longer being required, with an average of 18 days deprivation of liberty being unauthorised.
- 3 referrals were made for patients under 18 years who were being deprived of their liberty and 2 were progressed by the LA and approved at family court for a Court Approved DoL and the remaining child was discharged.
- 447 (16.6%) applications were not progressed to standard applications due to either duplicate application, discharged prior to the referral being valid or within 24 hours of receiving it, fluctuating/regained capacity, application of a mental health section used or due to relevant case law. This is an increase from last year by 140. (307). Duplicate and discharged patients was the most common theme. (Appendix 6).
- Statutory 7 day urgent and standard DoLS applications are made by staff via the Ulysses incident reporting system. Quality assurance of all DoLS applications inclusive of MCA and Best Interests (BI) is completed by the Lead Nurse for MCA. The below chart highlights the compliance percentages for DoLS applications by staff, improvements in compliance are noted. (see below chart).

DoLS application compliance	**20/21**	**21/22**	**22/23**	**23/24**
*RPR details included (NOK details)	61%	61%	66.8%	78.3%
*RPR booklet provided	56.4%	57%	59%	68.6%
DoLS applications requiring further information	n/a	**70%	58%	47.7%

*Identification and consent for a Relevant Persons Representative (RPR) and provision of a RPR booklet (statutory obligation) informing the RPR of their duties/responsibilities. **DoLS applications requiring further information data commenced in August 21.

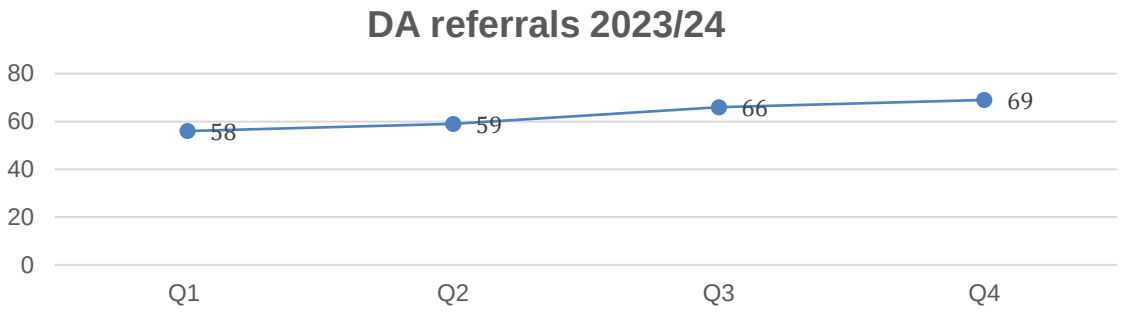
Best interest (BI) completion for DoLS MCAs continues to be 100%, 3.8% (86) of BI documentation are delayed being completed on average for 1.8 days, delaying DoLS from being valid.

- Delayed DoLS applications are monitored on a case-by-case basis. There are no other known organisations that monitor this KPI, and the trust internal practices exceed the requirements to measure when a delay occurs. Monitoring of this KPI during 2023/24 has enabled the Trust to understand a position of compliance for DoLS applications and accepted risk as highlighted below:
  - 86.5% (1946) of DoLS were received either within 3 days of admission or when a deprivation of liberty was identified further into the patient's journey in 2023/24, a slight increase from 2022/23 (79.6% -1598).
  - Deep dives are completed for delayed applications and if a valid reason to mitigate the delay is not identified then a clinical incident report is completed for significant delays and learning shared.
- Further improvement was identified to move from a manual process to digital, enabling direct monitoring of patient DoLS restrictions/capacity status via Cerner. This data collection is a requirement to support the yearly data set request for the NHS England's Learning Disabilities Improvement Standards National Survey moving forwards. This was requested and continues to await completion. The team continue to share expiry dates and restrictions with senior nurse management and request updates of any changes via daily email.

	• A cleansing exercise was commenced during 2023/24 to revert live DoLS flags within Cerner to inactive once patient has been discharged, regain capacity, or sectioned under Mental Health Act (MHA) providing further clarity and ability to view live status of inpatients. • Themes pertaining to MCA/DoLS compliance continue to be monitored and education and learning shared for identified areas requiring improvement, these can be seen in Appendix 7. • Numerous educational and development tool have been made available for all staff including: ➢ A wide range of bespoke MCA training sessions and educational briefs have been offered and provided throughout the year highlighting learning from Trust cases, inclusion of MCA within physical Intervention training, Lasting Power of Attorney/Advanced decisions, Refusal of medications/treatment and restrictive practices including bed rails, consent, and supervision inclusive of documentation requirements. ➢ Partnership working with divisional Clinical Practice Facilitators, Corporate Patient Safety and Harms Prevention, Continence Care, Medicines Management and Leads for DNACPR to ensure MCA continues to remain on their agenda. ➢ 3 MCA vodcasts have been developed and within Q3 have been made available along with other educational resources/links on the staff intranet following the Safeguarding Resources and Education being developed. • There is representation by safeguarding at the weekly Patient Safety Incident Response Framework meetings providing expertise to any incidents including MCA and represented at the Mental Health Transformation Group/subgroups to ensure an MCA oversight continues to be embedded into practice. • Lead for MCA has been supporting with the introduction of Right Care Right Person within the trust and embedding within the Patients who Walk Out of Healthcare (previously missing patient) Policy – due to go live in Q1 2024/25 • During Q2 changes were made to improve the process and oversight for Independent Mental Capacity Advocates (IMCA). Referrals are now completed via electronically via Cerner and notifies both Wirral Advocacy Hub and the Safeguarding Team which also provides audit trail of IMCA usage. This has resulted in MCA advice and support being offered by the safeguarding team for those patients requiring IMCA involvement. IMCA knowledge and awareness continues to be audited via WISE accreditation and has constantly remained above 95% since its improvement plan in Q2.
1.9	**The Counter Terrorism and Security Act (2015)** The threat of terrorism continues locally, nationally and globally and the strategy aims to ensure that the UK has the best response to the heightened threats from terrorism moving forwards. CONTEST is the framework that enables the government to organise work to counter all forms of terrorism and has four key components: • Pursue - to disrupt terrorist activity and stop attacks • Prevent - to stop people becoming or supporting violent extremists and build safer and stronger communities • Protect - strengthening the UK's infrastructure to stop or increase resilience to any possible attack • Prepare - should an attack occur then ensure prompt response and lessen the impact of the attack

	The NHS and its partners have a role in the 'PREVENT' section of this strategy. Whilst the Trust continues to be a non-priority site, the reporting mechanism is required via NHS Digital and via the SAAF to CMICB. The Counter Terrorism and Security Act (2015), places a specific duty on statutory bodies including the police, LA's and health organisations to have 'due regard' to help prevent people being drawn into terrorism. The Channel process (a standardised voluntary multi-agency programme for people at risk of radicalisation) is a legal requirement for public bodies across the country. **Trust position** • Trust policy 'PREVENT Policy and Guidance protecting those who are vulnerable to exploitation and radicalisation through a multi-agency approach' (policy reference 305) is in place; and was reviewed and ratified in September 2023. • The Trust monitors the number of Channel Panel requests for information received, this changed part through the year from CMICB to directly from Merseyside police PREVENT department. • The Trust received 24 requests for information to be shared with the Channel panel during the year, 16 for children and 8 for adults, 6 of these were for routine 6/12 monthly reviews. • 1 case required escalation for a radicalisation concern and this referral was appropriately completed by the trust to the Counter Terrorism unit. Feedback highlighted that the outcome was no current concern identified. • Quarterly data submissions for Prevent continue to NHS Digital and via the SAAF to CMICB; this includes referral numbers and training data. • Prevent mandatory awareness and Workshop to Raise Awareness of Prevent (WRAP) training continues as part of all levels of PVP training. The Department of Health and Social Care has set compliance for Prevent at 85%. Compliance is monitored via PVP through the SAG and PSQB, the Trust has finished 2023/24 is a positive position and have achieved compliance for all levels of Prevent training.
1.10	**The Domestic Abuse Act (2021)** The Domestic Abuse Act (2021) aims to ensure that victims have the confidence to come forward and report their experiences, safe in the knowledge that the state will do everything it can, both to support them and their children and pursue the abuser. Most of the provisions in the Act will be brought into force by commencement regulations, once the necessary preparatory work has been completed, for example, the making of court rules or the issue of guidance. **Trust Position** • Domestic abuse and harmful practices are included across all levels of PVP training which supports staff in the completion of risk assessing victims of domestic abuse. • The Trust has 2 policies in place; 1 to support staff with patients and 1 for support for staff that may experience domestic abuse: ➢ Domestic Violence and Abuse policy reference 035 was reviewed in 2023/24 ➢ Domestic Abuse Workplace Policy: Support for Staff policy reference 344 was reviewed in 2023/24

- The Trust has an identified lead for Domestic Abuse and Harmful Practices (Named Midwife for Unborn) and supports both patients and staff following any disclosures or concerns.
- In 2023/24 the Safeguarding Team received 252 referrals (a slight increase) relating to domestic abuse in comparison to 247 in 2022/23, a steady increase has been noted throughout the year.



- In 2023/24 4 members of staff were supported by the Safeguarding team following disclosures of domestic abuse which was a small decrease in comparison to 5 staff members in 2022/23.
- The domestic abuse routine enquiry questions were embedded within Cerner in 2019/20, prompting all patients 16yrs and above to be given the opportunity to disclose concerns to staff. Compliance of this question is monitored through daily IT reports and using the WISE audit programme. Compliance within ED continues to require improvement and is monitored by the division and reported into the SAG. There has been minimal improvement throughout the year and a request for an improvement plan has been made to the division to ensure that this action is met and maintained.
- The domestic abuse CAADA-DASH risk assessment is embedded within Cerner supporting practitioners to identify high risk cases of domestic abuse, stalking and honour- based violence. This assessment assists decision making of identifying high risk cases requiring referral to MARAC (Multi Agency Risk Assessment Committee) and enables support mechanisms to be identified. The Trust have referred 36 cases of high-risk domestic abuse victims into MARAC in 2023/24.This is a slight increase from 33 cases in 2022/23.
- The Trust has contributed towards 5 Domestic Homicide Reviews (DHRs) in Wirral. Reviews are first discussed at a consideration panel to determine if the concerns met threshold for a full review. The reviews await approval from the Home Office and publication, identified learning specific to the Trust will be shared, implemented and monitored through the SAG and mandatory/bespoke training.

Harmful Practices

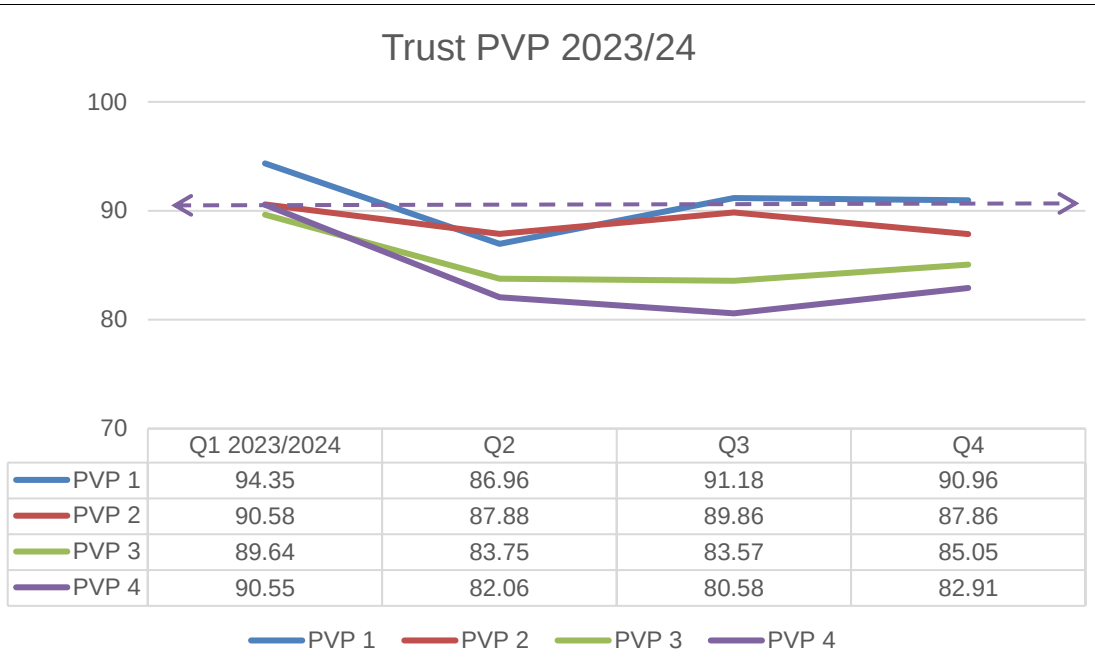
Harmful traditional practices are forms of violence which have been committed, primarily against women and girls, in certain communities and societies for so long that they are considered, or presented by perpetrators, as part of accepted cultural practice. They have often been embedded in communities for a long time and are born out of community pressure. The most common forms of Harmful Practices are:

- forced or early marriage
- so called ‘honour’ based violence
- female genital mutilation or cutting (FGM).

	Trust Position • 24 referrals relating to identified cases of Female Genital Mutilation (FGM) were received throughout the year, 15 were identified by midwifery services at the point of women booking into midwifery care and 8 were identified through gynecology services in comparison to 2 referrals in 2022/23. 1 referral was also received from ITU where staff noted an FGM safeguarding alert on patient's records. There has been an overall increase for the last 3 years from 12 cases in 2021/22 and 18 cases in 2022/2023. • The Lead for Domestic Abuse requested an IT build for the Department of Health FGM risk assessment to be added to Cerner. This action was completed in 2023 and the completion of the DOH risk assessment is now evident in the patients' records for those who disclose FGM. • Consultation remains ongoing with the Urology department in respect of the implementation of the FGM routine enquiry questions, it is proposed to be embedded within specific areas however this has been delayed due to the requirement of an IT build. There remains an expectation for the Urology department to have this completed in 2024/25. This action remains on the risk register until implementation is completed and embedded in Urology. • No referrals have been received for harmful practices outside of FGM during the year.
1.11	**People in Positions of Trust (PiPOT) (Staff allegations)** All incidents or allegations of abuse are taken seriously by the Trust and are treated in accordance with WSCP and WSAPB procedures. **Trust position** • Allegations against staff continue to be raised to the Safeguarding team following the People in Positions of Trust (PiPOT) policy and process. 68 were received during 2023/24, 5 more compared to 2022/23. • Allegations that do not require safeguarding involvement are managed via the divisions and/or Human Resources. Regular bi-weekly meetings continue to monitor progress of any cases to ensure all required actions have been completed. • Any allegations requiring safeguarding reporting processes to be initiated are also reported to the Designated Nurse/Professional Lead for Adults/Children and to the Local Authority Designated Officer (LADO) for children's concerns. • Staff allegations data and information is reported via the Quality and Patient Safety Intelligence Report into PSQB for wider learning and assurance. • Following the conviction of Lucy Letby neonatal nurse Countess of Chester Hospital the ADN for Safeguarding provided the Executive Board with a bespoke overview of the People in Positions of Trust processes in December 2023 providing assurance that the Trust has robust processes in place. • The responsibility, management and coordination of staff allegations was handed over to the Trust divisions in October 2023 whereby Safeguarding are invited to each fact find as part of the membership to determine if the PiPOT criteria is met and initiate any required safeguarding actions. This will be audited during 2024/25 for compliance and shared via the Safeguarding Assurance Group.

2	Inspections/Reviews
	Care Quality Commission (CQC) of Health Services for Children Looked After (CLA) and safeguarding across Wirral – May 2019 (update) Ensure children and young people receive care and treatment from suitably trained medical and nursing staff in line with national guidance for emergency paediatric care (CQC Safeguarding Wirral Wide Action Plan 2019). The business case for the integration of Children's ED and Paediatric Assessment Unit (PAU) was successfully completed and the 24hr Paediatric ED opened 19 February 2024.This transformation work included the recruitment of registered nurses with the appropriate paediatric training to care for children in the ED and now means that the Trust meets national standards ensuring children are cared for by appropriately trained staff in a suitable environment 24/7 with revised extended opening of PAU. Monitoring and assurances will be reported quarterly to the SAG by the Women's and Children's division.

3	Protecting Vulnerable People Mandatory Training (PVP)
	The Trusts PVP Strategy outlines the pathway for staff to access appropriate safeguarding education relevant to their role and competencies required written within the legislative framework and which reflects the findings and recommendations from the Safeguarding Children and Young People: roles and competencies for health care staff. Intercollegiate Document (2014) and the Safeguarding Adults: roles and competencies for health care staff Intercollegiate document (2018). **Trust Position** • PVP training level 1-3 is delivered through an eLearning package and the additional hours aspects of level 3 requirements set out in the safeguarding Intercollegiate documents is delivered as a face-to-face package (including MCA and DoLS). • The Trust did not reach the mandatory training compliance target of 90% for PVP by the end of the year 2023/24 for levels 2-4. However, the divisions have been able to maintain PVP compliance despite challenges faced during the strikes for Nursing, Medical and Clinical Support Workers throughout the year. • Divisionally 12 areas are noted to have achieved compliance at the close of 2023/24 with outstanding areas/levels all sitting all over 80% and above. Divisional compliance can be seen in the chart below:



Divisional position – Q4

Division	PVP 1	PVP 2	PVP 3	PVP 4
Acute	90.70	83.04	100	82.19
Surgery	86.43	92.08	86.81	90.00
Women's & Children	86.54	91.73	89.83	82.61
Medicine	90.58	80.43	80.56	N/a
Clinical Support	88.04	89.41	90.23	N/a
Corporate	93.28	90.00	88.33	100
Estates & Facilities	92.82	85.19	100	N/a

- Throughout the year visibility and bespoke training has continued to multiple departments and wards. Bespoke sessions are implemented for various reasons such as identified learning from incidents, lessons learnt following multi agency reviews, following WISE audit or requests made from managers.
- Assurance of safeguarding knowledge is monitored through WISE. 14 clinical areas have been audited during 2023/24 and the provision of bespoke training is completed in areas identified as requiring improvement. The average score for all audits completed during this period is 92.3% highlighting that staff have a good understanding and knowledge base for safeguarding and MCA (2005).

4 Governance Arrangements for Safeguarding

4.1 **Safeguarding Assurance Group (SAG) and Patient Safety and Quality Board (PSQB)**

The SAG provides opportunity for challenge and assurance regarding safeguarding arrangements within the Trust, monitor compliance and benchmarking with external standards, clinical effectiveness indicators including CQC outcomes and addresses any areas requiring improvement.

The SAG meets quarterly which allows for a defined and joint approach to safeguarding across all divisions within the Trust. The group has divisional representation alongside the named/lead professionals and is attended externally by the designated professionals

	for adults, children and CLA from the Cheshire and Merseyside ICB to allow scrutiny and oversight. SAG agenda includes the compliance with safeguarding standards, including the SAAF and mandatory safeguarding training compliance. The Associate Director of Nursing for Safeguarding provides a quarterly report into the PSQB and yearly annual report. Trust Governance structure arrangements are detailed in appendix 8. **Trust Position** • 4 SAG meetings were held during 2023/24 and subsequent chair's reports shared with PSQB by way of assurance and any required escalation.
4.2	**Safeguarding Accountability and Assurance Frameworks (SAAF) for Children, Children Looked After and Adults** The purpose of the SAAF is to set out clearly the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations, which is submitted quarterly. The responsibilities for safeguarding form part of the core functions for each organisation and therefore assurance regarding compliance of safeguarding responsibilities is provided to Cheshire and Merseyside ICB. Reporting began in Q1 on the new Cheshire and Merseyside SAAF commissioning standards which support a consistent approach to quality assurance. As part of the Q3 submission the Trust were required to complete the 2 yearly commissioning standards (Self-assessment). The Trust received positive feedback from the ICB highlighting it an example of good quality and assurance provision with an ask that this could be used as an exemplar for other organisations with permission. Compliance of the SAAF is monitored via the SAG and any areas of non-compliance are escalated when required to the PSQB.
4.3	**Safeguarding Incident Reporting** Safeguarding incident notifications are integrated into the Trust's Safeguard database to record all safeguarding incidents both internally and externally. Following receipt of the incident documentation received by the safeguarding team, it is recorded in Cerner to ensure all staff has access to all safeguarding information. The Safeguard system then automatically reports relevant safeguarding incidents to the National Reporting and Learning System (NRLS). Any alerts required are escalated to Cheshire and Merseyside ICB and the CQC as required. The Associate Director Nursing for Safeguarding or a deputy attends the weekly Trust's Patient Safety Incident Response Framework (PSIRF) meetings to provide safeguarding and MCA (2005) expertise, advice and overview of incidents presented. Clinical incident forms are completed by the safeguarding team for any concerns that do not meet the thresholds for statutory safeguarding investigations directly to the divisions to investigate and review for any potential gaps in processes outside of safeguarding.
4.4	**Safeguarding Supervision and Support** Safeguarding supervision is a term used to describe a formal practice of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance patient protection and safety in complex situations. There are 2 mechanisms for safeguarding supervision: • Advice on individual case management

	• Ensuring that those working with cases with safeguarding issues have sufficient knowledge, skills, and appropriate attitude. The requirement for Trust employees to have access to safeguarding supervision is explicitly stated in Working Together to Safeguard Children (2018): *"Effective practitioner supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support practitioners to reflect critically on the impact of their decisions on the child and their family."* The Care Act (2014) dictates the requirement for safeguarding supervision: *"Skilled and knowledgeable supervision focused on outcomes for adults is critical in safeguarding work. Managers have a central role in ensuring high standards of practice and that practitioners are properly equipped and supported. It is important to recognise that dealing with situations involving abuse and neglect can be stressful and distressing for staff and workplace support should be available."* **Trust Position** • Safeguarding supervision is provided to all health practitioners who hold safeguarding cases. • Safeguarding Supervision Policy – policy reference 247 is in place and is due to be reviewed in November 2024. • In line with recommendations from The Care Act (2014) safeguarding supervision sessions continue to be delivered via monthly drop-in sessions within the ED. This allows staff opportunity to access supervision for both adults and children. Records of supervision are recorded and kept securely by the safeguarding supervisors on a case-by-case basis. 98 members of staff have been recorded as being offered supervision, 19 member of staff accessed safeguarding supervision and 79 staff did not have any concerns/cases they wanted to discuss. • The safeguarding team use these opportunities to also educate staff, discuss safeguarding processes and promote training, CP-IS and domestic abuse questions. • ED Paediatric Peer Review continues to be delivered on a quarterly basis to share learning and identify how to improve practice. • The Trust Named professionals all access safeguarding supervision from Designated professionals and are 100% compliant with the agreed KPIs of the agreed SAAF. • In 2023/24 the Women and Childrens division maintained the management and responsibility in providing assurance regarding the compliance of safeguarding supervision for the division. This is reported at the SAG via divisional assurance report. The division have identified and trained additional supervisors to support improvement in compliance. The division have noted an improvement in 2023/24 but accept that this remains an area for further development to meet the required compliance**.**
4.5	**Complex Care** **Oliver McGowan Mandatory Training (OMMT)** Learning disability (LD) and autism training became a new legal requirement for CQC regulated service providers which came into force on 1 July 2022 (Health and Social Care Act 2022). The OMMT on Learning Disability and Autism is the government's preferred and recommended training for health and social care staff.

The training is named after Oliver McGowan, a young man whose death shone a light on the need for health and social care staff to have better skills, knowledge and understanding of the needs for autistic people and people with a learning disability.

The training is delivered in 2 Tiers. Staff need to complete either Tier 1 or Tier 2 and both tiers consist of 2 parts.
A proposal paper presented to Education Governance 09 February 2024, where a request was made to progress with the eLearning package and handbook as a starting point to implement the OMMT. A decision was made to escalate this to the Executive Board and to further explore, agree and seek approval for required next steps for OMMT within the organisation.

Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)
LeDeR is a service improvement programme for people with a learning disability and more recently autistic people. It was established in 2017 and is funded by NHS England and NHS Improvement.

The Objectives of LeDeR are to: Improve care for people with a learning disability and autistic people. Reduce health inequalities for people with a learning disability and autistic people. Prevent people with a learning disability and autistic people from early deaths.

A LeDeR review looks at key episodes of health and social care the person received that may have been relevant to their overall health outcomes. The reviewers look for areas that need improvement and areas of good practice.

LeDeR complete 2 types of reviews:

- Initial Review **-** completed for all deaths notified to the LeDeR programme for people with a Learning Disability or a diagnosis of Autism. It comprises GP records, family and multi-agency consultation and a review of the hospital mortality review where applicable. This review identified if there is a need for more in-depth focus review.
- Focus Review - focused review builds on the initial review requiring more detailed information about known health and social care involvement. Focus reviews will be undertaken when it is indicated there is learning from the life of the person to inform service improvements.

In 2023/24 LeDeR commenced quarterly forums facilitated by Cheshire and Merseyside ICB as a forum to share wider learning. This identified LeDeR were not meeting expected timescales to provide timely learning and feedback and have developed a work plan to make improvements during 2024/25.

Trust position

- There were 16 Structured Judgment Review (SJRs) mortality reviews completed in 2023/24, 12 were rated as good care, 2 found excellent care and 2 others identified organisational learning, areas included nutrition and hydration, MCA and documentation, catheter care and inconsistent repositioning. All identified learning was shared with the relevant steering groups to support improvements in practice.
- Deaths for those individuals with a diagnosis of learning disability and or Autism are reported by the Named Nurse for Safeguarding Adults into LeDeR.

	• During 2023/24 a decision was made combine the role of the Safeguarding Adults Practitioner and the Complex Care role vacancies, this incentive will provide the Trust with a more flexible service which is hoped to benefit the patients within our care. The roles plan to be advertised and appointed to within Q1 2024/25. • As part of Learning Disability week 2023/24 there was a focus on the launch of Health and Wellbeing Passport. The passport has vital information that supports our staff to identify any patients that may require any reasonable adjustments and what matters to them to provide the best possible care and experience. This was completed in collaboration with Wirral Mencap • As part of the patient experience strategy information videos for endoscopy and SEAL unit have been developed and launched as an informative and reassuring introduction to our hospital's facilities. • The Trust was shortlisted in the Learning Disabilities Initiative of the Year category of the HSJ patient safety awards for its Supporting Treatment in Additional-needs Requirements (STAR) Project. As part of the project, a sensory unit was opened in the SEAL unit to be set up specifically for adult patients with autism and additional needs, who are having planned surgery. • Coproduction with Mencap of a needle phobia video commenced in 2023/24 due to go live in 2024/25. • Named Nurse for Safeguarding Adults and Complex care has worked with Autism together and Mencap to produce sensory care bags for emergency admissions. The initiative is designed to offer comfort and reduce stress for people with autism and/or learning disabilities when attending the overwhelming departments. These bags are currently in the development stage and to be launched to the departments to pilot in 2024/25.

5	Looking forwards into 2024/2025
	Safeguarding remains a priority area of work for the Trust and this section defines the strategic priorities and work plan within safeguarding as we move forward into 2024/25. The strategic safeguarding aims related to the Trusts workforce are: • To improve compliance of the domestic abuse routine enquiry question being asked in ED as a direction of the Domestic Abuse Act (2022). • Continue to promote Domestic Abuse inclusive of harmful practices awareness in line with the partnerships Domestic Abuse Alliance strategy and agenda. • Moving forward in 2024/25 roll out of the system wide tracker collaborative to ensure further integration of IHA systems to reduce system delays in achieving statutory timeframes. • Reach the 100% compliance for supervision to ensure that all professionals are supported in their competence, assume responsibility for their own practice and enhance patient protection and safety in complex situations. • Achieve the 90% and above compliance for all PVP mandatory training and sustain this compliance providing further assurance that staff can make every contact count to prevent all forms abuse. • To achieve further improved position and roll out in outstanding areas in the checking of CP-IS across the divisions with the support for the CP-IS Champions as a key priority work workstream.

	• To embed the phase 2 of the HOPE boxes and understand the wider impact of trauma and how this will support the reduction in adverse childhood trauma (ACEs). • Improve the application of MCA adherence in key areas through themes and trends identified via PSIRF, SARs and incidents including the support of MCA within mental health workstreams. • Restrictive practices to be inputted and monitored by staff via Cerner to ensure staff oversight of practices in place for the patient, supporting continuity of care. • Develop and embed systemic practice across the Trust which recognises and understands how to support the child and family to reduce the impact of adverse childhood experiences (ACEs) and support trauma informed practice. • Roll out of part one of the Oliver McGowan Mandatory Training, to use the identified learning highlighted in OMMT to improve the care and experience for those patients attending with a learning disability and or autism.

6	**Conclusion and Recommendations**
6.1	The Trust continues to actively respond and contribute to regional and national developments. This Annual Report demonstrates that safeguarding vulnerable people remains a significant priority for the Trust and provides assurance that the statutory duties are met. Safeguarding provision is proactively and continuously developed and implementation of learning from adverse events into frontline practice is evident. We recognise there is much more to achieve and to this end the development and delivery of the future priorities will help ensure that the Trust is fully engaged in the effective prevention of and response to safeguarding concerns. The underpinning message, however, remains the same in that safeguarding is everyone's business irrespective of role or position. It is everyone's responsibility to safeguard and protect the most vulnerable adults and children in our society. The child and adult at risk must remain at the center and be the motivation of our actions.

Appendix 1
Definitions

Safeguarding: The Care Quality Commission (CQC) states; ‘Safeguarding means protecting people's health, wellbeing, and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care’ (CQC, 2022).

Safeguarding Children: A child is defined within the Children Act 1989 as “an individual who has not reached their 18th birthday”, the fact that a child may:

- Live independently
- Is a parent themselves
- Is in custody
- Is a member of the armed forces

does not change their entitlement to protection under The Children Act (1989). This is important because young people aged 16 and 17 years with safeguarding needs access, ‘adult’ services in the Trust and are seen and treated by adult trained and registered staff who may not acknowledge this entitlement.

Safeguarding Adults: An adult is an individual aged 18 years or over.

The Care Act (2014) defines an ‘adult at risk’ as:

- An adult who has care and support needs (whether the needs are being met or not).
- Is experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

All Wirral University Teaching Hospital NHS Foundation Trust (WUTH) all staff have a statutory responsibility to safeguard and protect those who access their care regardless of their position in the organisation. However, some defined named safeguarding roles exist, they include:

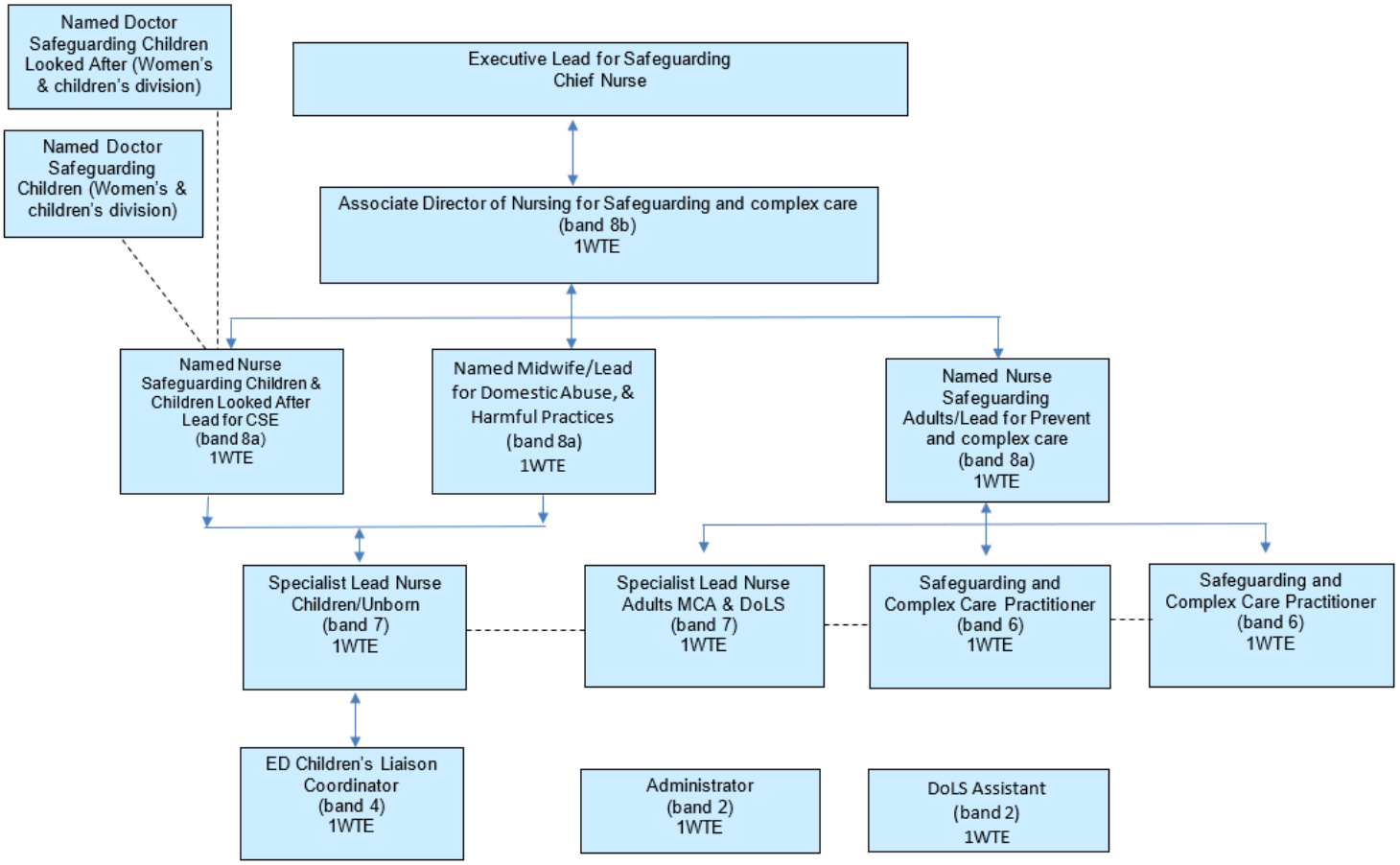
Named Professionals.

Named professionals have specific roles and responsibilities for Safeguarding Children and Adults, as described in the Intercollegiate Safeguarding Competencies for Adults (2018) and Children (2019).

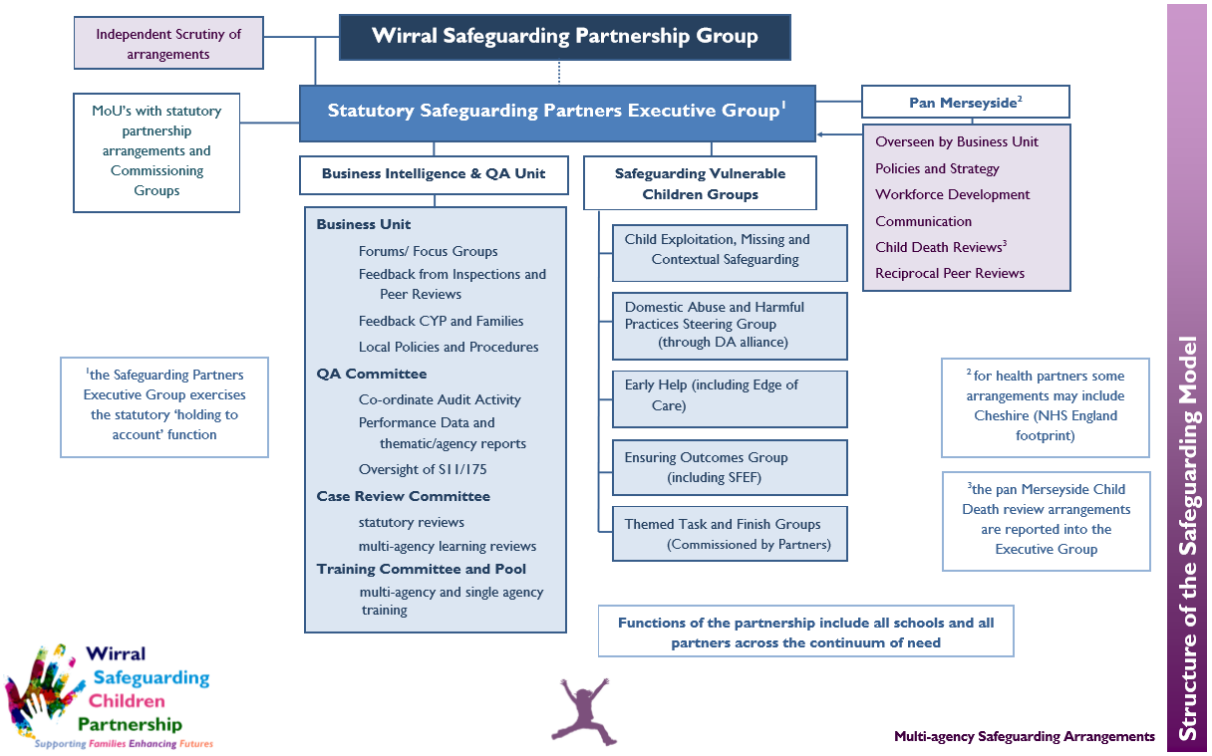
All NHS providers must identify a Named Doctor, a Named Nurse for Safeguarding Children and Young People, a Named Professional for Adults and a Named Midwife (if the organisation provides maternity services) to provide expert advice and support to Trust employees and promote good practice within their organisation as per Children Act (1989/2004) and the Care Act (2014).

From April 2022 - March 2023 the WUTH named professionals were:
- Named Doctor for Children and Young People – Dr Elizabeth Thompson
- Named Doctor for Children Looked After – Dr Vidya Raghavan
- Named Nurse for Children and Children Looked After – Nicola Denton
- Named Professional (Nurse) for Adults – Helen Brookes
- Named Midwife – Michelle Beales-Shaw

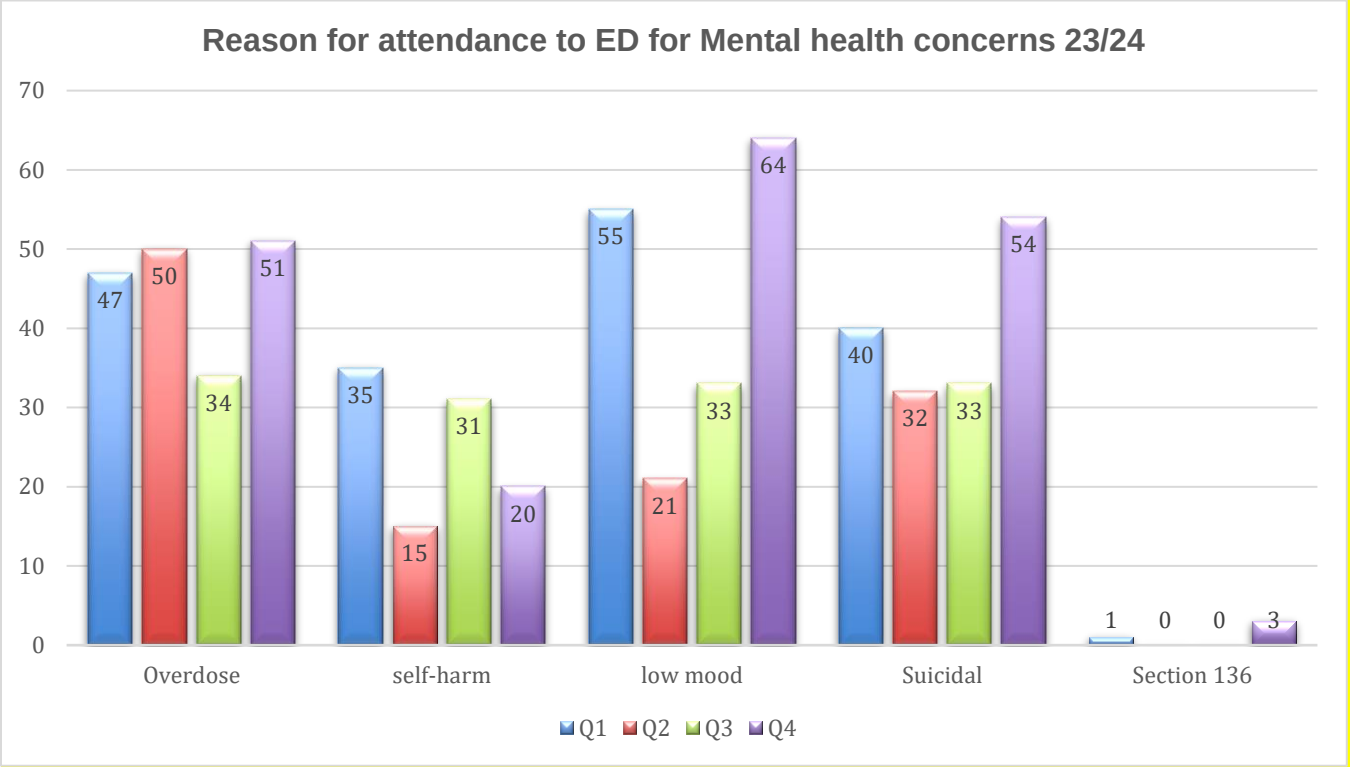
Appendix 2
Safeguarding Structure



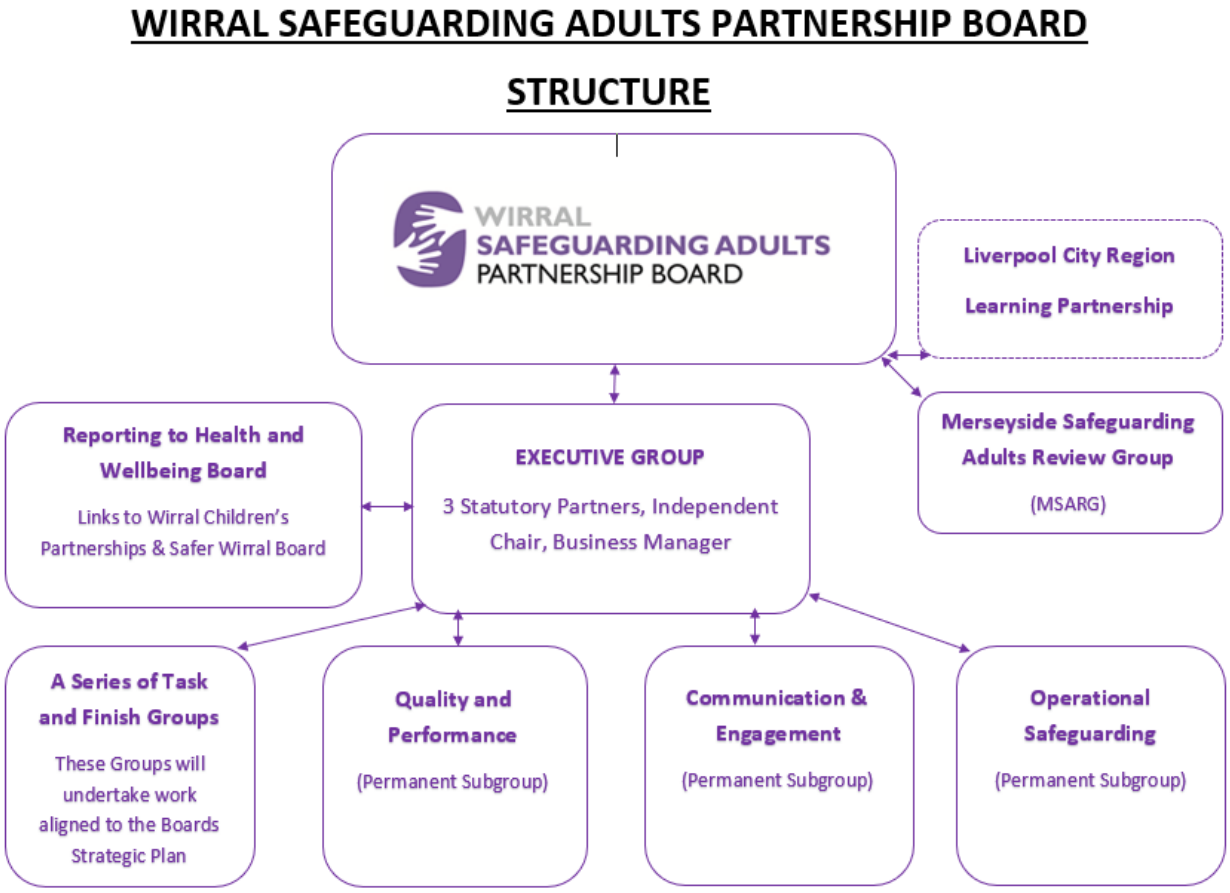
Appendix 3
Wirral Safeguarding Children's Partnership Structure



Appendix 4
Children and Young People Mental Health quarterly breakdown



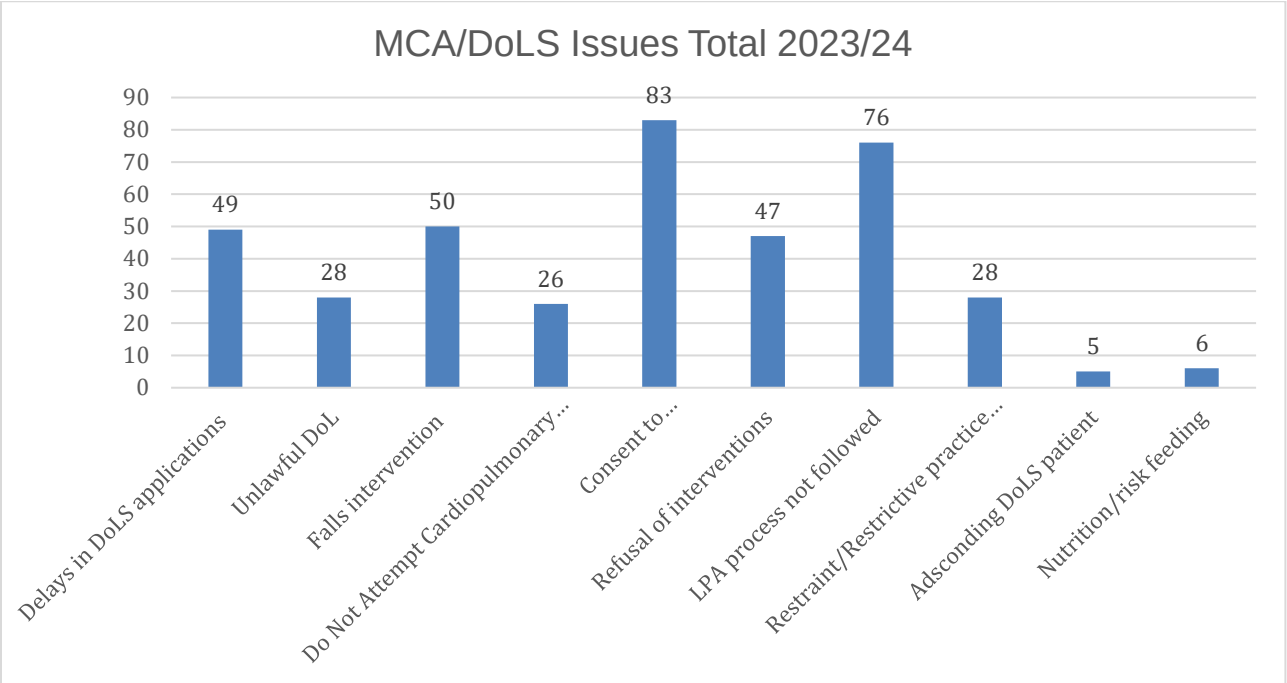
Appendix 5
Wirral Safeguarding Adults Partnership Board Structure

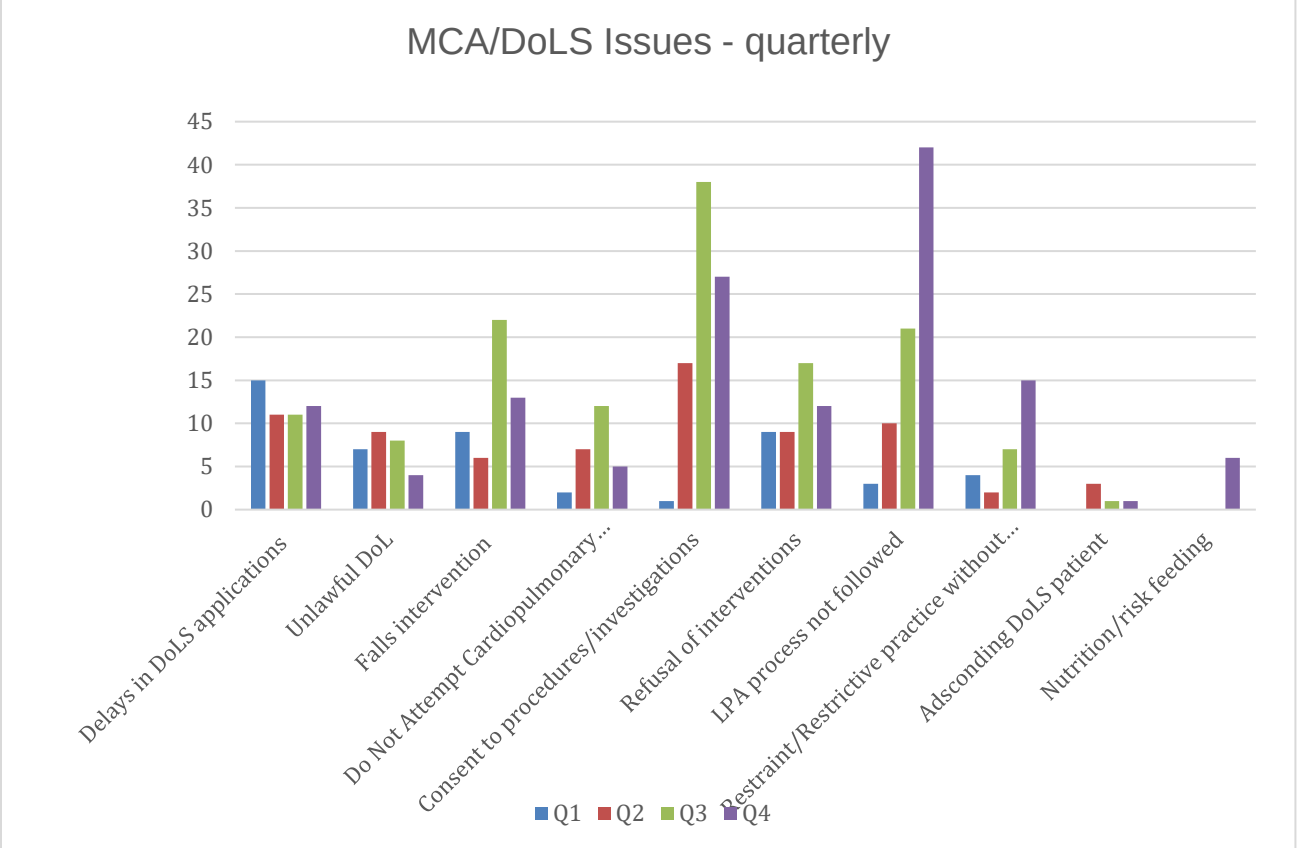


Appendix 6
DoLS applications not progressed.

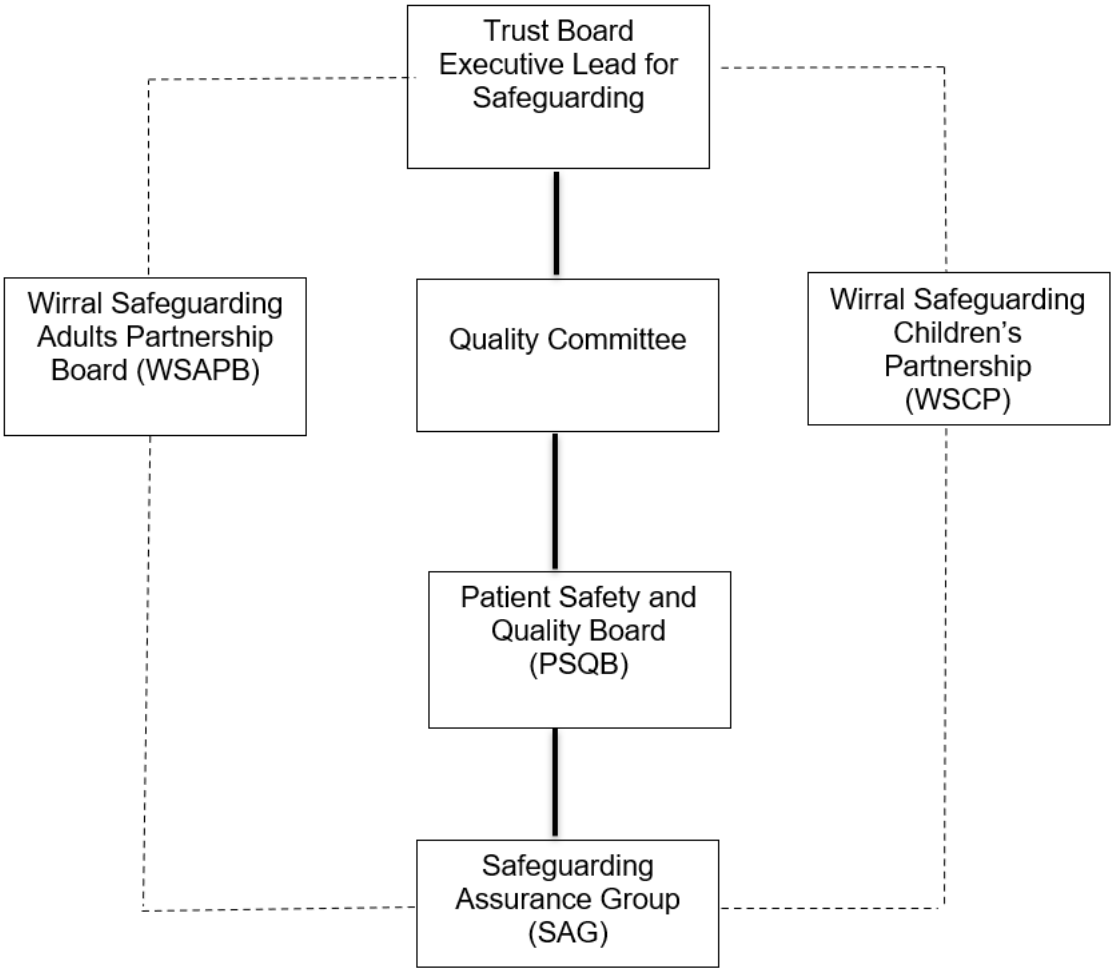
Not processed reason	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Total
Discharged	35 (31.8%)	43 (41.7%)	42 (32.3%)	25 (24.7%)	**145 (32.4%)**
Duplicate referrals	37 (33.6%)	29 (28.1%)	25 (19.4%)	25 (24.75%)	**116 (25.9%)**
Have capacity/regained Capacity	20 (18.2%)	15 (14.5%)	37 (28.7%)	27 (25.96%)	**99 (22.1%)**
Fluctuating capacity	5 (4.5%)	2 (1.9%)	4 (3.1%)	2 (1.99%)	**13 (2.9%)**
Deceased	9 (8.2%)	8 (7.7%)	10 (7.75%)	9 (9%)	**36 (8%)**
DoLS Criteria not met (case law)	1 (0.9%)	2 (1.9%	11 (7.75%)	13 (12.6%)	**27 (6%)**
Use of Mental Health Act	1 (0.9%)	2 (1.9%)	1 (0.8%)	1 (0.9%)	**5 (1.1%)**
Referral application error	2 (1.8%)	2 (1.9%)	0	1 (0.9%)	**5 (1.1%)**
Total not processed by team	110 (16.7%)	103 (14.6%)	130 (22.9%)	104 (16.4%)	**447 (16.6%)**

Appendix 7
MCA themes and Trends





Appendix 8
Trust Governance Structure



Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 13**

02 October 2024

Title	Managing Conflicts of Interest Biannual Update
Area Lead	David McGovern, Director of Corporate Affairs
Author	James Jackson-Ellis, Corporate Governance Officer
Report for	Information

Executive Summary and Report Recommendations

This report outlines the current process for recording interests and highlights the year-to-date position. The policy is not yet due for review, unless further guidance is published.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key risks:

- Ensuring robust processes and compliance with probity and transparency requirements.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	No
Better quality of health services for all individuals	No
Sustainable use of NHS resources	Yes

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey

Date	Forum	Report Title	Purpose/Decision
September 2024	Audit and Risk Committee	As above	As above

1	Narrative
1.1	**Conflicts of Interests** The Trust has an obligation to manage conflicts of interest and gifts/hospitality in a transparent way, with safeguards in place around the use of taxpayer funds. This is set out both in guidance from NHS England, and in the Trust's policies. The Managing Conflicts of Interest Policy was last updated and approved by Audit and Risk Committee and Board in September/October 2022, respectively. The policy remains fit for purpose and will be reviewed in line with the 3 year review date (August 2025) unless any amended guidance is published. **Current Process for Recording Interests** The Trust has a web based solution for managing declarations of interest – the platform is called Civica Declare. There is also a specific email address (wuth.conflictsofinterest@nhs.net) which is monitored by the Corporate Governance Team to address any queries staff may have. Information on the requirements for declaring interests is provided at both appointment and induction stages, and regular reminders are sent out from the system to those who are required to set out their interests. **Current position** At the time of writing, there are 1550 staff who fall within the categories outlined in the Trust policy, and 1147 of those have completed their annual declaration/review. This is 74% of those required and is compared to the position at this time last year of 57%. Best practice is considered 85% and above, and last financial year as at 31st March 2024 the Trust achieved 86%. The Corporate Governance Team continue to push to achieve at least this figure.

2	Implications
2.1	**Patients** • Declarations have no direct impact on patients, but continuing to encourage declarations of interest, and publishing the register in line with guidance, supports a culture of openness and trust.
2.2	**People** • This recording is a once annual requirement, and has been streamlined to ensure minimal time is required for staff to maintain this system. • There are no EDI concerns at this time, however, staff are able to contact the Board Secretary at any point to address any accessibility requirements.
2.3	**Finance** • There is a cost to licence the system, but this remains within budget.
2.4	**Compliance** • NHSE guidance is very clear around the requirements for declarations of interests, and the Trust's policy is written in line with the NHSE model policy to ensure all elements are accurate and correct. • Compliance with conflict of interest disclosures also contributes to compliance with well-led requirements.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 14**

02 October 2024

Title	Fit and Proper Persons Policy
Area Lead	David McGovern, Director of Corporate Affairs
Author	David McGovern, Director of Corporate Affairs
Report for	Information

Report Summary and Recommendations

This report provides the revised Fit and Proper Persons Test (FPPT) Policy, which has been subject to annual refreshment for 2024.

It is recommended that the Board:

- Note the policy.

Key Risks

This report relates to these key risks:

- Failure to have strong leadership and governance systems in place.
- Failure of the Trust to have the right culture and organisational conditions/structure to deliver our priorities for our patients and service users.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey

Date	Forum	Report Title	Purpose/Decision
September 2024	Audit and Risk Committee	As above	As above

1	Narrative
1.1	NHSE published a new Fit and Proper Persons Test (FPPT) Framework on 2nd August, 2023 which, on top of current requirements, introduced standardised board member reference, and requires FPPT checks to be part of an individual's Electronic Staff Record (ESR). ICB, CQC and NHSE Board members are now also required to comply with FPPT. Crucially, the framework makes specific the roles which the enhanced FPPT applies to, something which in the past has been left open to interpretation. The FPPT is now clearly situated within the range of measures organisations take to assure themselves of their Board members' ongoing effectiveness, including appraisal processes, effective recruitment, and Board development. The Trust fully adopted the new framework in September 2023 and ensured implementation of the full framework by 31st March 2024. All annual assessments against the framework were carried out in respect of relevant posts in 2024.
1.2	WUTH's current Fit and Proper Persons Test Policy (attached) continues to be fit for purpose and will be subject to its bi annual refreshment in November 2025.

2	Implications
2.1	**Patients** • No direct implications for patients, though the new policy will contribute towards ensuring directors are of good character, and in turn make decisions with integrity.
2.2	**People** • The main implications will be those listed as required to complete FPPTs, but overall will contribute to a culture of transparency and probity.
2.3	**Finance** • No direct implications from a financial perspective.
2.4	**Compliance** • The policy has been drafted in line with the new framework, and the internal audit undertaken by MIAA.

Wirral University Teaching Hospital
NHS Foundation Trust

Policy Reference: 282

FIT AND PROPER PERSONS POLICY

Version: 3

Name and Designation of Policy Author(s)	Director of Corporate Affairs
Ratified By (Committee / Group)	Trust Board
Date Ratified	4th October 2023
Date Published	4th October 2023
Review Date	31st November 2025
Target Audience	All directors
Other Associated Strategies, Policies, Procedures, etc	Disciplinary Policy Conflicts of interest guidance and policy Professional Codes of Conduct relevant to registered nurses, allied health professionals, medical staff and others

1 Introduction

1.1 All Executive and Non-Executive Director appointments are subject to the Fit and Proper Persons Test ("FPPT") as laid out in Regulation 5 of the Health and Social Care Act 2008 (Regulations of Regulated Activities) (Amendment) (Regulated Activities) Regulations 2014 (the "Regulations") which came into force on 27th November 2014. This Policy also incorporates the requirements of the refreshed framework introduced in August 2023.

1.2 Individuals in these roles must meet the requirements on appointment and continue to meet these requirements whilst holding office as a director.

1.3 The Trust will regularly review the ongoing continuing fitness of a director to hold a Directorship with the Trust. In the event that the Trust determines on reasonable grounds that the Director has ceased to be a "fit and proper person" within the meaning of the Regulations then the appointment may be terminated with immediate effect. (Subject to Trust HR processes for executive directors)

1.4 This policy applies to permanent and interim positions, whether the individual is employed directly or via a third party. The Trust will retain responsibility for carrying out checks on all interim staff, as well as maintaining the relevant evidence.

1.5 The word "Director" is used throughout this policy to include all individuals within this wider definition with autonomy & authority to act in the capacity of a director when required in a manner comparable to an executive director of the Trust.

2 Purpose

The purpose of this policy is to inform those outlined in the scope of their responsibilities in relation to the Fit and Proper Persons Test and to outline the processes that will ensure the test is correctly applied and regularly monitored.

The policy is to set out the required standards based on the guidance issued by the Care Quality Commission (CQC) which emphasises the importance of the Fit and Proper Persons Test in ensuring the accountability of directors of NHS providers.

To ensure the Trust meets its statutory and regulatory requirements, this policy defines the way in which areas of responsibility have been determined, together with processes for assessment checking and compliance monitoring.

The policy for Fit and Proper Persons Tests is based upon the following key principles:

a) The Trust complies with its statutory and regulatory obligations when appointing directors to the Trust Board.
b) The Trust meets the requirements of its Governance framework.
c) The Trust has in place a robust process for the assessment of directors in meeting the requirements of the Fit & Proper Persons Test at the point of recruitment and on an on-going basis.
d) The Trust is prepared for external monitoring and assessment undertaken by regulatory bodies.

3 Scope

3.1 This policy and procedure applies to all Board level appointments, whether on an interim or permanent basis.

The Trust regards the following posts as subject to the 2014 regulations:

a) The Chairman, Non-Executive Directors and Associate Non-Executive Directors
b) The Chief Executive and Executive Directors and those officers required to act as substitutes for Executive Directors in the presentation of reports to Board.

A list of the positions covered by this policy (as defined by the Board) is contained in appendix D.

4 Meeting the Requirements of Regulation 5

4.1 The Regulations places the ultimate responsibility on the Chair to discharge the requirement placed on the Trust, to ensure that all relevant post holders meet the FPPT and do not meet Chief Executive's letter to Executive Directors should include a paragraph to confirm this responsibility. Further detail is provided in the CQC Guidance for NHS Bodies: Fit and Proper Persons: Directors, November 2014,NHS Provider Fit and Proper Persons Regulations in the NHS February 2018 and NHS England Fit and Proper Person Test Framework for Board Members 2023.

4.2 Web links

Fit and proper person requirements: adult social care services | Care Quality Commission (cqc.org.uk)

http://nhsproviders.org/fit-and-proper-persons-regulations-in-the-nhs

4.3 The Trust will make every reasonable effort to assure itself about existing post holders and new applicants and to make specified information about board directors available to CQC on request.

All Directors falling within the scope of the policy as set out in sections (3.1 and 1.4) must provide evidence that they:

- are of good character
- hold the required qualifications and have the competence, skills and experience required for the relevant office for which they are employed
- are capable, by reason of their physical and mental health, after any necessary reasonable adjustments, of properly performing their work
- can supply relevant information as required by schedule 3 of the Regulations
- Have not have been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity).

Regulations a person is deemed "unfit" if:

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.

- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

4.4 In accordance with part 2 of the Regulations a person will fail the good character test if they:

- Have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence.
- Have been erased, removed, struck off a register of professionals maintained by a regulator of health care or social work professionals

4.5 **Serious misconduct or mismanagement**

Serious misconduct:

- Misconduct is defined by CQC as a breach of "a legal or contractual obligation imposed on the director," for example an employment contract, regulatory requirements, criminal law or engaging in activities which are morally reprehensible or likely to undermine public confidence. Examples of serious misconduct include assault, fraud and theft.

Mismanagement:

- Mismanagement is defined by CQC as "being involved in the management of an organisation in such a way that the quality of decision-making and actions of the managers falls below any reasonable standard of competent management." Examples of serious mismanagement include any dishonest conduct, continued failure to develop and manage business, financial or clinical plans, and having no regard to appropriate standards of governance.
- While serious misconduct tends to be a single incident, serious mismanagement is likely to refer to actions over a period of time.

Privy to" - misconduct or mismanagement

- "Privy to" means that there is evidence that the director was aware
- Of serious misconduct or mismanagement but did not take the appropriate action to ensure it was addressed. This action could include making a formal complaint or drawing the matter to the attention of the appropriate senior member of staff or a suitable person outside the organisation.
- "Responsible for, contributed to or facilitated" means that there is evidence that a person has intentionally or through neglect behaved in a manner, through action or omission, which would have led to, assisted or enabled serious misconduct or mismanagement.

5 Process for New Appointments

5.1 The Trust's comprehensive pre-employment checking processes are determined by the NHS employment standards and include the following:

- Employment history and reference checks, one of which must be the most recent employer (including validation of a minimum period of three consecutive years of continuous employment or training and details of any gap) and including reasons for leaving;

- Qualification and professional registration checks (as relevant to post).
- Right to work checks.
- Proof of identity checks.
- Occupational Health Assessment.
- Different types of criminal record check, including the Disclosure and Barring Service (DBS), where relevant to the post and where eligibility criteria are met.

5.2 In addition, the following checks shall be carried out for Director appointments:

- Search of the insolvency and bankruptcy register by individual's name
- Search of the insolvency and bankruptcy register by individual's company name, where appropriate
- Search of the disqualified directors register and the removed trustee register.

5.3 The Regulations introduce the requirement to complete a FPP Declaration form for new employees. This form and a copy of this policy will be included within the application pack and form part of the application process, regardless of whether the Trust is employing the individual on a temporary or permanent basis, directly or indirectly.

5.4 While the Trust will have regard to information on when convictions, bankruptcies or similar matters are considered 'spent,' there is no time limit for considering serious misconduct or responsibility for failure in a previous role.

5.5 The Chair of the appointments panel will be responsible for ensuring compliance supported by the relevant recruitment support, with input from the Director of Corporate Affairs. No offers of employment shall be met until this process has been complied with and evidenced.

A detailed checklist will be completed and will be retained on the post holder's personal file for the purposes of audit.

5.6 Any executive or non-executive appointment will take into account the Trust's obligations under the Regulations. Where the Trust makes a decision on the suitability of an individual, the reasons will be appropriately documented.

5.7 Where the Trust deems that the individual who is to be appointed is suitable, despite not meeting the characteristics outlined in Schedule 4, Part 2 of the Regulations (Good Character), and the reasons will be recorded in the minutes of the relevant meeting and the information about the decision will be made available to those that need to be aware. The appointment process will include an evaluation against the Trust's values, and any relevant external guidance. External advice will be sought as necessary.

5.8 Where specific qualifications are deemed by the Trust as necessary for a role, the Trust will make this clear and will only appoint those individuals that meet the required specification; including any requirements to be registered with a professional Regulator.

5.9 The Trust will carry out employment checks (as far as reasonably practicable) on a candidate's qualifications and employment records. The recruitment process will necessarily include a qualitative assessment and values based assessment.

5.10 If the Director has a physical or mental health disability, wherever possible, reasonable adjustments will be made to enable the individual to carry out the role that they have been appointed to.

6 Process for Existing Staff and Ongoing Fitness

6.1 Every year there will be a requirement for post holders to complete a further form of declaration confirming that they continue to be a fit and proper person.

6.2 Individuals will be required to make the Trust aware as soon as practicable of any incident or circumstances which may mean they are no longer to be regarded as a fit and proper person, and provide details of the issue, so that the Trust can consider this.

6.3 If concerns are raised at the pre-employment stage, then the matter will be raised with the Director of Corporate Affairs who undertakes the Fit and Proper Persons checks. The Director of Corporate Affairs will then inform the Chairman who will decide whether the candidate is to be appointed or rejected. It should be noted that any process in relation to the recruitment of the role of Director of Corporate Affairs will be carried out by the appointing person e.g. Chief Executive of Chief People Officer with approval to be received via the Board SID.

6.8 Should the Director fail the Insolvency, Bankruptcy, and Disqualified Directors checks or any other necessary check under the Regulations (post-employment /appointment), or if concerns about the Directors "fitness" are raised by a member of the public or otherwise, the Chief People Officer will notify the Director of Corporate Affairs, who in turn will then take appropriate action. In light of the evidence that is obtained following an investigation, the Chairman will decide whether the individual has ceased to be a "fit and proper person" within the meaning of the Regulations. Any investigation should be undertaken as soon as reasonably practicable.

6.9 The Trust reserves the right to suspend a director or restrict them from duties on full pay / emoluments (as applicable) to allow the Trust to investigate the matters of concern. Suspension or restriction from duties will be for no longer than necessary to protect the interests of service users or the Trust and/or where there is a risk that the Director's presence would impede the gathering of evidence in the investigation.

6.10 Should there be sufficient evidence to support the allegation(s), then the Trust will consider terminating the appointment of the Director with immediate effect (in line with the Trust's Disciplinary policy).

6.11 When a director no longer meets the requirements of Paragraph 3 of the Regulation and is a health care professional, or other professional registered with a health or social care regulator, then the Trust will inform the regulator in question.

7. Concerns regarding an individual have continued FPP compliance

7.1 If, either at the time of appointment or later, it becomes apparent that circumstances exist or have arisen whereby an Executive Director may not be considered to meet all the requirements of a 'fit and proper person', the Director of Corporate Affairs shall inform the Chair. If this concern relates to the Director of Corporate Affairs then the CEO will inform the Chair and oversee the matter.

7.2 The Chair will lead on addressing these concerns on a case by case basis and will need to consider whether an investigation is necessary or appropriate given the allegation.
Where it is necessary to investigate or take action, the Trust's current processes will apply using the Trust's Capability Policy and Procedure or the Attendance Management Policy (managing performance or sickness absence), Trust's Disciplinary procedure or afforded a similar process to this if the potential discontinuation could be due to 'some other substantial reason'.

7.3 The Trust reserves the right to suspend a director or restrict them from duties to allow the Trust to investigate the matters of concern. Suspension or restriction from duties will be for no longer than necessary to protect the interests of patients or the Trust and/or where there is a risk that the Director's presence would impede the gathering of evidence in the investigation.

7.4 Should the Chair consider the individual to be suitable, despite existence of information relevant to issues identified in Schedule 4, Part 2, the Chair's reasons should be recorded for future reference and made available.

7.5 If an investigation concludes that an individual carrying out an identified position under this policy may no longer meet the requirements of the "fit and proper person test" the following two-stage procedure will be applied:

7.6 **Fit & Proper Person Hearing** - If there is sufficient evidence that an individual carrying out one of the identified positions under this policy may no longer be a fit and proper person, and the evidence is such that formal action may be required, then that person will be invited to a hearing to give them the opportunity to test the evidence and/or offer an explanation for consideration.

7.7 **Fit & Proper Person Appeal Hearing** - If an individual carrying out one of the identified positions under this policy has been determined to no longer be a fit and proper person, then that person may appeal that decision in writing within fourteen calendar days of receipt of notification of the Trust's decision.

7.8 Should there be sufficient evidence to support the allegation(s), then the Trust may terminate the appointment of the Director with immediate effect, in line with the Trust's Disciplinary policy. Where an individual who is registered with a professional regulator (General Medical Council (GMC), Nursing & Midwifery Council (NMC) etc.) no longer meets the fit and proper person's requirement the Trust must inform the regulator and take action to ensure the position is held by a person meeting the requirements.

7.9 The criteria and process around the removal of Non-Executive Directors, including the Chair, is outlined in NHS Improvement's "Arrangements for the Removal or Suspension of NHS Trust Chair and Non-Executive Directors and NHS Charity Trustees" (or for a Foundation Trust within the Trust's Constitution)

8 Annual Review Process

8.1 The Trust is responsible for ensuring the continued "fitness" of those persons who the requirements apply. The Trust will therefore undertake the following on an annual basis:

a) The completion of an annual self-declaration form by all those named within the Scope of this policy, the process for this will be managed and co-ordinated by the Director of Corporate Affairs after the end of each financial year, 31st March. A copy of the signed self-declaration form should be returned to the Director of Corporate Affairs and subsequently placed on the director's personal file. It is the responsibility of the Director of Corporate Affairs to escalate any non-compliance to the Chair.

b) The Director of Corporate Affairs will undertake annual checks of the insolvency, bankruptcy and disqualified directors register after the end of the financial year, 31st March. It is the responsibility of the Director of Corporate Affairs to escalate any non-compliance to the Chair.

c) The formal appraisal process, enhanced to address the Fit & Proper Persons requirements, will be undertaken by the appropriate person with line management responsibility.

d) In the case that there is a non-compliance matter relating to the Director of Corporate Affairs then this matter will be overseen by the CEO in liaison with the Chair.

11 Duties & Responsibilities

Individual Roles

Chair	The Chair is ultimately responsible to discharge the requirement placed upon the Trust to ensure that all directors meet the requirements of the Fit and Proper Persons Test and do not meet any of the 'unfit' criteria. The Chair is also subject to the requirements of the test. The Chair is responsible for taking the necessary action to ensure existing directors who no longer meet the regulations of the FPPR (i.e., are deemed 'unfit') do not continue in their role
Senior Independent Director/Vice Chair	The Senior Independent Director or Vice Chair is responsible for undertaking independent verification on Fit and Proper Persons checks
Chief Executive	The Chief Executive although subject to the requirements of the test is also accountable to the Board for the Trust's compliance with statute and regulation.
Chief People Officer	The Chief People Officer is responsible for ensuring that all employment checks are undertaken in accordance with Trust policy and procedures for new appointments and that the annual checking process is adhered to for all those directors in post.
Director of Corporate Affairs	The Director of Corporate Affairs is responsible for ensuring that all checks are undertaken in accordance with the Fit and Proper Persons policy and that the Trust complies with its statutory and regulatory requirements.
Executive and Non-Executive Directors	All Executive and Non-Executive Directors as outline in the scope of this policy are accountable for ensuring they meet the requirements of the Fit and Proper Persons Test on appointment and complete annual self-declarations. They are also responsible for informing the Chair if during the course of employment or term of office they no longer meet the requirements of the Fit and Proper Persons Test and therefore are deemed "unfit."

Committee Roles

Board	The Board is responsible for the performance management of this policy.

12 References

Acts of Parliament
Health & Social Care Act 2008 (Regulated Activity) Regulations 2014: Regulation 19.
Regulations
Care Quality Commission (CQC) Guidance for NHS bodies November 2014 - Regulation 5: Fit and proper persons: Directors.

Websites
Care Quality Commission - www.cqc.org.uk

NHS Sources
NHS Employers - www.nhsemployers.org

NHS Improvement
Trust Licence No. 130142 section G4 – Fit and Proper Persons

Regulatory Bodies
Care Quality Commission (CQC)

Appendix A – Fit and Proper Persons Declaration – Non Executive Director

1. Non-executive roles in the NHS are positions of significant public responsibility and it is important that those appointed can maintain the confidence of the public, patients and NHS staff. NHS Improvement has a duty to ensure that those we appoint to NHS boards are of good character, will ensure an open and honest culture across all levels of the organisation. The "Fit and Proper Person" requirements are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2. By signing the declaration below, you are confirming that you are a "fit and proper person" outlined at (2), that you do not fall within any of the categories outlined at (4) or (5) below and that you are not aware of any pending proceedings or matters which may call such a declaration into question in the future.

3. The regulations require you are:

   (a) of good character.
   (b) have the necessary qualifications, competence, skills and experience; and
   (c) are able by reason of your health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position.

4. Do any of the following conditions apply to you? You are asked to confirm that you are not:

   (a) a person who has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.
   (b) a person who has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.
   (c) an undischarged bankrupt, or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.
   (d) the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
   (e) a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).
   (f) a person who has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
   (g) included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern

Ireland.

(h) a person who has been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.

5. In addition, the following conditions disqualify you from appointment as a chair or non-executive director of an NHS Trust. You are asked to confirm that you are not:

(a) an employee of the NHS Trust with the vacancy.
(b) a chair or member of the governing body of a clinical commissioning group, or employees of such group.
(c) a serving MP nor MEP or a candidate for election as MP or MEP.
(d) a person who has been dismissed (except by redundancy) by any NHS body.
(e) a person whose earlier appointment as chair or chair or non-executive director of an NHS trust was terminated.
(f) under a disqualification order under the Company Directors Disqualification Act 1986. and / or
(g) a person who has been removed from trusteeship of a charity.

DECLARATION

☐ I confirm that I do not fit within any of the categories listed at (4) or (5) and that there are no other grounds under which I would be ineligible for appointment. If appointed, I undertake to notify NHS Improvement immediately of any change of circumstances that may affect my eligibility to remain in post.

☐ I wish to declare the following information which may be relevant to my eligibility for this role:

Signature: **Name:** **Date**

Disclosure of wider interests

Role:	Organisation:	Detail:	Paid/Unpaid:

Appendix B – Fit and Proper Persons Declaration (Executive Director)

1. Executive roles in the NHS are positions of significant public responsibility and it is important that those appointed can maintain the confidence of the public, patients and NHS staff. The Trust has a duty to ensure that those we appoint to the board are of good character, will ensure an open and honest culture across all levels of the organisation. The "Fit and Proper Person" requirements are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2. By signing the declaration below, you are confirming that you are a "fit and proper person" outlined at (2), that you do not fall within any of the categories outlined at (4) or (5) below and that you are not aware of any pending proceedings or matters which may call such a declaration into question in the future.

3. The regulations require you are:

   (a) of good character.
   (b) have the necessary qualifications, competence, skills and experience; and
   (c) are able by reason of your health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position.

4. Do any of the following conditions apply to you? You are asked to confirm - Yes or No:

	Questions	**Y**	**N**
4a	a person who has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if omitted in any part of the United Kingdom, would constitute an offence		
4b	a person who has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals		
4c	an undischarged bankrupt, or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged		
4d	the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland		
	Questions	**Y**	**N**
4e	a person to whom a moratorium period under a debt relief order		

	applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40)		
4f	a person who has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it		
4g	included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland		
4h	a person who has been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (Whether unlawful or not) in the course of carrying on a regulated activity or discharging any functions relating to any office or employment with a service provider.		

5. In addition, the following conditions may disqualify you from being an Executive Director of an NHS Trust.

You are asked to confirm - Yes or No:

	Questions	**Y**	**N**
5a	a person who has been dismissed (except by redundancy) by any NHS body		
5b	under a disqualification order under the Company Directors Disqualification Act 1986; and/or		
5c	a person who has been removed from trusteeship of a charity		

You are asked to confirm that you have - Yes or No:

	Questions	**Y**	**N**
5d	the qualifications, skills and experience necessary for the relevant position		

You are asked to confirm that you are - Yes or No:

	Questions	**Y**	**N**
5e	capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010		

DECLARATION

☐ I confirm that I do not fit within any of the categories listed at (4) or (5) and that there are no other grounds under which I would be ineligible for appointment. If appointed, I undertake to notify the Trust immediately of any change of circumstances that may affect my eligibility to remain in post.

☐ I wish to declare the following information which may be relevant to my eligibility for this role:

Signature: **Name:** **Date:**

Disclosure of wider interests

Role:	Organisation:	Detail:	Paid/Unpaid:

Appendix C - Pre-Employment Fit and Proper Persons File Check List

Name:	
Position:	
Date of Commencement:	

Criteria for checking:	**Evident on file:**
Disclosure and Barring Service (DBS) disclosure	Yes/No If no state reason:
2 Satisfactory References (3 for Medical Director)	Yes/No If no state reason:
Employment History – application form or CV	Yes/No If no state reason:
Occupational Health Clearance	Yes/No If no state reason:
Relevant qualification(s) e.g., Professional Body (if applicable)	Yes/No/NA If no state reason:
ID Documentation	Yes/No
Fit & Proper Persons Test – Self Declaration Form	Yes/No If no state reason:

Has the insolvency, bankruptcy and disqualified directors register been checked by the Director of Corporate Affairs?	Yes, no concerns □	Yes, concerns escalated □	Register not checked: □
			Reason for not checking:

Authorising Signatory:

Signed:
Name:
Position: Senior Independent Director/Vice Chairman
Date:

A copy of this form should be retained on the individual's personnel file.

Appendix D – 25 Roles currently covered by the enhanced FPP Policy

ROLE
Chair of the Board
Senior Independent Director (SID)
NEDs x 5
Chief Executive Officer
Medical Director
Chief Nurse
Chief Operating Officer
Chief People Officer
Chief Finance Officer
Chief Strategy Officer
Director of Corporate Affairs
Chief Information Officer
Director of Communications and Engagement
Director of Estates and Facilities and Capital Planning
Deputy Medical Director (Professional Standards)
Deputy Medical Director (Quality and Patient Safety)
Deputy Chief Nurse
Deputy Chief Operating Officer
Deputy Chief People Officer
Deputy Chief Finance Officer
Board Secretary

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 15**

02 October 2024

Title	CMAST Joint Working Agreement and Committee in Common Refresh
Area Lead	David McGovern, Director of Corporate Affairs
Author	James Jackson-Ellis, Corporate Governance Officer
Report for	Approval

Executive Summary and Report Recommendations

The purpose of this report is to secure Trust endorsement to update Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) Joint Working Agreement and Committee in Common terms of reference following a review requested by the CMAST Leadership Board and signed off by the Board (Trust CEOs and Chairs) on 6 September.

It is recommended that the Board:

- Endorse and agree the updated CMAST Joint Working Agreement and Committee in Common terms of reference as set out

Key Risks

This report relates to these key risks:

- No risks

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

1	Narrative
1.1	Cheshire and Merseyside (C&M) acute and specialist providers have come together to collaborate on matters that can be best progressed and responded to, at scale, and

through shared focus or action. This is achieved via our provider collaboration: CMAST.

CMAST has worked together for a period of time and had its ways of working codified and set out including arrangements for shared decision making, when and as required, through a Joint Working Agreement and Committees in Common terms of reference since late summer 2022.

Given the existence of these agreements for a two-year period and a commitment to review following an initial period of operation, a review on or around the two-year anniversary has been progressed and taken forward by the relevant Trust Company Secretaries or equivalent.

Few significant changes have been implemented within the documents but a period of shared review, reflection and questioning has taken place in an appropriately collaborative manner. The areas of both discussion and proposed changes are detailed below, as relevant to each of the two key documents:

Joint Working Agreement (JWA), further detail, and to be read in conjunction with CiC ToR:

- 2.1 – updated vision to align with streamlined vision per CMAST Annual Plan 2024/5
- 2.3 – framed CMAST priorities as *Clinical Improvement and Transformation and Sustainability and Value* per CMAST Annual Plan 2024/5 which in being targeted will enable the achievement of the existing priorities (still referenced)
- Section 3.6.7 made reference to 104 week waiters which was a policy priority in 2022. This text has been updated to reflect the long waiters and is therefore less beholden to developments and/or policy updates.
- Section 4.4 refers to a rotation of Meeting Lead (or CMAST Chair). This has been updated to state that the first review will take place by no later than 2025 and will take place periodically at the will of the membership.
- 8.10 referred to an expectation an information sharing agreement would be developed and/or required. To date the Leadership Board has not identified this requirement, preferring to rely on established ICB / ICS practices and arrangements. The reference has been updated to state arrangements will be developed when and if the Leadership Board judges that they are required.

Suggestions noted but resulting in no proposed amendment to JWA:

- Reference to city or sub system workstreams – logic for determination is that the Provider Collaborative has been designed, built and operated, to date, sitting above individual and sub groupings of actions and to complement not compete
- Greater reference to the financial challenges the NHS is facing – logic for determination is that the Triple Aim of the NHS is referenced which includes a need for value for money and therefore efficiency. In an ideal world scoping and terms of reference documents should be framed in a way that supports adaptation and interaction without always requiring changes or updates
- Reference the range and scope of professional groups that exist within CMAST – logic for determination is that reference to professional groups is made without need to be beholden to future change or amendments

	Committee in Common - Terms of Reference (CiC ToR), further detail, and to be read in conjunction with JWA: Suggestions noted but resulting in no proposed amendment to ToR: • Reference to shared posts and need for clarification of voting – logic for determination is that the detailed CMAST committee in common arrangements (not joint committee) support single vote committees to operate on behalf of each Trust, meeting in common, therefore no changes to voting is required as this is linked to the relevant Trusts. • Section 6 sets reporting expectations. It has been questioned whether these remain valid. It is suggested that when, and if, CMAST CICs take on delegations that the level or reporting described remains applicable. **Consistent factual updates** • Updating references to Mersey and West Lancashire Teaching Hospitals NHS Trust (from Southport and Ormskirk and St Helens and Knowsley) • Updated references to be active e.g ICB delivery rather than time bound references to ICB establishment It is proposed that the documentation captures and appropriately reflects the outputs and culmination of a period of engagement and development with Trust leads nominated by the CMAST Leadership Board and endorses the continued operation, use and application of CMAST mechanisms as may be appropriate. The documentation delivers stability, reflects feedback and provides an updated position for the operations covered by the scope of the documents which necessarily focus on approach and governance. Business and content will continue to iterate and be defined by Boards as the scope and remit of CMAST develops and the ask of the system, for it, expands, varies or diminishes.

2	Implications
2.1	**Patients** • No implications
2.2	**People** • No implications
2.3	**Finance** • Collaboration is expected to be more efficient and should result in a more pragmatic response to any financial challenges within C&M
2.4	**Compliance** • No implications

Draft No: 1
Date of Draft: September 2024

Dated 2024

CHESHIRE & MERSEYSIDE ACUTE AND SPECIALIST TRUSTS PROVIDER COLLABORATIVE (CMAST) JOINT WORKING AGREEMENT

Between

(1) **COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST**

(2) **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

(3) **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST**

(4) **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST**

(5) **THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST**

(6) **LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST**

(7) **THE WALTON CENTRE NHS FOUNDATION TRUST**

(8) **LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**

(9) **ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST**

(10) **EAST CHESHIRE NHS TRUST**

(11) **MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST**

(12) **MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST**

and

(13) **NORTH WEST AMBULANCE SERVICE NHS TRUST**

CONTENTS

CLAUSE **PAGE**

1 Introduction

1.1 In this Agreement, the following words bear the following meanings:

Agreement	this agreement signed by each of the Trusts in relation to their joint working and the operation of the CMAST CiCs;
CMAST CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMAST CiC**" shall be interpreted accordingly.
CMAST Leadership Board	the CMAST CiC's meeting in common.
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it;
Meeting Lead	the CMAST CiC Member nominated (from time to time) in accordance with paragraph 7.6 of the Terms of Reference, to preside over and run the CMAST CiC meetings when they meet in common;
Member	a person nominated as a member of a CMAST CiC in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices 1-14 to this Agreement;
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, , Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey

	Children's Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire Teaching Hospitals NHS Trust, Mid Cheshire Hospitals NHS FT and "**Trust**" shall be interpreted accordingly.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change and develop CMAST as a provider collaborative.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a party to this Agreement as a participant in CMAST but is not forming a CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 The CMAST Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this agreement, this agreement shall not be legally binding. The CMAST Trusts enter into this agreement with the approval of their boards and intending to honour all their obligations to each other.

2 Background

Vision

2.1 Our vision did span a range of time horizons. However as we have become more confident and cohesive we have summarised it to: Our vision is to work collectively for a single healthcare system to provide high quality, timely, efficient and productive services to everyone in Cheshire and Merseyside.

Key functions

2.2 The key functions of CMAST are to:

2.2.1 Deliver the CMAST vision;

2.2.2 Support the delivery of the ICS triple aim in Cheshire and Merseyside;

2.2.3 Align priorities across the member Trusts,

2.2.4 Support delivery by ICBs with the capacity to support population-based decision-making, and working with other collaboratives and partners to develop and support ICS maturity and encourage wider system working and collaboration

2.2.5 Direct operational resources across Trust members to improve service provision;

2.2.6 Prioritise key programmes for delivery on behalf of the Cheshire and Merseyside system; and

2.2.7 Create an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision.

2.3 CMAST's stated priorities are to strengthen each of the Trusts by sharing collective expertise and knowledge to deliver:

2.3.1 Clinical Improvement and Transformation

2.3.2 Sustainability and Value

By achieving this we believe we will:

2.3.3 Reduce health inequalities;

2.3.4 Improve access to services and health outcomes;

2.3.5 Stabilise fragile services;

2.3.6 Improve pathways;

2.3.7 Support the wellbeing of staff and develop more robust workforce plans; and

2.3.8 Achieve financial sustainability.

2.4 The Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision making structures; the CMAST CiCs acting through the CMAST Leadership Board.

2.5 More specifically the CMAST CiCs and the CMAST Leadership Board will facilitate the Trusts' work in the following key work programmes at this initial stage of CMAST development*:*

2.5.1 Delivery and coordination of the C&M Elective Recovery Programme;

2.5.2 Cancer Alliance delivery and enablement – subject to requests of the Alliance;

2.5.3 Delivery and coordination of the C&M Diagnostics Programme including system decision making on pathology optimisation following existing C&M case for change and OBC;

2.5.4 Initiation of proposals and case for change for clinical pathway redesign - subject to discrete decision making as may be appropriate;

2.5.5 Coordinating and enabling CMAST members contribution and response to collective system wide workforce needs, pressures and the People agenda;

2.5.6 Coordinating and enabling CMAST members contribution and response to system wide financial decision making, pressures and financial governance;

2.5.7 Responding to and coordinating CMAST action in response to any national, regional or ICB initiated priorities for example TIF, system or elective capital prioritisation, reduction in long waiters; and

2.5.8 The CMAST Trusts are part of the C&M ICS. Regional and inter regional relationships should first and foremost be guided by the ICB. To support this CMAST will provide both intelligence to the ICB and respond to ICB calls for action. Where necessary and appropriate CMAST may seek to develop relationships with peers or for trusts, across other ICS's and ICB's (for example, related to specialised commissioning). This will be notified and communicated between the CMAST Trusts in accordance with the principle outlined in clause 4.6.

The areas within scope of this Agreement may be amended though variation, by Trust Board resolutions or agreement of the annual CMAST workplan.

2.6 The Trusts will remain as separate legal entities with their own accountabilities and responsibilities. The priorities for CMAST will be complementary to (and do not revise or replace) the existing statutory duties of the Trusts (such as the delivery of NHS Constitutional Standards

or equivalent). For avoidance of doubt there is no intention that the governance structure outlined in this Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3 Rules of working

3.1 The Trusts have agreed to adopt this Agreement and agree to operate the CMAST CiCs as the **CMAST Leadership Board** in line with the terms of this Agreement, including the following rules (the "**Rules of Working**"):

3.1.1 Working together in good faith;

3.1.2 Putting patients interests first;

3.1.3 Having regard to staff and considering workforce in all that we do;

3.1.4 Consider the wider system impact and perspective and discuss proposals before any unilateral Trust action which may impact other Trusts;

3.1.5 Airing challenges to collective approach / direction within CMAST openly and proactively seeking solutions;

3.1.6 Support each other to deliver shared and system objectives;

3.1.7 Empower and expect our professional (executive) groups to think from a system perspective and to develop proposals with this in mind;

3.1.8 Recognising and respecting the collective view and keeping to any agreements made between the CMAST CiC's;

3.1.9 Maintain CMAST collective agreed position on shared decisions in all relevant communications;

3.1.10 Be accountable. Take on, manage and account to each other for performance of our respective roles and responsibilities; and

3.1.11 Appropriately engage with the ICB and with other partners on any material service change.

4 Process of working together

4.1 The CMAST CiCs shall meet together as the CMAST Leadership Board in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-14).

4.1.1 Meetings of the CMAST Leadership Board will be categorised under three types of business, dependent on the agenda to be discussed and whether any formal decisions are required to be taken:

A. CMAST Leadership Board – Operational business - Informal CEO discussions and representing the standard regular meeting structure; [1]

B. CMAST Leadership Board – Decisions to be made under the CMAST CiC delegations - CiC CEOs;

C. CMAST Leadership Board –CiC CEOs and Chairs discussion (or NED designate)

[1] Chairs will be invited to CMAST Leadership Board meetings, at least quarterly.

4.2 The CMAST CiCs shall work collaboratively with each other as the CMAST Leadership Board in relation to the committees in common model.

4.3 Each CMAST CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of Reference and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any CMAST CiC or its duty to act in the best interests of its Trust, each CMAST CiC shall seek to reach agreement with the other CMAST CiCs in the CMAST Leadership Board and take decisions in consensus, in light of its aims and Rules of Working set out in clauses 2 and 3 above.

4.4 When the CMAST CiCs meet in common, as the CMAST Leadership Board, the Meeting Lead shall preside over and run the meeting. The intention is that the lead arrangements will be reviewed periodically reflecting the will of the membership. The next review point is expected to be no later than 2025.

4.5 The Trusts agree that they will adopt a tiered approach to bringing decisions which come within the Terms of Reference to the CMAST Leadership Board which will reflect the principle of subsidiarity (that issues should be dealt with at the most immediate level that is consistent with their resolution**)** in the following approach:

Scale of involvement/impact	**Approach to decision**
Matter under discussion has no involvement or impact on other CMAST Trusts (e.g. local issue related to place)	Matter for the Trust involved and notified to the CMAST Leadership Board if appropriate.
Matter only involves or impacts a smaller group of CMAST Trusts and not all (e.g. specialised commissioning issue for specialist trusts)	The CMAST CiC's for the Trusts involved shall consider the required decision if it is within their delegation as set out in the Terms of Reference. Notify the CMAST Leadership Board.
Matter involves or impacts all CMAST Trusts and comes within the delegation under the CMAST CiCs (e.g. collaborative approach to non-clinical services or workforce)	Matter to be dealt with through the CMAST CiCs at the CMAST Leadership Board in accordance with this Agreement and the Terms of Reference.

4.6 Each CMAST Trust will report back to its own Board and the CMAST Leadership Board will be responsible for transparent information sharing in the form of common briefings and updates to each of the CMAST Trust Board meetings. The CMAST Trust chairs will (as well as their quarterly CMAST meetings - clause 4.1.1 above) meet regularly as a group to share information and for general discussions on CMAST on an informal basis. In addition, the CMAST Leadership Board will seek to ensure that each CMAST programme has the opportunity for a Chair sponsor to be appointed whose role will include updating the chairs meetings on the progress of the relevant programme.

4.7 When CMAST CiC meetings are intended to take decisions under the delegations made to those committees (in accordance with clause 4.1.1 B) then the meeting of CMAST (or if relevant, section of the meeting), will be held in public except where a resolution is agreed by the CMAST Leadership Board to exclude the public on the grounds that it is believed to not be in the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or

succeeded from time to time. Papers and minutes of CMAST meetings held in public will be published.

5 Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Agreement.

6 Exit Plan

6.1 Within three (3) months of the date of this Agreement the Trusts shall develop and agree an exit plan which shall deal with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this Agreement;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the CMAST CiC Chairs varying the Agreement under clause 10.6.2.

6.2 Once agreed by all of the Trusts, the exit plan shall be inserted into this Agreement at Appendix 15 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

7 Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant CMAST CiC committee and exit this Agreement ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the CMAST Leadership Board of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exit the Agreement,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 15) exit this Agreement.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its CMAST CiC and exits this Agreement then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this Agreement; or

7.3.2 Amend and replace this Agreement with a revised Agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8 Information Sharing and Competition Law

8.1 For the purposes of any applicable data protection legislation the Trusts shall be the data controller of any Personal Data (as defined in the UK General Data Protection Regulation (UK GDPR)) created in connection with the conduct or performance of the principles of this Agreement.

8.2 Where appropriate the CMAST Trusts agree to use all reasonable efforts to assist each other to comply with their respective responsibilities under any applicable data protection legislation. For the avoidance of doubt, this may include providing other Trusts with reasonable assistance in complying with subject access requests and consulting with other Trusts, as appropriate, prior to the disclosure of any Personal Data (as defined in the UK GDPR) created in connection with the conduct or performance of this Agreement in relation to such requests.

8.3 All Trusts will adhere to all applicable statutory requirements regarding data protection and confidentiality. The CMAST Trusts agree to co-operate with one another with respective statutory obligations under the Freedom of Information Act 2000 and Environmental Information Regulations 2004.

8.4 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the operation of this Agreement in an honest, open and timely manner. The Trusts, shall not, (save as permitted by this Clause 8) either during or after the period of this Agreement divulge or permit to divulge to any person (including the other Trusts) any information acquired form other Trusts in connection with this Agreement which concerns:

8.4.1 any matter of commercial interest contained or referred to in this Agreement;

8.4.2 Trusts' manner of operations, staff or procedures;

8.4.3 the identity or address or medical condition or treatment of services received by any client or patient of any of the Trusts;

unless previously authorised by the Trusts concerned in writing, provided that these obligations will not extend to any information which is or shall become public information otherwise than by reason of a breach by a Trust of the provisions of this Agreement.

CMAST is committed to clear, consistent and transparent communication across the CMAST Trusts and with system partners' where appropriate. It is specifically recognised that CMAST Trusts are part of the ICS and members of Place Based Partnerships and will be working with their local partners and other collaboratives. Communication to and from Place Based Partnerships will be key for CMAST and the CMAST Trusts may be asked to represent both their own organisations and CMAST in such local place-based discussions.

8.5 For the avoidance of doubt, nothing in this Agreement shall be construed as preventing any rights or obligations that the Trusts may have under the Public Interest Disclosure Act (1998) and / or any obligations to raise concerns about any malpractice with regulatory or other appropriate statutory bodies pursuant to professional and ethical obligations including those obligations set out in the guidance issued by regulatory or other appropriate statutory bodies from time to time.

8.6 The Trusts acknowledge and agree that each may be required to disclose Confidential Information to others. For the purpose of this Agreement "Confidential Information" means all information provided in connection with this Agreement which is secret or otherwise not publicly available (in both cases in its entirely or in part) including commercial, financial, marketing or

technical information, know-know or trade secrets, in all cases whether disclosed orally or in writing before or after the date of this Agreement.

8.7 The Trusts undertake for themselves and their respective Boards and employees that:

8.7.1 the disclosing Trust shall confirm whether information is to be regarded as confidential prior to its disclosure by clearly marking all such documents with 'Confidential';

8.7.2 they will use no lesser security measures and degree of care in relation to any Confidential Information received from the other Trusts than they apply to their own Confidential Information;

8.7.3 they will not disclose any Confidential Information of the other Trusts to any third party without the prior written consent of the disclosing Trust; and

8.7.4 on the termination of this Agreement, they will return any documents or other material in their possession that contains Confidential Information of the other Trusts.

8.8 The Trusts agree to provide in a timely manner and without restriction all information requested and required by the relevant designated CMAST Programme Support team (either internal team or external contractor where agreed) to carry out work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to CMAST activities.

8.9 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law to the extent applicable.

8.10 The Trusts commit to agreeing a protocol to manage the sharing of information to facilitate the futher operation or development of CMAST across the Trusts as envisaged if and when required.. Once agreed by the Trusts (and their relevant information officers) , this protocol shall be inserted into this Agreement at Appendix 16 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement[2].

9 Conflicts of Interest

9.1 Members of each of the CMAST CiCs shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the CMAST Leadership Board will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of CMAST's decision-making processes.

9.2 The CMAST Leadership Board will, where relevant, agree policies and procedures for the identification and management of conflicts of interest which will be published on the CMAST website. It is proposed that such policies will either be CMAST developed or CMAST will support the adoption and application of the policy of the CMAST Chair and/or Meeting Lead.

9.3 All CMAST Leadership Board, committee and sub-committee members, and employees acting on behalf of CMAST, will comply with the CMAST policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by CMAST. Reuse / resubmission of host employer or home trust data, where applicable, will be supported

[2] To date (2022 – 2024) it has been considered unnecessary and unwarranted by virtue of ICS facilitated and governed ways of working

9.4 All delegation arrangements made by the Trusts will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures agreed by the CMAST Leadership Board.

9.5 Where an individual, including any individual directly involved with the business or decision-making of the CMAST Leadership Board and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CMAST Leadership Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Agreement and any agreed CMAST Conflicts of interest Policy and Standards of Business Conduct Policy.

10 Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Rules of Working set out in clause 3 above.

10.2 If a problem, issue, concern, or complaint comes to the attention of a Trust in relation to any matter in this Agreement, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the CMAST CiCs at the CMAST Leadership Board the appropriate course of action to take.

10.4 If the Meeting Lead and the CMAST Leadership Board reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the decision by written notice. Any decision of the Meeting Lead and the CMAST Leadership Board will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the CMAST Leadership Board, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the CMAST Leadership Board, may determine whatever action they believe necessary to resolve the Dispute which may include:

10.5.1 appointment of a panel of CMAST Leadership Board members who are not involved in the dispute to consider the issues and propose a resolution to the Dispute;

10.5.2 mediation arranged by C&M ICB for consideration and to propose a resolution to the Dispute; or

10.5.3 if considered appropriate selecting an independent facilitator and utilising the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the CMAST Trusts, the facilitator will be nominated by CEDR to assist with resolving the Dispute;

and who shall:

- be provided with any information they request about the Dispute;
- assist the Meeting Lead and CMAST Leadership Board to work towards a consensus decision in respect of the Dispute;
- regulate their procedure and, subject to the terms of this Agreement, the procedure of the Meeting Lead and CMAST Leadership Board at such discussions;

- determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Working Days of their appointment; and

- where appropriate have their costs and disbursements met by the Trusts in dispute equally.

10.6 If the independent facilitator proposed under clause 1.5 cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only if after such further consideration the Trusts again fail to resolve the Dispute, the Meeting Lead and CMAST Leadership Board may decide to recommend their Trust's Board of Directors to:

10.6.1 terminate the Agreement;

10.6.2 vary the Agreement (which may include re-drawing the member Trusts); or

10.6.3 agree that the Dispute need not be resolved.

11 Variation

No variation of this Agreement shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

12 Counterparts

12.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement.

12.2 The expression "counterpart" shall include any executed copy of this Agreement transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with English law.

This Agreement is executed on the date stated above by

……
For and on behalf of **COUNTESS OF CHESTER HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE CLATTERBRIDGE CANCER CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL HEART AND CHEST HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE WALTON CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL WOMEN'S NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **ALDER HEY CHILDREN'S HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **EAST CHESHIRE NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MID CHESHIRE HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **NORTH WEST AMBULANCE SERVICE NHS TRUST**

APPENDIX 1 – TERMS OF REFERENCE FOR THE COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Countess of Chester Hospital NHS Foundation Trust CiC]

APPENDIX 2 – TERMS OF REFERENCE FOR THE LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool University Hospitals NHS Foundation Trust CiC]

APPENDIX 3– TERMS OF REFERENCE FOR WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 4 – TERMS OF REFERENCE FOR THE WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Wirral University Teaching Hospital NHS Foundation Trust CiC]

APPENDIX 5 – TERMS OF REFERENCE FOR THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Clatterbridge Cancer Centre NHS Foundation Trust CiC]

APPENDIX 6 – TERMS OF REFERENCE FOR THE LIVERPOOL HEART AND CHEST HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Heart and Chest Hospitals NHS Foundation Trust CiC]

APPENDIX 7 – TERMS OF REFERENCE FOR THE WALTON CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Walton Centre NHS Foundation Trust CiC]

APPENDIX 8 – TERMS OF REFERENCE FOR THE LIVERPOOL WOMEN'S NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Women's NHS Foundation Trust CiC]

APPENDIX 9 – TERMS OF REFERENCE FOR THE ALDER HEY CHILDREN'T HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Alder Hey Children's Hospital NHS Foundation Trust CiC]

APPENDIX 10 – TERMS OF REFERENCE FOR THE EAST CHESHIRE NHS TRUST CIC

[Insert Terms of Reference for the East Cheshire NHS Trust CiC]

APPENDIX 11 – TERMS OF REFERENCE FOR THE ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Mersey and West Lancashire Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 12 – TERMS OF REFERENCE FOR THE MID CHESHIRE HOSPITALS NHS TRUST CIC

[Insert Terms of Reference for the Mid Cheshire Hospitals NHS Trust CiC]

APPENDIX 13 – TERMS OF REFERENCE FOR THE NORTH WEST AMBULANCE SERVICE NHS TRUST CIC

[Not applicable]

APPENDIX 14 - EXIT PLAN

1 In the event of termination of this Agreement by all parties, the Trusts agree that:

1.1 each Trust will be responsible for its own costs and expenses incurred because of the termination of the Agreement up to the date of termination UNLESS it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;

1.2 upon reasonable written notice, each Trust will be liable for one thirteenth of any professional advisers' fees incurred by and on behalf of CMAST in relation to the termination of this Agreement (if any) up to and including the date of termination of this Agreement;

1.3 each Trust will revoke its delegation to its CMAST Committee in Common (CiC) on termination of this Agreement;

1.4 termination of this Agreement shall not affect any rights, obligations or liabilities that the Trusts have accrued under this Agreement prior to the termination of this Agreement; and

1.5 there are no join assets and resources but should these be identified in the future, Trusts will need to confirm agreement at termination of this Agreement how any joint assets or resources will need to be dealt with on termination of the Agreement.

2 In the event of an Exiting Trust leaving this Agreement in accordance with clause 7, the Trusts agree that:

2.1 a minimum of six months' notice will be given by the Exiting Trust and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the Exiting Trust's exit from CMAST and this Agreement up to and including the Exiting Trust's date of exit from this Agreement. Notwithstanding this, the Exiting Trust's total aggregate liability, in respect of such reasonable costs and the expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the CMAST CiC;

2.2 upon reasonable written notice from the other Trusts, the Exiting Trust shall be liable to pay [one thirteenth of] any professional advisers' fees incurrent by and on behalf of CMAST as a consequence of the Exiting Trust's exit from the Working Together Partnership and this Agreement up to and including the date of exit of the Exiting Trust from this Agreement;

2.3 the Exiting Trusts will revoke its delegation to its CMAST CiC on its exit from this Agreement;

2.4 the remaining Trusts shall use reasonable endeavours to procure that the Agreement is amended or replaced as appropriate in accordance with clause 7.3.2;

2.5 subject to any variation to or replacement of this Agreement in accordance with paragraph 2.4 above, and clause 7.3.2, this Agreement shall remain in full force and effect following the exit of the Exiting Trust from this Agreement

APPENDIX 15 - INFORMATION SHARING PROTOCOL

[to be inserted once deemed necessary and agreed]

CMAST LEADERSHIP BOARD
TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER CMAST TRUSTS

TERMS OF REFERENCE

1 Introduction

1.1 In these terms of reference, the following words bear the following meanings:

Cheshire & Merseyside Acute and Specialist Trusts Provider Collaborative or CMAST	the partnership formed by the Trusts to work together to improve quality, safety and the patient experience; deliver safe and sustainable new models of care; and make collective efficiencies. This operates within the NHS Cheshire & Merseyside Integrated Care System.
CMAST Agreement	the joint working agreement signed by each of the Trusts in relation to their provider collaborative working and the operation of the **[TRUST]** CiC together with the other CMAST CiCs;
CMAST CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMAST CiC**" shall be interpreted accordingly;
CMAST Programme Steering Group	the Group, to provide programme support and oversight of the delivery of agreed collaborative activities;
CMAST Programme Lead	Named Lead Officer or any of subsequent person holding such title in relation to CMAST;
CMAST Programme Support	Administrative infrastructure supporting CMAST;
Meeting Lead	the CiC Member nominated (from time to time) in accordance with paragraph 7.6 of these Terms of Reference, to preside over and run the CMAST CiC meetings when they meet in common;
Member	a person nominated as a member of an CMAST CiC in accordance with their Trust's Terms of Reference, and Members shall be interpreted accordingly;
NHS Cheshire & Merseyside Integrated Care System or "C&M ICS"	the Integrated Care System (ICS) for Cheshire and Merseyside bringing together NHS organisations, councils, and wider partners in a defined geographical area to deliver more joined up care for the population.
[TRUST] CiC	the committee established by **[TRUST]** NHS Foundation Trust, pursuant to these Terms of

	Reference, to work alongside the other CMAST CiCs in accordance with these Terms of Reference;
[TRUST] NHS Foundation Trust	**[TRUST]** NHS Foundation Trust of [Address];
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey Children's Hospital NHS FT, East Cheshire NHS Trust, Mersey and West Lancashire Teaching Hospitals NHS Trust and Mid Cheshire Hospitals NHS FT and "**Trust**" shall be interpreted accordingly;
Working Day	a day other than a Saturday, Sunday or public holiday in England;

1.2 The [Trust] NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in CMAST to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a participant in CMAST but is not forming its own CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 Each Trust has entered into the CMAST Agreement on **[DATE]** and agrees to operate its CMAST CiC in accordance with the CMAST Agreement.

2 Aims and Objectives of the [TRUST] CiC

2.1 The aims and objectives of the [Trust] CiC are to work with the other CMAST CiCs on system work or matters of significance as delegated to the [Trust] CiC under Appendix A to these Terms of Reference to:

2.1.1 provide strategic leadership, oversight and delivery of new models of care through the development of CMAST and its workstreams;

2.1.2 set the strategic goals for CMAST, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

2.1.3 consider different employment models for service line specialities including contractual outcomes and governance arrangements;

2.1.4 review the key deliverables and hold the Trusts to account for progress against agreed decisions;

2.1.5 ensure all Clinical Networks or other collaborative forums, by working in partnership with the ICB, have clarity of responsibility and accountability and drive progress;

2.1.6 establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

2.1.7 receive and seek advice from the relevant Professional (reference) Groups, including Clinical, Finance, Human Resources;

2.1.8 receive and seek advice from the NHS Cheshire and Merseyside Integrated Care Board;

2.1.9 review and approve any proposals for additional Trusts to join the founding Trusts of CMAST;

2.1.10 ensure compliance and due process with regulating authorities regarding service changes;

2.1.11 oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.1.12 review the CMAST Agreement and Terms of Reference for CMAST CiCs on an annual basis;

2.1.13 improve the quality of care, safety and the patient experience delivered by the Trusts;

2.1.14 deliver equality of access to the Trusts service users; and

2.1.15 ensure the Trusts deliver services which are clinically and financially sustainable.

3 Establishment

3.1 The **[TRUST]** NHS Foundation Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the **[TRUST]** CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the **[TRUST]** CiC.

3.2 The **[TRUST]** CiC shall work cooperatively with the other CMAST CiCs and in accordance with the terms of the CMAST Agreement.

3.3 The **[TRUST]** CiC is a committee of **[TRUST]** NHS Foundation Trust's board of directors and therefore can only make decisions binding **[TRUST]** NHS Foundation Trust. None of the Trusts other than **[TRUST]** NHS Foundation Trust can be bound by a decision taken by **[TRUST]** CiC.

3.4 The **[TRUST]** CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The **[TRUST]** CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

4 Functions of the Committee

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in **[TRUST]** NHS Foundation Trust's Constitution.

4.2 **[TRUST]** CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 Functions reserved to the Board of the Foundation Trust

Any functions not delegated to the **[TRUST]** CiC in paragraph 4 of these Terms of Reference shall be retained by **[TRUST]** NHS Foundation Trust's Board or Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of **[TRUST]** NHS Foundation Trust to delegate functions to another committee or person.

6 Reporting requirements

6.1 On receipt of the papers detailed in paragraph 13.1.2, the **[TRUST]** CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to **[TRUST]** NHS Foundation Trust's Board for inclusion on the private agenda of **[TRUST]** NHS Foundation Trust's next Board meeting in order that **[TRUST]** NHS Foundation Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The **[TRUST]** CiC shall send the minutes of **[TRUST]** CiC meetings to **[TRUST]** NHS Foundation Trust's Board, on a monthly basis, for inclusion on the agenda of **[TRUST]** NHS Foundation Trust's Board meeting.

6.3 **[TRUST]** CiC shall provide such reports and communications briefings as requested by **[TRUST]** NHS Foundation Trust's Board for inclusion on the agenda of **[TRUST]** NHS Foundation Trust's Board meeting.

7 Membership

7.1 The [TRUST] CiC shall be constituted of directors of [TRUST] NHS Foundation Trust. Namely the [TRUST] NHS Foundation Trust's Chief Executive who shall be referred to as a "Member".

7.2 Each **[TRUST]** CiC Member shall nominate a deputy to attend **[TRUST]** CiC meetings on their behalf when necessary ("**Nominated Deputy"**).

7.3 The Nominated Deputy for **[TRUST]** NHS Foundation Trust's Chief Executive shall be an Executive Director of **[TRUST]** NHS Foundation Trust.

7.4 In the absence of the **[TRUST]** CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 attend [TRUST] CiC's meetings;

7.4.2 be counted towards the quorum of a meeting of [TRUST] CiC's; and

7.4.3 exercise Member voting rights,

and when a Nominated Deputy is attending a **[TRUST]** CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to "Members".

7.5 The chair of the **[TRUST]** CiC shall be nominated by the **[TRUST]** CiC.

7.6 When the CMAST CiCs meet in common, one person nominated from the Members of the CMAST CiCs shall be designated the Meeting Lead and preside over and run the meetings on a rotational basis for an agreed period.

8 Non-voting attendees

8.1 The Members of the other CMAST CiCs and the chief executive (or designated deputy) of the North West Ambulance Service NHS Trust shall have the right to attend the meetings of [TRUST] CiC. The **[TRUST]** 's Chair shall be invited to meetings of the CMAST CiCs on at least a quarterly basis (or where the CiC feels it is appropriate – see CMAST JWA) as a non-voting attendee.

8.2 The Meeting Lead's Trust Corporate Secretary shall have the right to attend the meetings of **[TRUST]** CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CMAST CiCs.

8.3 The CMAST Programme Lead shall have the right to attend the meetings of **[TRUST]** CiC.

8.4 Without prejudice to paragraphs 8.1 to 8.3**Error! Reference source not found.** inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the CMAST CiCs' meetings, but for the

avoidance of doubt, any such persons in attendance at any meeting of the CMAST CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of **[TRUST]** CiC.

9 Meetings

9.1 Subject to paragraph 9.3 below, [TRUST] CiC meetings shall take place monthly.

9.2 The [TRUST] CiC shall meet with the other CMAST CiCs as the CMAST Leadership Board in accordance with the CMAST Agreement (as set out in clause 4 of the CMAST Agreement) and discuss the matters delegated to them in accordance with their respective Terms of References.

9.3 Any Trust CiC Member may request an extraordinary meeting of the CMAST CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the CMAST Programme Lead shall give five (5) Working Days' notice to the Trusts.

9.4 Meetings of the [TRUST] CiC shall generally be held in public save where items are agreed to be private and confidential and otherwise in accordance with clause 4.6 of the CMAST Agreement.

9.5 Matters not discussed in public in accordance with paragraph 9.4 above and dealt with at the meetings of the [TRUST] CiC shall be confidential to the [TRUST] CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of [TRUST] Board.

10 Quorum and Voting

10.1 Members of the [TRUST] CiC have a responsibility for the operation of the [TRUST] CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the [TRUST] CiC shall have one vote. The [TRUST] CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be one (1) Member.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11 Conflicts of Interest

11.1 Members of the [TRUST] CiC shall comply with the provisions on conflicts of interest contained in [TRUST] NHS Foundation Trust Constitution/Standing Orders, the CMAST Agreement and NHS Conflicts of Interest guidance. For the avoidance of

doubt, reference to conflicts of interest in [TRUST] NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the [TRUST] CiC.

11.2 All Members of the [TRUST] CiC shall declare any new interest at the beginning of any [TRUST] CiC meeting and at any point during a [TRUST] CiC meeting if relevant.

12 Attendance at meetings

12.1 [TRUST] shall ensure that, except for urgent or unavoidable reasons, [TRUST] CiC Members (or their Nominated Deputy) shall attend [TRUST] CiC meetings (in person) and fully participate in all [TRUST] CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the [TRUST] CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) to speak to the other or others, and be heard by the other or others simultaneously.

13 Administrative

13.1 Administrative support for the [TRUST] CiC will be provided by CMAST Programme Support (or such other route as the Trusts may agree in writing). The CMAST Programme Support will:

13.1.1 draw up an annual schedule of CMAST CiC meeting dates and circulate it to the CMAST CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to CMAST CiC meetings; and

13.1.3 take minutes of each [TRUST] CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant [TRUST] CiC meeting.

13.2 The agenda for the [TRUST] CiC meetings shall be determined by the CMAST Programme Lead and agreed by the Meeting Lead prior to circulation.

13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the CMAST Programme Support to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE [TRUST] CIC

The Board of each Trust within CMAST remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to [TRUST] NHS Foundation Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the [TRUST] CiC to decide are set out in the table below.

If it is intended that the CMAST CiCs are to discuss a proposal or matter which is outside the decisions delegated to the [TRUST] CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the [TRUST] CiC meeting with a view to [TRUST] CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by [TRUST] NHS Foundation Trust's Board). Any proposals discussed at the [TRUST] CiC meeting outside of these parameters would come back before [TRUST] NHS Foundation Trust's Board.

References in the table below to the "Services" refer to the services that form part of the CMAST Agreement for joint working between the Trusts (as set out in Clause 2.6 of the CMAST Agreement and which may be supplemented or further defined by an annual CMAST Work Programme) and may include both back office and clinical services.

	Decisions delegated to [TRUST] CiC
1.	Providing overall strategic oversight and direction to the development of the CMAST programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the key Rules of Working;
3.	Seeking to determine or resolve any matter within the remit of the [TRUST] CiC referred to it by the CMAST Programme Steering Group or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the benefits and risks associated in terms of the impact to CMAST Programmes and recommending remedial and mitigating actions across the system;
5.	Formulating, agreeing and implementing strategies for delivery of CMAST Programmes;
6.	In relation to services preparing business cases to support or describe delivery of agreed CMAST priorities or programmes (including as required by any agreed CMAST annual work programme);

	Decisions delegated to [TRUST] CiC
7.	Provision of staffing and support and sharing of staffing information in relation to Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information; b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. carrying out an analysis of the implications of TUPE on the joint arrangements; d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. undertaking soft market testing and managing procurement exercises; f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. amendments to joint venture agreements for the Services.

	Decisions delegated to [TRUST] CiC
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;
12.	Reviewing the Terms of Reference and CMAST Joint Working Agreement on an annual basis.

APPROVED BY BOARD OF DIRECTORS: [DATE]

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public
2 October 2024

Item No 16.2

Report Title	Committee Chair's Report – People Committee
Author	Lesley Davies, Chair of People Committee

Overview of Assurances Received

- The Committee was provided with a presentation from the Chair of Disability Staff Led Group. The work undertaken by the group is comprehensive with members of the group co-creating improvements to the centralisation of support resources and improvements in accessibility for staff with disabilities to support. Initiatives to raise the awareness of disability across the Trust have also been taken forward. The next step will be for the Trust to evaluate the impact of the support given and if staff are benefitting from the resources and support available. The Committee was assured to see the range of actions being taken to support the Trust's staff and, as this is a key focus of the Trust's work this year, look forward to seeing the impact of this work to ensure that it is making a difference.

- The Committee discussed the recent board seminar on Equality, Diversity and Inclusion and the next steps in taking this work forward. The Trust's programme of work and focus on ensuring staff feel supported and that the Trust's processes and procedures support the equality agenda is extensive and measuring the impact of this work is at the forefront of ensuring that the Trust's actions are effective. The Committee will continue to review progress being made throughout the year.

- The Committee was updated on employee relations and noted the rise in race cases following the recent civil unrest. Staff are monitoring the situation closely and are taking action to ensure that staff and patients are protected. The main issues have related to alleged racist activity on social media.

- The Committee was assured of the work being undertaken to manage sickness absenteeism which has increased from 5.94% to 6.06% (12 month rolling sickness rate). The reasons for absence are monitored by Trust staff effectively and managers support staff to get back to work. Supportive interventions include a strong divisional focus, focus on workforce well being and preventative wellness programmes.

- The Trust's Safe Staffing Report was discussed in depth and the Committee took assurance of the actions being taken by the Chief Nurse to mitigate risks as detailed below. The Chief Nurse reported a positive improvement in the continued reduction in the number of Red Professional Judgement shifts for the past two months. The Chief Nurse also reported that the vacancy rate in Care Support Workers had increase but the Committee took good assurance of the mitigation and action being taken to address the situation.

- The Committee reviewed the Board Assurance risks assigned to the Chief People Officer

Items for Escalation/Action

- Nurse Safe Staffing Report. It was brought to the attention of the Committee that the ward-based nursing acuity review is overdue by 12 months. This review must be undertaken to ensure compliance with national quality board 'standards for safe sustainable and productive staffing' (2017) and NHSI's 'developing workforce safeguards, supporting providers to deliver high quality care through safe and effective staffing' (2018) and a full review of nurse staffing should be completed every 6 months to provide assurance that the staff establishment is adequate to meet the demands of the service.
- The process has been delayed as a result of industrial action and the launch of an updated version of the safer nursing care tool. Training has been provided to key individuals and that training is now being cascaded and the acuity and dependency review will commence in October 2024. Given the data analysis required to determine effective rosters/establishment, the results from this review is not expected until December 2024 at the earliest.
- There has been a change in the delivery of the recruitment of registered nurse and midwife graduate pipeline, which has been reduced from two cohorts per year to one in September. This will be the Trusts main recruitment opportunity and will require careful planning to ensure the unevenness of supply is effectively managed. Until recently the pipeline has been smoothed by a regular supply of international recruits. External recruitment for experienced staff will continue, however this process only provides a small number of applicants compared to new graduates.

New/Emerging Risks

- The delay to the acuity review has the potential impact assurance on safe effective staffing. However, the senior team have already commenced action to address this delay and is monitoring closely the staffing of shifts and there are currently no areas of high risk. The acuity review for the emergency department has been completed and an associated business case will be presented tot eh board on the 2nd October 2024.
- The reduction in recruitment opportunities to one per year is already being planned with mitigating action being undertaken. The Chief Nurse is also exploring the nursing associate apprenticeship route as part of a revised nursing workforce plan. Which would provide more flexibility and enable to Trust to be more responsive to staffing requirements throughout the year and offer progression opportunities for other staff within the Trusts for example, Care Support Workers

Other comments from the Chair

- The Committee noted the significant workload of those delivering the People Strategy and the increase in activity due in some part, to ongoing staff disputes and it thanked the staff for their work. The Committee is keen to see the impact of the programmes being undertaken this year, particularly in the area of equality, disability, and inclusion.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 16.3**
2 October 2024

Report Title	Committee Chair's Reports – Research and Innovation Committee
Author	Dr Steve Ryan, Non-Executive Director & Meeting Chair

Items for Escalation/Action

- The Committee received a presentation following a request at its last meeting. This was to articulate the aims and priorities arising from the research and innovation strategy. The vision is for WUTH to gain a clearer credibility so as to be recognised as a research active organisation, with a diverse portfolio of studies including an increasing number of commercially sponsored studies, with the aim of every patient being offered the opportunity to be involved in studies. For more and ultimately all relevant staff to be involved in raising awareness of researching promoting studies in this area.

- The Committee then received an update comparative performance in level of patient recruitment, by Department, Division and also compared to other Trusts in the Northwest Coast Comprehensive Research Network (NWC:CRN). This is based on the metric of total number of patients recruited into studies - whether they are receiving innovative new medicinal products in a high resource research setting or simply having data already held copied into a study. All agreed this was a blunt metric and did little to showcase the quality of research. The Committee were therefore pleased to see an outline proposal on a small group of metrics about that would better demonstrate our research quality. It was agreed that a more defined proposal would be brought back to a future meeting. It was agreed that alignment with the likely metrics to be used by the Northwest Regional Research Network from April 2026 would be important in managing the risk of a significant change in the assessment of research from which would flow research funding.

- Of 48 studies on the Trust's portfolio, 28 are open and active of which 5 are commercially sponsored. The research leadership team gave examples of how they were getting into the details of studies that were not reaching agreed milestones and taking action.

- The Committee were delighted to hear about the official opening of the Clinical Research and Innovation Centre at Clatterbridge on Thursday 12th September. Chris Smith the Chief operating Officer of the NWC CRN who attended the event said, *"The Wirral Research and Innovation Centre will improve access to research that is relevant to people's healthcare conditions and act as a catalyst for further collaboration. The launch today is a further step in delivering its strategy to improve healthcare through cutting edge research and innovation."*

- There was a discussion on two areas to make our research reach more patients and increase the chances of successful research. This included a more flexible approach to supporting research active staff (e.g. in critical care) and also in focussing more effort where we have the greatest chance of success. Where necessary the Target Operating Model for delivering our strategy will be adapted to take this into account.

- The Committee noted that the Terms of Reference were to remain unchanged this year.

New/Emerging Risks

- The transfer to the Northwest Regional Research Network based in Manchester from the NWC:CRN in April 2026 represents a risk of not securing adequate funding to enact our strategy. In part his is being clear on the likely metrics of assessment and ensuring that we strive for and achieve good results when measured against these metrics.

Overview of Assurances Received

- The Committee received good assurance that there is increasingly accurate assessment of research performance and a realistic understanding of the opportunities. There is a very good level of interest and ambition for research across the Trust and we are connecting those staff to opportunities to engage.

Other comments from the Chair

- Unfortunately, the meeting was not quorate but there were no substantive items requiring decision making.

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting Name Trust Board in Public **Item No 16.4**
Date October 2nd, 2024

Report Title	Chair's Report: Quality Assurance Committee 20th September 2024
Author	Dr. Steven Ryan

Items for Escalation/Action

- Clostridioides difficile remains a concern, as demonstrated in a number of reports and so remains a high priority. As well as focused input by the Infection Prevention and Control (IPC) Team in aspects such as speed of isolation, cleaning and sampling, a specific quality improvement collaborative in 5 clinical areas has been commenced. Additionally, the Chief Nurse shared the Trust's repose to NHS England's review of high C. Difficile rates across the Wirral in community and health care settings, to the Place Quality Performance Group. This was well received by all partners, and it was agreed to develop a "Four pillar plan" involving all partners including primary care. The oversight of this partnership plan will lie with the Wirral Public Health Protection Board.

- There had been an increase in violence and aggression from patients in one clinical area related to their underlying health condition being more prominent in male patients. Our new Head of Security is overseeing the provision of relevant training and support to staff. As a result of this being an exclusively male clinical area, it has been agreed that changing the sex mix of wards is necessary to manage the situation.

- A previously received national audit report showed that the Trust was achieving much lower reported delirium screening rates than on expected. As a result, vacancies in leadership positions in dementia have been addressed and technical issues in data recording are also being investigated. There is no evidence of this having had a specific impact on clinical quality, but thorough PSIRF and other intelligence, this will continue to be monitored.

- There remain 3 overdue risks on the CQC action plan: neonatal unit environment, individual care planning and clinical supervision. For the former active consideration of the best estates solution (noting the restricted level of capital funding available) is underway. The latter two actions are going to be reviewed in the light of changes in approach arising from national policy and learning. Never-the-less it was agreed that a report would be developed to show the degree of residual risk for each of these areas.

New/Emerging Risks

- No new risk was identified, and the committee were satisfied that the current Board Assurance Framework risks were correctly rated.

Overview of Assurances Received

- The Committee received 3 annual assurance reports which will be presented at this Trust Board meeting: Complaints, Organ Donation and Safeguarding. The Committee noted the high quality of these reports and gained substantial assurance in each area. Progress was noted in each area since last year's report but also noted that further progress was required in some respects which will continue to be monitored: e.g. timeliness of response to all of our complaints (albeit against a background against complaint rate of 0.04% of episodes) and comprehensives of use of the Child protection Information System in all relevant area. There was progress in timeliness of initial health assessments in children entering care, partly by addressing bottlenecks in inter-organisational information transfer. Very pleasingly over 2000 members of staff had accessed Tier 1 Oliver McGowan training on learning disability and autism in a 2-week period.

- The Committee was able to triangulate the intelligence it receives through the Mortality Review Group - that the Trust's high coding rate for palliative care relates to the timeliness and impact of our excellent specialist palliative care team, as demonstrated by metrics in the palliative care annual report.

- The Committee had sight of its first Patient safety incident investigation report. This gave assurance of the improved quality of process and engagement and clarity of learning. It was noted that we now have 3 patient safety partners in post.

- An update was provided on work on Local safety standards for invasive procedures (LocSSIPs), work which was initiated following a number of never events in recent years. Substantial evidence has been submitted from the services involved and we are due to receive an internal audit assurance report on the standards imminently.

Other comments from the Chair

- The reports provided to the committee were high quality and contained the necessary detail for the committee to test the assurances that were provided. Additionally, authors and area leads were able to respond to enquiries to assist the committee in formulating its opinion on assurance.

- The Committee reviewed its terms of reference noting the only changes that 5 executive directors will generally attend the meeting.