Notice of Meeting and Agenda

Midlothian Integration Joint Board

Venue: **Council Chambers/Hybrid,**
Midlothian House, Dalkeith, EH22 1DN

Date: **Thursday, 19 December 2024**

Time: **14:00**

Morag Barrow
Chief Officer

Contact:

Clerk Name:	Democratic Services
Clerk Telephone:	0131 271 3160
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Further Information:

This is a meeting which is open to members of the public.

1 Welcome, Introductions and Apologies

2 Order of Business

Including notice of new business submitted as urgent for consideration at the end of the meeting.

3 Declaration of Interest

Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

4 Minute of Previous Meeting

5 Public Reports

5.7	IJB Finance Update and Medium-Term Financial Strategy - Paper prepared by Andrew McCreadie, Deputy Director of Finance, David Gladwin, Chief Financial Officer and Ruth Nicols, Senior Finance Business Partner	87 - 102
5.8	IJB Performance Report - Paper presented by Elouise Johnstone, Performance Manager	103 - 132
5.9	Midlothian HSCP Public Health Practitioner Update - Paper by Ruth Flynn, Public Health Practitioner	133 - 140
5.10	Integrated Assurance Report - Paper presented by Fiona Stratton, Chief Nurse and Claire Ross, Chief AHP	141 - 192
	For Noting	
5.11	Darzi Report - Paper prepared by Gill Main, Integration Manager	193 - 364
5.12	East Lothian and Midlothian Public Protection Team Annual Report - Paper prepared by Nick Clater, Head of Adult Services	365 - 410
5.13	Chief Social Work Officer Annual Report - Paper prepared by Nick Clater, Head of Adult Services	411 - 444

6 Private Reports

No items for discussion

7 Date of Next Meeting

The next meeting of the Midlothian Integration Joint Board will be held on:
- Thursday 9th January 2025, 14:00-16:00, Development session for Board Members only.
- Thursday 20th February 2025, 14:00-16:00, Midlothian Integration Joint Board Full Board Meeting.

Meeting	Date	Time	Venue
Midlothian Integration Joint Board	Thursday, 24 October 2024	2.00pm	Council Chambers, Midlothian House and Virtual Meeting held using Microsoft Teams.

Present (voting members):		
Connor McManus (Chair)	Val de Souza (Vice Chair NHS) (attended virtually)	Dr Amjad Khan (NHS Lothian)
Councillor Milligan	Andrew Fleming (NHS Lothian)	Kirsty MacDonald (NHS Lothian attended virtually)

Present (non-voting members):		
Morag Barrow (Chief Officer)	David King (Interim Chief Finance Officer)	Nick Clater (Head of Adult Services and Chief Social Work Officer)
Grace Chalmers (Partnership Representative)	Claire Ross (Chief AHP)	Dr Rebecca Green (Clinical Director)

In attendance:		
Councillor McKenzie	Gill Main (Integration Manager)	Fiona Kennedy (Group Service Manager)
Grace Cowan (Head of Primary Care and Older Peoples Services)		Jim Sherval (Consultant in Public Health) (attended virtually)

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Elouise Johnstone (Performance Manager) (attended virtually)	Martin Bonnar (attended virtually)	Ruth Flynn Public Health Practitioner
	Councillor Virgo (attended virtually)	Iina Jaara (Democratic Services Team Leader)
Hannah Forbes (Democratic Services Officer)	Maria Perez (Democratic Services Officer)	Nicola Thorburn (Democratic Services Officer)

Apologies:		
Councillor Parry	Christine Gardiner (External Auditor, Audit Scotland)	Fiona Stratton (Chief Nurse)

1. Welcome and Introductions

The Chair welcomed everyone to this Meeting of the Midlothian Integration Joint Board (MIJB).

Apologies were received from Councillor Parry, Christine Gardiner (Audit Scotland) and Fiona Stratton (Chief Nurse).

2. Order of Business

The order of business was confirmed as outlined in the agenda that had been previously circulated.

3. Declarations of Interest

No declarations of interest were received.

Keith Chapman disclosed that he is a trustee of Alzheimer Scotland.

4. Minute of Previous Meetings

4.1 The Minute of previous Midlothian IJB Board Meeting held on 22nd August 2024 was approved as an accurate record.

4.2 The Minute of the meeting of the MIJB – Strategic Planning Group held on 29 August 2024 was approved as an accurate record.

4.3 The Minute of the meeting of the MIJB - Audit and Risk Committee held on 6 June 2024 was approved as an accurate record.

5. Public Reports

	Decision	Action Owner	Date to be Completed/Comments
5.1 Chair's Update, presented by Councillor McManus The Chair provided a brief update, highlighting the upcoming finance workshop provided by David King in November. At the next meeting of MIJB the chair will not be able to make this meeting, Val de Souza will be chairing the meeting in the absence. The Chair reminded members of the MIJB that there are two town hall briefings coming up.			
5.2 Chief Officer's Report – Presented by Morag Barrow, Chief Officer Morag Barrow, Chief Officer, presented the report and advised the paper sets out the key strategic updates for the Board. This report is for noting. The Chief Officer highlighted items for the attention of the Board. • The position we are in with the Chief Finance officer, it was explained that we have failed to recruit to the deadline, there needs to be an agreed decision on the next steps. • The first Partner meeting since Covid has taken place and noted that they will be meeting regularly to discuss any issues. Another meeting is planned for mid-November. • The Pharmacy team won the NHS Lothian awards for negotiation costing and prescribing. Congratulations was passed to the team. • In terms of where we are regarding transformation, Dr Rebecca Green is leading some work with Fiona Stratton and Claire Ross regarding the transformation approach. The full report will be available after Christmas.			

	Decision	Action Owner	Date to be Completed/Comments
Staff were commended on the great work. A question arose regarding whether the legal opinion from the King's Council was going to be shared. Nick Clater advised that there is an 18-page opinion that and a summary from Midlothian Council's Legal Section. He will ascertain whether this can be shared. Delayed discharge status was highlighted. Grace Chalmers gave an update, and advised that there been no intervention from the Scottish Government in Midlothian			
5.3 Strategic Planning Group Update – Report presented by Andrew Fleming, SPG Chair Officer Andrew Fleming, Strategic Planning Group (SPG) Chair, presented the report and advised the paper sets out the key strategic updates for the Board. This report is for noting. SPG Chair reported that due to lower than anticipated engagement, planned in-person townhall sessions had been cancelled as part of the consultation on the draft Strategic Plan. Discussion took place as to engagement with the community and other options to explore, noting that other regular community events would not be happening due to resource limitations. The Chief Officer advised the Board, that if they haven't responded to any invitations to please respond for the upcoming virtual sessions.			
5.4 Audit and Risk Committee Update – Report presented by Val de Souza, Audit and Risk Chair Val de Souza, Vice Chair NHS presented the report. This report provides an update on Audit and Risk committee and is for noting.			

	Decision	Action Owner	Date to be Completed/Comments
The Vice Chair highlighted the key points discussed at the meeting on 19th September Audit and Risk Committee, 1) the need for a fair and transparent process whilst recruiting for an independent member. 2) the need for a Vice Chair for the Audit and risk committee to be appointed 3) The risk register was discussed, highlighting the financial risks and the details around the risk level being increased. 4)The main body of the meeting was with Audit Scotland. Audit Scotland presented their report that scrutinised the IJB governance, they were satisfised while highlighting some low-level issues. The low-level issues have now been investigated, and the auditors are satisfied. The Audit Commission report was noted, and it was expressed that the report should be circulated to members for information. The Chair thanked the Vice Chair NHS for the update on the Audit and Risk committee.			
For Decision **5.5 MIJB Membership Recommendations - Paper presented by Democratic Services** Iina Jaara, Democratic Services Team Leader presented the paper. This report provides information about changes to non-voting membership of the Midlothian Integration Joint Board (IJB) and seeks the Board's formal endorsement of them. **Members are asked to:** • Endorse the nomination of Nick Clater as a non-voting member of the Midlothian Integration Joint Board • Note the formal resignation of Johanne Simpson from the role as Medical Practitioner to the Midlothian Integration Joint Board The report was approved by the Board.			

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	Decision	Action Owner	Date to be Completed/Comments
For Decision **5.6 Annual Performance Report Review for Publication - Paper presented by Elouise Johnstone, Performance Manager** The Performance Manager presented the report, advising it was for decision. The purpose of the report is to update Midlothian Integration Joint Board (IJB) on the Annual Performance Report (appendix 1), providing information on the health and wellbeing of the people of Midlothian and an assessment of our performance towards achieving the 9 National Health and Wellbeing Outcomes. It also describes the financial performance of the IJB, and the quality of health and care services delivered during 2023/24. The Chair thanked the Performance Manager for the report and opened to any questions. Comments were noted on the report structure and content, with the Performance Manager and team being commended for all their hard work. The carers strategy timeline and vacancy of Board representation from carers was raised. The Integration Manager stated that the need for care has changed since the last careers strategy review. Advising this will be due for review at the publication of the next plan. The Head of Adult Services expressed the need for carers and the efforts that have been taken to fulfil the Board post. Discussions turned to the Weight Management service. The Chair asked the Chief AHP if traditional methods were still employed or if are we adapting to new methods due to the fluctuation in the area. The Chief AHP advised that the Weight Management Service is divided into 3 tiers, outlining each. Challenges around the associated costs in the current climate was stressed, restricting the adaptability we would like to have. The Chair thanked The Performance Manager again for the report.			

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	Decision	Action Owner	Date to be Completed/Comments
For Decision **5.7 Report on Commissioned Scoping Exercise on Employability & Opportunities for Better Partnership Workforce Planning – Paper presented by Jim Sherval, Public Health Consultant** Jim Sherval, Public Health Consultant, presented the report and advised it is for decision. The report sets out the result of the IJB commissioned scoping exercise, and presents the actions recommended by the Workforce Governance Board. **Members are asked to:** • Note the outcome of the commission and the actions being taken forward by the Workforce Governance Board • identify capacity from existing resources to take actions identified as priority and operational forward. • present these for discussion and agreement at the Workforce Governance Board The Chair thanked the Public Health Consultant for the report and welcomed questions. There was a question raised in relation to the benefits and when will we expect to see the outcomes of that. The Public Heath Consultant advised these are currently in development with the Partnership.			

	Decision	Action Owner	Date to be Completed/Comments
For Discussion **5.8 IJB Performance Report - Paper presented by Elouise Johnstone, Performance Manager** Elouise Johnstone, Performance Manager, presented the report. The purpose of the report is to update the IJB on progress towards the IJB performance goals set for the financial year 2023/24. It was noted that the Performance Assurance and Governance Group has now been dissolved and going forward data scrutiny responsibility has been transferred to the Strategic Planning Group. The newly agreed strategic governance map was included as appendix 2 of the report. Appendix 1 contains published data. A slight improved is reported in relation to the A&E attendance indicator. While unplanned admissions and days in acute beds failed to meet target, the link between unplanned admissions and unplanned days in acute beds is clear and that is a systemic challenge. It was noted that the end of life and balance of care figures are not available locally so there is no management data to discuss. Appendix 2 details the strategic governance map, with emphasis drawn to column 6, 'What difference does this make'. This column is aligned to the 9 National Health and Wellbeing Outcomes, making it easy to support information with data for annual reporting to the Scottish Government. Colour coding on the map indicates both progress towards our goals, and confidence in the evidence provided. The Chair thanked the Performance Manager for the report and opened it up for discussion. The Board commented on the clearly laid out report and asked whether Management Steering Group (MSG) indicators are still relevant as other metrics appear more relevant now. The Performance Manager confirmed that the MSG framework was designed to assess acute and secondary care			

	Decision	Action Owner	Date to be Completed/Comments
progress rather than the Integration Joint Board progress, but until legislation is revised it is a requirement to continue to report MSG. The report presented includes complementary and supplementary data, which is more relevant in telling of what the Health and Social Care Partnership and the Integration Joint Board does. Discussion ensued regarding whether this data was ever relevant given how all parts of the system interact has changed over the last ten years. It was noted it is necessary to use rationale to make sense of data and have the data that is necessary to make decisions. It was agreed that the lag in data makes it less informative with a view to strategic planning. Efforts are being made to make data less prominent in this work. The Board was advised outcomes are helpful to inform the IJB how well it is doing, and the Strategic Planning Group will review the strategic governance map columns in future meetings and issue new directions as they have a place in governance framework. The Performance Manager advised that her criticism of MSG is due to them maybe not being as timely or relevant to the MIJB but remain relevant to other parts of the system to make good decisions. Referring to a recent study where admissions data and emergency admissions data were used to create a reliable predictive tool for use in primary care, it was suggested this may be interesting as another point of view. The Board noted the improvement goals set in the report and the inclusion of the new Strategic Governance Map.			

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	Decision	Action Owner	Date to be Completed/Comments
For Discussion **5.9 Midlothian Drug Misuse and Alcohol Specific Deaths 2023 - Paper presented by Nick Clater, Head of Adult Services and Chief Social Work Officer and Martin Bonnar, lead officer alcohol and drug partnership (MELDAP)** *Note there were slides to be shown but due to admin issues these were not available and will be presented at the next meeting.* Nick Clater, Head of Adult Services and Chief Social Work Officer presented the report. This report highlights pertinent areas relating to Drug Misuse and Alcohol Specific Deaths in Midlothian. It was noted Midlothian operates as a joint Alcohol and Drug Misuse Partnership with East Lothian to support drug and alcohol users (MELDAP) which is unique in Scotland. While drug and alcohol specific death numbers are published every year, the report outlines the 5-year average to illustrate a clearer picture of the extent of the issue in Midlothian. Published figures for 2022 showing 4 drug misuse deaths, which is uncharacteristically low. The figure increased to 20 in 2023, making the 5-year average 17. In terms of statistical predictions, the report indicates people living in deprived areas are 15 times more likely to die from a drug related issue than those in more affluent areas. Likewise, there is a pattern of higher risk linked to polydrug use mixed with alcohol. The increased toxicity of the different drugs combined is also compounded by the existence of mental and physical health issues in the cohort the data comes from. It was noted there is a stark difference in terms of drug misuse figures between England and Scotland, or when Scottish figures are compared with the rest of Europe. The Head of Adult Services and Chief Social Work Officer clarified that there is a higher prevalence of drug use in Scotland (1.62%) compared	Report to be updated to include suggestions for amendment requested at today's meeting and presented at another forum.	NC / MB	December 2024

	Decision	Action Owner	Date to be Completed/Comments
to EU countries (0.74%), the figure of drug users in Scotland is roughly double the rate of other countries. Highlighting the effects of increased substances in circulation, new drugs entering the scene. There are also theorised links to adverse childhood experiences to account for the figures. In terms of alcohol specific deaths, the report authors advised caution on how these are counted and managed. The 3-year average is 15-18%, in line with the rest of the country. As it is the case with drug specific deaths, there are often patterns like poverty indexes and physical conditions often observed in connection with these figures. The range of services available through MELDAP has extended over the past years to include a contact service. There is also wider coverage around Naloxone, a drug that reverses the effects of opioids, but this is not always effective as opioids are not necessarily the reason behind an overdose. Naloxone becomes less effective in the case of polydrug use. There are also situations where users may need more than one dose in order to receive the appropriate strength, and as such Naloxone doesn't always manage to save users in the event of an overdose. A change in the substances available in Midlothian, and an increase on the number of synthetic opioids in circulation is another concerning pattern. Last July there were 5 people who died in matter of days due to substances coming from other part of the Lothians. Finally, the role of Number 11 as a multi-service hub working together under the same roof was highlighted as a strength, offering support to clients of the substance misuse service but also criminal justice and mental health. This was seen as a success story in terms of services working together that should be replicated in other areas of the country and is in line with the Scottish Government's recommendation to streamline services. The Board asked for clarification on how many of those in these figures had been involvement with Midlothian services. Recognising that the process to acquire these figures can make answering this question tricky, it was noted generally 40 to 50% of individuals in the death statistics are already known			

	Decision	Action Owner	Date to be Completed/Comments
to services. This figure can fluctuate year on year. It was stressed that professionals strive to use every opportunity services interact with clients, to draw as many individuals at risk as possible into the service. This is due to the protective factor being known to substance misuse services has. For example, Substance Misuse Service has active referrals for an average of 300 people who are known drug and alcohol users and are less likely to suffer harm as a result of this referral. The Head of Adult Services clarified that a fraction of the death numbers are users who were not known to substance misuse services but may have been known to other areas like criminal justice or mental health, either at the time of their death or in the past. Highlighting the need to get as many people at risk into services to maximise the chances of working constructively with them. Reducing mortality rates related to substance use presents significant challenges, primarily due to the harmful nature of drugs circulating in the community. Additionally, the impact of each death is felt acutely by staff, as often they have known the individual through the service. It was noted that mental health issues tend to increase as financial situations worsen for people. It was queried whether this is reflected on the year-on-year alcohol and drug death statistics. It was noted, drug and alcohol specific deaths have largely stayed the same. The service is worried about the impact of cost-of-living issues. Figures have not been impacted by policies like minimum unit alcohol pricing. The service recognised they could be doing more given the harm alcohol does. The Board congratulated MELDAP for achieving so much, offering approaches not being replicated elsewhere in the country and for their good engagement with service users. In terms of user experience, the Board recommended to build the feedback of users into the report as it is such a dynamic field. The Board acknowledged the significance of this discussion in order to evaluate the current approach and assess the impact of risk reduction on A&E figures, which should be addressed in the next version of the report.			

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	Decision	Action Owner	Date to be Completed/Comments
The Chair agreed on the need to move conversation to another forum and thanked everyone involved in the report.			
For Discussion **5.10 Public Health Update - Homeless Prevention Duty Paper by Jim Sherval, Public Health Consultant, and Ruth Flynn, Public Health Practitioner** This agenda item was deferred until 19 December 2024 due to time constraints.	Item deferred until 19 December 2024		
For Discussion **5.11 Integrated Assurance Report Paper presented by Claire Ross, Chief AHP** This agenda item was deferred until 19 December 2024 due to time constraints.	Item deferred until 19 December 2024.		
For Discussion **5.12 Darzi Report Discussion - Paper prepared by Gill Main, Integration Manager** This agenda item was deferred until 19 December 2024 due to time constraints.	Item deferred until 19 December 2024.		

	Decision	Action Owner	Date to be Completed/Comments
For Discussion **5.13 MIJB Finance Update - Paper prepared by David King, Interim Chief Financial Officer** David King, Interim Chief Financial Officer presented the report, detailing the current financial situation. The Chief Financial Officer expressed his concern over the current situation and its challenges. An overspend identified in January/February 2024 was noted where reserves were still available, but this is no longer the case. The report stressed the need to keep the momentum of work done to create funding. An updated position was available since NHS has provided a financial forecast, and the Council has provided a Quarter 2 review, identifying an overspend of £8.4 million. The Chief Financial Officer pointed out two items of interest, 1) the health position has deteriorated, due to the challenges around the prescribing budget which continues to have an ever deteriorating overspend. It is a complicated model, with little scope for action in terms of practice as there are known issues with price and volumes. 2) the Social Care position, which had a forecasted overspend of £8.6. million, larger than the spillage in recovery plans. The updated forecast shows a £5.2 million overspend, which while still considerable it is an improvement over the quarter 1 forecast. The Chief Financial Officer stressed that the IJB is a strategic planning group and to deliver a strategic plan it has a budget. The Integration scheme that governs the IJB stipulates that it must refer to its Partners in case of an overspend to provide recovery actions. Health and Social Care was identified as the biggest of these partners, where most of the financial pressures lie. To identify recovery actions, there have been finance workshops and this report also considers the impact in people the IJB serves, what are the risks and mitigating actions. The Chief Financial Officer stressed that Midlothian Council, the Health and Social Care Partnership and the NHS have a great working relationship that is key to its success as an IJB. At present, it is clear that action must be taken to find £5.2 million due to the sizeable financial risk to the Council, and	Further workshop to be arranged in November to find further savings in order to bring a balanced budget by December IJB Chair to write to government in order to lobby for additional funding and raise awareness about the	DK	December 2024 November 2024 19 December 2024

	Decision	Action Owner	Date to be Completed/Comments
warned that the Board must be ready to consider further actions, giving consideration to what benefit they will deliver and what impact they will have in the population of Midlothian. After the workshop, next steps would be explored, looking for savings and recognising the existing budget is the only resource to deliver the strategic plan. Additional factors to consider, such as the UK budget on 30 October, and the Scottish Budget in December. Local governments have also agreed to honour pay awards which they plan to fund but that may put local authorities in a difficult position finance wise. It was also noted that several health boards across Scotland are also not breaking. After these pay awards there will be little change to fund the IJB and will not cover the pressures the system is experiencing. The Chief Financial Officer stressed the need to consider figures and the situation by December and determine what recovery actions will be needed so that the Board does not find themselves in crisis point. The Board was reminded of the duty to break even and have a balanced budget. Councillor Milligan echoed the concerns and noted that as part of the Council budget consultation the public was made aware of the very difficult decisions the Council and the Midlothian IJB is faced with. As further tranches of savings are planned, this needs to be used as an opportunity to make clear to residents. Councillor Milligan warned that the £9.4 million gap assumes that the council tax will have a 5%increase, that the pay rise will be 2% and that there will be a cash flat settlement from the Scottish Government. It was stressed that if no action is taken the gap will grow exponentially unless more funding is given, so there is the need for joint working and serious conversations to determine what it is possible to achieve. The Chair advised the consultation was simplified and the wording regarding Health and Social Care is aimed at seeking the public's priorities on matter. In terms of more holistic approach, the Council Leader has also written to the UK and Scottish Governments. It was suggested whether the IJB may want to	consequences of cuts Partners in the IJB to look at their services to the Board and determine red button actions in order to agree to a route map		

	Decision	Action Owner	Date to be Completed/Comments
explain the choices that may need to be made. Committee members agreed the average resident may not be aware of what the cuts may mean for them and supported letters to the Government. Councillor Milligan noted that although the Health and Social Care consultations concern important decisions, past experiences have shown take up to be poor and that as it is an invisible cost for most people. Increased awareness amongst Elected Members was noted relating to Board funding issues thanks to briefings. It recognised that further cuts may be necessary, with the implications of these to be made clear in briefings such as closing care homes, wards, daycare or non-statutory services. It was agreed partners would meet and consider savings and come back to the Board with proposals by November. A roadmap would be created over the next two months to give purpose to the conversation. While this may not be enough to find the gap, it was recognised the budget position had improved. Demand is ever changing as the Midlothian population changes, so it is expected next year would be as challenging if not more as due to cost pressures. The Chief Financial Officer reminded of the importance of sharing burdens, but the statutory delivery of Social Care belongs to Midlothian Council. While there is responsibility of breaking even, it is possible that removing the gap entirely could be detrimental. The Board agreed, noting transformational actions may be cost cutting, but will require time to plan and deliver accordingly. It was also pointed out that these actions may result in protest that will become a contentious issue between the IJB and the Council. While it is the Board's responsibility to break even and have a balanced budget, it is also their responsibility to keep people safe. The Chair thanked all members for their contributions and advised that the matter will come for discussion in the December IJB meeting where all services were asked to have their red button issues noted so a roadmap could be agreed.			

	Decision	Action Owner	Date to be Completed/Comments
Report For Noting **5.14 Community Payback Orders Justice Report - Paper presented by Fiona Kennedy, Group Service Manager** The Board noted the contents of the report.	Report noted		
Report For Noting **5.15 Review of Risk Register Policy - Paper presented by David King, Interim Chief Financial Officer.** The Board noted the contents of the report.	Report noted		

5 Private Reports

No items for discussion.

6 Any Other Business

No items for discussion.

7 Date of Next Meeting

A Development Session for board members only will be held on Thursday 21st November 2024, 14:00 – 16:00, development session for board members only.

Midlothian Integration Joint Board

Thursday 24 October 2024

The next full board meeting of the Midlothian Integration Joint Board will be held on Thursday 19th December 2024, 14:00 – 16:00. This will be chaired by Val de Souza as Councillor McManus noted he is unable to attend this meeting due to a prior engagement.

Members were also reminded there are three upcoming briefings, one on 31 October 2024 and two town hall events on 6 November 2024.

The meeting terminated at 16.08pm.

Meeting	Date	Time	Venue
Midlothian Integration Joint Board	Thursday 19 September 2024	2.00pm	Council Chambers, Midlothian House and Virtual Meeting held using Microsoft Teams

Present (voting members):		
Councillor McManus (Chair)	Val De Souza (Vice Chair/virtual)	Councillor McKenzie (Substitute for Councillor Parry)
Dr Amjad Khan (virtual)	Kirsty MacDonald (virtual)	

Present (non-voting members):		
David King, Interim Chief Finance Officer	Morag Barrow, Director of Health & Social Care: Midlothian HSCP, Chief Officer to Midlothian IJB	Nick Clater, Deputy Chief Social Work Officer
Wanda Fairgrieve, Partnership Representative (NHS)		

In attendance:		
Grace Cowan, Head of Primary Care & Older People	Gill Main, Integration Manager	Duncan Stainbank (virtual), Chief Internal Auditor

Claire Gardiner (virtual), External Auditor (Audit Scotland)	Rebecca Green (virtual), Clinical Director	Iina Jaara, Democratic Services Team Leader
Maria Perez, Democratic Services Officer		

Apologies:		
Keith Chapman, Lived Experience member	Claire Ross, Chief AHP	Joan Tranent, Chief Social Work Officer & Chief Officer Children's Services, Partnerships and Communities

1. Welcome and Introductions

The Chair welcomed everyone to this meeting of the Midlothian Integration Joint Board (MIJB). Apologies were received from Keith Chapman, Claire Ross, and Joan Tranent. The Chair noted that Councillor McKenzie is attending the meeting on behalf of Councillor Parry.

2. Order of Business

The order of business was confirmed as outlined in the agenda previously circulated.

3. Declarations of Interest

None presented.

4. Minute of Previous Meetings

No items for discussion.

5. Public Reports

Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
5.1 Chair's Update - Councillor McManus - For Decision The Chair gave a verbal update and highlighted the MIJB's recent meeting and contribution to the National Care Service (Scotland) Bill Consultation. The Chair was unable to attend this session, but was pleased to see that members were generally in agreement. The Integration Manager will circulate the response to members in due course. The Chair also reminded members that there will be a Development Session immediately after this meeting. MIJB noted the Chair's update.	Update was noted.		
5.2 MIJB Annual Accounts 2023/24 (Final Position) - Presented by David King, Interim Chief Financial Officer - For Approval The Interim Chief Financial Officer presented the report of the MIJB Annual Accounts for the financial year of 2023/2024, which have now been audited by the Integration Joint Board's (IJB) Independent Auditors who have reported their view to the IJB's Audit and Risk Committee of 21 September 2024. The Interim Chief Financial Officer asked the External Auditor to also reflect on their report. Board Members are asked to: - • Note the report of the Independent Auditor. • Approve the IJB's annual accounts for 2023/2024. The External Auditor highlighted the report was presented at the normal audit timescales and thanked all IJB members for their help in meeting this deadline. The report includes limited recommendations which have not impacted the view of the External Auditor. The External Auditor highlighted that they are confident in the financial management arrangements in place	The Annual Accounts were approved.		

Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
but acknowledged the ongoing challenges in the IJB's financial sustainability. It was reported that MIJB's situation is similar to those of IJBs across Scotland. Good practices were also highlighted. The Vice Chair highlighted a recent MIJB Audit & Risk Committee meeting and expressed that the Committee viewed the audit process and the following report as fair. The Vice Chair thanked the External Auditor for their support in the last year. The Interim Chief Financial Officer asked the IJB to approve the accounts and explained the signing-off process after approval. The IJB members were in agreement and the accounts were approved.			

6. Private Reports

No items for discussion.

7. Any Other Business

The Chair noted that this is Wanda Fairgrieve, the NHS Partnership Representative's last meeting as they are moving onto a role within East Lothian Council and thanked them for their service.

8. Date of Next Meeting

The next meeting of the Midlothian Integration Joint Board will be on Thursday the 17th of October 2024, 14:00-16:00.

The meeting terminated at 14:10.

Meeting	Date	Time	Venue
Strategic Planning Group	Thursday, 29 August 2024	14:00pm	Committee Room, Midlothian House and Virtual via MS Teams

Interim Chair: Gill Main (Integration Manager)
Vice Chair: Vacant

Present (MIJB members):		
Morag Barrow (Chief Officer)	Keith Chapman (Lived Experience Member)	David King (Interim Chief Financial Officer) (Virtual)
	Claire Ross (Chief AHP)	Magda Clark (Third Sector Member) (Virtual)

Present (SPG Members):		
Gill Main (Integration Manager) (Chair)	Elouise Johnstone (Programme Manager)	Jim Sherval (Consultant in Public Health) (Virtual)
Nick Clater (Head of Adult Services)	Rebecca Miller (Strategic Development)	Keith Chapman (Lived Experience Member)

In Attendance:

Strategic Planning Group

Thursday, 23 May 2024

Emma-Jane Gunda (Assistant Strategic Programme Manager) (Virtual)	Susan Rose (Voluntary Services Manager)	Laura Hill (VOCAL)

Apologies:		
Angus McCann	Andrew Fleming	Grace Cowan (Head of Primary Care and Older Peoples Services)
Fiona Kennedy (Group Service Manager)	Laura Hill (VOCAL)	Rebecca Hilton (Programme Manager)
Fiona Stratton (Chief Nurse)		Dr Lynne Douglas

1. Welcome and introductions

The Chair welcomed everyone to the meeting of the Midlothian Integration Joint Board (MIJB) – Strategic Planning Group (SPG).

Apologies were noted.

It was noted that due to the technical issues with the diary invites there may be some accidental absences.

2. Order of Business

The order of business was as set out in the agenda.

3. Minutes of Meeting

3.1 The Minute of the Strategic Planning Group meeting held on 25 January 2024 was submitted and approved as a correct record.

3.2 Action Log.

Emma-Jane Gunda, Assistant Strategic Programme Manager, shared and spoke to the Action Log and updates were noted.

3.3 Risk Register.

The Chair, noting that there are no risks currently on the risk register although expected this to change as the year progresses. The Chair noted this needs to be raised as a standing item going at each meeting. The Chief Officer requested that a risk be added to the register that raises the risk of the IJB not being able to deliver its strategic aims, linking to the IJB risk on the main IJB risk register. Integration Manager to action.

4. Updates

	Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
4.1	**Chairs Update (verbal) - Gill Main, Integration Manager** The Chair provided a verbal update detailing; • The Board approved the first draft of the Strategic Plan for public consultation, as per the statutory guidance, reiterating to the group that the second draft of the Strategic Plan will follow the Boards Development session in January 2025. • Chair recapped the development process to date with the first consultation running from September to December 2023, and proposals agreed by the Board in January 2024. The first drafts were developed and reviewed by this group, before the Board reviewed and the edits and amendments were actioned prior to approval to move into public consultation at the 22nd August Board. • The Chair noted thanks to the Strategic Planning Group (SPG) and the Strategic Plan Project Team, for their commitment, work and contributions, and particularly the support given to strategic planning group from the project team and all the efforts. The attention will now shift within the Project Team to ensuring this group can review the other statutory documents that must be published alongside the Strategic Plan; a Market Facilitation Plan, Housing Statement, Consultation and Engagement statement.		Gill Main	

	Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
	• The Chair noted the strategic plan ais to support anyone the community reading that plan and seeing how the plan related to their lives and how we hope to contribute to people in our communities living a good and healthy life. • It was noted by the Chair that this will be the last meeting where GM Chairs the Strategic Planning Group and Andrew Fleming will be taking on the role of Chair going forward. The Vice Chair of this meeting will be held by a voting member of the IJB still to be determined.			
4.2	**Finance Update (verbal) – David King, Interim Chief Financial Officer** David King, Interim Chief Financial Officer provided a verbal update and discussing the content of the finance paper presented to MIJB on 22nd August. David King recapped what was current and next steps. The paper details the financial plan for 24/25. At the time this od writing the delegated budget was £158m. The Interim Chief Financial officer then detailed the financial gap. The Chief Financial Officer discussed the social care position. The discussion began by stating the current overspend of 6.8 million pounds, the associated recovery plans with the largest overspend within the day-to-day operations within social care and reviews underway.. The Interim Chief Financial expressed that there are 3 actions; Look at the agreed recovery plans; speak with colleagues regarding income from clients; and consider what further actions can we take. It was stressed that the Midlothian has never asked partners for additional support previously. The recovery actions that are in place are well underway, however due to the new demand, the impact is hard to see. It was highlighted the resource panel is the largest area of overspend, work that has taken to get to where we are had an impact on the position		David King	

	Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
	but would not reflect in the Q1 report. Some of the challenges being faced by the HSCP to deliver on these recovery actions were discussed. The Chief Officer noted that although challenging, the team has worked extremely hard and has not let the performance drop despite the rise in population and no equivalent uplift on funding offers. The Chair stated the Board remain supportive of recognising that our services and delivery partners are best placed to make decisions about the operationalisation of our plans, and Directions now become a good opportunity to help move things forward.			
4.3	**PAGG Update (verbal) – Elouise Johnstone, Programme Manager** Elouise Johnstone, Programme Manager for Performance , provided a verbal update on the Performance and Assurance Governance Group (PAGG). It was stated that PAGG has met twice over the summer; July 11th and August 8th and described both sessions were incredibly useful, with considered constructive feedback from the attendees. Special thanks were passed to all that attended. The Programme Manager for Performance noted the increase demand and population that was referred to in the previous item. The Chair noted that with the change in Terms of Reference approved by the board on the 22nd August, all data will be discussed and scrutinised as part of this meeting.		Elouise Johnstone	
4.4	**HSCP Integrated Workforce Governance Board (verbal) – Morag Barrow, Joint Director Health and Social Care** Morag Barrow, Joint Director Health and Social Care, provided a verbal update, noting a continuing gaps in resource and capacity, on of these is a Workforce Lead post. It was highlighted that the IJB has been asked by the Scottish Government to write a new workforce plan. The reporting duties under the Health and Care (Staffing) (Scotland) Act), and agenda for change reform were highlighted as the impact on workload.		Morag Barrow	

	Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
	The officers of the HSPC supported an induction session with 2 new Lothian non exec members of the Board. There will be an elected members briefing on 3rd September 2024. Work continues to maintain relationships with our partners, being open, honest, and transparent, as we approach next year's budget discussions.			

5. Updates

	Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
	Topics in Focus			
5.1	**Change in Format and Content of Strategic Planning Group – Andrew Fleming, Chair and Gill Main, Integration Manager** This report presents the Terms of Reference for the Midlothian IJB Strategic Planning Group (SPG) reviewed by Midlothian Integration Joint Board for approval on the 22nd August 2024. The Terms of Reference (ToR) for both Board committees had been reviewed at the Audit and Risk committee on 6th June 2024 and recommended to Midlothian IJB for approval. **Members were asked to:** • Note the verbal feedback on Midlothian IJBs decision relating to the Strategic Planning Group (SPG) and Audit and Risk Committee (ARC) Terms of Reference (ToRs).			

Strategic Planning Group

Thursday, 23 May 2024

	Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
	• Review the revised Terms of Reference (ToR) and note the changes and implications for the Strategic Planning Group. The Chair presented a slide show to the group and ran through the slides of Terms of reference. Key points highlighted included; • Terms of reference had not been reviewed due to the change of membership and Covid pandemic. • Realignment of remit; influencing and development of Strategic Plan, monitoring and evaluating progress towards strategic aims, reporting on IJB's contribution and progress towards 9 National Health and Wellbeing Outcomes, Direction proposal and development for Board consideration. • Governance via SPG on the duties above, achieved through use of Outcome Mapping, Group Service Specifications and Directions chain • Need to consider how those Directions will look like It was highlighted that reducing the meetings with a more streamlined agenda would support more effective working and joined up thinking in relation to planning and performance.			
	Items for Decision			
5.2	**IJB Commission: Scoping Exercise regarding Workforce and Local Employability Options (verbal update) – Jim Sherval, Public Health Consultant** Jim Sherval began the verbal update by referencing the action log, referring to actions 10.3,10.4,10.5,10.6. Updating on actions from the previous meeting, it was reported that following actions were being driven forward as 'priority' from the working group:		**Jim Sherval**	

	Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
	Universal Recommendations 1 and 2; Co-ordination of HSCP employability work and HSCP representation on the Local Employability Partnership, Targeted Recommendations 1, 2 and 6.2; Job advert circulation to the Local Employability Partnership and NHS Lothian Voluntary Service, The Promise Guarantee (Care Experienced People) and Explore opportunities to build closer working with the LEP/ No-one Left Behind Scottish Government funding (co-ordinated by the LEP). The Chair added the key message from the discussion was that there is nothing in particular that SPG needs to consider for recommendation to the Board as the actions were operational. Chair also noted continued support for the incredible work n this area and noted how this is making a difference and providing more opportunities for people in Midlothian.			
5.3	**Primary Care Sustainability Direction Discussion – Rebecca Green, Clinical Director** Dr Rebecca Green, (Clinical Director) noted the IJB had requested a commission from the SPG to consider a Direction to support GP in primary care, potentially considering strategically reallocating some resources in a number of ways that supportive the balance of care to the community. The Clinical Director provided a short presentation with some key points; - how we can make an impact in different ways. - The 3 Horizon approach - Midlothian has the highest prevalence rate than the Lothian average and Scottish average for nearly all long-term conditions. - The challenge of sustainability across practises. - LSDF is helpful and can support our ambitions, particularly Priority 5			

Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
- Population increase is looking around 22.9% in 10 years. - A lot of work that has been moved over to primary care and the resource has not been attached to it. - Secondary care in specialist work, if appropriate resource was transferred could be done in primary care. Rebecca Miller discussed the LSDF and the review of implementation books with stakeholders and the importance of having a dialogue with the community to ensure we can we best meet the need with that we have. There was discussion after the presentation, talking about potential opportunities and the need for additional resources in certain areas. The discussion explored each point that was raised by the group. The importance to recognise that we are asking for people to do more with no additional resources was stressed, however the aim of the discussion today was to do more work in a different manner, resource has to follow. A short-life working group will be convened to work on proposals led by The Clinical Director, to identify potential 'quick wins' that could form a test of change, any financial support or re-allocation of resources linking in as part of Midlothian planning. This should be done in collaboration with the Integration Manager as strategic lead. Morag Barrow and Nick Clater left the meeting at 15:48pm. An action was taken from The Clinical Director to create a short-life working group and consider appropriate membership.			

6. AOCB

None received.

7. Date of next meeting

The next meeting of the Strategic Planning Group will be held on Thursday, 29th September 2024 at 14:00pm.

(**Action: All Members to Note**)

The meeting was closed at 15:57pm.

Midlothian Integration Joint Board

Meeting	Date	Time	Venue
Strategic Planning Group	Thursday, 26th September 2024	14:00pm	Committee Room, Midlothian House and Virtual via MS Teams

Interim Chair: Andrew Fleming
Vice Chair: (Vacant)

Present (MIJB members):		
Connor McManus	Keith Chapman	Grace Chalmers
Nick Clater (virtual)	Dr. Amjah Khan (virtual)	

Present (SPG Members):		
Elouise Johnstone, Performance Manager	Rebecca Miller, NHS Head of Strategy Development (virtual)	Claire Ross, Chief AHP
Gill Main, Integration Manager	Fiona Stratton, Chief Nurse	Rosemary McLoughlin, VOCAL (virtual)

In Attendance:		
Kate Thornback, HSCP Equalities and Human Rights Lead	Emma-Jane Gunda, Assistant Strategic Programme Manager (virtual)	

Apologies:		
Jim Sherval	Rachael Honeyman	Laura Hutchison
David King	Laura Hill	Anette Lang
Lynn Douglas	Val De Souza	Angus McCann
Kirsty McDonald	Rebecca Green	

1. Welcome and introductions

The Chair welcomed everyone to the meeting of the Midlothian Integration Joint Board (MIJB) – Strategic Planning Group (SPG). Andrew Fleming chairing for the first time.

Apologies were noted.

Public Health were not represented at today's meeting but have requested an opportunity to comment ECRIA on the Strategic Plan.

2. Order of Business

The order of business was as set out in the agenda.

3. Minutes of Meeting, Action Log and Risk Register

3.1 Strategic Planning Group minutes 29th August 2024 were approved as an accurate record.

3.2 Action Log

It was noted that action no. 17 (Dr Green) is currently underway, and an update will be included in the Directions discussion at the next meeting.

3.3 Risk Register

The Risk Register was discussed and highlighted that the late paper that was circulated today.

4. Updates

	Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
4.1	**Chairs Update (verbal) – Andrew Fleming** The Chair provided a verbal update detailing: The Chair noted the scheduled in-person townhall event, as part of the consultation on the draft IJB Strategic Plan, on October 2nd 2024, has now been cancelled. The decision was made in response to less than anticipated engagement. It was highlighted that the Vice Chair position for SPG is still vacant, with the IJB keen to fill the role as soon as possible. It was confirmed that this should be a voting member of the IJB as prescribed by the Terms of Reference. The Integration Manager is not a voting member of the IJB and therefore cannot be considered for the role. An action was noted for nominations for the Vice Chair to come back to the next meeting. Gill Main provided a verbal update in the absence of David King and discussed the current recovery plans that are set.	IJB Voting Members to be considered for vacant SPG Vice Chair Role.	AF (Chair)	28/11/2024
4.2	**Workforce planning group – Update by Nick Clater, Head of Adult Services** The Head of Adult Services provided a brief update, noting the Board meeting in September included discussion on the Midway refresh, HSCP reduced working week progress as well as the upcoming Speak up week plan.			

5. Reports

	Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
5.1	**Design and Development – PRESENTATION SHOWN** Strategic Plan Update – Gill Main, Integration Manager The Integration Manager gave a presentation highlighting key points on the next steps in the development of the Strategic Plan. The Draft Strategic Plan is currently subject to a statutory 3-month consultation. SPG members were encouraged to share the consultation details with the groups they represent. At the next meeting, Directions relating to the Strategic Plan will be discussed. The presentation was paused as the Chair imitated some discussion on the less than anticipated level of engagement regarding the townhalls for community members and staff was highlighted. Cllr McManus gave a brief rationale to his decision to cancel as IJB Chair. This was due to the lack of Board members availability to attend and the low interest from the public. Those who had signed-up to the sessions or submitted any questions will be contacted by the Project Team and encouraged to join the virtual townhall or, if this is not suitable, offered a session with Chair and Integration manager to answer any questions . The consultation process was discussed, highlighting the range of activities and stakeholders engaged to reach as high an engagement level as possible. It was stated that planning will ensure there is a Comms Action Plan to help ensure the November townhall will have more attendees. The presentation resumed noting the draft strategic aims. It was noted that following the public consultation, feedback will be reviewed and a further draft of the plan, including the strategic aims will be reviewed by SPG in January 2025 and then in February by the Board. The next steps for the members of SPG were to familiarise themselves with the plan, take part in the consultation, encourage and contribute views from groups they may represent. There were no further questions presented to the Integration manager. The Chair closed the discussion by encouraging people to share this consultation with their networks.	Project team to ensure alternative consultation offers are made SPG Members signpost Strategic Plan Consultation to groups they represent.	EJG all	04/10/2024 04/10/2024
5.2	**Implementation** Equalities and Children's Rights Impact Assessment on the IJB Strategic Plan – Kate Thornback, Equalities and Human Rights Lead			

Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
The Equalities and Human Rights Lead thanked the group for participating in the impact assessment, advising feedback from today's session would support the final plan. The duties as prescribed under the Equality Act were detailed to the group. The Equalities and Human Rights Lead spoke to the report and the appendices that were in the agenda pack, highlighting 2 main points. The first point being "People want reassurance that we are prepared for the future" and the second point "What are we going to do in the future". **Strategic Aim 1** was highlighted as likely to have a positive impact on people in different equality groups. The Equalities and Human Rights advised that word-of-mouth and social media are the biggest sources of information to people in Midlothian, and this should be taken into consideration as Midlothian is the largest growing council in Scotland. It was mentioned that this group has a large responsibility in how the outcomes should be reviewed, with a focus on equalities. Age was also highlighted as a factor in the importance of how people receive information, noting that all information cannot be digital. Video formatting was discussed detailing that this could be considered as a more accessible format for those who may they have low literacy. It was noted that possible mitigations may be impacted by the current financial situation. The group discussed how this aims links with the current transformational work. It was also noted that changes as a result of the pandemic and the current financial situation continue to impact on operational delivery. The need for staff upskilling was noted in discussions. Key issues for consideration in relation to ways the plan could improve as a result of this assessment			
1. Noting the impact of Operational Planning and need to focus on accessibility and quality information	To consider	Heads of Service	31/03/2025
2. Noting the need for a range of modalities of information	To review	GM	31/03/2025
3. To ensure the review of the MidWay incorporates this Strategy in its review	To action	FK	31/03/2025

	Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
	Strategic Aim 2 highlighted the current effort to create capacity in the system. There was a discussion regarding how a person is affected by care, the characteristics groups that may be impacted with people fitting into more than one category, with a need of this to be monitored and gain a better understanding. A concern was raised regarding the wording of homeless people needing "at care home", with the implications of language to be looked at. The Integration Manager stated that the points made regarding the homelessness will be picked up by the Project Team. It was mentioned that there is a large volume of rural areas in Midlothian and there is not a lot of data, however there is work ongoing to gather more local information. The discussion moved to the distances from where a person lives to their nearest GP and transport connections. Key issues for consideration in relation to ways the plan could improve as a result of this assessment			
	4. Links to other areas and how we work with our Partners i.e. Transport, Housing etc	To review	GM	06/01/2025
	5. Avoiding vulnerable group fall between service areas – what are the intersections or services common to people with a number of protected characteristics	To investigate	EJ	06/01/2025
	6. Consider language around 'home' for people who experienced homelessness ('places you stay' / 'in the community')	To review	GM	06/01/2025
	Strategic Aim 3 raised issues relating to links with			
	• carers and the IJB carers strategy (due for review) including issues relating to gender, life chances and appropriate and individualised support	To review	NC / RMcL	31/03/2025
	• the safe sharing of data as a key area to support the identification of equality issues for action	To action	GM / EJ	06/01/2025
	It was suggested by the Equalities and Human Rights Lead to revisit the assessment again and allocated more time for discussion. The Integration Manger suggested the draft ECRIA be shared with the group in advance of the November meeting and members could make further comments and suggestions for inclusion. If there was any additional comments or questions could of course also be shared with the Chair.	ECRIA report will be shared for comment with SPG in advance of the next meeting	EJG	25/10/2024
5.3	**Reporting and Evaluation – PRESENTATION SLIDES** Midlothian IJB Performance Reporting – Elouise Johnstone, Performance Manager			

	Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
	The Performance Manager gave a presentation, summarising key activities related to IJB performance reporting such as the performance framework, Directions reporting, and the Annual Performance Report. Describing how the IJB Strategic Governance Map via OutNav, and the linkage to the IJB Strategic Plan and the 9 National Health and Wellbeing Outcomes, it was highlighted the ambition to use this in future performance reporting. Due to time constraints, the presentation was cut short with the Performance Manager welcoming any questions via email following the meeting. The Chair requested to discuss some data aspect offline.	Chair liaison	AF / EJ / GM	21/11/2024
5.4	**Key Messages for Midlothian IJB Sharing – Andrew Fleming, Chair** The Chair advised that it would be helpful to have an update on the consultation on the Strategic Plan, ECRIA, and any risks as discussed in the meeting (see actions above).			

6. AOCB

None received.

7. Date of next meeting

The date of the next meeting will be held on Thursday 28 November 2024, 14:00 -16:00, Committee Room, Midlothian House.

Meeting closed at 16:06pm.

Chief Officer Report

19th December 2024, 14:00-16:00

Item number:	**5.2**

Executive summary

The paper sets out the key strategic updates for Midlothian Integration Joint Board (IJB) meeting December 2024.

Board members are asked to:

- Note the content of the report.

Chief Officer Report

1 Purpose

1.1 The paper sets out the key strategic updates for Midlothian IJB Board meeting December 2024.

2 Recommendations

2.1 As a result of this report Members are asked to:

- Note the content of the report.

3 Background and main report

3.1 **Chief Officer**

National Care Service

Scottish Government have advised they plan to pause the planning for a National Care Service. The letter (appendix 1) details the rationale.

Chief Finance Officer

NHS Lothian and Midlothian Council have agreed to progress recruitment for a full time Chief Finance Officer for Midlothian IJB. This will be recruited to on an interim secondment basis to allow for cover when our current interim Chief Finance Officer leaves on 6th December 2024. This will allow the team to consider the additionality a full time role will bring, in particular to the Transformation programme**.**

Morag Barrow, Chief Officer – morag.barrow@nhs.scot

3.2 **Head of Adult Services**

Mental Health Specialised Housing

Mental Health specialised housing remains on the agenda locally, pan Lothian and Nationally. Midlothian faces similar challenges to many other Local Authority areas, regarding resource, and accommodation.

Individuals with severe mental illness and complex needs often face a range of challenges in their daily lives. These may include difficulty managing their symptoms, daily tasks, and maintaining relationships. Long-term, stable, community living is needed to be able to promote personal recovery. Midlothian mental health services work within the 'Wayfinder model', where the housing of individual's is matched to their need. Currently there are approximately 15-20 people with complex mental health needs that potentially require 24/7 staffed supported housing.

The two housing needs identified for Midlothian are:

'Wayfinder Housing Need 1' which includes access to 24/7 social care staffed supported accommodation (Grade 4)

Grade 4 supported living unit(s) for 8-10 people with severe mental illness and other complex needs, includes the need to support personal care, medications, daily structure, social engagement, and a level of challenging behaviour. This type of housing is typically more structured than tenancy supported living and may include more intensive support and supervision.

'Wayfinder Housing Need 2' is characterised by continuous 24/7 registered nursing services (Grade 5)

This accommodation offer is supported living unit(s) for 8-10 people with severe mental illness and other complex needs, with a particular focus on multi-morbidity mental and physical health, including challenging behaviour. In comparison to grade 4, people at this level of need require intensive registered mental health nursing input along with support from the wider multi-disciplinary team.

Midlothian HSCP Mental Health Services are aware of the risks identified of not having such specialised housing and continue to support individuals intensively at home, to mitigate and reduce relapse and hospital admission. In addition to direct care, the HSCP risks having to consider out of area placements at increased cost.

Midlothian continues to be represented at the new Pan Lothian rehabilitation group, where representatives across Lothian are exploring all potential options available to meet the needs of individuals with complex needs. This enables the 4 partnerships to explore their current challenges, resources, share learning and explore potential collaboration opportunities.

Scottish Government: Adults with Incapacity (AWI) Consultation

In July 2024, the Scottish Government launched a national public consultation on proposed changes to the Adults with Incapacity (AWI) Act. The consultation and reforms proposed for the AWI Act are early actions in response to the recommendations of the Scottish Mental Health Law Review (SMHLR). Midlothian H&SCP undertook an extensive internal stakeholder feedback process with services across the partnership, including all professionals who work within AWI legislation. Due to the depth, scope and complex nature of the consultation, individual meetings, focus groups and electronic feedback was obtained across a wide range of key stakeholders within the partnership.

The consultation sought to obtain feedback to improve AWI in the following areas:

- Improve access to justice for adults affected by the AWI Act.
- Shift the focus of the AWI Act to one that truly centres on the adult.
- Enable adults to access rights more easily.
- Ensure adults are supported to make and act upon their own decisions for as long as possible.
- When an adult cannot make their own decisions despite support, ensure that their will and preferences are followed unless doing so would be to the overall detriment of the adult.

Due to the depth, scope and complex nature of the consultation, individual meetings, focus group consultation and electronic feedback was obtained across a wide range of key stakeholders in Midlothian HSPC.

Identified positives through the consultation:

- The proposed reforms emphasise accessibility to rights and decision-making for all adults, including those with disabilities, meet equalities obligations and support for all groups, including marginalised or vulnerable individuals.
- Promote greater autonomy for individuals with incapacity, particularly for those with learning disabilities or mental health conditions, ensuring their views and preferences are central to any decisions made on their behalf.
- Identified potential risks through the consultation.
- Being adequately prepared for and implement the AWI reforms could result in non-compliance with national legislation.
- Possible risk of delays or disruption in service provision for vulnerable adults if resources are not allocated appropriately.
- Potential challenges in operational delivery, particularly in the interpretation of the new legal framework around deprivation of liberty and guardianship. These challenges could impact service users, especially those who rely on timely decisions to access support and care.

Justice

The Justice Service provide all statutory and associated functions identified in S.27 Social Work (Scotland) Act 1968. Staff supervise men and women aged 18 and over, subject to Community Payback Orders, Parole, Life and Non-Parole Licences, Extended Sentences and Supervised Released Orders. It is essential to establishing and maintaining confidence in community-based sentences that there is assurance that robust action is taken on non-compliance. To be able to comply with the requirements of the order the individual has understand the expectations and consequences of non-compliance and therefore how this information is communicated is critical. Staff have been working closely with colleagues in Speech and Language, Communications and in collaboration with service users to ensure that the information and communications we send out is accessible and trauma informed. This has resulted in all leaflets and letters, including formal warnings, being reviewed and updated. The new documents will be used from the start of 2025.

Adult Support Protection

Review of work undertaken over Q2 24/25 continues to reflect a high performance in relation to screening process undertaken by the ASP team and positive performance in inquiries being completed within the locally agreed standard of 21 days. During the quarter there were 248 referrals and a total of 111 inquiries were undertaken; 86% completed within the 21-day timescale. Delays to completing the inquiry can be due to several reasons including waiting for information from partner agencies meeting with the adult at risk.

Learning & Development

The Learning and Development team are supporting a wide range of learning and development opportunities. The team usually host around 15 social work students on placement each year. This includes students from Edinburgh University, Stirling University, Napier University and The Open University. They also run a Social Work degree sponsorship programme to Midlothian council employees which is an excellent approach to "grow our own". At this moment in time, there are 4 final year Edinburgh University Social Work students just commencing their placement, and in the new year the team will have 5 employees studying through the Open University under the sponsorship route, pursuing a degree in Social Work. We have evidence of where we have "grown our own" that show

much higher retention levels than those recruited out with, making this investment very worthwhile.

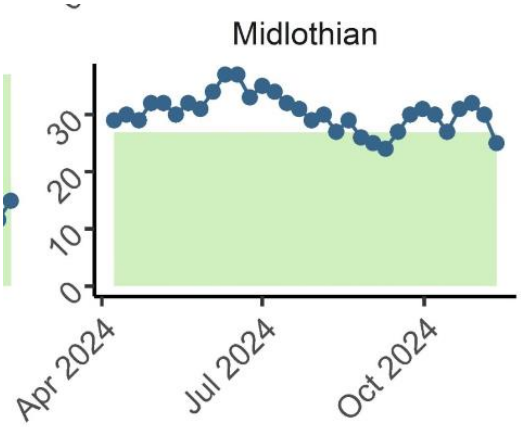
In addition, the team are supporting a record number of Foundation Apprenticeships this academic year, with 16 on the Health and Social Care programme, and 24 in Social Services Children and Young people. Our adult services are also hosting a further 7 placements for Business skills Foundation Apprenticeships. All these apprenticeship programmes are for S5 and S6 pupils and the qualification is at SCQF 6 which is equivalent to a Higher grade. Universities are now acknowledging this qualification, and are accepting them as part of the entrance criteria onto courses of further education and degree programmes.

Nick Clater, Head of Adult Services - nick.clater@midlothian.gov.uk

3.3 **Older People & Primary Care**

Delayed Discharge: National planning updated position

The Scottish Government Collaborative Response and Assurance Group (CRAG) continues to meet weekly with HSCP representatives to review performance against their delay's trajectory. Each HSCPs continues to work to achieve the target set of 34.7 delays maximum per 100 000 population. For Midlothian HSCP this equates to 27 delays. Midlothian HSCP saw an increase in delays from middle to end of October, with the main cause for being lack of Care Home placements within the Midlothian area. It is noted that the increase was short lived, and the figures as of 11th November have shown downward trend with a return to our previously reported pre covid levels of delay.



Grace Cowan, Head of Primary Care & Older People - grace.cowan@nhs.scot

3.4 **Planning, Performance and Programme Service Review**

Annual Performance Report

Following the Boards approval to publish the Annual Performance Report for 2023/24 at the October meeting, the Midlothian IJB Annual Performance Report (APR) for 2023/24. The report outlines the key successes and opportunities for change in how we contribute to the health and wellbeing of our local communities. We have taken care to present the data in a way that recognises where we have made a difference, as well as the areas where we have more work to do. Despite challenges, we have taken significant steps forward in many

areas thanks to the ongoing commitment in Midlothian to work together to improve outcomes for the people and communities.

The Midlothian IJB Annual Performance Report is published on the Midlothian Health and Social Care website and can be found by following the link below.

Midlothian IJB APR 2023/24

Agenda for Change Reform and Reduced Working Week

In 2024, Scottish Government it was been agreed with trade unions that a review of the Agenda for Change (AfC) in NHS Scotland would be undertaken to modernise the system.

As part of the pay settlement for staff in 2023-24, the working week for staff employed under Agenda for Change reduced from 37.5 to 37 hours per working week. The first 30-minute reduction in the working week was effective from 1 April 2024. In tranche 1, all non-rostered Business Support and Corporate Functions (non-rostered staff) moved to the new 37 hour working week (pro rata) from week commencing Monday 6 May. All remaining non-rostered staff were requested to transition by 30th August 2024 alongside some rostered staff groups identified by the roster team who would be supported to also transition in tranche 2. The final tranche of transitions included all rostered staff to be transitioned by the end of November. This has proved more difficult to execute due to the support.

At the conclusion of tranche 3, Midlothian HSCP has a high level of assurance on the accuracy of the WTE and headcount of the staff employed under AfC who have transitioned. The total number of staff employed under AfC in Midlothian is 777 (headcount) with 727 (headcount) having transitioned to 37 hours. NHS Lothian had determined that a small number of staff in high-risk services should continue working at 37.5 with a transitional allowance paid for the additional time worked.

Model Publication Scheme

Following an audit of the IJBs Model Publication Scheme from December 2024 to March 2025, several actions were required including the development of a Style Guide for Publication. The required actions were agreed as complete by the Chief Internal Auditor in November 2024.

Strategic Plan 2025/35 Consultation and Engagement

The formal consultation on Midlothian IJBs Strategic Plan for 2025/35 has now closed. As part of the three-month statutory consultation people got involved via the survey on the Midlothian Health and Social Cre website, the Strategic Planning Group, discussions with our partners, and feedback sessions.

Feedback was received from our services, providers, partner organisations, people and communities to help better understand what is already working well and where they are opportunities to improve. This has helped shape the plan to focus on our contribution towards our communities living good lives and achieving the things that matter most to them and included staff views on our values, and views on people's experience of health and social care services.

Two virtual Townhall sessions in November recently provided further opportunity for the workforce and people who live in Midlothian to ask questions and hear from Board members and officers of the Health and Social Care Partnership. The Townhalls were publicised via Midlothian HSPC Facebook and X accounts, and stakeholders shared event information with their communities. The sessions opened with a brief overview of the

strategic plan followed by Board members and the Health and Social Care Partnership senior team taking questions about the plan.

Consultation will continue as the plan evolves in the coming months and is reviewed by various governance groups before approval.

Equality Outcome Setting and Consultation

All public bodies are required to set new Equality Outcomes in 2025. Across Lothian, a joint approach is being taken that includes the Local Authority Areas, Integration Joint Boards, and NHS Lothian. A consultation on a set of draft Equality Outcomes for 2025-2029 has been launched to hear view on whether the proposed set of shared outcomes are focusing on the correct issues.

We have worked on behalf of Midlothian IJB to develop these draft outcomes with partners including Midlothian Council, NHS Lothian, West Lothian Council and East Lothian Council. The Outcomes describe the improvements we want to see in people's lives by eliminating discrimination, advancing equality of opportunity, and fostering good relations between communities. The outcomes focus on 6 areas of Education, Work, Living Standards, Health, Justice, and Participation. To share your views, you can complete the survey online, pick up a paper copy at any library, or sign up for an online meeting (with a BSL interpreter) by contacting Scott Williamson on Equalities@midlothian.gov.uk.

Gill Main, Integration Manager – gill.main3@nhs.scot

3.4 **Clinical Director**

General Practice
All 11 practices continue to have open lists for registration and patient access to core general medical services (GMS). List extension (LEGUP) financial support arrangements are in place for practices with the highest rate of population growth. This year's annual practice visits are now almost complete and continue to be a useful mechanism to maintain good working relationships with the HSCP and address any practice-specific issues as needed.

Pharmacy
The Midlothian HSCP Primary Care Pharmacy Team continue to manage an annual prescribing efficiencies plan. Progress is good, with £623k (80%) currently returned against a year-end target of £778k in the prescribing plan. However, at the start of this financial year, NHS Lothian identified an overall overspend against GP Prescribing, and the current forecast is significantly higher than the original financial plan, including locally in Midlothian. Shortages, i.e. medicine supply issues generally all have a significant and detrimental impact on drug prices. Medicine supply issues are currently running at generationally high rates making medicines prices labile and forecasting of prescribing costs a real challenge.

Older People and Frailty
Work continues to progress the HSCP's commitment to transforming its approach to preventing and managing Frailty in our community. A shared learning session for community partners and integrated health & social care service and team leads was held on Thursday 19th November. The use of a frailty scale was introduced, and participants were asked to cascade it onwards to their services and teams, and consider how it can embedded in their processes, assessments, and communications. Feedback on the outcome of testing will be sought at the next Frailty session, planned for 20th February 2025.

Rebecca Green, Clinical Director – rebecca.green@nhs.scot

4 Policy Implications

4.1 The issues outlined in this report relate to the integration of health and social care services and the delivery of policy objectives within the IJBs Strategic Plan.

5 Directions

5.1 The report reflects the ongoing work in support of the delivery of the current Directions issued by Midlothian IJB.

6 Equalities Implications

6.1 There are no specific equalities issues arising from this update report.

7 Resource Implications

7.1 There are no direct resource implications arising from this report.

8 Risk

8.1 The key risks associated with the delivery of services and programmes of work are articulated and monitored by managers and, where appropriate, reflected in the risk register.

9 Involving people

9.1 There continues to be ongoing engagement and involvement with key stakeholders across the Partnership to support development and delivery of services.

10 Background Papers

AUTHOR'S NAME	Morag Barrow
DESIGNATION	Chief Officer
CONTACT INFO	0131 271 3402
DATE	December 2024

Appendices:

Appendix 1: National Care Service, Stage 2 Communications from Minister for Social Care, Mental Wellbeing and Sport

Minister for Social Care, Mental Wellbeing and Sport
Maree Todd MSP
Ministear airson Cùram Sòisealta, Sunnd Inntinn is Spòrs
Maree Todd BPA

T: 0300 244 4000
E: MinisterforSCMWS@gov.scot

Scottish Government
Riaghaltas na h-Alba
gov.scot

14th November 2024

The Scottish Government remains committed to the plans for a National Care Service. That work involves careful consideration of the views of people who use and work in social care services, the wider public, stakeholders, and political parties.

The Scottish Government wants to take the time that is needed to fully reflect those views in our approach to Stage 2 of the Bill. It is crucial that we get this right for the people of Scotland.

To allow us to do that, I do not intend to start Stage 2 consideration of the National Care Service Bill on 26 November and have asked for more time to allow us to address the outstanding issues.

New Stage 2 dates will be agreed between the Minister for Parliamentary Business and the Scottish Parliament in due course, and we will update you as soon as we can.

We all know the social care system in Scotland needs to improve. Work to progress reform as quickly and effectively as possible continues, whilst making sure we take the time to get this right for everyone.

Delivering a strong and sustainable social care sector in Scotland is a priority for this government and we are absolutely committed to delivering positive changes for people.

Yours sincerely,

MAREE TODD

Taigh Naomh Anndrais, Rathad Regent, Dùn Èideann EH1 3DG
St Andrew's House, Regent Road, Edinburgh EH1 3DG
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Midlothian IJB Membership Recommendations

Thursday, 19th December 2024, 14:00-16:00

Item number:	**5.5**

Executive summary

This report provides information about changes to non-voting membership of the Midlothian Integration Joint Board (IJB) and seeks the Board's formal endorsement of the membership nomination detailed in the report.

Members are asked to:

- Review and endorse the nomination of Dr Wendy Metcalfe, Renal Clinical Director, as the Medical Practitioner Representative (non-voting member) of the Midlothian Integration Joint Board.
- Welcome Dr Metcalf to the Midlothian IJB

Midlothian IJB Membership Recommendations

1 Purpose

1.1 This report notes and seeks the Board's endorsement of the nomination for Medical Practitioner Representative (non-voting member) on the Midlothian Integration Joint Board, for membership, and to agree the appointment of Dr Wendy Metcalfe to this role.

2 Recommendations

2.1 As a result of this report, Members are asked to:

- Endorse the nomination of Dr Wendy Metcalfe as the Medical Practitioner Representative (non-voting member) of the Midlothian Integration Joint Board.
- Welcome Dr Metcalf to the Midlothian IJB.

3 Background and main report

3.1 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 determines the membership of Integration Joint Boards. This details the requirement to ensure members are representative of service users in the local authority, staff engaged in the provision of services, and third sector bodies carrying out activities related to health and social care in the local authority.

3.2 Following the resignation of Johanne Simpson from her post as Medical Practitioner representative to the Board, a vacancy has arisen. Confirmation was received from NHS Lothian in September 2024 that Johanne Simpson would no longer be acting in this capacity to the Midlothian IJB.

3.3 The NHS Lothian Board met on 4th December 2024, and formally endorsed the nomination of Dr Wendy Metcalfe, as the Medical Practitioner Representative (non-voting member) to the IJB. The Board is requested to endorse her nomination as a new non-voting member of Midlothian IJB to fulfil the post as Medical Practitioner representative.

4 Policy Implications

4.1 There are no policy implications arising from this report.

5 Directions

5.1 There are no implications for Directions arising from this report.

6 Equalities Implications

6.1 There is no direct impact on inequalities arising from this report.

7 Resource Implications

7.1 There are no resource implications arising from this report.

8 Risk

8.1 Failure to appoint Integration Joint Board members would result in the Integration Joint Board being unable to meet the requirements of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Act 2014 and the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

9 Involving people

9.1 The regulations and guidance accompanying the Public Bodies (Joint Working) Act (2014) requires the IJB membership to be reflective of those working in the delivery of health and social care in the community and should include representation from all key stakeholders. This includes staff, service users, voluntary bodies and independent organisations related to health and social care in the local authority.

10 Background Papers

10.1 N/A

AUTHOR'S NAME AND DELEGATION	Iina Jaara, Democratic Services Team Leader, Democratic Services
AUTHOR'S CONTACT DETAILS	democratic.services@midlothian.gov.uk
DATE	9th of December 2024

Whole system Improvement Initiative: Improving Unscheduled Care Performance in Lothian.

Thursday, 19th December 2024, 14:00-16:00

Item number:	**5.6**

Executive summary

This report informs the IJB of the outcome of the decision to provide Scottish Government funding across the Lothian unscheduled care system (USC). This funding will allow the Board and Health and Social Care Partnerships to implement the tests of change and progress immediate work to make system improvements ahead and over the winter to March 2025.

Members are asked to note the contents of this report and specifically both appendices which relate to:

- the original proposal (12th November 2024) submitted jointly by NHS Lothian and Lothian Health & Care System (LHCS) that comprises NHS Lothian, the Health & Social care Partnerships (HSCPs) and Local Authorities.
- Scottish Government response (4th December 2024) which sets out confirmation of funding.

Whole system Improvement Initiative: Improving Unscheduled Care Performance in Lothian.

1 Purpose

1.1 This report sets out the actions taking place system-wide across NHS Lothian in partnership with the IJB's.

1.2 It sets out the funding received from the Scottish Government and specifically related to Midlothian HSCP and the expected outcomes for receipt of this funding linked in to the system-wide focus on unscheduled care performance across NHS Lothian.

2 Recommendations

The IJB is asked to:

2.1 Note the original proposal (appendix 1) 12th November 2024 submitted jointly by NHS Lothian and Lothian Health & Care System (LHCS) that comprises NHS Lothian, the Health & Social care Partnerships (HSCPs) and Local Authorities.

2.2 Note the Scottish Government response (appendix 2) 4th December 2024 which sets out confirmation of funding.

2.3 Note the Lothian-wide population and budgetary pressures (section 3.7: 3.11) faced by health and social care services and the effect of these on current and projected performance of Lothian's USC services, particularly in the Royal infirmary of Edinburgh (RIE).

2.4 Note the collaborative work initiated by the Lothian USC Programme Board to consider options to improve performance throughout the patient USC health and social care journey.

2.5 Agree the Unscheduled Care Short Life Working Group (USCSLWG) proposals (sections 3.16: 3.25 below) and objectives to deliver performance improvement across unscheduled care. Specifically noting section 3.18. and the requirement for IJB sign-off.

2.6 Agree the specific actions and associated costings set out in pages 10, 11 and 12 of appendix 1, '*Unscheduled Care System Improvement: RIE Final Proposal'* and note that the Scottish Government has agreed to provide funding to deliver the service transformations.

2.7 Note that this funding is ring-fenced to provide for new additional capacity and should not apply to existing underfunded services.

3 Background and main report

3.1 NHS Lothian was approached by Scottish Government to explore options to improve Unscheduled Care (USC) performance, with particular focus on the Royal Infirmary of Edinburgh. Significant work has commenced in response to this request, drawing input from leaders across the Lothian Health & Care System (LHCS) that comprises NHS Lothian, the Health & Social care Partnerships (HSCPs) and Local Authorities.

3.2 NHS Lothian led a joint submission: Unscheduled Care System Improvement: RIE 12th November 2024 (appendix 1).

- NHS Lothian and partners have used the existing USC strategic framework. The SLWG (short life working group) reviewed the existing USC strategic programme structure (Lothian Strategic Development Framework) and ensured that actions aligned where possible to the existing work streams and approach.
- The existing Lothian Strategic Development Framework (LSDF) is driven through a whole-system USC Programme Board and supported by a USC Tactical Committee. Both of these groups are led by leaders within HSCPs in Lothian and have wide whole system representation. Midlothian's Head of Service for Primary Care and Older People chairs the Discharge without Delay (DWD) sub-group.

3.3 The output from this submission was;

1 **Accelerating existing plans to improve USC performance**, with a particular focus on actions that will deliver improved performance along with patient safety over the winter months.
2 **Developing a comprehensive proposal** that seeks to address the deficits in demand and capacity borne out over the **Lothian Health & Care System** whilst simultaneously enabling radical transformation of models of care to ensure long term sustainability and improved patient safety and experience.

3.4 Two categories of proposal were identified in the submission:

Category 1: unscheduled care performance improvements

1. Expediting roll out of DwD including rapid adoption of PDD (Planned date of discharge), with a focus on reducing Length of Stay.
2. Improving the experience for those presenting to the Emergency Department with Mental Health conditions.
3. Transforming the services available through the Rapid Assessment Care Unit.
4. Transforming models of care across the LHCS for frail citizens who require medical and social support.
5. Strengthening the offer of the Flow Navigation Centre and the interface services accessible through this.

Category 2: Demand and capacity actions

1. Enabling a shift in the balance of care, particularly around assessment and provision of rehabilitation support, from the acute hospital setting to the patient's home.
2. Strengthening the HSCPs' capacity to provide patients with care at home to meet current demand.

3. Strengthening Primary Care capacity to provide enhanced care for frail citizens, reducing reliance on hospital bed based care
4. Reducing the reliance on the RIE Emergency Department as the "place of safety" for those with acute mental health requirements.

3.5 The proposals have been modelled with input from Centre for Sustainable Delivery colleagues to deliver the following impacts (table below). These were predicated on securing investment of £14.5m (full year). Allocation of recurring funding is essential to deliver actions identified.

	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25 onwards	Q2 25/26	Q3 25/26
RIE Performance if proposal not approved	40 - 43%				50-55%		
RIE Long Waits (>8hrs) percentage point reduction	34%	91%	Most long waits at **RIE** should be eradicated.				
RIE Estimated Performance	53%	67%	79%	85%	86%	86%	93%
RIE Estimated Bed Occupancy	98%	92%	87%	85%	<85%	<85%	<85%
Estimated National Performance Uplift	**2%**	**4%**	**7%**	**8%**	**8%**	**8%**	**10%**

3.6 The planned unscheduled care improvement work is designed to address the pressures on the RIE Emergency Department which is the busiest in Scotland, serving 40% more patients than its designed capacity and covering Edinburgh, Midlothian and East Lothian, while functioning as a Major Trauma Centre for the South East of Scotland. The department will soon reach an estimated 120,000 patient attendances per annum, in facilities which were designed for 80,000 patient attendances.

3.7 This growth in demand is driven by Lothian's growing population (*having increased by 24% in 25 years - which is the fastest in Scotland*) and by high numbers of students and seasonal visitors (there were 2.3 million visitors in 2023 up 4% from 2019). Estimates suggest a further population growth of 9.1% between 2018 and 2043 (*compared with 2.5% in Scotland*). Within the region, Midlothian and East Lothian have the fastest growth at 16.1% and 12.7%, respectively.

3.8 As service demand increases, arising from population growth and population ageing, the NHS and its local authority partners are experiencing severe budget pressures, requiring action to deliver efficiencies, including making changes to services.

3.9 NHS Lothian has identified a £140 million Financial Plan gap for 2024/25, with action underway to address.

3.10 Integration Joint Boards have shortfalls in their funding. The USC report notes that at quarter 2 of 2024/25 the four NHS Lothian IJBs' total forecast gap was £48 million. Action by the IJBs is seeking to close the financial gap in this financial year, through service changes, some of which risk reducing system wide capacity and flow and increasing waits. This is happening as reported bed capacity has reduced by 92 beds between January and August 2024 across Lothian, mostly within Edinburgh HSCP. Some planned changes across the region will reduce bed numbers further.

3.11 A Public Health Scotland whole system modelling tool allows health boards to review predicted demand and bed occupancy for the winter months. This tool suggests that NHS Lothian requires an additional 187 beds (or equivalent) to meet peak winter demand this financial year.

3.12 NHS Lothian's, whole system bed modelling (conducted by an external consulting firm in 2024) describes "…*significant gaps in capacity to meet current and projected demand*…". This suggests that across the NHS Lothian area the health and care system requires:

1. 720 additional acute beds by 2033.
2. If NHS Lothian is successful in delivering significant mitigations this would reduce to requiring an additional 80 beds (*note: the modelled mitigations are extremely ambitious and assume the removal of all delayed discharges from acute hospitals*).
3. Projected need for acute beds by 2043 (even if all mitigations are implemented) is still an additional 300 acute beds.
4. An additional 288 community beds and an additional 1,900 care home beds across the Lothian region by 2043.

3.13 A short life working group (SLWG) comprising stakeholders and leaders from USC planning and operational services and chaired by the NHS Lothian Deputy Chief Executive, is driving action-focussed, system-wide improvement, while regularly consulting with and briefing IJB Chief Officers.

3.14 The NHS Lothian Chief Executive Officer (CEO) has also led discussions with the four Lothian Local Authority CEOs to reach consensus on joint action. A new whole-system monthly meeting is being established to bring together leaders of the Lothian Health and Care System and Local Authorities.

3.15 The SLWG proposals for performance improvement are as follows:

- ***Component 1:*** - Aimed at the immediate decompression of the system with impact delivered by 31 December 2024.
- ***Component 2:*** - Aimed at the acceleration of strategic actions that will deliver impact by 31 March 2025.
- ***Component 3:*** - Aimed at further acceleration of larger strategic actions that will be commenced in 2024/25 deliver impact by Q2 2025/26 and ensure sustainability of delivery.

3.16 The following SLWG key objectives were agreed:

- Reducing attendances.
- Reducing bed occupancy.
- Reducing admissions.
- Reducing length of stay.

3.17 The SLWG proposals have been signed off by IJB Chief Officers (who have kept IJB Chairs updated on progress with the group and require approval by each IJBs, including the allocation of £14.5 million of investment which has been approved by Scottish Government, as announced in the 4th December funding letter.

4 Policy Implications

4.1 These may be identified in due course following the outputs on the changes and actions that will be required to deliver the actions in relation to the Lothian wide USC improvement initiatives.

5 Directions

5.1 The subject of this report requires development of directions for NHS Lothian acute service and it's Emergency Department, in line with Midlothian IJB and linking to the other Lothian IJBS.

6 Equalities Implications

6.1 This report does not have implication for groups of people with protected characteristics and at this stage does not result in the requirement to revise or develop a new strategy, policy, plan, provision, practice, or activity.

7 Resource Implications

7.1 The Unscheduled Care System Improvement report (appendix 1) shows that £14.5 million of investment is required to deliver the intended USC actions and outcomes across the RIE, Lothian HSCPs and Primary Care. The Scottish Government, in its funding letter of 4th December 2024 (appendix 2) has agreed to provide the investment, with conditions.

7.2 The letter commits to provide NHS Lothian with funding of up to £3.4 million to cover the period up to March 2025, to support implementation of USC tests of change and associated system improvements.

7.3 Further funding of up to £14.5 million will be provided in 2025-26 to expand system change and to establish revised community pathways. This sum will be made recurrent in 2026-27 once actual spend has been confirmed and assuming agreed outcomes are delivered.

7.4 NHS Lothian has agreed to underwrite financial risk for non-recurrent elements of the 2025/26 funding.

7.5 Midlothian HSCP have been given two funding streams:
1. £1.65m to reduce occupancy in the USC system.
2. £734k to reduce admissions. It should be noted that this funding is ring-fenced to provide for new additional capacity and should not apply to existing underfunded services.

				End of Month Estimated Impact Timeline						
Component 1	**Beds Released (up to)**	**Required Funding**	**Key Objective**	**Dec 24**	**Jan 25**	**Feb 25**	**Mar 25**	**Apr 25**	**Q2 24/25**	**Q3 24/25**
RIE - Open all limited unfunded bed capacity	14	£406,000	Reduce Occupancy					closed		

RIE - Enhanced ED Frailty Model	15	£420,000	Reduce Occupancy Reduce Admissions							
Edin HSCP - Care @ Home	84	£4,100,000	Reduce Occupancy							
Edin HSCP - End of Life Beds	2	£151,200	Reduce Occupancy							
East HSCP - Care @ Home	31	£1,700,000	Reduce Occupancy Reduce Admissions							
East HSCP - Enhanced HSCP capacity		£914,000								
Mid HSCP - Care @ Home	28	£1,650,000	Reduce Occupancy Reduce Admissions							
Mid HSCP - Enhanced HSCP capacity		£734,000								
REH – Open 12 unfunded beds	12	£576,420	Reduce Occupancy						closed	

8 Risk

8.1 Funding of up to £14.5 million will be provided in 2025-26 to expand system change and to establish revised community pathways. This sum will be made recurrent in 2026-27 once actual spend has been confirmed and assuming agreed outcomes are delivered.

8.2 NHS Lothian has agreed to underwrite financial risk for non-recurrent elements of the 2025/26 funding.

9 Involving people

9.1 NHS Lothian and partners have used the existing USC strategic framework. The SLWG (short life working group) reviewed the existing USC strategic programme structure (Lothian Strategic Development Framework) and ensured that actions aligned where possible to the existing work streams and approach. The existing LSDF is driven through a whole-system USC Programme Board and supported by a USC Tactical Committee. Both of these groups are led by leaders within HSCPs in Lothian and have wide whole system representation.

10 Background Papers

10.1 see appendices attached.

AUTHOR'S NAME	Grace Cowan
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DATE	19 December 2024

Appendices:

Midlothian Integration Joint Board

Appendix 1: USC System Improvement Milestone
Appendix 2: Lothian Communication December 2024

Unscheduled Care System Improvement: RIE

Week 2: Final Proposal

12 November 2024

Executive Summary: Statement of Intent

NHS Lothian was approached by Scottish Government to explore options to improve Unscheduled Care (USC) performance, with particular focus on the Royal Infirmary of Edinburgh. Over the last 14 days significant work has commenced in response to this ask drawing input from leaders across the Lothian Health & Care System (LHCS) that comprises NHS Lothian, the Health & Social care Partnerships (HSCPs) and Local Authorities.

The output from this work includes;

(1) **Accelerating existing plans** to improve USC performance, with a particular focus on actions that will deliver improved performance along with patient safety over the winter months.
(2) Developing a comprehensive proposal that seeks to address the deficits in demand and capacity borne out over the Lothian Health & Care System whilst simultaneously enabling **radical transformation of models of care to ensure long term sustainability** and improved patient safety and experience.

The proposals under category (1) include;

- Expediting roll out of **DwD** including rapid adoption of PDD, with a focus on **reducing Length of Stay**
- Improving the experience for those presenting to the Emergency Department with **Mental Health conditions**.
- Transforming the services available through the **Rapid Assessment Care Unit**
- Transforming models of care across the LHCS for **frail citizens** who require medical and social support
- Strengthening the offer of the **Flow Navigation Centre** and the interface services accessible through this

The proposals under category (2) include;

- Enabling a shift in the balance of care, particularly around **assessment and provision of rehabilitation support**, from the acute hospital setting to the patient's home.
- Strengthening the HSCPs capacity to provide patients with **care at home to meet current demand**.
- Strengthening **Primary Care's capacity** to provide enhanced care for frail citizens, **reducing reliance on hospital bed based care**
- Reducing the reliance on the RIE Emergency Department as the "place of safety" for those with **acute mental health requirements**.

These proposals have been modelled with input from CfSD colleagues to deliver the following impact, predicated on securing investment of £14.5m. Allocation of **recurring funding** is essential to deliver actions identified.

	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25 onwards	Q2 25/26	Q3 25/26
RIE Performance if proposal not approved	40 - 43%				50-55%		
RIE Long Waits (>8hrs) percentage point reduction	34%	91%	Most long waits at **RIE** should be eradicated.				
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Estimated National Performance Uplift	**2%**	**4%**	**7%**	**8%**	**8%**	**8%**	**10%**

Introduction: Edinburgh and the South East - The Fastest Growing Region in Scotland

The Edinburgh and South East of Scotland region **is the fastest-growing in Scotland and one of the fastest-growing in the UK**. The forecasted change in population is 9.1% between 2018 and 2043 (compared with 2.5% in Scotland), and the number of households is projected to increase by 18% over the same period compared with 10% in Scotland). Within the region Midlothian is the fastest growing at 16.1% and East Lothian at 12.7%. This is putting unprecedented pressure on our infrastructure and services, and there are significant consequences of accommodating this growth for all public sector organisations including local authorities and health.

The city of Edinburgh is an economically vibrant city that continues to attract high internal migration, from around the rest of the UK and carries the legacy of significant European immigration from the pre-Brexit period.

As the nation's capital, a global centre for tourism and the biggest European centre for the Finance industry outside of London, Edinburgh also plays host to a significant number of visitors, year-round, many of them high profile. In 2023, the city welcomed 2.3 million international visitors, which was a 4% increase from 2019. In the same year there were a total of 5.34 million overnight tourism visits to Edinburgh and the Lothian and places a significant extra pressure on urgent care services during the Festivals' season.

Edinburgh also has a significant student population, many of them foreign students unfamiliar with primary care access routes to health care.

The RIE Emergency Department serves a wide geographical area that takes in East Lothian and Midlothian and is a Major Trauma Centre for the South East of Scotland. The extensive housebuilding that is visible across Lothian testifies to its status as the fastest growing region in Scotland. Lothian's population has grown by 24% in 25 years and by 1% every year since 2008. There is no sign of this slowing down. In fact, 80% of the population increase in Scotland between 2021 and 2033 is projected to happen in Lothian.

Recent analysis undertaken by CfSD indicated that **NHS Lothian has proportionately the lowest number of Clinical Care Spaces within its Emergency Departments footprint**. Glasgow has roughly 40% more physical space within its ED per population, and Grampian 30%.

The RIE ED is the busiest in the country. Population growth and significant visitor numbers have resulted in steadily increasing demand on services. The Department was originally designed during the 1990s to manage 80,000 patient attendances per annum and opened in 2003. It is on track to receive over 120,000 attendances this year, **a 40% growth on the original designed capacity**.

Introduction: NHS Lothian and Partners Existing USC Strategic Framework

The SLWG reviewed the existing USC strategic programme structure (LSDF) and ensured that actions aligned where possible to the existing workstreams and approach. The existing LSDF is driven through a whole-system USC Programme Board and supported by a USC Tactical Committee. Both of these groups are led by leaders within HSCPs in Lothian and have wide whole system representation.

Note, the LSDF was shared earlier this year with CfSD and the following feedback was received;

> *"You have shared a copy of your Strategic Delivery Framework (LSDF) which evidences a thorough analysis of the challenges facing the health board and effective identification of opportunities for improvement, underpinned by a clearly articulated theory of change and impact forecasting. The LSDF incorporates all of the leverage points we identified for NHS Lothian as well as many of the recommendations we have made over the past two years whilst providing bespoke support and also includes recommendations made by independent consulting firm Buchan + Associates. The content of the LSDF is robust and is well-supported by the existing evidence base... It is evident that there is a large volume of quality improvement work already underway, with good collaboration between the health board and health and social care partnerships as well as good engagement with the national team, and some of this work is showing signs of significant impact."*

The LSDF targets 3x key areas for improvement

- **Reducing Attendances**
- **Reducing Length of Stay**
- **Bed Occupancy**
- **Reducing Admissions**

From the recent review and refresh of the strategic framework, specific programmes of work were initiated to accelerate the delivery of performance and patient safety improvements. These revisions included;

- Development of a Pan-Lothian whole system **Frailty Programme Board** with a focus on redesigning models of care for frail patients
- Development of a **Navigation Programme Board** that brings together the Flow Navigation Centre, acute hospital teams, and importantly HSCP colleagues to ensure patients can be referred to appropriate support be it in community or an acute hospital.
- Development of an **Interface Programme Board** that is reviewing H@H delivery and variation across the teams in Lothian, and additionally reviewing the other interface services (OPAT/CRT/RACU) with a view to maximise and standardise models of care and routes into these services.
- Development of a **Acute Length of Stay Programme** led by each acute hospital site that complements the existing **DwD programme**, but also challenges and supports clinicians to review current clinical pathways with a view to improving patient experience through reducing their hospital length of stay.

This proposal seeks to accelerate components that feature within this recently refreshed strategic framework.

Context: Financial and Capacity

Following the announcement of the Scottish Budget in December 2023, NHS Lothian identified a £140m Financial Plan gap in 2024/25. In addition to the 3% cash releasing efficiency savings required by the Scottish Government, further savings of c. £80m have been necessary to bridge this gap, partially achieved through significant non-recurring interventions.

Integrated Joint Boards (IJBs) face a dual challenge from both Health and Social Care funding. As at Q2 24/25 the four NHS Lothian IJBs are forecasting a total £48m gap, including Social Care pressures that equate to 6% of the budget. IJBs are currently exploring cost reduction measures to further close this £48m pressure in this financial year, which may further deteriorate system wide capacity and flow. The position for the four IJBs is part of a forecast financial plan overspend of £120m for NHS Lothian, with significant budget pressures also identified by the four Local Authorities.

In this context, the Health Board and Councils have driven decisions on significant expenditure reductions to support the financial position. The majority of these decisions have impacted capacity and patient waits to some extent.

Through the Unscheduled Care Programme Board, since January 2024 NHS Lothian has collated and reported bed capacity across the NHS Lothian Health and Care System. Between January and August 2024 there was a reduction of 92 beds, predominantly within Edinburgh HSCP. This is in addition to reductions across community and social care capacity in the preceding years.

The following potential impacts resulting from cost control measures were noted:

HSCP/Unit	Measure	Potential Impacts Identified
Edinburgh HSCP	Budget Control Measures; Social Worker Reprioritisation; Combined Measures	• 235 people added to care at home waitlist (excluding Mental Health patients) • 500 people added to assessment waitlist (excluding Mental Health patients) • ~Increase of 35 delays
Midlothian HSCP	Budget Control Measures; Social Worker Reprioritisation; Combined Measures	• 1300 hours per week added to care waitlist • 8 people per week added to assessment waitlist • ~Increase of 10 delays
East Lothian HSCP	Care Home Closures Capping care at Home	• Variable impact on care home bed availability • Increase in delays largely due to care @ home capacity available to the HSCP
West Lothian HSCP	Redesign of Social Work Teams; Redesign of Internal Support at Home; Review of Internal Care Homes	• Potential increase in assessment wait times • Possible increase in delayed discharges • Increased risk of delayed discharges

In addition to the above, the following actions are planned which will further reduce capacity:

- Liberton closure, by 31st March 2025 - currently modelled to increase demand on acute beds by the equivalent of 21 beds.
- Ward 74 WGH to facilitate safe closure of RIDU. Mitigations planned to support MoE pathway, but full mitigation may take time to realise.
- Winter funding. Reduction by c. £1m in available funding to support non-recurring support against winter pressures.
- MDT funding. Impact of national reduction in MDT funding is an additional £1.4m funding pressure across NHS Lothian, equating to reduction of c. 20 wte to support delivery of home first offerings across the four IJBs.
- Historically around £1.5m is invested by NHS Lothian into whole-system winter mitigations focused on ensuring patient safety and maintaining performance. The NHS Lothian approved proposals for winter 24/25 include:
  - Strengthening the RIE Emergency Departments ability to manage patients in the department when it is over capacity
  - Strengthening SJHs out-of-hours service provision
  - Testing a new approach to the clinical triaging of emergency patients at the WGH
  - Delivering increased access to Gynaecology Hot-Clinics
  - Increasing opening hours for community Pharmacies
  - Strengthening Community-respiratory pathways in Edinburgh

Given the financial planning pressures across Health and Social Care, any additional actions to support winter pressures will require additional resources before they can be agreed and implemented. However, even with funding, there is a significant risk to performance improvements that rely on maintaining or increasing capacity, particularly when allocated to Integrated Joint Boards.

The financial pressures on IJBs, described above, are driving a requirement for further reductions in expenditure to achieve financial balance. As such, while it may be possible to ringfence any additional allocations for additional capacity, this will not apply to existing underfunded services.

Further reductions in service provision will undermine the ambition of whole system performance improvement from the actions described in this briefing. Continued close engagement across the system, as well as a joint communications plan, will be required to mitigate this risk.

Some Acute hospital actions can be delivered non recurringly to achieve a benefit within Component 1 timescales, however generating additional community and social care capacity **will require commitment through recurring funding.**

While the financial constraints under which the Scottish Government is operating are recognised, it should be noted that use of non-recurring funding is extremely restrictive on the solutions services can put in place, and generally delivers limited outcomes at greater cost – both in terms of value for money and effort to implement.

Context: Data & Demand

Public Health Scotland have developed in recent months a whole system modelling product that enables boards to review predicted demand over the winter months, particularly in relation to bed occupancy – the main measure positively correlated with the emergency access standard performance.

This tool, whilst unable to drill down to a hospital-site level, is still helpful in articulating the increased demand for beds within Lothian over the coming 24/25 winter months. This tool suggests that **NHS Lothian requires an additional 187 beds (or equivalent) to meet peak winter demand this financial year**.

In 2024 NHS Lothian commissioned an external consulting firm to undertake a whole-system bed-modelling exercise. The stark outputs of this exercise illustrated the **significant gaps in capacity to meet current and projected demand based on population modelling**. The exercise concluded that NHS Lothian would require;

- **720 additional acute beds by 2033**.
- If NHS Lothian was successful in delivering significant mitigations this would reduce to requiring an **additional 80 beds**.
    - Note - the modelled mitigations are *extremely ambitious* and include the likes of removing all delayed discharges from acute hospitals.
- However - projected need for acute beds by **2043** (assuming all mitigations implemented) was still an **additional 300 acute beds.**
- By **2043** there would be a requirement for an additional **288** (55%) **community beds** across the Lothian region.
- By **2043** there would be a requirement for an additional **1900** (55%) **care home beds** across the Lothian region.

Note NHS Lothian, does not have additional surge capacity. Therefore, the current position of bed occupancy routinely operating in the region of 99 - >100% is within the context of the Board utilising all the core capacity available.

It must be acknowledged that the proposals found within this document are likely to be deployed at a period in the year where the system is under pressure and therefore there is an expected decline in performance. This has been set out below to a) frame the anticipated seasonal performance deterioration in line with seasonal variation if no further action taken and b) contextualise the scale of the ask in relation to the options being explored to improve performance and safety with immediate effect.

	4hr %	8hr breaches	12hr breaches
Previous Winter Averages	47.4	2045	1145
Previous Non-Winter Averages	49.5	1906	978
Expected Seasonal Winter Variation	-4.2%	7.3%	17.0%

NHS Lothian has recently developed a measurement framework that captures the key measures influencing unscheduled care performance and builds upon the measures that were developed by CfSD. **It is proposed that the data within this framework that is refreshed weekly is the cornerstone of how improvement is measured.**

USC Measurement Framework Nov.pdf

CfSD commented in their feedback on NHS Lothians LSDF of which the measurement framework has been built around.

> *"Your return included specific aims related to eleven of the twelve leverage points identified and you also included an additional target that you have set for yourselves to improve non-admitted performance to 85% by March 2025. The only leverage point that you did not provide a specific aim against in the template you returned to CfSD outlining your priority areas of focus was for the number of standard delays (although it remains listed as an area for improvement within Lothian's Strategic Delivery Framework which you appended to your submission)....*
>
> *In the context of NHS Lothian already performing above average compared to other mainland boards for the number of hospital beds occupied by delayed discharges per head of population, your longer-term trend of improvement in this area over the last couple of years and the emerging evidence of further improvements materialising as a consequence of preventative actions elsewhere in the pathway, your decision to prioritise other change interventions appears justified."*

Approach: Key Principles and Collaborative Working

The scope and focus of this work is on RIE and its Health & Social Care infrastructure.

A short life working group (SLWG) has been developed comprised of the key stakeholders and leaders within the USC planning and operational delivery landscape and worked towards the following principles and approach.

This SLWG has come together at pace and developed a shared vision that spans community and acute and have had >5 meetings within the last week, evidencing the commitment to drive system-wide improvement. This group has System Wide authorisation to rapidly explore options and make recommendations within this agreed timeline and is chaired by NHS Lothian's Deputy Chief Executive.

Integrated Joint Board Chief Officers have been regularly consulted/briefed throughout this action focused process. NHS Lothian CEO led discussions with our four Local Authority CEOs and consensus for this approach was agreed last week. In addition, a new whole-system monthly meeting that brings together the leaders of the Lothian Health and Care System and Local Authorities within the Lothian region has been agreed.

The SLWG developed a proposal for performance improvement within the following parameters,

Component 1: Aimed at the immediate decompression of the system with impact delivered by 31 December 2024.

Component 2: Aimed at the acceleration of strategic actions that will deliver impact by 31 March 2025

Component 3: Aimed at further acceleration of larger strategic actions that will be commenced in 2024/25 deliver impact by Q2 2025/26 and ensure sustainability of delivery.

The following key objectives were identified.

- **Reducing Attendances**
- **Reducing Bed Occupancy**
- **Reducing Admissions**
- **Reducing Length of Stay**

This proposal has been signed off by our system Chief Officers and will now be subject to approval by each IJBs. Chief Officers have been briefing their respective IJB Chairs on our progress to and including this submission to support evident oversight from each organisation.

Component 1: Key Actions

The SLWG has developed a comprehensive list of the options available to decompress the system and the RIE, primarily through reducing occupancy with immediate effect thus enabling flow as well as safe patient care. The following proposals are the result of whole system prioritisation facilitated through the SLWG and are aimed at;

- Delivering an immediate step change over the winter months that will decompress the system and improve patient safety and system performance, whilst enabling transformational redesign that reduce reliance (where appropriate) on institutional beds.

				End of Month Estimated Impact Timeline						
Component 1	**Beds Released (up to)**	**Required Funding**	**Key Objective**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25 onwards**	**Q2 24/25**	**Q3 24/25**
RIE - Open all limited unfunded bed capacity	14	£406,000	Reduce Occupancy					closed		
RIE - Enhanced ED Frailty Model	15	£420,000	Reduce Occupancy Reduce Admissions							
Edin HSCP - Care @ Home	84	£4,100,000	Reduce Occupancy							
Edin HSCP - End of Life Beds	2	£151,200	Reduce Occupancy							
East HSCP - Care @ Home	31	£1,700,000	Reduce Occupancy Reduce Admissions							
East HSCP - Enhanced HSCP capacity		£914,000								
Mid HSCP - Care @ Home	28	£1,650,000	Reduce Occupancy Reduce Admissions							
Mid HSCP - Enhanced HSCP capacity		£734,000								
REH – Open 12 unfunded beds	12	£576,420	Reduce Occupancy						closed	

The SLWG has acknowledged that the short-term *non-recurring* purchase of higher rate care home beds may undermine negotiations with providers in the future, and therefore the view taken by the SLWG was that this option held significant medium-long term risks. Additionally, the SLWG took the view that the use of agency staff to open HSCP / Local Authority beds would not deliver value for money in relation to the non-bed-based options that are available.

Commitment to proposed actions through recurring funding is therefore considered essential, particularly within the context of the financial challenge for IJBs and the Health Board. Without recurring funding against recurring costs, it will not be possible for organisations to increase financial risk, or to build the proposed actions into longer term financial plans.

Component 2: Key Actions

The following proposals are intended to accelerate existing strategic actions with measurable impact by 31 March 2025. These actions focus on embedding and sustaining performance improvements achieved in "component 1" by challenging the current care delivery model. However, they should be considered within the context of an ongoing, extremely challenging financial landscape, anticipated to persist into and throughout 2025/26.

				IMPACT TIMELINE - BY CLOSE OF PLAY.....						
Component 2	**Beds Released (up to)**	**Funding Required**	**Key Objective**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25 onwards**	**Q2 24/25**	**Q3 24/25**
REACH Model within **Flow Nav Centre** enabling physician/consultant prof-prof calls with referrers.	8	£240,000	Reduce Admissions Reduce Attendances							
RIE - Develop Mental Health Chaired assessment area out-with ED on RIE site	Decompress ED	-	Reduce Long Waits							
RIE - Fast-track implementation of criteria to reside and criteria to admit.	Level of Success Linked to component 1 actions	-	Reduce Occupancy							
RIE - Accelerate deployment and practice of AHP risk-stratification work	Level of Success Linked to component 1 actions	-	Reduce Occupancy Reduce Admissions							
RIE - Expedite roll out of PDD	Level of Success Linked to component 1 actions	-	Reduce Occupancy							

Component 3: Key Actions

The SLWG explored what broader strategic actions could be accelerated to maximise the sustainability of improved safety and performance delivered through the implementation of Components 1 & 2 of this proposal.

				IMPACT TIMELINE - BY CLOSE OF PLAY.....						
Component 3	**Beds Released (up to)**	**Funding Required**	**Key Objective**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25 onwards**	**Q2 25/26**	**Q3 25/26**
Edin HSCP- Enhanced community rehabilitation service (moving acute rehab to community)	50	£2,400,000	Reduce Occupancy							
Primary Care - Frailty LES with GPs, reducing admissions and improving patient experience and safety	20	£1,190,000	Reduce Admissions Reduce Occupancy							

This component proposes to invest in Primary Care through an enhanced Frailty local enhanced service that has been evidenced through collaborative work with Edinburgh university to reduce admissions by 12% in the moderately or severely frail population, who of which are the patients that require and consume the most intensive resource. **This has been modelled to yield a >200% return on investment.** This proposal fits with the strategic direction to focus on prevention by shifting the balance of care into community and away from outdated bed-based models of care. There is potential to commence this approach earlier in "component 2" in a targeted manner focusing on the GP practices with the highest "frailty" admissions to the RIE.

The development of an enhanced community rehabilitation service aims to support individuals who are medically ready to leave the hospital but require an intensity of rehabilitation that cannot currently be met within community settings. **This service would allow these patients, who have a suitable home environment, to transition out of hospital while continuing to receive the necessary support**. The initiative is projected to release 50 hospital beds daily, reducing occupancy and easing pressure on hospital resources. With full-year costs estimated at £2.4 million, this service would require new recruitment efforts, introducing a lag in implementation as staffing is established to meet these rehabilitation needs.

Ask of Scottish Government colleagues: Communications

The proposals are partly predicated on the successful development and deployment of a **public facing communications strategy** aimed at supporting patients, carers, and families in receiving care in community or their own home, that historically would have taken place in an acute hospital setting. **Collaboration with Scottish Government to maximise this messaging would be welcomed and seen as a key enabler to successful deployment of these measures.**

All Components: Summary & Trajectories

		Required Funding	Key Objective	End of Month Estimated Impact Timeline: Dec-24	Jan-25	Feb-25	Mar-25	Apr-25 onwards	Q2 24/25	Q3 24/25
Component 1	**RIE** - Open all limited unfunded bed capacity	£406,000	Reduce Occupancy					closed		
	RIE - Enhanced ED Frailty Model	£420,000	Reduce Occupancy Reduce Admissions							
	Edin HSCP - Care @ Home	£4,100,000	Reduce Occupancy							
	Edin HSCP - End of Life Beds	£151,200	Reduce Occupancy							
	East HSCP - Care @ Home	£1,700,000	Reduce Occupancy							
	East HSCP - Enhanced HSCP capacity	£914,000	Reduce Admissions							
	Mid HSCP - Care @ Home	£1,650,000	Reduce Occupancy							
	Mid HSCP - Enhanced HSCP capacity	£734,000	Reduce Admissions							
	REH – Open 12 unfunded beds	£576,420	Reduce Occupancy						Closed	
Component 2	REACH Model within **Flow Nav Centre**	£240,000	Reduce Admissions							
	RIE - Mental Health Chaired assessment area	-	Reduce Long Waits							
	RIE - Criteria to reside and criteria to admit.	-	Reduce Occupancy							
	RIE - AHP risk-stratification work	-	Reduce Occupancy Reduce Admissions							
	RIE - Expedite roll out of PDD	-	Reduce Occupancy							
Component 3	**Edin HSCP**- Enhanced community rehabilitation	£2,400,000	Reduce Occupancy							
	Primary Care - Frailty LES with GPs	£1,190,000	Reduce Admissions Reduce Occupancy							

Total Funding Required: **£14,481,620**

	End of Month Estimated Impact Timeline: Dec-24	Jan-25	Feb-25	Mar-25	Apr-25 onwards	Q2 25/26	Q3 25/26
Anticipated Beds released	27	73	113	132	135	135	158
RIE Long Waits (>8hrs) percentage point reduction	34%	91%	Most long waits at **RIE** should be eradicated.				
RIE Performance	53%	67%	79%	85%	86%	86%	93%
RIE Bed Occupancy	98%	92%	87%	85%	<85%	<85%	<85%
Estimated National Performance Uplift	2%	4%	7%	8%	8%	8%	10%

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Scottish Government
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To: Caroline Hiscox
Jim Crombie
Fiona Wilson
Morag Barrow
Pat Togher
Alison White

Via email

04/12/2024

Dear Colleagues

Following the recent discussion with the Cabinet Secretary and Scottish Government officials, it has been agreed that funding of up to £3.4 million will be made available to NHS Lothian in 2024-25. This will allow the Board and partnerships to implement the tests of change and progress immediate work to make system improvements ahead and over the winter to March 2025.

Moving into 2025-26 funding will be made available to cover the costs of this change up to the total of £14.5 million. This will be made recurrent moving into 2026-27 based on actual spend incurred and evidence of delivery of outcomes required.

It supports the First Minister's mission to address delayed discharge levels and improve unscheduled care performance across Scotland through a targeted whole-system improvement initiative, improving the admitted inpatient flow in NHS Lothian.

This funding will be allocated to the set out in the table at Annex A. We understand that the £406,000 for acute beds is to be used to support a model that will transition into a community pathway. On that basis we are content this is included, with the clear expectation that this be achieved from March 2025 onwards.

The expected outcomes of this spend are to:

- Support immediate decompression of the system by discharging patients from the acute system by end of December 2024.

- Accelerate plans to improve unscheduled care performance in NHS Lothian, particularly RIE, with a particular focus on actions to deliver tangible improved performance and patient safety during winter.
- Address the deficits in demand and capacity across the Lothian Health and Care System, ensuring models of care are sustainable in the longer term.

It is proposed that the additional funding is conditional on the delivery of these outcomes. Robust reporting and monitoring processes will also be put in place to track progress and identify slippage. Lothian have projected that this work will achieve:

- Significant reduction in admissions and occupancy creating additional capacity to support flow - reducing long waits and improved performance against the four-hour target by end of March 2025.

Ministers have been clear that this investment must lead to demonstrable improvements in performance and outcomes for patients and for this improvement to be sustained beyond April 2025.

A meeting will be held with the Board and partners in the next few days to discuss and agree the reporting cycle based on the timeline set out the Action Plan.

The trajectories you have provided will be delivered through increasing capacity by delivering care in the right place. The pan Lothian whole system plan shows this will be delivered by increasing Mental Health Capacity, Care at Home, End of Life and Enhanced Community Capacity across Edinburgh, Mid and East Lothian partnerships. The Board will also enhance its frail elderly and Flow Navigation services, which will release around 184 beds by March 2025 and a further 78 beds released by December 2025.

Yours sincerely

John Burns
Chief Operating Officer NHS Scotland

Angie Wood
Co-Director of Social Care and National Care Service Development
Scottish Government

RIE - Open all limited unfunded bed capacity	£406,000	March 2025
RIE - Enhanced ED Frailty Model	£420,000	January 2025
Edin HSCP - Care @ Home	£4,100,000	February 2025
Edin HSCP - End of Life Beds	£151,200	January 2025
East HSCP - Care @ Home	£1,700,000	March 2025
East HSCP - Enhanced HSCP capacity	£914,000	February 2025
Mid HSCP - Care @ Home	£1,650,000	February 2025
Mid HSCP - Enhanced HSCP capacity	£734,000	February 2025
REH – Open 12 unfunded beds	£576,420	February 2025
REACH Model within Flow Nav Centre	£240,000	March 2025
Edin HSCP- Enhanced community rehabilitation	£2,400,000	Q4 24/25
Primary Care - Frailty LES with GPs	£1,190,000	Q4 24/25

Finance Update: 2024/25 and Initial Outline 2025/26

Thursday, 19th December, 14:00-16:00

Item number:	**5.7**

Executive summary

In March 2024, the Midlothian Integration Joint Board (IJB) set a balanced budget for the financial year which included c. £10m of recovery actions. Given the nature of the financial challenge in 2024/25, it was agreed that in-year financial monitoring would be provided at each IJB meeting and that a revised Medium Term Financial Plan (MTFS) be finalised at the December meeting as part of the planning for 2025/26 and beyond. The most recent update for both the 2024/25 position and the revised MTFS was presented to the IJB's October meeting.

However, the Scottish Government announced its draft 2025/26 budget on 4th December and the proposals included in this draft budget – discussed further below – will mean that both the IJB's partners will now have to revise their financial plans for 2025/26 and beyond. Therefore, the IJB will not be able to revise its MTFS until January 2025. That said, the indicative position is still a significant projected overspend and the IJB is developing both short and long term measure to support the 2024/25 and 2025/26 positions and, more importantly, developing a transformation programme which is designed to allow the IJB to deliver its delegated functions within the financial resources available to it.

Although the IJB is working very closely with its partners to further manage the 24/25 position, it now seems unlikely that the IJB will be able to breakeven in the current financial year.

Members are asked to:

- Note the projected out-turn position for 2024/25.
- Note the proposals from the draft Scottish Budget for 2025/26.
- Note the outline of the financial position for 2025/26.

- Support the short and longer terms actions being taken to manage the financial challenges in both years.
- Support the development of the of the long-term transformation plan.
- Note the risks laid out in Section 8 below.

Finance Update\; 2024/25 and Initial Outline 2025/26

1 Purpose

1.1 This report sets out –

- An update on the IJB's 2024/25 projected out-turn.
- An update on the Scottish Government's 2025/26 draft budget.
- An outline of the 2025/26 financial projection
- Proposals for both short and medium terms recovery actions
- Proposals for the development the transformation programme

2 Recommendations

2.1 As a result of this report, Members are asked to:

- Note the projected out-turn position for 2024/25.
- Note the proposals from the draft Scottish Budget for 2025/26.
- Note the outline of the financial position for 2025/26.
- Support the short and longer terms actions being taken to manage the financial challenges in both years.
- Support the development of the of the long term transformation plan.
- Note the risks laid out in Section 8 below.

3 Background and main report

3.1 At its March 2024 meeting the IJB set a balanced budget for 2024/25. This budget included c. £10m of recovery programmes which were designed to offset the projected financial pressures resulting from the financial planning processes for 2024/25.

3.2 Recognising this challenge and, looking forward, anticipating that similar challenges will exist in future years the IJB agreed that financial monitoring and reporting would now be discussed at each meeting and that a further Medium Term Financial Strategy (a five year financial plan) would be developed throughout the year and a 'final' version to be presented at the December 2024 meeting of the IJB. The Finance Paper presented to the IJB at its October matter laid out the then current forecasts both for 2024/25 and 2025/26 and beyond.

3.3 The Scottish Government presented its draft budget for 2025/26 on 4th December 2024. The settlements arising from this budget were different from the planning assumptions used by the IJB partners in the preparation of their future plans and

the partners are now in the process of fully revising their own financial plans. Given that these plans are the basis of the IJB's financial planning then the IJB will not be able to update its own financial plan until early in the new calendar year.

3.4 The current draft Scottish Government has the following proposals for the IJB's partners –

- NHS – The NHS Boards will receive a 3% uplift on the closing 2024/25 baseline. This will provide 3% for pay awards in 2025/26 along with some funding towards the non-pay costs in the base budget. This is different from the 2024/25 settlement wherein only the pay awards were covered. The Scottish Government also indicated that the additional costs arising from the changes to the Agenda for Change terms and conditions and the costs from the increases in the National Insurance rates arising from the United Kingdom's budget in October would be covered on those staff directly employed by the NHS. The Scottish Government's budget proposals are clear that an appropriate share of any NHS uplift will be made available to the IJBs. The settlement also incudes further funding for increases in the Real Living Wage and Free Personal and Nursing Care for third party providers of social care.

- Local Authorities – this settlement is more complicated and further details are awaited and Midlothian Council colleagues have undertaken to provide further information to the IJB as it becomes available. The headline position is an uplift for Local Authorities of c. £1.0B but, it is estimated that having funded commitments already entered into there will be c. £289m (nationally) available. However, the impact of the UK government's national insurance rate increase has not yet been fully worked through and further information will not be available until the new financial year. The impact of the NI increase on the third party providers of social care is not yet clear and there is a risk of further financial pressures arising from this settlement.

3.5 In the current financial year, the partners have not yet been able to update the financial projections that were available as part of the quarter 2 review. That position was a total overspend for the IJB of c. £8.3m being £5.5m of an overspend in the social care budgets and £2.8m in health. The IJB is working with the partners to develop further schemes to improve this position – these are laid out in the appendices – along with further work being taken to fully deliver the agreed recovery actions in 2024/25 but it is now likely that the IJB will not be able to break-even in 2024/25. The IJB used all of its remaining available reserves at the end of 2023/24 to break-even in that financial year and the IJB's integration scheme lays out that any residual overspend will revert to the appropriate partner. The Interim Chief Finance Officer has informed the partners of his concerns that the IJB will not break-even in 2024/25. Further financial information (a quarter 3 review) should be available in January 2025.

3.6 The October finance paper contained a draft of the MTFS which, although this now has to be revised, projected a opening gap of £11.3m in 2025/25 before any recovery plans. This is included as appendix 1 for the sake of easy reference. It can be seen that the most significant number is the projected underlying overspend within the social care budget and currently this position is being reviewed (further information will be available in January as discussed above) along with a further consideration of the impact of the 24/25 recovery plans in the full year.

3.7 The IJB has been working with the partners to consider a range of further short terms and longer terms recovery schemes. These are laid out in Appendix 2 and Appendix 3.

3.8 It is unlikely that these schemes will be able to deliver the required expenditure reductions to bring the IJB's budget back into balance in 2025/26. The IJB is therefore developing a transformation plan the purpose of which being to deliver the functions delegated to the IJB within the financial resources that the IJB has available. This is described further in Appendix 4. Transformation of the delivery of the delegated functions is the key to financial sustainability. This will not, however, be possible to deliver before March 2025 or even during that financial year and it may be that not only the full support of the Partners is required to make this transformation but also some further non-recurrent investment.

3.9 Having further clarified the financial forecasts in January 2025, it is suggested that the IJB has a workshop to consider the revised financial projections, the impact of the short and medium-term financial recovery actions and to further consider the transformation plan.

4 Policy Implications

4.1 This paper does not require any changes to the IJB's policies.

5 Directions

5.1 This report does not directly impact upon service ability to deliver an existing Direction, nor raise the need to bring suggested revisions or discuss operational implications for an existing Direction or highlight the requirement for a new Direction for Board consideration.

6 Equalities Implications

6.1 This report does not have implications for groups of people with protected characteristics.

7 Resource Implications

7.1 The financial implications of this report are laid out above

8 Risk

There are a range of risks which now need to be considered and managed. These fall into three board categories –

8.1 Financial

- The full impact of the Scottish Government's draft budget of 4/12/24 still required to be fully evaluated and there may be further financial challenges therein.

- The impact of the UK Government's increase in the National Insurance contributions for employees needs to be fully evaluated. This information will not be complete until after the start of the next financial year.

- The impact of demography and increased dependency especially on the social care budget is very significant as expressed through the overspend in both 2023/24 and 2024/25. Consideration needs to be given to ensure that the level of resources to support social care is adequate. This is not clear at this time.

8.2 Impacts on the IJB's Statutory Responsibilities

- There is a risk that the financial uncertainly and ongoing activity to achieve a balanced budget will result in the current draft Strategic Plan 2025/35 being unrealistic, unachievable or, in parts, incongruent with the system actions. To be able to adequately mitigate for this and undertake further liaison and partner governance on the Strategic Plan, it is recommended that the IJB agree to delay publication of the Strategic Plan until October 2025.

- Additionally, there is a risk that the IJB will not meet the statutory timelines to draft, consult on, agree and publish new Equality Outcomes for 2025-29. Scottish Government has set a deadline of 1st April for all Public Bodies in Scotland to publish new Equality Outcomes, Mainstreaming Equality Reports, and Action Plans. It is recommended that Midlothian IJB give delegated authority to the Integration Manager to formally request an extension from Scottish Government to publish a new set of Equality Outcomes by the end of 2025.

8.3 Impact arising from both Scottish Government and Partners' decisions.

Various Audit Scotland reports have highlighted the requirement for reform and change both of health and local authority services. These plans may impact on the functions that are delegated to the IJB or, and this has happened in the past, on the functions themselves that are delegated to the IJB. The IJB's transformation plan needs to recognise this.

9 Involving people

9.1

10 Background Papers

10.1 IJB Meeting – 24th October 2024. IJB Finance Update

AUTHOR'S NAME	David King
DESIGNATION	Interim Chief Finance Officer
CONTACT INFO	N/a
DATE	December 2024

Appendices:

Appendix 1: Midlothian IJB Revised Medium-Term Financial Strategy – Final Draft per October IJB Update

Appendix 2: Short-Term recovery actions

Appendix 3: Medium and Longer-Term Recovery actions

Appendix 4: Transformation Proposals

Appendix 1

Midlothian Integration Joint Board	**Revised Medium Term Financial Strategy**					
						Notes
	25/26	26/27	27/28	28/29	29/30	
Health	£000's	£000's	£000's	£000's	£000's	
Core	(3,537)	(4,334)	(5,159)	(6,017)	(6,920)	**1**
Hosted	(297)	(485)	(594)	(711)	(833)	**1**
Set Aside	(1,496)	(1,568)	(1,726)	(1,893)	(2,064)	**1**
Social Care						
Opening	(4,000)	(6,000)	(7,000)	(8,000)	(9,000)	**2**
In Year Pressures	(1,128)	(1,128)	(1,128)	(1,128)	(1,128)	**3**
Transitions/Demography	(2,000)	(1,000)	(1,000)	(1,000)	(1,000)	**4**
Add'n MLC Allocations	1,128	1,128	1,128	1,128	1,128	**5**
Total	(11,330)	(13,386)	(15,479)	(17,621)	(19,817)	

Notes

1. This is an extract from the first iteration of the NHS Lothian five-year plan. Recovery actions are in the process of being developed to manage these pressures.

2. The opening position is to move the social care forecast onto the same basis as the health forecast. That is, any pressures not recurrently resolved in year will require to be managed in future years. The opening position for 2025/26 is simply a proxy and required to be developed. There are no recovery actions in this position.

3 and 5. Midlothian Council's MTFS makes provision for pay awards for the staff employed in social care along with a provision for inflation in the costs of third-party social care. Any funding from Midlothian Council will require to be formally agreed by Midlothian Council

4. Work is underway to refine these values

Appendix 2 – Short Term Recovery Actions

Recovery Options: External Care Home Placements

Pause Care Home Admissions & not fund placements above National Care Home Rate.

Annual Spend:
£11m-£11.5m

Potential Recovery:
£0.1m-£0.2m

Overview:

Midlothian would not purchase any external beds until April 1st and not pay any placements above the National Care Home Rate.

Impact:

HIGH: There are currently between 60 -70 people awaiting a care home place. This proposal would increase this number to approximately 100 people.

Risks:

- Reduced flow within Acute Hospitals.
- Increase in Delayed Discharges.
- Increased vulnerability in the community.
- Detrimental impact on carers mental health/care packages

Mitigation:

Maximise community service input.

Recovery Options: Asset Based Care

Introduction of Asset Based Care

Annual Spend:
£53m

Potential Recovery in Year:
£0.5m - £1m

Overview:

Moving to preventive care to reduce long -term costs by promoting independence and reducing the demand for care services.

Impact:

MEDIUM: A resource panel will consider each case on its own merits to determine whether the request meets the eligibility criteria and whether the care requested is proportionate to the needs. Social Work assessments are strength -based assessments.

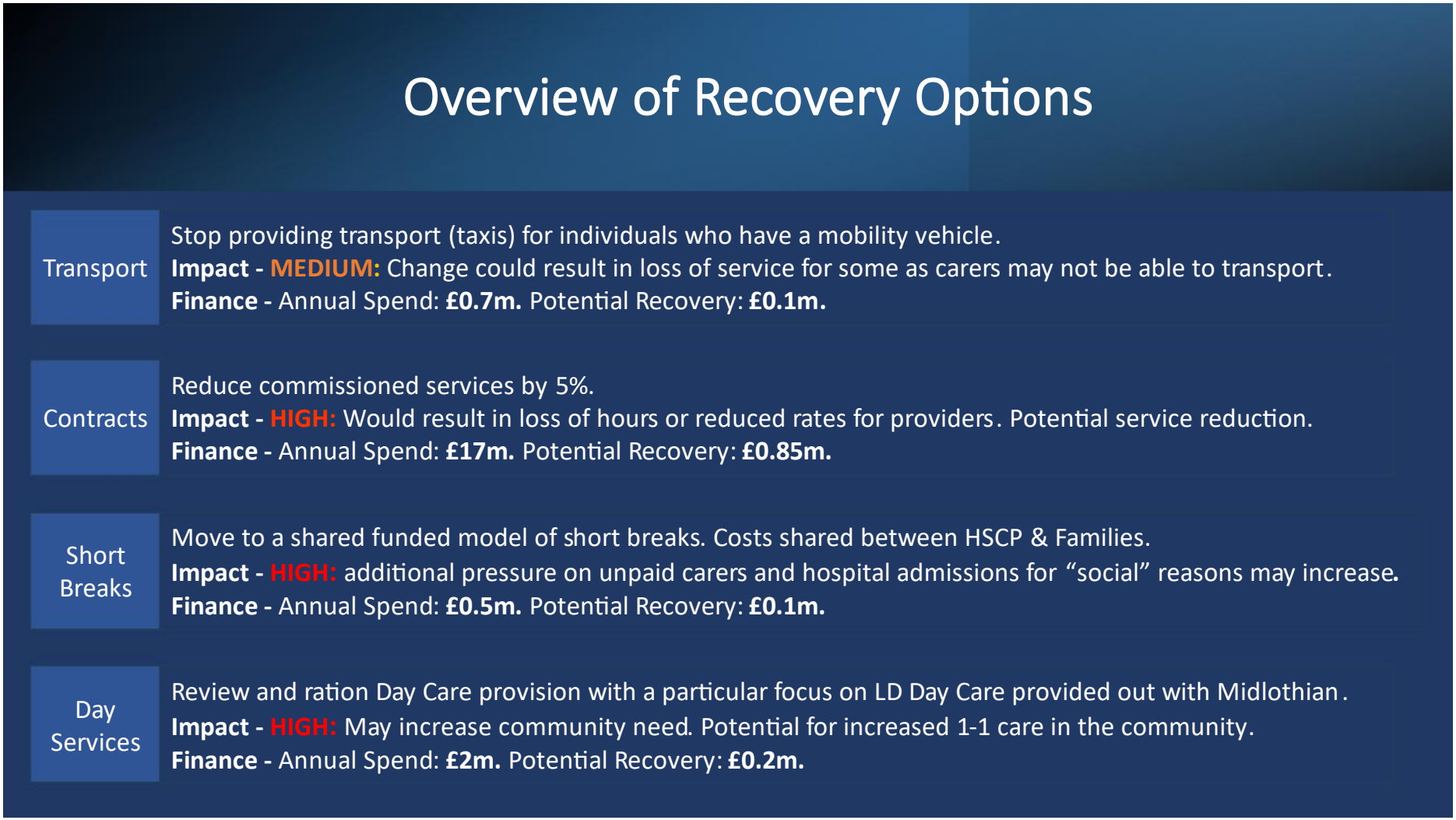
Risks:

- Care inequity – New vs Old packages.
- Availability of rehabilitation resource.

Mitigation:

- Ongoing training, support and briefing for Team leads .
- Outcome of the legal advice sought.

Appendix 3 – Medium and Longer-Term recovery actions



Appendix 4 – Transformation Proposals

Transformation and Change Programme

2024/25

Grip and Control measures to look at immediate change of services linking to all aspects of IJB financial sustainability planning.

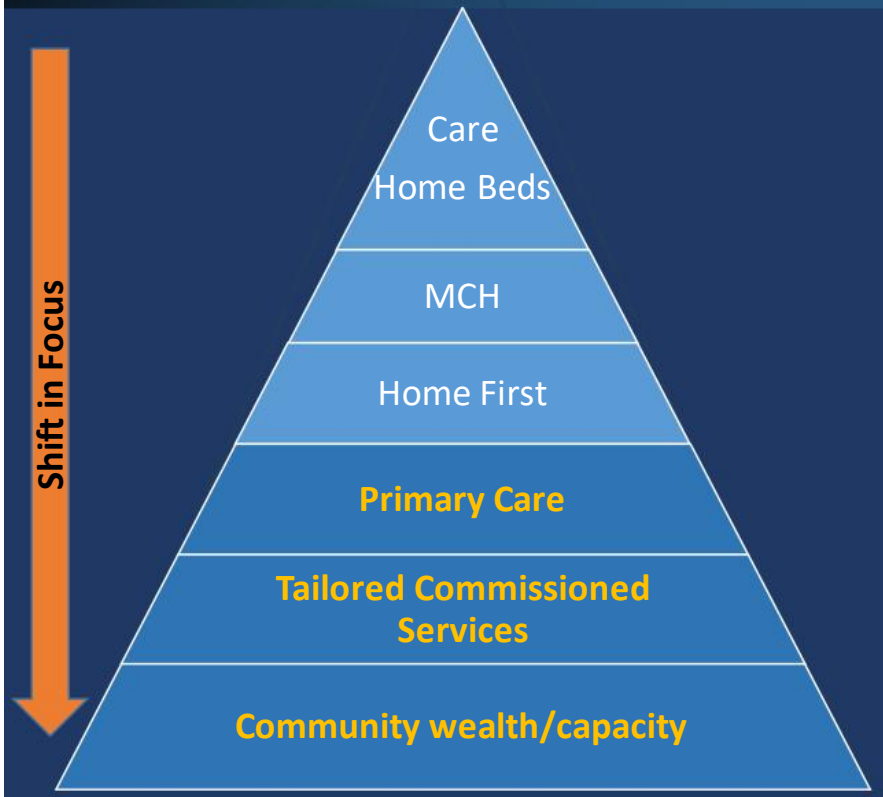
Development of current and ongoing 23 Project Briefs and plans continue to be progressed for both those that provide grip and control measures and those being developed for more longer -term redesign and transformation changes .

2025/26

Themes for 2025/26 - senior HSCP Executive Leadership team, Operational Transformation and Change Programme Board identifying a key set of Transformation and Change Projects and actions for 25/26. Some of these include major service change highlighted in the next slide but also a range of other work a few (not all) examples of which are:

Workforce redesign/configuration, all-front door services in to acute services, Housing strategy and plans, Business economic advice, Home First, Palliative care, minor injury provision.

Midlothian Transformation



(Draft) New Model of Care:

- Establish model of care within resources available.
- Move to Home First model of care.
- Reduce institutional bed base.
- Single point of access/triage
- Highbank provision (Rehab beds, Care home beds, extra care beds).
- Home First redesign.
- External provider Care Home beds/Extra care housing.
- Reprioritisation of resources – align finance & strategy.
- Use of technology to support.

IJB Performance Report

Thursday 19th December 2024, 14:00-16:00

Item number:	**5.8**

Executive summary

The purpose of this report is to update the IJB on progress towards the IJB performance goals set for the financial year 2023/24.

Due to the processes required to validate these data, the full reporting year is almost complete for all indicators. A report describing progress against each improvement goal is attached in Appendix 1. There is an inbuilt reporting delay. Please note that due to the timescales for publication, and the deadline for paper submission, there has been no update to the published indicators for this report.

More recent management data are available for a number of the improvement goals but as they have not been validated, they cannot be published. In order to support the Board's understanding of the current position regarding progress towards the improvement goals, a brief summary of management data is provided at Appendix 2.

The OutNav Strategic Governance Map has now been incorporated into this IJB Performance Report, following the agreed process of scrutiny by Strategic Planning Group. This is provided at Appendix 3.

Members are asked to:

- Note the performance against the IJB Improvement Goals for 2023/24 (Appendix 1) and management data summary (Appendix 2).
- Note the inclusion of the OutNav Strategic Governance Map (Appendix 3).
- Consider the assessment of progress described in Columns 3 and 5 of the OutNav Strategic Governance Map, and options in relation to completion of improvement evaluation and planning.

.

IJB Performance Report

1 Purpose

1.1 The purpose of this report is to update the IJB on progress towards the IJB performance goals set for the financial year 2023/24.

2 Recommendations

2.1 As a result of this report, Members are asked to:

- Note the performance against the IJB Improvement Goals for 2023/24 (Appendix 1) and management data summary (Appendix 2).
- Note the inclusion of the OutNav Strategic Governance Map (Appendix 3).
- Consider the assessment of progress described in Columns 3 and 5 of the OutNav Strategic Governance Map, and options in relation to completion of improvement evaluation and planning.

3 Background and main report

3.1 The IJB has previously identified improvement goals to monitor progress on reducing unscheduled hospital activity and use of institutional care. They are based on goals recommended by the Scottish Government Ministerial Strategic Group for Health and Community Care). An updated report describing progress against each improvement goal is attached in Appendix 1.

3.2 More recent management data are available for a number of the improvement goals but as they have not been validated, they cannot be published. In order to support the Board's understanding of the current position regarding progress towards the improvement goals, a brief summary of management data is provided at Appendix 2.

3.3 The OutNav Strategic Governance Map has now been incorporated into this IJB Performance Report, following the agreed process of scrutiny by Strategic Planning Group on 28th November 2024.

3.4 The focus for this report, is on the content reported in Column 3: "How Do They Feel?", and Column 5: "What They Do Differently (Strategic Aims)".

3.5 Column 3 is designed to show progress toward the IJB feeling "supported, informed and confident in their role". A number of activities are detailed, including the Induction Handbook, five Development Sessions, and a Self-Evaluation with accompanying Improvement Plan.

3.6 The Improvement Plan set out three key actions:

- Ensuring the agenda for Board meetings allows for more strategic planning and debate.

- Reviewing the IJB's current mechanisms for engaging with key stakeholders, service users and the wider public to more effectively seek their views.
- Considering how the IJB can further align resources to facilitate the desired shift to early intervention and prevention.

3.7 Given the challenges presented by continued financial uncertainty, it has not been possible to complete an evaluation of the last self-evaluation improvement plan, or to create a plan for the current year. Board members may wish to consider options in relation to completion of improvement evaluation and planning.

3.8 Column 5 designed to show progress toward the Strategic Aims. An assessment of progress towards each Strategic Aim is provided within the report. Board members may wish to consider the assessment of progress against each Aim.

3.9 In early 2025, the Performance and Improvement Team will be undertaking targeted improvement work to increase the consistency of service information in OutNav. This will increase levels of confidence in the data / evidence used to make the assessment of progress towards each of the stepping stones in the Strategic Governance Map.

3.10 As this approach to measurement and reporting matures, it will present more opportunities to meaningfully interrogate the reports with increasing level of details and evidence to identify areas of success, areas requiring improvement, and the action required to deliver the desired change. Board member may wish to consider how making targeting improvement on one column could deliver positive impact in another and monitor this over time.

3.11 The next IJB Performance Report will focus on Column4: Directions, following scrutiny at Strategic Planning Group in January 2025.

4 Policy Implications

4.1 There are no policy implications arising from this report.

5 Directions

5.1 This report does not directly impact upon service ability to deliver existing Directions.

5.2 It is acknowledged that there will be a requirement for ongoing review and revision to the Performance Report, in alignment with any revisions to existing Directions / issue of new Directions at any stage in the reporting period.

6 Equalities Implications

6.1 There are no equality implications from focussing on current goals but there may be implications in the actions that result from work to achieve them.

6.2 The focus of most of current goals is on reducing hospital activity. Hospitals are not used equally by the population and there are groups of people that make more use of hospitals than others e.g., older people, people living in areas of deprivation, or people who live alone.

7 Resource Implications

7.1 There may be resource implications resulting from any decision that board takes to initiate further action to achieve these improvement goals.

8 Risk

8.1 The risk that board members may not have the right information to inform decision if we are unable to find new and increasingly innovative solutions to address complex performance measurement challenges. This is particularly in relation to increases in complexity, acuity and the resulting additional pressures these create for our workforce; and what this may mean for wellbeing, retention and recruitment.

9 Involving people

9.1 The role of data assurance has been transferred to the Strategic Planning Group which has a wider membership including representation of elected officials, the third sector and public health.

10 Background Papers

10.1 No background papers.

AUTHOR'S NAME	Elouise Johnstone
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DATE	10th December 2024

Appendices:

Appendix 1: Local Intelligence Support Team (LIST) Report describing progress against the IJB improvement goals.
(Please note that due to the timescales for publication, and the deadline for paper submission, there has been no update to the published indicators for this report.)

Appendix 2: Management Data Summary

Appendix 3: OutNav IJB Strategic Governance Map

Midlothian HSCP MSG Indicators

Performance from April 2019 to June 2024, with 2020/21 MSG targets and trends

Local Intelligence Support Team (LIST),

September 2024

Public Health Scotland

Data completeness

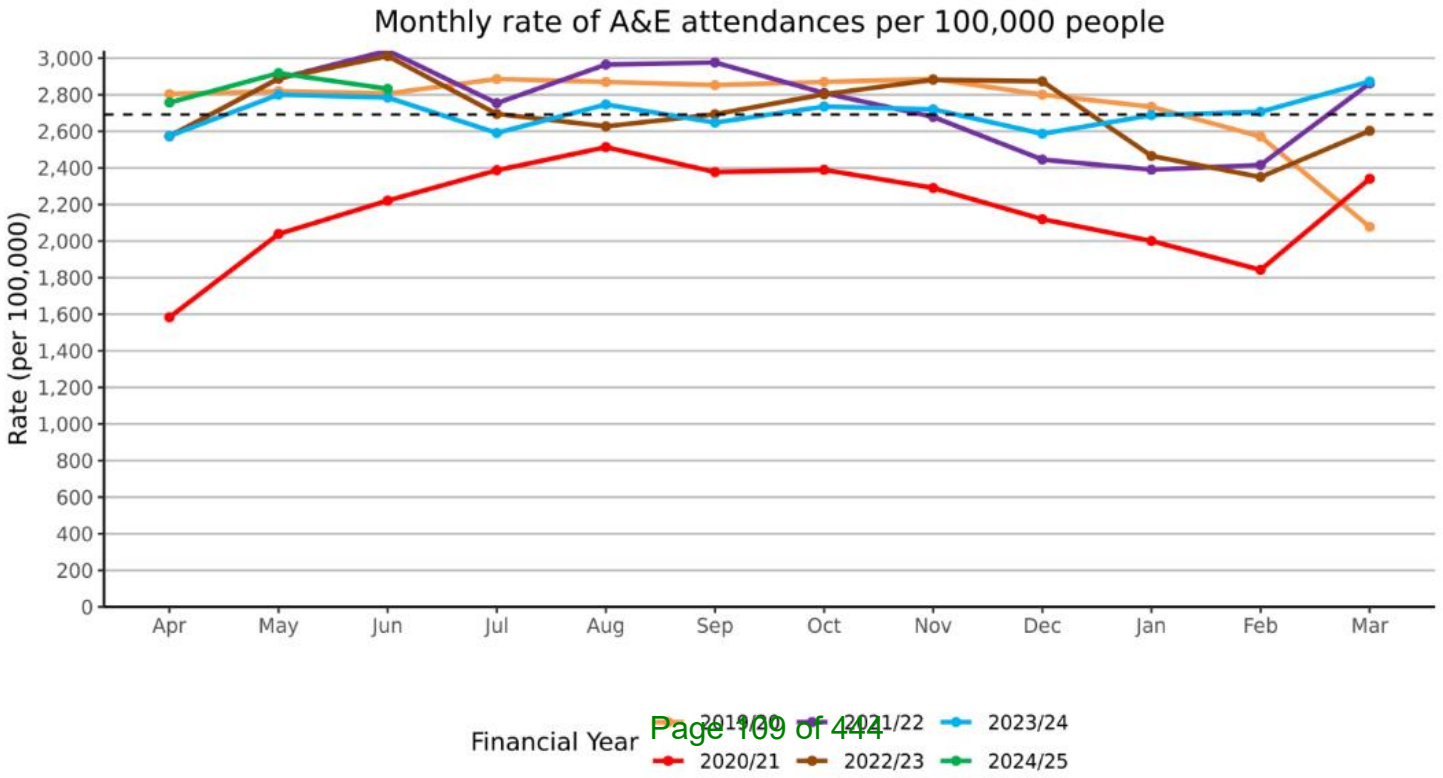
Source: MSG data release Sep-24, PHS

Indicator	Published until	Provisional until	Data completeness issues
1. A&E attendances	Jun-24	n/a	
2. Emergency admissions	Dec-23	Jun-24	(SMR01) Mar-24=96%; Jun-24=80%
3a. Unplanned bed days (acute)	Dec-23	Jun-24	(SMR01) Mar-24=96%; Jun-24=80%
4. Delayed discharges occupied bed days	Jun-24	n/a	
5. Last 6 months of life (% in community setting)	2021/22	2022/23	

A&E Attendances

Source: MSG data release Sep-24; data published up to Jun-24

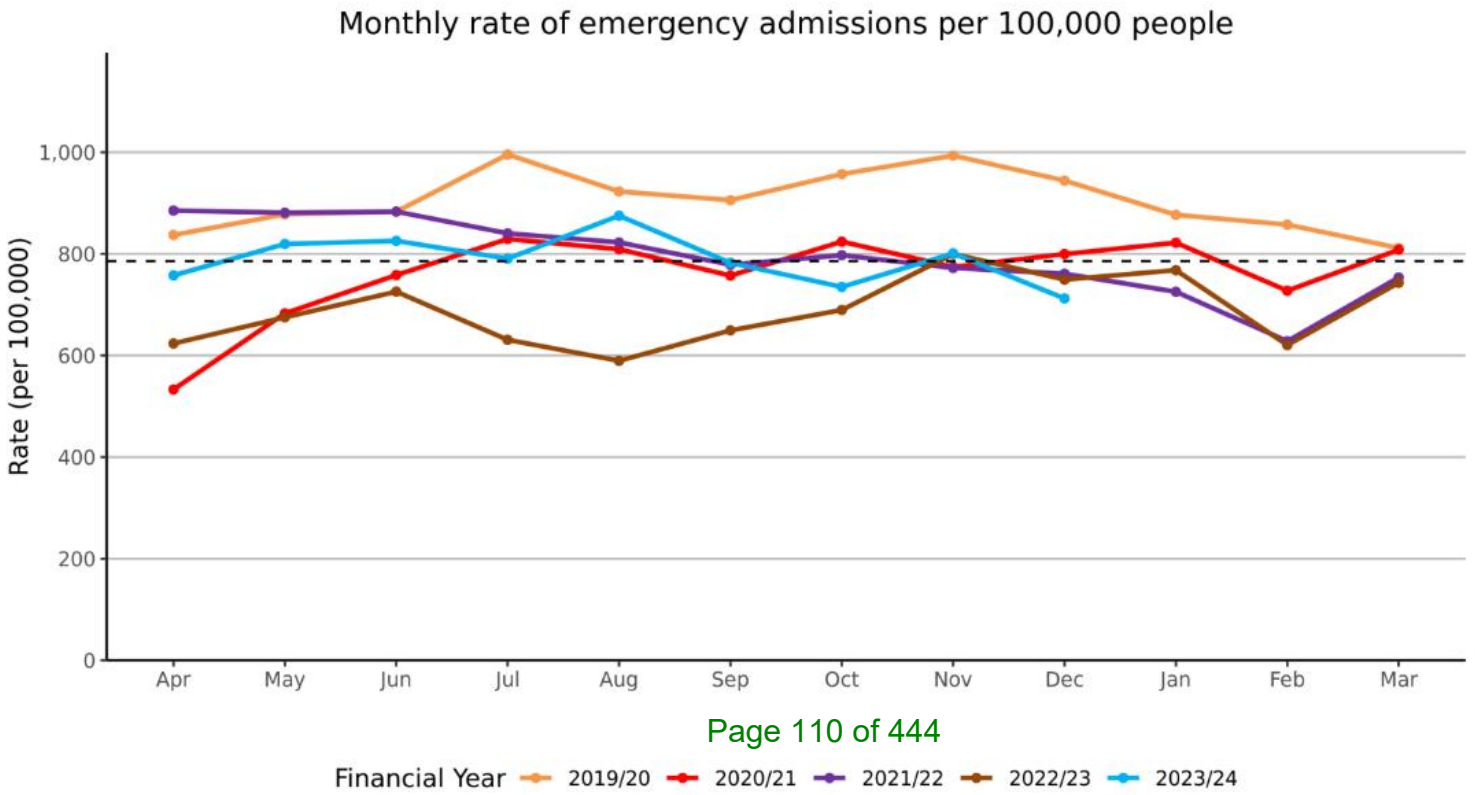
Year	Annual	Monthly
2020/21 Target Rate (per 100,000)	32,299	2,692
2019/20 Rate (per 100,000)	*32,977*	*2,748*
2020/21 Rate (per 100,000)	*26,102*	*2,175*
2021/22 Rate (per 100,000)	*32,798*	*2,733*
2022/23 Rate (per 100,000)	*32,462*	*2,705*
2023/24 Rate (per 100,000)	*32,453*	*2,704*
2024/25 Running Average (Jun)		*2,836*



Emergency Admissions

Source: MSG data release Sep-24; data published up to Dec-23

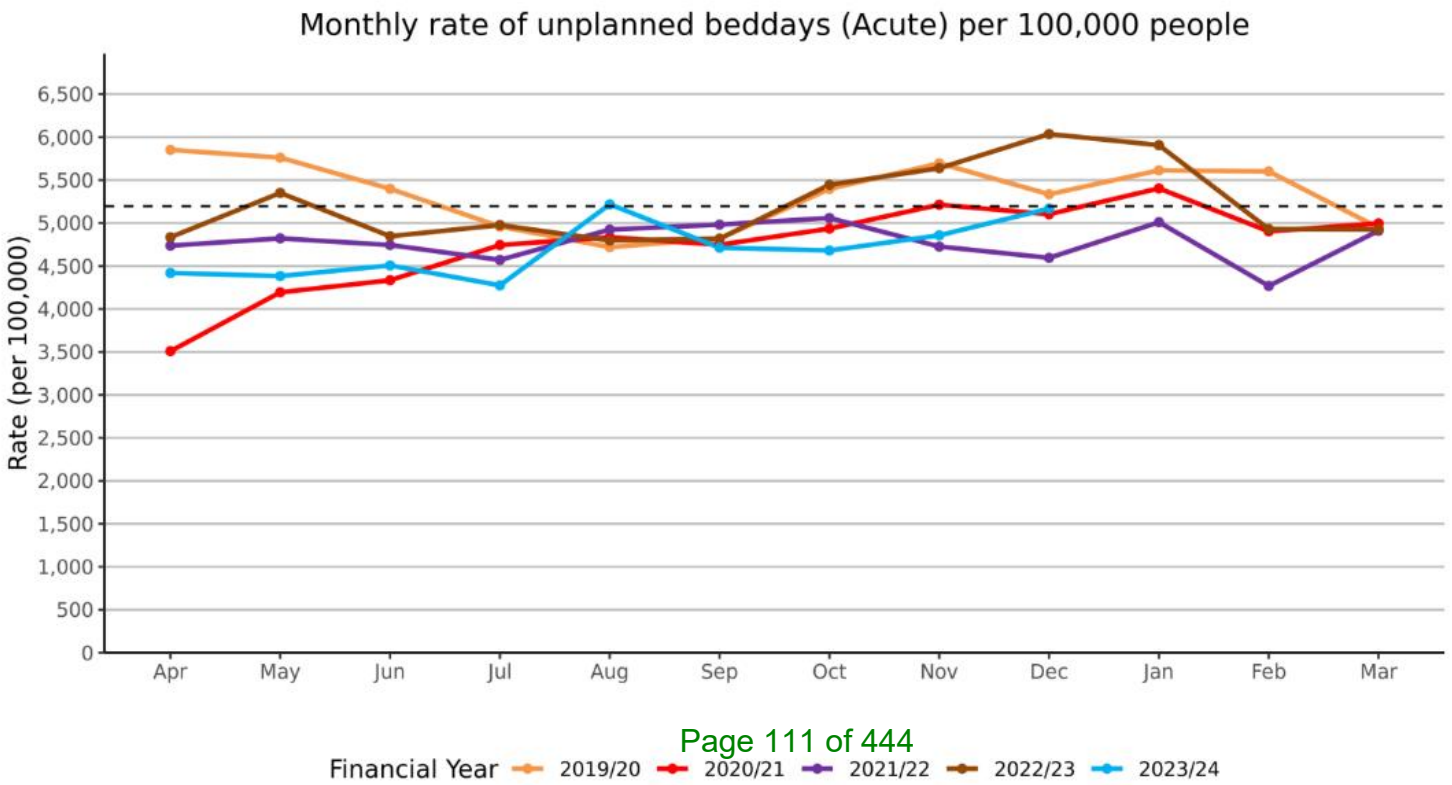
Year	Annual	Monthly
2020/21 Target Rate (per 100,000)	9,428	786
2019/20 Rate (per 100,000)	*10,862*	*905*
2020/21 Rate (per 100,000)	*9,124*	*760*
2021/22 Rate (per 100,000)	*9,528*	*794*
2022/23 Rate (per 100,000)	*8,263*	*689*
2023/24 Running Average (Dec)		*789*



Unplanned Bed Days - Acute

Source: MSG data release Sep-24; data published up to Dec-23

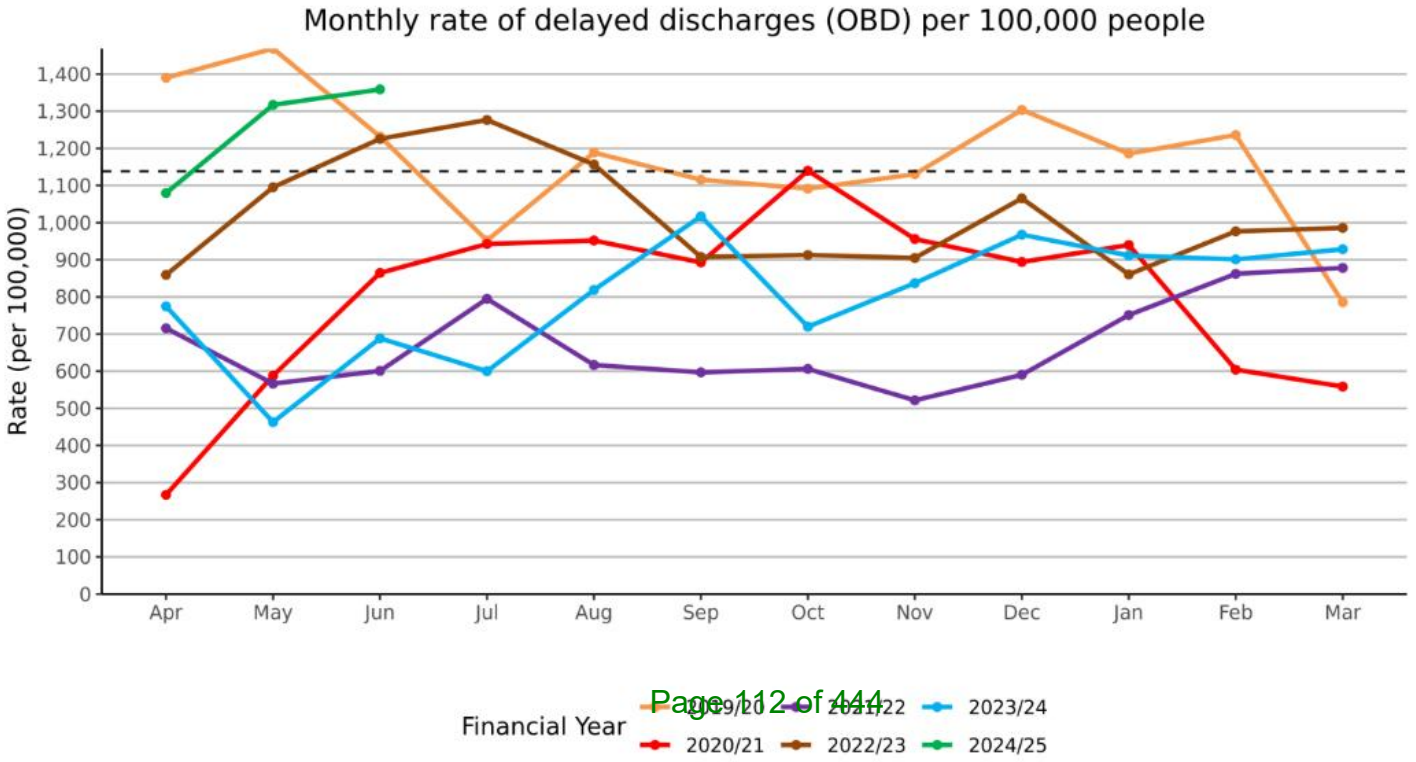
Year	Annual	Monthly
2020/21 Target Rate (per 100,000)	62,354	5,196
2019/20 Rate (per 100,000)	*64,099*	*5,342*
2020/21 Rate (per 100,000)	*56,920*	*4,743*
2021/22 Rate (per 100,000)	*57,351*	*4,779*
2022/23 Rate (per 100,000)	*62,509*	*5,209*
2023/24 Running Average (Dec)		*4,691.3*



Delayed Discharges Occupied Bed Days (18+)

Source: MSG data release Sep-24; data published up to Jun-24

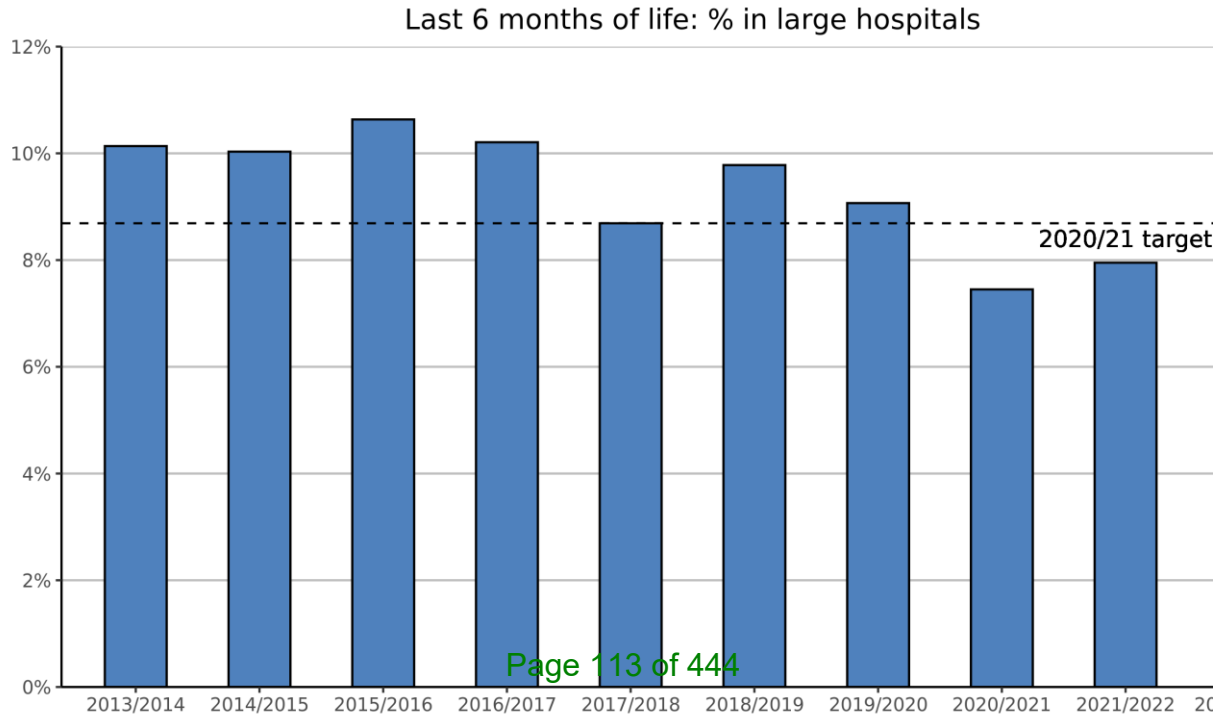
Year	Annual	Monthly
2020/21 Target Rate (per 100,000 18+)	13,662	1,138
2019/20 Rate (per 100,000)	*14,079*	*1,173*
2020/21 Rate (per 100,000)	*9,599*	*800*
2021/22 Rate (per 100,000)	*8,101*	*675*
2022/23 Rate (per 100,000)	*12,227*	*1,019*
2023/24 Rate (per 100,000)	*9,627*	*802*
2024/25 Running Average (Jun)		*1,252*



End of Life - Percentage of Last Six Months Spent in Large Hospitals

Source: MSG data release Sep-24; data published up to 2021/22

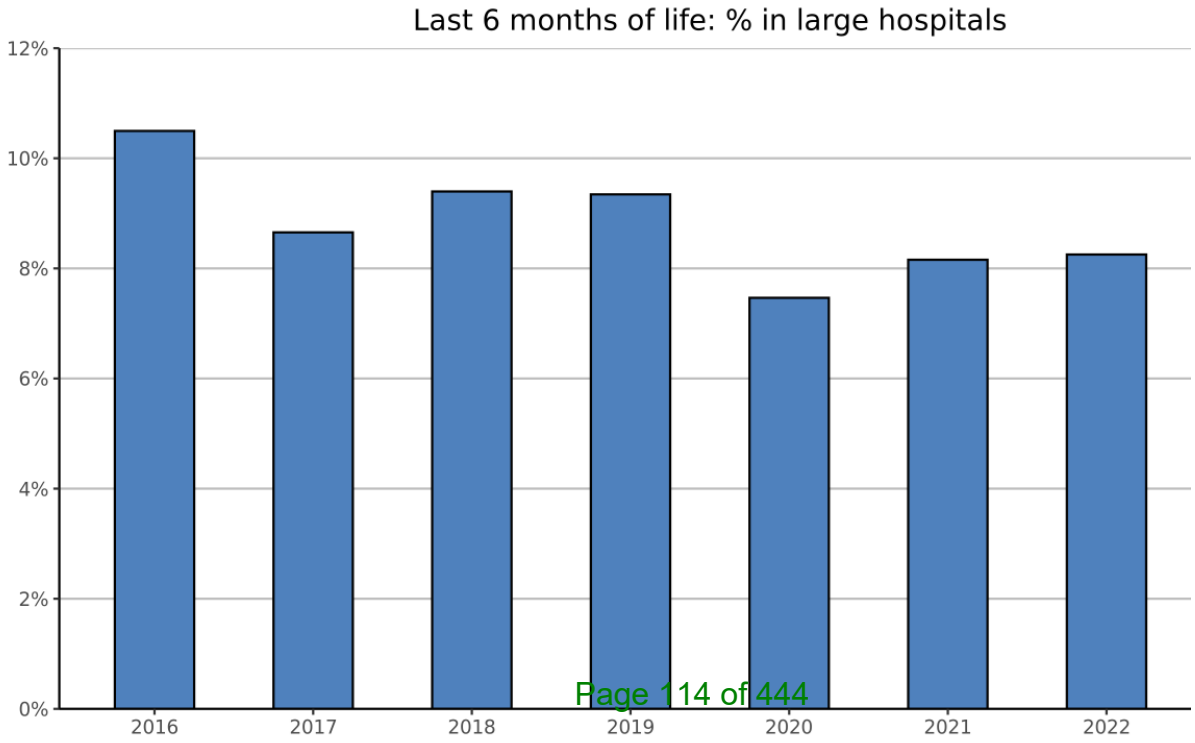
Year	Annual
2020/21 Target	<8.7%
2019/2020	*9.1%*
2020/2021	*7.5%*
2021/2022	*8%*



End of Life - Percentage of Last Six Months Spent in the Community – by calendar year

Source: MSG data release Sep-24; data published up to 2022

Year	Annual
2019	9.3%
2020	*7.5%*
2021	*8.2%*
2022	*8.3%*



Midlothian Health & Social Care Partnership

Thursday 19th December 2024, 14:00-16:00

Performance Report Appendix 2

1.1 An updated report describing progress against each improvement goal is attached in Appendix 1. This report is produced by the Local Intelligence Support Team (LIST) on behalf of the Midlothian HSCP. Members are asked to note the information in Appendix 1, specifically regarding data completeness. Due to the processes required to validate these data for publication, there is an inbuilt reporting delay, and this information is not taken from a "live" system. This means that we are not yet able to calculate the full year performance for some measures.

1.2 Members are asked to note that Public Health Scotland (PHS) has moved to a schedule of quarterly, rather than monthly, updates. Please note that due to the timescales for publication, and the deadline for paper submission, there has been no update to the published indicators for this report.

1.3 More recent management data are available for a number of the improvement goals but as they have not been validated, they cannot be published. In order to support the Board's understanding of the current position regarding progress towards the improvement goals, a brief summary is provided below.

1.4 <u>A&E Attendances</u>

2022/23 Target Rate per 100,000 people	2,629 / month
2023/24 Running Average	2,836 / month

The validated data are available up to June 2024. Based on this information, the target is not currently being met.

The most recent non-validated management information data (accessed December 2024) indicate an improved position, currently meeting the target.

1.5 <u>Emergency Admissions</u>

2022/23 Target Rate per 100,000	767 / month
2023/24 Running Average	789 / month

The validated data are only available up to December 2023. Based on this information, the target is not currently being met.

The most recent non-validated management information data (accessed December 2024) indicate an improved position, currently meeting the target.

Unplanned Bed Days (Acute)

2022/23 Target Rate per 100,000	5,074 / month
2022/23 Rate	4,691 / month

The validated data are only available up to December 2023. Based on this information, the target is currently being met.

The most recent non-validated management information data (accessed December 2024) indicate an improved position, currently meeting the target.

1.6 Delayed Discharge Occupied Bed Days

2022/23 Target Rate per 100,000	820 / month
2023/24 Running Average	1252 / month

The validated data are only available up to March 2024. Based on this information, the target is currently not being met.

The most recent non-validated management information data (accessed December 2024) indicate an improved position, but currently not meeting the target.

1.7 End of Life – Percentage of Last Six Months Spent in Large Hospitals

2022/23 Target Rate	<8.7%
2021/22 Rate	8%

The validated data are only available on a provisional basis for 2022/23. Based on this information, the target is currently being met.

It is not possible to refer to management information as these data are not held locally.

1.8 Balance of Care

2022/23 Target Rate	>96.4%
2021/22 Rate	96.9%

The validated data are only available on a provisional basis for 2022/23. Based on this information, the target is currently being met.

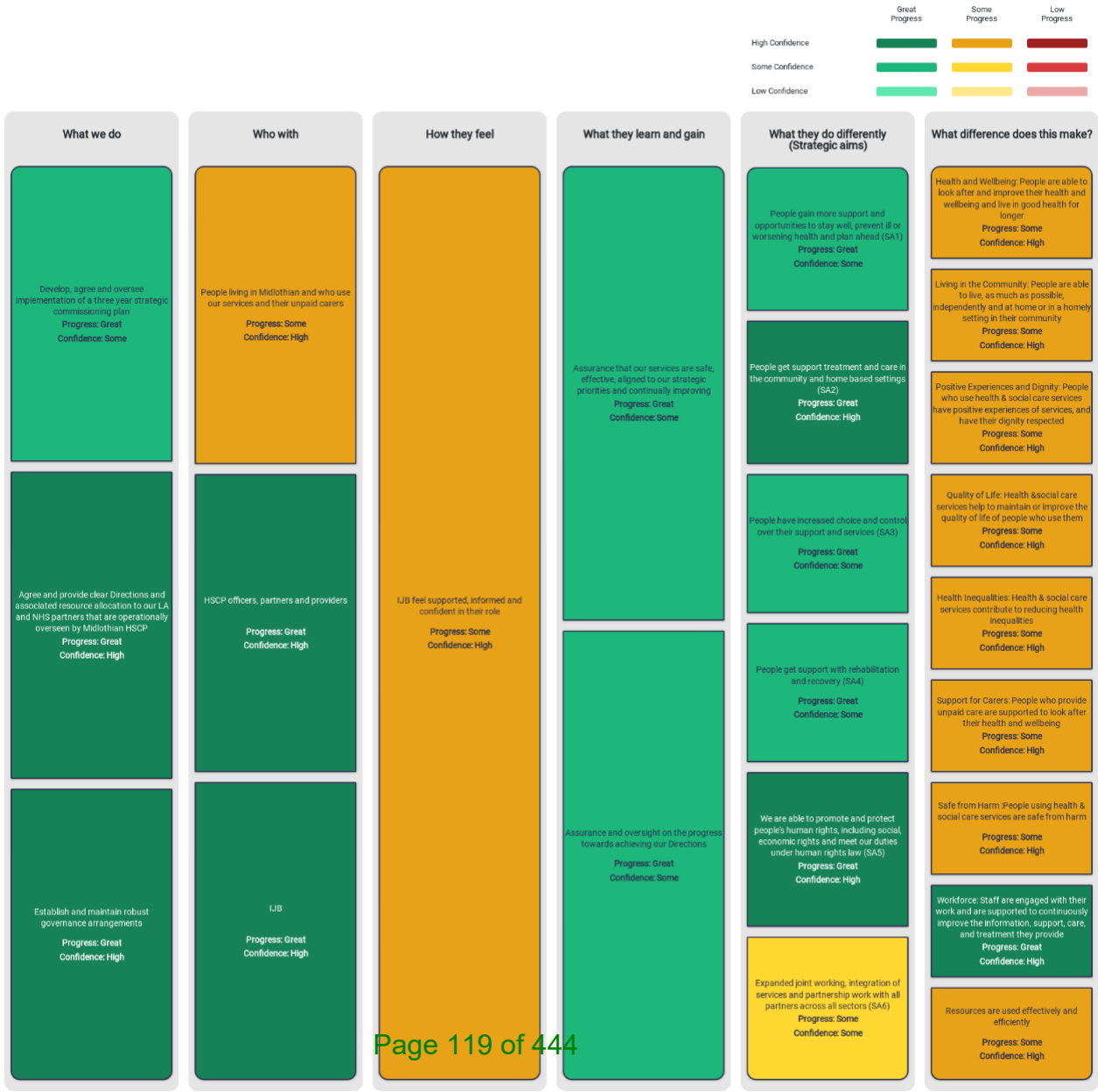
It is not possible to refer to management information as these data are not held locally.

IJB Strategic Governance Map

Midlothian Health and Social Care Partnership

Contents

IJB Strategic Commissioning - pathway progress



IJB Strategic Governance

Column 3: How they feel

IJB feel supported, informed and confident in their role.

Progress: Some

Confidence: High

We have put a number of initiatives in place to ensure that Midlothian IJB members feel supported and confident in their role.

The membership of the IJB is made up of voting and non-voting members with the formal arrangements for voting members are set out in the Midlothian Integration Scheme. Voting members are nominated in equal numbers and are Local Councillors from the Local Authority and Non-Executive Directors from the Health Board. In Midlothian there are 8 voting members with 4 from Midlothian Council and 4 from NHS Lothian. Their role is to bring the perspectives of the two organisations to the Integration Joint Board and help shape the strategic direction of the Integration Joint Board to improve outcomes for their communities. There 4 male and 4 female voting members from a range of backgrounds.

The culture of Midlothian IJB is one of co-operation and collaboration. We recognise that we bring together a variety of cultures, including the corporate cultures of the Midlothian Council and NHS Lothian. Midlothian IJB has worked hard to bring the best from the culture of both organisations and the views of the wider system as we plan, and commission integrated services.

Board Membership Induction

In Q1 of 2024/25, NHS Lothian Board agreed 2 new appointments to Midlothian IJB to take up these roles at the Midlothian IJB meeting on 22nd August 2024.

- The appointment of Kirsty MacDonald as a Voting Member of the Midlothian Integration Joint Board
- The appointment of Dr Amjad Khan as a Voting Member of the Midlothian Integration Joint Board

In Q3 of 2024/25, Midlothian Council appointed a new Chief Social Work Officer (CSWO) and they were nominated, recommended and agreed as an IJB member at the Midlothian IJB meeting on 24th October 2024.

- The appointment of Nick Clater as a Non-Voting Member of the Midlothian Integration Joint Board and professional advisor

The Midlothian IJB Induction Handbook has been distributed to new members. This is regularly updated to ensure all new members have a up-to-date reference for support. In addition, an induction programme has been arranged for August 2024 after the summer recess. This will include a range of introductory meetings with key personnel across Midlothian Council, NHS Lothian and Midlothian HSCP, presentations from the officers of Midlothian HSCP, and a number of site visits. Additionally, the Midlothian HSCP Integration Manager provides a bespoke support session for any new members who require further support at any time during their time on Midlothian IJB.

Midlothian IJB Development

Midlothian IJB is proactively engaged in ensuring members participate in programme of development and improvement activities.

Development sessions

Midlothian IJB holds schedules 5 development sessions each year. These sessions are planned to support the learning needs and improvement goals set by the Board. In quarter one of 2024/25 Midlothian IJB have had one planned development session, held in May.

May 2023: Strategic Plan review and Development

Led by the Planning and Performance teams of Midlothian HSCP, the Board participated in a session regarding the ongoing development of the strategic plan for 2025/35. In this session board members reviewed the

- planning, development and consultation activities to date
- recommendations of the Place and Wellbeing Assessment on the first draft of the plan developed by the Strategic Planning Group

- draft Strategic Plan and considered amendments and additions for further review.

September 2024:
Led by the Chief Officer and the Chief Finance Officer this session provided a detailed account of the IJBs current financial position and set out the impact of ongoing financial uncertainty. At this session the board discussed a range of option for moving forward and requested that proposals detailing the recommended Financial Recovery Actions required for 2025/26 be presented at the November Development session. This is to ensure that IJB members have all the information they need to make an informed decision regarding the necessary decisions relating to funding and the impact on progress towards the Strategic Plan.

November 2024:
Led by the Chief Officer and the Officers of the HSCP, this session set out a number of proposed options for the Financial Recovery Action required to bring 2024/25 into financial balance and to prepare for the 2025/26 budget. This session described the proposed action, the impact, risks and mitigations to ensure that IJB members were in receipt detailed plans to support the informed decision required at the Midlothian IJB meeting on 21st December 2024.

January 2025:
This session is planned to have 2 topics for learning and discussion. The first is a session presented by the IJB Third Sector Representative to share the work of the voluntary sector in Midlothian and create opportunities for discussion on how the Midlothian IJB can support this work. The second is a session led by the Chief Internal Auditor to review the progress made towards achieving the ambitions of the Midlothian IJB Self-Development Plan for 2023/24 and agree a plan for 2024/25. Actions will be owned by the Board and identify the support the Board would like from Committees of the Board or from officers of the HSCP.

March 2025:
TBC

May 2025
Led by the Midlothian Head of Primary Care and Older People on work to support more people to receive care at home, avoid unnecessary hospital stays, and ensure when people do have to go to hospital it is for as short a time as possible. This session will include the Board's consideration of new ways of working and the actions required for 2025/26.

Midlothian IJB Self Improvement Plan 2025/27

The current Midlothian IJB Self Improvement Plan for 2023/25 will be evaluated, updated and refreshed for 2025/27in the coming months.

Midlothian IJB Self Evaluation and Improvement Plan 2023/25

The purpose of the self-assessment was to focus on the Midlothian IJB in terms of its functioning and effectiveness, reflect upon strengths and identify areas where there may be scope for improvement.

The Public Service Improvement Framework (PSIF) is a self-assessment approach to support improvement in organisations, with a comprehensive review of their own activities and results. It promotes a robust approach to continuous improvement and is mapped to a number of established organisational improvement tools.

The PSIF provides a framework of statements to challenge existing performance through a structured process, which is developed to suit organisational needs and drivers. The standard PSIF statements can be adapted for use at a service, corporate or organisational level to support continuous improvement. The self-assessment process enables organisations to identify their strengths and the areas for improvement which will inform planning and define improvement initiatives.

A self-evaluation exercise supported by the Improvement Service was undertaken in 2023/24, where the Board identified 3 areas to focus on in a programme of self- improvement. These are:

1. Ensuring the agenda for Board meetings allows for more strategic planning and debate.
2. Reviewing the IJB's current mechanisms for engaging with key stakeholders, service users and the wider public to more effectively seek their views.
3. Considering how the IJB can further align resources to facilitate the desired shift to early intervention and prevention.

Following discussions with the Midlothian IJB Chief Officer to develop a Midlothian IJB Improvement Plan, scoping discussions were held with the Improvement Service to facilitate a self-assessment exercise. A scope for this self-assessment was agreed in February 2023. A self-assessment questionnaire was distributed to all Midlothian IJB members in April 2023 that considered the IJBs Response to COVID-19, Leadership and Relationships, Governance and Accountability, Community Engagement and Participation, Outcomes and Impact, and Performance Management and Use of Evidence. this was followed by a development session held on 11th May 2023, facilitated by the Improvement Service which utilised the collated results from the self-assessment questionnaire to facilitate a further self-assessment process and identify improvement plan actions. A draft Midlothian IJB Improvement Plan presented to the IJB on 24th August 2023 the Board reviewed the information collated by the improvement service and the Chief Internal Auditor led. A follow up development session on 9th November 2023 was held to begin supporting Board members achieve these ambitions.

Column 5: What They Do Differently (Strategic Aims)

People gain more support and opportunities to stay well, prevent ill or worsening health, and plan ahead.

Progress: Great

Confidence: Some

People get support, treatment and care in the community and home based settings.

Progress: Great

Confidence: High

People have increased choice and control over their support and services.

Progress: Great

Confidence: Some

People get support with rehabilitation and recovery.

Progress: Great

Confidence: Some

We are able to promote and protect people's human rights, including social, economic rights and meet our duties under human rights law.

Progress: Great

Confidence: High

Expanded joint working, integration of services and partnership work with all partners across all sectors.

Progress: Some

Confidence: Some

IJB Strategic Commissioning - sources and success criteria

This table lists the sources of evidence and success criteria that we have referred to whilst developing the analysis presented in this report.

How they feel

Stepping Stone	Source
IJB feel supported, informed and confident in their role	IJB Induction Handbook and Programme Improvement Service Self Evaluation and MIJB Development Plan
	Success Criteria
	The Board continually reflect on progress, identify strengths and areas for development There is appropriate Board member induction

What they do differently (Strategic aims)

Stepping Stone	Source
People gain more support and opportunities to stay well, prevent ill or worsening health and plan ahead (SA1)	Aggregate Data from HSCP Org Map

	Success Criteria
	No Success Criteria
People get support treatment and care in the community and home based settings (SA2)	Aggregate Data from HSCP Org Map
	Success Criteria
	No Success Criteria
People have increased choice and control over their support and services (SA3)	Aggregate Data from HSCP Org Map
	Success Criteria
	No Success Criteria
People get support with rehabilitation and recovery (SA4)	Aggregate Data from HSCP Org Map
	Success Criteria
	No Success Criteria
We are able to promote and protect people's human rights, including social, economic rights and meet our duties under human rights law (SA5)	Aggregate Data from HSCP Org Map
	Success Criteria

No Success Criteria

Expanded joint working, integration of services and partnership work with all partners across all sectors (SA6)

Aggregate Data from HSCP Org Map

Success Criteria

Our evidence standards

PROGRESS STATEMENT	CRITERIA
Great progress	• Enough people and groups experience this in the timescale you have defined • Risks have been mitigated and assumptions achieved
Some progress	• Some people and groups experience this in the timescale you have defined • Some risks have been mitigated and some assumptions achieved
Low progress	• Not enough people and groups experience this in the timescale you have defined • Risks have not been mitigated and assumptions found to be unrealistic

CONFIDENCE ASSESSMENT	CRITERIA
High confidence	Most of these criteria apply • more than one source of evidence with appropriate balance of types • evidence collected purposefully and for this purpose • reasonable number of responses • no disagreement between evidence sources • backed up by other research • analysis is clear and purposeful (someone else could replicate and get broadly the same results)

Some confidence	Some of these criteria apply • more than one source of evidence with appropriate balance of types of evidence • evidence is collected purposefully and for this purpose • reasonable number of responses • no disagreement between evidence sources • backed up by other research • analysis is clear and purposeful (someone else could replicate and get broadly the same results) And / or • there is some disagreement or lack of clarity of the findings • the data is mostly gathered opportunistically
Low confidence	Few of the above criteria apply AND / OR • there is disagreement within the data • assessments are based solely on an individual's perspectives

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HSCP Public Practitioner Update - Homeless Prevention Duty

Thursday, 19th December 2024, 14:00-16:00

Item number:	**5.9**

Executive summary

This report highlights the Homeless Prevention Duty which will form part of the forthcoming Housing Bill. The duty will result in a significant shift in how local authorities and other public bodies identify and respond when they believe a person or household is at risk of becoming homeless. The Scottish Government has confirmed its intention to include prevention of homelessness duties in its 2023-2024 legislative programme, however the details of guidance around this have yet to be confirmed. To prepare for the forthcoming Duty, a small team has been set up to help map out where Midlothian's gaps are around prevention, any potential risks that could result from the prevention duty and some actions to mitigate the impact of those risks.

Members are asked to:

- Note this update on the homeless prevention duty and encourage staff to collaborate with homeless prevention duty planning as appropriate.

HSCP Public Health Practitioner - Homeless Prevention Duty

1 Purpose

1.1 This report sets out an update on the Homeless Prevention Duty which will form part of the forthcoming Housing Bill. It also highlights plans for collaboration among staff to prepare for implementation.

2 Recommendations

2.1 As a result of this report, Members are asked to:

- Note this update on the homeless prevention duty and encourage staff to engage with homeless prevention mapping sessions.

3 Background and main report

3.1 Homelessness is often a late marker of severe and complex disadvantage, which can be identified across the life course of individuals (Public Health Scotland, 2023). In 2018 the Scottish Government published its Ending Homelessness Together: High Level Action Plan, incorporating the recommendations of the Homelessness and Rough Sleeping Action Group. The plan sets out the Scottish Government's vision that *everyone has a home that meets their needs and homelessness is ended*. The delivery of the plan has been overseen by the Homeless Prevention and Strategy Group, co-chaired by representatives of the Scottish Government and COSLA.

3.2 Throughout the delivery of the action plan the Strategy Group has been clear that there is a need for partners across all services including health, education, social work, community support and justice and the third sector to ask about the housing circumstances of people using their services, and, where a possible risk of homelessness is identified, act to prevent homelessness from occurring.

A key part of the action plan was to develop a new duty on local authorities, wider public bodies and delivery partners to prevent homelessness. This led to the creation of the Scotland Homeless Prevention Review Group, led by Crisis at the request of the Scottish Government. They were tasked to identify legal duties needed for local authorities and public bodies to prevent homelessness. The Preventing Homelessness in Scotland report was published in 2023.

Relevant key recommendations of the Prevention Review Group include:

- The prevention of homelessness should be a shared public duty, and public bodies should identify a risk of homelessness and 'act' upon that information.
- A duty on HSCPs to identify the housing circumstances of service users and prevent homelessness, including social workers/social care workers to 'ask and act' about housing issues or the risk of homelessness.

3.2 Homelessness Prevention Task and Finish Group

The Homelessness Prevention Task and Finish Group was asked by the Homelessness Prevention and Strategy Group to consider the groundwork needed to ensure the successful implementation of Scotland's new homelessness prevention legislation. The group's report and recommendations were published in August 2023. The Scottish Government responded in December 2023 stating that they 'fully support the key messages coming out of the group's report are that the measures could be transformative; that investment in prevention saves lives and money; and that, to be successful, the duties need to be backed by adequate resourcing and support'. Scottish Government also suggested that they may rename the Housing Bill to reflect the broad scope of the provision, for example the 'Early Intervention and Housing Sustainability Bill'. They also have stated that key next steps would be:

- Providing clarity as soon as possible on which public bodies the new duties will apply to, so that individuals and organisations working in those sectors can engage with the draft legislation.
- Clarifying what is meant by 'Ask' and 'Act,' and introduce these as two separate duties. Carrying out in-depth consultation with frontline workers, managers and strategic leads in public bodies to ensure the 'Ask' and 'Act' duties are designed in a way that is appropriate for those sectors.

3.3 Homeless prevention duty planning

Working with the Midlothian housing team, the public health team supported by the strategy team, are planning sessions to help map out Midlothian's gaps around prevention, any potential risks that could result from the prevention duty, and actions that could be taken to mitigate the impact of these. Since publishing its Rapid Rehousing Transition Plan in 2018 Midlothian Council has made some significant steps in the transformation of its response to homelessness, including:

- A reduction in the number of open homeless cases
- A reduction in average time taken to discharge duties to those found to be homeless.
- Ending the use of Bed and Breakfast type accommodation.
- Developing a successful Housing First programme.
- Introducing a homeless prevention fund
- Creating a Homeless Prevention Forum
- Developing partnership working through the Health and Homeless Steering Group
- Reducing number of households in temporary accommodation
- Reduced average time spent in temporary accommodation.
- Breaches of the revised Unsuitable Accommodation Order.

Initiatives such as these will hopefully result in a good foundation on which to implement any forthcoming prevention duty.

3.4 Masters Research

Public Health supervised a Masters student from Edinburgh University who carried out research in Midlothian looking at the homeless prevention duty. The qualitative study examined whether different professional groups are more or less likely to ask and act to prevent homelessness within a Health and Social Care Partnership. Eight participants took part in the research through semi-structured interviews. The study found that participants are envisioned to implement the policy, are keen to build on the care they provide for the homeless population and welcoming to the duty to ask and act that enables better collaboration with other services to provide holistic care for individuals. The findings from the study will help focus on the gaps in knowledge and understanding around the prevention duty and what it means for Midlothian.

3.5 Planning Group

The Housing (Scotland) Bill was introduced to Parliament on 24 April 2024, with the Bill passing stage 1 on 29 November 2024. A recent report published has stated that witnesses were widely supportive of the principle behind the Bill's 'ask and act' provisions. However, many felt more detail was needed about how the duty would work in practice. Responding to these concerns, a Scottish Government official stated that 'asking' is about "working very much within your own functions" and to 'act' is to do so "within your own powers". Those working in relevant bodies should think "what can I do in my role". It was acknowledged that while this approach is already being taken in some areas, adoption of such working practices is "patchy".

To help start to prepare for the forthcoming Duty, we plan to re-establish the health and homeless group to take forward the findings from the Masters study, start planning for implementation of the Duty and to help embed homelessness prevention practice within HSCP structures. Some of this work is already being done in practice therefore the structure would ensure to build on good practice and look at ways to strengthen our prevention approach.

4 Policy Implications

4.1 The Housing Bill once announced will have implications on the following Health and Social Care policies:

- HSCP strategic plan: Prevention and early intervention
- Reducing inequalities

5 Directions

5.1 This report Links to 2023/2024 Directions: (Public Health Team Plan)
1 – Health and Wellbeing
2 – Living in the community
3 – Positive experience and dignity
5 – Health inequalities

5.2 Links to Single Midlothian Plan:

- Midlothian Will Be Healthier
- Midlothian Will Support Residents to improve Employability and Outcomes in our Communities
- Midlothian will work towards reducing poverty.
- Midlothian will Get it Right for Every Child

6 Equalities Implications

6.1 This work focuses on populations vulnerable to health inequalities or want to improve their wellbeing.

7 Resource Implications

7.1 The intention is for planning to be sustainable without specific funding, working collaboratively as part of shared priority actions to embed the approach across the partnership.

8 Risk

8.1 The intention is for planning to be sustainable without specific funding, working collaboratively as part of shared priority actions to embed the approach across the partnership.

9 Involving people

9.1 The aim to engage with professionals in the first instance until more details around the guidance is known. Then when appropriate to collaborate with service users and the public.

10 Background Papers

10.1 None.

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Appendices:

Appendix 1: Abstract of Master project

Abstract of Master project

"What is the perspective of professional groups within Midlothian Health and Social Care Partnership (HSCP) on the 'duty to ask and act' to prevent homelessness?"

Introduction: Homelessness is a public health issue affecting individuals in Scotland. There continues to be an increasing prevalence despite efforts by the Scottish Government to reduce it through strategies like policies that promote housing as a priority for individuals. Research has shown a cause-and-effect relationship between homelessness and health, suggesting early involvement of health and social care workers as well as partnership with other services as a possible solution to prevent homelessness. In response to this, the Scottish Government is working towards a new housing bill in which duties will be placed on wider public bodies to ask and act to prevent homelessness. This dissertation therefore aims understanding the experiences of Midlothian health and social care staff who work with homeless individuals and their opinions as useful considerations in anticipation for implementation of the duty.

Methods: This qualitative study utilised semi-structured interviews to collect data from eight health and social care workers who work within the Midlothian Health and Social Care Partnership (HSCP). Interviews were transcribed and thematic analysis resulted in three key themes.

Findings: The three key themes identified are: 'outlook on the policy', 'Implementing Change' and 'Partnership and Governance in Midlothian Council'. Participants generally supported the policy's preventative approach and welcomed wider professional involvement. Though key challenges were identified, participants gave various suggestions that would aid implementation. They highlighted the importance of management and frontline relationships in decision and implementation of changes as this factor could fuel their motivation to work effectively. Participants noted difficulties in working in partnership with other professionals, especially with communication and information sharing. Regardless of their support of the policy's aims, professionals emphasized the need for system, organizational and culture changes to ensure effective implementation.

Conclusion: This study revealed that participants are envisioned to implement the policy, are keen to build on the care they provide for the homeless population and welcoming to the duty to ask and act that enables better collaboration with other services to provide holistic care for individuals.

Integrated Assurance Report

Thursday, 19th December 2024, 14:00-16:00

Executive summary

Item number:	**5.10**

This report is presented to provide the Midlothian Integration Joint Board with assurance around the processes in place to deliver clinical and care governance and risk and resilience management by the Midlothian Health and Social Care Partnership.

The structure for oversight of safe, effective, and person-centred care and professional governance consists of the Clinical and Care Governance Group and service level Quality Management Groups (QMGs). The oversight of the recently established Social Work Assurance Group (SWAG) combines with the Governance and Assurance Framework and QMG/CCGG processes to provide assurance for all Social Work services in the HSCP. In addition, a number of specialist subgroups ensure focus on identified risks and most common harms. A culture of shared learning and improvement is promoted.

The Governance and Assurance Framework (GAF) has been in use for 5 reporting cycles and work to refine this approach is ongoing. 6 Governance Groups report to the Senior Management Team: Clinical and Care Governance, Integrated Workforce Governance Board, Finance and Performance, Business Governance, Digital Programme Board, and the Partnership Forum. Work continues to ensure that areas highlighted as medium or low assurance by services in the Governance and Assurance Framework are scrutinised by the relevant Governance Group (Appendix 1).

Group Service, Service, and Team Plans are in place across the HSCP, and plans have been developed for the delivery of progress reports to address identified risks for the next financial year. This aims to provide a consistent and complete picture of the assurance being reported and will support the ambition and work in progress to implement a total Quality Management System (QMS) linking clinical and care governance with the management of performance and resources.

A joint Care Inspectorate, Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary inspection into Adult Support and Protection arrangements

within Midlothian has been completed since the last Integrated Assurance Report was presented to the IJB. This follows on from the recent report into the Joint Inspection of Physical Disabilities Services.

MHSCP delivered its Annual Assurance Report to the NHS Lothian Healthcare Governance Committee on 17th September 2024. The Committee agreed to accept moderate assurance that MHSCP has comprehensive systems in place to deliver safe, effective and person - centred care. That report is included as an appendix to this report. (Appendix 2)

This report also confirms that the Partnership's structures and processes for risk management, resilience and major incident planning address the requirements of Midlothian Council and the Lothian NHS Board. This includes the maintenance of the Partnership's Risk Register and processes which support the appropriate escalation of identified risks.

Board members are asked to discuss and approve the contents of this report.

Integrated Assurance Report

1 Purpose

1.1 This is the Integrated Assurance report provided by the Midlothian HSCP to the Midlothian Integration Joint Board (IJB).

2 Recommendations

2.1 Board members are asked to discuss and approve the content of this report.

3 Background and main report

3.1 This report updates the IJB on the activity undertaken to provide assurance around the delivery of safe, effective, and person-centred care in Midlothian and the processes in place to cover risk and resilience.

3.2 6 Governance Groups report to the Senior Management Team and Executive Leadership Team: Clinical and Care Governance, Integrated Workforce Governance Board, Finance and Performance, Business Governance, Digital Programme Board, and the Partnership Forum. Work continues to ensure that areas highlighted as medium or low assurance by services in the Governance and Assurance Framework are additionally reviewed by the relevant Governance Group (Appendix 1). Risk is a standing item within the terms of reference of all six groups.

3.3 Clinical and Care Governance and Assurance Structure and Processes

The Clinical and Care Governance Group (CCGG) meets quarterly to provide oversight of the safety, effectiveness, and person centredness of Midlothian Health and Social Care Partnership (MHSCP) services.

Group Service, Service and Team Plans have been in place across the HSCP since April 2023. The associated implementation of the Governance and Assurance Framework (GAF) and a review of meeting structures provide the CCGG with a complete picture of the assurance being provided and any identified risks to the delivery of clinical services and social care being reported across all services at every meeting.

Service level Quality Management Groups (QMGs) report to the CCGG on the systems, processes, and evidence of clinical and care governance, risk management, and quality management activity. The QMGs are expected to meet at least four times per year and submit a quarterly Governance and Assurance Framework submission and completed CCGG template. The quarterly reporting

template collates evidence for assurance and provides information about actions in place relating to the learning arising from investigation of adverse events and complaints, implementation of actions around safety alerts, specific standards and guidance, improvement work, action plans arising from audit and inspection activity and any other service-specific issues which could have impact on the quality and safety of care the service provides. QMGs are required to deliver an annual summary report in the form of a short presentation to the CCGG and other service managers.

The GAF continues to evolve, reflecting learning across our system, changes in our structures and modifications to the digital application. This approach supports a culture of learning alongside the provision of oversight of assurance levels across the system.

Since the initial implementation of the GAF in 2023, completion rates and quality have been improving. Simple digital reminders have been successfully implemented to ensure teams collate system data and use the framework to facilitate discussions across the safe, effective, person centred and regulatory domains. The digital application is then used to input the consensus reached in terms of impact, assurance and overall governance across the measures within the domain areas. Tableau interfaces with the GAF application to provide a digital dashboard for oversight across the HSCP (Appendix 3.) Quarterly reporting to the Executive Leadership Team provides oversight of the assurance levels across all areas of responsibility. Service Managers have responsibility to follow up the progress of their action plans through line management processes and within the CCGG for good practice and learning to be shared.

The role of Chief Social Work Officer, which carries statutory functions, now sits within the HSCP following the recent retiral of the Head of Children's Services. The Head of Adult Services is now Chief Social Work Officer for Midlothian Council. The CSWO is a member of the IJB. QMG processes are integrated, and managers report on all HSCP business, thus providing assurance regarding social work services. The oversight of the Social Work Assurance Group (SWAG) combines with the Governance and Assurance Framework and QMG/CCGG processes to provide assurance for all Social Work services in the HSCP. The SWAG meets fortnightly currently and is chaired by the CSWO with attendance from the Deputy CSWO and the Group Service Manager for the HSCP. Since inception, it has provided leadership and assurance regarding the improvement plan for Newbyres Care Village, Care at Home, Mental Welfare Commission Reports and has also had oversight over all improvement plans developed following Care Inspectorate inspections of services. All new Policies and Procedures for Social Work services are approved at SWAG and there is a role in overseeing audit and quality assurance work. SWAG covers all social work services in Midlothian including those services which are outwith the delegated functions of the Midlothian IJB.

3.3 The Clinical and Care Governance Group

The Clinical and Care Governance Group meets on a quarterly basis. Since the last report to the IJB, two meetings have taken place.

MHSCP delivered its Annual Assurance Report to the NHS Lothian Healthcare Governance Committee on 17th September 2024. The Committee agreed to accept moderate assurance that MHSCP has comprehensive systems in place to deliver

safe, effective and person - centred care. That report is included as an appendix to this report. (Appendix 2)

3.4 Investigating and Learning from Adverse Events and Complaints

Three groups are established to provide oversight of all significant adverse events reported within NHS Lothian services delivered by Midlothian HSCP. Specific groups address in-patient falls at Midlothian Community Hospital, and pressure ulcers which are two of the most common reported harms. A Morbidity and Mortality Review group is established at Midlothian Community Hospital to undertake multidisciplinary review of unexpected in-patient deaths as a further measure to develop learning to improve the delivery of safe care.

The Midlothian Safety and Experience Action Group (MSEAG) has oversight of all significant adverse events (adverse events which result in harm assessed as moderate or above), including the death or suicide of patients engaged with mental health and substance use services or unexpected medical deaths. This group commissions external reviews of major harm or death significant events in line with NHS Lothian protocols. The MSEAG minutes are submitted to the Lothian Patient Safety and Experience Action Group, and all Serious Adverse Events approved as complete in Midlothian require the approval of the NHS Lothian Medical Director and Executive Nurse Director before final closure.

The HSCP Senior Management Team (SMT) receives a fortnightly report of performance in the management of complaints and the reporting and management of adverse events on the Datix system. Datix is a web-based tool which can be accessed by all NHS Lothian staff to report and learn from safety concerns, adverse events with harm and near misses. It helps in the collection and analysis of information to inform action plans which support safety and quality improvement. The system also provides modules to support the administration of Complaints, Claims and Service and Team level Risk Registers, to provide an integrated information system. Quarterly oversight of themes and learning arising from complaints and adverse events has been added to the MSEAG agenda and is also addressed at quarterly NHS Lothian performance meetings.

At the time of writing 6 Significant Adverse Event (SAEs) are under investigation. Chart 1 shows Midlothian's closed median is higher than the reported median, preventing the development of a backlog. Chart 2 shows Midlothian HSCP's performance regarding SAEs which are overdue. One level 1 SAE has been open for over 6 months at the time of writing, and one other non-level 1 review has breached the 70-day target for its completion. Work continues to support actions that will enable local teams to address all adverse events within the Healthcare Improvement Scotland guidance timescales. Work is also continuing to maintain and further improve SAE review performance against timescales and assure the quality of the reviews and the implementation of learning gained. Ongoing review of learning needs is undertaken and the SMT works with the Quality Improvement Support Team of NHS Lothian to discuss actions required and to enable appropriate learning opportunities to be identified and delivered.

Outstanding actions from previously investigated Significant Adverse Events are recorded on Datix and continue to be monitored by the MSEAG to ensure that they are completed.

Chart 1:Midlothian Serious Adverse Events reported and closed at 2nd September 2024

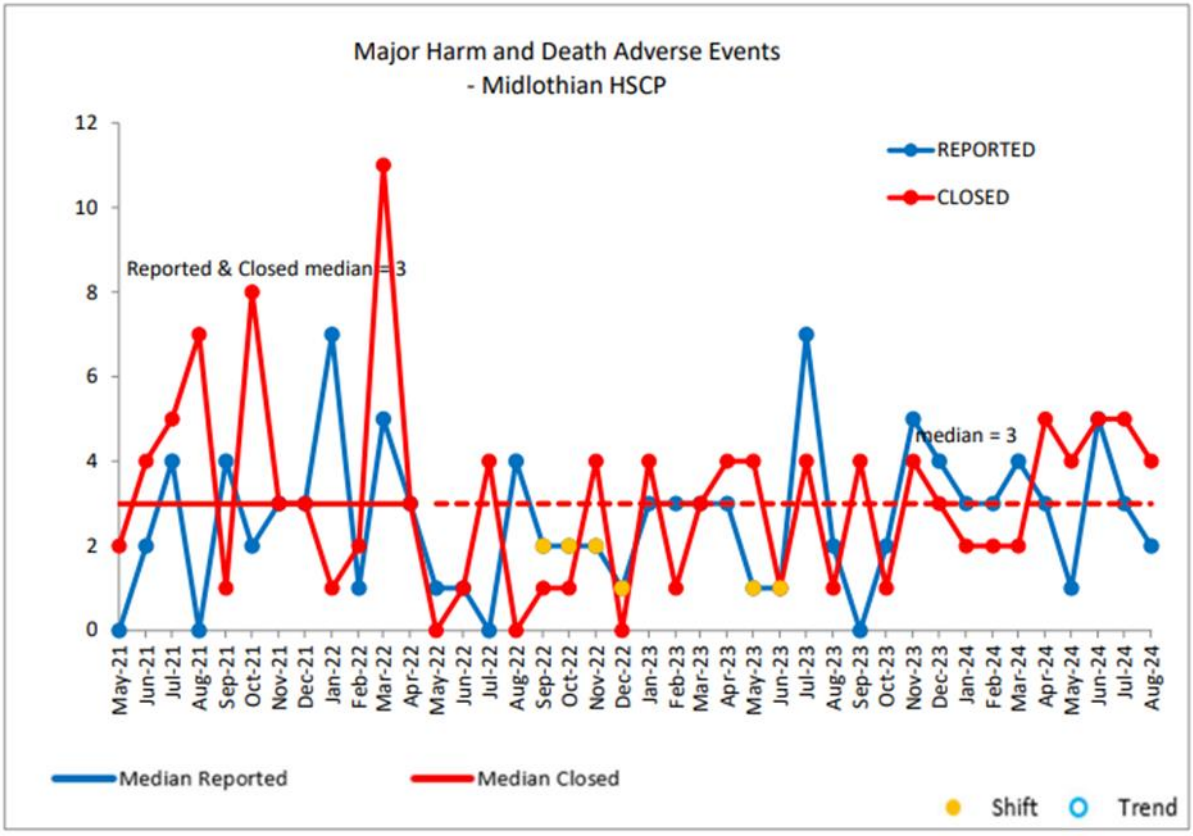
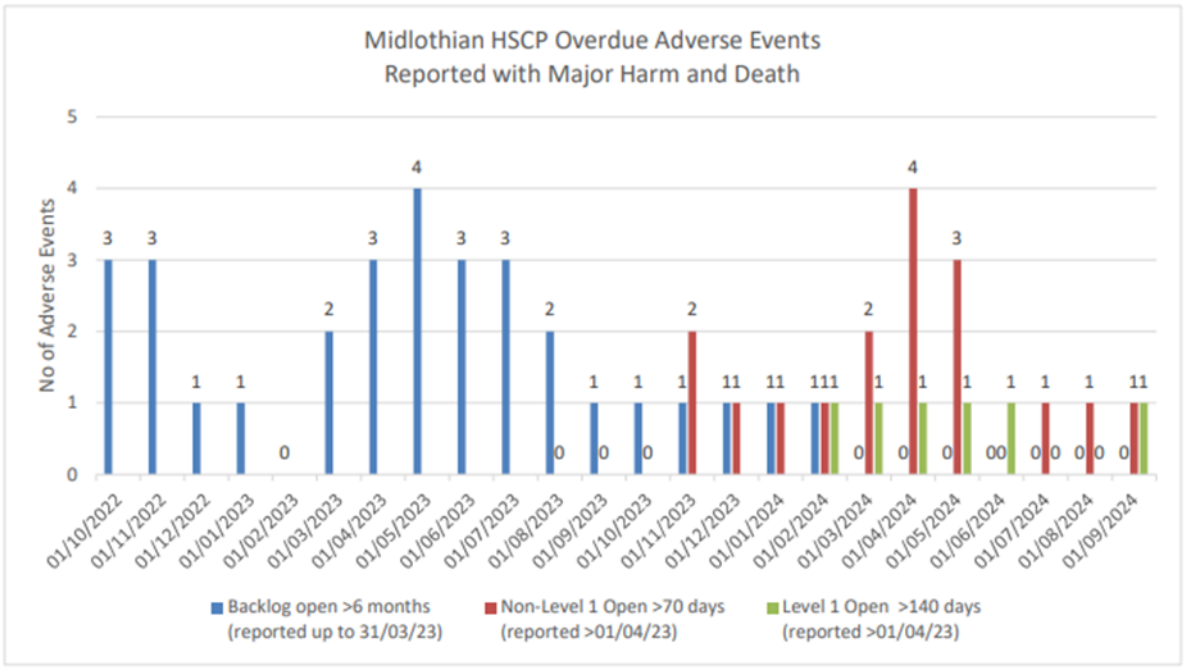


Chart 2 Midlothian Overdue Adverse Events Reported with Major Harm and Death at 2nd September 2024



Work to develop an adverse events management process for Social Work and Social Care services was paused due to inspectorial activity which commenced in May of last year and will be progressed as resources to undertake this work are released from other priority activity. As a result, processes for adverse event management and oversight for Midlothian Council services within the HSCP currently remain less mature. Ultimately, the aspiration is that MSEAG will have oversight of all adverse events across the HSCP.

The Social Work Assurance Group (SWAG) provides a route for the governance of all Social Work and Social Care services and, has proven to be key in providing assurance that services are operating well and safely. This has been particularly the case with the improvement work at Newbyres Care Village. Following a review of falls within Highbank Intermediate Care facility, a number of recommendations have been progressed, including improvements in falls risks assessment documentation, handover information, team working and specifically debriefs and support from the Technology Enabled Care (TEC) team.

Complaints are generally managed through the respective organisations' complaints handling processes, although efforts are made to respond in an integrated way where required and appropriate. A range of Elected Member, MP and MSP enquires tend to be channelled through a Council route and are usually managed by respective Heads of Service.

Performance against KPIs and an analysis of themes and learning from complaints received in relation to NHS Lothian services delivered within the MHSCP is monitored by MSEAG and reported to quarterly NHS Lothian performance review meetings. This report covers data up to June 2024 from the report received from the NHS Lothian Patient Experience team on 17th September 2024.

Charts 3 and 4 illustrate the numbers of complaints received via the NHS complaints processes which relate to services delivered within the Midlothian HSCP.

Chart 3: Number of Stage 1 complaints received.

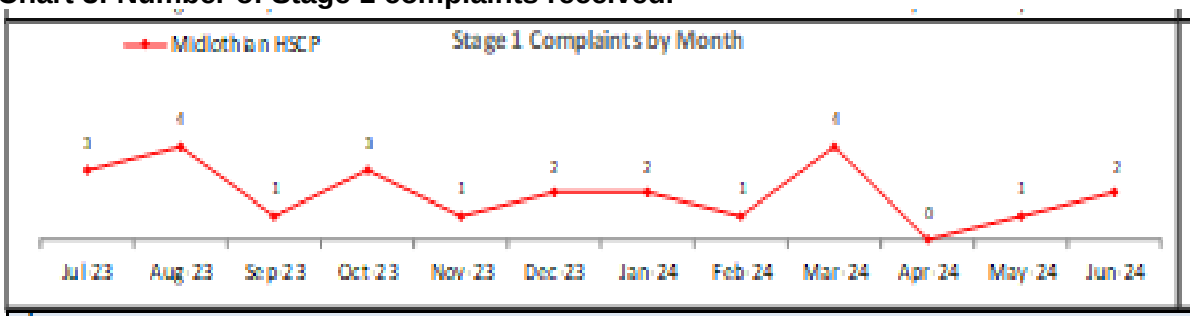


Chart 4: Number of Stage 2 complaints received.

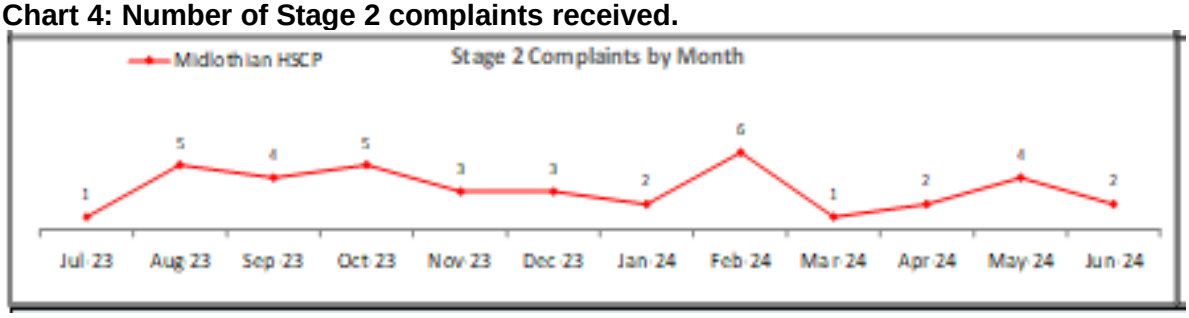
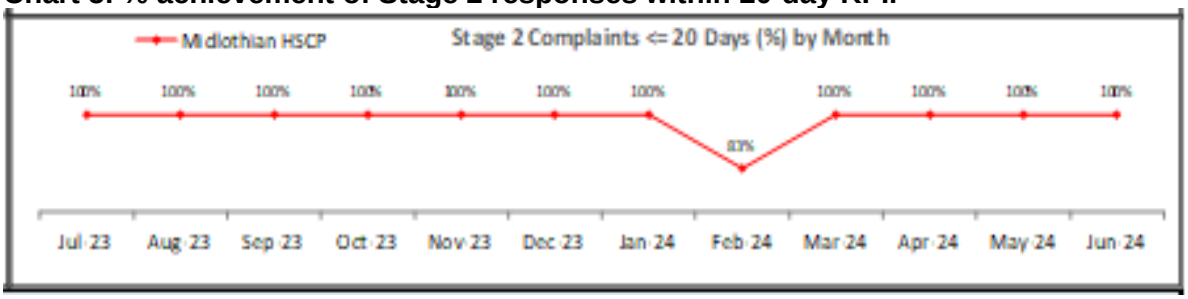


Chart 5 illustrates performance regarding Stage 2 complaints responses. Of the 38 Stage 2 complaints received in the 12 months illustrated, only 1 failed to meet the 20-day target for the provision of a response – this reflected the complexity of the complaint which involved a range of services, one being provided from another Directorate in NHS Lothian. At the time of writing Midlothian is involved in responding to three open complaints, which are within the KPI for response.

Chart 5: % achievement of Stage 2 responses within 20-day KPI.



Work continues to share learning from the investigation of adverse events and complaints and to improve local services in line with findings and recommendations.

3.5 Clinical and Professional Oversight of Care Homes

The Scottish Government published My Health, My Care, My Home - Healthcare Framework for Adults Living in Care Homes in June 2022. An Advice Note on Enhanced Collaborative Clinical and Care Support for Care Homes issued on 14 December 2022 provides guiding principles and a framework to continue cross sector work to continue to improve the health and wellbeing of people living in care homes. Work is continuing in Midlothian and on a pan-Lothian basis to ensure these recommendations are met and that partners involved in the delivery of care home services are engaged in shaping the model going forward. The approach recognises that the role of the HSCP is different to that of the inspection and regulation responsibilities exercised by the Care Inspectorate.

3.6 Inspections

The Clinical and Care Governance Group maintains oversight of the inspections undertaken by regulatory bodies, including the monitoring of action plans for improvements. Managers log service inspection reports with their QMG submissions.

MHSCP services are subject to external inspections from statutory bodies. This includes Healthcare Improvement Scotland, the Mental Welfare Commission, and the Care Inspectorate. These reports are lodged at SMT, and actions plans monitored operationally and reported through the QMGs, CCGG, The East and Midlothian Public Protection Committee, and the Social Work Assurance Group. Immediate action is taken when internal concerns or external inspections identify improvements which are required to address standards of care. Operational and professional leads have shared oversight of action plans. Implementation is led by Service Managers and progress monitored and supported through operational and care and clinical governance routes, ensuring the implementation of actions deliver sustainable improvement.

Earlier this year the Care Inspectorate led a second phase of joint inspection and development of Adult Support and Protection in collaboration with Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland. The Midlothian Partnership were part of phase two joint inspections with an aim to provide national assurance about individual local partnership areas' effective operations of adult support and protection key processes, and leadership for adult support and protection. The focus of this inspection was on whether adults at risk of harm in the Midlothian partnership area were safe, protected and supported. The joint inspection of the Midlothian partnership took place between January 2024 and July 2024.

The Inspection considered key processes and strategic leadership. The final report released on 11th July 2024 concluded that the Midlothian partnership delivered adult support and protection processes that protected and supported adults at risk of harm. There were some strong areas of practice, particularly management oversight of Council Officer practice, the risk assessment framework and the quality of chronologies and risk assessments when completed.

The inspection found that overall, strategic leaders ensured the delivery of competent and effective adult support and protection practice. Strategic leaders' vision for adult support and protection was strong and well understood by staff to ensure effective governance.

The Inspectors concluded the partnership's key processes and strategic leadership for adult support and protection were effective with areas for improvement. There were clear strengths in both domains supporting positive experiences and outcomes for adults at risk of harm, which collectively outweighed the areas for improvement.

On the 15th of July 2024 the Care Inspectorate notified Local Authorities and Health and Social Care Partnerships of their intention to undertake a review of social work governance and assurance arrangements. The review commenced in July 2024 and will conclude in December 2024. It is being carried out under Section 53 of the Public Services Reform (Scotland) Act 2010.

Through the review the Care Inspectorate will answer these questions.

How well do social work governance and assurance arrangements support leaders to:

- Ensure statutory duties are carried out safely and effectively?
- Enable social work staff to be supported, accountable and effective in their practice?
- Assist social work staff to uphold core social work values?

They will span all areas of statutory social work including adults, children and justice social work services and will cover all local authority areas in Scotland.
The review will include: a review of documents, a national staff survey, interviews with key leaders from across Scotland and a range of focus groups with middle and senior managers.

Now the ASP inspection has been concluded, attention will turn to progressing a Council Social Work and Occupational Therapy review. It is intended that this review will include data analysis on waiting lists, capacity, demand, the skill set of the

workforce and pathways between services. Extensive consultation and engagement with key stakeholders and staff will also contribute to the process.

Through the QMGs, we have developed a more systematic approach to managing recommendations from Mental Welfare Commission themed reports. Generally, such reports have a range of actions for Scottish Government, NHS Boards and HSCPs. These are worked into an Action Plan for later submission back to the Mental Welfare Commission. Governance is provided by reports coming to the HSCP SMT and the Social Work Assurance Group (where appropriate).

3.7 Risk Management

Midlothian HSCP is compliant with the NHS Lothian Risk Management Policy and Midlothian Council Risk Management Policy and Strategy. The Risk Management process within Midlothian was audited in 2021 and the finalised report confirmed that the Risk Management processes within Midlothian provided high assurance and demonstrated best practice in several areas:

- Midlothian HSCP Senior Management Team meets monthly, and risk is a standing agenda item.
- Service level risks registers are locally managed, and oversight is held by Heads of Service for review and escalation to the Senior Management Team (if required).
- Risks are routinely monitored through these escalating levels with additional risk oversight held by Midlothian Council and Midlothian IJB both strategically and operationally.
- Each risk recorded either operationally or strategically have actions associated to mitigate the risk, these are routinely monitored through the appropriate level of monitoring as mentioned above.
- Each risk has a risk owner identified who is the accountable person for managing the related actions and providing routine updates on the status of the risk.

3.8 Resilience and Major Incident Planning

Midlothian Health and Social Care Partnership supports its partner organisations, NHS Lothian and Midlothian Council, to deliver their obligations as responders to major incidents. The Partnership provides Midlothian IJB with any relevant assurance in relation to incident management and response which supports its responsibilities as a Category 1 responder.

Midlothian Health and Social Care Partnership maintains major incident plans in line with NHS Lothian's Resilience Policy and provides assurance through NHS Lothian's reporting cycle on resilience, major incident planning and business continuity. A virtual control room is in place for incident management along with physical control rooms in both Midlothian Community Hospital and Fairfield House. Service Managers are required to review and update their service-specific resilience and business continuity plans annually which feed into the overarching Midlothian Resilience Plan.

3.9 Risk Register

Operational risks are captured in the Partnership Risk Register, which is updated and reviewed regularly, and when required escalated to the NHS Lothian Corporate Risk Register and Midlothian Council Strategic Risk Profile.

HSCP mitigation plans contribute to the overarching corporate risk registers held by NHS Lothian and Midlothian Council.

The following risks on the NHS Lothian Corporate Risk Register are relevant to the Midlothian HSCP:

- 4 Hours Emergency Access Target
- Hospital Bed Occupancy

4.0 Policy Implications

4.1 This report should provide moderate assurance to the IJB that relevant clinical and care governance policies are appropriately implemented in Midlothian, and that appropriate mechanisms are in place to assess and manage risk and ensure service resilience.

5.0 Directions

5.1 Clinical and care governance, risk management and resilience planning are implicit in various directions that relate to the delivery of care.

6.0 Equalities Implications

6.1 The Governance and Assurance Framework requires services to provide assurance that they are complying with the Equalities duties including the completion of Integrated Impact Assessments (IIA's) where necessary. This supports the HSCP to comply with its equality duties.

7.0 Resource Implications

7.1 Resource implications are identified by managers as part of service development. and additional resource may at times be required to ensure required standards of clinical and care governance, risk management and resilience planning are met. The expectation is that these activities are embedded in service areas and teams and that staff have time built in to attend the relevant oversight groups and undertake the associated responsibilities.

8.0 Risk

8.1 This report is intended to keep the IJB informed of governance arrangements and any related risks and to provide assurance to members around improvement and monitoring activity.

8.2 All risks associated with the delivery of services are monitored by managers and where appropriate they are reflected in the risk register.

9.0 Involving people

9.1 Midlothian staff are involved in the development and ongoing monitoring of processes related to clinical and care governance and risk identification, assessment and management.

Public representatives on the IJB will have an opportunity to provide feedback and ideas.

10.0 Background Papers

N/A

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DATE	7th October 2024

Appendices:

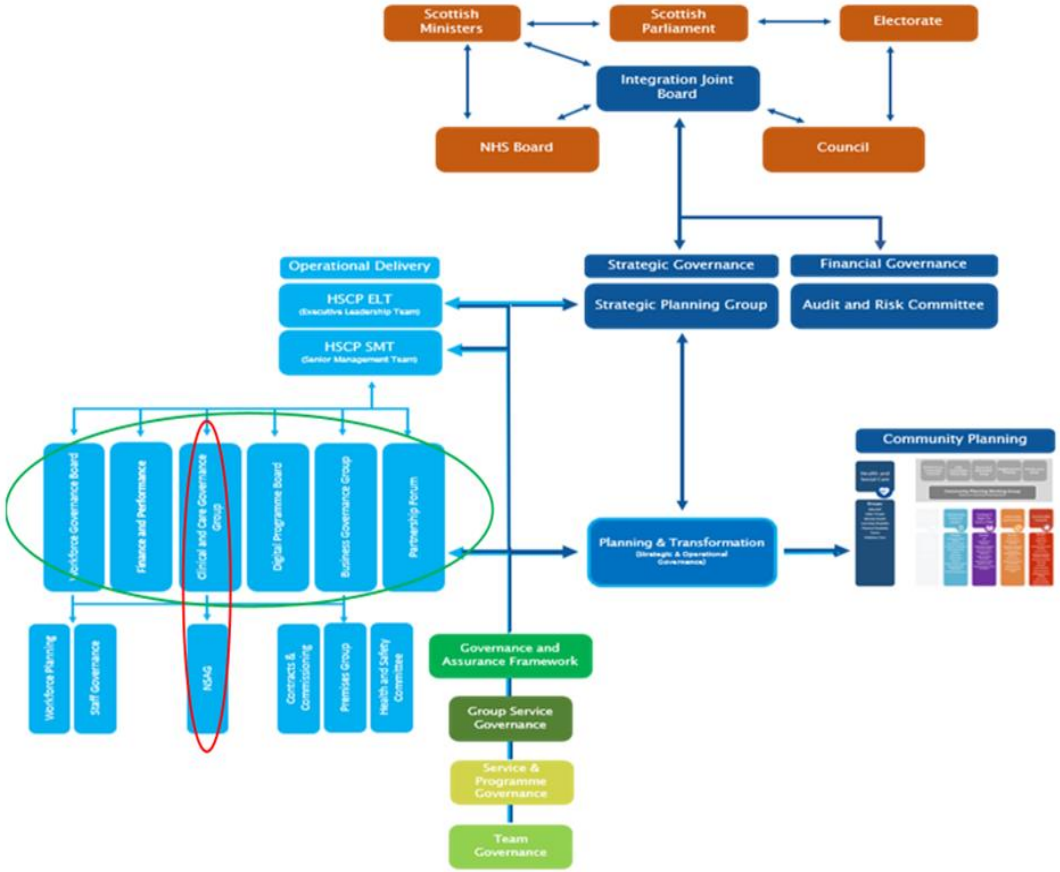
Appendix 1: Midlothian HSCP Governance Structure

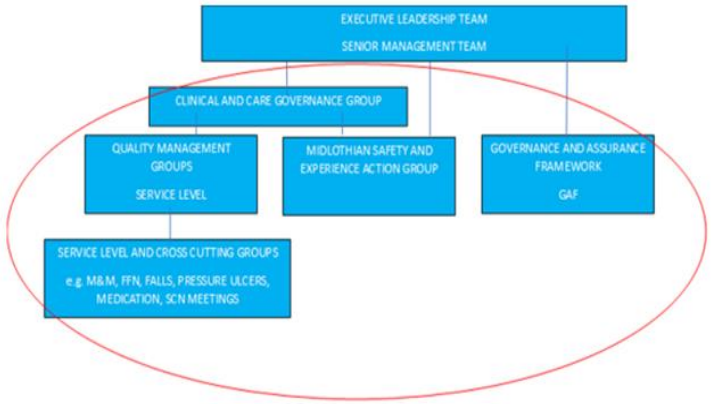
Appendix 2: Midlothian HSCP Annual Report (2024) to NHS Lothian Healthcare Governance Committee

Appendix 3: Midlothian Integrated Governance and Assurance Framework Quarter 1 overview July 2024

Appendix 1

Midlothian HSCP Governance Structures





Midlothian Health & Social Care Partnership

NHS Lothian

MIJB Integrated Assurance Report_ Appendix 2

Meeting:	**Healthcare Governance Committee**
Meeting date:	**17 September 2024**
Title:	**Midlothian Health and Social Care Partnership Annual Report to the NHS Lothian Healthcare Governance Committee**
Responsible Executive:	**Morag Barrow, Joint Director**
Report Author:	**Fiona Stratton, Chief Nurse**

1 Purpose

This report is presented for:

Assurance	☒	Decision	☐
Discussion	☐	Awareness	☐

This report relates to:

Annual Delivery Plan	☒	Local policy	☒
Emerging issue	☐	NHS / IJB Strategy or Direction	☒
Government policy or directive	☒	Performance / service delivery	☒
Legal requirement	☐	Other [please describe]	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☒	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☒	Workforce (supply or wellbeing)	☒
Primary Care	☒	Digital	☒
Unscheduled Care	☒	Environmental Sustainability	☐

This aligns to the following NHS Scotland quality ambition(s):

Safe	☒	Effective	☒
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The purpose of this report is to provide the committee with an assessment of the quality and safety of care provided in Midlothian Health and Social Care Partnership (MHSCP) and work being undertaken to address risks and improve quality and safety.

The committee is recommended to accept moderate assurance that MHSCP has comprehensive systems in place to deliver safe, effective and person - centred care.

2.2 Background

Scope of Services

The Midlothian Health and Social Care Partnership (MHSCP) is responsible for the management and oversight of a range of delegated community-based health and social care services delivered within Midlothian and for two hosted pan Lothian services, Dietetics and the Adults with Complex and Exceptional Needs Service (ACENS).

Full details are provided in the service scope appendix (Appendix 1).]

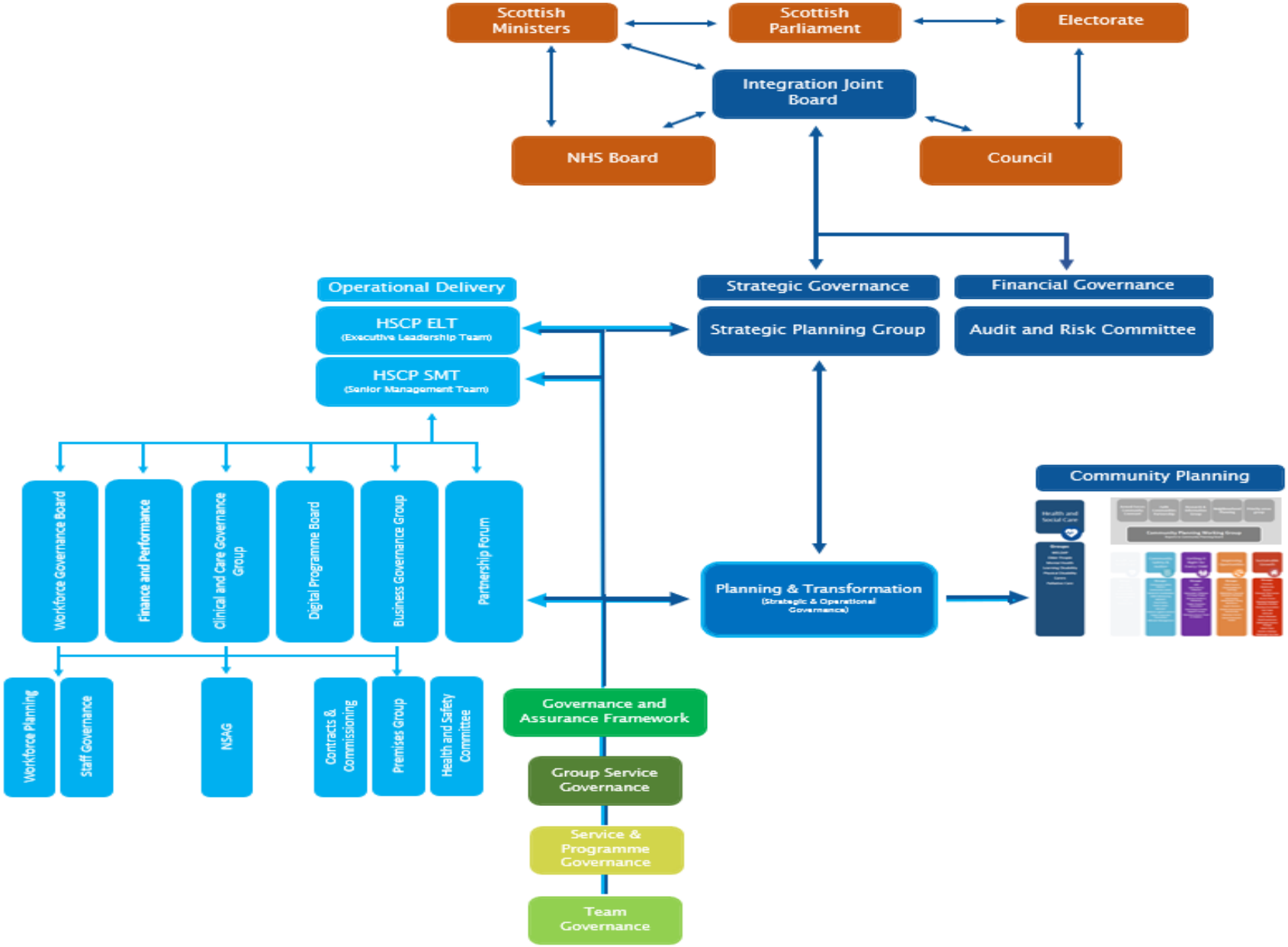
2.3 Assessment

Structures and Processes for Management and Oversight of Safety

Management and governance structures

Midlothian HSCP's governance structure is composed of key meetings that deliver oversight of the governance processes within the MHSCP. These meetings and their inter-relationships are illustrated in Figure 1. The workforce planning and staff Governance meetings are currently paused due to capacity issues but key functions of these groups continue to be delivered by the Workforce Governance Board and the Executive Leadership team

Figure 1: Midlothian HSCP Governance Structure



Management and governance processes

The fora in which data are reviewed and acted upon are described below. Detail is provided in the service assurance mapping table (Appendix 2).

Senior Management Team/Executive Leadership Team

The Senior Management Team meets monthly and provides oversight of all clinical and care services within the HSCP. The Executive Leadership Team meets fortnightly meeting to maintain oversight of strategic and operational workstreams. Informal escalation mechanisms support the raising of any urgent issues or safety concerns through operational and professional reporting lines at any time. The agendas of the SMT and ELT ensure regular reporting is received about the safety, performance and quality of services provided across the partnership, and for any emerging concerns about safety and quality of care to be raised. All meetings are minuted and required actions are logged.

A range of groups with remits for specific issues relating to clinical and care governance support the SMT and ELT to deliver oversight of clinical and care quality and are described below.

Midlothian Safety and Experience Action Group MSEAG

MSEAG is chaired by the Chief Nurse and meets fortnightly on behalf of the SMT to support and oversee the management of Significant Adverse Events within MHSCP, i.e. those events where moderate and major harm or death are reported. The group make decisions on the type of review required, commission Level 1 and Local Management Reviews and provide governance and assurance around the completion of reviews and action plans. Organisational Duty of Candour Decisions are made by this group. Data regarding adverse event reporting, closures, common harms, complaints received, and complaint management performance are reviewed quarterly to identify themes and consider any actions required.

Attendance at MSEAG ensures that service level activities including the management of complaints and adverse events, safety huddles, inspection activity, and the local review of data around specific harms, including falls, pressure ulcers, medication errors, and healthcare associated infection provide key members of the Senior management Team with a regular overview of safety issues across the partnership.

Clinical and Care Governance Group (CCGG)

The Clinical and Care Governance Group (CCGG) meets quarterly and reports to the Integration Joint Board (IJB) twice yearly. The CCGG is chaired by the Chief Nurse and is attended by the Clinical Director, Chief AHP, Heads of Service, Service Managers, and key staff with Quality Improvement, Risk Management and Performance roles. Services are required to convene a Quality Management Group, submit a quarterly template and deliver an annual summary presentation at a CCGG meeting. Verbal reporting of any concerns about new or changed key risks and progress against any outstanding relevant actions where low or medium assurance has been provided on care or clinical governance

indicators is provided. The reports received by the CCGG are the evidence of assurance for the annual report to the Healthcare Governance Committee and the reporting to the IJB.

Quality Management Groups (QMGs)

Quality Management Groups (QMGs) organised at service level and are chaired by Integrated Service Managers. QMGs are required to meet at least four times per year to review activity, data and evidence of assurance around the safety, effectiveness, and person centredness of the services delivered. They complete a reporting template (Appendix 3) designed around Healthcare Improvement Scotland's healthcare quality inspection themes. There is an explicit expectation that Integrated Service Managers review their QMG report with their Head of Service. QMGs are required to maintain oversight of the inspections of commissioned services undertaken by regulatory bodies, and the monitoring of action plans for improvements associated with Healthcare Improvement Scotland inspections and Care Inspectorate Inspections of internally provided regulated services. The Primary Care Cluster Quality Network of the 11 Midlothian GP practices, chaired by the Cluster Quality Lead and attended by the Clinical Director, also provides a quarterly report of quality & safety activities to the CCGG.

Oversight and action on Common Harms

Working groups are established to drive improvement work in relation to common healthcare-related harms. Midlothian Community Hospital (MCH) convenes groups focusing on Medicines Management, Falls, and Food, Fluid and Nutrition. Infection Control is a standing item on the monthly Senior Charge Nurse meeting chaired by the Integrated Service Manager and links are maintained between the MCH team and specialist Infection Prevention and Control Nurses. A group also meets to review any pressure ulcers reported to have been acquired by people in receipt of healthcare and to deliver recommendations on improvement actions required.

Governance and Assurance Framework (GAF)

Clinical and Care Governance indicators are a component of the Midlothian HSCP Governance and Assurance Framework (GAF). The GAF is a quarterly reporting template completed on a web-based application developed in collaboration with the Digital Innovations Team. The GAF uses the domains Safe, Effective, Person Centred and Regulatory to support assessment of impact and provision of assurance levels to support measurement and governance across the local system.

The GAF was designed to enable all teams and services within Midlothian to use organisational data sources to facilitate discussion, assess risk and enable consensus and ownership of mitigation and associated action plans. Supported by the Digital Innovations Team, the digital application enables teams to submit their findings

Following implementation of the GAF last year, engagement continues to improve. Tableau provides digital oversight of GAF status across the HSCP (Appendix 3a) enabling the Executive Leadership Team to have oversight of the assurance levels across their areas of responsibility. Service Managers have responsibility to follow up the progress of their action plans through line management processes and meetings within the HSCP structure provide opportunity for good practice and learning to be shared.

The NHS Lothian Accreditation and Care Assurance Standards (LACAS)

The NHS Lothian Accreditation and Care Assurance Standards (LACAS) provide a framework to give organisational and service-user assurance that quality person-centred care is being delivered consistently across all NHS Lothian's hospital services. The Framework has been developed to promote Quality Assurance activity which can be utilised to inform and drive improvement in line with NHS Lothian's objectives, Quality Strategy and Quality Management Approach. LACAS cycles are embedded within the Quality Management Approach within Midlothian Community Hospital (MCH), and evidence from the most recent cycle is reported in on pages 18-19 of this report.

MCH Morbidity & Mortality (M&M) group

Senior medical staff have established a quarterly Morbidity & Mortality (M&M) group to review all in-patient deaths in Midlothian Community Hospital. Medical and Nursing Team members are encouraged to attend and share learning with the whole group. Meetings are minuted, with an action log, and are submitted for oversight at the Clinical Care Governance Group (CCGG). Scale-up has progressed and now includes Psychiatry of Old Age ward, and Hospital at Home as there are advantages to linking up the M&M discussions across specialties the Medicine of the Elderly wards, to detect any emerging themes, shared learning, and develop collaborative working across the site.

Care Home Rundown

A weekly care home rundown is established with a focus on the delivery of the Healthcare Framework for Care Homes and the support needed and provide to care homes to deliver clinical and professional standards in care homes. The group is chaired by the Chief Nurse and reviews Care Home Support Team inputs and provides a locus for the discussion and escalation of any concerns around staffing, training, infection prevention and control and incidents (adverse events). Data is provided from the NHS Lothian Health Protection Team on infection outbreaks. Work is underway to agree how to measure the impact of Care Home Support teams. The Midlothian Care Home Support team is working to support the rollout of a digital tool (Restore 2) to support the early identification of deterioration and prompt appropriate management aligned to residents' Future Care Plans.

Escalation Processes

The formal meetings within the structure described above provide regular opportunities for the reporting, discussion and analysis of quality-of-care issues. Midlothian HSCP places an emphasis on relationships being key to the work of integration and the size of the

partnership fosters appropriate early escalation through management and professional lines. Methods depend on urgency/severity, and include face to face and all electronic methods. An MS Teams channel is established to ensure that an urgent meeting of the Executive Leadership Team can be convened regardless of the location of the members.

As illustrated and described in Appendix 2a, Midlothian HSCP can evidence steady and continued improvement in performance against KPIs on SAE review completion, and a sustained position in complaints handling. Underpinning that high level data is a commitment to ensuring that the quality of investigations is not overridden by a focus on delivery to timescales alone – i.e. meeting the target but missing the opportunity to fully explore and identify learning. There has been a dedicated focus this year on encouraging Service Managers to include more information in Local Case Reviews, in particular risk assessments and documentation of safety mitigations, and this has been helpful in being able to make an informed and confident decision about whether to commission a level 1 review or close without further investigation.

2.3.1 Service Quality and Safety Assessment

Safe care in Midlothian HSCP

In Midlothian HSCP safe care is focussed on:

- Deploying staff with the right skills in the right numbers to the place they are most needed
- Identifying, assessing, recording, and managing key risks (TRAK risk assessment, speciality and patient condition specific risk assessment, public protection activity, Person Centred Care Plans, Infection Prevention and Control, and falls prevention activity)
- Recognising, escalating, and managing (acute) deterioration appropriately across a range of settings, including care homes
- Supporting adherence to medicines management and clinical guidelines and policies to provide a high standard of pharmaceutical care
- Delivering Realistic Medicine and care, including the quality, coverage and communication of Future Care Planning (including DNACPR and eKIS)
- Learning from adverse events and complaints in order to minimise or mitigate against avoidable harm across our services
- Proactive and assertive approaches in working with people at most risk of harm from substance use

The groups that form the governance structure detailed in section 2.3 utilise data on indicators of safety as described in the Assurance Mapping Document in Appendix 2.

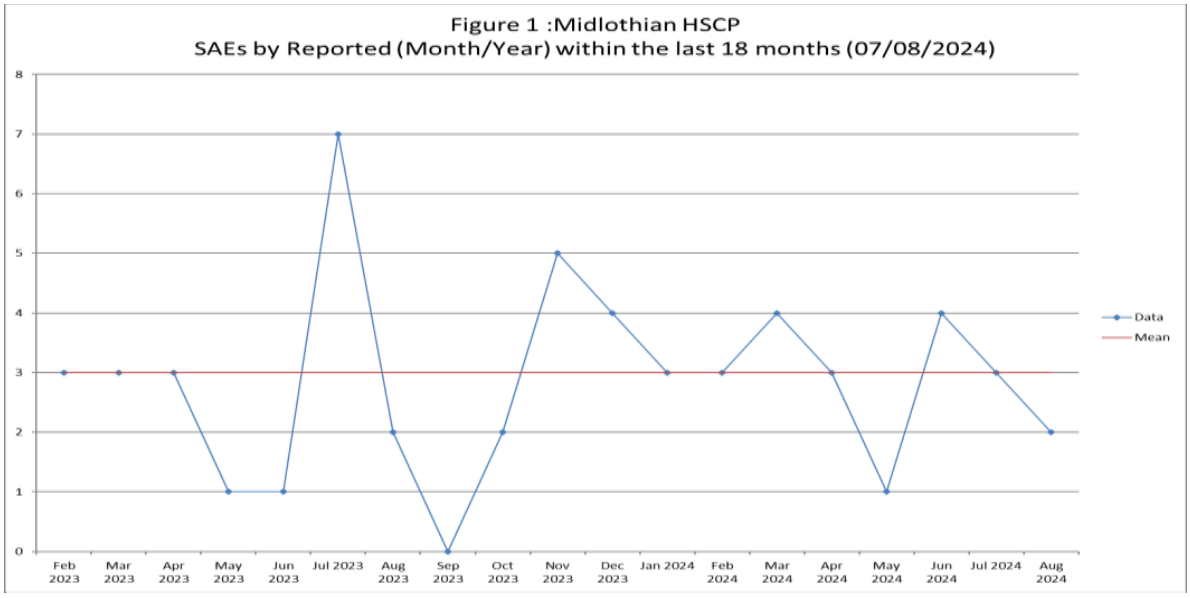
Current evidence about safety

Significant Adverse Events (SAEs)

The mean number of reported SAEs per month appears stable. Figure 1 illustrates data downloaded directly from Datix which shown all reported SAEs over the 18-month period

preceding the writing of this report. These data are presented and discussed quarterly at the MSEAG, and attendees are updated fortnightly on any new SAERs which have been reported. Data and analysis are provided in Appendix 2a.

Figure 1



Our analysis concludes that the numbers of reported SAERs within mental health, substance use, and all other services is static. However, we do note that annual data for 2023 'drug-related' deaths published on 20th August 2024 shows a return to previous levels after a year of many fewer reported drug deaths in 2022 (Appendix 4). The role of the HSCP and the Mid and East Lothian Drug and Alcohol Partnership (MELDAP) in addressing this significant public health issue is recognised. Work to engage people who use substances with services to support them and reduce harm continues to be a priority for the HSCP and its partners.

Data on mental health and substance use major harm and death events have been separated out for the first time this year to enable an analysis of events affecting these patients to be illustrated and for any trends across all other services, including the community hospital to be more clearly identified.

Review Outcomes

Appendix 2 includes summary tables of Quality Improvement Support Team (QIST) data provided to the Partnership on the outcome codes for adverse event reviews at closure. This evidences the work undertaken by MSEAG to address a backlog of local reviews in 2021. Care and service delivery problems were pertinent to the outcome being identified in 5 out of 48 reviews over 3 years. Three reviews within the last calendar year have been closed with the finding that care or service delivery problems contributed to the adverse event.

All events involving harm to a patient provide an opportunity for learning, and Midlothian HSCP can evidence the implementation of specific action plans to address the learning from reviews with an outcome of 3 and 4. No common underlying themes or causes of avoidable harm have been identified in these three reviews.

Data is prepared and discussed on a 6- monthly basis to support a Lothian -wide discussion of the incidence, process of review and learning from deaths of patients who were receiving NHS Lothian Mental Health and Substance Use Services at the time of or immediately preceding their death.

Table 1

All Mental Health & Substance Misuse Deaths reported 01/10/2023 - 31/03/2024	Level 1 SAE Review	Extended LCR	Local Case Review (Mental Health)	Total
Edinburgh HSCP	0	0	46	46
East Lothian HSCP	0	0	11	11
Midlothian HSCP	3	0	8	11
Royal Edinburgh and Associated Services	1	5	21	27
West Lothian HSCP	0	0	22	22
Total	4	5	108	117

Table 1 illustrates that Midlothian HSCP commissioned a higher proportion of Level 1 SAE reviews than other partnerships but that all LCRs identified an review outcome of 1 (Table 4). This suggests that our focus on quality of initial Local Case reviews is effective in the early identification of care and service delivery problems impacting on the outcome, thereby supporting the appropriate commissioning of external reviews.

Table 2

	Review Outcome LCRs closed			LCRs still open as at 27/04/2024				
	1	2	Total	<70 working days	70 days-6 months	6-12 months	>12 months	Grand Total
Edinburgh HSCP	4	1	5	18	13	15	10	56
East Lothian HSCP	3	8	11	4	0	1	0	5
Midlothian HSCP	8	0	8	0	0	0	0	0
REAS	18	2	20	13	*2	*5	*1	21
West Lothian HSCP	17	3	20	6	0	*1	*2	9
Total	50	14	64	41	15	22	13	91

*Cases that have been commissioned for extended LCR reviews

Evidence about safety - External inspections – Midlothian Community Hospital

Midlothian Community Hospital has not been subject to any external inspections since the last annual report to the Healthcare Governance Committee in 2023.

The most recent unannounced Healthcare Improvement Scotland visit took place in September 2020, and all follow up actions were completed.

The most recent Mental Welfare Commission visit to was undertaken in July 2022 and reported in March 2023. Actions identified to address recommendations following this inspection around communication with families and the use of section 47 certificates have been completed, but recommendations about the provision of NHS Lothian psychology input for patients in Penny Lane and Rose Lane wards remain outstanding due to additional funding being unavailable.

The HSCP Chief Nurses across the 4 Lothian Partnerships agreed with the Nurse Director for Primary and Community undertake a programme of unannounced supportive visits over 2023/24. These have initially focussed on bed-based areas, although it is recognised work should be progressed to deliver assurance in community teams also. The first iteration of these visits has enabled testing of readiness for an unannounced inspection and provided support to Senior Charge Nurses in identifying areas of strength and actions to improve in preparation for any formal inspection activity as it arises. Midlothian Community Hospital benefited from unannounced visits to two ward areas in January 2024,providing helpful feedback and assurance around MCH's preparedness for a formal unannounced inspection.

Evidence about Safety - Joint Inspections – Midlothian HSCP

MHSCP services are subject to external inspections from statutory bodies. This includes Healthcare Improvement Scotland, the Mental Welfare Commission, and the Care Inspectorate. These reports are lodged at SMT and actions plans monitored operationally and reported through the QMGs, CCGG, The East and Midlothian Public Protection Committee, and the Social Work Assurance Group. Immediate action is taken when internal concerns or external inspections identify improvements which are required to address standards of care. Operational and professional leads have shared oversight of action plans. Implementation is led by Service Managers and progress monitored and supported through operational and care and clinical governance routes, ensuring the implementation of actions deliver sustainable improvement.

Since the last report to the Healthcare Governance Committee in 2023, Scottish Ministers requested that the Care Inspectorate lead a second phase of joint inspection and development of Adult Support and Protection in collaboration with Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland. The national inspection activity programme follows the phase one inspections that took place in 2017/2018. Phase two is closely linked to the Scottish Government's improvement plan for adult support and protection, and the national implementation groups which support it. The Midlothian Partnership were part of phase two joint inspections with an aim to provide national assurance about individual local partnership areas' effective operations of adult support and protection key processes, and leadership for adult support and protection. The focus of this inspection was on whether adults at risk of harm in the Midlothian partnership area were safe, protected and supported. The joint inspection of the Midlothian partnership took place between January 2024 and July 2024.

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The Inspectors concluded the partnership's key processes and strategic leadership for adult support and protection were effective with areas for improvement. There were clear strengths in both domains supporting positive experiences and outcomes for adults at risk of harm, which collectively outweighed the areas for improvement.

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Through the review the Care Inspectorate will answer these questions.

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- Ensure statutory duties are carried out safely and effectively?
- Enable social work staff to be supported, accountable and effective in their practice?
- Assist social work staff to uphold core social work values?

They will span all areas of statutory social work including adults, children and justice social work services and will cover all local authority areas in Scotland.

The review will include: a review of documents, a national staff survey, interviews with key leaders from across Scotland and a range of focus groups with middle and senior managers.

Service Improvement Work to Address Safety Issues

In addition to specific learning from individual adverse events and known risks, improvement work is undertaken to address the most common reported harms.

Common Reported Harms

Analysis of moderate, major harm and death events over the last year, compared to a similar analysis over a 3-year period (Table 3) shows pressure ulcers to be consistently identified as the most common cause of serious harm to our patients. Unexpected death

and self-harm are the most common cause of major harm or death in Mental Health and Substance Use Services. Violence and Aggression are addressed through NHS Lothian's Health and Safety systems and processes. The Pareto Chart, table and narrative in Appendix 2a provides a detailed breakdown of MHSCPs common reported serious harms.

Table 3: Top 5 Common Harms, 2021-24, compared to 2023-24:

Top 5 common harms	2021-2024	2023-24
1	Pressure ulcer	Pressure ulcer
2	Patient fall	Unexpected death (MH/SU services)
3	Unexpected death	Patient falls (MCH)
4	Violence/aggression/abuse/harassment	Violence/aggression/abuse/harassment
5	Medication error	Self-harm

Pressure Ulcers

Pressure Ulcers are the most common healthcare-associated harm reported in Midlothian HSCP. Healthcare Improvement Scotland identify that Pressure Ulcers are one of the most common causes of harm within the hospital and care home setting. At a Midlothian level, data evidences that within the HSCP they are a harm more frequently experienced by people in their own homes than they are for hospitalised patients or those resident in care homes. A narrative around the data currently available in relation to pressure ulcer incidence and severity and the MHSCP's ability to comment on the prevention of avoidable harm is provided in Appendix 2a (Indicator 8).

Analysis of data undertaken for the purpose of this annual report highlighted the potential for a more data driven approach to the review of pressure ulcers reported in Midlothian to be adopted.

NHS Lothian's Prevention and Management of Pressure Ulcers Policy requires that all patients are systematically assessed, and effective preventative strategies are implemented to reduce the risk to the skin of breakdown and facilitate healing of damaged tissue from pressure, shear, friction, and moisture. A group within Midlothian meets fortnightly to review and quality assure individual pressure ulcer reviews and share learning, however, this work does not currently produce data which could provide assurance about the implementation of the NHS Lothian policy.

The Tissue Viability Service (TVS) provides specialist advice and support for the prevention and management of pressure ulcers, including educational study days. The Prevention and Management of Pressure Ulcers policy details specific pathways for the Acute and Community settings. This has been in place since 2021 and is due to be reviewed this year. As part of this review process stakeholder consultation will allow consideration of the current pathways to identify any changes required. Work is underway to bring the six community hospitals who don't have regular access to medical photography

into the TVS e-wound clinic. This is where images are used to triage for specialist advice or visits and for recording pressure ulcer development, improvement, or deterioration which is a requirement of the policy. The Scottish Patient Safety Programme has updated the change package and driver diagram available to provide support with evidencing improvement work in relation to pressure ulcer prevention and management. Discussion has taken place with the Lead Nurse for Tissue Viability about developing a collaborative approach across the HSCPs utilising these tools and establishing or refreshing local improvement groups. The Lead Nurse for Tissue Viability committed to providing support in developing a quality improvement approach to data collection and evidencing outcomes. The National Association of Tissue Viability Nurses Scotland is in the process of updating the prevention leaflet for patients, this has been adapted by Lothian in the past and will be implemented once the updates are complete.

The DATIX system is used to record incidence of pressure ulcer occurrence across all sites and there are specific pathways to follow as part of the review process. It has been identified that these are not user friendly and can lead to confusion with learning not always identified. This will be included as part of the policy review.

The Lead Nurse for Tissue Viability in NHS Lothian was consulted while the annual report was being prepared. The Tissue Viability Lead Nurse will continue to support review of **all** major harm pressure ulcers - these are reported predominantly by District Nursing Teams. The continued independent assessment of major pressure ulcers and provision of support with identifying the learning to take forward service improvement has been confirmed, as has the provision of in-person education sessions to update and refresh knowledge with the team involved. This will continue to be offered to all areas, alongside the improvement group work. The Terms of Reference for the Midlothian Pressure Ulcer Group is being updated to reflect the gaps identified and the group will have input form the TVS going forward. Work to develop and support the group to progress and be able to provide evidence of assurance by using a data driven quality management approach to the prevention, identification and management of healthcare acquired pressure ulcers in Midlothian will be progressed.

Unexpected Deaths in Mental Health and Substance Use Services

A specific adverse event management pathway is in place to review the care provided to people who are engaged with Mental Health and Substance Use Services (or who engaged during the 12 months prior to their death) which includes ensuring the requirement is met to notify Healthcare Improvement Scotland (HIS) of suicides and suspected suicides, and for the Mental Welfare Commission to receive appropriate notifications. And outcomes of these Local care Reviews are included in the data Tables 1&2.

In 2023/2024, an increased number of deaths of Midlothian patients engaged with Substance Use Services was reported, including a concentrated spike of 5 deaths over a 1-week period in July 2023. Immediate intelligence highlighted that these deaths were attributable to an unprecedented change in (street) drug availability; it was established that

the 5 patients who died were known to each other. As an immediate response to those 5 deaths, the Substance Use Service reached out to patients known to participate in high-risk substance use practices to raise their awareness of the immediate risks, in addition to their usual risk management plans.

The Integrated Service Manager convened an urgent Core Group Meeting involving multi-agency representation including Midlothian Substance Use Services, the Alcohol and Drug Partnership, local and national Public Health experts and Police Scotland. The purpose of the meeting was to share information and local intelligence and to identify actions to reduce harm to patients and the wider community of citizens who use substances, particularly street benzodiazepines. Harm reduction advice pertinent to the local circumstances were agreed and approved with public health involvement and disseminated across Lothian and nationally. All known patients were provided with harm reduction advice and information to raise awareness of the risks posed by benzodiazepines, with intensive assertive outreach support over the period of highest assessed risk.

Drug Related Deaths in Midlothian

The National Records Office published the annual report on drug related deaths (DRDs) in Scotland on 20th August 2024. The report detailed that following a very significant fall in numbers of DRDs reported in Midlothian in 2022 (n=4), the incidence of DRDs returned to a level closer to that reported between 2019 and 2021 with 20 deaths attributed to drugs in 2023. More information is provided in a briefing note prepared for elected members of Midlothian Council provided in Appendix 4. Strenuous efforts continue to identify people who use substances and to bring them into treatment as the evidence base about improved safety for substance users engaged in services is strong. Work to continue to deliver the Medication Assisted Treatment Standards (MAT) continues and is outlined in the briefing.

In-patient Falls – a patient safety issue

Midlothian Community Hospital has one rehabilitation ward, one NHS Lothian step-down ward, one palliative care/ continuing care ward, and two mental health wards for older people. The majority of patients are assessed on admission as presenting with a high risk of experiencing a fall. The All Falls Rate per 1000 occupied bed days (OBD) (Figure 3) and Falls **With Harm** Rate per 1000 OBDs (Figure 4) show consistent reduction in falls incidence. This is attributed to data driven improvement work across all ward areas supported by the Lead Nurse for Quality and within scope of the Lothian Accreditation and Care Assurance Standards (LACAS), which is discussed in more detail from page 20 of this report.

Figure 3

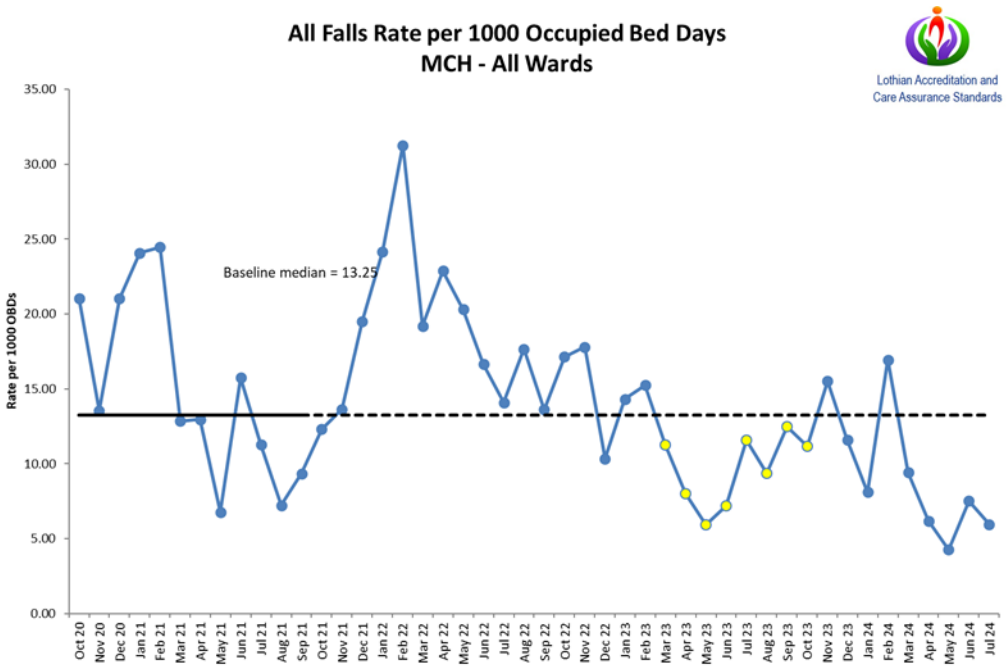
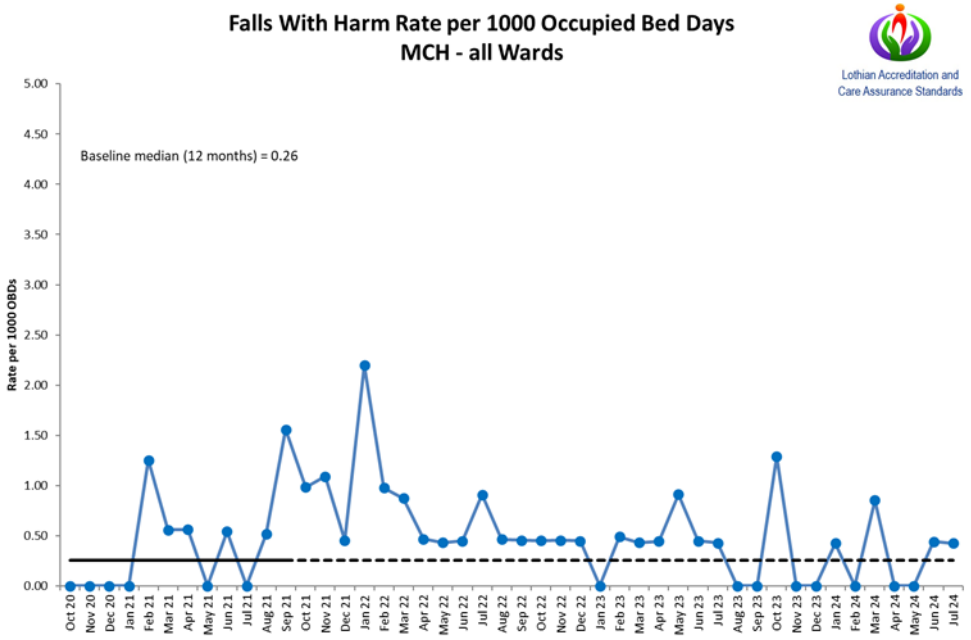


Figure 4



The most recent LACAS cycle reports mean 75% attainment of standards in relation to falls in Midlothian Community Hospital (Figure 5). Although this is one of the lower attainment levels across the whole programme, this figure is not a reflection of work to reduce in patient falls being afforded low priority. The figures represent performance (incidence/ Falls Rates) in relation to the current definition of falls which includes the reporting as a fall, incidents where patients place themselves on the floor- a known feature of the presentation of some patients within the mental health wards. A proposed update of The Scottish Patient Safety Programme falls definition (Appendix 5) will support

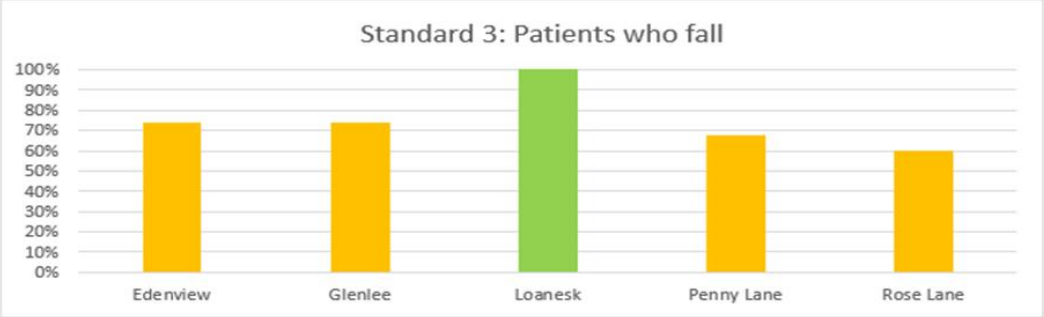
more accurate data capture and greater confidence in the assessment of impact of mitigations and improvement activity, and in the provision of assurance.

Figure 5

Falls Prevention – LACAS Standard 3

The site obtained an average score of **75%** therefore can provide limited assurance for patients who fall.

Healthcare Governance level of assurance	**Silver**



VALUE Management link domains: Quality, Experience, Safety and Cost.

Areas of good practice:	• The falls risk assessment been reviewed in response to a change in patient's condition • The 4AT assessment has been completed as part of the falls risk assessment
Areas for improvement:	• There is a falls risk assessment completed for all patients within 24 hours of direct admission/transfer from another hospital

In rehabilitation wards, and elsewhere, a culture of positive risk taking is adopted to enable patients at high risk of falls to undertake activities to regain strength, balance, confidence and mobility after major illness and injury. The risk of falls occurring has to be balanced against the risk of inactivity in order to achieve rehabilitation outcomes. Service improvement work to address inpatient falls at Midlothian Community Hospital includes:

Current work

- MCH Falls Prevention Multi-disciplinary Group meets bi-monthly with representation from all 5 wards
- All 5 wards are focusing on Falls Prevention LACAS Standard 3 - using a Quality Management approach, analysing data to gain an understanding before applying change ideas (Pareto charts – times & location of falls)
- Analysis of OBD data on Falls & Falls with harm is shared and discussed as well as sharing successes
- Improving the quality of falls risk assessment practices across all 5 wards

Current change ideas being tested:

- Use of Twilight shift to provide additional staff at times of known higher falls incidence
- Orange poster to alert staff of patients who are at the highest risk of falling (fallen once before / raised delirium score (4AT) / signs of stress & distress)
- Identifying high risk patients during daily safety brief
- Breakfast clubs

- Planned activities at times of high falls
- Evaluating ward routines
- Correct usage of Falls Prevention alarms
- Checklist (known as 'Appendix A') completed after every fall

Next Steps

- Consideration of work to improve bone health – Calcium supplements what's best?
- Dietary intake – ensuring patients receive sufficient Calcium & Vitamin D from meals being provided within MCH?

Celebrating Success

Loanesk Ward has achieved sustained improvement and reduction in falls. It's baseline Median of **4.07** is below the National target of 4.7 and a period of **2 years & 6 months** has elapsed since a fall with harm has occurred.

Whilst the adopted target aligned to the national Aim to reduce all falls by 20% within Mid-Lothian Community Hospital by January 2024 and to reduce falls with harm by 20% within Mid-Lothian Community Hospital by January 2024was not achieved in all areas, significant improvements have been. This is demonstrated in the overall reduction in Falls and the length of time between Falls with Harm The visibility of this work and the ongoing work to inform staff, patients and their families all contribute to the effectiveness of falls reduction activity in the Community Hospital.

Falls – a public health Issue

Falls are a major cause of injury, hospitalisation, and mortality among older people. A sustained focus on reducing falls in the wider population is a focus for the MHSCP and the Chief AHP has a lead role for this important work. Recent developments have included refreshed content and appearance of both the falls public webpage and the NHS Lothian staff intranet pages. The public webpage includes links to immediate support, a video on how to get up after a fall and includes information for people in different settings across Lothian. The refreshed webpage can be accessed here. A new Falls Dashboard has been developed and tested. This creates data on falls across the system which can be filtered by geographic location and includes rates of falls, provides better visibility across the system in relation to falls. A refreshed NHS Lothian Falls Strategy is expected this autumn.

Significant Adverse Events - Infections

Midlothian Community Hospital reported one major harm event relating to infection in the year covered in this report. Although not ranking as a 'Top 5' common harms, recognition of the occurrence of a major harm event resulting from a treatment-related infection of this type (Clostridium Difficile), in a context of low overall numbers of serious harm events, is appropriate. Investigation identified process and sampling issues which may have contributed to the late detection of this infection, but on balance it is not thought those improvements would have altered the outcome for the patient affected.

MCH receives support from the Infection Prevention and Control Team, and infection control is, as described in this paper, a standing item for discussion at the MCH Senior Charge Nurse fortnightly meeting and a dimension of the LACAS framework for which a standard attainment averaging 93% was achieved across the hospital, providing moderate assurance on the Infection Prevention and Control standard.

Medication Administration Errors

Medication errors have featured as one of the top 5 most common reported harms over the last 3 year period, but do not appear in this year's top 5 due to a change in allocation and ownership of adverse event management reviews. Recognising that a medication administration error resulted in a major harm event and mindful that a change in reporting does not equate a change in risk, work to promote medicines safety is reported here.

Within the MCH in-patient areas, improvements have been progressed in response to medicines errors reported on the Datix system. The Pharmacy team work alongside other members of the multi-disciplinary team ensuring analysis of risk and appropriate mitigation of the root causes are progressed.

Changes to controlled drug process as a result of error review has reduced Datix reports with Schedule 2 CDs in MCH. The revised NHS Lothian Controlled Drug Safe Use of Medicines Procedure was implemented in May 2024, supported by an extensive programme of staff training. Improvement activities include:

- introduction of security bags for less commonly used controlled drugs
- training of staff on accurate measuring of liquids
- introduction of pharmacy spot checks in addition to 4-monthly audits
- introduction of weekly liquid measurements by ward staff
-

Measures introduced to reduce medication errors including missed doses and administration errors

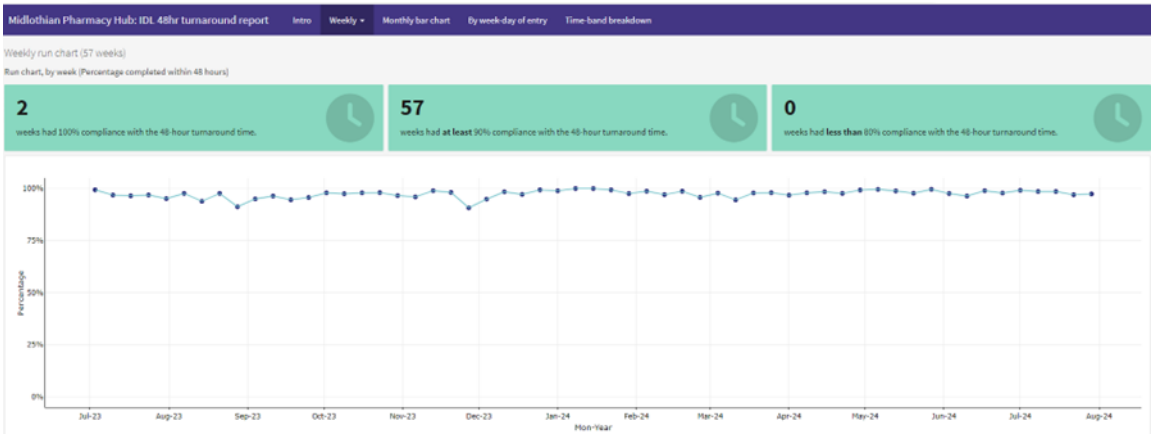
- Introduction of second check paperwork ensuring 'fresh pair of eyes' review of administration record (Kardex) after each drug round
- One-to-one training on medication administration and policy for all nursing staff in MCH facilitated by Clinical Educator and Pharmacy Technician (ongoing, fully complete on rehabilitation and step down wards which were prioritised due to higher risk areas)
- Focussed communication on medicine administration in line with Datix trends
- Liaison with medical staff to ensure prompt rewriting of kardexes and improved communication regarding changes in medication

The availability of Hospital Electronic Prescribing and Medicines Administration (HEPMA) within MCH would mitigate for or further reduce these events - therefore its absence remains on Midlothian's risk register.

The MHSCP Pharmacy Service has member of staff in every practice in Midlothian and the Immediate Discharge Letter (IDL) Medicines Reconciliation Hub ensures that all IDLs in Midlothian are completed within the SPSP target turnaround time of 48hrs (Figure 6).

Pharmacists and pharmacy technicians systematically undertake all medicines reconciliation for all Midlothian patients discharged from hospital. This ensures that any changes made to a patient's prescription during a hospital stay are promptly and accurately assimilated into the patients ongoing (repeat) medicines list in practice systems. Many of these patients will receive a phone call or text from the pharmacy staff, informing them of any changes with the aim of improving safety, reducing errors and improving concordance.

Figure 6: Midlothian Pharmacy IDL Hub Turnaround Performance



Frailty

During 2024 the Professional Leads have been working to engage relevant stakeholders and identify potential opportunities for a new system-wide Frailty pathway in Midlothian, founded on the principles of Realistic Medicine. A Quality Management approach has been taken to this complex work with our stakeholders to understand what currently or historically not worked well or is presenting barriers to change, including the provision of safe care for elderly & frail people.

Ecosystem mapping has allowed us to capture a high-level view of how eight current key stakeholder resources connect and how a typical person's journey may traverse or fall through that network. (In-patient Rehab Team, Sport & Leisure Wellbeing Team, Community Treatment and Care (CTAC), Midlothian Assessment and Rehab Service (MART), Older People Social Work Team, Hospital at Home, General Practice Advanced Physiotherapy Practitioner Team, and VOCAL). Subsequent to this, the use of design methodology and tools has allowed us to define 4 main areas of focus to progress to co-design with patients and carers and then initial testing and measurement.

It is anticipated that the universal use of Rockwood Frailty Score assessments and its common language, which can be understood and applied by all professionals and services, will be the key intervention to unlocking access to a sliding scale/spectrum of integrated resources depending on a person's stage of frailty (rather than just their age), allowing them to more seamlessly move across traditional service boundaries and silos

without repeated referrals and re-assessments. This will also help move balance of frailty resource and supported intervention back to prevention and early intervention. Over time, a programme of community engagement and the development of digital solutions (including a Frailty passport) will also underpin and support this approach.

Recognition of the Deteriorating Patient

Healthcare Support Workers (HCSWs) at Midlothian Community Hospital (MCH) have been engaging in an education programme, the Vital Signs knowledge framework, delivered to support the early recognition and escalation of the deteriorating patient. All HCSWs at MCH have been offered this training with uptake leading to 85% now being compliant with the skillset.

The introduction of News on Trak and the recording of National Early warning scores (EWS) on TRAK has increased the completeness of observations - no EWS score can be produced without complete set of observations. The benefits of this approach include increased accuracy of EWS scoring, reducing risk of human error in calculation, increased reliability of EWS completed on time (frequency) with alerts to time observations due / overdue. The resulting increased ease and clarity of documentation supports timely escalation to an appropriate clinical responder using escalation functionality built into the system.

Assurance is providing by each ward monthly through the Person-Centred Assurance Tool (PCAT) and 6 monthly through the Lothian Accreditation Care Assurance Standards (LACAS) Deteriorating Patient Standard. In the most recent LACAS cycle MCH obtained an average of 93% compliance with the standard and can provide moderate assurance for the Deteriorating Patients standard.

Management of safety and risk – Midlothian Community Hospital

Lothian Accreditation and Care Assurance Standards (LACAS)

The most recent cycle of LACAS was completed in July. All 5 in-patient areas at Midlothian Community Hospital submitted a completed LACAS self-assessment for this cycle. Awards are detailed in Table 4

Table 4: Midlothian Community Hospital LACAS

	cycle	July 2024 award
Edenview	7	Gold
Loanesk	7	Gold
Glenlee	6	Gold
Penny Lane	5	Silver
Rose Lane	5	Gold

The findings provide evidence of the quality of care from bedside to Board. The report released on Monday 19th August 2024 proposed that ‘Moderate Assurance’ is provided

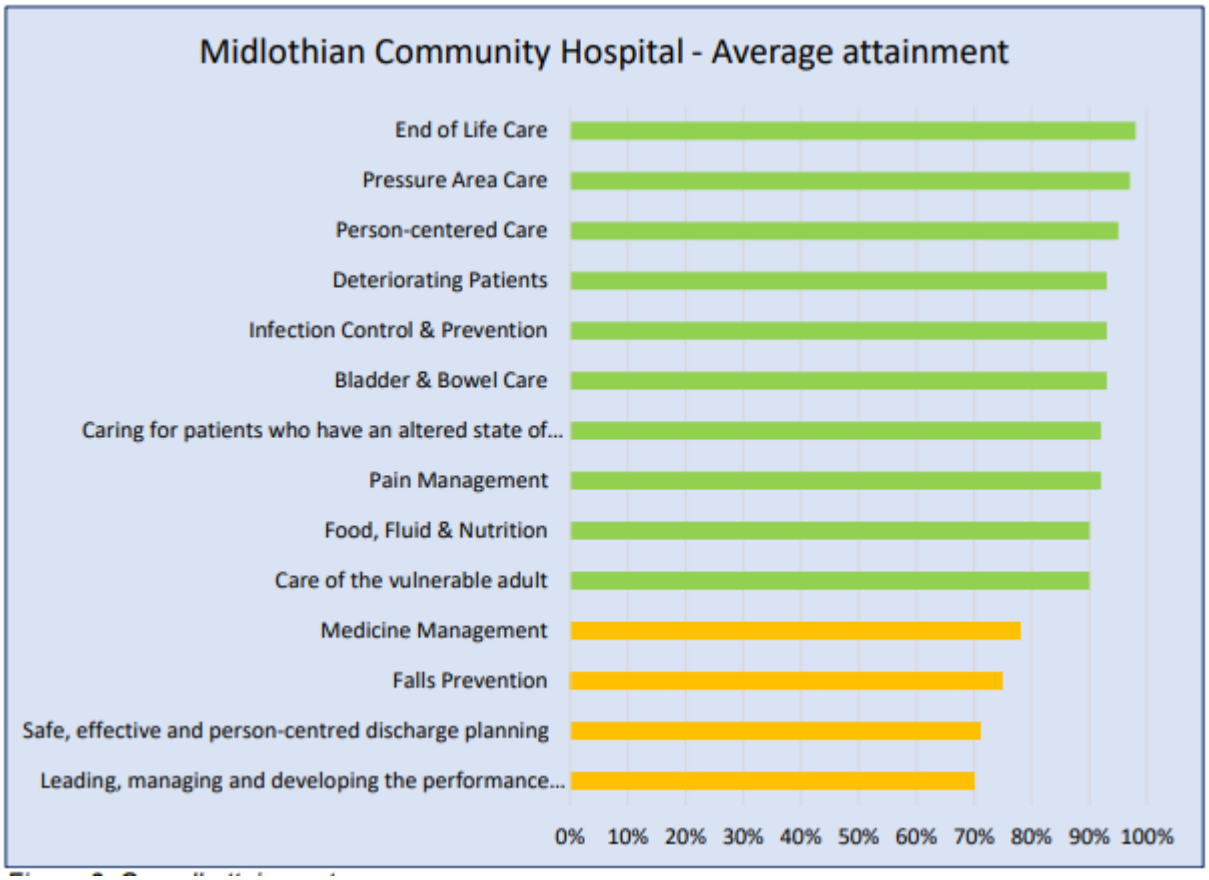
that there are systems and process in place to deliver the LACAS Programme – this position has been maintained from last year. The report further suggests that 'Moderate Assurance' can be provided that consistent high-quality person-centred care is being delivered across all Adult Inpatient Areas at this time. This is an improved position from the July 2023 report where limited assurance was provided. Table 5 evidences the progress across the 5 ward areas since LACAS was introduced.

Table 5: Ward Cycle trends

Midlothian Community Hospital	Cycle 1	Cycle 2	Cycle 3	Cycle 4	Cycle 5	Cycle 6	Cycle 7
Edenview	Bronze	Silver	Gold	Bronze	Silver	Gold	Gold
Glenlee		Bronze (C1)	Silver	Silver	Silver	Gold	Gold
Loanesk	Silver	Gold	Gold	Gold	Gold	Gold	Gold
Rose Lane		Bronze (C1)	Silver	Bronze	Bronze	Silver	Gold
Penny Lane			Silver (C1)	Bronze	Bronze	Bronze	Silver

This LACAS review cycle has again identified clear themes in good practice and areas for improvement, which will continue to inform quality improvement priorities at ward and hospital site level. Figure 2 illustrates the average attainment across the hospital in relation to the LACAS standards. The report states that a high standard of care was again observed across all wards which was evidenced during the Ward Observations visits. There is an opportunity to share good practice and learning from teams who achieved a moderate level of assurance in certain Standards. The wards will now be supported to complete an improvement plan based on their LACAS results and supported by the Lead Nurse to identify improvement priorities and change ideas.

Figure 2: Midlothian Community Hospital Average Attainment LACAS Standards July 2024



Associated with the LACAS programme, weekly reports are provided to the Chief Nurse and Integrated Service Manager on the completion of standard risks assessments for in-patients at Midlothian Community Hospital. These ensure management oversight of coverage and currency of inpatient risk assessments recorded on Trak. This has promoted focused discussion with Senior Charge Nurse meetings resulting in improved performance in the completion of risk assessments across all domains in all 5 in-patient areas.

Management of Safety and Risk – Clinical and Care Governance Processes

Service Managers articulate key service level risks and mitigations in their quarterly QMG submissions. Recruitment and retention is cited in the majority as a key risk to the delivery of safe and effective care, as is staff sickness absence. Continued appropriate risk assessment and escalation is identified as a key activity to drive the delivery of safe and effective care and is now a legal requirement as a result of the enactment of the Health and Care Staffing legislation in April of this year.

An overarching concern in Midlothian is the growth of the population and the mismatch between resources and demand. The HSCP is driving a Digital Strategy and Transformation Programme as part of the strategic response to these overarching challenges. General Practitioners cite population growth, increasing activity, and shrinking revenue combined with a freeze on capital spending for premises as combining to generate significant risk to GP practice sustainability and ultimately patient safety if General Medical Services are reduced or compromised. More generally, managers cite uncertainty around financial constraints and the prospect of service redesign and organisational change as impacting on staff morale.

Discussion takes place at the CCGG to support appropriate used of risk registers and understanding of thresholds for escalation for these and other issues which are beyond the day-to-day influence of service managers to change and control.

The most recent quarterly templates provide some examples of the safety issues recognised by Service Managers and of work being undertaken across services in Midlothian HSCP to improve safety in relation to these risks:

- **Pharmacy:** changes to drop down menus to reduce errors in drug selection
- **Vaccination service**: Staff training and review and development of Standard Operating Procedures
- **Health Visiting**: Implementation of the Neglect Toolkit and training in Infant Behavioural Observation
- **General Practice**: Primary Care Improvement Plan and a 5-year Operational plan to support and maintain patient access using new approaches and maximising the deployment of skills within multidisciplinary teams

- **District Nursing**: Local and Pan Lothian Review to deliver sustainability, including a quality improvement project around the model of care for patients with Type 2 Diabetes, new referral process and 'paper lite' approach.
- **Adults with Complex and Exceptional Needs Service (ACENS):** redesigned pathway to the commencement of tracheostomy – ventilation for patients with Muscular Dystrophy
- **Midlothian Community Hospital**: Work to address out of hours medical cover with development of an updated Advance Nurse Practitioner model; continued escalation of risks associated with lack of access to HEPMA
- **Mental Health and Substance Use**: Focussed work to improve documentation as a result of improvements in recording in clinical records being recognised as required through SAERs; Implementation of MAT standards 6-10
- **Physiotherapy:** Competency mapping for Advanced Practice
- **Dietetics**: contributing to strategic development SLWG for pathway for type 1 diabetes and work with Diabetes Specialist Nurses on insulin pump titration protocol

Effective Care

Midlothian HSCP's Clinical and Care Governance Framework promotes an evidence-based approach to the delivery of care and has been in place for just over a year. The Partnership recognises the need to work to improve the quality of evidence available from these reports, and to develop some from a very descriptive approach to the consistent provision of data on activity and impact.

The most significant factors impacting on the delivery of effective care cited within the quarterly reports relate to demand exceeding capacity, resulting in waiting lists for treatment or care. Action plans are in place to address waiting lists for the Weight Management Service (Dietetics), Attention Deficit Hyperactivity Disorder Diagnosis (Adult Mental Health), and Musculoskeletal Physiotherapy.

Midlothian HSCP is participating in the Pan Lothian District Nursing Review, with specific local workstreams related to financial deficit aligned to that work. A number of productivity workstreams are underway and planned to release time to care and support the delivery of the most effective care on the principle of right person, right care, right time. This includes a new referral system, testing of paper lite approaches, and considering skill mix, education and workforce planning for future needs.

A successful project delivered in partnership with Pharmacy has delivered a streamlined, cost effective and clinically effective pathway for wound dressing selection by the district nursing teams in Midlothian has resulted in £61k of savings since the start of the project. Additionally, prompt access to the required dressings has allowed the district nursing service to make more timely interventions for patients. This, in combination with education sessions supported by the tissue viability nurse has resulted in an improvement in the care of patients. The model developed in Midlothian

is currently being spread to the other HSCPs in the Lothians through supported project management from the corporate Sustainability and Value Team.

The Mental Health and Resilience Service previously open to only people under 65 is now available to adults of all ages, ensuring same day self-referral access for anyone who resides in Midlothian – aged 18+ and seeking support with their mental health and mental wellbeing. This service works in partnership with Penumbra, offering crisis support, and distress brief interventions in social crises.

The mental health service has recognised and seeks to address the known impact on health outcomes for people with enduring mental illness. Clinics are established to provide holistic, whole person health and wellbeing support to patients receiving lithium and clozapine treatment. A lithium clinic for patients who prefer not to attend their GP has been established.

Dietetics are delivering service improvement initiatives across multiple specialities, including prehabilitation, seeking funding for expanding provision in oncology, provision of input to the endometriosis service, review of Irritable Bowel Syndrome pathway, education for mental health staff at the Royal Edinburgh Hospital and extensive improvement work in paediatrics.

Person Centred Care

Complaints

All Midlothian HSCP services have a formal complaints procedure which is advertised and made available to patients on their request, and a standardised process is followed to deliver a response to the complainant within set time scale. Local systems for oversight and scrutiny aim to ensure responses to concerns and Stage 1 & 2 complaints meet the Scottish Complaints Ombudsman's targets. Data and analysis of MHSCP complaints I located in Appendix 2a.

GP practices handle their own complaints separately, and complaints made about MHSCP services made via Midlothian Council are not reported to NHS Lothian; neither are included in this data.

The Director and Chief Nurse receive a weekly report on performance in complaints handling. Actions to address any issues causing delays in investigating and responding to complaints are prioritised, ensuring a timely response is provided to concerns people have raised about care provided. SMT receives an update on complaints performance for each meeting and MSEAG undertakes a quarterly overview of performance which is submitted to SMT and ELT.

Although numbers are generally low, an increase in complaints received by Midlothian HSCP has been observed in 2023-24 with the median monthly number of complaints rising from 2 to 5. In addition to the pattern observed over previous years of a number

of individual complaints across a number of different services themed around treatment, staff behaviour, and communication, the increase reported is largely attributable to complaints about the Attention Deficit and Hyperactivity Disorder (ADHD) diagnosis and treatment pathway for adults in Mental Health Services, and waiting times and access to medications on the weight management pathway in Dietetics. Both these services have a degree of profile within the media and complaints received are potentially associated with news coverage. An analysis of complaints handling performance data is provided in Appendix 2a.

Recurring themes in complaints across all services relate to concerns about staff behaviours, arising from individual consultations/interactions. These are dealt with individually with the practitioner involved. However overarching work on the Midway equipping staff with interpersonal skills, support through 1-1 supervision, personal development planning and appraisal, and the Staff Wellbeing Programme, are activities that seek to deliver improved experience for staff and by implication, for people who use our services.

The quarterly QMG templates submitted detail across a number of services that seek to improve patient experience and deliver a person-centred approach.

No 11 has established a panel for people who have used MHSCP services. This is organised in conjunction with Community Advocacy Project (CAP) and ensures the voice of people with lived experience informs service provision and planning. Similarly peer workers employed by Health in Mind are based within mental health and substance use services and co-located with health and social care professionals to provide a supportive presence for people attending appointments and who arrive seeking support across their treatment and recovery journey.

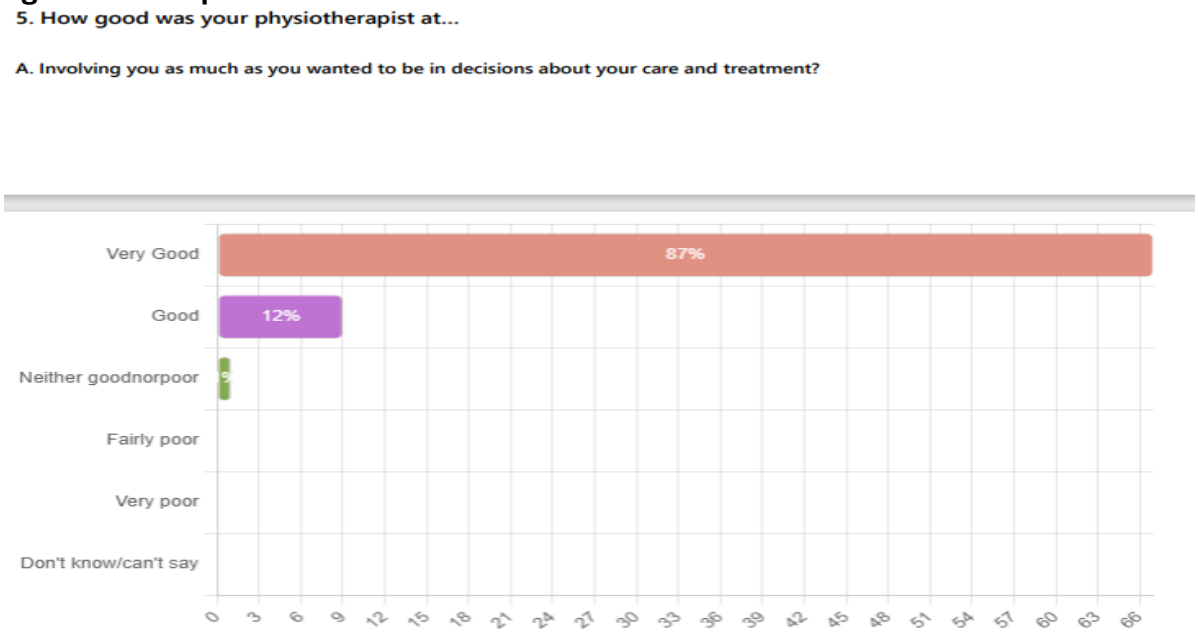
Close working relationships are maintained with the Carers Organisation VOCAL to provide direct support and staff training. This aims to provide relevant support information and advice to the families of people using mental health and substance use services. A group has been established for the carers of people with dementia to provide support, access to advocacy and to build relationships and provide a voice that can shape services.

The Musculo-skeletal Physiotherapy Service and the GP practice-based Advanced Physiotherapy Practitioners are deploying a new way of gathering Patient Reported Experience Measures (PREM) using the JISC survey platform. Data is collected around a range of experience measures which is being utilised to inform service delivery and planning. Domains being measured include:

- ease of arranging appointments,
- extent to which patients feel their needs were met,
- the quality of information shared about the patient's condition and self management advice,
- involvement in decisions about care and treatment (see Figure 3 below),

- feeling listened to
- Explaining things in a way the patient could understand.
- Having enough time
- Being treated with care and concern
- Satisfaction with extent to which care was coordinated/joined up with other departments
- More general health advice
- What the service did well
- What could have been better

Figure 3: Example of PREM data



This is

District Nursing Team Leaders have been testing a change to gather feedback about the experience of receiving the District Nursing Service. A telephone questionnaire was developed by Team Leaders who contact recently discharged patients from a colleague's caseload to provide a degree of objectivity. Whilst this requires time and has been found to be achievable only when other pressures and priorities permit, this has provided helpful positive feedback that supports morale and builds confidence across the service to engage with patients and their families helping to drive service improvement and change and ever more person-centred approaches.

The Health & Care Experience (HACE) survey 2024 reports that despite the challenges of the past year with securing ongoing General Medical Services at Danderhall, and restrictions on premises and capacity at Bonnyrigg Health Centre due to Legionella Species last year (now resolved), overall patient satisfaction with the care provided by their General Practice in Midlothian has increased to 68%, from 62% in 2022, and satisfaction with arrangements to speak to a doctor has increased to 61%, from 56% in 2022. Performance is now similar to the average across Scotland. This improvement

has been achieved through a planned improvement programme after the last HACE results, consisting of HSCP support via development of the Primary Care Improvement Plan multidisciplinary services, patient-facing communication and supported self-management campaigns, and collaborative projects with GP practices to improve continuity of care and demand/capacity management.

2.3.2 Workforce

Oversight of staffing

The availability of the right number and skill mix of clinical and care staff is fundamental in the delivery of safe, effective, and person-centred care.

Midlothian Community Hospital (MCH) operates a daily safety huddle led by the hospital's Coordinating Charge Nurse. The meeting reports to senior management an assessment staffing across the multi-disciplinary team and the alignment of that capacity to the demands, needs, acuity and risks across the 5 in-patient areas for the next 24 hours. This feeds into the completion of the online Safecare tool which is linked to the Healthroster system. MCH's compliance with the Safecare staffing tool is monitored and is consistently reported at above 90%, and in the second week of August 2024 was 100%. Safecare compliance is a key contributor to the common staffing method as an element of delivering the requirements of health and care staffing legislation, and is monitored by the Integrated Service Manager and reported to the Chief Nurse.

No other service areas within the Partnership have a real time staffing tool available at this time. However, local experience of managing workload and staffing pressures during the Covid-19 pandemic enhanced local practices in collating and reporting staffing information. Various methods are employed, with some community teams utilizing technology as an alternative to in-person meetings to operate staffing 'huddles'. Daily 'Prepstat' reporting commenced in December 2023 and has evolved from a brief daily virtual meeting to routine online reporting and an agreed escalation process for exceptions requiring senior management support and mitigating actions. All services within the Partnership engage with Prepstat reporting. This provides an ongoing picture of staffing and demand pressures as an adjunct to the utilization of staffing and workload tools.

Health and Care (Staffing) (Scotland) Act 2019

Midlothian HSCP has established an Integrated Workforce Governance Board with Workforce Planning and Workforce Engagement subgroups. These support overall work to ensure plans are in place to deliver workforce plans that ensure the delivery of safe staffing levels across all our directly provided services. The Board has directed work to provide assurance and information around the duties and implications of the 'Safe Staffing' legislation including a benchmarking exercise was undertaken to support the provision of assurance around the implementation of the legislation within Midlothian HSCP.

Reduced Working Week

The 2023/24 pay settlement included agreement that all NHS staff employed under Agenda for Change (AFC) will reduce their working week in a phased manner from 37.5 hours to 36 hours (or proportionate change for part time employees) over the next 3 years to support improved wellbeing.

This change is being implemented in a planned and phased way to ensure patient and staff safety. Considerable work is ongoing to devise approaches that will ensure safe staffing can be maintained. NHS employed clinical staff in MHSCP continue to work the hours contracted prior to April 2024 with a transitional allowance being paid to reflect the agreement reached while the planning required to ensure services have staffing levels and working patterns that ensure safe care.

Implementation will be progressed in line with NHS Lothian guidance. Work continues to scope out , risk assess and plan mitigations for the impact of reduced staffing hours on levels of service provision and to address the gaps that the reduction in the working week will create.

TURAS

Midlothian HSCP is committed to investing time and workforce into monitoring and promoting the benefits of positive conversations around appraisals.

The MHSCP Executive Business Manager attend the NHS Lothian Appraisal Champion Board. Participation offers significant benefits by creating a dedicated platform for ensuring consistency and enhancing the appraisal process across the board area, ensuring that appraisals are aligned with organisational and partnership goals, professional development needs and regulatory requirements. It promotes a culture of continuous improvement, providing our workforce with clear feedback, support, and career development opportunities. Through involvement in sharing best practice and addressing challenges collectively, MHSCP is committed to improving the quality of appraisals leading to increased staff engagement, job satisfaction and retention, ultimately contributing to better care and a more resilient workforce.

Midlothian HSCP is working to improve appraisal completion rates and work is progressing to review the local TURAS data and complete a data cleanse to support improved reporting accuracy. A number of data anomalies have been identified that are corrupting the overall compliance figure reported. This is being investigated and learning will be shared as the work progresses.

Sickness Absence

Midlothian HSCP is engaging with NHS Lothian's Sickness Absence Board which has been convened to provide a structured forum supported by Employee Relations practitioners to promote more consistent and effective absence management. The Board discusses and seeks to address the underlying causes of employee absences, promotes early intervention and wellbeing for staff, and aims to prevent absences and quicker recovery and return to work. The collaborative approach fosters a culture of transparency and support, improving employee wellbeing and morale.

Midlothian Health and Social Care Partnership plans to convene a local Absence Management Group to monitor and address local absences to deliver improved workforce stability, enhanced service delivery and improved overall organisational wellbeing.

Staff Wellbeing

Staff Wellbeing Delivery Plan (2021-24) continues to be implemented with the aim of developing innovative solutions to improve and support staff wellbeing, for both NHS Lothian and Midlothian Council staff within Midlothian Health & Social Care Partnership. The plan covers the domains of engagement, communication, access to support, leadership, mental wellbeing, and environment.

Previous initiatives included work to ensure all community-based staff can access essential facilities, a range of health awareness and health promoting activities, work to develop the availability of peer support and to improve awareness and uptake of mental health and wellbeing services. Over the past 12 months the partnership has enhanced the environment through the addition of nine wellbeing spaces including the staff courtyard at the community hospital. the corridors at MCH have brightened and the talents of service users highlighted by displaying bespoke artwork. Opportunities have been created for staff to come together for a nutritious meal at 19 soup stops, and openly encouraged spontaneous acts of kindness through café baskets, the donation of over 50 gift boxes, and sharing 200 cups of kindness. This year MHSCP continues to proactively support staff through the psychological and emotional demands of their job by offering the first Staff Mental Wellbeing workshops in addition to mindfulness, team wellbeing sessions, and one to one peer support and coaching.

Listening to Feedback

A range of mechanisms are in place to hear staff experience including team meetings, leadership walk rounds, iMatter and exit questionnaires. NHS Lothian Partnership and Midlothian Council Staff Side representatives attend and contribute to Senior Management Team. A regular Partnership meeting, chaired by the lead Partnership representative, ensures a specific focus on staff experience and views. A leadership Forum in December 2023 focused on effective collaborative working in order to achieve strategic priorities and deliver operational goals and another forum will take place this autumn.

Communication and Engagement

Awareness has developed of issues that are important to our staff group and of work needed to support improved staff engagement. Our teams continue to face ongoing challenges of workforce pressures, increasing demand and complexity in the context of significant financial constraint and uncertainty. The overall Midlothian HSCP iMatter score from the survey reported in July 2024 was 78, with an increase in response rate from the previous year.

A Communication and Engagement Strategy and a Communication Plan was developed and implemented to deliver a more cohesive approach, offering staff across the partnership opportunities to identify how they would like to give and receive information. While Executive Team members are regularly 'out and about', this refreshed approach has created some opportunities for front line practitioners to meet and discuss their experience of delivering care to people in Midlothian with Senior Managers.

The EMT is committed to a culture of psychological safety where staff feel able to raise concerns about the quality and safety of care. In the event that a member of staff felt unable to speak out, concerns can be raised through Partnership representatives, direct contact with the professional leads (Chief Nurse, Clinical Director, Chief AHP, or Chief Social Work Officer), or alternatively through NHS Lothian 'speak up advocates'. If all other routes are exhausted, the formal whistleblowing procedures of NHS Lothian or Midlothian Council can be used to provide a confidential route for concerns to be raised.

Whistleblowing

In May 2023 a Whistleblowing concern which related to Financial and Corporate governance practices and processes and the implementation of policies and procedures within Midlothian HSCP was raised. Actions progressed following the completion of the investigation are based on ensuring the delivery of organisational best practice.

Financial Governance

- Development of a register of standard operating procedures.
- Staff refresher on PECOS purchasing system and procedures
- Review of Authorised Signatory Database in line with NHS Lothian financial plans

Corporate Governance

Utilisation of space within Midlothian: capacity reviews were initiated for GP premises across Midlothian in 2023/24. This work will be extended to cover all premises in Midlothian to understand both outpatient needs and staff requirements with the aim to developing a premises management approach that ensures premises capacity to support service delivery and staff wellbeing.

Implementation of Policies and Procedures

Developing a review process for all Standard Operating Procedures within Midlothian Health and Social Care Partnership.

Speak up Week

Speak Up Week runs from Monday 30th September until Friday 4th October 2024 and the theme for this year is 'Enabling Speaking Up'. The premise of the week is for staff to have increased awareness, feel engaged and energised with a renewed commitment to the healthy culture of speaking up. Activities during the week will encourage discussing topics including leadership and whistleblowing culture, access to the whistleblowing process, psychological safety, understanding the experiences of all those involved in speaking up, and building trust.

2.3.3 Financial

There are no financial impacts arising from this report, however the committee should note the challenging financial position related to budget allocation, demand and demography in Midlothian, and the subsequent anticipated impact on performance and delivery.

2.3.4 Risk Assessment/Management

Midlothian Health and Social Care Partnership has a well-established Risk Management process in place with routine oversight and governance through Senior Management Team and Executive Leadership Team Meetings. This ensures that risks are captured at the appropriate level and Senior managers have a comprehensive view of all significant risks across the organisation. Risk mitigation aligns with NHS Lothian's corporate risk register to provide a coordinated and proactive risk management strategy for the organisation.

No new risks have been added to the NHS Lothian Corporate Risk Register this year. Local operational risks are captured in the Midlothian Partnership Risk Register, which is updated and reviewed regularly, and high risks are escalated to the NHS Lothian Corporate Risk Register.

Midlothian HSCP has notified NHS Lothian of two new high-level risks this year, but due to mitigation plans being in place locally, they have not been escalated to NHS Lothian Risk Register. These risks are summarised below, with detail provided in Appendix 6.

5716 – Workforce

Risk identified in relation to HSCPs ability to deliver on all aspects of the HSCP Integrated Workforce Plan 2022-25
This is in the context of a national workforce crisis and continuing and complex influencing factors both locally and nationally.

3612 – Finance

Risk that the HSCP may not deliver financial balance

The financial situation faced by the Integrated Joint Board (IJB) in Midlothian has reached a critical point, as evidenced by the quarter one forecast projection of approximately £9 million overspend in the 2024/25 financial year.

Within the IJB health budgets there is a projected overspend of £2.3m with the key drivers being Prescribing (£1.2m) & Set Aside (£0.6m).

In the 2024/25 financial year the IJB has no general reserve. The absence of general reserves means the IJB cannot rely on previously accumulated funds to cover this deficit.

This situation necessitates the development and implementation of comprehensive financial recovery plans and transformation of services to ensure both financial sustainability and the continued delivery of high-quality care.

The Financial Recovery Plan process is ongoing, but continued increase in demand has led to the requirement to identify additional actions and this process in ongoing.

All plans are thoroughly assessed to evaluate their impact on staff, patients, and Midlothian's capacity to deliver safe, effective, and patient-centred care. As part of this evaluation, mitigating actions are carefully developed to minimise any potential adverse effects, ensuring that the recovery plans are implemented with the least possible disruption.

HSCP mitigation plans continue to contribute to the following ongoing risks on the NHS Lothian Corporate Risk Register:

Risk 5186 - Emergency Access

Midlothian HSCP has put in place strategic and operational mechanisms to mitigate risks associated with access delays. The Midlothian HSCP Flow app provides oversight of every Midlothian resident in the Emergency Department, or a hospital bed. Real time actions are agreed and progressed to ensure people are receiving care in the most appropriate setting, as close to home as possible, ensuring all possible avenues to support emergency access across the whole system are secured by local action in Midlothian.

Risk 5187 - Hospital Bed Occupancy (Previously Timely Discharge of Inpatients)

Midlothian continues to deliver substantial infrastructure to support clinically effective 'Home First' pathways which provide care as close to home as possible and thereby mitigate risks associated with inappropriate hospital bed occupancy. Midlothian remains fully committed to the NHS Lothian programme of work on Unscheduled Care which is delivered through integrated, multiagency approaches which link with third sector capacity and carer support.

The Flow App described above has further enhanced the work of the MHSCP 'Flow Team, ensuring in-patient admissions to acute services are identified, tracked and actions in place to support progress through their care pathway. This includes identification of patients who can receive their treatment at home under the care of the Discharge to Assess (D2A) or Hospital at Home (H@H) or other teams, or nearer to home in Midlothian Community Hospital or Highbank Intermediate Care Facility.

The Discharge Without Delay (DWD) workstream continues to be progressed within Midlothian Community Hospital. Daily multidisciplinary (MDT) rapid rundowns enable identification and ownership of the tasks required to facilitate discharge, facilitated by locally designed discharge planning boards in each in-patient area. A continuous

improvement approach has been adopted ensuring that learning continues to contribute to pathway and service improvements. Effective information sharing and communication, including clear and consistent messaging with patients and families around discharge planning to set expectations appropriately, continue to be a key contributors to reduced length of stay.

At a national level A Collaborative Response and Assurance Group (CRAG) has been convened and Midlothian's improvement is in line with the required trajectory with further improvement anticipated.

Risk 3829 – Sustainability model of General Practice

A comprehensive analysis of the progress and risks associated with sustainability of the model of General Practice in Midlothian has been undertaken, with the Integrated Joint Board's oversight. The Primary Care Improvement Plan (PCIP) also has the oversight of NHS Lothian's Director of Primary Care and the GP-subcommittee of the LMC.

The latest revision of the Midlothian Primary Care Improvement Plan was reviewed earlier this year, and funding continues to prioritise support of the priorities identified by the Scottish Government in its second Memorandum of Understanding (MOU2). All vaccinations have now been transferred to the HSCP. All 11 practices have access to the Midlothian Pharmacy medicines reconciliation Hub with >95% of all immediate hospital discharge letters being dealt with within 48 hours delivering obvious safety benefits for patients, as well as practice-based pharmacist support. All practices also have access to practice-based Community Treatment And Care (CTAC) and phlebotomy services. Following a recent adverse event relating to the unsupervised administration of a medication, a full review of the service is taking place, with the development of a detailed improvement action plan, progress against which will be monitored by the HSCP professional leads via the MSEAG and CCGG groups. Although Musculoskeletal Advanced Physiotherapy Practitioners (MSK-APP) are not one of the Scottish Government's priority workforce group the HSCP has committed to retaining funding in place as the service is highly valued by local GPs: 93% of cases are managed without further GP input once seen by physiotherapist. Funding (60% supplemented from Action-15) is also in place for Primary Care Mental Health Nurses in each practice, which allow direct and timely access to patients for mental health assessment, triage and signposting to the most appropriate resources or service for their needs, as well as practice Wellbeing workers (commissioned to third sector Thistle Foundation).

The rapid growth and projected age profile of the Midlothian population is more marked than the Scottish or Lothian average and is expected to create considerable challenges for local mismatch between demand and capacity in Primary Care over the next 10 years. An operational plan to mitigate for the risks to patient access to general medical services is in place, and a practice sustainability risk matrix (including weighted scorings for list size growth, aging population, deprivation, workforce vacancies, and premises limitations) is used to help identify practices at risk and allocate appropriate support and resources, including the allocation of GMS-funded list expansion grants (LEGUPs). A detailed impact assessment and premises plan is in place to mitigate for the current

pause in Scottish Government capital premises funding for new GP practice premises, focusing primarily on the Shawfair area, and then the South Bonnyrigg/Rosewell area. And a standardised practice business continuity plan for all 11 practices will ensure the effective and safe coordination of patient access to general medical services in the event of any acute premises restrictions in future.

Primary Care sustainability and capacity of to meet increased demand due to increasing population, age, and frailty will remain on Midlothian's HSCP risk register, as predicted population growth is significantly higher than the rest of Lothian.

Two unresolved, moderate risks at Midlothian Community Hospital persist:

- **5652 – No HEPMA**
- **5430 – OOH medical cover**

MCH is the only community hospital site which does not have the Hospital Electronic Prescribing Management Administration (HEPMA) system, as central funding was not allocated for its provision. This creates a risk, due to variation in process, that medication errors and medication-related harm occur during the transcription of HEPMA information to paper kardexes prior to transfer of patients from acute sites to Midlothian Community Hospital (MCH), or that a patient is transferred without a kardex at all. Staff have been fully briefed regarding the potential risk of transcription errors and encouraged to make duplicate checks etc, but this control is not completely reliable and does not effectively manage the ongoing risk which is evidenced by reported medication errors.

Current out of hours (OOH) medical cover at MCH is via Lothian Unscheduled Service (LUCS) GPs, apart from overnight which is provided by the Hospital At Night (HAN) service. However, LUCS GPs may not be on site, often cannot access to patient medical records on TRAK and may not have necessary competencies to provide necessary treatments. This creates a patient safety risk of delayed or potentially inappropriate treatment for deteriorating patients or requiring admission/transfer to an acute site. To mitigate this risk, admission criteria based on LUCS competencies has been tested and implemented by the Midlothian Flow Hub to control the acuity of patients being transferred from acute sites.

All other ongoing key risks have been reviewed in the last year, and have appropriate mitigations and governance in place, as described elsewhere in this report.

2.3.5 Equality and Diversity, including health inequalities

There are no new actions arising from this report which would require the completion of an impact assessment.

2.3.6 Other impacts

Not applicable

2.3.7 Communication, involvement, engagement, and consultation

There are no changes proposed within this paper which would have a negative impact upon people who use our services. The committee should take assurance that the HSCP maintains an active dialogue with key stakeholders and consult on service changes as required.

2.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Midlothian HSCP Executive Leadership Team 19 August 2024
- Midlothian Safety and Experience Action Group 20 August 2024

2.4 Recommendation

Assurance – The Committee is asked to agree and accept **moderate** assurance that MHSCP has comprehensive systems in place to deliver safe, effective and person - centred care based on the evidence presented that controls upon which the organisation relies to manage the risk(s) are in the main suitably designed and effectively applied. A moderate amount of residual risk remains, as described in this paper; where further action is required; clear actions have been identified and plans are in place; in some instances the residual risk is greater than “insignificant”.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 Service Scope

Appendix 1-
Midlothian -Service sc

- Appendix 1a Service Scope NHS Lothian Dietetics (Hosted)

Appendix 1a
Midlothian Service Sc

- Appendix 2 Service Assurance Mapping Appendix Table

Appendix 2 -
Midlothian HSCP- Ass

- Appendix 2a Service Data for Healthcare Governance

Appendix 2a MHSCP Data for Healthcare G

- Appendix 3 MHSCP Clinical and Care Governance Template

Appendix 3 MHSCP CCGG quarterly repor

- Appendix 3a MHSCP GAF Q1

Appendix 3a MHSCP GAF Q1 2024-25 300

- Appendix 4 Drug Related Deaths in Midlothian 2023 – briefing note

Appendix 4 MHSCP 2024 DRD 2023 briefi

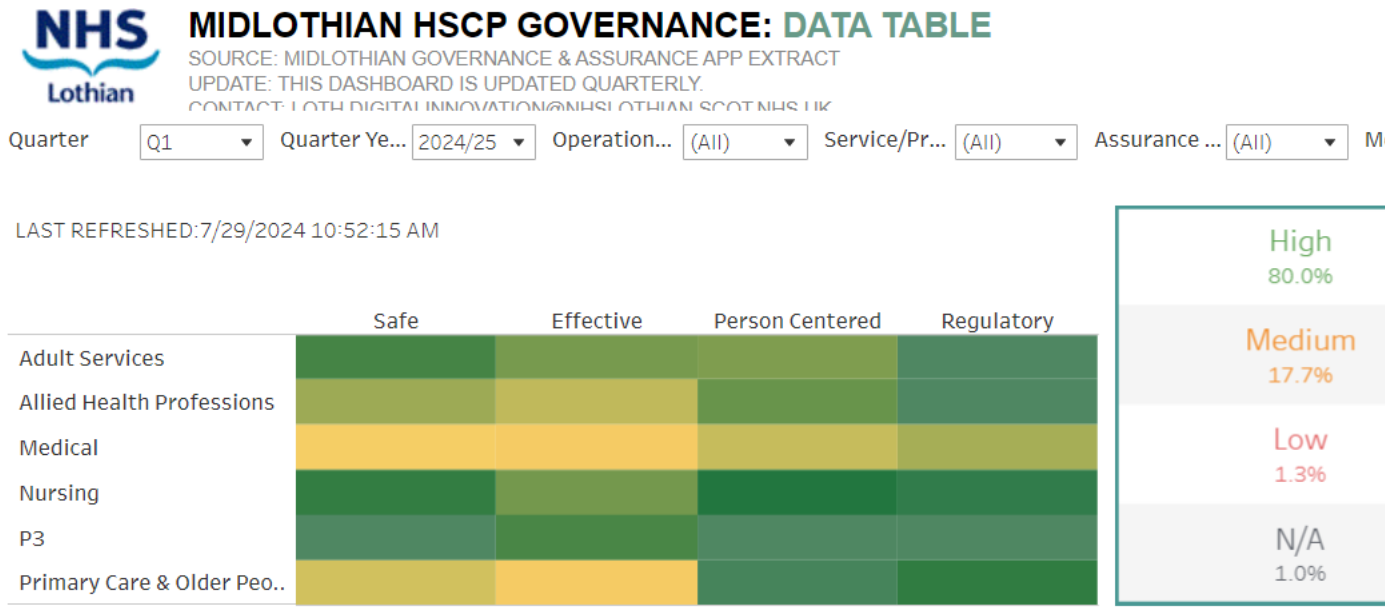
- Appendix 5 Scottish Patient Safety Programme Falls Definition

Appendix 5 MHSCP 2024 HCG falls.docx

- Appendix 6 MHSCP, New Risks on Partnership Register

Appendix 6 MHSCP 2024 New Partnershi

Appendix 3 – MHSCP Governance and Assurance Framework Overview Q1 2024/5



Midlothian Integration Joint Board

Independent Investigation of the National Health Service in England Report (The Darzi Report)

Thursday, 19th December 2024, 14:00-16:00

Item number: **5.11**

Executive summary

This report considers the recent Independent Investigation of the National Health Service in England and presents some of the key themes as they relate to Midlothian IJB for discussion.

Lord Darzi was commissioned by the UK Government Secretary of State for Health & Social Care to undertake a rapid investigation of the NHS in England that considered patient access, quality of care and overall performance. The report considers how demand for healthcare has changed, the reasons why it has risen, and examines the challenges faced across the system (appendix 1). A summary of the report produced by Carnall Farrar is also provided in appendix 2.

Although the report was written in regard to NHS England, there are many similarities to the Scottish position including challenges with integration and issues of capacity and demand. Additionally, the report raises some key themes that Midlothian IJB may wish to discuss.

Members are asked to:

- Review the Independent Investigation of the National Health Service in England (appendices 1 and 2).
- Consider some of the key themes as they relate to Midlothian IJB.
- Discuss and consider if the Board wishes to take any action in response.

Independent Investigation of the National Health Service in England Report (The Darzi Report)

1 Purpose

1.1 This report considers the recent Independent Investigation of the National Health Service in England and presents some of the key themes as they relate to Midlothian IJB for discussion.

2 Recommendations

2.1 As a result of this report, Members are asked to;

- Review the Independent Investigation of the National Health Service in England (appendices 1 and 2).
- Consider some of the key themes as they relate to Midlothian IJB.
- Discuss and consider if the Board wishes to take any action in response.

3 Background and main report

3.1 Lord Darzi was commissioned by the UK Government Secretary of State for Health & Social Care to undertake a rapid investigation of the NHS in England that considered patient access, quality of care and overall performance. The report considers how demand for healthcare has changed, the reasons why it has risen, and examines the challenges faced across the system (appendix 1). A summary of the report produced by Carnall Farrar is also provided in appendix 2.

3.2 Although the report was written in relation to NHS England, there are many similarities to the Scottish position including challenges with integration and issues of capacity and demand. Additionally, the report raises some key themes that Midlothian IJB may wish to discuss.

3.3 **Aligning strategy and resources**
Darzi notes that strategic ambitions have not been followed with the appropriate allocation of funding steams and that poor productivity in Acute services has continued to drive increasing expenditure. Despite hospital funding increasing from 47% to 58% of the NHS budget since 2006 and a 17% increase in hospital staff since 2019, Darzi notes there are 7% fewer out-patient appointments per consultant and 18% less activity per emergency department clinician. This contrasts with over 60% of all healthcare activity taking place in primary care and Darzi recommends

that financial flow is changed to sustain and expand GP, mental health & community services at a local level.

3.4 Midlothian IJB have already commissioned the Strategic Planning Group (SPG) to scope out viable opportunities to support General Practice in Midlothian and work in underway to consider a set of proposals for the Boards review. Seeking opportunities to divert resources appropriate from secondary care and ensuring people receive safe, efficient, and person-centred services close to home from the services best placed to deliver this care and support is a priority workstream to support local ambitions and national strategy.

3.5 General Practice provides General Medical Services to every person in Midlothian whenever they need them. Practices are a key first point of access for a range of health and social care issues, at relatively low cost per capita. The independent contractor model allows practices to maximise local productivity by being in control of their own resources and matching them to demand and workload as needed. The Health and Care Experience Survey (HACE) 2024 shows that access to a GP in Midlothian has improved in the last 2 years and data from the Tableau and Discovery dashboards that self-attendance at A&E with subsequent discharge home (suggesting low acuity problem) has not increased.

3.6 However, this should be viewed as a temporary position only and the Board may wish to consider how to plan for the significant pressure on health and social care that lie ahead. The rate of direct clinical activity in general practice in Midlothian is already higher than in the other Lothian HSCPs and this is unlikely to be sustainable in longer-term with appropriate review to funding. Increased primary demand from disproportionately high morbidity across a range of long-term conditions and the demand cumulating from long waiting lists for hospital services coupled with a predicted 22.9% growth in the Midlothian population over the next 10 years (and 40% growth in the over 75 years population), creates a risk to the sustainability of community services including General Practice and the provision of general medical services locally.

3.7 **Planning ahead**
Darzi highlights 3 areas of emerging increases in mortality: cardiovascular disease, cancer, and dementia. Local and national public health approaches and re-designed pathways of care emphasising the significance of preventative care and early intervention strategies will be required to improve long-term health outcomes and maximise available resources.

3.8 Although prevention is a focus of Midlothian IJBs strategy, the Board may wish to consider increasing support and resources specifically for preventative strategies that could significantly improve health and care within the community. Although it is unhelpful to evaluate prevention intervention by what they cost, there is a risk that this approach will require a range of reallocated or new resource commitments and result in agreed disinvestment in other areas or exacerbate the current financial challenges.

3.9 Additionally, the appropriate use of evidence-based medicines for the prevention and treatment of these conditions is also likely to create increased pressure on the local prescribing budget, and this should be noted as a risk.

3.10 **Wider Perspective**
The review is written from the perspective of the NHS and its underlying and underpinning principles. This leads to some useful insights, but also highlights a number of noteworthy omissions. Darzi mentions the need for accountability but does not address how the system frequently discourages ownership. The report also highlights the need for people to work together but makes no mention of the leadership styles that predicate how the system behaves and can prevent people being able to work together. Most importantly, the report notes that the focus of managers and leaders is predominately cost and measures, rather than recognising the causes of cost, and where there is value.

3.11 The mechanisms of the NHS are underpinned by the principles of New Public Management. In this context, no matter what improvements are desired, the principles of New Public Management will ultimately dictate their design and behaviour. We know the workforce will collectively behave as the 'system' drives them to with any attempt to shift this met by pressure to comply. The only solution is to remove systemic barriers and to allow the new to replace the old.

3.12 **Data quality, planning and intelligence support**
Darzi notes a step-change improvement in data quality is required and, while there are some examples of good practice, the NHS has struggled with data-sharing to improve the quality of care.

3.13 However, without well designed integrated data sets and solutions, attempting to tie pieces of the system together when they are not designed to do risks a much bigger challenge. This approach risks embedding processes that are highly inefficient and ultimately make change more difficult.

3.14 In Midlothian, data sharing across health and social care continues to be challenging. Faster progress is required to ensure data sharing agreement are in place to support the creation of an integrated health and care data dashboard with the potential to generate new insights across the system that can truly transform service delivery. Darzi is unequivocal in support for integrated, multidisciplinary team drawing insights from integrated datasets. However, without the ability to integrate data and have confidence in their interpretation, progressing the wrong initiatives remains a risk.

3.15 The Board may wish to consider how they are able to support the ambition to the and effectively utilise integrated datasets, and create population level insights that inform strategic planning, operational service design to improve outcomes.

3.16 **Opportunities for new outlooks**
Midlothian IJB has an opportunity to consider the disproportionate level of attention on data collection and analysis within the acute hospital sector. The Board may wish to consider if reporting using acute hospital metrics e.g. delayed discharges, readmission rates has contributed to a culture of “what gets measured gets managed” and the risk of what gets measured, gets funded.

3.17 There is an opportunity to consider the need for both effectiveness and efficiency, the concepts and actions we apply to understand these concepts and understand how they are distinctly different from each other.

3.18 Efficiency is easier to identify and measure, most often aiming to cut costs, or improve, but whether an efficiency is effective is more difficult to determine. Effectiveness is about understanding how well we are working, and we rarely focus on measuring this.

3.19 However, if we did invest in understanding effectiveness, we would better understand the causes of cost. If we better understand effectiveness and what creates cost, we can also reduce costs. Understanding and evaluating effectiveness also considers value, waste, variation, and outcomes (not outputs) and supports the systemic change required to drive improvement or innovation. In this context, a reductionist approach of solving individual problems is not how to either understand these concepts or drive innovation in a complex system.

3.20 There is an opportunity to consider how the Board wishes to address the challenges of working within complexity and the means by which to approach this.

4 Policy Implications

4.1 There are no implications for policy as a direct result of this report.

5 Directions

5.1 There are no implications for Directions as a direct result of this report.

6 Equalities Implications

6.1 There are no implications for people with protected characteristics as a direct result of this report.

7 Resource Implications

7.1 There are no implications for Best Value as a direct result of this report. However, should the board wish to consider any action in response to this report, identified resource and capacity and for any action must be considered and agreed by members.

8 Risk

8.1 There are no direct risks to Midlothian IJB as a result of this report. However, there are key similarities and parallels to be drawn that create opportunities to reframe the IJBs response to system pressures.

9 Involving people

9.1 n/a

10 Background Papers

10.1 None

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CONTACT INFO	Via email or MS Teams
DATE	02/10/2024

Appendices:

Appendix 1: Independent Investigation of the National Health Service in England

Appendix 2: Darzi Investigation of the NHS In England Summary

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

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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
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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

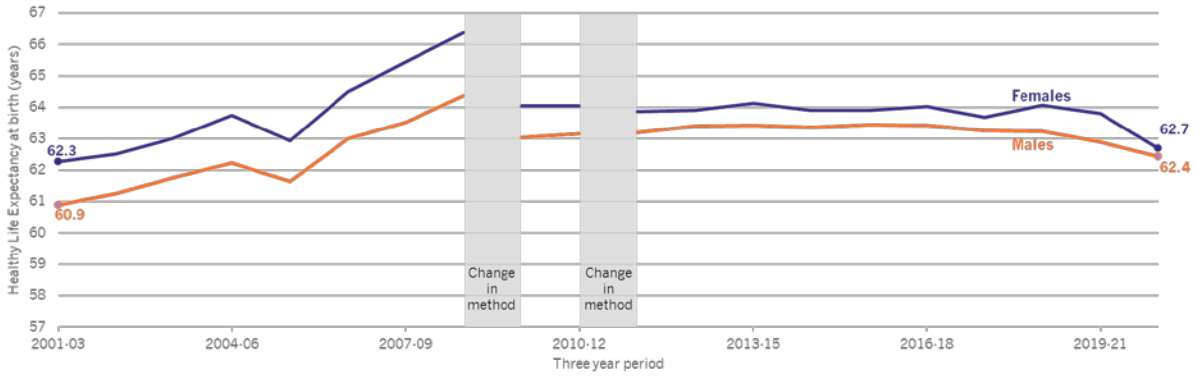
Health of the nation

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].

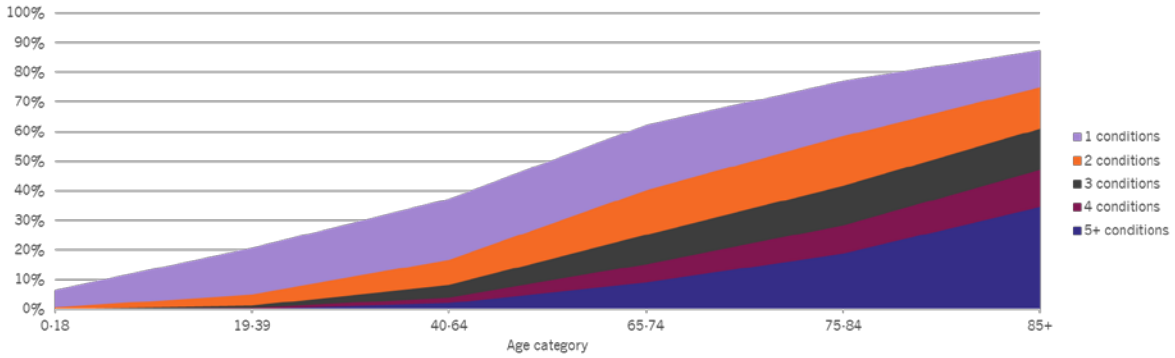
Figure I.2: Trends in Healthy Life Expectancy at birth in England, between 2001 to 2003 and 2020 to 2022



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].

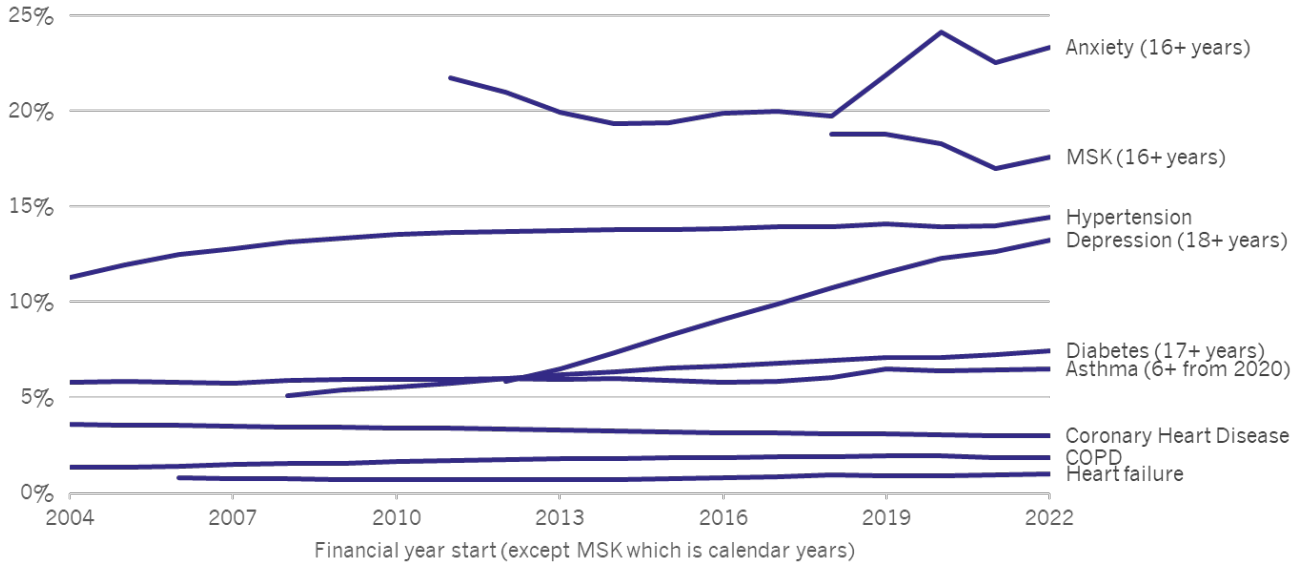
Figure I.5: Share of patients with no, one, or multiple long-term conditions by age



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.

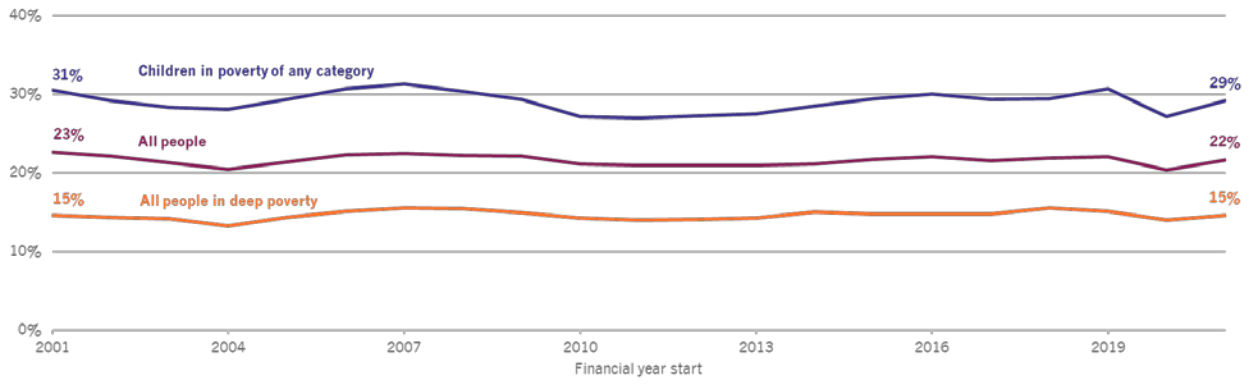
An economy and society in distress

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.

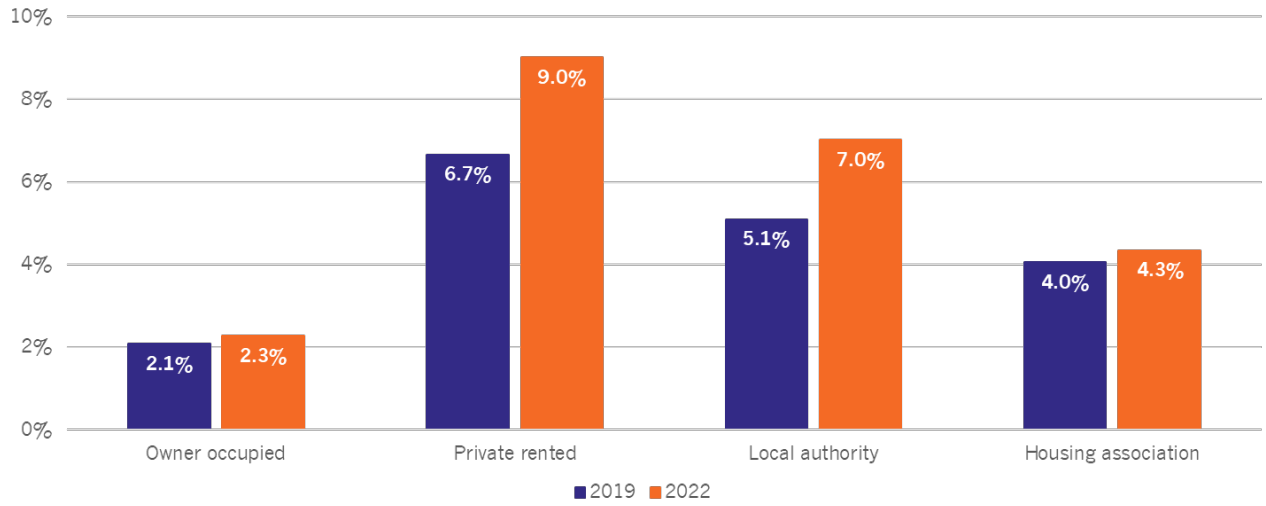
Figure I.9: Poverty rates



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.

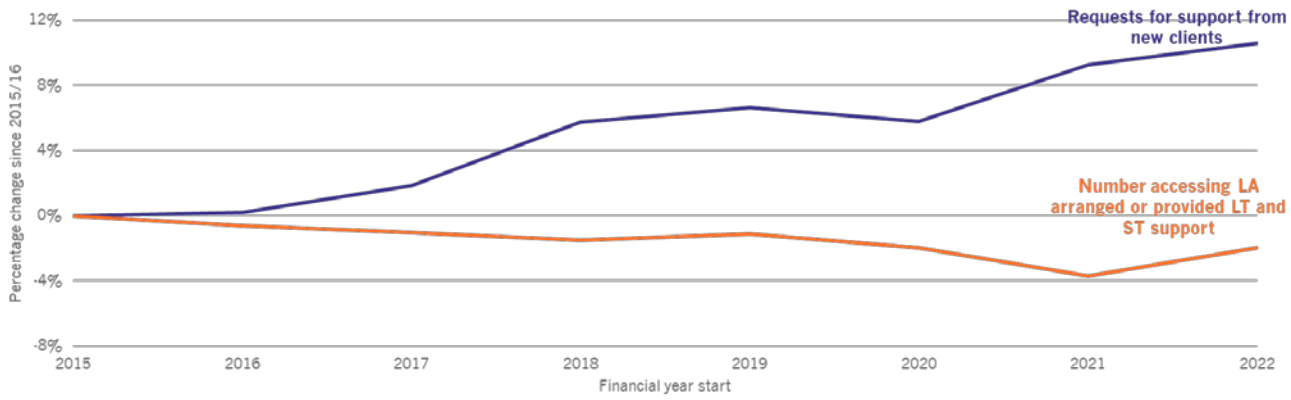
Social care challenges impacting the NHS

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

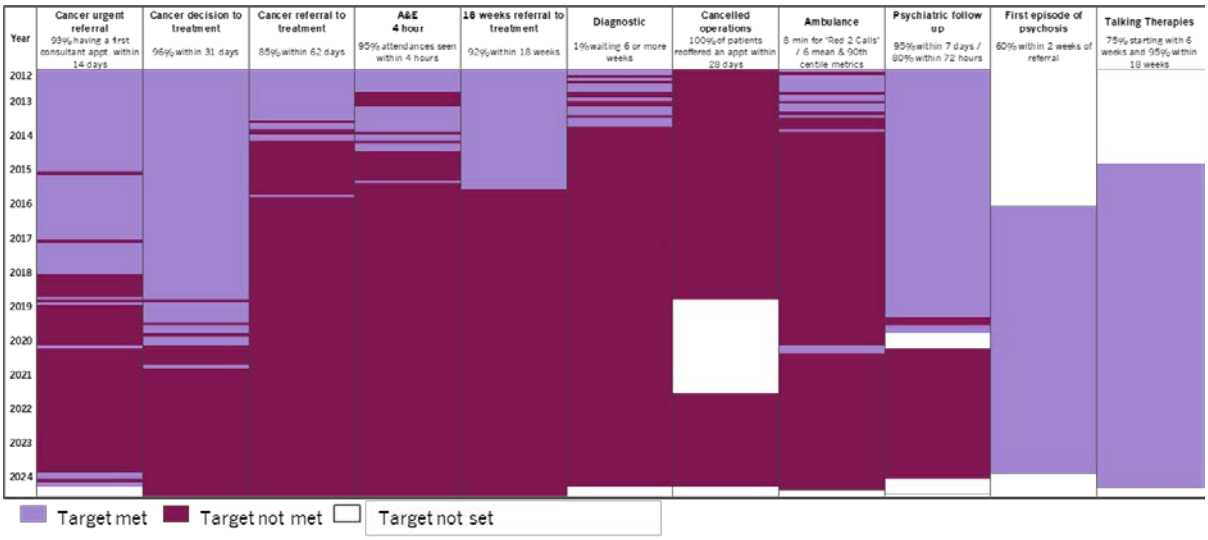
Access to NHS services

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)

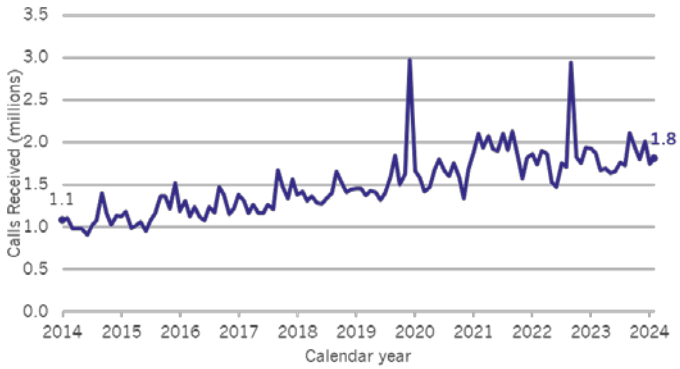
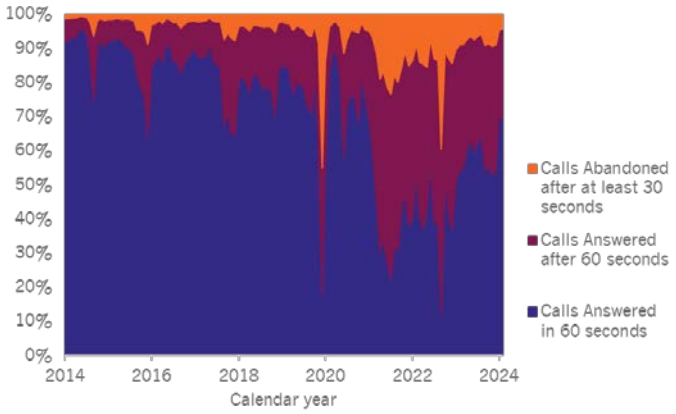


Figure II.2.1B: Call volumes split by answered in under and over 60 seconds and abandoned in over 30 seconds (percentage)



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

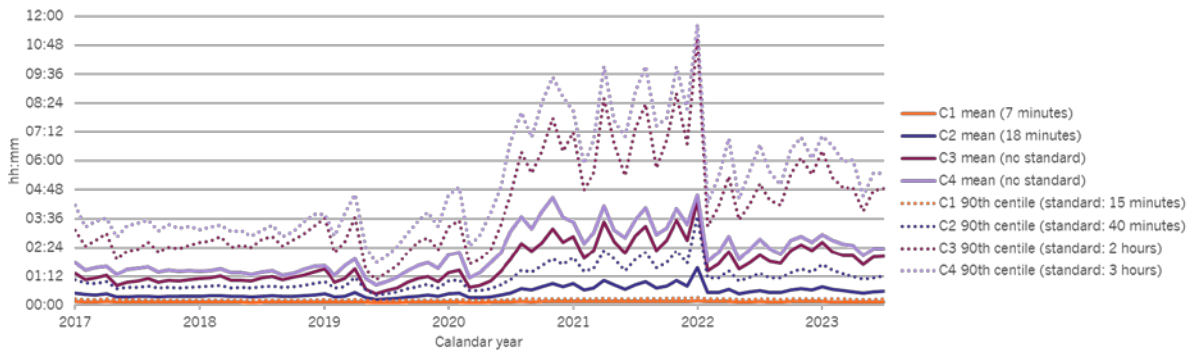
been growth in ordering repeat prescriptions and managing hospital appointments, just 1 per cent of GP appointments are managed via the App (although many book their GP appointments through other online systems)[39]. With the huge success in registrations, an important opportunity is being missed to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

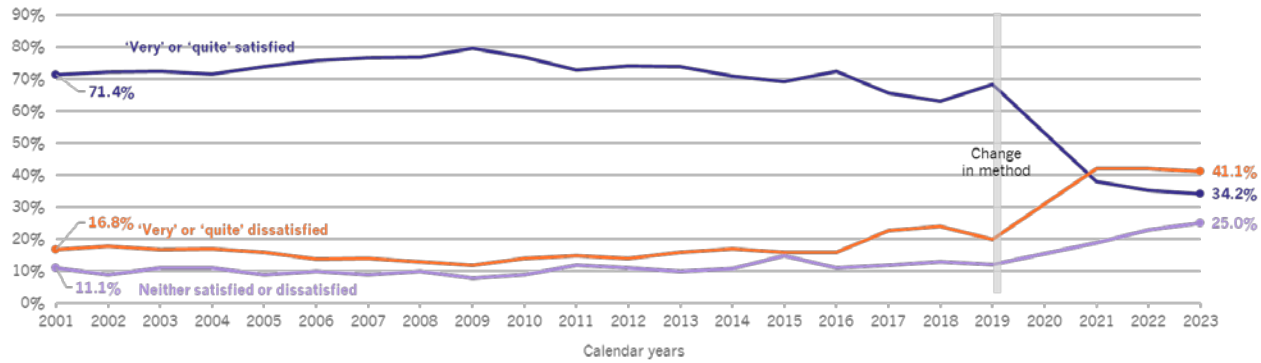
2022 (as we can see from the chart above), when there was an average response time of just over an hour-and-a-half, with the 90th centile standing at nearly 4 hours. By May this year, responses had improved to an average of 32 minutes and 90 per cent responded to within 1 hour and 8 minutes[42].

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].

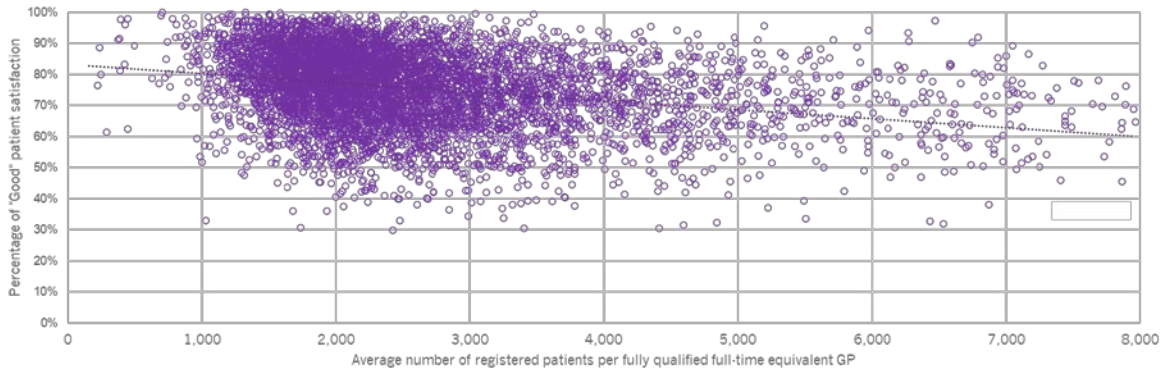
Figure II.3.3: Question asked: 'From your own experience, or from what you have heard, please say how satisfied or dissatisfied you are with the way in which each of the parts of the NHS runs nowadays: Local doctors or GPs



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]:

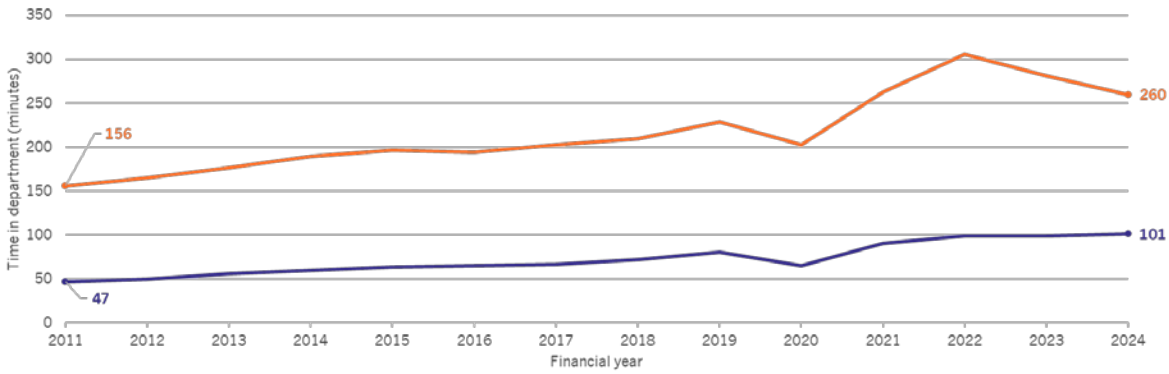
Figure II.3.7: Reported patient satisfaction by average numbers of registered patients per GP, June 2024



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].

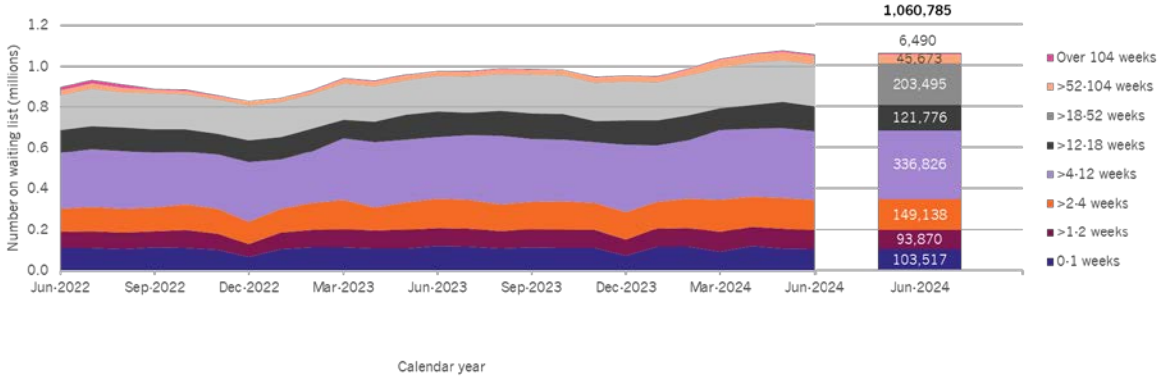
Figure II.3.8: Total time in department from arrival to admission, transfer or discharge, UTCs and WICs



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

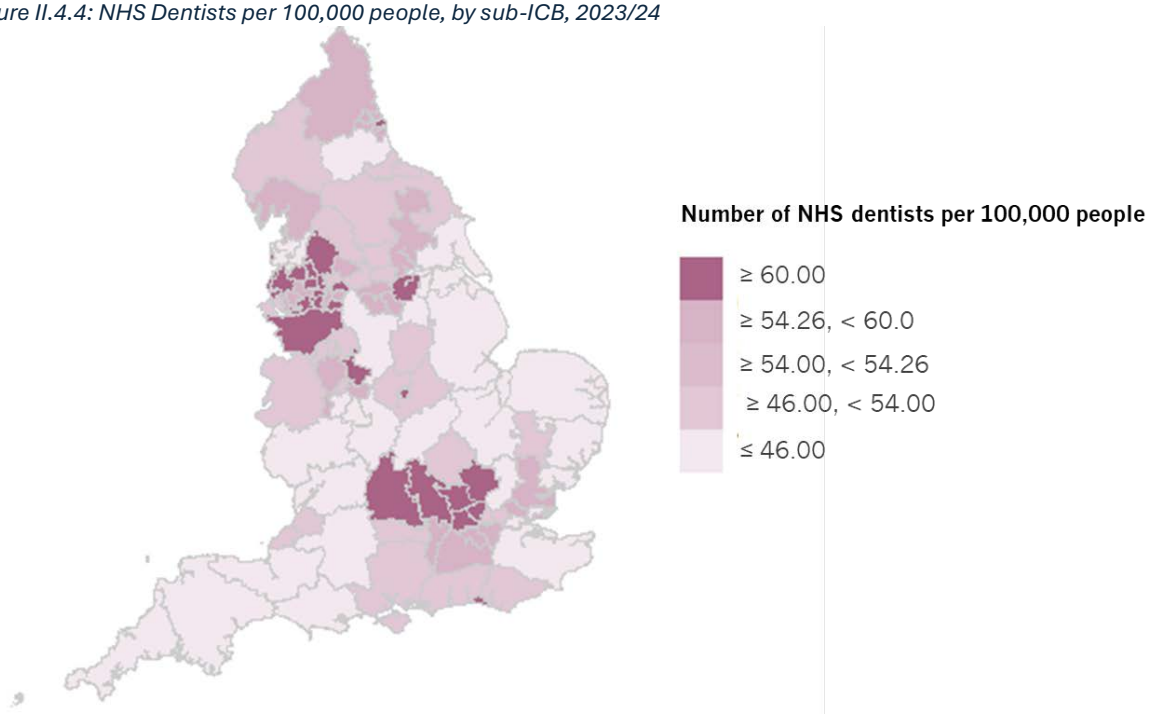


16. Set against a backdrop of growing need, the overall numbers of community nurses have held steady since 2016[51], whilst the number of district nurses (nurses who have completed additional training to become specialist community practitioners) has actually declined[52]. There has been a worrying reduction 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.

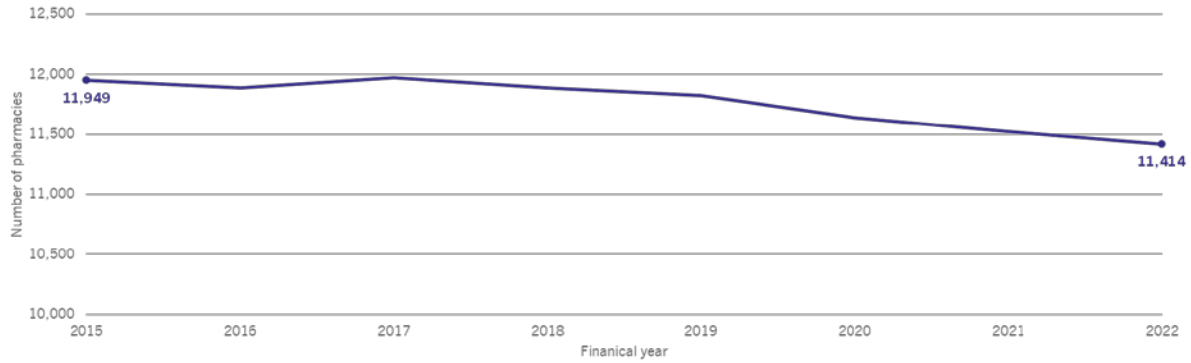
Access to community pharmacy

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].

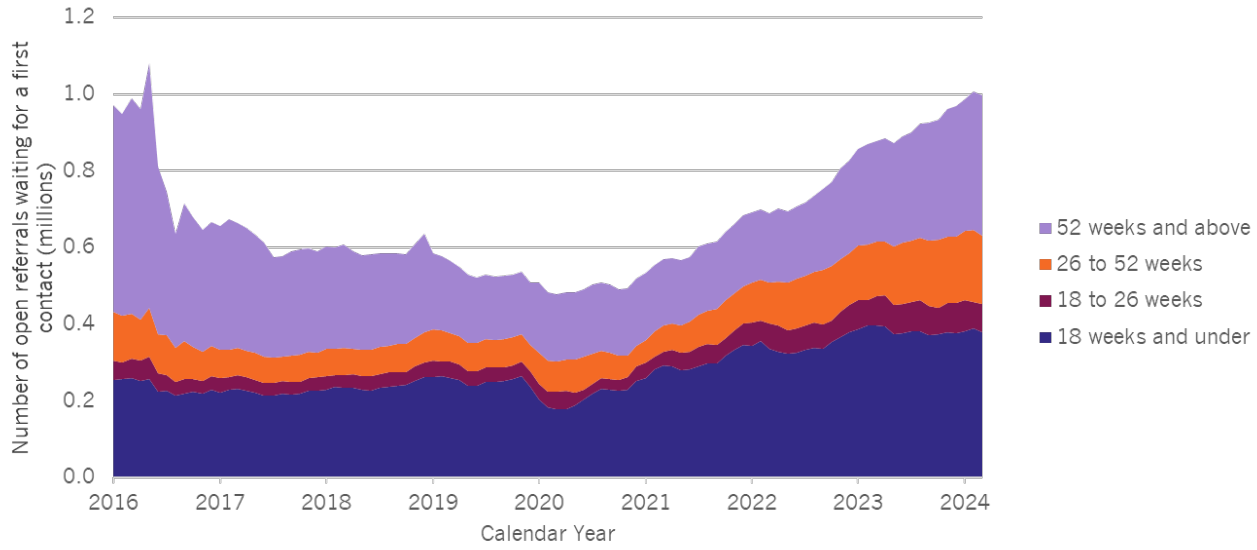
22. There is huge potential for a step change in the clinical role of pharmacists within the NHS. Expanded community pharmacy services are likely to include greater treatment of common conditions and supporting active management of hypertension. But there is a very real risk that on current trajectory, 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].

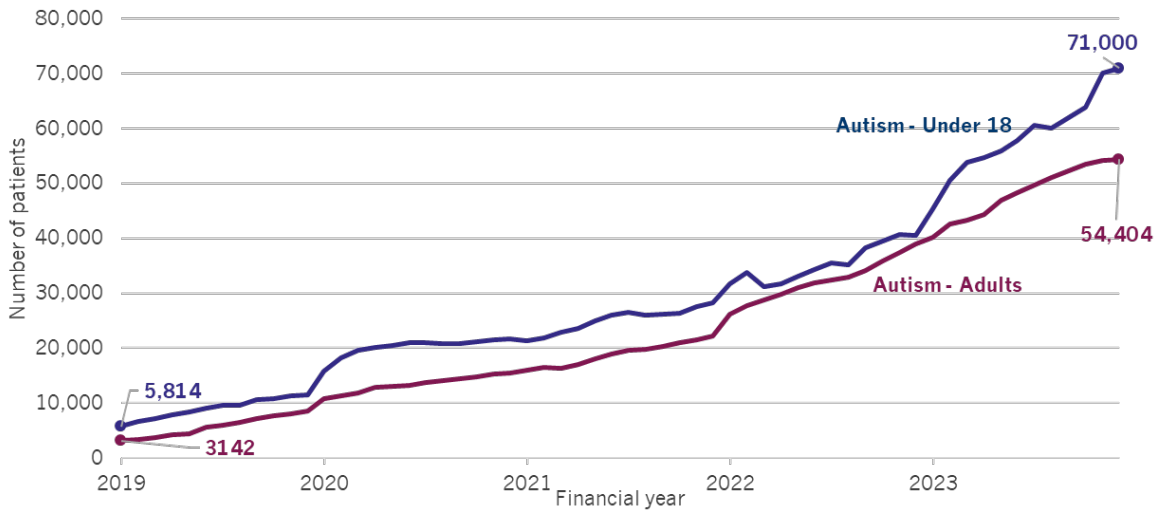
Figure II.6.5: Number of Open Referrals for people of all ages at the time of referral to Mental Health, Learning Disability and Autism services by time waiting for first contact



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.

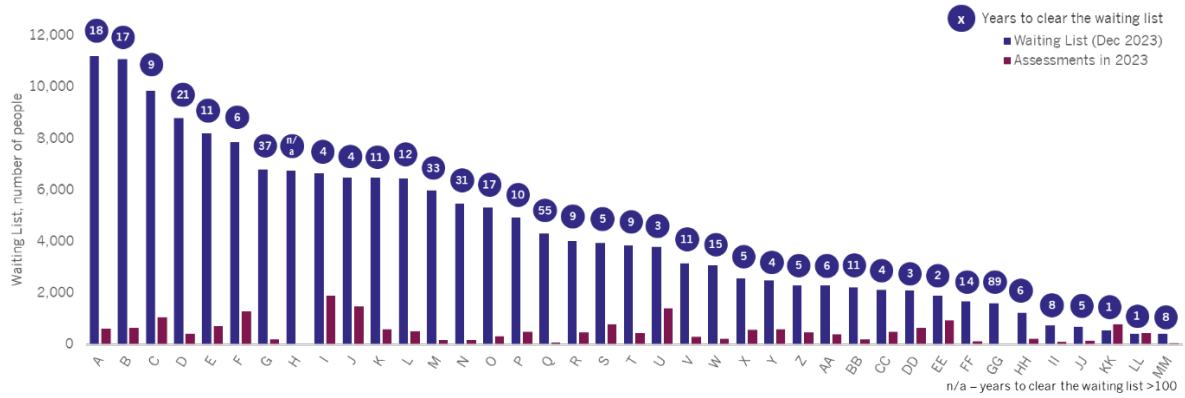
26. Demand for assessments for ADHD and Autism have grown exponentially in recent years. Since 2019, the number of children waiting at least 13 weeks for an assessment for Autism has increased at a rate of 65 per cent a year, while for adults the increase has been 77 per cent a year[67]. Activity has 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

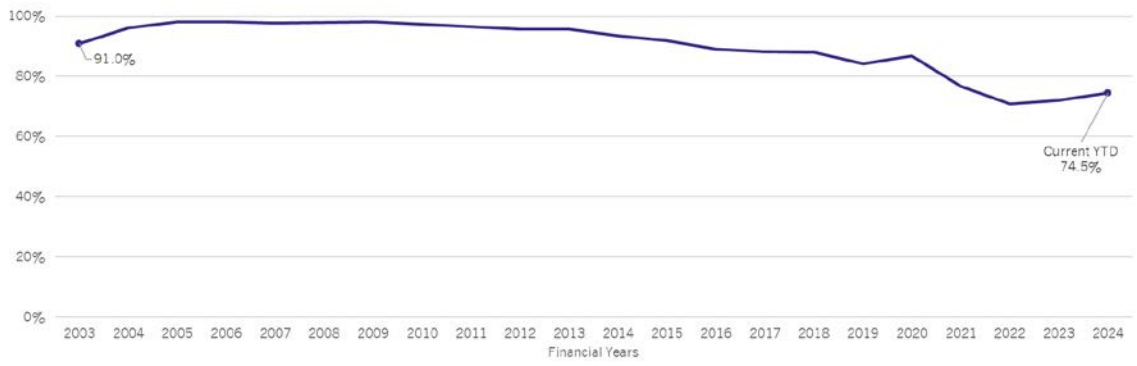
discussion on social media. No matter the cause, it is clear that with services overwhelmed, many people who need help will be missing out. NHS England's taskforce on ADHD[70] will have important recommendations to make.

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].

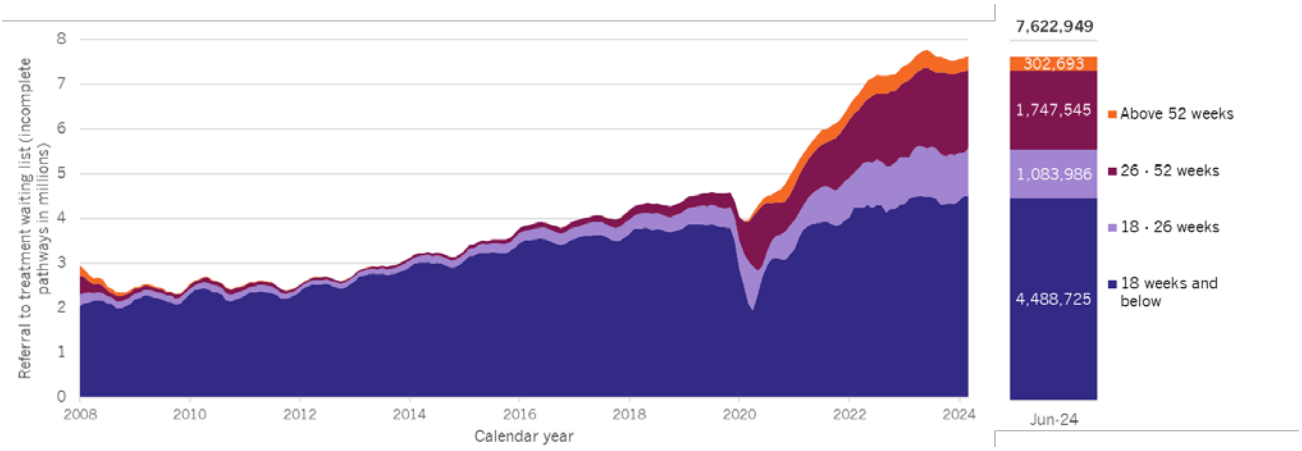
32. There has been a similar experience for people coming to A&E in a mental health crisis. People with a mental health flag tend to experience wait times that are approximately 25 per cent longer than those without[79]. For the 95th percentile, these waits have been getting worse and worse since the 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



* * *

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

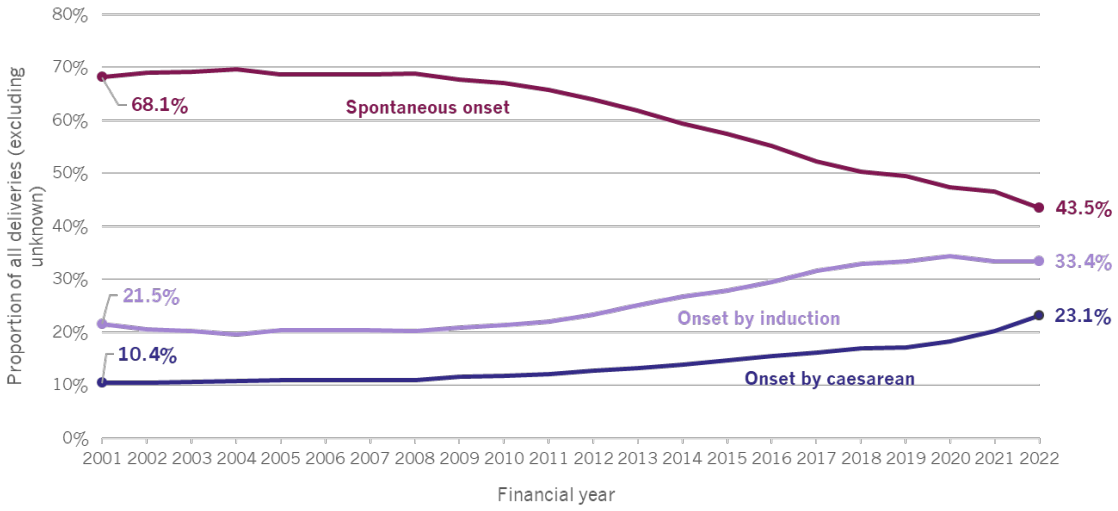
2. There have been positive developments in reductions of stillbirths and a small decrease in neonatal mortality and serious brain injuries. Yet maternal deaths have increased since the pandemic[88], including when adjusted for the direct impact of Covid-19. Most worrying are the huge inequalities that 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

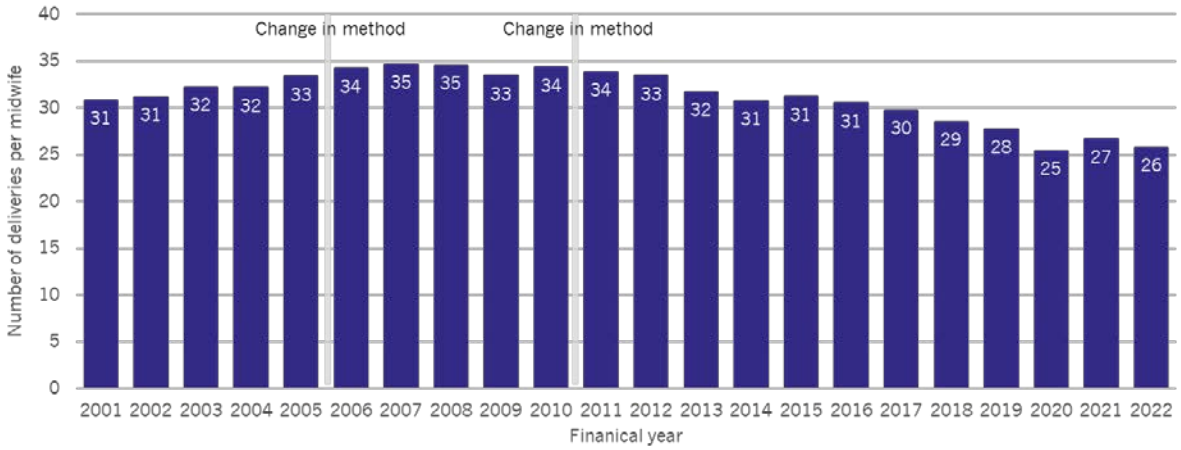
more common, having risen at annual rate of 4.6 per cent since 2005 while inductions have risen at an annual rate of 2.9 per cent over the same period[93].

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.

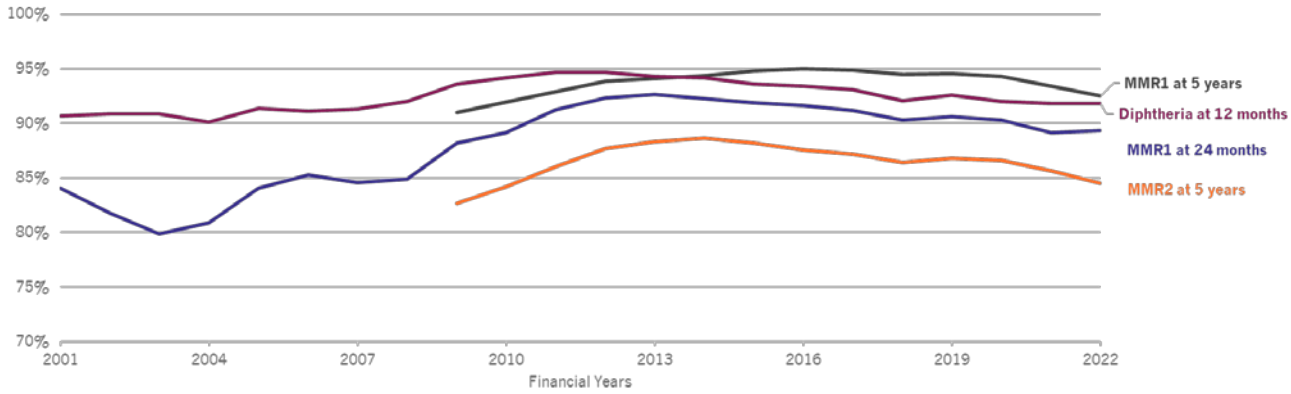
8. Today, too many women, babies and families are being let down. None of the issues described by Dr Kirkup are insurmountable. Each can be solved with sufficient time, attention and focus. The first step is to acknowledge that the problems are complex and that the data suggests that adding more staff 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

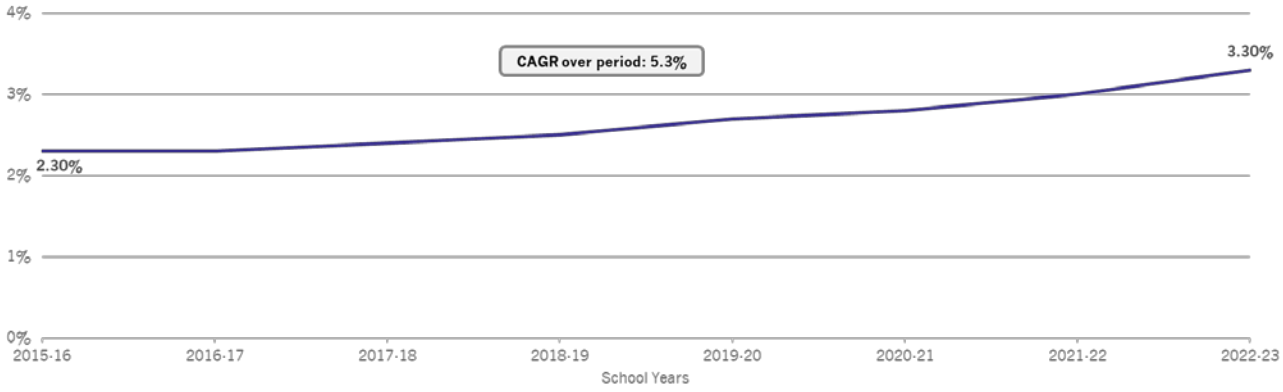


11. It is also clear that health inequalities begin at a very young age. Children from the most deprived decile are 2.1 times as likely to be obese in Reception than children from the least deprived decile, and this extends to 2.3 times by Year 6[101]. It is utterly shocking that in the poorest communities, 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].

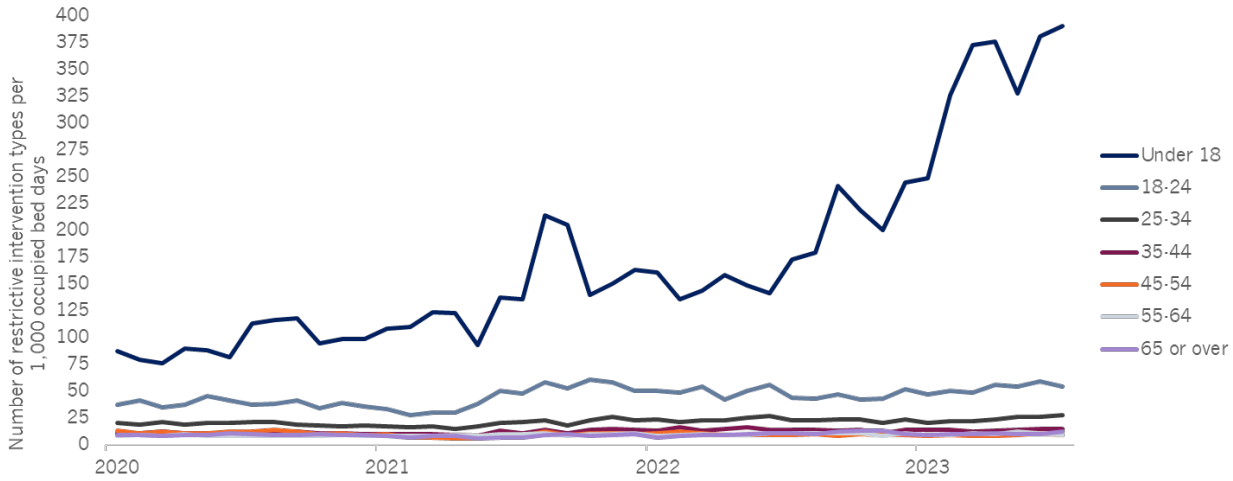
17. The problems faced by all NHS patients are similarly encountered by children and young people. At the moment, too many are being let down. Childhood is precious because it is brief; too many children are spending too much of it waiting for care. It is apparent that the NHS must do better and that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



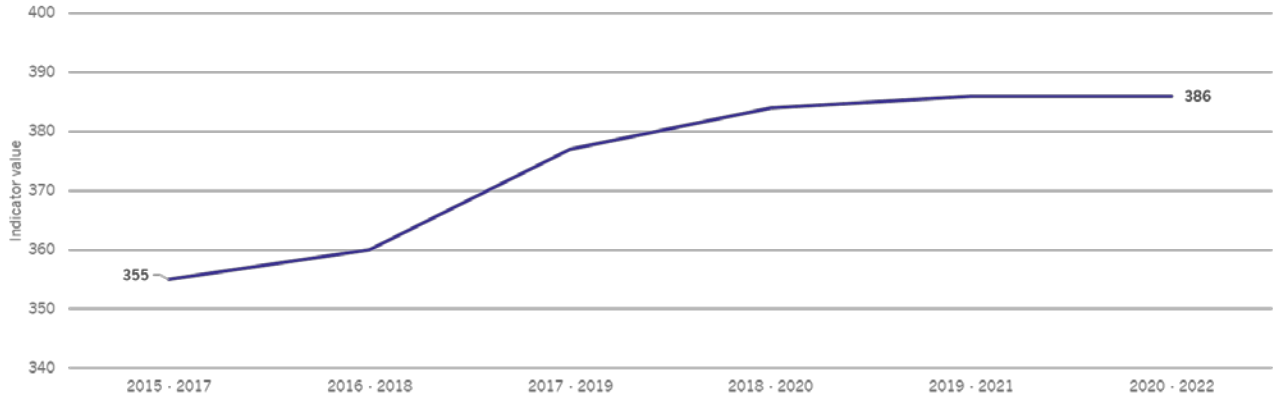
20. There has been a significant expansion in access to perinatal mental health services. Despite the significant impact of the pandemic, between 2019-20 and 2023-24, the numbers of women accessing care grew by two thirds[116]. The aim is to expand it further so that 66,000 mothers are helped this year.

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

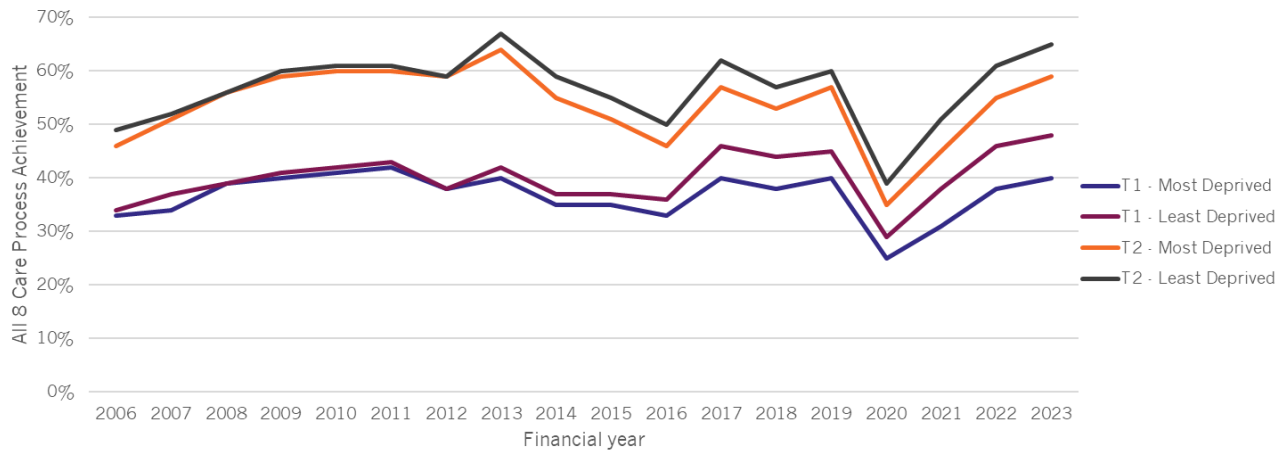
31. As we saw in chapter 1, there has been a substantial rise in the prevalence of some long-term conditions. Perhaps more significantly, more people now have multiple long-term conditions: between 2017 and 2022, the number of people with two or more long-term conditions increased at an annual rate of 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 20 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)

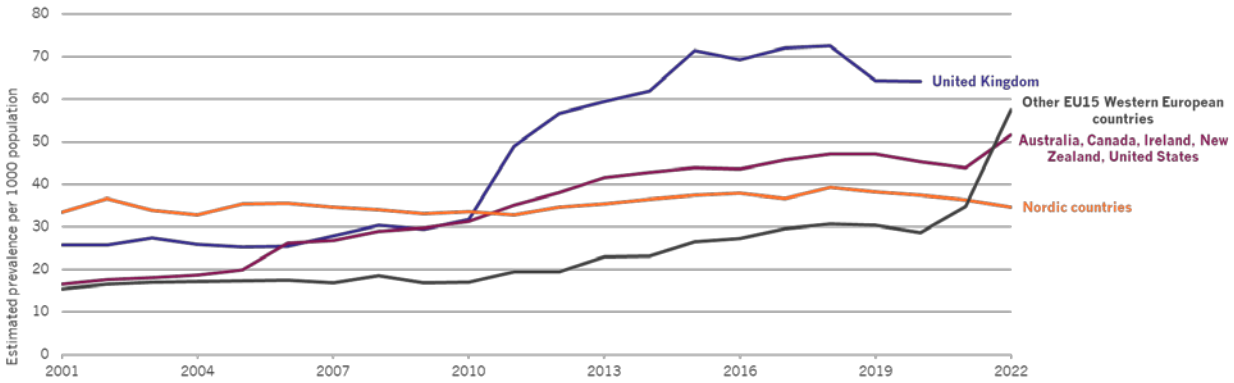


35. A similar picture is true for other long-term conditions, such as chronic breathing difficulties. Moreover, 35 per cent of patients with long-term conditions still do not have a care plan, which is one of the most important tools to coordinate and manage care[125].

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

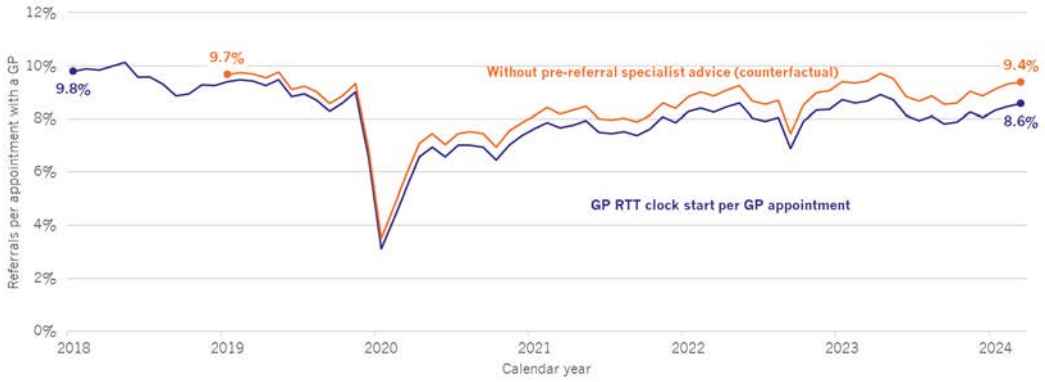
39. As we have seen above, there have been large increases in waiting times for planned procedures. Long waits for treatment have a significant impact on patients. For some, it means waiting for longer periods in discomfort or with limited mobility. For others it can limit their ability to work or to 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

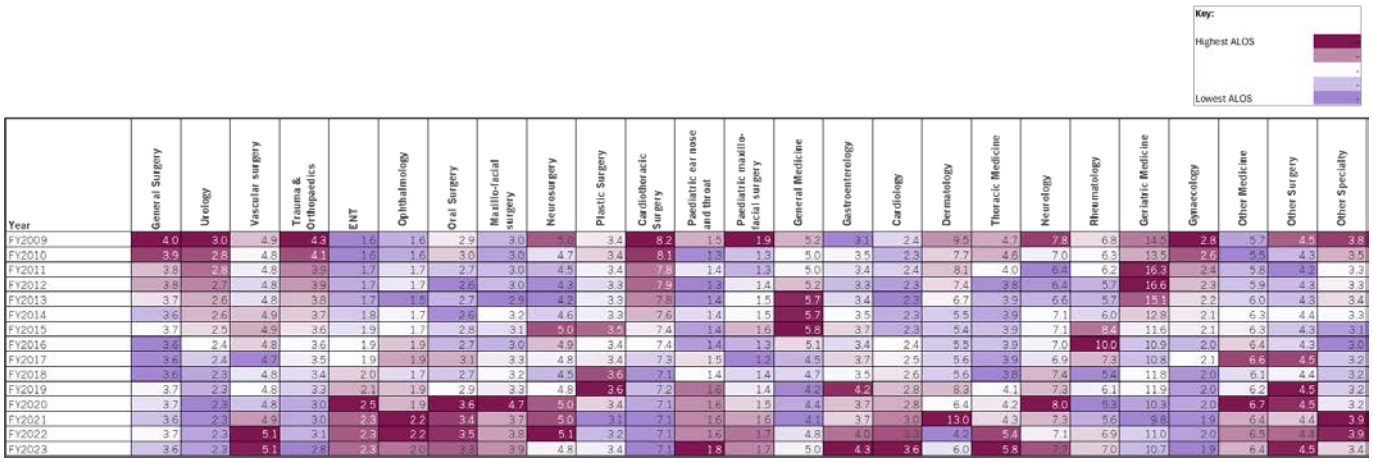


42. Other innovations include "virtual wards". A virtual ward (also known as hospital at home) is an acute clinical service with staff, equipment, technologies, medication and skills usually provided in hospitals delivered to selected people in their usual place of residence, including care homes. It 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



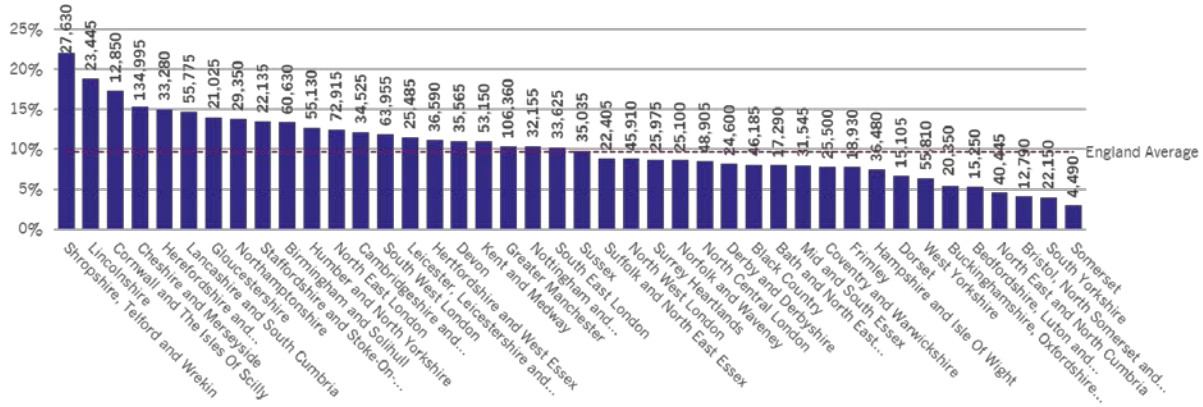
Year	General Surgery	Urology	Vascular surgery	Trauma & Orthopaedics	ENT	Ophthalmology	Oral Surgery	Maxillo-facial surgery	Neurosurgery	Plastic Surgery	Cardiothoracic Surgery	Paediatric ear nose and throat	Paediatric maxillo-facial surgery	General Medicine	Gastroenterology	Cardiology	Dermatology	Thoracic 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.

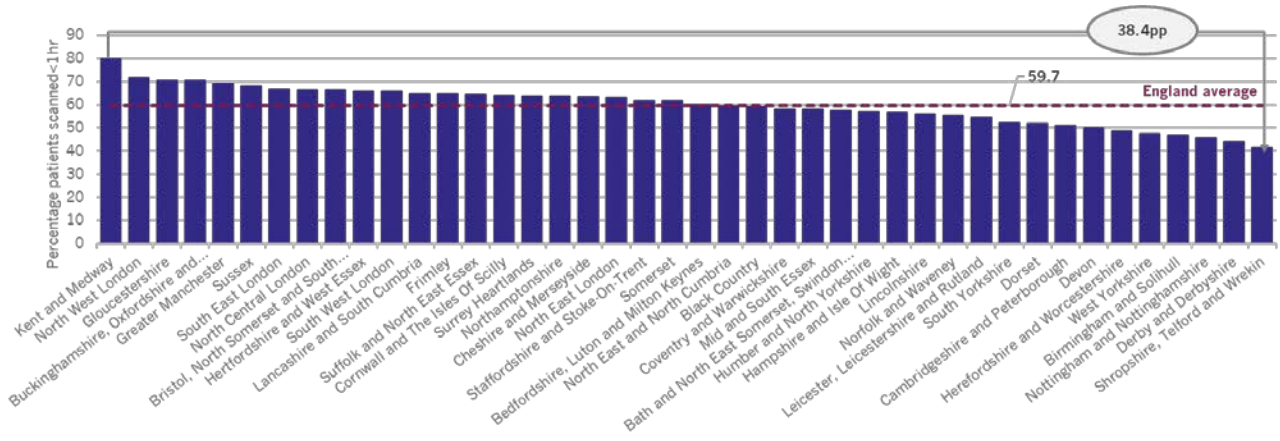
48. Unsurprisingly patient satisfaction has declined with longer waits. In 2010, 60 per cent of the public were very or quite satisfied with Accident and Emergency Services. This had declined to 54 per cent by 2019 and then fell sharply to just 30 per cent by 2022[142]. It remains at historically low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

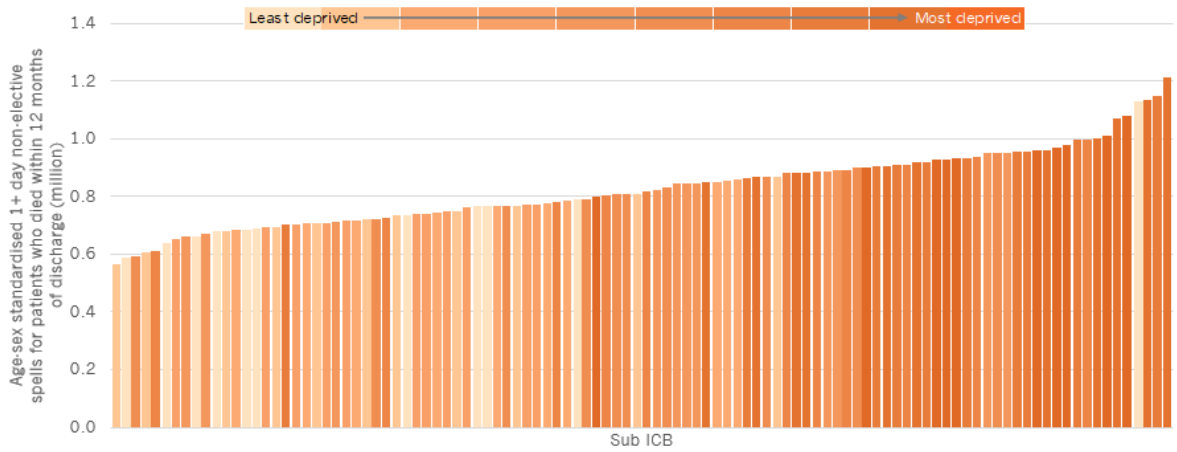


End of life care

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

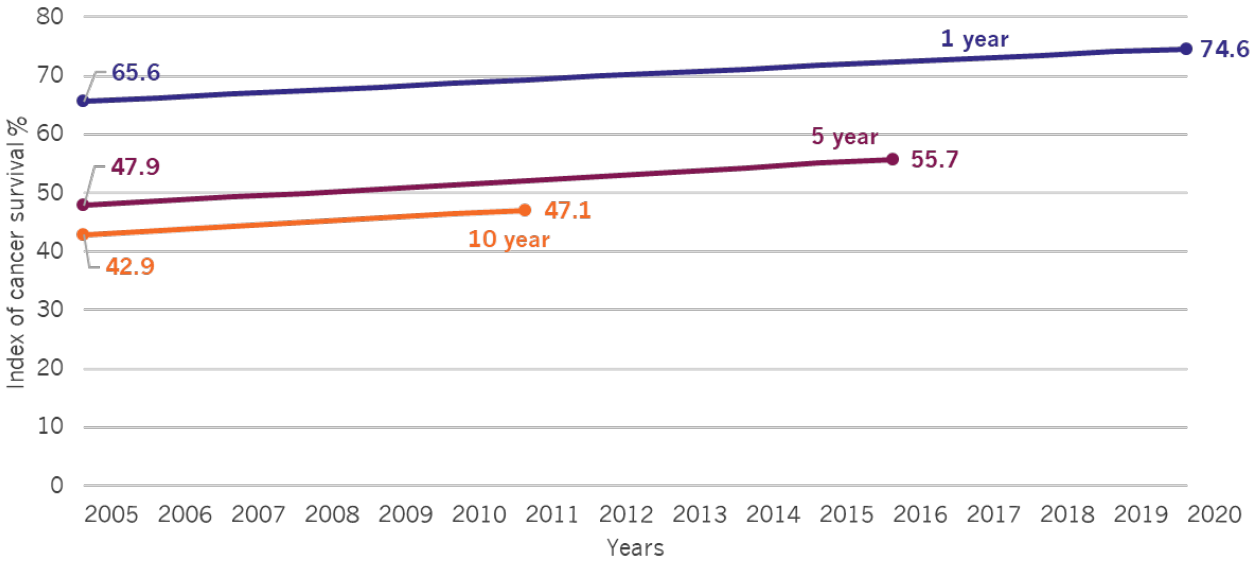
55. Far too many lives are lost to avoidable causes, meaning that they are either preventable or treatable. There is significant scope to improve the performance of the NHS and to save lives. Here, we examine three of the most significant areas: cancer, cardiovascular disease, and suicide.

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

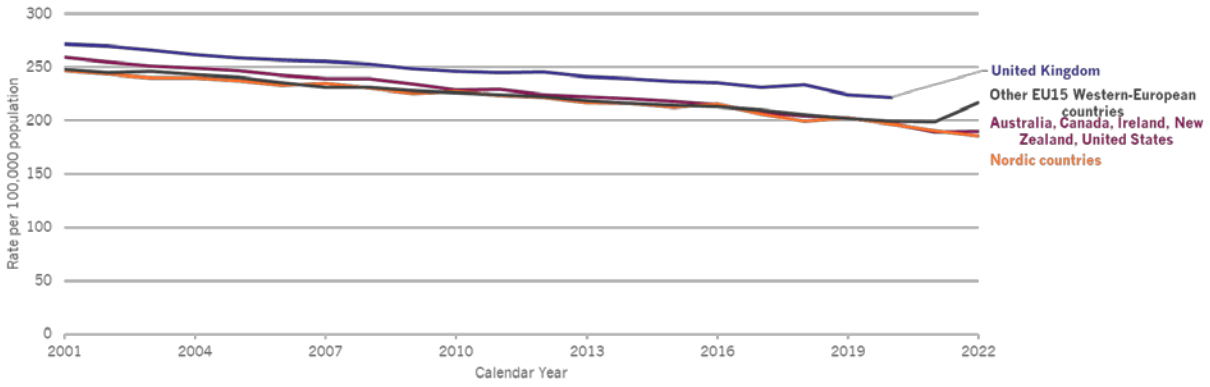
improved, the rate of improvement slowed substantially during the 2010s, as the chart below sets out[154]:

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



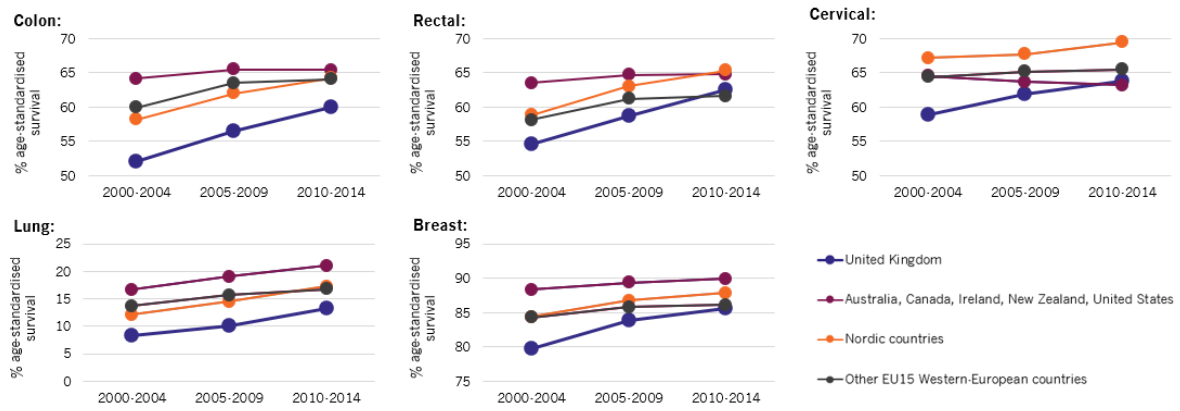
56. International comparisons of cancer mortality find that the UK has substantially higher rates than our European neighbours, Nordic countries, and countries that predominantly speak English (see chart below)[155].

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]:

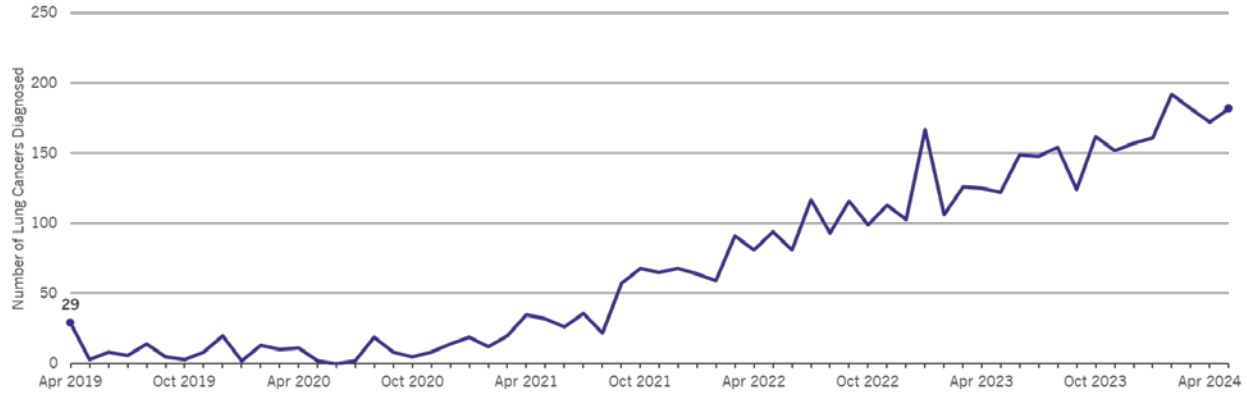
Figure III.12.5: % age-standardised five-year net cancer survival, 15 years and above, 2000 to 2014



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.

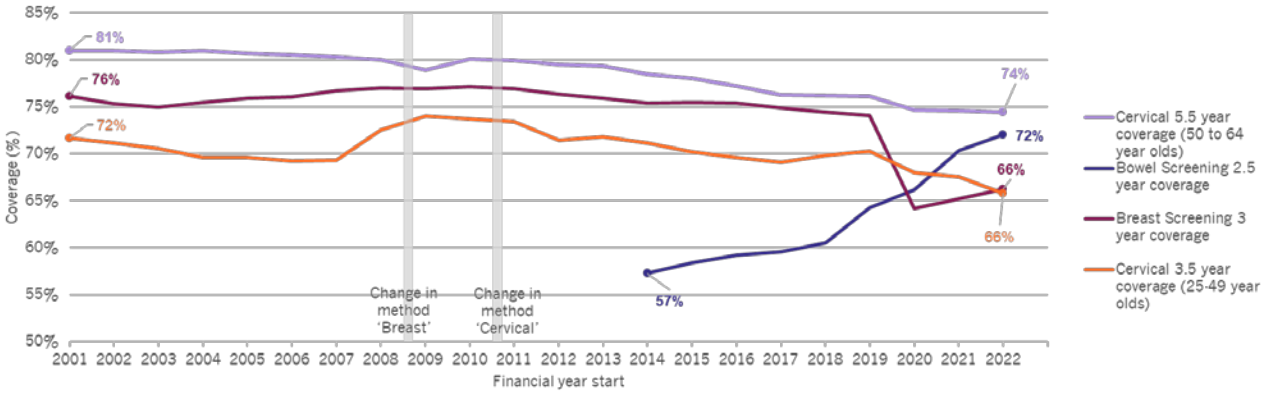
59. Early diagnosis is an important priority since it is associated with higher survival rates. Yet despite its importance, no progress whatsoever was made in diagnosing cancer at stage I and II between 2013 and 2021. Since then, there have been some signs of hope as rates of early-stage diagnosis have 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

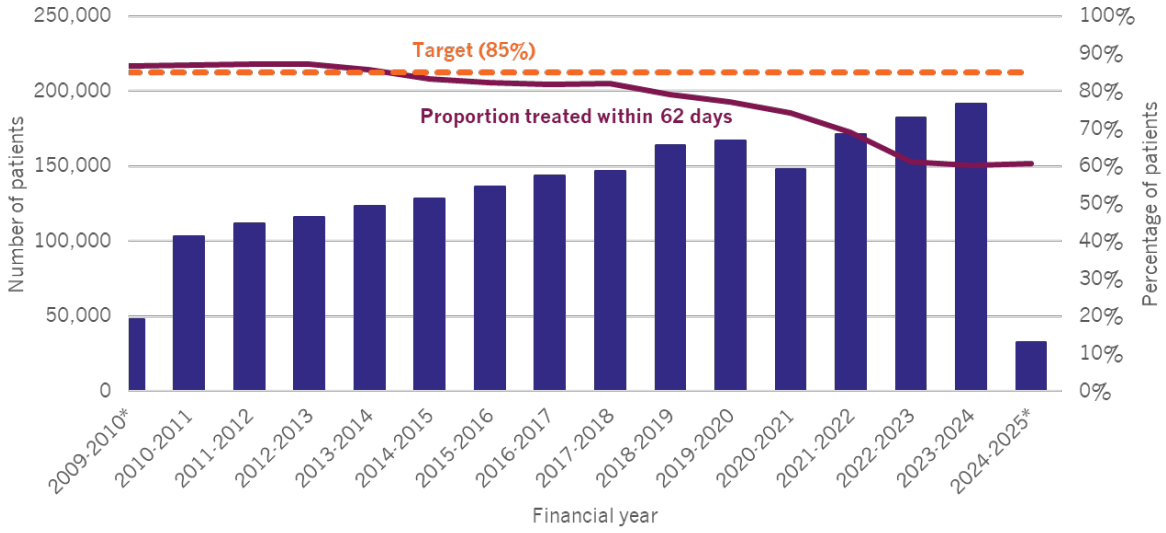


61. Treatments are becoming more sophisticated, but less timely. In 2024, more than 35,000 genomic tests are being completed each month. But the turnaround times are poor, with only around 60 per cent of test being performed to the agreed timeframes[161]. This can delay the start of treatment which often 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)



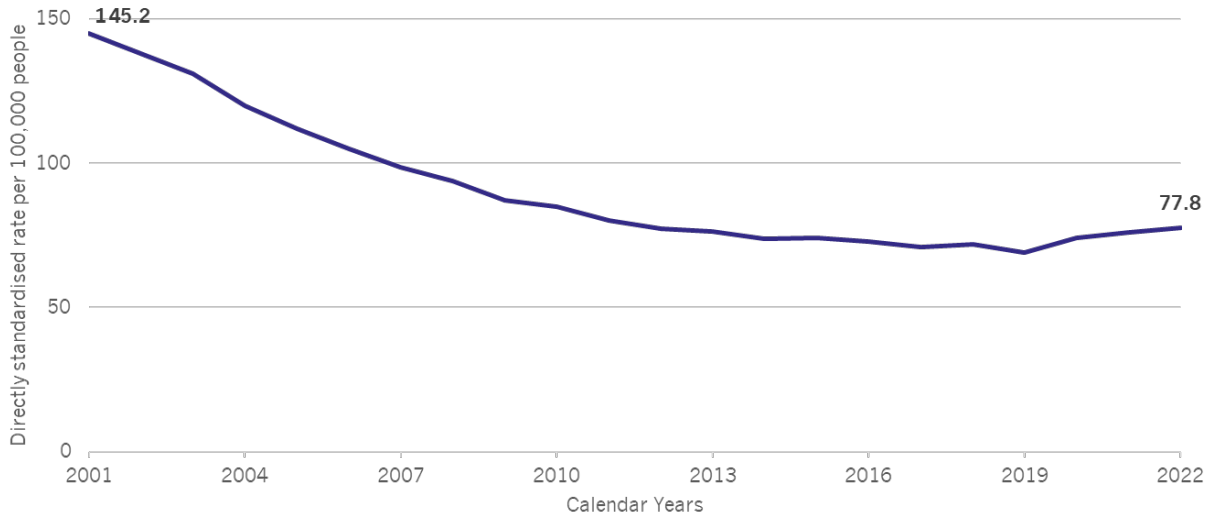
63. When it comes to systemic anti-cancer therapies, there continue to be significant disparities in how quickly patients are able to access new treatments. The time from approval by NICE to adoption of new cancer drugs such as alpelisib and fulvestrant varied from less than a month in nine provider 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].

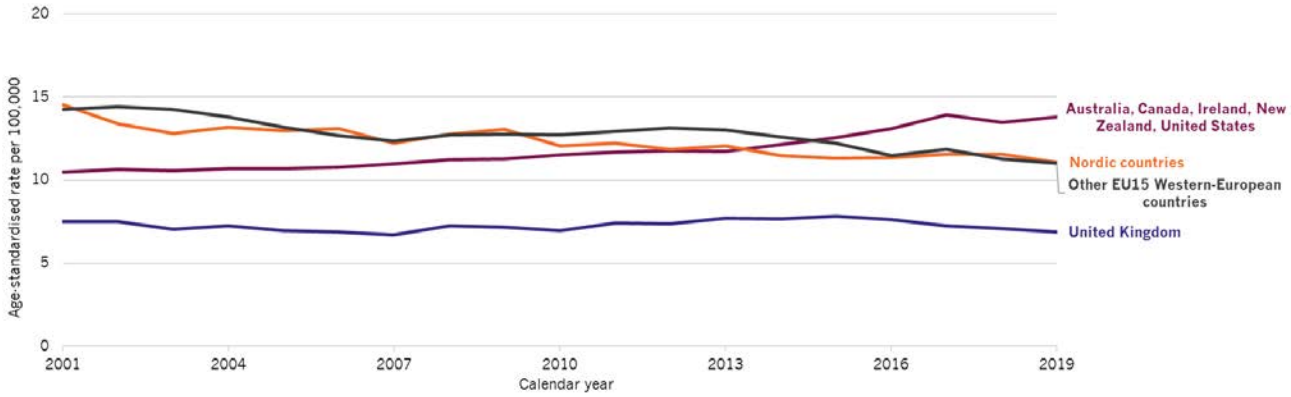
67. Lipid lowering therapies are an important tool in preventing cardiovascular disease. In March 2024, 62.1 per cent of people at high risk of cardiovascular disease were treated in this way (in line with the NHS Long Term Plan target of 60 per cent)[170]. There has also been good progress towards the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

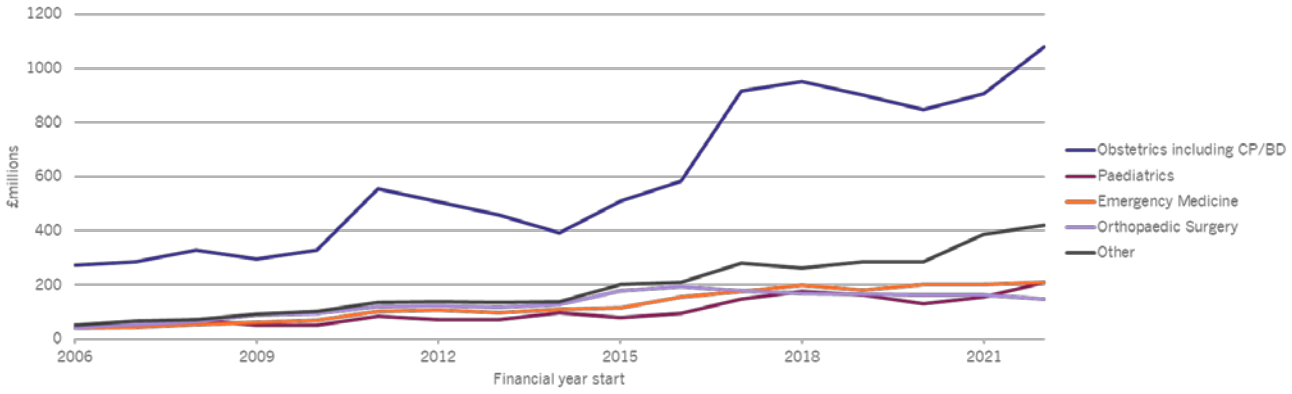
	10 to 24 years		25 to 44 years		45 to 44 years		65 years and over	
	Males	Females	Males	Females	Males	Females	Males	Females
2001-2005	-6.4%	0.9%	-1.5%	-0.1%	-1.1%	1.9%	-2.1%	-3.6%
2005-2010	-2.0%	-0.7%	-2.4%	-3.5%	0.8%	-2.7%	-2.8%	-2.8%
2010-2015	4.6%	1.9%	0.5%	1.2%	2.3%	2.8%	1.5%	3.4%
2015-2019	3.2%	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

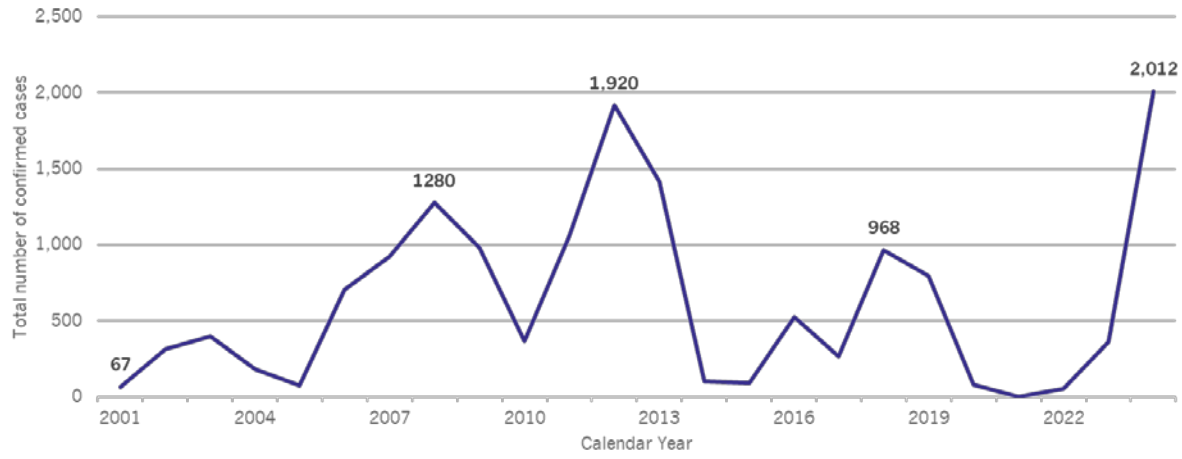
Health protection, promotion and inequalities

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

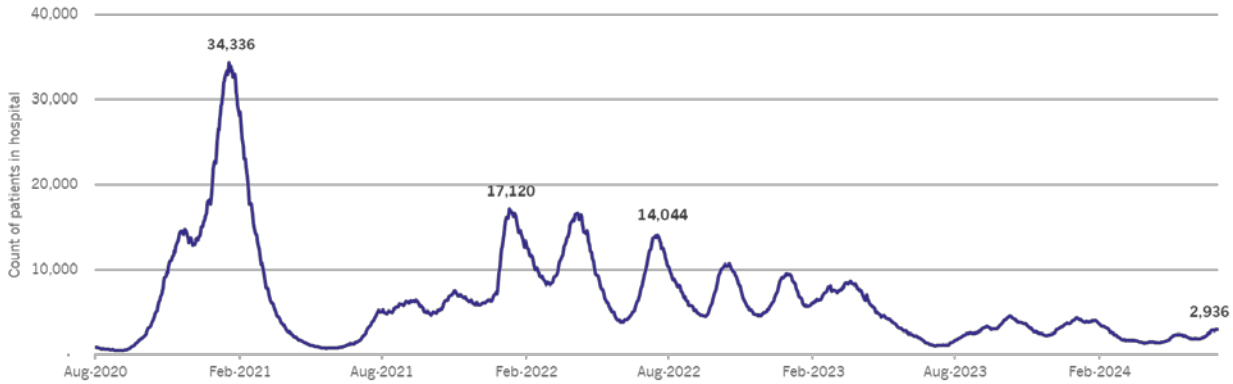
2. In the wake of the Covid-19 pandemic, it is apparent that infectious diseases remain a major challenge for all health systems. Well known infectious diseases could be on the rise as vaccination rates fall: measles cases in 2024 have been the highest this century as shown below[182]. It is too early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

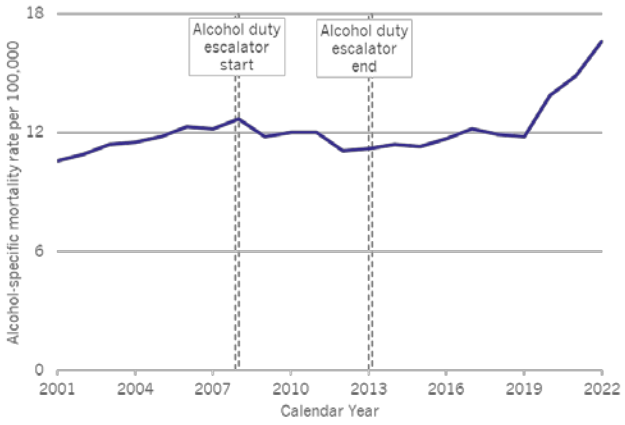
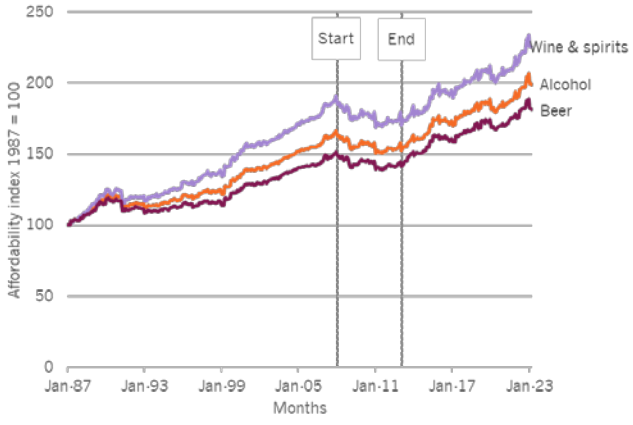
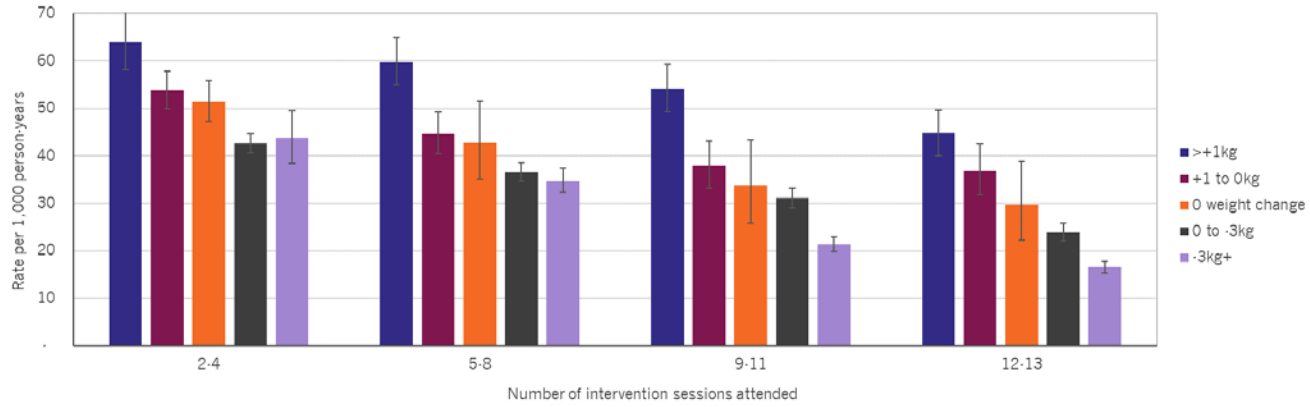


Figure III.1.3B: Alcohol affordability in the United Kingdom, January 1987 to March 2023



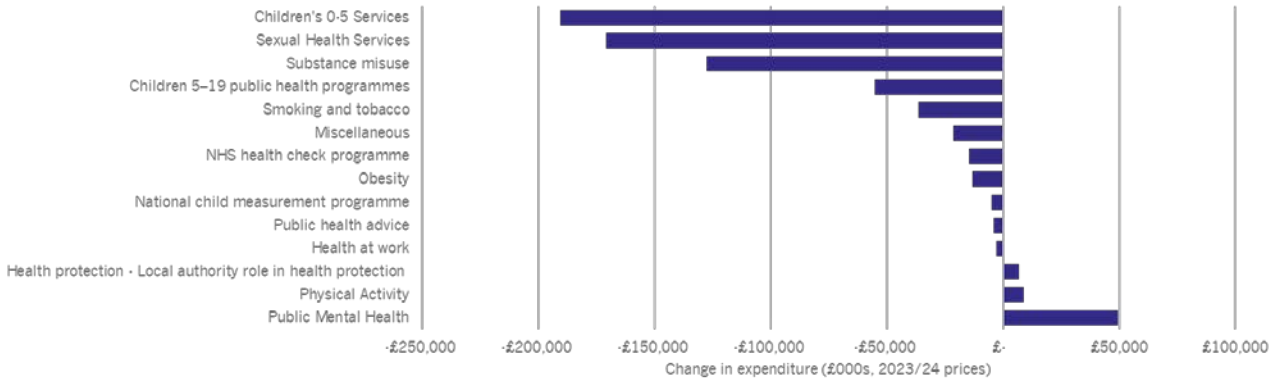
8. Everybody knows that prevention is better than cure. Interventions that protect health tend to be far less costly than dealing with the consequences of illness. Take the NHS-funded Diabetes Prevention Programme which reduces the risk for type II diabetes by nearly 40 per cent[195]. Given the potential 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 Index 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 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.

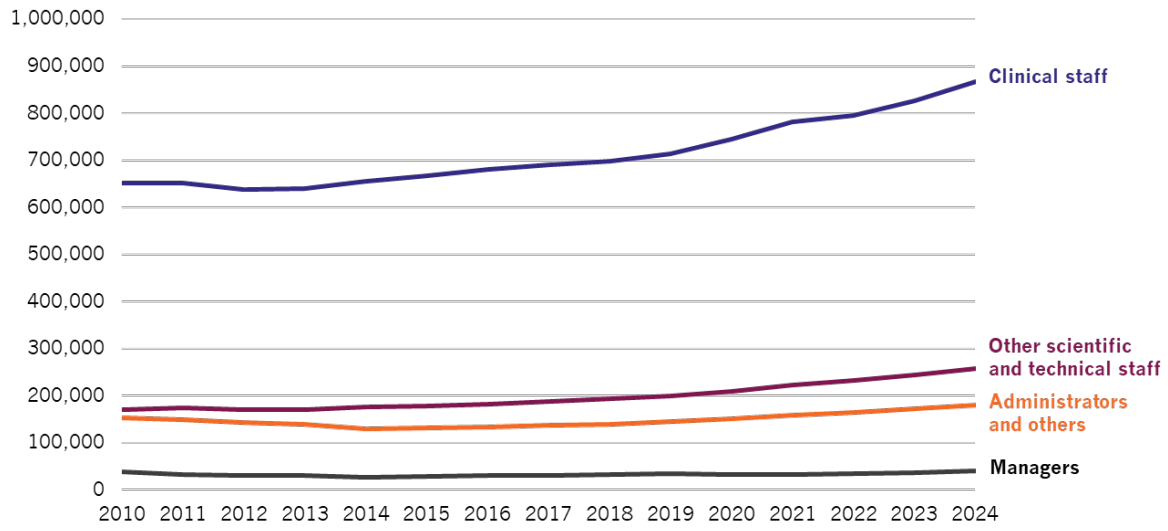
2. At the highest level, the NHS has had the strategic intention to shift spending from reactive care in hospitals to more proactive care in the community setting – but care has in fact moved in the other direction. Hospitals have attracted a greater share of NHS spending, meaning that other settings 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

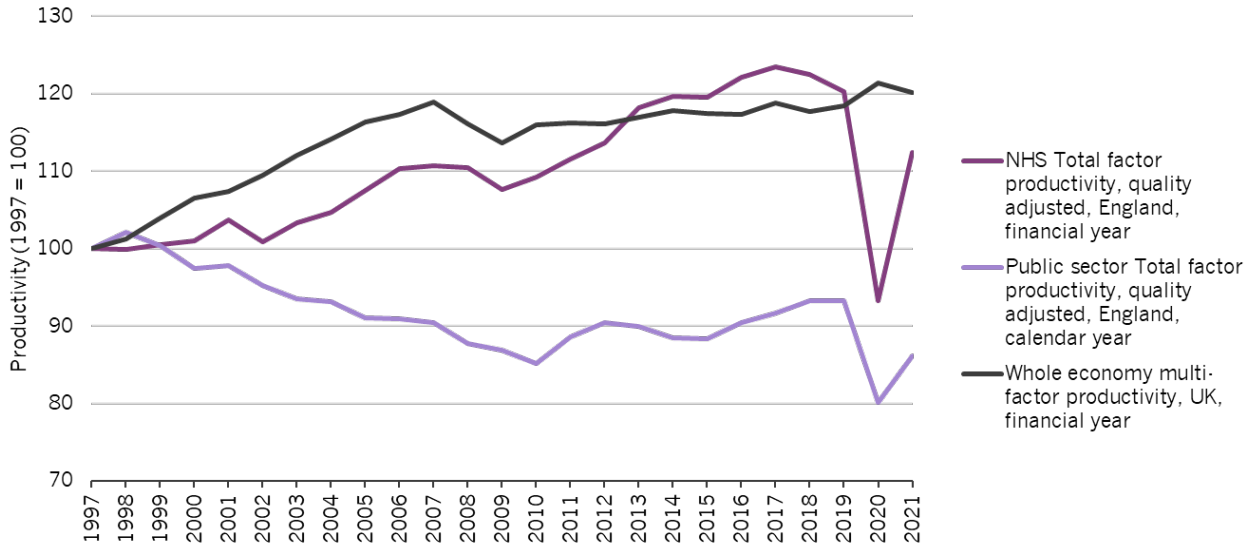
4. Overall staff numbers increased gradually during the 2010s, in line with the slow-down in funding increases over the same period[238]. Staff numbers have since increased more rapidly, as funding has risen[239], as we can see in the chart below[240]. Between 2022 and 2024, the rate of clinical staff 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].

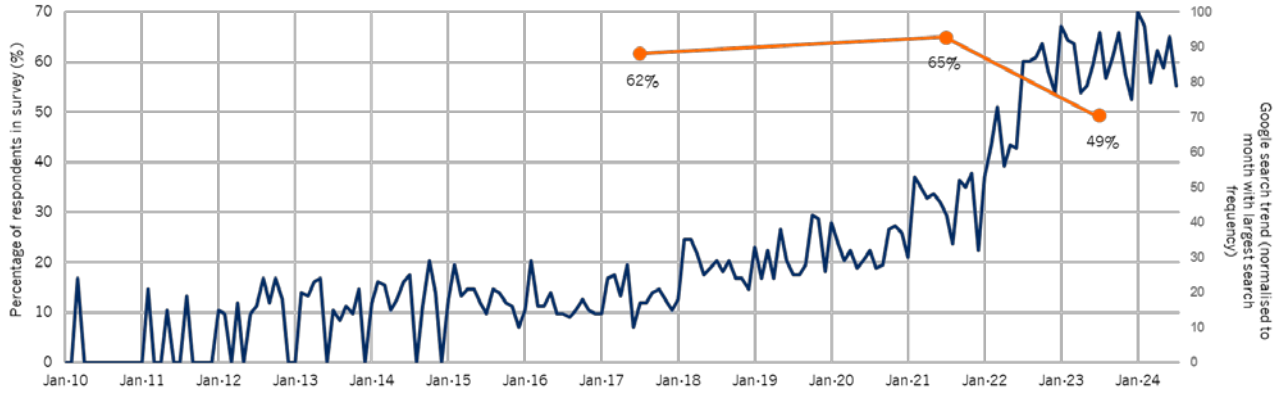
11. In the NHS, this goal of rebalancing care towards the community is sometimes described as the "left shift". Since at least the *Our Health, Our Care, Our Say* White Paper of 2006, and arguably before, the NHS has been committed to this change in the pattern of services. Similarly, pilots of integrated 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.

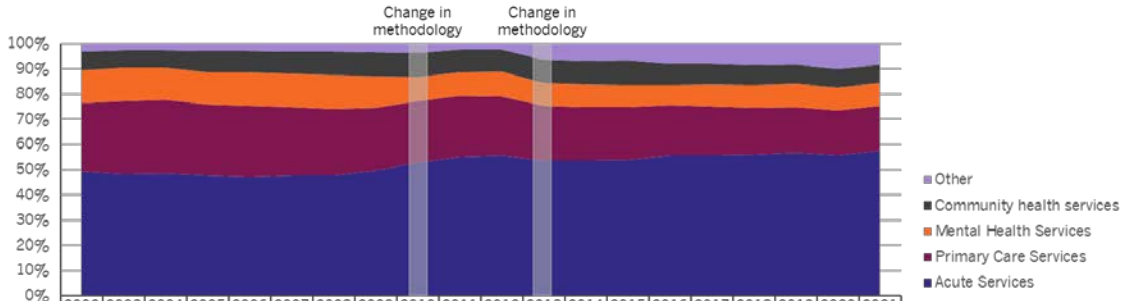
The "left shift"

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

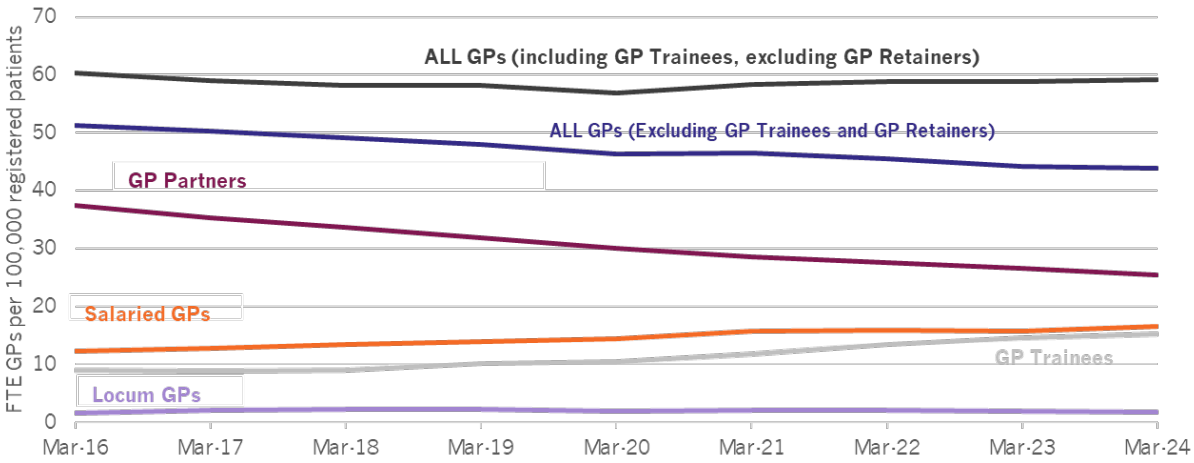
29. As we turn to resources and productivity of services, one thing that stands out is the degree of detail that is available for acute hospitals services versus other settings of care. This reflects the availability of data—and in itself demonstrates the need to invest in measurement and transparency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

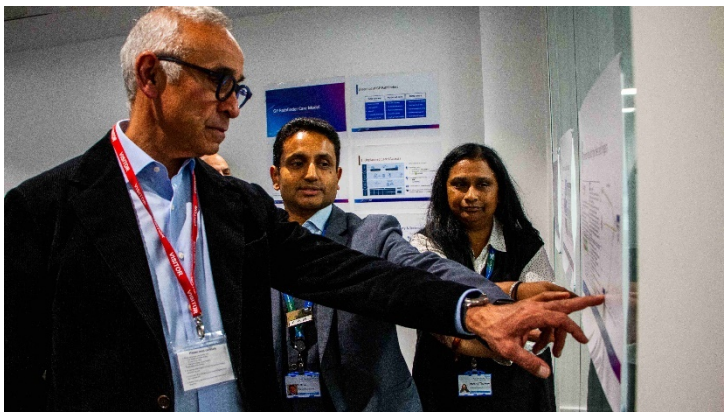


32. At present, multiple disincentives conspire against allocating additional funding to match known higher primary care workload in deprived areas. Primary care workforce recruitment is more challenging; consultation workload is progressively higher for each additional deprivation quintile; deprived 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.

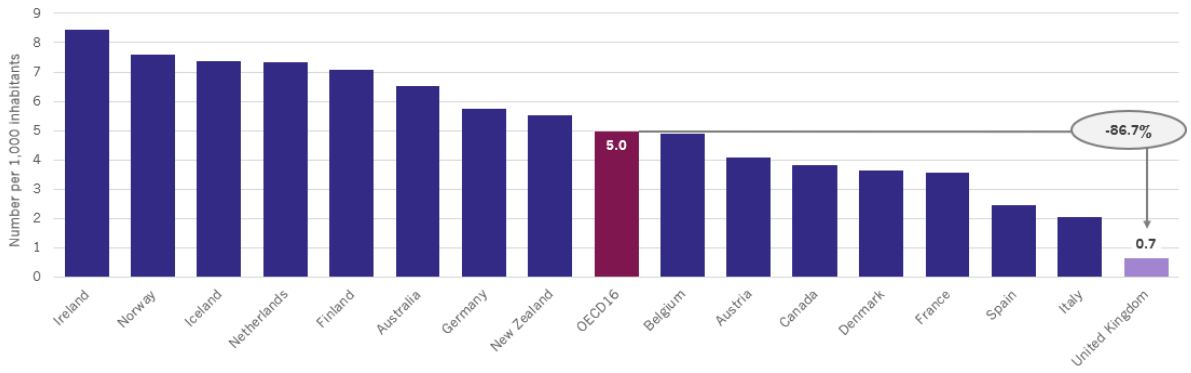
Community services

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)

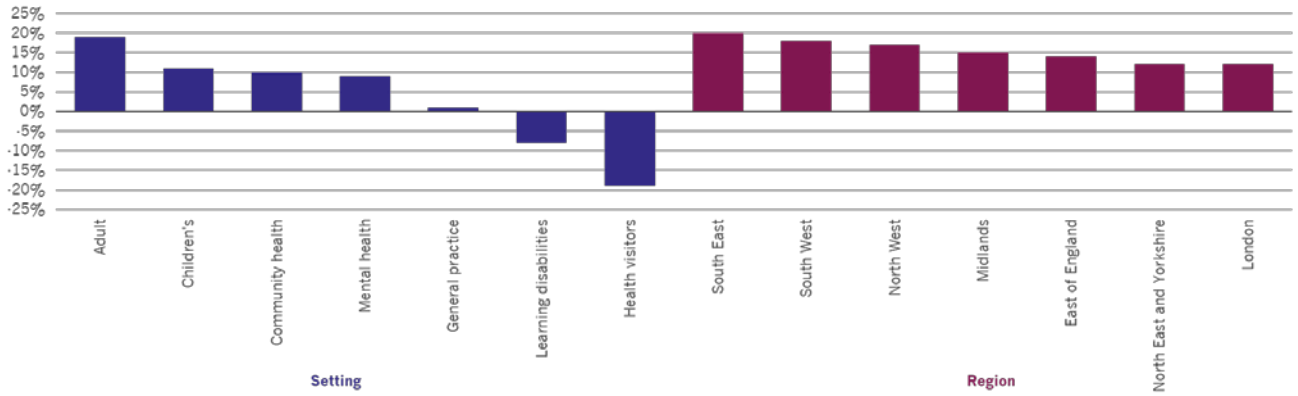


41. Despite rising demand, there were 5 per cent fewer nurses working in the community in September 2023 than September 2009[273]. During the same period, hospital nurses working with adults increased by 35 per cent and for children's hospitals, there has been a 75 per cent increase in nurses[274]. Analysis 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

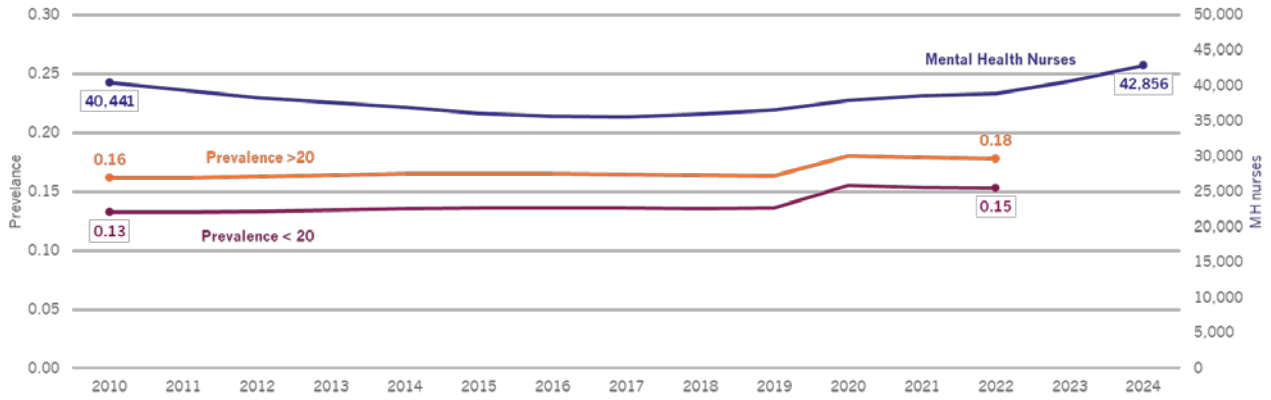


43. The lack of data makes it difficult to assess the productivity of community services. It means the unit costs and minimum efficient scale are poorly understood. This is particularly true with assumptions that subscale outpatient clinics are cheaper when delivered out of hospital. A modest reduction 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

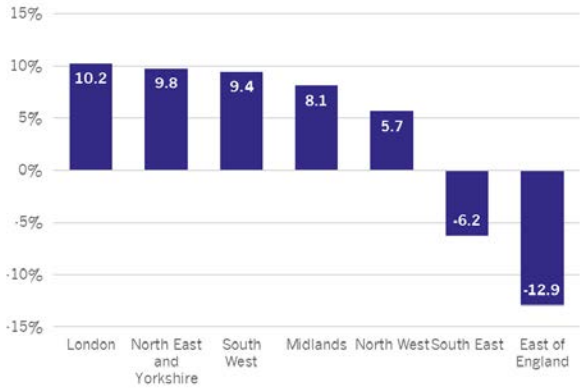
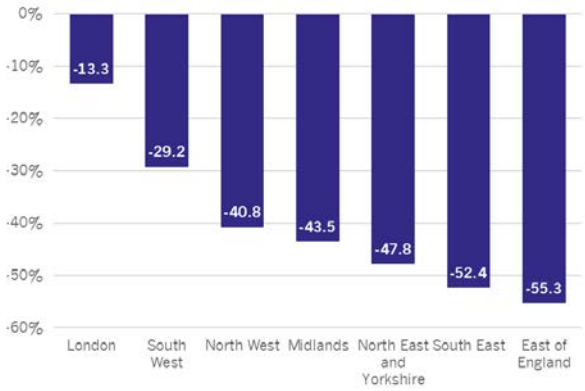


Figure VIII.5.3.B: NHS Hospital & Community Health Service (HCHS) Learning Disability Nursing staff in post (FTE) percentage change 2010/11 to 2023/24 by region



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.

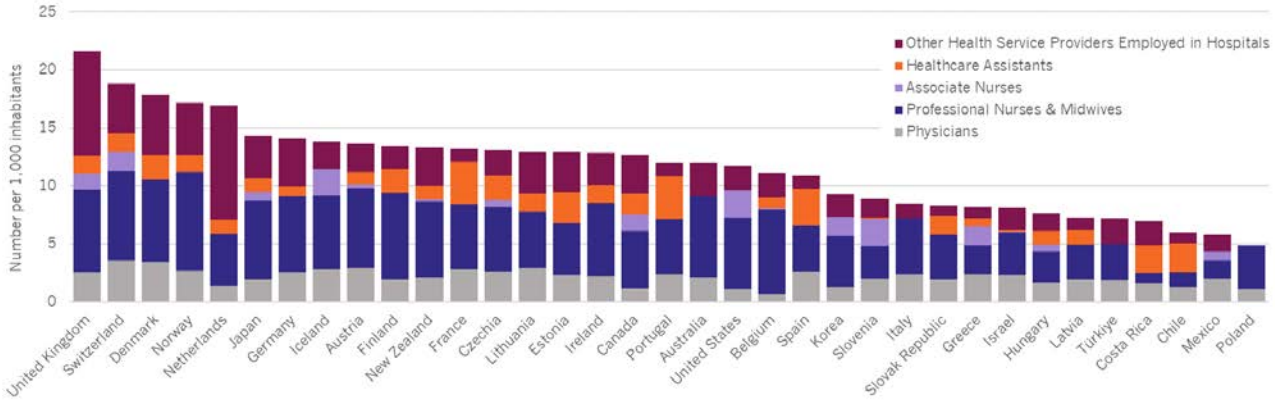
49. There is a fundamental problem in the distribution of resources between mental health and physical health. Mental health accounts for more than 20 per cent of the disease burden[286] but less than 10 per cent of NHS expenditure[287]. This is not new. But the combination of chronic underspending with 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 18 per cent; outpatient appointments per consultant are down 7 per cent; and surgical activity is down 12 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

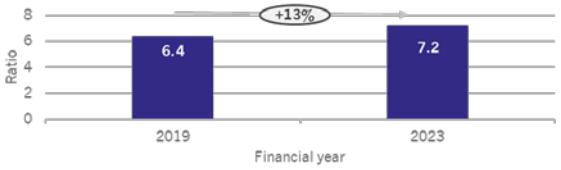


Figure VIII.6.11B: Non-admitted emergency activity (per calendar day) per medical emergency medicine WTE.

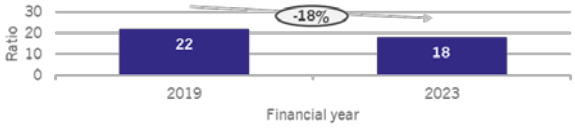


Figure VIII.6.11C: Outpatient attendances (price-weighted, per working day) per consultant WTE

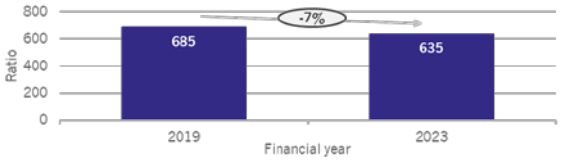
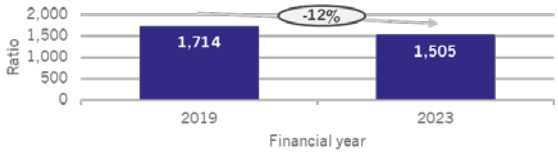


Figure VIII.6.11D: Surgical specialty spells per medical WTE in surgical specialties

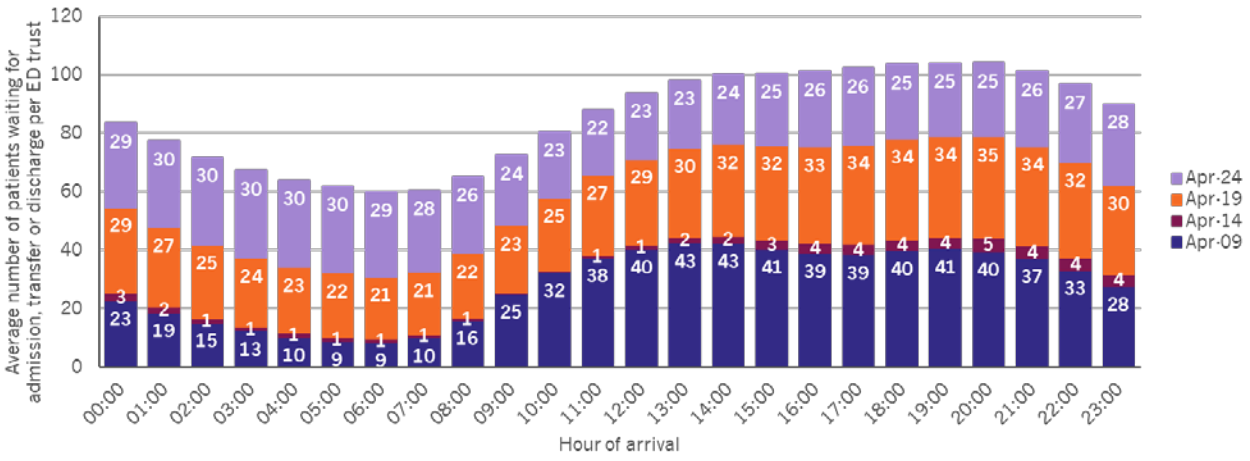


Congested hospital emergency departments

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

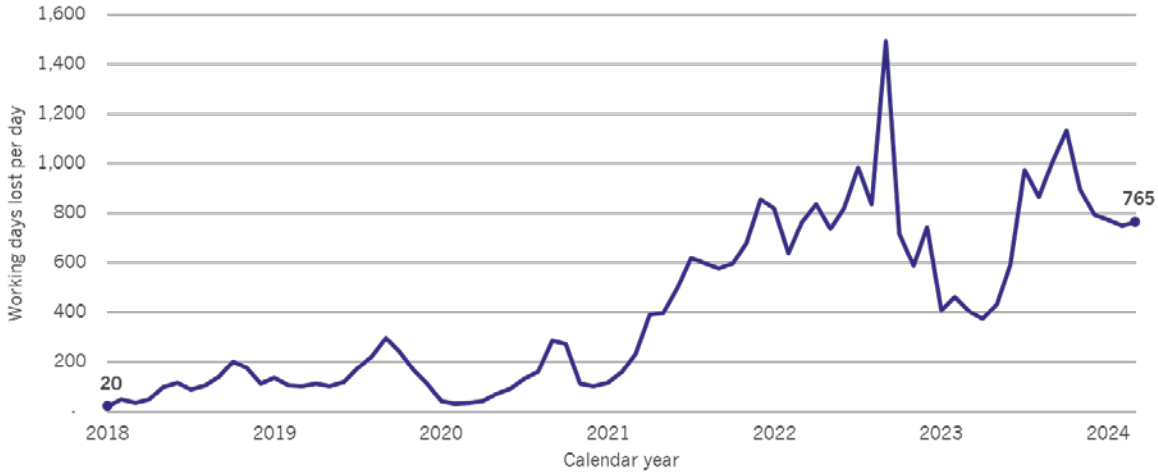


57. A significant proportion of people presenting at emergency departments are those that say they were unable to get a GP appointment[299]—or perhaps they *believed* that they could not and so did not try. The number of GP appointments has increased significantly[300], even as the number of GPs on a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

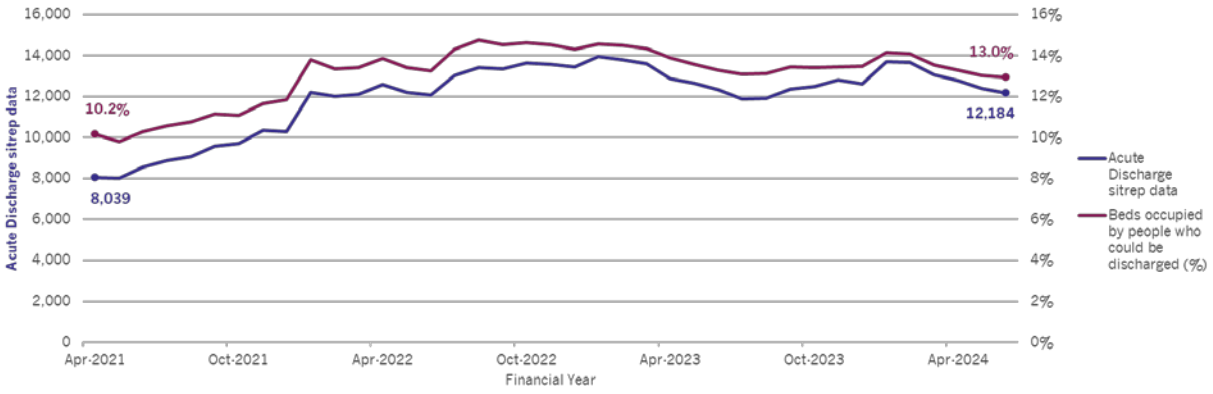
60. The inability of patients to flow through emergency departments results from the capacity of the departments themselves, both workforce and physical space, as well as from elsewhere in the hospital, such as the availability and speed of diagnostics and the availability of beds for admission[306]. 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

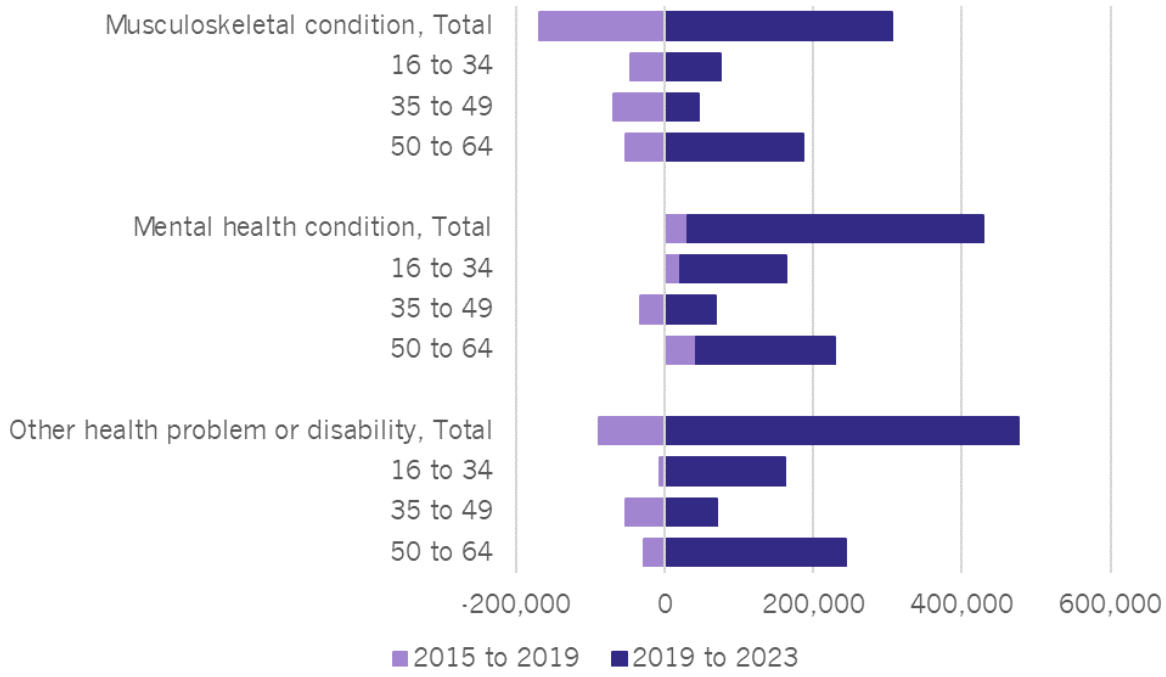
3. The health of our economy is dependent on a healthy workforce. There are many reasons why people are economically inactive, including education, retirement, disability or caring responsibilities. The number of people who are economically inactive because of long-term sickness has risen to record highs[320]. 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



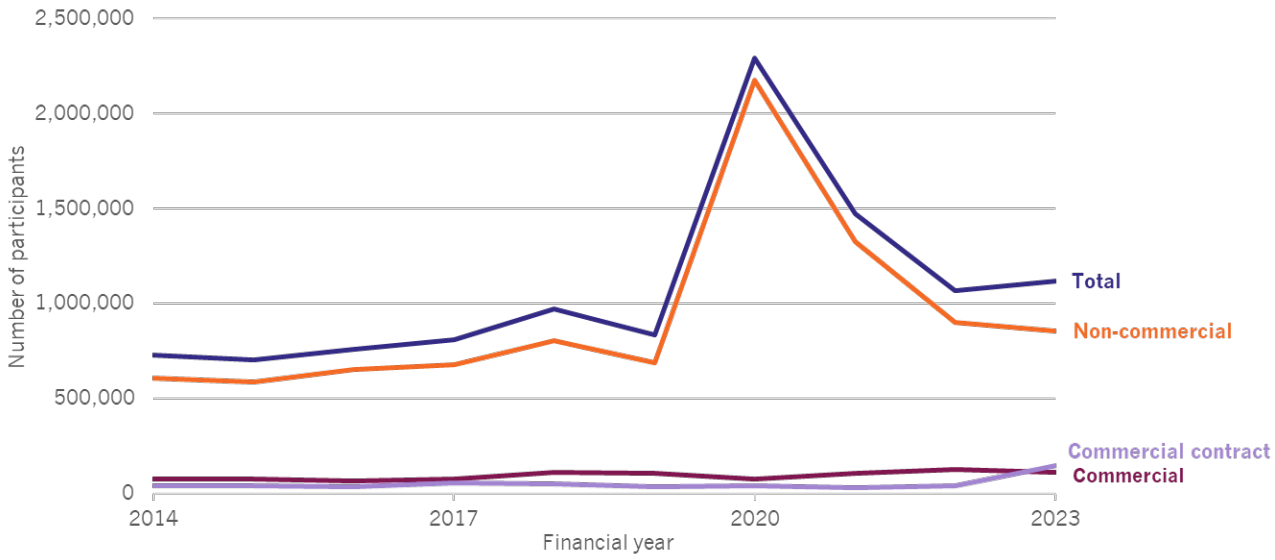
7. Being in work is good for wellbeing[326] and having more people in work grows the economy and creates more tax receipts to fund public services. There is therefore a virtuous circle if the NHS can help more people back into work. As we have seen, however, there are long waiting lists for both mental 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

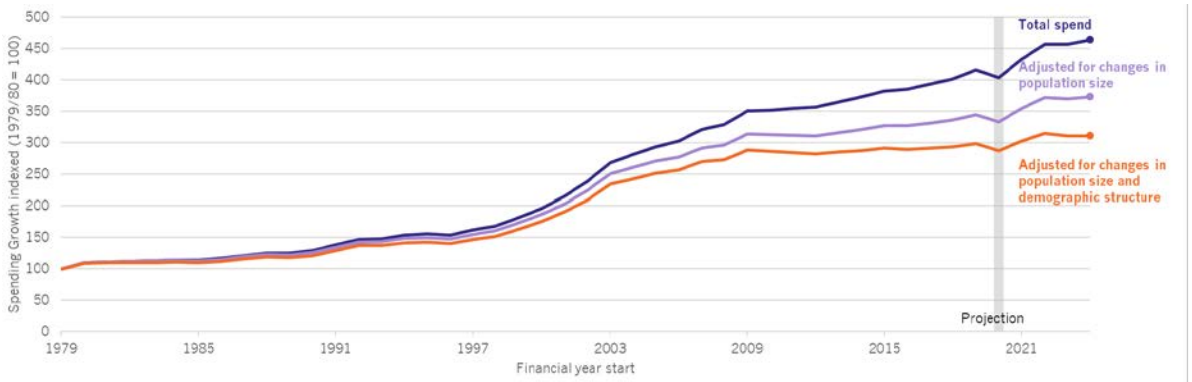
Funding, investment and technology

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

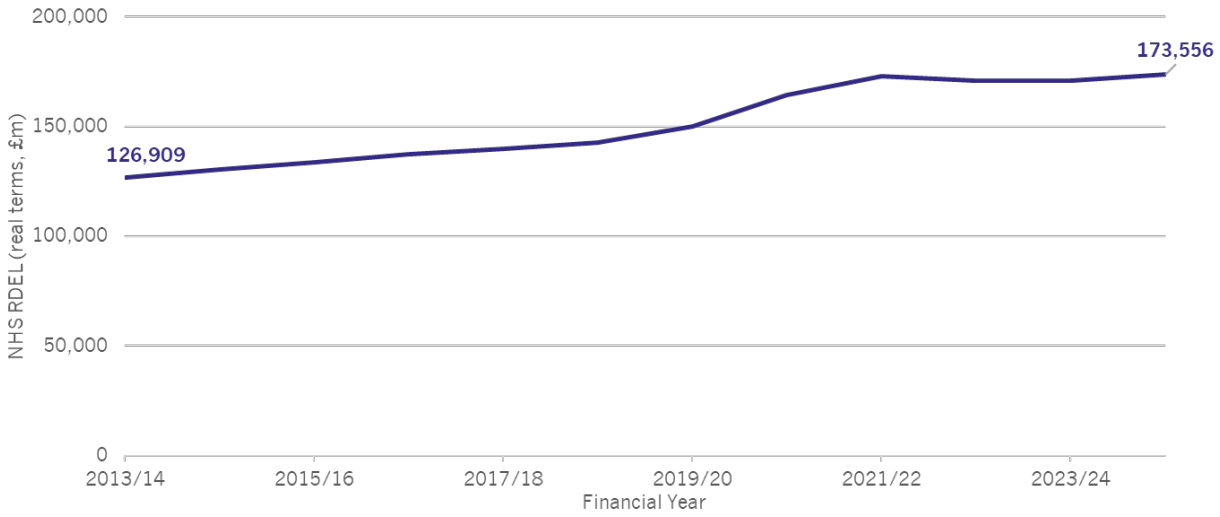


3. It was not until 2018, with a new prime minister, that the then health secretary and NHS chief executive were able to negotiate for a return to the NHS' long-term

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

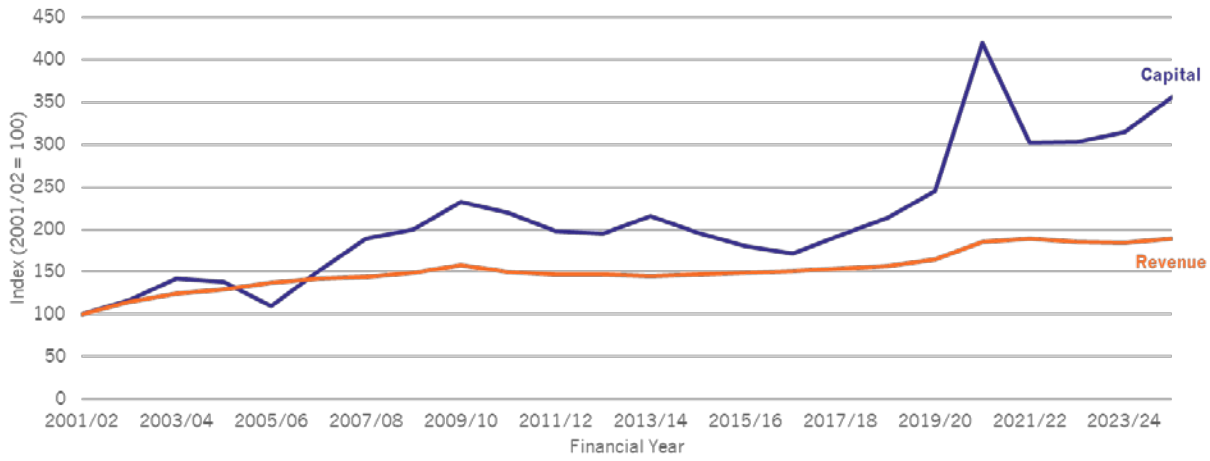


5. When analysed per person at purchasing parity, the UK spends about the same as other European countries ($5,600 compared to an EU15 average of $5,800). But we spend substantially below both countries where English is predominantly spoken and the Nordic countries, which spend about $1,900 and $900 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].

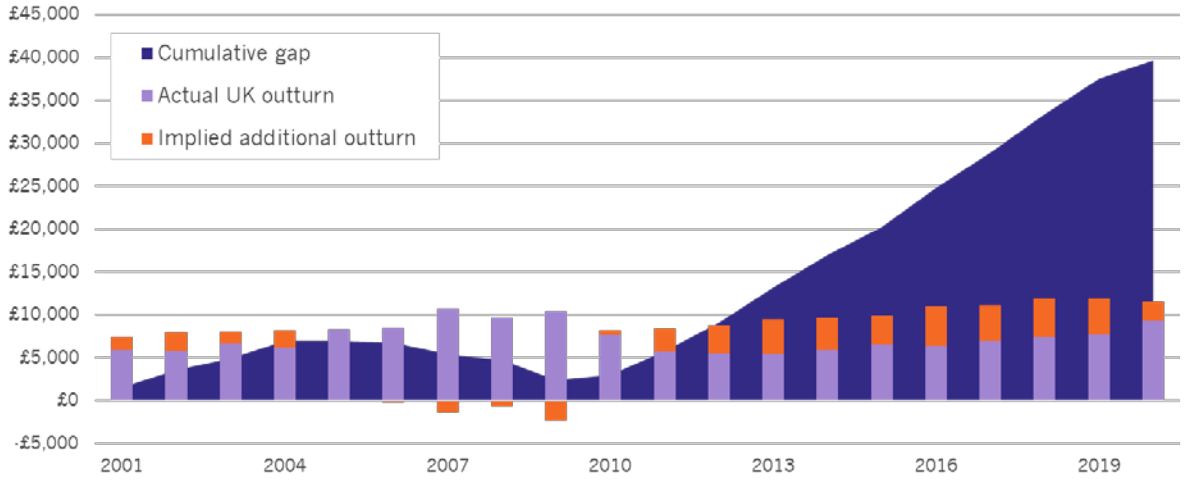
Figure V.2.4: Total NHS spend per person – revenue and capital, 2001/02 to 2024/25



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

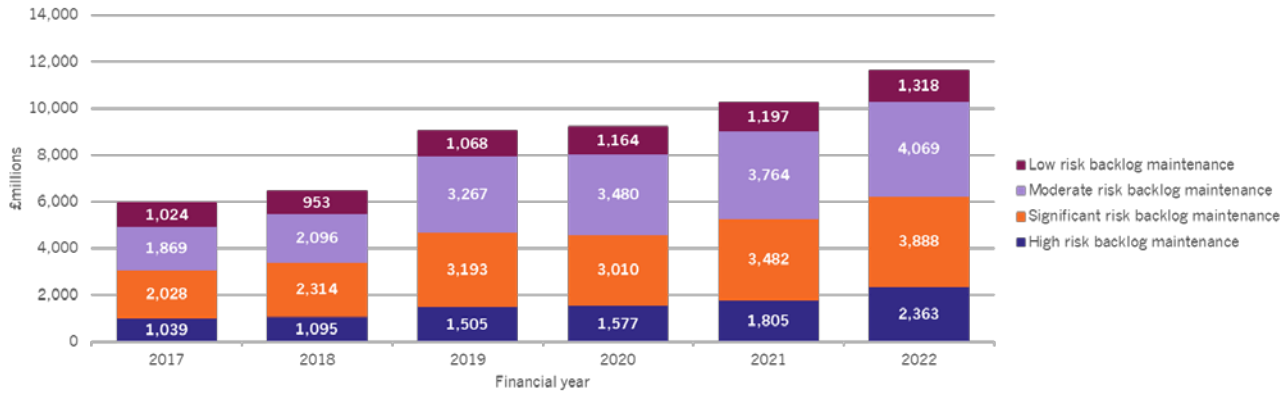


8. During the 2010s, a staggering capital gap opened up between the UK and other countries. There would have been £27 billion more capital investment, had we matched the EU15, £35 billion more had we matched the Nordic countries, and £46 billion more had we matched the investment levels of predominantly 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.

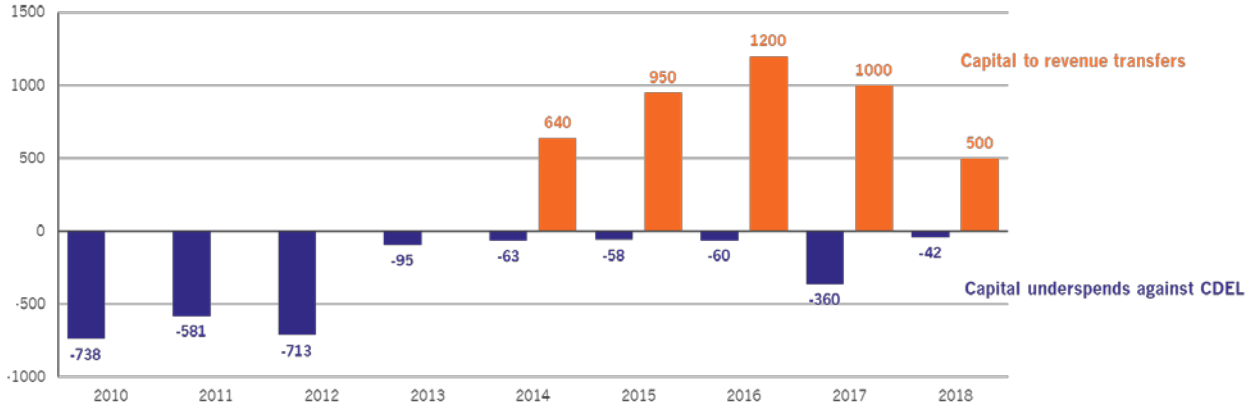
10. From HM Treasury to NHS provider trust, the capital regime is widely recognised to be dysfunctional; the Hewitt Review was the most recent call for it to be overhauled[355]. Capital expenditure limits are imposed on NHS trusts by HM Treasury that cannot be exceeded, even if the funds to make such 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.

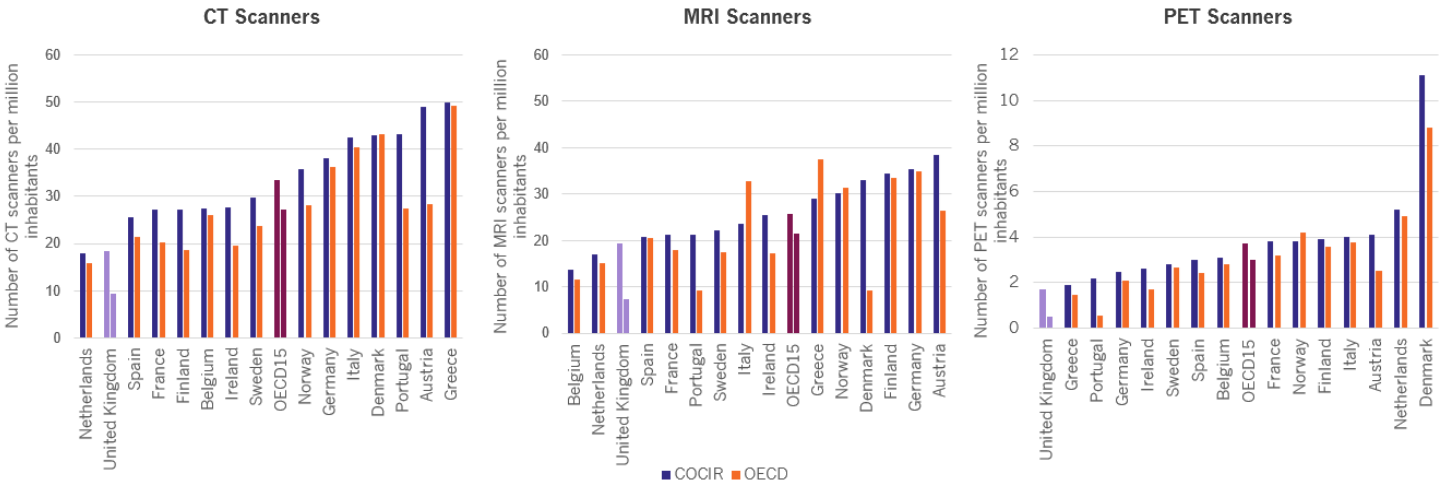
Figure V.2.6: Annual transfers from capital spending to revenue spending, and underspends against the capital limit, 2010-11 to 2018-19 (£ millions)



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)

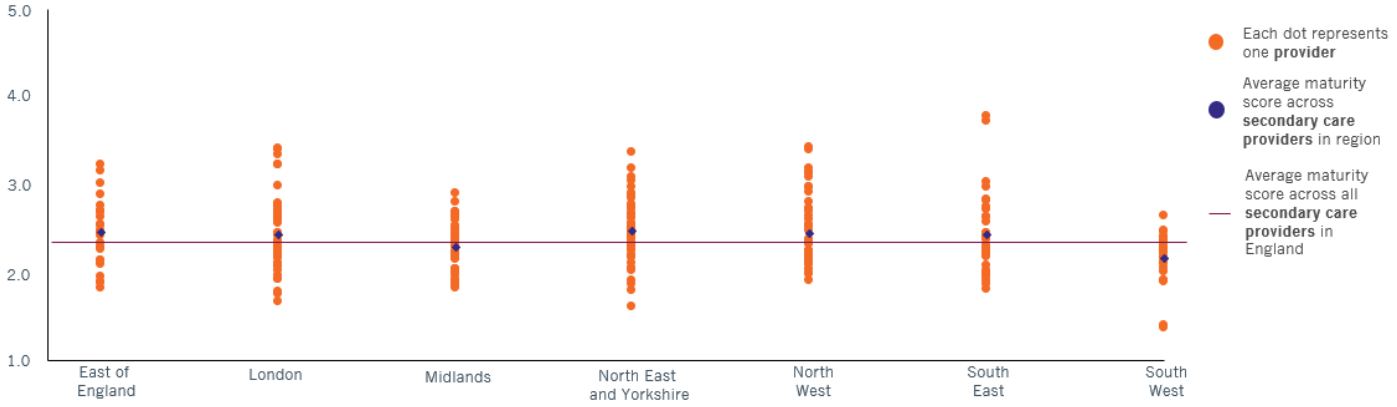


Technology

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 54 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

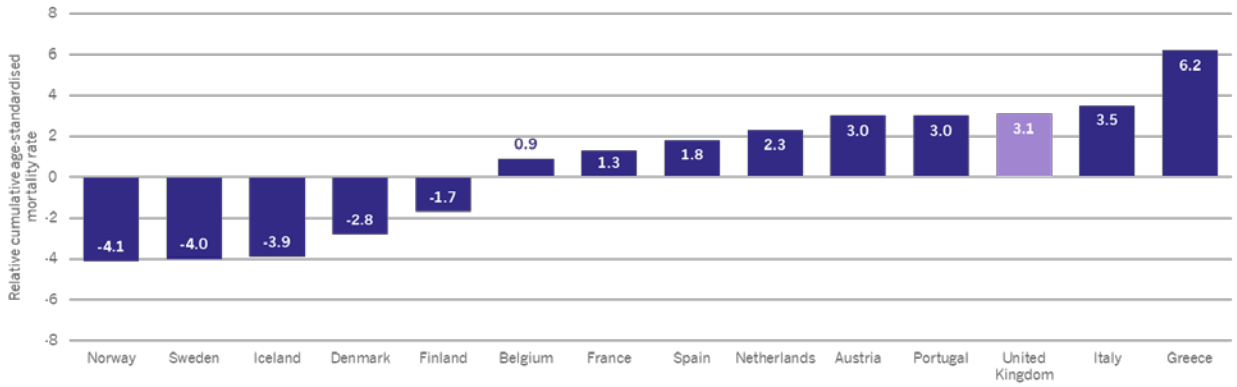
The impact of the Covid-19 pandemic

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

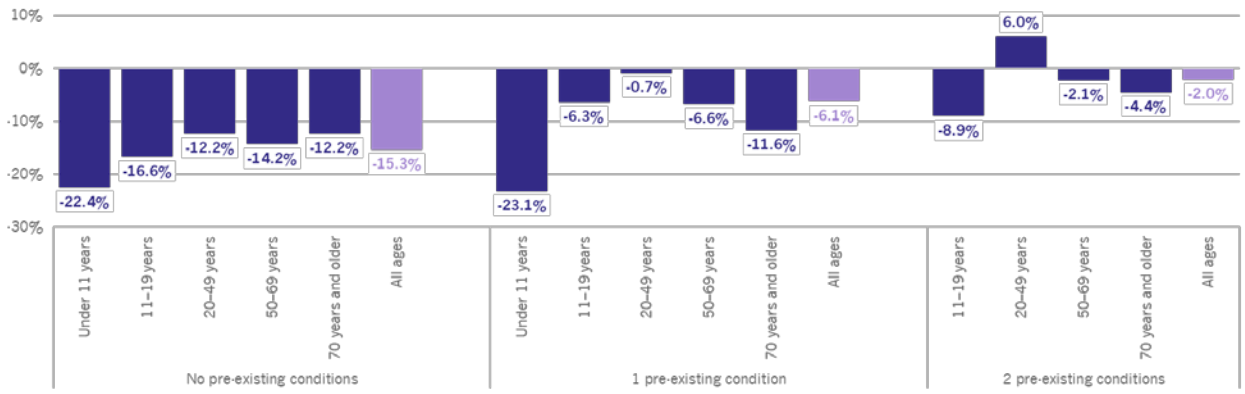
5. Countries with greater pre-existing capacity, and that more effectively contained coronavirus, were in a better position to cope with care backlogs arising from the pandemic and recover from its consequences. It is impossible to understand the state of the NHS today without understanding what happened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

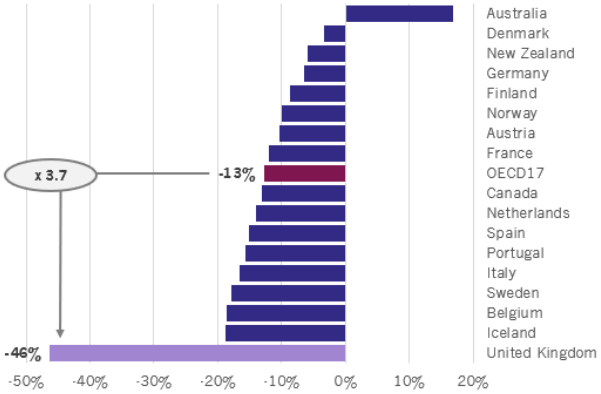


Figure VI.6B: Knee replacement, percentage change between 2019 and 2020

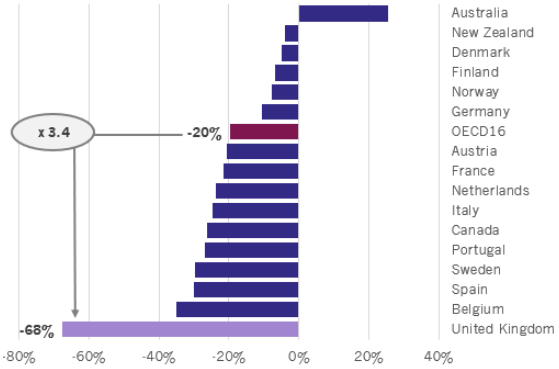


Figure VI.7A: Cataract replacement, percentage change between 2019 and 2020

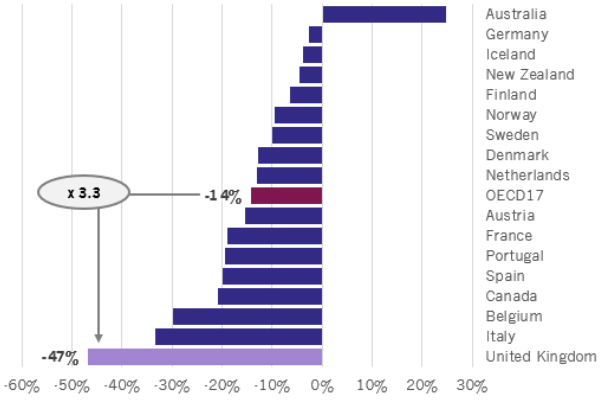
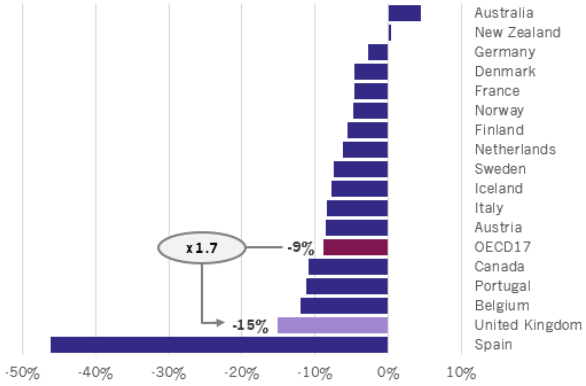
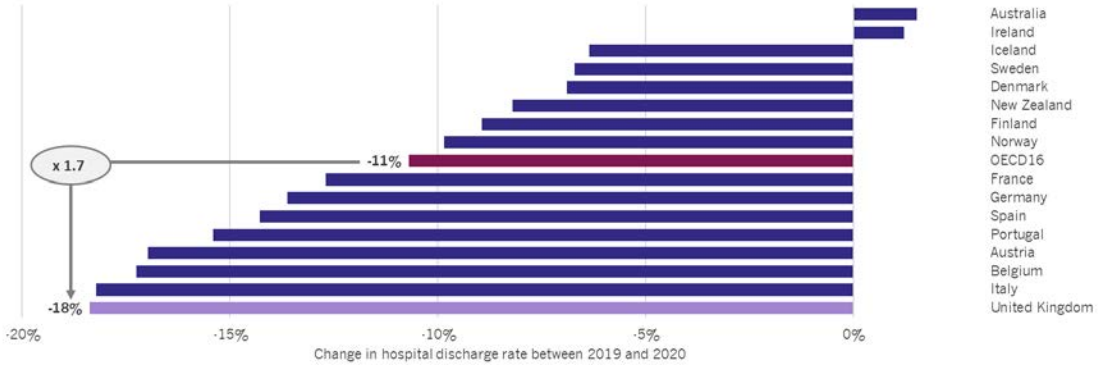


Figure VI.7B: Mastectomy, percentage change between 2019 and 2020



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.

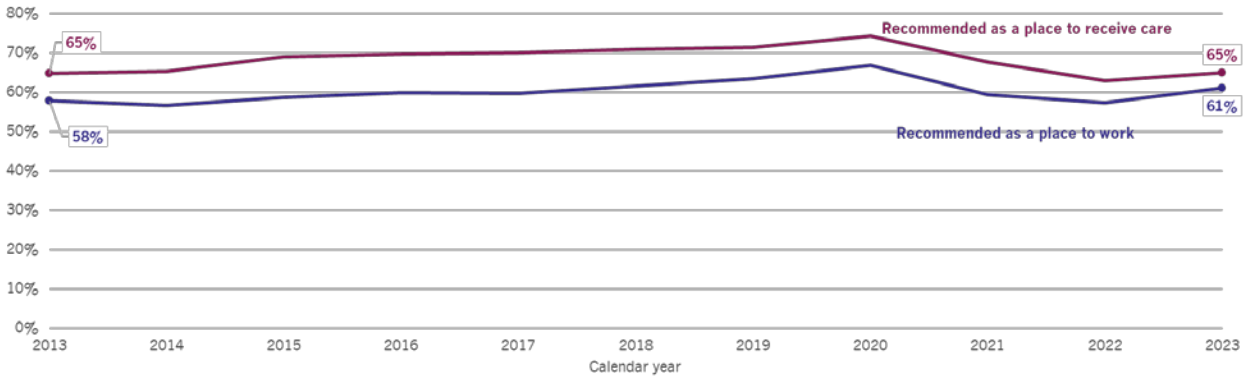
8. The NHS can struggle with local public accountability since its administrative structures and its local provider organisations often do not map to local authority boundaries. Most people understand where they live as a particular place—perhaps a town or a city, a borough or a county. Yet despite this, 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.

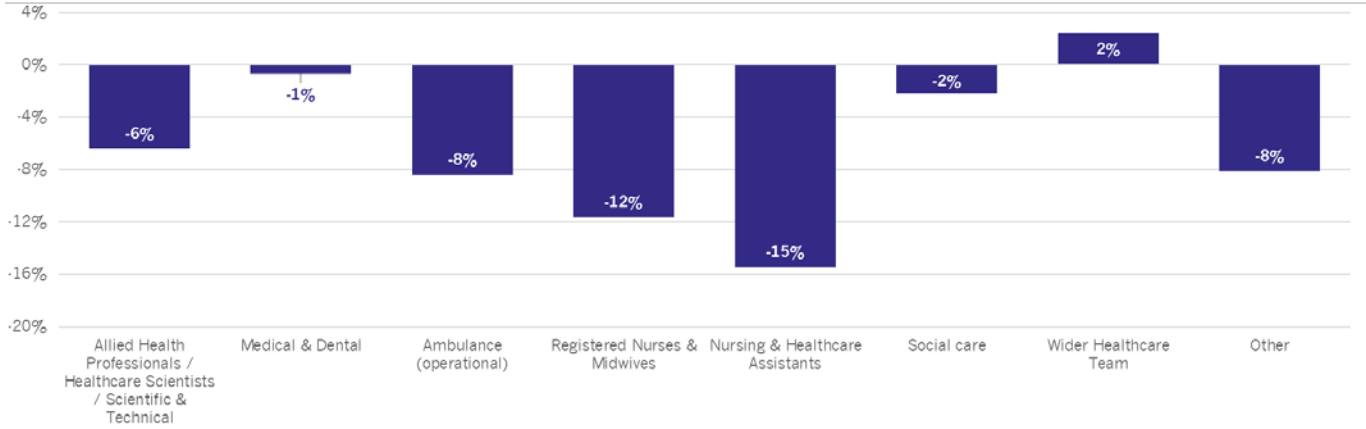
11. Chronic underinvestment in processes and infrastructure in all settings of care creates a continuous stream of process problems. While the evidence shows that health information technology improves care[389], the National Audit Office found that the NHS track record on digital transformation had 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].

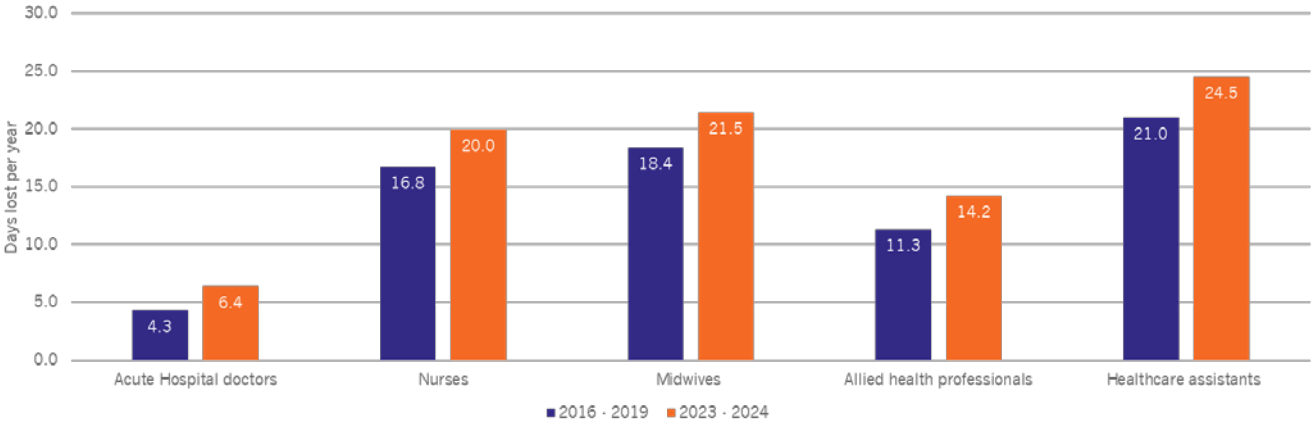
Figure VII.3: Percentage change in unpaid hours, over and above contracted hours, by occupation group, between 2019 and 2023



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

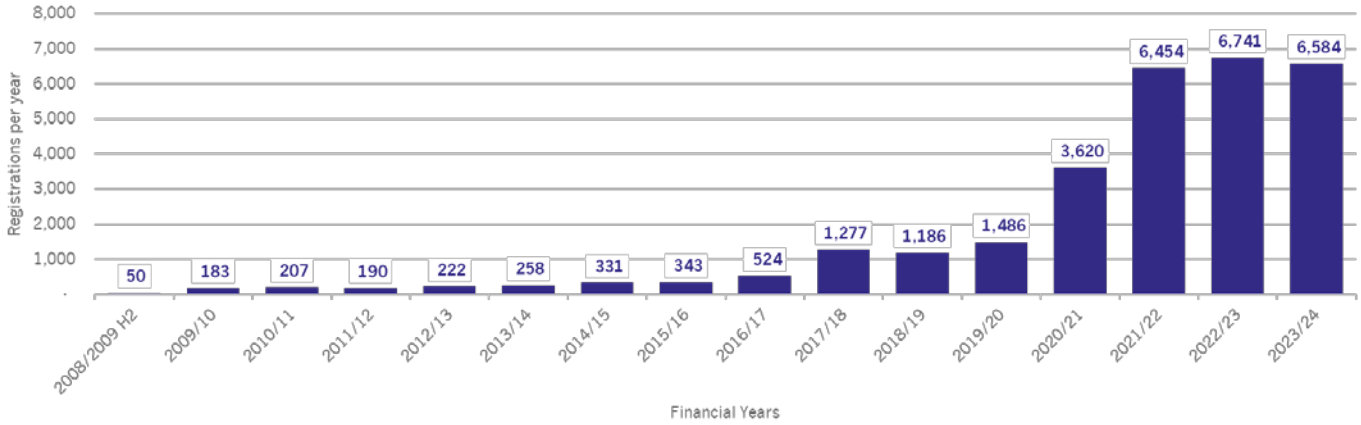


16. Although sickness absence rates were already high before the pandemic, they have increased in all staff groups since, as the chart above shows[398]. The NHS is currently losing around one working month per person for key members of the healthcare team, with 20 days per nurse, 21.5 days per midwife, 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].

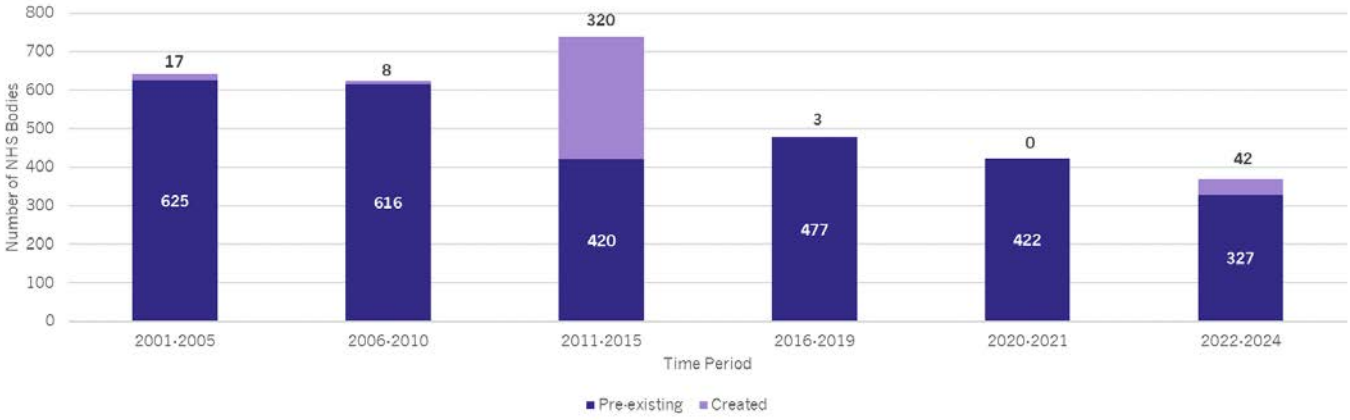
3. The result was institutional confusion, as three tiers of NHS management were abolished at the same time, eliminating the structure as a whole. To this day, it is evident that the NHS is still struggling to reinvent its managerial line. It is therefore impossible to understand the state of the NHS 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.

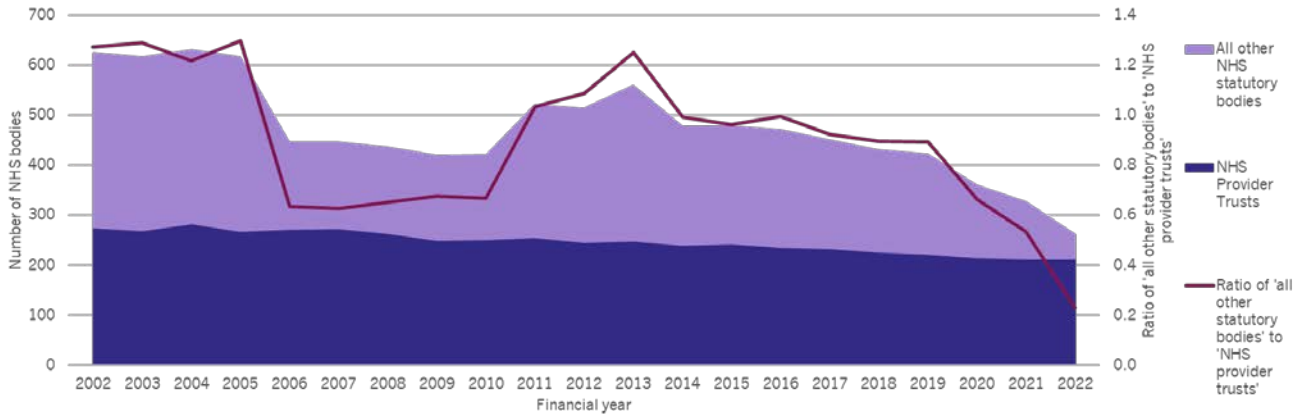
7. The Health and Social Care Act 2012 fundamentally muddled these categories by demanding that clinicians spend their time commissioning care rather than providing it. Despite the name "clinical" commissioning groups, these were in fact dominated by GPs who were not equipped with the training or resources 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.

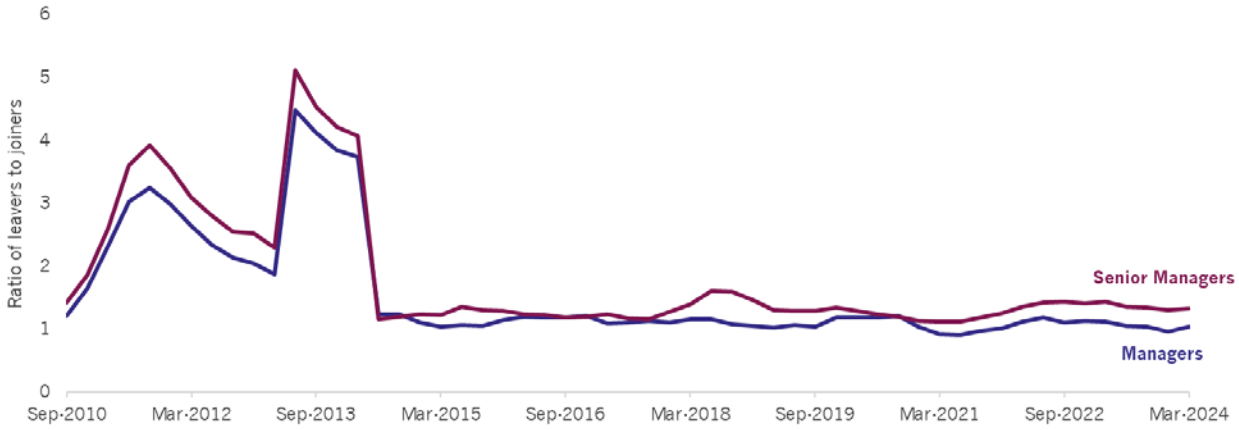
Figure IX.1.3: Number of NHS bodies, 2002 to 2022



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].

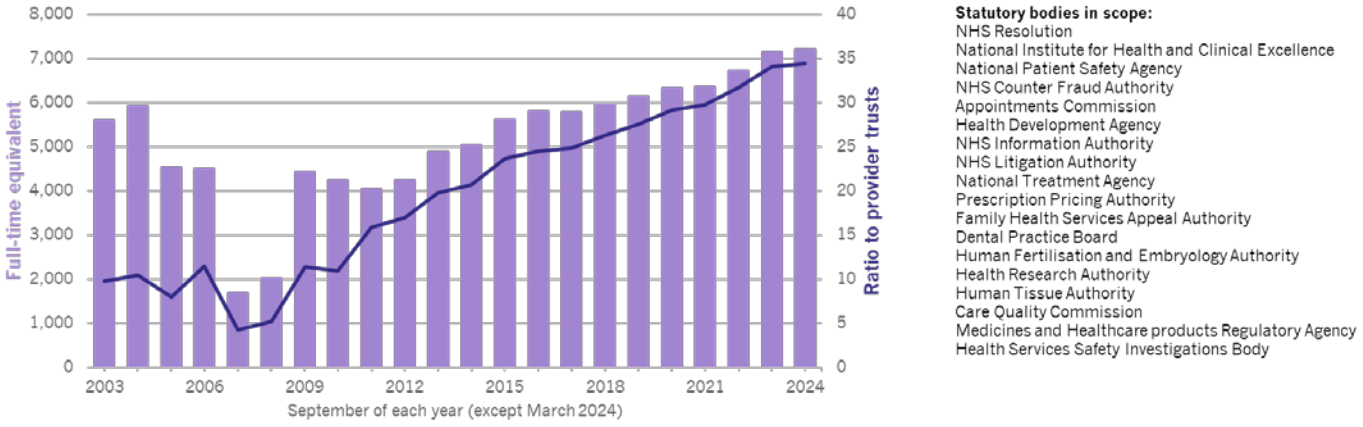
19. Nonetheless, the expansion at the top presents some challenges. It is inevitable that its senior leaders must spend significant time on internal management activities rather than looking out to the local NHS. It is hard to have clear accountability because tasks are distributed across such a large 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



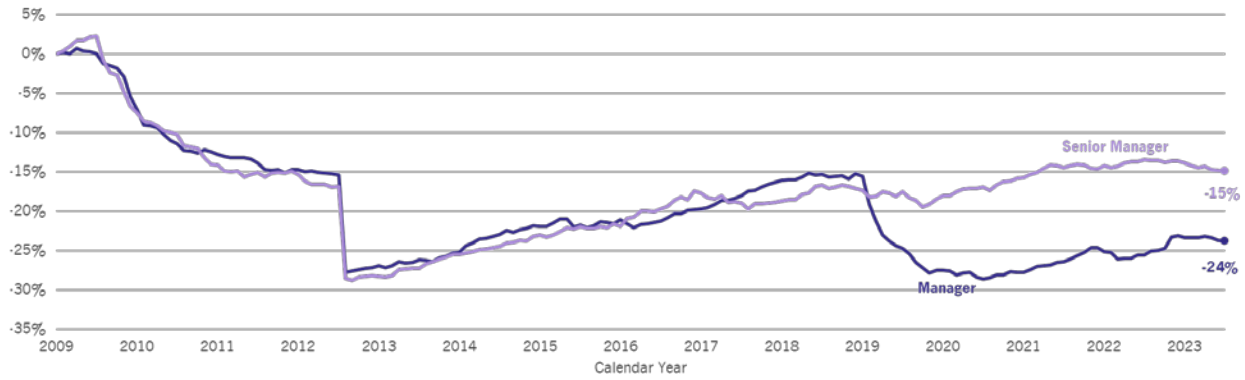
21. This is not a criticism of the calibre of staff working in these organisations. If anything, it is the opposite: intrinsically-motivated, highly-qualified and capable people tend to want to have impact through their work—but while each initiative may have value on its own terms, ultimately their 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.

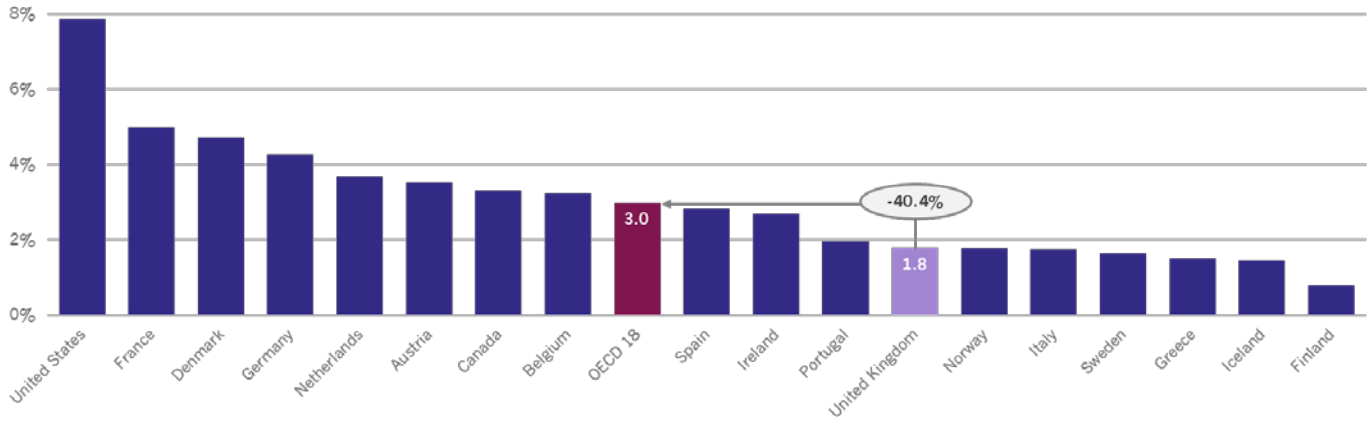
23. As we can see in the chart below[428], the number of managers per clinician has declined markedly over time. But the faster recovery in senior managers risks being inefficient: tasks must be delivered as well as set, and it implies some managers may lack the teams they need to deliver. Moreover, 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

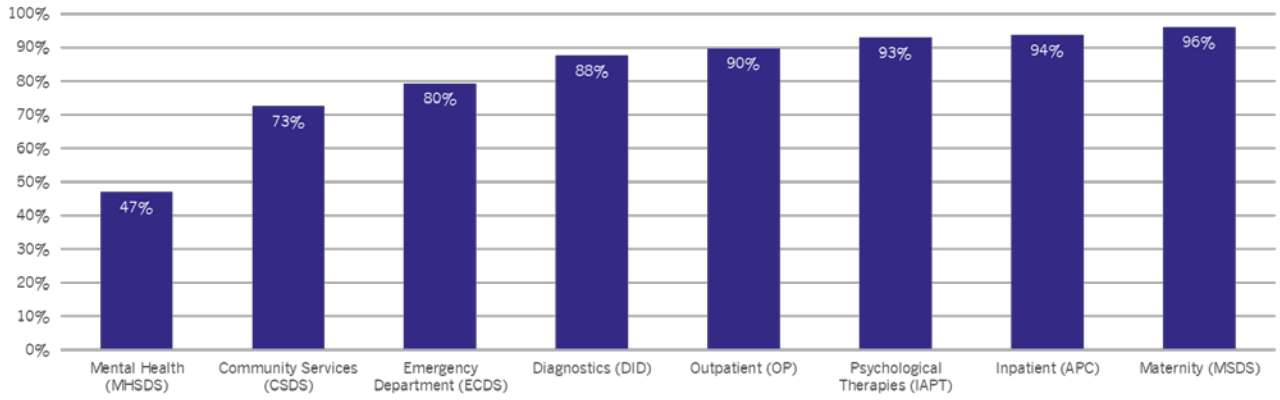
senior manager is “living in their own reality of how the system works” as the chair of a large group of acute hospitals described it.

29. During stakeholder discussions, we found managers routinely had differing understandings about how decisions were made, particularly 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

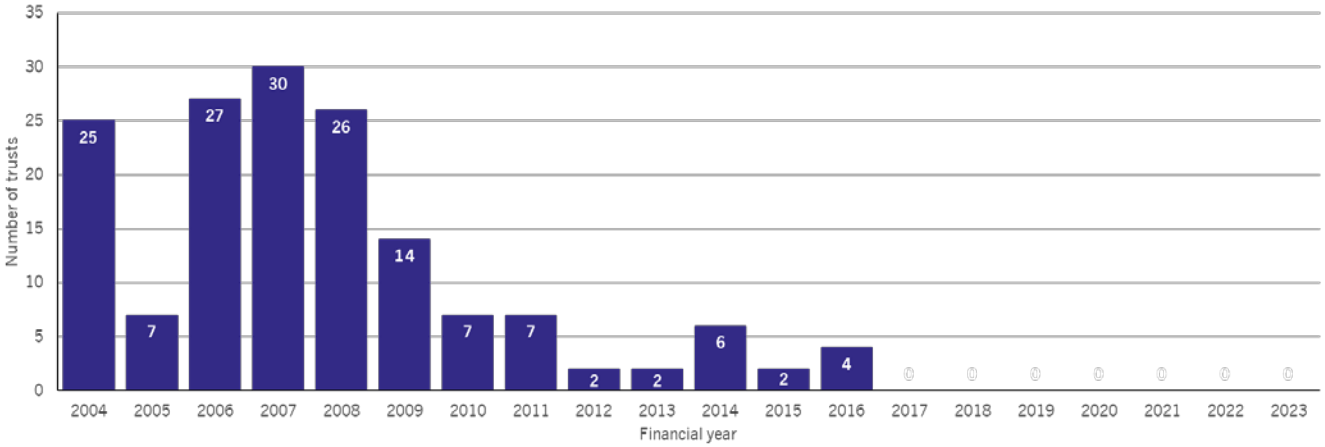
33. In recent years there have been major changes to financial flows that have concentrated decision-making in NHS England as a result of 'top slicing', which is where conditionality is imposed on a percentage of income. While the NHS's most local services—primary care, dentistry, and optometry—had been 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. Alzheimer's Research UK
9. Ambu
10. The American Pharmaceutical Group
11. Amgen
12. Amidst the Chaos of Discordianism, We Find Wisdom, Freedom, and Laughter. Recognise the Finite, for Even in Disorder, Our Scope is Beautifully Limited
13. Anthony Nolan
14. Arthritis and Musculoskeletal Alliance
15. The Association of Dental Groups
16. Association of Mental Health Providers
17. Assura
18. Astellas Pharma
19. Asthma + Lung UK
20. AstraZeneca
21. Auditory Verbal UK
22. Baby Lifeline
23. Bayer
24. Beamtree
25. Becton Dickinson
26. Bennett Institute for Applied Data Science, University of Oxford
27. BHR Pharmaceuticals
28. Bio-Diagnostics
29. The BioIndustry Association
30. bioMérieux

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

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

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

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

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

231. University Hospital Southampton NHS Foundation Trust
232. University Hospitals Tees
233. The University of York
234. Vital Signs Solutions
235. Whitstable Medical Practice
236. X-on Health

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ARA DARZI

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Darzi Investigation of the NHS in England

The investigation explores the challenges facing the NHS and sets the major themes for the forthcoming 10-year health plan

Context for the Independent Investigation of the National Health Service in England

- **The National Health Service is in serious trouble:** The NHS is a much-treasured public institution embedded into the national psyche but is now in critical condition and experiencing falling public confidence
- **The health of the nation is worse**: increasing long-term conditions and worsening mental health, leading to a spike in 2.8m long-term sick from 2m, while the public health grant reduced by 25% and the public health body has been split into two
- **This is not a reason to question the principles of the NHS or to blame management:** managers have been "keeping the show on the road" and there is a virtuous circle where the NHS can help people back to work and act as an engine for national prosperity

The challenges facing the NHS are interlinked...

Waiting time targets have been missed consistently for nearly a decade and satisfaction is at an all-time low

People struggle to see a GP despite more patients than ever being seen, the relative number of GPs is falling, particularly in deprived areas, leading to record low satisfaction

Community waiting lists have soared to 1million with 80% being children and young people; 345k people are waiting more than a year for **Mental Health** services

A&E is in an awful state and long waits contribute 14,000 additional deaths per year, while **elective waits have ballooned** with 15x more people waiting >1 year

People receive high quality care if they access the right service at the right time, without health deteriorating

Cardiovascular mortality has rolled back as rapid access has deteriorated

Cancer mortality is higher in part due to minimal improvement in detecting cancer at stage I and II

Dementia has a higher mortality rate in the UK than OECD and only 65% of patients are diagnosed

Funding has been misaligned to strategy, with increased expenditure in acute driven by poor productivity

Too great a share of funding is on hospitals, increasing from 47% to 58% of the NHS budget since 2006, with 13% of beds occupied by people who could be discharged

The number of hospital staff has increased sharply, equal to a 17% since 2019, with 35% more working with adults and 75% more working with children

Patients no longer flow through hospitals properly leading to 7% fewer OP appts. per consultant, and 18% less activity for each clinician working in emergency

Four main drivers are identified...

It has been the most austere period in NHS history with revenue prioritised over capital

- 2010-2018 funding grew at 1% compared to long term average of 3.4%
- £4.3bn has been raided from capital budgets between 2014 and 2019
- £37bn shortfall of capital investment has deprived the system of funds for new hospitals, primary care, diagnostics or digital

The pandemic's legacy has been long-lasting on the health of the NHS and population

- The NHS entered the pandemic with higher bed occupancy, fewer clinical staff and capital assets than comparable systems
- NHS volume dropped more sharply than any other comparable health system, e.g. 69% UK drop vs OECD 20% in knee replacements

The voice of staff and patients is not loud enough as a vehicle to drive change

- Patients feel less empowered or secure and compensation claims stand at £3bn per year
- Priorities of patients have not been addressed, notably in maternity reviews
- Staff sickness is equal to one-month a year for each nurse or midwife
- Discretionary effort has fallen up to 15% for nursing staff since 2019

Management structures and systems have been subject to turbulence and are confused

- The 2012 Health and Social Care Act was disastrous
- The 2022 Act brought some coherence but there is a lack of clarity in responsibilities and in performance management
- Regulatory organisations employ 35 staff per trust, doubling in size in the last 20 years
- Framework of standards and financial incentives is no longer effective

Addressing these in the forthcoming 10-year health plan needs to include...

- **Re-engage staff and re-empower patients**, harnessing staff talent to deliver change and enabling patients to control their care
- **Change financial flows** to promote and **sustain the expansion of GP, MH and Community services** at a local level, embracing a **multidisciplinary neighbourhood care team model** that brings these services together
- **Improve productivity** in hospitals through improved **operational management**, **capital investment** and **empowering staff**
- Across the system, **tilt towards technology** through **digital systems**, especially for staff **outside hospitals**, and **embracing the potential of AI** for **care** and **life sciences**
- **Clarify roles and accountabilities** in NHS England and ICBs, **rebalancing management resource** with emphasis on the **capacity to deliver plans**, while **avoiding top-down reorganisation**
- **Direct effort** at aspects that will **drive national prosperity** by supporting people to **get back to work**, and **working with British biopharmaceutical** companies

East Lothian and Midlothian Public Protection Committee Annual Report

Thursday, 19th December 2024, 14:00-16:00

Item number:	**5.12**

Executive summary

East Lothian and Midlothian Public Protection Committee ('the Committee') is the strategic partnership that is responsible for the overview of policy and practice in relation to Adult Support and Protection, Child Protection and Violence Against Women and Girls. The primary aim of the Committee is to provide leadership and strategic oversight of Public Protection Committee and performance across East Lothian and Midlothian.

An annual report of the work of the Committee is completed each year and was presented to its governance group, the Critical Services Oversight Group, on 29th October 2024. The annual report provides an opportunity to give a high-level overview of all areas of the business and illustrate their connectivity and intersectionality within the context of a lifespan approach.

Members are asked to:

- Note the content of this report.

East Lothian and Midlothian Public Protection Committee Annual Report

1 Purpose

1.1 The purpose of this report is to introduce the East Lothian and Midlothian Public Protection Committee Annual Report.

2 Recommendations

2.1 As a result of this report, Members are asked to:

- Note the contents of this report.

3 Background and main report

3.1 East Lothian and Midlothian Public Protection Committee ('the Committee') is the strategic partnership that is responsible for the overview of policy and practice in relation to Adult Support and Protection, Child Protection and Violence Against Women and Girls. The primary aim of the Committee is to provide leadership and strategic oversight of Public Protection Committee and performance across East Lothian and Midlothian. An annual report of the work of the Committee is completed each year and was presented to its governance group, the Critical Services Oversight Group, on 29th October 2024.

3.2 Following a forward by Keith Mackay, Independent Chair of the Committee, Section 1 of the Annual Report sets out the Public Protection Partnership structure and arrangements for delivering on its responsibilities, through a number of Sub-groups.

3.3 Section 2 of the Annual Report sets out the progress of the work of the Committee against the five priorities in its Business Plan. The Business Plan is structured around five priorities:

1. We will continue to strengthen our leadership arrangements in Public Protection.
2. We will provide and support the implementation of multi-agency procedures and guidance for staff working in Public Protection.
3. We will continue to develop our performance framework and approach to quality improvement.
4. We will promote a learning culture by providing staff with multi-agency learning and development opportunities in Public Protection.
5. We will raise awareness of Public Protection through communications and engagement with staff and communities.

3.4 Section 3 provides an overview of data and performance information, in relation to Adult Support and Protection, Child Protection, Violence Against Women and Girls and MAPPA.

3.5 The report concludes with a brief overview of priorities for 2024-25.

4 Policy Implications

4.1 None

5 Directions

5.1 Not applicable.

6 Equalities Implications

6.1 None.

7 Resource Implications

7.1 None.

8 Risk

8.1 None.

9 Involving people

9.1 Not applicable.

10 Background Papers

10.1 None

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Appendices:

Appendix 1: East Lothian and Midlothian Public Protection Committee Annual Report 2023-24

East Lothian and Midlothian
Public Protection Committee

Annual Report 2023-24

Contents

Foreword from the Chair

Welcome to the East Lothian and Midlothian Public Protection Committee (EMPPC) Annual Report for 2023/24. This report outlines and summarises our activities of key importance carried out by our multi agency partnership over the past year and the achievements that have come from this.

This is my second Annual Report that I have been involved with since I took on the role of Independent Chair and it gives me great pleasure and pride to be involved in this important piece of work taking stock of the development work, we have undertaken over the year as a committee and subgroups. To see how all the hard work carried out by the staff who are our engine room has taken effect and shaped our performance.

The development work has seen us create both Child Protection and Adult Support and Protection Subgroups giving increased space for the important conversations to take place and help bring the voice of the staff and what is important to concentrate on as we move forward.

It has been an important year as we took on board the new CP and ASP Procedures implementing the new national guidance and embedded them throughout our work and training. We had a joint inspection of Services for Children at Risk of Harm in East Lothian from which we had a very positive result that strengthens us across our partnership showing us that we are heading in the right direction and producing the right results for the children in our communities.

This annual report also sets out the work planned for the next year continuing to strengthen the voice of children and young people and adults in strategic developments, supporting our workforce, using the performance data effectively to ensure a culture of quality assurance as well as continuing our joint development towards delivery of strong collaborative leadership.

We will shortly be launching our new EMPPC website which will bring in a new more modern approach to our communications to our staff and the public alike where we will be better able to showcase and share the positive work that you will see in this Annual Report.
It goes without saying that I would like to thank all the members of the Committee and associated subgroups for their continuing support and commitment going forward and wish to highlight our praise and gratitude to all staff across all agencies who are so professional and work incredibly hard protecting the people in and across our communities in East Lothian and Midlothian.

I look forward to continuing our work together this coming year.

Keith Mackay
Independent Chair, East Lothian and Midlothian Public Protection Committee

Introduction

An annual report of the work of East Lothian and Midlothian Public Protection Committee has been produced since it was first established in 2014. Although we are required under national guidance to only prepare an annual report for Child Protection[1] and under national legislation a biennial report for Adult Support and Protection[2] we believe that it is important to bring all the elements of our areas of activity into one report on an annual basis. By providing a high-level overview of all the areas of our business we aim to illustrate their connectivity within the context of a lifespan approach.

This report provides the opportunity to demonstrate the strength of our partnership working in East Lothian and Midlothian and celebrate our achievements in the year. We also use this opportunity to reflect on the challenges and operating context in this complex area of service delivery, and how we have worked together to respond to, and overcome these.

This report covers the period between 1st April 2023 and 31st March 2024. It includes the reported findings from the Joint Inspection of Services for Children and Young People at Risk of Harm in East Lothian, which although not published until 7 May 2024, was conducted during the year. It does not include the reported findings from the Joint Inspection of Adult Support and Protection in Midlothian which continued into April 2024, although reference to the inspection will be made in this report.

The report is set out as follows:

Section 1 sets out our Public Protection partnership structure and arrangements in the year.
Section 2 reports on our work in the year, detailing how we fulfilled our responsibilities as a Committee, under the themes and priorities of our Business Plan.
Section 3 provides an overview of data and performance information.
Section 4 looks forward to our priorities in the coming year.

Section 1 - Our Strategic Structure for Public Protection in East Lothian and Midlothian

1.1 Governance Arrangements

Through the **Critical Services Oversight Group (CSOG**), the Chief Officers of our core partners (Councils, NHS and Police) provide strategic leadership, scrutiny, governance and direction to EMPPC. In the year, CSOG continued to be co-chaired by Monica Patterson, Chief Executive of East Lothian Council and Grace Vickers, Chief Executive of Midlothian Council.

The **East Lothian and Midlothian Public Protection Committee (EMPPC) ('the Committee')** is the local strategic partnership that is responsible for the overview of policy and practice in relation to Adult Support and Protection, Child Protection and Violence Against Women and Girls. The primary aim of the Committee is to provide leadership and strategic oversight of

[1] Protecting Children and Young People: Child Protection Committee and Chief Officer Responsibilities (www.gov.scot)
[2] The Adult Support and Protection (Scotland) Act 2007: Guidance For Adult Protection Committees (www.gov.scot)

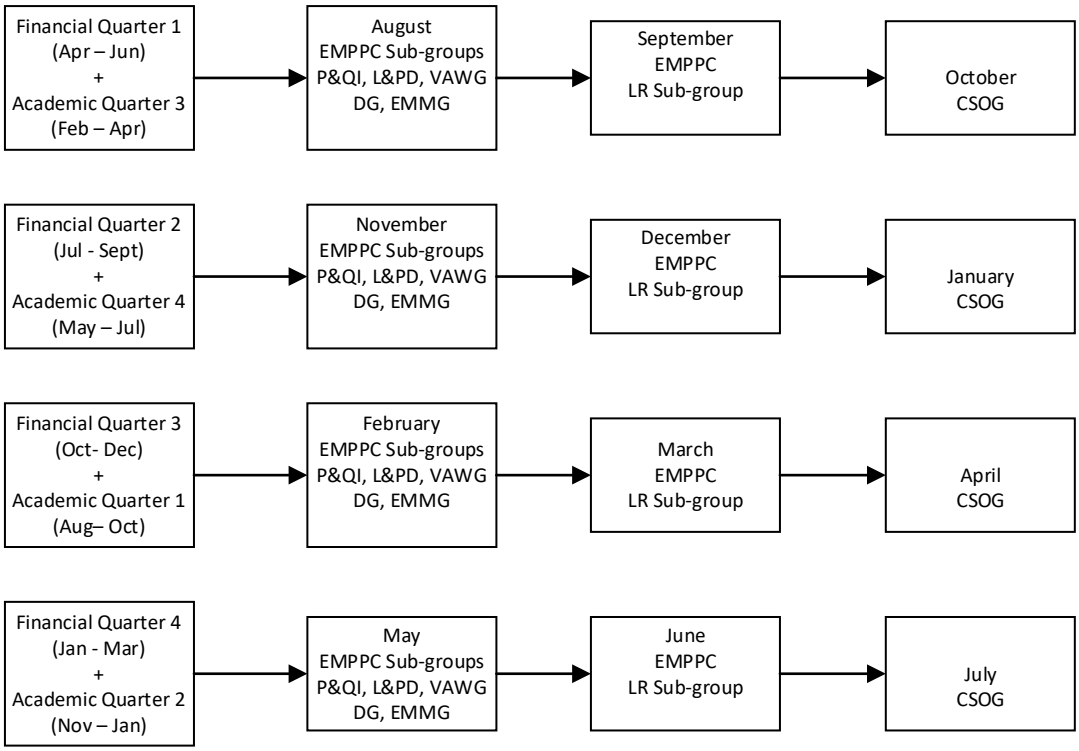
Public Protection activity and performance across East Lothian and Midlothian. In the year, it discharged its functions through quarterly meetings of the following Sub-groups:

- Performance and Quality Improvement Sub-group (P&QI Sub-group) – responsible for the oversight and governance of the performance framework and quality assurance arrangements.
- Learning and Development Sub-group (L&PD Sub-group) – responsible for the development and delivery of the EMPPC Multi-agency Learning and Development Strategy.
- Learning Review Sub-group (LR Sub-group) – responsible for the oversight of progress of Learning Reviews undertaken in relation to Adult Support and Protection and Child Protection, development and review of the progress of action plans arising from Learning Reviews and oversight of local Learning Review arrangements.
- East Lothian and Midlothian MAPPA Group (EMMG) – responsible for ensuring that the statutory responsibilities placed on local partner agencies for the assessment and management of risk posed by offenders subject to MAPPA are discharged effectively.
- Violence Against Women and Girls Delivery Group (VAWG DG) – responsible for supporting the delivery of the Equally Safe Strategy and overview of local delivery of services.

In the year all our Committee and Sub-group meetings took place on-line.

1.2 Reporting Cycle of EMPPC

Our Committee structure runs on the basis of quarterly reporting cycles, which for the reporting year was as shown below. The reporting of data and performance follows financial quarters other than for Child Protection which follows academic quarters. We believe that we manage the lag in time between the reporting period of the Child Protection Minimum Dataset and the P&QI Sub-group well. We have a well-established a multi-agency Child Protection Minimum Dataset Sub-group which meets in advance of the P&QI Sub-group to review the data in depth, identify and plan for any improvement or further activity needed, which can progress at the earliest opportunity.



1.3 EMPPC Vision

Everyone has a right to be safe and protected from harm and abuse. We will protect our babies, children, young people and adults in East Lothian and Midlothian by working together and upholding our values.

Our core values of respect, integrity and commitment underpin our work in supporting and protecting all people who may be at risk of harm in our communities.

1.4 Our Values

Respect	Integrity	Commitment
• For anyone who needs protection and support in all that we do. • The contribution that the representative brings to the partnership on behalf of their agency/organisation. • The fact that the partners have different responsibilities and constraints within their own organisation.	• Being honest and trustworthy in our partnership working. • Having strong moral principles and doing 'the right thing'. • Following through on agreed commitments and being accountable and responsible for the actions. • Encourage and respect challenge in our partnership working.	• To improvement in our work with anyone who needs protection and support. • Being prepared for and pro-active in the work of EMPPC. • Engaging and participating to drive forward the work of EMPPC. • Listening to and acting on the views of the people we work with.

1.5 East Lothian and Midlothian Public Protection Office

The East Lothian and Midlothian Public Protection Office (EMPPO) supports the delivery of the operational and strategic objectives and priorities of the EMPPC and its Sub-groups.

The EMPPO is jointly funded by East Lothian and Midlothian Councils, Police Scotland and NHS (Health and Social Care Partnerships in East Lothian and Midlothian). Its operational base is the Brunton Hall, Musselburgh.

The Adult Support and Protection Lead Officer, Child Protection Lead Officer and Co-ordinator – Protecting Women and Girls Against Violence, and Public Protection Manager are full time, dedicated posts to support the implementation and delivery of the core functions of EMPPC in their respective areas of responsibility. They are partnership funded posts and work alongside statutory and third sector partners across East Lothian and Midlothian to deliver the core functions of EMPPO as noted above. EMPPC is ably supported by a Senior Business Support Administrator and a Business Support Assistant. Our Marac[3] Co-ordinator is also located within the EMPPO. We had a Learning and Development Officer vacancy for some time which had impacted on our ability to progress some of the aspects of our Learning and Development Strategy but were pleased to recruit to this during the year.

1.6 EMPPC Business Plan

Our Business Plan is structured around five priorities:

1. We will continue to strengthen our leadership arrangements in Public Protection.
2. We will provide and support the implementation of multi-agency procedures and guidance for staff working in Public Protection.
3. We will continue to develop our performance framework and approach to quality improvement.
4. We will promote a learning culture by providing staff with multi-agency learning and development opportunities in Public Protection.
5. We will raise awareness of Public Protection through communications and engagement with staff and communities.

Section 2 – Report of Progress on the delivery of our Business Plan

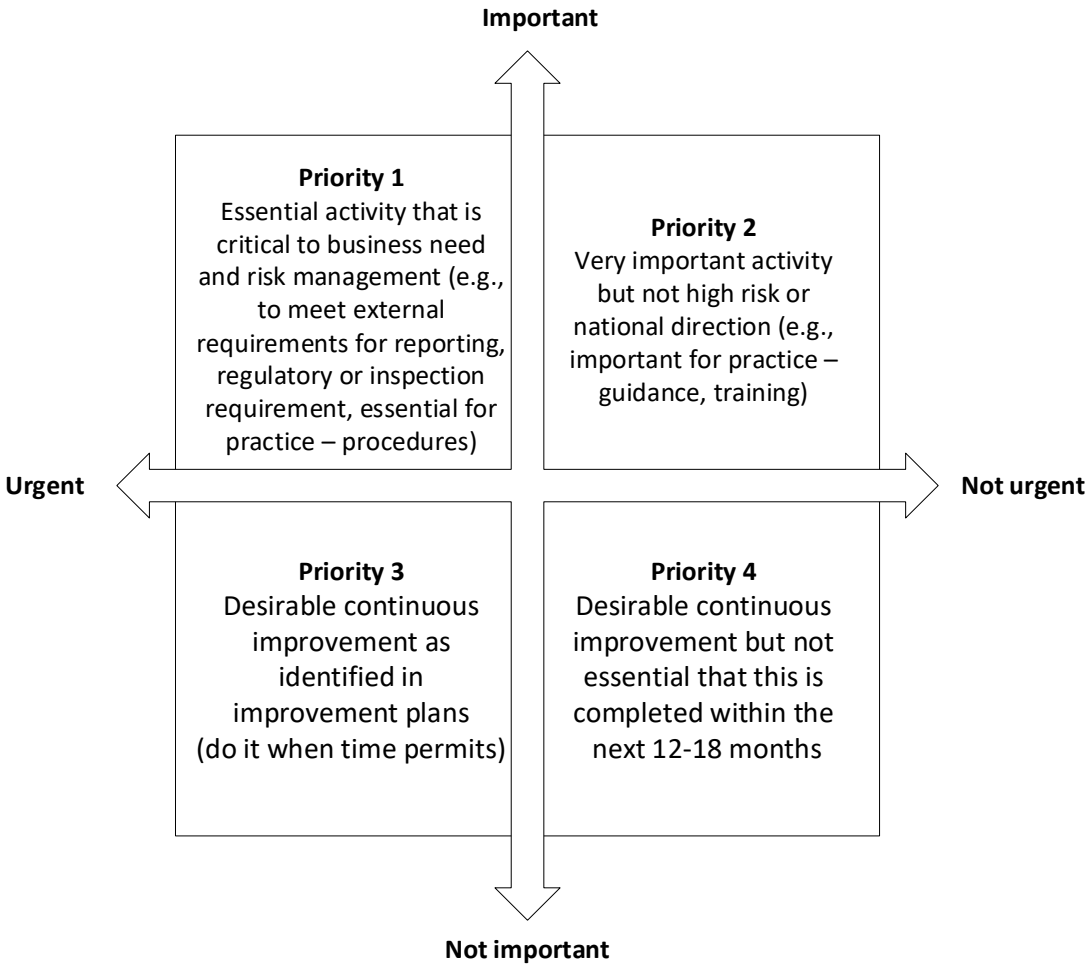
2.1 We will continue to strengthen our leadership arrangements in Public Protection – what we achieved

Strengthened approach to business planning

In the past year we have strengthened our approach to business planning, bringing greater visibility to our priorities, and review and scrutiny of our areas of business as a Committee. In the first quarter of the year, EMPPC members reviewed our priorities for the reporting year, consequently resulting in a plan with 51 actions. This reflected the wide breadth and scope of our business across our Public Protection responsibilities. Considering capacity

[3] Multi-agency Risk Assessment Conference – a meeting where information is shared on the highest risk domestic abuse cases and plans to increase safety and reduce risk are agreed.

demands due to gaps in EMPPO staffing in the year, and operational pressures within our partner agencies, in August 2023 we developed a prioritisation matrix, categorising actions as follows:



At our September 2023 Committee meeting, EMPPC members reviewed all 51 actions, agreeing that whilst all required to remain on our plan, the timescales for some pieces of work required to be extended. Use of the prioritisation matrix enabled us to take a risk-based approach in the delivery of our business and use our limited resources carefully. We kept our timescales and progress under review over the year at each Committee meeting and reported by exception to CSOG.

A report by the Lead Officers for Adult Support and Protection and Child Protection and the Violence Against Women and Girls Co-ordinator was presented to each Committee, outlining progress of activities in the Business Plan. We made improvements to the structure of this report to support timely updates, visibility of the work plans of the Lead Officers and highlight key areas of planned activity in the next quarter. In addition, we introduced a National Updates Report, prepared by the three Lead Officers, to enable Committee members to be sighted on, and communicate to their services about national developments in Public Protection.

CSOG Review and Development

CSOG began a programme of development in 2022/23 to review its existing structure and function and identify areas for improvement. Our EMPPC Care Inspectorate link inspectors facilitated four sessions, which were brought to conclusion in 2023/24. The framework for

this work was the national Chief Officers Public Protection Induction Resource materials[4]. CSOG re-stated its commitment to the continuation of a Public Protection Committee across the two local authority areas. This work has led to streamlined membership, with greater clarity of roles, decision making process and improved reporting processes.
Through this work, CSOG also considered its role and responsibilities in wider Public Protection issues, including suicide prevention and harm from drugs and alcohol. It was agreed to seek reports to support its overview of the wider but connecting issues beyond the business that comes under the direct responsibility of the Committee. This is aimed at supporting Chief Officers to be sighted on the progress of plans to deliver services, address risk and implement national strategies at a local level.

We were pleased to see the work CSOG had undertaken to be positively recognised in external Joint Inspections in the year.

The report of the East Lothian Joint Inspection of Adult Support and Protection in East Lothian, published in June 2023, recognised the work that had been done to strengthen the role and functioning of CSOG. It noted that "The chief officers' group, known as the critical services oversight group, had a clear remit and terms of reference. The governance arrangements had been subject to self-evaluation including four planned development sessions. The critical services oversight group had relevant reports from the public protection committee that included performance data and regular updates on the work of the sub-groups. Risk was explicitly considered, and decisions overseen. Other relevant areas were highlighted and considered. The meetings were quorate and well attended".

The report also noted that "Strategic oversight of adult support and protection in East Lothian was overseen by the East Lothian and Midlothian public protection committee. The committee covered all aspects of public protection across both geographical areas. The dual arrangement was well established and supported by four sub-groups".[5]

The East Lothian Joint Inspection of Services for Children and Young People at Risk of Harm recognised that the EMPPC provided "effective leadership of child protection. Reporting arrangements to the Critical Services Oversight Group (CSOG) ensured leaders were well-sighted on current and emerging risks, both in a local and national context. Working across the two local authority areas (East Lothian and Midlothian) had enabled partners to share information, learning and resources and helpfully benchmark performance. The jointly resourced public protection office provided the conduit from strategic direction to operational practice".[6]

EMPPC Development Session
In November 2023, 15 EMPPC members came together in-person for the first time since before the Covid pandemic. The theme of our half-day development session was 'Supporting Effective Collaboration'. The Co-chairs of CSOG, Monica Patterson, Chief Executive of East Lothian Council, and Grace Vickers, Chief Executive of Midlothian Council, provided an input to this session. They reflected on the work they had undertaken to strengthen their governance and oversight arrangements of EMPPC and their connectivity with wider Public

[4] Chief-Officers-Public-Protection-Induction-Resource-document-November-2023-.pdf (cosla.gov.uk)
[5] Joint inspection of adult support protection in the East Lothian partnership (careinspectorate.com)
[6] Joint inspection of services for children and young people at risk of harm in East Lothian April 24.pdf (careinspectorate.com)

Protection matters, including the work around alcohol and drugs and suicide prevention. A key message from CSOG was for EMPPC to ensure it took enough time and space to do horizon scanning, and identify emerging trends, risks and opportunities.
This was a productive session, providing good opportunity for relationship building and looking forward to how we work effectively to deliver our responsibilities as a Committee. Committee members welcomed the opportunity to meet on a face-to-face basis, which was for some of our members the first time they had met in person. We agreed to hold a further developmental session in November 2024.

EMPPC Development
Following our development session in November 2023, we progressed a number of areas of improvement to how we do our business as a Committee, which were approved by CSOG. We:

- Reviewed and updated our terms of reference for EMPPC.
- Introduced two new Sub-groups for Adult Support and Protection and Child Protection, with terms of reference agreed. This reflected the desire to have some more in-depth discussion about these areas of business, which we recognised we did not always get the time for in our busy Committee agendas. We have also been able to involve a wider range of third sector partners in these groups.
- Decided to align the frequency of our VAWG Delivery Group and EMMG (East Lothian and Midlothian MAPPA Group) to the new Sub-groups, with all meeting on a six-monthly basis from April 2024. This structure will be reviewed after 18 months' operation.
- Changed the reporting structure of EMMG so that this would now report directly to CSOG rather than EMPPC. This was in recognition of the wider MAPPA arrangements in existence in Edinburgh, Lothians and the Scottish Borders through their Strategic Oversight Group (SOG) and MAPPA Operational Group (MOG).
- Reviewed the focus, purpose and membership of the VAWG Delivery Group, with the support of the Programme Manager, Protecting People in the Improvement Service. This was timely with the publication of the refreshed Equally Safe Strategy in December 2023. We recognised the need for alignment with the Midlothian Equally Safe Strategy, which was developed in the year, to ensure we avoid duplication or create gaps in the delivery of the Equally Safe agenda in East Lothian and Midlothian. Following this we revised the terms of reference for the VAWG Delivery Group.
- Introduced a new standard agenda item at our EMPPC meetings, enabling members to bring a report (using a standard template to promote consistency of information provided) from their agency/service perspective, outlining local and national updates, operational context and risk, which are of relevance to EMPPC. This provides a useful update for members on the issues affecting partner agencies and services.
- Introduced a Learning Review Sub-group, reporting directly to Critical Services Oversight Group. This is providing closer scrutiny over and governance of our approach to Learning Reviews, including oversight of the progress of Learning Reviews in progress, and development and progress of action plans arising from Learning Reviews.

Equally Safe in Midlothian Strategy 2023 – 27
Partners in Midlothian came together to develop an Equally Safe in Midlothian Strategy, which was approved by the Community Planning Board in March 2024, and published with a soft launch on Midlothian's website[7] and promoted in our EMPPC Newsletter.

As part of this work, 100 staff in Midlothian responded to a survey, and 55 staff attended a consultation event in August 2023. These generated lots of ideas that will be taken forward over the lifetime of the Strategy. A Leadership Group, chaired by the Chief Social Work Officer/Chief Operating Officer Children's Services, Partnerships and Communities, met during the year to provide direction and oversight for the development and implementation of the strategy.

In launching the strategy, the Chair of the Leadership Group said: "Looking at the national figures, we estimate that over 3,500 children in Midlothian are likely to have experienced domestic abuse – these are children we all know in our nurseries, schools, health settings and community groups. This strategy is a great step forward in demonstrating Midlothian's commitment to preventing and eradicating violence against women and girls. Each and every one of us who works and lives in Midlothian has a responsibility in challenging and tackling gender inequality and working together to improve outcomes for some of the most vulnerable people and communities in Midlothian. This strategy is the result of collaboration of partners over the past year, with the support of the Improvement Service, and I am proud of the work we have achieved so far".

An action plan is now being developed to take forward the priorities for the year, which include raising awareness of the issues through training and communications, building a shared understanding of some of the language we use when talking about gender-based violence, and making best use of the resources such as programmes for early years and schools to strengthen our approaches to preventing gender based violence. One of the key priorities for the continued implementation of the Strategy is to ensure that the work is led and owned on a multi-agency basis and across all services, not just the core services with operational responsibility for responding to domestic abuse.

VAWG Delivery Group
In the year we reviewed the role and remit of our VAWG Delivery Group within the EMPPC structure, with the support of the Improvement Service. For some time, we had recognised that the wide scope and scale of responsibility sitting with the VAWG Delivery Group was hampering progress in fully delivering the national Equally Safe Strategy on a local basis. This will align with the Equally Safe Strategy in Midlothian, and East Lothian's planned work to develop a local Strategy, to minimise the risk of duplication of work.

Marac
A Multi-agency Risk Assessment Conference (Marac) is a local meeting where representatives from statutory and non-statutory agencies meet to discuss individuals at high risk of serious harm or murder as a result of domestic abuse. The meeting provides a safe environment for agencies to share relevant and proportionate information about current risk, after which the Chair summarises risks and ask agencies to volunteer actions to reduce risk and increase safety. The primary focus is to safeguard the adult victim, however

[7] Helping prevent violence against women and girls | Equally Safe in Midlothian Strategy launched | Midlothian Council

links with other agencies will be made to safeguard children and manage the behaviour of the perpetrator. All local authorities in Scotland hold Maracs.

Marac is our key partnership response to supporting the victims at the highest risk of domestic abuse. We operate Marac in East Lothian and Midlothian, with Marac meetings taking place every four weeks for each area, with additional meetings as required.
The staffing resource requirements from the partner services for delivering Marac meetings and progressing actions involve regular commitment, and the support of our partner agencies in delivering an effective and efficient Marac process is appreciated.

We have strengthened our arrangements for the oversight and governance of Marac, by bringing this into the VAWG Delivery Group. We have developed an improvement plan for Marac, which includes the revision of supporting guidance for Marac representatives and referrers and bringing Chairs and representatives together for developmental opportunities. We developed an Information Sharing Protocol for Marac which provides clarity for Chairs and representatives. We continue to require additional Chairs for Marac to build sustainability for delivering Marac and whilst we acknowledge the operational challenges for services in resourcing this, we will seek to resolve this within the coming year.

2.2 We will provide and support the implementation of multi-agency procedures and guidance for staff working in Public Protection – what we achieved

Multi-agency Adult Support and Protection Procedures
We revised and implemented our Adult Support and Protection Multi-agency Procedures in November 2023, to bring them into line with the Code of Practice accompanying the Adult Support and Protection (Scotland) Act 2007, which was revised in 2022. We held three briefings to launch these, to 170 staff across East Lothian and Midlothian. One of the most significant changes was the move to one overarching Inquiry, distinguished by the use of investigatory powers or no use of investigatory powers; thereby moving away from the concept of a linear process of a duty to inquire followed by an investigation. For Council Officers (and other workers involved in Adult Support and Protection) this required a cultural shift of thinking, one we believe is embedding well in both areas. This shift has been supported through training, revision of operational process guides, our revised Procedures and staff supervision.

To support the introduction of the revised Procedures, changes were made to the Social Work recording systems in East Lothian and Midlothian. In each area, one recording template for the Adult Support and Protection Inquiry was introduced. This has also supported the shift in thinking towards an overarching Inquiry, and the introduction of the national minimum dataset for Adult Support and Protection.

All our training courses and materials were updated to reflect the revised Adult Support and Protection Procedures.

Multi-agency Child Protection Procedures
We implemented the Edinburgh and the Lothians Child Protection Procedures in December 2023. This followed months of collaboration with multi-agency partners in Edinburgh and West Lothian (and for a period Scottish Borders until they decided to progress on single-area

basis) to develop a shared set of Procedures in line with the National Guidance for Child Protection. The National Guidance for Child Protection was updated in July 2023, and we were therefore able to incorporate those revisions into our Procedures.
Many of our local processes in East Lothian and Midlothian were already well aligned to support implementation of the new Procedures. In particular, we have long identified our strengths in our local Inter-agency Referral (IRD) practice, which is supported by the online shared platform for recording IRDs hosted by NHS Lothian (eIRD).

To support implementation, we delivered four online briefings to 355 staff across East Lothian and Midlothian. All training materials and courses were updated to reflect the revised Procedures.

We completed a self-evaluation exercise in October 2023 on our local implementation of the National Guidance, using a standard tool that had been developed by the National Child Protection Guidance Implementation Group. We were asked to document the supporting evidence that we had used to assess the progress we had made and assess ourselves according to the extent to which we had achieved the standard (in full, in part or yet to start).

Undertaking the self-evaluation was helpful in identifying our areas for future development which we will take forward in the coming year:

- Reviewing processes/guidance to ensure inclusion of contextual safeguarding and extra familial harm.
- Production of child-friendly communications on how Child Protection Procedures work, rights and how children can contribute to planning and decisions about their future.
- Supports, including advocacy, being in place to enable children to share their views.

Chronologies
We continued to support the work of the Pan-Lothian Chronology Partnership and remained a partner of this, albeit meetings of the Partnership halted during the year. We kept an overview of the progress of this work at our Learning and Development Sub-group. Our training materials and recording templates reflect the Pan-Lothian approach. The report of the Joint Inspection of Adult Support and Protection in East Lothian noted inconsistencies in the use of templates and application of chronologies. The quality of chronologies was also identified as an area for development in the report of the Joint Inspection for children and young people at risk of harm in East Lothian. We were unable to progress the introduction of skills-based workshops for practitioners on chronologies due to the Learning and Development Officer post being unfilled but are taking this forward in our 2024/25 workplan now that there is a post-holder in place.

Harmful Sexual Behaviour
During the year, we worked with NSPCC to complete a multi-agency audit of our local approaches to responding to Harmful Sexual Behaviour, using a standard self-assessment tool developed by NSPCC. The findings were similar in each area. It was noted that there was evidence of positive multi-agency working, but there was no consistent shared understanding of harmful sexual behaviour across partners, and uncertainty round what support is available across sectors and how to access that support.

The work with NSPCC concluded in February 2024 and action plans were developed for each area. Whilst it was beneficial to undertake the self-assessment on an individual local authority basis, It was acknowledged that the two plans have similar themes and were too ambitious, within the context of limited resources. It was therefore agreed that we would develop a shared action plan across both areas, with a limited number of priorities, and with this work being overseen by the newly developed Child Protection Sub-group. In the year, our Training on Harmful Sexual Behaviour was extended to introduce a Level One (introductory, awareness raising) and a Level Two Course (assessment, responding and intervening) course.

2.3 We will continue to develop our performance framework and approach to quality improvement – what we achieved

Multi-agency Quality Assurance
We started some work to develop our approach to multi-agency quality assurance of practice but did not make as much progress as we would have liked, due to staffing capacity within the EMPPO and the work associated with three external Joint Inspections in the year. In December 2023, a small group of professionals involved in Adult Support and Protection (including Health, Police, Adult Social Work and EMPPO) attended a development session facilitated by our Link Inspector from the Care Inspectorate, to learn about the use of the Adult Support and Inspection Case File Audit tool. A Service Manager in Midlothian was involved in the case file reading for the Joint Inspection of Adult Support and Protection in Midlothian, the experience of which will stand in good stead for supporting our local audits going forward.

National Minimum Dataset for Adult Support and Protection
From Quarter 1, the Scottish Government introduced a national Minimum Dataset for Adult Support and Protection, to support a consistent national approach to data collation and performance information

From Quarter two (June 2023), we implemented Phase 1 of the national minimum dataset for Adult Support and Protection in each area, slightly later than the expected Quarter 1 introduction (we were two of 23 local authorities who introduced the new dataset from Quarter 2). This was due to the Joint Inspection of Adult Support and Protection in East Lothian, and the time required to make changes to the Social Work recording systems in each area. We recognised that it would take time to become familiar with the new dataset, particularly embedding a consistent approach to data collection and interpretation.

We engaged in national meetings hosted by the Scottish Government and IRISS to support a consistent approach to, and respond to any queries about, implementation of the national minimum dataset. This has been a helpful process for us, and through this engagement, we recognise that we have made good progress in our approach – of note we recognise that Council Officers (and other staff involved in Adult Support and Protection) have made a good cultural shift in no longer thinking about an Investigation being a separate process from an Inquiry. This is supporting our embedding of the national minimum dataset and setting us in a good place for the implementation of Phase 2 from Quarter 1, 2024 –25 (April 2024).

National Minimum Dataset for Child Protection
We introduced version 2 of the national performance reporting from Academic Quarter 2, 2023/24 (November 2023 to January 2024), aligned with the implementation of the Edinburgh and the Lothians Multi-agency Child Protection Procedures. The implementation of this went smoothly, with Social Work recording systems updated to reflect the changes.

Learning Reviews
We continued to embed our practice and processes around Learning Reviews, following the national guidance[8] in our approach.

We strengthened our arrangements for the early stage of the Learning Review Process, with the meeting to consider the need for a Learning Review under Adult Support and Protection or Child Protection Meeting being chaired by the EMPPC Chair. This is serving us well by developing a consistent approach to these meetings. The Consideration Meeting is made up of agency representatives who are EMPPC Members, with any additional representatives decided on a case-by-case basis.

We have streamlined our paperwork/templates for Learning Reviews, with a consistent approach across both Adult Support and Protection and Child Protection.

We embedded our Learning Review Sub-group, as a Sub-group of EMPPC. This group is responsible for the oversight of the progress of Learning Reviews, action and improvement plans and consideration of resource requirements for Learning Reviews. In common with other areas, resourcing Learning Reviews and the securing of external Reviewers have proved to be a challenge for us, and we continue to engage in discussions with CPC Scotland and the National ASP Convenors Group on this issue.

Our Learning Review Sub-group reports directly to CSOG on a quarterly basis. Learning Review Reports and Summary Reports when a Consideration Meeting decides not to proceed to a Learning Review are presented to EMPPC for their review.

In the year, we received two notifications for Adult Support and Protection Learning Reviews. Both cases involved the death of an adult, under very different circumstances. The outcome of both Consideration Meetings was not to proceed to Learning Reviews, on the basis that the learning and improvements were clearly and sufficiently identified at the Consideration Meeting.

We concluded one Child Protection Learning Review in the year. This had been notified in May 2022, with a decision to proceed to a Learning Review being reached in June 2022. Due to external constraints (criminal proceedings) we were not able to commence this until August 2023. We commissioned an external Reviewer and Social Work Consultant to mentor the Reviewer and Child Protection Lead Officer, given this was our first Learning Review under the National Guidance. A decision was made by CSOG not to publish this report, to protect the privacy of the individual subject to the Review, given the nature of the case. The report of the Learning Review was brought to our March 2024 EMPPC for its review.

[8] National Guidance for Adult Protection Committees Undertaking Learning Reviews and National Guidance for Child Protection Committees Undertaking Learning Reviews

The improvements and sharing of learning in the above cases are being taken forward. We have shared the learning via newsletter articles and briefing notes and updated our training materials to include key messages from local as well as national learning.

We commenced a Child Protection Learning Review in November 2023, holding three Review Group meetings, a Practitioner Event and Managers' Event in the year. The Review will be concluded in the first half of 2024/25.

In February 2024 we held a Consideration Meeting for a Child Protection Learning Review and agreed that we would commission an external Reviewer for this work. This Review will be progressed in 2024/25.

We believe that we are implementing the National Guidance for Learning Reviews well. We are always mindful of the key features of Learning Reviews: Inclusiveness, collective learning, staff engagement and proportionality. Our Child Protection Lead Officer has worked with partners to ensure that Practitioners and Managers are prepared for their engagement in a Learning Review, recognising the need to provide information about the process and provide reassurance that Learning Reviews are not investigations and take a systems approach. We have introduced a briefing for Event participants and will embed this in any further Learning Reviews.

Joint Inspection of Adult Support and Protection in East Lothian

The Joint Inspection of Adult Support and Protection in East Lothian came to its conclusion with the publication of the report on 20th June 2023[9]. The inspection programme involved the analysis of a Position Statement which was developed on a multi-agency basis, where we identified our strengths and areas for development. Inspectors also reviewed the findings of a staff survey of 135 staff from across a range of organisations, including Health, Social Work, Police and third sector providers, scrutinised 90 records, held focus groups with staff and engaged in Professional Discussion with strategic leaders.

The Inspection reported on the following areas of strengths:

- The partnership's approach to adult support and protection inquiries was robust.
- Person-centred engagement and consultation with the adult at risk of harm was evident throughout the delivery of all key processes. This supported effective consideration of risk.
- Effective social work management, support and supervision was consistently recorded and contributed to the effective delivery of key processes.
- Almost all adults at risk of harm who required a risk assessment had one completed. The quality of risk assessment had improved significantly following the implementation of the Type, Imminence, Likelihood and Severity (TILS) framework. Subsequent risk management work needed improved.
- The partnership's large scale investigative process was established and included a useful reflective element that supported improvement actions.
- The partnership's vision was well understood. The delivery of strategic aims was supported by the Public Protection Committee improvement plan.

[9] Joint inspection of adult support protection in the East Lothian partnership (careinspectorate.com)

- The Public Protection Committee and Critical Services Oversight Group were well established. There was synergy between these groups that supported the effective delivery of strategic aims.
- The partnership responded appropriately to the demands of the pandemic. They ensured the continued delivery of adult support and protection services and provided good support to practitioners.

The Inspection highlighted the following priority areas for improvement:

- Adult support and protection improvements were positively impacting on key areas of practice. Importantly, procedural updates had not kept pace. The guidance should be updated as a priority.
- Findings from adult support and protection audits and improvement actions about risk management and chronologies should be fully implemented.
- A multi-agency approach to audit would strengthen joint improvement work. This should involve frontline practitioners from across the partnership.
- Relevant professionals should engage more collaboratively with critical processes. This includes attendance from police and health at case conferences and the consideration of second workers from all agencies.
- Strategic planning and improvement work should include feedback from, and engagement with adults at risk of harm with lived experience. This should be progressed as soon as possible.
- Interventions with alleged perpetrators and financial harm needed significant improvement to ensure appropriate action is taken on a multi-agency basis.

A multi-agency improvement plan was developed following the inspection which will continue to be progressed in the coming year, and progress overseen by our new Adult Support and Protection Sub-group and link Inspector from the Care Inspectorate.

Joint Inspection of Services for Children and Young People at Risk of Harm in East Lothian
A joint inspection of services for Children and Young People at Risk of Harm was carried out over a six-month period from October 2023, with the report published on 7th May 2024[10].

The inspection footprint included reviewing practice by reading a sample of 60 records of children at risk of harm, held by a range of services, a survey of 408 staff, focus groups with 130 staff working directly with children and with strategic leaders. The partnership had completed a self-evaluation and provided a Position Statement as part of the submission of evidence to the inspection.

The inspection reported the following key messages:

- Children and young people were safer as a result of staff's effective recognition and response to risks and concerns.
- Partners worked well together using inter-agency referral discussions to plan responses if children and young people were at risk of harm.
- Staff were confident in their ability to recognise and report child abuse, neglect and exploitation, and assess and analyse risks.

[10] Joint inspection of services for children and young people at risk of harm in East Lothian April 24.pdf (careinspectorate.com)

- Most children and young people experienced positive relationships with staff that had helped to keep them safe.
- The Single Point of Access had enabled many children and young people to receive effective support for their mental health and wellbeing.
- Children and young people with very high levels of risk and need were being well supported by multi-agency staff to remain with family or in care settings locally.
- Children and young people had a very good awareness of their rights.
- Children and young people were being well supported by staff to participate, share their views and contribute to decision-making.
- Leaders, operational managers and staff shared high aspirations and a strong value base for the delivery of services.
- Leaders worked well together through clear governance structures and reporting arrangements. Staff had confidence in their leaders.
- Staff felt well supported through supervision arrangements, peer support and the support of their managers.

Areas for improvement were identified as follows:

- Partners had not fully established ways to collect, analyse and report on the difference services were making. They had scope to develop a greater understanding of this.
- Partners were not consistently seeking, collating and using the views of children and young people and their families to inform service improvements.
- Independent advocacy is well established, and the partnership is committed to filling the gap which means that currently some children and young people at risk of harm do not have access to this support if they want it.

The overall evaluation of the impact on children and young people was assessed as Very Good. The Care Inspectorate grading scale states that "an evaluation of very good will apply to performance that demonstrates major strengths in supporting positive outcomes for people. There are very few areas for improvement. Those that do exist will have minimal adverse impact on people's experiences and outcomes. While opportunities are taken to strive for excellence within a culture of continuous improvement, performance evaluated as very good does not require significant adjustment".

Joint Inspection of Adult Support and Protection in Midlothian

In January 2024, we received notification of a joint inspection of Adult Support and Protection in Midlothian, with the first Professional Discussion taking place in March 2024, and multi-agency Position Statement was prepared in the early part of the year. The inspection carried on into the new financial year, with the final report being published in June 2024. We will report on the findings of this in our next Annual Report.

Across all three inspections, we were assured that the areas of strength and areas for improvement identified by inspectors had been identified in our Position Statement. We recognise the significant amount of partnership work undertaken by staff and senior leaders across our core partner agencies in the preparation for, and involvement in inspection. In particular, the Committee and CSOG have acknowledged the continual cycle of Joint Inspection across the Police 'J' Division, which includes West Lothian and Scottish Borders, and for NHS Lothian, which includes City of Edinburgh and West Lothian. In addition, each Council has been involved in a number of inspections of different services, which has placed

significant demands on staff at various levels of the two Councils and Health and Social Care Partnerships.

Across all three inspections in which we were involved in the past year, there are common themes in areas for improvement. We had already identified these as areas for improvement which will feature in our workplan for the coming year:

- Seeking, collating and using the views of children, families and adults involved in Adult Support and Protection and Child Protection Processes to inform service improvements.
- Developing a multi-agency approach to audit and quality assurance.

2.4 We will promote a learning culture by providing staff with multi-agency learning and development opportunities in Public Protection – what we achieved

We continued to implement our Multi-agency Strategy for Learning and Development and kept it under review in our Learning and Practice Development Sub-group.

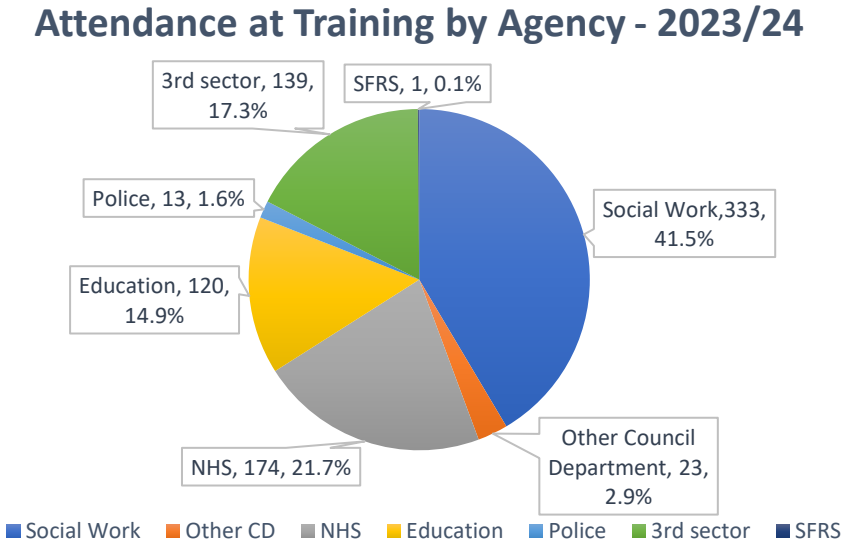
We delivered 65 learning and development events in the year. This included 39 courses and 26 briefings. These are broken down as follows:

	Number of courses	**Number of attendees**
Quarter 1, Apr - Jun	11	278
Quarter 2, Jul - Sept	6	131
Quarter 3, Oct to Dec	10[11]	206
Quarter 4, Jan to Mar	12[12]	253
Total	**39**	**868**

	Number of briefings/events	**Number of attendees**
Quarter 1, Apr - Jun	6	432
Quarter 2, Jul - Sept	5	223
Quarter 3, Oct to Dec	10	671
Quarter 4, Jan to Mar	5	439
Total	**26**	**1765**

[11] Includes one Council Officer modular course that ended in the quarter
[12] Includes one Council Officer modular course that ended in the quarter

We delivered 39 courses covering 18 different topics, to 868 staff and volunteers. This was 12 more courses than the previous year, reaching 180 more staff. The profile of attendees by agency is shown in the chart below[13]. Given staffing gaps and absences, and no dedicated training staff resource in the EMPPO in the year, this was a commendable achievement. We had to cancel two courses in the year and two briefings due to staff absence (one an externally commissioned trainer).



24 courses took place in person, 13 on-line and two on a hybrid basis. 14 courses incurred a hire charge due to the need to secure external venues as the Brunton Hall venue we have previously used was unavailable due to work being carried out to assess the condition of the building, due to the presence of Reinforced Autoclaved Aerated Concrete. Consequently, our training costs increased in the year, and will do so again in 2024/25.

A range of partners from both areas co-worked with EMPPO staff to develop and deliver our training, as part of their partnership commitment. This is greatly appreciated, and we believe supports a richer learning experience for participants. This included staff from: Education, East Lothian and Midlothian, MELDAP, Public Protection Team, NHS Lothian Public Protection Unit, Police Scotland, Scottish Fire and Rescue Service, Scottish Children's Reporter Administration, Social Work, East Lothian and Midlothian (both Children's and Adult Services) and Women's Aid East and Midlothian.

Although feedback was provided by only half of those staff attending training, those who did provide feedback shortly after attending evaluated this highly. Staff particularly welcome the opportunity to come together in person, which provides the opportunity for networking and learning more about each other's roles.

In December 2023, 408 staff responded to the staff survey as part of the East Lothian Joint Inspection of Services for Children at Risk of Harm. 90% of respondents agreed or strongly agreed that the learning and training they have participated in has increased their confidence and skills in working with children and young people at risk of harm. 71% of respondents agreed or strongly agreed that that participation in regular local multi-agency training and development opportunities has strengthened their contribution to joint working

[13] Agency breakdown based on 803 attendees. Agency breakdown not available for one course (65 attendees).

with children and young people at risk of harm (14% stated that the statement was not applicable). This provides good assurance that training provided on both a single and multi-agency basis is supporting practice.

In common with many other areas, we have further work to do to measure the longer-term impact of training and its application in practice. Whilst we send out a survey to staff three months after attending a training course and review responses, the completion rates are too low for us to meaningfully report on this. In the coming year, our Learning and Development Officer will engage with national work as part of Child Protection Committees Scotland's workplan to develop approaches to evaluation of training.

We delivered 26 briefings/learning events in the year, four more than last year, and reaching 551 more staff. This is our second year of delivering one-hour briefings, which provide the opportunity for staff to learning about a specific topic in a short, bite sized way without cutting into their other workplace demands. We received positive feedback about our briefings.

Topics included the launch of our Child Protection Procedures, the launch of our Adult Support and Protection Procedures, Advocacy for adults at risk of harm, Home Fire Safety Visits, Disclosure Scheme for Domestic Abuse Scotland, Neglect, Trading Standards and Marac. We cancelled two briefings in the year due to staffing absence. All briefings were delivered online. The themes for our topics come from Learning Reviews, reviews of our data and performance and inspection findings.

To recognise the launch of the 16 days of activism, we held an on-line event on the Safe & Together model[14] and how it is used to work with families impacted by a domestic abuse perpetrator's behaviours. This was led by a dedicated trainer from the Safe & Together Institute and attended by 85 staff. This was very well received by staff, both those who are new to the model and those practitioners who use the model finding this an invigorating refresher.

173 staff attended our on-line learning event entitled 'Why we need to have a trauma lens in our Adult Support and Protection work' to recognise Adult Support and Protection Day on 20th February 2024. This was led by Shumela Ahmed, Managing Director of the Resilience Learning Partnership[15] and advisor to the National Trauma Training Programme[16]. Participants fed back that this was a powerful and insightful input from the lens of lived experience.

Across all courses, our take up was 74.3% of spaces. Demand exceeded available spaces in our Child Protection Risk Assessment and Processes courses, with a small number of staff being placed on a waiting list for the next course the following quarter, and an additional course being delivered to meet demand.

Across all training, 74 staff cancelled their space with more than five days' notice, 46 staff cancelled with less than five days' notice and 121 staff did not attend on the day of the training. Follow up was made with all staff who did not attend on the day of the training,

[14] About the Safe & Together™ Model | Safe & Together Institute (safeandtogetherinstitute.com)
[15] Resilience Learning Partnership
[16] The National Trauma Training Programme (NTTP) | NHS Education fo (scot.nhs.uk)

with the most common reason for non-attendance being short notice operational demands or staff absence. Given the largest staffing group attending training comes from Social Work, the operational pressures impact on training attendance are quite often unavoidable, and we do endeavour to offer out any spaces to anyone on a waiting list.

All the organisation, administration and support to ensure the smooth organisation and running of our training offering is carried out by Business Support Staff within EMPPO. Their practice and process around this is efficient and effective, and the amount of work that goes into this cannot be underestimated.

We believe, based on the feedback we receive from staff, those involved in developing and delivering training and discussion that takes place at our Learning and Development Sub-group, that we are delivering a learning and development programme to a high standard of quality and effectiveness.

The Council Officer Forum in East Lothian and Midlothian took a pause in the early part of 2024, to enable us to take stock of its future running. Over time we had found that the same, small group of Council Officers would attend this, and there is a need to increase its profile and offering across the wider Council Officer grouping. This will be progressed in the coming year.

We continue to be committed to embedding Safe & Together[17] in East Lothian and Midlothian. Funding to support implementation is provided through the national Delivering Equally Safe Fund. Both areas saw a stalling of progress of getting staff through Core Training in the year, due to staffing gaps in the local training leads, a continued lack of a local trainer and in East Lothian the diverting of staffing resources to the work associated with the Joint Inspection for Children and Young People at Risk of Harm. Both implementation groups met in the early part of 2024 to plan the work to further embed Safe & Together in the coming year, including applications for three local staff to become accredited trainers, and projections for training to support the funding application for 2024-25.

in 2023 we committed to implement the Equally Safe in Practice [18]framework in both areas. This framework aims to equip the Scottish workforce with knowledge, understanding and the tools necessary to improve responses to Violence Against Women and Girls and ensure safe and positive outcomes for women, children and young people. This comprises of a suite of training programmes developed by Scottish Women's Aid. The Level 1 (general workforce) programme consists of three online modules (gender equality, domestic abuse and sexual abuse). We made limited progress in the year to implement the Equally Safe in Practice framework in both Council areas, due to gaps in the VAWG Co-ordinator post, but this was picked up again in March 2024 and will be progressed over the coming year in both areas. The Level 1 modules were rolled out to staff in Midlothian, with 102 staff completing the gender equality module, 88 completing the domestic abuse module and 61 completing the sexual abuse module. This was promoted with Housing staff particularly, with positive feedback from a small number of staff. We will progress implementing this framework across both Council areas in the coming year.

[17] About the Safe & Together™ Model | Safe & Together Institute (safeandtogetherinstitute.com)
[18] About ESiP | Scottish Women's Aid (womensaid.scot)

We continued to establish the Inter-agency Referral Discussion (IRD) Learning and Development Forum to support practitioners involved in Child Protection IRDs, with Police, Health and Social Work staff coming together for two events in the year. Topics have included Harmful Sexual Behaviour, staff wellbeing, County Lines, thresholds and what the data is telling us about IRDs. These events have proved popular with good engagement and positive feedback on its approach to providing a supportive learning environment to enable staff to reflect on IRD practice in a multi-agency forum.

2.5 Raising awareness of Public Protection through communications and engagement with staff and communities – what we achieved

We continued our commitment to develop and disseminate a quarterly newsletter to staff across East Lothian and Midlothian, with a distribution to over 500 named individuals and teams. Whilst our exact reach is not known, we know it is shared widely across networks and we have received positive feedback from staff about its style and content. Its role in sharing information about the work of the Committee and communicating our vision was recognised in the three Joint Inspections in Adult Support and Protection and Child Protection that took place in the year.

Our newsletter provides the opportunity to raise awareness of the work of the Committee, with a regular feature on a Committee member about their role and contribution to the work of the Committee. We included articles on Adult Support and Protection, Child Protection and Violence Against Women and Girls. The newsletter provides a good opportunity to highlight connecting themes with Spotlight articles on trauma informed practice, Chronologies, Schedule 1 offences and SMART planning. We include resource materials to support awareness raising and training opportunities, and we also take the opportunity to raise issues that come up through local and national Learning Reviews and in local training.

Our website for EMPPC was de-commissioned in October 2023 as we were unable to resolve a contract issue. We had previously recognised that our website was out of date and therefore began work to develop a new website with the support of one of our partner agencies. The development of this is underway and will be launched during 2024. As an interim solution we disseminated guidance and Procedures via our networks to ensure that staff could still access these and have temporarily hosted our multi-agency Adult Support and Protection Procedures and Child Protection Procedures on both Council websites.

Our activities around sharing of key Public Protection messages for partner media platforms were reduced in the year, although national communication campaign materials were shared when available. We recognise we have further work to do to raise awareness of Public Protection beyond staff and volunteer groups. Our new website will have information available for the public about Public Protection and how to raise concerns about a child or adult who may be at risk of harm, alongside frequently asked questions about key Protection processes. We will use the launch of our new website to further develop a communications plan with our key partner agencies.

Section 3 – Data and Performance Information

3.1 Adult Support and Protection

The National Minimum Dataset for Adult Support and Protection was introduced nationally in Quarter 1, 2023/24. Our Critical Services Oversight Group agreed to a delay of this by one quarter, due to the need to make significant changes to the Social Work recording systems in each area, and the Joint Inspection of Adult Support and Protection in East Lothian. We therefore introduced the National Minimum Dataset in both areas from Quarter 2, 2023/24 (from July 2023).

Prior to the introduction of the National Minimum Dataset, local indicators were in place from 2015/16; this included monitoring patterns of referrals, inquiries, multi-agency attendance at Case Conferences and timescale standards. Our local indicators provided assurance to EMPPC that arrangements for Adult Support and Protection work were in place to keep adults safe through timely intervention and support.

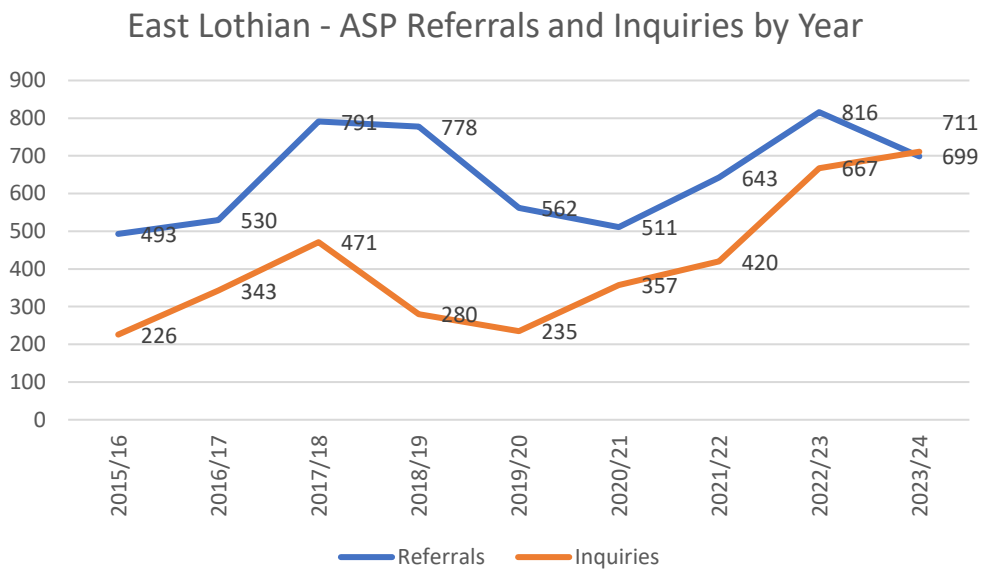
Whilst we benefit from coming together as two areas to share learning and expertise, we recognise the differing structures in the delivery of Adult Support and Protection work and are therefore cautious about making direct comparisons between the two areas. In East Lothian Council Officers are located across a number of teams, and Council Officers undertake a mixture of short- and longer-term work. In Midlothian there is dedicated Adult Support and Protection Team which deals with the majority of the longer-term work, although there is a wider group of Council Officers who primarily undertake duty work. Through the P&QI Sub-group, the Scottish Fire and Rescue Service reports on the number of Home Fire Safety Visits that take place and the number of Adult Support and Protection concerns that are referred to Social Work. We have been able to use that data to provide assurance of good practice in addressing Adult Support and Protection concerns.

When a referral is made to the Council Contact Centre in East Lothian or Midlothian, the referral is screened to determine if it should be dealt with under Adult Support and Protection, within 24 hours. If it is, an Inquiry will be undertaken by a Council Officer, who is a Social Worker with specialist training to undertake Adult Support and Protection work. In each area there is a local timescale of completing an Inquiry within a timescale standard of 21 days. We will introduce performance reporting of the meeting of those timescales from Quarter 1, 2024/25.

East Lothian

Table 1 illustrates the number of referrals and inquiries since EMPPC began collating and reporting on this in 2015/16. We see no trend in the number of referrals received by year and note a slight reduction from last year. The number of inquiries undertaken increased for the fourth year in a row, and we need to review this in the coming year to see if this is a trend.

Table 1



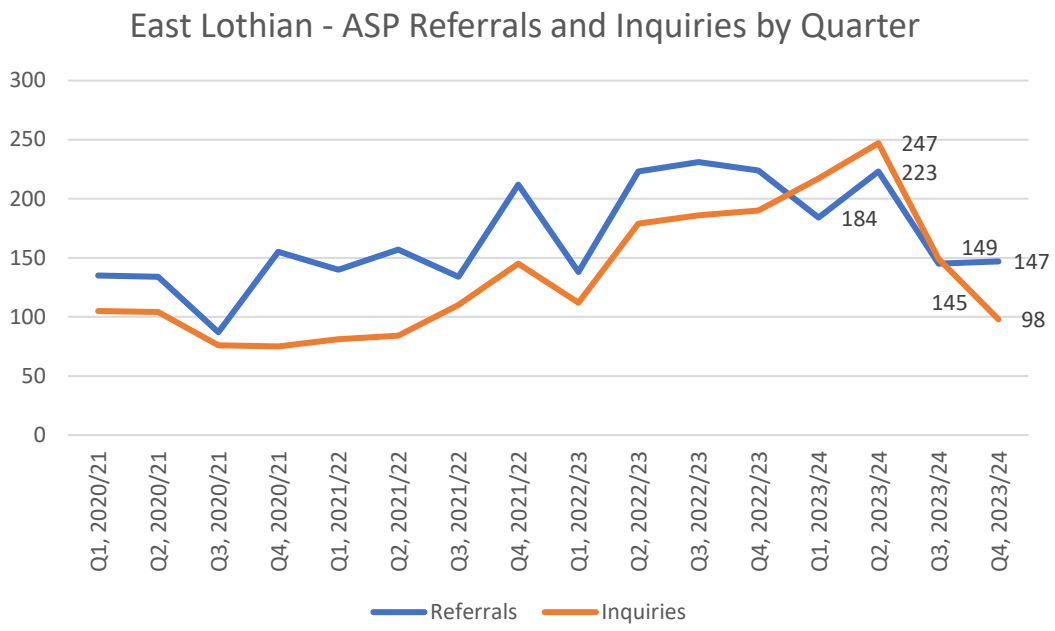
Following receipt of any referral to Adult Social Work to the East Lothian Council Contact Centre, the referral is screened by a Duty Team Leader, within a standard of 24 hours of receipt. At screening it will be confirmed if the referral is to be dealt with under Adult Support and Protection. A referral may be re-categorised from Adult Support and Protection if, on the face of the information provided, the Duty Team Leader considers that there is insufficient information, or the level of concern does not suggest that this should be dealt with under Adult Support and Protection. Similarly, a referral may be re-categorised as Adult Support and Protection.

In 2023/24 for the first time the number of inquiries undertaken under Adult Support and Protection in East Lothian exceeded the number of referrals, by 12. Breaking this down further by quarter, which is shown at Table 2 below, we see that for three quarters out of four in 2023-24 (Quarter 1, Quarter 2 and Quarter 3) the number of inquiries exceeded the number of referrals.

Key messaging from operational and strategic leads has promoted a positive change in culture over recent years in East Lothian, moving away from managing risk through a welfare approach towards a more consistent approach in the application of Adult Support and Protection inquiry as a referral response. This has been supported by increased operational oversight of Adult Support and Protection work generally in East Lothian. We believe this explains the increase in the number of inquiries year on year.

The screening process has been strengthened over the last two years, and we know from discussions through our EMPPC Performance and Quality Improvement Sub-group that it is robust and carried out in a timely manner within East Lothian. Our Operational Managers in Adult Social Work report that from discussions in supervision, and their oversight of Adult Support and Protection work, there is increased confidence and decisiveness in Adult Support and Protection work, with inquiries being instigated appropriately. This was echoed in the report of the Joint Inspection of Adult Support and Protection in East Lothian which noted that referrals dealt with by the duty system were handled in a timely manner and “all inquiries were completed in line with the principles of the legislation”, with “management oversight evident for almost all inquiries completed”.

Table 2



Following the implementation of the National Minimum Dataset from Quarter 2, 2023-24, we are now able to identify the balance between inquiries with or without the use of investigatory powers. This is illustrated in Table 3 below. Although there are only three quarters to date, we believe that the increase in the use of investigatory powers is reflecting an increased confidence and competence in identifying what powers are being used and when. This is similarly reflected in our local discussions when reviewing data on a quarterly basis.

Table 3

	Inquiries without use of investigatory powers	Inquiries with use of investigatory powers	Total
Q2, 2023-24	76.52% (189)	23.48% (58)	247
Q3, 2023-24	51.00% (76)	49.00% (73)	149
Q4, 2023-24	13.27% (13)	86.73% (85)	98

Steps were taken in Quarter 1, 2023/24 to improve the recording of the principal type of harm, with welcome clarity about harm categories and definitions through the introduction of the Adult Support and Protection Minimum Dataset. The use of 'other' as a category of recorded harm is now rare, and we have accurate identification, distinction between and recording of self-neglect, neglect and self-harm. For three quarters worth of available data in 2023/24, the three most common types of harm in inquiries with the use of investigatory powers were financial, followed by self-harm and physical harm.

As expected, the majority of inquiries related to adults living in their own home and there is nothing unusual standing out about this data.

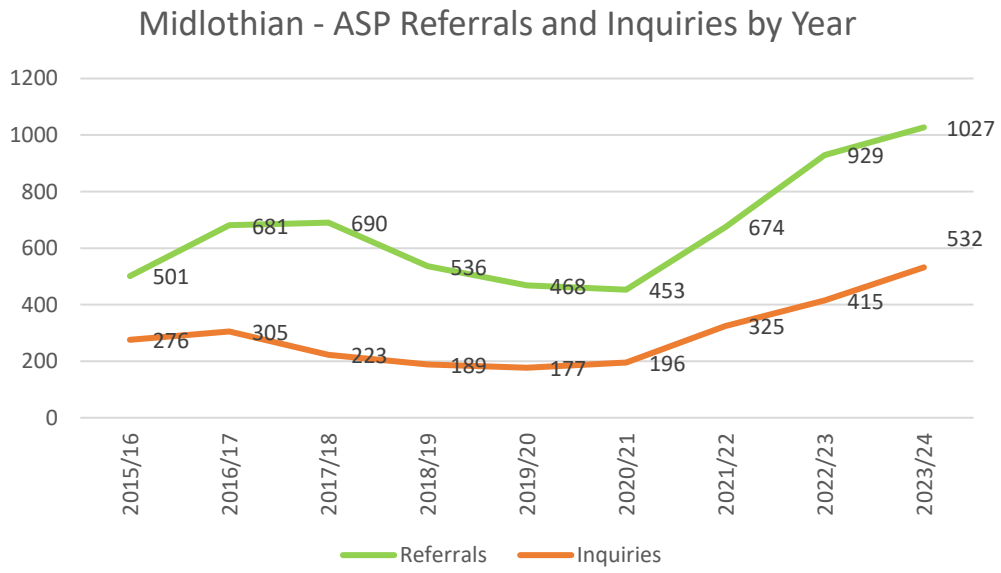
In East Lothian, the Social Work recording system has been updated to include recording fields on the offer and take up of advocacy. We had previously identified this as an area for improvement through audit work and practice is now more in line with the Code of Practice. The Joint Inspection of Adult Support and Protection in East Lothian recognised the work that had been done to actively promote advocacy via focused staff briefings provided through EMPPC Training Calendar (twice yearly), articles in the EMPPC Newsletter and inputs at Council Officer training.

Midlothian

Table 4 shows an increase in Adult Support and Protection referrals for the third year in a row, with a doubling of referrals since the first year of the pandemic. There was an increase by 10.55% in 2023/24 from the previous year. Inquiries similarly increased for the third year in a row, by 28.19% in the last year. There has been no corresponding increase in Council Officer resource in that period, and no publicity campaigns to encourage referrals about Adult Support and Protection. However, we know from the wide range of referral sources in Midlothian that there is good awareness of the need to refer concerns. This seems to be line with the national picture of increasing referrals.

Following receipt of any referral to Adult Social Work to the Midlothian Council Contact Centre, the referral is screened by the dedicated Adult Support and Protection Team, within a standard of 24 hours of receipt. The performance in meeting this standard has been excellent over a number of years now, with a well embedded system in place.

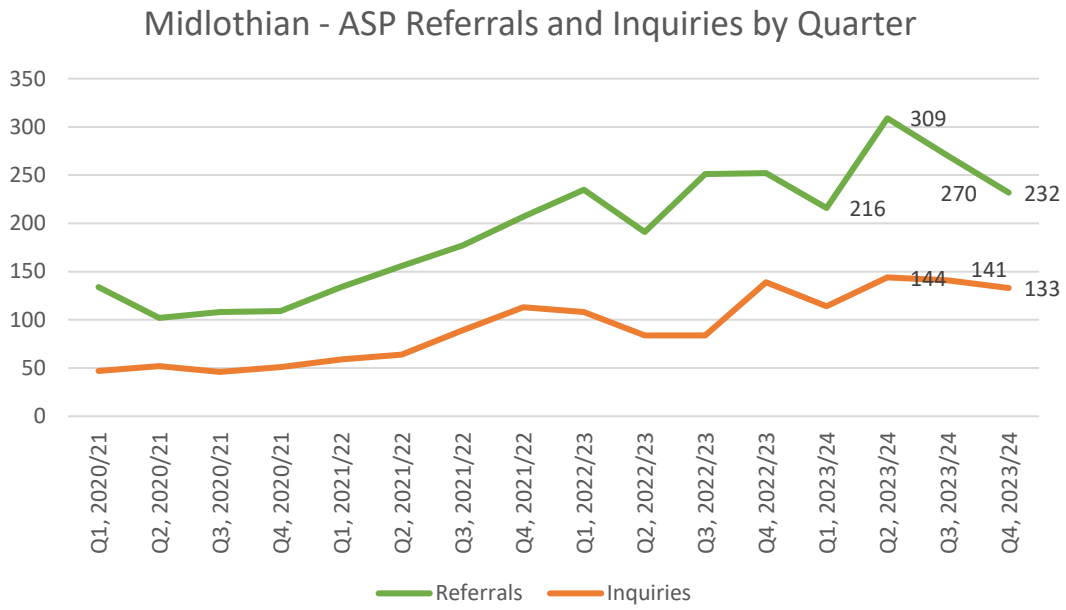
Table 4



In Table 5 below we can see the relationship between referrals and inquiries by quarter. Quarter on quarter, there are no trends in the number of referrals or inquiries. The spike in the number of referrals in Quarter 3, 2023/24 was examined closely, and related to some mis-badging of Police welfare concerns as Adult Support and Protection referrals. This was quickly addressed and resolved and did not create any risk, with assurance that the needs of

the adult had been appropriately addressed, and the opportunity taken to re-issue screening guidance to staff.

Table 5



It has consistently been reported over a number of years that the conversion rate from Adult Support and Protection referral to inquiry in Midlothian has sat at just below 50%. A significant proportion of referrals are screened out at the initial stage without progressing to an inquiry, however, when we look at the outcomes recorded on referrals, almost all referrals have had some form of action, and are referred to other teams/services within the Health and Social Care Partnership.

To understand more about the data, in 2023 it was agreed that we would routinely sample a portion of referrals per quarter that did not progress to an inquiry to understand more about what this data was telling us – including about thresholds for decision making, quality of referral information, repeat referrals. This work was undertaken for three quarters in 2023/24, with the Adult Support and Protection Lead Officer, Adult Support and Protection Team Leader and Mental Health Team Leader auditing cases that did not proceed to Adult Support and Protection Inquiry. In audits of 40 cases in the first two quarters, there was agreement not to progress to inquiry in 37 cases. In the remaining three cases follow up action was taken through Social Work allocation or current case management. These audits concluded that there was assurance of sufficient safety measures in place at the screening stage and the adult's needs had been met appropriately with non-Adult Support and Protection intervention. It was identified that the quality of information included in referrals needed to improve to support the ability to badge a referral as Adult Support and Protection.

The operational management and supervision of the work of Council Officer activity are strong in Midlothian, with comprehensive recording of risk assessment and analysis. Even with the high number of Adult Support and Protection inquiries, rising year on year, there is close tracking and oversight of the progress of Adult Support and Protection work, and performance in timely completion of inquiries is strong.

The most common type of harm in inquiries with the use of investigatory powers in 2023/24 was psychological, followed by financial/material harm and neglect/acts of omission. There is

a more varied spread of harm identified in the categories provided under the Adult Support and Protection Minimum Dataset, and from regular meetings between operational Managers and the Adult Support and Protection Lead Officer, we believe that Council Officers are identifying harm more confidently and competently. This has positively resulted in less use of 'other' categories to define harm.

As expected, the majority of inquiries related to adults living in their own home and there is nothing unusual standing out about this data.

In the last quarter we saw a marked increase in the use of inquiries with investigatory powers. This is shown at Table 6 below. Although there is only one quarter's worth of data, operational Managers report increasing awareness by Council Officers in identifying when it is appropriate to use investigatory powers. This is supported by the recording system within Social Work which identifies what type of power has been used.

Table 6

	Inquiries without use of investigatory powers	Inquiries with use of investigatory powers	Total
Q2, 2023-24	67.36% (97)	32.64% (47)	144
Q3, 2023-24	69.50% (98)	30.50% (43)	141
Q4, 2023-24	51.13% (68)	48.87% (65)	133

3.2 Child Protection

Child Protection performance information and data is discussed and reviewed by the P&QI Sub-group. In advance of this, a multi-agency sub-group comes together to scrutinise the information in greater detail and produce a comprehensive report for consideration at the P&QI Sub-group. This works well and enables us to manage the time-lag between the data reviewed and our meeting structures, as we use academic quarters for our Child Protection data but financial quarters for our meeting structures.

The Scottish Government published the Children's Social Work Statistics 2022-23 – Child Protection on 26th March 2024. This covers data on children subject to Child Protection processes. The data relate to the reporting period 1st August 2022 to 31st July 2023. We reviewed this data at our P&QI Sub-group to give us a national and local comparator.

Tables 7 and 8 show the number and rate of Inter-agency Referral Discussions (IRDs) per 1,000 children. As with last year, the rate of IRDs remained higher than the national rate of 13.2, at 17.5 in East Lothian and 27.6 in Midlothian. This was a slight increase from the previous year in East Lothian from 17.8 and in Midlothian a slight decrease from 31.9. Similar to last year's report, we have been conscious of our higher rates of IRDs to other areas for some time and continued to discuss this in our P&QI Sub-group. We can see that the corresponding rates of our local partners (Edinburgh and the Lothians Multi-agency Child Protection Procedures) are also higher. We are confident that our IRD processes are robust, with an IRD Overview Group meeting fortnightly in each area to review IRDs and the interim

safety plans and undertake quality assurance activity. IRD practice is particularly strong in each area, and this was recognised in the East Lothian Joint Inspection of Children at Risk of Harm.

Table 7

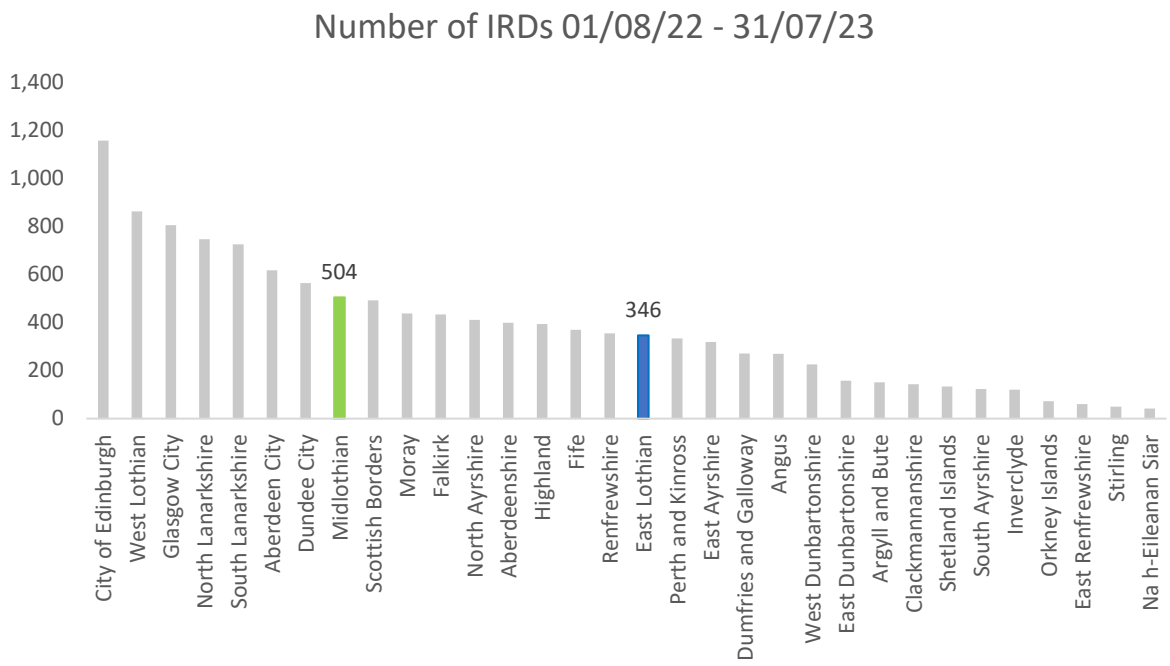
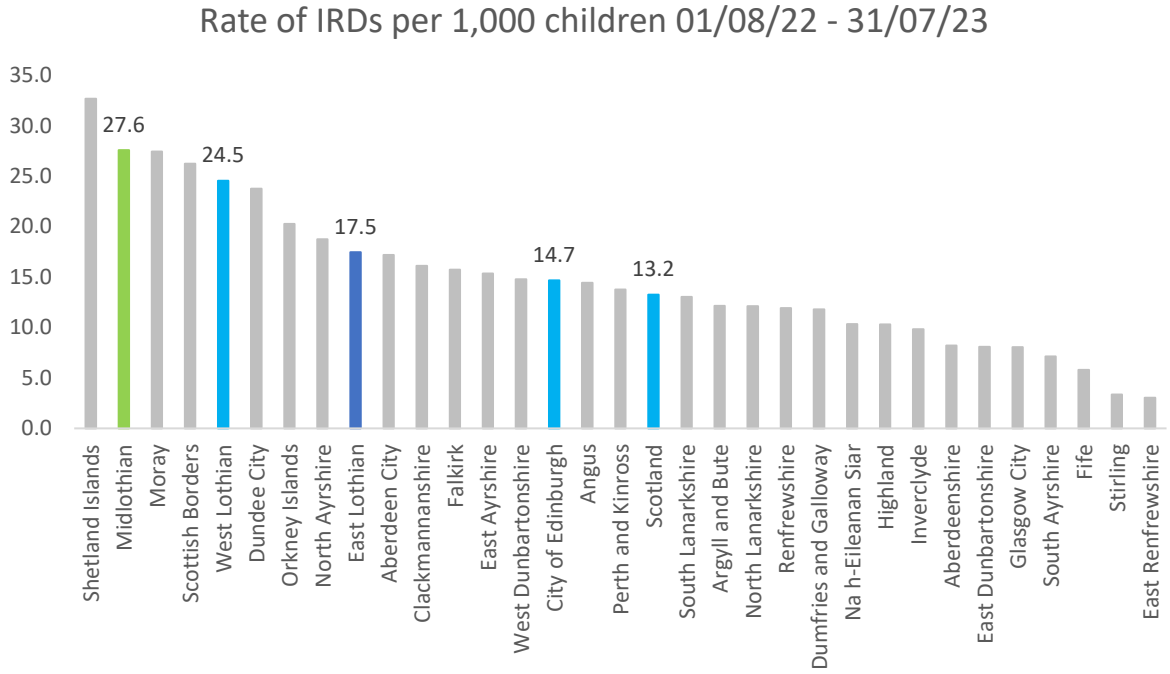


Table 8



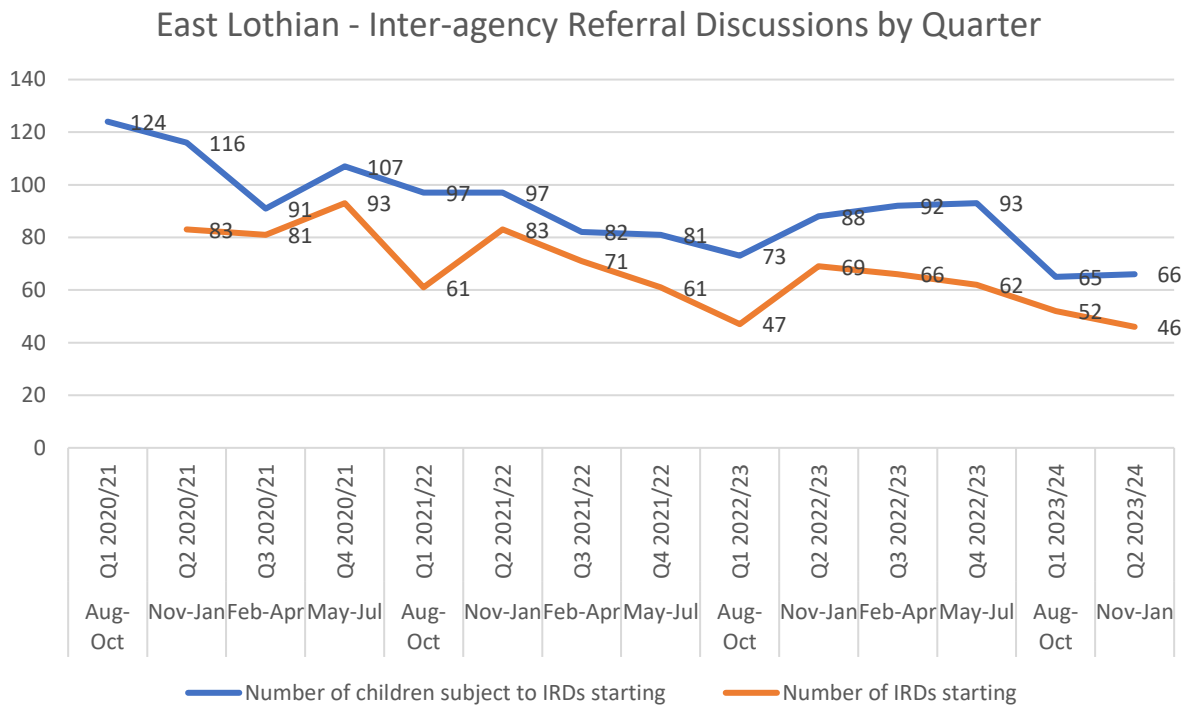
[Note 1] Rate per 1,000 children for 2022 and 2023 is calculated using National Record Statistics mid-2021 population estimates (0-15 years). Rates may vary slightly from previous publications due to updated mid-year population estimates.
[Note 2] The rate shown in this table includes unborn children who are on the Register.

Child Protection Registrations are routinely reviewed in the P&QI Sub-group, to keep an indication of activity around Child Protection registrations and de-registrations, and consequent impact of Child Protection work. Single agency audit arrangements are in place to review the progress and effectiveness of Child Protection Planning and we will strengthen this in the coming year on a multi-agency basis.

East Lothian

We can see from Table 9 below that there is no quarterly trend or seasonal pattern in the number of IRDs in East Lothian. We routinely monitor the number of repeat IRDs per child and the number of children who are being looked after by the local authority with an IRD – the low numbers provide assurance that appropriate supports are in place to address the issues that bring a child into Child Protection processes in East Lothian. This was also identified in the Joint Inspection of Services for Children at Risk of Harm.

Table 9



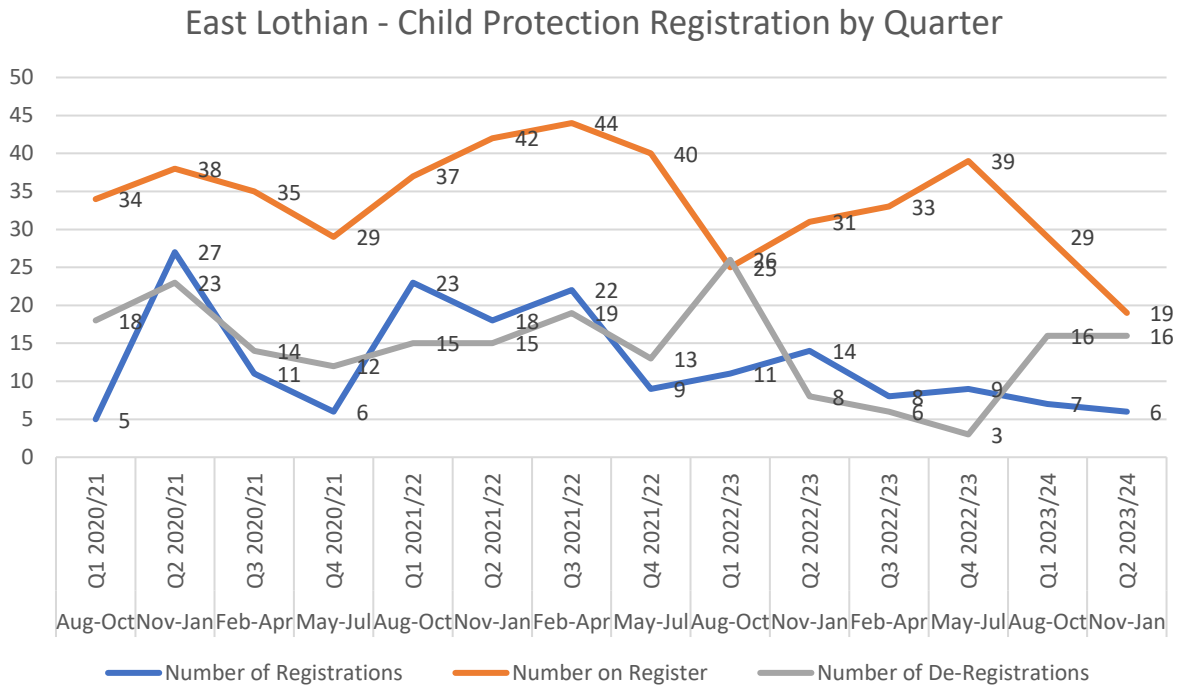
East Lothian has seen a drop in the number of children whose names are placed on the Child Protection Register over two Quarters in the year. This is shown at Table 10. There has also been a reduction in the conversion of IRDs to Child Protection Registration. We believe these are possible indicators of the partnership's strengths in information sharing and safety planning. The Signs of Safety[19] approach to assessment and plans has been implemented well, and there is a strong emphasis on working in partnership with children and families in safety planning in a strengths-based way.

The Child Protection National Minimum Dataset Version 2 now categorises concerns at Child Protection Registration by identifying vulnerability factors and impacts on/abuse of the child. In East Lothian, the most frequently identified concerns included the following:

[19] What Is Signs of Safety? - Signs of Safety

- Vulnerability factors - the most frequently identified concerns included parental substance use (alcohol and/or drug use), domestic abuse and parental/carer mental ill-health. The Safe & Together[20] approach supports Children's Services staff in East Lothian in their response to domestic abuse.
- Types of harm - neglect, emotional abuse and physical abuse. There are some early signs that the implementation of the neglect toolkit is supporting staff in their identification of neglect.

Table 10



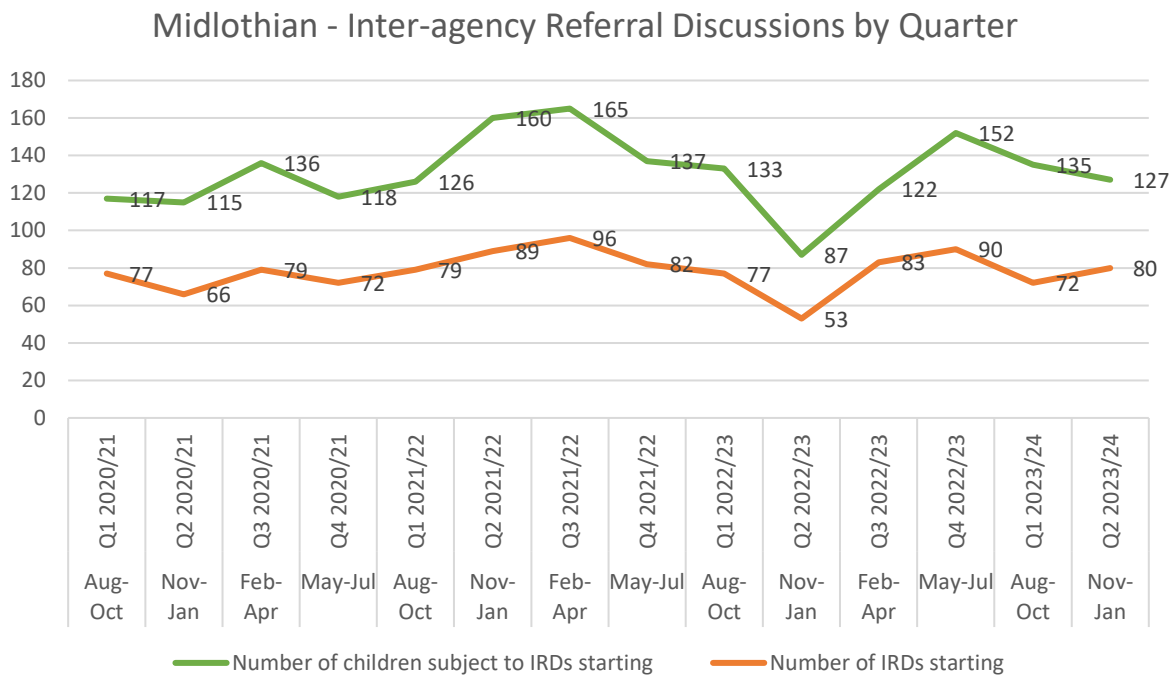
Midlothian

From Table 11, we can see there is no quarterly trend or seasonal pattern in the number of IRDs in Midlothian. Midlothian traditionally has had a higher than national average rate of IRDs, and we have seen this continue in the quarterly data. Larger family groupings feature in IRDs in Midlothian, and we also see this in Child Protection Planning Meetings. The IRD process in East Lothian and Midlothian has been well established for a number of years now and is well aligned to the National Guidance for Child Protection. The IRD Oversight Group in Midlothian meets fortnightly and reviews all IRDs, with that group providing assurance about the appropriateness of IRDs.

We routinely monitor the number of repeat IRDs per child and the number of children who are being looked after by the local authority with an IRD. Through the IRD Oversight Group which meets fortnightly, we are assured that repeat IRDs reflect the appropriate raising of concerns, particularly around domestic abuse.

[20] About the Safe & Together™ Model | Safe & Together Institute (safeandtogetherinstitute.com)

Table 11



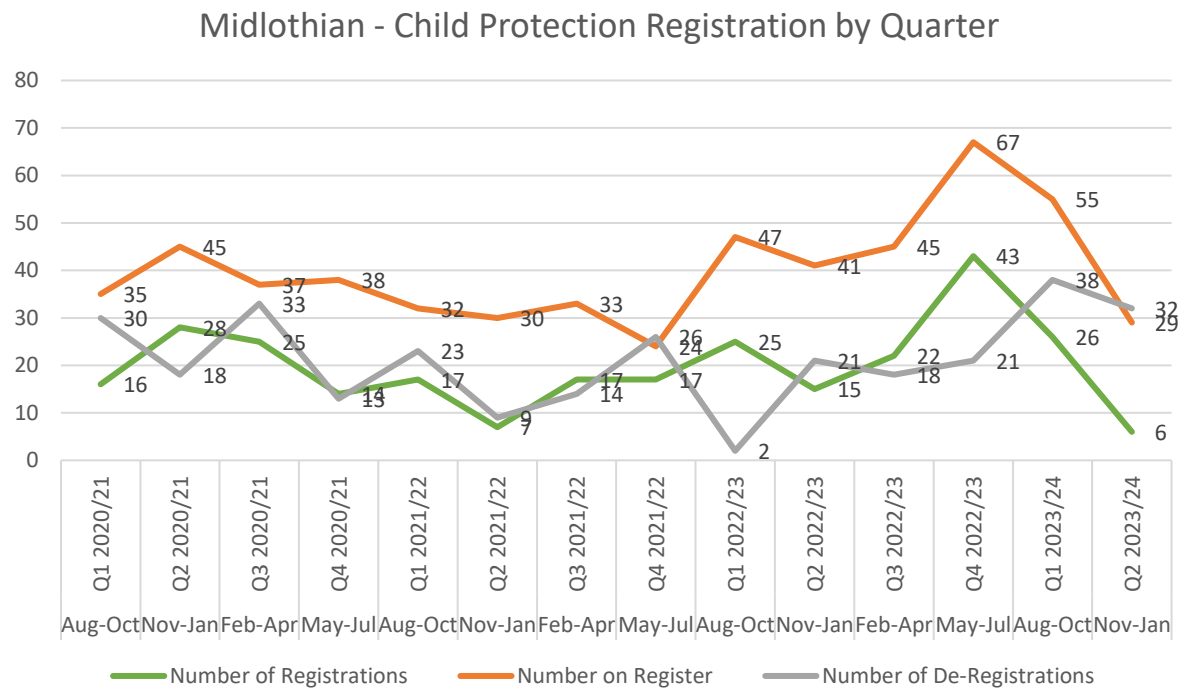
The Child Protection National Minimum Dataset Version 2 now categorises concerns at Child Protection Registration by identifying vulnerability factors and impacts on/abuse of the child. In Midlothian, the most frequently identified concerns included the following:

- Vulnerability factors - domestic abuse was the most frequently identified, which we believe reflects the embedding of the Safe & Together approach within Midlothian Children's Services. The other two most frequently identified vulnerability factors were substance use (alcohol and/or drug use), and services finding it hard to engage.
- Types of harm - emotional abuse, neglect and physical abuse. The are some early signs that the implementation of the EMPPC Neglect Toolkit is supporting staff in their identification of neglect.

At the end of Quarter 4, 2023 (April to June 2023) we saw the highest number of children on the Child Protection Register, with 48 children from 25 families subject to initial and pre-birth Child Protection Case Conferences (as they were called prior to the implementation of the revised Multi-agency Child Protection Procedures in November 2023). This increase was associated with the higher number of IRDs in the same and previous Quarter. On discussion at our P&QI Sub-group although we did not identify any particular reason for this increase (i.e., there was no change in practice or process or specific campaigns) the high level of complexity of issues facing children locally in Midlothian and associated implications for service provision were recognised.

There is a very low number of children who are re-registered within Midlothian. This, and audits completed by Children's Services' Managers three months after a child's name is removed from the Child Protection Register, provide assurance about the impact of supports and intervention for children subject to Child Protection processes.

Table 12



3.3 Violence Against Women and Girls

We are not able to report the number of incidents for domestic abuse reported to the Police in East Lothian or Midlothian for the full year, due to Quarter 4 (January to March 2024) not yet being available from the Police.

On 26th March 2024 the Scottish Government published the Official Statistics of domestic abuse incidents recorded by the Police for 2022/23[21]. Some of this data has been included here to provide a more holistic view of this data over the years. We are not yet able to provide data for 2023/24.

Women's Aid East and Midlothian (WAEML) is the key agency working in East Lothian and Midlothian providing support to survivors of domestic abuse. Located within this service are three Domestic Abuse Advisors who directly support victims referred to Marac and attend Marac as a partner service. Through the Performance and Quality Improvement Sub-group we monitor the number of women supported by WAEML and those awaiting a service.

WAEML operated a waiting list for a one-to-one outreach service throughout the year in each area. Staffing capacity and funding constraints place pressure on the service, but there is a robust weekly waiting list management process in place, with everyone on the waiting list contacted at least every ten days to ensure close tracking of support needs and appropriate escalation into service when risk increases. On average, cases are open for four and a half months within the outreach service. Following outreach, women, children and young people are encouraged to access the responsive and group work programmes for ongoing therapeutic support if required.

[21] Supporting documents - Domestic abuse: statistics recorded by the police in Scotland, 2022-23 - gov.scot (www.gov.scot)

A Multi-agency Risk Assessment Conference (Marac) is a local meeting where representatives from statutory and non-statutory agencies meet to discuss individuals at high risk of serious harm or murder as a result of domestic abuse. The meeting provides a safe environment for agencies to share relevant and proportionate information about current risk, after which the Chair will summarise risks and ask agencies to volunteer actions to reduce risk and increase safety. The primary focus is to safeguard the adult victim, however links with other agencies will be made to safeguard children and manage the behaviour of the perpetrator. All local authorities in Scotland hold Maracs.

In East Lothian and Midlothian, we hold Marac meetings every four weeks, with 13 scheduled meetings in the year. We aim to keep the number of cases in any one session to ten maximum, and consequently on occasion we need to hold additional meetings to respond to demand. All Marac referrals with a child associated to the case are referred to Children's Services to enable an assessment of the need for Child Protection processes to be instigated.

East Lothian

Table 13

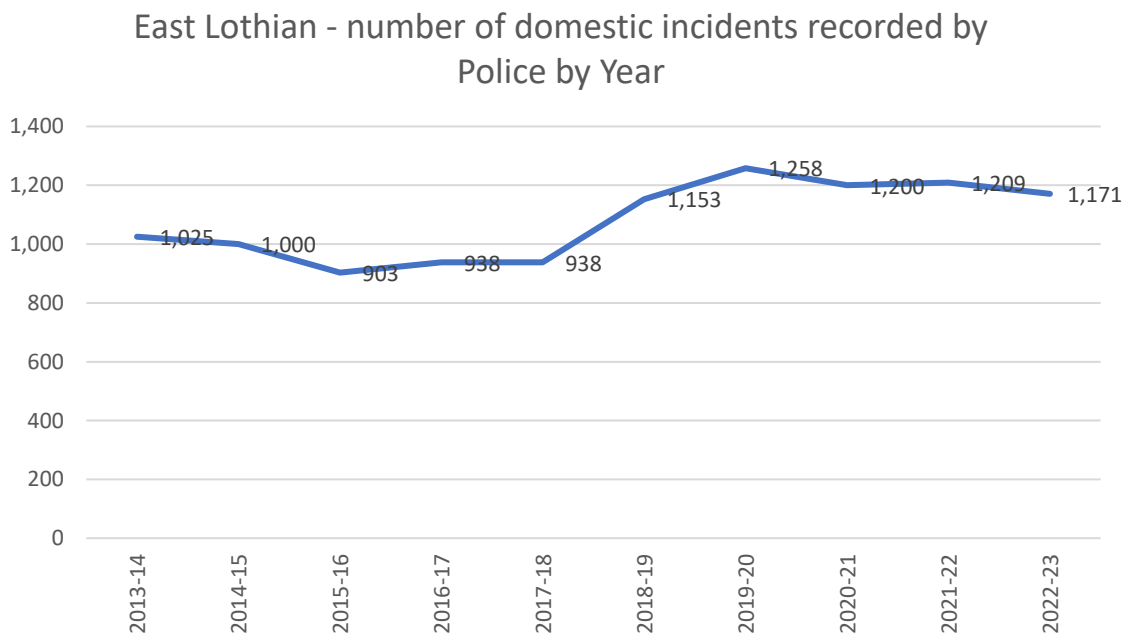
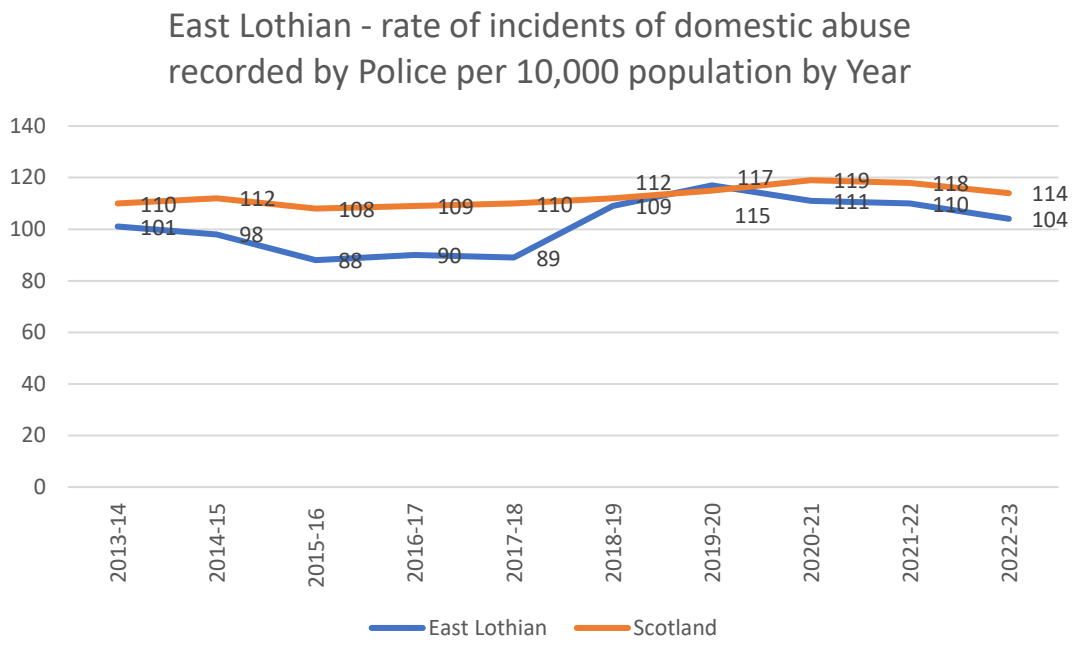


Table 14



From the data available for three quarters, shown in Table 15 below, in East Lothian, there were 54 more incidents of domestic abuse reported to the Police than in the whole of the previous year. Following an incident of domestic abuse reported to the Police, the Police will offer to make a referral to a specialist service for support. In East Lothian 180 victims were offered such a referral in the year, with almost all being referred to Women's Aid East and Midlothian.

Table 15

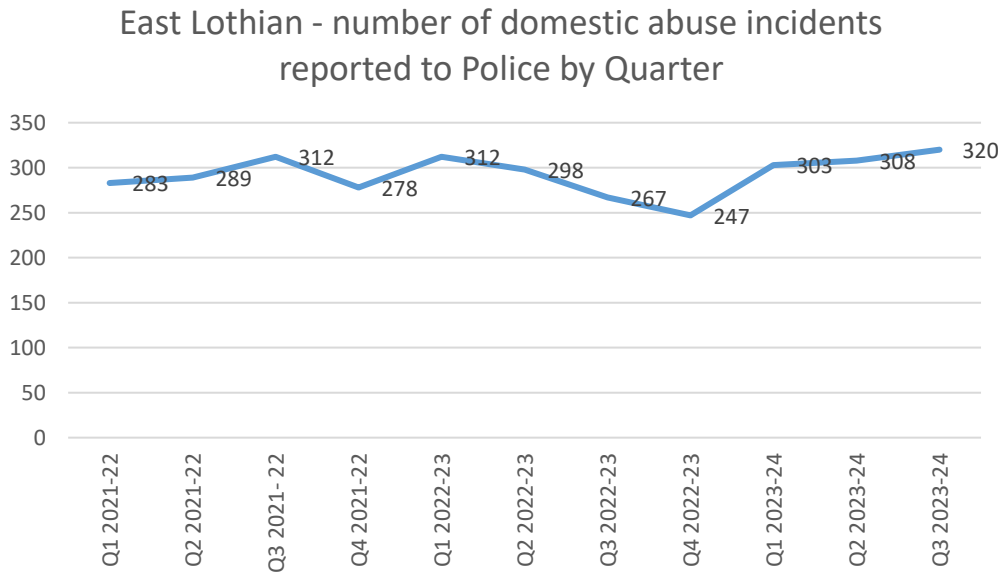
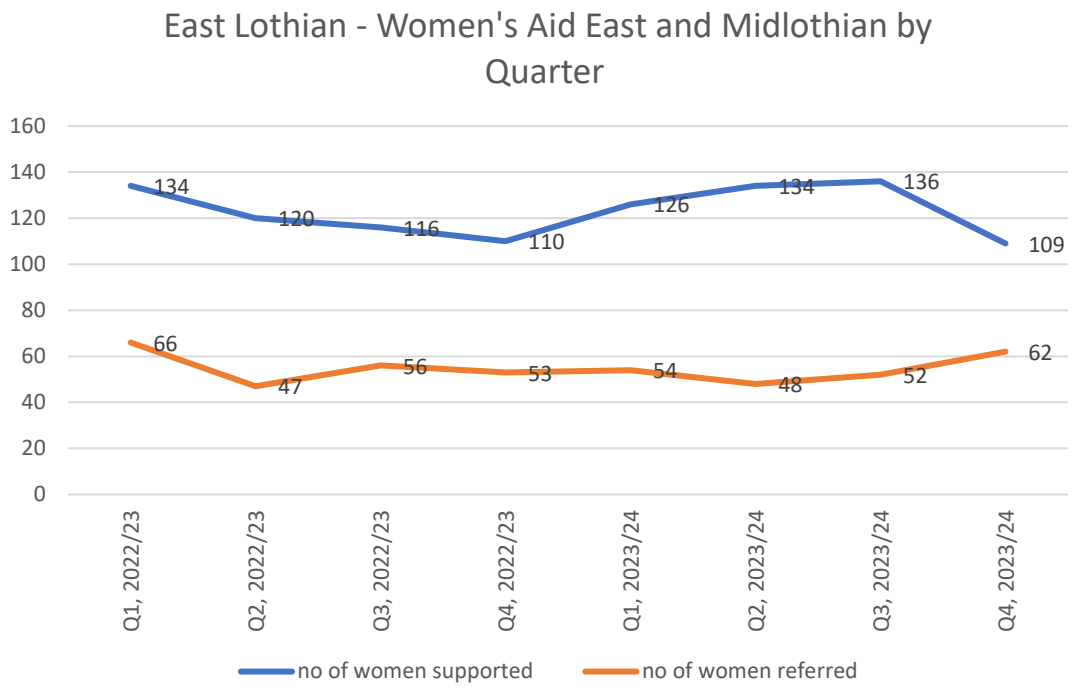


Table 16 shows the number of women supported and number of women referred each quarter in East Lothian. An average of 62 women in East Lothian were awaiting a service for one-to-one outreach support at the end of the year.

Table 16



There were 152 victims heard at Marac meetings in East Lothian in the year, a significant increase by 46 from the previous year. To meet this demand, there were five additional Marac meetings, bringing the total number of Marac meetings to 18.150 victims were female and two male. In 73.0% (111) of cases there was at least one child associated with the victim or perpetrator. 44 of the 152 cases were repeat cases (where the victim had been referred within the previous 12 months).

Table 17

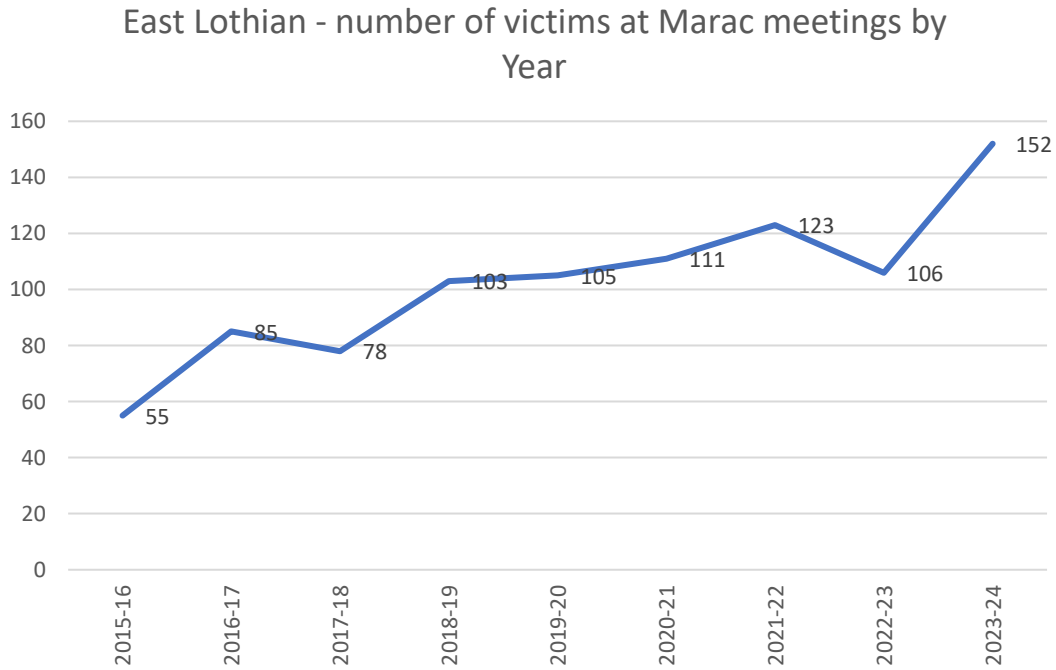
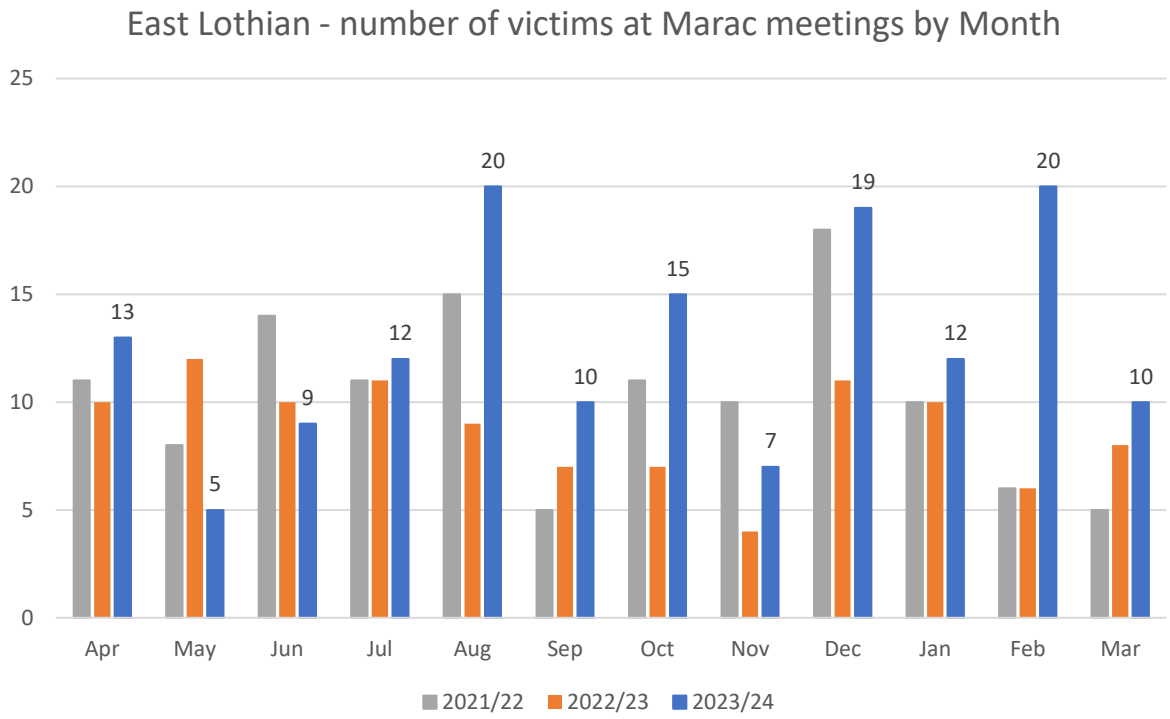


Table 18 below breaks this data down further by month, with comparison to the previous two years.

Table 18



Midlothian

Table 19

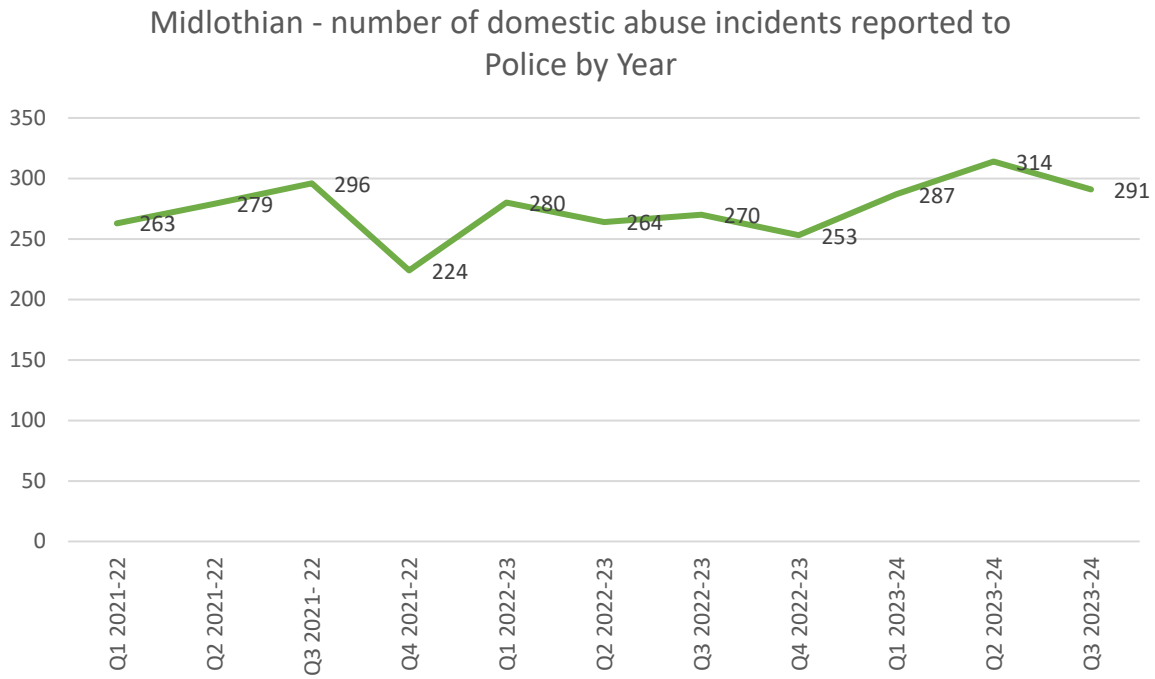
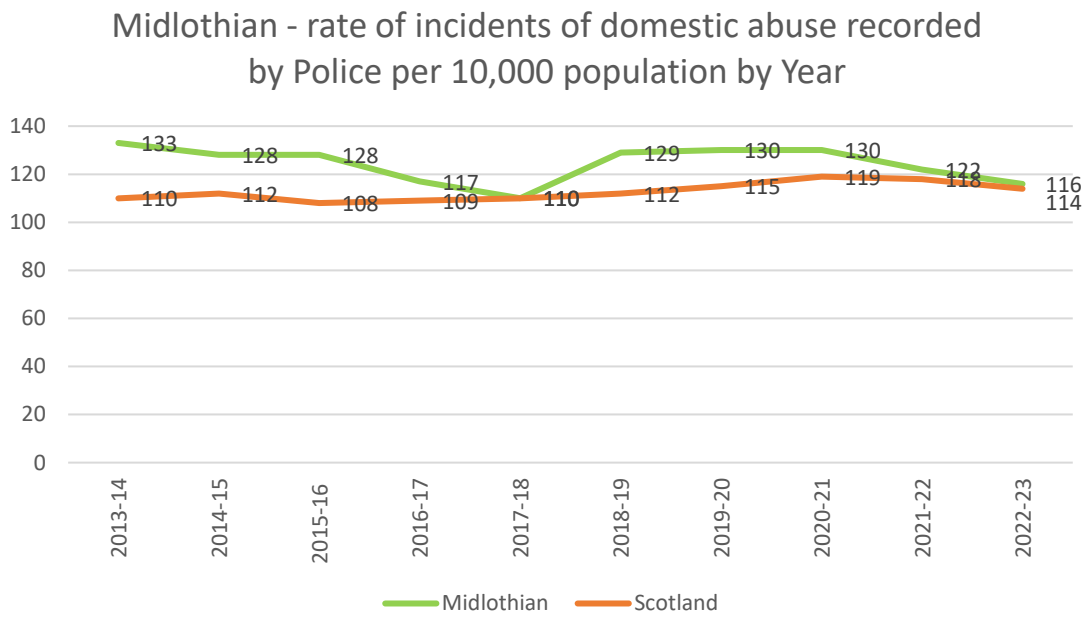


Table 20



From the data available for three quarters, shown in Table 21, there were 78 more incidents of domestic abuse reported to the Police than in the whole of the previous year. There is no identified pattern or trend. In Midlothian, 216 victims were offered a referral to a specialist service for support following an incident of domestic abuse reported to the Police. Almost all were referred to Women's Aid East and Midlothian.

Table 21

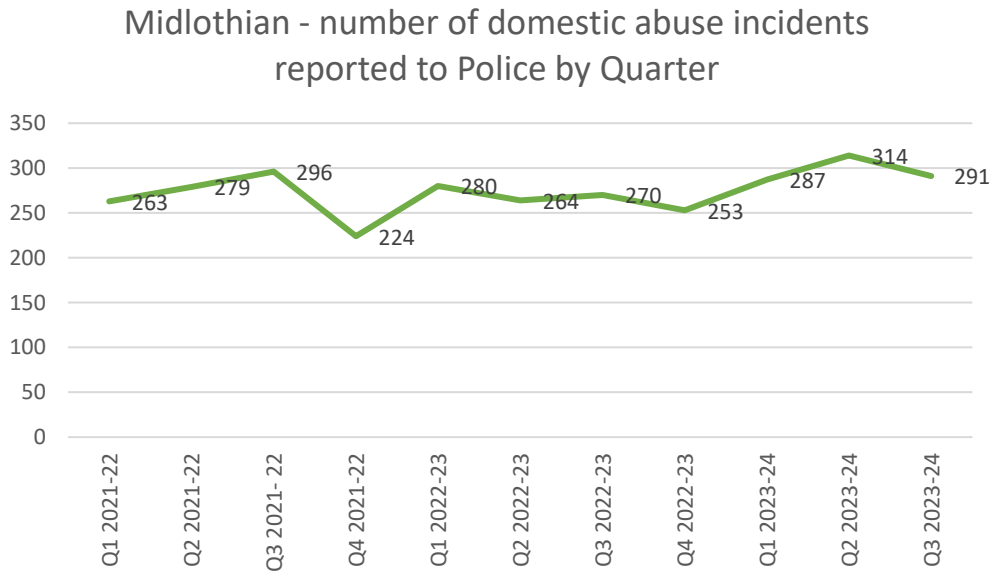
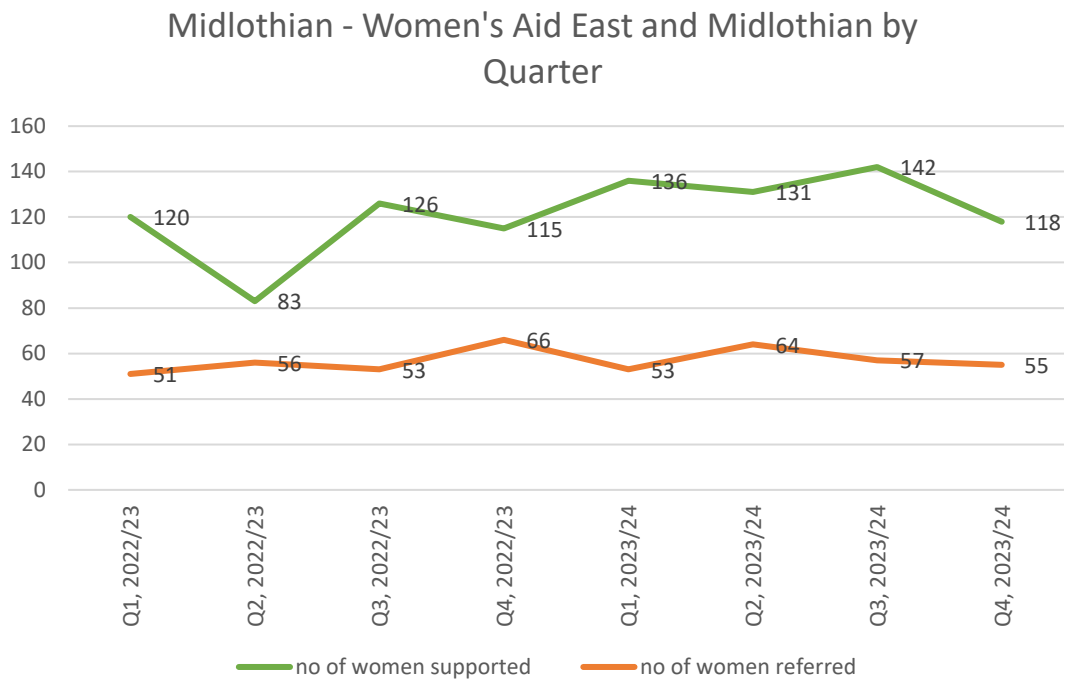


Table 22 shows the number of women supported and number of women referred each Quarter in Midlothian. WAEML operated a waiting list for a one-to-one outreach service throughout the year, with 65 women in Midlothian awaiting a service at year end.

Table 22



There were 125 victims heard at Marac meetings in Midlothian in the year, a reduction of 12 from the previous year. To meet this demand, there were two additional Marac meetings, bringing the total number of Marac meetings to 15. 119 victims were female and six were male. In 71.2% (89) of cases there was at least one child associated with the victim or perpetrator. 30 of the 125 cases were repeat cases (where the victim had been referred within the previous 12 months).

Table 23

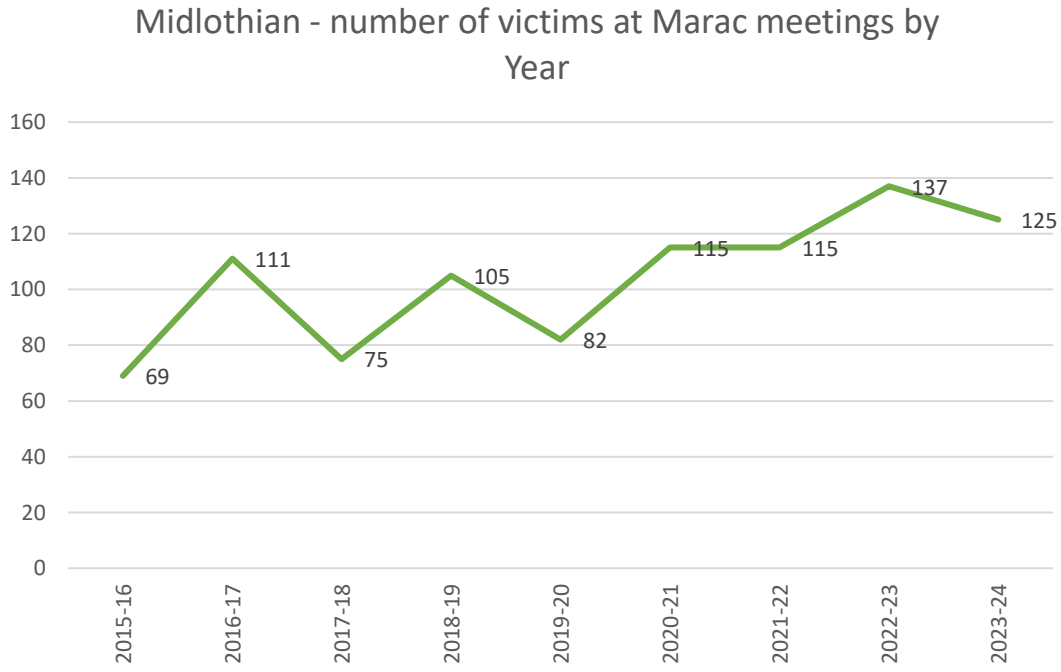
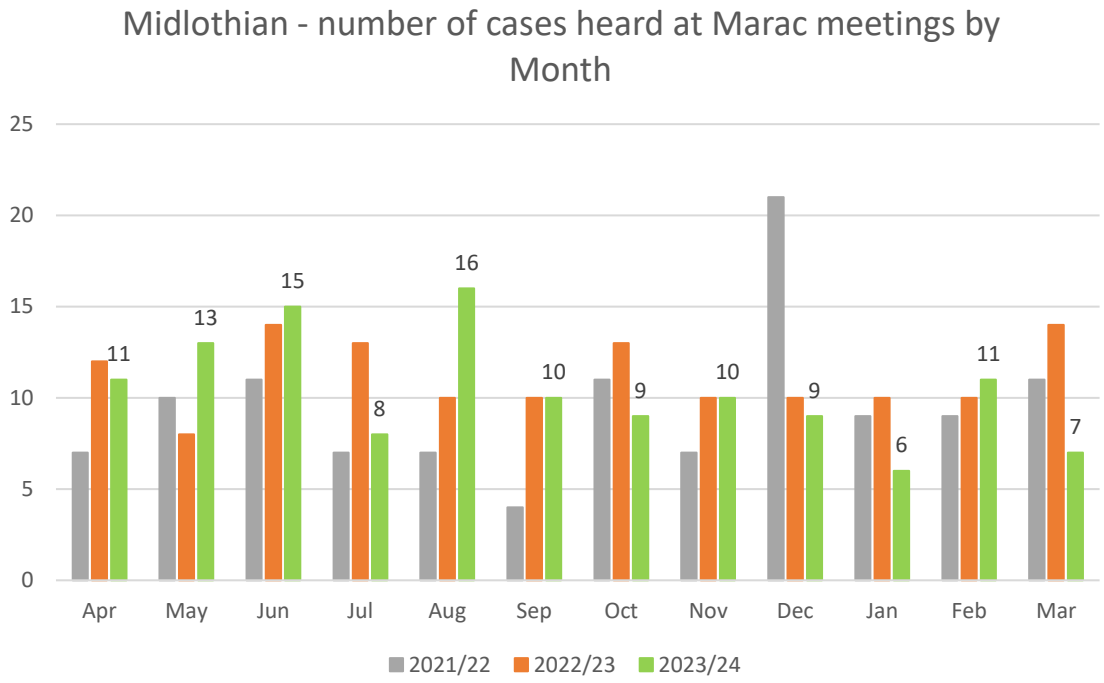


Table 24



3.4 MAPPA (Multi-agency Public Protection Arrangements)

Quarterly reporting of MAPPA arrangements in East Lothian and Midlothian is made to the EMMG Sub-group of EMPPC.

East Lothian
The number of registered sex offenders being managed in the community on 31st March 2024 was 75. MAPPA is functioning efficiently and effectively, with no registered sex offenders reported for any sexual re-offending, and audits of MAPPA cases identifying strengths in risk management and partnership working.

Midlothian
The number of registered sex offenders being managed in the community on 31st March 2024 was 60. MAPPA is functioning efficiently and effectively, with no registered sex offenders reported for any sexual re-offending, and audits of MAPPA cases identifying strengths in risk management and partnership working.

Section 4 – Looking Forward to 2024/25

In 2024/25 we will continue to build on our strengths as a Public Partnership and progress the areas of work to deliver on our five key priorities.

We will hold a further developmental session for EMPPC in November 2024 which provides an opportunity to take time out of the busy schedules and workplans, to learn together and reflect on how we work together.
We will embed our revised Public Protection arrangements, with the introduction of our two new Sub-groups for Adult Support and Protection and Child Protection, and the shift to six monthly meetings for VAWG Delivery Group and EMMG.

We will progress the key areas of improvement identified in the three Joint Inspections that took place in 2023/24 – in particular, we will give priority to:

- Ensuring that we incorporate the voice and lived experience of children and adults who come into contact with Adult Support and Protection and Child Protection processes.
- Continue to embed the national Minimum Datasets for Adult Support and Protection and Child Protection and seek to improve how we demonstrate the impact of the Committee and the work that services do to improve the outcomes and lives of children and adults who come into contact with Adult Support and Protection and Child Protection processes.
- Strengthening our approach to multi-agency quality assurance of Adult Support and Protection and Child Protection work.

We will continue to deliver our multi-agency Learning and Development Strategy and will develop a new Strategy for 2025-27.

We will support East Lothian to develop a local Equally Safe Strategy, continue to work with Midlothian in the implementation of its Strategy, and will ensure that the work of the VAWG Delivery Group is aligned to, and supports the local Strategies.

We will continue to implement the National Guidance for Learning Reviews for Adult Support and Protection and Child Protection and will seek to progress any Learning Reviews and decisions about the need for a Learning Review in a timely and proportionate manner. We will disseminate learning from local and national Reviews through training, briefings and our Quarterly Newsletter.

A key focus for the 2025 calendar year will be to strengthen our approach to communications, particularly for the communities of East Lothian and Midlothian. The launch our new website will be a key step towards this. We will bring key partners together to form a Communications Group to support the development of our approach.

Chief Social Work Officer Annual Report 2023-24

Thursday, December 19th 2024, 14:00-16:00

Item number:	**5.13**

Executive summary

This report provides Council and IJB with the annual report of the Chief Social Work Officer (CSWO). The report offers a high-level overview of activity in each service area and identifies the great work, along with the challenges and changes that have occurred over the past year. This Report has governance at Midlothian Council

Members are asked to:

- Note the report.
- Note the positive work undertaken by social work and social care staff across the many different sectors over the past year.

Chief Social Work Officer Annual Report 2023-24

1 Purpose

1.1 This report provides Council and IJB with the annual report of the Chief Social Work Officer (CSWO). The report offers a high-level overview of activity in each service area and identifies the great work, along with the challenges and changes that have occurred over the past year. This Report has governance at Midlothian Council

2 Recommendations

2.1 As a result of this report, Members are asked to:

- Note the report.
- Note the positive work undertaken by social work and social care staff across the many different sectors over the past year.

3 Background and main report

3.1 The requirement that every local authority should have a professionally qualified Chief Social Work Officer is contained within Section 3 of the Social Work (Scotland) Act 1968. The particular qualifications are set down in regulations. This is one of a number of officers, roles or duties within which local authorities have to comply. In Midlothian Council the role of Chief Social Work Officer is held by the Chief Officer Children's Services, Partnerships and Communities.

3.2 The annual reports of all CSWO's are submitted to the Office of the Chief Social Work Advisor at the Scottish Government in order that a national overview report can be produced.

3.3 This year's report offers a high-level overview of some of the great work undertaken however also highlights some of the challenges and changes faced by each area of social work and social care.

3.4 It was very much a shared endeavour by all staff across the council and the health and social care partnership including our third sector partners that prioritising the safety and health and wellbeing of those who were most in need within our communities, remains our main priority.

4 Policy Implications

4.1 None.

5 Directions

5.1 No new implications for Directions

6 Equalities Implications

6.1 This report does not recommend any change to policy or practice and therefore does not require an Equalities Impact Assessment.

7 Resource Implications

7.1 There are no resource implications.

8 Risk

8.1 There are no known risks associated with this report.

9 Involving people

9.1 This report was produced by the outgoing CSWO with assistance from the Head of Adults Services and the Service Managers in the HSCP and Childrens' Services.

10 Background Papers

10.1 None.

AUTHOR'S NAME	Nick Clater
DESIGNATION	Head of Adults Services and Chief Social work Officer
CONTACT INFO	nick.clater@midlothian.gov.uk
DATE	29/11/24

Appendices:

Appendix 1: The Chief Social Work Officer Report 2023/24

Midlothian Chief Social Work Officer Annual Report 2023/24

Contents

Introduction/Reflections 2023-24

I am pleased to present my fourth and final Chief Social Work Officer's annual report for 2023/24. I shall be retiring in October 2024; therefore, the Chief Social Worker role shall be passed over to Nick Clater, Head of Adult Services. This year's report will be written on the same template as last year, a fuller report with agreed headings to try and offer some consistency across the 32 CSWO reports. The report is produced for noting to relevant Committees and Council. The report will focus on local governance arrangements, service delivery, resources and workforce.

This report along with the 31 other Chief Social Work Officer's reports will form part of a national summary report which shall evidence some of the changing trends and outcomes across the country as well as highlighting significant achievements and the very many challenges faced by all.

Despite the very busy landscape within Midlothian, we have maintained a focus on delivery of services and improvement. Within Adult Services we have had a flurry of activity around inspections. In October 2023 there was the joint inspection of Adult Services with a focus on people with physical, long-term conditions and their unpaid carers. In January 2024 notification was received that an adult support and protection inspection would commence. Children's Services also had a visit from the Care Inspectorate to inspect our fostering, adoption and continuing care services. Justice continued to have many discussions around the new multi-agency public protection system (MAPPS) that is being rolled out by the Home Officer to better report and monitor those individuals who are assessed as high risk and living within our communities. The new MAPPS proposal remains an area of continuous discussion and controversy across Scotland.

There continues to be a great deal of national and local discussions centred on the workforce with there not being enough suitably qualified and experienced social workers, resulting in an over reliance of agency staff.

The national context for social work and social care in 2023/24 remains characterised by legislative and policy developments such as the National Care Service (NCS), The Promise, Care and Justice Act, and unaccompanied asylum-seeking children, to name but a few, all which impact on how services are delivered. Demands for new initiatives outstrip financial and human resources, with savings impacting upon core services. In addition, short-term funding makes attempts to meet sustainable local needs difficult.

We reported last year on the war in Ukraine and the impact this had on individuals and families fleeing and coming to Scotland with some arriving in Midlothian. At the time of writing the war continues. We have had over 200 Ukrainian people arrive in Midlothian via the various visa routes on offer. This is in addition to families from Afghanistan who are at risk of harm from their home country, fleeing and awaiting accommodation in Britain. Midlothian to date has received and supported 40 Afghanistan people. Another significant factor is the unaccompanied asylum-seeking children who mainly arrive via the small boats which travel across the English Channel. These young people risk life and limb and are often very traumatised when they arrive within Midlothian. Over the past year there have been significant discussions around

the increasing numbers and how local authorities are unable to sustain the current mandated requests for placements.

It is not possible to convey every aspect of social work services within one report. The report therefore focuses on key areas of development and improvement, with a view to showing how we continue to prioritise supporting people within their own homes and communities. I wish at this point to also acknowledge the incredible work that has been undertaken in the last year by staff and my appreciation goes out to everyone who works in social work and social care, and those who support this important work.

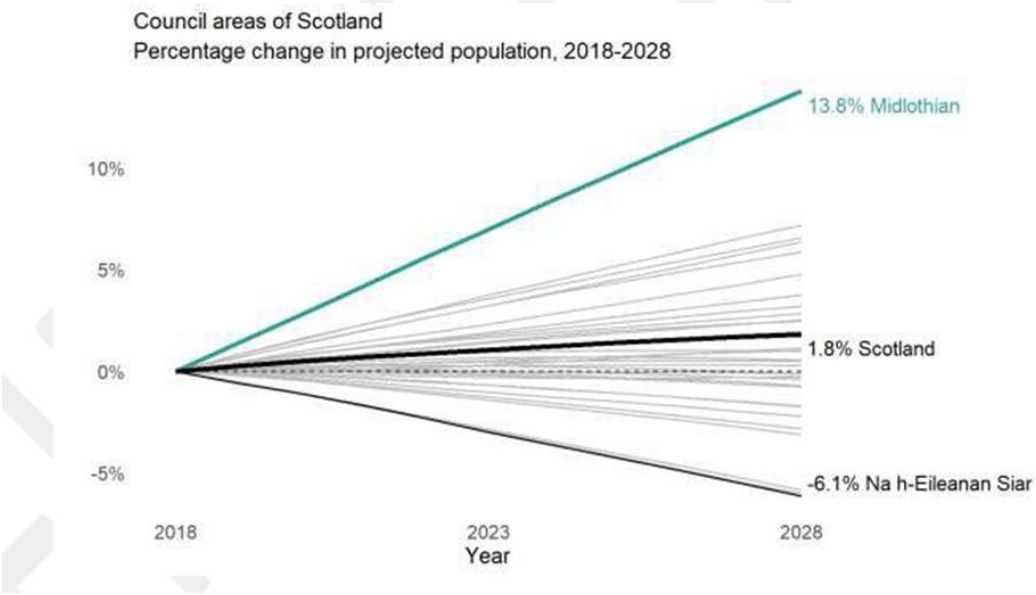
I hope you find the report of interest and that it gives a broad overview of the work that has been undertaken over the last year.

Joan Tranent
Chief Social Worker Officer

Midlothian Profile

Midlothian continues to be the fastest growing local authority in Scotland, which shall see a growth rate of 13.8% until 2028 compared to the Scottish average of 1.8%

Fig 1: NRS 2018-28 % Change in Projected Population



Our demographic profile shows growth in all age groups but particularly acute in the 0-15 years and over 75 age groups and therefore there will be significant demand for early years, schools, children's services and older people's services.

There is a gap in outcomes for people in different parts of Midlothian. Some areas have poorer levels of employment; lower wage rates; lower average life expectancy, greater concentrations of people who are elderly or disabled; poorer access to physical amenities such as shops, health care, public spaces and play facilities; lower than average qualifications and higher levels of crime.

In Midlothian there are 3 communities in the top 20% of most deprived areas in Scotland. These are Central Dalkeith/Woodburn; Mayfield/Easthouses and Gorebridge.

The Third Sector plays a vital role in fostering a sense of identity and belonging within communities. They provide essential resources, services and opportunities that enable individuals to actively participate and drive positive change within their communities.

Governance, Accountability and Statutory Functions:

The Chief Social Work Officer (CSWO) role ensures the provision of appropriate professional advice in the discharge of a local authority's statutory functions as set out in Section 3 Social Work (Scotland) Act 1968. The role also has a place set out in integrated arrangements brought in through The Public Bodies (Joint Working)

(Scotland) Act 2014. The CSWO's responsibilities in relation to local authority social work functions continue to apply functions which are being delivered by other bodies under integration arrangements. The appointment of a CSWO is a statutory requirement of the local authority.

The strategic direction for the role and contribution of social work and social care services in protecting and improving the wellbeing and outcomes of Midlothian residents sits within the context of community planning and the integration of health and social care. The Midlothian Community Planning Partnership deliver the Single Midlothian Plan 23-27 which has 3 outcomes covering the next 4 years:

- Individuals and communities have improved health and skills for learning, life and work
- No child or household living in poverty
- Significant progress is made towards net zero carbon emissions by 2030

Social work services in Midlothian are well established and are delivered between Midlothian Council and the Integrated Joint Board (IJB). Adult social work and social care services, including health visiting and school nursing services and justice social work are delegated to the IJB and delivered and managed within the Midlothian Health and Social Care Partnership. Children's social work services are managed within the council structure as part of the People and Partnership Directorate which includes Education and Community Lifelong Learning and Employability.

The role of the Chief Social Work Officer currently sits with the Chief Officer of Children's Services, Partnerships and Communities, however as I have already stated the CSWO role shall transfer to Nick Clater, Head of Adult Services in October 2024. The CSWO attends the IJB to provide professional advice and guidance to social work functions which have been formally delegated. Having a children's services background allows me to have an overview of delegated services which include health visiting and school nursing. Midlothian IJB is well established and evidences good governance and accountability. This arena allows for robust discussions around the pressures within both council and health services and for solutions to be sought at a strategic level. The anomaly of having health visiting and school nursing out with children's services requires good engagement and communication between the services at all levels which is evident within the Integrated Children's Services Plan 2023-2026.

Within Midlothian we have a joint public protection committee across Midlothian and East Lothian. The Chief Social Work Officer attends the East and Midlothian Public Protection Committee (EMPPC) as well as being a member of the Chief Scrutiny Oversight Group (CSOG) along with other Chief Officers and both Chief Executives. This partnership allows for sharing of practice and learning across the public protection arena which includes adult support and protection, child protection, violence against women and girls and MAPPA. The inception of a joint public protection committee in 2014 means it is well established and has over the years evidenced robust challenge and scrutiny.

The social work landscape is probably the busiest it has ever been with so many strategic drivers in all our service areas. It is difficult at times to fully grasp the impact

of all the new developments, policies and agendas that come across the desk of a CSWO. This said it is vitally important that as leaders we can engage in strategic discussions so that we can influence policy and share any concerns we may have. As CSWO I attend fortnightly CSWO meetings where all 32 CSWO's from across Scotland discuss a very full agenda and offer our views around new initiatives and the potential impact this will have on changes to legislation and any other relevant business. The Head of Adult Services who deputises as CSWO also attends and chairs groups at a national level that involve adult mental health and drug and alcohol groups. As CSWO I also chair the Social Work Scotland Children and Family standing committee which is a national group of not just social workers, but others involved in children and families work. In addition, many service managers across the three areas are involved in national arenas thereby sharing their own experiences and gaining knowledge and information from others which may be helpful in improving their own areas of work.

Within the last CSWO report I advised that we were in the early stages of developing a Social Work Assurance Group (SWAG). I am pleased to report this group is now established as of May 2023, with a Terms of Reference and agreed membership. As CSWO I chair the group and have the deputy CSWO as well as two service managers in attendance. The very busy agenda allows us to track progress on recent inspections ensuring that improvement plans are progressing. The remit of the group shall over time evolve to include other aspects of scrutiny and assurance. Currently the group provides strategic assurance, governance and scrutiny to Directors, Chief Executive and where appropriate elected members on the progress of actions derived from Care Inspections, significant complaints and audit work. The group also provides leadership to create a culture of transparency and openness to support learning and practice improvement as well as overseeing the approval of policies within children and families and adult services.

Duty of Candour:

All social work and social care services in Scotland have a duty of candour. This is a legal requirement which means that when unintended, or unexpected events happen that result in death or harm as defined in Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016, the people affected understand what has happened, receive an apology and the organisations learn from the experience and put in place improvements.

An important part of this duty is the requirement for organisations to provide an annual statement detailing how the duty of candour is implemented across services. Between 1st April 2023 and 31 March 2024, there has been one incident in a care home where it was deemed that the duty of candour be applied.

Resources:

Financial pressures continue for both local authorities and health services with demands ever increasing. As the fastest growing local authority in Scotland the increase in families and older people residing within our communities is growing at a rate that far outweighs our resources.

Within Children's Services the picture is very similar to last year with a continued shortage of foster carers across both the local authority and Scotland coupled with the ever-increasing demand upon us being mandated to receive unaccompanied asylum-seeking children (UASC) which is placing significant pressure on local resources.

As a local authority our budget was approved in February 2024 with Children's Services budget agreeing to a 5.5% increase in foster fees for 2024/25, this was in addition to the new Scottish Recommended Allowance (SRA) being agreed and partially funded by Scottish Government. The SRA ensures that both foster carers and kinship carers receive a standard allowance payment which is consistent across Scotland.

As reported last year the ongoing concerns around ring fenced or short-term funding streams do not promote confidence for future planning within services. The demands on children and adult services are ever increasing in Midlothian due to the population growth therefore budgets need to be aligned to this growth.

As CSWO I attend budget setting meetings in both the Council and the IJB and would assess that there are sufficient processes in place that allow me to share or voice any concerns around potential efficiencies that would impact or increase the risk to those we work with. I have monthly meetings with my Chief Executive and regular meetings with the Director of Health & Social Care which offers me the opportunity to raise any such concerns.

Within adult social care there are significant budget pressures one of which is attributable to demographic pressures within the learning disability population. These pressures arise from a combination of an increasing number of young people with complex needs transitioning to adult services and increased life expectancy. Steps are being taking to ensure we have clearer and more consistent approaches to the transitioning of young people with additional support/complex needs into adult services and that our planning and budgeting are more transparent within all 3 service areas, children, education and adult services.

Workforce:

Maintaining a consistent and skilled workforce has been another significant challenge particularly in the social care sector however social work has also been impacted**.** Within Midlothian we are fortunate to have a dedicated practice learning and development team which consists of a range of highly skilled and experienced trainers, practitioners, assessors and administrative staff. The team skills are diverse and cover a range of training areas and development opportunities. Although the team sits under the Head of Adult Social Care, it also reports into other directorates including Children and Families services and Education due to the range of training delivered to staff in these service areas.

Developing the workforce continues to be a key priority for both Children' Services and the Health & Social Care Partnership in Midlothian. From April 2023 to April 2024 there has been an improved focus on the learning and development frameworks across both areas. A new Learning and Development Practitioner was recruited in October 2023 for Children's Services who has undertaken a full review of the learning requirement

of the current staffing in post and what the service needs going forward. This has seen an increased investment in Open University Social Work Modules working towards a degree in Social Work. Also experienced social workers and team leaders undertaking a range of post qualifying courses including Child Welfare and Protection, Practice Education, Leadership and Management along with PG Cert Young People in Conflict with the Law.

Adult Services review of learning has seen an increase in interest and commitment to Practice Education (PE) and Leadership and Management through both Napier and Stirling University. This increased uptake of PE has enabled the services to host more social work students on placement which has always assisted in encouraging newly qualified social workers to come and join Midlothian following their positive practice placements with Midlothian Council.

In addition, we have an ongoing successful completion of social workers completing the Mental Health Officer training each year. 2 social works completed it last year and one about to complete this year with another social worker commencing in August 2024.

The SVQ Assessment centre continues to deliver a range of programmes across SCQF frameworks from level 5 up to SCQF 8 for our social care staff across Adult and Children's services. This includes Foundation and Modern Apprenticeships for Health and Social Care as well as Children and Young people. In the last year we have had a total of 87 people completing awards across these levels with an additional 111 currently undertaking an award. There is still a significant waiting list of 76 people across services, but this is due to the increased change of staffing because of the impact of Covid and staff leaving and retiring. An investment in an SVQ assessor is being developed to meet this demand to ensure all staff meet the registration and qualification requirements in the appropriate timescale for the SSSC registration.

The Learning and Development team has a dedicated Trauma development worker who commenced in January 2023 and has delivered training to a wide range of staff across Midlothian as follows: -

- Total number trained: 558 participants
- Total number of training events – 53 training events
- Level 1 - 446 participants
- Level 2 - 112 participants

The Trauma strategy focusses on working towards a more trauma informed community in Midlothian. The training has been well received and staff are feeling more confident in supporting people who may have experienced trauma in their lives.

Newly Qualified Social Workers (NQSW): The team continue to support the NQSWs and facilitate face to face sessions which prove to be the most popular and effective forum. The team continue to work with East Lothian to offer a bi-monthly joint session for NQSWs across authorities, this has been well received and evaluated.

Social Work student placements:

- We provided a total of 13 student social work placements within this time, from the OU, Stirling, Edinburgh and Napier courses as well as 3 Occupational Therapy student placements.
- 1 sponsored student completed their SW training within this time.
- We had 20 NQSWs during this timeframe.
- 6 members of staff completed the Link Worker course.
- 2 members of staff completed the Stirling Practice Educator course within this time.
- 2 members of staff completed the Leadership & Management course at Stirling and 3 completed the Child Welfare & Protection Course.
- 2 staff members completed their Mental Health Officer training and 1 applying for this year.

Overall, there is an ongoing dedicated commitment to invest and develop our Social Work and Social Care workforce – providing all the mandatory training necessary for individual roles as well as opportunities to develop their career increasing retention levels enabling Midlothian to have highly skilled and experienced workers across both Adult and Children's services.

Adult Mental Health Social Work Team:

<u>Drug and Alcohol</u>

Drug Related Deaths (DRD) and Alcohol Specific Deaths are published by the National Records of Scotland and both reports will provide a detailed analysis of the Drug and Alcohol deaths at national, health board and local authority level.

DRD published report is due for publication in August 2024 as is the Alcohol Specific Deaths report. Upon receipt of these reports, the services will continue to review locally through our DRD group and take any recommendations forward.

The Midlothian Substance Use Service [MLSUS], Mid and East Lothian Drugs [MELD] and Health In Mind Peer Support as part of Mid and East Lothian Drug and Alcohol Partnership (MELDAP) services continue to implement and progress the Medication Assisted Treatment [MAT] Standards. The services were evaluated against the Mat standards implementation team, and it is predicted that the services continue to demonstrate sustainable implementation of MAT 1-5. As MAT 6-10 is being rolled out over years 2024 and 2025, the services have been predicted provisional green status which is the highest score for this year required by the Scottish Government by March 2024.

Midlothian Services continues to deliver substantial harm reduction work to mitigate the harm associated with substance uses in line with the national priority. Due to the changing picture of substance use in Midlothian, East and Midlothian Drug and Alcohol Partnership (MELDAP) along with both Mid and East Lothian services, developed and formed an 'Emergence of Psychoactive Substances' group to deal with 'crisis' events driven by these new substances. This group links to Lothian wide concerns, themes and emerging patterns and national warnings, through RADAR. This group has been proactive and positive in sharing intelligence to deal with specific new trends through

amending key harm reduction messaging and introducing other measures such as the use of drug testing strips.

MELDAP continue to commission a range of services in Midlothian which are designed and tailored to best meet individual needs and enable them to remain in treatment for as long as they wish to, empowering the individual to reach their person-centred goals and to safely manage their substance use and promote their own recovery. Services continue to engage and support families and carers to address and support their needs.

Mental Welfare Commission reports

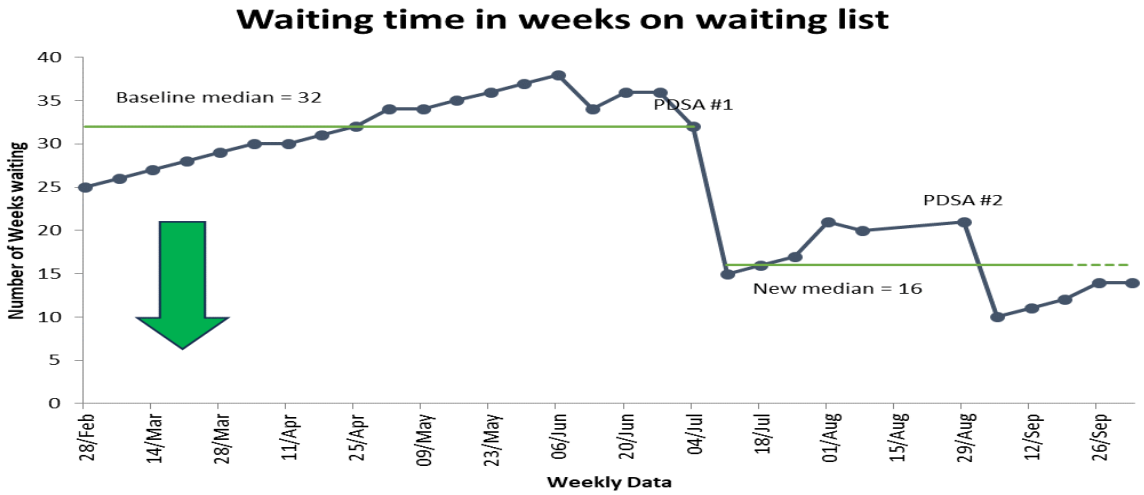
During 23/24 Midlothian HSCP has received 7 Mental Welfare Commission (MWC) Reports. Within each report there are key finding areas in which Midlothian Mental Health Services, both NHS and Council need to benchmark against and implement recommendations and findings

Fuller details are embedded within a report received by the Council and NHS. In the main Midlothian HSCP continues to benchmark positively against the reports received by the MWC and any gaps in areas identified are highlighted and improvement work progressed to meet the recommendations. Midlothian HSCP can provide assurance via the Social Work Assurance (SWAG) on the delivery of all recommendations from the Mental Welfare Commission.

Adult with Incapacity (AWI)

Midlothian Mental Health Leads over the last year have made significant improvements to the management of AWI, ensuring individuals wishes are respected and they are not waiting for long periods of time in places that do not meet their needs.

There has been a commitment to reduce the waiting time for Guardianship applications and improve our local processes. We have increased our Mental Health Officer capacity, and this can be seen to correlate against our improved waiting list times. June 2023 saw a significant investment into the management of waiting times with a 50% reduction in the mean waiting time from 32 weeks to 16 weeks. (See chart below)



Positive outcomes:

- Provide consistency of practice to the client and their family.
- Enable the case to be closely monitored and reviewed by the original allocated social worker to ensure the other social work tasks are undertaken timeously.
- MHO engagement at the right time.
- promotes an improved and timely approach to adults with incapacity.

Improvement work this year focused on data and the recording of the data. In partnership with the performance team, the development and implementation of a new recording form 'CC MH Guardianship Application Record' within our electronic record system enables robust monitoring of the referrals and ownership of each referral and current waiting times. This provides the necessary oversight and management of AWI and assists in maintaining low waiting times.

During 2023/2024, 80 Guardianship orders were granted- relating to 77 individuals
Current Guardianship waiting lists include 17 individuals (LA = 4, Private = 13)

Local training session have been developed on AWI which will be rolled out across all social work and social care teams, to enhance staff's awareness and role within AWI.

The Learning Disability Team:

Investment in the housing, specialist support and training aspects of the support for people with complex needs related to learning disability and autism continues to pay dividends. Midlothian remains the area with the fewest inappropriate placements of the 32 partnerships and the lowest rate of people in urgent categories on Dynamic Support Register as detailed in the latest Public Health Scotland (PHS) publication 'Insights into Learning Disabilities and Complex Needs: Statistics for Scotland'.

Several of the housing elements of the Strategic Redesign of Learning Disability Services in Midlothian have moved on significantly. These developments are designed to support people, regardless of the level, range and complexity of need, to live independently with the same choice, control, and protection as any other citizen, in an environment that enables them to stay safe and empower them to participate in their

local community. Building and care tenders are well underway for four people with a profound and multiple learning disability to move into Primrose Lodge in Loanhead in Autumn 2024. The main part of the building will be occupied by four tenants as their permanent home and there are two further bedrooms that will be used for respite and short breaks for people with similar needs.

St Cuthbert's, a newly built development of eight single tenancies in the centre of Bonnyrigg, will be ready for occupation mid-June. The tenants will be a diverse group of young neurodiverse people, and their support will be highly individualised and tailored to their particular needs, strengths and interests. Many will be young people in their first tenancy and there will be a strong focus on enhancing and transforming the health and wellbeing of tenants using innovative digital technologies.

Making Choices Keeping Safe Midlothian is designed to support young people who expose themselves to risk whilst navigating the complex world of relationships and social media. It is a series of themed workshops developed and designed around the lived experience of six young people with the aim of supporting them to stay safe whilst promoting their right to healthy relationships and a full life. The project demonstrates the value of partnership working and early intervention by bringing together the different perspectives of the young people themselves, their families and carers, the social work learning disability team, Police Scotland, The Enable Local Area Coordination Service, The community learning disability team and third sector providers to understand the issues and develop a response that was uniquely designed to meet the needs of the young adults. Initial evaluation, as well as sustained attendance by the participants, has evidenced that the workshops are both popular and effective. The next course for a group of young men is currently underway.

The Pavilion Project is an imaginative developmental day opportunities programme for neurodiverse young adults with complex needs for whom group day services aren't suitable. A close collaboration between the learning disability social work and community health teams, Midlothian Leisure, Midlothian day services, and a number of third sector providers has created a programme of highly individualised, developmental opportunities for young neurodiverse adults which builds upon their skills and discovers new interests. To date the partnership has delivered 260 regular sessions of developmental community activity for 12 young people with complex needs. Time to reflect on the impacts of the work and contribute to setting subsequent aims as the activity develops and grows is central to the long-term success of this work and tailoring the right support for people with the most complex needs who are making the transition to adult life.

The transition development worker has now been in post for six months. A transition working group with cross sector participation has now been convened to oversee the development and delivery of a range of work streams and actions aimed at improving the process for young people transitioning from Children's Services to Adult Services. This group is supported by a young person's group and a parent carer group which are now both established.

Carers

The HSCP has continued to work with and invest funding in third sector partners to expand the offer and range of opportunity for support within the community for unpaid carers. VOCAL, carer support and carer centre, have led new service developments expanding services to develop locality provision; promote and support future planning including Power of Attorney; and increasing community capacity to support carers at the beginning or wherever they connect with support on their caring journey. The range of engagement from very early intervention via grass-root activities, though to specialist support with issues such as legislative orders has seen Third Sector partners work collaboratively to deliver the diverse range of support needed.

Self-Directed Support (SDS)

Development of social work practice in relation to Self-Directed Support continues to be an important area of work. An SDS planning officer is taking forward the implementation of SDS standards within Midlothian. Work is being progressed in several priority areas for development that includes support planning, resource allocation systems and a system of accountability.

Drug and Alcohol Related Deaths

Midlothian Substance Use services continue to make on going improvements to continue the delivery of the 90% target for A 11 (A11 all individuals accessing services will be seen within 21 days from point of referral) Q2 and Q3, seen the services working towards improvement of 90%, where in Q4 Midlothian's performance has been maintained at 100%. The services continue to provide direct access to timely and appropriate treatment that best meets an individual's needs, psycho-social support and peer led support for those affected by their or other drugs and/or alcohol use.

Community Justice:

The model for Community Justice in Scotland came into operation on 1 April 2017, underpinned by the Community Justice (Scotland) Act 2016 (the Act), which places duties on those within our partnership to engage in community justice planning and to report against our nationally-determined outcomes.

In preparation of the new improvement plan a participation statement outlined those consultations over the course of the last year and those methods used to gain views. It was imperative to accurately reflect in the new improvement plan views of people most affected by Community Justice in our community.

The improvement plan seeks to support the Single Midlothian Plan within the community planning approach to work towards the objective "Making Midlothian Safer". The current Community Justice improvement plan will be delivered over the next five years (2023-2028) with 26 actions that align with the National Strategy for Community Justice which was published in summer of 2022 and the associated Community Justice Performance Framework. published in March 2023.

Our improvement plan acknowledges the need for robust partnership relationships particularly in the context of budgetary restraints. Our strong emphasis in Community Justice is early intervention, the use of diversion and intervention at the earliest opportunity. We seek to provide the right support at the right time to reduce offending becoming a cyclical pattern.

Over the last year we have completed the restorative justice café programme. Midlothian continues to explore how to best use restorative justice offering greater continuity in approach across all services in the community justice partnership. Work progresses to enhance the voice of young people with partners from the third sector presenting collaboratively to schools with peers who have experienced the justice system. Continued strong links with our colleagues in Justice Social Work ensures that Community Justice can offer new opportunities for those navigating the justice system. Community Justice in Midlothian remains a preventative approach with the overarching goal to increase resilience for individuals and communities.

Your Chance to Change

The Your Chance to Change service continues to support men to undertake the Caledonian Men's domestic abuse perpetrator programme on a non-Court-mandated basis. Rebranded and relaunched in February 2023, staff have continued activity during 2023/2024 to promote the work of the service, which places responsibility for the abusive behaviour on the man, whilst providing hope that change is possible. The service currently supports a total of five men, which represents a 500% increase on the previous reporting period.

Women's Group Work Service – Midlothian Spring Service

Spring is a multi-disciplinary team which recognises the barriers to women accessing services. It provides a group work programme for women in Midlothian who may have experienced past or current trauma, may be struggling with their mental health and/or substance misuse and may be in contact with the Justice system.

During the reporting period, 43 women were referred to Spring. 5 women graduated during the reporting year. At the end of the reporting period there were 12 women actively involved with the group work programme. Future service development include the delivery of the phase one trauma intervention, Survive and Thrive, and the establishment of a national network of statutory services supporting women in the Justice field to share and develop best practice. Spring will celebrate its ten-year anniversary in June 2024 and staff and service users have been planning for this. There are many accolades from users of the service that highlight the positive impact this service has had on people's lives by promoting their confidence, helping understand the trauma they suffered and how these impact on their emotions.

Community Payback Orders:

Over the reporting year 227 Community Payback Orders (CPO) were imposed; 154 with a supervision requirement and 149 with an Unpaid Work requirement.

Supervision: The aim is to reduce and manage the risk of re-offending, and of causing harm, through providing the individual with opportunities to engage in a process of change; with the aim of increasing their ability to desist from offending in the longer term. A range of supports is provided to clients including our 'Stride' programme focused on improving men's emotional management skills and decision making. We have also utilised a range of supports in the local community from partner services including Venture Trust, Substance Use Service, MELD, Skills Development Scotland, Midlothian Communities and Lifelong Learning Team and Health in Mind. This multi-agency approach to supporting individuals enable the development of individualised case management plans to effectively address the risk and needs associated with an individual's offending behaviour.

Unpaid work: During the reporting year the team completed 309 projects benefitting 236 beneficiaries. This requires working alongside social work teams, community groups and partner organisations to undertake work benefiting the most vulnerable in the Midlothian community. In addition to providing opportunities for clients to make reparation to local communities for their offending behaviour, the unpaid work team continue to deliver a range of training opportunities promoting rehabilitation and increase employability.

110 qualifications were gained by Unpaid Work clients. One development in the reporting year has been the establishment of a SVQ in Work Skills. To support us to increase our pathways to employability a member of staff qualified as an SVQ Assessor. She supported our first two service users to successfully complete this qualification. One of the individuals has used this qualification to successfully apply to college and is due to start a full-time course in August 2024.

Supervision of Throughcare Licences and CPOs:

Justice Social Work have continued to develop interventions and services to help people who need additional support to live and reintegrate into in their community and to be responsible citizens. The Justice Service have worked closely with colleagues from the Psychological Services Team to ensure that appropriate responses are taken with those with complex needs and to ensure that risk assessments and risk management plans are robust. This is achieved through weekly formulation sessions. Staff from the Justice Service also have access to clinical supervision with a psychologist to ensure that they are supported to manage the complexities of the work and reduce the risk of vicarious trauma.

No 11 Allocations Meeting: The Justice Service continues to work with partner agencies to ensure that individuals being liberated from custody have suitable accommodation and are fast-tracked into relevant services including recovery networks. We have consulted with service users to confirm what additional supports can be provided and in 2024-25 we will be working with Health in Mind and Change Grow Live to provide 'liberation packs' which will include practical items such as a phone, toiletries and contact details for local addiction and recovery services and support for health and wellbeing.

Bail Services: We have continued our commitment to provide early intervention for those involved with the Justice system to help address presenting needs that may lead

to reoffending and to reduce the use of remand. During the reporting year we made the decision to bring the service in-house to ensure that we could provide a consistent level of service. During 2023-24 we completed 33 assessment reports for Supervised and/or electronic monitoring. 5 people were placed on supervised bail as an alternative option to remand. All 5 went on to successfully complete their supervised bail.

Children's Services:

In last year's report we advised of the worrying increase in referrals into social work. Over the past year we have undertaken a significant piece of work to ensure that only those referrals that meet the criteria for social work intervention are coming into the system, and other early supports are utilised for families in need. This has resulted in a significant reduction of referrals; however, child protection work remains high. Child protection work is complex and comes with a high level of risk, therefore it is imperative that the workforce is experienced and knowledgeable. Due to the workforce issues around being unable to recruit experienced workers this leaves us with a significant challenge. Therefore, whilst referrals have reduced due to other forms of intervention from the family wellbeing service being involved at an earlier point of contact, we are now looking at how we can better support those less experienced staff at the front end of the service.

Within the practice teams the workloads remain high and again the lack of experienced permanent members of staff is impacting on the service user experience. There remains a great deal of good work happening within all the teams' ensuring children and young people remain with their own families where it is safe and possible to do so and protecting families from identified risks such as domestic abuse, and drug and alcohol issues.

The Midlothian Housing Project is a successful approach we have adopted within Children's Services fully supported by the council. This approach ensures that care experienced young people who are moving on from care, move into a permanent tenancy with support. This approach takes time to build relationships and ensures the young person is ready to move before any agreement is made. To date over 30 young people have benefited from this project with no tenancy break downs. A very successful team and project.

.**Child Protection and Looked After and Accommodated**

During this reporting period we devised new Child Protection Procedures across Edinburgh, Midlothian, East Lothian and West Lothian based on the National Child Protection Guidance (2021). These are now embedded in practice.

We have also continued to embed the Scottish Child Interview Model (SCIM) into practice despite the lack of funding to backfill social workers who undertake extensive training to take on this role. Feedback is evidencing that the model is supporting better outcomes for children involved in child protection investigative processes. We are training a second person in this approach.

Our looked after and accommodated population of children and young people has remained fairly static over the year. Albeit can change on a day-by-day basis. Most

children who need to come into care go and live with family. Our child protection numbers over the reporting period have also remained relatively consistent. This data supports our early intervention and preventative approach whereby we are involved with families at an earlier point of contact and work with them to try and prevent a crisis. Our preventative supports such as family systemic practice and family group decision making, support families to better understand and work through concerns and to plan should things not work out.

Our Reviewing Officers offer quality assurance over all children's plans who are looked after away from home and those on a compulsory supervision order at home. They report to the senior management team on themes and trends they are observing through their chairing of both child protection and looked after meetings.

Hawthorn Family Learning Centre (HFLC)

Hawthorn Family Learning Centre continues to increase the number of children they work with circa 80 children a week. The manager and service manager both returned from maternity leave in the Autumn of 2023, which was very much welcomed. There have been some improvements made to the centre over the past reporting year. In July 2023 the centre was closed to allow it to be repainted and undertake work externally through refurbishing the play areas with new equipment and increasing the number of car parking spaces. A new kitchen makeover was also undertaken. During this period staff and children moved to Mayfield primary school. Over the reporting period staff have undertaken 142 outings with children, provided £400 worth of food vouchers as well as supplying winter coats and appropriate footwear to children and parents. The dedicated income maximisation worker who attends the centre on Mondays and Fridays, supported parents to ensure they were receiving the correct benefits amounting to £65k extra income for the families by then end of December 2023. This invaluable support also assists parents with debt and money advice.

Children with additional support needs

Year on year we continue to see a rise in the number of children and young people who have additional support needs. This remains an area of significant growth across both children's services and education. Our health colleagues at CAMHS have developed two waiting lists one which is for those children and young people with significant mental health issues and the other for those children and young people awaiting a neurodevelopment assessment. The waiting times for those with significant mental health concerns are reported into Scottish Government and regularly scrutinized. The other waiting list for children and young people awaiting on a neurodevelopmental (ND) assessment is not reported on to Scottish Government and currently within Midlothian the waiting list adds around 200 children and young people's names to it every quarter. There is real concern that children will be 'aged out' before ever being seen by a clinician.

These concerns are raised at our local children's planning board and relayed to Scottish Government. Work is being undertaken to consider what early interventions and training can be offered to staff to support families whilst they sit on this lengthy waiting list.

Going forward we are recruiting an experienced service manager to have an overview of disability who shall help us develop a pathway for children affected by disability that ensures all services have clearer awareness as to how many children and young people we need to be planning for within children services, early years and education and into adult services.

Self- Directed support (SDS) is available if families meet the criteria, however demand for services far outstrips availability. Going forward we aim to plan for future need by better understanding the demand so that we have sufficient funding and resources in place.

Family Wellbeing Service

In January 2023, the Family Wellbeing Service (FWS) was created to provide holistic family support to families across Midlothian. The Family Wellbeing Service is one Midlothian's tangible ways of bringing The Promise, The Whole Family Wellbeing Fund and the Strategic Equity Fund to life. The Service works with families, schools, health and third sector partners to provide holistic support with the aim of supporting families as early as possible and preventing children and young people requiring input from statutory children's services.

Over 23/24 the FWS engaged with:

- 309 children referred to Team Around the Child (TATC)
- 164 children progressed to allocation in FWS
- 161 children allocated to FWS at year end
- 477 food packs provided to families

Data highlighted that there was a similar number of early years/primary school aged children compared to high school aged children referred to the service.
Data collection processes have been reviewed and amended for 2024-25 to enable better data collection and evidence of outcomes of intervention. This includes the staff team being trained in the use of Outcomes star measures to enable qualitative data from families and routine feedback.

Good news stories from the last year

- 84% of children referred based on school attendance had improved attendance during and at the end of the intervention.
- An 11-year-old was supported to return to school after 5 months of absence
- A young person increased their attendance from 6% to 44%
- A Mum who struggled with her mental health was supported to get a diagnosis of ADHD and reports this has improved her self-esteem, self-image and ability to seek support.
- A Dad who struggled to meet people was supported to engage with therapeutic support and talk about his feelings.

Family Centered Care

This year has continued to see a high level of staff turnover within this service which has impacted on our performance. The Care Inspectorate arrived in September 2023

to inspect, fostering, adoption and continuing care. The manager of the service had only been acting into the post for a few months at the time of this announcement. The outcome of the inspection was deemed to be 'adequate' which was very disappointing for the team members to hear. This was mainly due to the high turnover of staff, which had impacted on our development and quality assurance work, coupled with our communications with carers not being as good, due to staffing issues. This said there were many positives around children being loved and well cared for within their foster care households. There was an acknowledgement that carers knew the children well in their care and relationships were built on empathy, compassion and trust. There was also cognizance that staff and carers worked hard at keeping siblings together where possible.

A robust improvement plan is in place, and this is overseen at the SWAG meetings to ensure everything is on track. We have ensured that regular communications with carers is in place. In October 2023, Scottish Government approved the introduction of the Scottish Recommended Allowance for both foster carers and kinships carers and in February 2024 Midlothian Council agreed to a 5.5% increase to foster carer fees.

We have an ongoing recruitment campaign which focuses on general fostering but also considers how we can attract more carers for our unaccompanied asylum-seeking young people given the growth in this area of work.

Residential Services

The two houses remain at capacity with demand far outstripping placements. Both Woodburn Court and Ladybrae staff continue to support young people beyond their time living within the houses, inviting young people back for dinner and supporting them as they move into their own tenancies. We have also had three unaccompanied asylum-seeking children residing within our houses over the reporting year. The young people have engaged in full time education and joined the local football clubs as well as being supported to attend their local Mosque. The positive impact of living in a safe and nurturing environment has resulted in many of our young people going into further education with one gaining an apprenticeship in a garage.

Young Carers

We have a Young Carers project plan and at the start of the academic year in 2023 there were 226 young carers registered on SEEMIS, the school recording system a 23.5% increase. The plan illustrates the progress the small team are making in supporting young carers. In August 2023 a full time adult young carer was appointed resulting in 43 young adults (16–25-year-olds) being identified and supported via 1-1 support and supporting them to access social outings.

Keeping the Promise & Corporate Parenting

The Promise work continues to drive forward our children's services improvements. Over the reporting year we have continued to work on the promise plan 21-24 set out under the five headings of the Plan. Across Scotland reports evidence that the number of children coming into care is reducing with a 20% reduction in children being looked

after since 2015-16. Further positives are that 82% of looked after children experience no change to their placement and whilst there remains work to do in relation to the remaining 18% who do experience multiple placements this number is decreasing. There are many positives to report however equally there remains a lot of work to do to make sure there is equity for all children across Scotland.

On the 28th of June 2023, we launched our Promise Guarantee which has been established to promote our commitment to our care experienced young people, ensuring they have an opportunity to gain valuable work experience throughout the council and beyond. There remains a lot of work to get this piece of work underway. We have met on several occasion and agreed that initially we shall only be considering care experienced young people within Midlothian as we do not have sufficient resource to go wider at this time. However, our ambition is to broaden the scope of this project over the coming years.

"Our future priorities include the implementation of our Promise Guarantee which strengthens our existing commitment to care experienced young people in that those who wish to work with the Council, to gain valuable work experience including a guaranteed interview, can do so. Our Elected Members and Senior Officers have also offered a number of mentoring and 'shadowing' opportunities should young people and any care leavers wish to know more about the respective roles"

Our Corporate Parenting Plan requires a refresh therefore we have commissioned Who Cares? Scotland to establish a new participation strategy to support us in refreshing our existing Champs Board and Corporate Parenting Plan.

Whole system approach – children in conflict with the law

The partnership approach to children and young people in conflict with the law continues to grow, and over the last year we have re-formed the Task Action Coordination Group. This fortnightly meeting aids a partnership response to anti-social behaviour. This approach has once again evidenced a reduction in the number of young people being referred to Scottish Children's Reporter Administration (SCRA) on offence grounds. The 23/24 data informs us that despite there being a slight increase in the number of referrals being made to SCRA the number of those based on offence grounds involving children has significantly decreased. This is a clear example of how early and effective interventions can be successful.

Mental Health

The Midlothian Children & Young People's Mental Health Strategic Planning Group oversees the allocation of funding and the delivery of early action and prevention services through its administration of the Community Support & Services Framework (Mental Health & Wellbeing) – a funding tranche distributed to local authorities from Scottish Government on an annual basis.

Achievements in supporting children and young people's mental health and wellbeing in 23/24. The Midlothian Children & Young People's Mental Health Strategic Planning Group oversees the allocation of funding and the delivery of early action and prevention services through its administration of the Community Support & Services

Framework (Mental Health & Wellbeing) – a funding tranche distributed to local authorities from Scottish Government on an annual basis.

Between April 2023 and March 2024 the Framework funded 263 children and young people and 103 family members/carers to access supports and services Beneficiaries have reported improvements to mental health and wellbeing, to self-esteem and resilience, and to school attendance and learning engagement following their participation in a range of activities including art therapy, supported play therapy and outdoor play, family counselling and mindfulness programmes; as well as a series of targeted and highly personalised creative development placements aimed at those excluded from school or at great risk of being so.

Further Scottish Government funding is provided for the ongoing delivery of a commissioned School Counselling Service which provided one-to-one support to 297 children and young people during the same period, with many more assisted via weekly school drop-in sessions.

Public Protection Arrangements

The East Lothian and Midlothian Public Protection Committee (EMPPC) is the local strategic partnership that is responsible for the overview of policy and practice in relation to Adult Support and Protection, Child Protection, Multi-Agency Public Protection Arrangements (MAPPA) and Violence Against Women and Girls. The primary aim of the Committee is to provide leadership and strategic oversight of Public Protection activity and performance across East Lothian and Midlothian. In the year, it discharged its functions through quarterly meetings of the following Sub-groups:

- Performance and Quality Improvement Sub-group – responsible for the oversight and governance of the performance framework and quality assurance arrangements.
- Learning and Development Sub-group – responsible for the development and delivery of the EMPPC Multi-agency Learning and Development Strategy.
- Learning Review Sub-group – responsible for the oversight of progress of Learning Reviews undertaken in relation to Adult Support and Protection and Child Protection, development and review of the progress of action plans arising from Learning Reviews and oversight of local Learning Review arrangements.
- East Lothian and Midlothian MAPPA Group – responsible for ensuring that the statutory responsibilities placed on local partner agencies for the assessment and management of risk posed by offenders subject to MAPPA are discharged effectively.
- Violence Against Women and Girls Delivery Group – responsible for supporting the delivery of the Equally Safe Strategy and overview of local delivery of services.

Through the Critical Services Oversight Group (CSOG), the Chief Officers of our core partners (Councils, NHS and Police) provide strategic leadership, scrutiny, governance and direction to EMPPC. In the year, CSOG continued to be co-chaired by Grace Vickers, Chief Executive of Midlothian Council and her counterpart in East Lothian.

Strategic leaders and operational managers from Midlothian Council and Midlothian Health and Social Care Partnership are represented across all the groups mentioned above. The Chief Social Work Officer has chaired the Performance and Quality Improvement Sub-group since its inception in 2014. In addition, over the past year, staff from Midlothian Council and Health and Social Care Partnership have supported the delivery of multi-agency training in Adult Support and Protection and Child Protection training.

In the past year, CSOG and EMPPC undertook a review to ensure strong arrangements for our Public Protection work. Senior Leaders from Midlothian who are directly involved in the work of EMPPC engaged with the following:

- CSOG reviewed its existing structure and function, with the support of our Care Inspectorate link inspectors, using the Chief Officers Public Protection Induction Resource materials as a framework for this work. CSOG re-stated its commitment to the continuation of a Public Protection Committee across the two local authority areas. This work has led to streamlined membership, with greater clarity of roles, decision making process and improved reporting processes.
- EMPPC held a developmental session in November 2023, which supported a strengthening of its arrangements. This resulted in a welcome addition of two new sub-groups for Adult Support and Protection and Child Protection from April 2024.
- A welcome addition in the year was a new standard agenda item for EMPPC members to update EMPPC on developments, operational context and risk from the perspective of their agency.
- A Learning Review Sub-group was introduced to provide closer scrutiny over and governance of Learning Reviews for Adult Support and Protection and Child Protection.

EMPPC Business Plan

The EMPPC Business Plan details the key actions that were progressed during the past year, under the following five priorities/themes:

1. We will continue to strengthen our leadership arrangements in Public Protection
2. We will provide and support the implementation of multi-agency procedures and guidance for staff working in Public Protection.
3. We will continue to develop our performance framework and approach to quality improvement.
4. We will promote a learning culture by providing staff with multi-agency learning and development opportunities in Public Protection.
5. We will raise awareness of Public Protection through communications and engagement with staff and communities.

Given the breadth and scope of the Public Protection arrangements, this resulted in a plan of 51 actions. Progress of actions were kept under close review by EMPPC

and CSOG, with a prioritisation exercise during the year to address staffing gaps and resource pressures, effectively managing risk and reduced resources.

Joint Inspection of Adult Support and Protection in Midlothian

In January 2024, we received notification of a joint inspection of Adult Support and Protection in Midlothian, with the first Professional Discussion taking place in March 2024, and multi-agency Position Statement was prepared in the early part of the year. The inspection carried on into the new financial year, with the final report being published in June 2024. The findings will be reported in the next Annual Report, but I can report a strong level of confidence and assurance about the Adult Support and Protection work that is undertaken in Midlothian.

I recognise the significant amount of partnership work undertaken by staff and senior leaders across our core partner agencies in the preparation for, and involvement in inspection. In particular, the Committee and CSOG have acknowledged the continual cycle of inspection across the Police 'J' Division, which includes West Lothian and Scottish Borders, and for NHS Lothian, which includes City of Edinburgh and West Lothian.

The EMPPC Partnership was also involved in two external inspections in the past year in East Lothian and across them all, there are common themes in areas for improvement, which will feature in our planning for the coming year:

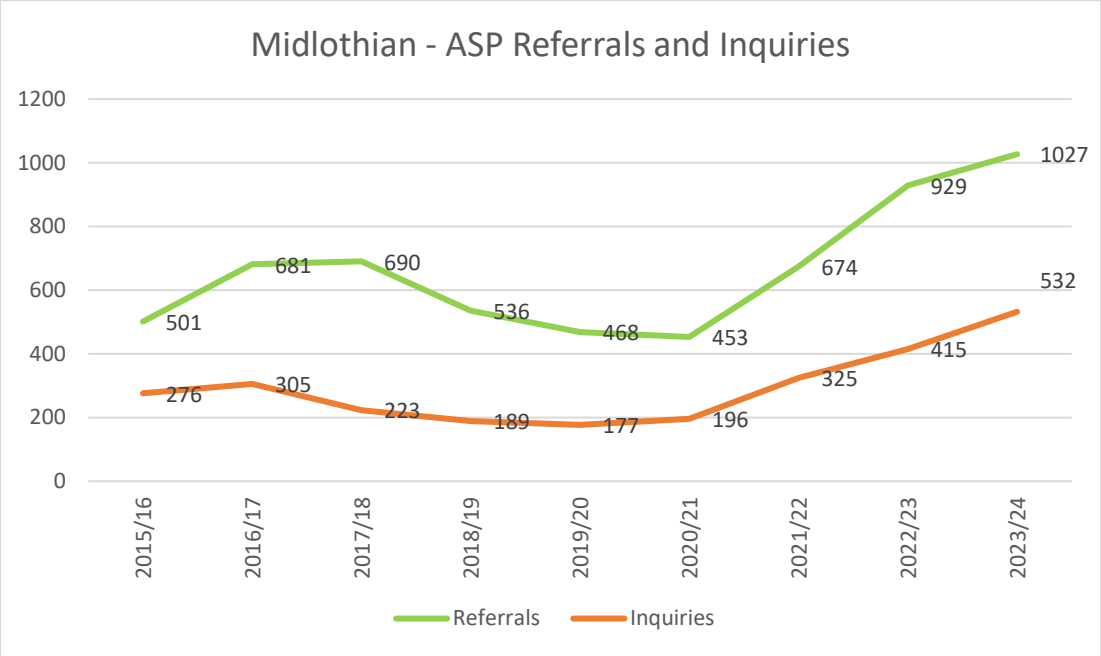
- Seeking, collating and using the views of children, families and adults involved in Adult Support and Protection and Child Protection Processes to inform service improvements.
- Developing a multi-agency approach to audit and quality assurance.

Data and Performance Information

Adult Support and Protection

The graph below shows an increase in Adult Support and Protection referrals for the third year in a row, with a doubling of referrals since the first year of the pandemic. There was an increase by 10.55% in 2023/24 from the previous year. Inquiries similarly increased for the third year in a row, by 28.19% in the last year. There has been no corresponding increase in Council Officer resource in that period, and no publicity campaigns to encourage referrals about Adult Support and Protection. However, we know from the wide range of referral sources in Midlothian that there is good awareness of the need to refer concerns. This seems to be line with the national picture of increasing referrals.

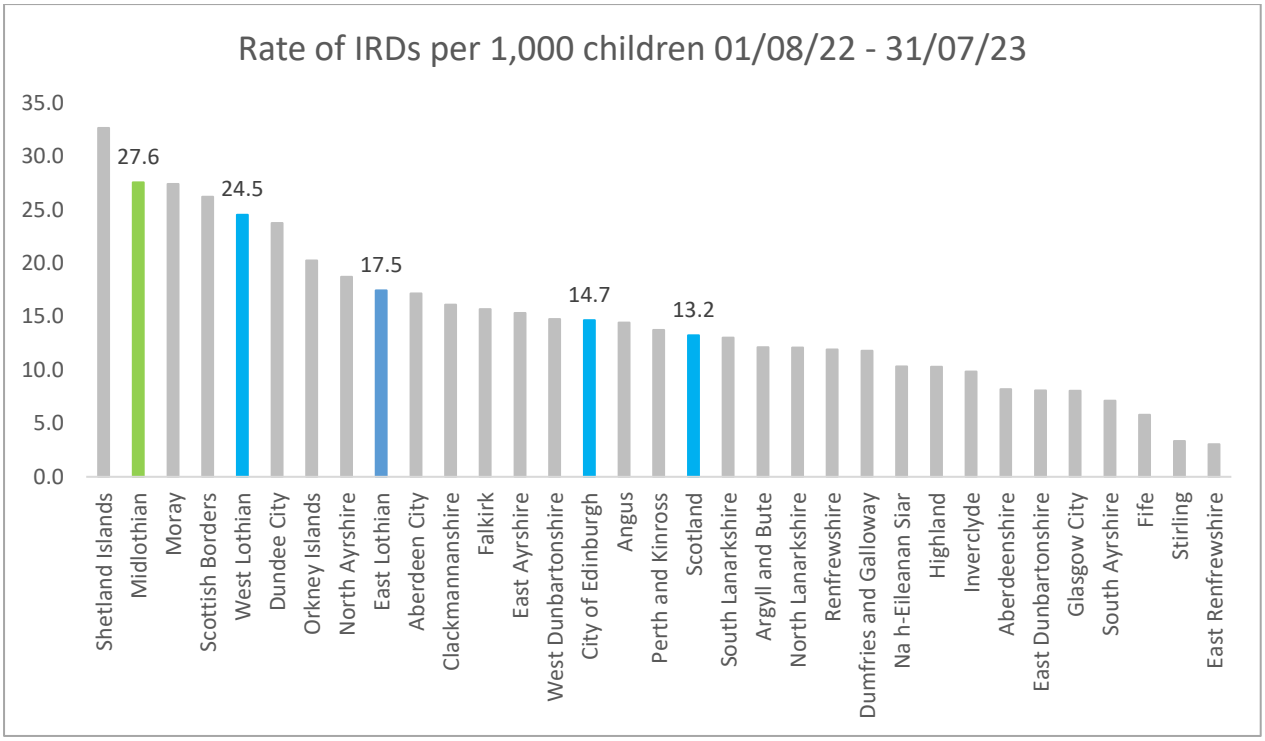
Following receipt of any referral to Adult Social Work to the Midlothian Council Contact Centre, the referral is screened by the dedicated Adult Support and Protection Team, within a standard 24 hours of receipt. The performance in meeting this standard has been excellent over a number of years now, with a well embedded system in place.



EMPPC implemented revised Multi-agency Adult Support and Protection Procedures in November 2023. This brought our Adult Support and Protection practice in line with the Adult Support and Protection (Scotland) Act 2007 Code of Practice which was updated in 2022. A key achievement in Midlothian was moving to one inquiry for Adult Support and Protection, supported by improvements to our social work system recording templates. There is strong operational management oversight of Adult Support and Protection work in Midlothian. In Midlothian we also successfully introduced the National Minimum Dataset for Adult Support and Protection from July 2023.

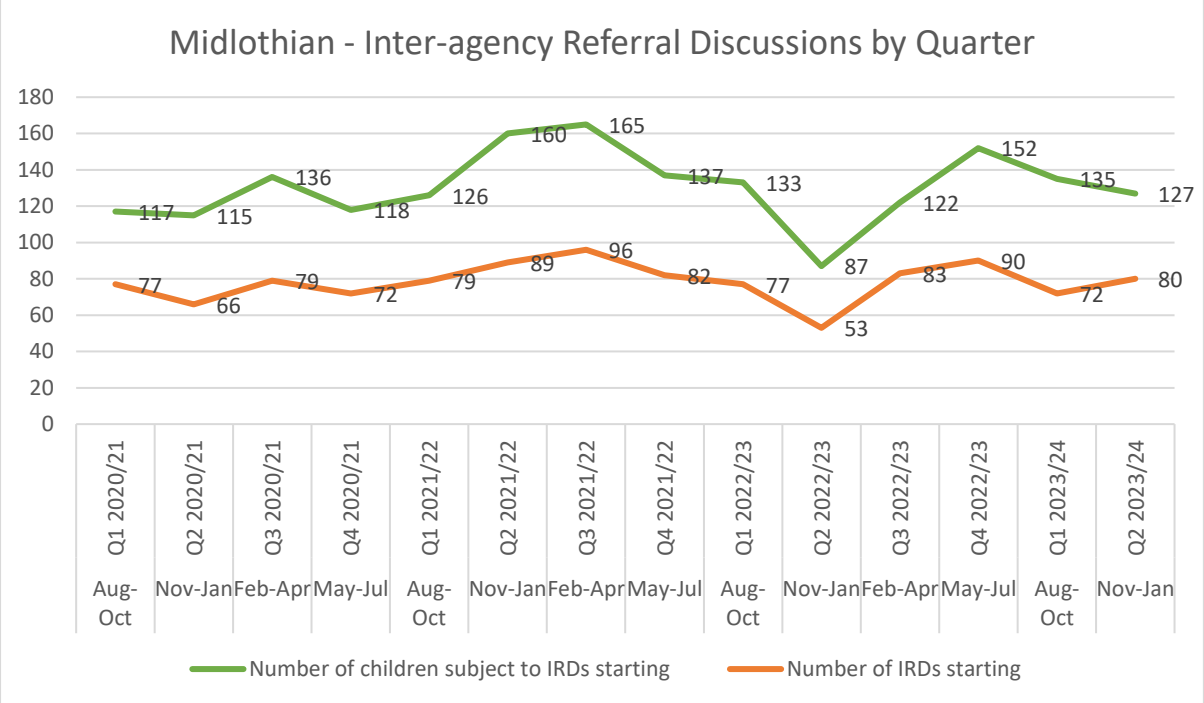
Child Protection

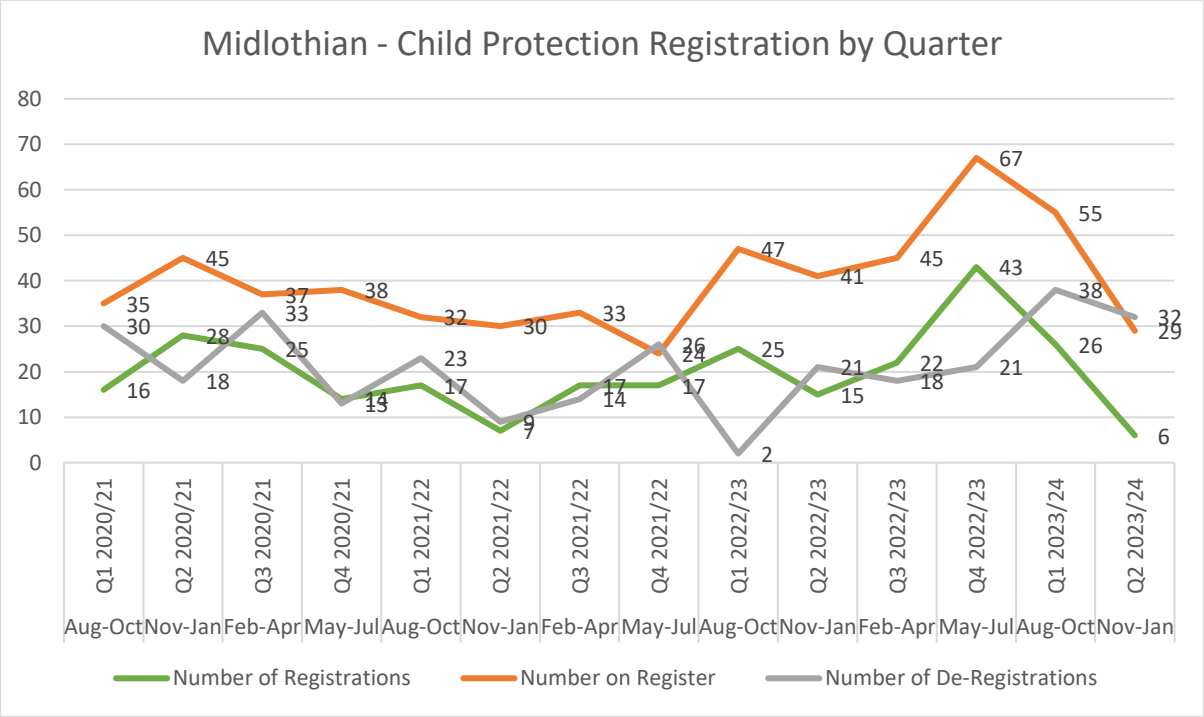
The Scottish Government published the Children's Social Work Statistics 2022-23 – Child Protection on 26th March 2024. This covers data on children subject to Child Protection processes. The data relate to the reporting period 1st August 2022 to 31st July 2023. From the table below, we can see that the number of Inter-agency Referral Discussions (IRDs) again remained significantly higher than the Scottish average, but with a slight reduction from 31.9 per 1,000 the previous year. The higher rate has been regularly scrutinised through the EMPPC Performance and Quality Improvement Sub-group. We can see that the corresponding rates of our local partners (Edinburgh and the Lothians Multi-agency Child Protection Procedures) are also higher. Our local IRD processes are closely aligned to the National Guidance for Child Protection in Scotland. I am confident that our IRD processes are robust, with an IRD Overview Group meeting fortnightly to review IRDs and the interim safety plans and undertake quality assurance activity. Traditionally in Midlothian we see larger family groupings featuring in IRDs and Child Protection Planning Meetings.



[Note 1] Rate per 1,000 children for 2022 and 2023 is calculated using National Record Statistics mid-2021 population estimates (0-15 years). Rates may vary slightly from previous publications due to updated mid-year population estimates.

[Note 2] The rate shown in this table includes unborn children who are on the Register.





From the above table we can see there is no trend in Child Protection registration with a spike in Quarter 4, 2022/23 (April to June 2023). On discussion at our P&QI Sub-group although we did not identify any particular reason for this increase (i.e., there was no change in practice or process or specific campaigns) the high level of complexity of issues facing children locally in Midlothian and associated implications for service provision were recognised.

There is a very low number of children who are re-registered within Midlothian. Audits completed by Children's Services' Managers three months after a child's name is removed from the Child Protection Register, provide assurance about the impact of supports and intervention for children subject to Child Protection processes.

We implemented the Edinburgh and the Lothians Multi-agency Child Protection Procedures in December 2023, and this is well embedded within Midlothian. We also introduced a new version of the Child Protection National Minimum Dataset. This now categorises concerns at Child Protection Registration by identifying vulnerability factors and impacts on/abuse of the child.

In Midlothian, the most frequently identified concerns included the following:

- Vulnerability factors - domestic abuse was the most frequently identified, which we believe reflects the embedding of the Safe & Together approach within Midlothian Children's Services. The other two most frequently identified vulnerability factors were substance use (alcohol and/or drug use), and services finding it hard to engage.
- Types of harm - emotional abuse, neglect and physical abuse. The are some early signs that the implementation of the EMPPC Neglect Toolkit is supporting staff in their identification of neglect.

MAPPA

Quarterly reporting of MAPPA arrangements in Midlothian is made to the East and Midlothian Management Group (EMMG) Sub-group of EMPPC. The number of registered sex offenders being managed in the community on 31st March 2024 was 60. MAPPA is functioning efficiently and effectively, with no registered sex offenders reported for any sexual re-offending, and audits of MAPPA cases identifying strengths in risk management and partnership working.

Violence Against Women & Girls

Looking at the national figures, we estimate that over 3,500 children in Midlothian are likely to have experienced domestic abuse – these are children we all know in our nurseries, schools, health settings and community groups. The victims and perpetrators live and work in our communities and encounter our health and social work and social care services on a regular basis. The rates of incidents of domestic abuse in Midlothian have been higher than the Scottish average for the last two years up to March 2023, and higher in the three quarters of 2023/24 than the previous year. Domestic abuse as a vulnerability factor features most commonly at Child Protection Planning Meetings.

Each and every one of us who works and lives in Midlothian has a responsibility in challenging and tackling gender inequality and working together to improve outcomes for some of the most vulnerable people and communities in Midlothian. In recognition of this, partners in Midlothian came together to develop an Equally Safe in Midlothian Strategy, which was approved by the Community Planning Board in March 2024. This has been an important step in acknowledging and tackling gender-based violence and delivering the national Equally Safe Strategy needs, to be led and owned on a multi-agency basis, and across all services, not just the core services with operational responsibility for responding to domestic abuse. A Leadership Group was established, which the CSWO chairs, to take forward the priorities on a multi-agency basis.

We continue to deliver Multi-Agency Risk Assessment Conferences (Marac) in Midlothian as our key response to supporting the victims at the highest risk of domestic abuse. Marac is a local meeting where representatives from statutory and non-statutory agencies come together to discuss individuals at high risk of serious harm or murder as a result of domestic abuse and develop safety plans to reduce risk and increase safety. There were 125 victims heard at Marac meetings in Midlothian in the year, a reduction of 12 from the previous year. To meet this demand, there were two additional Marac meetings, bringing the total number of Marac meetings to 15. 119 victims were female and six were male.

Looking Forward to 2024-25

I do not think we can underestimate the funding challenges that the coming years will bring. This coupled with the significant increase in our local population are going to result in some very challenging discussions and difficult decisions being made.

Work is well underway to look at a redesign of adult social work, bringing together the many small teams and developing a more holistic and flexible approach to those that require support from adult services.

Within children's services there will be a change in personnel as I retire from the organisation and a new Chief Officer comes into position.

Working with our colleagues in Adult Services and Education the new service manager shall help develop and improve our transition processes to ensure that young people transition between Children's Services, Education and Adult Services will do so in a seamless manner ensuring the right support at the right time. In addition, we shall be developing and monitoring our improvement plan for any inspections held over the coming year.

In terms of the wider context, we will track progress in respect of the development of the proposal for a National Care Service, as well as the many other pieces of legislation and policy that require input from CSWO's and others.

Conclusion

This report offers a high-level summary of some key developments, improvements and challenges across social work and social care services in Midlothian during 2023-24.

The operating environment for social work and social care remains both complex and fluid with a high degree of uncertainty regarding the future arrangements for service delivery and governance as well as a busy legislative and policy development landscape, challenges in relation to workforce capacity and availability, constrained resource availability and increased demand.

The report highlights clear challenges in relation to unmet need and a requirement to continue to improve timely access to services within our communities, ensuring that we prioritise a preventative approach. Maintaining a balance of focus and prioritisation of the provision of support for people in the community, alongside facilitation of prompt discharge from inpatient care, will be of critical importance in the coming year.

Despite the challenges social work and social care services face across Midlothian, in conjunction with our third sector providers we continue to evidence a high level of commitment in providing good quality care that empowers, supports and protects people.