July 17th – July 31st 2023

Urgent and emergency care improvement guide same day emergency care flow – Uploaded July 19th 2023

NHS England – 19th April 2023

This guide has been designed for providers and systems to consider embedding as good practice to reduce ambulance handover delays. The contents have been drawn from the Winter Improvement Collaborative which was set up to identify solutions to the problems facing the
system over the winter period. Members of the collaborative were asked to co-design a series of plans and potential improvement measures, to be adapted and trialled at local level.

Urgent and emergency improvement guide same day emergency care flow

Medical Evolution – Measures to improve the interface between primary and secondary care - Uploaded July 18th 2023

Policy Exchange – 29th June 2023

The interface between primary and secondary care is the space of a growing volume and variety of activities for the NHS, ranging from referrals to specialist care, diagnostic testing and medicines management. An effective and efficient interface has never been more important, but new analysis from Policy Exchange finds the equivalent of 15 million GP appointments per year are spent dealing with issues in care management between GP practices and hospitals, creating frustration and patient safety issues Medical Evolution sets out twenty recommendations which seek to ensure that the interface is proactively managed in the future.

Measures proposed range from providing patients with greater transparency about referral decisions so they can 'track' who is responsible for their care to significantly enhancing communication capabilities between clinicians.

The report also calls for the development of hybrid doctor roles – 'interface specialists' – able to work more routinely across hospitals and GP practices and for a massive boost to research activity in primary care to deliver the latest treatments and technologies through a new "Academic Primary Care Accelerator".

Read the Report – Medical Evolution – Measures to improve the interface between primary and secondary care

Digital transformation in the NHS – Report Summary - Uploaded July 18th 2023

Health and Social Care Committee – June 2023

Successive Governments have recognised the importance of moving the NHS onto a digital footing. "Digital transformation" encompasses "digitising" services and processes that have traditionally been delivered physically, and greater use of innovative approaches to care that are enabled by advances in technology. Digital transformation is vital for the long-term sustainability of the health service: the Department of Health and Social Care (the Department) and NHS England believe that a shift to digital channels (such as the NHS App) is necessary to delivering priorities such as reducing care backlogs and improving access to primary care. Digital can also deliver improvements in care to patients, ranging from increased convenience to access to cutting-edge treatments and diagnostics.

Read the report – Digital transformation in the NHS – Report Summary

From Inception to Implementation: A Year of Integrated Care Systems - Uploaded July 18th 2023

Care England – July 2023

This study seeks to investigate how Integrated Care Systems have developed since July 2022, with a specific focus on how they have managed and overcome pressures associated with the planning, coordination and commissioning of health and care services. Understanding these systems and their key pressure points will allow wider system partners to steer improvement across regions through best practices and partnerships across both short and long-term pressures.

Read the report – From Inception to Implementation: A Year of Integrated Care Systems

MHRA Corporate Plan 2023 to 2026 - Uploaded July 18th 2023

MHRA – July 2023

Focusing on keeping patients safe and enabling access to high quality, safe and effective medical products. Contents include the priority actions and activities which the agency will take forward to ensure delivery of the statutory role and functions of the agency.

Medicines and Healthcare Products Regulatory Agency: Corporate Plan 2023 to 2026

Professional Standards Authority strategic plan 2023 to 2026 - Uploaded July 18th 2023

The Professional Standards Authority Strategic Plan 2023-26 sets out the approach to delivering our statutory duties effectively and efficiently. It also outlines our commitment to continuous improvement in our processes and providing value for money in the work of the Authority. In this plan we make frequent references to 'regulation and registration' to acknowledge that our functions cover the work of the professional regulators and of the accredited registers.

In addition to our core duties, this plan describes our work to make professional regulation better and fairer. In terms of better, this means ensuring our work adds value to regulators, accredited registers and registrants, helping them to do an even better job in the interests of patients, service users and the wider public. It also means championing the reform of professional regulation, and supporting the implementation of that reform, in order that regulators and accredited registers can make a greater contribution to safer care for all. Making the system fairer relates to our commitment to equality, diversity and inclusion (EDI). This means promoting and monitoring EDI in our work and in those we oversee, so that issues of unfairness and harm in regulation and registration are resolved and that improvements are seen in
outcomes for all patients and service users.

This strategic plan also includes our work to deliver and support the recommendations from our Safer care for all report, published in September 2022. We will work with regulators, accredited registers, stakeholders in health and social care, patients, service users and governments to take forward these recommendations to improve the safety and quality of care for all.

Read the Report – Professional Standards Authority strategic plan 2023 to 2026 (web accessible)

Background Report – Safer care for all

England state of maternity services 2023 - Uploaded July 18th 2023

Royal College of Midwives – July 2023

According to this report, if the number of NHS midwives in England had risen at the same pace as the overall health service workforce since the last general election, there would be no midwife shortage. It highlights the lack of investment in maternity services and the impact of staffing shortages on women. It also describes how more complex needs, including rising levels of obesity in pregnancy and increases in the number of older women having babies, are increasing demands on maternity services.

Read the Report – England state of maternity services 2023

The Practice of Collaborative Leadership: Across health and care services - Uploaded July 18th 2023

Kings Fund – 18th July 2023

Overview

The health needs of the population are changing, and many people need more co-ordinated care across primary, community, social and hospital services. More co-ordinated care requires organisations and staff to collaborate well across organisational and professional boundaries.

This report draws on interview and survey data from senior leaders working in integrated care boards, NHS providers, local government and the voluntary, community and social enterprise sector, and shares insights and evidence about how to collaborate well.

The research shows health and care leaders at all levels have a critical role in modelling and rewarding collaborative behaviours but this is insufficient on its own. Leaders also need to pay attention to six leadership practices if they want to build a stronger collaborative ethos.

This style of working is hard especially in a resource-constrained environment. We recommend leaders give greater attention to designing more participatory processes and developing the collaborative skills of other groups of staff.

Given the pace of change and disruption needed to solve many of the problems facing our health and care system, we recommend leaders extend the practice of collaborative leadership to work with a broader range of local organisations as well as local communities

Further information – The Practice of Collaborative Leadership: Across health and care services

Annual report and accounts 2021/22 – CQC - Uploaded July 19th 2023

CQC – July 2023

Our ambition is set out in our strategy, published in 2021. What we have learned from the past 5 years puts us in a better position for the future. Our new strategy combines this learning and experience, and is further enhanced through valuable contributions from the public, service providers and all our partners.
Delivering on our strategy means our regulation will be more relevant to the way care is now delivered, and more flexible to manage risk and uncertainty. It will enable us to respond in a quicker and more proportionate way as the health and care environment continues to evolve.
Our purpose and our role as a regulator won't change – but how we work will be different.
Our strategic ambitions are set out under 4 themes: people and communities, smarter regulation,
safety through learning, and accelerating improvement. Running through each theme are 2 core ambitions: assessing local systems and tackling inequalities in health and care.

Read the Report – Annual report and accounts 2021/22 – CQC

Acute inpatient mental health care for adults and older adults - Uploaded July 19th 2023

NHS England – July 2023

Guidance to support the commissioning and delivery of timely access to high quality therapeutic inpatient care, close to home and in the least restrictive setting possible.

Further information – Acute inpatient mental health care for adults and older adults

World Heart Report 2023: Confronting the World's Number One Killer - Uploaded July 19th 2023

World Heart Federation (WHF) – 2023

This first-ever World Heart Report is aimed at equipping policymakers and advocates around the world with the information needed to help reduce CVD deaths and accelerate progress in cardiovascular health. The report
findings highlight the main differences between geographies in terms of CVD burden and risk factors, as well as structural barriers and inequities in CVD health, with the goal of guiding policymakers at national and international levels toward the priorities they should seek to address.
Key policies to tackle CVD and its risk factors are also summarized. Future World Heart Reports, along with WHF's data hub the World Heart Observatory8, will aim to provide easy access to CVD data to inform research and advocacy.

The report begins with a comprehensive overview of the main dimensions of cardiovascular health, bringing together epidemiological, policy and economic data. It then provides assessment of policy implementation through the
WHF Policy Index, and provides relevant policy recommendations. Throughout the report, the latest comprehensive
sources for which data disaggregated by country, age and sex are available have been used. (Appendix Figure 1). Global, regional9, and country level estimates from 2019 relevant to atherosclerotic CVDs10 are presented in this report, as these are the most comprehensive and recent data set available.

Read the Report – World heart report 2023

NHS Blood and Transplant annual report and accounts: 2022 to 2023 - Uploaded July 19th 2023

NHSBT – July 2023

This report details the performance of NHS Blood and Transplant (NHSBT) in the year 2022 to 2023, and outlines key objectives and risks.

Read the Report – NHS Blood and Transplant annual report and accounts: 2022 to 2023

The importance of non-patient facing NHS services in patient safety - Uploaded July 20th 2023

HDSIB – 19th July 2023

In the context of patient safety, there is often more to see 'behind-the-scenes' in non-patient facing services. These services may be less visible, but they play a vital part in ensuring

patient safety. Understanding the importance of these services, and how they are crucial to the ability of the NHS to operate effectively, is often underestimated.

Further information – The importance of non-patient facing NHS services in patient safety

Medicines and Healthcare Products Regulatory Agency Annual Report and Accounts 2022 to 2023 - Uploaded July 20th 2023

Medicines and Healthcare products Regulatory Agency – 19th July 2023

The Medicines and Healthcare products Regulatory Agency annual report and accounts 2022 to 2023 were laid in Parliament on 19 July 2023. It provides an overview of our performance and the events that have had most impact on the Agency during the past year.

Medicines and Healthcare Products Regulatory Agency Annual Report and Accounts 2022 to 2023

Human Medicines Regulations 2012 Advisory Bodies Annual Report 2022

Commission on Human Medicines – 19th July 2023

Annual Report of the Human Medicines Regulations 2012 Advisory Bodies – the Commission on Human Medicines (CHM) and the British Pharmacopoeia Commission.

Human Medicines Regulations 2012 Advisory Bodies Annual Report 2022

NHS Improvement: Annual report and accounts 2022 to 2023 - Uploaded July 20th 2023

NHS England – July 2023

Annual report and accounts for NHS Improvement. A review of performance, governance statement, and the annual accounts for the financial year 1 April 2022 to 31 March 2023.

NHS Improvement is the operational name for the organisation that brings together Monitor and NHS Trust Development Authority (NHS TDA).

Monitor annual report and accounts 2022 to 2023

NHS Trust Development Authority annual report and accounts 2022 to 2023

Building capacity and capability for quality improvement: developing an organisational approach - Uploaded July 20th 2023

British Journal of Healthcare Management 29(6), pp. 1-14

:There has been an increase in the adoption of quality improvement methods to tackle complex problems in healthcare. One of the key requisites for sustainable quality improvement is ensuring that organisations have the capacity and capability to make these changes effectively. This article uses a case study methodology to describe the learning

from 9 years of developing, delivering and evaluating quality improvement learning programmes at East London NHS Foundation Trust. The key quality improvement learning programmes are evaluated using a Kirkpatrick framework across four levels: reaction, learning, behaviour and outcomes. Five key principles were identified: using a dosing approach; standardising development, delivery and evaluation; developing a community to support learners; making training relevant; and the importance of leadership. However, the authors believe that more research is needed to develop standardised approaches to evaluating quality improvement capability building and to understand why some quality improvement projects are less successful than others.

Further information –Building capacity and capability for quality improvement: developing an organisational approach

Maternity and neonatal services in East Kent report: government response - Uploaded July 20th 2023

Department of Health and Social Care – 20th July 2023

In February 2020, NHS England commissioned Dr Bill Kirkup to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust. –

In his report, Dr Bill Kirkup made 5 recommendations for the healthcare system. In March 2023, the government provided an interim response to the report via a written ministerial statement. This is a full response which details how we are implementing the recommendations.

This response is for the healthcare system, the families involved in the inquiry and all who hold an interest in and receive care from maternity and neonatal services in England.

Further information – Government response to ‘Reading the signals: maternity and neonatal services in East Kent – the report of the independent investigation’

Background Report – Reading the signals: maternity and neonatal services in East Kent – the report of the independent investigation (print ready)

Background – Three year delivery plan for maternity and neonatal services

Improving Regulation for the Future – NHS Providers survey - Uploaded July 21st 2023

NHS Providers

This report sets out the findings of NHS Providers’ eighth annual regulation survey, which explores NHS trusts’ and foundation trusts’ experiences of regulation. We asked respondents to reflect on their experience of regulation during 2022/23, with a specific focus on the roles of CQC and NHSE.

This year’s survey was carried out between April and May 2023, against a backdrop of severe challenges relating to performance, finances, ongoing industrial action, and staff burnout.

This year also marks the first anniversary of the establishment of integrated care systems (ICSs) in law. The Hewitt Review recently reflected on how the oversight and governance of ICSs could enable them to succeed, balancing greater autonomy and robust accountability. Meanwhile, the CQC and NHSE have been adapting their own regulatory approaches within a new system environment, by making changes to their assessment, oversight and operating frameworks.

Read the Report – Improving Regulation for the Future

NHS Confederation responds to NHS Providers report 'Improving Regulation for the Future'

Pregnancy Loss Review: Independent Report - Uploaded July 25th 2023

Department of Health and Social Care – 23rd July

The Pregnancy Loss Review Group was commissioned to consider the:

registration and certification of pregnancy loss occurring before 24 weeks' gestation

quality of National Health Service care

The review was led by 2 independent experts: Zoe Clark-Coates MBE BCAh and Samantha Collinge RM.

The review looks at options to improve NHS gynaecology and maternity care practice for parents who experience a miscarriage, ectopic pregnancy, molar pregnancy or termination for medical reasons.

It makes 73 recommendations, which are intended to support the government and the NHS in creating a forward-looking approach to improve the safety and care experience for all those who have a pre-24-week baby loss.

The independent Pregnancy Loss Review meets the requirement set out in the Civil Partnerships, Marriages and Deaths (Registration etc) Act 2019. This act requires the Secretary of State for Health and Social Care to publish a report on whether the law should be changed to require or permit the registration of pregnancy losses that cannot be registered as still-births under the Births and Deaths Registration Act 1953.

The government response to the independent Pregnancy Loss Review sets out the immediate actions government will be taking in the short term in response to the recommendations made in the review.

Read the Report – Pregnancy Loss Review: care and support when baby loss occurs before 24 weeks' gestation (print-ready)

government response to the independent Pregnancy Loss Review

Clinical guide for front line staff to support the management of patients with a learning disability and autistic people – relevant to all clinical specialties - Uploaded July 25th 2023

NHS England – 24th July 2023

This guidance supports healthcare professionals deliver good quality care for people with a learning disability and autistic people.

Clinical guide for front line staff to support the management of patients with a learning disability and autistic people – relevant to all clinical specialties

Informed, heard, empowered: placing women at the heart of reproductive health policy - Uploaded July 25th 2023

Bayer UK

This report from pharmaceutical company Bayer UK calls for a woman-centred and evidence-based approach to supporting women in maintaining optimal sexual and reproductive health, identifying a series of recommendations that could ultimately lead to higher quality, more accessible and more consistent care for women across the UK.

Read the Report – Informed, heard, empowered: placing women at the heart of reproductive health policy

Getting the fundamentals right: how to better prepare for discharge pressures next winter - Uploaded July 25th 2023

Nuffield Trust – 24th July 2023

Delayed discharges, where a patient is medically fit to leave hospital but is not discharged, were a particular problem in England last winter. In this long read, Camille Oung highlights some possible solutions to help better prepare health and care services for discharge pressures next winter.

Further information – Getting the fundamentals right: how to better prepare for discharge pressures next winter

Standards for the education, training and preceptorship of reporting practitioners in adult chest X-ray - Uploaded July 25th 2023

Royal College of Radiologists (RCR); 2023.

Clinical imaging services play a pivotal role in the diagnosis, treatment and monitoring of various disease processes and injuries. Patients are referred to imaging services for assistance in both diagnosis and deciding on the best subsequent management of a patient's condition. Imaging services are therefore vital for the delivery of effective health and social care. Chest radiographs are a high-volume test, with nearly 7 million performed annually in England. Patients who have a chest X-ray (CXR) performed require accurate and timely results.

The value and benefits of effective team working to deliver clinical imaging services are well known. The 2020 Diagnostics: Recovery and Renewal report sets out the principles and arrangements for providing high-quality patient care within multiprofessional teams. The current document defines the education and training required for all members of the multiprofessional team who report CXRs within a clinical imaging service. It is expected that

other CXR reporters operating outside of a clinical imaging service should follow the same standards for education and training to ensure that they are trained to the same level of overall competence. Any practitioner who is reporting an adult CXR formally should fulfil the criteria in this document.

Read the document – Standards for the education, training and preceptorship of reporting practitioners in adult chest X-ray

Burnout in healthcare: risk factors and solutions - Uploaded July 25th 2023

Society of Occupational Medicine (SOM); 2023.

A new approach is needed to tackle high levels of burnout among healthcare workers, a new report has concluded. Shocking figures recently showed that NHS England experienced an absence rate of 5.6 percent in 2022, the equivalent of losing nearly 75,000 staff to illness, often caused by burnout. 170,000 staff have also left, or are planning to leave, the NHS due to stress and workload pressures.

SOM has published Burnout in healthcare: risk factors and solutions which details the steps needed to help combat the condition, found to be rife in healthcare.

Drawing on research data from a wide variety of sources, the report found that those working in healthcare, such as doctors, nurses and care workers, are particularly prone to experiencing burnout.

According to the 2022 NHS workforce survey, more than a third of healthcare staff report feel burned-out at work, with staff in clinical roles found to be most vulnerable. Further data shows that 54 percent of doctors displayed signs of emotional exhaustion and nearly 40 percent of nurses ‘often’ or ‘always’ felt burned-out at work.

Burnout is not a medical condition, but a state of physical and emotional exhaustion caused by excessive, prolonged, and untreated interpersonal workplace stress. It occurs when individuals become emotionally exhausted, cynical, and disengaged from the job and feel a sense of ineffectiveness and loss of purpose. It can have wide-ranging damaging effects on workers’ health, job performance and quality of life and is extremely costly for the healthcare sector.

The thoroughly evidenced report recommends primary, secondary, and tertiary interventions throughout the healthcare sector to protect employees against burnout and enable those returning from absence because of the condition to do so effectively and safely.

Primary level interventions are those that tackle the root causes of burnout. It is crucial to ensure workload is manageable, adequate support is available, leadership is compassionate, inclusive, and ethical and staff are recognised and rewarded for their work and achievements. Training managers to support the wellbeing of their staff, identify early signs of burnout and encourage help-seeking are also particularly important.

Secondary level interventions focus on improving people’s ability to cope with the challenging aspects of their roles. Particularly effective strategies include enhancing opportunities for peer support, promoting self-compassion and self-care, providing training in a range of stress management tools, and helping staff maintain a healthy balance between their work and personal life.

Tertiary level interventions focus on treatment and encourage a safe and healthy return to work. These include taking a person-centred approach to identifying the factors that contributed to burnout and taking appropriate steps to address them.

With burnout being such a pressing issue in healthcare, occupational health, the specialist and expert field of health and wellbeing at work, will be a crucial part of the solution.

The UK is in a fortunate position, with specially trained occupational health professionals, but more investment is needed to expand this workforce through the newly announced workforce plan. SOM is calling for universal occupational health access and will continue to press for more provision until everyone, whether they work in healthcare or in other industries, has the coverage they need to be healthy and happy at work.

Read the Report – Burnout in healthcare: risk factors and solutions

Organisational Wellbeing Interventions: Case Studies from the NHS - Uploaded July 25th 2023

Society of Occupational Medicine (SOM) – July 2023

A new report looking at organisational measures to support staff wellbeing in the NHS identifies a range of factors underpinning the most successful interventions.

The Organisational Wellbeing Interventions: Case Studies from the NHS report is published by the Society of Occupational Medicine (SOM) and produced by a team of researchers from universities across the UK.

It comes as working conditions and psychological wellbeing of NHS staff is an increasing cause for concern, and more questions are being raised about how they can best be supported in these challenging times.

The report aims to:

identify examples of organisational interventions to improve NHS staff wellbeing

map how these interventions attempt to reduce demands on and increase resources for individuals, groups, leaders, organisations and overarching context

identify the barriers and facilitators of success for organisational interventions

summarise key recommendations to encourage more, and better, organisational interventions to support staff wellbeing.

Using case study examples, it provides insights from 13 interventions. These include overhauling rotas and shift patterns, removing bureaucracy and reducing meeting times, changing patient care processes, co-designing fatigue management strategies, and improving team formation and psychological support.

It also details the learnings from these interventions, including facilitators and barriers that affected their success.

The learnings are summarised into six key principles to guide organisational approach on supporting staff wellbeing:

Recognise staff wellbeing is a systems issue.

Tailor the intervention to the organisational context.

Involve staff in the process.

Get support from leaders.

Interventions need to continually evolve.

Plan for the long haul.

Read the Report – Organisational Wellbeing Interventions: Case Studies from the NHS

Health in 2040: projected patterns of illness in England - Uploaded July 25th 2023

The Health Foundation's REAL Centre in partnership with the University of Liverpool – July 2023

Produced by The Health Foundation's REAL Centre in partnership with the University of Liverpool, this report aims to support policy-makers prepare for the future by looking at patterns of illness over the next two decades. The analysis lays out the potential scale and impact of the growth in the number of people living with major illness as the population ages, assigning scores to 20 conditions based on how likely the illness is to affect people's use of primary care and emergency health services and likelihood of death. The report projects that 9.1 million people will be living with major illness by 2040, 2.5 million more than in 2019.

Read the Report – Health in 2040: projected patterns of illness in England

Progress in improving NHS mental health services - Uploaded July 25th 2023

House of Commons Public Accounts Committee (PAC) – July 2023

This report finds that mental health service staff shortages are holding back mental health services from improving and expanding. Increased workload is leading to burnout for remaining staff, which contributes to a higher rate of staff turnover and a resulting vicious cycle of more staff shortages. The PAC calls on the NHS to address the fact that staff increases are being outpaced by the rise in demand for services. Mental health services are also lagging behind physical services in the area of good data and information to a concerning degree. Another area of particular concern is a continuing lack of progress in treating mental health services with equal priority as physical services.

Read the Report – Progress in improving NHS mental health services

The Independent Pregnancy Loss Review – Care and support when baby loss occurs before 24 weeks gestation - Uploaded July 26th 2023

Independent Pregnancy Loss Review Group – July 2023

The Pregnancy Loss Review Group was commissioned to consider the registration and certification of pregnancy loss occurring before 24 weeks' gestation, and the quality of National Health Service care. The review looks at options to improve NHS gynaecology and maternity care practice for parents who experience a miscarriage, ectopic pregnancy, molar

pregnancy or termination for medical reasons. It makes 73 recommendations, which are intended to support the government and the NHS in creating a forward-looking approach to improve the safety and care experience for all those who have a pre-24-week baby loss.

Read the Report – The Independent Pregnancy Loss Review – Care and support when baby loss occurs before 24 weeks gestation

Government response to the independent Pregnancy Loss Review: care and support when baby loss occurs before 24 weeks' gestation

Urgent and emergency care survey 2022 - Uploaded July 26th 2023

CQC – 25th July 2023

This survey looks at the experiences of people using type 1 and type 3 urgent and emergency care services.

Two questionnaires were used, tailored to each service type. Results are reported for each service type at trust and overall England level.

Type 1 services include A&E departments, and may also be known as casualty or emergency departments.

Type 3 services include urgent treatment centres, and may also be known as minor injury units. The survey only includes services directly run by an acute NHS trust.

The 2022 urgent and emergency care survey received feedback from 29,357 people who attended a type 1 service in September 2022 and 7,418 people who attended a Type 3 service in September 2022.

What we found

People's experiences of urgent and emergency care are worse than in previous years. This applies more so to results for Type 1 services, where results have declined for all questions evaluating care. For some aspects of care in Type 3 services, results have remained positive, such as being listened to by health professionals.

Further information – Urgent and emergency care survey 2022

UKHSA strategic plan 2023 to 2026 - Uploaded July 26th 2023

UKHSA – 25th July 2023

This plan outlines UKHSA's goals and strategic priorities for the next 3 years to protect the nation's health from current and future threats.

The UK Health Security Agency (UKHSA) prepares for, prevents and responds to infectious diseases and environmental hazards to keep all our communities safe, to save lives and protect livelihoods.

The first strategic plan of UKHSA shares our vision to protect every person, community, business and public service from infectious diseases and environmental hazards, helping to create a safe and prosperous society.

Through scientific and operational leadership and in partnership with local, national and international partners our work will deliver 3 core goals:

Prepare – be ready for, and prevent, future health security hazards

Respond – save lives and reduce harm through effective response

Build – develop the UK's health security capacity

By ensuring our preparedness for, and ability to respond to, current and future health security threats, we will save lives and reduce harm, support the NHS, protect the nation's public services and support economic growth.

The strategy sets out UKHSA's ambitions to:

- be ready to respond to all hazards to health
- improve health outcomes through vaccines
- reduce the impact of infectious diseases and antimicrobial resistance
- protect health from threats in the environment
- improve action on public health through data and insight
- develop UKHSA as a high-performing agency

The importance of strong health protection systems that address health inequalities has never been clearer. We recognise that health threats impact people in different ways, and often disproportionately impact certain groups. We want to see reductions in health inequality over the lifetime of this strategic plan to achieve more equitable outcomes.

Read the Report – UKHSA strategic plan 2023 to 2026: securing health, saving lives and protecting livelihoods

Prevention, integration and implementation: healthcare leaders' views on the major conditions strategy - Uploaded July 26th 2023

NHS Confederation – July 2023

The major conditions strategy is a national framework being developed by the Department of Health and Social Care (DHSC) and the Office for Health Improvement and Disparities (OHID). This briefing considers how the strategy can set the conditions to prevent, treat and manage multimorbidity in England.

Read the Briefing – Prevention, integration and implementation: healthcare leaders' views on the major conditions strategy

2023 – Impact Report – HQIP - Uploaded July 26th 2023

Every project within the NCAPOP has been established to address a clinical area (or areas) where healthcare improvement is required, and the common aim of each project is to have a positive impact on patient care. This compendium provides a summary of some of the key impacts the projects have had.

Impact has been categorised into four categories: national; system; local and public.

In addition, we're focusing in greater detail on a number of projects in a collection of in-focus impact reports:

2023 – Impact Report –

2022 – Impact Report

2021-22 – In focus Impact Reports

New review identifies poorer care and lower life expectancy for ethnic minorities with a learning disability - Uploaded July 27th 2023

NHS Race and Health Observatory – July 2023

People with a learning disability from Black, South Asian (Indian, Pakistani or Bangladeshi heritage) and minority ethnic backgrounds face shorter life expectancy triggered by poorer healthcare access, experience and outcomes.

The average age of death for people with a learning disability who are from an ethnic minority is 34 years, just over half the life expectancy of white counterparts, at 62 years of age. Of those with a learning disability who die in hospital, 51% from ethnic minority groups have a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) recommendation, compared to 73% for those who are white.

These, and other findings, will be discussed as the independent NHS Race and Health Observatory launches its new recommendations report that examines two decades of research looking into discriminatory barriers preventing equitable healthcare treatment.

Supported by NHS England, the comprehensive five-part report contains data, personal interviews and analyses undertaken by the University of Central Lancashire, in collaboration with Manchester Metropolitan University, Learning Disability England and the Race Equality Foundation.

Read the Report – 'We deserve better: Ethnic minorities with a learning disability and access to healthcare'

The selection and insertion of vascular grafts in haemodialysis patients – HSIB Report - Uploaded July 27th 2023

HSIB – July 2023

This investigation aims to improve patient safety by supporting healthcare staff in a surgical setting to select and insert the appropriate type of implant (vascular graft) for haemodialysis treatment.

Dialysis is a procedure to remove waste products and excess fluid from the blood when a person's kidneys stop working properly. Almost 30,000 people in the UK receive regular dialysis. The most common type of dialysis is haemodialysis, during which a patient's blood goes through a tube into a machine to be filtered, and is then passed back into the patient's body. To carry out haemodialysis, access is required to the bloodstream; one option for this is a vascular graft. This is a synthetic implant used to connect an artery and vein, to create a larger and stronger opening through which the blood can travel.

There are numerous types of vascular grafts produced by different manufacturers. Vascular grafts are available in different diameters and lengths, and may be either tapered or non-tapered in shape. Some vascular grafts are for delayed use, needing around 2 weeks between insertion and first use, and others are for rapid access and can be used approximately 72 hours after insertion.

This investigation used a real patient safety incident, referred to as 'the reference event', to examine aspects of the selection and insertion of vascular grafts, including measures to ensure the correct type is inserted. The reference event involved Teri, who had to undergo an additional procedure after the incorrect type of vascular graft was inserted for haemodialysis treatment.

The investigation's findings, safety recommendations and safety observations aim to prevent the selection and insertion of incorrect vascular grafts from happening in the future and to improve care for patients across the NHS.

Read the Report – The selection and insertion of vascular grafts in haemodialysis patients

Cancellations of NHS care are having serious impacts on two-thirds of patients – Healthwatch report - Uploaded July 27th 2023

Healthwatch – July 27th 2023

Our new research, published today, shows that people are currently facing multiple cancellations or postponements of care which are having a significant impact on their lives and symptoms, while further increasing health inequalities.

About our research

We commissioned a survey of 1084 people who have seen their NHS care either cancelled or postponed this year to understand the extent of disruption to care amid rising waiting lists, workforce issues, and industrial action, and other pressures on the NHS.

Key findings

Over one in three, 39%, have had their NHS care cancelled or postponed two or more times this year. This has included hospital operations, tests, scans, outpatient appointments, and community health service appointments.

Nearly one in five (18%) of the respondents have had their care cancelled or postponed at the last minute, which the NHS defines as on the day of or on arrival to an appointment. And almost half, 45%, experienced a cancellation with between one- and seven-days notice.

Two-thirds of the respondents, 66%, said cancellations to care had impacted their lives, reporting ongoing pain, worsening mental health, worsening symptoms, and disrupted sleep, among many other problems.

Read the Report – Cancelled care research

Delivering operational resilience across the NHS this winter - Uploaded July 28th 2023

NHS England July 2023

Letter setting out our national approach to 2023/24 winter planning, and the key steps we must take together across all parts of the system to meet the challenges ahead, and a set of recommended winter roles and responsibilities to ensure clarity on what actions should be undertaken by each part of the system.

Delivering operational resilience across the NHS this winter

Rapid Literature Review: The characteristics of safety cultures - Uploaded July 30th 2023

CQC – 26 July 2023

This review sets out to address what the key characteristics of good safety culture are, what are the key enablers and barriers, what evidence of good practice exists and what gaps exist in the evidence.

Read the Report – Rapid Literature Review: The characteristics of safety cultures

Expert Panel: evaluation of the Government's commitments in the area of pharmacy in England - Uploaded July 31st 2023

Health and Social Care Committee – July 2023

The Committee's independent Expert Panel evaluating Government commitments on pharmacy has found that overall progress 'requires improvement' across a number of areas.

Evidence shows that demand for community pharmacy services has increased significantly with community pharmacies struggling to deliver services within the existing funding model, or even to remain open.

Community pharmacy was one of five policy areas examined by the Panel along with integrated care, hospital pharmacy, workforce education and training, and extended services. Experts found that available funding was not sufficient to keep pharmacies open, struggling financially with increased demand for dispensing, workforce pressures and rising costs due to inflation. One of the other commitments requiring improvement covered a scheme intended to protect access to local physical NHS pharmaceutical services in areas where there were fewer pharmacies.

A commitment by Government to eliminate paper prescribing in hospitals and introduce digital or e-prescribing across the entire NHS by 2024 was rated 'inadequate' overall. Experts found that poor 'digital maturity' was partly responsible and reported that even prioritised funding for IT systems was insufficient.

On workforce education and training, the report ranks a government commitment to roll out a three-year education and training programme for primary care and community pharmacy professionals as requiring improvement, with providers unable to afford to pay to backfill staff sent on courses. A commitment to make legislative changes to improve the skill mix in pharmacies and enable the clinical integration of pharmacists has not been delivered and was rated 'inadequate' overall.
Out of nine commitments separately evaluated over five areas, two were rated as 'good', five as 'requires improvement' and two were 'inadequate'.

Read the Report – Expert Panel: evaluation of the Government's commitments in the area of pharmacy in England