

A statistical process control (SPC) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

XmR chart

The most common SPC chart type is the XmR chart. Each data point is shown as a grey dot on a grey line. From this data, the mean is calculated and added between the dots as a solid line, and process limits are added as grey dashed lines. If there is a target, it is shown as a red dashed line.

Process limits

In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.

The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:

- a point beyond the process limits
- a run of points all above or all below the mean
- a run of points all increasing or all decreasing
- two out of three points close to a process limit as an early warning indicator

Recalculations

After a sustained change, a recalculation may be added. This splits the chart with the mean and process limits calculated separately using the data before and after. This gives a more accurate reflection on the system as it currently stands.

Baselines

Baselines are commonly set as part of an improvement project, which are shown with solid line process limits. The mean and process limits are calculated from the data in this period and fixed in place for the data points afterwards. This will more easily show if a change has occurred. If a recalculation is later added, the fixed mean and process limits end and are recalculated from the data starting at this point.

Summary icons

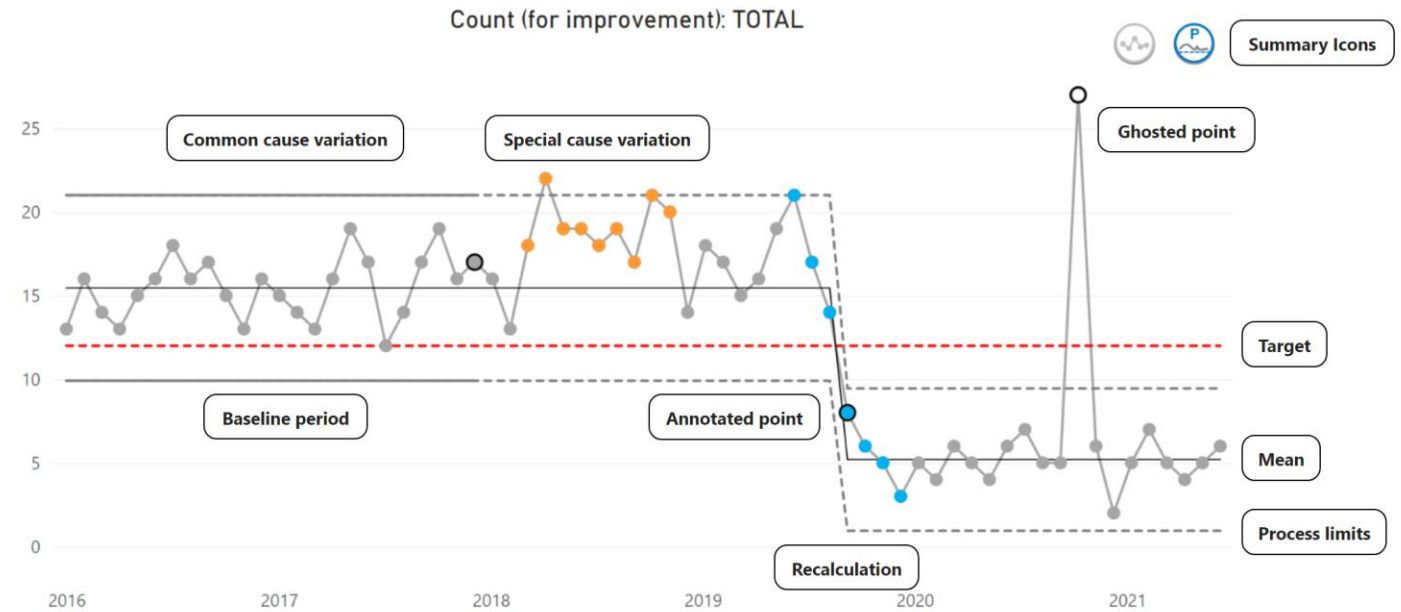
Summary icons are shown in the top-right of the chart and explained on the *Icon Descriptions* page.

Ghosting

There is sometimes a need to remove a data point from the chart because it is a known anomaly – for example, a high referral count after a one-off migration – and will skew the data to render the chart meaningless. An alternative is to ghost the data point. The data point remains visible on the chart as a white dot but is excluded from all calculations.

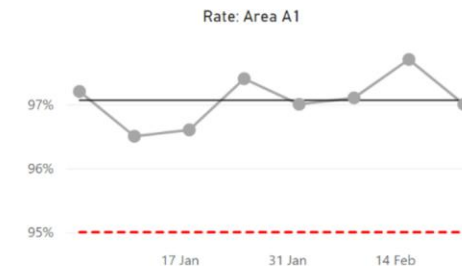
Annotations

If a dot has a black circle around it, there is an annotation that can be viewed in a tooltip by placing the mouse cursor over it in the interactive version of the report.



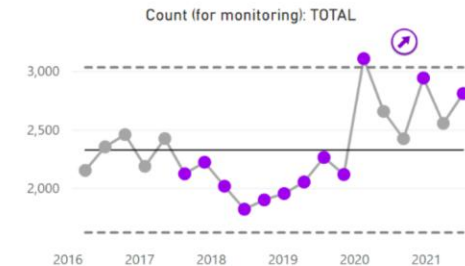
Not enough data points?

An SPC chart requires enough data for a robust analysis. If there are too few data points, the SPC elements are not displayed.



Purple dots

It is not always possible to say that higher values are better or worse, for which purple is used instead of blue and orange.



Assurance



Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**.

This process is capable and will consistently **PASS** the target if nothing changes.

Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**.

This process will not consistently **HIT OR MISS** the target as the target lies between process limits.

Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**.

This process is not capable and will **FAIL** the target without process redesign.

Special cause variation of an **IMPROVING** nature where the measure is significantly **HIGHER**.

Assurance cannot be given as there is no target.



Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**.

This process is capable and will consistently **PASS** the target if nothing changes.

Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**.

This process will not consistently **HIT OR MISS** the target as the target lies between process limits.

Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**.

This process is not capable and will **FAIL** the target without process redesign.

Special cause variation of an **IMPROVING** nature where the measure is significantly **LOWER**.

Assurance cannot be given as there is no target.



Common cause variation, **NO SIGNIFICANT CHANGE**.

This process is capable and will consistently **PASS** the target if nothing changes.

Common cause variation, **NO SIGNIFICANT CHANGE**.

This process will not consistently **HIT OR MISS** the target as the target lies between process limits.

Common cause variation, **NO SIGNIFICANT CHANGE**.

This process is not capable and will **FAIL** the target without process redesign.

Common cause variation, **NO SIGNIFICANT CHANGE**.

Assurance cannot be given as there is no target.



Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**.

This process is capable and will consistently **PASS** the target if nothing changes.

Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**.

This process will not consistently **HIT OR MISS** the target as the target lies between process limits.

Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**.

This process is not capable and will **FAIL** the target without process redesign.

Special cause variation of a **CONCERNING** nature where the measure is significantly **HIGHER**.

Assurance cannot be given as there is no target.



Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**.

This process is capable and will consistently **PASS** the target if nothing changes.

Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**.

This process will not consistently **HIT OR MISS** the target as the target lies between process limits.

Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**.

This process is not capable and will **FAIL** the target without process redesign.

Special cause variation of a **CONCERNING** nature where the measure is significantly **LOWER**.

Assurance cannot be given as there is no target.



Special cause variation of an increasing nature where **UP** is not necessarily improving or concerning.

Assurance cannot be given as there is no target.



Special cause variation of an increasing nature where **DOWN** is not necessarily improving or concerning.

Assurance cannot be given as there is no target.



There is insufficient data to determine either special cause or common cause variation.














Assurance cannot be given as there is no target.













Variation

COCH SOF - SPC Variation Icon Explanation

- Metric**
- Search
- Select all
 - HSMR
 - Number of Women giving birth
 - Number of Live Births (All Babies)
 - SHMI
 - Registered Staffing %
 - Total Number of Women experiencing a Caesarean Section
 - Number of Maternal Deaths
 - Unregistered Staffing %
 - Incident Reporting

- Group**
- Search
- Select all
 - 12 Hour DTA Breaches
 - 18 Week Referral To Treatment (RTT) Incomplete Pathways
 - 30-60 minutes
 - 60 minutes +
 - All Incidents
 - Annual Appraisal Compliance
 - Better Payment Practice Code (number)
 - Better Payment Practice Code (value)
 - Born in Co-located MLU
 - Cancer Treatments: 14 Day Standard
 - Cancer Treatments: 28 Day FDS
 - Cancer Treatments: 31 Day Standard
 - Cancer Treatments: 62 Day Standard
 - Coroner Reg 28 made directly to Trust
 - Diagnostics Test Exceeding 6 Weeks Waiting Time (DM01)
 - Diverts
 - Eclampsia
 - ED 4 Hour Wait Standard
 - ED 4 Hour Wait Standard - Type 1
 - Falls Rate Per 1000 Bed Days

						Total
Improvement	4	4	8	9		25
		2	4			6
	4	2	4	9		19
Common Cause	2	17	3	29		51
	2	17	3	29		51
Concern		1	2	5		8
		1	1	5		7
			1			1
Neither						
						
						
Empty				6		6
				6		6
Total	6	22	13	49		90

		Assurance			
					
Variation					
		•	•	•	•
		•	•	•	•
			•	•	•
				•	
					
					
				•	

Council of Governors
13th February 2025

Report	Agenda Item 14b.	Council of Governors Action Plan Update					
Purpose of the Report	Decision		Ratification		Assurance	X	Information
Accountable Executive	Karan Wheatcroft			Director of Governance, Risk and Improvement			
Author(s)	Karan Wheatcroft			Director of Governance, Risk and Improvement			
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			X	Supports the overarching governance arrangements.		
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						X
CQC Domains	Safe Effective Caring Responsive Well led						X
Previous considerations	Not applicable.						
Executive summary	<p>The purpose of this report is to provide an update on progress against the action plan from the Council of Governors Workshop held on 17th October 2024.</p> <p>Progress includes:</p> <ul style="list-style-type: none"> • Walkabout schedule circulated to Governors • COG workplan refreshed • Governor newsletter introduced • Buddy system in place for new Governors • Committee observation and involvement proposal drafted for COG consideration (Feb 2025) 						
Recommendations	The Council of Governors is asked to note the progress against the COG action plan.						

Corporate Impact Assessment	
Statutory/regulatory requirements	Governors are a key part of the NHS health and care act, code of governance and Trust constitution. The paper supports Governors to fulfil their role as described in the addendum to statutory duties, reference guide for NHS foundation trust governors.
Risk	An overarching governance risks is included on the Board Assurance Framework.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published as part of Council of Governors papers.

COG Workshop Action Plan Update

1. Introduction

A workshop was held with the Council of Governors on the 17th October 2024. This was attended by 12 Governors, including public, staff and partnership governors.

The workshop was led by the Trust Chair and the Director of Governance, Risk and Improvement, and supported by the Lead Governor and Deputy Director of Governance and Risk.

An action plan was developed and agreed at the Council of Governors meeting 21st November 2025.

2. Purpose

This paper provides an update on progress against the action plan.

3. Action Plan Progress

The following provides a high level summary of progress:

- Walkabout schedule circulated to Governors
- COG workplan refreshed
- Governor newsletter introduced
- Buddy system in place for new Governors
- Committee observation and involvement proposal drafted for COG consideration (Feb 2025)

The full action plan is included in Appendix A.

4. Conclusion

The workshop discussions captured valuable feedback which in turn has supported the development of a prioritised action plan. Progress is being made and we will continue to work with Governors to support them in fulfilling their roles and increase engagement and involvement in driving this forward.

Progress against the action plan will continue to be reported to the formal Council of Governor meetings.

5. Recommendations

The Council of Governors is asked to consider and ratify the action plan.

Appendix A – Action Plan Progress

Action Details	Responsible Officer	Date	Progress
1. Annual calendar of activities to be agreed and provided to all Governors.	Director of Governance, Risk and Improvement	November 2024	In Progress: 2025/26 Board calendar is currently being finalised and dates will be shared in Feb 2025. To include COG meetings, COG workshops, Board of Directors meetings, and AMM.
2. Annual walkabout schedule to be provided to all Governors to ascertain availability against planned dates / times.	Director of Governance, Risk and Improvement	November 2024	Complete: The 2025 schedule has been collated and this has been shared with Governors to confirm their attendance.
3. COG workplan to be reviewed and refreshed. To include greater NED involvement in agenda items; summary of walkabout feedback; strategy updates.	Trust Chair	November 2024	Complete: Draft updated workplan to be presented to November COG meeting.
4. Monthly Governor Newsletter to be produced.	Trust Chair/ Director of Governance, Risk and Improvement	December 2024	Complete: Governor newsletter developed and implemented to provide a focused summary of key communications for Governors.
5. Access to key information for Governors.	Director of Governance, Risk and Improvement	December 2024	In progress: Liaising with Interim Director of Digital to explore options. Further consideration needed on types of information.
6. Patient and family engagement events dates for Governor attendance.	Director of Governance, Risk and Improvement	December 2024	In progress: Liaising with the Associate Director of Nursing regarding linking Governors into these events.
7. Committee 'observation' to be reviewed and process/ role agreed.	Trust Chair/ Lead Governor	January 2025	In progress: Paper provided to COG (Feb 2025).
8. Buddy system to be re-established for new governors.	Lead Governor	Complete	Complete: in place
9. Membership and engagement group role/ activity to be further developed.	Director of Governance, Risk and Improvement/ Lead Governor	March 2025	In progress: Review of the current Membership Engagement Group to be undertaken and look at provision for a Trust Membership Strategy to be produced. Referred to in COG paper (Feb 2025).
10. Plan for recruitment to vacant Governor posts and review of the composition of the Council of Governors.	Trust Chair/ Director of Governance, Risk and Improvement	March 2025	Outstanding

Council of Governors
13th February 2025

Report	Agenda Item 15.	Governor Committee Involvement					
		Decision		Ratification	X	Assurance	Information
Purpose of the Report							
Accountable Executive	Karan Wheatcroft			Director of Governance, Risk and Improvement			
Author(s)	Karan Wheatcroft			Director of Governance, Risk and Improvement			
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			X	Supports the overarching governance arrangements.		
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						X
CQC Domains	Safe Effective Caring Responsive Well led						X
Previous considerations	Not applicable.						
Executive summary	<p>The purpose of this report is to provide clarity on the role of Governors attending Committees, to agree an approach and to seek involvement going forward.</p> <p>The proposal has been developed to reflect best practice, as well as consider the Governor role and the need to increase involvement across the range of Governors to ensure we get diverse input and views. The focus is on the Governor statutory role to hold Non-Executive Directors, individually and collectively, to account for the performance the Board of Directors.</p> <p>The key aspects of the proposal are:</p> <ul style="list-style-type: none"> Continue to encourage all Governors to attend to observe the Board of Directors (at least once per year) 						

	<ul style="list-style-type: none"> • Attendance at Board Assurance Committees (Quality and Safety; People, Finance and Performance; and Audit) to observe the effectiveness of the Committee. This will be on a rotational basis to provide greater opportunity for more Governors and ensure the focus remains on their role as a Governor. • Re-establish the Governor led Membership and Engagement Group to help drive forward the development of a membership strategy and focus on engagement. • Develop the role of the Nominations Committee (NEDs), with clear Governor membership, TOR and workplan. <p>Alongside this, the NED/Governor walkabouts will provide further opportunities for Governors to get involved and we will continue to explore how Governors are part of the patient experience feedback activities.</p>
Recommendations	<ol style="list-style-type: none"> i. The Council of Governors is asked to discuss and approve the proposal for Governor involvement in Committees. ii. Governors are asked to consider the opportunities and support to the involvement going forward.

Corporate Impact Assessment	
Statutory/regulatory requirements	Governors are a key part of the NHS health and care act, code of governance and Trust constitution. The paper supports Governors to fulfil their role as described in the addendum to statutory duties, reference guide for NHS foundation trust governors.
Risk	An overarching governance risks is included on the Board Assurance Framework.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published as part of Council of Governors papers.

Governor Committee Involvement

1. Introduction

Governors provide an important role in NHS Foundation Trust's with clear statutory duties set out by Monitor in 2013 (A reference Guide for NHS Foundation Trust Governors).

It is acknowledged that over time the role of Governors can become less clear as they become involved in more activities in different ways.

We are committed to supporting Governors in discharging their roles, and in 2024/25 we have embarked on a series of workshops to support understanding, involvement and engagement. Alongside this as part of the COG action plan from the October workshop, we have reviewed Governor involvement in Committees.

2. Purpose

This paper is intended to provide clarity on the role of Governors attending Committees, to agree an approach and to seek involvement going forward.

3. Governor involvement in Committees

Governors are currently 'assigned' to a range of Committees including some of the Board Assurance Committees, along with more specific operational commits such as End of Life Care, Faith and Culture, and Research and Development. There is a lack of clarity on the role in Committees in terms of attendance, involvement, membership, observation, and feedback.

'A guide to good governance in the NHS' (NHS Providers) provides useful context to the proposal, albeit for us to determine how we manage involvement locally (Refer Appendix A).

The proposal is

- Continue to encourage all Governors to attend to observe the Board of Directors (at least once per year)
- Attendance at Board Assurance Committees (Quality and Safety; People, Finance and Performance; and Audit) to observe the effectiveness of the Committee. This will be on a rotational basis to provide greater opportunity for more Governors and ensure the focus remains on their role as a Governor.

At this stage we recognise that there may be continued value in Governor attendance at other operational committees. We propose that discussions are held between the Governor, the Committee Chair and the Director of Governance, Risk and Improvement to ensure clear definition of role and involvement.

4. Council of Governor Committees

The Council of Governors has two committees/groups as follows:

- Membership and Engagement Group
- Nomination Committee (NEDs)

The Membership and Engagement Group has not met for some time, and there is a need to re-establish this Group to develop and drive forward the membership strategy and opportunities for engagement.

The Nominations Committee has tended to operate virtually with papers and decisions being taken to a Private COG meeting for ratification. This Committee is responsible for the appointment of Non-Executive Directors providing a recommendation for approval to the Council of Governors. The Trust Chair would usually chair this Committee with membership made up of a majority of Governors. Membership for this group needs to be confirmed following changes in Governors. We can then provide support in understanding the role and requirements of the Committee.

5. Conclusion

It is important that we maximise the value from Governor's time and involvement, ensuring that we support them in fulfilling their statutory duties in the most effective way.

The proposal is to re-set the Governor involvement in Committees aligned to best practice, and ensure well established and functioning COG Committees/ Groups.

6. Recommendations

The recommendations are as follows.

- i. The Council of Governors is asked to discuss and approve the proposal for Governor involvement in Committees.
- ii. Governors are asked to consider the opportunities and support to the involvement going forward.

Appendix A – NHS Providers ‘A guide to good governance in the NHS’

The two extracts below are taken from ‘A guide to good governance in the NHS’ (NHS Providers) chapter on effective board assurance committees. This provides the context to the proposal, albeit for us to determine how we manage involvement locally.

Observers

“The rationale that governors may put forward for attending committees is that they need to see NEDs in action to hold them to account for the performance for the board. It is not the governor role to assess how good their individual NEDs are, though chairs should ask governors to play a part in NED appraisals. It is the governor role to form a view on the performance of the board of directors and to hold the NEDs to account for this performance, so it is the board’s performance, not the NEDs’ performance, with which governors should concern themselves.

There is also the danger of creating individual 'expert' governors who are closer to the work of the Board and this can impair their ability to act independently when sitting on the council of governors. Clear guidance and reporting back to the council is vital if this practice is allowed to ensure that the observations add value to the role of the council, rather than allowing individual governors influence in roles out with the statutory function of the council.

As discussed in the section above, the act of observation alone can impact on outcomes. For these reasons, we recommend governors are not invited to observe committees of the board.

Having said that, we acknowledge that governor attendance is established practice in some trusts, and may be felt to bring other benefits. Where it is decided not to exclude governors from committee meetings it is crucial that the chair ensures that their presence is as observers only. It is the committee that is accountable for its work, and it is important that it is not diverted from that by the presence or contribution of those who have no role in the effective performance of the committee. Indeed it is the role of the audit committee in particular, which has the overarching responsibility on behalf of the board to assess the effectiveness of the board’s committees and the governance arrangements that they underpin”

Holding the NEDs to account for the performance of the board

“This is a statutory duty... However, it is worth noting that the legislation says nothing about what this duty means or how it is to be performed. This can be a problem if governors are not given clear guidance by the trust and can lead to councils attempting to duplicate the work of the board, or to governors seeing themselves as quasi-NEDs. Clearly this should be avoided.

But the lack of prescription in the legislation also presents an opportunity to do things your way. There is no right or wrong way to do this, but it makes sense to be clear with governors and NEDs that it is unrealistic to expect governors to identify mistakes made by the board that the board itself failed to spot. Councils are not the last line of defence, though the act of explaining to governors may in itself be helpful to boards in terms of assurance.

...Where the FT chooses to enable governor observation of committees, care must be taken to ensure that the committees’ ability to conduct itself openly is not curtailed, and that governors are clear that they are there to observe the process of challenge, support and scrutiny undertaken at assurance committees: they are not there to appraise individual NED performance. To prevent

mission creep, it can be helpful to rotate observation between different governors, and across each of the committees throughout the year. This avoids individual governors getting too close to the subject matter. Equally, having a pre-brief and debrief with the NED chair of the committee can help governors understand the context of the meeting, and give them a forum to ask questions or raise any concerns at the end of their observation. Governor observers should feed back to the whole council on their observation of the process at a committee, to ensure the whole council benefits from what they have learned. This again reinforces the purpose of the observation as to understand the process undertaken rather than seek to scrutinise the content.

Council of Governors Workplan
2024 – July 2025 - updated 16th December 2024

Item	Frequency	Lead	Operational Lead	Nov 2024	Feb 2025	April 2025	July 2025
1	Welcome and apologies for absence	Each meeting	Trust Chair	Trust Chair	✓	✓	✓
2	Declarations of interest	Each meeting	Trust Chair	Trust Chair	✓	✓	✓
3	Minutes of last meeting	Each meeting	Trust Chair	Director of Governance, Risk and Improvement	✓	✓	✓
4	Matters arising and action log	Each meeting	Trust Chair	Director of Governance, Risk and Improvement	✓	✓	✓
5	Patient Story	Each Meeting (to be presented on the day)	Director of Nursing & Quality /Deputy Chief Executive	Director of Nursing & Quality /Deputy Chief Executive	✓	✓	✓
6	Trust Chair's Briefing	Each meeting (verbal update)	Trust Chair	Trust Chair	✓	✓	✓
7	Chief Executive Officer's Report	Each meeting	Chief Executive Officer	Chief Executive Officer	✓	✓	✓
8	Lead Governor Update	Each meeting	Lead Governor	Lead Governor	✓	✓	✓
9	Staff Survey - Outcomes	Annually	Chief People Officer	Chief People Officer		✓	

Item	Frequency	Lead	Operational Lead	Nov 2024	Feb 2025	April 2025	July 2025
10	Inpatient Survey - Outcomes	Annually	Director of Nursing & Quality /Deputy Chief Executive	Director of Nursing & Quality /Deputy Chief Executive	✓		
11	Patient / Family Experience Update	Annually	Director of Nursing & Quality /Deputy Chief Executive	Director of Nursing & Quality /Deputy Chief Executive			✓
12	Anchor Institution	Twice annually	Director of Strategic Partnerships	Director of Strategic Partnerships		✓	✓
13	Feedback - Membership Engagement Group	Each meeting (from February 2025)	Director of Governance, Risk and Improvement	Director of Governance, Risk and Improvement		✓	✓
14	To receive questions on:						
	a) Board of Directors meeting date (minutes) and Board of Directors meeting date (agenda)	Each Meeting	Director of Governance, Risk and Improvement	All Executive Directors	✓	✓	✓
	b) The recent reports from the Chairs of the Board of Directors Sub-Committees	Each Meeting	Director of Governance, Risk and Improvement	Non-Executive Directors	✓	✓	✓
	c) Strategic Oversight Framework Report <ul style="list-style-type: none"> • Operational Performance • Quality • Safety • Finance • Human Resources & People 	Each meeting	Chief Operating Officer	Chief Operating Officer / Director of Nursing & Quality/Deputy Chief Executive / Medical Director / Chief Finance	✓	✓	✓

Item		Frequency	Lead	Operational Lead	Nov 2024	Feb 2025	April 2025	July 2025
				Officer / Interim Chief People Officer				
15	Feedback from Governors	Each meeting	Lead Governor	All Governors	✓	✓	✓	✓
16	Feedback from Council of Governor Workshops	Each meeting	Trust Chair / Director of Governance, Risk & Improvement	Trust Chair / Director of Governance, Risk & Improvement		✓	✓	✓
17	Feedback from NED / Governor Walkabouts	Each meeting	Non-Executive Directors / Governors	Non-Executive Directors / Governors	✓	✓	✓	✓
18	For noting:							
	a) Council of Governors Workplan	Each meeting	Director of Governance, Risk & Improvement	Committee Secretary	✓	✓	✓	✓
	b) Council of Governors Photosheet link	Each meeting	Director of Governance, Risk & Improvement	Committee Secretary	✓	✓	✓	✓
19	Any other business	Each meeting	Trust Chair	Trust Chair	✓	✓	✓	✓

→ indicates original position of item on workplan and intention to defer and reschedule

Build a health and care system for the future

with the aim of shortening the amount of time people spend in poor health

NHS AND SOCIAL CARE THAT
IS THERE WHEN PEOPLE
NEED IT

(timely access to high quality
health and care)

*Action largely within the
health and social care system*

Hospital to Home
*Change so that more people get care at home
in their community*

FEWER LIVES LOST TO THE
BIG KILLERS

(reducing early death from
major conditions))

*Action requiring a whole government approach (including health
and social care)*

Analogue to Digital
*Change so we have a workforce we need,
with the technology to deliver the best care*

FAIRER BRITAIN, WHERE
EVERYONE LIVES WELL FOR
LONGER

(reducing the number of years
spent in ill-health)

Treatment to Prevention
Change so that we focus on prevention

The 10 Year Health Plan will be built around 3 shifts:

These changes will be the focus of our conversation today

Moving more care from hospitals to communities

Moving care from hospitals into homes, closer to the places people live and their community.

Making better use of technology

Using digital technology promises faster, higher-quality, more connected care.

Preventing sickness, not just treating it

Preventing rather than simply treating sickness will keep people healthier for longer.



Moving more care from hospitals to communities

What is the challenge?

- People are living longer but with more complicated health conditions.
- Treating people in hospital is expensive – and this is where most of the NHS budget is spent.
- There are longer waiting lists for A&E, hospital treatments and mental health services.

What might this include?

- Moving from delivering lots of care in hospitals, to delivering more care in communities (e.g. GPs, pharmacists) and in people's homes.

What impact might it have?

- More care in communities would be more suitable for people's needs.
- Fewer people going to hospital means hospitals can focus on emergency and specialist care.

Example of community healthcare – virtual wards

What are virtual wards?



Virtual wards let patients get hospital care at home. Patients wear medical devices at home which send information about their health to hospitals.

For example heart rate and temperature.

Doctors use this information to check patients are well. They also visit or video call patients every day.

Virtual wards can be good for people with breathing or heart problems, and older people.



Good things about virtual wards

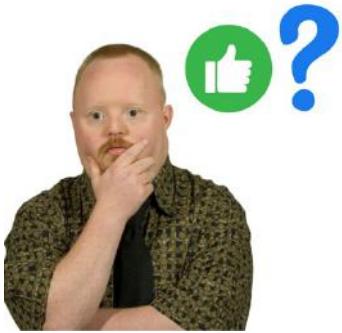
- Virtual wards give us more beds in hospitals for people who need hospital care.
- Some patients get better more quickly when they are at home or have friends and family nearby.
- Virtual wards are cheaper than hospital wards.

And things to think about

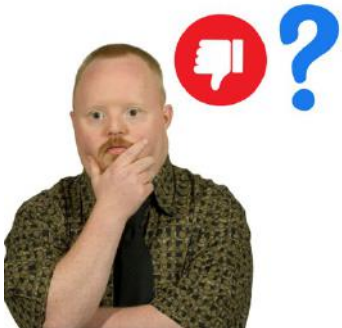
- It means GPs can get the latest patient information.
- They let NHS staff work at different places and times.
- Not all patients have good enough internet for them.



Good and bad things about virtual awards



Good things about
virtual awards?



Bad things about
virtual awards?

Example of community healthcare

Community Test Centres



What are Community Test Centres?

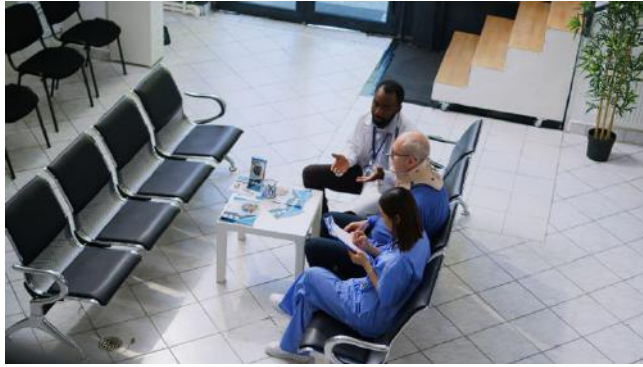
These are places where patients can get health tests.

Like blood tests, scans and other checks.

GPs and hospitals ask centres to do the tests.

These centres are often far from hospitals, like in shopping centres.

This means people can get tests closer to home.



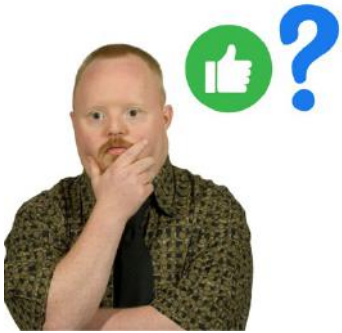
Good things about Community Test Centres

- There is more hospital space for people in need.
- Patients can get health tests quickly. This can mean faster care and medicine.
- It is easier to get health tests and people do not have to travel as far.

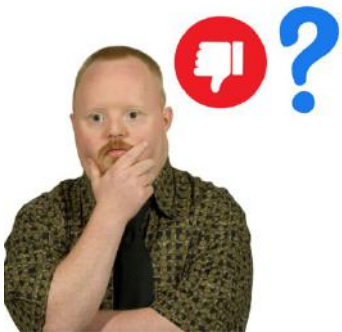
And things to think about...

- Should different centres have different tests?
- Centres cost a lot of money to set up. But are cheaper to run when lots of patients use them.
- Patients cannot get all health tests there.

Good and bad things about Community Test Centres



Good things about
Community Test Centres?



Bad things about
Community Test Centres?

Example of community healthcare

Ambulance assessment first



What is ambulance assessment first?

When you call for an ambulance, the ambulance staff phone a hotline to a healthcare expert.

They tell the expert what happened, the patient's background, and what staff plan to do.

Experts then help ambulance staff with what to do.

The patient might get another service instead.

This means the patient gets the best care for them.

This is good for people over 75 years old who often go to A&E when they do not need to.



Good things about ambulance assessment first

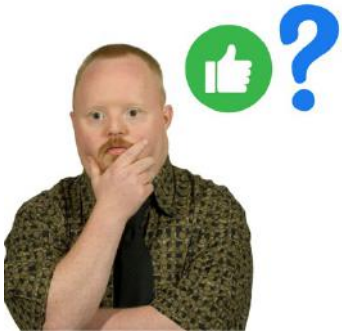
- Patients get the care that they need.
- Patients do not have a long wait in A&E.
- Fewer people go to A&E so hospital staff can help patients who need urgent or serious care.



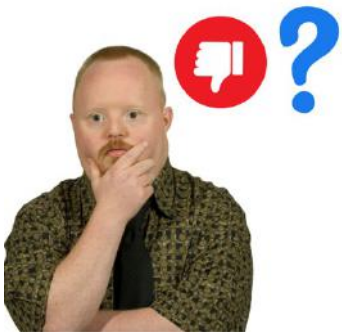
And things to think about...

- An expert must be free to help ambulance staff over the phone.
- Some ambulance staff have lots of training and can already look after patients at home.

Good and bad things about ambulance assessment first



Good things about
Ambulance Assessment First?



Bad things about
Ambulance Assessment First?

Making better use of technology in health and care

What is the challenge?

- Some parts of the NHS still rely on paper and pagers, slow computers and outdated software
- Slow and uneven use of new technology means access to the latest treatments often depends on where you live
- Keeping talented staff is difficult without the technology they need

What might this include?

- Investing in digital technology such as imaging machines and scanners
- Using shared electronic records
- Investing in AI tools to predict possible health outcomes
- Virtual appointments with healthcare professionals

What impact might it have?

- Spotting and diagnosing illnesses earlier
- Improvements in patient care, for example, avoiding having to explain details many times
- Less administration for staff, so they can have more time to care for patients

Why do we want to use better technology?



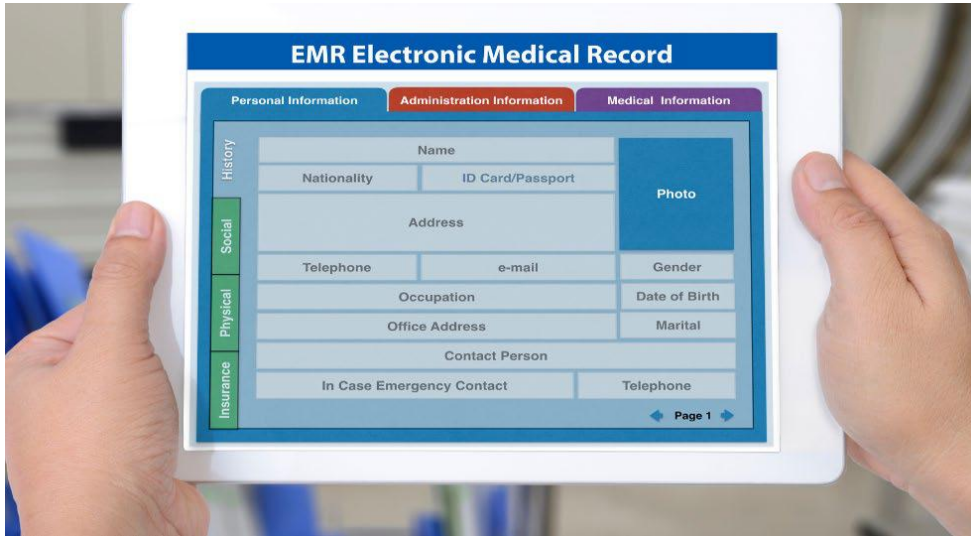
- Parts of the NHS still use paper, pagers and very slow computers.
- Some patients cannot get the latest healthcare and medicines because of where they live.
- It is hard for the NHS to keep good staff without good technology.

What will better technology mean for the NHS?



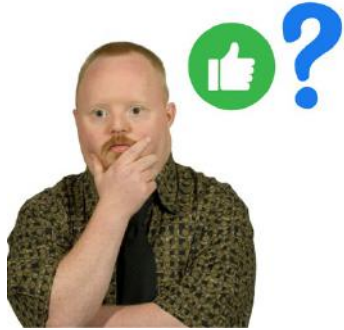
- More money for new digital machines for scanning and taking images.
- We can easily share digital patient information with other health services.
- We can spend more money on **AI** to help us understand health problems.
- Video appointments with doctors and nurses.

How can better technology help the NHS?

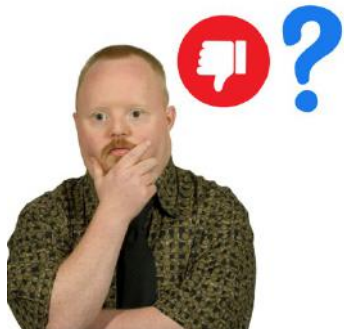


- Doctors can spot illnesses more quickly.
- Patients only give their details once.
- Less paperwork for NHS staff.
This means more time with patients.

What might be good about this change? And what might be bad about this change?



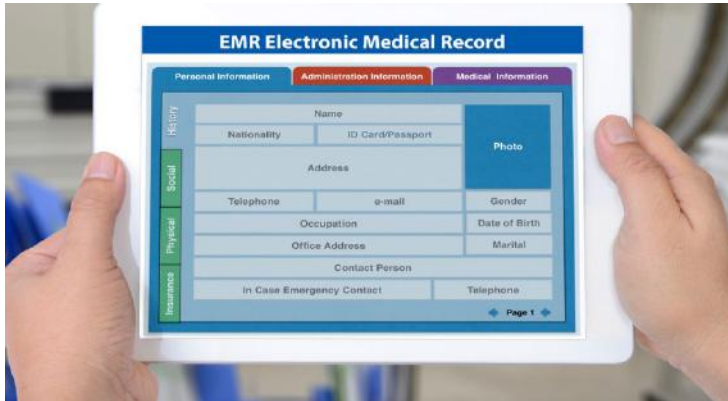
Good things about better technology?



Bad things about better technology?

Examples of using better technology in the NHS

Digital patient information in hospitals



Digital patient information is a computer system where hospitals keep all patient health information.

This system would have your medical history, test results and medications.

Staff can use it to get information so they can give the right care. In the future, GPs could use it too.

Using **AI** to check scans



AI is when a computer can think and do things that normally only people do.

Scans for illnesses like breast cancer and lung cancer are checked by 2 human experts.

But the NHS could use **AI** to help check scans. So only 1 expert would need to check scans.



Virtual GP appointments



Patients could use the NHS app to book a GP appointment.

Patients could choose to have a video appointment using the app.

But they could still see the doctor in person.

Modern computers and tablets for NHS staff



All NHS staff in England could use up to date computers, iPads or other tablets.

Everyone will be able to go online using WiFi wherever they are in a hospital.

AI Health Care Assistant



The AI Health Care Assistant will help patients by using information from their **medical record**.

It could

- look at symptoms
- see changes in someone's health
- book healthcare appointments
- tell patients how to stay healthy.

Using better technology

We think the NHS should get these 3 technologies first ...

1. Write technology here

Write why you have chosen it here

2. Write technology here

Write why you have chosen it here

3. Write technology here

Write why you have chosen it here

Technology we are worried about

Write why you are worried about it here

Focussing on preventing sickness, not just treating it

What is the challenge?

More could be done to help the nation stay healthier for longer, for example:

- Smoking is the cause of 25% of cancer deaths
- More than half of our nation is overweight or obese
- Levels of poor mental health have risen – this is now the main health related cause of people being unemployed

What might this include?

- More screening services to identify early stages of diseases
- More support for those wanting to quit smoking and prevent the development of lung cancer
- Weight management programmes to encourage people to live healthier lifestyles and prevent obesity

What impact might it have?

- Preventing ill health will cost the NHS less in the long-term
- People will also live healthier lives for longer and be able to work and engage in society for longer

Why do we want to stop people from getting ill?



We can do more to help people stay healthy for longer.

- Smoking causes 25% of cancer deaths.



- More than half the people in the UK are very overweight.



- More and more people have bad mental health.
This is the main reason people do not have a job.

What will this big change mean?



- More help for people who want to stop smoking.
- More help for people to stay a healthy weight.
- More **screening** services to find illnesses earlier.

How can this help the NHS?

NHS



- Stopping people getting ill can save the NHS money.

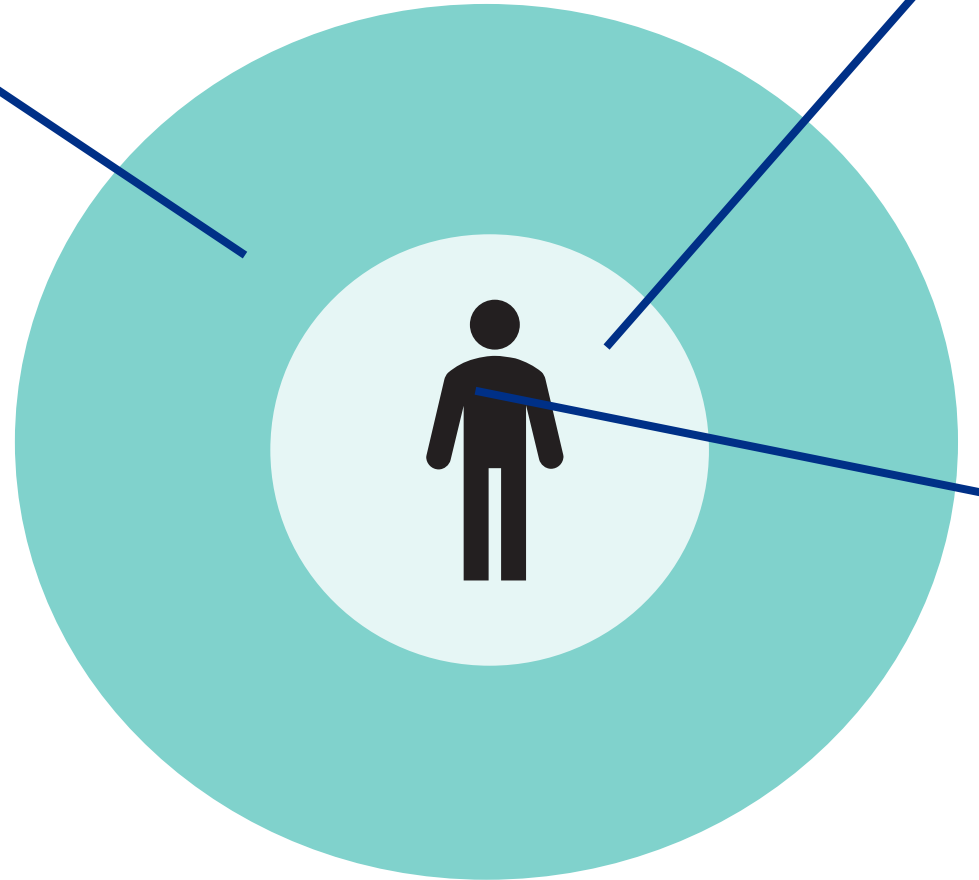


- People will be healthier for longer. This means they can do more, stay active and keep working for longer.

What can keep us healthy?

Things around us

- Safe homes
- Enough money
- Healthy food
- Parks
- Green spaces.



Rules and laws

- No smoking places
- Alcohol awareness
- Healthy food information.

Our own choices

- Choosing healthy foods
- Keeping active and fit
- Contact with family and friends.

Do more to stop people getting ill – what this means

NHS staff check how likely you are to get ill. They might look at your...



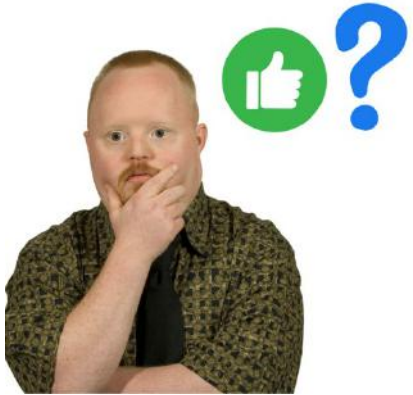
- weight
- age
- blood
- family history
- medical history
- vaccines



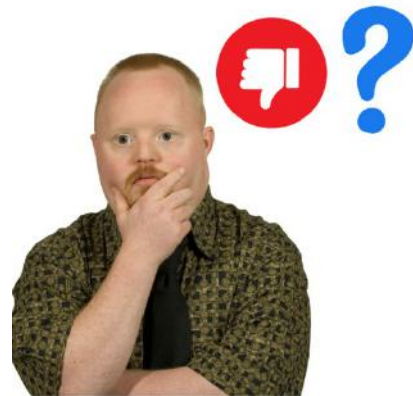
NHS staff can help you do things to keep healthy.

It is your choice if you do these or not.

What difference would this make to you?



Tell us good things



And bad things

Examples of how the NHS stops people getting ill



Mental health support teams

These teams help children with mental health problems in schools and colleges in England.



When children get help quickly it can stop their mental health problems from getting worse.

This can help them stay healthy as they become adults. And save the NHS money.

NHS



Child measurement programme



Children are weighed and measured in school. This information helps us know if children are healthy and helps us plan health services.

Parents can say if they do not want their child to take part.



Children who are overweight are more likely to have health problems when they grow up.

The NHS helps children who are not a healthy weight and their parents.

Cancer screening



Screening means testing people to see if they have a disease before they get ill.

NHS

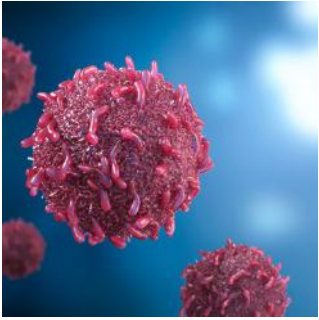


Cancer screening saves thousands of lives every year. And saves the NHS money.



Not everyone chooses to do the screening. The NHS is trying out tests that can be done at home.

Vaccine for HPV



HPV is a virus which can cause cancer.
Viruses are germs.

The HPV **vaccine** is very good at protecting people from HPV and some cancers.

A **vaccine** is a medicine that protects your body from an infection.

All children aged 12 to 13 can have the HPV vaccine.
Most children will get this at school.
Not all parents want their child to have the vaccine.

Weight loss jobs



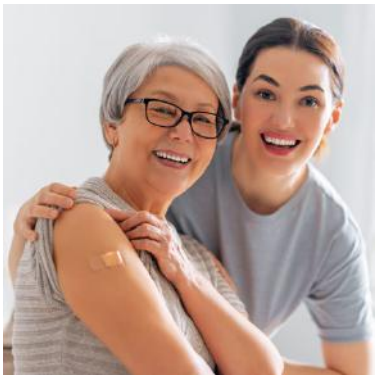
This job from the NHS is for people who cannot lose weight. It works by making you feel less hungry.

NHS



It works very well but it costs the NHS lots of money. So people should try diet and exercise first.

But healthcare for very overweight people also costs money.



This **job** might also help people get back to work.

We think the NHS should do these 3 things to stop people getting ill...

1. Write idea here

Write why you have chosen it here

2. Write idea here

Write why you have chosen it here

3. Write idea here

Write why you have chosen it here