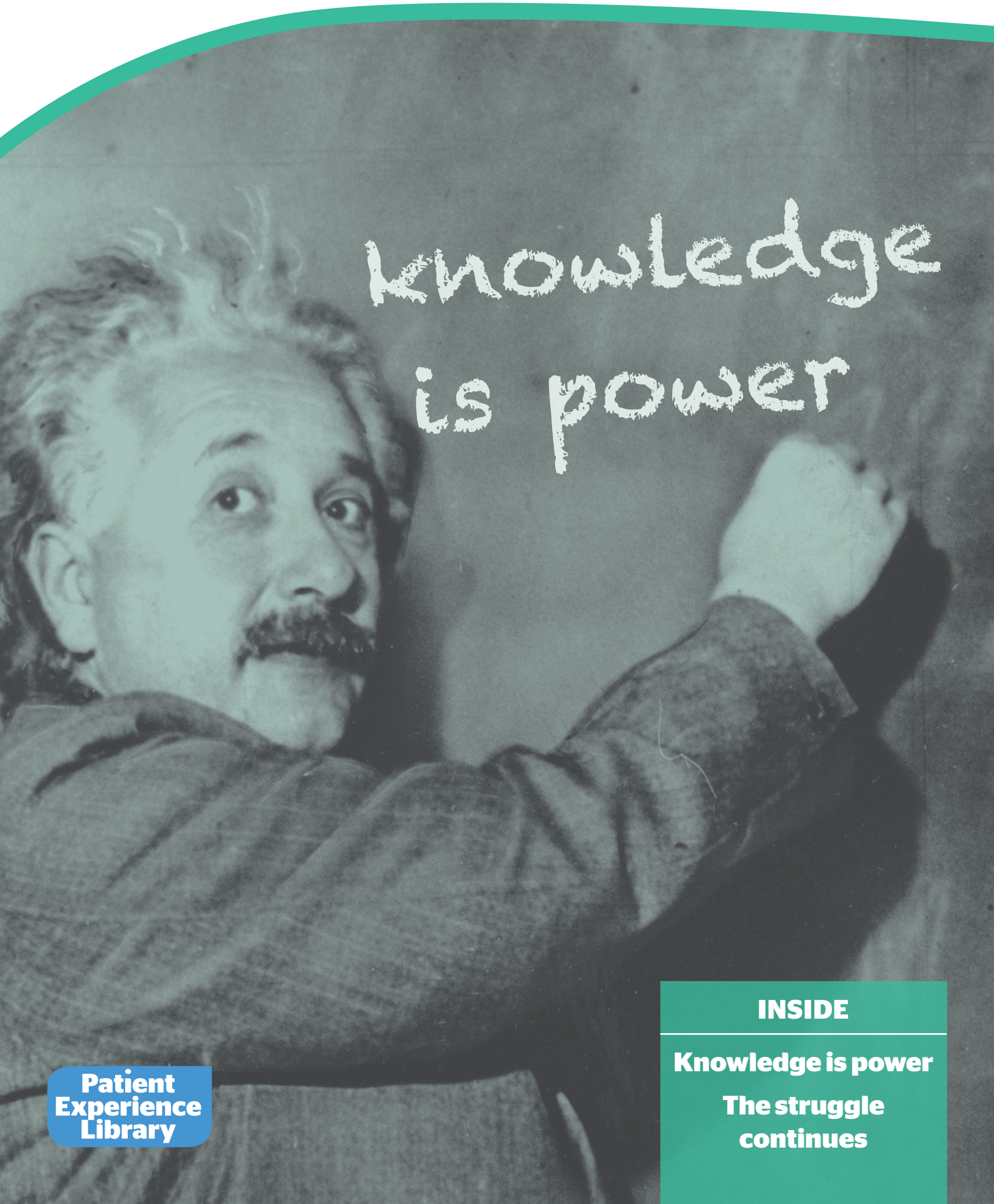
Patient Experience

and patient/public involvement in health and care services

Summer 2025



Patient Experience Library

INSIDE

Editorial

Knowledge is power, and power matters in healthcare. People with long term conditions want to know about those conditions so that they can have informed dialogue with healthcare professionals. They want to know about their treatment options so that they can give informed consent. And they want to know about their medications so that they can self-manage effectively.

On page 3 of this latest edition of our quarterly magazine, Lelainia Lloyd describes her journey from undiagnosed illness to knowledge and understanding of her condition. From that, she developed the power to advocate – for herself and for others like her.

Kath Sansom on page 4 writes about life five years on from the First Do No Harm report which detailed harms to thousands of women from pelvic mesh. For her, knowledge means tracking the continuing activities of mesh manufacturers, keeping an eye on potentially untrustworthy lawyers, and educating politicians about the need for stronger regulatory controls. Her power is the determination to keep going in the struggle for justice.

Along with these comment pieces, we bring you the latest and best patient experience research, packaged in handy summaries for busy people. And we're always keen to hear from our readers, so if you know of a standout report that we should be featuring, or if you want to submit a comment piece, get in touch!

Miles

Miles Sibley, Editor *info@patientlibrary.net*

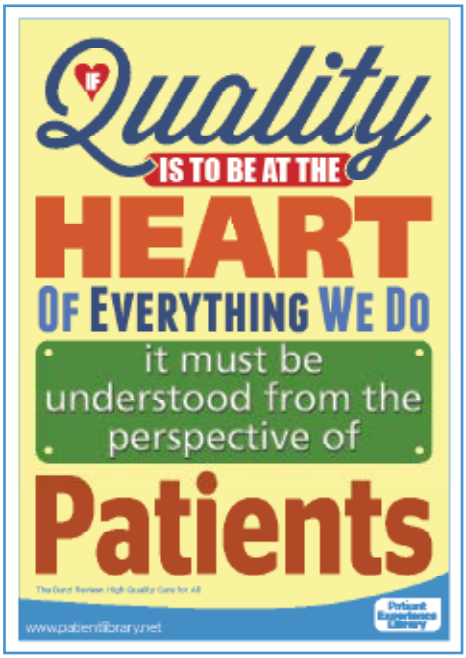
Services

Feel free to browse the Patient Experience Library – a wealth of reporting on all aspects of patient experience and engagement. We can build tailor-made local libraries for your Trust or Integrated Care Partnership – drop us a line to find out how.

Check out our research-based publications, and sign up to our weekly newsletter for regular updates. We offer bespoke search and literature reviews like this and this – get in touch to find out more.

Our Patient Surveys Tracker, Waiting Lists Tracker and Evidence Maps help you make sense of the things that matter to patients. Let us know if you want to talk about custom-made analytics, adapted to your specific requirements.

Contact: *info@patientlibrary.net*



Comment

Do you have opinions, insights or good practice examples that you'd like to share with our readers? Drop us an e-mail to receive our guide for contributors: *info@patientlibrary.net*

COMMENT

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Knowledge is power

Lelainia Lloyd

I grew up in a world where disability was normal.

I knew people who were deaf, who had survived multiple strokes, and who had heart conditions so severe they could hardly leave their house. I never thought to pity these people, instead I grew up loving and accepting them for the individuals they were.

Their disabilities never seemed like a deficit to me. How could they, when that person remained so potent and capable of so much?

I'm grateful that I learned early on that disability is just another part of the continuum of what it means to be human. My youngest grandson will only ever know me as someone with a disability and I hope he learns the same lessons from me that I learned from those role models in my own life.

Disability doesn't change who we are. It's just something that happens to us. And then we find ways to get on with it.

In a way, I've been living this lesson my whole life. I was born hearing impaired, but it went undiagnosed for decades. As a child, I had periodic attacks where my body wouldn't cooperate. I'd fall down the stairs one day, fall off my bike the next. I experienced fatigue and overwhelming nausea; sometimes I spent months with persistent pain radiating down my right arm. In the face of all this, I found ways to cope without ever realizing that was what I was doing. I just kept moving forward.

Then, in 2007 – after a relatively minor fall left me unable to feel anything from my collarbone down – I was referred to a neurologist and misdiagnosed with multiple sclerosis (MS).

This wreaked havoc on my health. I spent five years cycling through different MS treatments, including chemotherapy. Not only was I failing to see any improvement from running this gauntlet, I was in pain every day and my mental health was deteriorating.

It wasn't until 2012 that I finally got an accurate diagnosis: neuromyelitis optica, or NMO. As any rare disease patient will tell you, having the true name for what I was dealing with changed everything. Knowledge is power in the world of rare disease.

The last 20 years have seen an explosion of new research and medications for this disease, and so this is a very hopeful time to be an NMO patient. And I was very fortunate to get diagnosed before my own disease had progressed too far.

As my own quest for empowerment and accessibility as a newly-minted NMO patient began, I quickly realized that the fight was bigger than just me. Before I knew it, I became a full-time advocate, speaking on panels, writing a column and hosting a podcast. It's a bit wild. No little kid ever says, "When I grow up, I want to be diagnosed with a rare disease and become an advocate." It's something you do out of necessity.

And advocacy is necessary. The rarity of these diseases can make you feel invisible. But when there's awareness, education, access, funding, social programs, and well-supported research, the outcomes can be incredible.

Thanks to treatment, I've been relapse-free now for five and a half years – and that gives me confidence to live well and be unapologetically me. That means everything to me. Honestly, I never would've thought it was possible, but with the right management and care team, this disease can be controlled. I believe that every patient deserves that chance.

We're mothers, we're fathers, we're spouses, we're employees, we're neighbours. We're people with value, contributing to society in so many beautiful ways. We have lives we want to get on with.

You can read more about NMO and Lelainia's experiences here.

COMMENT

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The struggle continues

Kath Sansom. Founder, Sling The Mesh

It is now five years since Baroness Cumberlege's First Do No Harm report told the story of pelvic mesh, and the harm that it has caused to many thousands of women.

The report described the life-changing injuries to the women affected, and recounted conflicts of interest, denials and cover-up from medical professionals and manufacturers of pelvic mesh. But the battle for justice is far from over.

TVT (tension-free vaginal tape) continues to be manufactured and enthusiastically sold to healthcare providers. Indeed, Caldera Medical has recently stated that it is "thrilled" at its acquisition of a TVT mesh range from Johnson & Johnson.

Some mesh products were suspended in the UK in 2018 after the government accepted they had caused severe complications. Health authorities in New Zealand and Australia followed suit, recognising the irreversible damage that can be caused.

So where does Caldera think it can sell its TVT mesh?

Its announcement on LinkedIn says that its mission is "to improve the quality of life for women globally". And its website states that it aims to "provide treatment to one million underserved women". Could it be thinking about women in developing countries and the global south? To try to find out, I clicked on the FAQs link posted on its LinkedIn page – only to discover that it goes to a "Page not found".

In the meantime, our fight for justice for UK mesh victims continues, and for our legal battles we need help. But here, too, we encounter mistreatment.

A few weeks ago, we heard that a solicitor who acted for hundreds of women in vaginal mesh claims is to appear before the Solicitors Disciplinary Tribunal.

The Solicitors Regulation Authority (SRA) closed down the firm in May 2023 because there was "reason to suspect dishonesty". Allegations include the solicitor telling a client she was receiving a settlement but not that he had already taken nearly half of the offered amount in costs. He is also accused of failing to deal with requests for payments from a third party, making misleading demands for costs, misleading another party as to the payment of costs, and dishonestly keeping settlement money to pay supposed success fees.

The allegations are unproven pending the hearing, but they have understandably left mesh victims angry and distraught.

We – the Sling the Mesh Campaign – demand transparency, accountability, and justice. To governments, health regulators, and health ministries, we say beware of corporate spin. If bladder mesh slings and vaginal prolapse mesh are deemed too dangerous for women in the UK, Australia and New Zealand, they are too dangerous for women everywhere.

And let's be mindful here of the current global narrative that abdominal prolapse mesh is "not the mesh in the media" and is low risk / gold standard. Lived experience in our group shows hundreds are suffering from this type – which is the same polypropylene plastic material supporting the same prolapsed organs just inserted via a different route.

To mesh victims and legal regulators, we say beware of predatory lawyers. Women who have suffered life-changing injuries need compensation, and we want good legal representation. But any lawyers looking for rich pickings must be stopped and, if necessary, punished.

To the UK government we say introduce tougher approval, regulations and oversight of medical devices to improve patient safety. Implement all nine First Do No Harm key recommendations. And bring in Sunshine Payment legislation to require the pharmaceutical and medical device industry to declare money given to doctors, researchers, lobby groups, health charities, surgeon societies and teaching hospitals.

Members of Sling the Mesh continue to live with the injuries and complications caused by pelvic mesh. We are not giving up the fight for justice. And so the struggle continues.

RECENT REPORTS

Here, we review our top picks of studies and surveys from the last three months. Some are newly published – others are featured because they shed useful light on recent issues and developments. For full attributions, and copies of the original documents, click on the report pictures.
Do you know of a stand-out report that we should be featuring? Contact us! ***info@patientlibrary.net***

Public mood improving

This report presents the latest findings from a six-monthly rolling programme of research carried out by Ipsos on behalf of the Health Foundation. The programme aims to track changing public perceptions of health and social care, and to generate policy insights.

The report opens with the observation that the public are less critical of NHS care and services than a year ago, in May 2024. They are also more optimistic for the coming 12 months, with around one in five (21%) thinking the general standard of care will get better, up from 11% in May 2024.

People are more likely to agree that the NHS is providing a good service locally (45% now, against 37% a year ago). There is also a greater sense that government has the right policies for the NHS (17%, up from 8% in May 2024).

When asked about different priority areas for the NHS, the public's top priority is making it easier to get appointments at GP practices (38%). This is followed by improving waiting times for A&E (33%), reducing the number of staff leaving the NHS by improving working conditions (29%), and reducing waste and improving efficiency of NHS services (29%).

The survey found that around three-quarters (73%) of the English public are unaware of the 10 Year Health Plan. They are, however, generally supportive of the plan's "three shifts". Preventing sickness rather than just treating it is the most popular shift (86% support), followed by moving more care from hospitals to communities (82%). Making better use of technology receives the least support, although support is still high overall (73% support).

On social care, views of general standards have improved, and people are more likely to think social care services will remain about the same (up from 29% to 41%). But they continue to be negative about social care services in their local area, with only 12% agreeing they are good.

The majority of the English public (76%) are unaware of the government's promise to create a National Care Service. However, 40% think the government should prioritise delivering social care reform quickly.

The NHS/healthcare is the public's top priority to receive more public spending in the future, with 65% support. People also support tax increases to maintain spending, though support for this has dropped from 53% to 42%.

Addressing antimicrobial resistance

The report comes from the National Audit Office which has been investigating the government's response to antimicrobial resistance (AMR) 'because it is a serious public health threat, and because the UK's experiences during the COVID-19 pandemic showed the country was not as resilient to such threats as it expected to be'.

A key finding is that AMR acceleration 'is driven partly by people's misuse and overuse of antimicrobials'. In England 20% of antibiotics prescribed in primary care are inappropriate.

The problem is compounded by the fact that only one new class of antibiotic has been discovered since 1987. This is because 'the financial returns to pharmaceutical companies from discovering antibiotics are insufficient to incentivise investment, even though new antibiotics would be of great public value'.

The report says that 'There are huge foreseeable consequences'. By 2050 AMR is likely to contribute to an estimated 8.2 million deaths globally each year. Importantly, 'The future health effects will not be evenly spread. Health inequalities could worsen, and several groups will be disproportionately affected, particularly babies and the elderly, people with lower socio-economic status, and specific ethnic groups'.

The UK's National Action Plan 2019-2024 (NAP) is reviewed, with mixed results. For example, only one of the government's five quantified domestic targets in NAP19-24 was met or on track to be met.

A key target is that awareness of AMR among health workers and the public needs to improve. However, a 2019 survey of UK health workers found that only 59% could correctly answer a set of questions about antibiotic use and antimicrobial resistance, and only 78% felt they knew enough about the subject. Meanwhile, 90% of the UK public knew antibiotics were becoming ineffective but only 49% knew that antibiotics do not work against viruses.

The report concludes that AMR is a serious threat to the health of the public and has the capacity to change our society radically for the worse. But, it says, 'the UK remains a long way from the 20-year vision the government expressed in 2019: to control, contain and mitigate AMR'.

Responding to Challenge

In October 2022, Dr. Bill Kirkup published his report into avoidable harm and death in maternity services at East Kent. The report – called "Reading the Signals" – urges everyone involved in healthcare to get better at spotting the warning signs of harmful cultures.

We – the Patient Experience Library – have published the Responding to Challenge report to show what those warning signs look like. We went back over ten years of avoidable harm inquiry reports, digging out over a thousand references to the organisational and professional cultures that lie at the heart of harm. We then carried out a thematic analysis to reveal the patterns of behaviour that crop up time and again in healthcare disasters.

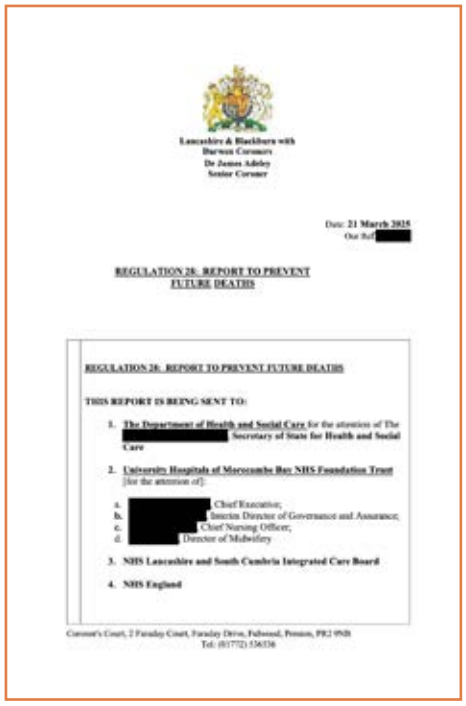
The approach enabled us to go beyond the vague notion that culture is just "the way we do things around here". Instead, we have forensic insights based on real-life examples, as documented by official investigations. We can now show what poor cultures look like – in teamwork, compliance, accountability, organisational learning and more.

The report, produced for the Care Quality Commission, contains a link to an online Red Flags Tracker which enables users to see those real-life examples for themselves. It can help anyone who sees something 'not quite right' to check their concerns against an extensive evidence base.

The report and tracker can be used as the basis for staff training and organisational learning – helping people to get a better idea of what "culture" actually looks like in healthcare, and how it can go wrong. They are already being drawn on by Maternity and Newborn Safety Investigations, who have fed the learning into a cultural assessment tool that is being piloted with 12 NHS Trusts.

The learning will also be useful for people charged with the task of "reading the signals" of harm – complaints managers, Freedom to Speak Up Guardians and local Healthwatch staff. And last but not least, it will be of interest to service managers and Trust Board members – the people who are ultimately accountable for organisational cultures and their impacts.

You can view the Responding to Challenge report and the Red Flags tracker here.



Lancashire & Blackburn with Darwen Coroners
Dr James Adeley
Senior Coroner

Date: 21 March 2025
Our Ref: [redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. The Department of Health and Social Care for the attention of The [redacted] Secretary of State for Health and Social Care
2. University Hospitals of Morecambe Bay NHS Foundation Trust [for the attention of]:
   a. [redacted], Chief Executive;
   b. [redacted], Interim Director of Governance and Assurance;
   c. [redacted], Chief Nursing Officer;
   d. [redacted], Director of Midwifery
3. NHS Lancashire and South Cumbria Integrated Care Board
4. NHS England

Coroner's Court, 2 Faraday Court, Faraday Drive, Fulwood, Preston, PR2 9NB
Tel: (01772) 536536

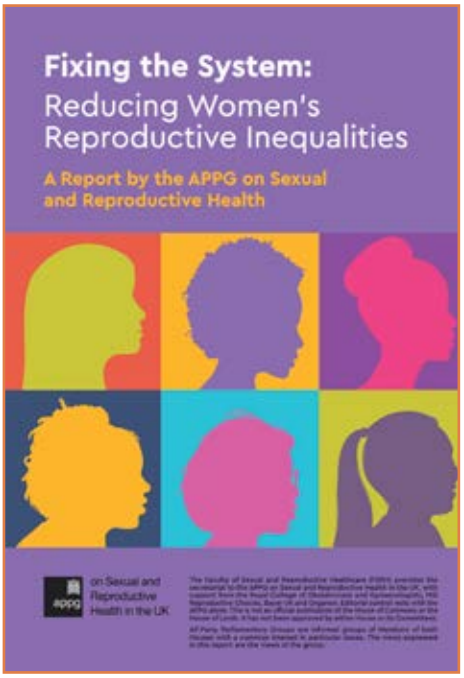
Preventing future deaths

Prevention of Future Deaths reports are issued by coroners if they have reason to believe that the circumstances leading to a death could be repeated unless action is taken. This PFD report was issued by a coroner investigating the case of a baby, Ida Lock, who died after failures in basic medical care.

The report outlines the clinical circumstances of the case. But it also points to multiple instances of poor organisational and professional cultures. These include:

- Poor reporting culture. The coroner cites 'concern about the reliability of Trust's data' and 'lack of version control and audit of documents'.
- Poor compliance culture. We hear of 'lack of compliance with clinical governance requirements' and 'failure to comply with the Duty of Candour'.
- Poor caring culture. The report describes a 'lack of transparency and openness', along with 'rolling disclosure of documents [which] caused additional distress to the family'. There is also 'inappropriate self-congratulation'.
- Poor accountability culture. There was a failure to 'notify the external bodies namely the CQC and the then CCG', as well as a senior staff member 'reneging on the Trust's acceptance of the HSIB report'.
- Poor learning culture. There was 'non-completion of mandatory training [by midwives]' and a failure by the Trust to 'undertake any examination of its own clinical governance processes'.

These symptoms of harmful cultures are not confined to maternity and neonatal services. Multiple investigations, including Mid Staffordshire, Gosport and more, have pointed to similar problems. Readers wanting to understand how medical cultures can go wrong could start here.



Women's reproductive inequalities

The most recent Labour Party manifesto made a promise: 'Never again will women's health be neglected. Labour will prioritise women's health as we reform the NHS'. This report takes that promise as a backdrop to an examination of inequalities in women's sexual and reproductive health.

It starts with the observation that women's reproductive health has historically been overlooked by policy makers, with only 2% of medical research funding spent on pregnancy, childbirth and female reproductive health. This, it says, 'leaves stark evidence gaps about female-specific health'.

There are also 'acute variations of women's access to local reproductive health services due to the fragmented way the system is designed and delivered'. According to the authors, these variations deepen inequalities. Problems include the following:

- Care pathways that are disjointed, difficult to navigate and create artificial divisions between contraception, sexual and reproductive health.
- A lack of ethnicity reporting, leading to disparities in care and outcomes.
- Cuts to Public Health Grant funding, with real terms spending on contraception falling by 29% between 2015/16 and 2022/23, and with big reductions in the availability of specialist sexual and reproductive health clinics. These cuts 'tend to be greater in more deprived areas, which compounds and entrenches existing health inequalities'.

The report points to 'the untapped potential of Women's Health Hubs', which can bring together healthcare professionals in a 'flexible, one-stop service with diagnostic capabilities and integrated pathways with secondary care'. These would be 'an ideal opportunity for the Government to move care into the community for many women'.

There are further recommendations, at both the national and the local and regional levels. The report's authors are clear that 'sexual and reproductive health forms a central part of women's health', and call on the government to deliver on its manifesto promise.

Health and politics

This report starts with the observation that 'Health is an under-appreciated influence on politics'. It says that health has long been an undercurrent in politics. But 'More Europeans than ever are living with chronic diseases and disabilities'. On top of that, the COVID-19 pandemic 'precipitated a crisis of well-being and health system performance, forcing entire populations to confront the importance of health protections to their lives'. In this context, say the authors, health may be more relevant to politics than ever.

A key focus is people with poor health and disability. The report states that limited mobility and financial constraints can hinder their ability to participate in the democratic process. So they are less likely to vote and are under-represented by their elected officials.

People in poor health also report negative experiences with the health system, social programmes, and other public institutions meant to support them. So they have 'lower trust, confidence and satisfaction with the health system, government, politicians and other public institutions'.

One consequence is that 'The political alliances of people in poor health may be shifting'. The rise of populist parties, especially on the ideological right, has given voice to people who feel 'left behind' by public institutions. Their anti-establishment rhetoric, according to the report, 'appears to have appealed to people in poor health, even though many populist parties oppose public health protections'.

There is, however, an opportunity: 'The political salience of health gives policy-makers an opportunity to promote health alongside trust in democratic institutions'. Health issues motivate many people to engage with patient advocacy groups and health professional societies. And 'people have high trust in their individual health care providers, who may represent an opportunity for rebuilding trust'.

The report states that 'the public often rewards elected officials for health-promoting policies. They are more likely to do so when a policy has visible, meaningful benefits; provides universal coverage; and conveys respect to beneficiaries'. And it concludes that 'Understanding the political influences of health can help policy-makers protect not only the health of populations but also democratic institutions'.

The dark side of the plate

Food has a profound effect on our health and wellbeing. And, according to this report, 'UK dietary health is at a crisis point'.

The report states that 'Babies born today will enjoy a year less of good health compared to babies born a decade ago, while type two diabetes among under 25-year-olds has increased by 22% in just five years'. It goes on to say that 'The cost of our poor diets is ravaging the NHS'.

The focus of the study is food industry lobbying of MPs. One key finding is that between 2020 and 2024, government ministers met with food businesses and their trade associations 1,408 times – 40 times more than with food NGOs.

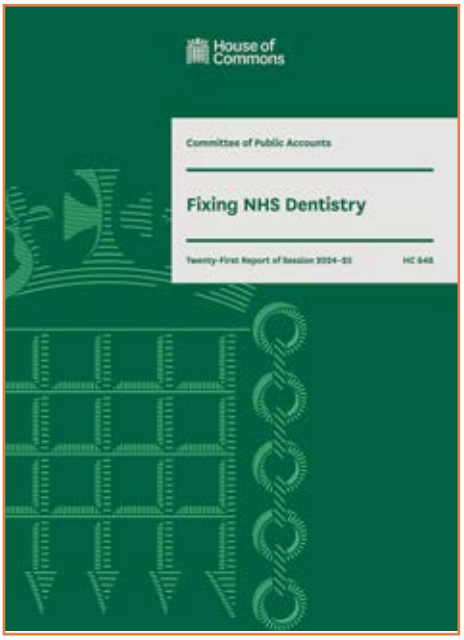
Keeping track of these kinds of connections is difficult because 'the UK's system to disclose lobbying practices is opaque at best and could and should be substantially improved'. And greater transparency matters because 'countries with a greater degree of corporate capture are less likely to implement evidence-based health policies'.

The report lists some examples of food industry influence, including:

- Repeated objections by McDonald's to local authority attempts to prevent fast food outlets being sited near schools.
- A scheme run by Tesco in which midwives funded by Danone offered infant feeding advice to new parents.
- Food education in schools supported by an industry body that receives funding from companies including Coca Cola, PepsiCo, Mars, Nestle and British Sugar plc.

Additionally, at the policy level, 'more than half of the experts on the UK government's Scientific Advisory Committee on Nutrition... have links to the food industry... with the likes of Nestlé, Tate and Lyle, and Unilever'.

The report makes a series of recommendations: stronger disclosure requirements, better data systems, and tackling the 'revolving door' through which people move between employment in the public and private sector.



Fixing NHS Dentistry

In recent years we have become familiar with the idea of 'dental deserts' – areas of the country where it is impossible to get basic dental treatment on the NHS.

The situation was already bad five years ago when, pre-pandemic, only half of the adult population (49%) had access to an NHS dentist. Covid accelerated the decline and now only 4 in 10 have access.

This report, from the House of Commons Committee of Public Accounts. explains that in 2024 the then government launched a dental recovery plan. There were three main goals: to deliver an additional 1.5 million courses of treatment in 2024-25, to improve children's oral health through the Smile for Life programme, and to introduce measures to support the dental workforce.

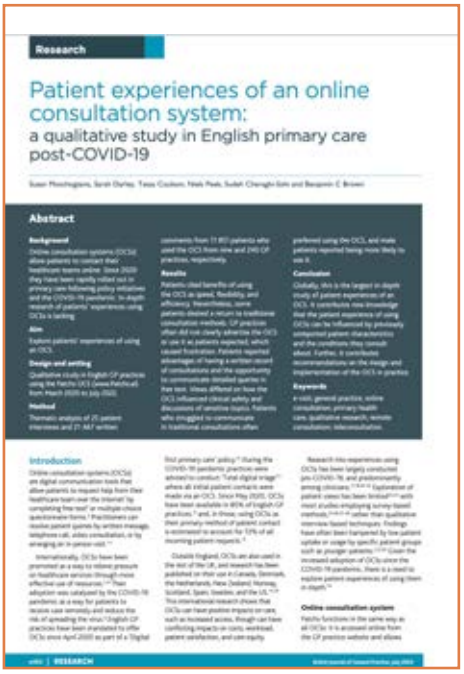
The Committee's judgement on the plan is blunt. They say that it has 'comprehensively failed to deliver improvements in access to NHS dentistry'. One consequence is that 'the most vulnerable patients continue to suffer the most from long-standing failures in the system'.

There are various aspects to the failure:

- The dental contract 'remains unfit for purpose and fails to incentivise practices to deliver sufficient NHS care'.
- The New Patient Premium, meant to incentivise recruitment of NHS patients by dental practices has actually resulted in 3% fewer new patients since the scheme was introduced in March 2024.
- The 'golden hello' recruitment scheme has seen less than 20% of the 240 expected dentists appointed.
- One final initiative – mobile dental vans – has been dropped.

The underlying cause, according to the Committee, was that 'The modelling that underpinned the dental recovery plan was flawed, and even if the plan had performed in line with expectations it was never actually ambitious enough to meet its stated aim of ensuring that everyone who needs to see an NHS dentist would be able to'.

The Committee notes that the current government has committed to introducing more fundamental reform to the dental contract. But, it says, 'NHSE and DHSC do not yet know what that reform might look like or to what timescales it can be delivered'.


Research

Patient experiences of an online consultation system:
a qualitative study in English primary care post-COVID-19

Abstract

Introduction

GPs online

This paper explores patients' use of online consultation systems (OCSs) – in particular, why they chose to use the OCS, the circumstances in which they preferred to use it, and the perceived facilitators and barriers to its use.

A key benefit for patients was the ability to receive a quick response to their query, compared with the delay (typically 2-3 weeks) associated with traditional routine in-person appointments. Full-time workers and people with childcare considerations also like the convenience and flexibility of the OCS. People believed it saved them time by avoiding busy phone lines, unnecessary travel, and long waits due to delayed appointments.

Barriers to use included the following:

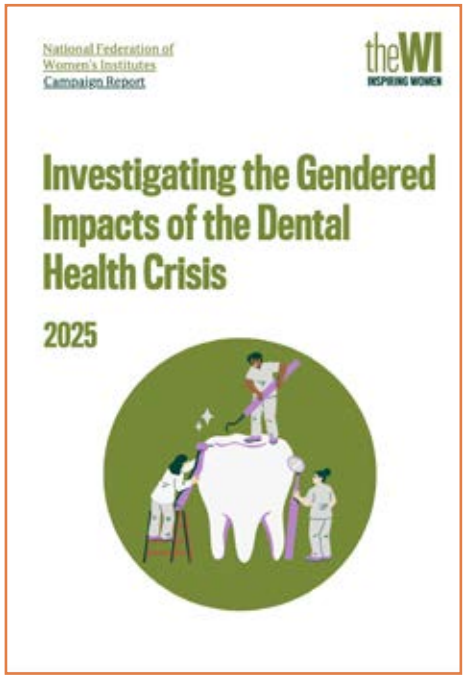
- GP practice websites were frequently criticised for being overloaded with information, and needing clearer signposting to the OCS.
- Some patients were confused about the purpose of the OCS, particularly when their practice offered other online systems, for example, to order prescriptions.
- If an OCS request was not resolved within the timeframe advertised (eg 48 working hours), people often telephoned the GP practice to chase a response. They also expressed irritation when the GP had not read the details of their request before an in-person or telephone consultation.

The paper also touches on the particular needs of patients with communication challenges. This included patients with hearing loss, anxiety, and autistic spectrum disorders, as well as people for whom English was a second language. These often preferred the OCS because they were more confident writing rather than speaking English, and had access to free online tools to support them.

Male patients, too, were more likely to use the OCS. Some were concerned about wasting GP time and saw OCSs as more efficient for practices. Others delayed contacting their GP practice as an avoidance tactic to cope with anxiety. The impersonal nature of the OCS helped them to emotionally detach.

Finally, the study found that older people, although initially apprehensive about the OCS, found the system easier to navigate than expected and often preferred using it to contact their GP.

The paper makes a number of recommendations for GP use of OCSs, and concludes that design and use of OCS systems by GP practices are key drivers of patient experience.



Women and the dentistry crisis

'There is limited research on how a poor dental health service impacts the lives of women', according to this report from the National Federation of Women's Institutes. It looks at the ways in which the UK dentistry crisis disproportionately affects women, based on a survey that obtained over 960 responses.

The central theme of the report is that dental health is a feminist issue. This is partly a matter of biology: in pregnant women, for example, hormonal changes can lead to gingivitis – an inflammation of the gums.

It is also because women take a disproportionate amount of the caring responsibility for children and ageing parents. The report states that with NHS dental appointments becoming harder to obtain, women are bearing financial, temporal, physical, and mental health burdens for not only themselves but also their loved ones.

Pregnant women and children are entitled to free NHS dental healthcare. But survey respondents reported being unable to find a dentist taking NHS patients to treat them. So some women are turning to private dentistry but are then finding that they are required to pay high bills.

The report makes the point that the lack of available NHS dental healthcare, and the financial burden of private dental care, forces women to choose between their own health and the well-being of their families, further exacerbating inequalities in access to dental healthcare.

Some women who could not support their loved ones in finding dental healthcare expressed embarrassment and guilt for failing to provide the care they felt they were responsible for.

The report finishes with a series of calls on government, including that all policies looking to solve the dental health crisis should consider the women who act as primary caregivers in their families and communities, and therefore face significant emotional and financial burdens while managing their family's dental care.

The health mandate

'The nation's health is now a top-tier political issue' says this report, based on polling of 2,000 UK adults, and focus group work in key battleground constituencies.

It says that the NHS is the second most important issue for voters, behind the cost-of-living crisis but ahead of the economy. But people also have a wider understanding of health beyond the NHS – for example recognising the links to long hours and work stresses. 'Strikingly', says the report, 'people felt the food and drink industry (84%) had greater responsibility for health outcomes than the NHS (79%)'.

An important political implication is that 'Public health policies are popular in general, and even more so amongst key voter groups for the next general election'. Moreover, 'Concerns about 'nanny statism' are likely overstated: a majority supported bold regulatory policies like advertising restrictions (65%) or further smoking bans (61%)".

The report offers these messaging recommendations for policymakers:

- Anchor health messaging in people's lived reality. The public does not talk in terms of 'social determinants' or 'health inequalities', but in terms of everyday things like a warm home, and having the time and energy to make a healthy meal.
- Make the economic case in terms of day-to-day financial pressures, not GDP metrics. Arguments about productivity and growth can come across as too abstract.
- Appeal to the collective benefits of a healthier nation. Policymakers could appeal to voters' sense of civic responsibility and pride in national institutions like the NHS.
- Focus on tangible, immediate benefits at the household level. Policies that were proactively raised in complimentary terms – such as plain packaging for cigarettes or the sugar tax – were those which had had a significant and visible impact on everyday products.
- Frame in terms of creating 'a level playing field'. The focus groups revealed a widespread sense of unfairness that big businesses (particularly in food, drink, and tech) profit from promoting unhealthy habits while individuals are left to pick up the cost.

The report concludes that 'The case for action is clear. The public is ready. What remains is for policymakers to match public appetite with bold, credible, and visible change that improves lives and strengthens the nation's health'.

Health Services Safety Investigations Body

Investigation report

Mental health inpatient settings: overarching report of investigations directed by the Secretary of State for Health and Social Care

Date Published:
13/05/2025

Theme:
Mental health

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Risks in mental health safety

This report brings together findings on patient safety risks as revealed by a series of investigations focused on mental health inpatient settings. It sets out a catalogue of issues and concerns including the following:

- Learning culture: There is a fear of blame in mental health settings when safety events happen. This contributes to a more defensive culture despite staff actively wanting to learn.
- Accountability culture: A lack of clear accountability can result in poor outcomes for people with mental illness. Delivery of care is challenging because health and social care services are not always integrated and their goals are not always aligned.
- Capability: Integrated care boards lack the required data and the necessary analytical capability to assess disparities in access, experience and outcomes related to the physical health needs of people with severe mental illness.
- Lack of insight: Integrated care boards cannot consistently draw reliable insights from data at national, system or local level, to optimise and improve services.
- Caring culture: 'Doing' tasks, like ticking checklists, overshadow meaningful, empathetic 'being' interactions with patients. 'Tick box' culture inhibits open and honest conversations and the ability to put the patient, as their authentic self, at the heart of them.

There are further observations and recommendations which, say the authors, 'offer opportunities to facilitate improvements in systems, practices and future plans to support patient safety in mental health inpatient settings'.

Importantly, they add that 'Findings may also be applicable to other healthcare services in England'.

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Further information and booking

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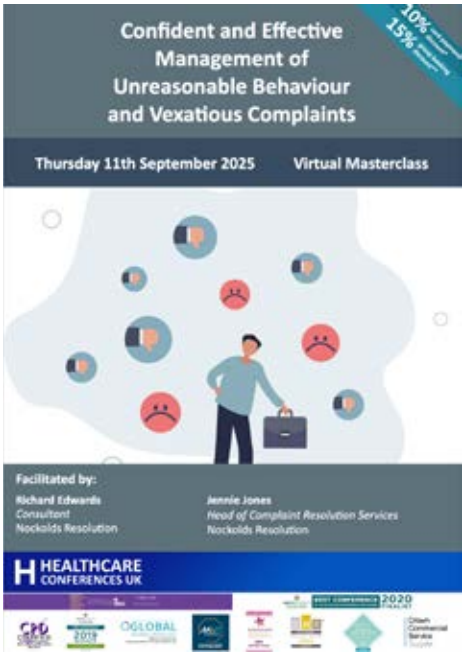
Further information and booking



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