Maternal Request Caesarean Section:

a report into the variances in practice and procedure across NHS Trusts in the UK

December 2021

Foreword

Most birth experiences are positive, with a safe outcome for mother and baby, but childbirth is not without risk and complications can occur.

In recent years, the law has increasingly recognised the doctrine of "informed consent" in healthcare - the principle of involving patients in their treatment and sharing information with them about risks so that they can make fully informed decisions about their healthcare.

The landmark legal case of ***Montgomery v Lanarkshire Health Board*** [2015] UKSC 11 has clarified the legal position and its continuing trend away from paternalism to patient autonomy.

Since 2011, National Institute for Health and Care Excellence (NICE)'s Guideline CG132 has recognised that women should be the primary decision makers in childbirth and that *"For women requesting a caesarean section, if after discussion and offer of support…a vaginal birth is still not an acceptable option, [Trusts should] offer a planned caesarean section."*

In 2018, **Birthrights**, a charity that works to promote women's rights in childbirth, published a **report into Maternal Request Caesarean** (MRCS), i.e. planned caesarean sections requested by pregnant women in the absence of medical indication. This highlighted that despite the NICE Guidance CG132, nearly 75% of NHS Trusts did not have written guidelines that committed to upholding a woman's autonomy in this area and concluded that *"the majority of Trusts in the UK made the process of requesting a caesarean lengthy, difficult or inconsistent, adding anxiety and distress to women at a vulnerable time."*

These findings were entirely consistent with the **report of the Morecambe Bay investigation** which identified a *"pursuit of normal childbirth 'at any cost'"* and **Donna Ockenden's evidence** to the Health and Social Care Select Committee (HSCC) as part of their 2021 **Inquiry into the Safety of Maternity Services**. She gave evidence that the Ockenden review had heard from *"hundreds of women who said to us that they felt pressurised to have a normal birth…at that trust, there was a multi-professional, not midwife-led, focus on normal birth pretty much at any cost."* Anecdotally the HSCC heard plenty of evidence suggesting that there is still clinician-led pressure for women to choose vaginal delivery, rather than the focus being on achieving a safe, healthy, positive experience of birth. The HSCC heard that collection of central data on caesarean rates and the penalisation of maternity units with high rates had the potential to act as a perverse incentive to reduce C-section rates to the detriment of safety.

In 2021, NICE Guideline CG132 was updated to **NG192**. Whilst its recommendations have not changed significantly, they aim to clarify certain points that the committee felt were unclear or ambiguous in the 2011 guidelines.

We have taken the opportunity to update the Birthrights research and to consider the extent to which Trusts are now consistently providing compassionate, women-centred care for those requesting a caesarean section.

This research report is based on the results of a Freedom of Information (FOI) request made to 99 NHS Trusts across the UK on 28 May 2021 by Tees Law. It follows on from, but is completely independent to, the Birthrights 2018 report.

We hope this report will act as a stimulus for maternity care providers to not only ensure there are clear written guidelines that commit to helping a woman to make the right choice for themselves and their baby, but also to ensure this translates into practice, so women feel their views are respected and not pressured into a vaginal birth.

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Background

NICE Guideline CG132 (revised 2011)

In 2011, NICE Guideline CG132 was updated to recommend that women requesting a caesarean section without any medical indication should be offered appropriate discussion and support. If, after exploring and discussing the reasons for the request, the overall risks and risks associated both with caesarean birth and vaginal birth, the woman still requests a caesarean birth, a planned caesarean section should be offered. If the healthcare team were unwilling to carry out a caesarean birth, the woman should be referred to an obstetrician who will carry out the caesarean.

Whilst NICE Guidelines are not legally binding, there should be very good reasons for departing from them.

Montgomery

In 2015, in the case of ***Montgomery v Lanarkshire Health Board***, the Supreme Court ruling made it clear that patients must be aware of all options and that their healthcare professional must support them to make an informed choice.

Nadine Montgomery was small in stature and had type 1 diabetes, which increases the risk of a large baby and complications from a vaginal birth. Antenatally, she had raised concerns that her baby might be too big to be delivered vaginally. Evidence showed a 9-10% risk of dystocia where a diabetic woman gives birth via a vaginal delivery. It was accepted that shoulder dystocia can cause serious complications for mother and baby but that the risk of cerebral palsy was low at around 0.1%. Mrs Montgomery was not warned of the risk or offered a caesarean section as an alternative and indicated that had she been advised of the risks she would have opted for a caesarean section. The treating obstetrician gave evidence that she felt that she did not discuss the risks of shoulder dystocia with Mrs Montgomery as she did not believe a caesarean section was in her best interests. Mrs Montgomery's son was born with cerebral palsy as a result of shoulder dystocia during birth and she brought a legal claim. The Court awarded Mrs Montgomery's son over £5 million to meet his future needs.

The original Birthrights report

The 2018 Birthrights report highlighted instances where women reported feeling as though the risks of a caesarean section had been exaggerated. Meanwhile, the *"small but significant"* number of women who went on to suffer injuries during vaginal birth, for example perineal tears, felt as though they had not been sufficiently informed about these risks.

At the time Birthrights' research was published, UK Trusts should have been basing their policies and procedures relating to MRCS on the NICE Guideline CG132. However, the report revealed a highly inconsistent approach to MRCS across the UK, finding that:

- Just 26% of Trusts were compliant in their policies, procedures and attitudes in relation to MRCS
- 47% of Trusts had problematic or inconsistent policies or processes
- 15% of Trusts had policies or processes that explicitly did not support MRCS
- 11% of Trusts did not provide enough information to be categorised

Due to rounding, these percentages add up to 99 rather than 100%

NICE updates its guidelines

In March 2021, NICE revised its guidelines with respect to MRCS – NG192. Its recommendations have not changed significantly. However, the 2021 version makes it clear that perinatal mental health support should only be offered to women with tokophobia (a pathological fear of pregnancy) or severe anxiety about childbirth, and not to all women who have requested a caesarean section.

Why did we undertake this research?

We support more and more women who, despite requesting MRCS or expressing concern about a vaginal delivery, have been counselled in such a way that steers them towards a vaginal delivery. Many were entirely unaware that in the UK nearly 40% of women giving birth have an instrumental delivery or a caesarean section; that for first-time mothers, this rises to 50%; or that 4% of women suffer third or fourth degree tears during childbirth, which can lead to life-changing, long-term problems with bowel control and incontinence. Unfortunately, they have then gone on to endure a traumatic birth, with significant and often permanent chronic mental health and/or physical difficulties. In some cases, their babies may have suffered injury.

Therefore, our anecdotal experience suggested that notwithstanding the 2011 Guidelines (now revised), the case of *Montgomery* and the 2018 Birthrights report, many Trusts were still not empowering women in the area of MRCS through the provision of full and unbiased evidence about the risks associated with caesarean births, other interventions, vaginal birth, and/or respecting their decisions.

Birthrights has not repeated its 2018 study in subsequent years, and three years have now elapsed since its report was published. Prior to the publication of this report, there is no data we are aware of that seeks to establish whether policies and procedures in relation to MRCS have changed in response to Birthrights' 2018 findings. Nor is there any information relating to Trusts' responses to the revised NICE guidelines since their publication in March 2021.

This report therefore seeks to evaluate whether UK Trusts have evolved their policies and procedures relating to women's autonomy over their mode of birth and their right to request a caesarean section where they feel that this is the right choice for them. It focuses on those Trusts that were previously identified by Birthrights as failing to offer MRCS or partially offering/offering with concern to assess whether they are now doing so, and whether they have updated their policies and procedures in line with the 2021 recommendations.

Methodology

The 2018 Birthrights report classified all Trusts that responded to its FOI request into the following categories:

1. Offers MRCS
2. Partially offers or offers MRCS with concerns
3. Does not offer MRCS
4. Did not provide enough information to be categorised

We made an FOI request to 99 NHS Trusts in the UK on 28 May 2021. Trusts were selected for the study on the basis of their categorisation in Birthrights' 2018 report on MRCS, namely:

- Those identified as only partially offering MRCS or offering MRCS with concerns
- Those identified as not offering MRCS
- Those whose policy on MRCS was categorised as unknown
- Those that did not respond to Birthrights' 2018 FOI request

We did not seek information from those Trusts identified in the 2018 Birthrights report as already offering MRCS in line with NICE guidelines. We were interested to see how far policies on MRCS had developed in the last three years.

In the FOI request, 99 Trusts were contacted and asked the same three questions as were asked in the 2018 Birthrights FOI request, i.e.

1. How many maternal request caesareans were carried out in your Trust between April 2019 and April 2020 with no other significant medical, obstetric or psychological indication?
2. Do you have a written Trust guideline for Maternal Request Caesarean Sections (MRCS)? If so, please provide a copy of the written guideline.
3. Please confirm how your Trust complies with the revised NICE guideline [NG192], published in March 2021, in relation to points 1.2.25 – 1.2.31 on Maternal Request for Caesarean Section[1].

We also asked some additional questions as a point of further exploration as follows:

4. What were the total number of caesareans carried out in your Trust between April 2019 and April 2020[2]?
5. Do you have an explicitly stated policy not to offer Maternal Request Caesarean Sections (MRCS) in your Trust?
6. Do you require a compulsory mental health appointment in order for a Caesarean Section to be offered?
7. Do you have a policy which states the number of weeks into pregnancy the decision for a Caesarean Section would be made? If yes, please state the number of weeks.
8. Are there any other conditions which must be met in order to be offered a Maternal Request Caesarean Section (MRCS) in your Trust? If yes, please provide a copy of the conditions.

[1] This question was updated in light of the publication of the 2021 NICE guidelines.

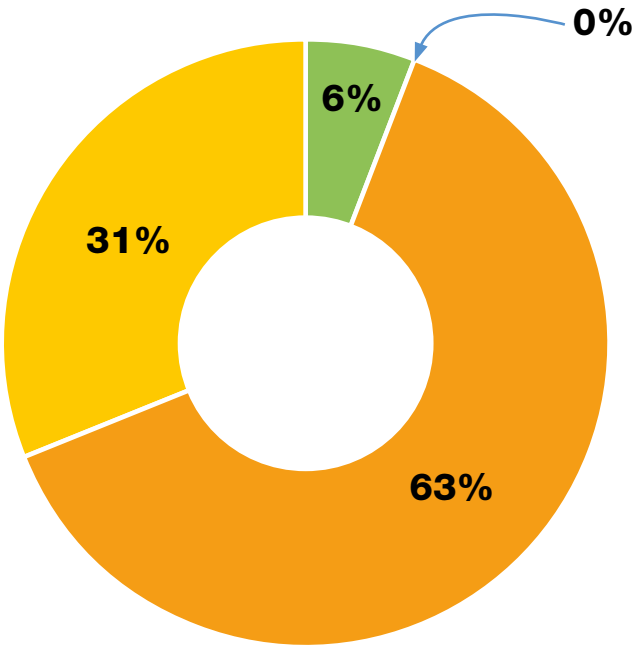
[2] This was intended to gauge the proportion of MRCS carried out as a percentage of the total number of caesareans during the period in question.

Summary of Results

Of the 99 Trusts contacted, 68 (69%) responded by the cut-off date of 30 June 2021. Trusts were given an additional two working days beyond the statutory deadline of 28 June 2021 (i.e. 20 working days as set out by the Freedom of Information Act 2000) to allow more time for their response. 24 Trusts responded after the deadline and seven Trusts did not respond, so these 31 Trusts were not included in this study.

Of the Trusts who responded to our FOI request:

- **6%** are offering MRCS
- **63%** are partially offering or offering MRCS with concerns
- **0%** do not offer MRCS
- **31%** did not provide enough information to be categorised



Analysis

We have attempted to classify those Trusts which responded to the 2021 FOI request according to the same criteria applied by Birthrights in 2018, i.e.

1. Trusts offering MRCS in line with NICE Guidance ("Green")

   These Trusts are (in the words of Birthrights' original report) "committed to the spirit of the NICE guidance".

   A number of Trusts would in fact have been categorised as Green, but for the fact that their guidelines were under review / had not yet been updated in line with the NICE 2021 Guidance, for example, to explicitly facilitate access to the planned place of birth during the antenatal period for those providing perinatal health support.

2. Trusts partially offering or offering MRCS with concerns ("Amber")

   These Trusts meet at least one of the following criteria (as outlined in the 2018 Birthrights report) and have been placed in the Amber category:

- Trusts that said they offer MRCS but had no written guideline.
- Trusts that said they offered MRCS but had carried out none between April 2019 and April 2020 (if the Trust had over 2000 births per year)[3].
- Trusts that had a policy to request a second opinion but it was unclear what would happen if the second opinion was a 'no'.
- Trusts that always required the permission of two consultants.
- Trusts that mentioned referring women to another hospital as part of their process.
- Trusts that seemed to have an incomplete guideline (for example, where the guideline only dealt with maternal request caesarean section stemming from a mental health issue).
- Trusts where the policy was not to make a decision until after 36 weeks.
- Trusts where the CS would not be scheduled until after 40 weeks.
- Trusts where there was any other concern about the policy/process described.

3. Trusts do not offer MRCS ("Red")
4. Trusts did not provide enough information to be categorised ("White")

We have relied on the responses and, if provided, MRCS guidelines to categorise Trusts. A proportion of the responses received back from Trusts contained qualitative, rather than purely quantitative, data. As a result, the categorisation of Trusts in the below analysis is subjective to some degree and a result of careful interpretation of the data. All the information provided to us by Trusts has been made available on our website so that individuals can consider this and form their own view.

Of the 68 responses we received, 17 (25%) explicitly stated their compliance with NICE 2021 guidelines. However, on careful analysis, we concluded that four Trusts (6%) offer MRCS. These Trusts demonstrated that where a woman, with no medical indication, requests a caesarean birth, they were offered the opportunity to explore the reasons for this, and to discuss the overall benefits and risks of a caesarean birth compared with a vaginal birth. If the woman has tokophobia or other severe anxiety about childbirth, they are offered a referral to a healthcare professional with expertise in providing perinatal mental health support to help with the anxiety and that the healthcare professional has access to the planned place of birth during the antenatal period into order to provide care. If a vaginal birth is still not an acceptable option after discussion of the benefits and risks and offer of support, a planned caesarean section should be offered. If the healthcare team are unwilling to offer this, the woman should be referred to an obstetrician willing to perform a caesarean birth.

We concluded that 43 Trusts (63%) partially offer or offer MRCS with concerns. The reasons for Trusts being placed into this category were multifactorial. The most common reasons were: the Trust did not have a written guideline; or the Trust did not have an unequivocally clear policy that if the current healthcare team were unwilling to offer a caesarean birth, the woman would be referred to an obstetrician willing to perform a caesarean birth. Although 43 Trusts were placed in the Amber category, there is a broad spectrum within this category – some Trusts were on the cusp of being classified Green.

[3] Trusts that stated they did not track MRCS data in the present report will be deemed to have met this criterion.

For example, several Trusts which appeared to have a very good pathway for MRCS as judged by the 2018 NICE Guidelines, have been categorised as Amber as their MRCS policy did not demonstrate that women with tokophobia or other severe anxiety about childbirth were offered referral to a perinatal mental health specialist and underlined that healthcare professionals providing perinatal mental health support had access to the planned place of birth during the antenatal period to provide care as per the updated 2021 NICE Guidance. Such Trusts included Cwm Taf Morgannwg University Health Board, Southport and Ormskirk Hospital NHS Trust and the Princess Alexandra Hospital NHS Trust.

Conversely, there were many Trusts who are in this category, despite confirming in varying terms that they do not offer a caesarean section to women based on maternal choice alone.

For example:

If there are no identifiable factors that increase the risk of vaginal birth then caesarean section will not be offered routinely as a birthing option.

(Royal Free London NHS Foundation Trust)

If after discussion and offer of support […] a vaginal birth is still not an acceptable option, a planned caesarean should be considered.

(University Hospitals Dorset)
NB: considered rather than offered.

Maternal request alone is not an indication for LSCS.

(University Hospitals Sussex NHS Foundation Trust)

CS is not routinely offered for maternal request. The reasons behind the request should be fully explored, discussed and documented. Alternative solutions should be explored. […] High BMI (>50) alone is not an indication for planned CS.

(University Hospitals of North Midlands NHS Trust)

Maternal request is not on its own an indication for CS and specific reasons for the request should be explored, discussed and recorded...

(Yeovil District Hospital NHS Foundation Trust)

Responses such as these appear to be at odds with the NICE 2011 and 2021 Guidance. The phrase “Maternal request on its own is not an indication for caesarean section” is historic and dates back to the 2004 NICE Guidance. However, subsequent guidance appears to imply that provided women have been advised of the risks and benefits, and are making an informed choice, then maternal request is an indication for caesarean birth. However, the above Trusts did not have an explicit policy not to offer MRCS and, in some cases, provided data to suggest that at least some MRCS were undertaken in the period in question. Therefore, these were categorised Amber, rather than Red.

None of the Trusts (0%) who responded had an explicitly stated policy not to offer MRCS.

There were a number of Trusts (21) that we felt unable to categorise as they did not provide enough information. This includes some Trusts who, in 2018, were assessed by Birthrights as partially offering or offering MRCS with concerns; however, we felt that they had provided insufficient information in response to our 2021 FOI request to enable them to be fairly categorised. Several Trusts in this category stated that they were fully compliant with the NICE Guidelines, but, in our view, did not provide sufficient evidence to demonstrate this. In some cases, guidelines were referenced in Trusts’ replies, but not provided on request. In other cases, Trusts responded that their policy was presently under review and provided insufficient information to us on their current policy to be categorised. Although providing insufficient information overall to be categorised, some gave responses which were of concern.

For example:

The Trust does not say it does not offer, but we do not offer Lower Segment Caesarean Section (LSCS) as an option without indication.

(George Eliot Hospital NHS Trust)

We DO offer LSCS (Lower Segment Caesarean Section) for maternal request, but only in certain cases

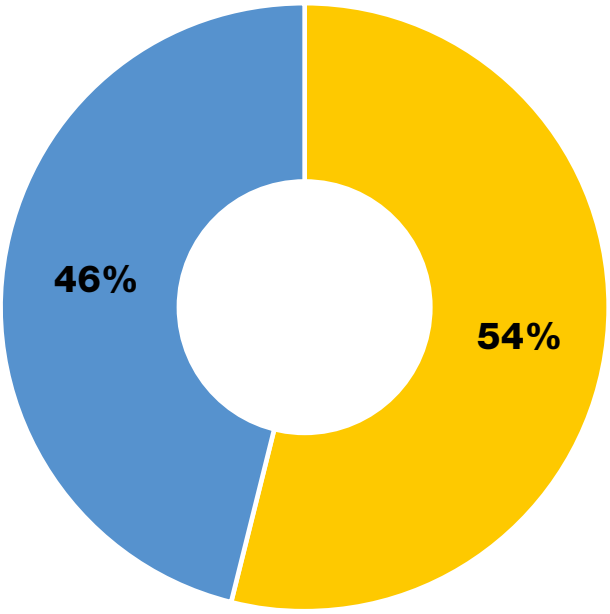
(Salisbury NHS Foundation Trust)

Digging into the Detail

How many Trusts had a written guideline for MRCS?

Of the 68 Trusts that responded:

- 37 **(54%)** said they have an MRCS policy or guideline in place.
- 31 **(46%)** said that they do not have an MRCS policy or guideline in place or did not provide details of the policy.
- **Of the 37 above, 15 stated that their policies relating to MRCS are under review in light of the revised NICE guidelines.**



Do the Trusts track data for MRCS?

Of the 68 Trusts that responded:

- 69% of Trusts track and have provided the number of MRCS carried out
- The average number of MRCS carried out by these Trusts was 118, the lowest being 0 and the highest nearly 800
- 31% of Trusts say that they do not track MRCS, or that the information is not centrally held.

What proportion of overall caesarean births are MRCS?

Of the 47 Trusts that track MRCS data:

- MRCS represent between 1% and 10% of all caesarean births in 41 of the 47 Trusts during the period in question
- Around two thirds of the 47 Trusts are seeing a rate of 2% to 7% of MRCS against all caesarean sections
- Six Trusts are reporting data indicating that they performed more than 10% of MRCS during the period in question.

Do Trusts require a compulsory mental health appointment in order for MRCS to be offered?

Of the 68 Trusts that responded:

- 2 (3%) explicitly state that a mental health appointment is compulsory for women suffering from anxiety about childbirth or tokophobia to be offered a caesarean section
- 7 (10%) state that a mental health appointment is offered to women suffering from anxiety about childbirth or tokophobia (this includes those that referred to their compliance with NICE guidelines) but do not state that it is compulsory to be offered a caesarean section
- 8 (12%) state that mental health support is offered to women dependent on their situation, but is not compulsory to be offered a caesarean section
- 51 (75%) state that a mental health appointment is not compulsory to be offered a caesarean section but provided no further details.

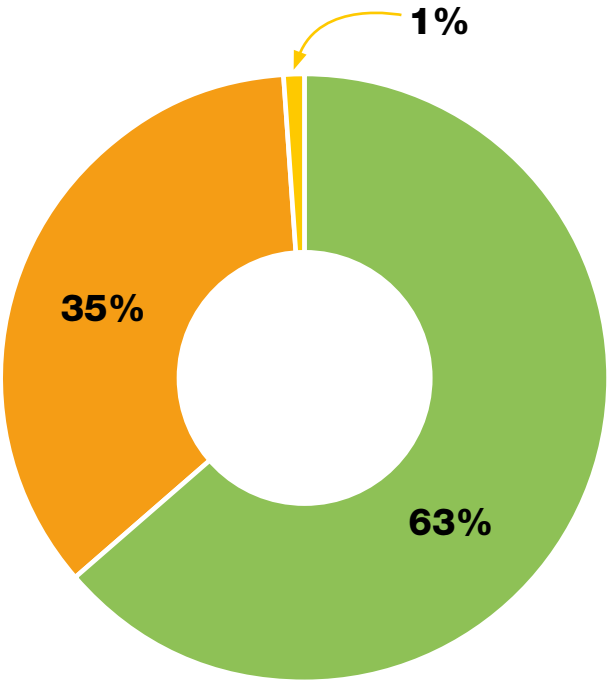
Other conditions for a MRCS to be offered?

Some answers were difficult to interpret/categorise; for example, 'discussions with health practitioners' may potentially overlap with 'referral to another obstetrician for a second opinion'. The 'colleague' could be a second obstetrician or some other health practitioner.

Of the 68 Trusts that responded:

- **43 (63%)** state there were no other conditions to be met for MRCS, other than counselling and/or discussions with health practitioners (as per NICE guidelines).
- **24 (35%)** require that two obstetricians agree or that the woman be referred to another obstetrician for a second opinion.
- **1 (1%)** states that MRCS will be considered where the risk is deemed to be equivalent to, or the risks (including to mental health and wellbeing) are outweighed by, those of a vaginal birth.

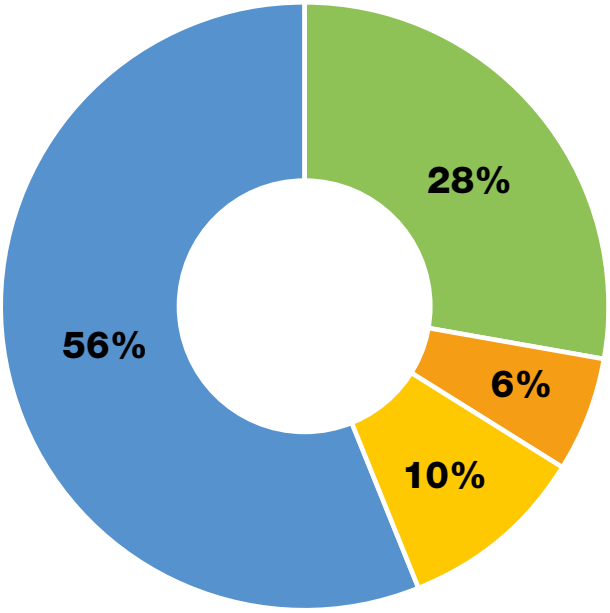
Due to rounding these percentages add up to 99 rather than 100%



When is the decision for MRCS made?

Of the 68 Trusts that responded:

- **19 (28%)** gave a number of weeks into pregnancy at which the decision would be made, which ranged anywhere from 16 to 39 weeks, with the median number of weeks being 36
- **4 (6%)** confirmed that the decision could be made at any point in the pregnancy
- **7 (10%)** did not state a number of weeks into pregnancy at which a decision would be made, but stated that MRCS should be scheduled for 39+ weeks' gestation and/or referred to guidelines stipulating the same
- **38 (56%)** said they had no policy and offered no further information.



Conclusions

Our report has found that, since the 2018 Birthrights research, there has been improvement across 15 Trusts, with 4 Trusts now offering MRCS without concerns and 11 Trusts being re-categorised as partially offering MRCS or offering MRCS with concerns where previously their policy was either unknown or they did not offer MRCS.

However, whilst there have been some improvements, Birthrights' summary of the situation in 2018 still holds true for many of the women who request elective caesarean sections in Trusts across the UK. 43 of the 68 Trusts responding to our 2021 study are deemed to be *'offering MRCS with concerns'*. Taking into account those Trusts who did not provide sufficient detail to the request for information in order to be categorised, and/or who did not reply to our FOI request and/or replied late, but who were previously deemed by Birthrights as offering MRCS with concerns, this figure could actually be much higher.

Our findings are set against a backdrop of maternity scandal after maternity scandal across UK Trusts and the recent **report published by the Health and Social Care Select Committee** into the Safety of Maternity Services in England. The HSCC recognised that the government's progress towards providing personalised care is *"inadequate"*; that personalisation must go hand in hand with safety; and that women must be fully and impartially informed about the safety risks associated with all birthing options. That report's recommendation included a number of steps in the right direction:

- maternity services no longer use the term 'normal birth'
- NHS England and NHS Improvement establish a working group "to develop a set of actions for maternity services to consider in order to ensure no woman feels pressured to have a vaginal delivery and is always informed clearly what the safest option is for her birth".
- an immediate end to the use of total caesarean section percentages as a metric for maternity safety.

It is positive that an IDECIDE tool is being developed to establish better choice and consent procedures to ensure that women have access to full and unbiased evidence about the risks associated with caesarean births, other interventions and vaginal births.

However, technology alone is not the answer – there has to be an opportunity for women to be able to engage with those caring for them. This means making time and space for meaningful conversations from an early stage and that takes clinical time and resources.

We would like to see a single MRCS Guideline adopted and implemented by all Trusts to ensure compliance with NICE Guideline NG192 and consistency for women who feel a caesarean birth is the right option for them. This will address the postcode lottery, provide certainty and clarity for women at a vulnerable time, and promote a woman-centred approach.

The task of ensuring that all women have autonomy over their mode of birth is clearly far from over. It is vital that women are fully supported to come to an informed conclusion about how they would like their baby to be delivered, and for Trusts to respect that choice.

Appendix 1: List of Trusts

Trusts Offering MRCS

- Blackpool Teaching Hospitals NHS Foundation Trust
- Frimley Health NHS Foundation Trust
- Gateshead Health NHS Foundation Trust
- Peterborough City Hinchingbrooke Hospital (North West Anglia NHS Foundation Trust)

Trusts that partially offer or offer MRCS with concerns

- Aneurin Bevan University Health Board
- Barts Health NHS Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Buckinghamshire Healthcare NHS Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Croydon Health Services NHS Trust
- Cwm Taf Morgannwg University Health Board
- Dorset County Hospital NHS Foundation Trust
- East Kent Hospitals University NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- East Suffolk and North Essex NHS Foundation Trust
- Grampian Health Board
- James Paget University Hospitals NHS Foundation Trust
- Kettering General Hospital NHS Foundation Trust
- King's College Hospital NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- Lewisham and Greenwich NHS Trust
- Liverpool Women's NHS Foundation Trust
- Medway NHS Foundation Trust
- NHS Ayrshire & Arran
- NHS Forth Valley
- North Tees and Hartlepool NHS Foundation Trust
- Portsmouth Hospitals University NHS Trust
- Royal Free London NHS Foundation Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust
- South Tyneside and Sunderland NHS Foundation Trust
- Southport and Ormskirk Hospital NHS Trust
- Stockport NHS Foundation Trust
- Swansea Bay University Health Board
- The Princess Alexandra Hospital NHS Trust
- The Shrewsbury and Telford Hospital NHS Trust
- The Royal Wolverhampton NHS Trust
- University Hospital Southampton NHS Foundation Trust
- University Hospitals Bristol and Weston
- University Hospitals Dorset
- University Hospitals of Leicester NHS Trust
- University Hospitals of North Midlands NHS Trust
- University Hospitals Sussex NHS Foundation Trust
- Western Health and Social Care Trust
- Worcestershire Acute Hospitals NHS Trust
- Yeovil District Hospital NHS Foundation Trust

Trusts that did not provide enough information to be categorised

- Airedale NHS Foundation Trust
- Belfast Health and Social Care Trust (Northern Ireland)
- Betsi Cadwaladr University Health Board (BCUHB)
- Borders NHS Board
- Calderdale & Huddersfield NHS Trust
- Cardiff and Vale University Health Board
- Doncaster & Bassetlaw Teaching Hospitals
- Fife NHS Board
- George Eliot Hospital NHS Trust
- Greater Glasgow NHS Board
- Highland NHS Board
- Hywel Dda University Health Board
- Lanarkshire NHS Board
- Milton Keynes University Hospital NHS Foundation Trust
- NHS Orkney
- North Cumbria Integrated Care NHS Foundation Trust
- Royal United Hospitals Bath NHS Trust
- Salisbury NHS Foundation Trust
- Tayside NHS Board
- The Hillingdon Hospitals NHS Foundation Trust
- Whittington Health NHS Trust

Trusts which responded after the deadline

- Bedfordshire Hospitals NHS Foundation Trust
- Dartford and Gravesham NHS Trust
- East and North Hertfordshire NHS Trust
- Great Western Hospitals NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust
- Hampshire Hospitals NHS Foundation Trust
- Hull University Teaching Hospitals NHS Trust
- Kingston Hospital NHS Foundation Trust
- London North West University Healthcare NHS Trust
- Newcastle Upon Tyne Hospitals NHS Foundation Trust
- Northampton General Hospital NHS Trust
- Northern Health and Social Care Trust (Northern Ireland)
- Northumbria Healthcare NHS Foundation Trust
- Royal Berkshire NHS Foundation Trust
- Royal Cornwall Hospitals NHS Trust
- Sandwell and West Birmingham Hospitals NHS Trust
- Torbay and South Devon NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- University College London Hospitals NHS Foundation Trust
- University Hospitals of Derby and Burton
- Warrington and Halton Teaching Hospitals NHS Foundation Trust
- West Hertfordshire Hospitals NHS Trust
- Wirral University Teaching Hospital NHS Foundation Trust
- York Teaching Hospital NHS Foundation Trust

Trusts which did not provide a response

- Barking, Havering and Redbridge University Hospitals NHS Trust
- Barnsley Hospital NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Imperial College Healthcare NHS Trust
- Mid and South Essex NHS Foundation Trust
- North Middlesex University Hospital NHS Trust
- Oxford University Hospitals NHS Foundation Trust

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