

**Appendix**

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

# Board of Directors

**28th September 2016**

**Legal, Regulatory and Policy Update**

**For: Information**

**Executive Summary**

This is the monthly report to inform the Board of Directors on recent regulation and compliance guidance issued by bodies such as Monitor, the Care Quality Commission, NHS England, NHS Trust Development Authority and other relevant bodies where their actions have a consequential impact on the Trust or an awareness of the change/impending change is relevant to the Board of Directors. This report covers the period from August 2016 to mid-September 2016 and includes noteworthy contributions covered in the media and by health think tanks.

The Update Report is designed to reflect changes in legislation, guidance, the structure of the NHS, and government policy and direction on health and social care. A summation of the change is provided as an introduction for each item. The Board of Directors is asked to consider and note the content of the report and where relevant, members should each be satisfied of their individual and collective assurances that the internal controls in place to deliver compliance against the Trust’s obligations are effective. Chairs of Board Committees should consider whether more detailed assurances relevant to their committees, are necessary, utilising this report as a constructive stimulant to inform the composition of meeting agendas and reporting focus as necessary or appropriate.

The Director of Corporate Affairs will make certain Executive Directors are aware of the changes relevant to their portfolios and will take forward any key actions arising from the Legal, Regulatory and Policy Updates. Progress updates on any relevant actions will be reported to the Board of Directors, as pertinent and appropriate.

The Director of Corporate Affairs will continue to develop or enhance internal control mechanisms to support the Trust in complying and being able to evidence compliance with relevant mandatory frameworks/obligations.

**Author: Kerry Rogers, Director of Corporate Affairs and Company Secretary**

**ADDENDUM TO CHIEF EXECUTIVE REPORT**

**LEGAL, REGULATORY AND POLICY UPDATE REPORT**

**1 PURPOSE OF REPORT**

This report provides an update to inform the Board of Directors on recent regulation and compliance guidance issued by such as Monitor, NHS England, the Care Quality Commission, NHS Trust Development Authority and other relevant bodies where their actions have a consequential impact on the Trust or an awareness of the change/impending change is relevant to the Board of Directors.

Proposals regarding any matters arising out of the regular Legal & Regulatory Update report will be received by the Executive Team Meeting to enable the Trust to respond as necessary or helpful to consultations and to ensure preparedness for the implications of, and compliance with changes in mandatory frameworks.

**2 LEGAL/POLICY/NEWS UPDATES**

**2.1 Trusts’ finances on track but ‘nasty surprise’ predicted for later in year**

Most hospital trusts are currently forecasting to meet their financial target for 2016/17, but experts have warned of a “nasty surprise” later in the year. In providers’ finance reports covering the three months to June, more than three-quarters of acute trusts have predicted they will meet their “control total” set by NHS Improvement for the year. With most trusts forecasting to meet or get close to their control total, regulators may see the figures as evidence of the impact of stricter financial controls and efficiency measures, however doubts have been raised about providers’ ability to meet the controls, and several trust sources said they expect their position to worsen significantly over the rest of the year. Nuffield Trust senior policy analyst, Sally Gainsbury, said: “People are now talking about a ‘big reveal’ around January [2017] when we could get a nasty surprise about the real deficit.” NHS Providers chief executive Chris Hopson said: “On one hand this is good news but we are slightly nervous about the rest of the year. The normal trajectory is for providers to miss their plans in quarter one and then recover their positions. But we think there are different incentives operating and people will be very keen to show how on track they are in the first three quarters of the year. People won’t want to miss their numbers and lose access to the STF money.

<https://www.hsj.co.uk/topics/finance-and-efficiency/exclusive-trusts-finances-on-track-but-nasty-surprise-predicted/7009937.article>

**2.2 Agency cap set to save NHS up to £800m in first year**

NHS Improvement has said the cap on agency rates for temporary staff in the NHS is expected to save up to £800m in its first year. The regulator has also shared incident data reported by trusts when they believe the cap has led to patient harm or service closure. It shows two incidents of potential harm since the cap was introduced in November; 23 incidents with no harm; and 11 incidents of service closure. An average of 214 trusts – 90% – breached the cap on the grounds of patient safety each week during quarter one of 2016-17, however the overall number of price cap breaches fell by 8% during the first quarter of 2016-17. NHS Improvement director of economics, Chris Mullin, said: “The messages we keep getting back from trusts is that the price caps are challenging but are very helpful overall. We have seen no systematic evidence to show that the agency caps have had any net overall effect on supply.” He added that the cap had delivered £300m of savings in its first six months, £500m by August, and was expected to save £700m-800m in its first year.

<https://www.hsj.co.uk/topics/policy-and-regulation/agency-cap-expected-to-save-nhs-up-to-800m-in-first-year/7009918.article>

**2.3 NHS under pressure to review contracts with Priory group**

The Times reported that NHS bosses are under pressure to review tens of millions of pounds in contracts with the Priory group after an investigation revealed concerns about patient deaths and standards of care at some clinics. The Priory is now the largest mental health provider in Britain, however it is not subject to the same transparency rule as NHS-run hospitals because as a private enterprise it is not covered by the Freedom of Information Act. Although the Priory successfully treats thousands of vulnerable patients each year, experts are concerned that this transparency loophole hinders scrutiny when things do go wrong. A Times investigation found: at least 10 patient deaths since 2012 over which the Priory group was heavily criticised at inquests; safety concerns about 12 Priory hospitals in England raised by Watchdogs; anonymous employee allegations of staff shortages in some hospitals and a lack of specialised health and safety training in others. Sarah Woollaston, chair of the parliamentary health committee, said: “It is absolutely essential where services are contracted out to the private sector that there is clear transparency. The government needs to ensure that private health companies are held to the same standards of transparency when it is clearly in patients’ interests.”

<http://www.thetimes.co.uk/article/nhs-comes-under-fire-over-millions-spent-on-priory-clinics-to-the-stars-9fk70t8qw>

**2.4 Health chiefs warn doctors are leaving for EU already**

The Times reports that leading hospitals have warned that medical expertise in areas from cancer treatment to brain surgery will be damaged by an exodus of European staff following Brexit. Hospitals say that some European doctors and nurses are already leaving the NHS, threatening specialist care that relies on them and potentially putting patients at risk. A quarter of the doctors in some specialist hospitals come from the EU and because they have rare skills they could not be replaced by British staff. In a letter to the Times the Federation of Specialist Hospitals has urged the government to guarantee European staff that their future in the NHS is secure so that patients do not suffer. They write: “Our ability to provide exceptional care to patients hinges on recruiting and retaining the best clinical talent from the UK and further afield. In the wake of the EU referendum result our greatly valued European colleagues are understandably feeling uncertain about what the future holds for them in this country. Indeed, one or two have already left and, as things stand; more will be heading in the same direction with little return traffic.”

<http://www.thetimes.co.uk/article/doctors-are-leaving-for-eu-already-health-chiefs-warn-nzgwtb6s6>

**2.5 Language tests for medics ‘not stringent enough’**

Leading medics have said patient safety could be at risk because doctors, nurses and dentists from elsewhere in Europe are not facing stringent enough language tests. According to data obtained by the Royal College of Surgeons, in only one year, 29 medics from the European Economic Area faced allegations of “inadequate knowledge of English language”. By contrast, the figures show that only 10 doctors from outside the EEA faced the same accusations during 2014/15. Under current EU rules, doctors coming to Britain from the EEA only have to show they have general English skills, while those arriving from further afield have to prove their language abilities in a clinical context. The RCS said that Brexit negotiations pose an “excellent opportunity” to ensure language checks are up to scratch. Professor Nigel Hunt, dean of the faculty of dental surgery at the RCS, said: “While the professional regulators are able to require proof of the clinical language skills of non-EU applicants, the same checks do not apply to EEA applicants and our fear is that this could be putting patients at risk. We want the same rules to apply to all non-UK professionals, regardless of where in the world they come from.

<https://www.theguardian.com/society/2016/aug/17/patient-safety-at-risk-because-language-tests-for-medics-not-stringent-enough>

**2.6 Department of Health warned about ‘fragmentation’ of NHS procurement system**

Supply chain experts have warned that plans from the Department of Health to change the way the NHS buys goods could result in the “fragmentation” of the procurement system. The Health Care Supply Association, which represents NHS procurement staff, has said the “whole supply chain is being put at risk” by the proposals. Under the DH’s “future operating model”, when the current NHS Supply Chain contract with DHL ends in October 2018, the procurement system will be split into 11 “category towers” with each covering a different category of goods, and private companies and NHS procurement hubs will be invited to bid to run these towers. If they win a contract, they will be responsible for carrying out tenders on behalf of the NHS for the category of goods covered by that tower. However, there are concerns that the creation of towers operated by multiple providers will cause confusion among trust procurement staff about who is responsible for what, and prevent the NHS from getting better deals by putting different types of good into a single tender. The HCSA called on the DH to “urgently evaluate the benefits of a further extension to the contract in order to maintain the momentum of these savings initiatives”.

<https://www.hsj.co.uk/topics/finance-and-efficiency/dh-warned-about-fragmentation-of-nhs-procurement-system/7009953.article>

**2.7 People with dementia are being let down by local services across the country**, according to new government data that critics say has revealed a postcode lottery in care for the chronic and degenerative brain disease. An interactive “dementia atlas”, published online by the Department of Health, shows that standards of care vary widely in different areas, with services failing to reach almost half the patients for check-ups even once a year in one area.

Jeremy Hunt, the health secretary, said the data would “shine a spotlight” on the areas with the worst performance, and so drive improvements across the country. But political opponents said it revealed a healthcare system struggling to stay afloat. The Liberal Democrat health spokesperson, Norman Lamb, said: “This is yet more evidence of the NHS and the care system on its knees. We are the sixth largest economy in the world and yet we are letting down very vulnerable people in a completely unacceptable way.”

The information exposes wide differentials in aspects of dementia care. For example, while in some parts of England, 85.8% dementia patients have their care looked at every year, in others just 49.3% receive the same service. Those checks are seen as important because, as dementia is a long-term and degenerative condition, “reviewing those with a diagnosis at least annually will ensure that the needs of people with dementia and their carers are discussed and appropriate care plans can be implemented”, the atlas says.

Similarly, while some areas have as many as 8,000 “dementia friends” available to help patients, others have none at all. There is also a more than three-fold variation in the number of those with dementia being admitted to hospital as an emergency. That ranges from 1,840 for every 100,000 people aged 65+, to as many as 6,046 for every 100,000.

“Making more user-friendly information on dementia accessible online is a step in the right direction,” said George McNamara, head of policy and public affairs at Alzheimer’s Society. “People can now see which parts of the country are leading the way with developing dementia-friendly communities, and how many dementia friends there are in each area.” However, the atlas should be expanded to become even more useful by including the experiences people with dementia have had of the health and care systems, in order to enable NHS bosses to make improvements in areas which are lagging behind, McNamara added.

To make hospitals more transparent and accountable, they are calling for trusts to publish an annual statement on dementia care. The health secretary is also seeking to improve NHS early diagnosis of dementia by ensuring that people aged between 40 and 64 are asked about it when they have an NHS health check. The new component of the health check will now be trialled through more than 250 GP surgeries in four places: Birmingham, Bury, Manchester and Southampton.

<https://www.theguardian.com/society/2016/aug/16/new-care-atlas-reveals-disparity-in-dementia-care-across-uk>

**2.8 NHS failure on medicine prices costs £125m**

According to a cache of emails seen by the Times, NHS officials approved medicine price rises of up to 600% with no questions asked. Health staff queried the “large difference” in prices set by the British company AMCo, but merely asked for confirmation that the changes were correct. The new prices for just 54 medicines cost the NHS an extra £125 million last year, which included eye drops which were raised by 243% and an anticoagulant called phenindione, which rose by almost 200%. Health secretary Jeremy Hunt has previously pledged to take action on drug companies, with the Department of Health warning that “no pharmaceutical company should be exploiting the NHS”. The Times says the hundreds of pages of emails released under freedom of information laws now reveal the extent of government complicity in the price-rising, while Hunt has failed to stop the tactics. AMCo said that it had not put up its prices since June, and added that the generic medicines industry saved the NHS more than £13 billion a year.

<http://www.thetimes.co.uk/article/nhs-failure-on-medicine-prices-costs-public-125m-j2jtb02xw>

**2.9 The number of days patients are spending in hospitals due to so-called “bed blocking” is at its second-highest figure on record.**

New data for England has revealed that people occupying beds when they no longer needed care took up a total of 171,298 days in June. It marks a considerable rise of more than 30,000 days on June 2015, during which 139,538 days were taken up by the delays. But NHS England said that, although the figure was still “significant”, it had decreased on the previous month, when it hit a record high.

Figures show that major hospitals in England are failing to see almost one in seven patients within four hours, as medics warn that emergency staffing has reached crisis levels. New statistics for June reveal that nearly 15% of people in larger A&E departments and almost 10% of people in all hospitals are not discharged within what is considered the expected time. The target of seeing 95% of patients within four hours has not been hit by an A&E at any major hospital since July 2013.

It comes the day after the Royal College of Emergency Medicine warned that a gap between supply and demand for emergency doctors was leading to a “real crisis”. NHS England defended the figures, saying they showed “another improvement in performance” at a time when “frontline services continue to come under intense pressure”.

But a number of other key targets were missed by the health service – including on ambulance response times and cancer waiting times. Hospitals across the country have been blighted by disrupted services in the wake of funding cuts. A national shortage of emergency doctors led the Grantham and District Hospital in the East Midlands to announce it was to temporarily close its doors at night. St Helens clinical commissioning group caused outcry after suggesting financial demands could lead it to ban all non-vital operations for four months.

The Department of Health said that despite shortages in specific A&Es, there were 1,250 extra doctors working in emergency departments compared with 2010. A spokesman said: “The NHS had its busiest June ever but hospitals are performing well, with nine out of 10 people seen in A&E within four hours – almost 60,000 people per day seen within the standard.”

<https://www.theguardian.com/society/2016/aug/11/british-medical-association-call-for-action-on-bed-blocking>

**2.10 Mental health target being ignored**

Some mental health patients in England are being denied timely treatment promised by the government, according to the BBC. Freedom of information figures suggest a quarter of clinical commissioning groups are ignoring the target to provide intensive treatment within two weeks, which was introduced in April 2016 to give mental health the same referral priority as cancer. NHS England says it is investing more money in services to help meet demand. The waiting-time target requires that any patient aged 14 to 65 experiencing their first episode of psychosis receives treatment within two weeks of referral. But the FOI request, sent to the 209 CCGs in England by the Liberal Democrats, reveals that in some areas this is not happening. Of the 170 CCGs that responded, 23% said they had applied the target to 14- to 35-year-olds only, and more than three-quarters of those had no firm plans to extend it to 35- to 65-year-olds this year. About 64% of the CCGs that responded did not or could not say what they were spending on early intervention in psychosis, while 32% could not say what their overall planned spending on EIP would be this year. Liberal Democrats health spokesman Norman Lamb said: “It shows that across the country people are not getting the evidence-based treatment set out in the programme.”

<http://www.bbc.co.uk/news/health-37022701>

**2.11 Trusts failing to report hundreds of mental health patient deaths to coroners**

Discrepancies in official data, reveal that hundreds of patients who died while being detained under the Mental Health Act could have been denied inquests. By law all deaths in state detention should be examined by a coroner, however inconsistencies between official data on deaths reported to coroners in England and Wales and notifications sent to health regulators by NHS trusts suggest coroners may not have conducted inquests into every death. According to data held by the Ministry of Justice, between 2011 and 2014 a total of 373 deaths of people detained under the Mental Health Act were reported to coroners in England and Wales. In contrast, data compiled over the same period by the Care Quality Commission and Health Inspectorate for Wales, and supplied to the government’s Independent Advisory Panel on Deaths in Custody, reveal a total 1,115 deaths – 742 more than was reported to coroners. The Department of Health said all deaths in detention should be properly investigated and while some differences in data could be explained by different methods of recording, it accepted that it could not rule out the risk that some patients and families had been denied inquests. Charity leaders said they were shocked at the inconsistent data and said more needed to be done to ensure openness around deaths in state custody.

<https://www.hsj.co.uk/topics/policy-and-regulation/exclusive-trusts-fail-to-report-hundreds-of-mental-health-patient-deaths-to-coroners/7009813.article>

**2.12 Promises, platitudes and plans are piling up for mental health, but how much is going to be delivered?**

Mental health accounts for roughly £12bn of the NHS budget. In parliamentary terms the current support for mental health is unprecedented – parity of esteem with physical health services is enshrined in the Health and Social Care Act 2012, plus last year’s spending review made explicit reference to improving quality, choice and outcomes in mental health. But a recent report by the health select committee on the impact of the spending review on health and social care was sceptical about whether the rhetoric is being matched by actions. The committee called for verifiable evidence that the additional cash promised to mental health was reaching the front line, and that the cultural change necessary to deliver parity of esteem was happening.

The NHS planning guidance for 2016-21 instructs clinical commissioning groups to increase investment in mental health at least at the level which matches their overall spending increase, but whether this is being done is disputed. NHS clinical commissioners insisted to MPs that this is happening while NHS Providers maintained the money is not coming through. It even accused commissioners of using “weird and wonderful calculation methodology” to justify their claims.

The government has made specific promises: more cash for young people with eating disorders, a “system-wide transformation” of children and young people’s mental health and perinatal mental health, and improved access to psychological therapies. But it is far from clear how the money for this will avoid being dragged into the black hole of the acute sector’s deficit.

Even if these promises are delivered, they are still largely focused on crisis management. The big win will come when services routinely support people who are at risk of mental illness before they reach crisis. This is a long way off. NHS England has just published its implementation plan for the mental health Five Year Forward View. It sets some impressive targets, such as treating at least 70,000 additional children and young people each year from 2020-21. The scale of the task is becoming clearer, but it is daunting.

This target illustrates the enormity of the change being envisaged. For example, inappropriate use of inpatient facilities needs to be eliminated and a drastic increase in community-based support for eating disorders is needed to reach it. At least 1,700 more therapists and supervisors will be required. **Local plans to deliver this are supposed to be in place by October.**

But delivering national goals on mental health requires transformation well beyond the borders of the NHS. As the Mental Health Foundation points out in its guidance on population-based mental health care, many of the people most at risk of self-harm or suicide are in contact with the police or in prison.

Police forces across the country feel they are routinely left to deal with dangerous mental health crises because of failures in NHS care. Suicides in prison are now their highest for at least 25 years – 100 in 12 months – that’s one death every three to four days. Much closer working with police and prison services is just one of the changes in culture that ‘“parity of esteem” for mental health requires, alongside massive investment in prison services and facilities.

In the West Midlands, local government is providing leadership on mental health with a commission set up by the region’s combined authority, chaired by the MP and former Liberal Democrat health minister Norman Lamb. It is assessing the scale of mental health problems and identifying good practice nationally and internationally in areas such as suicide prevention, with the aim of driving through reforms to the way public services are delivered based on sound evidence of the costs of mental illness and the benefits of tackling it.

It is a huge objective, but the ambition is there and Lamb is clearly determined to make things happen. The scale of the task of improving mental health is at least becoming clearer, but it is daunting. It means getting into every school, prison, workplace and custody suite. The commitment is growing, but the capacity and the investment are still a long way short.

<https://www.theguardian.com/healthcare-network/2016/jul/29/commitments-mental-health-all-talk-no-action>

**2.13 Confederation chief says tracking money ‘acid test’ for £4bn mental health plans**

Former Mental Health Network chief executive Stephen Dalton – currently interim chief of the NHS Confederation – has said that guaranteeing promised funds reach frontline services will be the “acid test” for NHS England’s mental health plans. He added that unless there was a transparent and independent process to track the money so the public could see it was going to the services it was promised to, the plans would be an “abject failure”. Last month, NHS England pledged £3.97bn of planned investment in mental health services by 2020-21, and outlined how regulators, commissioners and providers will meet the recommendations of the Mental Health Taskforce. Dalton said: “The ‘how’ is just as important as the ‘when’. However we do it, it needs to be completely transparent and there needs to be a degree of independence around it.” He said the proposals were ambitious and it was important to set out a long term outline of what was expected from commissioners, providers and sustainability and transformation plans.

<https://www.hsj.co.uk/sectors/mental-health/tracking-money-acid-test-for-4bn-mental-health-plans-says-confed-chief/7009585.article>

**2.14 NHS England takes action to ease pressures on general practice and provide joined-up care**

NHS England today agreed new steps to implement plans to strengthen general practice, ease the pressure on GPs and improve services for patients. The measures aim to help struggling GP practices, protect GPs from the rising cost of negligence claims and introduce new models of care that will create more joined-up services.

It follows the publications in April of The General Practice Forward View, a five year programme that aims to put General Practice on a sustainable footing for the future. The full NHS England Board at its public meeting agreed a package of immediate actions including:

* Release the first £16m of the new £40 million Practice Resilience Programme, a key part of the five-year General Practice Forward View, to help struggling practices across the country.
* The first phase of the three-year, £30 million general practice development programme, which will give every practice in the country the opportunity to receive training and development support.
* New funding to fully offset the rising cost of GP indemnity, and wider plans to reform indemnity arrangements

Simon Stevens, NHS England chief executive said: “We meant it when we said we would take concrete action to help relieve pressure on GP practices, and today’s funding is just the first instalment. Practices need support, now, and a few weeks on from the GP Forward View we’re getting on with practical action to do so.”

<https://www.england.nhs.uk/2016/07/joined-up-care/>

**2.15 More people than ever receiving psychological therapies and recovering**

More people than ever are receiving psychological therapies and April saw the highest recovery rates so far in the history of the programme, end of year data has shown. The number of people referred for treatment from January to March (Quarter 4) increased to 367,689 by around 17,000 from 350,505 in Q3 (Quarter 3). The 15 per cent access target was exceeded hitting a new high of 16.8 per cent.

And the number of people recovering hit an average 48.2 per cent in Q4, up from 45.9 per cent in Q3. In April 21,117 people moved to recovery, meaning a recovery rate for people finishing a course of treatment of 49 per cent, and the highest recovery rate seen so far missing the standard by just one per cent.

Waiting times continue to surpass the standard that 75% of people should start treatment within six weeks: in April, 84.6% of people starting treatment were within 6 weeks of referral, and 97.1% within 18 weeks.

<https://www.england.nhs.uk/mentalhealth/2016/07/27/psychological-therapies/>

**2.16 NHS England will intervene if mental health cash does not reach frontline**

NHS England’s national mental health director has said the national body will take action in areas where funding pledged for mental health services is not reaching the frontline. Claire Murdoch said that NHS England will step in if commissioners and providers are not investing in services as set out in its implementation plan or hitting key performance targets. The plan outlined how £3.97bn of additional cash for mental health services by 2020/21 would be spent. Murdoch said: “I am well aware, and NHS England is well aware, that this will challenge the system at a time when the system is already challenged, but ministers have made this commitment, NHS England has given this commitment and we will work with the system to deliver these targets nationally.” NHS England will publish new data next month on finances and performance to allow people to track where the money is being spent, and Murdoch said that while the data might need “finessing”, an important part of delivering the plan was to make sure the process was transparent.

<https://www.hsj.co.uk/4605.more?blocktitle=Central-and-North-West-London-NHS-Foundation-Trust&contentID=4605>

**2.17 Secret documents reveal official concerns over 'seven-day NHS' plans**

The health service has too few staff and too little money to deliver the government’s promised “truly seven-day NHS” on time and patients may not notice any difference even if it happens, leaked Department of Health documents reveal. Confidential internal DH papers drawn up for Jeremy Hunt and other ministers in late July show that senior civil servants trying to deliver what was a totemic Conservative pledge in last year’s general election have uncovered 13 major “risks” to it.

<https://www.theguardian.com/society/2016/aug/22/secret-documents-reveal-official-concerns-over-seven-day-nhs-plans>

**2.18 NHS England's MCP framework – an insight into the future for MCPs**

NHS England has published "The Multispecialty Community Provider (MCP) emerging care model and contract framework" (the Framework), which brings together features and lessons learned from the 14 MCP Vanguards into a high-level framework for future MCPs to work from.

The logic of the new care model is to create more efficient, joined-up pathways that focus on preventative (rather than reactive) care, with the intention of improving health, wellbeing and quality of care, whilst also reducing avoidable hospital admissions and elective activity. The Framework is not intended as a definitive national policy, but a useful guide which provides an insight into inspiring new opportunities for integration and the dissolution of boundaries, building on the vision set out in the Five Year Forward View. It focusses on the drive to transfer specialist care out of hospitals and into the community; bridging the gaps between primary, mental health, social care and community services.

Highlights:

**General Practice must be at the heart of the MCP.** As the gatekeepers to the NHS, engaging with and placing General Practice at the heart of the new care model will be essential for a successful MCP. With the dissolution of traditional boundaries between primary, community and secondary care providers, there are opportunities for how clinicians come together and over time, redesign pathways for the benefit of patients which will create the underlying logic of the new care model.

**MCPs must be procured in a transparent way, but this does not necessarily mean that procurement will involve multiple bidders.** Following engagement and consultation we expect there to be significant work undertaken on the scope of an MCP. This should lead to a call for competition and we expect potential providers to be looking out for these.

**In its most integrated form, the MCP holds a single, whole population budget for all the services it provides, including primary medical services.** This should support the dissolution of boundaries and delivery of efficiencies. We expect that MCPs will need to sub-contract services to deliver against the contract, at least initially.

**NHS England is discussing with DH an amendment to primary care legislation which would create a formal provision for commissioners to agree with GPs a suspension of GMS/PMS contracts for a defined period.** Allowing a right to return to GMS/PMS at a defined future point. This should provide GPs, which must be at the heart of the MCP, with the confidence to collaborate and integrate to develop MCPs.  The MCP may start off as a loose coalition, but sooner or later it has to be established on a sound legal footing. The Framework describes the publication of a new first draft MCP contract by the end of September (a streamlined hybrid of the NHS Standard Contract and a primary medical services contract, with a 10-15 year term).

There are 3 emerging visions of MCP contracting:

* an alliance contract between various providers and the commissioner(s) or 'virtual MCP'. This is the least disruptive of the options but arguably a more complex contractual structure as GPs continue to hold their GMS/PMS contracts
* a “partially integrated” contract. This is a single contract under which the commissioner procures all community services except primary care services. The provider integrates these services with the services under their GMS/PMS contract
* a “fully integrated model” under which the MCP holds a single whole-population budget for the full range of primary medical and community services. This is the most radical option, but gives the MCP the greatest freedom to redesign care

MCPs need to be formal legal entities and capable of bearing financial risk. Following the collapse of the Uniting Care contract, there may be additional levels of commissioner scrutiny to ensure that the provider can bear appropriate risk and demonstrate this throughout the procurement process.

Partially integrated models may consider managing primary medical care differently at a local level. This might include integration agreements overlaying existing GMS/PMS contracts or sub-contracts helping to break down barriers and committing GPs to new ways of working. In areas where there is not yet the confidence to rely on a suspension of GMS/PMS contracts, and a move into a fully integrated model, this will allow confidence to build, in a sound legal structure, whilst creating the care model and driving the patient benefits.

New care models will move the boundary between what is commissioning and what is provision. The commissioner and provider split cannot be removed without a change to legislation. Commissioners must continue to exist and perform their functions. With the development of a single MCP contract for the provision of services traditionally procured from multiple providers, it is predicable that the boundary between what is commissioning and provision may change. For example, future providers may need contracting teams to manage sub-contracts, whereas the need for large teams of contract managers in a CCG may evolve. Much will depend on the MCP contract and where data flows and reporting will sit and the local delivery model.

CCGs will need to address conflicts of interest. Whilst this is no change to the current position, CCGs may find it difficult to commission an MCP without experiencing significant conflicts of interest. CCGs may need to work with other commissioners to develop solutions and ensure that a fair and transparent process is undertaken.

NHS England, NHS Improvement and the CQC are working together to agree the approach to the on-going oversight of MCPs.  These organisations regulate and assure commissioners and providers in different ways. The challenge of providing on-going oversight to MCPs, which are unlikely to be uniform nationally and made up of many different variables, is likely to be high. Providers are likely to welcome this news from NHS England.

The Framework lists ten essential jobs in establishing a successful MCP, as well as creating an engine room, design stages and sharing good news stories and lessons learned – there is a focus on the merits of using IT, the importance of information sharing and enhanced signposting across services. There are also plans to increase population coverage of new care models from 8% to 25%. Areas will be invited to submit applications for future MCPs, PACs and acute care collaborations in the autumn.

**2.19 Accident and emergency: fixing the NHS**

A feature in the **Economist** explores the pressures facing the NHS, saying the health service “is in a mess” but reformers believe that new models of health care can fix it. They write that like healthcare systems around the world, the NHS is struggling to provide good care at low cost for patients. Its business model has not kept up with the changing burden of disease, and as people are living longer, demand is increasing for two costly types of care in particular: looking after the dying and caring for those with more than one chronic condition. To fix the NHS requires changes in three areas: funding; hospitals’ efficiency; and better public health and joined-up care. They write that the NHS is already on the verge of a crisis, noting that several hospital divisions face closure, according to NHS Providers chief executive Chris Hopson. The article goes on to discuss improving efficiency, workforce, hospital chains, improving the GP system and vanguards. <http://www.economist.com/news/britain/21706563-nhs-mess-reformers-believe-new-models-health-care-many-pioneered>

**2.20 Understanding quality in district nursing services**

A new report by the King’s Fund investigates what ‘good’ district nursing care looks like from the perspective of people receiving this care, unpaid carers and district nursing staff and puts forward [a framework](http://www.kingsfund.org.uk/publications/quality-district-nursing/framework) for understanding the components involved. It also looks at the growing demand–capacity gap in district nursing and the worrying impact that this is having on services, the workforce and the quality and safety of patient care. The report makes recommendations to policy-makers, regulators, commissioners and provider organisations as to how to start to address these pressures.

<http://www.kingsfund.org.uk/publications/quality-district-nursing>

**2.21 Single Oversight Framework**

Following consultation, NHS Improvement has published the revised version of the Single Oversight Framework, along with a summary of consultation responses.

Some of the key changes made following consultation include:

* for providers in segment 1, although some data will be collected monthly, it will only be reviewed on a quarterly basis for segmentation purposes, unless there is evidence to suggest that a provider may be in breach of its licence (or equivalent for NHS trusts)
* there will be a focus on overseeing a number of national targets and standards, and also a look at wider data to inform the tailored support package
* the language of the framework has been changed to describe segment 1 (‘maximum autonomy’) in more positive terms and to describe segments 2 and 3 in terms of levels of support
* agency spend will now be part of the finance and use of resources score – this applies from quarter 3 2016/17 (with no shadow period)
* segment 4 will now exclusively consist of providers in special measures

Further refinements to the framework as set out below remain subject to consultation until the end of September

* specific changes to the finance and use of resources theme:
* to use income and expenditure (I&E) margin, rather than EBITDA (Earnings Before Interest, Tax, Depreciation and Amortisation) margin, to monitor efficiency
* for providers that have not agreed a control total, that their finance and use of resources score will be at least a 3 (i.e. 3 or 4) if they are planning a deficit, and at least a 2 (i.e. 2, 3 or 4) if they are planning a surplus
* following the approach set out in Strengthening financial performance and accountability, to expand the broader value-for-money approach to consider pay bill growth, consolidation of back office and pathology services, and addressing unsustainable services
* to remove six of the metrics that we had previously included in the quality of care theme (never events rate of incidence, serious incidents rate, NRLS medication errors as % of harmful events, NRLS % of reported patient safety incidents that are harmful, NRLS % of harm-free care, and NRLS % of new harms)

It is planned to **introduce the framework from 1 October 2016**, at which point the Monitor Risk Assessment Framework and TDA Accountability Framework will no longer apply. A shadow segmentation based on how organisations would have performed under the framework over the last two months has been completed and regional teams will be in contact with organisations to discuss this. The whole sector’s shadow segmentation will be set out in early October. <https://improvement.nhs.uk/resources/single-oversight-framework/>

**2.22 Scope of performance assessments of providers regulated by the Care Quality Commission (CQC)** - The CQC currently regulate and inspect providers of health and social care and the ratings are limited to NHS trusts, NHS foundation trusts, GP practices, adult social care providers and independent hospitals. The government would like CQC to develop ratings for other sectors and is seeking views on these proposed changes. The consultation closes on 14 October 2016. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/547103/Scope_of_CQC_ratings_Con_Doc_A.pdf>

**2.23 Delayed discharges and hospital type: evidence from the English NHS**

Delayed discharges of patients from hospital, commonly known as bed-blocking, is a long standing policy concern. Delays can increase the overall cost of treatment and may worsen patient outcomes. This paper investigates how delayed discharges vary by hospital type, and the extent to which such differences can be explained by demography, case mix, the availability of long-term care and hospital governance as reflected in whether the hospital has Foundation Trust status, which gives greater financial autonomy and flexibility in staffing and pay. <http://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP133_discharges_hospital_NHS.pdf>

**2.24 CQC Safe Data Safe Care report / NDG Review of data security, consent and opt-outs**

A TIAA Client Briefing Note is available on the CQC and NDG’s reports reviewing data security, consent and opt-outs. A consultation (closing date 7th Sept 2016) is now seeking views on the proposed data security standards and the consent/opt-outs model. The NDG review includes: ten new data security standards; a method of testing compliance with these standards; and a new consent model for data sharing in health and social care.

<http://www.cqc.org.uk/content/safe-data-safe-care> <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/535170/NDG_consultation_A.pdf>

<https://www.gov.uk/government/publications/review-of-data-security-consent-and-opt-outs>

**2.25 Strengthening financial performance and accountability in 2016/17-**

A suite of new measures for providers and commissioners is set out by NHSI, in partnership with NHS England, to restore financial discipline and help ensure ongoing financial sustainability for the NHS. The document sets out action to stabilise NHS finances in 2016/17, provides further detail on access to the Sustainability and Transformation Fund, outlines the proposed basis for assessing the financial performance of provider organisations and introduces new programmes of financial special measures for providers and commissioners that are unable to ensure sufficient financial discipline. <https://improvement.nhs.uk/uploads/documents/Strengthening_financial_performance_and_accountability_in_2016-17_-_Final_2.pdf>

**2.26 NHS Standard Contract: new requirements outlined**

NHS England [has outlined six new requirements in the NHS Standard Contract for hospitals to adhere to in relation to the hospital/general practice interface](http://links.nhs.mkt5643.com/ctt?kn=27&ms=NTE5MzU0NTIS1&r=NTMyMjc2Nzk3NTUS1&b=0&j=OTY0MDkxOTk4S0&mt=1&rt=0). Included are requirements for hospitals to publish local access policies, to send discharge summaries within 24 hours, to improve management of onward referrals, provide medication on discharge, and detailed requirements around notification of the results of investigations and treatments. <https://www.england.nhs.uk/wp-content/uploads/2016/07/letter-contract-requirements.pdf>

**2.27 Five big issues for the NHS after the Brexit vote**

Health is not an area of significant EU competence; its role is by and large limited to supporting member states in their health endeavours. Nevertheless, the impact of the UK’s vote to leave the EU could have major implications for health and social care, not least because it has ushered in a period of significant economic and political uncertainty at a time when services are facing huge operational and financial pressures. While the impact on the NHS of leaving the EU is impossible to forecast, it is clear that a number of important issues will need to be resolved, five of which are set out in this article. <http://www.kingsfund.org.uk/publications/articles/brexit-and-nhs>

**2.28 More than shelter: supporting accommodation and mental health**

This report reviews evidence about the provision of supported housing services for people with mental health problems. It argues that people using mental health services should get access to high quality housing support when they need it. The report also highlights the significant links between housing and mental wellbeing, indicating that factors such as overcrowding, insufficient daylight and fear of crime all contribute to poorer mental health. <http://www.centreformentalhealth.org.uk/more-than-shelter>

**2.29 A basic need: housing policy and mental health**

The Housing and Planning Act 2016 reformed the way in which the state supports vulnerable people who cannot afford housing on the open market. This briefing considers the actual and potential impact of these policy reforms, the significance of affordable housing to mental wellbeing, and potential priorities for mental health policy going forward. <https://www.centreformentalhealth.org.uk/briefing-49-a-basic-need>

**2.30 Six principles for engaging people and communities: putting them into practice**

This briefing discusses how person-centred, community-focussed approaches to health, wellbeing and care can be created. It builds on the proposed new relationship with patients and communities set out in the NHS Five Year Forward View. It aims to complement a wider suite of products to be produced by national bodies for the health and care system as it moves forward with the implementation of innovations in care delivery. <http://www.nationalvoices.org.uk/sites/default/files/public/publications/six_principles_-putting_into_practice_-_web_hi_res.pdf>

**2.31 Draft guidance on good governance in a local health economy**

As the Five Year Forward View sets out, better outcomes for patients can be achieved if providers collaborate across local health economies (LHE) to improve the quality and sustainability of services. A number of providers are already doing this, through their [Sustainability and Transformation Plans](https://improvement.nhs.uk/resources/nhs-shared-planning-guidance/#stf) (STPs) or as part of a new care model. In this guidance, NHSI set out what they expect from NHS Trusts and Foundation Trusts as good governance when working in a LHE. <https://improvement.nhs.uk/resources/draft-guidance-good-governance-local-health-economy/>

**2.32 Data Quality Maturity Index report**

Health and Social Care Information Centre (HSCIC) has published the first [Data Quality Maturity Index report](http://links.nhs.mkt5643.com/ctt?kn=12&ms=NTE0OTc5OTUS1&r=NTMyMjc2Nzk3NTUS1&b=0&j=OTIzODkyMTgzS0&mt=1&rt=0" \t "_blank). The report presents a record of the coverage and validity of data submitted to HSCIC by NHS providers in 2015. This report, of particular interest to chief information officers and commissioners, will be produced on a quarterly basis, and its findings supported by advice and guidance for providers on how to improve data quality. It currently assesses the completeness and validity of the core set of data fields required across six main national datasets. <http://www.hscic.gov.uk/dq>