

**Appendix**

**BOD 121(ii)**

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

# Board of Directors

**26th October 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 NHSI, 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 mid-September 2016 to mid-October 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 a summary 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.

As Chief Executive I 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.

**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 ensure that the Trust is updated in a timely fashion, 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/REGULATORY/POLICY UPDATES AND OPINION PIECES**

**2.1 Social care cuts take English service to tipping point, warns CQC**

The Guardian reported that, according to the CQC, A&E units are struggling to cope because social care services that help elderly people have been cut so much that they are reaching a “tipping point”. The CQC warned that elderly and disabled care sector as a whole is at risk as providers pull out over rising costs and cuts to council budgets. Hospitals are ending up dangerously full and have seen “bed blocking” hit record levels because of a widespread failure to give elderly people enough support to keep them healthy at home. A worsening lack of at-home care services and beds in care homes are forcing hospitals to admit more patients as emergencies, which deepens their already serious financial problems. “What’s happening, we think, is that where people aren’t getting access to [social] care, and we are not preventing people’s needs developing through adult social care, is that they are presenting at A&E,” said David Behan, the CQC’s chief executive.

Figures contained in the Commission’s annual report show that the number of hospital bed days lost through patients being unable to leave because social care was not available to allow them to be discharged safely soared from 108,482 in April 2012 to 184,199 in July this year – a 70% rise. The fact that growing numbers of mainly frail, elderly people are being left without the help they need with basic chores such as washing, dressing and cooking “creates problems in other parts of the health and care system, such as overstretched A&E departments or delays in people leaving hospital,” he added. GP surgeries also have to treat patients who became unwell or suffered an injury because they did not receive help they needed.

<https://www.theguardian.com/society/2016/oct/13/social-care-cuts-take-english-service-to-tipping-point-regulator-warns>

**2.2 Vast majority of mental health trusts have safety concerns, warns CQC**

The Health Service Journal reported that mental health trusts are facing serious safety concerns, with all but three of those rated by the Care Quality Commission before July needing to improve on safety. The regulator’s State of Care report showed that of the 47 mental health acute trusts inspected by the CQC before July 2016, forty were rated as requires improvement for the key question “are services safe?” The regulator found that acute mental health wards and psychiatric intensive care units were the most dangerous, while the report singled out poor “physical environments” as “frequently” contributing to safety concerns. CQC chief executive David Behan said: “One of the big issues is about the presence of ligature points in the physical environment where people are attempting suicide, or indeed in one or two cases people have committed suicide.” The report called for “greater investment in purpose built wards” in the long term, and also noted that the CQC has seen people with severe mental health problems remaining in hospital for “months or years at a time” and criticised long stay units for not being “focused enough on people’s recovery”.

<https://www.hsj.co.uk/topics/quality-and-performance/vast-majority-of-mental-health-trusts-have-safety-concerns-cqc-warns/7011452.article>

**2.3 Waiting times in A&E units in England this summer have been worse than every winter for the past 12 years bar one, figures show.**

The colder months have traditionally been the most difficult for hospitals but pressures have grown so much that this summer saw one in 10 patients wait for over four hours in A&E during June, July and August, the BBC reported. Only last winter saw a worse performance since the target started in 2004, figures from NHS England showed. During the summer months 90.6% of patients were seen in four hours against the target of 95% in four hours. The data also showed hospitals are missing a number of other key targets for cancer, routine operations and ambulance response times. And the delays hospitals experienced in August discharging patients reached a record high. There were over 188,000 days of delays - a 30% rise on the same month the year before.

These delays occur when there are no services available in the community to care for frail patients on release. Dr Mark Holland, president of the Society for Acute Medicine, said the figures once again showed the NHS was locked in an "eternal winter". The Care Quality Commission review said emergency care was one of the poorest-performing parts of the system. It cited safety as a major weakness, with 22 of 184 units rated inadequate and another 95 requiring improvement. Problems it found included overcrowding, delays getting access to vital equipment and resuscitation bays and poor hygiene pratices.

But the regulator did not blame the NHS. Instead it said rationing of council care, including access to home help for daily tasks such as washing and dressing and care homes, was pushing more old and frail people into hospital.

While the CQC expressed concern about the pressures being seen, it also said there were many examples of good care among the 20,000 inspections it had carried out. Despite the cuts to council care services, the help that was being provided in the home and in care homes was rated as good or outstanding in 72% of cases. Meanwhile, 87% of GP practices were good and outstanding, as was 42% of hospital care overall. No mental health service was rated as outstanding and just 34% as good. Not every service has yet been inspected, although the vast majority of hospitals and mental health care facilities have - and over half of GP practices and care services have been.

<http://www.bbc.co.uk/news/health-37634687>

**2.4 New care models - Emerging innovations in governance and organisational form**

A report by the King’s Fund looks at the different approaches being taken by multispecialty community provider (MCP) and primary and acute care system PACS vanguards to contracting, governance and other organisational infrastructure. It focuses on developments at five sites: Dudley; Sandwell and West Birmingham (Modality Partnership); Salford; Northumberland and South Somerset (Symphony Project).

The 23 vanguard sites chosen to develop the MCP and PACS new care models have been working to pool budgets and integrate services more closely. Some are continuing to use informal partnerships, but others are opting for more formal governance arrangements. Commissioners are grappling with how to contract for the new systems, while providers are exploring how to work together within emerging partnerships, how to allocate funding, and how to share risk and rewards.

**Key findings**

* Many of the vanguard sites would like to bring together the budgets for core primary care services and other local services, but it seems unlikely that GPs will give up their core General Medical Services or Personal Medical Services contracts in the immediate future.
* Many of the sites would like to bring together the budgets and contracting for some health and social care services, but only a small number have made substantial progress in incorporating social care.
* Many commissioners plan to contract with a single provider or entity to hold the budget and oversee or deliver a broad range of services, although most are still deciding which organisation or partnership should do this.
* Commissioning and developing new care models involves risks as well as opportunities, underlining the importance of how these models are governed, their organisational form and how risks are shared.
* Building and strengthening collaborative relationships is just as important as focusing on the technical elements of integrated care.

<http://www.kingsfund.org.uk/publications/new-care-models>

**2.5 STPs making plans ‘they do not believe can be delivered’**

The Health Service Journal reported that NHS Providers chief executive Chris Hopson has said health economy leaders are being forced to draw up sustainability plans which they do not believe can be delivered. He told the Commons health committee that financial requirements placed on sustainability and transformation plans are leading to “vastly over-ambitious” proposals. Chris told the committee that the “financial gap” in many STPs totals “hundreds of millions of pounds”. Chris said members are saying they are spending a lot of time creating plans that in their view are not deliverable and usually involve major structural service changes because “that’s the only way they can create a balanced plan”. He said the plans are deemed overly ambitious because “they won’t command the required political support and there isn’t the capital available”. He stressed that trusts believe they can do more to deliver efficiencies, but want “realistic targets”.

<https://www.hsj.co.uk/home/news/stps-are-making-plans-they-do-not-believe-can-be-delivered/7011425.article?blocktitle=News-(grid)&contentID=20682>

**2.6 Huge spike in ‘high risk’ maintenance problems at trusts**

The Health Service Journal reported that the backlog of “high risk” maintenance problems at NHS trust estates has increased by almost 70% last year, as capital investment has continued to fall. According to estates data relating to 2015-16, NHS trusts face costs of £775m to deal with high risk maintenance issues, compared to £458m in 2014-15 and £357m in 2013-14. The estates and returns information collection published by NHS Digital revealed there was also a sharp spike in issues classed as “significant risk”, while issues classed as “moderate” or “low” risk both declined. Overall costs to eradicate the total backlog increased by 15% last year to almost £5bn. NHS Providers head of analysis, Siva Anandaciva, said: “We are operating in a capital starved environment and time and again we have seen the NHS pay the price of under-investing in capital in the long term.” He added: “We need the autumn statement [on 23 November] to provide a solution for greater capital investment that includes funding for both maintenance of our existing capital assets, and investment in new capital building programmes and equipment.”

<https://www.hsj.co.uk/topics/finance-and-efficiency/huge-spike-in-high-risk-maintenance-problems-at-trusts/7011401.article>

**2.7 Moving beyond consultation to genuine public engagement is key to STPs**

Writing in the Heath Service Journal, Director of Communications Daniel Reynolds, said old school methods of consultation won’t cut it if the changes brought in by sustainability and transformation plans are to succeed. Daniel wrote that NHS trusts and the wider health and care system stand on the verge of some of the most significant conversations they will have with local communities as 44 sustainability and transformation plans (STPs) are being developed across the country, which will inevitably cause controversy as much-cherished local services may face being downgraded or even closed. Before plans have even been published there is a sense the NHS will need to recover lost ground in battle for local hearts and minds, and how effectively stakeholders are engaged in this process is one of the risks that have been identified by NHS trusts and system leaders. While NHS trusts, CCGs and councils have separate duties to consult, NHS England is encouraging joint public engagement exercises, but ultimately, NHS trusts will need to take a judgment about how and when to engage their communities in any proposed changes. Effective approaches to public engagement based on transparency, openness and a collective discussion on the trade-offs stand a much better chance of securing less divisive outcomes than traditional, more limited approaches to consultation.

<https://www.hsj.co.uk/topics/service-design/moving-beyond-consultation-to-genuine-public-engagement-is-key-to-stps/7011301.article?blocktitle=Comment&contentID=7808>

**2.8 Police say they are becoming emergency mental health services**

Police say they are being relied on as an emergency mental health service and that cuts in psychiatric provision are probably to blame, the Guardian reported. Officers pointed to an increase of more than 50% in a decade in the use of powers to detain people under section 136 of the Mental Health Act. It allows police to remove someone from a public place and take them to a place of safety. Police chiefs have begun new initiatives to help officers cope with the mental health crisis being played out on Britain’s streets. Alex Marshall, head of the College of Policing, said: “There is a real risk the high number of cases that frontline police deal with is because the police are stepping in where other agencies would have provided the support.”

Police suspect a dramatic increase in their use of emergency powers to deal with people suffering a mental health crisis is because of cuts to community psychiatric care. The number of instances of section 136 powers being used increased to 28,271 last year, up from 17,417 in 2005-06. Marshall said: “This is a real live issue in all parts of the country. People in a mental health crisis should receive support, whatever time of day or night, from a properly trained mental health professional.”

The increased use of section 136 powers by police has happened despite several forces sharply reducing their use of the power because of street triage schemes, in which mental health experts go to patients and assess them, thus avoiding police having to detain them. As well as government funding, police have put greater effort towards reducing the number of mentally ill people being held in cells because health services do not have beds for them. That initiative has been successful, although there are sharp local variations, probably due to local health service capacity. In the Avon and Somerset force area one in six people detained because of concerns about their mental health spend time in a cell. In Merseyside the figure is zero.

Last week it emerged that a police chief is threatening to take legal action over his force having to cover the gaps in mental health services. Shaun Sawyer, the chief constable of Devon and Cornwall, threatened to sue his local NHS trusts over a lack of mental health beds. He said he would no longer tolerate a practice he regards as unlawful.

<https://www.theguardian.com/uk-news/2016/oct/09/police-forces-mental-health-section-136>

**2.9 Legal cases against the NHS have cost the taxpayer nearly £1.5 billion in the last year, figures have revealed**.

Data from the NHS Litigation Authority (NHSLA) shows the health service paid hundreds of millions of pounds in damages, claimant and defence costs, after claims were pursued. In the year 2015-16, it was hit with a bill of £418 million to cover the lawyer fees of claimants, prompting accusations that legal firms have "grossly over-inflated" charges. It comes as financial pressures have placed considerable strain on the NHS, with major hospitals routinely missing waiting list targets and health chiefs recently warning that staffing shortages have reached "crisis" levels. The amount paid out for patient legal costs marks a 43 per cent increase on the previous year, when it stood at £291.9 million.

Similarly, the amount being paid out for damages has also soared, up 23 per cent to £950.4 million, figures from NHSLA show. But the price of defending the claims brought against the NHS rose more moderately, up by just under £17 million to £120.1 million.

The enormous rise in the amount claimed for patients' lawyers was condemned by Conservative MP James Davies. Dr Davies, who is also a member of the Commons Health Select Committee, told the Mail on Sunday: "As a GP, I have direct experience of the spiralling costs of medical defence cover."Patients should have legal avenues open to them for true medical negligence, but some fees are grossly inflated and morally questionable." He added: "The NHS faces numerous pressures and it can do without ever-increasing litigation costs. Unless this situation can be tackled, such costs risk making the NHS unsustainable."

<http://www.telegraph.co.uk/news/2016/10/09/taxpayer-foots-15billion-bill-for-legal-cases-against-nhs-in-a-y/>

**2.10 NHS care complaints double**

The [Sunday Times](http://nhsproviders.cmail20.com/t/t-l-hjiydyy-oczyhju-v/) reported that complaints made to the Parliamentary and Health Service Ombudsman over care funding have doubled in five years, highlighting the growing tension between families and an NHS in financial crisis. A total of 319 complaints were received between 1 April, 2011, and 31 March, 2012, compared to 600 in the 12 months to 31 March this year. The figures from the ombudsman are indicative of an NHS under intense pressure to cut costs and an ageing population. The disputes surround the continuing healthcare (CHC) system, a source of funding which entitles an individual to have all their care costs paid for by the state, which can be highly complex. Caroline Abrahams, charity director at Age UK, said: “The [CHC] system has been creaking for many years and there is a huge backlog of older people and their families waiting for decisions. Sadly the poor state of continuing healthcare reflects the stresses and strains across health and care more generally.”

<http://www.thetimes.co.uk/article/nhs-care-complaints-double-3vwglwzq5>

**2.11 Trusts given new targets to achieve provider sector surplus**

Every trust in England has been issued new financial targets that aim to bring the NHS provider sector into balance in 2017/18. In a guidance document sent by NHS Improvement last week, the regulator says trusts have until 24 November to agree their financial “control totals” for the next two years. Although the baseline used for each trust was its current year target, trusts in deficit have had their control totals ratcheted down, while trusts in surplus must also improve their position. Trusts must agree their control target in order to receive their share of the £1.8bn “sustainability and transformation fund”, and conditions attached to the extra funding mean control totals and STF payments require sign off by the Treasury. The guidance document says the STF will “again focus on supporting sustainability rather than transformation, aiming not to fund service enhancements but to sustain services”. Richard Murray, director of policy at The King’s Fund said: “I’m struck by the ruthless clarity here that the STF is specifically all about sustainability and not transformation. The Treasury also appear several times in the document, which shows just how tightly the centre is now controlling things.”

<https://www.hsj.co.uk/topics/finance-and-efficiency/all-trusts-given-new-targets-to-achieve-provider-sector-surplus/7011057.article?blocktitle=News&contentID=15303>

**2.12 Prime minister under fire for saying foreign doctors are in UK only for ‘interim period’**

The Guardian reported that Theresa May had been criticised for suggesting foreign doctors will only be working in the NHS for an “interim period” until more UK-trained physicians are available. The prime minister was speaking on BBC Breakfast about plans to make the NHS more “self-sufficient” ahead of an announcement at the Conservative party conference by health secretary Jeremy Hunt. Asked whether she could reassure foreign NHS staff they were welcome to stay for now, she said: “Yes. There will be staff here from overseas in that interim period – until the further number of British doctors are able to be trained and come on board in terms of being able to work in our hospitals…But I think it’s right that we say we want to see more British doctors in our health service.” Her comments were criticised by Nicola Sturgeon, the first minister of Scotland, while Labour MP Tulip Siddiq compared the policy to the controversial “go home” vans aimed at illegal immigrants, describing the rhetoric as “dangerous and disgraceful”.

<https://www.theguardian.com/politics/2016/oct/04/jeremy-hunt-accused-devaluing-contribution-foreign-doctors-to-uk>

**2.13 NHS will not realise full pathology and back office savings this year**

NHS Improvement’s productivity director told the Health Service Journal that the health service will not be able to fully realise savings from planned back office and pathology consolidation in 2016/17. However, Jeremy Marlow said there were some sustainability and transformation plan footprints that would deliver “cash this year” from consolidation, while the rest of the NHS needs to “start now” with rationalising services. In June, NHS Improvement chief executive Jim Mackey and chair Ed Smith wrote to every trust chief executive requiring them to draw up plans for consolidating pathology, back office and “unsustainable” elective services, as part of an effort to get the 2016/17 provider sector deficit down from a planned £580m to £250m. Marlow said that pathology and back office consolidation could yield savings “in the order of half a billion [pounds]”. He added: “We’re not going to be able to get it out…in the space of five or six months” but said consolidation could still contribute to bringing down the 2016/17 provider deficit.

<https://www.hsj.co.uk/topics/service-design/pathology-and-back-office-savings-wont-all-be-achieved-this-year/7011042.article?blocktitle=News-(grid)&contentID=20682>

**2.14 PAC report spotlights challenges faced by mental health sector**

The Public Accounts Committee has published a new report, *Improving access to mental health services,* giving insight into the growing funding and workforce challenges around achieving parity of esteem. The committee said the Department of Health and NHS England have a “laudable ambition” to improve mental health services, but, given the current financial pressures facing the NHS, are “sceptical about whether this is affordable or achievable without compromising other services”. The report adds that achieving parity of esteem between mental and physical health is “a task for the whole of government”, and the workforce needed and the consequential cost to achieve the ambition is poorly understood. NHS Providers director of policy and strategy, Saffron Cordery, said: “We have long been saying that parity of esteem between mental and physical health is a tall order with the unprecedented financial pressures facing the NHS.” Saffron highlighted our recent survey which revealed that commissioners are not clear or consistent about how frontline mental health services should be prioritised. She added: “We strongly support the committee’s call for greater transparency on mental health spending by commissioners, more joined-up services and incentivisation to improve patient outcomes by prioritising better this important aspect of care.”

<http://www.publications.parliament.uk/pa/cm201617/cmselect/cmpubacc/80/80.pdf>

**2.15 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness**

The University of Manchester’s Centre for Mental Health and Safety Annual Report and 20-year Review 2016 presents findings from 2004 to 2014, and reviews 20 years of data collection. It provides the latest figures on suicide, homicide and sudden unexplained deaths and highlights the priorities for safer services. Key messages include:

* There are now around **3 times as many suicides by CHRT patients as in in-patients.** The crisis team is now the main setting for suicide prevention in mental health
* Many people who died by suicide had a history of drug or alcohol misuse, but **few were in contact with specialist substance misuse services**. Access to these specialist services should be more widely available, and they should work closely with mental health services
* More patients who died by suicide were reported as having **economic problems, including homelessness, unemployment and debt**
* There has been a **rise in the number of suicides by recent UK residents**: those who had been in the UK for less than 5 years, including those who were seeking permission to stay
* There are a number of ways in which mental health care is safer for patients, and it is clear **what services can do to reduce suicide risk**:
  + Safer wards
  + Early follow-up on discharge
  + No out-of-area admissions
  + 24 hour crisis teams
  + Outreach teams
  + Dual diagnosis service
  + Family involvement in ‘learning lessons’
  + Guidance on depression
  + Personalised risk management
  + Low staff turnover
* In England the number of **homicides by people with schizophrenia appears to have risen** since 2009, though the numbers are small
* **Most patients who committed homicide had a history of alcohol and drug misuse**. This was found in all UK countries but was more common in Scotland and Northern Ireland

[**http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/**](http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/)

**2.16 Car parking charges at hospitals in England - rises average 15% since 2014**

A third of hospital trusts in England have increased their car parking charges in the last year, figures show. Some are now charging as much as £4 for a one-hour stay, with a third increasing their average charge over a three-hour period. The analysis, by the Press Association, includes figures obtained directly from NHS trusts and data submitted to [NHS](https://www.theguardian.com/society/nhs) Digital. The NHS Digital data suggests a 15% average rise in parking charges across trusts in England between 2014/15 and 2015/16. Some trusts allow patients and visitors to park for free for the first 30 minutes before charges kick in but others have scrapped a one- or two-hour charge, meaning people have to pay a flat fee for three hours even if they stay for less than that.

The most expensive trust in the country for a one-hour stay is the Royal Surrey county hospital in Guildford, where patients pay £4 for any stay up to two hours. It does have a few bays where people can park for 20 minutes before being charged. Hereford county hospital lets people park for free for 10 minutes, but then charges £3.50 for an hour and £5 for two hours. Meanwhile, London’s Royal Free hospital charges a flat rate of £3 an hour. Of the 209 hospital trusts that reported figures to NHS Digital for both 2014/15 and 2015/16, a third (69 trusts) showed an increase in their average hourly charge when calculated across three hours. 126 (60%) showed no change over the year while 14 (7%) showed a decrease. Among those trusts that have hiked up parking charges in 2016 are the Royal Surrey, where the cost of an hour has doubled from £2 in 2013 to £4. Stockport NHS foundation trust increased its prices by about 40% over the summer. The cost of a four-hour stay at the town’s Stepping Hill hospital rose from £6 to £8, with a short stay rising from £2.50 to £3.50.

At the other end of the scale, car parking at Trafford general hospital in Greater Manchester is free for up to three hours. Alder Hey children’s NHS foundation trust charges £2 a day and the Christie cancer hospital in Manchester charges £1.50 a day. The Clatterbridge Cancer Centre on the Wirral offers free parking. Some NHS trusts offer concessions to people visiting someone who is terminally ill, and also discounts or weekly tickets for lengthy courses of treatment.

Last December, figures obtained under the Freedom of Information Act by the Press Association revealed that some NHS trusts are making more than £3m a year from car parking fees. Of more than 90 trusts that responded to the FoI request, half are making at least £1m a year. Seven NHS trusts earned more than £3m in 2014/15 from charges, a further eight made more than £2m a year while a further 33 earned more than £1m a year.

Shadow health secretary Jonathan Ashworth said: “These figures show a worrying increase in the cost of car parking charges in our hospitals. “Racking up charges on people who have no choice isn’t fair and will only cause more distress for patients and their families. “Hospitals across the country are hard-pressed because of this Government’s underfunding of the NHS, but money should not be made up through charging patients and their families more and more for an essential service. These increases cannot be justified.”

## ****Most expensive trusts in England for a one-hour visit:****

|  |  |
| --- | --- |
| * Royal Surrey county hospital £4 * Hereford county hospital £3.50 * Stockport £3.50 * Bristol royal infirmary £3.40 * West Suffolk hospital £3.30 * Northampton general £3.10 * Royal Free, London £3 * Basildon hospital, Essex £3 * Whittington hospital, London (after 5pm) £3 * St Thomas’ hospital, London £3 | * Chelsea & Westminster hospital, London £3 * Aintree university hospital £3 * Luton and Dunstable £3 * Mid Cheshire hospitals £3 * Mid Essex £3 * Southend university hospitals £3 * Princess Alexandra hospital, Essex £3 * University hospital of South Manchester £3 * Warrington hospital £3 |

<https://www.theguardian.com/society/2016/oct/14/car-parking-at-hospitals-in-england-rises-average-15-since-2014>

**2.17 Financial special measures promise significant savings for the NHS**

**Published on:**

Up to £100 million in savings have been identified at some of England’s most financially troubled hospitals by a programme designed to support NHS trusts rapidly improve their finances.

The financial special measures programme, that we launched as part of the [financial reset in July 2016](https://improvement.nhs.uk/resources/strengthening-financial-performance-and-accountability-201617/), provides a rapid turnaround package for trusts and foundation trusts which have either not agreed savings targets (also known as control totals), or planned to make savings but deviated significantly from this plan.

The [trusts that are already in financial special measures](https://improvement.nhs.uk/news-alerts/strengthening-trusts-financial-and-operational-performance-201617/) are responding well. It's anticipated that some of these providers will be released from special measures in a few months’ time, when they have demonstrated continued delivery of their plan and key milestones.

However, in some, further changes are likely to occur. This is true in Bristol, where the STP process is indicating the benefits to service and financial sustainability of developing shared leadership arrangements across the acute providers.

<https://improvement.nhs.uk/news-alerts/financial-special-measures-promise-significant-savings-nhs/>

**2.18 Shared planning guidance for NHS trusts and foundation trusts**

This year’s operational and contracting planning guidance for the NHS for 2016/17 to 2020/21 was published three months earlier than normal to help Trusts plan more strategically. For the first time, the planning guidance covers **two financial years**, to provide greater stability and support transformation. This is underpinned by a two-year tariff and two-year NHS Standard Contract. The planning guidance in 2016/17 described nine ‘must do’ priorities. These remain the priorities for 2017/18 and 2018/19. These national priorities and other local priorities will need to be delivered within the financial resources available in each year.

The detailed requirements for commissioner and provider plans are set out in accompanying technical guidance. Plans will need to demonstrate:

* how they will be delivering the nine ‘must-dos’;
* how they support delivery of the local STP, including clear and credible milestones and deliverables;
* how they intend to reconcile finance with activity and workforce to deliver their agreed contribution to the relevant system control total;
* robust, stretching and deliverable activity plans which are directly derived from their STP, reflective of the impact that the STP’s well-implemented transformation and efficiency schemes will have on trend growth rates, agreed by commissioners and providers and consistent with achieving the relevant performance trajectories within available local budgets;
* how local independent sector capacity should be factored into demand and capacity planning from the outset, and local independent sector providers engaged throughout;
* the planned contribution to savings;
* how risks have been jointly identified and mitigated through an agreed contingency plan; and
* the impact of new care models, including where appropriate how contracts with secondary care providers will be adjusted to take account of the introduction of new commissioning arrangements for MCPs or PACS during 2017-19.

<https://improvement.nhs.uk/resources/nhs-shared-planning-guidance/>

**Key Dates:**

|  |  |
| --- | --- |
| Submission of STPs  Submission of full draft 17/18-18/19 operational plans  National deadline for signing contracts  Final plans approved by Boards of providers  Submission of final 17/18-18/19 operational plans, aligned with contracts | 21 October 2016  24 November 2016 (noon)  23 December 2016  23 December 2016  23 December 2016 |