

**Appendix**

**BOD 02(ii)/2017**

(agenda item: 4)

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

# Board of Directors

**25th January, 2017**

**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 December 2016 to mid-January 2017 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.

The Chief Executive 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 either through the report itself or via the relevant Board reports of individual Executives.

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.

1. **LEGAL/POLICY UPDATES**
   1. **Whole system flow in health and social care**

Improving the flow of patients, service users, information and resources within and between health and social care organisations can have a crucial role to play in coordinating care around the needs of service users, and driving up service quality and productivity.

Getting flow right is critical to support efforts to integrate services and deliver new models of care. Poor flow is not only a source of significant waste and delay, but can be devastating for patients and service users and deeply frustrating for people working in health and social care.

The Health Foundation and AQuA have today published a new report, The challenge and potential of whole system flow. This report draws on over 20 examples from across the UK and internationally. It outlines an organising framework and tested methods that local health and social care leaders can use to improve whole system flow.

There are many flow-related initiatives across the UK. Our work has found that most focus on a small segment of the patient or service user journey, usually within hospitals. The time is right to look beyond the hospital and join up work in every team, service and organisation that patients and service users encounter. This report will help guide those on this journey.

[**http://www.health.org.uk/publication/challenge-and-potential-whole-system-flow?dm\_i=4Y2,4N7X2,FLR8HP,HB86K,1**](http://www.health.org.uk/publication/challenge-and-potential-whole-system-flow?dm_i=4Y2,4N7X2,FLR8HP,HB86K,1)

**OH position: Much of the content is familiar, but it pulls together a lot of useful material, with some helpful case studies, checklists and tools we will use to make sure we have been systematic in our approach to managing flow. It is a concept which is at the heart of so much we do, and is the key to a number of our key strategic and financial challenges and has been circulated to senior managers with a request it be circulated widely to teams. It also makes the link between the Centre for Quality (Institute) and flow, which will be important for us to develop.**

* 1. **Care Quality commission consults on next phase of regulation**

The The Care Quality Commission (CQC) has published its consultation on the next phase for developing its approach for how it regulates NHS foundations trusts and trusts, in line with the direction of travel outlined in its five year strategy for 2016-2021. The consultation also covers a set of principles that CQC is proposing to apply for regulating new and complex models of care.

In addition, CQC and NHS are jointly consulting on their shared approaches to the ‘well-led’ framework and assessing use of resources. Both consultations will run from 20 December 2016 to 14 February 2017.

<http://www.cqc.org.uk/content/our-next-phase-regulation>

<https://improvement.nhs.uk/uploads/documents/Consultation_on_use_of_resources_and_well-led_assessments.pdf>

**OH position: The consultation documents will be considered such that the Trust can plan for the implications to existing CQC compliance systems, use of resources and the well led assessment following final publication of any changes to existing regulations.** **CQC’s schedule of inspection will change to target those areas where concerns have been identified and this will see a significant reduction in the number of comprehensive inspections it undertakes. CQC will commit to inspect at least one core service of each trust and will separately look to inspect trusts for overall leadership on an “approximately annual basis”. This could lead to the reduction of the regulatory burden placed on us and would be welcomed.**

* 1. **CQC to review children and adolescent mental health services nationally**

The Prime Minister on 9 January delivered the annual Charity Commission Lecture where she announced a series of measures to "transform mental health support".

As part of this, she has asked the Care Quality Commission to lead "a major thematic review of children and adolescent mental health services across the country" to identify what is working well and what is not. CQC will take forward this work in discussion with other agencies and inspectorates, and expects to report on its findings in 2017/18.

Welcoming the announcement that CQC will carry out a thematic review on CAMHS in England, Dr Paul Lelliott, CQC's Deputy Chief Inspector of Hospitals (lead for mental health), said: "We know from our own inspections of all mental health services in England that there are problems with the quality of care that children and adolescents receive. These include long waiting times for assessment and treatment and difficulty accessing inpatient care close to home for those who need it.

"Through our inspection and ratings, we are holding mental health services to account. However, good mental healthcare for young people is about much more than the work of these specialised services. It requires all those responsible for healthcare, social care and education to work together to identify mental health problems early and to provide the support and care that young people need to attain and maintain good mental health.

"Our thematic review will identify the strengths and weaknesses of the current system to support young people's mental health and help us better understand the pathways that children with mental health issues follow and the obstacles that they face."

<http://www.cqc.org.uk/content/cqc-review-children-and-adolescent-mental-health-services-nationally-following-prime>

**OH position: The current focus on access and waiting times will continue and the Trust will welcome the learning from this thematic review and the national focus on the challenges faced for child and adolescent patients/service users in order to strengthen its improvement activity.**

* 1. **Priorities for the NHS and Social Care – Kings Fund**

The Kings Fund reports that 2017 promises to be another challenging year for the health and care system, with demand for care increasing faster than the supply of resources.

A system already stretched to its limits will have to work even harder to maintain current standards of care and to balance budgets. This requires a continuing focus on operational performance and renewed efforts to transform the delivery of care at a time when frontline staff are working under intense pressure.

The NHS five year forward view (Forward View) will be tested to its limits as leaders work to improve performance and transform care. The NHS locally has to deliver £15 billion of the £22 billion efficiency improvements required under the Forward View, with the remaining £7 billion to be delivered nationally. It also has to provide evidence that new care models are delivering benefits. Failure to do so will raise serious questions about the assumptions on which the Forward View was based and on the ability of leaders to deliver their plans.

Against this background, the Kings Fund has identified five main priorities for 2017.

<https://www.kingsfund.org.uk/publications/priorities-nhs-social-care-2017>

* 1. **Government response to 5YFV for mental health**

NHS Providers issued a briefing in January which covers announcements by the prime minister and the secretary of state for health on the government's response to the NHS Five year forward view for mental health, and the third progress report on the cross-government outcomes strategy to save lives.

The announcements focus on priority areas of mental healthcare through measures including:

* + - children's and young people's services
    - mental health in employment settings
    - improved community-based provision of mental health services
    - improved digital and online mental health services

<https://www.nhsproviders.org/resource-library/briefings/on-the-day-briefing-government-response-to-5yfv-for-mental-health>

* 1. **Failures in investigated deaths uncovered by CQC report**

The Care Quality Commission has published [Learning, Candour and Accountability](http://www.cqc.org.uk/content/learning-candour-and-accountability), the report of its review of the way NHS foundation trusts and trusts review and investigate the deaths of patients in England.

The Secretary of State offered the Government’s initial response to the House of Commons, announcing a range of measures in response to the recommendations. For trusts, these will include:

From March 31 2017 the boards of all NHS Trusts and Foundation Trusts will be required to:

* Collect and report to NHS Improvement a range of specified information, to be published quarterly (this requirement will be confirmed in new regulations), on deaths that were potentially avoidable and serious incidents and consider what lessons need to be learned on a regular basis.
* This will include estimates of how many deaths could have been prevented in their own organisation and an assessment of why this might vary positively or negatively from the national average, based on methodology adapted by the Royal College of Physicians from work by Professor Nick Black and Dr Helen Hogan.
* Alongside that data, trusts must publish evidence of learning and action‎ that is happening as a consequence of that information.
* Identify a board-level leader (likely the medical director) as patient safety director to take responsibility for this agenda and ensure it is prioritised and resourced within their organisation.
* Appoint a non-executive director to take oversight of progress.
* Follow a new, standardised national framework to be developed for identifying potentially avoidable deaths, reviewing the care provided, and learning from mistakes.
* Government will ensure that investigations of any deaths that may be the result of problems in care are more thorough and genuinely involve families and carers.
* The NHS National Quality Board will draw up guidance on reviewing and learning from the care provided to people who die, in consultation with Keith Conradi, Chief Investigator of Healthcare Safety.
  + These guidelines will be published before the end of March 2017, for implementation by all Trusts in the year starting April 2017.
* Health Education England will review the training for all doctors and nurses with respect both to engaging with patients and families after a tragedy and maintaining their own mental health and resilience in extremely challenging situations.

To address particular challenges for the investigations of deaths of people with learning disabilities:

* The Government will ensure that the NHS reviews and learns from all deaths of people with learning disabilities, in all settings.
* The Learning Disabilities Mortality Review Programme will provide support to both families and local NHS areas to enable reporting and independent, standardised review of all learning disability deaths between the ages of 4 to 74.
* There will be coverage in all regions by the end of 2017 and full national roll out by 2019.
* As the programme develops, all learnings will be transferred to the national avoidable mortality programme.
* The LeDeR programme has been asked to provide annual reports to the Department of Health on its findings and how best to take forward the learnings across the NHS.
* In acute trusts: particular priority will need to be given to identifying patients with a mental health problem or a learning disability to make sure their care responds to their needs; and that special effort is made during any mortality investigations to ensure wrong assumptions are not made about the inevitability of death for these patients.

A copy of the full report and a summary version and a data annex are also available on the <http://www.cqc.org.uk/content/learning-candour-and-accountability>, along with the Inquest submission and report on a family listening day.

**OH position: The Director of Nursing presenting the outcome of externally supported reviews of the Trust’s processes at the January Board Seminar, set out plans for improvements supported by the Board. Progress will be monitored by the Quality Committee and through the Quality Accounts process.**

* 1. **Local authorities underspending on mental healthcare**

The Times reports that new figures released in response to a freedom of information act request have shown how local authorities are spending under 1% of their public health budgets on mental healthcare, with 13 spending nothing at all during 2015/16. While NHS clinical commissioning groups provide treatment for mental health conditions, local authorities are expected to finance schemes which aim to stop such conditions deteriorating. Mind Chief Executive Paul Farmer said: “The current spending on public mental health initiatives is negligible… it undermines the government’s commitment to giving mental health equality with physical health.”

<http://www.thetimes.co.uk/article/councils-fail-on-mental-healthcare-820nnl8b5>