

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

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**RR/App 34(i)/2022**

(Agenda item: 19)

# Board of Directors

**25th May 2022**

***READING ROOM PAPER***

***LEGAL, REGULATORY AND POLICY UPDATE***

**SITUATION**

This report provides an update to inform the Board of Directors on recent regulation and compliance guidance issued by such as NHSI/NHS England, the Care Quality Commission and other relevant bodies where their action/publications have a consequential impact on the Trust, or an awareness of the change/impending change is relevant to the Board of Directors. A section in the Addendum to pick up learning or consider a ‘True for Us’ position is also included to support development/improvement activity and focus of the Board and its committees.

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

**BACKGROUND**

1. **Health and Care Bill granted Royal Assent**

*DHSC, 28 Apr 2022*

The Health and Care Bill has become law and includes measures which are targeted at supporting data sharing between health and social care. The bill, which received Royal Assent on April 28, has been backed by £36billion over the next three years through the Health and Care Levy. Part of the bill includes addressing “the barriers to joined up working, by supporting data sharing between health and social care”.

Another measure included is for every part of England will be covered by an Integrated Care System (ICS) and to [give these organisations statutory footing](https://www.digitalhealth.net/2021/02/nhs-overhaul-icss-to-be-enshrined-in-law-for-more-integrated-care/) from 1 July 2022. ICSs have been established with the aim to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

The Health and Care Act builds on the proposals for legislative change set out by [NHS England in its Long Term Plan](https://www.digitalhealth.net/2019/01/nhs-long-term-plan-technology-focus/), while also incorporating valuable lessons learnt from the pandemic to benefit both staff and patients

[**https://www.gov.uk/government/news/health-and-care-bill-granted-royal-assent-in-milestone-for-healthcare-recovery-and-reform**](https://www.gov.uk/government/news/health-and-care-bill-granted-royal-assent-in-milestone-for-healthcare-recovery-and-reform)

1. **Health and Care Act 2022: Preventing modern slavery in NHS supply chains**

Shortly before the Health and Care Bill 2021 (‘the Bill’) was given Royal Assent on 28 April 2022 and became the Health and Care Act 2022 (‘the Act’), the Department of Health and Social Care announced that it had tabled a “landmark amendment” to the Bill, aimed at eradicating “the use of goods and services in the NHS that are tainted by slavery and human trafficking”.

The amendment was agreed and has been incorporated into the Act. The Secretary of State for Health and Social Care stated that he wanted “this to be a turning point in the UK’s mission to eradicate slavery and human trafficking in supply chains around the globe. As the biggest public procurer in the country, the NHS is well placed to spearhead this work.” This will be a welcome addition to ensuring transparency in some of the largest supply chains, especially given the criticisms of the current approaches to reporting under the Modern Slavery Act 2015. This approach is also consistent with the government’s transparency in supply chains consultation which resulted in a commitment from government that large public bodies not currently captured by legislation would be required to publish a modern slavery statement. This would require legislative change, although, in practice, many public sector organisations already voluntarily publish statements

[**Health and Care Act 2022: Preventing modern slavery in NHS supply chains (dacbeachcroft.com)**](https://www.dacbeachcroft.com/en/articles/2022/april/health-and-care-act-2022-preventing-modern-slavery-in-nhs-supply-chains/)

**Trust position: The Board approves annually its Statement which is published on the website. Any new guidance will be taken into account as and when it is published**

1. **Government’s Mandate to NHS England**

This mandate sets a framework for NHS England in the year ahead, leading the NHS in recovering services impacted by the pandemic, so that we can get back on track with further improving them, tackling health and healthcare disparities, and supporting system leaders to build the effective relationships with local government and other partners that will foster innovation. It will underpin continued progress to integrated ways of working for health and care that will step up the pace of reform as, subject to Parliament's agreement, we implement the Health and Care Bill.

[**The government's 2022 to 2023 mandate to NHS England (publishing.service.gov.uk)**](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1065713/2022-to-2023-nhs-england-mandate.pdf)

**Trust’s position: The mandate sets out 13 priorities for NHS delivery in the year, but confirms its objectives will be reset in an “NHS long-term plan update” to be agreed between government and NHSE and published in summer 2022. The Trust (and ICS) will await the published changes to the long term plan and respond accordingly.**

1. **Changes to the MCA Code of Practice and implementation of the Liberty Protection Safeguards**

This consultation seeks views on proposed changes to the Mental Capacity Act 2005 Code of Practice and implementation of the Liberty Protection Safeguards. It is also seeking views on the LPS regulations, which will underpin the new system. This consultation closes on 7 July 2022.

[**https://www.gov.uk/government/consultations/changes-to-the-mca-code-of-practice-and-implementation-of-the-lps**](https://www.gov.uk/government/consultations/changes-to-the-mca-code-of-practice-and-implementation-of-the-lps)

**Press release:** [**https://www.gov.uk/government/news/government-to-improve-protections-for-people-deprived-of-their-liberty**](https://www.gov.uk/government/news/government-to-improve-protections-for-people-deprived-of-their-liberty)

Collection: Mental Capacity (Amendment) Act 2019: Liberty Protection Safeguards (LPS) [Collection of documents relating to this topic.]

[**https://www.gov.uk/government/collections/mental-capacity-amendment-act-2019-liberty-protection-safeguards-lps**](https://www.gov.uk/government/collections/mental-capacity-amendment-act-2019-liberty-protection-safeguards-lps)

**Trust position: As reported in previous updates, the Mental Health Act and Law Committee is overseeing preparations with regard to the anticipated impact of this suite of legislative change.**

1. **New guidance promotes greater alignment of service change and capital business cases in the NHS**

NHS England and Improvement (NHSEI) has published an addendum to its service change guidance “*Planning, Assuring, and Delivering Service Change for Patients*”.

The addendum seeks to improve the alignment of service reconfiguration and capital business cases and the evaluation criteria that are used to identify preferred options. This clarification will benefit programme managers and directors working on business cases for planned service changes, including those under the New Hospital Programme.

[**B0595\_addendum-to-planning-assuring-and-delivering-service-change-for-patients\_may-2022.pdf (england.nhs.uk)**](https://www.england.nhs.uk/wp-content/uploads/2018/03/B0595_addendum-to-planning-assuring-and-delivering-service-change-for-patients_may-2022.pdf)

1. **Acquired brain injury call for evidence**

This consultation seeks views and ideas to help develop and build the government's acquired brain injury strategy and to identify ways to improve services and support. This consultation closes on 6 June 2022

[**https://www.gov.uk/government/consultations/acquired-brain-injury-call-for-evidence**](https://www.gov.uk/government/consultations/acquired-brain-injury-call-for-evidence)

**Press release:** [**https://www.gov.uk/government/news/call-for-evidence-to-support-people-with-acquired-brain-injuries**](https://www.gov.uk/government/news/call-for-evidence-to-support-people-with-acquired-brain-injuries)

1. **SEND review: right support, right place, right time**

Views on the green paper about the changes intended to the special educational needs and disabilities (SEND) and alternative provision (AP) system in England. This consultation closes on 1 July 2022.

[**https://www.gov.uk/government/consultations/send-review-right-support-right-place-right-time**](https://www.gov.uk/government/consultations/send-review-right-support-right-place-right-time)

1. **Prevention of Future Deaths reports in inquests – recurring themes**

The steady flow of Prevention of Future Deaths Reports (PFDs) issued by coroners to health and social care providers continues, but what can we learn from them?

This report looks at 200 PFDs issued by coroners over the course of 2021 to see what themes emerge. The section specific to Mental Health Trusts shows the results of reviewing 72 PFDs issued over the course of 2021 and illustrates the top ten issues raised by coroners with family involvement, risk assessments and communications being key themes also for the Trust.

[**inquest-prevention-of-future-deaths-reports-recurring-themes-2021-final.pdf (dacbeachcroft.com)**](https://www.dacbeachcroft.com/media/3125502/inquest-prevention-of-future-deaths-reports-recurring-themes-2021-final.pdf)

**Trust Position: The Trust’s solicitor and safety and risk team are reviewing the report against the Trust’s own analysis of inquest outcomes and PFDs. A review of the Trust’s process of action plan completion and learning from PFDs is included in the Internal Audit workplan for 22/23. Oxford Healthcare Improvement Team are leading quality improvement initiatives that drive improvement across some of the known themes (eg communicating with and involving families).**

1. **Racial Equality Report**

This report enables organisations to compare their performance with others in their region and those providing similar services, with the aim of encouraging improvement by learning and sharing good practice. It provides a national picture of WRES in practice, to colleagues, organisations and the public on the developments in the workforce race equality agenda.

The number of executive directors from ethic minority backgrounds on the boards of NHS Trusts has declined for the first time since records began four years ago with the report showing a drop from 155 in 2020 to 144 in 2021. It is encouraging to see year on year improvements in the number of ethnic minority staff at both very senior manager level within trusts, and at board level as a whole. However, the decrease in representation among executive directors in the NHS will need to be addressed if progress in other areas is to be maintained.

Small but consistent measures of progress addressing the disciplinary gap for ethnic minority staff compared with their white peers, is shown in the report with much work to be done, with a lack of improvement in equitable access to training and development, and career progression opportunities for ethnic minority staff.

NHS staff should never be on the receiving end of harassment or bullying – either from their colleagues, managers or patients and their families. The report underscores the fact that these issues need to be tackled head on.

[**NHS England » Workforce Race Equality Standard 2021**](https://www.england.nhs.uk/publication/workforce-race-equality-standard-2021/)

**RECOMMENDATION**

The Board of Directors is invited 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 plans and controls in place to deliver or prepare for compliance against any of the Trust’s obligations are appropriate and effective.

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

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**Addendum A**

**AWARENESS/LEARNING/’TRUE FOR US’/THOUGHT PIECES**

**CQC Inspections and updates**

***Black Country Healthcare NHS Foundation Trust***

*CQC overall rating: Good*

*12 May 2022*

*Press release:* [**https://www.cqc.org.uk/news/releases/black-country-healthcare-nhs-foundation-trust-rating-remains-good-following-cqc**](https://www.cqc.org.uk/news/releases/black-country-healthcare-nhs-foundation-trust-rating-remains-good-following-cqc)

**Report:** [**https://www.cqc.org.uk/provider/TAJ**](https://www.cqc.org.uk/provider/TAJ)

***CQC finds improvements at Leicestershire Partnership NHS Trust***

*CQC, 12 May 2022*

The Care Quality Commission (CQC) has published a report following a focused inspection of the acute wards for adults of working age and psychiatric intensive care units at Leicestershire Partnership NHS Trust.

*Press release:* [**https://www.cqc.org.uk/news/releases/cqc-finds-improvements-acute-wards-adults-working-age-psychiatric-intensive-care-units**](https://www.cqc.org.uk/news/releases/cqc-finds-improvements-acute-wards-adults-working-age-psychiatric-intensive-care-units)

**Report:** [**https://www.cqc.org.uk/provider/RT5**](https://www.cqc.org.uk/provider/RT5)

***CQC rates Norfolk and Suffolk NHS Foundation Trust inadequate and serves a warning notice***

*CQC, 12 May 2022*

The trust provides mental health and learning disability care for people across Norfolk and Suffolk. Although the latest inspection found some areas where people received better care compared to the previous inspection, there were more areas where deterioration in quality and safety were noted. In some cases, this exposed patients to risk of harm.

*Press release:* [**https://www.cqc.org.uk/news/releases/cqc-rates-norfolk-suffolk-nhs-foundation-trust-inadequate-serves-warning-notice**](https://www.cqc.org.uk/news/releases/cqc-rates-norfolk-suffolk-nhs-foundation-trust-inadequate-serves-warning-notice)

**Report:** [**https://www.cqc.org.uk/provider/RMY**](https://www.cqc.org.uk/provider/RMY)

***CQC publishes report on child and adolescent mental health wards at Greater Manchester Mental Health NHS Foundation Trust***

*CQC, 12 May 2022*

CQC carried out an unannounced focused inspection of Junction 17 and the Gardener Unit, to ensure standards were being met since the previous inspection in 2018. The overall rating for the CAMHS service remains unchanged and is good. The rating for how safe the service is, improved from requires improvement to good. Caring improved from good to outstanding*.*

*Press release:* [**https://www.cqc.org.uk/news/releases/cqc-publishes-report-child-adolescent-mental-health-wards-greater-manchester-mental**](https://www.cqc.org.uk/news/releases/cqc-publishes-report-child-adolescent-mental-health-wards-greater-manchester-mental)

**Report:** [**https://www.cqc.org.uk/provider/RXV**](https://www.cqc.org.uk/provider/RXV)

**Hospital discharge and community support guidance**

*DHSC, 31 Mar 2022*

Sets out how health and care systems should support the safe and timely discharge of people who no longer need to stay in hospital.

[**https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance**](https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance)

**Restraint, segregation and seclusion review: Progress reports**

*CQC, Mar 2022*

These reports comment on the progress following publication of their Out of sight – who cares? report and highlight the main areas where further work is still needed. CQC finds that there are still too many people in hospital. Once in hospital they often stay too long, do not always experience therapeutic care and are still subject to restrictive interventions.

[**https://www.cqc.org.uk/publications/themed-work/restraint-segregation-seclusion-review-progress-reports**](https://www.cqc.org.uk/publications/themed-work/restraint-segregation-seclusion-review-progress-reports)

**Press release:** [**https://www.cqc.org.uk/news/releases/more-action-needed-ensure-people-learning-disability-autistic-people-people-mental-ill**](https://www.cqc.org.uk/news/releases/more-action-needed-ensure-people-learning-disability-autistic-people-people-mental-ill)

**NHS Providers briefing:** [**https://nhsproviders.org/resources/briefings/next-day-briefing-cqc-out-of-sight-progress-report-march-2022**](https://nhsproviders.org/resources/briefings/next-day-briefing-cqc-out-of-sight-progress-report-march-2022)

**Five-year NHS autism research strategy for England**

*NHS England, 25 Mar 2022*

[**https://www.england.nhs.uk/publication/five-year-nhs-autism-research-strategy-for-england/**](https://www.england.nhs.uk/publication/five-year-nhs-autism-research-strategy-for-england/)

**An early integrated pathway for autism**

*NHS England, 29 Mar 2022*

A system-facing summary of an Integrated Early Care Pathway for Autism viewpoint published by a Manchester-based clinical-academic partnership. This summary describes how commissioners and providers can innovate the diagnosis-care pathway for young autistic children, including considerations for practice.

[**https://www.england.nhs.uk/publication/an-early-integrated-pathway-for-autism/**](https://www.england.nhs.uk/publication/an-early-integrated-pathway-for-autism/)

**The economic case for investing in the prevention of mental health conditions in the UK**

*Mental Health Foundation, Mar 2022*

The report, produced together with the London School of Economics and Political Science, makes the case for a prevention-based approach to mental health that would both improve mental wellbeing while reducing the economic costs of poor mental health.

[**https://www.mentalhealth.org.uk/publications/mental-health-problems-cost-uk-economy-least-118-billion-year**](https://www.mentalhealth.org.uk/publications/mental-health-problems-cost-uk-economy-least-118-billion-year)

**Infants, children and families to benefit from boost in support**

*DHSC, 2 Apr 2022*

To support parents, 75 local authorities have been announced as eligible for a share of £302 million to create new Family Hubs in their areas. These hubs give parents advice on how to take care of their child and make sure they are safe and healthy – providing services including parenting and breastfeeding support. There is also funding to support perinatal mental health. Oxfordshire and BOB areas are not included in the list.

[**https://www.gov.uk/government/news/infants-children-and-families-to-benefit-from-boost-in-support**](https://www.gov.uk/government/news/infants-children-and-families-to-benefit-from-boost-in-support)

**(See also** [**https://www.gov.uk/government/publications/family-hubs-and-start-for-life-package-methodology-for-pre-selecting-local-authorities**](https://www.gov.uk/government/publications/family-hubs-and-start-for-life-package-methodology-for-pre-selecting-local-authorities)**)**

**Leadership Framework for Health Inequalities Improvement**

*NHS Confederation, 31 Mar 2022*

Support and guidance for chairs and non-executive directors to help lead stronger NHS action on health inequalities.

[**https://www.nhsconfed.org/articles/leadership-framework-health-inequalities-improvement**](https://www.nhsconfed.org/articles/leadership-framework-health-inequalities-improvement)

**FAQs:** [**https://www.nhsconfed.org/articles/leadership-framework-health-inequalities-improvement-faqs**](https://www.nhsconfed.org/articles/leadership-framework-health-inequalities-improvement-faqs)

**Equity and endurance: how can we tackle health inequalities this time?**

*King's Fund, 16 Mar 2022*

In this new long read, the King's Fund explore what can be learnt from past attempts and make the case for developing a long-term approach to tackling health inequalities.

[**https://www.kingsfund.org.uk/publications/how-can-we-tackle-health-inequalities**](https://www.kingsfund.org.uk/publications/how-can-we-tackle-health-inequalities)

**Inclusive Britain: government response to the Commission on Race and Ethnic Disparities**

*DHSC + others, 17 Mar 2022*

Inclusive Britain is the government’s response to the report by the Commission on Race and Ethnic Disparities, which was published in March 2021. The report sets out over 70 actions in response to these recommendations, grouped under 3 main themes: trust and fairness, opportunity and agency, and inclusion.

[**https://www.gov.uk/government/publications/inclusive-britain-action-plan-government-response-to-the-commission-on-race-and-ethnic-disparities**](https://www.gov.uk/government/publications/inclusive-britain-action-plan-government-response-to-the-commission-on-race-and-ethnic-disparities)

**CQC inspects urgent and emergency care services in Gloucestershire**

*CQC, 17 Mar 2022*

CQC undertook inspections at a number of urgent and emergency care services across the One Gloucestershire ICS. Inspectors visited the emergency departments, as well as minor illness and injury units. They also inspected both the emergency operation centre and the emergency ambulance service, and an independent NHS 111 service and out of hours service.

[**https://www.cqc.org.uk/news/releases/cqc-inspects-urgent-emergency-care-services-gloucestershire**](https://www.cqc.org.uk/news/releases/cqc-inspects-urgent-emergency-care-services-gloucestershire)

**CQC prosecutes United Lincolnshire Hospitals NHS Trust for failing to provide safe care and treatment**

*CQC, 28 Mar 2022*

The state of the hospital environment ultimately led to the burns sustained by an elderly patient after she had fallen. The Trust has been ordered to pay a total of £111,204 after pleading guilty to failing to provide safe care and treatment to a patient.

[**https://www.cqc.org.uk/news/releases/cqc-prosecutes-united-lincolnshire-hospitals-nhs-trust-failing-provide-safe-care**](https://www.cqc.org.uk/news/releases/cqc-prosecutes-united-lincolnshire-hospitals-nhs-trust-failing-provide-safe-care)

**CQC rates Hertfordshire Partnership University NHS Foundation Trust’s child and adolescent mental health inpatient unit inadequate and serves a warning notice**

*CQC, 30 Mar 2022*

CQC found a significant deterioration in the quality of the service which was previously rated outstanding in March 2019.

[**https://www.cqc.org.uk/news/releases/cqc-rates-hertfordshire-partnership-university-nhs-foundation-trust%E2%80%99s-child-adolescent**](https://www.cqc.org.uk/news/releases/cqc-rates-hertfordshire-partnership-university-nhs-foundation-trust%E2%80%99s-child-adolescent)

**CQC publishes report on service for people with a learning disability or autistic people in Derbyshire**

*CQC, 30 Mar 2022*

CQC carried out this unannounced focused inspection of Hillside ward at Ash Green Learning Disability Centre, run by Derbyshire Community Health Services NHS Foundation Trust, to look at how safe and well-led the ward is, after receiving concerns relating to staffing, care planning, restraint and staff engagement.

[**https://www.cqc.org.uk/news/releases/cqc-publishes-report-service-people-learning-disability-or-autistic-people-derbyshire**](https://www.cqc.org.uk/news/releases/cqc-publishes-report-service-people-learning-disability-or-autistic-people-derbyshire)

**Clinical Law Insight: Spring 2022**

*Capsticks, 10 Mar 2022*

Among other items, the Advisory section contains updates on the latest approach to CQC inspections and data protection.

[**https://www.capsticks.com/insights/clinical-law-insight-spring-2022**](https://www.capsticks.com/insights/clinical-law-insight-spring-2022)

**High Profile failings – learning/’true for us’**

A number of high profile corporate governance failures continually litter the headlines over recent weeks and the events that damage such organisations do not just happen. They are commonly linked to boards being blind to the underlying risks that threaten their organisations and to the effectiveness of governance systems. Whilst these are predominantly headline news items with some containing merely allegations – they are presented to the Board in this report to stimulate consideration of the importance of corporate governance (and of perception) and to give due regard to there being no risk of it being ‘true for us’ .

**NHSE wants ‘witch hunt’ lessons shared widely**

The high profile bullying scandal was reported in the last update to Board, and now a fourth “inadequate” rating in eight years follows at this mental health trust. This is despite Norfolk and Suffolk Foundation Trust’s inclusion in the national failure regime and being buddied up with the “outstanding” East London FT in recent years.

In early 2020, the long-troubled trust was rated “requires improvement” by the Care Quality Commission but kept in special measures. Patient safety concerns identified in November and December 2021 and CQC Inspectors found most services had deteriorated with a severe decline in care identified on children and young people’s wards. This service was previously rated “outstanding”.  Inspectors warned of a lack of permanent nurses and doctors, and high use of restrictive interventions.

**Finance team at scandal trust was ‘under-staffed and unable to whistleblow’**

An under-resourced finance department where staff did not feel they could blow the whistle on senior colleagues was a factor in enabling ‘intentional misstatement’ of a major acute trust’s financial position, as reported by the HSJ.

University Hospitals of Leicester Trust is subject to ongoing investigations into its financial accounts, after a near £50m hole was uncovered in its 2018-19 position, with the trust subsequently unable to complete its accounts in 2019-20 and 2020-21. The trust has since recruited a completely new senior management team, including a new chief executive, chair and chief financial officer.

It was stated that problems delivering control totals were compounded by the finance function being significantly understaffed and it was difficult for that team to see how they could whistleblow and raise concerns.