

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

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**RR/App\_BOD\_ 56(i)/2022**

(Agenda item: 14(a))

# Board of Directors

**28th September 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. **A new single assessment framework**

The CQC’s quality ratings and five key questions will stay central to their approach but they are replacing their existing key lines of enquiry (KLOEs) and prompts with new ‘quality statements’. It is intended these will reduce the duplication that’s in their four current separate assessment frameworks to allow the CQC to focus on specific topic areas under each key question, and will link to the relevant regulations to make it easier for providers.

[**https://www.cqc.org.uk/news/our-new-single-assessment-framework**](https://www.cqc.org.uk/news/our-new-single-assessment-framework)

**Trust position: The Trust’s external Well Led Governance Review is incorporating an assessment of the Trust’s position against the new quality statements.**

1. **Post-implementation Review Of Regulations Relating To The Care Quality Commission**

There will be a post-implementation review conducted of 3 sets of regulations made under the Health and Social Care Act 2008. These regulations are:

* Care Quality Commission (Registration) Regulations 2009
* Health and Social Care Act 2008 (Regulated Activities) Regulation 2014
* Care Quality Commission (Reviews and Performance Assessments) Regulations 2018

Feedback will be sought from all providers of a regulated activity that are registered with the Care Quality Commission (CQC) in England.

[**https://www.gov.uk/government/consultations/post-implementation-review-of-regulations-relating-to-the-care-quality-commission**](https://www.gov.uk/government/consultations/post-implementation-review-of-regulations-relating-to-the-care-quality-commission)

**Trust Position: The Trust will participate in the review as and when invited.**

1. **NHS Emergency Preparedness, Resilience and Response Framework**

This is a strategic national framework containing principles for health emergency preparedness, resilience, and response for NHS-funded organisations. All NHS-funded organisations must meet the requirements of the Civil Contingencies Act 2004, the NHS Act 2006, the Health and Care Act 2022, the NHS standard contract, the NHS Core Standards for EPRR and NHS England business continuity management framework.

The Framework has been updated to reflect the changes introduced from the Health and Care Act 2022 and the formation of Integrated Care Boards.

[**https://www.england.nhs.uk/publication/nhs-emergency-preparedness-resilience-and-response-framework/**](https://www.england.nhs.uk/publication/nhs-emergency-preparedness-resilience-and-response-framework/)

**Trust Position: The Trust has an EPRR policy supported by an annual EPRR work programme to ensure all cores standards are delivered. The DoCA is the accountable emergency officer (AEO). Trust’s EPRR manual has been updated to reflect the role of the ICBs since the dissolution of Clinical Commissioning Groups. The Trust’s assessment of its compliance with the legal and regulatory obligations set out in this Framework are subject annually to an assurance process (previously led by the CCG). We annually complete an assurance self-assessment based on these core standards. This assurance process is led nationally and regionally by NHS England and locally by integrated care boards. Until recently, the Trust had a NED Champion for EPRR Following a national review of NED champions, the requirement for a NED to support the AEO has been removed to recognize the whole board should assure themselves that requirements are being met. The Audit Committee will review the annual reporting of our EPRR assurances post the external assurance process and will make a recommendation to Board as to whether it is able to approve the Trust’s policy and procedure framework and arrangements.**

1. **First Ever Patient Safety Commissioner Appointed**

Dr Henrietta Hughes OBE has been appointed as the first ever Patient Safety Commissioner for England. The independent commissioner will act as a champion for patients and lead a drive to improve the safety of medicines and medical devices. Dr Henrietta Hughes will improve how the healthcare system listens to patients, the government and the NHS to put patients first.

[**https://www.gov.uk/government/news/first-ever-patient-safety-commissioner-appointed**](https://www.gov.uk/government/news/first-ever-patient-safety-commissioner-appointed)

1. **Consultation Outcome: The Future Regulation of Medical Devices in The United Kingdom**

In this far-reaching public consultation, the MHRA has received strong support for proposals that will enable the MHRA to improve patient safety and safeguard public health by enabling access to a high-quality supply of safe and effective medical devices through appropriate regulatory oversight. The MHRA will therefore proceed with preparing regulations reclassifying products such as certain implantable devices, extending the scope of regulations to capture certain non-medical products with similar risk profiles to medical devices (e.g., dermal fillers, coloured contact lenses) and to strengthen and increase post-market surveillance requirements ensure better incident monitoring reporting and surveillance. Strong support was also heard for improved traceability of medical devices, including the use of Unique Device Identification (UDI).

The consultation also outlined changes with potential to improve support for innovation in medical devices, and access to medical devices. These included improving regulation of novel and growing areas such as software (including artificial intelligence (AI)) as a medical device to offer alternative and safe routes to market for game changing innovation.

[**https://www.gov.uk/government/consultations/consultation-on-the-future-regulation-of-medical-devices-in-the-united-kingdom**](https://www.gov.uk/government/consultations/consultation-on-the-future-regulation-of-medical-devices-in-the-united-kingdom)

**Trust Position: The sub and sub-sub committees responsible for medical devices will assess the implications of any newly published requirements that affect the business of the Trust and oversee compliance accordingly.**

1. **A Guide To The Health and Care Act 2022**

The April Legal Update to the Board referred to the Health and Care Act 2022 having received Royal Assent. This is a comprehensive guide to the Act for trusts and foundation trusts and focuses on those sections of most relevance and interest to trust leaders. The Health and Care Act 2022 (the Act) contains the biggest reforms to the NHS in nearly a decade, laying the foundations to improve health outcomes by joining up NHS, social care and public health services at a local level and tackling growing health inequalities.

The majority of the Act is focused on developing system working with integrated care systems (ICSs) being put on a statutory footing through the creation of integrated care boards (ICBs). It also moves the NHS away from competitive retendering by default and towards collaborative delivery. The Act formally merges NHS England and NHS Improvement and gives the secretary of state a range of powers of direction over the national NHS bodies and local systems and trusts.

Other provisions include putting the Healthcare Safety Investigation Branch (HSIB) on a statutory footing; a new legal power to make payments directly to social care providers; the development of a new procurement regime for the NHS; and a new duty on the secretary of state to report on the system for assessing and meeting the workforce needs of the health service in England. The NHS will have to have regard to the wider effects of its decisions ('the triple aim duty'), and new duties will apply with regards to the environment. Regulations are planned to eradicate modern slavery and human trafficking from supply chains.

[**https://nhsproviders.org/a-guide-to-the-health-and-care-act-2022**](https://nhsproviders.org/a-guide-to-the-health-and-care-act-2022)

1. **Building The Right Support For People With A Learning Disability and Autistic People**

The government have updated their action plan to strengthen the community support for people with a learning disability and autistic people and reduce reliance on mental health and inpatient care. It aims to make further and faster progress and drive long-term change for people with a learning disability and autistic people.

[**https://www.gov.uk/government/publications/building-the-right-support-for-people-with-a-learning-disability-and-autistic-people**](https://www.gov.uk/government/publications/building-the-right-support-for-people-with-a-learning-disability-and-autistic-people)

[**https://nhsproviders.org/resources/briefings/next-day-briefing-building-the-right-support-for-people-with-a-learning-disability-and-autistic-people-action-plan**](https://nhsproviders.org/resources/briefings/next-day-briefing-building-the-right-support-for-people-with-a-learning-disability-and-autistic-people-action-plan)

**Trust Position: The Quality Committee oversees compliance with the relevant standards ensuring that people with a learning disability and autistic people cared for by OHFT experience high quality, timely support that respects individual needs and wishes and upholds human rights**, **Board has received reports evidencing amongst other requirements, collaboration across the system to put in place the support that prevents crisis and avoids admission ensuring that, when someone would benefit from admission to a mental health hospital, they receive therapeutic, high quality care, and remain in hospital for the shortest time possible**

1. **NHS Providers Response to the MCA Draft Code and LPS Implementation Consultation**

LPS provisions will allow the NHS, rather than local authorities, to make decisions about patients and service users, resulting in a more efficient and clearly accountable process because patients are most likely to be onsite or in touch with NHS services at the time they require these provisions. Other demands being placed on the system, and the capacity of health and care staff to deliver what is required, need to continue to be carefully considered as this work progresses.

[**https://nhsproviders.org/resources/submissions/nhs-providers-response-to-the-mca-draft-code-and-lps-implementation-consultation**](https://nhsproviders.org/resources/submissions/nhs-providers-response-to-the-mca-draft-code-and-lps-implementation-consultation)

**Trust Position: Previous updates to the Board concerning the Mental Capacity Act and Liberty Protection Safeguards have highlighted the role of the Mental Health and Law Committee in overseeing the Trust’s preparedness.**

1. **Integrated Care Systems: Autonomy and Accountability: Inquiry**

The Health and Social Care Committee has launched a new inquiry to consider how Integrated Care Systems will deliver joined up health and care services to meet the needs of local populations.

[**https://committees.parliament.uk/work/6821/integrated-care-systems-autonomy-and-accountability/**](https://committees.parliament.uk/work/6821/integrated-care-systems-autonomy-and-accountability/)

1. **Integrated Care Boards: Counter Fraud Statutory Guidance**

This outlines the counter fraud requirements for integrated care boards (ICBs) and describes the interaction and division of responsibilities between the counter fraud functions of ICBs and NHS England.

[**https://www.england.nhs.uk/publication/integrated-care-boards-counter-fraud-statutory-guidance/**](https://www.england.nhs.uk/publication/integrated-care-boards-counter-fraud-statutory-guidance/)

1. **Working In Partnership With People and Communities: Statutory Guidance**

This guidance is for Integrated Care Boards, NHS trusts, foundation trusts and NHS England. It supports effective partnership working with people and communities to improve services and meet the public involvement legal duties.

[**https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/**](https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/)

**Trust Position: Involvement is a contractual responsibility for Provider organisations, as set out in the NHS Standard Contract. The Trust strives to build positive, trusted and enduring relationships with communities in order to improve services, support and outcomes for people. The Board receives reports across a number of areas to cover provider collaboratives, co-production, patient and staff feedback and surveys and feedback from such as Healthwatch and is of course cognisant of engagement activity with our own Governors. The Director of Strategy and Partnerships will progress work across this statutory guidance and is reporting to the September board meeting with a particular focus on the VCSE community.**

1. **Delivering A ‘Net Zero’ National Health Service**

This report outlines trajectories to a net zero and the interventions required to achieve them. It sets out the direction, scale and pace of change, and early steps the NHS needs to take to decarbonize.

[**https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/**](https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/)

**Trust Position: The Trust has received updates on the developments in the Trust’s Green plan and carbon reduction strategies which will continue to be driven and overseen by the Sustainability Group chaired and championed by the Trust Chair.**

1. **Regular Asymptomatic Testing Paused In Additional Settings**

Routine asymptomatic testing was paused across remaining settings, including hospitals and care homes, from 31st August as Covid-19 cases continued to fall. Symptomatic testing in high-risk settings will continue.

[**https://www.gov.uk/government/news/regular-asymptomatic-testing-paused-in-additional-settings**](https://www.gov.uk/government/news/regular-asymptomatic-testing-paused-in-additional-settings)

[**https://www.england.nhs.uk/publication/covid-19-testing-in-periods-of-low-prevalence/**](https://www.england.nhs.uk/publication/covid-19-testing-in-periods-of-low-prevalence/)

**Trust Position: In response to the lower Covid-19 prevalence, and in line with national guidance, the Trust paused asymptomatic testing for staff and patients from Thursday, 1st September 2022. Asymptomatic staff are no longer required to undertake and report twice weekly LFD tests (unless through personal choice). Staff may need to LFT when visiting/accessing care homes. Asymptomatic patients will no longer need LFD testing on admission or throughout their stay if they remain asymptomatic. The recent BA.5 wave has now peaked, and the prevalence of Covid-19 and other epidemiological indicators are declining and are likely to continue to decline in the coming weeks. This means there is less Covid-19 circulating and this reduces the risk of transmission including in high-risk settings (such as the NHS), As guidance is under constant review it is subject to change and any updates will be cascaded accordingly.**

1. **Patient Safety Incident Response Framework and Supporting Guidance**

The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between ‘patient safety incidents’ and ‘serious incidents’. The PSIRF is not a different way of describing what came before – it fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement.

[**https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/**](https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/)

[**https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/**](https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/)

[**https://nhsproviders.org/resources/briefings/on-the-day-briefing-patient-safety-incident-response-framework-psirf**](https://nhsproviders.org/resources/briefings/on-the-day-briefing-patient-safety-incident-response-framework-psirf)

**Trust Position: The Trust has already ceased to maintain the “serious incidents” classification and threshold, and does not now differentiate between PSIs and “serious incidents”. Through investigations, reporting, themes and trends the Trust is developing on an ongoing basis its patient safety incident profile, ongoing safety actions in response to investigation recommendations, as well as established programmes of improvement. The Trust is applying and embedding the PSIRF into the development and maintenance of our PSI response policy and plan and aims to be compliant within the required 12 month timeframe.**

1. **Equality Delivery System 2022 – Guidance and Resources**

Implementation of EDS 2022 is a requirement of both NHS commissioners and NHS provider organisations. In light of the inclusion of EDS 2022 in the NHS standard contract, NHS organisations should use the EDS 2022 reporting template to produce and publish a summary of their findings and implementation.

[**https://www.england.nhs.uk/publication/equality-delivery-system-2022-guidance-and-resources/**](https://www.england.nhs.uk/publication/equality-delivery-system-2022-guidance-and-resources/)

[**https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/**](https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/)

**Trust Position: The People, Leadership and Culture Committee oversee the Trust’s equality delivery system and annual reporting process which is also reported subsequently to the Board of Directors.**

1. **Race Inequality and it’s Impact on NHS Workforce, Patients and Communities.**

Race inequality and its impact on our NHS workforce, our patients and communities has never been a higher priority for boards. COVID-19, the murder of George Floyd and subsequent antiracism protests have all shone a spotlight on long-standing racial injustices and how profoundly they affect people's lived experience and life chances.

Within the NHS, data from NHS staff survey results, and the Workforce Race Equality Standard (WRES) have consistently highlighted inequalities in the experiences of ethnic minority staff. Similarly, in the report *Race 2.0 Time for real change* published earlier this year, only 4% of respondents said they felt that race equality is fully embedded as a core part of their board’s business. There is clearly so much more for us all to do. One of the biggest reported challenges for leaders is having the time and capacity to make an impact on race equality. This is particularly the case if they experience an uphill struggle in persuading other board members that race equality should be a priority.

[**Race 2.0 - Time For Real Change (nhsproviders.org)**](https://nhsproviders.org/race-2-0-time-for-real-change)

**Trust Position: Again, the People, Leadership and Culture Committee oversee the Trust’s WRES delivery system and annual reporting process which is also reported subsequently to the Board of Directors.**

**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 and reassurances 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**

**CQC Rates South Central Ambulance Service NHS Foundation Trust Inadequate Following Inspection**

*CQC, Sept 2022*

The CQC found issues with the trust’s governance which undermined the quality of care it was providing to people. To focus the trust’s attention on addressing these issues, the CQC has issued a warning notice requiring immediate and significant improvements are put in place. Following this inspection, CQC’s overall rating for the trust and its ratings for how safe and well-led it is have dropped from good to inadequate. CQC rating for how responsive to people’s needs the trust is, has deteriorated from good to requires improvement, while its ratings for being effective and caring remained good.  For the core services within in the trust that CQC inspected, the rating for the EOC has dropped from good to requires improvement, and the rating for emergency and urgent care has deteriorated from good to inadequate.

[**https://www.cqc.org.uk/press-release/cqc-rates-south-central-ambulance-service-nhs-foundation-trust-inadequate-following**](https://www.cqc.org.uk/press-release/cqc-rates-south-central-ambulance-service-nhs-foundation-trust-inadequate-following)

**CQC tells West London NHS Trust to improve its community mental health services**

*CQC, 15 Jul 2022*

West London NHS Trust provides a range of mental health services for people across the boroughs of Ealing, Hammersmith, Fulham and Hounslow. CQC visited community mental health teams in each area to assess the care being provided to people.

[**https://www.cqc.org.uk/press-release/cqc-tells-west-london-nhs-trust-improve-its-community-mental-health-services**](https://www.cqc.org.uk/press-release/cqc-tells-west-london-nhs-trust-improve-its-community-mental-health-services)

**CQC inspects wards at Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust**

*CQC, 8 Jul 2022*

Rose Lodge is a standalone assessment and treatment inpatient unit for adults aged 18 and over with learning disabilities, autism, mental health problems or severely challenging behaviour. The unannounced focused inspection was carried out after receiving information of concern.

[**https://www.cqc.org.uk/press-release/cqc-inspects-wards-cumbria-northumberland-tyne-and-wear-nhs-foundation-trust**](https://www.cqc.org.uk/press-release/cqc-inspects-wards-cumbria-northumberland-tyne-and-wear-nhs-foundation-trust)

**Buckinghamshire Healthcare NHS Trust retains good rating following CQC inspection**

*CQC, 1 Jul 2022*

[**https://www.cqc.org.uk/press-release/buckinghamshire-healthcare-nhs-trust-retains-good-rating-following-cqc-inspection**](https://www.cqc.org.uk/press-release/buckinghamshire-healthcare-nhs-trust-retains-good-rating-following-cqc-inspection)

**Clinical Law Insight: Summer 2022**

*Capsticks, 12 Jul 2022*

Includes analysis of recent cases involving NHS Trusts covering liability, duty of candour, CQC prosecutions and GDPR.

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

**CQC inspects wards at Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust – wards for people with a learning disability or autism**

*CQC, 12 Aug 2022*

The CQC carried out an inspection of wards for people with a learning disability or autism in May. In 2020, following a focused inspection, CQC issued four requirement notices. At this inspection these breaches had been met.

[**https://www.cqc.org.uk/press-release/cqc-inspects-wards-cumbria-northumberland-tyne-and-wear-nhs-foundation-trust-0**](https://www.cqc.org.uk/press-release/cqc-inspects-wards-cumbria-northumberland-tyne-and-wear-nhs-foundation-trust-0)

**Gloucestershire Health & Care NHS Foundation Trust retains good rating following CQC inspection**

*CQC, 19 Aug 2022*

Inspectors looked at two mental health core services and five community health core services.

[**https://www.cqc.org.uk/press-release/gloucestershire-health-care-nhs-foundation-trust-retains-good-rating-following-cqc**](https://www.cqc.org.uk/press-release/gloucestershire-health-care-nhs-foundation-trust-retains-good-rating-following-cqc)

**CQC finds improvement at Essex Partnership’s mental health inpatient services but there is still more to do**

*CQC, 29 Jul 2022*

The child and adolescent mental health wards at Essex Partnership University NHS Foundation Trust have been rated requires improvement by the Care Quality Commission (CQC), following an inspection undertaken in March and April 2022.

[**https://www.cqc.org.uk/press-release/cqc-finds-improvement-essex-partnerships-mental-health-inpatient-services-there-still**](https://www.cqc.org.uk/press-release/cqc-finds-improvement-essex-partnerships-mental-health-inpatient-services-there-still)

**CQC warns Cambridgeshire and Peterborough NHS Foundation Trust to make improvements to keep people safe**

*CQC, 22 Jul 2022*

This inspection followed information received by CQC of a patient allegedly sexually assaulting another patient at the service.

[**https://www.cqc.org.uk/press-release/cqc-warns-cambridgeshire-and-peterborough-nhs-foundation-trust-make-improvements-keep**](https://www.cqc.org.uk/press-release/cqc-warns-cambridgeshire-and-peterborough-nhs-foundation-trust-make-improvements-keep)

**Surrey and Borders Partnership NHS Foundation Trust: Trust Headquarters**

***CQC, 29 Jul 2022***

**Overall: Good (HQ only, not services)**

[**https://www.cqc.org.uk/location/RXXHQ**](https://www.cqc.org.uk/location/RXXHQ)

**CQC publishes report on community health services for children and young people at Bradford District Care NHS Foundation Trust**

*CQC, 24 Aug 2022*

CQC carried out an inspection in June after receiving concerns about the quality of care being provided. Following this inspection all the ratings remain the same. The service is rated as requires improvement overall and for being safe and responsive to people’s needs. Effective, caring and well-led are rated as good.

[**https://www.cqc.org.uk/press-release/cqc-publishes-report-community-health-services-children-and-young-people-bradford**](https://www.cqc.org.uk/press-release/cqc-publishes-report-community-health-services-children-and-young-people-bradford)

**Improvements found at North East London NHS Foundation Trust and rated good by CQC**

*CQC, 26 Aug 2022*

The overall rating of the trust improved from requires improvement to good, as did the rating for acute wards for adults and psychiatric intensive care units. The rating for mental health crisis services and health based places of safety moved from inadequate to good.

[**https://www.cqc.org.uk/press-release/improvements-found-north-east-london-nhs-foundation-trust-and-rated-good-cqc**](https://www.cqc.org.uk/press-release/improvements-found-north-east-london-nhs-foundation-trust-and-rated-good-cqc)

**Recent case law on gender critical beliefs**

*Capsticks, 9 Aug 2022*

These judgments demonstrate how difficult it is to balance the sometimes conflicting rights of not only employees, but also service users and members of the public at large. These cases highlight that this is a developing area of legal and social debate, where employers and organisations need to tread with care.

[**https://www.capsticks.com/insights/recent-case-law-on-gender-critical-beliefs**](https://www.capsticks.com/insights/recent-case-law-on-gender-critical-beliefs)

**System guidance documents**

*DHSC, 29 Jul 2022*

* **Health overview and scrutiny committee principles:**
* [**https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles**](https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles)
* **Guidance on the preparation of integrated care strategies:**
* [**https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies**](https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies)
* **Health and wellbeing boards: draft guidance for engagement:**
* [**https://www.gov.uk/government/publications/health-and-wellbeing-boards-draft-guidance-for-engagement**](https://www.gov.uk/government/publications/health-and-wellbeing-boards-draft-guidance-for-engagement)
* **Adult social care principles for integrated care partnerships:**
* [**https://www.gov.uk/government/publications/adult-social-care-principles-for-integrated-care-partnerships**](https://www.gov.uk/government/publications/adult-social-care-principles-for-integrated-care-partnerships)

**NHS Providers summary and briefing:**

[**https://nhsproviders.org/resources/briefings/on-the-day-briefing-system-guidance-documents**](https://nhsproviders.org/resources/briefings/on-the-day-briefing-system-guidance-documents)

**NHS Confederation briefing:** [**https://www.nhsconfed.org/publications/integrated-care-strategy-and-health-and-wellbeing-board-guidance**](https://www.nhsconfed.org/publications/integrated-care-strategy-and-health-and-wellbeing-board-guidance)

**Providers In Place-Based Partnerships**

This looks at case studies of local collaboration, supporting the development of successful place-based partnerships by articulating the essential contributions of trusts and exploring how trusts’ role might evolve over time. It sets out how trusts are involved in strategic place-based planning in partnership with others and in delivering joined up care.

[**https://nhsproviders.org/case-studies-of-local-collaboration**](https://nhsproviders.org/case-studies-of-local-collaboration)

**Realising the Benefits of Provider Collaboratives**

This report looks at some of the emerging benefits that provider collaboratives are working to realise as well as identifying some key enablers and risks that trust boards will need to consider. Trust leaders see significant opportunities in working collaboratively to benefit patients and service users. They know that no single organisation can tackle the systemic challenges facing the health and care sector alone and want to build on the success of collaboration during the Covid-19 response to deliver high quality, joined up and more efficient care for local communities.

[**https://nhsproviders.org/realising-the-benefits-of-provider-collaboratives**](https://nhsproviders.org/realising-the-benefits-of-provider-collaboratives)

**Health and Care Act 2022 briefing for governors**

*NHS Providers, 26 Jul 2022*

In this briefing, NHSP set out an overview of proposals and a summary of the key parts of the Bill. This was made available to the Trust’s governors.

[**https://nhsproviders.org/resources/briefings/health-and-care-act-2022-briefing-for-governors**](https://nhsproviders.org/resources/briefings/health-and-care-act-2022-briefing-for-governors)

**HIGH PROFILE FAILINGS – LEARNING/’TRUE FOR US’**

A number of high profile corporate governance failures continually litter the headlines 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 any risk of it being ‘true for us’.

**Lawyers warned trust that staff could ‘pick and choose’ documents for coroners**

An ambulance trust accused of withholding key evidence from coroners was previously warned its staff needed training to ‘understand the real risk of committing criminal offences’ in relation to inquests into patient deaths.

The Ambulance Service, which has been accused by whistleblowers of withholding details from coroners in more than 90 deaths, was told by its lawyers in 2019 about serious shortcomings in its processes for disclosing information, according to internal documents obtained by a campaigner. According to the documents, the lawyers said trust staff could “pick and choose” documents to release to coroners “regardless of relevance.”

The following year, an audit report said the issues had not been addressed.

Whistleblowers’ concerns about the trust were first reported by *The Sunday Times* in the spring, with a review highlighting several cases between 2018 and 2019 where key facts were omitted in disclosures to coroners.

A review in spring 2020 found key evidence was not shared with coroners in a number of cases, and statements were changed or suppressed to hide potential shortcomings in care.

Dame Marianne Griffiths, who was chief executive of University Hospitals Sussex Foundation Trust, will chair an NHS England inquiry into the alleged cover-ups.

The trust highlighted it commissioned several external and independent investigations and reviews following staff concerns being raised in early 2019, which showed the trust’s processes and governance were causing delays in disclosure to coroners. However, they claimed the reviews did not find the trust was withholding evidence, and that the trust established a task force in April 2020 to ensure full disclosure to coroners. They said claims of continued failure in disclosing information are “incorrect”.

The Care Quality Commission has previously confirmed it received concerns from an employee in May 2020 regarding allegations the trust was withholding information from coroners. The CQC said it requested additional information from the trust which showed “improvements made to their coronial reporting systems remained in place,” and there was “no indication of any risk to patient safety”.

**CQC found to have unfairly dismissed a whistleblower**

An employment tribunal has just found the Care Quality Commission guilty of unfairly dismissing a whistleblower. HSJ examined the case and is implications highlighting that good leaders model the behaviours they expect of others. When you expect an inclusive culture with psychological safety for staff and patients in those you regulate, it helps to demonstrate such qualities oneself.

All leaders make errors. What leaders do to prevent errors, and especially what they do when they make errors, is a good measure of their leadership qualities, especially if those errors contravene the core values of the organisation. The Care Quality Commission has just been found by an Employment Tribunal to have made such an error. When one of its own inspectors reported serious concerns about patient safety and the treatment of staff in Trusts, it failed to act on those concerns and instead “disengaged” him.

The staff member provided evidence of multiple concerns about patient safety, patient harm including suspicious deaths and issues of probity including removing from the subsequently published CQC Inspection Report concerns that he had raised in an inspection. Mr Kumar told the Tribunal that in one trust “people are scared to submit clinical incidents due to loss of anonymity as some colleagues have met with reprisals”.

When the allegations were independently investigated, they were largely upheld (including through a Royal College of Surgeons review). The Employment Tribunal found that it was the raising of those multiple protected disclosures that led to his “disengagement”. Describing CQC managers’ evidence in part as “not plausible” the Tribunal unanimously found in favour of the sacked CQC inspector, agreed his disclosures were made in good faith and caused his dismissal, awarding damages.

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