

# Report to the Meeting of the

# Oxford Health NHS Foundation Trust

**RR/App 09(i)/2023**

(Agenda item: 25(a))

#

# Board of Directors

**29th March 2023**

***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. **CQC's assessment of integrated care systems**
 |
| From April 2023, the Care Quality Commission (CQC) will have power to assess integrated care systems, implementing a phased approach to developing the necessary competencies and relationships needed to assess these complex systems. NHS Confederation’s new briefing [summarises the current guidance on the CQC's approach](https://protect-eu.mimecast.com/s/Zb_4CWP4ysPBJvziYEm0u?domain=email.nhsconfed.org), and shares the NHS Confederation's analysis and viewpoint.**Trust Position: The aim of the assessment framework is to understand how ICSs are working to tackle health inequalities and improve outcomes for people. To understand this, the CQC will look at how services are working together within an ICS, as well as how systems are performing overall and so as well as the changing License condition mandating the Trust to be a system player, the Trust will prepare for those aspects of the regulatory environment assessing the same. As part of our assessment of partnership working, this will need to be a key component of future reporting to the Board.**  |

1. **Reforming the Mental Health Act**

A series of updates have been provided for the Board over a number of months but this briefing outlines in one place, the background to the reforms to the Mental Health Act 1983, including the main proposals in the white paper, the consultation and Government response, the draft Mental Health Bill and pre-legislative scrutiny.

[**https://commonslibrary.parliament.uk/research-briefings/cbp-9132/**](https://commonslibrary.parliament.uk/research-briefings/cbp-9132/)

**Trust Position: Various updates have already been provided in previous reports to the Board with regard to the Trust’s readiness for the reform and the work of the Mental Health Act and Law Committee.**

1. **The Being Fair report, three years on**

NHS Resolution’s Head of Safety and Learning, reflects in the update on what has been happening across the health system, since the publication of the Being Fair report.

[**https://resolution.nhs.uk/2023/01/27/the-being-fair-report-three-years-on/**](https://resolution.nhs.uk/2023/01/27/the-being-fair-report-three-years-on/)

1. **WRES Report warns of disadvantage**

The 2022 Workforce Race Equality Standard (WRES) report is the seventh publication, since the WRES was mandated and covers all nine indicators. The report has the following key roles:

* To enable 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;
* To provide a national picture of WRES in practice, to colleagues, organisations and the public on the developments in the workforce race equality agenda

This latest WRES report reveals white applicants remain 54% more likely to be appointed from NHS job shortlistings compared to ethnic minority candidates, a metric that has hardly budged since 2016. The report has revealed a significant rise in the proportion of staff from ethnic minority backgrounds, and while there had been progress on some key targets since last year, others have stagnated.

The Nursing Times picked up on the results pulling out that it evidences that Black nurses are the least likely to feel their organisation provides equal career opportunities and they also report some of the highest levels of discrimination The [2022 report, published by NHS England](https://www.england.nhs.uk/publication/nhs-workforce-race-equality-standard-2022/), said these findings pointed to a "striking disadvantage" affecting Black nurses.

**Trust Position: The People Leadership and Culture committee has delegated responsibility for overseeing the Trust’s improvement in its WRES findings, and the Trust’s own results are part of its workplan/agenda. Its oversight function will look to use results to drive evidence-based actions to reverse adverse trends. National data and benchmarking also help the Trust to replicate areas of improvement by some other trusts.**

1. **Rapid review into data on mental health inpatient settings**

The purpose of the rapid review will be to produce recommendations to improve the way data and information is used in relation to patient safety in mental health inpatient care settings and pathways, including for people with a learning disability and autistic people. A report will be produced in spring 2023.

[**https://www.gov.uk/government/publications/terms-of-reference-for-rapid-review-into-data-on-mental-health-inpatient-settings**](https://www.gov.uk/government/publications/terms-of-reference-for-rapid-review-into-data-on-mental-health-inpatient-settings)

**HSCC comment:** [**https://committees.parliament.uk/committee/81/health-and-social-care-committee/news/185888/government-response-to-report-impact-of-body-image-on-mental-and-physical-health/**](https://committees.parliament.uk/committee/81/health-and-social-care-committee/news/185888/government-response-to-report-impact-of-body-image-on-mental-and-physical-health/)

**Trust Position: On publication of the findings, the report will be reviewed to assess any opportunities for learning and improvement at the Trust, and where such exist nationally, no doubt guidance will follow from government. The Quality Committee workplan will incorporate any relevant focus as it transpires in the published findings.**

1. **Net Zero Building Standards Published**

|  |
| --- |
| NHS England has published its [net zero building standards](https://protect-eu.mimecast.com/s/E4lHCw0WDuAQWvrIP-xHd?domain=email.nhsconfed.org), which aim to reduce emissions in the construction and running of new facilities. The standards will apply **from October 2023 to new buildings** and upgrades to existing estates that require Treasury business case approval. They also explain how carbon and energy limits must be set for new developments using a set methodology.In 2020, the NHS became the first national health system in the world to commit to net zero emissions, launching its new National Programme for a Greener NHS. ‘Delivering a “Net Zero” National Health Service’ (2020) plots an ambitious set of actions to respond to climate change with clear targets for achieving a net zero health service for direct emissions by 2040 and indirect emissions by 2045 |

**Trust Position: The NHS Net Zero Building Standard creates a clear set of performance criteria relating to various elements of a net zero carbon building – both in construction and in operation. The Standard lays the foundation for major construction and refurbishment projects in the NHS that are expected over the next decade. The guidance is being reviewed in terms of its impact on the Trust’s Estate Strategy and in particular on the Warneford Park ambitions.**

1. **Revised launch date for new organisations**

Ministers have announced that there will be a delay of six months until the establishment of the Health Services Safety Investigations Body (HSSIB) and the Maternity and Newborn Safety Investigations Special Health Authority (MNSI). The revised date for the launch of both organisations is now October 2023.

[**https://www.hsib.org.uk/news-and-events/revised-launch-date-for-new-organisations/**](https://www.hsib.org.uk/news-and-events/revised-launch-date-for-new-organisations/)

1. **NHS to expand services to keep vulnerable out of hospital**

Community services including falls and frailty teams will be scaled up, with up to 50,000 people a month supported by clinicians at home in high-tech ‘virtual wards’. Urgent community response teams will be scaled up to provide more patients with support at home within 2 hours.

[**https://www.gov.uk/government/news/nhs-to-expand-services-to-keep-vulnerable-out-of-hospital**](https://www.gov.uk/government/news/nhs-to-expand-services-to-keep-vulnerable-out-of-hospital)

**NHS Providers briefing:** [**https://nhsproviders.org/resources/briefings/on-the-day-briefing-delivery-plan-for-recovering-urgent-and-emergency-care-services**](https://nhsproviders.org/resources/briefings/on-the-day-briefing-delivery-plan-for-recovering-urgent-and-emergency-care-services)

**Case studies:**

* Case study: Warwickshire frailty service keeps half of patients at home after falls, [**https://www.england.nhs.uk/publication/case-study-warwickshire-frailty-service-keeps-half-of-patients-at-home-after-falls/**](https://www.england.nhs.uk/publication/case-study-warwickshire-frailty-service-keeps-half-of-patients-at-home-after-falls/)
* Case study: 20,000 plus people avoid hospital admission in Birmingham thanks to new health approach, [**https://www.england.nhs.uk/publication/case-study-20000-plus-people-avoid-hospital-admission-in-birmingham-thanks-to-new-health-approach/**](https://www.england.nhs.uk/publication/case-study-20000-plus-people-avoid-hospital-admission-in-birmingham-thanks-to-new-health-approach/)

**Trust Position: Updates have previously been provided to the Board with regard to the Trust’s plans to provide care closer to home which are also a key part of the partnership work with Oxford University Hospitals NHS FT and the Trust’s frailty work. See also below re the work of the Trust:**

* **Number of virtual wards across the South East increased as expansion announced as part of national plan**,

**Includes an example from Oxford:** [**https://www.england.nhs.uk/south-east/2023/02/01/number-of-virtual-wards-across-the-south-east-increased-as-expansion-announced-as-part-of-national-plan/**](https://www.england.nhs.uk/south-east/2023/02/01/number-of-virtual-wards-across-the-south-east-increased-as-expansion-announced-as-part-of-national-plan/)

1. **The state of community health services in England**

It has proved difficult to realise a long-standing ambition to deliver more services out of hospital. In this explainer, Sarah Scobie and Stephanie Kumpunen describe what community services are, who uses and provides them, who pays for them, and some of the challenges they face.

[**https://www.nuffieldtrust.org.uk/resource/the-state-of-community-health-services-in-england**](https://www.nuffieldtrust.org.uk/resource/the-state-of-community-health-services-in-england)

1. **Introducing Integrated Care Systems – Report**

ICSs have the potential to improve the health of the populations they serve by better joining up services and focussing more on longer-term actions and preventative measures to address the causes of ill-health. However, they will not succeed unless the Department addresses the multiple longstanding challenges facing the NHS and social care which remain unresolved.

[**https://committees.parliament.uk/committee/127/public-accounts-committee/news/185951/latest-nhs-reforms-will-not-succeed-until-government-fixes-longstanding-problems/**](https://committees.parliament.uk/committee/127/public-accounts-committee/news/185951/latest-nhs-reforms-will-not-succeed-until-government-fixes-longstanding-problems/)

1. **Specialised Services and System Working**

This briefing outlines NHSE’s changes to specialised commissioning, beginning April 2023, as well as an analysis of the benefits and risks that come with greater system leadership.

[**https://nhsproviders.org/resources/briefings/specialised-services-and-system-working**](https://nhsproviders.org/resources/briefings/specialised-services-and-system-working)

**Trust Position: The Trust will continue to work with the ICB in support of the delegation of commissioning functions where the greatest difference to patient care can be made.**

1. **People, partnerships and place: How can ICSs turn the rhetoric into reality?**

Integrated care systems are now legally responsible for leading the charge on using a localised approach to bring multiple aspects of the health care system closer together. But this is far from a new aspiration. Nuffield Trust hosted a series of roundtables to discuss concerns with stakeholders and experts and understand how to ensure the aims are achieved.

[**https://www.nuffieldtrust.org.uk/research/people-partnerships-and-place-how-can-icss-turn-the-rhetoric-into-reality**](https://www.nuffieldtrust.org.uk/research/people-partnerships-and-place-how-can-icss-turn-the-rhetoric-into-reality)

1. **Foundation trust capital resource limits – statutory guidance**

The Health and Care Act 2022 includes a new discretionary power allowing NHS England to make an order imposing a limit on the capital expenditure of an NHS foundation trust. As part of the Act, NHS England must publish statutory guidance about the circumstances in which they are likely to make an order and the method they would use to determine the limit; this document provides that guidance.

[**https://www.england.nhs.uk/publication/foundation-trust-capital-resource-limits-statutory-guidance/**](https://www.england.nhs.uk/publication/foundation-trust-capital-resource-limits-statutory-guidance/)

**Trust Position: The guidance will of course have significance to the Trust as it develops its short- and longer-term capital expenditure plans, and as such, the guidance will influence the work of the Trust’s capital programme committee, Finance and Investment Committee and the Audit Committee. The same will apply regarding the guidance below.**

* **Capital investment and property business case approval guidance for NHS trusts and foundation trusts**

This guidance sets out the overarching principles relating to delegated limits and the business case approval process for capital investment and property transactions. This guidance is applicable to all NHS trusts and foundation trusts.

[**https://www.england.nhs.uk/publication/capital-investment-and-property-business-case-approval-guidance-for-nhs-trusts-and-foundation-trusts/**](https://www.england.nhs.uk/publication/capital-investment-and-property-business-case-approval-guidance-for-nhs-trusts-and-foundation-trusts/)

1. **DHSC's areas of research interest**

This document sets out the areas of research interest relevant to the Department of Health and Social Care (DHSC). DHSC has 3 ARIs which are set out below. ARI 1: early action to prevent poor health outcomes; ARI 2: reduction of compound pressures on the NHS and social care; ARI 3: shaping and supporting the health and social care workforce of the future.

[**https://www.gov.uk/government/publications/department-of-health-areas-of-research-interest**](https://www.gov.uk/government/publications/department-of-health-areas-of-research-interest)

1. **Next day briefing: Spring Budget 2023**

This briefing outlines the key policy announcements and NHS Providers' analysis of the implications for the health and care sector.

[**https://nhsproviders.org/resources/briefings/next-day-briefing-spring-budget-2023**](https://nhsproviders.org/resources/briefings/next-day-briefing-spring-budget-2023)

1. **NHS Standard Contract 2023/24**

There is a suite of documents including the full contract, shorter contract, technical guidance and more in the link below.

[**https://www.england.nhs.uk/publication/?filter-category=standard-contract**](https://www.england.nhs.uk/publication/?filter-category=standard-contract)

1. **Correspondence: Joint capital resource use plans: directions to ICBs and NHS trusts**

Directions to integrated care boards (ICBs), their partner NHS trusts and NHS foundation trusts specifying the period to which joint capital resource use plans must relate. This letter from Lord Markham sets out new obligations under the Health and Care Act 2022 for integrated care boards, their partner NHS trusts and NHS foundation trusts.

[**https://www.gov.uk/government/publications/joint-capital-resource-use-plans-directions-to-icbs-and-nhs-trusts**](https://www.gov.uk/government/publications/joint-capital-resource-use-plans-directions-to-icbs-and-nhs-trusts)

1. **Listening well guidance – A blueprint for organisations**

This document details the current landscape and proposes several ways that NHS trusts could expand on their approach to listening from local and national surveys through to staff networks and expert forums, using good practice from the NHS and private sector.

[**https://www.england.nhs.uk/publication/listening-well-guidance/**](https://www.england.nhs.uk/publication/listening-well-guidance/)

1. **NHS Staff Survey: National results briefing**

The survey ran from September to December 2022, amid winter demand, all-time high vacancy rates, a cost of living crisis and widespread industrial action. The survey was aligned to the overarching categories of the NHS People Promise and there were a number of new questions related to patient safety.

[**https://www.nhsstaffsurveys.com/static/8c6442c8d92624a830e6656baf633c3f/NHS-Staff-Survey-2022-National-briefing.pdf**](https://www.nhsstaffsurveys.com/static/8c6442c8d92624a830e6656baf633c3f/NHS-Staff-Survey-2022-National-briefing.pdf)

**NHS Providers briefing:** [**https://nhsproviders.org/resources/briefings/on-the-day-briefing-nhs-staff-survey-results-2022**](https://nhsproviders.org/resources/briefings/on-the-day-briefing-nhs-staff-survey-results-2022)

**Trust Position: The Board is considering the Trust’s results at the next meeting and PLC Committee will oversee progress of any action plans going forwards.**

**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**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Addendum A**

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

**CQC Inspections and updates**

* **London mental health service improves its CQC rating**

CQC inspected Camden and Islington NHS Foundation Trust’s acute wards for adults of working age and psychiatric intensive care units to check on the progress with improvements it previously told the trust to make.

[**https://www.cqc.org.uk/press-release/london-mental-health-service-improves-its-cqc-rating**](https://www.cqc.org.uk/press-release/london-mental-health-service-improves-its-cqc-rating)

* **CQC rates Somerset NHS Foundation Trust as good**

Somerset NHS Foundation Trust (SFT) is the first NHS trust on the English mainland to provide community, mental health, and acute hospital services. Inspectors visited the trust in September to assess three core services: acute wards for adults of working age and psychiatric intensive care unit (PICU); community end of life care services; specialist community mental health services for children and young people.

[**https://www.cqc.org.uk/press-release/cqc-rates-somerset-nhs-foundation-trust-good**](https://www.cqc.org.uk/press-release/cqc-rates-somerset-nhs-foundation-trust-good)

**CQC tells Cheshire and Wirral Partnership NHS Foundation Trust to make significant improvements**

The Care Quality Commission (CQC) has told Cheshire and Wirral Partnership NHS Foundation Trust to make significant improvements following an inspection of acute wards for adults of working age and psychiatric intensive care units (PICUs) in November found them to be inadequate.

[**https://www.cqc.org.uk/press-release/cqc-tells-cheshire-and-wirral-partnership-nhs-foundation-trust-make-significant**](https://www.cqc.org.uk/press-release/cqc-tells-cheshire-and-wirral-partnership-nhs-foundation-trust-make-significant)

* **CQC tells Greater Manchester Mental Health NHS Foundation Trust to make safety improvements**

CQC carried out this unannounced focused inspection due to concerns received about the safety of the wards and the care and treatment being provided in the wards for older people with mental health problems at Woodlands Hospital.

[**https://www.cqc.org.uk/press-release/cqc-tells-greater-manchester-mental-health-nhs-foundation-trust-make-safety**](https://www.cqc.org.uk/press-release/cqc-tells-greater-manchester-mental-health-nhs-foundation-trust-make-safety)

* **CQC tells Manchester mental health trust to make further improvements**

The Care Quality Commission (CQC) has told Greater Manchester Mental Health NHS Foundation Trust it must make improvements following an inspection of their community-based mental health services for people of working age in October.

[**https://www.cqc.org.uk/press-release/cqc-tells-manchester-mental-health-trust-make-further-improvements**](https://www.cqc.org.uk/press-release/cqc-tells-manchester-mental-health-trust-make-further-improvements)

* **Birmingham Women and Children’s NHS Foundation Trust rated as requires improvement following Care Quality Commission inspection**

Inspectors visited the following areas across the trust; specialist community mental health services for children and young people, child and adolescent mental health wards (CAMHS), community-based mental health services for adults of working age and mental health crisis services and health-based places of safety.

[**https://www.cqc.org.uk/press-release/birmingham-women-and-childrens-nhs-foundation-trust-rated-requires-improvement**](https://www.cqc.org.uk/press-release/birmingham-women-and-childrens-nhs-foundation-trust-rated-requires-improvement)

* **CQC publishes report on West London NHS Trust**

This is a report on community health services for adults based at West London NHS Trust following an inspection. West London District Nursing service is part of Ealing Community Partners. This is a group of NHS, local authority and voluntary organisations working together to deliver community health and care services for people.

[**https://www.cqc.org.uk/press-release/cqc-publishes-report-west-london-nhs-trust**](https://www.cqc.org.uk/press-release/cqc-publishes-report-west-london-nhs-trust)

* **Trust Headquarters, Central and North West London NHS Foundation Trust**

There was an announced follow up inspection carried out of healthcare services provided by Central and North West London NHS Foundation Trust (CNWL) at HMP Downview on 7 December 2022. This was in response to a His Majesty’s Inspectorate of Prison’s (HMIP) joint inspection carried out in July 2021 when it was found the quality of care needed improvement.

[**https://www.cqc.org.uk/location/RV3X2**](https://www.cqc.org.uk/location/RV3X2)

**Report (pdf):** [**https://api.cqc.org.uk/public/v1/reports/d92f446f-c2dd-46ef-b489-315232777f7b?20230214100039**](https://api.cqc.org.uk/public/v1/reports/d92f446f-c2dd-46ef-b489-315232777f7b?20230214100039)

* **Urgent action needed to prevent eating disorder deaths**

PHSO recently upheld a case about the death of a 35-year-old college teacher who believed her food was being tampered with and refused to eat. The woman had been sectioned and cared for by Cheshire and Wirral Partnership NHS Foundation Trust (CWP) and Wirral University Teaching Hospital NHS Foundation Trust (WUTH), in the six weeks before she died. The UK’s Health Ombudsman has warned that people with eating disorders are being repeatedly failed by the system and radical changes need to be made to prevent further tragedies.

[**https://www.ombudsman.org.uk/news-and-blog/news/urgent-action-needed-prevent-eating-disorder-deaths**](https://www.ombudsman.org.uk/news-and-blog/news/urgent-action-needed-prevent-eating-disorder-deaths)

* **Progress in improving mental health services in England. Report - Value for money**

This report focuses on the implementation of NHS commitments as set out in: the Five Year Forward View for Mental Health (July 2016); Stepping forward to 2020/21: The mental health workforce plan for England (July 2017); the NHS Long Term Plan.

[**https://www.nao.org.uk/reports/progress-in-improving-mental-health-services-in-england/**](https://www.nao.org.uk/reports/progress-in-improving-mental-health-services-in-england/)

* **Mental health and the cost-of-living crisis report: another pandemic in the making?**

This policy briefing paper provides an overview of the current and likely effects of the so-called ‘cost-of-living crisis’ on mental health.

[**https://www.mentalhealth.org.uk/sites/default/files/2023-01/MHF-cost-of-living-crisis-report-2023-01-12.pdf**](https://www.mentalhealth.org.uk/sites/default/files/2023-01/MHF-cost-of-living-crisis-report-2023-01-12.pdf)

* **Ombudsman extremely concerned about culture at University Hospitals Birmingham**

Recent and ongoing investigations by the Parliamentary Health Service Ombudsman (PHSO) into University Hospitals Birmingham (UHB) have uncovered a number of significant concerns. Investigations flagged serious issues around the culture and leadership of the Trust.

[**https://www.ombudsman.org.uk/news-and-blog/news/ombudsman-extremely-concerned-about-culture-university-hospitals-birmingham**](https://www.ombudsman.org.uk/news-and-blog/news/ombudsman-extremely-concerned-about-culture-university-hospitals-birmingham)

* **Case studies to support integrated care systems to adopt and spread innovation**

Whilst not comprehensive of the broad range of activities that ICSs will need to undertake to support innovation locally, this collection of case studies seeks to provide practical examples for how innovation can be implemented.

[**https://www.england.nhs.uk/publication/case-studies-to-support-icss-to-adopt-and-spread-innovation/**](https://www.england.nhs.uk/publication/case-studies-to-support-icss-to-adopt-and-spread-innovation/)

**See also:**

* [**https://www.england.nhs.uk/publication/case-study-norfolk-and-waveney-community-voices-the-power-of-shared-insight-across-partners-in-an-integrated-care-system/**](https://www.england.nhs.uk/publication/case-study-norfolk-and-waveney-community-voices-the-power-of-shared-insight-across-partners-in-an-integrated-care-system/)
* [**https://www.england.nhs.uk/publication/case-study-surrey-heartlands-integrated-care-system-ics-tackles-workforce-challenges-through-partnership-working-and-talent-strategy/**](https://www.england.nhs.uk/publication/case-study-surrey-heartlands-integrated-care-system-ics-tackles-workforce-challenges-through-partnership-working-and-talent-strategy/)
* [**https://www.england.nhs.uk/publication/case-study-collaborative-working-transforms-the-lives-of-people-with-a-learning-disability-autism-or-both-in-leicester-leicestershire-and-rutland-integrated-care-system/**](https://www.england.nhs.uk/publication/case-study-collaborative-working-transforms-the-lives-of-people-with-a-learning-disability-autism-or-both-in-leicester-leicestershire-and-rutland-integrated-care-system/)
* **Daily Insight: The high price of truth**

In legal fees and compensation, the Macanovic case cost Portsmouth Hospitals University Trust nearly £700,000. Provides a summary of the whistleblowing and dismissal case.

[**https://www.hsj.co.uk/daily-insight/daily-insight-the-high-price-of-truth/7034395.article**](https://www.hsj.co.uk/daily-insight/daily-insight-the-high-price-of-truth/7034395.article)

* **Nobody’s listening: what families say about prison healthcare**

According to this report, involving families more proactively in prisoners’ health care would reduce deaths in custody, relieve pressure on the NHS and the criminal justice system, and cut crime. The report also sets out some of the statistics that illustrate the extent of the health problems facing the prison population.

[**https://www.prisonadvice.org.uk/nobodys-listening**](https://www.prisonadvice.org.uk/nobodys-listening)

[**https://www.hsj.co.uk/workforce/nhse-wrongly-dismissed-discrimination-claim-from-black-nurse-tribunal-finds/7034283.article**](https://www.hsj.co.uk/workforce/nhse-wrongly-dismissed-discrimination-claim-from-black-nurse-tribunal-finds/7034283.article)

* **Safe and wellbeing reviews: thematic review and lessons learned**

As part of the NHS response to the safeguarding adults review concerning a number deaths at Cawston Park, a national review has been undertaken to check the safety and wellbeing of all people with a learning disability and autistic people who are being cared for in a mental health inpatient setting. This document sets out the themes emerging from the review findings.

[**https://www.england.nhs.uk/publication/safe-and-wellbeing-reviews-thematic-review-and-lessons-learned/**](https://www.england.nhs.uk/publication/safe-and-wellbeing-reviews-thematic-review-and-lessons-learned/)

Supporting people with a learning disability and autistic people to live happier, healthier, longer lives: bitesize guide for local systems. This guide contributes to the commitment in the 'Building the right support' action plan (Jul 2022) to publish a range of guidance and information for commissioners.

[**https://www.england.nhs.uk/publication/supporting-people-with-a-learning-disability-and-autistic-people-to-live-happier-healthier-longer-lives-bitesize-guide-for-local-systems/**](https://www.england.nhs.uk/publication/supporting-people-with-a-learning-disability-and-autistic-people-to-live-happier-healthier-longer-lives-bitesize-guide-for-local-systems/)

* **Children’s mental health services 2021-2022**

This report finds that the NHS estimates that 18 per cent of children aged 7 to 16 years and 26 per cent of those aged 17 to 19 have a probable mental health disorder, up from 17 per cent in 2021. It aims to assess children’s ability to access timely treatment, and to understand how that has changed in recent years.

[**https://www.childrenscommissioner.gov.uk/resource/29751/**](https://www.childrenscommissioner.gov.uk/resource/29751/)

* **Being an anchor institution: partnership approaches to improving population health**

This new report showcases just some of the many innovative approaches taken by trusts as they work to realise the benefits of their role as anchors in local communities.

[**https://nhsproviders.org/being-an-anchor-institution**](https://nhsproviders.org/being-an-anchor-institution)

* **No more sticking plasters: repairing and transforming the NHS estate**

This new report explores the state of capital funding and allocations across the NHS provider sector and sets out how capital investment has the potential to transform the NHS.

[**https://nhsproviders.org/no-more-sticking-plasters**](https://nhsproviders.org/no-more-sticking-plasters)

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

A number of high profile corporate governance failures and/or weaknesses 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 allegations to be investigated – they are presented to the Board in this report to stimulate consideration of the importance of corporate governance (and of perceptions on reputation) and to give due regard to there being any risk of it being ‘true for us’.

**Outstanding Trust handed warning notice**

An ‘outstanding’ rated acute trust has been served with a warning notice by the Care Quality Commission and told to make ‘significant and immediate improvements’ to its mental health and learning disabilities services.

The CQC said staff at Newcastle upon Tyne Hospitals Foundation Trust had not always carried out mental capacity assessments when people presented with mental health needs. And this included when decisions were made to restrain patients in the emergency department.

A CQC warning notice has been published alongside a report of an inspection between 30 November and 1 December last year, which says the trust must make “significant and immediate improvements in the quality of care being provided” to people with mental health issues, learning disabilities, or autism. The warning notice also says the trust must ensure people with a learning disability and autistic people “receive care which meets the full range of their needs”. The trust’s records “did not show evidence that staff had considered patients’ additional needs,” the regulator said.

**Rapid Review – into the safety of patients**

As also highlighted earlier, the government has launched a rapid review into the safety of patients in mental health hospitals in the wake of a series of reports of abuse and poor care. Mental health minister Maria Caulfield announced the short inquiry in a [parliamentary statement](https://questions-statements.parliament.uk/written-statements/detail/2023-01-23/hcws512?utm_campaign=1203163_Press%20release%20response%20to%20rapid%20review%20on%20MH%20inpatient%20settings&utm_medium=email&utm_source=NHS%20Confederation&dm_i=6OI9,PSD7,4WZ9VK,36YFP,1) .

“This review is an essential first step in improving safety in mental health inpatient settings,” she said. “It will focus on what data and evidence is currently available to healthcare services, including information provided by patients and families, and how we can use this data and evidence more effectively to identify patient safety risks and failures in care.”

The review will be led by former national clinical director for mental health at NHS England Dr Geraldine Strathdee, who is also chairing a [parallel independent inquiry into mental health deaths in Essex over the past two decades.](https://www.emhii.org.uk/)

The review follows a series of reports of abuse and poor care in inpatient settings including:

* Footage of staff assaulting, inappropriately restraining, secluding and verbally humiliating patients at the Edenfield Centre run by Greater Manchester Mental Health NHS Foundation Trust, [screened by the BBC’s Panorama programme last year.](https://www.communitycare.co.uk/2022/09/28/police-opens-investigation-into-abuse-at-mental-health-hospital-revealed-by-bbc/)
* [A call from NHS England for mental health providers to root out “toxic and closed” working cultures](https://www.communitycare.co.uk/2022/10/04/panorama-abuse-nhs-chief-urges-mental-health-leaders-to-tackle-toxic-and-closed-cultures/) in reviewing their safeguarding systems in the wake of the Edenfield Centre case.
* Patients reporting that a lack of activities was leading to increased violence on wards, with staff shortages undermining services’ ability to respond to this, according to the [Care Quality Commission’s latest annual report on its monitoring of the Mental Health Act 1983.](https://www.communitycare.co.uk/2022/12/01/older-people-unlawfully-detained-in-mental-health-hospitals-because-of-poor-dols-practice-warns-cqc/)
* Findings that staff were failing to carry out basic health checks, patients were not treated for the side effects of antipsychotic medication and rapidly deteriorating health going unnoticed and untreated, according to [an analysis of coroner reports over the past decade by *The Independent.*](https://www.independent.co.uk/news/health/mental-health-nhs-patient-deaths-b2148501.html)

The latter, published in December, led Labour to call for a rapid review of mental health settings.