THE LAMPARD INQUIRY

OPENING STATEMENT ON BEHALF OF NHS ENGLAND

Introduction

1. NHS England welcomes the Lampard Inquiry, fully supports its work and is grateful for the opportunity to participate. We are committed to assisting the Inquiry and learning from the evidence provided to it, as well as its findings.

2. NHS England recognises how important this Inquiry is for those who have lost loved ones, or who are affected in any way by the issues it is exploring. We welcome and support the Chair's intention to ensure that those affected remain at the heart of the Inquiry's work. During this phase of hearings, we will listen to families so that we can make sure we are hearing where improvements can be made and ensure that our later contributions to the Inquiry reflect compassionately and constructively on the experiences of patients and their families.

3. At this stage, the emphasis of the Inquiry is on hearing the stories from families and NHS England does not want to do anything to detract from this approach. NHS England has not yet provided evidence to the Inquiry nor seen any disclosure from other participants.

4. This statement is intended to assist the Inquiry, families and all core participants by giving a very brief explanation of NHS England and how it fits in as part of the wider National Health Service (NHS) structure that delivers or supports the provision of mental health services. As we consider that this stage of the hearings is focussed on hearing from the families, we do not intend to supplement this statement by an oral opening statement. This statement is not intended to pre-empt or replace the fuller provision of requested evidence, which we are happy to provide to the Inquiry in due course.

Structure of the NHS

5. The NHS in England is not one organisation. It is a complex ecosystem of organisations that each have their own roles and responsibilities. From time to time, these organisations and the functions they fulfil change, as the health needs of the population do and new evidence about how best to deliver services is made available. Since 1948, successive governments have determined how the NHS should be organised, with many reforms being undertaken through legislation, these include the changes which have taken place since 2000 which we cover below.

6. To help the Inquiry understand how the different parts of the NHS work together and to provide context for the Inquiry's relevant period, an overview is set out below.

7. Broadly, the NHS in England can be broken down into organisations with distinct roles and responsibilities for planning and delivering care to patients and the public and monitoring the quality of that care. These organisations consist of:

    a. Providers – these organisations (which include Trusts and Foundation Trusts, GPs, dentists and others) provide care directly to patients. The day-to-day care and management of patients is the responsibility of the provider but decisions about individual patient treatment are taken by clinical teams who use their professional judgement and relevant clinical guidelines to decide what treatment a patient should be offered and receive. Some providers are NHS organisations, but it is important to note that there are also independent organisations that provide NHS care and are funded by NHS contracts with commissioners.

    b. Commissioners – these organisations will assess health needs across a population or group of patients and are responsible for planning, prioritising, purchasing and monitoring health services. This involves deciding what services are needed, where they are needed, and ensuring that they are provided to the contractual specification.

    c. Regulators – these organisations will stipulate quality, treatment or professional requirements and assess, monitor and oversee the provision of health services by organisations and individuals. Organisations include

National Institute for Health and Care Excellence (NICE), the Care Quality Commission (CQC), the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC).

d. Policy, leadership and oversight – in general, it is the responsibility of the Department of Health and Social Care (DHSC) to set priorities and funding and direct national strategy. NHS England provides input and information to DHSC, then itself provides the national level strategic leadership to ensure that the government's policies are implemented. There are other organisations that also work at a national level providing policy and guidance across the NHS.

8. During the period covered by the Inquiry, there have been five key Acts of Parliament which changed the NHS landscape:

    a. National Health Service Reform and Health Care Professions Act 2002, which amended the previous structural framework of the NHS, abolishing regional health authorities and delegating functions to Primary Care Trusts (PCTs). This legislation created new Strategic Health Authorities (SHAs);

    b. Health and Social Care (Community Health and Standards) Act 2003, which allowed for the creation of Foundation Trusts;

    c. National Health Service Act 2006, which forms the foundation of the way in which the current NHS is structured and operates;

    d. Health and Social Care Act 2012, which created Clinical Commissioning Groups (CCGs) to replace PCTs and set up the NHS Commissioning Board (NHS England);

    e. Health and Social Care Act 2022, which created Integrated Care Systems and Integrated Care Boards (ICBs) (which have replaced CCGs), and has emphasised collaborative commissioning, with the vision that the Health and Social Care Systems should be more integrated and work together.

Key Changes in the Relevant Period

9. We understand the difficulties presented by the changing NHS structure over the long period of time that the Inquiry covers. ‘Corporate memory’ will be pieced together from the many parts. To assist the Inquiry and other Core Participants in following these changes in roles and responsibilities, we have set out below some of the key structural changes:

Providers

10. The first 57 NHS Trusts were established on 1 April 1991 under the National Health Service and Community Care Act 1990. By 2000, all NHS hospitals were under the management of an NHS Trust. NHS Trusts were subject to the Secretary of State’s powers of direction. Originally, this power of direction applied only in certain limited areas (such as the terms and conditions of staff, and powers to generate income) but, following the changes introduced by the Health Act 1999, NHS Trusts were subject to a general power for the Secretary of State to direct them about the exercise of any of their functions. The Health and Social Care Act 2012 removed the powers of direction over NHS Trusts except in the event of failure.

11. In 2004, a new form of NHS Trust was created called NHS Foundation Trusts. These Foundation Trusts had more freedoms than NHS Trusts in deciding their governance as well as having greater financial control. The (then) Government's original aim was that by 2008, all NHS Trusts would have reached a standard which would enable them to apply for NHS Foundation Trust status. Foundation Trusts are not subject to the Secretary of State power of direction and were authorised, monitored and regulated by Monitor.

Commissioners

12. In 2000, the NHS was managed nationally by a unit known as the NHS Executive. The NHS Executive was part of the DHSC and through 8 regional offices had the power to direct local bodies called Health Authorities and Primary Care Groups and in certain circumstances NHS Trusts. These local bodies were responsible for planning, purchasing and providing healthcare services, including mental health services.

13. In 2002, Primary Care Groups and Health Authorities were abolished and PCTs and SHAs were established in their place. PCTs were charged with responsibility to

commission most health care services locally and they reported to the SHAs. SHAs were responsible for overseeing and managing healthcare services at a regional level and were required to manage the performance of PCTs and NHS Trusts in their region by assessing data submitted by PCTs and Trusts and through their own reviews of assessments by other regulatory bodies. SHAs did not carry out their own inspections but, through the data reporting, assessments from other regulators and other reporting mechanisms, they formed an overall picture of performance of the organisations within their region.

14. Under the Health and Social Care 2012, PCTs and SHAs were abolished, and most commissioning obligations were transferred to CCGs. This Act also established the NHS Commissioning Board (later known as NHS England). NHS England took on the commissioning responsibilities from a range of legacy bodies. The services NHS England was responsible for are covered further below. NHS England also had responsibility for co-ordinating the provision of health services and consequently overseeing the operation of CCGs.

15. In 2023, CCGs were abolished, and the commissioning functions were transferred to newly established ICBs.

Regulators

16. In 2000, the Commission of Health Improvement (CHI) began operating as the first independent regulator of healthcare services. The CHI later became the Commission for Healthcare Audit and Inspection and then the Healthcare Commission.

17. In 2009, the Healthcare Commission was abolished and replaced by the CQC as the regulator of health and social care services. The National Quality Board was also established at this time to consider the risks and opportunities for quality and safety across the whole NHS system.

18. In 2000, there was already in place an organisation which was known as the National Institute for Clinical Excellence. This is now known as the National Institute for Health and Care Excellence and more commonly known as NICE. NICE is directly accountable to the DHSC to assess costs and benefits of interventions and make recommendations on treatment pathways.

19. As a result of the creation of NHS Foundation Trusts in 2004, a new NHS body was created called the Independent Regulator for Foundation Trusts (known as Monitor) to authorise, monitor and regulate the newly emerging Foundation Trusts. Later (in 2012), the Trust Development Authority (TDA) was established to manage the process of NHS Trusts becoming Foundation Trusts and to performance manage the remaining NHS Trusts.

20. In 2016, NHS Improvement was created by direction of the Secretary of State and brought together several organisations including Monitor and the TDA.

21. In 2019, NHS Improvement and NHS England came together to work as a single organisation to help improve care for patients and provide leadership and support to the wider NHS. The Health and Social Care Act 2022 formally brought the organisations together on 1 July 2022.

22. Throughout 2020, NHS England started setting up NHS-Led Provider Collaboratives for certain services including Specialised Mental Health, Learning Disability and Autism Services. NHS-Led Provider Collaboratives are a way for NHS Trusts and Foundation Trusts to work together, along with independent sector providers, in a collaborative manner to improve the provision of mental health services.

Commissioning of Mental Health Services

23. From 2013, NHS England had responsibility for the commissioning of some NHS services itself, often referred to as its ‘direct commissioning’ responsibilities. One set of such services are referred to as specialised services.

24. Unlike most healthcare, which is planned and arranged locally, specialised services in 2013 were planned nationally and regionally by NHS England, and the majority still are. Specialised services are defined as services to support people with a range of rare and complex conditions. They often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. They are listed in The National Health Service Commissioning Board and CCG (Responsibilities and Standing Rules) Regulations 2012 (as amended). Further information to accompany these Regulations is set out in the Prescribed Specialised Services Manual published by NHS England. Specialised services change from time to time and the regulations are amended by government.

25. The following services are Specialised Mental Health Services:

    a. Adult Secure – low, medium and high secure;

    b. Children and Young People Mental Health Services - General Adolescent; Psychiatric Intensive Care (PICU); Low Secure; Medium Secure, Eating Disorder; Children's (under 13s); Deaf; Forensic Child and Adolescent Mental Health Services (FCAMHS);

    c. Adult Eating Disorder;

    d. Obsessive Compulsive Disorder, Body Dysmorphic Disorder;

    e. Tier 4 Personality Disorder;

    f. Adult Secure and Non-secure Deaf;

    g. Mother and Baby In-patient Units (Perinatal);

    h. Offender Personality Disorder services (in partnership with HM Prison & Probation Service).

26. As part of the commissioning of specialised mental health services nationally, NHS England has Clinical Reference Groups (CRGs) to provide clinical advice and leadership. These groups of clinicians, commissioners, public health experts, people with lived experience of inpatient services and carers use their specific knowledge and expertise to advise NHS England on the best ways that specialised services should be provided.

27. An important part of the work of CRGs is to produce the tools used by the commissioning teams to contract for clinical services, such as Service Specifications. Service Specifications clearly define the care expected of organisations and describe core and developmental service standards.

28. NHS-Led Provider Collaboratives are now responsible for some elements of specialised mental health services, with NHS England remaining the accountable commissioner, and the Lead Provider acting as a subcontractor.

29. In the Relevant Period to the Inquiry, most mental health services (i.e., of a non-specialised nature) were and are commissioned locally, to ensure they meet the needs of people in the local area by CCGs and now ICBs. Typically, these would be mental health services provided in primary care (for example by GPs), or in the community by mental health teams, or in hospitals.

30. Care providers include NHS organisations, voluntary and community sector enterprises, local authorities and independent providers.

Other Roles of NHS England

31. In part of the Relevant Period to the Inquiry, NHS England (and its legacy bodies) was responsible for the oversight of local commissioners and providers of those healthcare services.

32. Regulation of providers was the responsibility of Monitor (for Foundation Trusts) and the NHS TDA (for NHS Trusts) as well as CQC. Monitor regulated NHS Foundation Trusts via the NHS Provider Licence which sets out conditions that providers of NHS services must meet. It also had a range of intervention and enforcement actions that it could take, as well as its role in supporting Foundation Trusts who were failing, or at risk of failing. Although Monitor was not directly responsible for carrying out inspections to assess the safety or quality of the care an NHS Foundation Trust was providing (this being the role of the CQC), evidence of poor-quality care or safety issues could potentially indicate a failure of governance. Monitor worked alongside the CQC to take action, using its licence enforcement powers, when the CQC reported that a hospital trust was failing to provide good quality care.

33. In 2015, Monitor and the TDA were brought together to create NHS Improvement and a single oversight framework was introduced. NHS Improvement and NHS England merged in 2022. Since 2023, both NHS Trusts and NHS Foundation Trusts have been required to hold an NHS Provider Licence.

34. The current version of the oversight framework was introduced in 2022 in order to bring together commissioner and provider oversight. The aim is that this reflects a more collaborative and supportive working approach between commissioners and providers as part of local systems.

35. NHS England is operationally distinct from the DHSC. The DHSC is responsible for setting policies that deliver the Government's strategic health objectives. However, NHS England has a key role in advising and providing other inputs to government and determining how to implement those policies to ensure effective delivery and it is accountable to the DHSC for their delivery. This means that one of NHS England's roles is to provide guidance to other NHS organisations. This national role means that the requirements to provide NHS services are the same across the country.

36. NHS England provides national level leadership, strategy and direction through policies, programmes and frameworks. This can be seen across a number of different areas including:

    a. How services should be commissioned and provided – there is a vast amount of guidance and frameworks produced to provide a national approach to the provision, implementation and improvement of NHS care in order to drive improvements in safety and quality. For example, the recently published Commissioning Framework for mental health inpatient services; the Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme and the Culture of Care standards for mental health inpatient services.

    b. How NHS organisations should run (sometimes known as clinical governance) – this is around how organisations deliver safe care and continuously try to improve the quality of their services. Examples include guidance on whistleblowing and freedom to speak up; estates policies and guidance; and the Safeguarding Accountability and Assurance Framework.

    c. National Patient Safety – NHS England has published a national patient safety strategy which describes how the NHS will continuously improve patient safety. It has also put in place a number of key frameworks including the Patient Safety Incident Response Framework.

d. How the leadership of NHS organisations should act – examples include guidance for commissioner and Provider Boards, code of governance for provider Boards, Guidance for Boards on implementing Freedom to Speak up.

e. Training and Development – planning, education and training of the workforce. This ranges from education and training programmes at student level to developing leadership in the NHS and production of the Long Term Workforce Plan.

Conclusion

37. NHS England recognises the incredibly important role for this Inquiry in identifying lessons that can be learned from the events that led to these tragic deaths in order to improve NHS mental health services both in Essex and nationally. We recognise that there will be areas where NHS England and the organisations that came before us could have done better. We know there is still work to do to provide high quality and timely mental health care for everyone who needs it, and to tackle inequalities in access, experience and outcomes and NHS England will value all the learning that will come out of this Inquiry to help us with this work.

38. NHS England wants to take the valuable opportunity these hearings provide to listen and hear what families have to say. We see this as an important part of the process of learning lessons from this Inquiry. We are committed to assisting the Inquiry so it can identify learning that can improve the care of patients and families using NHS services.