Summary of Evidence from NHS England

1. This is a summary of the evidence provided to the Inquiry by NHS England (NHSE).

2. It should be noted that this summary will not cover the totality of the information provided.

The role of NHSE

Background

3. The evidence submitted on behalf of NHSE as to its role was provided in a statement by Duncan Burton, Chief Nursing Officer, dated 24 March 2025 **[Core Bundle Index item 24, page 458]**. NHSE is a system of commissioners, regulators and providers each with distinct roles. It is an executive, non-departmental public body of the Department of Health and Social Care (DHSC). Since its establishment in 2013, it has been the commissioner of certain specialised mental health services; the statutory regulator of local commissioners and Trusts; it has an overall leadership role; and a patient safety role.

4. NHSE was formerly the NHS Commissioning Board for England. During the Relevant Period, there was significant legislative reform which led to NHS regulatory bodies coming together. The first change was NHS Improvement in 2016, which combined Monitor and the NHS Trust Development Authority, regulators of the Foundation Trusts and Trusts respectively. NHS Improvement and NHSE came together in

2019, formally merging in 2022. NHSE also merged with NHS Digital in February 2023 and with Health Education England in April 2023.

5. Commissioning is defined as the role of planning and securing the provision of healthcare services. It involves an ongoing process of assessment, planning, agreement and monitoring to ensure services are provided and delivered to the required standard. Commissioning responsibility falls to NHSE for specialised services and to Integrated Care Boards (ICBs) for non-specialised services.

6. Patients receive their care from providers who have an arrangement to deliver services with one or more commissioners. Providers are accountable to commissioners through their contracts, and it is their responsibility to ensure services are carried out in accordance with specifications and in line with clinical guidance and nationally determined healthcare standards. The providers employ their own staff and procure their own supplies. NHSE exercises an appointment role in relation to certain senior roles within Trusts but, aside from that, none of the staff are employed or managed by NHSE.

7. NHSE's core legal function and purpose is to promote a comprehensive health service to secure improvement in physical and mental health, and the prevention, diagnosis and treatment of physical and mental illness. It also has a role in respect of oversight of local commissioners and providers, and the NHSE works with the DHSC to contribute to the development of policy and to support the government in understanding the implications of their policies. To that end, NHSE engages with other people and organisations as necessary, including service users.

8. NHSE is governed by its own Board which provides leadership and accountability. It has regional teams responsible for the performance of all NHS organisations, overseeing interactions with Clinical Commissioning Groups (CCGs), and for commissioning functions in the region. Each regional team is led by the Regional Director who is part of the NHSE Executive. In relation to mental health services, each region provides the functions of strategic, quality and patient safety oversight, and policy implementation. The Regional Medical Director and Chief Nurse are responsible for leading regional quality teams and ensuring robust clinical governance and quality assurance. They chair the Regional Quality Committee which oversees quality improvement and patient safety including reviewing serious incidents.

9. Regional teams also participate in ICB Executive Quality Groups. For ICB-level failures, they assess the implications and support the providers. In addition, if a provider receives a Care Quality Commission (CQC) Warning Notice, the regional team supports them in implementing the relevant guidance. For any providers in a Recovery Support Programme (formerly Special Measures Programme), they support the central NHSE team in managing recovering providers.

10. In its role as commissioner, NHSE enters contracts with independent and NHS providers. From 2013, NHSE had statutory responsibility for commissioning primary care services, prescribed specialised services (including for mental health), certain military and veteran health services, services supporting children and adults throughout the criminal justice system, and a limited number of public health services. They directly commissioned mental health services that included adult secure, children and young people, specialist autism

spectrum disorder, adult eating disorder, and OCD and body dysmorphic disorder services.

11. Specialised services commissioned by NHSE are grouped into six National Programmes of Care, one of which is mental health. The programmes work primarily through a network of Clinical Reference Groups (CRGs) which develop national service specifications and guidance. One of the aims of the CRGs is to integrate lived inpatient experience to enhance mental health services.

12. Since 2020 NHS-led Provider Collaboratives have been in force. These are groups of providers of specialised mental health, learning disability and autism services who work together to improve care pathways for their local population. The collaboratives deliver specialised services in children and young people's mental health, adult low and medium secure, and adult eating disorder services.

13. Since April 2024, ICBs in the East of England, Midlands and North West have assumed full delegated commissioning responsibility for suitable services. CCGs, established in 2013, were responsible for planning and commissioning healthcare services within their local areas and were clinically led by statutory NHS bodies. As co-commissioners, CCGs worked with NHSE regional teams before being replaced by ICBs in 2022.

14. Since 2003, a Trust can be an NHS Trust or NHS Foundation Trust. The key difference is that Foundation Trusts have more autonomy. Each Trust is responsible for ensuring compliance with statutory and regulatory requirements for the delivery of safe, effective, efficient, and high-quality services. It is also the responsibility of the provider to

manage day-to-day care and the management of patients. This includes decision making around a patient's suitability for treatment and whether a patient should be admitted. Clinical treatment decisions are made in accordance with operational policy, provider procedure, clinical guidance and subject to regulatory requirements.

15. NHS Trusts and Foundation Trusts are subject to legal duties around health and safety, patient safety, complaints, data protection, safeguarding, etc. in their own right. Compliance with those duties informs NHSE and CQC oversight. Legal enforcement can occur outside of this sphere however, for example, through health and safety prosecutions and judicial review.

16. Before the introduction of Monitor with the Health and Social Care Act 2012, the Foundation Trusts were regulated by the Independent Regulator of Foundation Trusts, established in 2004. Monitor had a range of intervention and enforcement actions as well as a role in supporting failing Foundation Trusts. It became aware of patient safety issues in a variety of ways and conducted its own assessments to decide whether a formal investigation was necessary and enforcement action appropriate. As of 1 April 2013, the Trusts were monitored and regulated by the NHS Trust Development Authority.

17. Mental health services are delivered by a range of professionals in multidisciplinary teams, the majority of which are also regulated by the NMC, GMC, or the HCPC.

18. In 2016, NHS Improvement was created and became responsible for regulating NHS hospitals, before being subsumed into NHSE in 2019. At this point, the NHSE's role did not change, but rather the two organisations came together. NHSE continued to be responsible for

commissioning, and NHS Improvement responsible, through Monitor and the Trust Development Authority, for the regulation of providers. On 1 July 2022, NHSE and NHS Improvement formally merged at which point NHSE took on the regulatory functions of Improvement.

19. As to oversight, providers are subject to, primarily, registration and regulation by the CQC, contractual controls via the commissioning contract, and for Foundation Trusts and certain independent providers, the NHS Provider Licence. Since 1 April 2023, NHS Trusts have been required to hold a Provider Licence. The Foundation Trusts were expected to comply with the NHS Foundation Trust Code of Governance which echoed the requirements of the Provider Licence.

20. The 'fit and proper' person test applies to both organisations and individuals. In 2012 and 2014, statutory requirements imposed fit and proper persons requirements in relation to appointments to Foundation Trust boards. Enforcing compliance with the Fit and Proper Person Regulation was the responsibility of the CQC although it was incorporated into the Provider Licence framework.

21. Before 2016, there were separate oversight frameworks which applied to Foundation Trusts and Trusts. From September 2016, the Single Oversight Framework was introduced with the aim of supporting more Trusts to achieve good or outstanding ratings. When NHSE and NHS Improvement merged, a single NHS Oversight Framework applying to commissioners and providers was implemented.

22. There are also Primary Care Networks in which GP practices work together with the community, mental health, social care, pharmacy, hospital and voluntary services. The networks ensure that mental

health services are closely linked to community healthcare and encourage a more comprehensive approach to mental health care.

Involvement with providers

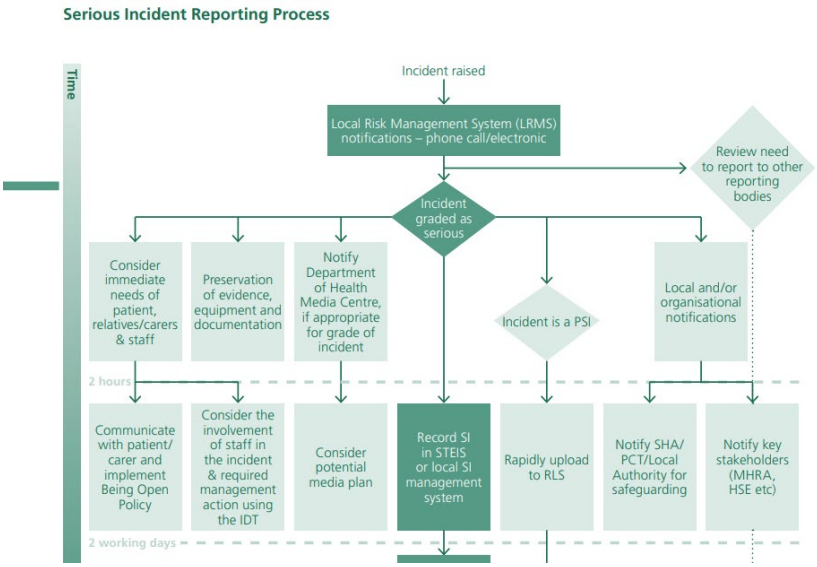
23. NHSE operates as an arms-length body that has a shared responsibility, with similar organisations, to oversee patient safety. Patient safety is part of a wider concept of quality and success in healthcare; it means the avoidance of unintended harm and the reduction of risk of such harm to an acceptable level. It does not concern deliberate or intended harm, as these are events concerning the police and safeguarding bodies.

24. NHS bodies are expected to deliver and/or oversee services including those that improve patient safety. This expectation is established through their legal duties, reporting requirements, observance of clinical standards, and their commissioner requirements. Trusts make their own policies for risk management and health and safety, which are informed by guidance from organisations such as the CQC. For example, the CQC has published guidance on reducing harm from ligatures on mental health wards [**Exhibits bundle, exhibit DB/019, page 6171**].

25. NHSE was established to deliver key statutory patient safety duties across the NHS including collecting information about what goes wrong and using that to provide advice and guidance. These included collecting information about what goes wrong in the health service and using that information to provide advice and guidance. Between 2012-2018 there were a number of patient safety initiatives directed by the government. The NHS Patient Safety Strategy 2019, updated in 2021 and 2023, was one of these and aimed at improving the way the

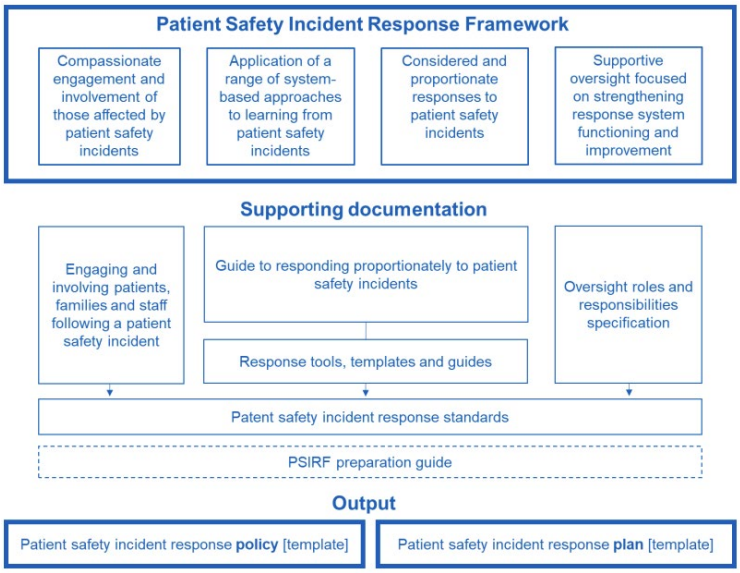
NHS learns about patient safety, building capability to address safety challenges and focus on key improvement priorities.

26. There are two systems which set out the expectations for the way in which the NHS should identify and manage certain patient safety incidents and serious incidents: the first is the 'National Framework for Reporting and Learning from Serious Incidents Requiring investigation' in place between 2010 and 2013 **[Exhibit DB/024, page 6224, excerpt below page 6230]**, which details a serious incident reporting process.



27. Secondly, the 'Serious Incident Framework', first published in 2013 **[Exhibit DB/025, page 6272]** and refreshed in 2015 **[Exhibit DB/026, page 6316]**. A new policy was announced when NHSE published the 'Patient Safety Incident Response Framework' (PSIRF) in 2022 **[Exhibit DB/027, page 6406]**. The PSIRF replaced the Serious Incident Framework and is one of the main systems for developing and maintaining effective processes for responding to patient safety incidents and facilitating learning. There is an overview of the framework and associated documentation at **[page 6415 below]**.

Figure 1: Overview of the Patient Safety Incident Response Framework documentation



28. Patient Safety Incidents are defined as "any unexpected or unintended event occurring in healthcare that could have, or did, lead to harm to one or more patients". There were three patient safety incident reporting tools used during the Relevant Period: the National Reporting and Learning System (NRLS) created in 2003, the Strategic Executive Information System (StEIS), and the Learn from Patient Safety Events Service (LFPSE). StEIS was primarily used as a mechanism for Trusts to notify regional and national health bodies about incidents meeting the threshold for 'Serious Incident', which included 'Never Events', specific types of serious incident listed under NHSE guidance. The NRLS and LFPSE systems are secondary use systems collating information already on Trusts' local risk management systems like Datix and Ulysses. Initially, incident reporting was voluntary, however, providers now have a statutory responsibility to notify the CQC about certain patient safety incidents such as unexpected deaths.

29. The current PSIRF was implemented following concerns about the earlier Serious Incident Framework raised by inquiries, investigations and reviews into the NHS. In response to the reports, NHS Improvement launched an engagement programme in March 2018 to gather feedback to support a new approach **[Exhibit DB/030, page 6419]** and **[Exhibit DB/031, page 6449, excerpt below page 6495]**. Compliance with PSIRF is a contractual requirement under the NHS Standard Contract.

Appendix 2: Response summary

This table summarises the responses to the suggestions surveyed in relation to each engagement topic area. (Note: 'blank responses' are the reason many of the responses do not add up to 100%.)

How effective would the following options be for supporting and involving patients, families and carers?	% don't know/ undecided	% completely ineffective	% not very effective	% somewhat effective	% very effective
Providing patients/families/carers with clear standardised information explaining how they can expect to be involved. This will mean they can more easily judge if an organisation is meeting its requirements and if it is not, raise this with the organisation (with support from their key point of contact who organisations are currently required to provide).	1	3	6	38	49
Requiring organisations to establish a process for gathering timely feedback from patients/families/carers about the investigation process. Concerns can then be more easily addressed and reliance on the formal complaints process as a means of addressing potential problems reduced.	1	5	14	37	39
Asking patients/families/carers to complete a standard feedback survey on receipt of the final draft investigation report that asks whether their expectations were met. This could help those responsible for overseeing investigations determine if a report can be signed off as complete.	3	16	19	34	24

At the same time, the National Patient Safety Team launched a consultation on developing the first Patient Safety Strategy.

30. Unlike the Serious Incident Framework, the PSIRF does not distinguish between patient safety incidents and 'Serious Incidents'. Instead, it is intended to promote a proportionate approach to reporting patient safety incidents. NHSE published a template plan and related guidance **[Exhibit DB/033, page 6501** and **Exhibit DB/035, page 6550]** respectively. The PSIRF emphasised the importance of engagement with families and those affected by an incident.

31. NHSE and the CQC were given duties to cooperate with each other under the Health and Social Care Act 2012, and in 2013 they signed a Partnership Agreement. The Agreement set out their respective roles and stipulated the common goal of the delivery of safe and good quality care. The primary statutory responsibility of the CQC is detailed as regular site visits and on the ground inspections of care delivery. The NHSE places considerable reliance on these assessments.

32. There is a Joint Strategic Oversight Group which provides a national forum for intelligence sharing, and Quality Surveillance Groups which facilitated NHSE engagement with the CQC and other regulators. The model for the Groups was first published in 2013 **[Exhibit DB/044, page 6585]**. In January 2022, the National Quality Board replaced the Quality Surveillance Groups and Risk Summits with a new operating model **[Exhibit DB/045, page 6615]**.

33. In relation to emerging concerns and the involvement of professional regulators, it should be noted that the CQC, and others concerned with quality and safety and public protection, have developed an Emerging Concerns Protocol (the "Protocol"). The Protocol was first published in 2018, having arisen as an action following a forum convened by a meeting of system regulators and professional regulators in October 2016. Professional regulators (such as the GMC and the NMC), the Local Government and Social Care Ombudsman, Health Education England, and the Parliamentary Health Standards Ombudsman) are signatories to the Protocol.

34. The Healthcare Safety Investigation Branch was established under the NHS Trust Development Authority regulations in 2016. It was an independent division responsible for investigating patient safety incidents. The incidents investigated were those that the Chief

Investigator considered evidenced risks affecting patient safety, following which it made recommendations to improve safety. The organisation's role was to encourage a culture of learning and improvement within the NHS. In 2022, the Healthcare Safety Investigation Branch became the Health Services Safety Investigation Branch (HSSIB), which was established on an independent statutory footing with more independence.

35. As to investigations, most investigations are undertaken by providers. NHSE has the power to undertake investigations directly, albeit this power has never been used; investigations are usually commissioned at a regional level. NHSE becomes aware of incidents in several ways albeit they would not be aware of every incident subject to investigation. In some circumstances, the incidents would be escalated to ICBs and then to NHSE. This would normally be appropriate in situations when, for instance, an independent investigation is deemed necessary to ensure public confidence in investigation integrity and/or where the incident represents significant learning potential for the wider system. As an example, there was an NHSE-commissioned independent investigation into homicides committed by patients treated for mental illness in 2013.

36. A medical examiner system was formally implemented in 2023. The system had several purposes including providing a better service for the bereaved. In addition, NHSE and the coronial service work together in relation to Prevention of Future Death (PFD) reports. NHSE would often receive PFD reports in its role as commissioner.

37. There is a statutory framework for complaints. Any concerns not in the form of complaints would be dealt with informally and many Trusts

had Patient Advice and Liaison Services to assist. Concerns could also be referred to the Parliamentary and Health Service Ombudsman. The NHSE as a commissioner of mental health services required providers to agree arrangements for the delivery of services within the terms of the NHS Standard Contract. The contract requires that a provider complies with its statutory obligations around complaints. NHSE also has a duty to handle, record and monitor complaints in its role as a commissioner, regulator and under its oversight obligations.

38. Safeguarding is an integral part of providing high quality healthcare and NHSE adopts a broad approach to safeguarding. NHSE is responsible for ensuring that the health commissioning system works effectively in safeguarding and promoting the welfare of vulnerable people, and for leading improvement of safeguarding practice. The Chief Nursing Officer has lead responsibility for ensuring the effective discharge of NHSE statutory safeguarding responsibilities. NHSE also facilitates the sharing of best practice and safeguarding improvements to ensure the health system is working effectively.

39. In respect of whistleblowing, NHSE publishes guidance to providers which is intended to set a minimum standard with which providers should comply. National guidance on whistleblowing was first issued in 2016. NHSE has also published a 'Freedom to Speak Up' policy to normalise speaking up for the benefit of patients and workers. This policy came with a guide for leaders in the NHS and organisations delivering services. All Trusts were expected to adopt the policy.

Mental health policy, standards and funding

40. In relation to mental health policy, the 'Five Year Forward View' was published in 2014 **[Exhibit DB/064, page 6649]** setting out an intention to transform the NHS by 2020. The document was a joint publication by NHSE, the CQC, Health Education England, Monitor, Public Health England, and the NHS Trust Development Authority. A further document, 'Implementing The Five Year Forward View for Mental Health' **[Exhibit DB/102, page 6829]** was published in 2016 setting out plans for developing mental health services following recommendations by an independent NHSE-commissioned report.

41. The NHS Long Term Plan was published in 2019 which detailed a plan to transform mental health services further. There was subsequently an NHS Mental Health Implementation Plan for 2019/20-2023/24 published **[Exhibit DB/103, page 6911, excerpt below page 6915]**. The plan detailed aims including eliminating out of area placements and reducing the length of inpatient stays to improve patient experience and outcomes.

42. In 2015, NHSE introduced waiting time standards for three mental health service areas: talking therapy services, early intervention in psychosis, and eating disorder services. Since 2015, the NHS met the standard for talking therapy and early intervention in psychosis. NHSE later published a consultation on a range of proposed waiting times. Also in 2015, NHSE published guidance to the NHS and local authority commissioners setting out a plan for developing community and inpatient facilities close to home.

43. NHSE and NHS Improvement commissioned the Mental Health Safety Improvement Plan, a national patient safety programme. It was

developed after a pilot programme saw a significant reduction in the use of restrictive practice. Its aim was to improve safety and experience in mental health, learning disability and autism inpatient services. The programme ran from 2021-2023 and worked with 54 NHS Trusts, as well as the CQC and regional NHS Improvement teams. NHSE then launched a Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme to develop a new model of care across NHS-funded mental health and inpatient settings.

44. The Culture of Care Standards for Mental Health Inpatient Services standards were then published in April 2024. These were co-produced with input from people with lived experience of inpatient settings and their families **[Exhibit DB/067, page 6690]**. The Culture of Care Standards included core commitments and standards for the culture of mental health inpatient care.

45. In relation to funding, NHSE introduced the Mental Health Investment Standard in 2017 requiring commissioners to increase their spend on mental health. As to staffing, NHSE recognises that staff shortages remain a major constraint to improving and expanding mental health services. NHSE published, in 2017 and 2019, estimates of how many additional staff would be required to deliver improved mental health services. In 2023, NHSE published the NHS Long term Workforce Plan which anticipated that demand for mental health services would grow faster than other NHS services.

46. NHSE stated that between 2017/18 and 2022/23, total spending on mental health services went up by an average of 2.7% a year (in real terms). In the same period, spending on Children and Young People's mental health increased by an average of 7% a year. Mental health

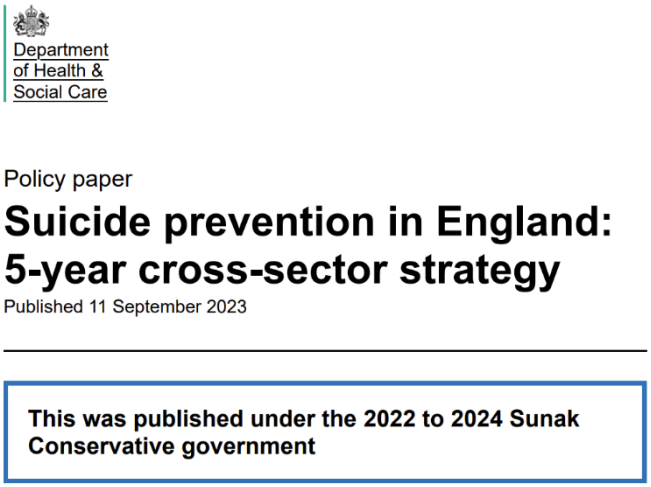
spend as a proportion of total recurrent NHS spend increased from 8.9% in 2022/23 to 9% in 2023/24.

47. On the issue of suicide specifically, the Five Year Forward View made a commitment to reducing suicides nationally. This was supported by the government's 'National Suicide Prevention Strategy' **[Exhibit DB/071, page 6724]** in 2017.


HM Government

Preventing suicide in England:
Third progress report of the cross-government outcomes strategy to save lives

In September 2023, the government published a policy paper on suicide prevention in England **[Exhibit DB/072, page 6762]**.


Department of Health & Social Care

Policy paper

Suicide prevention in England: 5-year cross-sector strategy

Published 11 September 2023

This was published under the 2022 to 2024 Sunak Conservative government

NHSE also commissions the National Confidential Inquiry into Suicide and Homicide.

48. The Mental Health Services Data Set (MHSDS) is dealt with in more detail shortly. This data aims to deliver nationally consistent information regarding individuals in contact with mental health services. The data is released regularly via the NHS Digital website. In 2016, NHSE introduced the Mental Health Dashboard which aimed to bring together data across mental health services.

Out of area placements, data systems and inpatient mental health data

49. The evidence submitted on behalf of NHSE regarding out of area placements, data systems and inpatient mental health data, was provided in a statement by Clare Panniker, NHSE Regional Director for East of England, dated 24 March 2025 **[Core Bundle Index item 54, page 858]**.

Involvement with mental health services

50. As aforementioned, NHSE has statutory responsibility for commissioning certain mental health services. Not every ICB has every service available in its area which is why patients may be placed away from home to access appropriate care and treatment. The term 'Natural Clinical Flow' is used to describe appropriate out of area placements and defines the range of specialist services available. It must be clinically appropriate for a patient to be placed out of area, proportionate to any risk, and local responsibility and involvement must be maintained. A patient may be placed out of area for reasons including limited provision nationally, patient and/or family choice, and safeguarding considerations.

51. NHSE produced a Standard Operating Procedure on Commissioning Specialised Services in 2020 **[Exhibit CP/002, page 6996]**.


Commissioning Specialised Services – Placing Patients Outside Natural Clinical Flows (Mental Health, Learning Disability and Autism Services)

Standard Operating Procedure

NHS England and NHS Improvement

The procedure reiterated that an out of area placement must be clinically appropriate and that all specialised services must have defined Natural Clinical Flows. It also set out the process for out of area placements.

52. Mental health data started being reported nationally in 2009. The first set of national mental health data collected was the Mental Health Minimum Data Set between 1 April 2006 and 31 March 2014. Between 1 September 2014 and 31 September 2015, data was stored on the Mental Health and Learning Disabilities Set. On 1 January 2016, the MHSDS, mentioned earlier in this summary, was introduced.

53. The MHSDS records all activity relating to patients who receive care for a suspected or diagnosed mental health need. The statement notes that recordkeeping has improved with better IT services, and, in 2012, the Health and Social Care Act gave NHSE the power to require data from health and social care bodies. Between 2016-2021,

additional data was held on the Specialised Mental Health Patient Level Dataset as specialist services were not identifiable in the MHSDS. The sets were integrated in 2021.

Out of area placements

54. There is an NHSE spreadsheet on out of area placements **[Exhibit CP/001, page 6995]**. The spreadsheet sets out various details regarding specialised mental health services accessed by patients who were registered with a GP in Essex prior to their admission during the Relevant Period and placed 'out of area', as well as those patients placed with Independent Providers. The data has limitations, e.g. it runs from 2016 onwards as no Specialised Mental Health Service datasets were identified prior to that. Exhibited with the statement is a list of all Specialised Mental Health Services commissioned by NHSE in the East of England area as at June 2021 **[Exhibit CP/003, page 7007]**.

Inpatient mental health deaths

55. The Inquiry asked NHSE what data it holds nationally for inpatient deaths as defined in its Terms of Reference. NHSE has explained that MHSDS records the date of an individual's death but does not detail the circumstances. NHSE also notes that the MHSDS is designed to understand current activity flow in secondary mental health services, and is not designed to track mortalities within services. Further, MHSDS is limited in that it will only capture deaths where the person died at the time of being known to services.

56. Separately, the NHSE is informed of, and collects information relating to, patient safety incidents including where a patient has died. The Learn From Patient Safety Events (LFPSE) is said to collect around 2.4

million patient safety incident records each year and can indicate specific mitigating actions to reduce risk. NHSE also located 300 hard copy Serious Untoward Incident reports stored between 2007-2010.

57. NHSE was unable to provide certain specific data in relation to inpatient deaths for Essex. In summary:
    a. It does not hold specific data regarding patient deaths prior to 2009;
    b. For data between 2009 and 2015 data does not provide bed/service type, there is limited data from Independent Providers, and this does not include CAMHS or, prior 2014, learning disability and autism patients;
    c. NHSE cannot provide details of those who died whilst awaiting an assessment under the Mental Health Act, those who died whilst waiting for a bed within 3 months of a clinical assessment of need, those who died withing 3 months of a decision not to admit, or those who died within 3 months of discharge from an inpatient unit.

58. After 2009, NHSE is able to provide data on those who died on an inpatient unit, on leave, whilst AWOL or having absconded, and those who died within 3 months of transfer from inpatient units.

13 May 2025

Counsel to the Inquiry