Witness Name: Clare Panniker

Statement No: 1

Dated: 24 March 2025

**LAMPARD INQUIRY**

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**FIRST WITNESS STATEMENT OF CLARE PANNIKER**

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I, Clare Panniker, will say as follows: -

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. We will continue to listen to families and carers so that we can make sure we are hearing where improvements can be made, and can maximise learning.

3. This is NHS England's first formal witness statement to this Inquiry.

**BACKGROUND**

4. I am the NHS England Regional Director for East of England. The role of a Regional Director is to oversee the performance of this health system and provide assurance and oversight. Myself and my team are also responsible for allocating resources in line with the population's health needs and overseeing the performance of key services. A significant part of our work also relates to monitoring budgets and the financial health and operating standards of the organisations within the region. We work with providers in our region to oversee their performance and make sure NHS Trusts and NHS Foundation Trusts that need to improve are given the support to do so.

5. I am a nurse by background and have spent over 30 years working in the NHS. Prior to becoming Regional Director in July 2022, I was Chief Executive at Mid and South Essex NHS Foundation Trust from when it was first formed in April 2020 (following the merger of Mid Essex Hospital Services NHS Trust, Southend University Hospital NHS Foundation Trust and Basildon and Thurrock University Hospitals NHS Foundation Trust). From 2017 to 2020 I was Chief Executive of Mid and South Essex Hospital Group. Before this, from 2012 to 2017, I was Chief Executive at Basildon and Thurrock University Hospital. In 2016 I also became Chief Executive of Broomfield Hospital in Chelmsford, and in 2017 Chief Executive for Southend University Hospital in 2017. Before that I was Chief Executive of North Middlesex University Hospital NHS Trust for nine years.

6. I am aware that recent announcements about the future of NHS England may be of concern but I can assure families, carers and the Inquiry that we continue to work hard to support our mental health providers and to ensure that any identified improvements are implemented. My heart goes out to all those who have suffered losses or been affected by the issues under investigation. I acknowledge the ongoing pain and distress families and carers are experiencing, and the emotional toll bringing these events to Inquiry must take.

**(1) Approach to the NHS England Rule 9 Request**

7. This witness statement was drafted on my behalf by the external solicitors acting for NHS England in respect of the Inquiry, with my oversight and input. The request received by NHS England on 24 February 2025 pursuant to Rule 9 of the Inquiry Rules ("the Rule 9 Request") goes beyond matters which are within my own personal knowledge. As such, this statement is the product of drafting after communications between those external solicitors and a number of specialist experts and senior individuals in writing, by telephone and video conference. I do not, therefore, have personal knowledge of all the matters of fact addressed within this statement. However, given the process here described, I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief.

8. The statement has been produced following a targeted review of documents and data with the intention of providing as much information as possible to assist the inquiry within the limited time available. NHS England has not been able to access all of the data requested by the Inquiry in time for submission of this statement. NHS England is making further enquiries regarding this data and will seek to update the Inquiry. NHS England will also notify the Inquiry as soon as practicable if information comes to light that would have been included in this statement if it was known to us before the deadline for its production.

9. The NHS England Rule 9 Request relates to a 24 year time-period, with the Relevant Period being from 1 January 2000 until 31 December 2023. During this extensive period of time there have been a number of important changes to NHS system. This includes but is not limited to structural changes as a result of legislative and policy developments.

10. NHS England, formerly the NHS Commissioning Board for England, is an executive non-departmental public body of the Department of Health and Social Care

("**DHSC**"). It was established in shadow form in October 2012, becoming fully operational on 1 April 2013.

11. References throughout this statement to 'NHS England' and 'we' represent the voice of the organisation at the present day, unless it is obvious from the context that the statement is describing the actions of NHS England before its Legacy Bodies merged into it. I have referred to all individuals (including myself) in the third person, by job title.

## (2) Outline of this corporate witness statement

12. This statement contains responses to topics and questions set out in the NHS England Rule 9(2) Request. The statement adopts its own structure and deals with the Inquiry's questions and topics in a different order to the way they appear in the Rule 9 Request:
    a. Part A (An overview of Specialised Commissioning/Specialised Mental Health Services) sets out an overview of Specialised Commissioned Mental Health services (also known as 'specialised mental health services'). It also explains 'out of area placements', and the corresponding term 'Natural Clinical Flow', in more detail, as well as relevant NHS England guidance and protocols.
    b. Part B (NHS England Mental Health services data systems explained) describes the evolution of NHS England's mental health services data systems over the Relevant Period.
    c. Part C (Out of Area and Independent Provider Specialised Mental Health Spreadsheet) sets out the data NHS England has provided in the 'Out of area' data spreadsheet **[exhibit CP/001]**, including an explanation of the way that NHS England has interpreted specific information, and the limitations of the data provided.
    d. Part D (Data on inpatient mental health deaths) describes data that NHS England holds in relation to inpatient mental health deaths including as part of its oversight role.

## (3) Summary of data provided to the Inquiry

13. The Inquiry has asked NHS England to provide the following data relating to mental health services:

a. A spreadsheet setting out various ward level data including patient numbers regarding (1) Specialised Mental Health services outside Essex used for Essex patients placed 'out of area' during the Relevant Period and (2) Independent Provider Specialised Mental Health services used for Essex patients within Essex during the Relevant Period.
b. The specific reasons why each Essex patient was placed 'out of area' into Specialised mental health services in the Relevant Period.
c. Confirmation as to what data NHS England holds in relation to mental health inpatient deaths nationally.
d. Confirmation as to whether NHS England would be able to provide the Inquiry with a list of deceased patients falling within each element of the Inquiry's definition of inpatient death.

14. In summary, NHS England can provide the following data:
    a. The majority of the data requested in the Inquiry's template spreadsheet from 2016 onwards. There are a number of limitations and caveats to the data which are set out in more detail below.
    b. Whilst NHS England can confirm a number of details regarding patients who have been placed out of area, we cannot confirm the specific reasons for each of those out of area placements. This level of patient-specific information would usually be held within the clinical team caring for the patient.
    c. The datasets controlled by NHS England hold limited data regarding inpatient deaths, i.e. only a date of death, but NHS England has access to and can link across to the Office of National Statistics data which is the official data source for deaths in the UK and contains additional information.
    d. NHS England can provide a substantial amount of the information requested by the Inquiry regarding inpatient deaths (according to the Inquiry's definition of 'inpatient deaths'). There are a number of limitations to this data though. These are explained in more detail below.

## PART A: An overview of Specialised Commissioning/Specialised Mental Health Services

### (1) Specialised Commissioning/Specialised Mental Health services

15. This Part explains specialised mental health services and how they differ to other mental health NHS services. This is set out in NHS England's first corporate witness statement. For ease of reference, we repeat the key detail relevant to this statement below. Part A also describes out of area placements and natural clinical flows, as context for the data provided.

16. Since its operational establishment in 2013, NHS England has statutory responsibility for commissioning certain services ("Specialised Services"), including certain mental health services (“Specialised Mental Health Services”).

17. Specialised Mental Health Services are comprised of the following:
    a. Children and young people’s inpatient mental health services ("CYPMHS" or also known as "CAMHS"): Children and young people's mental health services include inpatient care, bespoke packages of care and associated out of hospital care when provided by Specialist Children and Young People’s Inpatient Mental Health Centres.
    b. Specialist perinatal mental health services: Specialist perinatal mental health services are provided by Specialist Mother and Baby Units. Services include inpatients and associated non-admitted care including outreach provided by these units when delivered as part of a provider network.
    c. Adult specialist eating disorder services: Adult specialist eating disorder services includes inpatient care and bespoke packages of care services provided by Adult Specialist Eating Disorder Centres.
    d. Specialist mental health services for Deaf adults: Specialist mental health services for Deaf adults includes inpatient and non-admitted care including assessment and treatment services for Deaf people provided by Specialist Centres.
    e. Mental health service for Deaf children and adolescents: Mental health services for Deaf children and adolescents include services provided by Highly Specialist Deaf Child and Adolescent Mental Health Centres including outreach when delivered as part of a provider network.

f. Specialist services for severe personality disorder in adults: Specialist services for severe personality disorder in adults includes inpatients and bespoke packages of care provided by Specialist Centres.
g. Severe obsessive compulsive disorder and body dysmorphic services: Severe obsessive compulsive disorder and body dysmorphic services include services provided by Highly Specialist Severe Obsessive Compulsive Disorder and Body Dysmorphic Disorder Centres. This applies to provision in adults and adolescents.
h. Adult forensic secure mental health services: Adult secure mental health services include high, medium and low secure inpatient care and associated non-admitted care including Access Assessment Services and Forensic Outreach and Liaison Services when delivered by a specialist service.

18. These are nationally defined specialist services which have a relatively small number of patients across the country and, given their high level of specialism, require increased financial resource. Mental health services which do not fall into the above categories are not commissioned by NHS England and are instead commissioned by Integrated Care Boards ("ICBs").

**(2) Out of Area Placements and "Natural Clinical Flow"**

19. We understand that the Inquiry is interpreting 'Out of Area Placements' as those placements made for Essex patients outside of Essex. The Inquiry has also asked for data on placements into commissioned Independent Provider units within the Essex area and it is assumed the Inquiry has therefore interpreted Out of Area Placements to also include Independent Providers within area. We have set out below the mechanisms that NHS England has for considering and identifying Out of Area Placements and the rationale for those categorisations.

20. Due to the specialised nature of the services offered within specialist mental health services, units are spread nationally and not every ICB will have every service available in its area. Consequently, patients may necessarily be placed away from their immediate home area (i.e. out of area) in order to access the care and treatment they require. There is therefore frequent and clinically appropriate movement between areas for specialised services. For example, a patient from Essex may be admitted to Rampton Hospital in Nottinghamshire, which is one of only three national adult high secure hospitals in England. Given the way that specialised services operate, and the difference between these services and standard NHS mental health

services commissioned by ICBs, the term ‘Natural Clinical Flow’ is preferred to describe appropriate placements out of area in respect of Specialised Mental Health Services.

21. The term Natural Clinical Flow defines the range of particular services or group of services that are available to patients from any given area. As demonstrated by the example above, catchment areas or boundaries are not set for specific Specialised Services in the same way they may be for standard mental health services commissioned by ICBs. The aim of Natural Clinical Flows is to ensure that a person is placed in the most clinically suitable setting to meet their needs and risks, as close to home as possible. Taking the above example of an Essex patient placed in Rampton Hospital, whilst the placement is geographically out of area it would still be considered within the patient's Natural Clinical Flow. The Natural Clinical Flow terminology and approach is considered to more accurately reflect treatment pathways for those within Specialised Mental Health services.

22. Although Specialised Mental Health services prefer to use the terminology Natural Clinical Flow for the above reasons, the Inquiry uses the term 'Out of Area' and the data provided for the purposes of this statement has been extracted based on geographical location as that was the data specifically requested by the Inquiry. Therefore, other than further brief reference to Natural Clinical Flows relating to the section setting out the Standard Operating Procedure below, throughout the remainder of this statement NHS England has used the term 'Out of Area'.

**(3) The process used for making out of area placements**

23. The Inquiry has asked NHS England to explain the process by which specialised mental health commissioned units that were used for Essex patients out of area were selected. The overarching principle with placements (whether in area or out of area) is that patients should be able to access the right type of service, as close to home as possible, in the least restrictive environment. Where a patient needs to be placed outside of their area this must be clinically appropriate, proportionate to any risk presented, and local responsibility and involvement must be maintained from a clinical and commissioning perspective.

24. Patients can be placed out of area for a number of reasons, including the following:

a. Limited provision nationally – for example where the service is a specialised service and in the nearest service is outside the patient's immediate area.
b. Lack of local capacity - where there is local in-area provision but the units are at capacity.
c. Justice/index offence/criminal restrictions.
d. Victim risk/exclusion zone or safeguarding considerations.
e. Patient/family choice - for some services patients may have a choice of which service they are admitted to.
f. Geographical proximity to patient's home address or patient's family.
g. Requires more specialised provision or specific clinical intervention – even within specialised services, there may be a service in another part of the country that has a clinician with a 'special interest'/expertise in a specific mental health matter, and therefore the patient may benefit from care and treatment under that team with better outcomes and/or shorter length of stay.
h. To maintain patient confidentiality for staff members requiring treatment outside of their employing trust.

25. Whilst most of the reasons set out above are considered appropriate reasons for placing a patient out of area, an out of area placement due to a lack of local capacity is broadly considered inappropriate. Even then, the specific reasons for capacity issues are not always clear – some units may have an appropriate level of capacity available for the majority of the year but could at any one point become busy and lack capacity temporarily.

26. NHS England produced a Standard Operating Procedure ("SOP") titled *Commissioning Specialised Services – Placing Patients Outside Natural Clinical Flows (Mental Health, Learning Disability and Autism Services)* dated 11 June 2020 **[exhibit CP/002]**. The SOP set out an overarching principle that, where a patient does need to be placed outside of area or outside of the Natural Clinical Flow (which it notes may sometimes be unavoidable), this must be clinically appropriate. When placing a patient outside of natural clinical flow, the placing team should look to neighbouring geographical areas to minimise distance from home and ensure that local involvement is facilitated more easily and effectively. The SOP explained that all specialised commissioned mental health, learning disability and autism services must have Natural Clinical Flows defined. Where placements outside of Natural Clinical Flow result in any way from constraints on or a deficit in capacity of local services,

the SOP explained that the placement will be described as an inappropriate placement outside natural clinical flow.

27. The SOP confirmed that the placing commissioner/case manager[1] will consider the care and treatment needs of the individual, along with any other relevant factors, and identify potential services that could meet their needs. The process, as set out in the SOP (dated 2020), in summary was as follows:
    a. The case manager must contact the host geographical area in which the prospective service is situated to inform them of the intention to place someone in their service.
    b. The case manager must explain the reasons for the placement, intended outcomes, timescales associated and arrangements for monitoring the patient's pathway and placement.
    c. All referrals and admissions to services must be considered based on clinical presentation and urgency, including referrals and admissions from outside natural clinical flows.

**(4) NHS England guidance, policies and protocols on Specialised Mental Health Services out of area placements**

28. In addition to the SOP described above, NHS England also sets national contracts and service specifications that each provider must comply with. Mental health service contracts contain a section relating to 'repatriation' and set an expectation that the provider will *"support the delivery and monitoring of the national objective in Specialised Mental Health to end inappropriate out of area placements; for example, plans for repatriation of patients to their originating geography."*

29. These contracts also contain detailed information regarding data processing and sharing between NHS England and the provider.

[1] Case managers are responsible for oversight of the pathway of an individual and contribute to the monitoring of quality, safety and compliance of specialised services

**PART B: NHS England Mental Health services data systems explained**

30. Before setting out the data NHS England can provide in more detail along with the limitations of that data, it may assist to first explain the development of NHS England's mental health services data systems over the Relevant Period.

31. Mental health data started being reported nationally in the NHS from 2009 onwards (this was prior to the establishment of NHS England in 2013). Datasets were initially focussed on adult mental health only. Over the years, systems have changed and developed to include data relating to learning disabilities, autism and children and young people services. The datasets have also advanced from a technological perspective over the years, collecting more detailed information and improving the coverage and data quality of the data collected.

32. We have set out below a chronology of the datasets used to hold mental health data over the years.

33. The first set of national Mental Health data collected was the **MHMDS** (Mental Health Minimum Data Set) which was used between 1 April 2006 until 31 March 2014. The MHMDS only covered adults and did not include people with learning disabilities or autistic patients. Between 1 September 2014 until 31 September 2015, mental health data was collected and stored on **MHLDDS** (Mental Health and Learning Disabilities Data Set). When this dataset was introduced, it started to include data relating to learning disability and autism services and patients. The **MHSDS** (Mental Health Services Data Set) was created on 1 January 2016. This data introduced CYPMH/CAMH services which had not been included previously.

34. Mental health data has improved over the years since the collections started. The data now covers a wide range of services and in depth information about each service and the care a patient receives. The earlier datasets did not collect this breadth of information and as such are not able to identify specialised commissioning services or different bed types.

35. The MHSDS is a patient level, output-based, secondary-uses data set which aims to deliver robust, comprehensive, nationally consistent and comparable person-based information for all patients who are in contact with mental health services. The MHSDS covers services located in England as well as those outside England which treat patients whose care is commissioned by the NHS in England. As a secondary-

uses data set, the MHSDS re-uses clinical and operational data for purposes other than direct patient care. The ability for NHS England to collect this data is set out in the NHS England De-identified data analytics and publication Directions 2023. Prior to this, NHS Digital was responsible for commissioning and provision of mental health data sets to NHS England Specialised Commissioning.

36. The MHSDS defines the data items, definitions and associated value sets extracted or derived from local information systems. All activity relating to patients of any age who receive care for a suspected or diagnosed mental health and wellbeing need, learning disability, autism or other neurodevelopmental conditions is within scope of the MHSDS.

37. MHSDS is a reliable dataset and holds a variety of data. This dataset is the source of much of the data provided in this statement. Data is submitted monthly by providers through the SDCS (Strategic Database Collection Service) portal.

38. When assessing the quality of data collection over the Relevant Period, it is worth noting that data collection and IT systems have developed over the years. This applies both to systems in the NHS and more broadly across the globe. The Health and Social Care Act 2012 also gave NHS England the power to require data from health or social care bodies, which enabled improved data collection. In 2018 NHS England initiated a drive to improve data quality of mental health data collected within the MHSDS, particularly from Independent Providers. These developments have made data collection easier and more comprehensive.

39. Between April 2016 – March 2021 additional data was also held on **SMH PLD** (Specialised Mental Health Patient Level Dataset). This dataset was created because NHS England recognised that Specialised Mental Health Services were not identifiable in MHSDS and so the SMHPLD was set up in order to ensure accurate collection of data relating to those services. The SMHPLD was then integrated into and superseded by the MHSDS in April 2021.

**PART C: Out of Area and Independent Provider Specialised Mental Health Spreadsheet (including an explanation of collection, interpretations and limitations of data)**

40. We have exhibited the template spreadsheet requested by the Inquiry to this statement **[exhibit CP/001]**. This data has been extracted from a mixture of SMHPLD (the bespoke Specialised Commissioning dataset) between 2016-2021 and then the MHSDS from 2021 onwards.

41. 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 specifically sets out the following information from 2016 onwards:
    a. Ward Site
    b. Provider
    c. Ward Type
    d. Ward name (although not in every case)
    e. Service description/Specialty Unit Type
    f. Gender
    g. Security
    h. Date the ward was first used by an Essex patient within the Relevant Period
    i. Date the ward was last used by an Essex patient within the Relevant Period
    j. Number of Essex patients placed Out of Area into that service over the Relevant Period

42. In order to retrieve this data, NHS England identified Essex patients by their ICB using the various codes associated with the following ICBs which are located in the Essex area:
    a. NHS Hertfordshire and West Essex ICB
    b. NHS Suffolk and North East Essex ICB
    c. NHS Mid and South Essex ICB.

43. Treatment locations outside of the Essex area were identified by any location with a unit (physical site of treatment) postcode outside of Essex. The Independent Provider data was identified by searching for all Essex patients placed into any Independent Provider units (both out of area and within area).

**(a) Interpretations/definitions**

44. In collating this data, NHS England has made the following interpretations:

a. The Inquiry asked NHS England to categorise services as short stays, long stays, intensive or high dependency.

i. Regarding short and long stays – specialised mental health services do not have a set criteria or threshold regarding length of stay, some of the patients on a unit may be admitted for a short period and others in the same unit may be an inpatient for a much longer period. The length of stay is determined by the individual and their progress. There are some services which generally tend to have longer admissions , for example adult secure units, but these are trends rather than how the unit/service defines itself and it is by no means a prescriptive rule. NHS England has therefore not completed these fields in the spreadsheet.

ii. Where the Inquiry asks for NHS England to categorise 'intensive' wards, this is not a term that is used to define specialist mental health services as the nature of these services is such that the majority of them would be considered 'intensive'. It would therefore be misleading to mark some services as intensive and not others. NHS England has therefore not completed this field. There are, however, some units technically referred to as Psychiatric Intensive Care Units ("PICU"). These are easily identifiable in the 'ward type' and 'service description' columns in the spreadsheet.

iii. With regards to the Inquiry's 'High Dependency' field, as with the term 'intensive', specialised mental health services do not categorise themselves in this way. Whilst there are some High Dependency Units in mental health services, these types of services are not identified in the same way as PICUs and may be part of a larger ward or unit providing other services. They are therefore not easy to label or identify. NHS England has therefore not completed this field.

b. Where the Inquiry has asked for NHS England to confirm *"the last date within the Relevant Period on which any ICB-funded patient was an inpatient on the unit (if this post-dated the Relevant Period, please enter the last date of the Relevant Period)"*, NHS England has assumed this should read *'NHS England-funded patient'*.

c. Although rare, in theory a patient could move ICBs during their inpatient stay (for example if their home address changes). NHS England has therefore used the ICB linked with each patient at the point at which they were first admitted to the unit in order to determine whether they are an Essex patient.

*Data limitations*

45. The data has a number of limitations, as set out below:
    a. The data provided is from 2016 onwards. It is not possible to identify Specialised Mental Health Services in the datasets before 2016.
    b. Ward codes and names are determined locally and can change at the discretion of the care provider. In addition, they are not consistently provided in the data. The quality of data provided by adult secure service providers regarding ward names has been variable since the Covid pandemic. NHS England has engaged with providers to encourage them to improve reporting with reference to contractual requirements. As a result, the lowest granular location level consistently and accurately reported nationally from 2016 is the Unit name. For completeness, we have therefore provided both the ward name (where it is known) and also the ward site and unit. It may be that individual providers are able to clarify ward names separately.
    c. Due to the way that the number of patients were calculated, a patient will only be counted once irrespective of how often they were admitted to the same service/unit within the Relevant Period.
    d. The data request required aggregation at granular levels with the inclusion of gender and other "classification" fields. Therefore, a unit will appear more than once for several reasons, including if it has multiple genders, provides multiple services or has more than one ward.
    e. The Inquiry asked for the number of beds per ward. In the time available, NHS England has only been able to collate a limited set of data relating to bed numbers. The data is not consistent and is potentially misleading. As such, NHS England has not provided this data with this statement. NHS England is making further enquiries regarding the data and will seek to provide an update to the Inquiry where further information is identified. In the meantime, NHS England has exhibited a list of all Specialised Mental Health Services commissioned by NHS England in the East of England area as at June 2021, with numbers of commissioned beds for each ward (except row 57) **[CP/003]**. We trust this will be of assistance to the Inquiry. For the avoidance of doubt, this confirms the number of the beds commissioned at a

particular point of time in June 2021. Beds numbers will have varied to some extent throughout the relevant period for a number of reasons.

f. Whilst NHS England holds a range of information regarding placements out of area, the datasets do not show the specific reasons why each individual was placed out of area. NHS England anticipates that at least some of this information is likely to be held by NHS-led Provider Collaboratives, which hold the National Case Management System.

**PART D: Data on inpatient mental health deaths (including an explanation of interpretations and limitations of data)**

46. The Inquiry has asked what data NHS England holds nationally on 'inpatient deaths' (a term defined by the Inquiry) in mental health services (not just specialised services). The MHSDS records the date of an individual's death but does not contain any further detail on the circumstances of their death. The official source of data relating to deaths in the UK is the Office of National Statistics ("ONS"). The ONS data includes the person's NHS number so NHS England is able to link the data with the MHSDS. Storing the same data on MHSDS which is already contained within ONS datasets would effectively be a duplication of data. It is also worth noting that the MHSDS is designed to understand current activity flow in secondary mental health services, it is not a system 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.

47. Separately, as part of its oversight role, NHS England is informed of - and collects information in relation to - patient safety incidents for all healthcare services, including where a patient has died. This information can be provided to NHS England via different routes. We set those out in more detail below.

48. Patient safety incidents were reported via the National Reporting and Learning System (**"NRLS"**). NRLS was established by the National Patient Safety Agency ("**NPSA**") in 2003 as a voluntary scheme. All NHS organisations in England and Wales have been able to report to the system from 2005. Separately, serious incidents were reported via the Strategic Executive Information System (**"StEIS"**). StEIS reports contain information such as the date of the incident, site/location of incident, type of incident, patient status, a brief description of what happened and immediate action taken.

49. Following an update to NHS England's Patient Safety Strategy and publication of the Patient Safety Incident Response Framework ("**PSIRF**") in 2022, there is no longer a distinction between 'serious incidents' and 'patient safety incidents'. Rather, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

50. Subsequently, NRLS has been replaced with the Learn From Patient Safety Events (**"LFPSE"**) service from 2023. StEIS will remain in use until the next version of LFPSE is rolled out to replace it. LFPSE is a new national NHS service for the recording and analysis of patient safety events that occur in healthcare. Around 2.4 million patient safety incident records are collected each year by LFPSE. By taking a bird's eye view of risks across the NHS, NHS England's National Patient Safety Team can specify national mitigating actions that can reduce risk to patients.

51. Before NHS England was created, Serious Untoward Incidents ("SUIs") were reported to the relevant local Strategic Health Authority. These related to a range of patient safety issues. NHS England has located roughly 300 SUI hardcopy reports stored by the local SHA in Cambridge between roughly 2007-2010.

52. The Inquiry has asked whether NHS England can provide the following data for Essex inpatient deaths covering all mental health services both in area and out of area across the Relevant Period:

    a. Those who died on an NHS mental health inpatient unit or in receipt of NHS funded inpatient care within the independent sector (whether detained under section or informally). Units to be included are:
        1. Adult mental health units
        2. Adult PICU
        3. CAMHS PICU
        4. Mental Health Assessment units
        5. Mother and baby mental health units
        6. Older adult mental health units
        7. Eating disorder units
        8. Adult secure units
    b. Those who died while on leave from any of the above units, including supervised leave
    c. Those who died while absent without leave or having absconded from any of the above units within 3 months of going absent without leave or absconding
    d. Those who died during or within 3 months of transfer from any of the above units, including transfer to a physical health setting or to an out of area mental health service
    e. Those who died whilst awaiting an assessment under the Mental Health Act

f. Those who died whilst waiting for a bed in a mental health inpatient unit within 3 months of a clinical assessment of need
g. Those who died within 3 months of any mental health assessment provided by the Trust(s) where the decision was not to admit as an inpatient (this includes but is not limited to any death following a review in A&E, or an assessment under section 135 and 136 of the Mental Health Act)
h. Those who died within 3 months of discharge from any of the above units.

*Data limitations*

53. NHS England does not hold specific data on its data systems regarding patient deaths prior to the commencement of routine data collection and reporting of mental health patients in 2009. After that date, NHS England recorded the date of death for patients in the relevant dataset. In order to provide the Inquiry with this data, NHS England would use a combination of this data linked with more detailed data stored by the ONS, to which NHS England has access.

54. NHS England would therefore be able to provide the data set out in (a) – (d) above for the period **2016-2023**. For the avoidance of doubt, the units listed by the Inquiry in (a) cover both specialised mental health services and standard ICB commissioned mental health services.

55. For data prior to 2016, NHS England would be able to provide the data requested in (b) – (d) from **2009-2015**. However, the 2009-2015 data does not provide the bed/service type analysis requested in (a), and there is limited data from Independent Providers. In addition, the 2009-2015 dataset does not include learning disability and autism patients until 2014 and does not include CYPMHS/CAMHS as they were only included in the updated dataset MHSDS from 2016 onwards.

56. NHS England is unable to provide the specific data requested in (e) – (h) from any dataset. It does not hold this level of detail in its datasets. Specifically, it is unable to identify within the dataset that someone is waiting for a bed or waiting for an assessment, or that someone has had an assessment and a decision to not admit was made. However, the data can identity that someone has had a referral and is waiting to be seen, and that someone has had contact with services. The data does not specify the nature, detail or reasons for that contact.

**STATEMENT OF TRUTH**

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

**Signed:**

[I/S]

**Dated:** 24 March 2025