Witness Name: Dale Bywater

Statement No: WITN0310001

Dated: 8 December 2025

NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DALE BYWATER

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I, Dale Bywater, of NHS England, Wellington House, 133-135 Waterloo Road, London, SE1 8UG will say as follows:

NHS England would like to emphasise that our thoughts remain focused on all of the those affected by the matters to which this Inquiry relates. NHS England acknowledges the pain and anguish that those affected have suffered and which they continue to suffer.

Corporate witness statement

1. Prior to being appointed as Regional Director at NHS England I held Director roles in NHS Improvement, NHS Trust Development Authority, and a Strategic Health Authority. During the first 10 years of my career I worked in a variety of senior operational roles within NHS acute hospitals and led a number of national programmes.

2. This corporate witness statement was drafted on my behalf, and with my input, by external solicitors acting for NHS England in respect of the Inquiry. The rule 9 request received on 17 June 2025 and the supplementary rule 9 requests received on 25 June 2025 and 17 July 2025 (together the "**Rule 9 Request**") to NHS England are broad in scope and 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 senior individuals in writing, by telephone and by video conference. I do not, therefore, have personal knowledge of all the matters of fact addressed within this statement and have not been able to personally review each document exhibited. 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.

3. During the period referred to in the Inquiry Terms of Reference (2019 up to and including 13 June 2023 (the "**Relevant Period**")), NHS England merged with:

   a. NHS Improvement on 1 July 2022;[1]

   b. NHS Digital on 1 February 2023;[2] and

   c. Health Education England ("**HEE**") on 1 April 2023.[3]

4. This statement refers to the legacy organisations above as is necessary to respond to the Rule 9 Request.

5. As this statement includes evidence from a breadth of sources, combined to represent the evidence and voice of NHS England, references throughout to 'NHS England' and 'we' represent the voice of the organisation. I have referred to all individuals (including myself) in the third person and by job title where possible.

6. This corporate statement has been produced with input from a number of colleagues across NHS England and following a targeted review of documents collated to date. In the time available it has not been possible to review every potentially relevant document, and it is highly likely that relevant documents exist that have not been reviewed. This statement is accurate to the best of our knowledge, but we cannot exclude the possibility that it will require updating as further evidence emerges through our ongoing process of internal investigation

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[1] On 1 April 2016, the Trust Development Authority and Monitor were brought together to create "NHS Improvement".
[2] The statutory functions of NHS Digital were transferred to NHS England on 1 February 2023 pursuant to the Health and Social Care Information Centre (Transfer of Functions, Abolition and Transitional Provisions) Regulations 2023.
[3] The statutory functions of HEE were transferred to NHS England on 1 April 2023 pursuant to the Health Education England (Transfer of Functions, Abolition and Transitional Provisions) Regulations 2023.

and document review. NHS England will of course notify the Inquiry as soon as practicable if information comes to light that would have been included in this statement if it was available before the deadline for its production.

7. Within this witness statement, we refer to documents which are exhibited to support a particular point being made.

Approach to the Rule 9 Request

8. NHS England welcomes the chance to assist the Inquiry to understand and examine the key issues it has identified as in scope for the Inquiry (and in subsequent engagements with the Inquiry team).

9. We understand that the purpose of this document is to provide a corporate statement on behalf of NHS England to assist the Chair of the Inquiry in exploring a range of matters as set out in the Rule 9 Request.

10. This statement comprises of six sections:

11. **Section 1** provides detail on:

    a. the structure of the NHS in England;

    b. how services are organised;

    c. the roles and responsibilities of NHS England including NHS England's role in relation to incidents (civil contingencies);

    d. an overview of the commissioning landscape; and

    e. an overview of the psychosis pathway.

12. **Section 2** describes the mental health policy landscape, including:

a. a high level overview of relevant legislation applicable to the Inquiry;

b. overarching policy and improvement programmes relevant to adult mental health; and

c. specific policy background relevant to psychosis in adults.

13. **Section 3** provides detail on the patient safety incident response framework and related policies, including the commissioning of patient safety incident reports.

14. **Section 4** sets out the data available to NHS England relevant to this Inquiry.

15. **Section 5** provides information relating to Nottinghamshire Healthcare NHS Foundation Trust ("**NHFT**"), including:

a. oversight and enforcement action taken by NHS England; and

b. details of reviews commissioned by NHS England.

16. **Section 6** details the incident response by NHS England, including:

a. the immediate incident response on 13 June 2023 and the following days; and

b. the patient safety incident response, including the commissioning of the independent patient safety incident investigation.

17. A list of key individuals is set out at **Annex 1**.

18. An overview of key groups is set out at **Annex 2**.

19. Throughout this statement we refer to updates to guidance or policy that have occurred since the incident.

20. In this statement we have referred to NHS England, the Department of Health and Social Care ("**DHSC**") and the Secretary of State for Health and Social Care ("**SSHSC**") in accordance with how they are structured today, but such references include all predecessor organisations and roles as the context may require.

21. NHS Trusts and NHS Foundation Trusts are referred to collectively as "**Trusts**" in this statement unless otherwise stated.

22. In this statement, references to workforce or healthcare staff within the NHS should be interpreted as broadly as possible. However, where issues pertain to a particular profession or job role, or to a function of the NHS such as primary care, we have included more specific detail.

SECTION 1: THE NHS IN ENGLAND

23. In accordance with the framework established by Parliament, the NHS in England is not one organisation. It is an ecosystem of commissioners, regulators and service providers, each with their own distinct role. The publicly funded health service (excluding public health) in England comprises primary care, secondary care, tertiary care, mental health and community health. These are explained further below (as relevant to the scope of the Inquiry), but essentially NHS England is one part of the NHS, alongside local commissioners (which are now Integrated Care Boards ("**ICBs**") but were previously Clinical Commissioning Groups ("**CCGs**")), providers and so on that comprise the whole NHS system.

24. Many bodies hold contracts with the NHS and are part of the publicly funded health service, such as GP practices, independent hospitals and community rehabilitation providers, but not all are NHS bodies. For the most part, the term 'NHS' is used as an umbrella term to mean all those performing their services pursuant to NHS funding and contracts.

NHS England overview

25. NHS England is an Executive Non-Departmental Public Body ("**NDPB**") sponsored by DHSC. It is referred to as an Arm's Length Body ("**ALB**") as it is a public body established with a degree of autonomy from the SSHSC. It was established on 1 October 2012 and is operationally distinct from DHSC. NHS England became fully operational on 1 April 2013.

26. Statutory ALBs (such as NHS England) do not set strategic national health and/or public health policy but have a key role in implementing and advising on it. The Government, via DHSC, will seek input from NHS England on how to improve existing policies or address new challenges. NHS England may engage other people and organisations across the healthcare sector, including service users, before providing its advice. The Government is then responsible for selecting from the policy options and ensuring any policy selected is appropriately financed.

27. NHS England is responsible for determining how to operationalise those policies to ensure effective delivery and evaluating their impact. This is reported to Government, via DHSC.

28. NHS England's primary responsibility is the co-ordination of the provision of health care services in England, certain commissioning and oversight of local commissioners and providers of those health care services. To achieve this, NHS England's role includes:

    a. setting direction by: developing and setting national policy and strategy; managing the relationship between the NHS in England and Government; determining NHS priorities (subject to the mandate),[4] providing thought leadership and subject matter expertise for national priorities;

    b. allocating resources by: leading on national workforce innovation; being

[4] Before the start of each financial year, SSHSC issues an annual 'mandate' for NHS England setting out its objectives which NHS England must seek to achieve and its budget, which sets limits on the use of capital and revenue resources (in effect, this sets NHS England's financial allocation) (section 13A of the 2006 Act),

responsible for financial stewardship of the NHS;

c. ensuring accountability and enabling improvement by: defining accountability structures; setting standards for performance; deploying resources to supported challenged organisations (when required); instigating regulatory intervention when required; and implementing a recovery support programme (see from paragraph 97 below);

d. mobilising expert networks by: bringing together expert knowledge to support service improvement; supporting delivery of improved outcomes and providing benchmarks for services; managing relationships across national and professional bodies; enabling and supporting the development of systems;

e. delivering centralised services, collecting data sets, and setting minimum standards (for example, in cyber security and privacy) and promoting interoperability;

f. managing the NHS England medicines procurement and supply chain through the NHS England Medicines Value and Access Directorate, which aims to (amongst other things) deliver efficiencies for the NHS in the procurement of medicines and ensure an efficient and effective supply chain for medicines to the patient;

g. managing performance concerns for medical, dental and optometry practitioners, maintaining the performers list, and managing appraisal and revalidation, the Responsible Officer functions and the Controlled Drugs Accountable Officer.

[NHSE0000378]

29. The status and constitution of NHS England is set out in Schedule A1 to the National Health Service Act 2006 (the "**2006 Act**"). NHS England:

    a. is governed by its Board, which comprises a Chair, a Chief Executive Officer and a number of executive and non-executive directors. The Board provides strategic leadership and accountability to Government, Parliament and the public, and is supported by a number of committees; and

    b. operates by way of a national team and a number of regional teams. From 2019, there have been seven regional teams: East of England, London, Midlands, North East and Yorkshire, North West, South East and South West.

30. Regional teams are managed by regional directors who, at the time of the incident, reported to NHS England's Chief Operating Officer. They now report to NHS England's Chief Executive Officer.

31. The NHS England Regional Team relevant to the Inquiry's investigations is NHS England's regional office referred to as 'NHS Midlands' in this statement. NHS Midlands directly commissions services and oversees 11 integrated care systems and 42 Trusts across Birmingham, the Black Country, Coventry, Derbyshire, Herefordshire, Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire, Shropshire, Staffordshire, Warwickshire and Worcestershire. An example of the NHS Midlands governance structure from 2024 is exhibited at **[NHSE0000516]**.

32. Regional teams are responsible for overseeing the performance of all NHS organisations in their region in relation to quality, finance and operational performance.

33. In accordance with the NHS England Operating Framework in place during the Relevant Period, regions:[5]

a. act as the main voice to integrated care systems and the primary interaction between NHS England and systems;

b. translate national strategy and policy to fit local circumstances, ensuring local health inequalities and priorities are addressed;

c. agree 'local strategic priorities' with individual integrated care systems;

d. provide oversight to ICBs and agree oversight arrangements for place-based systems and organisations;

e. develop leadership within ICBs and providers;

f. within national frameworks, determine the 'how' of delivery to achieve outcomes and expectations to reflect local populations, workforce, service structures and digital capabilities;

g. develop mechanisms for systematically collating and sharing good practice and lessons learnt;

h. manage regional level relationships, including regional government;

i. provide support to integrated care systems to enable delivery.

[5]Since the end of the Relevant Period, in January 2025, a new operating model has been adopted.

[NHSE0000378]

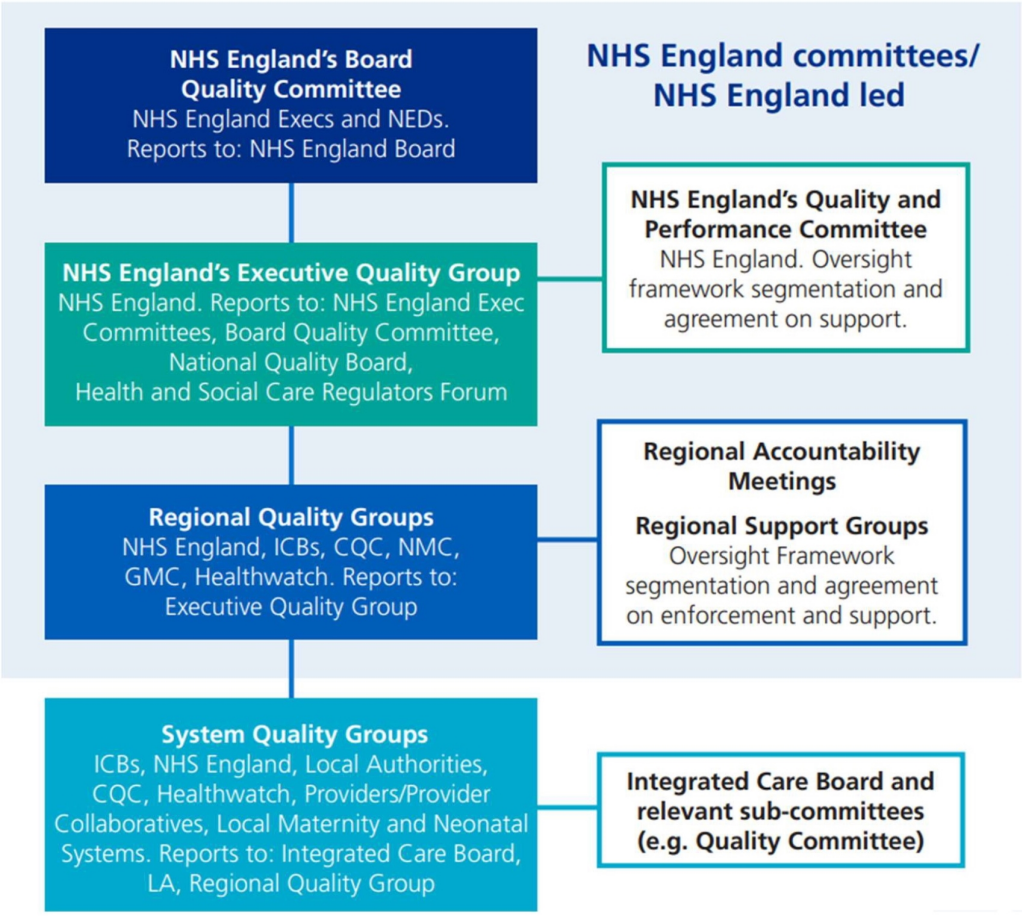
34. In discharging its statutory functions, NHS England works closely with a number of other partners in the 'health family' at national and regional level, including HEE and NHS Digital (during the Relevant Period and pre-merger), the Care Quality Commission ("**CQC**")[6] and the National Institute for Health and Care Excellence ("**NICE**"), to ensure services are safe, effective and clinically and financially sustainable. For example:

a. NHS England and the CQC entered into a partnership agreement in 2013 which sets out the commitment between both bodies to work together **[NHSE0000309]**; and

b. the National Quality Board ("**NQB**"), which has members from NHS England, the CQC, the UK Health Security Agency ("**UKHSA**"), NICE, the Office for Health Improvement and Disparities, DHSC, Healthwatch England, the National Guardians Office and the Health Services Safety Investigations Body. The NQB provides advice, recommendations and endorsement on matters relating to quality, and acts as a collective to influence, drive and ensure system alignment of quality programmes and initiatives. It is jointly chaired by NHS England's National Medical Director and CQC's Medical Director (see paragraphs 273 to 275 for further details).

[6] The CQC is responsible for ensuring that organisations who are required to be registered with the CQC provide safe, effective and high quality care.

c. The diagram below provides an overview of the quality governance structure within NHS England following the implementation of the Health and Care Act 2022 (the "**2022 Act**"), and how system partners are engaged:



35. NHS England also works with other agencies outside of the health family, such as the police and local authorities, as well as providing guidance on sharing information with the police **[NHSE0000544]**.

36. NHS England is not:

a. a core political or governmental decision-making body;

b. responsible for setting national health or public health policy;

c. a provider of patient services; or

d. an inspector of clinical services (the CQC undertake this role).

37. NHS England has a limited role in disseminating clinical information and recommending best clinical practice, this being the role of other bodies.

38. NICE is primarily responsible for issuing guidance on the diagnosis, treatment and management of diseases and other conditions. In addition, the Royal Colleges, professional bodies, such as the General Medical Council ("**GMC**") and Nursing and Midwifery Council ("**NMC**"), and many professional societies publish clinical and professional guidance for use across the system.

Future of NHS England

39. On 13 March 2025, the Prime Minister announced the integration of NHS England into DHSC. Further details were set out by the SSHSC in a statement to Parliament on the same day. Since 1 April 2025, a Transition Chief Executive Officer of NHS England has been heading the transformation team to implement these reforms.

40. NHS England can only be abolished by an Act of Parliament with provision made for the transfer of all its commissioning and regulatory functions (this cannot be achieved through regulations, see section 103(3) of the 2022 Act).

Clinical Advisers

41. Decision-making in NHS England has always relied on the input of National Clinical Directors ("**NCD**") who are supported by National Specialty Advisers ("**NSA**"), who sit alongside formal governance structures. NCDs and NSAs relevant to the Inquiry's investigations are detailed in Annex 1.

42. NCDs and NSAs provide clinical leadership, advice and support in the following ways:

a. national policy and programme development; shaping of vision and bringing a person-centred, clinical and culturally competent perspective;

b. guidelines and guidance development; bringing an overview of clinical activity and research and education activities in their specialty areas and through connections with research and guideline development bodies;

c. professional engagement; through relationships with the Royal Colleges and professional bodies and membership;

d. communicating key messages to patients, service users and voluntary sector organisations; and

e. providing evidence where needed for responses to parliamentary questions and briefing requests.

43. In addition, 'Getting It Right First Time' (see paragraphs 276 below) clinical leads provide advice and leadership to help identify unwarranted clinical variation within their specialty, at national, local, and provider level. They also provide advice on identifying and implementing best practice standards.

Clinical Reference Groups

44. To assist NHS England's specialised commissioning role, there is a standing expert clinical advisory structure in place which includes a number of specialty based Clinical Reference Groups ("**CRG**"). The exact role of a CRG depends on its terms of reference. In general, a CRG is a group of advisers, independent

of NHS England, who provide subject matter expertise and clinical advice to support specialised services. Increasingly, CRGs are led by a NCD or NSA.

Clinical Commissioning Groups

45. CCGs were established on 1 April 2013 following the Health and Social Care Act 2012. CCGs were responsible for planning and commissioning healthcare services within their local areas and were clinically led statutory NHS bodies.

46. CCGs worked with NHS England regional teams to ensure joined up care. They were replaced by ICBs on 1 July 2022.

Integrated care systems

47. As stated above, the NHS is an ecosystem, and that means it is at its best when it is working in an integrated way to provide joined-up care for patients.

48. The NHS in England is now organised across a number of integrated care systems or "ICSs". These built on earlier initiatives by NHS England to increase collaboration (as opposed to competition) between local NHS organisations so that population care could be better planned, joined up and more efficient.

49. In January 2019, NHS England and NHS Improvement published the NHS Long Term Plan ("**NHS LTP**") **[NHSE0000014]**, which set out the ambition for all parts of the country to become part of an ICS by April 2021, within the legal framework that applied at the time. NHS England and NHS Improvement also recommended changes to legislation to remove barriers to integrated care.

50. While the policy which led to the 2022 Act was being developed, ICSs continued to operate and develop collaborative ways of working. Patients needed support

that was joined up across local authorities, NHS and voluntary organisations, based on a common understanding of the risks and issues faced by different people. It required openness in data sharing, collaboration commitment in the interests of patients and communities, and agile collective decision-making, all of which were features of the 'system working' approach of ICSs **[NHSE0000542]**.

51. In July 2021, NHS England put into place a memorandum of understanding ("**MoU**") between NHS England, the Nottingham North and East CCG and the Trusts in the Nottingham and Nottinghamshire ICS, in relation to oversight arrangements in 2021/22 in the ICS. The purpose of this MoU was to describe the local oversight arrangements that would support the delivery of NHS priorities in the Nottingham and Nottinghamshire ICS in 2021/22 **[NHSE0000541]**.

52. The 2022 Act put ICSs on a statutory footing by establishing two new statutory bodies:

    a. ICBs: new statutory bodies that bring together commissioners and providers of healthcare services into a single organisation, and which took over the functions of CCGs as regards the planning and delivery of healthcare services in order to meet local health needs; and

    b. Integrated Care Partnerships: statutory committees bringing together representatives from ICBs, local authorities within their areas, and other partners (including NHS providers, public health, social care, housing services, etc), responsible for developing an integrated care strategy setting out how the wider needs of the local population will be met.

53. In 2022, a new MoU was put into place between NHS England and Nottingham and Nottinghamshire ICB ("**NNICB**") setting out:

a. the principles that underpin how NNICB and NHS England would work together to discharge their duties to ensure that people across the system have access to high quality, equitable health, and care services;

b. the delivery and governance arrangements across NNICB and its partner organisations;

c. how NHS England, NNICB and NHS partner (foundation) Trusts will work together to implement the requirements set out in the NHS Oversight Framework, taking into consideration local delivery and governance arrangements, risks and support needs; and

d. how NNICB and NHS England would work together to address development-specific needs in the ICS and across the region **[NHSE0000376]**.

54. Section 14Z59 of the 2006 Act requires NHS England to conduct a performance assessment of each ICB in respect of each financial year. The assessment for financial year 2023/24 for NNICB is exhibited at **[NHSE0000455]**. It is also published on NNICB's website.

Commissioning

55. The majority of NHS services are commissioned locally by ICBs. In such instances, the relevant ICB is the responsible commissioner and NHS England's role is centred around oversight and setting national policy, which is then implemented by local commissioners and providers.

56. "Commissioning" is the continual process of planning, agreeing and monitoring that services are delivered. For example, where NHS England commissions a service, it develops and issues a service specification, which forms part of a contract between NHS England and the relevant provider. Under this contract, the provider agrees to deliver the service in accordance with the service specification, in return for payment by NHS England.

57. Commissioning responsibilities are set out in the 2006 Act and in regulations made by the SSHSC under the 2006 Act, namely the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (the "**Standing Rules**").

58. ICBs (and CCGs before that) were given responsibilities relating to the commissioning of mental health services unless NHS England had a duty to arrange provision. In practice this means the day to day oversight of these services rests with ICBs.

59. NHS England is required (pursuant to the Standing Rules and Sections 3B and 6E of the 2006 Act) to arrange for the provision of:

    a. fixated threat assessment services;

    b. services for prisoners and other detainees;

    c. services for rare and very rare conditions ("**Specialised services**"). These include:

        i. adult secure mental health services;

        ii. child and adolescent mental health in-patient service; and

iii. secure forensic mental health service for young people.

60. NHS England is accountable for 149 specialised services via its Specialised Commissioning Team (even if it then delegates those functions).

61. On the basis that Valdo Calocane ("**VC**") was an adult at the time of first presentation and did not receive any Specialised Services before 13 June 2023, we have not described mental health service commissioning for children and young people or Specialised Services further.

62. From April 2025, specialised mental health, learning disability and autism services functions were delegated to ICBs, however, NHS England remains accountable for the commissioning of such services.

Leadership and Culture

63. NHS England expects leaders at all levels and across all organisations operating within the NHS to model certain values. NHS England seeks to support and enable this nationally through training and development, as well as through its regional offices in the form of more localised support for providers.

64. In addition, NHS England has also sought to influence and inform workplace culture, through national initiatives including:

a. the NHS People Promise, which includes a range of core expectations and actions required by all those working as part of the NHS; and

b. Our Leadership Way, which complements the NHS People Promise. It has been designed as a 'Leadership Compact' that defines the NHS leadership ethos, by which we mean how leaders are expected to

behave towards each other and their teams, delivering on a day-to-day basis the NHS People Promise.

Kark Review

65. In 2018, an independent review was undertaken into how effectively the Fit and Proper Person Test, pursuant to Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("**2014 Regulations**"), prevents unsuitable staff from being redeployed or re-employed in health and social care settings (the "**Kark Review**") **[NHSE0002290]**.

66. The NHS People Plan (published in July 2020), included an update on NHS England's response to the Kark Review, as well as details of work by NHS England to develop a set of competency frameworks for board positions in NHS provider and commissioning organisations. It included details of work undertaken to build confidence around speaking up (see below).

67. In August 2023, NHS England published, in response to the Kark Review, the "NHS England fit and proper person test framework for board members" ("**FPPT Framework**")**[NHSE0000519][NHSE0002363][NHSE0002309] [NHSE0002328][NHSE0002313][NHSE0002335][NHSE0002314] [NHSE0002315][NHSE0002364][NHSE0002365]**.

68. An enhanced offering for learning and development has been an ongoing focus for NHS England and can be seen through the publication of the Directory of Board level learning and development opportunities, which sit as part of the FPPT Framework.

69. For completeness, it is highlighted that the Provider Licence includes a condition that licensees (which includes Trusts and other licensees) must not appoint or have in place a person as a Director of the licensee who is not fit and proper (condition G3, previously condition G4).

70. Whilst the FPPT Framework and the Provider Licence take into account the position in the 2014 Regulations (see paragraphs 114 to 118 below), these do not replace the 2014 Regulations or CQC's oversight in this regard.

71. On 28 February 2024, NHS England published the "Leadership Competency Framework For Board Members" ("**LCF**") **[NHSE0002356][NHSE0002357]**.

72. The LCF provides a framework for board member recruitment and appraisal and will inform future board leadership and management training and development. As with the FPPT Framework, it has been developed in response to a recommendation from the Kark Review.

73. The LCF provides a consistent competency and skills benchmark against which board members will individually self-assess as part of the annual 'fitness' attestation under the FPPT Framework. A revised framework for conducting annual appraisals of NHS chairs was also published to align to the LCF **[NHSE0002358]**.

74. On 1 April 2025, a New Board Member Appraisal Framework was launched which incorporates the LCF into a single approach for all executive and non-executive roles and aligns with the FTTP Framework **[NHSE0002360][NHSE0002359]**.

75. In November 2024, DHSC launched a consultation regarding proposals to regulate NHS managers. It sought views from stakeholders on the most effective way to strengthen oversight and accountability of NHS managers in England **[NHSE0002362]**.

76. NHS England welcomed and supported the government's consultation on the regulation of managers. In the lead-up to the launch of the formal consultation, NHS England convened a number of round-table discussions on the question of regulation.

77. Factors that NHS England believes should be considered in the development of any formal regulatory system are:

a. duplication and differentiation, recognising that many NHS managers are already regulated professionals by virtue of their clinical background;

b. the entry level of regulation;

c. the cohorts of managers in scope of regulation, and to what standards, needs to be determined;

d. the identity of the regulator, how it will operate and its interaction with the existing professional regulatory bodies;

e. the balance between accountability and development and improvement; and

f. fairness and proportionality, to ensure that any system does not introduce unnecessary barriers for existing NHS staff or those moving into leadership roles from other industries.

Messenger Review

78. The Leadership for a Collaborative and Inclusive Future (2022) Report (the "**Messenger Review**") highlighted successful leadership as an important driver for improving organisational culture, setting out a series of recommendations that would further support and develop leaders to engender a positive culture more widely in the NHS **[NHSE0002361]**.

79. All 7 Messenger Review recommendations were accepted by the Government.

80. In response to the Messenger Review recommendations, NHS England developed a roadmap of initiatives to identify appropriate standards, underpin quality-assured development opportunities and support talent and career management for NHS managers and leaders at all levels **[NHSE0002387]**.

Freedom to Speak Up

81. An open and honest reporting culture in the NHS is a key aspect of mitigating against issues in both patient care and staff culture.

82. Following the Inquiry into the Mid Staffordshire NHS Foundation Trust, the then SSHSC commissioned the Francis Freedom to Speak Up ("**FTSU**") Review **[NHSE0002282]**. NHS England wrote to NHS managers following the review to "*emphasise both the overall importance of the Freedom to Speak Up review and the importance of you as managers ensuring that all of your staff are made fully aware of the expectation that they will come forward, speak up and raise any concerns, and that they know how to do this outside their line manager relationship if necessary....*" **[NHSE0002283]**.

83. NHS workers (which is anyone who works in NHS healthcare, including healthcare professionals, clinical and non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers, and former workers) can make disclosures to NHS England under the Employment Rights Act 1996 and receive protection if they have a reasonable belief that the failure being disclosed falls within NHS England's remit and that the information disclosed is true. Concerns raised to NHS England through this route are considered pursuant to NHS England's External Freedom to Speak Up Policy for NHS Workers **[NHSE0002366]**.

84. The Prescribed Persons (Reports on Disclosures of Information) Regulations 2017 require NHS England to publish information annually on the number of whistleblowing cases that it receives that are considered to be 'qualifying disclosures' and how they were taken forward.

85. NHS England uses information from NHS workers to inform its oversight of, and support for, NHS providers, in conjunction with other relevant information (in line with the applicable oversight framework in force at the relevant time).

86. In June 2022, NHS England published the minimum standard for local FTSU policies across the NHS **[NHSE0002306]**. The purpose of this standard was to ensure that those who work in the NHS know how to speak up and what will happen when they do. It is designed to be inclusive and support resolution by managers wherever possible.

87. Also in June 2022, NHS England and the National Guardian's Office published updated FTSU guidance and a FTSU reflection and planning tool **[NHSE0002303][NHSE0002304]**. The aim of these documents is to help the

NHS deliver the People Promise for workers, by ensuring they have a voice that counts and by developing a speaking up culture **[NHSE0002296]**.

88. The NHS Standard Contract (see paragraph 144 below) also includes obligations on providers (at General Condition 5.10) to "*have in place, promote and operate (and ensure that all Sub-Contractors have in place, promote and operate) a policy and effective procedures, in accordance with Freedom to Speak Up Policy and Guidance, to ensure that Staff have appropriate means through which they may speak up about any concerns they may have in relation to the Services and how they can be improved*."

Insightful Board

89. In November 2024, NHS England published its Insightful Board guidance. This is best practice guidance which aims to support boards at both Trusts and ICBs in relation to their approach to handling and acting on the information they receive.

90. The Insightful Provider Board guidance provides six domains of indicative areas of oversight: strategy; quality; people; access and targets; productivity; and finance. It also includes an overview of the factors that make it challenging for the right information to flow to the board and the role of effective governance in tackling this; how boards should handle and act on information; and the importance of a curious, problem sensing and open culture. The importance, and difference between, assurance and reassurance is also considered **[NHSE0002368][NHSE0002367]**.

91. In relation to patients, the guidance covers mandatory information that the boards must receive e.g., cases where a patient safety incident investigation is mandatory, and therefore must be reported to the board, as well as how safety information should be triangulated with other quality metrics (including for example, staff absence and FTSU data).

92. For ICBs, the Insightful ICB Board guidance considers matters such as triangulation in a system context **[NHSE0002369]**.

Responsible Officers

93. The Medical Act 1983 (section 45A) requires designated bodies to nominate or appoint a responsible officer. Designated bodies are set out in the Medical Profession (Responsible Officers) Regulations 2010 and include DHSC, NHS England, ICBs and Trusts.

94. The responsibilities of responsible officers are (in summary):

a. to ensure that the designated body carries out regular appraisals on medical practitioners;

b. to establish and implement procedures to investigate concerns about a medical practitioner's fitness to practice raised by patients or staff of the designated body or arising from any other source;

c. where appropriate, to refer concerns about the medical practitioner to the GMC;

d. where a medical practitioner is subject to conditions imposed by, or undertakings agreed with, the GMC, to monitor compliance with those conditions or undertakings;

e. to make recommendations to the GMC about medical practitioners' fitness to practise; and

f. to maintain records of practitioners' fitness to practice evaluations, including appraisals and any other investigations or assessments.

95. These obligations are not imposed upon provider bodies but on individual practitioners nominated or appointed to the role of responsible officer.

96. The above regulations relating to responsible officers apply only in relation to professionals registered with the GMC. There are no equivalent regulations relating to other registered professionals. However, NHS England has a general expectation that where concerns arise in relation to an individual who is a member of a regulated profession, an appropriate reference would be made to their regulatory body.

Provider and commissioner oversight

97. NHS England has statutory accountability for oversight of both ICBs and providers of NHS services.[7]

98. Prior to 2019, there had been several types of oversight frameworks to monitor the performance of Trusts and CCGs.

99. With the coming together of NHS England and NHS Improvement in 2019 (see Annex 3 for information regarding the legacy bodies Monitor and NHS Trust Development Authority), alongside the move to system working through (non-

[7] Persons providing primary medical services (GPs) or primary dental services only are currently outside the licensing and enforcement regime described in the NHS Enforcement Guidance. NHS England does not oversee or inspect clinical services, but considers the work of the CQC as part of its oversight as set out in this section.

statutory) ICSs, previous frameworks were replaced by the NHS Oversight Framework which applied to both CCGs and Trusts. This was later replaced by the NHS System Oversight Framework until the end of June 2022.

100. In June 2022, the new NHS Oversight Framework was published in readiness for the re-organisation of the NHS (referenced above at paragraphs 47 to 53) **[NHNB0018961]**.

101. The way in which NHS England sought assurance was through the Oversight Framework and the associated oversight metrics (for the purposes of the Inquiry, the relevant version is the NHS oversight metrics for 2022/23). The metrics were used to indicate potential issues and prompt further investigation. The metrics aligned with the five national themes of the Oversight Framework[8]:

    a. quality of care, access and outcomes;

    b. preventing ill health and reducing inequalities;

    c. people;

    d. finance and use of resources; and

    e. leadership and capability.

102. The metrics (aligned with these themes) were reviewed, and organisations were placed into segments according to their performance against those metrics.

103. There were four segments, with Trusts in segment one having no specific support needs and those in segment four requiring mandated intensive support.

[8] There is a sixth theme - "Local Strategic Priorities" but metrics are not allocated to this domain

Importantly, the CQC's view of the organisation was considered as part of the framework. The segmentation of NHFT prior to the incident is detailed in Section 5 below.

104. An overview of support needs, relevant to the Oversight Framework referenced above, is provided below in relation to Trusts:

Segment	**Description**	**Scale and nature of support needs**
1	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities.	No specific support needs identified. Trusts encouraged to offer peer support. Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations.
2	Plans that have the support of system partners in place to address areas of challenge. Targeted support may be	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. Getting It Right First Time, Right Care, pathway redesign, NHS

	required to address specific identified issues.	Retention Programme) or a bespoke support package via one of the regional improvement hubs.
3	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS Provider Licence.	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required.
4	In actual or suspected breach of the NHS Provider Licence with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support.	Mandated intensive support delivered through the Recovery Support Programme.

105. On 26 June 2025, NHS England published the 2025/26 Oversight Framework **[NHSE0000517][NHSE0000518]**. ICBs will not be segmented in 2025/26 due to the current transformation programme. Support for ICBs in 2025/26 will focus on the safe implementation of their plans. ICBs that are currently in the Recovery Support Programme ("**RSP**") will continue in the programme.

Recovery Support Programme

106. ICBs and Trusts who were allocated to segment 4 of the NHS Oversight Framework in place during the Relevant Period would enter the RSP. Prior to this, there were separate quality and finance "special measures" programmes between 2013 and 2021.

107. For Trusts, an Improvement Director would be appointed. This is not someone who sits on the Board of a Trust, but rather someone who would work closely with them to develop an improvement plan for sign off by NHS England.

108. Further information is available in Section 6 of the NHS Oversight Framework applicable during the Relevant Period.

Enforcement

109. Unless they are exempt, providers of NHS funded care are required to hold a licence[9]. This includes Trusts[10] and independent sector providers which provide services to the NHS under contract.

110. The NHS Provider Licence is used to regulate providers of NHS services and was managed by NHS Improvement until it merged with NHS England. The licence sets out the conditions that providers of healthcare services, for the purposes of the NHS in England, must meet to help ensure that the health sector works for the benefit of patients **[NHSE0000389]**.

[9] Foundation Trusts have always been required to hold a licence and this was extended to include NHS Trusts from April 2023.
[10] The governance structure of Trusts is determined by statute.

111. NHFT's Provider Licence conditions until April 2023 are exhibited at **[NHSE0000311]**. After this time, the new licence conditions (exhibited in the paragraph above) apply.

112. NHS England has a wide range of enforcement powers, which are detailed in the NHS Enforcement Guidance **[NHSE0000416]**. Enforcement options against ICBs and providers include:

a. the power to direct ICBs, when NHS England is satisfied that an ICB is failing or at risk of failing, to discharge its functions;

b. imposing undertakings for breach of licence conditions (see below);

c. directions for NHS Trusts;

d. additional governance licence conditions for NHS Foundation Trusts; and

e. revocation of licence.

113. In exercising its enforcement powers, NHS England, where appropriate, will discharge its duties in collaboration with ICBs, asking the relevant ICB to oversee and seek to resolve local issues before escalation. Where NHS England intervenes directly with individual providers, this will happen with the awareness of the relevant ICB.

CQC

114. All Trusts are required to be registered with the CQC. Independent sector providers (including charities and not for profit organisations) who carry out 'regulated activities' must also be registered with the CQC. Regulated activities are set out in Schedule 1 of the 2014 Regulations.

115. The CQC inspect Trusts and independent sector providers (as registered providers) to verify their compliance with the 2014 Regulations. NHS England has no powers of inspection and relies on the CQC's work in this regard.

116. The 2014 Regulations cover a wide range of matters, including that:

a. Trusts must not appoint or have in place an individual as a director or performing the functions of, or functions equivalent or similar to the functions of a director, unless they are "fit and proper" (Regulation 5);

b. care and treatment is being provided to patients in a safe way (Regulation 12); and

c. staffing, which requires Trusts to have enough suitably qualified, competent and experienced staff to meet regulatory requirements (Regulation 18).

117. The CQC has various powers under the Health and Social Care Act 2008 ("**2008 Act**") to issue warning notices. This includes a section 29A Warning Notice for Trusts where the CQC identifies concerns across either the whole or part of a Trust, and there is a need for significant improvements in the quality of health care.

118. The CQC also has a number of criminal enforcement powers ranging from simple cautions through to prosecution. The CQC can hold both providers and certain individuals to account. For more information, see exhibit: **[NHSE0000537]**.

Section 48 Reports

119. Section 48 of the 2008 Act gives the CQC the power to conduct a special review or recommendation. A special review or investigation may look into:

a. the provision of NHS care;

b. the provision of adult social services;

c. subject to SSHSC consent, the exercise of functions by NHS England or an ICB in arranging for the provision of NHS care under the 2006 Act or section 117 of the Mental Health Act 1983 (the "**1983 Act**"),

d. subject to SSHSC consent, the exercise of the functions of English local authorities in arranging for the provision of adult social services; or

e. the exercise of functions by English Health Authorities.

120. The CQC must undertake a special review or investigation if the SSHSC requests. Following the conviction of VC, the SSHSC commissioned CQC to carry out a rapid review of NHFT under section 48.

Types of NHS services

121. There are four broad categories of services, which denote the typical way in which a patient can experience the health system from first point of contact. These services are intended to act as an integrated system:

a. primary care, which includes general medical practice (GP). Almost all primary care providers are independent businesses operating in accordance with contracts commissioned by NHS commissioners;

b. secondary care, which includes urgent and emergency care including 999, ambulance services, hospital emergency departments and some mental health services (including some mental health community

services). Secondary care is predominantly provided by public sector organisations such as Trusts, but can also be provided by independent sector organisations under contract to the NHS;

c. tertiary care, which is highly specialist care provided to patients who are referred from primary or secondary care services. Tertiary care includes a range of specialist mental health services, including secure forensic mental health services. Whilst tertiary care is predominantly provided by public sector organisations, independent sector organisations also provide this under contract to the NHS. Very specialist care is sometimes described as 'quaternary care', which is considered an extension of tertiary care; and

d. community care, although in terms of mental health service provision, this should not be confused with community care which is commissioned as part of secondary care.

122. Mental health services cover a wide range of conditions, including eating disorders, stress, anxiety and depression, dissociative disorders, personality disorders and psychosis (see below for further information on psychosis). There are also specific services for certain groups of people, for example:

a. maternal mental health services, which combine maternity, reproductive health and psychological therapy for women experiencing moderate to severe or complex mental health difficulties directly arising from, or related to, their maternity experience;

b. secure mental health services (also known as forensic mental health services), which provide services for patients with mental health

conditions who are considered a risk to the public. These can be low, medium and high secure (there are three high-security psychiatric hospitals in England: Ashworth, Broadmoor and Rampton).

123. Given the broad nature of mental health services, the patient pathway - the route a patient takes from initial contact and assessment through to treatment and care - will vary. Similarly the range of treatment options available will vary depending on the diagnosis, but may include talking therapy or prescriptions for medication, and in certain situations individuals may be held (sectioned) for assessment and treatment (see paragraphs 204 to 216 below).

Psychosis pathway

124. The following paragraphs, together with Annex 4, provide a typical psychosis pathway for an adult for contextual purposes.

Psychosis and schizophrenia

125. Psychosis describes a set of symptoms rather than a particular disorder. There are several mental health conditions that may give rise to symptoms of psychosis, such as bipolar affective disorder ("**BPAD**"), schizophrenia, depression with psychotic symptoms, postpartum psychosis and schizoaffective disorder.

126. Psychosis describes a set of symptoms where an individual loses touch with reality. This might mean seeing or hearing things that aren't there (hallucinations), having strong beliefs that others don't share (delusions), or finding it hard to think clearly and communicate. Hallucinations and delusions can impact people's behaviour. Command hallucinations are a particular type

of hallucination where an individual hears voices telling them to do things/ take certain actions (i.e., they 'command' them).

127. Schizophrenia is a specific long-term mental health condition or disorder. It causes a range of different psychological symptoms affecting how an individual thinks, feels, and experiences the world. Individual experiences of this condition, the types and degree of symptoms that they have, and how those symptoms impact them, varies between individuals.

128. Symptoms can include:

a. hearing or seeing things that do not exist outside of the mind (hallucinations);

b. unusual beliefs not based on reality or accounted for by culture or spiritualty (delusions);

c. muddled thoughts and speech;

d. losing interest in everyday activities;

e. not wanting to look after yourself and your needs, such as not caring about your personal hygiene;

f. wanting to avoid people, including friends; and/or

g. feeling disconnected from your feelings or emotions.

129. Individuals with schizophrenia may have episodes of psychosis, such as hallucinations or delusions (positive symptoms), alongside difficulties with concentration, motivation, and expressing emotions (negative symptoms). A

common feature of schizophrenia is that individuals are unaware that there is something wrong, or they lack insight into the fact they are unwell.

130. It is important to note that psychosis can be a highly variable condition in terms of how it presents, the disease course it follows, and relatedly the care that is needed to treat and support those living with it.

Diagnosis

131. Unlike many physical health conditions, diagnosis in mental health care is based primarily on clinical presentation (rather than using diagnostics such as blood tests or imaging). This and other clinical factors mean that diagnosis can take more time.

132. Diagnosis in first episode psychosis is often provisional. Early presentations may not meet full criteria for schizophrenia, schizoaffective disorder, or bipolar disorder. The International Classification of Diseases (or "**ICD**") and Diagnostic and Statistical Manual of Mental Disorders (or "**DSM**") criteria for schizophrenia require persistence or multiple episodes. Symptoms can overlap with mood disorders, substance use, or trauma related conditions. Comorbidities (depression, anxiety, PTSD, neurodevelopmental disorders, substance misuse) complicate assessment and the overall clinical picture.

133. Diagnosis evolves over time, so services tend to prioritise support and engagement over premature labelling.

Overview of the care pathway

134. There is a well-established care pathway in England for people experiencing first episode psychosis. This is delivered by a specialist team (Early intervention

in Psychosis ("**EIP**")) for around three years (these teams are sometimes referred to as First Episode Psychosis (FEP) teams). After this, the individual's care is either transferred back to primary care if they are in remission, or onwards to a secondary care community mental health team ("**CMHT**") if they have ongoing needs which are best met by mental health services.

135. Some individuals recover after an episode of psychosis, however, others go on to have longer-term needs. Individuals will likely have longer-term needs when the psychosis is related to the disorder schizophrenia. It must, however, be noted that disease course, social and environmental factors, healthcare system, treatment and engagement and biological and personal factors all influence prognosis and the development of longer-term needs. Individuals requiring longer-term care may require ongoing secondary community mental health care and/or rehabilitation care in community or inpatient settings. Social care, including housing support and rights under the Care Act 2000, are usually relevant to longer-term needs.

136. Psychosis and associated disorders (e.g., schizophrenia) usually involve relapse and remittance. During relapse, more acute and intensive care can be needed. This is delivered through crisis resolution and home treatment teams (based in the community), or mental health inpatient settings in line with the acuity of needs. For those requiring more specialist care than that which can be provided in adult inpatient services (due to higher acuity), more specialist units such as psychiatric intensive care ("**PICU**") services or forensic inpatient settings are available (the latter not being relevant to VC during the Relevant Period). Admission to these care settings is usually determined by risk.

137. Forensic and secure services can be part of the pathway for psychosis according to needs and presentation. If the individual has a serious mental disorder and poses a risk of harm to others, often linked to offending behaviour, care in the community or in acute inpatient or rehabilitation pathways may be delivered through secure pathways. Movement into and out of these pathways is determined by the individual's risk of harm to others, whether their needs can be sufficiently met in general adult services, and relevant legal frameworks.

138. Further information on the care pathway is covered in Annex 4, and includes:

a. access: how people present to and relatedly access services;

b. referrals to EIP services together with initial engagement and EIP care;

c. pharmacological treatment;

d. treatment response and treatment resistance;

e. psychological and social interventions;

f. crisis and hospital care;

g. criminal justice pathways; and

h. continuity of care and care transitions.

Providers of mental health services

139. Providers of the different groups of care range from public sector organisations e.g., NHS Trusts (established by orders of the SSHSC) and NHS Foundation Trusts (public benefit corporations), to independent providers including for-

profit and charitable and other not-for-profit providers, and independent contractors (e.g., GP practices).

140. Trusts can operate multiple hospital and community sites.

141. All providers of NHS funded care (whether they are public or independent sector providers) employ and manage their workforce; there is not a centrally employed 'NHS workforce'. Providers are responsible for ensuring they have appropriately qualified staff and adequate staffing levels.

142. Providers of NHS services i.e., those that provide direct care to patients at an organisational and clinician level, are regulated by multiple regulators depending on their structure and the services being delivered. This includes:

    a. the CQC, the independent regulator for the quality and safety of care who oversees and inspects organisations that provide health and social care services;

    b. NHS England (see above); and

    c. for clinicians themselves, the relevant healthcare professional bodies, such as the GMC and the NMC.

143. Ambulance services are commissioned from 'ambulance trusts' by ICBs[11]. Each of the ten ambulance trusts covers a wide geographical footprint and supports the ambulance needs of individuals present in their region. In addition, they provide support and assistance to neighbouring regions and cross border

[11] Ambulance trusts are always Trusts.

assistance with the devolved nations by way of mutual aid in accordance with agreed protocols.

144. Specific service contracts are mandated for use by commissioners including:

a. the NHS Standard Contract (consisting of particulars, general conditions and service conditions), which:

i. exists to ensure that commissioners and providers operate in accordance with one clear and consistent set of rules which everyone understands, giving a level playing field for all types of providers. The service conditions are drafted such that some apply to all services (such as EPRR at condition 30 and safeguarding at condition 32), whilst others will apply to specific services e.g., mental health and learning disability services;

ii. is mandated by NHS England for use by commissioners (NHS England and ICBs) for all contracts for NHS funded healthcare services (including acute, ambulance, patient transport, continuing healthcare services, community-based, high-secure, mental health and learning disability services); and

iii. has been the responsibility of NHS England since 2013. The 2023/24 version is exhibited at **[NHSE0000388][NHSE0000390] [NHSE0000392]**,

b. specific contracts for different primary care services e.g., GP services.

145. Providers are accountable to commissioners through their contracts for the services commissioned. It is the responsibility of the provider to ensure that

services are carried out in accordance with specifications, allocated budgets and appropriate clinical guidance. Providers also make their own decisions on, amongst other things, staffing, purchasing and stock levels and maintenance.

146. The day-to-day management of patients is the responsibility of the relevant provider. For example, in hospitals clinicians use their professional judgement and appropriate clinical guidelines to determine the treatment that a patient should be offered and receive. This judgement includes the patient's suitability for treatment options (assuming those are NHS-funded and commissioned services/treatments), as well as whether or not a patient should be admitted.

147. Mental health services are delivered by a range of professionals working in multidisciplinary teams. This includes psychiatrists, psychologists, mental health nurses, support staff and peer support workers. The majority of mental health professionals will be regulated by the GMC or the NMC.

Duty of Candour

148. There are two types of duty of candour: statutory and professional.

149. Although compliance with the duty of candour is a requirement under the NHS Standard Contract, neither of the two types of duty of candour are set by or regulated by NHS England.

Statutory Duty of Candour

150. The statutory duty of candour is a requirement under Regulation 20 of the 2014 Regulations. It is regulated by the CQC.

151. This duty requires regulated providers and registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them.

152. The statutory duty of candour also includes specific requirements for certain situations, known as 'notifiable safety incidents'. Regulated providers must notify the CQC without delay in relation to these incidents.

153. Notifiable safety incidents must meet the following criteria:

    a. have been unintended or unexpected;

    b. have occurred during the provision of an activity which the CQC regulate; and

    c. in the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care.

154. A key aspect of the statutory duty of candour is the provision of an apology in respect of what has gone wrong in the delivery of patient care. Such an apology is not considered an admission of liability. NHS Resolution, the organisation that manages clinical negligence claims against the NHS, confirms that:

    Saying sorry is:

    • *always the right thing to do*

    • *not an admission of liability*

    • *a way to acknowledge something could have gone better*

• *the first step to learning from what happened and preventing it recurring.* **[NHSE0002311]**.

Professional Duty of Candour

155. The professional duty of candour is overseen by health and care professionals' regulators, for example the GMC and the NMC.

156. Health and care professionals must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress. This means that health and care professionals must:

a. tell the person (or, where appropriate, their advocate, carer or family) when something has gone wrong;

b. apologise to the person (or, where appropriate, their advocate, carer or family);

c. offer an appropriate remedy or support to put matters right (if possible); and

d. explain fully to the person (or, where appropriate, their advocate, carer or family) the short and long term effects of what has happened.

157. Health and care professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested.

158. The GMC and NMC have produced joint guidance, which is exhibited at **[NHSE0002334]**.

159. It is important to note that in circumstances where the criteria for a 'notifiable safety incident' are met, it will not be sufficient to meet expectations of the professional duty in isolation. The requirements outlined by the statutory duty will also need to be upheld.

Provider Collaboratives

160. The move towards integrated care has resulted in many providers working more closely together, in partnership, to deliver more efficient and sustainable services. These partnerships are known as 'Provider Collaboratives' and are collections of providers of commissioned services to the NHS. They feature a lead Trust, which acts as the commissioned provider, a number of other Trusts and, in some cases, further providers such as third sector organisations or other independent providers who collaborate with the lead Trust under partnership arrangements. The intention is that working at scale in this way enables providers to come together to improve quality of care by; standardising clinical practice to tackle variations in access and outcomes across different sites, to increase sustainability through better use of a limited workforce, and to consolidate corporate services for greater efficiency.

161. The successful functioning of Provider Collaboratives is seen as an important contribution to improving services. The lead provider's role involves understanding their local population and empowering local clinicians and 'Experts by Experience' to design improved pathways of care. The lead provider will sub-contract to other providers, manage contracts, assure the quality of services and lead the necessary reporting regionally and nationally to NHS England.

162. Provider Collaboratives were a key constituent of the NHS Mental Health Implementation Plan **[NHSE0000013]** (see Section 2) and all Trusts providing acute and mental health services, including specialist trusts, were expected to be part of one or more Provider Collaboratives by April 2022 **[NHSE0000357]**. Community trusts, ambulance trusts and non-NHS providers were expected to be part of Provider Collaboratives where this would benefit patients and made sense for the providers and systems involved.

163. NHFT is the lead provider for the East Midlands Provider Collaborative for Adult Secure Care, known as "IMPACT". The partnership consists of nine NHS, independent and third sector organisations that provide NHS Adult Secure Care services in the East Midlands.

164. As a Provider Collaborative, IMPACT takes responsibility for local pathway delivery of a number of service lines within the scope of their contract with commissioners (either an ICB or NHS England). Commissioners retain accountability for the services and associated national standards and hold a contract with the lead provider. NHFT, as lead provider, is then responsible for sub-contracting to its partners to support the range of services to be delivered.

165. Provider Collaboratives are neither legal entities nor commissioners of NHS services. NHS England does not delegate commissioning functions for specialised services to Trusts.

Use of independent sector hospitals

166. Trusts and commissioners of NHS services contract with independent sector organisations for delivery of a range of NHS services in different ways.

167. A common example is a Trust sub-contracting with an independent sector organisation for additional capacity. The independent sector organisation would provide treatment to the patient on behalf of the Trust which would remain contractually and clinically ultimately responsible for the patient (even if 'out of area'). The Trust that subcontracted the work (as opposed to the local NHS commissioner) would pay the independent sector organisation.

Emergency Preparedness, Resilience and Response

Overview

168. NHS England is a Category 1 Responder pursuant to the Civil Contingencies Act 2004 ("**CCA 2004**") and its subsidiary regulations, the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005 (the "**2005 Regulations**"). The CCA 2004 requires Category 1 Responders to assess, plan and advise, which includes a requirement to undertake a number of tasks, specified in section 2(1) of that Act.

169. NHS England, as a Category 1 Responder, has certain duties of co-operation under the 2005 Regulations. This includes co-operation with other general Category 1 Responders in connection with the performance of their duties and co-operation with relevant general Category 2 Responders (listed in part 3 of schedule 1 to CCA 2004, and which included CCGs until July 2022), in so far as such co-operation relates to or facilitates the performance of the relevant general Category 1 Responder's duties.

170. There is a reciprocal duty on relevant Category 2 Responders to co-operate with relevant Category 1 Responders, as well as a duty for Category 2

Responders to co-operate with each other. Under the CCA 2004 and 2005 Regulations, responders have a duty to share information with partner organisations.

171. Since 1 July 2022, ICBs have been Category 1 Responders.

172. NHS England also has a specific statutory role in respect of emergencies which may affect NHS England, ICBs or providers of NHS services, whether by increasing the need for services or otherwise under the 2006 Act ("**relevant emergencies**"). Section 252A of the 2006 Act requires NHS England to take steps to be properly prepared, and to secure that each ICB and each provider of NHS services is properly prepared, for such emergencies. In addition, where a relevant emergency occurs, NHS England has a power to take such steps as it considers appropriate to facilitate a co-ordinated response by ICBs and relevant providers.

173. Section 252A also requires that ICBs must take appropriate steps for securing that it is properly prepared for dealing with a relevant emergency.

174. In England, NHS England is responsible for setting a risk-based Emergency Preparedness, Resilience and Response ("**EPRR**") strategy for the NHS, ensuring there is a comprehensive NHS EPRR system.

175. In relation to EPRR, NHS England works with a range of national partners, including the devolved administrations and other Government departments and public bodies, as well as regional and local partners.

176. NHS England has had an EPRR team in place since 1 October 2012. The EPRR function is organised on a national and regional basis, to reflect the fact

that planning, preparation and response can require different levels of co-ordination. The national EPRR team was part of the NHS England Chief Operating Officer's directorate at the time of the incident. The team is now part of the Urgent and Emergency Care and Operations directorate.

177. NHS England maintains an EPRR Framework (**[NHSE0000410]**), together with a number of specific incident plans and a generic overarching 'Incident Response Plan' (**[NHSE0000379]**), not only to discharge its obligations under civil contingencies legislation but also because NHS England has a duty under NHS legislation to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. The types of incidents that NHS England must prepare for includes casualty and mass casualty, hazardous materials (HAZMAT) and chemical, biological, radiological and nuclear (CBRN), adverse weather, business continuity and infectious diseases and pandemics.

178. Under the EPRR Framework, NHS incidents are categorised as:

    a. business continuity: an incident where an event or occurrence disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities etc.

    b. critical: any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also

be down to the environment potentially being unsafe, requiring special measures and support from other agencies to restore normal operating functions. A critical incident is principally an internal escalation response to increased system pressures/disruption to services.

c. major: any occurrence that presents a serious threat to the health of the community, or causes such numbers or types of casualties as to require special arrangements to be implemented. A major incident may involve a single agency response, although it is more likely to require a multi-agency response, which may be in the form of multiagency support to a lead responder. The decision to declare a major incident will always be made in a specific local and operational context. There are no precise, universal thresholds or triggers.

179. In addition to the categories above, incidents are also classified by their type e.g., “rapid onset” (a serious transport accident, explosion, or series of smaller incidents), “rising tide” (a developing infectious disease epidemic, or a capacity/staffing crisis or industrial action), or "mass casualty" (an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services ability to manage). A non-exhaustive list of classifications is set out in the NHS England EPRR Framework.

180. Within the NHS, incidents are also described in terms of the level of response and coordination required, which may change as the incident evolves. These levels are specific to the NHS in England and are not interchangeable with other organisations’ incident response levels. They must be used by all organisations

across the NHS when referring to incidents. The Framework describes how escalation and de-escalation decisions are made and the box below details, at a high level, each incident level, which informs how the NHS will respond:

Level 1	An incident that can be responded to and managed by an NHS-funded organisation within its respective business as usual capabilities and business continuity plans
Level 2	An incident that requires the response of a number of NHS-funded organisations within an ICS and NHS coordination by the ICB in liaison with the relevant NHS England region
Level 3	An incident that requires a number of NHS-funded organisations within an NHS England region to respond. NHS England to coordinate the NHS response in collaboration with the ICB. Support **may** be provided by the NHS England Incident Management Team (National).
Level 4	An incident that requires NHS England national command and control to lead the NHS response. NHS England Incident Management Team (National) to coordinate the NHS response at the strategic level. NHS England (Region) to coordinate the NHS response, in collaboration with the ICB, at the tactical level.

181. Separately to managing incidents, as part of preparedness NHS England takes part in exercises funded by DHSC and it commissioned UKHSA to test existing plans. The theme is linked to the National Risk Assessment[12] (e.g., terrorism, pandemic influenza etc.). Separate to this exercising is also carried out on a regional basis and at a Trust level, as well as with partners locally across the Local Resilience Forum ("**LRF**") footprint.

182. LRFs are multi-agency forums made up of representatives from Category 1 Responders and are supported by Category 2 Responders. The geographical area of forums is based on police areas (apart from London, where one area covers London boroughs and the City of London). The mandatory requirements relating to LRFs are set out in the 2005 Regulations.

183. In August 2024, NHS England wrote to Trusts and ICBs around exercise themes to assist the NHS in being fully prepared for incidents **[NHSE0000499]**.

[12] This is a classified assessment of the most significant threats and hazards that the UK could face over the following 5 years, and is led by the CCS within the Cabinet Office.

184. Formal assurance of local, regional and national emergency preparedness takes place annually. The assurance process helps to identify areas requiring further attention as well as building upon good practice that can be shared.

NHS Nottingham and Nottinghamshire Local Resilience Forum Representation Agreement

185. The NHS Nottingham and Nottinghamshire Local Resilience Forum Representation Agreement ("**EPRR MoU**") outlines the governance arrangements for how the NHS is represented and structured in the Nottingham and Nottinghamshire LRF, including its subgroups with their desired membership from across the local health service **[NHSE0000405]**[13].

186. Regional teams engage with a number of partners through LRFs and Local Health Resilience Partnerships ("**LHRP**") (including sub-groups) and various regional groups (e.g., steering groups and health protection groups). Regional teams also directly engage with, for example, NHS funded organisations, NHS commissioners, safety advisory groups, the Ministry of Defence (Joint Regional Liaison Officers), Directors of Public Health and the UKHSA.

187. LHRPs provide a strategic forum for joint EPRR planning across a geographical area. LHRPs coordinate strategic planning for incidents impacting on health or continuity of patient services and effective engagement across LHRP and local health economies. LHRPs feed into the activity of LRFs in relation to health planning, but are not formally part of LRFs.

[13] Note that although the EPRR MoU is dated post-incident, the principles within it applied at the time of the incident.

188. Pursuant to the EPPR MoU, ICBs attend LRFs on behalf of the NHS (excluding ambulance services) and feedback through various reporting mechanisms.

189. ICBs will also attend incident response groups as representatives of the NHS (excluding ambulance services), but they must notify the NHS Midland's regional EPRR team immediately of their attendance and provide a briefing to the wider health system and to NHS Midlands immediately afterwards, for consideration of wider implications across the region.

190. Notwithstanding this, the NHS England EPRR team at a regional or national level (as appropriate) may attend incident response groups.

Operation Plato

191. Operation Plato is the agreed national police identifier for a Marauding Terrorist Attack ("**MTA**") and sets out the agreed response to such an incident.

192. An MTA is a fast moving violent attack where an assailant(s) moves through a location with the aim to kill or injure as many people as possible before a response can be co-ordinated. Attacks can involve bladed weapons, vehicles, explosives or firearms. As an act of terrorism, the attack must also be designed to influence the government, an international governmental organisation, or to intimidate the public or a section of the public, and it must be for the purposes of advancing a political, religious, racial or ideological cause (Terrorism Act 2000, section 1). Examples include the London Bridge and Westminster Bridge Attacks, both in 2017.

193. When Operation Plato is declared, there is a defined response involving the police, other agencies and COBR[14]. Operation Plato may be called to put agencies 'on notice' of an MTA, but it may later be stood down if the incident is not an MTA. Operation Plato would lead to the declaration of a Level 4 NHS EPRR incident if COBR is stood up in response to the attack.

194. When Operation Plato is stood up, the Regional EPRR team will notify the National EPRR team, who will then liaise with counterparts in DHSC. The NHS aligns to the Operation Plato response at a national level but the NHS does not lead the response.

195. If Operation Plato is stood down because the incident is not an MTA, the police will stand up another operation, which again the NHS will support as appropriate, with the Police being the lead agency.

196. Depending on the impact on local NHS services as a result of the incident, the NHS may also declare an incident under the NHS EPRR Framework at a local, regional or national level.

Hazardous Area Response Team (HART)

197. The Hazardous Area Response Team ("**HART**") is a nationally commissioned and available resource that is hosted across the 10 ambulance trusts in England.[15]. HART personnel are paramedics with additional specialist training.

[14] COBR or "the Cabinet Office Briefing Rooms" are where the Government stands up the Civil Contingencies Committee to handle national emergencies and disruption.
[15] Isle of Wight service does not have HART, Isle of Wight is a combined Trust and so acute and ambulance are all part of single trust.

198. There are 15 HART vehicles, which are not patient carrying vehicles. If a patient needs transport then a standard NHS emergency ambulance is deployed. HART personnel may or may not accompany a patient.

199. HART was established to deal with incidents such as CBRN and MTA, Safe Working at Heights and Swift Water Rescue.

Covid-19

200. The Relevant Period covers almost the entire period of the pandemic – NHS England stood up its pandemic response on 30 January 2020 and it was not stood down until 18 May 2023.

201. Whilst the NHS did not become a Covid-19 only service, changes to the way in which the NHS operated were required to help prevent the spread of the virus and to free-up capacity for those with Covid-19. The response varied throughout the different phases of the pandemic, and included:

a. the use of remote consultations where clinically appropriate;

b. reducing reporting requirements on providers; and

c. changes to the way in which NHS England engaged with systems and organisations, with oversight focusing on critical issues only.

202. The CQC also paused routine inspections as part of its response to the pandemic.

203. Throughout this statement we have highlighted relevant Covid-19 policies.

SECTION 2: MENTAL HEALTH POLICY LANDSCAPE

Mental Health Act 1983

204. The 1983 Act is the primary legislation that covers the assessment and treatment of people with a mental health disorder.

205. The principal aim of the law and in all clinical practice is to minimise the use of compulsory treatment, under the principle that least restrictive options should always be sought first to support a person's care. Restrictive practice can cause iatrogenic harm, breach human rights and damage the relationship between the person needing care and treatment and the services available to deliver it.

206. Current reform of the 1983 Act reflects these challenges and responds to the significant known inequalities in its use, with disproportionate use for Black people. Schizophrenia and psychotic disorders account for about half of all detentions under the 1983 Act, but these numbers can vary.

207. The 1983 Act allows for the detention of individuals in certain circumstances, this includes:

    a. section 2, which permits detention for assessment. The detention period is up to 28 days beginning with the day on which the individual is admitted. Persons detained pursuant to section 2 may be subject to compulsory treatment, for example, if they refuse treatment but the medical team believes it is necessary;

    b. section 3, which is concerned with admission for treatment. The period of detention permitted under section 3 is six months, after which it may be extended initially for a further six months and thereafter for further periods of one year at a time;

c. section 37, which allows a Crown Court or Magistrates Court (in certain circumstances) to authorise the admission to and detention of an individual to a hospital. As with section 3, the period of detention permitted under section 37 is six months, after which it may be extended initially for a further six months and thereafter for further periods of one year at a time.

208. In certain circumstances, a warrant may also be issued pursuant to section 135 authorising the police together with medical professionals to enter premises and take an individual to a place of safety (or keep them in a place of safety).

209. Section 136 also allows a police officer to take an individual to a place of safety or keep them in a place of safety if they think it is necessary in the interest of that individual or for the protection of the person without a warrant.

210. The period of detention under section 135 or section 136 is 24 hours, which may be extended up to 36 hours in certain circumstances (section 136B).

211. Some decisions under the 1983 Act can only be taken by people who are Approved Clinicians (as defined under section 145 of the Act).

212. All Responsible Clinicians for detained patients must be Approved Clinicians (see section 34 of the 1983 Act). A Responsible Clinician is the Approved Clinician with overall responsibility for the care of a patient detained under that Act. Certain decisions, such as renewing a patient's detention or placing a patient on a community treatment order ("**CTO**"), can only be taken by the Responsible Clinician.

213. CTOs allow an individual who is detained under section 3 or section 37 to be discharged from a hospital and treated in the community, with conditions applied to individuals placed on a CTO. Individuals may be recalled if they do not comply with the associated conditions (section 17B). An individual may also need to be recalled to hospital if they require medical treatment in hospital and there would be a risk of harm to the health or safety of the individual or to other persons if they were not recalled to hospital for that purpose (section 17E). CTOs are valid for a period of six months unless extended (section 20A).

214. Pursuant to section 118 of the 1983 Act, DHSC published the Mental Health Act 1983: Code of Practice ("**MHA CoP**"). The latest version of the MHA CoP has been in effect since 1 April 2015 and is statutory guidance for medical practitioners and others in relation to the treatment of patients in England suffering from mental disorder **[NHSE0000312]**.

215. The MHA CoP sets out five overarching key principles:

    a. Least restrictive option and maximising independence: where it is possible to treat a patient safely and lawfully without detaining them under the 1983 Act, the patient should not be detained. Wherever possible, a patient's independence should be encouraged and supported, with a focus on promoting recovery wherever possible.

    b. Empowerment and involvement: patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

c. Respect and dignity: patients, their families and carers should be treated with respect and dignity and listened to by professionals.

d. Purpose and effectiveness: decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery, and should be performed to current national guidelines and/or current available best practice guidelines.

e. Efficiency and equity: providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

216. Guidance is provided in the MHA CoP regarding sectioning and CTOs.

Mental Capacity Act 2005

217. Section 1 of the Mental Capacity Act 2005 ("**2005 Act**") sets out five principles:

a. A person (aged 16 and over) must be assumed to have capacity unless it is established that he lacks capacity.

b. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

c. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

d. An act done, or decision made, under the 2005 Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

e. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

218. The 2005 Act then provides the legal framework for situations where decisions are made on behalf of individuals who lack capacity.

219. Pursuant to sections 42 and 43 of the 2005 Act, a code of practice was issued providing guidance on the 2005 Act **[NHSE0000343]**.

Overarching policy

220. As set out at paragraph 38 above, NICE is primarily responsible for setting out guidance on the diagnosis, treatment and management of diseases and other conditions, whilst the Royal Colleges, professional bodies and other professional societies publish clinical and professional guidance for use across the system. Providers are then required to ensure that their services meet relevant legislation and guidelines.

221. However, as part of its role in leading and overseeing national policy for the commissioning and delivery of all NHS services across England, which includes driving service improvement and ensuring high quality care, NHS England publishes overarching policy and guidance documents that are of relevance to all NHS services nationally, as well as service models and other support that local providers and commissioners can use.

222. Practically, this means that NHS England is responsible for overseeing national mental health policy and its mental health strategy is set out in a series of key publications, as explained further in this section.

223. NHS England also considers requests for advice and guidance from the system. Often guidance is developed in collaboration with providers and other key stakeholders.

224. Most of the guidance and policy produced by NHS England is typically available through its public website. NHS England often directs guidance and policies to the relevant audience, for example ICBs and providers, through system letters and annual planning guidance. This is done in conjunction with NHS England's national and regional operations centres. Where appropriate, guidance will be sent direct to the CEOs and/or chairs of the relevant NHS body. It may also be cascaded to specific roles within the NHS (for example, chief finance officers, medical directors, chief nurses, chief people officers, etc.), depending on the subject matter.

225. Guidance and policies will usually be cascaded to the relevant audience on the day they are published on the NHS website. However, some guidance may be shared via the FutureNHS Collaboration Platform.

226. FutureNHS is an online collaborative working platform that is managed by NHS England. Members of the platform can join or create workspaces and communities to connect with others, learn and share. FutureNHS is open to anyone working in, or for, health and social care. The platform supports commissioners, providers, senior management, frontline staff, clinicians, health

and social care colleagues, voluntary community sector organisations and other interested stakeholders.

227. It is made up of different workspaces. Workspaces are self-contained areas with their own managed membership, which are dedicated to a project, programme or subject area. A workspace can either be open (accessible to all members) or restricted (membership access requests must be approved).

228. Other information may be shared through bulletins, for example, in the weekly healthcare leaders bulletin or the mental health, learning disability and autism bulletin.

229. In addition to national policies, ICBs and providers will manage their own local policies.

The Five Year Forward View

230. The 'Five Year Forward View' (October 2014) was published jointly by NHS England **[NHSE0000313]** and other national NHS bodies with a vision to transform the NHS by 2020. This was focused on addressing three identified gaps:

a. the health and wellbeing gap: the need to reduce demand on the NHS by shifting focus towards prevention and addressing health inequalities;

b. the care and quality gap: to harness technology and innovation to reduce variations in the quality of care, including in relation to safety and outcomes in care; and

c. the funding and efficiency gap: to ensure that additional funding for the NHS is used to improve efficiencies, transform services and achieve financial sustainability.

231. Following this, in 2016 NHS England published the 'Five Year Forward View for Mental Health' **[NHSE0000002]** together with its implementation plan ('Implementing the Five Year Forward View for Mental Health' **[NHSE0000003]**) for developing mental health services for all ages, following recommendations made in an independent report of the Mental Health Taskforce commissioned by NHS England.

232. The Five Year Forward View for Mental Health recommendations included:

a. from April 2016, 50% of people experiencing a first episode of psychosis have access to a NICE–approved care package within two weeks of referral, rising to at least 60 per cent by 2020/21;

b. community-based mental health crisis response availability in all areas across England and ensuring that services are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission; and

c. the elimination of Out of Area Placements ("**OAP**").

233. In July 2017, HEE published 'Stepping forward to 2020/21: The mental health workforce plan for England' to support delivery of the Five Year Forward View for Mental Health in England **[NHSE0000317]**.

The NHS Long Term Plan

234. In 2019, the NHS LTP was published, which set out an ambitious plan to transform mental health services and build on progress from the Five Year Forward View for Mental Health **[NHSE0000014]**.

235. The NHS LTP included a number of commitments for adult mental health including:

a. new and integrated models of primary and community mental health care to support adults and older adults with severe mental illness to access care, treatment and support at the earliest point of need, so they can live as well as possible in their communities;

b. expanding services for people experiencing a mental health crisis; and

c. eliminating inappropriate out of area placements.

236. In addition, the NHS LTP renewed the commitment that mental health services would grow faster than the overall budget, with a ringfenced investment worth at least £2.3 billion a year by 2023/24.

237. NHS England's Mental Health Programme oversees the policy development and tracks national delivery of relevant national policy commitments. For example, between 2018-2023 the national Mental Health Team was responsible for co-ordinating the mental health input to the NHS LTP, based on engagement with stakeholders, analysis of available evidence, consideration of international benchmarks and listening to patients and their families. The National Mental Health Programme was then responsible for co-ordinating delivery across a range of arms-length bodies (e.g., HEE) and working with

regions to support systems to plan and deliver the national commitments set out in the NHS LTP.

238. The National Mental Health Programme provided ongoing support, based on feedback from regions, to enable systems to deliver national priorities as well as responding to future priorities, investigations etc.

NHS Mental Health Implementation Plan 2019/20 – 2023/24

239. The NHS Mental Health Implementation Plan 2019/20 – 2023/24 **[NHSE0000013]** focused on implementing the commitments of the Five Year Forward View for Mental Health and the NHS LTP, setting out planning and delivery requirements over five years.

240. The policy aim was to provide more integrated services for people with mental health needs in the community. This involved new care models with better coordination between the range of different NHS mental and physical health services and other services (for example, social care) that an individual may need.

241. These successive national policies demonstrated commitment to reducing the significant treatment gap in mental health care caused by historic under investment in mental health services. It was acknowledged by NHS England that delivery of the Five Year Forward View and the NHS LTP would go some way to reducing the treatment gap but it would not be able to close it, and ongoing investment and transformation would need to continue to bring true parity of esteem across mental health and physical health. This issue was also

recognised in the Independent Investigation of the National Health Service in England by Lord Darzi of Denham in 2024:

"There is a fundamental problem in the distribution of resources between mental health and physical health. Mental health accounts for more than 20 per cent of the disease burden but less than 10 per cent of NHS expenditure. This is not new. But the combination of chronic underspending with low productivity results in a treatment gap that affects nearly every family and all communities across the country."

NHS Priorities and planning guidance

242. One method which NHS England uses to communicate priorities out to the sector is through publication of the NHS Priorities and Operational Planning Guidance ("**Planning Guidance**") which sets out the NHS' priorities, typically for the year ahead.

243. Following the NHS LTP, the Planning Guidance had a focus on improving mental health. For example, the 2022/23 guidance focused on improving mental health services and services for people with a learning disability and/or autistic people, maintaining continued growth in mental health investment to transform and expand community health services, and to improve access, which included:

a. to continue to expand and improve mental health crisis care provision for all ages; and

b. to ensure admissions are intervention-focused, therapeutic and supported by a multidisciplinary team, utilising the expansion of mental

health provider collaboratives across the whole mental health pathway where systems plan such developments. These collaboratives would support systems to transform services and reduce reliance on hospital-based care delivered away from people's local area.

244. For completeness, it is highlighted that the 2020/21 Planning Guidance was suspended in response to the pandemic. Equally, as a result of the pandemic, planning guidance from 2021 onwards has had to consider the new care demands and care backlogs that occurred as a direct result of the pandemic.

245. The Planning Guidance for the Relevant Period is exhibited at: **[NHSE0002280] [NHSE0002281] [NHSE0002284] [NHSE0002285] [NHSE0002288] [NHSE0002297] [NHSE0002299] [NHSE0002307] [NHSE0002320] [NHSE0002332]**.

Mental Health Investment Standard

246. The Mental Health Investment Standard ("**MHIS**") was introduced by NHS England in 2016/17 and requires local commissioners to increase their spend on mental health services by at least as much as their overall programme allocations, maintaining mental health as a proportion of total local spending on health services.

247. In the NHS LTP, NHS England made an additional commitment to increase the share of the total recurrent NHS budget which is spent on mental health services. This includes MHIS spend, as well as specialised commissioning spend on mental health and national spending on mental health transformation.

248. In addition to independent auditing of the MHIS, the 2022 Act requires an annual statement to Parliament by ministers on mental health funding and share of spend. For the financial year 2023-24, mental health spending was forecast to make up 9% of all recurrent NHS spending. For the financial year 2024/25, mental health spending was forecast to make up 9.01% of all recurrent NHS spending **[NHSE0000486]**, and was reported to be 8.78% on 27 March 2025, with a forecast of 8.71% for 2025/26 **[NHSE0002341]**.

249. 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).

250. In 2023/24, ICBs spent £15.1 billion on mental health, learning disability and dementia services in England. This is 14.5% of the total funding allocated to ICBs for health services.

251. NHS England spent a further £2.5 billion on specialised commissioning for mental health services, for a total of £17.6 billion. This figure has risen from £12 billion in 2017/18 (in cash terms).

The community mental health framework for adults and older adults

252. The Community Mental Health Framework **[NHSE0000015]** was published in 2019. Its purpose was to realise the objectives of the NHS LTP to develop new and integrated models of primary and community healthcare for adults and older adults with severe mental illness:

"A new community-based offer will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-

informed care, medicines management and support for self-harm and coexisting substance use. This includes maintaining and developing new services for people who have the most complex needs and proactive work to address racial disparities. Local areas will be supported to redesign and reorganise core community mental health teams to move towards a new place-based, multidisciplinary service across health and social care aligned with primary care networks. By 2023/24, new models of care, underpinned by improved information sharing, will give 370,000 adults and older adults greater choice and control over their care, and support them to live well in their communities."

253. The Framework proposed replacing the care programme approach ("**CPA**") for community mental health services (see paragraphs 313 to 316 below), while retaining "*its sound theoretical principles based on good care coordination and high-quality care planning*." Therefore, a key component of the framework is to enable high-quality personalised care and support planning in accordance with the NHS England Comprehensive Model of Personalised Care **[NHSE0000543] [NHSE0000318]**.

254. The Framework confirmed:

a. every person who requires support, care and treatment in the community should have a co-produced and personalised care plan that takes into account all of their needs, as well as their rights under the Care Act 2014, and Section 117 of the 1983 Act when required;

b. the level of planning and coordination of care will vary, depending on the complexity of the person's needs. For people with more complex

problems who may require interventions from multiple professionals, one person will have responsibility for coordinating care and treatment (known as a care-coordinator, see exhibit **[NHSE0000514]**;

c. care plans will include timescales for review, which should be discussed and agreed with the person and those involved in their care at the outset. Digital technologies can be used to maximise the interoperability of plans, and to allow users to manage their care or record advance choices;

d. that it would subsume the important aspects of the CPA for community mental health services, including care planning and care coordination, and reframe them in a system that will work for everyone, will focus on improved outcomes, and will deliver place-based integrated mental health care to people whatever their level of need; and

e. a shift away from risk assessments and ineffective predictive approaches to safety planning and "positive risk taking", with staff supported by managers, and to do so under progressive, partnership clinical governance arrangements.

The Mental Health Safety Improvement Programme

255. The Mental Health Safety Improvement Programme ("**MHSIP**") was a national patient safety programme commissioned by NHS England as the NHS LTP had a strong focus on expanding and improving the quality of inpatient care for people with mental health problems, including people with a learning disability and autistic people **[NHSE0000548]**.

256. MHSIP was developed following a pilot programme which saw a significant reduction in recorded restrictive practice. Its aim was to improve safety and experience in mental health, learning disability and autism inpatient services, and specifically to reduce restrictive practices in mental health inpatient settings.

257. MHSIP commenced in 2021 and concluded in September 2023. It worked with the 54 NHS Trusts providing mental health services in England and closely with the CQC and regional NHS England teams. It also involved the National Collaborating Centre for Mental Health (a collaboration between the Royal College of Psychiatrists and University College London) and the Mental Health Patient Safety Networks (which are supported by Patient Safety Collaboratives).[16]

258. The learning from the Mental Health Safety Improvement Programme was used as part of the co-production of the Culture of Care Standards for Mental Health Inpatient Services (see below) and the associated national implementation support offer, which saw a new Culture Change Programme delivered across all NHS-commissioned providers of inpatient services.

Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme

259. In 2022, NHS England launched a three-year Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme to support cultural change and develop a new model of care across all NHS-funded mental health,

[16] The National Patient Safety Improvement Programmes fund 15 regionally based Patient Safety Collaboratives, hosted by the Health Innovation Network, which bring together the NHS, industry, academic, third sector and local organisations to foster innovation and improve health.

learning disability and autism inpatient settings. The programme subsumed elements of the MHSIP and looked at the root causes of poor-quality care and safety in inpatient mental health settings and to support cultural change. The programme has the following objectives:

a. localising and realigning inpatient services, harnessing the potential of people and communities;

b. improving culture and supporting staff;

c. supporting systems and providers facing immediate challenges;

d. improving oversight arrangements; and

e. reducing restrictive practice through least coercive care.

260. Since it was created, the programme has published commissioning guidance to support ICBs. This has included the "Commissioning framework for mental health inpatient services" **[NHSE0000520]** and the "Commissioner guidance for adult mental health rehabilitation inpatient services" **[NHSE0000521]**.

261. In 2023/24 Planning Guidance, every ICB was required to use the above guidance to develop a three year plan to localise the inpatient care they commission for their local adult population. This included acute and psychiatric inpatient care, inpatient rehabilitation care and inpatient care for adults with a learning disability and autistic adults. To support this work, every ICB was provided with inpatient baselines, toolkits to develop their plans, webinars, roadshows and access to inpatient dashboards.

262. As part of 2023/24 financial allocations, £42 million recurrent revenue was provided to ICBs through service development funding, which was then moved

to ICB allocations (e.g., included in the MHIS) from 2024/25. In addition, in 2024/25, £75 million capital was made available to systems to bid for capital investment to support their three year plans.

263. Additional improvement resource is also made available to systems to support improvement of inpatient services which are struggling, or the achievement of the localising care ambition. Supports includes access to the national Mental Health Intensive Support Team, access to additional senior executive capacity, access to 'Senior Intervenors' (people with experience of working within adult social care who can support systems struggling to discharge patients), access to additional capacity to manage hospital closures or discharges and access to peer advocacy.

264. The programme has also published the Culture of Care Standards for Mental Health Inpatient Services. This guidance provides support to all providers to achieve the culture of care that patients, families and staff want to experience. The standards are co-produced with people with lived experience of inpatient services and their families, health professionals working in mental heath and various organisations, including voluntary sector organisations, royal colleges and academic experts **[NHSE0000035]**.

265. In February 2024, NHS England launched a culture change improvement programme as part of the quality transformation programme. It has been established as a universal support offer for 60 NHS commissioned mental health, learning disability and autism providers. It will be delivered over two years up to March 2026.

266. The Quality Transformation Programme has also co-produced a suite of evidence based Early Warning Signs, for providers and commissioners to use to help identify quality and safety concerns in mental health inpatient settings more proactively. This framework is currently being tested by multiple ICBs and providers prior to wider roll out.

National Confidential Inquiry into Suicide and Homicide

267. NHS England commissions (via the Healthcare Quality Improvement Partnership or "HQIP") the National Confidential Inquiry into Suicide and Homicide ("**NCISH**") to develop research from national data collections and comparisons regarding suicides. It is based in the University of Manchester.

268. NCISH was established in 1996 and the programme of work changed in 2018. The scope of work relating to homicide was reduced, but NCISH continue to report the number of homicides by people in contact with mental health services.

269. According to the National Confidential Inquiry into Suicide and Safety in Mental Health in 2018, 11% of people convicted of homicide were mental health patients.

270. Between 2012 and 2022, NCISH states that there were an estimated 637 patients in recent (within 12 months) contact with mental health services convicted of a homicide offence, an average of 58 per year; these are referred to as patient homicides. See exhibit **[NHSE0000483]** (pages 22 to 23).

271. The NCISH programme of work in relation to homicides has been recommissioned, and the proposal which was approved by NHS England is exhibited at **[NHSE0000467]**.

272. For completeness, we highlight that:

a. in recent years, the focus of risk from harm has predominantly been the risk of self-harm, as the evidence and NICE guidelines changed regarding this issue. NHS England recently published guidance on 'Staying Safe from Suicide', which supports the National Suicide Prevention Strategy (2023). The guidance committed to improving mental health services and aligns with the Culture of Care Standards for Mental Health Inpatient Services (2024). There has not, however, been a change to NICE guidelines or evidence regarding risk of harm to others.

b. as part of the Culture of Care inpatient improvement programme, NCISH are delivering support to every provider of NHS commissioned inpatient services to move away from the use of predictive risk tools to a personalised approach to risk management (in relation to risk to self) **[NHSE0000526]**.

National Quality Board

273. The National Quality Board ("**NQB**") was established in 2009 as the single forum where national bodies with some responsibility for quality of care come together to provide strategic oversight and leadership on quality across the whole system.

274. It acts as an important forum to align and develop quality policy and governance, as well as providing advice, recommendations and endorsements on matters relating to quality, aiming to support delivery of the NHS LTP's ambition for quality in the NHS. Recently this has included publishing a set of key principles to support assessment and management of risks across integrated care systems. It organises discussions around six themes:

a. supporting system transformation;

b. digital transformation;

c. research and innovation;

d. support for the health and social care workforce;

e. patient safety; and

f. improving population health and health inequalities.

275. Since its establishment, the NQB has played an important role in publishing advice and guidance on key quality areas and quality governance structures affecting the wider health and care system. Guidance provided by the NQB relating to mental health includes:

a. Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing **[NHSE0000115]**;

b. Safe, sustainable and productive staffing: An improvement resource for mental health **[NHSE0000145]**; and

c. National Guidance on Quality Risk Response and Escalation in Integrated Care Systems: this is one of the frameworks for managing quality in providers, and highlights how quality risks should be identified and escalated **[NHSE0000369]**.

Getting it Right First Time

276. Getting it Right First Time ("**GIRFT**") is a national programme which has been hosted by NHS England since July 2021 and which aims to improve the treatment and care of patients through in-depth service reviews, benchmarking and presenting a data-driven evidence base to support change.

277. The programme was first conceived and developed to review elective orthopaedic surgery to address a range of observed and undesirable variations in orthopaedics. There are now multiple GIRFT workstreams, including workstreams for the following areas of mental health:

a. rehabilitation: mental health rehabilitation services provide community and inpatient treatment and rehabilitation of adults with severe mental illness, predominantly psychosis; around 80% of people have a primary diagnosis of schizophrenia, schizoaffective disorder or other psychosis. The GIRFT rehabilitation report (April 2022) is exhibited at **[NHSE0000296]** ("**Mental Health Rehab Report**");

b. adult crisis and adult care: adult crisis and acute mental health services encompass the care, treatment and rehabilitation of adults with severe mental illness as part of wider health and social system responses. The services cover both urgent and emergency care and planned care. The

GIRFT adult crisis and adult care report (April 2021) is exhibited at **[NHSE0000223]** ("**Mental Health Adult Crisis and Acute Care Report**"); and

c. children's and young people's services: children and young people's mental health services support under 18s with psychosis, eating disorders and personality disorders and neuro-disabilities such as autism and/or learning disabilities[17].

Mental Health Rehab Report

278. The Mental Health Rehab Report was prepared in response to two reports made by the CQC in 2017 and 2019, highlighting the need for local rehabilitation whole system pathways to be in place.

279. It explains that between 2014 and 2019 in England (according to NHS Benchmarking Network (NHSBN) annual data collections), the number of NHS mental health rehabilitation beds reduced by 33% from 2,539 in 2014 to 1,700 in 2019. It is unclear and not possible to ascertain at a national level where those people who were previously in mental health rehabilitation beds were placed subsequently.

280. As part of the Quality Transformation Programme, NHS England set the requirement for ICBs to localise the rehabilitation inpatient care they commission and provided detailed guidance on inpatient rehabilitation, both through the commissioning framework and further guidance **[NHSE0000521]**.

[17] We have not included further information on these services on the basis that VC was an adult at the time of first presentation.

281. In addition, NHS England is currently working to support systems to define their natural clinical flow area, which will enable them to report in the future whether rehabilitation patients are 'out of area' or not. This is a 2025/26 deliverable.

Mental Health Adult Crisis and Acute Care Report

282. This Report reviewed the current state of adult crisis and mental health care across England (taking into account the extant geographical variation) and makes recommendations based on visits to mental health trusts, analysis of data and audits.

283. Of particular relevance to this Inquiry, the Report found the following in respect of the EIP services:

a. although a vast amount of data is recorded, its collection and processing tends to be inconsistent and inefficient, hindering attempts to assess the effectiveness of services and plan for the future;

b. there is no routinely available data on which treatments people receive in community care, leading to reliance on sources such as EIP survey data and patients' notes to assess use and variation of interventions;

c. NCAP audit data of EIP metrics show huge variation on uptake of NICE-recommended interventions, a target for improvement in the NHS LTP. For example, whereas several trusts offered clozapine to 100% of patients with first episode psychosis after they had either not responded to or tolerated other antipsychotic drugs (as per NICE guidance), this drops to 10% at the lowest level. Similarly, broad variation exists in the use of cognitive behavioural therapy and family intervention; and

d. recording of interventions for early psychosis is likely to be improved by the introduction of SNOMED CT clinical terminology[18] into Mental Health Services Data Set ("**MHSDS**") (see below). All Trusts were to become compliant with the SNOMED CT platform by 2020/21.

284. As a result of the GIRFT work, the following actions were undertaken:

a. the 10 discharge principles for mental health were published, which made up part of the national discharge challenge **[NHSE0000029]**;

b. national guidance on inpatient mental health care for adults and older adults was published **[NHSE0000515]**; and

c. the commissioning framework for mental health inpatient services was put in place **[NHSE0000520]**; and

d. a requirement was introduced for ICBs to develop three year plans, in line with both of the above guidance documents.

285. Through the work of the NHS England Mental Health teams, mental health crisis lines are now universally accessible through NHS 111.

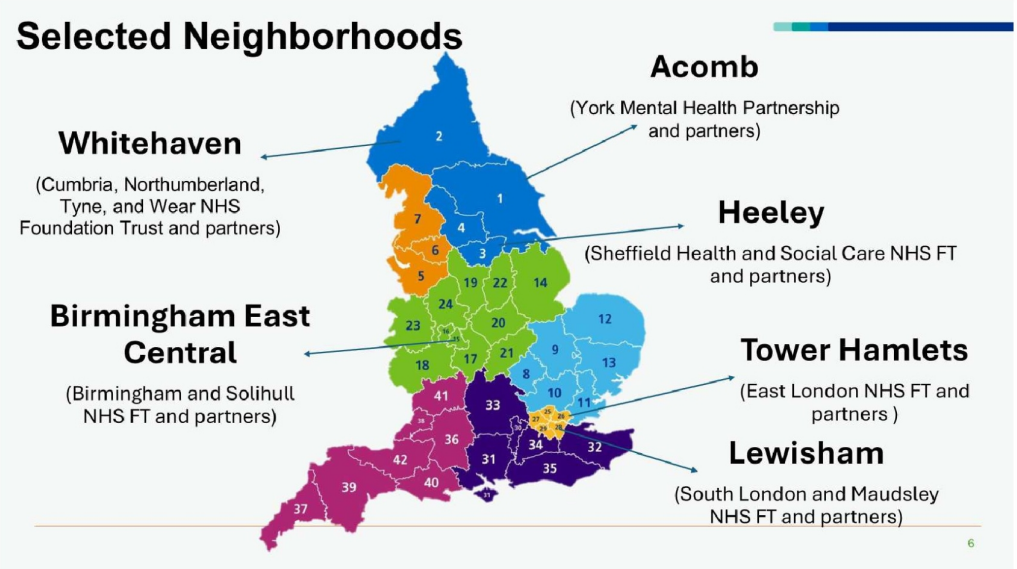
New model of mental health care

286. In recognition of the quality challenges faced within inpatient mental health care, NHS England has been progressing changes to the model of care. This involves testing and learning from the evidence generated from international models of care and follows the recommendation by the World Health

[18] SNOMED CT (Systemized Nomenclature of Medicine – Clinical Terms) is the most comprehensive and internationally validated system to record clinical information in the patient record.

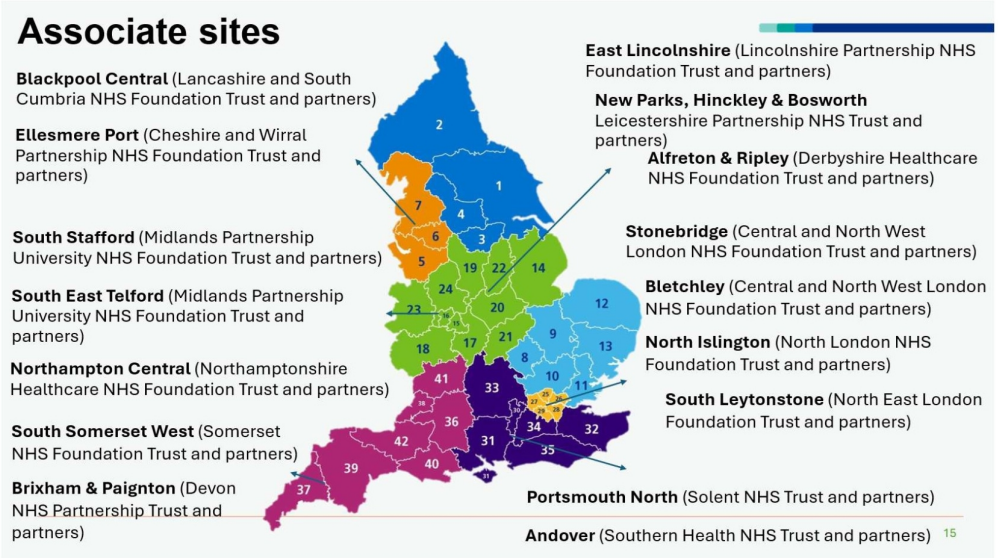
Organisation[19] as a world standard for rights-based care which promote autonomy and choice.

287. In the summer of 2024, NHS England launched six Neighbourhood Mental Health Centres:



288. In addition to these six sites, which are being formally evaluated, there are 16 'Associate Sites' who are in receipt of the formal implementation support offer, but not additional funding. The level of interest from the sector is significant, with the majority of NHS Mental Health Trusts having expressed an interest in implementing the model.

[19] Comprehensive mental health service networks: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (Guidance and technical packages on community mental health services: promoting person-centred and rights-based approaches).



289. The Neighbourhood Mental Health Centres will be open 24 hours a day and seven days a week, bringing together all aspects of community mental health services, including crisis services, community mental health services and crisis beds. This seeks to move the specialist expertise from sitting in separate teams, which the patient is moved between, to bringing those specialisms to the person in an integrated Neighbourhood Team.

290. Key features of the model include:

a. continuity of care:

i. whereby the same team will support people with serious mental illnesses throughout all stages of their interaction with services, be that a short episode to access help with staying safe and receiving help with employment through to people who need longer-term support through crises and provision of biological, psychological and social care and treatment;

ii. where patients need admitting to hospital this will be possible, but critically staff in the relevant centre will remain involved in the person's care whilst they are in hospital, i.e., no break in the continuity of care with hospital admission.

b. the provision of 'crisis beds', enabling people who are unable to stay safe at home to stay overnight at the centre. This builds on successful expansion of crisis houses and other alternatives to admission;

c. reduced length of stay in hospital; and

d. open access, whereby the patient or their family can walk into the centre without referral to receive assessment and access to the right support. Whilst some patients will continue to need a more assertive approach to treatment, their family and people who are worried about them will be able to easily access the team caring for the patient.

291. The centres will be run by the NHS in partnership with a range of local partners in health and social care, including voluntary, community and social enterprise sector ("**VCSE**") organisations (which includes faith based organisations), and critically in partnership with people with lived experience. The centres are based in people's local neighbourhood; anyone with serious mental health problems can drop into the centre without an appointment to receive care and treatment from psychiatrists, mental health nurses, social workers, voluntary sector workers and peer support workers.

292. People will be able to receive psychological therapies, medication and other interventions, while also having access to expertise that can help with other

important and related issues that may impact on their wellbeing and recovery, such as housing or employment. International examples have seen significant reductions in admission to hospital, use of detentions under the mental health legislation and improved clinical outcomes.

293. Tackling inequalities is critical to the model, with specific emphasis being placed upon the model reaching communities who have not historically felt able to access mental health services.

294. NHS England's previous NCD for Mental Health is the NSA for the Neighbourhood Mental Health Centres.

Workforce

295. Since NHS England's merger with HEE, it has national responsibility for supporting the development and planning of health workforces and education and training programmes. This work covers more than 100 programmes, from planning and commissioning through to recruiting and developing healthcare staff in a range of healthcare and community settings. It also includes programmes in respect of autism and mental health and there is a workstream dedicated to developing new ways of working in mental health.

296. Relevant guidance documents include:

a. Mental Health Staffing Framework **[NHSE0000104]**, which is based around standards set by the NQB; and

b. Safe staffing for nursing in inpatient mental health settings **[NHSE0000101]**, which is a NICE guideline that DHSC and NHS England asked NICE to develop.

Reducing inequalities

297. Tackling mental health inequalities is a key policy objective for NHS England. In 2019, NHS England set out its expectations for local systems to reduce mental health inequalities by 2023-24. In 2020, NHS England published its 'Advancing Mental Health Equalities Strategy' **[NHSE0000019]**, which prioritised a number of actions, including supporting local health systems to adopt population health approaches, improving data and information, and developing a more diverse workforce. A taskforce (the Advancing Mental Health Equality Taskforce) was set up to oversee the strategy.

298. In 2022/23, NHS England provided funding of around £695 million to ICBs, on the condition that they had clear plans in place to address inequalities in their area. In 2023, NHS England published the 'Patient and Carer Race Equality Framework' for all mental health Trusts and mental health service providers across England to embed **[NHSE0000485]**.

299. The mandatory framework provides support to Trusts and providers to become 'actively anti-racist organisations' and provides guidance on how to reduce racial inequalities within their services. The Framework supports improvements in three domains:

    a. leadership and governance: Trusts' boards will be leading on establishing and monitoring concrete plans of action to reduce health inequalities;

b. data: new data set on improvements in reducing health inequalities will need to be published, as well as details on ethnicity in all existing core data sets; and

c. feedback mechanisms: visible and effective ways for patients and carers to provide feedback will be established, as well as clear processes to act and report on that feedback.

Early Intervention in Psychosis

300. NICE defines EIP services as "*care for adults with a first episode of psychosis during the first 3 years of psychotic illness. However, this may be extended if the person has not made a stable recovery from psychosis or schizophrenia*" **[NHSE0000538]**.

301. EIP services are multidisciplinary community services providing the full range of pharmacological, psychological, social, occupation and educational interventions for people with psychosis. Adults with a first episode of psychosis should start treatment within two weeks of being referred to an EIP service. This timeframe is based on the Mental health services: achieving better access by 2020 policy paper (2014) **[NHSE0000088]**.

302. From 1 April 2016, the access and waiting time standard for EIP services required that more than 50% of people aged between 14 and 65 experiencing first episode psychosis would be treated with a NICE-approved care package within two weeks of referral.

303. NHS England further committed that by 2020/21, the standard would be extended to reach at least 60%. Nationally, performance was 66.9% as of April 2025.

304. The standard is 'two-pronged' and both conditions must be met for the standard to be deemed to have been achieved:

a. a maximum wait of two weeks from referral to start of treatment; and

b. treatment delivered in accordance with NICE guidelines and Quality Standards for psychosis and schizophrenia in adults (CG178 **[NHSE0000539]** and QS80 **[NHSE0000538]**) [20].

305. Guidance was produced by NHS England and NICE on implementing the EIP standard in 2016 ("**EIP Guidance**") **[NHSE0000315]**.

306. Updated guidance was published by NHS England in February 2023 **[NHSE0000032]**.

National Clinical Audit of Psychosis

307. The National Clinical Audit of Psychosis ("**NCAP**") is commissioned by the HQIP (on behalf of NHS England and the Welsh Government) to conduct an annual audit of EIP services' ability to provide timely access to NICE approved packages of care. It is coordinated by the Royal College of Psychiatrists.

308. The following services are expected to participate in the audit:

a. all NHS-funded Early Intervention in Psychosis teams in England and Wales; and

[20] NICE guidelines and quality standards for children have not been included.

b. NHS-funded Children and Young People's Mental Health/Child and Adolescent Mental Health Services in England where Early Intervention in Psychosis teams do not extend their offer to Children and Young People.

309. The data collection parameters have recently changed **[WITN0310002]**:

"For the current programme running from 2022-2025 the audit will move away from collecting bespoke audit data and will instead use routine data (e.g., MHSDS in England) which will reduce the burden of data collection on EIP teams and allow them to focus resources on patient care. Additionally, we will develop an online dashboard which will allow teams to view their performance as soon as the data is uploaded. The first year of this programme will be a developmental year during which we set up the new audit methodology and pilot it with a few teams prior to rolling it out nationally.

In addition, NHS England have advised that the new contract for NCAP would not offer their Mental Health Policy Team sufficient information to assess psychosis services against the NHS Long Term Plan. Therefore, they have proposed and funded at least one further round (one year) of the bespoke data collection audit which took place in 2023 and 2024."

310. The NHS LTP committed to improving compliance with NICE guidelines by enabling every service to achieve level 3 compliance. Data from the NCAP provided this benchmarking and enabled NHS England to support systems to improve their performance in line with the national commitment.

311. Calculating a team's score (compliance level) is based on a number of factors - the overall score is calculated based on the number of domains rated as 'top performing', 'performing well', 'needs improvement' and 'greatest need for improvement', see exhibit **[NHSE0000380]** for an example of scoring.

312. The NCAP EIP reports are exhibited at: **[NHSE0000323] [RCPS0000008] [NHSE0000354] [RCPS0000028] [RCPS0000029]**.

Care Programme Approach

313. The CPA has existed in mental health for almost 30 years. It involved a package of care through a care programme and a care co-ordinator (typically a nurse, social worker or occupational therapist).

314. The CPA was superseded by the Community Mental Health Framework, following a commitment in the NHS LTP to transform community mental health services for adults by implementing new and integrated models of primary and community mental health services for people with severe mental health problems across every ICS in England.

315. NHS England released a position statement regarding the move away from the CPA **[NHSE0000252]**, and confirmed (amongst other things):

    a. the CPA had not been updated for almost 15 years. Community mental health policy and practice have evolved significantly over this time, along with the introduction of new relevant legislation such as the Care Act 2014, and more recent relevant policy signals;

    b. a number of concerns have been raised by a range of stakeholders in recent years that the continued way in which the CPA is used in

community mental health services represents a major barrier to providing the higher quality, more flexible and personalised care that the Community Mental health Framework envisages and that patients need;

c. the shift does not mean taking away any positive aspects of care that someone currently on the CPA is experiencing;

d. the new approach is based on five broad principles, including:

i. a shift from generic care co-ordination to meaningful interventions;

ii. a named key worker for all service users, with a clearer multidisciplinary team approach; and

iii. co-produced, holistic, personalised care and support planning (evidence shows that the safest care is care that is personalised and highly responsive).

316. Following the Nottingham incident and wider discussions within the sector, NHS England committed to reviewing the position statement, and providing further guidance to support providers in delivering personalised care planning - this is currently in development.

Assertive Outreach

317. Assertive Outreach Teams ("**AOT**") are part of secondary mental health services and are usually attached to the community mental health team. They work with people who are 18 to 65 years old with particularly complex needs and who need more intensive treatment and engagement.

318. AOTs were first introduced by the National Service Framework for Mental Health in 1999, and the NHS Plan in 2000 set out to deliver 220 assertive outreach teams by 2003 (this target was met). This framework was never 'decommissioned'.

319. However, NHS funding challenges in 2010 and questions about the efficacy of AOTs through research led to nationwide disinvestment in these services. A few areas, however, retained them, and there is current variation nationwide as to whether areas have a dedicated team, a dedicated function within their community mental health services (including EIP teams and forensic outreach teams), or no AOT function.

320. Guidance suggests that people may need assertive outreach if they have a set of specific criteria linked to severity and complexity of their illness and a number of hospital admissions. Providers have always been expected to follow the applicable NICE guidelines relating to intensive case management for people with psychosis or schizophrenia who are likely to disengage from treatment or services. NICE guidelines do not stipulate a specific team formation required to deliver intensive case management.

321. NHS England has been working to strengthen intensive and assertive outreach, with the 2024/25 NHS Planning Guidance asking all ICBs to:

"review their community services by Q2 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge…"

322. In July 2024, NHS England published 'Guidance to Integrated Care Boards on Intensive and Assertive Community Mental Health Care' as a result of the Nottingham incident **[NHSE0000527] [NHSE0000046]**.

323. The guidance sets out features of intensive and assertive community care, which is designed to meet the needs of individuals who (non-exhaustive):

a. are presenting with psychosis (but are not necessarily given a diagnosis of psychotic illness);

b. may not respond to, want or may struggle to access and use 'routine' monitoring, support and treatment that would minimise harms;

c. are vulnerable to relapse and/or deterioration with serious related harms associated (especially, but not limited to, violence & aggression);

d. have multiple social needs (housing, finance, self-neglect, isolation etc);

e. likely present with co-occurring problems (e.g. drug and alcohol use/dependence);

f. may have had negative (e.g. harmful and/or traumatic) experiences of mental health services or other functions of the state (e.g. the criminal justice systems); and

g. concerns may have been raised by family/carers.

324. While some ICBs commission AOTs (or similar), others may not commission a specific team or service that is focused on intensive and assertive approaches. ICBs are not required to commission AOTs, however, meeting the needs of individuals described above is required through an identified resource. ICBs

were required to undertake reviews of their local policies and practices in relation to providing intensive and assertive community care.

325. The NNICB review is exhibited at **[NHSE0000462]**, and the Regional Summary of Midlands ICB Community Mental Health Review - Maturity Index Returns is exhibited at **[NHFT0004006]**.

326. The national NHS England guidance (as exhibited above) also includes key themes and lessons from serious untoward incidents, which includes:

a. long-term planning of care: a long-term view of an individual's care is vital;

b. lack of continuity of care and failure to join-up presentation history and missed 'red flags' of earlier minor offending / not reflected in risk assessments: knowledge of an individual's care history is vital to ensure services understand a person's needs and how to meet them;

c. failure to review treatment/medication: people with severe mental illness should have access to a full range of evidence-based treatments, including medication/depot medication and psychological therapies.

327. The guidance is clear that where there is a history of poor engagement, consideration should be given to the use of supervised treatment within the framework of a CTO (where eligible). The guidance goes on to highlight the related issues regarding the consideration of depot injections for those with psychotic illnesses, with or without the use of a CTO.

328. NHS England does not otherwise issue guidance on the use of CTOs or depot medication. The MHA CoP sets out the purpose of CTOs and how they should

be used, and NICE guidelines set out when to consider use of depot medication.

329. On 29 May 2025, the NHFT Board of Directors meeting in public considered assertive and intensive community mental health treatment (see exhibit **[NHSE0000497]** from page 97). Appendix B of that document (from page 104) sets out the assertive and intensive treatment action plan.

Out of Area Placements

330. As set out above, both the Five Year Forward View for Mental Health and the NHS LTP sought to reduce and eliminate inappropriate OAPs.

331. Current guidance is provided on the use of OAPs on the FutureNHS platform **[NHSE0000525]**. It defined an OAP as:

"An 'out of area placement' for acute mental health in-patient care happens when a person with assessed acute mental health needs who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of the usual local network of services. By this, we mean an inpatient unit that does not usually admit people living in the catchment of the person's local community mental health service and where the person cannot be visited regularly by their care co-ordinator to ensure continuity of care and effective discharge planning."

332. The guidance sets out key considerations to support identification as to whether a patient is in the right bed and to support continuity of care, as well as key questions for local systems seeking to address OAPs - taken from areas who have successfully transformed their acute mental health systems.

333. The key principles of continuity which providers of mental health services are expected to meet are set out as follows:

a. clear shared pathway protocols between units/organisations, particularly around admission and discharge;

b. an expectation that a person's care coordinator visits as regularly as they would if the patient was in their most local unit and retains their critical role in supporting discharge/transition;

c. robust information sharing, including the ability to identify cross-system capacity and access full clinical records with appropriate information governance in place where necessary;

d. support for people to retain regular contact with their families, carers and support networks e.g. this might be achieved with optional use of technology, transport provision etc.

Discharge

334. The discharge of patients, as well as their admission and treatment, is a matter of clinical judgment.

335. Decisions about hospital discharges require a multidisciplinary assessment of the patient's health and social care needs, including appropriate communication with patients regarding their care needs. As set out at paragraph 212 above, certain decisions are ultimately the responsibility of the Responsible Clinician.

336. Trust clinicians rely on a large body of literature, studies and best practice guidance on hospital discharge.

337. In March 2018, NICE published guidance on discharge planning for emergency and acute medical care in over 16s. It set out scientific evidence about the role of discharge planning in improving clinical outcomes for adults in secondary care **[NHSE0000536]**.

338. NICE has also produced guidance regarding the transition between inpatient mental health settings and community settings or care homes (NG53) **[NHSE0000540]**.

339. Guidance on discharge includes:

a. Hospital discharge and community support guidance (updated January 2024), which is statutory guidance intended for NHS bodies including Trusts and ICBs in England **[NHSE0000304] [NHSE0000306]**. Whist discharges from mental health hospitals are not within the scope of this guidance, those organisations are encouraged to embed some of the principles, adapted for mental health care pathways. Prior to this, the hospital discharge service policy and operating model had been published in 2022 **[NHSE0000513]**.

b. Discharge from mental health inpatient settings, which is also statutory guidance that outlines how health and care systems should work together to support discharge from all mental health and learning disability and autism inpatient settings for children, young people and adults **[NHSE0000305]**.

c. 72 hour follow up post discharge from mental health inpatient care, although this primarily considers the compelling evidence that there is

an increased risk of dying by suicide on days 2-3 following discharge from hospital **[NHSE0000338]**.

d. Multi Agency Discharge Events (MADEs) for Adult and Older Adult Acute Mental Health Inpatient Beds Guidance, which is intended to support discharge from hospital for patients who are clinically ready for discharge, but who might otherwise spend avoidable time in hospital (often referred to as 'delayed discharge'). Delayed discharge can be the result of various issues, including the availability of suitable community service provision to support a patient following discharge **[NHSE0000391]**.

Covid-19 Policies

340. The Relevant Period included the duration of the Covid-19 pandemic, which is recognised to have had a major impact on the delivery of healthcare nationally. This included changes to the manner in which services were traditionally delivered, i.e., from face-to-face to remote (where clinically appropriate).

341. The use of technology during the pandemic was necessary to enable the NHS to maintain care in a way that would not have otherwise been possible.

342. NHS England published a number of guidance documents to assist with the adoption of remote consultations and remote working in secondary care **[NHSE0000547]**.

343. NHS England also published a specialty guide on 27 March 2020 **[NHSE0000333]** to mitigate against inappropriate use. This offered practical guidance to clinicians and managers, including the following principles:

a. remote consultations are suitable for patients who do not need a physical examination or test and can communicate by phone or video (with a preference for video if there is benefit in seeing the patient or their surroundings); and

b. a clinical risk assessment should take place in all cases in order to stratify services and individual patients, with remote consultation only taking place where there is a low risk of impact to patient safety and outcome.

344. Of further and particular potential relevance to the Inquiry are the following:

a. Mental Health, learning disabilities and autism: Guidance (**[NHSE0000549]**). This publication brings together a series of documents, guidance and letters to help those working with patients with mental health, learning disabilities and autism during the pandemic, including:

i. Getting NHS help when you need it during the coronavirus outbreak - information for patients about how to access NHS services, including an easy read version (**[NHSE0000336]**).

ii. Legal guidance for services supporting people of all ages during the coronavirus pandemic - concerning the use of the 1983 Act and other systems supporting the legal rights of people receiving mental health, learning disability and autism services during the pandemic.

iii. Patient carer and family engagement and communication during the Covid-19 pandemic (**[NHSE0000501]**), which

included advice for both commissioners and providers and for patients and families.

b. Managing capacity and demand within inpatient and community mental health, learning disabilities and autism services for all ages (**[NHSE0000500]**), which was produced by the national NHS England mental health, learning disability and autism and specialised commissioning Covid-19 response cell (part of NHS England's pandemic response structure). It provided information and guidance for providers and their clinical and non-clinical teams in planning how best to manage their service capacity and contingency plans for resource-constrained scenarios.

NHS 10 Year Plan

345. On 3 July 2025, the '10 Year Health Plan for England: fit for the future' was published by the Government (the "**10 Year Plan**") **[NHSE0000524]**.

346. Relevant to this Inquiry, it states the NHS will:

a. focus on community care, utilising a neighbourhood health service model;

b. reform the NQB, with all other bodies, including royal colleges, feeding in. It will also be tasked with developing a new quality strategy, as well as the development of modern service frameworks. Early priorities will include cardiovascular disease, mental health, frailty and dementia;

c. invest up to £120 million to develop more dedicated mental health emergency departments, to ensure patients get fast, same day access to specialist support in an appropriate setting; and

d. expand mental health support teams in schools and colleges and provide additional support for children and young people's mental health through Young Futures Hubs.

347. The 10 Year Plan also acknowledges that "*people with severe and enduring mental illness face being bounced from one service to another, with little to no continuity. For many, care only comes during a crisis, with emergency departments acting as the default care provider. Even then, waits are unacceptably long…*". It then commits to:

a. transforming mental health services into 24/7 neighbourhood care models; and

b. improving assertive outreach care and treatment to ensure 100% national coverage in the next decade, with a focus on narrowing mental health inequalities.

348. The 10 Year Plan further sets out how the NHS will be reconfigured. This will change how ICBs and providers will operate in the future, with a focus on devolution and earned autonomy.

Medium Term Planning Framework

349. On 24 October 2025, NHS England published the Medium Term Planning Framework – delivering change together 2026/27 to 2028/29. The Framework sets out ambitions for a new operating model and financial regime for the NHS

to support the reform agenda laid down in the NHS LTP **[WITN0155002]**.

350. A key aspect of the Framework is aimed at the NHS embracing the 'digital-by-default' principle. From April 2026, the NHS must begin to ensure that all providers in acute, community and mental health sectors will be onboarded to the Federated Data Platform ("**FDP**") and using its core products to support elective recovery, cancer and urgent and emergency ("**UEC**") services.

351. The Framework sets out various targets aimed at improving mental health services, including:

a. the introduction of modern service frameworks ("**MSFs**"), which will support more consistent delivery of high-quality care in conditions where there is potential for rapid and significant improvements in both quality and productivity. The criteria and methodology are being tested through the development of a first set of three MSFs, including serious mental illness. This will be led by a new national lead for mental health alongside the mental health NHS leadership community;

b. establishment of mental health emergency centres in Type 1[21] emergency departments, in recognition of the need to improve the ability of UEC services to respond to patients in mental health crisis and ensure the needs of mental health patients are met in an appropriate environment; and

c. a requirement for all ICBs and mental health providers to reduce inappropriate OAPs and locked rehabilitation inpatient services, with the

[21] A consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

aim of reducing the number to zero by 2029.

SECTION 3: PATIENT SAFETY

352. In the context of NHS England's role in fulfilling its statutory patient safety duties under section 13R of the 2006 Act (Information on safety of services provided by the health service), NHS England collects information about what goes wrong in the health service and uses that information to provide advice and guidance "for the purposes of maintaining and improving the safety of the services provided by the health service".

353. NHS England's National Patient Safety Team delivers these functions, as well as supporting NHS England's wider duty to improve quality pursuant to section 13E of the 2006 Act (which by definition includes patient safety). The Patient Safety Team was formerly part of NHS Improvement between 2016 and 2022, and before that it was part of NHS England (2012 until 2016). The National Patient Safety Team rejoined NHS England on 1 July 2022.

354. The NHS Patient Safety Strategy (**[NHSE0000502]**) (published in 2019 and updated in 2021 and 2023) was created by the National Patient Safety Team and sets a vision for the NHS to continuously improve patient safety. While all aspects of the NHS (from finance to estates, IT to workforce, service design to medicines) will impact on the safety of services, the Patient Safety Strategy does not seek to direct the whole of the NHS. Elements of the NHS, such as workforce and financial planning, clinical training/education and guidance and estates and facilities maintenance, remain subject to each provider's own strategic leadership and implementation and to wider support and guidance provided by other parts of NHS England and beyond.

NHS Serious Incident Framework

355. Between 2013 and 2023, the principal policy setting out expectations for how the NHS should identify and manage certain patient safety incidents and other defined 'serious incidents' was the Serious Incident Framework (first published 2013 and refreshed in 2015) ("**SIF**")(**[NHSE0000058]**).

356. Under the SIF, a serious incident was described as an event "*in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response*." There was no definitive list of serious incidents, but the SIF set out the circumstances in which a serious incident must be declared. This included homicide by a person in receipt of mental health care within the last 6 months, although it should be noted that this was not a strict cut-off - it may have been appropriate to declare a serious incident for a homicide by a person discharged from mental health care more than 6 months previously, depending on circumstances.

357. The SIF set out a standard operating model for investigating homicide by those in receipt of mental health care at Appendix 1, and the process for undertaking independent investigations more generally was set out at Appendix 3.

Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services

358. In November 2015, DHSC published advice on Article 2 of the European Convention on Human Rights (right to life) and the investigation of serious incidents in mental health services for NHS organisations **[NHSE0000314]**.The

purpose of the advice was to assist NHS organisations in meeting Article 2 when making decisions about serious incidents in mental health services.

359. The advice confirms that NHS England and NHS bodies are public authorities who must comply with the Human Rights Act 1998 and the European Convention on Human Rights. NHS bodies implicated in serious incidents may be considered to be 'State agents' for the purposes of Article 2.

Patient Safety Incident Response Framework

360. As set out in the NHS Patient Safety Strategy (**[NHSE0000502]**) (published in 2019), "*compelling evidence from national reviews, patients, families, carers and staff and an engagement programme in 2018 revealed that organisations struggle to deliver*" the expectations in the SIF. As a result, the Patient Safety Incident Response Framework ("**PSIRF**") was developed, tested and launched.

361. In 2022, NHS England published the PSIRF, setting out how NHS trusts should respond to patient safety incidents **[NHSE0000054] [NHSE0000038]**. PSIRF, one of the key initiatives under the Patient Safety Strategy, replaced the 2015 Serious Incident Framework.

362. PSIRF has four key aims:

a. compassionate engagement and involvement of those affected by patient safety incidents;

b. application of a range of system-based approaches to learning from patient safety incidents;

c. considered and proportionate responses to patient safety incidents; and

d. supportive oversight focused on strengthening response system functioning and improvement.

363. After a preparation phase between 2022 and 2023, organisations were asked to transition to PSIRF during Autumn 2023. Subsequent to that, compliance with the PSIRF was made a contractual requirement under the NHS Standard Contract from April 2024 (through service condition 33), and as such is now mandatory for all services provided under that contract. All Trusts are now working under PSIRF.

364. Implementation of PSIRF is overseen by ICBs. ICBs have a responsibility to establish and maintain structures to support a co-ordinated approach to oversight of patient safety incident response in all the services within their system. ICBs do not oversee the response to every single incident, or sign off every patient safety incident investigation report as commissioners did while working under the Serious Incident Framework. Instead, ICBs are required to establish systems and processes to ensure that the providers that they commission services from have effective patient safety incident response systems and processes.

365. Under the PSIRF, NHS providers are expected to use a wide range of qualitative and quantitative data sources, including incident records, stakeholder views and existing data collections, to develop a thorough understanding of their patient safety incident profile and then use this with their stakeholders to create a Patient Safety Incident Response Plan. This plan then guides how the organisation responds to and learns from incidents. NHS England publishes a template Incident Response Plan as part of the core

materials to support the PSIRF. It also publishes a guide called 'Engaging and involving patients, families and staff following a patient safety incident' (**[NHSE0000026]**).

366. While PSIRF supports NHS providers to create their own Patient Safety Incident Response Plan based on the specific safety challenges they face, the PSIRF does require certain events to lead to specific responses. The PSIRF Guide to Responding Proportionately to Patient Safety Incidents (**[NHSE0000490]**) includes a requirement that all mental health-related homicides are referred to the NHS England Regional Independent Investigation Team for consideration for an independent patient safety incident investigation. More broadly, all deaths thought to be more likely than not due to problems in care require a patient safety incident investigation in response.

367. It should be noted that it was the SIF that guided NHFT's response to the events in Nottingham in June 2023. NHFT transitioned to using the PSIRF in 2024.

Patient Safety Incident Recording

368. A patient safety incident is defined as "*an unexpected or unintended event during the provision of healthcare that could have or did harm one or more patients*".

369. When an incident occurs, Trusts and other providers are encouraged to record the details of the incident on their local risk management system if they have them (which all Trusts do). Trusts are required to have their local risk management system connected to the Learn From Patient Safety Events Service ("**LFPSE**") if services are being delivered under the NHS Standard

Contract. For services not delivered under the Standard Contract and for providers without a local risk management system connected to LFPSE (e.g. in primary care), there is also a LFPSE web portal that can be used to record incidents. LFPSE is the mechanism by which NHS England collects information about what goes wrong in NHS services in order to fulfil its statutory duty under section 13R of the 2006 Act.

370. The Strategic Executive Information System ("**StEIS**"), which was previously the way in which all serious incidents were to be reported, will be completely replaced by LFPSE. StEIS, however, is currently still in use while all local risk management systems are transitioned to compliance with version 6 of LFPSE, which includes new fields relating to PSIRF implementation.

371. Patient safety incident recording in the NHS is largely voluntary. A subset of patient safety incidents, principally those incidents thought to have directly caused death or severe harm, must be notified to the CQC. Trusts are able to notify the CQC about such incidents by recording them on a LFPSE-compatible local risk management system, or via the LFPSE web portal. NHS England then provide a full set of the data collected via LFPSE to the CQC. The purpose of NHS England collating patient safety incident data is to support learning and improvement.

372. Trusts are advised to directly inform their ICBs and relevant regional team of any mental health homicide, as referenced above. This also enables the regional team to consider an independent investigation where relevant.

373. While the vast majority of patient safety incident investigations conducted in the NHS are led by provider organisations, ICBs and NHS England may also

directly commission patient safety incident investigations in certain circumstances, including where a provider does not have the capability, skills, knowledge or objectivity to deliver an effective patient safety incident investigation itself, or where it is identified that an incident spans multiple health systems and so it makes more sense for an organisation with a wider remit to commission the investigation, thus enabling collaboration across providers, pathways and/or local health systems.

Mental health homicide investigations

374. The SIF included a standardised approach that Trusts were advised to take in relation to mental health homicides. In brief, this advised Trusts to:

a. report the incident and conduct an initial review, producing a report within 72 hours; and

b. then conduct an internal investigation, producing a more detailed report within 60 days (also known as a Level 2 report or Serious Incident Investigation report).

Independent mental health homicide investigations

375. This section focuses specifically on independent homicide investigations where there has been a homicide by an individual who was in recent receipt of care and treatment for a mental health disorder. This was the type of report commissioned in respect of VC. Exhibit **[NHSE0000443]** sets of the different types and levels of investigations more generally that may occur in the health sector.

376. In April 2013, NHS England became responsible for commissioning, if appropriate, independent investigations into homicides that are committed by patients being treated for mental illness. In the SIF, independent investigations were referred to as Level 3 investigations and reports **[NHSE0000058]**.

377. The SIF stated that, in general, independent investigations are required where:

a. the integrity of any internal investigation and its findings are likely to be challenged; or

b. it would be difficult for an organisation to conduct a proportionate and objective investigation internally due to the size of the organisation, or the number of individuals or organisations involved.

378. Independent investigations also avoid conflicts of interest and should be considered if such conflicts exist or are perceived to exist.

379. The SIF stated that an independent investigation should be considered in various circumstances, including **[NHSE0000058]**:

a. "*where the organisation is unable to conduct an effective, objective, timely and proportionate investigation…particularly…where the obligation on the authorities to account for the treatment of an individual is particularly stringent including… Deaths (and near deaths resulting in severe harm) of those detained under the Mental Health Act (1983)… where the cause of death is unknown: and/or there is reason to believe the death may have been avoidable or unexpected*";

b. "*where the commissioner(s) or provider(s) or the patient/family feel that the nature of the potential causes of an incident warrant independent*

scrutiny in order to ensure lessons are identified and acted upon in a robust, open and transparent manner"; or

c. *"…when a homicide has been committed by a person who is, or has been, subject to a care programme approach, or is under the care of specialist mental health services, in the past six months prior to the event.*"

380. The SIF states that the "*decision to commission an independent investigation can be made at any stage of the incident management process, depending on the nature and circumstances of the incident. For provider-focused independent investigations, it is the commissioner of the care within which the serious incident occurred who should make the final decision on the type of investigation required*." However in the case of mental health homicides, the SIF states that "*an independent investigation should be commissioned by NHS England's regional investigations team when a homicide has been committed by a person who is, or has been, subject to a care programme approach, or is under the care of specialist mental health services in the past six months prior to the event."*

381. An NHS England Regional Investigation Team ("**RIT**"), in conjunction with the relevant Regional Independent Investigations Review Group ("**IIRG**"), considers whether the commissioning of an independent investigation is required. The NHS Midlands IIRG terms of reference are exhibited at: **[NHSE0000457]**.

382. The National Patient Safety Independent Investigations Team ("**NPSIIT**") was established in 2022 as part of the national patient safety team in NHS England.

The NPSIIT's role is to support a consistent approach to the overall governance, process and insight gained from NHS England commissioned independent patient safety incident investigations, whilst aiming to reduce inappropriate variation in the approach to those investigations. In addition, the team support the work of the regional independent investigations leads, support a consistent approach to investigation commissioning and escalation, and support responses to insight generated where appropriate. Accountability of regional teams remains to their leadership, and through them to Executive Quality Group, not to the NPSIIT or national patient safety team.

383. The purpose of an independent patient safety investigation ("**IPSI**") is to generate insight to inform safety improvement through investigation and exploration of the care, treatment and healthcare systems and processes for one or more patients at any level of the healthcare system. They support the NHS to identify areas for improvement to reduce the possibility of a reoccurrence of similar events.

384. IPSIs do not inquire into how a person died - this is the role of the Coroner. They also do not assign blame or liability in relation to any incident which has occurred, or consider fitness to practice (which is the role of the relevant professional regulators (e.g., the GMC and the NMC)). In cases of breach of regulations, the CQC may consider prosecution (as referred to in paragraph 118 above), but this is entirely separate to the IPSI process. Similarly, the criminal justice system would respond to concerns about criminality, and internal human resource systems at an organisational level would consider any breaches of employment terms and conditions (e.g., disciplinary processes).

385. Patient safety incidents might signal underlying systemic issues that require wider system-level action. Taking action against an individual member is rarely appropriate as most patient safety incidents will not be the fault of any one individual, but will rather reflect risks that exist within the wider system. In rare circumstances, a learning response may raise concerns about an individual's conduct or fitness to practice. If an independent investigation team has a concern regarding an individual's behaviour, fitness to practice or other related issue, there is guidance on referrals to regulatory bodies **[NHSE0000414]**.

386. In May 2025 NHS England published the 'being fair tool' to help decide what next steps to take if there are concerns about an individual's role in a patient safety incident **[NHSE0000523] [NHSE0000494]**.

Publication of IPSIs commissioned by NHS England

387. The final part of any investigation process involves the publication of the IPSI report on the NHS England website, along with links to any action plans. This process is to facilitate the purpose of the investigation, which is learning to prevent recurrence.

388. NHS England does not currently have a standalone document describing its policy on the publication of reports. However, it had previously provided guidance in the SIF, and currently guidance is provided in PSIRF.

389. NHS England has made efforts to prepare a policy in collaboration with stakeholders and, as is explained below, this process is not complete. This is in part due to the backdrop of a complex legal regime.

390. In order to help the Inquiry, we set out below the background and an explanation of decisions made in the process of pursuing an agreed policy, in light of our legal advice.

391. To assist the Inquiry, NHS England has waived legal professional privilege in respect of the policy advice referenced below. The purpose of the waiver is to assist understanding of the broad policy issues relating to publication.

Publication position in SIF

392. The SIF stated **[NHSE0000058]**:

"Serious incident investigation reports must be shared with key interested bodies including patients, victims and their families. It is recommended that reports are drafted on the basis that they may become public, so issues concerning anonymity and consent for disclosure of personal information are important and should be considered at an early stage in the investigation process. Each NHS organisation has a Caldicott Guardian who is responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Those investigating serious incidents can seek advice from the Caldicott Guardian if guidance is needed about the disclosure of patient identifiable information."

393. The SIF further confirmed that:

"• Reports should be made public in the interests of learning and transparency. NHS England will publish and share the independent investigation reports on its website. In order to encourage greater local accountability and ownership,

independent reports will also be published by the relevant commissioners and the provider organisation.

• Independent Investigation reports are publicised in an anonymised format. Perpetrators can be named at their request, as can victims or where the families make a request.

• Resultant action plans will be published on the provider organisations website and be updated until completion."

Publication position in PSIRF

394. The guidance in PSIRF relating to publication is as follows **[NHSE0000028]**:

"Publication of sensitive and confidential information in independent patient safety investigation reports

Independent PSII reports must be shared with internal and external stakeholders, including the affected individuals and families, and should be written in a clear and accessible way as described in the Patient safety incident response standards. Where possible independent PSIIs will be published in full.

The impact of publishing an independent PSII report can have on those affected must be carefully considered, especially when individuals may be identifiable.

Where a patient, the family of a deceased patient or another affected person does not consent to publication, their rights must be balanced against the wider public interest when deciding whether to publish. If publication could prevent a similar patient safety incident, the wider public interest could outweigh the rights of individuals to privacy. However, this right for both individual and family life,

provided under Article 8 of the European Convention on Human Rights (ECHR), must be considered.

Where risks to individuals outweigh the wider public interest, other approaches can be considered, such as publishing a summary report of the investigation and/or thematic work, or system improvement plans relating to similar incident types/issues.

A contemporaneous written record of the factors considered in the decision to publish sensitive material or not must be retained."

Review of publication approach

395. IPSIs commissioned by NHS England are published on the NHS England website where possible and appropriate. There are some circumstances where publication may not be appropriate, for example where safeguarding concerns override the imperative to be transparent.

396. The legal frameworks which underpin decisions relating to the publication of IPSIs impose strict safeguards on personal data. Openness and transparency must be balanced against individual's privacy rights, particularly under the UK General Data Protection Regulation (**"GDPR"**), Data Protection Act 2018 and the common law duty of confidentiality. Those considerations are especially acute in circumstances where the IPSI contains data concerning an individual's health, as this gives rise to additional privacy obligations. A brief background of the legal regime is set out at Annex 5.

397. In 2020, the Independent Investigations Governance Committee ("**IIGC**") (see paragraph 411 below) commissioned a legal review of publication practices.

This indicated that the publication practice of IPSIs, specifically those relating to mental health homicide, did not conform with data protection law **[NHSE0002383]**. This advice was challenged by a lay member of the IIGC, who considered other competing legal duties had not been appropriately considered **[NHSE0002292]**. Following discussion between the chair of IIGC and the National Medical Directorate, a decision was made to continue to publish full reports unless individual circumstances determined otherwise.

398. In 2023, following (amongst other things):

a. the establishment of the NPSIIT in NHS England in 2022;

b. the creation of the Independent Investigations Committee ("**IIC**"), which replaced the IIGC (see paragraph 413 below);

c. the development of PSIRF; and

d. the standing down of the NHS major national incident (Covid-19), during which many publications has been slowed or stopped,

regional independent investigation leads once again raised the issue of publication to the NPSIIT.

399. A subsequent legal review was commissioned in September 2023 regarding the publication of Mental Health Homicide IPSI reports containing personal identifiable information and the risks around GDPR compliance.

400. The September 2023 advice confirmed that reports need to be truly anonymised before publication. The advice also confirmed that although there would be a lawful basis to share an identifiable version of the report with those

who had previously treated the patient who carried out the homicide, it would be a breach of the GDPR to share a similar version with a victim's family **[NHSE0002310][NHSE0002378]**.

401. This advice was taken to the IIC in November 2023, who welcomed the option of publishing a summary learning document that has been anonymised and excluded medical history **[NHSE0002312]**.

402. Some stakeholders remained concerned with this approach, and in January 2024 further advice was provided which considered the extent to which a substantial public interest would establish a lawful basis to publish reports containing identifiable information concerning the patient who carried out the homicide. The advice outlined that this would need to be determined on a case-by-case basis, but the starting presumption must always be in favour of non-disclosure, before considering whether there are specific factors to support displacing that presumption **[NHSE0002317]**.

Publication Practice Working Group

403. In April 2024, a working group, known as the Publication Practice Working Group ("**PPWG**"), was established by the IIC to consider and review the legal advice received in relation to the processing of IPSI reports and to consider the impact on the current processing of this information, including publication and sharing with stakeholders (including families/carers of those affected) **[NHSE0002322][NHSE0002324]**.

404. Membership was wide and included representatives from NHS England's patient safety team, the Information Commissioner's Office, NHS Resolution, Patient Safety Partners and victims advocacy group representatives.

405. The PPWG considered the legal framework (and balancing that against the public interest), the legal advice that had been received by NHS England and other relevant guidance documents.

406. The PPWG reported back to the IIC in August 2024 and at that stage confirmed it had drafted, but not achieved consensus on, a set of publication principles. In the interests of good administration, the IIC considered the draft principles and made minor amendments. In effect, the draft principles advised that the contents of reports needed to be considered on a case-by-case basis.

407. The IIC further identified that the draft principles required approval by the NHS England Executive and potentially the DHSC. They were therefore submitted for consideration by the NHS England Executive and have subsequently been raised with the DHSC. However, these have yet to be approved by NHS England and DHSC.

408. The minutes of the PPWG, together with relevant papers, are exhibited at: **[NHSE0002319][NHSE0002323][NHSE0002325] [NHSE0002326][NHSE0002327][NHSE0002329] [NHSE0002370][NHSE0002371][NHSE0002372][NHSE0002379][NHSE000 2380][WITN0310003][WITN0310004]**.

Naming of clinicians

409. The judgment in the case of *Abbasi and another (Respondents) v Newcastle upon Tyne Hospitals NHS Foundation Trust (Appellant)* [2025] UKSC 15 is being considered as part of an ongoing review by NHS England into the publication of IPSI reports.

410. We will share a copy of the review with the Inquiry once available.

Independent Investigations Governance Committee

411. The Independent Investigations Governance Committee ("**IIGC**") was established in 2015 and reported to NHS England's Quality Assurance Group.

412. The IIGC:

a. was part of NHS England's governance structure and provided strategic governance oversight for Independent Investigations following mental healthcare related homicides, and all mental healthcare independent investigations (see IIGC meeting minutes exhibited at: **[NHSE0002291] [NHSE0002293] [NHSE0002294] [NHSE0002295] [NHSE0002340] [NHSE0002342] [NHSE0002343] [NHSE0002345][NHSE0002346]**).

b. provided a route to escalate and consider issues arising from independent investigations commissioned by NHS England regional teams; and

c. commissioned an independent review of the Independent Investigations for Mental Health Homicides in England, which was published in 2018 and is exhibited at: **[NHSE0000326]**.

413. The IIGC was disbanded in 2022, following the merger of NHS England and NHS Improvement, and its functions transferred to the new IIC chaired by the National Director of Patient Safety.

414. The IIC provides regular reports on independent investigation activity to the NHS England Executive Quality Group and Quality and Performance Committee. The IIC met for the first time in February 2023 and fulfils a broadly similar role to the IIGC, including supporting a standardised approach and decision making to the management of investigations, resolving strategic and directional issues between independent investigations and ensuring good governance of all NHS England independent investigations.

Annual Independent Investigation Reports

415. The IIGC published some Independent Investigation Annual Reports, although it was not required to do so.

416. These reports provided an overview of the work undertaken by the then NHS England Regional Independent Investigation Teams (RIITs), or combined NHS England and NHS Improvement regional teams (noting that this period straddled the time when these organisations moved from being separate to operationally merged). They include information on investigations commissioned and completed, key learning themes, governance arrangements, and financial data. Due to the relatively low volume of cases, data should be interpreted with appropriate caution. The reports also summarised development activity within each region and outlined future plans to strengthen governance and enhance the quality and dissemination of learning.

417. The reports covering 2018/19 and 2019-2021 are exhibited at: **[NHSE0000200]** and **[NHSE0000233]**. These reports highlighted a number of themes in relation to mental health homicide reports, such as the number of investigation reports in the relevant periods, and specific aspects like patient diagnoses and the relationships between patients and victims.

418. The 2018/19 Annual Report contained one recommendation asking the IIGC to note the report's content and consider the national and regional independent investigation priorities for 2019/20. We are unable to locate a formal record of this recommendation being discussed, accepted, rejected or closed by the IIGC.

419. The 2019-2021 Annual Report made six recommendations, and as noted below, changes have been made that have since either delivered on or superseded these recommendations:

Recommendation	**Comments**
NHS England and NHS Improvement IIGC is requested to note the independent investigations in the Annual Report 2019/2021 and to consider the national and regional independent investigation priorities for 2021/2022, as detailed above.	The IIGC did note the recommendations and made an initial commitment to exploring owners and implementation **[NHSE0002347]**.
NHS England and NHS Improvement to consider the findings of this report as part of the NHS Long Term Plan.	The NHS LTP has been superseded by the 10 Year Plan.

	This recommendation has therefore been superseded.
Clear links should be established between patient safety risks and actions arising from investigations, in quality improvement projects/processes.	NHS England agrees with this recommendation. In April 2024, PSIRF became a contractual requirement for all NHS providers contracted under the NHS standard contract. This makes clear that insight from investigations (and other learning responses) must be used to inform improvement at relevant levels of the system. Processes for achieving this should be described in the provider's Patient Safety Incident Response Policies and Plans.
To improve knowledge of systemic patient safety risks, underlying contributory factors, and inform decision making to improve patient safety, NHS England and NHS Improvement commissioned independent investigation reports should meet a minimum set of standards. Such standards should align with methodologies best suited	NHS England agrees with this recommendation. PSIRF and the NHS England National Independent Patient Safety Investigation Framework require the use of systems-based learning response methodologies and set standards for the same.

to uncovering systemic issues and risk factors in the long term, e.g., in the Human Factors Analysis and Classification System.	
Providers and commissioners should be reminded of the importance of timely accurate data entry and consistent field selection when reporting via StEIS, to facilitate meaningful data extraction.	Significant work has taken place to create an updated Learn From Patient Safety Events services (LFPSE) which in time will entirely replace StEIS. This uses a new taxonomy and supports a focus on data quality amongst other things. Focus continues on supporting providers to record patient safety incidents for the purpose of learning and improvement.
Providers and commissioners are reminded of the importance of identifying ethnicity on StEIS.	Recording of data related to inequalities, including ethnicity, is a focus for the recently published Patient Safety Healthcare Inequalities Reduction Framework (**[NHSE0002348]**), and we encourage this in relation to incident recording via LFSPE. However, we are also clear that availability of inequalities data cannot be an

	impediment to timely incident recording, so we do not mandate recording of this data given it may not be available at the time of incident recording.

420. These annual reports, previously commissioned by the IIGC, are no longer commissioned as the reports were considered to be of limited value for the resources required to create them.

Independent Investigations Procurement Framework

421. NHS England has a Framework Agreement for the Provision of Independent Investigation Services. This is intended to facilitate the process of commissioning independent investigations. The current version of this Framework breaks services down into a number of lots:

a. Individual Experts Investigations (Lot 1);

b. Partnership Investigations (Lot 2);

c. Local Care System Investigations (Lot 3);

d. Health & Social Care & Partners Investigations (Lot 4);

e. Systematic Independent Investigations (Lot 5).

422. Providers can be selected to undertake investigations through either a mini-competition or a direct award.

423. There are currently 16 providers on the Framework. The Framework is refreshed on a regular basis, with the current version live from December 2022.

424. A key facts document regarding the framework is exhibited at **[NHSE0000394]**. The contract award notice is exhibited at **[NHSE0000546]**.

425. Specific details regarding the commissioning of the VC investigation are set out in Section 6 below.

Mental Health Patient Safety Improvement Group

426. A new learning and improvement focused group been established: the Mental Health Patient Safety Improvement Group ("**MHPSIG**"). The MHPSIG was established in response to a request from NHS England's Chief Executive Officer following the Nottingham incident to ensure that NHS England had a stronger structure for what it does, with insight generated from IPSI reports and other sources of information that are informative about the safety of mental health services. The first meeting took place in January 2025. Meetings are chaired by the National Medical Director for Mental Health **[NHSE0000488]**.

427. The purpose of MHPSIG is to translate insight derived from patient safety incident records, IPSIs commissioned by NHS England in mental health services and other mental health patient safety related information into effective and sustainable improvement in the safety of mental health services. This includes through improvements to national policy **[NHSE0000492]**.

428. The work undertaken by MHPSIG and any subsequent actions will form part of the regular updates received through NHS England's governance structure.

Freedom of Information Act requests

429. NHS England has received a number of Freedom of Information Act 2000 ("**FOIA**") requests relating to mental health homicides and independent investigations.

430. Copies of the FOIA requests and NHS England's responses are exhibited as follows:

a. request regarding central database and percentage of homicides meeting serious incident criteria: **[NHSE0000489]**;

b. requests regarding numbers of independent homicide reports and related matters: **[NHSE0000464] [NHSE0000465] [NHSE0000476]**;

c. request regarding how many civil legal proceedings have been brought against NHS England for the unauthorised disclosure of confidential patient information in NHS England commissioned Independent Mental Health Homicide investigations for each of the last five years **[NHSE0002355]**. NHS England did not hold the requested information.

Review of patient safety across the health and care landscape

431. On 7 July 2025, DHSC published the review of patient safety across the health and care landscape **[NHSE0000528]**.

432. The review considered six organisations which were established to assure, or contribute to, improving the quality of care. The six organisations were: the CQC; the Health Services Safety Investigations Body ("**HSSIB**"); the Patient Safety Commissioner; the National Guardian's Office; Healthwatch England and Local Healthwatch; and the patient safety learning aspects of NHS Resolution.

433. Finding 3 relates to investigations: "*there is a large number of organisations carrying out reviews and investigations. A very high number of recommendations have been made to the NHS, most of which lack any cost-benefit analysis*." It further states that:

"The NHS in England has significantly enhanced its own capacity and capability to undertake reviews and investigations over the last 5 to 10 years with the establishment of the Patient Safety Incident Response Framework (PSIRF) and Learn from patient safety events (LFPSE) service. Of the 600 million patient or user interactions with the NHS in England each year, current (unpublished) estimates indicate that up to 3,000 patient safety incident investigations are conducted by trusts on an annual basis. Around 15,000 other learning responses are captured following patient safety events."

434. The review goes on to consider the focus of recommendations and the importance of the balance of risk:

"Recommendations are often focused on inputs, rather than outputs or outcomes, and fail to recognise the balance of risks within organisations and across systems. The review heard that the existence of so many recommendations causes considerable confusion for staff. They result in more clinical staff moving into supervisory roles to check that other clinical staff are adhering to the recommendations. The overwhelming majority of recommendations lack data as to the cost of implementation or the expected impact.

This risks disempowering local provider boards and clinical teams, where safety responsibility must sit every day."

435. The review concluded (amongst other things) that there is a need to "*streamline, simplify and consolidate functions where considerable duplication and overlap currently exist - specifically when it comes to:… investigations*."

436. The purpose of the review was to make recommendations about future roles. Of particular relevance to the Inquiry are the recommendations around the future role of the NQB.

437. Recommendation 1 of this review considers the role of the NQB, and consistent with the 10 Year Plan, recommends that it is revamped, revitalised and its role is significantly enhanced:

"A revamped, revitalised and reinforced NQB should be responsible for developing a comprehensive strategy to improve quality of care that is in line with the aims of DHSC and the NHS in England. This should build on data and analysis about current quality of care, evidence and examples of high-quality care and, where appropriate, recommendations from previous reviews and inquiries."

438. The review also sets out how NQB should:

a. operate a clearing-house function to prioritise existing and new recommendations (such as those based on evidence of cost-effectiveness and that fit with strategic priorities) (recommendation 1);

b. set standards for the quality of health and care in co-ordination with the CQC (recommendation 2); and

c. collaborate with HSSIB to agree the scope of investigations that HSSIB carries out (recommendation 3), further stating that recommendations

arising from all investigations should be considered as part of the clearing-house function of NQB.

SECTION 4: MENTAL HEALTH DATASETS

439. This section provides an overview of the data collected relating to mental health services throughout the Relevant Period.

Mental Health Services Data Set

440. The Mental Health Services Data Set ("**MHSDS**") is a patient level, output based, anonymized, secondary uses data set collected monthly. It is mandatory for all providers of NHS-funded specialist mental health services to submit relevant data to the MHSDS, including the voluntary and independent sector[22].

441. MHSDS statistics offer a comprehensive national picture of the use of specialist mental health, learning disabilities or autism services in England and can be used by policy makers, commissioners, mental health service users and members of the public.

442. At a national level, the data is used to inform national performance management and benchmarking, in particular against the priorities and targets set for the mental health system relating to areas such as inappropriate out of area placements, length of stay, access to community services and addressing health inequalities. For example, this happens via national reporting at NHS England board level, to Ministers, and/or in national-regional forums.

Mental Health Dashboard

[22] Further information is available on the MHSDS website www.digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/about

443. In 2016, as part of the Five Year Forward View for Mental Health, NHS England introduced the Mental Health Dashboard to bring together key data from across mental health services and to provide transparency in assessing how NHS mental health services are performing. It also provides technical details explaining how mental health services are funded and delivered. The dashboard is primarily populated by data collated as part of the MHSDS.

444. The dashboard provides NHS England and the Trusts with insight on mental health service performance, allowing them to review and benchmark providers. It also measures the performance of the NHS against the ambitions of the Five Year Forward View for Mental Health and the NHS LTP, and presents activity and implementation data for specific ambitions, with a view on the progress that has been made in the latest quarter.

445. NHS England also expects that services will utilise data from their systems at a local level, alongside that referred to above, in order to obtain assurance and monitor data trends.

446. Dashboards covering the Relevant Period are exhibited, and detail:

a. EIP: percentage of people who started treatment within 2 weeks of referral; and

b. the use of out of area placements (also see below at paragraph 455)

[NHSE0000193] **[NHSE0000195]** **[NHSE0000197]** **[NHSE0000209]**
[NHSE0000211] **[NHSE0000212]** **[NHSE0000213]** **[NHSE0000227]**
[NHSE0000241] **[NHSE0000245]** **[NHSE0000263]** **[NHSE0000270]**

[NHSE0000275] [NHSE0000282] [NHSE0000284] [NHSE0000285] [NHSE0000286] [NHSE0000290].

Mental Health Act Statistics

447. NHS England publishes a data collection containing the official statistics about the uses of the 1983 Act in England.

448. The data covers the use of sections 2 and 3 of the 1983 Act, and the use of CTOs. This publication does not cover people in hospital voluntarily for mental health treatment as they have not been detained under the 1983 Act, or uses of section 136 where the place of safety was a police station as this is published by the Home Office.

449. The data collection for the Relevant Period is exhibited **[NHSE0000183] [NHSE0000203] [NHSE0000229] [NHSE0000291] [NHSE0000292] [NHSE0000293]**.

Bed Occupancy rates

450. The data collection for bed occupancy has been in its current form since 2010[23]. It covers:

a. day-only inpatient beds, which includes general and acute ("**G&A**"),[24] learning disabilities, maternity and mental illness admissions;

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[23] See NHS England's published 'Bed Availability and Occupancy Data' – Overnight Statistics.
[24] Please note: (i) critical care encompasses 'intensive care' and 'high dependency' units. Critical care is needed if a patient needs specialised monitoring, treatment and attention, for example, after routine complex surgery, a life-threatening illness or an injury; (ii) G&A beds are intended for those patients who require short-term medical care and treatment in hospital, for acute illnesses or injuries. They are typically located in medical, surgical, or speciality wards in hospitals; and (iii) a 'hospital bed' includes any device that may be used to permit a patient to lie down when the need to do so is as a consequence of the patient's condition rather than the need for active intervention such as examination, diagnostic investigation, manipulation/treatment, or transport.

b. overnight inpatient beds, which again includes G&A, learning disabilities, maternity and mental illness admissions; and

c. critical care beds.

451. The data collection covering June 2023 is exhibited at **[NHSE0000452]**.

452. NHS England can provide the data collection for the entire Relevant Period. However, it should be noted that hospital capacity had to be organised in new ways as a result of the pandemic in order to treat Covid-19 and non-Covid-19 patients separately and safely, to meet the enhanced infection prevention control measures. As a result, caution should be exercised in comparing overall occupancy rates in the financial year 2020/21 with previous and current data.

Mental Health Clinical Outcome Review Programme

453. NHS England may commission specific analyses on mental health data. For example, HQIP on behalf of NHS England jointly commissioned the National Clinical Audit and Outcomes Programme. This includes the Mental Health Clinical Outcome Review Programme, which examined suicide and homicide committed by people who had been in contact with secondary and specialist mental health services.

Out of Area Placements

454. Between October 2016 and March 2024 NHS Digital published the Out of Area Placements ("**OAP**") in Mental Health Services publication series. From 2024/25 reporting onwards, all OAP data has been monitored using only the MHSDS.

455. The data collection for the Relevant Period is exhibited at:

[NHSE0000319] [NHSE0000320] [NHSE0000321] [NHSE0000322]
[NHSE0000324] [NHSE0000325] [NHSE0000327] [NHSE0000328]
[NHSE0000329] [NHSE0000330] [NHSE0000331] [NHSE0000332]
[NHSE0000334] [NHSE0000335] [NHSE0000337] [NHSE0000339]
[NHSE0000340] [NHSE0000341] [NHSE0000344] [NHSE0000345]
[NHSE0000346] [NHSE0000347] [NHSE0000348] [NHSE0000350]
[NHSE0000351] [NHSE0000352] [NHSE0000353] [NHSE0000355]
[NHSE0000356] [NHSE0000358] [NHSE0000359] [NHSE0000360]
[NHSE0000361] [NHSE0000363] [NHSE0000364] [NHSE0000366]
[NHSE0000367] [NHSE0000368] [NHSE0000370] [NHSE0000372]
[NHSE0000374] [NHSE0000375] [NHSE0000377] [NHSE0000381]
[NHSE0000382] [NHSE0000385] [NHSE0000386] [NHSE0000387]
[NHSE0000393] [NHSE0000406] [NHSE0000407] [NHSE0000408]
[NHSE0000409] [NHSE0000411] [NHSE0000412] [NHSE0000413]
[NHSE0000415] [NHSE0000417] [NHSE0000422] [NHSE0000439]
[NHSE0000445] [NHSE0000450] [NHSE0000453].

Mental Health Waiting Time Targets

456. In 2015, NHS England introduced specific waiting times standards for three mental health service areas:

a. EIP services;

b. eating disorder services for children and young people; and

c. talking therapy services.

457. The access and waiting time standard for mental health was an important step towards parity of esteem with physical health services.

458. Since 2015, the NHS has met the standard for early intervention in psychosis services.

459. NHS England routinely publishes waiting times data for mental health services. Until October 2019, the EIP waiting times were published as part of a separate data set - they now form part of the MHSDS.

460. The EIP waiting times data sets covering January to September 2019 are exhibited at: **[NHSE0000166] [NHSE0000168] [NHSE0000170] [NHSE0000172] [NHSE0000175] [NHSE0000176] [NHSE0000178] [NHSE0000181] [NHSE0000185]**.

Rapid review into data on mental health inpatient settings

461. In 2023, DHSC commissioned Dr. Geraldine Strathdee (as an independent chair), in respect of a rapid review into data on mental health inpatient settings **[NHSE0002374]**.

462. This review was commissioned in response to serious concerns about the safety, quality and transparency of mental health inpatient care in England. The review set out to evaluate how data was collected and used to monitor service performance, and whether it adequately reflected the realities of inpatient care. One of the key aspects of the review was that the system has *"some way to go to universally measure what matters in relation to patient safety."*

463. The review goes further to state that:

"patients and families and clinical teams told us that the system is not measuring what matters. They do not consider we are measuring what will truly have an impact on patient safety and outcomes. Too much data collection is about activity and processes and too little about patient experience, what therapeutic treatments are provided, and the 'real time' patient and clinician reported progress and outcomes. Despite the reduction in burden that could be achieved by use of digital tools, there was not a universal level of knowledge about, or provision of, these enablers."

464. The review also found that culture and FTSU (see paragraphs 65 to 92 above in relation to these matters) was key:

"Board members told us that culture is key. For a person to feel safe, the experience and culture of care needs to be kind, compassionate and hopeful, so they can make the progress that supports them to achieve a good quality of life back in their community. Staff also need to feel safe and supported to speak up early when a service does not meet the standards they want to deliver. Only a live and frequent presence by board and senior staff on wards could provide the assurance needed."

465. The review found that national datasets were often delayed, fragmented or lacked sufficient detail to detect safety concerns in real time. The issue of digital infrastructure in mental health services was also highlighted with many inpatient units being described as "digital deserts," lacking modern tools for data capture and analysis. Staff reported spending excessive time manually entering data that did not contribute to patient care, suggesting a high data burden with limited clinical value.

466. To address these issues, the review recommended a shift toward more purposeful, patient-centred metrics developed through a "Measuring What Matters" initiative, led by NHS England in partnership with patients and professionals. It also called for improved interoperability, better use of technology, and a reduction in unnecessary data entry through smarter design.

467. NHS England is currently consulting on the future of mental health reporting, with the aim of improving the relevance, usefulness, and accessibility of national data publications. The consultation covers the Mental Health Services Monthly Statistics and the Mental Health Annual Bulletin.

468. The Mental Health Bulletin 2023-24 Annual Report and the Mental Health Services Monthly Statistics provided a link to a survey to allow users to contribute to the consultation **[NHSE0002376]**. The consultation closed on 12 October 2025. The goal is to gather feedback from users across the system, including providers, commissioners, analysts and the public, to help shape how mental health data is collected, presented and used going forward. The review is intended to ascertain which metrics are most valuable, how frequently data should be published, and how to reduce reporting burdens while improving transparency.

469. In responding to the need to 'measure what matters', NHS England has undertaken a significant amount of work identifying the most important quality indicators, as recommended by the review. These indicators are the 'Early Warning Signs' data metrics, as highlighted at paragraph 266 above.

470. A copy of the review and the government response are exhibited at: **[NHSE0002373][NHSE0002377]**.

471. For completeness, it is highlighted that Dr. Strathdee is a former NHS England NCD for Mental Health who supported the launch of Mental Health Intelligence Networks in 2014 to support the collection of better data which can be turned into information and then intelligence **[NHSE0002375]**.

Improving the quality of mental health data

472. NHS England has been working to improve the quality of mental health data. As of July 2025, over 420 mental health service providers were submitting data to the MHSDS. This contains a diverse range of organisation types, only circa 22% of which are NHS organisations, the remainder being a combination of VCSE, independent sector organisations, social care and local authorities.

473. Within NHS England, a number of solutions have been developed to support providers in improving the quality of the data submitted to the MHSDS. These include:

    a. dedicated teams working with providers on a 1-2-1 basis to support them throughout the data submission journey;

    b. tools and guidance to assist service providers with their submissions and to evaluate the quality of the submissions they make;

    c. a multiple submission window process allows providers to address data quality issues throughout the financial year through resubmission of data;

    d. extensive guidance, how-to videos, mailbox support, as well as the underlying code being published; and

e. new solutions such as Neurodevelopmental Resource Groups (Currencies) and Mental Health Productivity are aimed at driving improvements in data quality.

474. NHS England is exploring how solutions such as the FDP could be employed to improve the quality of data captured, as well as reduce burden on service providers.

475. The FDP brings together health data in one secure place to help NHS staff make better decisions about patient care and service planning. It operates at three levels[25]:

a. NHS England National Instance: combines data from multiple legacy systems to give leaders accurate, up-to-date information for planning health services across England;

b. Local ICB Instances: helps integrated care boards plan and buy health services for their local area by providing the data and capabilities they need to understand what their population requires;

c. Trust Instances: gives frontline staff quick access to patient information in one place. This helps teams view the most current patient data, manage waiting lists, schedule operations and plan better care.

476. As part of the FDP Programme's continued evolution, a new workstream was formally established in January 2025 to support the next phase of delivery and

[25] NHS England has purchased licences for a FDP for all NHS providers and the 42 ICBs until March 2031. Implementation of the FDP is not mandatory.

strategic alignment. The Transforming Operational Delivery workstream is leading the FDP expansion to support transformation across new areas.

477. The FDP programme takes a deliberate, insight-led approach to understanding the operational challenges and pain points faced by this sector. We are working closely with mental health trusts to improve the integration of local systems and make data more actionable at the point of care. The approach is grounded in co-design with Trusts and national policy teams, ensuring that solutions are tailored to real operational challenges and user needs. The programme identifies opportunities where FDP can deliver measurable improvements, whether through existing FDP proven capabilities, or co-designed, innovative solutions.

478. Addressing these challenges and working alongside Trusts has led to the development of two products:

a. Crisis Response: NHS England is piloting an FDP Crisis Response tool with several Mental Health Trusts to help teams triage and manage urgent referrals more efficiently. Early results show faster response times and improved operational processes.

b. Waiting List Management: NHS England is supporting Trusts to standardise and streamline community waiting lists. The FDP Waiting List Tool provides a single, accurate view of waiting lists, helping teams reduce bottlenecks and improve access to care.

479. The workstream is working on a wider roadmap, directly linking to engagement with Trusts and policy teams and supporting national priorities.

SECTION 5: NHS ENGLAND ENGAGEMENT WITH NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

480. NHFT was authorised to become an NHS Foundation Trust pursuant to section 35 of the 2006 Act on 1 March 2015 by Monitor (which was the independent regulator of Foundation Trusts and has since merged into NHS England).

481. NHFT is an integrated healthcare provider and provides community health care and mental healthcare, including high secure services and offender health services.

482. As a Foundation Trust, NHFT is governed by its constitution, applicable legislation (predominantly the 2006 Act), and its licence conditions. It is required to have a Board of Directors, which must include certain directors pursuant to Schedule 7 of the 2006 Act, and a Council of Governors.

483. NHFT must also have regard to guidance published by NHS England. In some cases, it is required to report compliance against guidance as part of its annual report and accounts, for example, the Code of Governance for NHS Provider Trusts **[NHSE0000522]** and the previous NHS Foundation Trust Code of Governance **[NHSE0000310]**. Part of the governance framework includes strongly encouraging Trusts to undertake an externally facilitated developmental review of their leadership and governance using the NHS England Well-led Framework every three to five years **[NHSE0000316]**[26].

[26] The CQC and NHS England have jointly developed and published new well-led guidance for Trusts under the Single Assessment Framework which has been applicable to all Trusts since April 2024. NHS England's Well-led Framework is under review and will be updated in due course.

484. NHFT is required to report against a number of matters as set out in the Foundation Trust Annual Reporting Manual (see **[NHSE0000425]** for an example). This includes reporting on performance, quality and the applicable oversight framework (which must include details of any breach, or suspected breach, of licence conditions where these have been notified by NHS England and any action(s) taken to remedy).

485. NHFT is required to publish its annual reports online.

486. Every year, NHFT is required to hold an annual meeting of its members (which includes members of the public, patients and staff) (paragraph 27A of Schedule 7 to the 2006 Act). During this meeting in September 2024, the NHFT Chief Executive Officer updated members of NHFT on lessons and actions **[NHSE0000461]**.

Oversight and enforcement

487. Prior to the incident (during the financial year 2021/22), NHFT had been in segment 3 of the Single Oversight Framework (referred to as "**SOF 3**"), using the metrics described in paragraphs 101 to 102 above.

488. The key drivers for NHFT entering SOF 3 were the CQC ratings for the Rampton Hospital (high secure services) and the Seacole Ward at the Wells Road Centre (low secure inpatient services), both of which are commissioned by NHS England's Specialised Commissioning Team **[NHSE0000383]**. Neither of these services provided care to VC. At this point, NHFT's CQC rating overall was Requires Improvement and Requires Improvement for Well-led.

489. The NHS Oversight Framework Dashboard for NHFT for quarter 1 of 2023/24 (**[NHSE0000545]**) shows that NHFT was in the highest performing quartile of Trusts for:

a. relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants (WRES);[27] and

b. older adult acute length of stay over 90 Days (as a % of total discharges).

490. NHFT was in the lowest performing quartile of Trusts for:

a. relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants (WDES);[28]

b. sickness absence rate; and

c. NHS Staff Survey[29] elements.

491. For all other metrics, NHFT was in the second or third quartile, as shown by the dashboard exhibited above.

492. At the end of June 2023, following the quantitative and qualitative assessments of the five national themes and one local priority contained within the NHS Oversight Framework (see paragraph 101 above), it was agreed that NHFT

[27] The Workforce Race Equality Standard (WRES) was introduced in 2015 to help NHS organisations identify improvements to manage and monitor inequalities through nine workforce indicators. It aims to support a more inclusive NHS workforce and improving care quality, patient satisfaction and workforce experience.
[28] The NHS Workforce Disability Equality Standard (WDES) was introduced in 2019 and is built around 10 evidence-based measures (metrics) which enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.
[29] The NHS Staff Survey offers a snapshot in time of how people experience their working lives, gathered at the same time each year. Its captures a national picture alongside local detail, enabling NHS England to explore staff experience across different parts of the NHS and work to bring about the necessary improvements.

should remain in segment 3 (known as NOF 3 at this stage) **[NHSE0000530] [NHSE0000529]**.

493. On 22 February 2024, a paper was presented to the Midland's Regional Support Group ("**RSG**") outlining the reasons why NHFT required mandated intensive support i.e., placing NHFT in segment 4 of the NHS Oversight Framework ("**NOF 4**") and as a result the RSP **[NHSE0000426]**.

494. The considerations for NOF 4 related to:

a. the provision of high secure services and re-licensing;

b. offender health service provision;

c. staff suspensions due to serious misconduct, including falsifying records and mistreating patients;

d. investigation relating to the care and treatment of VC[30];

e. concerns around certain medium secure services; and

f. concerns regarding the financial position of NHFT.

495. The RSG supported the recommendation that NHFT should be moved into NOF 4 and placed in the RSP, subject to approval at Quality Performance Committee ("**QPC**").

496. The QPC approved the move and NHFT entered the RSP on 27 February 2024. On 4 March 2024, NHS England's Chief Operating Officer wrote to NHFT confirming that it would enter the RSP and confirmed what they could expect

[30] An incident of this nature does not automatically result in regulatory action.

by way of support **[NHSE0001191]**. Part of this provision includes Improvement Director support, who act as the 'Air Traffic Controller' for support within an RSP Trust.

497. An Improvement Director undertook a diagnostic stocktake following the commencement of RSP **[NHSE0002330] [NHSE0001613]**. The diagnostic stocktake is the starting point for designing an Integrated Improvement Plan ("**IIP**") (the IIP would also take into account the Section 48 recommendations).

498. The IIP is the pathway to sustainable improvement and ultimately exit from NOF 4. The IIP details five workstreams which relate to reason for entry. Each workstream has quarterly monitoring metrics which are reported on internally, at the Regional Joint Oversight Group as well as at the RSP quarterly review meetings.

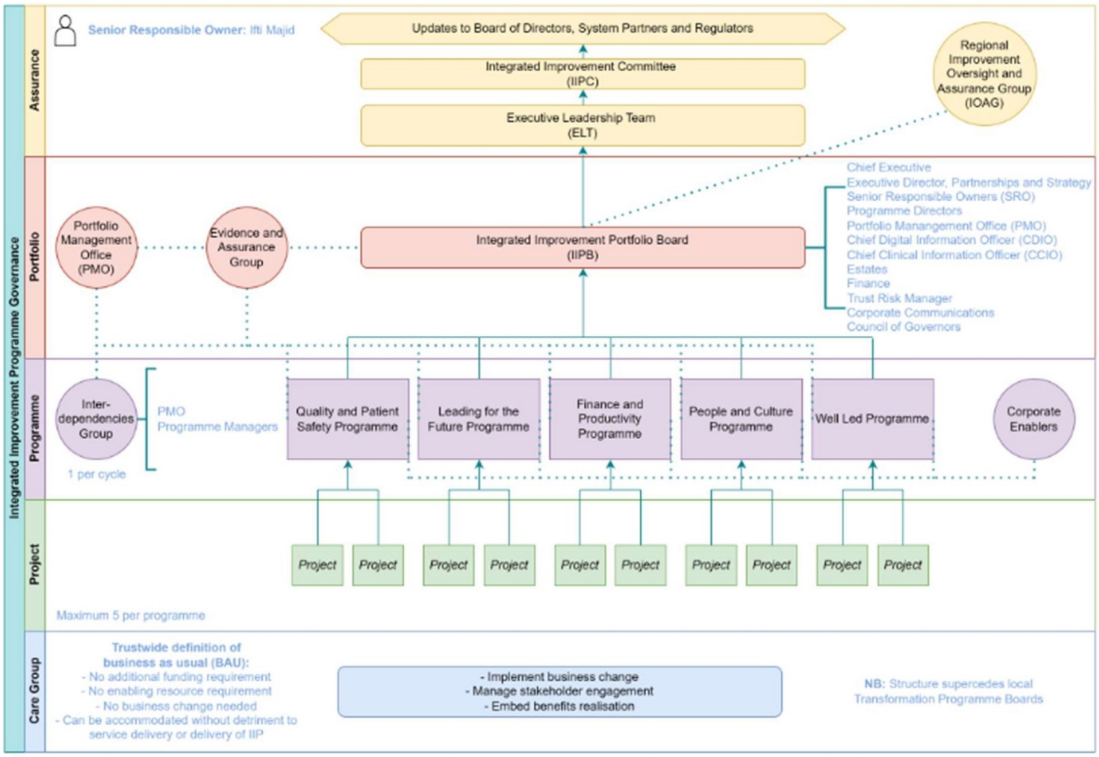
499. An update was provided to the RSG on 25 July 2024 **[NHSE0000454]**, which included an update on the diagnostic stocktake to identify the root causes of the issues to be addressed. Key areas identified in the diagnostic included:

a. quality and safety concerns, including serious incidents, medicines management, clinical observations, deteriorating patients, waiting times, crisis service (and rapid tranquilisation and seclusion practices at the Rampton Hospital) and staffing levels (particularly at the Rampton);

b. governance concerns and financial slippage; and

c. leadership and culture concerns - NHFT has a "quiet clinical voice", with staff not feeling heard or having visibility of the top team.

500. System-level governance was established to support NHFT and oversee improvement – see below the IIP programme governance structure **[NHSE0000447]**:



501. Progress against improvement criteria is overseen by the Improvement Oversight and Assurance Group ("**IOAG**"), which is jointly chaired by the Regional Medical Director and NNICB CEO **[NHSE0000446]**.

502. The IOAG also receives assurance regarding the professional practice review of decision making clinicians involved in the care of VC **[NHSE0000509][NHSE0000510]**.

503. In addition to the above, there are also 'board to board' meetings between:

a. NHFT and NHS Midland's board members; and

b. NHFT and NHS England's national team, which includes members of NHS England's Board as well as the Improvement Director.

504. A reset of the NHFT improvement plan took place one year post RSP entry to take into account the independent homicide investigation report.

505. In addition to the above:

a. NHS England's Mental Health Improvement Support Team ("**MHIST**") is working with NHFT on the challenges identified with inpatient and community services. The focus of the MHIST is to implement quality improvement, not performance management or assurance. The memorandum of understanding between NHS England and NHFT is exhibited at **[NHSE0000456]** and the workplan is exhibited at **[NHSE0000491]**;

b. NHS England has also supported NHFT in the recruitment of additional non-executive directors by advertising the roles through its national networks and joining their appointment panel (noting they are a foundation trust, so NHS England were not required to do this - this was an additional offer);

c. a finance turnaround director has been appointed;

d. executive team coaching has been put in place;

e. NHS England has supported with the Medical Leadership Programme, funding both the facilitator and the external medical management training courses; and

f. NHS England has funded 'buddying' arrangements from:

i. Northamptonshire Healthcare NHS Foundation Trust for CEO to CEO support; and

ii. (although outside of the scope of this Inquiry), Ashworth Hospital and Broadmoor Hospital for expert high secure support for the Rampton Hospital.

506. Since the commencement of RSP, the following has taken place:

a. removal of the Director of Corporate Governance due to capability issues;

b. recruitment started for three new Non-Executive Directors (particularly seeking clinical acumen); and

c. discussions between NHS England and NHFT CEO regarding executive capacity.

507. Improvements have been demonstrated through:

a. 66 single assessment framework CQC visits, demonstrating significant improvements (as at the end of July 2025);

b. positive overall CQC review – NHS England understands that a positive rating change for the Rampton Hospital is imminent;

c. National Oversight Group recommendation to the SSHSC for a four year licence for the Rampton Hospital;

d. data driven decisions and reduction in harm (including the Safe Now dashboard), which is used daily and commended by NHS England and NNICB; and

e. significant quality and safety improvements in seclusion, restraint and National Early Warning Score (NEWS) 2 score.

508. Whilst improvements have been made around the financial position, at this stage this remains the primary issue in terms of RSP exit. That is, if significant financial control improvement is not made, NHFT will not exit RSP in March 2026.

509. In July 2025, a further funding bid was submitted by the Improvement Director to support NHFT's journey to RSP exit **[NHSE0002349] [NHSE0002350]**.

Enforcement action

510. NHS England identified a number of breaches in respect of NHFT's Provider Licence **[NHSE0000468]**.

511. As a result, and in accordance with its enforcement powers pursuant to section 106 of the Health and Social Care Act 2012, NHS England accepted undertakings from NHFT for a breach of its licence conditions on 28 November 2024 **[NHSE0000469]**. Compliance with the undertakings is monitored through IOAG.

Well-led review

512. NHS England's National Recovery Support team conducted an independent well-led developmental review of NHFT between March and October 2024 **[NHSE0000463]**.

513. The review followed the well-led developmental review guidance published by NHS England in 2017, which incorporates the CQC's well led key lines of enquiry. It is structured against the CQC's Single Assessment Framework eight new quality statements under the well-led domain, which were published in April 2024. NHFT accepted the findings and recommendations, and set out how they would integrate these with the core improvement programmes **[NHSE0000466]**.

514. Updates on progress are provided to the IOAG - see for example at **[NHSE0000493]**.

Homicide and Attempted Homicide Review

515. NHS England required NHFT to conduct a review of homicides and attempted homicides. NHFT identified five cases in total since 2022 – two homicides (including the VC incident), two attempted homicides, and one complex case (which was nether a homicide or an attempted homicide). The review is exhibited at **[NHFT0003517]**.

516. For each case, the following is provided as requested:

a. date and description of incident;

b. date of Trust review (initial review and serious incident investigation);

c. brief chronology of NHFT's involvement with individual/interaction with services;

d. summary of identified areas for improvement;

e. actions to be taken to address the above, and when they were actually taken/completed;

f. how the improvement has been maintained/how they know it has been maintained; and

g. board oversight of above.

Incidents within the Relevant Period

517. For the Relevant Period, NHS England has extracted data regarding incidents of violence and aggression in relation to NHFT specifically, and also more broadly on mental health homicide incidents recorded by all Trusts.

518. The data shows that for the Relevant Period there were:

a. 397 incidents of apparent, actual or suspected homicide cases meeting the serious incident criteria across all Trusts; and

b. 162 incidents of disruptive, aggressive, or violent behaviour meeting the serious incident criteria at NHFT (these will overlap to some extent with (a) above, but they are not a subset of the 397 incidents referenced in (a)).

519. Of the 397 incidents referenced above, five relate to NHFT (and this includes the attacks by VC).

520. NHS England has also received a FOIA request regarding the total number of apparent/suspected/actual mental health related homicides reported by providers of mental health services to NHS England on StEIS for each of the calendar years from 2018 to 2023 inclusive (i.e., a longer period than the Relevant Period). The information provided confirmed there had been 442 such instances **[NHSE0002352] [NHSE0002337]**.

Previous investigations and reports

521. Prior to the incident, there had been two independent homicide investigations relating to NHFT:

a. independent investigation into the care and treatment of service user Mr A in Nottinghamshire: The investigation resulted from the death of a 87 year-old man in 2019 and was commissioned by NHS England once all related criminal proceedings had been concluded **[NHSE0000281]**.

b. independent investigation into the care and treatment of Mr R: At the time of the homicide Mr R was under the care of Northamptonshire Healthcare NHS Foundation Trust (the incident occurred in September 2008). Mr R had previously had contact with Nottinghamshire Healthcare NHS Trust. **[NHSE0000069]** (this incident pre-dates NHS England and NHFT in its current form).

522. There are currently two incidents under consideration for independent reviews which relate to NHFT: one incident for an independent homicide investigation; and one for a domestic homicide review.

SECTION 6: INCIDENT RESPONSE

523. The following paragraphs set out how NHS England responded to the incident, from the 'on the day response' through to the commissioning of the independent homicide investigation.

EPRR response

524. The NHS emergency response included NHS England, NNICB, NHFT, East Midlands Ambulance Service NHS Trust (and their HART team).

525. NHS Midlands Regional Head of EPRR received a call just before 0630 on Tuesday 13 June 2023 confirming that Operation Plato had been declared. It confirmed that there had been six fatalities with six further people injured and being conveyed to hospital.

526. As set out at paragraphs 191 to 196 above, Operation Plato is a specific response to a MTA. On 13 June 2023, the NHS Midlands Regional Director and Director of Performance and Improvement were immediately notified, along with the National Director of Resilience and the National EPRR first on call, who then alerted the DHSC through the usual channels.

527. Operation Plato was stood down later the same morning (at 0918), on the basis the incident was not an MTA. At this point Operation Hendrix was stood up by the Police - NHS England aligned itself to the Police incident, but did not declare a regional (Level 3) or national (Level 4) NHS EPRR incident.

528. The Police chaired the response groups in respect of Operation Hendrix, with NNICB attending in accordance with the EPRR MoU and reporting back to NHS England.

529. At 1600 on 13 June 2023, a briefing was provided to the senior leadership of NHS England outlining what had taken place and next steps **[NHSE0000396]**.

530. The Regional EPRR timeline is exhibited at **[NHSE0000403]** and the National Call Log is exhibited at **[NHSE0000498]**.

531. The information received by the regional EPRR team regarding the incident is exhibited at **[NHSE0000398] [NHSE0000399] [NHSE0000400] [NHSE0000402] [NHSE0000401] [NHSE0000395]**.

532. Anonymised EPRR lessons from incidents are routinely shared by the NHS Midlands team, and in the case of the Nottingham incident T17 and T18 in section 4.9 of the exhibit **[NHSE0000459]** have been shared. These lessons came from the multiagency debrief conducted by the Nottingham and Nottinghamshire LRF as learning for all organisations.

Strategic Executive Information System ("StEIS") record

533. As set out in paragraphs 368 to 373, incidents are reported by Trusts through patient safety systems, which includes StEIS.

534. The StEIS record for the incident is exhibited at **[NHSE0000511]**. It includes:

a. the date and location of the incident;

b. the clinical area: psychiatry;

c. patient type: discharged from Mental Health services care within recent past (i.e. last six months- this should be applied as a guide only);

d. the type of incident: apparent/actual/suspected homicide meeting SI criteria;

e. a description of what happened: major incident declared in Nottingham City Centre on 13.6.23. This incident involved the fatality of 3 people who were stabbed by a male perpetrator. Same perpetrator also alleged to have driven a van at members of the public. The male was detained by police and is currently remanded in HMP Nottingham. This male was known to NHFT, his last inpatient admission was from Jan 22 - Feb 22 at Highbury Hospital and he had been under EIP county south team on discharge from hospital. The patient had been discharged from EIP in September 2022; and

f. correspondence history by NHFT.

Investigations

535. NHS Midlands Head of Independent Investigations ("**HII**") was formally alerted to the incident and VC's history with mental health services in Nottingham on 15 June 2023 by the Regional Director of Nursing **[NHSE0000397]**.

536. NHFT produced terms of reference which were shared with the HII for their internal (Level 2) serious incident investigation which would meet the requirements of the SIF **[NHSE0000404]**. The HII also assisted with the facilitation of communication between NHFT and the families.

537. The HII was kept up-to-date by NHFT in respect of its internal investigation, which was subject to directions from the police in terms of making contact with VC and his family. A draft internal investigation report from NHFT was received on 13 February 2024 **[NHSE0002318]**, with the final report being available on 15 March 2024 **[NHFT0000451]**.

538. On 1 February 2024, a briefing note was provided to the Midlands IIRG Chair regarding the approval to commission an independent investigation into three homicides and three attempted homicides in Nottingham **[NHSE0000418]**.

539. As set out at paragraphs 421 to 424 above, there is a Framework Agreement for the Provision of Independent Investigation Services. NHS England used this framework to procure the services of Theemis Consulting Limited ("**Theemis**") in respect of the independent investigation into the incident. Theemis's Framework Agreement is exhibited at **[NHSE0000384]**.

540. Theemis was one of three providers on Lot 5 of the framework who were considered by NHS England. The others were niche Health and Social Care Consulting ("**niche**") and Verita Consultancy Ltd ("**Verita**"). All three organisations included individuals with significant experience in patient safety and other health based investigations.

541. Theemis provided its Investigation Team biographies to NHS England **[NHSE0000428]**, as did niche **[NHSE0000421]** and Verita **[NHSE0000420]**.

542. On 1 February 2024 there was a meeting between the HII, Regional Medical Director and Regional Director of Patient Safety and System Improvement. The draft agenda for this meeting is exhibited at **[NHSE0000512]**, and during the meeting the following was concluded **[NHSE0002316]**:

a. Verita did not have an appropriate team ready to deploy;

b. niche's proposed methods were not aligned to PSIRF; and

c. Theemis had an experienced team ready for deployment and their proposed methods were aligned to PSIRF[31].

543. On 5 February 2024, a briefing note for NHS England's National Team was prepared **[NHSE0000423]**, providing two options: Theemis undertake the whole investigation; or Theemis undertake the investigation with the support of a specialist adviser. The second option was selected by NHS England and the award was made to Theemis on 14 February 2024 **[NHSE0000424]**.

544. An investigation proposal was provided by Theemis on 21 February 2024, setting out their family engagement strategy, draft terms of reference, investigation plan and methodology **[NHSE0000427]**. This was later updated **[NHSE0000441]**.

545. On 28 February 2024, the HII wrote to the victims' families confirming the commissioning of an independent investigation and the name of the company procured to carry out the investigation. The letters also confirmed that NHS England would welcome sharing the draft terms of reference and a meeting to explain the process **[NHSE0000429] [NHSE0000433] [NHSE0000430] [NHSE0000431] [NHSE0000432] [NHSE0000437] [NHS00000436] [NHSE0000435] [NHSE0000434]**.

546. On the same date, the HII wrote to the family of VC outlining the same information **[NHSE0000442]**.

547. On 29 February 2024, the HII wrote to VC to explain the process and that NHS England would be requesting his medical records **[NHSE0000438]**. This was

[31] The standard approach taken to commissioning includes checking that the proposed team have the requisite skills and experience for the commission.

followed up by requests to healthcare organisations highlighting that it was important for Theemis to have access to his records **[NHSE0000448]**.

548. On 20 March 2024, the HII wrote to the external adviser to the independent investigation, setting out the aims and deliverables **[NHSE0000444]**.

549. The terms of reference for the independent investigation were updated following a meeting with the families. The post-family meeting terms of reference dated 10 May 2024 are exhibited at **[NHSE0000458]**.

550. In January 2025:

a. the HII informed surviving families of the publication of the independent investigation report **[NHSE0000475] [NHSE0000473] [NHSE0000474] [NHSE0000478] [NHSE0000479] [NHSE0000480] [NHSE0000481] [NHSE0000482]**.

b. NHS England and the IPSI team met with the deceased victims' families, their legal team and advocate to discuss the full report, share the findings and recommendations, and discuss publication.

551. VC had provided his consent for the report to be shared in full with affected families **[NHSE0000472]**.

552. As highlighted in paragraphs 387 to 405 above, the position on publication of IPSIs is complex. The position with regards to the IPSI relating to VC was also not straightforward. As set out above, VC gave his consent for the full IPSI to be disclosed to the affected families. However, this step created further difficulties, as the families were concerned that disclosure of the contents to themselves alone would not allow them to speak freely to other public bodies

or to the media about the findings, and thus raised the issue of 'gagging public debate'.

553. On 5 February 2025, NHS England published the IPSI regarding VC in full. The decision was taken on the basis of various factors relating to VC's case. They included not only the fact that NHS England had operated a policy of publishing summary version reports over the previous six months, but the strong and legitimate public interest (articulated by stakeholders, such as the affected families and the DHSC) in understanding the reasons why the tragic events of 13 June 2023 had occurred or had not been prevented, and the fact that a significant amount of the data concerning VC's health was already in the public domain.

554. Notwithstanding the above, NHS England considers that the tensions or competing privacy interests which were debated in the policy advice and the papers of the PPWG (see paragraph 405 above) have not been resolved. Legislation or further action may be required to resolve them, or to set clearer guidelines for public bodies such as itself or successor bodies in the future.

555. The Theemis report is exhibited at **[NHSE0000298]**. The NHFT and ICB joint action plan is available online and exhibited at **[NHSE0002333]**.

556. Following publication, NHS England's National Director for Mental Health, Learning Disabilities and Autism, and the Medical Director for Mental Health and Neurodiversity sent a letter outlining next steps and requirements of Trust and ICB boards **[NHSE0000048]**.

557. As stated above, the Theemis recommendations for NHFT are part of the overall improvement work and oversight is provided by the IOAG. The progress as of December 2024 (drafted recommendations mapped to the improvement plan) is exhibited at **[NHSE0000470]**. The final 'refreshed' improvement plan was presented at the Integrated Improvement Portfolio Board on 12 March for agreement and to the Trust Board on 27 March 2025 for approval **[NHSE0000496]**. The refreshed plan is exhibited at **[NHSE0000495]**.

558. The relevant papers from the June 2025 and July 2025 IOAG, which highlight progress against recommendations as at that date, are exhibited at: **[NHSE0000508] [NHSE0002195] [NHSE0000506] [NHSE0000504] [NHSE0000505] [NHSE0000507] [NHSE0000503] [NHSE0002339] [NHSE0002344] [NHSE0002351]**.

559. The recommendations set out for NHS England were:

    a. area for improvement 1 – care delivery: *"NHS England and other national leaders, including people with lived experience, should come together to discuss and debate how the needs of people similar to VC are being met and how they are enabled to be supported and thrive safely in the community"*; and

    b. area for improvement 2 – risk: "*NHS England should, in the next six months consider:*

        i. How mental health and social care understand the concept of risk, risk assessment and risk management systems to ensure the effective identification and evaluation of risk across all care and

public settings, together with the appropriate implementation of adequate safety measures.

ii. *What mechanisms are in place to communicate risk across multiple agencies to hold, share and communicate risk in real time.*

iii. *How current mental health services take a dynamic approach to risk management, adapting to manage individuals' fluctuating risk and need.*

iv. *Given that the NCISH is no longer funded to carry out data collection, analysis, and research on patient homicide, there is a requirement at a national level for data that accurately assists with the identification and the likelihood of the risks of particular outcomes."*

560. In relation to area for improvement 1, NHS England set up a working group to design the national guidance for assertive and intensive community mental health care (see paragraphs 317 to 328 above). This has since been supplemented with further work currently taking place to review the CPA position statement (see paragraphs 313 to 316 above) and associated standards for community mental health care.

561. Area for improvement 2 covers a number of areas which have been actioned through the work that relates to area for improvement 1: paragraphs 559.b.i to 559.b.iii above are part of the ongoing work regarding the CPA position statement.

562. Paragraph 559.b.iv relating to NCISH has been actioned through the recommissioning of the research, as set out in paragraph 271 above.

CQC Section 48 actions for NHS England

563. The actions addressed to NHS England within the CQC's Section 48 report are set out below, together with how they have been addressed:

a. The National Director for Mental Health has been appointed as the named individual to take ownership for the delivery of the recommendations.

b. The remainder of the actions (replicated below for ease of reference) have been addressed through the work associated with the Guidance to Integrated Care Boards on Intensive and Assertive Community Mental Health Care (see paragraphs 317 to 328 above).

i. *"Ensures that providers' boards fully understand their role in the oversight of the needs of patients who have a serious mental illness and who find it difficult to engage with services. This includes developing local services in partnership with others to provide intensive support in order to prevent this cohort of patients from falling through the gaps.*

ii. *Ensures every provider and commissioner in England undertakes a review of the model of care in place for patients with complex psychosis who typical services struggle to engage, and who present with high risk.*

iii. *Within the next 12 months, provides evidence-based guidance setting out the national standards for high-quality, safe care for people with complex psychosis and paranoid schizophrenia.*

iv. *Within 3 months of the publication of the national standards for high-quality, safe care for people with complex psychosis and paranoid schizophrenia, ensures every provider and commissioner develops and delivers an action plan to achieve these.*

v. *Through the providers' boards, ensures delivery of the actions within 12 months of the standards being published.*

vi. *Together with the Royal College of Psychiatrists:*

1. *reviews and strengthens the guidance to clinicians relating to medicines management in a community setting, for example depot vs oral medication*

2. *reviews how legislation is used in the community to deliver medication for those patients who have a serious mental illness and where it is known they are non-compliant with medication regimes."*

564. For completeness, we highlight that NHS England received a FOIA request regarding how many Integrated Care Boards have reported the outcomes of their reviews to NHS England. This confirmed that all 42 ICBs in England returned their reviews **[NHSE0002353] [NHSE0002354]**. The returns for the NNICB are set out at paragraph 325 above.

Information sharing within NHS England governance structures

National information sharing

565. In addition to the other ways in which information is shared relating to this incident and the follow-up actions, updates and information are also shared with both the NHS England Executive Group and Board. Examples of this are provided below.

566. NHS England's Executive Group has been kept up-to-date on matters relating to this incident – for example, see exhibit: **[NHSE0002331]**.

567. NHS England has considered the Nottingham incident in a number of Board meetings in public:

a. on 1 February 2024 **[NHSE0000531]**:

i. the Chief Executive Officer highlighted the issues identified at NHFT and Greater Manchester Mental Health Trust in the context of the continuing challenges around access, funding, prevention and quality of care across inpatient mental health services. Assurance was provided on the comprehensive programme of work underway to address this and transform inpatient services to ensure people who need care can access it in a way that is safe, effective and compassionate to both the individual and their families; and

ii. consideration was given to the systemic issues and risks that were being addressed through the Mental Health, Learning

Disability and Autism Quality Transformation Programme, including the issues identified at NHFT.

b. on 28 March 2024, the Board were provided with an update regarding NHFT's segmentation and move into the RSP **[NHSE0000532]**;

c. on 3 October 2024, the Board received a paper regarding supporting people with severe mental illness in community mental health services. This update specifically notes:

"notable Serious Untoward Incidents have occurred recently involving Mental Health patients who have not received the care they should have. One of these is Valdo Calocane (VC) who was convicted of manslaughter in January 2024 on the grounds of diminished responsibility due to severe mental health illness. He is now detained in a high secure hospital. The Secretary of State subsequently commissioned the Care Quality Commission (CQC) as the regulator, to undertake a Section 48 review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust. The review did not identify one single point of failure, however the CQC identified multiple points where poor decision-making, omissions, and errors of judgement contributed to a patient with very serious mental health issues not receiving the support and follow up that he needed. Immediate actions were, and continue to be, taken in the wake of this incident at local, regional and national level. Many of them are described in this paper which sets out the ongoing work at a national level to improve patient and public safety in CMH services." **[NHSE0000534] [NHSE0000533]**

d. on 6 February 2025, the Chief Executive Officer noted the publication of the Independent mental health homicide report into the treatment of VC and extended her condolences to the patients and families impacted by these events. The work underway to ensure that learnings from the incident are identified and implemented across the NHS were considered. A report was requested to a future Board meeting on the actions being taken to address the report findings **[NHSE0000535]**.

Mental Health Summits

568. In January 2024, following the conviction of VC, the Regional Chief Nurse, NHFT and the ICB Chief Nurse worked collaboratively to support staff and take forward improvements required.

569. An extraordinary meeting took place on 19 April 2024 for all Midlands ICB Chief Nurses and Mental Health Provider Directors of Nursing, to have a focused discussion in relation to the findings and concerns raised. There was a commitment to proactively capture the learning to strengthen existing quality oversight arrangements within community as well as in-patient settings, ahead of awaiting the findings from the CQC's section 48 review and the NHS England IPSI review **[NHSE0001629]**.

570. A series of four summits were planned. The fourth summit was purposefully delayed until the publication of the IPSI report was published in January 2025. This was to enable NHFT to implement actions and to fully capture and share the learning.

571. The summits sought to bring systems together, to provide a platform for collaboration and create opportunity for systems and providers to seek peer support, critical friends and transparency of shared risks and issues, with a focus on measuring what matters to people using services. The summits were facilitated by ICB's and providers in collaboration with the NHS England Regional Chief Nurse and her team. Each summit encouraged sharing best practice and exploring what is currently in place with regards to what is working well, what are the gaps and what are the risks **[NHSE0001629]**.

572. The four summits were as below:

a. ICB and Provider oversight (29 April 2024);

b. Creating a Positive Culture, early warning signs of closed closures (14 May 2024);

c. Learning from Host & Home ICB Guidance (11 June 2024);

d. Nottingham Healthcare Foundation Trust Section 48: Learning from ICB & Provider response and improvements (20 February 2025).

Statement of Truth

I believe the content of this statement to be 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: GRO-B

Dated: 8 December 2025

ANNEX 1

Key Individuals

This Annex sets out a brief summary of key individuals within NHS England during the Relevant Period.

National		
Chief Executive Officer	The Chief Executive Officer ("CEO") of NHS England leads the NHS's work nationally to improve health and ensure high quality care for all. The CEO is jointly accountable to the Board of NHS England, the Department of Health and Social Care, and to Parliament. Mental health is within the current CEO's portfolio.	Lord Simon Stevens (1 April 2014 until 31 July 2021) Amanda Pritchard (1 August 2021 until 31 March 2025) Sir James Mackey (Transitional CEO) since 1 April 2025
Chief Operating Officer	During the Relevant Period, the Chief Operating Officer ("COO") was responsible for operational delivery of the NHS in England, including performance standards across all systems. This includes oversight of EPRR incidents, ensuring that appropriate plans are in place to support the delivery and recovery of NHS services. They are also responsible for the Delivery of National programmes for urgent and emergency care, cancer, mental health and learning disabilities.	Amanda Pritchard (1 August 2019 until 31 July 2021) Sir David Sloman (December 2021 until August 2023) Dame Emily Lawson (1 November 2023 until 31 March 2025) NHS England no longer has a COO.

Chief Finance Officer	The Chief Financial Officer ("CFO") is responsible for strategic financial management of NHS England's resources. They oversee the development and administration of financial policy levers and lead financial and corporate performance management. During the Relevant Period this role was held by Julian Kelly.	Elizabeth O'Mahoney (since 1 April 2025) Julian Kelly (April 2019 until 31 March 2025) Elizabeth O'Mahony (since 1 April 2025)
Chief Nursing Officer	The Chief Nursing Officer ("CNO") for England is employed by NHS England to provide expert clinical and workforce advice to the Board and is formally the CNO providing advice to the Government and the Department of Health and Social Care. The role also provides professional leadership for all Nurses and Midwives in England (with the exception of public health nursing).	Dame Ruth May (2019 until 24 July 2024) Duncan Burton (since 25 July 2024)
National Medical Director	The National Medical Director ("NMD") is the most senior doctor in the NHS in England and provides clinical governance across the health system. The NMD is responsible for patient safety.	Professor Sir Stephen Powis (2018 until July 2025) Dr Claire Fuller (since 1 April 2025) and Professor Meghana Pandit (on 18 month secondment, since 1 April 2025)

Urgent and Emergency Care Director	EPRR is now the responsibility of the Urgent and Emergency Care Director.	Sarah-Jane Marsh (since November 2022)
National Director for Mental Health	The National Director for Mental Health is responsible for overseeing mental health services commissioned by the NHS and implementing quality improvement.	Claire Murdoch (April 2016 until 11 September 2025)
National Director for Primary Care, Community Services and Strategy	Throughout the Relevant Period, the National Director for Primary Care, Community Services and Strategy has the strategic responsibility for primary care and community services.	Dr. Amanda Doyle (since 13 June 2022)
National Director of Patient Safety	The National Director for Patient Safety oversees patient safety policies nationally.	Dr. Aidan Fowler (since March 2020)
National Director for NHS Resilience	The National Director for NHS Resilience oversees NHS England's Emergency Preparedness Resilience and Response function.	Dr. Mike Prentice (since April 2022) Professor Sir Keith Willett (September 2019 until 4 July 2021)
Director of EPRR	Reported to the National Director for NHS Resilience.	Stephen Groves (2013 – 31 March 2025)
Improvement Director	NHS England's appointed improvement director overseeing RSP in relation to NHFT.	Moira Durbridge (since 15 April 2024)
Midlands Region		
Regional Director	Dale Bywater	Since 2018

Medical Director	Dr. Jessica Sokolov	Interim November 2022; substantive since February 2024
Chief Nursing Officer	Professor Nina Morgan	Substantive since November 2022 (worked with the National CNO as Executive Nurse Fellow on secondment prior, from 2021)
Director of Patient Safety and System Improvement	Bhavisha Pattani	Since January 2023
Director of Commissioning	Roz Lindridge	Since January 2022
Chief Operating Officer	Simon Evans	Since September 2024
Head of EPRR	Ash Canavan	Since February 2020
Head of Independent Investigations	Mette Vognsen	Since April 2020

National Clinical Directors and National Speciality Advisers

National clinical director for adult mental health	Dr. Mary Docherty (since April 2025)
National medical director for mental health and neurodiversity	Dr. Adrian James (since June 2024 – this is a new role)
National specialty adviser for secure mental health	Dr. Mayura Deshpande (since January 2024 this is a new role)
National clinical director for mental health	Professor Tim Kendall (2016-2022) (recruitment ongoing)
National specialty advisor specialised commissioning (mental health)	Dr Daniel Dalton (2019 – 2022) (recruitment ongoing)
National specialty advisor for adult mental health	Dr Mike Hunter (since 2020)

ANNEX 2

Key Mental Health Groups

Group	Purpose
Independent Investigations Governance Committee	Established in 2015 and disbanded in 2022 following the merger of NHS England and NHS Improvement National oversight and assurance role for independent investigations. **[NHSE0000365]**
National Independent Investigation Committee	The Independent Investigation Committee (IIC) exists to provide direction to the independent investigations and reviews commissioned and supported by NHS England. **[NHSE0000471]**
Mental Health Patient Safety Insight Group	The Mental Health Patient Safety Insight Group exists to translate insight derived from patient safety incidents in mental health services into effective and sustainable improvement in the safety of mental health services, including through improvements to national policy, particularly insight derived from independent investigations and reviews in Mental Health services supported and commissioned by NHS England. **[NHSE0000492]**

Improvement Oversight Assurance Group	The purpose of the Improvement Oversight and Assurance Group (IOAG) is to bring together appropriate interested parties (multi–stakeholder) from across the local and wider health and social care system in strategic oversight of the NHT Quality improvement programme. **[NHSE0000446]**
Regional Quality & Performance Oversight Meeting	The group provides insight to the Regional Executive Team to inform the wider strategic approach for the region, where relevant, and supports the review and moderation of all segmentation decisions on a quarterly basis. **[NHSE0000451]**
Regional Support Group	The NHS Executive established a Regional Support Group for the Midlands to (in partnership with the Quality and Performance Committee) help ensure that NHS England adopts a consistent and appropriate approach to supporting integrated care boards (ICBs) and providers in the Midlands to continuously improve and to enable the review of all regulatory processes and actions as required of ICBs and providers. Where necessary to protect and promote patient interests, this will include using NHS England's formal intervention powers. **[NHSE0000449] [NHSE0000460]**

Midlands Independent Investigations Review Group	The purpose of the Independent Investigation Review Group (IIRG) is to improve the care provided to patients, escalate national recommendations to the Independent Investigation Governance Committee (IIGC) to ensure learning is shared and embedded nationally and locally, support staff in sharing and improving practice and ensure families affected by tragedy have a voice. **[NHSE0000457]**

ANNEX 3

Legacy Bodies

1. On 1 April 2016, the Trust Development Authority ("**TDA**") and Monitor were brought together to create "NHS Improvement".

2. Monitor was originally (from 2006) the independent regulator of NHS Foundation Trusts - a category of health care provider with greater freedoms and 'independence' from central administration than NHS Trusts. Under the Health and Social Care Act 2012 (the "**2012 Act**"), Monitor's role was expanded and it became an independent regulator for NHS health care services in England. In exercising its functions, it was required to protect and promote the interests of patients by promoting the provision of health care services which were economic, efficient and effective and which maintained or improved the quality of services. A key part of this regulatory role was to licence providers of NHS health care services and to enforce the conditions of the licence, under Chapter 3 of Part 3 of the 2012 Act. In this role, 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.

3. The TDA was a Special Health Authority established by the SSHSC by order under section 28 of the 2006 Act. The TDA was established primarily to exercise such functions as the SSHSC may direct in connection with the management of the performance and development of NHS trusts (a category of health care provider, subject to greater SSHSC oversight), in particular with a view to those NHS Trusts becoming NHS Foundation Trusts.

4. Acting together as NHS Improvement, Monitor and the TDA were therefore responsible for overseeing and supporting providers of NHS services. This included issuing guidance to Trusts about how they performed their responsibilities, and taking steps to ensure those trusts operated effective governance arrangements to comply with relevant health care standards set by other bodies (such as CQC, NHS England or the statutory regulators of health care professions).

5. However, in exercise of their responsibilities for oversight and regulation, those bodies, acting together as NHS Improvement, sought to ensure that relevant operational guidance was considered and applied by providers.

6. From April 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. They were collectively referred to as "NHS England and NHS Improvement" or "NHSEI". Although the two organisations operated as one, the statutory framework applicable at the time did not allow the creation of joint boards and joint board committees. Accordingly, the Board and Board Committees of the two organisations met in common with a view to allowing the organisations to meet together and have joint discussions while having separate membership and taking their own decisions.

7. In February 2021, the Government confirmed its intention to formally merge NHS Improvement into NHS England in its Integration and innovation White Paper (**[NHSE0000349]**). The merger took place on 1 July 2022 (see sections 33 – 39 2022 Act).

ANNEX 4

Psychosis Pathway

How individuals access services

1. Individuals can present to services when they are in early stages of illness (prodromal changes) or when they are very unwell in a full episode of psychosis. How unwell they are when they come to the attention of services will influence whether they access care in the community or through a hospital pathway first.

2. "Prodromal" means the early warning phase of an illness; the period when changes start happening before the full condition clearly appears. The prodromal phase of psychosis refers to the early signs and symptoms that come before a first episode of psychosis. These changes are often non specific and can include:

    a. withdrawing from friends and family;
    b. declining performance at school or work;
    c. feeling anxious, depressed, or irritable;
    d. subtle changes in thinking (odd ideas, suspiciousness); and/or
    e. trouble concentrating or coping with stress.

3. For some individuals, being very unwell with a full episode of psychosis can mean they withdraw, self neglect and retreat into their own world; other people may not notice they have become unwell and they may present to services late. For others, the converse can happen, and how they respond to their delusions and hallucinations may lead to more overt behaviour change.

4. How the illness is presenting can impact how and when individuals come into contact with mental health services and what care they are offered first (e.g., community, crisis or hospital).

5. Illness factors, social factors (e.g., stigma, culture) and health services factors (such as access to care, clinician awareness) can also impact how and when an individual first comes into contact with mental health services.

6. Behaviour change due to the individual acting on their delusions and/or hallucinations can account for why some individuals experiencing an episode of psychosis may come to the attention of the police and access care through a police section (section 136 of the 1983 Act) or criminal justice pathway.

7. People with an emerging or first presentation with psychosis can present to and access mental health services in a range of ways. This may be via self referral, family/carer/school concerns, GP referral, emergency/crisis services (A&E, liaison psychiatry, crisis lines), community services (Child and Adolescent Mental Health Services, CMHTs), or the criminal justice system.

8. Stigma can lead to delays in families or individuals seeking help. There are established inequalities in relation to access, with a higher proportion of people from minority groups accessing care through the criminal justice system or accessing help late. Studies consistently show higher rates of criminal justice involvement and compulsory detention and lower rates of voluntary or GP referral among Black people.

9. Individuals from Black African and Black Caribbean communities are more likely to come into contact with services through police, courts, or compulsory routes

(e.g., 1983 Act detention), rather than voluntary referral. GP referral is less common for Black patients with first episode psychosis. These inequalities are not fully explained by illness severity **[NHSE0002279]**.

Early intervention in psychosis (EIP) services

Referral

10. Wherever an individual has initially presented with the first signs of psychosis, and all suspected psychosis, they should be referred EIP teams in line with NICE guidance (NICE CG178) **[NHSE0000539]**. This guidance was first published in 2014 and is a very established part of mental health care.

11. As set out in paragraphs 300 to 306 above, the NHS Access & Waiting Time Standard for Early Intervention in Psychosis requires assessment and start of treatment within 2 weeks of referral. Commencement of treatment means completion of an assessment, caseload acceptance, and care coordinator allocation. This standard applies both if the individual has been identified with suspected psychosis on a community pathway (e.g., through the GP), or if they have been so unwell at presentation to require an admission to a mental health hospital.

12. The access and waiting time standard was introduced in April 2016 as part of NHS England's first access and waiting time standards for mental health. Both aspects of this pathway - the referral to EIP services for suspected first episode of psychosis and the access and waiting time standard - are well established, embedded and expected basics of care.

Initial engagement and EIP care

13. Once an individual has accessed an EIP service, they should expect to receive care in line with NICE CG178. This includes receiving a comprehensive multidisciplinary assessment covering psychiatric, physical, psychological, social and occupational domains. Care planning should be personalised, recovery focused, and culturally competent.

14. The NCAP (see paragraphs 307 to 312 above) and RCPsych Early Intervention in Psychosis Network (a quality improvement and service accreditation network for early intervention in psychosis team), provide quality improvement support for services to operate in line with NICE guidance and other currently accepted aspects of good practice in psychosis care. The NCAP provides the most regular update on local and national standards of care.

15. Treatment plans are biopsychosocial and should be evidence based in line with existing guidance.

Engagement techniques in EIP

16. An important component of EIP care is the use of engagement techniques.

17. Assertive outreach approaches include use of home visits, flexible locations and youth friendly approaches. Development of a therapeutic alliance between staff and patients is an aim of care. Consistent contacts with a named care coordinator is part of the model of EIP to realise this.

18. Additional techniques and approaches include involvement of carers, family, friends or support networks from the outset and cultural competence in care, including tailoring care to cultural/religious needs.

19. Peer support is increasingly available through employment of lived experience workers.

20. Motivational interviewing is a technique to engage individuals in treatment for any co-occurring substance use, which can be common.

21. Building a therapeutic alliance and developing plans to prevent or support during crisis/relapse, developing advance statements and plans on what should happen if the individual becomes unwell, and building understanding of relapse signatures are all core approaches to the care model.

At Risk Mental States

22. Some individuals have subthreshold psychotic symptoms (e.g., unusual beliefs, mild hallucinations, decline in functioning). This is termed At Risk Mental State ("**ARMS**") or 'ultra high risk' ("**UHR**").

23. Around 20% to 30% of ARMS individuals transition to psychosis within two to three years **[NHSE0002381]**. Some early intervention in psychosis teams assess and monitor ARMS, and this has been recommended as gold standard care in RCPsych standards for EIP services since 2018 **[NHSE0002286] [NHSE0002298][NHSE0002336]**. However, provision of this assessment and follow-up can be more variable. Interventions focus on psychoeducation, cognitive behavioural therapy ("**CBT**"), family support, and addressing comorbidities. Antipsychotics are not routinely recommended unless clear transition occurs. Emphasis is on watchful waiting, supportive therapy, and risk reduction.

Pharmacological treatment

24. Medication guidelines specify which antipsychotic medications to use, how to use them, and how to monitor them to prevent or mitigate side effects. Monitoring includes management of impact on cardiometabolic health due to the particular side effect burden of these medications and the impact of psychosis itself on the individual's overall lifestyle and health behaviours. Conventional practice is still to offer oral medication first and then to offer a long acting injection (depot) if adherence is a challenge for the individual.

25. Evidence on the respective efficacy of oral versus long acting injections means that there are changing views within the clinical community on this practice. Some respected prescribing guidelines have suggested that patient choice should ensure patients are informed of the evidence for the relative clinical effectiveness of these different medication formulations and be offered a long acting injection or oral medication first. This is an evolving area and one where there is still some current clinical debate. Hesitancy around offering long-acting injections first may relate to concerns about restrictive practice.

26. Individuals can be wary of medication for many reasons, for example they:

    a. may not think they are unwell and do not think there is a need for it;
    b. may simply not want to take medication; or
    c. may worry about or experience side effects.

27. Enforced medication is only possible if certain conditions of the 1983 Act are met. Engagement and building a trusted relationship with an individual to come to a decision collaboratively should be the priority. This relationship can be of

great importance if the individual does not have insight and does not believe they are unwell.

28. Restrictions through the 1983 Act to enforce or give treatment are considered below and at paragraphs 204 to 216 above.

Treatment response and treatment resistance

29. Not everyone will respond to medication. Two challenges exist:

    a. individuals not taking their medication (an adherence problem); and
    b. individuals taking it but it not improving their symptoms (a response problem).

30. International guidelines exist in responding to these situations **[NHSE0002287]**. The Treatment Response and Resistance in Psychosis ("**TRRIP**") consensus guidelines outline standardized criteria for diagnosing treatment resistant psychosis. According to these guidelines, treatment resistance includes these three core elements:

    a. confirmed diagnosis of schizophrenia;
    b. adequate pharmacological treatment trials, meaning at least two different antipsychotics, each at therapeutic doses and sufficient duration with verified medication adherence; and
    c. persistence of significant symptoms, despite these adequate treatment efforts, confirmed by standardized symptom rating scales and evidence of moderate functional impairment.

31. Ideally, one of the trials should be with a long acting injectable ("**LAI**") antipsychotic lasting at least four months, to rule out non-adherence. The LAI requirement and monitoring aims to distinguish true treatment resistance from pseudo-resistance due to non-adherence.

32. The importance of establishing whether an individual is not responding to medication because they are not taking it or because it is not working is important. If it is not working, there is a highly effective medication (clozapine) known to reduce mortality rates that needs to be used if an individual is not responding **[NHSE0002289]**. Despite clear guidelines on the use of this medication and its evidence base in reducing mortality, it is under used **[NHSE0002301]**. There are multiple reasons behind this underuse, including that it requires additional monitoring due to its side effect profile.

33. These challenges with medication can mean that an individual's treatment pathways can vary. Some individuals will respond well and quickly to medication, their symptoms will improve and other psychosocial interventions in the care pathway can be prioritized. Remission might be effectively achieved, and relapse prevention and recovery goals become the focus of care.

34. For those who do not respond and/or who are not taking medication, it can take longer to address the symptoms that are causing behavioral changes, distress and deterioration in functioning. In these episodes, more intensive care may be needed, delivered through crisis resolution and home treatment teams or inpatient care.

Psychological and social interventions

35. NICE recommend a clear set of psychosocial interventions alongside medication. These include family interventions:

    a. structured sessions focusing on education;
    b. communication;
    c. problem solving; and
    d. relapse prevention.

36. Individual therapies include CBT for psychosis.

37. IPS (Individual Placement and Support) enables return to work/education.

38. Integrated dual diagnosis care is essential where substance misuse or comorbid mental health problems exist. Physical health monitoring and lifestyle interventions should be a core part of care plans. NCAP shows current practice and related treatment gaps.

Crisis and hospital care

39. Some individuals (but not all) will receive additional care through mental health hospitals and/or crisis care teams (e.g., crisis resolution and home treatment teams ("**CRHTT**")). These are higher intensity tiers of care.

40. The most common reason for individuals requiring hospital care is that they have not taken, or are not responding to, their medication. Relapse can be precipitated by multiple factors (e.g., nonadherence to medication, social stressors, substance use, or simply as a feature of the disease course).

41. Hospital care is used when individuals require 24/7 intensive support and cannot manage safely in the community. A change in risk (to self, to others, or from self neglect) are the most common reasons why hospital care is used. Due to national bed occupancy rates and a view that alternatives to hospital (e.g., crisis resolution home treatment team) are preferrable to hospital, in most cases admission to hospital is used in response to a change in risk.

42. Individuals are admitted to hospital informally or under the 1983 Act. To be admitted informally the individual needs to be well enough to retain decision making capacity about their care and wish to receive care in hospital. Many individuals when they are unwell lose decision making capacity, resulting in the need to use appropriate legislation – namely, detention under the 1983 Act.

43. It is a requirement of the law that least restrictive pathways and care environments are completely explored before compulsory admission is used. Compulsory admission (sectioning) must meet several requirements set out in the 1983 Act relating to nature and degree of the illness and associated risks and availability of treatment.

44. CRHTT provide more intensive community input with regular home visits and delivery of biopsychosocial interventions. They are described as an alternative to hospital. Pathways in and out of hospital typically involve CRHTT. For example, as the intensity of care is escalated, some individuals will go from community services (e.g.,EIP/ CMHT) to CRHTT. If they do not sufficiently improve or further deteriorate, they will then go to hospital. When sufficiently improved, they may be transferred from the hospital back to CRHTT for more

intensive input, and then when further improved, go back to community services (e.g., EIP/ CMHT).

45. Some individuals may not use CRHTT as it may not work for them or they may not wish to do so. Focus on reducing length of stay and early discharge from hospital means that CRHTT is increasingly a part of an individual's care pathway, as it permits earlier discharge when an individual is not fully recovered. The aim is also to reduce the use of more restrictive inpatient settings for care.

Ongoing care

46. EIP services usually support individuals for three years, but can offer support for longer if needed on a case by case basis. As described above, an individual's care pathway after accessing EIP services will vary according to their needs.

47. Primary care is used for those in remission, where their needs can be supported in that setting. There is, however, national variation in what care is offered in primary care for individuals with schizophrenia, including whether or not GPs will prescribe and oversee long-acting injection medication. Some do; some do not. Primary care does not prescribe clozapine, so those taking this medication cannot currently fully return to primary care.

48. Secondary care general adult mental health services (usually CMHTs) provide ongoing support and interventions for individuals who are not in remission or who still have active biopsychosocial needs best met through secondary mental health care.

49. Rehabilitation services can be accessed through secondary care community mental health services. They provide care for individuals with longer term needs, often associated with treatment resistance and for those who require support with goals around recovery. They work closely with social care and housing services, as they seek to promote the highest level of independent living possible for the individual. Clinical guidance on rehabilitation services is well-established **[NHSE0002385]** and is also the subject of current improvement efforts to eliminate outdated models of care and improve commissioning of these services **[NHSE0000521]**.

50. Some individuals who do not think they are well (due to the nature of their illness) and/or due to other social factors (including commonly homelessness and substance use), do not wish to or do not engage with community mental health services. Assertive outreach teams (AOTs) were a response to these populations and the need to provide more assertive care (see paragraphs 317 to 329 above).

51. The aim of these services was to provide additional, more intensive and assertive support to individuals who: were at risk of social exclusion, were not engaging with community mental health services and/ or were frequently deteriorating, such that they needed higher levels of crisis and inpatient care.

52. The methods used by these teams are similar to those described in the section on EIP engagement techniques (above) and focus on key principles of providing intensive, persistent engagement, small caseloads and multidisciplinary support.

53. Overall, due to the relapsing and remitting nature of these conditions, individuals may have periods of time in various care settings and move between them according to their illness and overall needs.

Continuity of care and care transitions

54. Due to the variability and changing nature of care needs associated with a long term relapsing and remitting condition like schizophrenia, access to a comprehensive array of services (e.g., acute through to mental health care rehabilitation, physical health, social care, substance misuse, housing, welfare, employment services etc.) may be needed over the course of an individual's life. Clinical guidance and standards all emphasize the importance of multidisciplinary and multiagency working for individuals living with psychosis.

55. Continuity of care and coordination across providers, care agencies and care pathways is required, but can be challenging for many reasons. This can include, for example, lack of interoperable clinical or care notes systems, the individual moving (or being moved) between different locations and, relatedly, local authorities and mental healthcare providers, and different practices and ways of working across agencies and providers. Each transition or interface requires close working across service or organisational boundaries. Clinical guidelines and quality standards outline what gold standard management of transfers, transitions and multiagency working looks like **[NHSE0000539] [NHSE0000538] [NHSE0000540] [NHSE0002301] [NHSE0002386] [NHSE0002302] [NHSE0002308]**.

<u>Care Programme Approach</u>

56. Continuity of care has been shown to be important to improving outcomes in schizophrenia **[NHSE0002300]**. Allocation of a named person or care coordinator has been the key mechanism used to enable both the development of a therapeutic alliance and continuity of care across care settings and phases of illness. This has been the focus of the CPA since its inception in 1991 (see paragraphs 313 to 316 above). A 2019 policy around community transformation introduced the Community Mental Health Framework for Adults and Older Adults **[NHSE0000015]**. It sought to address some limitations and unintended consequences arising from how the CPA had been implemented **[NHSE0000252]**. In practice, subsequent to this policy change there has been variation in how continuity is managed, both through the CPA and the allocation of designated care coordinators or named workers. Staff vacancy and turnover rates, pathway and service reconfigurations, commissioning patterns and resource and treatment gaps in practice add to challenges of ensuring continuity of care and smooth transitions.

Students

57. Individuals who face homelessness, individuals being discharged from prison and students are some of the populations who require particular attention and care around transitions, including where their care is to be delivered and by whom. Housing availability can particularly impact on care continuity.

58. Students are in a population group who, because of their age, may encounter a first episode of psychosis during their time at university, which is a time when they may be moving between different locations and require particular attention

due to inevitable transitions and breaks in continuity where care is being delivered.

59. University mental health services are variable and usually not designed nor equipped to respond to serious mental illness (e.g., schizophrenia and BPAD). Care for these conditions remains with secondary care mental health services, in the locality of the university when the individual is there and in the home locality when the individual returns during holidays etc.

60. Liaison and co-working with student mental health services will be required according to the individual's needs and presentation. Carefully managed transfers require information sharing on risk and care plans and transition co-working between the individual's home and university community mental health services. These areas of care are specified in established clinical guidelines and standards.

Risk management

61. Other important areas of multiagency working relate to risk management. This may include safeguarding **[NHSE0002382]**, use of Multi Agency Risk Assessment Conferences (MARAC) and also Multi Agency Public Protection Arrangements (MAPPA) **[NHSE0002321]**.

Criminal justice pathways

62. Additional care may come through the criminal justice pathway where an individual has been arrested for a crime.

63. Liaison and diversion mental health teams are located in criminal justice pathways to support the identification and management of mental ill health and to facilitate access to appropriate mental health care. That may be through diversion back to community mental health care pathways, into forensic mental healthcare inpatient settings or into the prison system. This will vary according to the individual's presentation, the nature of the crime and its relationship to the mental disorder. Whether an individual is charged with and/ or convicted for a crime will impact on these pathways.

64. During the Relevant Period, VC was not being cared for through a criminal justice pathway.

ANNEX 5

Data Protection Background

1. The GDPR imposes a range of obligations on 'data controllers' in relation to the way in which they handle and use 'personal data'.

2. A data controller is the entity that makes the substantive decisions about, amongst other things, what personal data is to be used for.

3. Personal data is any information from which a living individual can be identified and otherwise concerns or relates to them. In addition, any data concerning an individual's health is 'special category data' under the GDPR.

4. One of the key obligations on data controllers under the GDPR is that any use, including publication, of personal data must be 'lawful'. This means that it must satisfy one of the 'lawful bases' set out in Article 6 GDPR, and where that data is also special category, one of the lawful bases set out in Article 9 GDPR must also be satisfied.

5. The lawful bases under Articles 6 and 9 UK GDPR include the consent of the individual to whom the data relates for the data to be used in the manner proposed. Consent is not, however, the only lawful basis. There are others which would, in effect, legitimise the use of personal data where it is necessary in connection with NHS England's statutory functions. This is further discussed below in the context of the legal advice received from NHS England on this issue.

6. In addition to the GDPR, the common law duty of confidentiality imposes further obligations that NHS England (or any other data controller) must consider.

7. A duty of confidence arises in respect of information relating to an individual's health and treatment on the basis that they would reasonably expect it to remain confidential. That duty is not sacrosanct in the sense that it can be overridden in certain circumstances, including implied consent if the use of patient information relates to their ongoing care and treatment, explicit consent for other uses of data, a legal obligation such as a statutory duty or court order and an overriding public interest. In the absence of consent, an overriding public interest is the only lawful basis that would satisfy the common law requirements.

8. NHS England (or any data controller) must operate within the legal framework when deciding how to use personal data/special category data (health data) contained within IPSIs. In particular, it must assess on a case-by-case basis whether an individual IPSI can be published by reference to the lawful bases and potential legal justifications outlined above. This includes an assessment of the extent to which it would serve the public interest to put personal data into the public domain. This in turn depends on the nature and volume of that personal data and in particular the extent of special category data i.e., does it contain significant amounts of information and detail concerning a person's medical history and if so, is it necessary to put that into the public domain.

Index to Witness Statement

No.	Inquiry URN	Document Description
1.	NHSE0000378	Policy document RE: Operating framework for NHS England, by NHS England
2.	NHSE0000516	Policy document RE: Regional Governance Framework, by NHS England Midlands
3.	NHSE0000309	Agreement between: Care Quality Commission and NHS Commissioning Board, January 2013 (re: CQC/NHS CB working relationship)
4.	NHSE0000544	Guidance, Re: Sharing information with the police, NHS Transformation Directorate [Web Page]
5.	NHSE0000014	Report dated 20/08/2019, compiled by NHS Re: The NHS Long Term Plan v1.2
6.	NHSE0000542	Policy Document, Re: Development Plan, Nottingham & Nottinghamshire Integrated Care System
7.	NHSE0000541	Memorandum of understanding compiled by NHS England & NHS improvement and Nottingham and Nottinghamshire integrated care system RE: for oversight arrangements 01/07/2021
8.	NHSE0000376	Policy document Re: Memorandum of Understanding Nottingham and Nottinghamshire Integrated Care Board and NHS England, by Nottingham and Nottinghamshire ICB

9.	NHSE0000455	Letter from Julie Grant to Kathy McLean RE: Annual assessment of Nottingham and Nottinghamshire Integrated Care Board's performance in 2023/24 [Assessment enclosed]
10.	NHSE0002290	Report dated [unknown], compiled by Tom Kark QC and Jane Russell Re: A review of the Fit and Proper Person Test.
11.	NHSE0000519	Policy document, RE: NHS England Fit and Proper Person Test Framework for board members, NHSE
12.	NHSE0002363	Report dated 02/08/2023, Compiled by NHSE, Re: Appendix 1: Recommendations from the Kark Review (2019)
13.	NHSE0002309	Policy document, re: Appendix 2: The board member reference template, by [unknown]
14.	NHSE0002328	Appendix 3: New starter/annual NHS FPPT self-attestation Form, NHS England (Blank)
15.	NHSE0002313	Policy document, Re: Appendix 4: Letter of confirmation, by NHSE
16.	NHSE0002335	Appendix 5: NHS FPPT submission reporting template form of NHS England (blank)
17.	NHSE0002314	Policy document, re: Appendix 6: Template Board Member FPPT Privacy Notice, by NHSE
18.	NHSE0002315	Policy document, Re: Appendix 7: FPPT checklist, by NHSE

19.	NHSE0002364	Report datetd 02/08/2023, Compiled by NHSE, Re: Appendix 8: Future considerations for the Fit and Proper Person Test Framework
20.	NHSE0002365	Policy Document, Re: Fit and proper person test: frequently asked questions, NHSE
21.	NHSE0002356	Report dated 28/02/2024, Compiled by Dr Navina Evans CBE, Re: Leadership competency framework for board members.
22.	NHSE0002357	Report dated 28/02/2024, Compiled by NHSE, Re: NHS leadership competency framework for board members
23.	NHSE0002358	Report dated 21/03/2024, Compiled by NHSE, Re: Framework for conducting annual appraisals of NHS chairs (CAF)
24.	NHSE0002360	Policy Document, Re: New board member appraisal framework with submission dates, NHSE
25.	NHSE0002359	Guidance, Re: Board member appraisal guidance, NHSE
26.	NHSE0002362	Report dated 21/07/2025, Compiled by Departments of Health and Social Care, Re: Leading the NHS: proposals to regulate NHS managers
27.	NHSE0002361	Report dated 08/06/2022, Compiled by Departments of Health and Social Care, Re: Independent report- Leadership for a collaborative and inclusive future
28.	NHSE0002387	Policy Document, Re: NHS Management and leadership programme (Webpage), NHSE

29.	NHSE0002282	Report, dated 11/02/2015, compiled by Sir Robert Francis QC, re: Freedom to Speak Up - An independent review into creating an open and honest reporting culture in the NHS
30.	NHSE0002283	Letter from David Bennett to NHS Managers and NHS Foundation Trusts Re: "Freedom to Speak Up", the review
31.	NHSE0002366	Policy document,, Re: External freedom to speak up policy for NHS workers, NHSE
32.	NHSE0002306	Guidance Re: Freedom to Speak Up policy for the NHS, NHS
33.	NHSE0002303	Policy Document Re: Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services, NHS England
34.	NHSE0002304	Guidance Re: Freedom to Speak up, A reflection and planning tool, NHS, National Guardian freedom to speak
35.	NHSE0002296	Policy Document Re: People Promise, NHS
36.	NHSE0002368	Guidance document, Re: The insightful provider board, NHSE
37.	NHSE0002367	Guidance document, Re: The insightful provider board – supporting guidance, NHSE
38.	NHSE0002369	Guidance document, Re: The insightful ICB board, NHSE

49.	NHNB0018961	Policy Document, re: NHS Oversight Framework, by NHS
40.	NHSE0000517	Policy document compiled by Health England RE: Publication of the NHS Oversight Framework 2025/26 dated 26/06/2025
41.	NHSE0000518	Policy document, RE: NHS Oversight Framework 2025/26, NHSE
42.	NHSE0000389	Policy document compiled by NHS England RE: NHS Provider Licence Standard Conditions 31/03/2023
43.	NHSE0000311	Policy Document, Re: Nottinghamshire Healthcare NHS Foundation Trust, Standard Licence Conditions, Licence Number: 120155, Monitor
44.	NHSE0000416	Policy document, RE: NHS enforcement guidance, NHSE
45.	NHSE0000537	Policy document compiled by CQC RE: Holding providers and individuals to account undated
46.	NHSE0000388	Policy document compiled by NHS England RE:NHS Standard Contract 2023/24Particulars (Full Length)Contract title dated 01/03/2023
47.	NHSE0000390	Policy document RE: NHS Standard Contract 2023/24 General Conditions (Full Length) by NHS England
48.	NHSE0000392	Policy document RE: NHS Standard Contract 2023/24 Service Conditions (Full Length), by NHS Standard Contract Team, NHSE
49.	NHSE0002311	Policy Document, Re: Saying Sorry, NHS

50.	NHSE0002334	Guidance, Re: Professional standards - Openness and honesty when things go wrong: The professional duty of candour, Nursing & Midwifery Council
51.	NHSE0000013	Policy document, Re: NHS Mental Health Implementation Plan 2019/20 - 2023/24, NHS
52.	NHSE0000357	Guidance RE: Working together at scale guidance on provider collaboratives August 2021, by NHS England and NHS Improvement
53.	NHSE0000410	Policy document compiled by NHS England RE:NHS Emergency Preparedness Resilience and Response Framework dated 01/07/2022
54.	NHSE0000379	Policy document RE: Incident Response Plan (National), by NHS England
55.	NHSE0000499	Policy document RE: NHS emergency preparedness, resilience and response exercise programme 2024 to 2030 by NHSE
56.	NHSE0000405	Policy document Re: NHS Nottingham and Nottinghamshire Local Resilience Forum Representation Agreement, NHSE Midlands
57.	NHSE0000312	Policy document dated 01/01/2015 compiled by Department of Health RE: Mental Health Act 1983: Code of Practice
58.	NHSE0000343	Policy document RE: Mental Capacity Act 2005 Code of Practise, by DHSC

69.	NHSE0000313	Policy document, RE:FIVE YEAR FORWARD VIEW by NHS England
60.	NHSE0000002	Report compiled by the independent Mental Health Taskforce to the NHS in England Re: The five year forward view for mental health
61.	NHSE0000003	Report compiled by the NHS Re: Implementing the five year forward view for mental health
62.	NHSE0000317	Report dated 01/07/2017, compiled by Health Education England, re: Stepping forward to 2020/21: The mental health workforce plan for England, July 2017 (intended to support the Five Year Forward View for Mental Health)
63.	NHSE0002280	Guidance, re: Everyone Counts: Planning for Patients 2014/15 to 2018/19, NHS England
64.	NHSE0002281	Report undated, compiled by NHS Re: THE FORWARD VIEW INTO ACTION: PLANNING FOR 2015/16
65.	NHSE0002284	Guidance, Re: Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21, NHS
66.	NHSE0002285	Guidance, Re: NHS Operational Planning and Contracting Guidance 2017 - 2019, NHSE
67.	NHSE0002288	Guidance Re: NHS Operational Planning and Contracting Guidance 2019/20, NHS
68.	NHSE0002297	Policy Document Re: 2021/22 priorities and operational planning guidance: October 2021 to March 2022, NHS
69.	NHSE0002299	Policy Document Re: 2022/23 priorities and operational planning guidance, NHS

70.	NHSE0002307	[Policy Document/Guidance], Re:[2023/24 priorities and operational planning guidance], [NHSE]
71.	NHSE0002320	Guidance Document, Re: 2024/25 priorities and operational planning guidance, NHSE
72.	NHSE0002332	Guidance, Re: 2025/26 priorities and operational planning guidance, NHSE
73.	NHSE0000486	Policy document, RE: Mental Health: Expected Spend Volume 747, UK Parliament
74.	NHSE0002341	Policy document, Re: Mental Health: Expected Spend for 2025-26, by Wes Streeting [SoS for Health and Social Care]
75.	NHSE0000015	Policy document, re: The Community Mental Health Framework for Adults and Older Adults, National Collaborating Centre for Mental Health, NHS
76.	NHSE0000543	Policy Document, Re: Comprehensive model of personalised care, NHS England [Web page]
77.	NHSE0000318	Guidance, Re: Comprehensive Personalised Care Model
78.	NHSE0000514	Report dated 22//12/2023, compiled by NHS England, re: Workforce development framework for care co-ordinators
79.	NHSE0000548	Report dated 01/05/2024 by Health Innovation Network RE: Mental Health Safety Improvement Programme, end of programme report
80.	NHSE0000520	Guidance, re: Commissioning framework for mental health inpatient services, NHSE [Web page]

81.	NHSE0000521	Guidance, Re: Commissioner guidance from adult mental health rehabilitation inpatient services, NHS England [Web page]
82.	NHSE0000035	Policy Document RE: Culture of care standards for mental health inpatient services, NHS England
83.	NHSE0000483	Report undated, compiled by Louis Appleby, Nav Kapur, Pauline Turnbull and others re: National Confidential Inquiry into suicide and safety in mental health
84.	NHSE0000467	Report dated [unknown] compiled by The University of Manchester Re: Homicide and Mental Illness in England National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) Proposed variation to HQIP contract NCA 802205063
85.	NHSE0000526	Policy document RE: Design of the programme, by RCPS
86.	NHSE0000115	Policy Document. Re: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time, National Quality Board.
87.	NHSE0000145	Policy Document. Re: Safe, sustainable and productive staffing. An improvement resource for mental health, National Quality Board, NHSI
88.	NHSE0000369	Guidance Re: National Guidance on Quality Risk Response and Escalation in Integrated Care Systems, by National Quality Board

89.	NHSE0000296	Report dated April 2022 compiled by Dr Sridevi Kalidindi. Re: Mental Health Rehabilitation, GIRFT Programme National Specialty Report
90.	NHSE0000223	Report dated April 2021, compiled by Dr Ian Davidson RE: Mental Health - Adult Crisis and Acute Care
91.	NHSE0000029	Letter from Lesley Watts [NHSE], Claire Murdoch [NHSE] and Dr Amanda Doyle [NHSE] to ICB chief executives and CEs of local authorities, re: Discharge Challenge for Mental Health and Community Services providers
92.	NHSE0000515	Policy document, Re: Acute inpatient mental health care for adults and older adults, NHS England
93.	NHSE0000104	Policy Document. Re: Mental Health Staffing Framework, Health Education West Midlands and NHS England
94.	NHSE0000101	Policy Guidance. Re: Guideline scope Safe staffing for nursing in inpatient mental health settings, National Institute for Health and Care Excellence.
95.	NHSE0000019	Report dated September 2020, complied by NHS Re: Advancing mental health equalities strategy
96.	NHSE0000485	Guidance Re: Patient and carer race equality framework, NHS England
97.	NHSE0000538	Policy document RE: Psychosis and schizophrenia in adults, by National Institute for Health and Care Excellence

98.	NHSE0000088	Policy Document. Re: Achieving Better Access to Mental Health Services by 2020, Department of Health and NHS England
99.	NHSE0000539	Policy document RE: Psychosis and schizophrenia in adults, by National Institute for Health and Care Excellence
100.	NHSE0000315	Guidance, Re: Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance, NHS England, the National Collaborating Centre for Mental Health and the National Institute for Health and Care Excellence
101.	NHSE0000032	Policy Document RE: Implementing the early intervention in psychosis access and waiting time standard, NHS England
102.	WITN0310002	National Clinical Audit of Psychosis, About Page [website]
103.	NHSE0000380	Policy document, RE: Early Intervention in Psychosis Scoring Matrix 2023, Royal College of Psychiatrists
104.	NHSE0000323	Report dated 01/01/2018 compiled by The National Clinical Audit of Psychosis Implementation Group Re: National report for the Early Intervention in Psychosis Spotlight Audit 2018/2019
105.	RCPS0000008	Report dated 2019/2020, compiled by the National Audit of Psychosis Project Team, re: National Clinical Audit of Psychosis, Early Intervention in Psychosis Audit, National Report 2019/2020

106.	NHSE0000354	Report dated [unknown] compiled by National Clinical Audit of Psychosis, Re: National Report Early Intervention in Psychosis Audit 2020/2021
107.	RCPS0000028	Report dated 2021/22 compiled by The National Clinical Audit of Psychosis project team, Re: National report for England Early Intervention in Psychosis Audit
108.	RCPS0000029	Report dated 02/2025, compiled by the NCAP Project Team, re: State of the Nation Report 2024, Audit of Early Intervention in Psychosis Provision in England and Wales in 2022/23 and 2023/24
109.	NHSE0000252	Policy Document. Re: Care Programme Approach NHS England position statement, NHSE
110.	NHSE0000527	Guidance RE: Guidance on intensive and assertive community mental health treatment compiled by NHSE
111.	NHSE0000046	Guidance RE: Guidance to integrated care boards on intensive and assertive community mental health care, NHSE
112.	NHSE0000462	Report undated, compiled by Tracey Gilford Re: Intensive and assertive Community Mental Health treatment: ICB review outcome template
113.	NHFT0004006	Report dated 01/02/2025, compiled by NHS England Midlands Re: Regional Summary of Midlands ICB Community Mental Health Review - Maturity Index Returns Nottinghamshire ICB Benchmarking Report

114.	NHSE0000497	Minute of Meeting RE: Public Board of Directors Meeting compiled by NHFT dated 29/05/2025
115.	NHSE0000525	Guidance, Re: Out of Area Placements (OAPs), NHS England
116.	NHSE0000536	Guidance RE: Emergency and acute medical care in over 16s: service delivery and organisation by NICE
117.	NHSE0000540	Policy document Re: Transition between inpatient mental health settings and community or care home settings, NICE guideline, National Institute for Health and Care Excellence
118.	NHSE0000304	Guidance RE: Hospital discharge and community support guidance, by NHS England and DHSC
119.	NHSE0000306	Guidance RE: Hospital discharge and community support: staff action cards (all roles), by DHSC
120.	NHSE0000513	Guidance Re: Hospital discharge and community support guidance, Gov.UK
121.	NHSE0000305	Guidance, Re: Discharge from mental health inpatient settings, Gov.UK Department of Health & Social Care
122.	NHSE0000338	Guidance RE: 72 hour follow up post discharge from mental health inpatient care - Guidance to support changes to the NHS Standard Contract 2020/21, by NHS England and NHS Improvement
123.	NHSE0000391	Policy document compiled by Emergency Care Improvement Support Team RE: Multi Agency Discharge

		Events (MADEs) for Adult and Older Adult Acute Mental Health Inpatient Beds Guidance dated 01/03/2023
124.	NHSE0000547	Policy document RE: Choosing how to consult with your secondary care patients undated, by Nuffield Department of Primary Care Health Sciences
125.	NHSE0000333	Guidance Re: Clinical guide for the management of remote consultations and remote working in secondary care during the coronavirus pandemic, NHS England and NHS Improvement
126.	NHSE0000549	Policy document RE: Mental health, learning disabilities and autism: Guidance, by NHS England
127.	NHSE0000336	Report dated [unknown] compiled by NHS RE: Getting NHS help when you need it during the coronavirus outbreak
128.	NHSE0000501	Guidance, Re: Patient carer and family engagement and communication during the coronavirus (COVID-19) pandemic, NHSE [Web page]
129.	NHSE0000500	Policy document RE: Managing demand and capacity across MH and LD, by NHS England
130.	NHSE0000524	Policy Document RE: Fit for the Future: 10 Year Health Plan for England, UK Government, NHS
131.	WITN0155002	Medium Term Planning Framework, NHS England
132.	NHSE0000502	Report dated 06/06/2025, RE: The NHS Patient Safety Strategy, NHS England

133.	NHSE0000058	Policy document, re: Serious Incident Framework, NHS England Patient Safety Domain
134.	NHSE0000314	Policy document dated 01/11/2015 compiled by Department of Health November 2015 RE: Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services
135.	NHSE0000054	Policy Guidance re: Patient Safety Incident Response Framework [NHSE] - Copy of NHSE webpage
136.	NHSE0000038	Policy Document RE: Working in partnership with people and communities: Statutory guidance, NHS England
137.	NHSE0000026	Guidance Re: Patient Safety Incident Response, Framework supporting guidance, Engaging and involving patients, families and staff following a patient safety incident, NHSE
138.	NHSE0000490	Policy document RE: Patient Safety Incident Response Framework supporting guidance Guide to responding proportionately to patient safety incidents, NHSE
139.	NHSE0000443	Policy document, RE: Appendix Two Types and levels of investigations National independent patient safety investigations toolkit by NHS England National Patient Safety Independent Investigations Team

140.	NHSE0000457	Report document dated 01/06/2019 compiled by Mette Vognsen RE: Terms of Reference Midlands Independent Investigations Review Group August 2020
141.	NHSE0000414	Policy document, RE: Fitness to Practice and Professional Regulatory Body Referrals, by National Patient Safety Independent Investigations Team
142.	NHSE0000523	Policy document, RE: Being Fair Tool, NHSE
143.	NHSE0000494	Policy Document, Re: Being fair tool: Supporting staff following a patient safety incident, NHS England
144.	NHSE0000028	Patient Safety Incident Response Framework supporting guidance: Oversight roles and responsibilities, version 1, August 2022
145.	NHSE0002383	Report dated 28/02/2020, Compiled by: Mills & Reeve, Re: NHS England Advice in relation to Publication of Homicide Reviews 28 February 2020
146.	NHSE0002292	Report dated October 2020, compiled by Julian Hendy (Lay member IIGC) Re: Draft Response to Mills and Reeve letter on Publication of Independent Investigations following Patient Homicides.
147.	NHSE0002310	Legal Advice Report, dated September 2023, compiled by Philippa Doyle, Re: GDPR Considerations to Apply in Relation to Mental Health Homicide Inquiries
148.	NHSE0002378	Report dated 06/11/2023, Compiled by Hempsons Solicitors LLP, Re: Legal Advice for Publication

149.	NHSE0002312	Minute of meeting re: Independent Investigations Committee, dated 20/11/2023
150.	NHSE0002317	Legal Advice Report, dated January 2024, compiled by Philippa Doyle, re: GDPR Considerations to Apply in relation to Mental Health Homicide Inquiries - Annex addressing additional question
151.	NHSE0002322	Policy Document, Re: Independent Investigations Publication Practice Review Working Group - Terms of Reference, NHSE
152.	NHSE0002324	Report dated unknown, compiled by NHS England Re: Publication Practice Review Working Group (PPRWG) Membership
153.	NHSE0002319	Policy Document, Re: Independent Investigations Publication Practice Review Working Group - Heads of Terms, NHSE
154.	NHSE0002323	Report dated unknown, compiled by Heenal (unknown surname or Org) Re: Publication Practice Review Working Group
155.	NHSE0002325	Notes by unknown, Re: Query Raised and Response (legal)
156.	NHSE0002326	Email from Heenal Ghedia [Home Office] to NPSIIT [NHS England] Re: Action 14 response.
157.	NHSE0002327	Minute of Meeting Re: Publication Practice Working Group dated 04/06/2024

158.	NHSE0002329	Letter from ICO to [unknown] Re: Independent Investigations Publication Review Working Group
159.	NHSE0002370	Minutes of meeting, Re: Publication Practice Working Group, dated 07/05/2024
160.	NHSE0002371	Minutes of meeting, Re: Publication Practice Working Group, dated 02/04/2024
161.	NHSE0002372	Minutes of meeting, Re: Publication Practice Working Group, dated 17/07/2024
162.	NHSE0002379	Report dated 09/05/2024, Compiled by Meg Kay, Re: Publication Practice Review Working Group – Update
163.	NHSE0002380	Report dated 27/08/2024, Compiled by Meg Kay, Re: Publication Practice Review Working Group Update
164.	WITN0310003	Publication Practice Review Working Group, Action 7 – Organisation vs individual GDPR liabilities
165.	WITN0310004	Publication Practice Working Group: Independent Patient Safety Investigation Definition and Purpose
166.	NHSE0002291	Minute of Meeting Re: Independent Investigation Governance Committee (IIGC) dated 29/07/2020
167.	NHSE0002293	Minute of Meeting Re: Independent Investigation Governance Committee (IIGC), dated 09/10/2020
168.	NHSE0002294	Minute of Meeting Re: Independent Investigation Governance Committee (IICG), dated 12/01/2021
169.	NHSE0002295	Minute of Meeting Re: Independent Investigation Governance Committee (IIGC), dated 20/04/2021

170.	NHSE0002340	Minute of meeting, Re: Independent Investigation Governance Committee Workshop, dated 27/09/2020
171.	NHSE0002342	Minute of meeting re: Independent Investigation Governance Committee, dated 13th July [unknown year]
172.	NHSE0002343	Minute of meeting re: Independent Investigation Governance Committee dated 06/06/2019
173.	NHSE0002345	Minute of meeting re: Independent Investigation and Governance Committee, dated 13/12/2021
174.	NHSE0002346	Minute of meeting re: Independent Investigation Governance Committee (IIGC), dated 12/10/2021
175.	NHSE0000326	Report dated 01/10/2018 compiled by Professor Hilary McCallion CBE RE: An independent review of the Independent Investigations for Mental Health Homicides in England (published and unpublished) from 2013 to the present day Section One Executive Summary
176.	NHSE0000200	Report document dated 01/07/2020 compiled by NHS RE: Independent Investigations 2018-19 Annual Report
177.	NHSE0000233	Report dated 01/12/2021, compiled by NHS, Re: Independent Investigations 2019/21 Annual Report
178.	NHSE0002347	Minute of meeting, Re: Independent Investigation Governance Committee (IIGC) Annual Report Sign off meeting, dated 1st September [Year Unknown]
179.	NHSE0002348	Guidance document, Re: Patient safety healthcare inequalities reduction framework, NHSE

180.	NHSE0000394	Guidance RE: FRAMEWORK KEY Facts Independent Investigations Information valid between 16/12/2022 - 15/12/2023 by NHS East of England NHS Collaborative Procurement Hub
181.	NHSE0000546	Policy document, RE: Independent Investigations Contract Award Notice, by NHS England
182.	NHSE0000488	Report dated [unknown], compiled by Adrian Fowler, re: National Independent Patient Safety Investigations (IPSI) Update [For Quality and Performance Committee to be held on 25/03/2025, NHSE.]
183.	NHSE0000492	Terms of Reference for Mental Health Patient Safety Insight Group (NHSE)
184.	NHSE0000489	Policy document compiled by Unknown RE: FOI Response dated undated
185.	NHSE0000464	Report dated [unknown] compiled by [unknown] Re: FOI Received
186.	NHSE0000465	Report dated [unknown], compiled by [unknown] re FOI Received
187.	NHSE0000476	Report dated [unknown], compiled by [unknown], Re: FOI Response
188.	NHSE0002355	Email from FOICRM (NHSE) to Julian Hendy, Re: Request under the Freedom of Information Act 2000 Ref: FOI - 2311-2045609 NHSE:0797010
189.	NHSE0000528	Policy document RE: Review of patient safety across the health and care landscape by Department of Health & Social Care

190.	NHSE0000193	Report document dated 01/06/2020 compiled by NHS RE:NHS Mental Health Dashboard June 2020
191.	NHSE0000195	Report document dated 01/12/2019 compiled by NHS RE:NHS Mental Health Dashboard December 2020
192.	NHSE0000197	Report document dated 01/02/2020 compiled by NHS RE: NHS Mental Health Dashboard
193.	NHSE0000209	Report dated 01/12/2020 compiled by NHS England RE: NHS Mental Health Dashboard
194.	NHSE0000211	Report dated 01/05/2021, compiled by NHS Re: NHS Mental Health Dashboard
195.	NHSE0000212	Report dated 01/03/2021, compiled by NHS Re: NHS Mental Health Dashboard
196.	NHSE0000213	Report, dated May 2021, compiled by NHSE, Re: NHS Mental Health Dashboard for Quarter 3 2020/21
197.	NHSE0000227	Report, dated November 2021 compiled by NHS, Re: NHS Mental Health Dashboard (re-publication) Quarter 4 2020-21
198.	NHSE0000241	Report, dated February 2022, compiled by NHSE. Re: NHS Mental Health Dashboard for Quarter 2 2021/22
199.	NHSE0000245	Report, dated May 2022, compiled by NHSE. Re: NHS Mental Health Dashboard for Quarter 3 2021/22
200.	NHSE0000263	Draft Report, dated November 2022, compiled by NHSE, Re: NHS Mental Health Dashboard Quarter 1 2022/23
201.	NHSE0000270	Draft Report, dated February 2023, compiled by NHSE, Re: NHS Mental Health Dashboard Quarter 2 2022/23

202.	NHSE0000275	Report, dated May 2023, compiled by NHSE, Re: NHS Mental Health Dashboard Quarter 3 2022/23
203.	NHSE0000282	Report, dated August 2023, compiled by NHSE, re: NHS Mental Health Dashboard Quarter 4 2022/23
204.	NHSE0000284	DRAFT Report, dated November 2023, compiled by NHSE, re: NHS Mental Health Dashboard Quarter 1 2023/24
205.	NHSE0000285	Report, dated February 2024, compiled by NHSE, re: NHS Mental Health Dashboard Quarter 2 2023/24
206.	NHSE0000286	Report, dated April 2024, compiled by NHSE, re: NHS Mental Health Dashboard Quarter 3 2023/24
207.	NHSE0000290	Report, dated August 2024, compiled by NHSE. Re: NHS Mental Health Dashboard. Period: Quarter 4 2023/24
208.	NHSE0000183	Report dated 29/10/2019 compiled by NHS Digital RE: Mental Health Act Statistics, Annual Figures 2018-19
209.	NHSE0000203	Report dated 27/10/2020 compiled by NHS Digital RE: Mental Health Act Statistics, Annual Figures 2019-2020
210.	NHSE0000229	Report dated 26/10/2021, compiled by Community and Mental Health Analysis Team, NHS Digital, Re: Mental health act statistics, annual figures 2020-2021
211.	NHSE0000291	Report, dated 27/10/2022, compiled by National Statistics, NHS Digital . Re: Mental Health Act Statistics, Annual Figures 2021-22
212.	NHSE0000292	Report, dated 12/09/2024, compiled by NHS Digital, NHS England. Re: Mental Health Act Statistics, Annual Figures 2023-24

213.	NHSE0000293	Report, dated 25/01/2024, compiled by NHS Digital, NHS England.. Re: Mental Health Act Statistics, Annual Figures 2022-23
214.	NHSE0000452	Policy Document, Re: Development Plan, Nottingham & Nottinghamshire Integrated Care System
215.	NHSE0000319	Policy document, Re: Out of Area Placements in Mental Health Services, NHS Digital
216.	NHSE0000320	Report dated 09/05/2019 compiled by NHS England RE: Out of Area Placements in Mental Health Services February 2019
217.	NHSE0000321	Report dated 13/06/2019 compiled by NHS England RE: Out of Area Placements in Mental Health Services March 2019
218.	NHSE0000322	Policy document dated 08/08/2019 compiled by NHS England RE: Out of Area Placements in Mental Health Services May 2019
219.	NHSE0000324	Policy document dated 12/09/2019 compiled by NHS England RE: Out of Area Placements in Mental Health Services June 2019
220.	NHSE0000325	Report dated 10/10/2019 compiled by NHS England RE: Out of Area Placements in Mental Health Services July 2019
221.	NHSE0000327	Report dated 14/11/2019 compiled by NHS England RE: Out of Area Placements in Mental Health Services August 2019

222.	NHSE0000328	Policy document, RE: Out of Area Placements in Mental Health Services September 2019, NHS
223.	NHSE0000329	Policy document, Re: Out of Area Placements in Mental Health Services, NHS Digital
224.	NHSE0000330	Report dated 09/01/2020 compiled by NHS England RE: Out of Area Placements in Mental Health Services October 2019
225.	NHSE0000331	Policy document, RE: Out of Area Placements in Mental Health Services November 2019, NHSE.
226.	NHSE0000332	Policy document dated 12/03/2020 compiled by NHS England RE: Out of Area Placements in Mental Health Services December 2019
227.	NHSE0000334	Report dated 09/04/2020 compiled by NHS, Re: Out of Area Placements in Mental Health Services
228.	NHSE0000335	Report, dated 14/05/2020, compiled by NHS Digital, Re: Out of Area Placements in Mental Health Services for February 2020
229.	NHSE0000337	Report, dated 11/06/2020 compiled by NHS, Re: Our of Area Placements in Mental Health Services
230.	NHSE0000339	Report dated 13/08/2020 compiled by NHS Digital RE: Out of Area Placements in Mental Health Services May 2020
231.	NHSE0000340	Report, dated 09/07/2020 compiled by NHS, Re: Our of Area Placements in Mental Health Services

232.	NHSE0000341	Report, dated 10/09/2020 compiled by NHS, Re: Out of Area Placements in Mental Health Services, June 2020
233.	NHSE0000344	Report, dated 08/10/2020 compiled by NHS, Re: Out of Area Placements in Mental Health Services, July 2020
234.	NHSE0000345	Report, dated 12/11/2020 compiled by NHS, Re: Out of Area Placements in Mental Health Services, August 2020
235.	NHSE0000346	Report, dated 10/12/2020 compiled by NHS, Re: Out of Area Placements in Mental Health Services, September 2020
236.	NHSE0000347	Report, dated 14/01/2020 compiled by NHS, Re: Out of Area Placements in Mental Health Services, October 2020
237.	NHSE0000348	Report, dated 11/02/2021 compiled by NHS, Re: Out of Area Placements in Mental Health Services, November 2020
238.	NHSE0000350	Report, dated 11/03/2020 compiled by NHS, Re: Out of Area Placements in Mental Health Services, December 2020
239.	NHSE0000351	Report, dated 08/04/2021 compiled by NHS, Re: Out of Area Placements in Mental Health Services
240.	NHSE0000352	Report, dated 13/05/2021 compiled by NHS, Re: Our of Area Placements in Mental Health Services
241.	NHSE0000353	Report dated 10/06/2021, compiled by NHS Digital, Re: Out of Area Placements in Mental Health Services

242.	NHSE0000355	Report, dated 08/07/2021 compiled by NHS Digital, Re: Out of Area Placements in Mental Health Services, April 2021
243.	NHSE0000356	Report, dated 01/05/2021 compiled by NHS Digital, Re: Out of Area Placements in Mental Health Services, May 2021
244.	NHSE0000358	Report, dated 09/09/2021 compiled by NHS Digital, Re: Out of Area Placements in Mental Health Services, June 2021
245.	NHSE0000359	Report, dated 14/10/2021 compiled by NHS Digital, Re: Out of Area Placements in Mental Health Services, July 2021
246.	NHSE0000360	Report, dated 11/11/2021 compiled by NHS Digital, Re: Out of Area Placements in Mental Health Services, August 2021
247.	NHSE0000361	Report, dated 09/12/2021 compiled by NHS Digital, Re: Out of Area Placements in Mental Health Services, September 2021
248.	NHSE0000363	Report, dated 18/01/2022 compiled by NHS Digital, Re: Out of Area Placements in Mental Health Services, October 2021
249.	NHSE0000364	Report, dated 10/02/2022 compiled by NHS Digital, Re: Out of Area Placements in Mental Health Services, November 2021

250.	NHSE0000366	Report, dated 10/03/2022 compiled by NHS Digital, Re: Out of Area Placements in Mental Health Services, December 2021
251.	NHSE0000367	Report, dated 14/04/2022 compiled by NHS Digital, Re: Out of Area Placements in Mental Health Services, January 2022
252.	NHSE0000368	Report, dated 12/05/2022 compiled by NHS Digital, Re: Out of Area Placements in Mental Health Services, February 2022
253.	NHSE0000370	Report, dated 09/06/2022 compiled by NHS, Re: Out of Area Placements in Mental Health Services, March 2022
254.	NHSE0000372	Report, dated 14/07/2022 compiled by NHS, Re: Out of Area Placements in Mental Health Services, April 2022
255.	NHSE0000374	Report, dated 11/08/2022 compiled by NHS, Re: Out of Area Placements in Mental Health Services, May 2022
256.	NHSE0000375	Report, dated 08/09/2022 compiled by NHS, Re: Out of Area Placements in Mental Health Services, June 2022
257.	NHSE0000377	Report, dated 13/10/2022 compiled by NHS, Re: Out of Area Placements in Mental Health Services, July 2022
258.	NHSE0000381	Report, dated 10/11/2022 compiled by NHS, Re: Out of Area Placements in Mental Health Services, August 2022
259.	NHSE0000382	Report, dated 08/12/2022 compiled by NHS, Re: Out of Area Placements in Mental Health Services, September 2022

260.	NHSE0000385	Report dated 12/01/2023 compiled by NHS Digital RE: Out of Area Placements in Mental Health Services October 2022
261.	NHSE0000386	Report dated 09/02/2023 compiled by NHS England RE: Out of Area Placements in Mental Health Services November 2022
262.	NHSE0000387	Report dated 09/03/2023 compiled by NHS England RE: Out of Area Placements in Mental Health Services December 2022
263.	NHSE0000393	Report dated 13/04/2023, compiled by NHS England RE: Out of Area Placements in Mental Health January 2023 Services
264.	NHSE0000406	Report document dated 10/08/2023 compiled by NHS England RE: Out of Area Placements in Mental Health Services May 2023
265.	NHSE0000407	Report dated 11/05/2023 compiled by NHS England RE: Out of Area Placements in Mental Health Services February 2023
266.	NHSE0000408	Report document dated 08/06/2023 compiled by NHS England RE: Out of Area Placements in Mental Health Services March 2023
267.	NHSE0000409	Report dated 13/07/2023 compiled by Community and Mental Health Team, NHS England RE: Out of Area Placements in Mental Health Services

268.	NHSE0000411	Policy document compiled by NHS England RE: Out of Area Placements in Mental Health Services dated 14/09/2023
269.	NHSE0000412	Report dated 12/10/2023 compiled by NHS England RE: Out of Area Placements in Mental Health Services
270.	NHSE0000413	Report dated 09/11/2023, compiled by Community and Mental Health Team, NHS England, re: Out of Area Placements in Mental Health Services, August 2023
271.	NHSE0000415	Report dated 14/12/2023 compiled by NHS England RE: Out of Area Placements in Mental Health Services
272.	NHSE0000417	Report dated 11/01/2024 compiled by NHS England RE: Out of Area Placements in Mental Health Services
273.	NHSE0000422	Report dated 08/02/2024, compiled by NHS England Re: Out of Area Placements in Mental Health Services, November 2023
274.	NHSE0000439	Report dated 14/03/2024 compiled by NHS England RE: Out of Area Placements in Mental Health Services December 2023
275.	NHSE0000445	Report document dated 11/04/2024 compiled by NHS England RE: Out of Area Placements in Mental Health Services January 2024
276.	NHSE0000450	Report dated 09/05/2024 compiled by NHS England RE: Out of Area Placements in Mental Health Services February 2024

277.	NHSE0000453	Report document dated 13/06/2024 compiled by NHS England RE: Out of Area Placements in Mental Health Services
278.	NHSE0000166	Report, dated 14/03/2019, compiled by SDCS Data Collection & NHSE, Re: Waiting Times - First Episode Psychosis
279.	NHSE0000168	Report, dated 11/04/2019, compiled by SDCS Data Collection & NHSE, Re: Waiting Times - First Episode Psychosis for February 2019
280.	NHSE0000170	Report, dated 09/03/2019, compiled by SDCS Data Collection & NHSE, Re: Waiting Times - First Episode Psychosis for March 2019
281.	NHSE0000172	Report, dated 13/06/2019, compiled by SDCS Data Collection & NHSE, Re: Waiting Times - First Episode Psychosis for April 2019
282.	NHSE0000175	Report, dated 11/07/2019, compiled by SDCS Data Collection & NHSE, Re: Waiting Times - First Episode Psychosis for May 2019
283.	NHSE0000176	Report dated 08/08/2019, compiled by NHS, Re: Early Intervention in Psychosis Waiting Times (June 2019)
284.	NHSE0000178	Report, dated 12/09/2019, compiled by NHS, RE: Early Intervention in Psychosis Waiting Times
285.	NHSE0000181	Report document dated 10/10/2019 compiled by NHS RE: Early Intervention in Psychosis Waiting Times

286.	NHSE0000185	Report dated 14/11/2019 compiled by NHS RE: Early Intervention in Psychosis Waiting Times September 2019
287.	NHSE0002374	Guidance document, Re: Terms of reference for rapid review into data on mental health inpatient settings, Department of Health and Social Care
288.	NHSE0002376	Report dated 10/10/2024, Compiled by NHSE, Re: Mental Health Bulletin, 2023-24 Annual report
289.	NHSE0002373	Report dated 21/03/2024, Compiled by Department of Health and Social Care, Re: Rapid review into data on mental health inpatient settings: final report and recommendation
290.	NHSE0002377	Policy document, Re: Government response to the rapid review into data on mental health inpatient settings, UK GOV Department of Health & Social Care
291.	NHSE0002375	Report dated 19/06/2014, Compiled by Dr Geraldine Strathdee, Re: Blog - A revolution in mental health information
292.	NHSE0000522	Policy document Re: Code of governance for NHS provider trusts, NHS England
293.	NHSE0000310	Policy document, Re: The NHS Foundation Trust Code of Governance, Monitor
294.	NHSE0000316	Policy document RE: Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts by NHS Improvement

295.	NHSE0000425	Report dated 02/2024, compiled by NHS England Re: NHS Foundation Trust Annual Reporting Manual 2023/2024
296.	NHSE0000461	Report dated 20/09/2024, compiled by NHFT, re Annual General Meeting and Annual Members Meeting
297.	NHSE0000383	Letter from Amanda Sullivan [NHNB] to Ifti Majid [NHFT] and Anne-Maria Newham [NHFT], re: NHS Oversight Framework 2022-23 - Quarter 2 Segmentation
298.	NHSE0000545	Report complied by Nottinghamshire Healthcare NHS Foundation Trust RE: NHS Oversight Framework 2023/24 - Mental Health Provider View dated between 2022 – 2028
299.	NHSE0000530	Letter from Amanda Sullivan to Ifti Majid RE: NHS Oversight Framework 2023-24 – Quarter 1 Segmentation
300.	NHSE0000529	Segment Recommendation Form re: NHFT [Unknown Author]
301.	NHSE0000426	Minute of Meeting re: Nottinghamshire Healthcare NHS Foundation Trust - RSP Entry, dated 22/02/24
302.	NHSE0001191	Letter from Dr Dame Emily Lawson [NHSE] to Ifti Majid [NHFT], Re: The Nottinghamshire Healthcare NHS Foundation Trust (NHFT) entry into the Recovery Support Programme
303.	NHSE0002330	Policy document, Re: RSP Entry: Diagnostic Stocktake Flow Chart, [Author & Organisation Unknown].

304.	NHSE0001613	Report dated 05/06/2024, compiled by unknown Re: Recovery Support Programme -Diagnostic Stocktake: Nottinghamshire Healthcare NHS Trust - May 2024
305.	NHSE0000454	Report dated [unknown], compiled by Dominic Raymont, re: Nottinghamshire Healthcare NHS Foundation Trust – RSP Proposed Transition Criteria and Transition Date [For Regional Support Group (Midlands) meeting to be held on 25/07/2024, NHS England (Midlands).
306.	NHSE0000447	Briefing pack for Meeting [date of circulation unknown] re: Quality Performance Oversight Group to be held on 22 April 2024
307.	NHSE0000446	Report document dated 01/02/2024 compiled by Nottinghamshire Healthcare Trust Improvement Oversight & Assurance Group (IOAG) RE: Nottinghamshire Healthcare NHS Foundation Trust Improvement Oversight and Assurance Group (IOAG)
308.	NHSE0000509	Minute of Meeting Re: Extra Ordinary Improvement, Oversight and Assurance Group: Professional Practice Review of Decision Making Clinicians involved in the Care of Valdo Calocane dated 13/06/2025
309.	NHSE0000510	Report dated 10/06/2025, compiled by NHS Nottinghamshire Healthcare NHS Foundation Trust (NHFT) RE: Professional Practice Review of Doctors involved in the Care of Valdo Calocane

310.	NHSE0000456	Letter from Paul Hopley to Diane RE: Mental Health Improvement Support
311.	NHSE0000491	Policy document, RE: MHIST Nottingham Healthcare Foundation Trust Draft Support Offer, [Unknown]
312.	NHSE0002349	Email from Moira Durbridge (NHSE) to Matthew Fox (NHSE), Cc'd Sarah Seaholme (NHSE), Simon Elliott (NHSE) and others, Re: NHFT Bids
313.	NHSE0002350	Report dated 09/06/2025, compiled by NHSE, Re: NHFT Bid Principles and Evolution Template v3; RSP Funding Audit - 2024-25
314.	NHSE0000468	Minute of Meeting Re: Nottinghamshire Healthcare NHS Foundation Trust – Regulatory Action dated 25/11/2024
315.	NHSE0000469	Report dated 29/11/2024, compiled by Julie Grant, re: Nottinghamshire Healthcare NHS Foundation Trust License
316.	NHSE0000463	Report dated [unknown] compiled by NHS England re: Nottinghamshire Healthcare NHS Foundation Trust
317.	NHSE0000466	Letter from Ifti Majid [NHS] to Jess Sokolov, Dale Bywater, Julie Grant and others Re: RE: Response to the NHSE Well-Led Developmental Review Report
318.	NHSE0000493	Report document compiled by Nottinghamshire Heathcare Foundation Trust RE: Developmental Well-Led Review IOAG Update dated 01/04/2025

319.	NHFT0003517	Briefing from Diane Hull to Jess Sokolov Re: Learning from Homicides/Attempted Homicides and a Complex Case from May 2022 to current day
320.	NHSE0002352	Email from FOICRM (NHSE), to Julian Hendy (NHSE), Re: Request under the Freedom of Information Act 2000 - Ref: FOI-2501-2181376, NHSE:0793616
321.	NHSE0002337	Note re: Table of region and year, by [unknown].
322.	NHSE0000281	Report, dated March 2022, compiled by Psychological Approaches. Re: Independent Investigation - the Care and Treatment of Mr A - NHFT.
323.	NHSE0000069	Report, dated 01/05/2012, compiled by Caring Solutions UK. Re: Independent Investigation into the Care of 'R' by NHFT and Northamptonshire Healthcare NHS FT.
324.	NHSE0000396	Memo from Dom Fear to CEO Office, CDO Office, Ruth May and others [NHS England] Re: Briefing document, Operation PLATO – Nottingham
325.	NHSE0000403	Email from Ash Canavan [NHSE] to Ash Canavan [NHSE] RE: Tues Log Notts
326.	NHSE0000498	Email from Ash Canavan [NHSE] to Ash Canavan [NHSE] RE: Tues Log Notts
327.	NHSE0000398	Report dated 14/06/2023 compiled by Hazel Buchanan RE: Completed SBAR Incident Report Form

328.	NHSE0000399	Report dated 15/06/2023 compiled by CQC RE: Major Incident declared by police for Nottinghamshire system through casualties at Nottingham University Hospitals
329.	NHSE0000400	Report document dated 15/06/2023 compiled by CQC RE: Major Incident declared by police for Nottinghamshire system through casualties at Nottingham University Hospitals
330.	NHSE0000402	Report document dated 16/06/2023 compiled by by Hazel Buchanan RE: Major Incident declared by police for Nottinghamshire system through casualties at Nottingham University Hospitals
331.	NHSE0000401	Report dated 16/06/2023 compiled by Hazel Buchanan (NHNB) RE: SBAR Reporting Template
332.	NHSE0000395	Report dated 13/06/2023 compiled by Hazel Buchanan, NHS Nottingham and Nottinghamshire ICB RE: Methane Reporting Template (Version 2)
333.	NHSE0000459	Report dated 10/2023, compiled by NHS Re: Midlands EPRR Lessons Identified
334.	NHSE0000511	Report dated 20/06/2023 compiled by Unknown, Re: Valdo Calocane StEIS Record
335.	NHSE0000397	Email from Sylvia Knight, Director of Nursing [NHSE], to Mette Vognsen [NHSE] RE: In confidence heads up
336.	NHSE0000404	Policy document RE: Terms of reference for internal trust serious incident level 2 serious incident investigation by NHS Nottinghamshire Healthcare NHS Foundation Trust

337.	NHSE0002318	Report dated 07/02/2024, compiled by Jackie Craissati , Joanne Parry and Rachel Lees, Re: Level 2 Comprehensive Investigation Report
338.	NHFT0000451	Report dated 15/06/2023, compiled by Jackie Craissati, Joanne Parry, Rachel Lees, NFT, Re: Level 2 Comprehensive Investigation Report
339.	NHSE0000418	Briefing Note for Midlands Independent Investigation Review Group Chair Re: briefing note for debate
340.	NHSE0000384	Policy document RE:NHS Framework Agreement for the Provision of Services, by NHS Commissioning Board
341.	NHSE0000428	Report dated [unknown], compiled by Theemis re Invesigtation Team Biographies
342.	NHSE0000421	Report dated 31/01/2024, compiled by Niche Re: Proposed team - Nottingham Homicides
343.	NHSE0000420	Notes by unknown author Re: Experience of Verita team members
344.	NHSE0000512	Email from Bhavisha Pattani [NHS England] to Laura Sadler [NHS England] RE: VC Investigation
345.	NHSE0002316	Email from Jessica Sokolov [NHSE] to Dale Bywater [NHSE] and Claire Murdoch [Central and North West London NHS Foundation Trust], re: Independent Review - ToR and team proposal for review
346.	NHSE0000423	Briefing Note for Mette Vognsen Head of Independent Investigations Midland Region dated 05/02/2024

347.	NHSE0000424	Letter from Mette Vognsen [NHS] to Kathryn [Theemis Consulting] Re: Direct Award – STEIS REF: 2023 11918
348.	NHSE0000427	Report dated 21/02/2024, compiled by Theemis Re: Nottingham Investigation Proposal
349.	NHSE0000441	Report dated 28/02/2024 compiled by Theemis RE:NHS England Nottingham Investigation Proposal
350.	NHSE0000429	Letter from Mette Vognsen (NHS) to David and Emma Webber Re: Independent Investigation into the care and treatment by Valdo Calocane by the NHS
351.	NHSE0000433	Letter from Mette Vognsen [NHSE] to Darren Coates, Re: Independent Investigation into the care and treatment received by Valdo Calocane by the NHS
352.	NHSE0000430	Letter from Mette Vognsen (NHS) to Dr Kumar and Dr O'Malley Re: Independent Investigation into the care and treatment received by Valdo Calocane by the NHS.
353.	NHSE0000431	Letter from Mette Vognsen (NHS) to Ms Elaine Newton Re: Independent Investigation into the care and treatment by Valdo Calocane by the NHS
354.	NHSE0000432	Letter from Mette Vognsen [NHSE] to James Coates, Re: Independent Investigation into the care and treatment received by Valdo Calocane by the NHS
355.	NHSE0000437	Letter from Mette Vognsen, Head of Independent Investigations, to Marcin Gawonski RE: Independent Investigation into the care and treatment received by Valdo Calocane by the NHS

356.	NHSE0000436	Letter from Mette Vognsen, Head of Independent Investigations, to Marcin Gawonski RE: Independent Investigation into the care and treatment received by Valdo Calocane by the NHS
357.	NHSE0000435	Letter from Mette Vognsen to Sharon Miller RE: Independent Investigation into the care and treatment received by Valdo Calocane by the NHS
358.	NHSE0000434	Letter from Mette Vognsen to Mr Wayne Birkett re: Independent Investigation into the care and treatment received by Valdo Calocane by the NHS
359.	NHSE0000442	Letter from Mette Vognsen to Mr & Mrs Calocane re: Independent Investigation into the care and treatment received by your son, Valdo Calocane by the NHS
360.	NHSE0000438	Letter from Mette Vognsen to Valdo Calocane re: Independent Investigation into your care, treatment and services provided by the NHS and other relevant agencies
361.	NHSE0000448	Letter from Mette Vognsen, Head of Independent investigations (NHSE) to whom it may concern at Midlands & East of England Region (NHSE) RE: Request for the release of Primary Care Medical Records – Valdo Amissão Mendes Calocane - Date of Birth: 04/09/1991
362.	NHSE0000444	Letter from Dr Jessica Sokolov to Oliver Shanley RE: External Adviser to the Independent Investigation into the

		care provided to Valdo Calocane by the NHS on behalf of NHS England, Midlands Region
363.	NHSE0000458	Policy document, Re: Post family meeting Final Terms of Reference, independent Investigation into the care and treatment provided by the NHS Mental Health Services, Primary Care, and Partner organisations to VC 2023-11918, NHS England
364.	NHSE0000475	Letter from Mette Vognsen [NHSE] to Mr Marcin Garwonski, Re: Independent Investigation into the care and treatment received by Valdo Calocane by the NHS
365.	NHSE0000473	Letter from Mette Vognsen [NHSE] to Ms Sharon Miller, Re: Independent Investigation into the care and treatment received by Valdo Calocane by the NHS
366.	NHSE0000474	Letter from Mette Vognsen [NHSE] to Mr Wayne Birkett, Re: Independent Investigation into the care and treatment received by Valdo Calocane by the NHS
367.	NHSE0000478	Letter from Mette Vognsen [NHSE] to Mr Wayne Birkett, Re: Publication of the Independent Investigation into the care and treatment received by Valdo Calocane
368.	NHSE0000479	Letter from Mette Vognsen [NHS] to Marcin Gawronski Re: Publication of the Independent Investigation into the care and treatment received by Valdo Calocane
369.	NHSE0000480	Letter from Mette Vognsen [NHSE] to Ms Sharon Miller, Re: Publication of the Independent Investigation into the care and treatment received by Valdo Calocane

370.	NHSE0000481	Letter from Mette Vognsen [NHSE] to Ms Tracey Hodgson, re: Publication of the Independent Investigation into the care and treatment received by Valdo Calocane
371.	NHSE0000482	Letter from Mette Vognsen [NHSE] to Ms Carol Parlor, Re: Publication of the Independent Investigation into the care and treatment received by Valdo Calocane
372.	NHSE0000472	Report dated 02/01/25, compiled by Theemis, Re: report sharing consent
373.	NHSE0000298	Report dated January 2025, compiled by Theemis Consulting Ltd, Re: Independent investigation into the care and treatment provided to VC
374.	NHSE0002333	Report dated unknown, compiled by NHFT, Re: Independent investigation into the care and treatment provided to VC, Nottinghamshire Healthcare NHS Trust and Nottinghamshire Integrated Care Board Action Plan
375.	NHSE0000048	Policy Document, RE: Independent Mental Health Homicide Review into the tragedies in Nottingham, NHSE
376.	NHSE0000470	Report dated [unknown], compiled by NHFT, Re: Nottinghamshire Healthcare Foundation Trust Integrated Improvement Plan
377.	NHSE0000496	Minutes of meeting RE: Improvement Oversight Committee dated 27/05/2025
378.	NHSE0000495	Policy document compiled by ICS Mental Health Board RE: Notts Healthcare Integrated Improvement Plan Refresh v2.0 dated 14/05/202

379.	NHSE0000508	Agenda for NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST IMPROVEMENT OVERSIGHT AND ASSURANCE GROUP, meeting to be held on Thursday 19 June 2025, NHS England Midlands and NHS Nottingham and Nottinghamshire
380.	NHSE0002195	Minutes of Meeting Re: Nottinghamshire Healthcare NHS Foundation Trust Improvement Oversight and Assurance Group Meeting, dated 23/05/2025
381.	NHSE0000506	Policy document, RE: ACTION LOG for the Nottinghamshire Healthcare NHS Foundation Trust (NHT) Improvement Oversight and Assurance Group (IOAG) Meeting, NHSE
382.	NHSE0000504	Policy document RE: Section 48 Recommendations Status IOAG Update by Nottinghamshire Healthcare Foundation Trust
383.	NHSE0000505	Policy document RE: Valuing Medical Leadership by NHFT
384.	NHSE0000507	Report [undated] [unknown author], Re: Crisis Services undated
385.	NHSE0000503	Policy document compiled by Parliamentary and Health Service Ombudsman RE: Discharge from mental health care: making it safe and patient-centred undated
386.	NHSE0002339	Agenda for NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST IMPROVEMENT OVERSIGHT AND ASSURANCE GROUP MEETING, meeting to be

		held on Thursday 24 July 2025, NHFT, circulated on unknown date.
387.	NHSE0002344	Report, dated July 2025, compiled by NHFT, re: Rampton Visit, S.48 Recommendations Status IOAG Update
388.	NHSE0002351	Report dated 01/07/2025, Compiled by NHSE Midlands, Re: RSP Transition Criteria: Progress Report – NHFT
389.	NHSE0002353	Email from FOICRM (NHSE), to Julian Hendy (NHSE), Re: Freedom of Information Internal Review outcome (Our Ref: FOI-2501-2191039) NHSE:0374623
390.	NHSE0002354	Email from Freedom Of Information CRM (NHSE), to Julian Hendy (Unknown organisation), Re: Request under the Freedom of Information Act 2000 Ref: FOI-2412-2180123 NHSE:0816980
391.	NHSE0002331	Report dated 24/08/2020, compiled by Claire Murdoch Re: NHS Executive Meeting; Supporting people with Severe Mental Illness in Community Mental Health Services
392.	NHSE0000531	Minutes of Meeting RE: Minutes of a public meeting of the NHS England Board, dated 01/02/2024
393.	NHSE0000532	Report dated 28/03/2024, compiled by NHS England, re: Annex: operational performance update - 28 March 2024 (Agenda item: 4.1.1 (public session)
394.	NHSE0000534	Minute of Meeting RE: Minutes of a public meeting of the NHS England Board held on Thursday 3 October 2024

395.	NHSE0000533	Report dated 03/10/2024, compiled by Claire Murdoch, Dr Adrian James and Mark Ewins, Re: Supporting people with severe mental illness in community mental health services
396.	NHSE0000535	Minute of Meeting re: Minutes of a public meeting of the NHS England Board, dated 06/02/2025
397.	NHSE0001629	Mental Health Quality Summit – Interim Report dated 28 August 2024
398.	NHSE0000365	Policy document RE: Terms of reference Independent Investigations Governance Committee, by Linda White
399.	NHSE0000471	Report dated 03/12/2024, compiled by NHSE Independent investigations committee re: Terms of Reference
400.	NHSE0000451	Terms of Reference for Regional Quality & Performance Oversight Meeting (NHSE Midlands)
401.	NHSE0000449	Policy document dated 10/08/2023 compiled by NHS England RE: Regional Support Group Midlands Terms of Reference
402.	NHSE0000460	Policy document, re: Regional Support Group Midlands Terms of Reference, NHSE
403.	NHSE0000349	Policy document RE: Integration and Innovation: working together to improve health and social care for all, by SoS for Health and Social Care

404.	NHSE0002279	Report, dated May 2005, compiled by Craig Morgan, Gerald Hutchinson, Kevin D Morgan and others, re: Pathways to care and ethnicity. I: Sample characteristics and compulsory admission - Report from the AESOP study
405.	NHSE0002381	Report dated 14/07/2021, Compiled by: JAMA Psychiatry, Re: Probability of Transition to Psychosis in Individuals at Clinical High Risk An Updated Meta-analysis
406.	NHSE0002286	Guidance, Re: Standards for Early Intervention in Psychosis Services - 1st Edition, by EIPN, CCQI, RCPS,
407.	NHSE0002298	Guidance Re: Quality Standards for Early Intervention in Psychosis Services (Second Edition), Royal College of Psychiatrists, CCQI
408.	NHSE0002336	Policy document, Re: Quality Standards for Early Intervention in Psychosis Services (Third Edition), by RCPS & EIPN
409.	NHSE0002287	Report, dated March 2017 , compiled by Oliver D Howes, Rob McCutcheon, Ofer Agid and others, Re: Treatment resistant schizophrenia: Treatment Response and Resistance in Psychosis (TRRIP) working group consensus guidelines on diagnosis and terminology
410.	NHSE0002289	Clozapine and all-cause mortality in treatment-resistant schizophrenia: a historical cohort study, Acta Psychiatrica Scandinavica

411.	NHSE0002301	Article, Underuse of clozapine in treatment-resistant schizophrenia, Cambridge University Press
412.	NHSE0002385	Guidance, Re: Rehabilitation for adults with complex psychosis, NICE
413.	NHSE0002386	Guidance, Re: Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services, NICE
414.	NHSE0002302	Policy Document Re: CCQI Standards for Community Mental Health Services, Fourth Edition, Royal College of Psychiatrists
415.	NHSE0002308	[Policy Document/Guidance], Re:[CCQI Standards for Inpatient Mental Health Services], [Rob Chaplin, Harriet Clarke, Mary Docherty, Hannah Lucas-Motley and Peter Thompson]
416.	NHSE0002300	Report dated 2019, compiled by BJPsych Re: Continuity of care and clinical outcomes in the community for people with severe mental illness
417.	NHSE0002382	Policy document, Re: Safeguarding children, young people and adults at risk in the NHS, NHSE
418.	NHSE0002321	Guidance, re: MAPPA Guidance, by National MAPPA Team HMPPS Public Protection Group