

Witness Name: Amanda Sullivan

Statement No: WITN0223001

Dated: 03 December 2025

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF AMANDA SULLIVAN

I, Amanda Sullivan, will say as follows: -

INTRODUCTION

1. My full name is Amanda Jean Sullivan. I am the Chief Executive and Accountable Officer of NHS Nottingham and Nottinghamshire Integrated Care Board ("the ICB"). I have held this role since the ICB was established on 1 July 2022.
2. I make this witness statement on behalf of the ICB to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request addressed to the ICB dated 16 June 2025 (the "Request"). The Request is broad in scope, covering the background to the ICB, its role in respect of mental health services and reviews in light of the incidents on 13 June 2023. Therefore, in order to answer the Request fully, this statement has been necessarily prepared with the input of senior colleagues in the ICB, working with me and with the ICB's external solicitors. I do not have personal knowledge of all the facts addressed within the statement, but I can

confirm that all the facts within this statement are true to the best of my knowledge and belief.

3. I have a clinical background, qualifying as a nurse in 1988 and as a midwife in 1991. I worked at Lodge Moor Hospital, Sheffield as a nurse and at Nottingham City Hospital as a Student Midwife and then Midwife. I became a consultant midwife in 2001, following which I worked at local, regional and national levels in antenatal screening professional networks. In 2001, I was awarded a PhD for research investigating decision-making during pregnancy. I chaired a working group on behalf of the National Screening Committee between 2004 and 2005, which developed national standards for ultrasound consent in pregnancy. I have also edited midwifery academic textbooks published in 2005 and 2006.
4. I have worked in senior management roles since 2005:
 - a. Between 2005 and 2006 I was Acting Executive Director of Nursing at Nottingham City Hospital NHS Trust. When this Trust merged with the Queen's Medical Centre NHS Trust in 2006, I became Interim Deputy Director of Nursing at the City Hospital Campus of the newly formed Nottingham University Hospitals NHS Trust until 2007.
 - b. Between 2007 and 2012 I worked for Nottinghamshire County Teaching Primary Care Trust. Initially as Executive Director of Nursing, Quality and Governance until 2011 when I became the Designate Chief Executive and Accountable Officer of NHS Newark and Sherwood Clinical Commissioning Group, prior to its formal establishment in 2012.
 - c. Between 2012 and 2020 I was Chief Executive and Accountable Officer of NHS Mansfield and Ashfield Clinical Commissioning Group and NHS Newark

and Sherwood Clinical Commissioning Group. In 2018 I also became Chief Executive and Accountable Officer of NHS Nottingham City Clinical Commissioning Group, NHS Nottingham North and East Clinical Commissioning Group, NHS Nottingham West Clinical Commissioning Group, and NHS Rushcliffe Clinical Commissioning Group. When these six Clinical Commissioning Groups merged in April 2020, I became Chief Executive and Accountable Officer of the newly formed NHS Nottingham and Nottinghamshire Clinical Commissioning Group.

- d. I then became Chief Executive and Accountable Officer of the ICB when it was established in July 2022, and I continue to hold this role today.
5. As Chief Executive and Accountable Officer of the ICB, I am responsible for the overall strategic direction and operational performance of the ICB, in line with directions from NHS England. I also have responsibility for ensuring that the ICB fulfils its statutory duties, manages resources effectively, and delivers high-quality care for the population it serves.

BACKGROUND

6. I have been asked to set out the background of the ICB, including its role and responsibilities, management and governance structure. In line with the relevant period under consideration by the Inquiry, I will also briefly cover the Clinical Commissioning Groups as the predecessor organisations to the ICB.

Clinical Commissioning Groups

7. Clinical Commissioning Groups were established as statutory NHS bodies under the NHS Act 2006 (as amended by the Health and Social Care Act 2012). They were

formed in 2013, replacing Primary Care Trusts, and were ultimately abolished in June 2022, with their functions transferred to ICBs from July 2022.

8. Clinical Commissioning Groups were clinically led membership organisations (comprised of the GP practices operating within their areas), responsible for commissioning most NHS services in line with the healthcare needs of their populations.
9. In discharging their commissioning role, Clinical Commissioning Groups assessed the physical and mental healthcare needs of their populations, determined priorities, and purchased healthcare services through contracts with a range of providers, including NHS organisations set up by statute (NHS Trusts and NHS Foundation Trusts), independent sector providers, voluntary sector providers and other bodies. Clinical Commissioning Groups also had responsibility for managing the NHS budget for their areas and for monitoring the quality of commissioned services.
10. Whilst legislation set out a number of requirements with regards to the governance structure of Clinical Commissioning Groups, the member GP Practices were responsible for determining many of the governing arrangements for Clinical Commissioning Groups, including delegations to Governing Bodies and arrangements for clinical leadership.
11. There were initially seven Clinical Commissioning Groups operating across the Nottingham and Nottinghamshire area:
 - a. NHS Bassetlaw Clinical Commissioning Group.
 - b. NHS Mansfield and Ashfield Clinical Commissioning Group.
 - c. NHS Newark and Sherwood Clinical Commissioning Group.
 - d. NHS Nottingham City Clinical Commissioning Group.

- e. NHS Nottingham North and East Clinical Commissioning Group.
 - f. NHS Nottingham West Clinical Commissioning Group.
 - g. NHS Rushcliffe Clinical Commissioning Group.
12. Following their establishment in 2013, NHS Mansfield and Ashfield Clinical Commissioning Group and NHS Newark and Sherwood Clinical Commissioning Group (“the Mid-Nottinghamshire CCGs”) collaborated closely with aligned governance arrangements operating under a single executive management structure.
13. During 2017/18, the Governing Bodies of NHS Nottingham City Clinical Commissioning Group, NHS Nottingham North and East Clinical Commissioning Group, NHS Nottingham West Clinical Commissioning Group and NHS Rushcliffe Clinical Commissioning Group (“the Greater Nottingham CCGs”) agreed to establish a joint commissioning committee. That joint commissioning committee was enacted from 1 April 2018 through a formal delegation agreement, with the following delegated functions:
- a. Arranging for the provision of health services to secure improvement in the physical and mental health of the population; and the prevention, diagnosis and treatment of illness.
 - b. Exercising commissioning related functions, including improving the quality of services, reducing inequalities, patient choice, promoting innovation and integration, and public involvement and consultation.
14. At this time, the Greater Nottingham CCGs also aligned their wider governance arrangements and developed a single staffing structure; effectively operating as one

organisation whilst retaining their individual statutory responsibilities, including a single executive management team.

15. During 2018/19, the Greater Nottingham CCGs and the Mid-Nottinghamshire CCGs established joint working arrangements and aligned plans to create a single, strategic commissioning organisation as part of the Nottingham and Nottinghamshire Integrated Care System (“ICS”) in line with national policy. The joint committee of the Greater Nottingham CCGs mentioned above was disestablished as part of the alignment.
16. Following a comprehensive due diligence process the Greater Nottingham and Mid-Nottinghamshire CCGs legally merged and NHS Nottingham and Nottinghamshire Clinical Commissioning Group was established on 1 April 2020.
17. NHS Nottingham and Nottinghamshire Clinical Commissioning Group (“the CCG”) had 130 member GP Practices covering Nottingham City and the neighbouring boroughs/districts of Ashfield, Broxtowe, Gedling, Mansfield, Newark and Sherwood, and Rushcliffe. The CCG served a population of approximately 1,270,500 people.
18. The CCG’s Constitution and Governance Handbook set out the statutory framework in which the CCG operated, and the governance arrangements established to discharge its responsibilities. The committees established by the CCG’s Governing Body included a Prioritisation and Investment Committee (to oversee the development of the CCG’s commissioning strategies and plans to reduce health inequalities, improve health outcomes and improve quality of care), a Quality and Performance Committee (to scrutinise arrangements for ensuring the quality of the CCG’s commissioned services and to oversee the development, implementation and monitoring of performance management arrangements), and a Finance and

Resources Committee (to scrutinise arrangements for ensuring the delivery of the CCG's statutory financial duties).

19. The CCG employed over 500 staff. The organisational structure was divided into a number of directorates that had responsibilities in the areas of commissioning and contracting, finance and resources, and quality and governance. Additional clinical expertise to commissioning activities was provided from GP Advisors, appointed from member GP Practices.
20. Throughout this period, NHS Bassetlaw Clinical Commissioning Group operated separately to the Greater Nottinghamshire CCGs, Mid-Nottinghamshire CCGs, and NHS Nottingham and Nottinghamshire Clinical Commissioning Group, and was aligned to the South Yorkshire and Bassetlaw ICS.

Emergency governance arrangements during the COVID-19 pandemic

21. In March 2020, the Governing Bodies of the Greater Nottingham and Mid-Nottinghamshire CCGs agreed interim governance arrangements to apply during the period of emergency response to the COVID-19 pandemic. These arrangements, which were adopted by NHS Nottingham and Nottinghamshire Clinical Commissioning Group upon its establishment in April 2020, were designed to ensure agility in decision-making without compromising oversight of care quality or statutory responsibilities. The arrangements were designed in line with national guidance **[NHNB0019534]**.
22. Governance arrangements during this period included continuing Governing Body meetings virtually with streamlined agendas, supported by weekly briefings focused on finance, compliance, workforce, and key risks. Emergency decisions were enabled through Standing Orders, with provisions to allow flexibility in quoracy where

necessary. Transparency was maintained through published updates and public questions. A Non-Executive Director oversight forum provided retrospective scrutiny of urgent decisions, replacing the former Clinical Commissioning Groups' usual committee arrangements.

23. Operationally, an Incident Coordination Centre was established at a Nottinghamshire-wide level, supported by specialist 'Cells', including a Clinical Quality and Safety Cell. This Cell oversaw safeguarding, service quality, and risk during the pandemic. Service changes were reviewed jointly by the Clinical Quality and Safety Cell and a Service Change Cell.
24. The arrangements were kept under review during the period, with the Governing Body of NHS Nottingham and Nottinghamshire Clinical Commissioning Group agreeing a full return to 'business as usual' governance arrangements at its meeting on 2 June 2021.
25. In response to the pandemic, NHS Bassetlaw Clinical Commissioning Group modified its governance and assurance processes to reflect the need for agility, whilst maintaining its statutory responsibilities, mainly enacted through moving to virtual Governing Body and committee meetings. NHS Bassetlaw Clinical Commissioning Group's Interim Chief Nurse participated in the Nottinghamshire-wide Clinical Quality and Safety Cell, as described above.

Establishment of the ICB

26. In July 2021, following draft legislation proposing the formal establishment of ICBs, it was agreed that the area of Bassetlaw would move into the Nottingham and Nottinghamshire ICS and comprehensive work was undertaken during 2021/22

between NHS Nottingham and Nottinghamshire Clinical Commissioning Group and NHS Bassetlaw Clinical Commissioning Group to prepare for the establishment of NHS Nottingham and Nottinghamshire ICB.

27. The transition work included a comprehensive due diligence process designed to ensure the safe transfer of staff and property into the new organisation and to ensure that corporate memory was preserved.
28. Formal governance and operational arrangements and staffing structures between NHS Nottingham and Nottinghamshire Clinical Commissioning Group and NHS Bassetlaw Clinical Commissioning Group largely remained separate during this period; however, some committee meetings were held 'in common' to support the transition and a single executive team was appointed (following a national recruitment process) in readiness for the new organisation.
29. NHS Nottingham and Nottinghamshire ICB was established on 1 July 2022 by the Integrated Care Boards (Establishment) Order 2022, following the abolishment of Clinical Commissioning Groups under section 14Z27 of the NHS Act 2006.
30. The ICB is a statutory body whose main powers and duties are to commission certain NHS services as set out in sections 3 and 3A of the NHS Act 2006, including arranging for the provision of services or facilities to secure improvement in the physical and mental health of those for whom it has responsibility, and to prevent, diagnose and treat illness in those people.
31. The ICB has a wide range of statutory powers and duties, many of which are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010, the Care Act 2014, the Children Acts, the Data Protection Act 2018, and the Civil Contingencies

Act 2004. Some of the statutory duties that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions.

These duties include but are not limited to:

- a. Duty to promote NHS Constitution (s14Z32).
 - b. Duty as to effectiveness, efficiency etc (s14Z33).
 - c. Duty as to improvement in quality of services (s14Z34).
 - d. Duty as to reducing inequalities (s14Z35).
 - e. Duty to promote involvement of each patient (s14Z36).
 - f. Duty as to patient choice (s14Z37).
 - g. Duty to obtain appropriate advice (s14Z38).
 - h. Duty to promote innovation (s14Z39).
 - i. Duty in respect of research (s14Z40).
 - j. Duty to promote education and training (s14Z41).
 - k. Duty to promote integration (s14Z42).
 - l. Duty to have regard to wider effect of decisions (s14Z43).
 - m. Duties as to climate change etc (s14Z44).
 - n. Public involvement and consultation by ICBs (section 14Z45).
32. The ICB's arrangements for discharging its duties in relation to quality improvement are considered in detail later in this statement.
33. The ICB covers the areas of the District of Ashfield, District of Bassetlaw, Borough of Broxtowe, Borough of Gedling, District of Mansfield, District of Newark and Sherwood, City of Nottingham and Borough of Rushcliffe.

34. At the time of writing this statement, the ICB is in the process of establishing formal arrangements for working in partnership with two neighbouring ICBs (NHS Derby and Derbyshire ICB and NHS Lincolnshire ICB), in line with the direction set out in the Department of Health and Social Care's new ten-year health plan for England, "Fit for the Future". These partnership arrangements (referred to nationally as 'ICB clustering') will enable the three ICBs to operate within their reduced running cost allowances from 1 April 2026 through economies of scale, which include the establishment of aligned governance arrangements, and the introduction of joint leadership appointments (where permissible) and a single staffing structure. This has included my joint appointment as Chief Executive and Accountable Officer of the other two clustering ICBs from 1 October 2025. It is important to note that the three ICBs involved in the clustering arrangements will remain separate legal entities with distinct statutory duties until such time as any formal merger occurs. Due to this, and as the period under consideration by the Inquiry largely pre-dates ICB clustering, I have not included the detail of these arrangements within this statement, other than where it is felt relevant to do so.
35. In line with requirements as set out in the NHS Act 2006, the ICB's Constitution describes the governing principles, rules and procedures that have been established to ensure probity and accountability in the day to day running of the ICB. It sets out the membership of the ICB's Board and the ICB's commitment to ensuring that decisions are taken in an open and transparent way and that the interests of patients and the public remain central at all times. Appended to the Constitution at Appendix 2 are the Standing Orders that set out the arrangements and procedures to be used for meetings and the processes to appoint the Board's committees. The Constitution and Standing Orders are published on the ICB's website.

36. Membership of the ICB's Board is comprised of me, as Chief Executive and Accountable Officer, together with our Chair (appointed by NHS England with the approval of the Secretary of State for Health and Social Care), and further non-executive, executive, and partner members (nominated by NHS Trusts and NHS Foundation Trusts, local authorities, and providers of primary medical services in the ICB's area, in line with legislative requirements).
37. The ICB's Chair is required to ensure that at least one of the Board's members has knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness. From the date of the ICB's establishment until 31 October 2025, this requirement was satisfied through the appointment of the Chief Executive of Nottinghamshire Healthcare NHS Foundation Trust ("NHFT") to a partner member role on the Board, with robust arrangements in place to manage inherent conflicts of interests (this is in line with arrangements put in place at other ICBs to meet this requirement). However, since 1 November 2025, in line with the move to ICB clustering arrangements (as described earlier in this statement), this requirement has been met through the joint appointment of the Chief Executive of Derbyshire Healthcare NHS Foundation Trust to the three ICBs' Boards, and NHFT's Chief Executive is no longer an ICB Board member.
38. The ICB's Constitution is supported by a Governance Handbook, which is published on the ICB's website and includes:
- a. The terms of reference for all the committees and sub-committees of the Board that exercise ICB functions and make decisions.
 - b. The Standing Financial Instructions, which set out the arrangements for managing the ICB's financial affairs.

- c. The Scheme of Reservation and Delegation, which sets out those functions and decisions that are reserved to the Board and those that have been delegated to the Board's committees and sub-committees and to ICB employees. In accordance with the powers of the ICB, the Scheme of Reservation and Delegation also sets out any functions that have been delegated to other bodies or to joint committees established with other bodies in line with sections 65Z5 and 65Z6 of the 2006 Act. The Scheme of Reservation and Delegation also sets out how any functions delegated to the ICB (for example from NHS England or another ICB) will be exercised.
- 39. The committees established by the ICB's Board were revised in November 2025 in line with the move to ICB clustering arrangements; however, prior to this, the Board's committees included:
 - a. Strategic Planning and Integration Committee – to exercise the ICB's duties and powers to commission certain health services, as set out in sections 3 and 3A of the National Health Service Act 2006 (as amended). In exercising these functions, the Committee makes strategic commissioning decisions to further the four aims of the ICB to: improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience and access; enhance productivity and value for money; and help the NHS support broader social and economic development. The Committee also actively promotes system development in line with the principles of subsidiarity, integration and collaboration, and compliance with the general duties of ICBs, public sector equality duties, social value duties, and the rules set out in the NHS Provider Selection Regime. The Committee also has responsibility for scrutinising the robustness of research arrangements and the effectiveness of patient and

public engagement arrangements, and for overseeing the development of the NHS Joint Forward Plan for Nottingham and Nottinghamshire. This plan is the NHS delivery commitment for all NHS organisations within the ICS. In addition, the Committee has responsibility for the relevant requirements set out within the Delegation Agreement between NHS England and the ICB for primary medical services, insofar as they relate to the planning, design and commissioning of services.

- b. Quality and People Committee – to ensure that the ICB is meeting its statutory requirements regarding continuous quality improvements and enabling a single understanding of, and shared commitment to, quality care across the ICS that is safe, effective, equitable, and that provides a personalised experience and improved outcomes. The Committee’s responsibilities include scrutinising actions to tackle health inequalities and deliver improved health outcomes and ensuring the development of robust arrangements with ICS partners to support the principle of having ‘one workforce’ by leading on the development and implementation of the ICS People and Workforce Plan on behalf of the ICB. The Committee also scrutinises the robustness of the ICB’s safeguarding processes and arrangements, medicines optimisation and compliance with equality legislation.
- c. Finance and Performance Committee – to oversee arrangements for ensuring the delivery of the ICB’s statutory financial duties in line with sections 223GB to 223N of the NHS Act 2006 (as amended). It oversees the ICB’s performance management framework which includes addressing shortfalls in performance against national and local health targets and performance standards. The Committee’s duties also include overseeing the ICB’s

arrangements and delivery in relation to operational planning, estates, environmental sustainability, and digital transformation, ensuring continuous improvements in performance and outcomes.

40. As the ICB's Accountable Officer, I produce a Governance Statement on an annual basis that forms part of the ICB's Annual Reports. The Governance Statements include a description of the work of the ICB's Board and its committees during the year and an assessment of their effectiveness. All ICB Annual Reports are published in full on the ICB's website.
41. The ICB has a suite of key policy documents, covering different aspects of its corporate and commissioning responsibilities. This includes its Standards of Business Conduct Policy (which incorporates the ICB's policy and procedures for the identification and management of conflicts of interest) and its Policy for Public Involvement and Engagement (which describes the ICB's approach to ensuring public involvement and engagement in the development, implementation and review of health and care policies and services across the organisation). All ICB policies are published in full on the ICB's website.
42. The ICB's Executive Management Team is comprised of me as Chief Executive and Accountable Officer, and further Executive Directors with responsibilities in the areas of strategy and planning, operational delivery, clinical and medical oversight, quality and nursing, and finance. The Executive Management Team is responsible for the strategic leadership and operational management of the ICB.

COMMISSIONING OF MENTAL HEALTH SERVICES IN NOTTINGHAM

43. The ICB (and former Clinical Commissioning Groups) are responsible for commissioning most NHS mental health services, with the exception of some

specialised inpatient and secure psychiatric services, for which NHS England has commissioning responsibility.

44. NHS England has a national programme for the delegation of its direct commissioning functions. This has seen ICBs increasingly taking delegated responsibility for a range of commissioning functions with the aim of services being commissioned closer to the populations served, removing the potential for service fragmentation and improving outcomes for patients.
45. In April 2025, the ICB took on delegated responsibility for the commissioning of a number of specialised mental health services:
 - a. Elements of adult medium and low secure and specialised mental health services.
 - b. Adult specialist eating disorder services.
 - c. Elements of children and young people's inpatient mental health services.
 - d. Specialist secure forensic mental health services for young people.
 - e. Specialist perinatal mental health services for adults and adolescents.
46. NHS England currently retains direct commissioning responsibility for:
 - a. High secure mental health services.
 - b. Specialist mental health services for deaf adults.
 - c. Specialist services for severe personality disorders in adults.
47. The ICB has a Mental Health, Children and Maternity Commissioning Team that is responsible for all aspects of mental health commissioning and the transformation of mental health provision. This includes leading system-wide transformation programmes to ensure improved patient outcomes. The team also monitors

compliance with national performance standards and fulfils the specific requirements associated with the national Mental Health Investment Standard.

48. The ICB commissions a wide range of mental health services from NHFT. These include community mental health services, inpatient mental health services and specialised services (in line with the delegation agreement with NHS England) for children, young people and adults. The ICB's role in commissioning mental health services does not include determining specific staffing numbers. Responsibility for establishing safe and appropriate staffing levels sits with NHFT as the provider. However, as part of the NHS Long Term Plan implementation guidance, NHS England produced a series of workforce calculators and workforce planning models and where relevant, these have informed the ICB's (and the former Clinical Commissioning Group's) funding decisions for investment into mental health services.

Planning of mental health services

49. In 2019, the former Clinical Commissioning Groups and wider ICS partners established an All-age Integrated Mental Health and Social Care Strategy 2019-2024 **[NHNB0009168]** ("the Strategy"), which addressed the requirements of the NHS Long Term Plan for Mental Health (published in 2019) and the mental health needs of the local population. The Strategy aimed to increase support for prevention and self-care, implement an approach that focused on the individual (physical and mental health), improve access to services, better equip the mental health workforce, and establish a fully integrated system.
50. Shortly after the Strategy was introduced, the COVID-19 pandemic led to a notable increase in patient acuity that affected the pace of service transformation required.

During the period of the pandemic, efforts shifted towards managing the immediate impact of the virus and addressing workforce shortages. The focus on transformation resumed once the pressures of the pandemic began to ease. At this time, additional national funding was allocated to NHFT to support COVID-19 recovery efforts, and the CCG collaborated with NHFT to identify priority areas for investment and improvement. These investments were aligned with the requirements of the national Mental Health Investment Standard.

51. Since 2019, the ICB (and the former Clinical Commissioning Groups) have commissioned mental health services in line with the Strategy. The ICB's commissioning priorities have also been informed by two national guidance documents that were published by NHS England in early 2024:
 - a. Commissioner guidance for adult mental health rehabilitation inpatient services, published in January 2024 **[NHNB0018986]**.
 - b. Commissioning framework for mental health inpatient services, published in February 2024 **[NHNB0018985]**.
52. In July 2024, the ICB established a new Three-Year Integrated Mental Health Pathway Strategic Plan (2024/25–2026/27) for adult mental health services in Nottingham and Nottinghamshire **[NHNB0000167]**. The Strategic Plan was developed collaboratively with ICS partners and people with lived experience and is aligned to the Nottingham and Nottinghamshire Integrated Care Strategy, the Nottingham and Nottinghamshire NHS Joint Forward Plan, and the latest commissioning guidance from NHS England (as referenced above). The Strategic Plan is also informed by the findings and recommendations arising from

various reviews and reports following the incidents currently under consideration by the Inquiry.

53. The Strategic Plan is focussed on:

- a. Improving access to care and support in the right place at the right time – supporting people to live well in their local community and to access the right care at the right time to prevent the need for an inpatient admission to hospital.
- b. Delivering high quality care for people – ensuring that when people do need support from inpatient services, they receive high quality care in their local area in the least restrictive environment to meet their needs.
- c. Ensuring timely discharge to the place people call home – ensuring that people only stay in hospital for the time they need to, with partners working together to identify, act upon and commission appropriate housing and support needs to enable people to go to the place they call home as soon as they are ready, and to prevent the need for readmission.

54. During the relevant period under consideration by the Inquiry, the ICB (and the former Clinical Commissioning Groups) made significant additional investments in mental health services. In April 2024, the ICB's Executive Management Team completed an assessment of mental health investments. This identified that since 2019/20, there had been £56.8 million in cumulative additional investments, with £39.1 million of this going to NHFT. Additional investments had been allocated in line with the priorities set out in the NHS Long Term Plan for Mental Health.

Oversight of mental health services

ICB assurance arrangements

55. As described earlier in this statement, a number of committees have been established by the ICB's Board (and by the former Clinical Commissioning Groups' Governing Bodies prior to the ICB's establishment) to oversee and scrutinise differing elements of the ICB's commissioning functions.
56. Many reports have been received by these committees during the relevant period under consideration by the Inquiry. These include monthly reports examining service quality, service performance, financial performance and contractual arrangements. These were complemented by specific reports relating to mental health services, which included:
- a. Focussed reports on a wide range of quality concerns regarding mental health services provided by NHFT presented to the ICB's Quality and People Committee (and the former Clinical Commissioning Groups' quality committees) in September and October 2019, January, June and September 2020, June and October 2021, April 2022, February, April, June and September 2024, and February 2025. The reports describe the initial identification of quality and safety issues at NHFT, the escalation of these issues leading to regulatory action, the improvement actions being taken by NHFT, and the oversight arrangements in place to monitor progress. Copies of these reports have been shared with the Inquiry.
 - b. A focussed performance report relating to the delivery of local and national mental health standards presented to the ICB's Finance and Performance Committee in February 2023. A copy of this report has been shared with the Inquiry.

- c. Assurance reports relating to mental health service transformation received by the ICB's Strategic Planning and Integration Committee in October 2022 and September 2023. These outlined progress across seven transformation programme areas, identified risks to delivery, and set out the mitigating actions in place. A copy of the October 2022 report has been shared with the Inquiry. The September 2023 report is attached at **[NHNB0018964]**.
- d. A further assurance report received by the ICB's Strategic Planning and Integration Committee in July 2025, focussed on the first year of implementing the Three-Year Integrated Mental Health Pathway Strategic Plan **[NHNB0018971]**. The full report was also shared with the ICB's Board in July 2025. The report highlighted progress during the first year of the Strategic Plan in eight priority areas covering programme governance, performance data, outcomes to monitor impact and experiences, inpatient bed modelling, housing and accommodation, a review of locked rehabilitation, integrated commissioning opportunities, and coproduction.

ICB operational oversight arrangements

- 57. The ICB has established a range of operational oversight forums which oversee services commissioned by the ICB, including the mental health services provided by NHFT. These arrangements have built on those established by the former Clinical Commissioning Groups (albeit that names of some forums may now be different). In line with national policy direction, the change from Clinical Commissioning Groups to ICBs placed greater emphasis on collaboration across organisational boundaries, with ICBs being required to take on a broader NHS system leadership role. In line

with this, where appropriate, the ICB's oversight arrangements have been designed to enable collective responsibility and mutual accountability across the NHS system.

58. The oversight forums include:

- a. Contract Review Meetings (chaired by the ICB's Associate Director of Contracting) are held with all providers of ICB commissioned services, including NHFT. These meetings are used to review delivery of the requirements set out in providers' contracts and to apply formal contract levers, as necessary. Any contractual issues unable to be resolved through the Contract Review Meetings are escalated for resolution at provider-specific Contract Executive Boards (co-chaired by the ICB's Executive Director of Finance and Executive Director of Nursing), with Executive Directors from the relevant provider also in attendance. During the COVID-19 pandemic in early 2020, governance arrangements were aligned with the Level 4 national incident response, and NHS England suspended Clinical Commissioning Group contractual arrangements in accordance with national policy. Consequently, the Contract Review Meetings and Contract Executive Boards were stood down. Contract Review Meetings resumed in January 2025, and by May 2025, the Contract Executive Boards were re-established with a renewed focus on both quality and financial oversight.
- b. System Oversight Group – Chaired by me as the ICB's Chief Executive and Accountable Officer, this Group is comprised of the ICB's Executive Directors, the Chief Executives of all local NHS partners, and Corporate Directors from Nottingham City Council and Nottinghamshire County Council. The Group oversees the delivery of local plans and monitors and addresses areas where quality concerns exist or where performance is off-track. Concerns relating to

services provided by NHFT were escalated to this Group during the relevant period. This enabled system-wide oversight at the most senior level of the actions needed to address the concerns.

- c. System Quality Group – Co-chaired by the ICB’s Executive Director of Nursing and Executive Medical Director, this Group enables ICS partners to share intelligence, identify quality risks, and coordinate improvement efforts. It ensures quality is embedded in system planning and delivery and plays a key role in overseeing system-level quality risks. The Group operates in full alignment with the National Quality Board (“NQB”) guidance issued in January 2022, meeting all core expectations and principles for system quality groups within ICSs. The Group is supported by a Provider Quality Assurance and Improvement Group, which conducts routine quality surveillance across all providers of NHS commissioned services. When a specific provider requires enhanced quality surveillance, a dedicated Quality Improvement Group is temporarily established to provide focused oversight. From an NHFT perspective, a dedicated Quality Improvement Group was established in 2020 (referred to as the Quality Assurance Group until April 2023) and was in place until February 2024, at which time it was subsumed into the Improvement Oversight and Assurance Group (“IOAG”) that was set up jointly between the ICB and NHS England’s regional team to monitor NHFT’s response to the increased quality and regulatory concerns that had arisen at that time. These concerns are detailed later in this statement. In February 2025, the dedicated Quality Improvement Group for NHFT was reinstated due to the wide range of issues being overseen by the IOAG to ensure a specific focus on quality was maintained.

- d. Performance Oversight Group – The Group is chaired by the ICB’s Executive Director of Delivery and Operations and Chief Operating Officers of all local NHS/NHS Foundation Trusts are members. The Group undertakes detailed monitoring of delivery against national and local performance targets and measures, identifies areas where performance is off-track, and agrees and monitors delivery of recovery actions. The Group examines service performance across mental health, planned care, cancer, diagnostics, primary care, community care, and urgent and emergency care. This Group escalates issues to the System Oversight Group and feeds into discussions at Contract Review Meetings, as required.
- e. Mental Health Performance and Delivery Programme Board – This Programme Board has been established to have a dedicated focus on NHS commissioned mental health services. The Programme Board is chaired by the ICB’s Deputy Director of Mental Health Commissioning, and its membership includes representatives from all local providers of mental health services, including NHFT. The Programme Board tracks progress against operational plans and performance trajectories, monitors delivery against NHS constitutional standards, identifies and resolves areas of underperformance, monitors progress against recovery and improvement plans, and coordinates system-wide improvement actions. The Programme Board also enables the sharing of intelligence to form a collective view of risks and escalates any areas of concern to the Performance Oversight Group. Progress regarding improvement actions is also reported to the Nottingham and Nottinghamshire Adult and Children’s Mental Health Partnership Board (referenced later in this statement).

59. Since May 2025, formal arrangements have been operating to triangulate intelligence from across the ICB's commissioning, contracting, quality, performance, and finance functions to ensure a shared, informed view of mental health services delivered by NHFT is held. These arrangements enable the early identification of issues and concerns that may require escalation to the relevant operational oversight forums.
60. The ICB's oversight arrangements are supported by a wide range of mental health data. The ICB collects and monitors this data through a dedicated ICB dashboard and broader intelligence infrastructure in support of both its operational oversight arrangements and strategic commissioning functions. The dashboard includes mental health data aligned to national targets, contract performance, and activity metrics. It is used by the ICB to:
- a. Track performance against national mental health standards.
 - b. Monitor contract compliance and service delivery across NHFT and other mental health providers.
 - c. Analyse activity and outcomes across pathways such as perinatal mental health, children and young people's mental health services, adult severe mental illness, talking therapies, crisis care, and mental health inpatient services.
 - d. Support mental health commissioning decisions by providing data intelligence on demand trends, service utilisation, out of area placements, and lengths of stay.
 - e. Inform mental health strategic planning and transformation programmes.

- f. Enable population health management by integrating data on deprivation, serious mental illness prevalence, and inequalities across Nottingham and Nottinghamshire.
- 61. A 'Safe Now' dashboard, developed by NHFT in collaboration with the ICB, has also recently been introduced. This dashboard was designed to provide real time visibility of the quality and safety of mental health services provided by NHFT by offering a live, data driven view of key metrics and indicators. From a quality perspective, this information is triangulated with intelligence gathered by the ICB from homicide reviews, unlawful killings and coronial investigations to enhance safeguarding arrangements, strengthen oversight, and drive service improvement and learning.

Partnership arrangements for delivery of service transformation

- 62. Partners across the ICS have established a Nottingham and Nottinghamshire Adult and Children's Mental Health Partnership Board ("the Partnership Board"). This was previously led by NHFT; however, in 2024, with the support of system partners, the ICB appointed an Independent Chair to bring impartiality to the work of the Partnership Board and to ensure all voices have a fair and equal hearing.
- 63. The Partnership Board oversees seven transformation workstreams:
 - a. Specialist Community Perinatal Mental Health.
 - b. Children and Young People's Mental Health.
 - c. Adult Common Mental Illnesses (Talking Therapies).
 - d. Adult Severe Mental Illnesses (Community Care).
 - e. Mental Health Crisis Care and Liaison.
 - f. Therapeutic Acute Mental Health Inpatient Care.

- g. Suicide Reduction and Bereavement Support.
64. Each transformation workstream has a multi-partner steering group from across the ICS, ensuring the delivery of transformation programme objectives.
65. An ICS-wide Integrated Mental Health Pathway Oversight Group has also been recently established to monitor progress against the Integrated Mental Health Pathway Strategic Plan. This Group reports into the Partnership Board and provides assurance to the ICB's Mental Health Performance and Delivery Programme Board.

Inpatient beds and out of area psychiatric placements

66. Prior to and during the relevant period under consideration by the Inquiry, NHFT experienced sustained pressure on inpatient mental health services, with bed occupancy at full capacity, due in part to NHFT's decision to downsize its bed base (as part of NHFT's cost improvement plans), and in part to increased lengths of stay for inpatients.
67. This led to an increased dependence by NHFT on sub-contracted provision, and in 2018, NHFT established a sub-contracting arrangement with the Priory Hospital Group to provide additional inpatient beds. In line with the terms of the NHS Standard Contract, NHFT is responsible for ensuring it has effective oversight of the mental health beds it sub-contracts to private healthcare providers.
68. Pressures on local bed capacity also led to an increase in out of area psychiatric placements, which the ICB routinely monitors.
69. An out of area placement occurs when a person who requires mental health inpatient care is admitted to an inpatient hospital facility that is outside of the catchment area of the person's local community mental health service. This is sometimes necessary if the person requires specialised care that is not available locally, or where the

placement is based on a person's specific clinical needs. However, out of area placements are considered to be inappropriate when they occur due to a lack of available mental health inpatient beds in the person's local area, or where the person cannot be visited regularly by their local care co-ordinator to ensure continuity of care and effective discharge planning. The elimination of inappropriate out of area placements remains a key national priority for mental health services.

70. Significant progress was made in reducing inappropriate out of area placements in Nottingham and Nottinghamshire resulting in a period of zero inappropriate out of area placements prior to the COVID-19 pandemic. At this time, NHFT was operating robust arrangements for continuity of care for all sub-contracted private sector beds and NHS England supported the reporting of this activity as appropriate placements. However, following the pandemic there was an increase in demand, which led to an increase in the number of inappropriate out of area bed placements during 2023/24. In response, the ICB led a targeted system-wide approach to address this issue, which resulted in NHFT reporting a significant reduction of inappropriate out of area bed placements during 2024/25. By June 2025, NHFT reported that the number of patients placed inappropriately out of area had decreased to four.
71. A key mechanism to ensure the appropriateness of out of area placements is robust implementation of continuity of care principles. These standards ensure that patients placed out of area receive care equivalent to that provided locally and that care is joined up with clear clinical oversight. Concerns around continuity of care have been highlighted in inspections of NHFT by the Care Quality Commission ("CQC") and the ICB is continuing to work with NHFT to ensure that all placements are accurately reported in line with national guidance and that continuity of care remains central to patient experience, regardless of provider.

72. Through its mental health strategies and plans, the ICB has also been taking forward actions to ensure that Nottingham and Nottinghamshire have the optimal number of local mental health inpatient beds and to improve patient flow through inpatient settings to make better use of bed capacity. For example, the ICB has supported access to capital funding to introduce a new bedded facility (Sherwood Oaks Hospital), which has provided additional beds and supported the requirement to eradicate dormitory-style accommodation in mental health facilities. Capital funding has also been accessed to refurbish the former Millbrook Mental Health Unit (now known as the Blossomwood Unit) into non-dormitory-style accommodation. Both of these facilities are provided by NHFT.
73. In line with the ICB's Integrated Mental Health Pathway Strategic Plan (referenced earlier in this statement), a bed demand and forecasting tool has been developed to inform the future commissioning of the inpatient bed base, with the aim of ensuring that the right number and type of inpatient provision is in place and to reduce reliance on local independent sector and out of area beds.

Assertive and intensive community mental health care services

74. Historically, the former Clinical Commissioning Groups commissioned a dedicated Assertive Outreach Team, and the associated service specification was included in the NHFT contract until 2019. Assertive Outreach Teams work with individuals who have severe mental health problems and are not currently engaging with traditional mental health services. They aim to build relationships and provide intensive support, often in the individual's own environment, to improve their health and social functioning.

75. During 2019, NHFT implemented a revised operating model by amalgamating its Assertive Outreach Team into its Local Mental Health Teams. This was in line with national policy direction at the time (as set out within the NHS Long Term Plan and the Community Mental Health Framework), which advocated for integrated, place-based care, removing siloed specialist teams in favour of multi-disciplinary teams that could flexibly meet a range of needs.
76. The 2024/25 NHS Priorities and Operational Planning Guidance asked 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.”* This was in response to the initial findings of the CQC’s special review into mental health care at NHFT, published in March 2024 [NHNB0018989].
77. Further guidance on intensive and assertive community mental health treatment was published by NHS England in July 2024 [NHNB0018987] and ICBs were asked to use this to review policies and practices and confirm to NHS England by the end of September 2024 if they were assured that services are able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow-up. ICBs were asked to use the review to identify gaps and barriers to providing good care.
78. The ICB completed its review in September 2024. The review process included a facilitated workshop with over 60 stakeholders, with representatives from the ICB, NHFT, NHS England, Nottingham City Council, Nottinghamshire County Council, and the voluntary, community and social enterprise sector. Carer representatives were also in attendance. At the workshop, stakeholders used the Maturity Index Self-

Assessment Tool developed by NHS England to assess the level of NHFT's service provision. Engagement with people with lived experience also took place after the workshop.

79. The review identified the following gaps, barriers, and challenges to meeting the needs of the group of patients requiring assertive engagement in line with the national guidance:

- a. While some assertive engagement was occurring, there was no standardised pathway across services. NHFT's previous merger of Assertive Outreach Teams into Local Mental Health Teams had led to inconsistencies and challenges in maintaining engagement due to large, mixed caseloads.
- b. Job plans and workforce structures did not support assertive engagement practices. Caseloads were high and diverse, and there were gaps in training for new staff in assertive approaches.
- c. Step-up and step-down pathways were under pressure, affecting service responsiveness.
- d. More support was needed to ensure patients adhered to prescribed medication.
- e. There was a need for improved communication with partners and greater involvement of people with lived experience and carers in service development.

80. The outcome of the review was that the ICB was not assured that the services provided by NHFT were able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow up.

81. In October 2024, the ICB agreed an Assertive and Intensive Engagement Improvement Plan with NHFT to address the review's findings, with the majority of actions due for completion by December 2024. A Task and Finish Group was established by NHFT to take forward the actions, reporting on progress to NHFT's Rapid Improvement Board. ICB representatives attend the Task and Finish Group's meetings to monitor progress.
82. The ICB's Board received a report in November 2024 setting out the findings from the review and the actions being taken to address them **[NHNB0000273]**.
83. A further progress update report was presented to the ICB's Board in May 2025 **[NHNB0000055]**. This noted the progress that had been made, which included:
- a. Confirmation of operational standards and procedures.
 - b. Implementation of a discharge checklist to ensure robust discharge processes.
 - c. Improved oversight of patients requiring assertive engagement, including those with multiple 'Did Not Attends'.
 - d. Improved engagement with carers.
 - e. Development of best practice guidelines for medicines management.
 - f. Development and use of a 'Safe Now' dashboard to monitor service delivery, discharges, carer engagement, and medication management.
84. The ICB's Board expressed some concern that 15 of the 28 actions had not yet been completed. Delays in the publication of national guidance, delays in national funding

announcements, and delays due to interdependencies with other work taking place at NHFT were noted as causal factors.

85. The ICB's Board expressed a particular concern that a dedicated Assertive Outreach Team had yet to be established, with services continuing to be delivered through Local Mental Health Teams, where staff managed mixed caseloads. It was noted that NHFT has agreed a timeline for delivery of a dedicated team by end of September 2025.
86. Due to the lack of assurance regarding progress against the Assertive and Intensive Engagement Improvement Plan, an additional layer of oversight has been put in place through the Mental Health Performance and Delivery Programme Board (referenced earlier in this statement), which now receives regular reports that enable detailed monitoring of progress in implementing the required actions.
87. During summer 2025, NHS England asked all ICBs to complete a further assessment of assertive and intensive community mental health care services against a set of principles of best practice for the care pathway. The assessment considered partnership working, workforce, access and oversight, key working arrangements and caseload management, out of hours provision, care delivery, information sharing, family and carer involvement, and demonstrating impact. The outcome of the assessment, which was completed in partnership with NHFT, was submitted to NHS England on 3 September 2025 [**NHNB0019536**]. This resulted in most areas being assessed as 'amber' by the ICB, as further improvements were required. The ICB concluded that progress was being made, but that full assurance could not yet be provided that the needs of this population group were being met.

88. The Assertive and Intensive Engagement Improvement Plan was updated following the assessment and monthly meetings are taking place to monitor delivery of the required actions. Progress continues to be reported to the Mental Health Performance and Delivery Programme Board and to the IOAG. As part of these reporting arrangements, a clinical triangulation deep dive of the assertive outreach pathway was presented to the IOAG on 24 October 2025 [NHNB0019535] to better understand the impact of improvement actions taken.

Primary care

89. Mental health support in primary care is delivered through multiple ICB commissioned arrangements:

- a. General Practices provide core mental health services under their standard contracts.
- b. Social prescribing services are commissioned from various providers to enhance support within primary care settings.
- c. Mental Health Practitioners are commissioned from NHFT to provide support and interventions for individuals experiencing mental health difficulties, bridging the gap between primary care and specialist mental health services.
- d. Health Improvement Workers are commissioned to support the completion of physical health checks for people with severe mental illness.
- e. Targeted services are commissioned from primary care providers to support specific clinical pathways – for example, the ICB commissions medical monitoring for individuals receiving care from NHFT's Eating Disorder Service.

90. Primary care mental health services are complemented by a range of support services, such as NHS Talking Therapies, which can be accessed by General Practices and directly by patients.

Policies and procedures

91. The ICB's policies relate to the ICB as an organisation. The ICB does not provide NHFT or other providers with policies relevant to their delivery of mental health services.
92. In line with NHS standard contract requirements, providers of services are responsible for adherence to national guidance and related legislation. Providers are required to develop their own policies and processes to reflect applicable guidance and law.
93. As and when new national guidance is published, the ICB works proactively with its providers to review and update service specifications. There is also a reactive element to the ICB's role regarding the assurance of providers' compliance to national guidance, particularly when there are performance or quality concerns about services. For example, the ICB has specifically defined continuity of care principles as a quality requirement within the NHFT contract, in order to give the ICB additional assurances regarding out of area placements.

MONITORING THE QUALITY OF MENTAL HEALTH SERVICES

94. Section 14Z34 of the NHS Act 2006 sets out the ICB's duty as to improvement in quality of services as follows:
- (1) *"Each integrated care board must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness."*

(2) In discharging its duty under subsection (1), an integrated care board must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of services.

(3) The outcomes relevant for the purposes of subsection (2) include, in particular, outcomes which show –

(a) the effectiveness of the services,

(b) the safety of the services, and

(c) the quality of the experience undergone by patients”

95. The ICB has established arrangements for delivering these requirements, building on the strong foundations put in place by the former Clinical Commissioning Groups. Whilst there have naturally been changes over time as the organisation has evolved, these arrangements have remained consistent in intent and focus, whilst adapting in line with national direction. As an ICB, the arrangements have been strengthened by enhanced collaboration through system working and greater transparency across NHS and wider ICS partners.

96. Under the leadership of the Executive Director with responsibility for quality and nursing matters, the ICB has a team of staff responsible for oversight of quality standards and quality improvement and ensuring the delivery of the ICB's statutory duties relating to quality, which include responsibilities around safeguarding, continuing healthcare, infection prevention and control and patient safety. These staff ensure that services are safe, effective and in line with the needs of the population. This includes some specialist posts, such as the designated roles required for safeguarding.

97. The ICB's Executive Director with responsibility for quality and nursing matters also has executive lead responsibility for the following population groups:
- a. Children and young people (aged 0 to 25).
 - b. Children and young people with special educational needs and disability (aged 0 to 25).
 - c. Safeguarding (all-age).
 - d. Learning disability and autism (all-age).
 - e. Down syndrome (all-age).

Quality monitoring and escalation processes

98. The ICB (and the former Clinical Commissioning Groups) has developed increasingly sophisticated systems and processes that have been continuously refined and adapted to support the ongoing monitoring, escalation, and improvement of quality across the ICS. These arrangements, which have been developed in line with NQB guidance, are underpinned by the triangulation of multiple intelligence sources – including quantitative performance data, qualitative information and soft intelligence – to enable timely identification of risks and emerging themes and to enable ongoing monitoring and scrutiny of any identified issues.
99. The ICB's approach to quality oversight combines both informal and formal mechanisms to ensure early identification and effective escalation of concerns. Frontline feedback and observational insight are gathered through a regular presence of senior ICB staff within NHFT, including weekly attendance at NHFT meetings, strong relationships with clinical, managerial, and operational staff, and quality insight visits to clinical areas. These activities provide real-time, relational intelligence that complements formal reporting. In parallel, formal enhanced

surveillance arrangements operate through clearly defined governance pathways, from operational oversight groups through to the ICB's committees and ultimately its Board, ensuring structured and consistent escalation of quality concerns. Additionally, system quality forums provide both ICB and peer-level oversight of emerging quality challenges. Information from these sources is triangulated to support robust quality monitoring and escalation. As the ICB has developed, so too have the mechanisms for quality oversight, ensuring they remain fit for purpose, responsive to emerging challenges, and aligned with national guidance and local priorities.

100. Robust risk management processes are also in place, which are fully embedded within all ICB activities and are integral to our approach to maintaining and improving quality. Risks to safety, effectiveness, and experience are identified, assessed, and acted upon, with clear escalation routes into governance forums, informing both assurance and decision-making.
101. Insights generated through the ICB's quality surveillance mechanisms are used to inform system learning, support improvement activity, and shape the ICB's commissioning and planning decisions.
102. The ICB (and the former Clinical Commissioning Groups) have close working relationships with the CQC, which include regular touchpoint meetings to share intelligence.
103. The ICB also engages with a range of professional regulators, including the General Medical Council, the Nursing and Midwifery Council, and the Health and Care Professions Council, as needed in the delivery of its commissioning functions and as relevant to its role as an employer of registered professionals.

Concerns regarding NHFT

104. Through the quality monitoring and escalation processes described above, the ICB (and the former Clinical Commissioning Groups) have identified and monitored concerns about NHFT for some time. NHFT provides a complex range of services and as such, the issues identified have been wide-ranging in nature and severity and have evolved during the relevant period under consideration by the Inquiry, with NHFT demonstrating improvements in some areas and deterioration in others.
105. In line with established working arrangements, these concerns were (and continue to be) consistently escalated to NHS England via regional quality meetings, meetings to discuss NHFT's NHS Oversight Framework segmentation, and Quarterly System Review Meetings as part of NHS England's performance oversight and improvement process.
106. Increased scrutiny of NHFT commenced following the publication of the CQC's inspection of NHFT on 24 May 2019, where an overall rating of 'Requires Improvement' had been given. The inspection report recognised NHFT for its compassionate care and committed workforce; however, emphasis was given to the need for stronger governance, safer environments, better staff engagement, and a more consistent approach to quality and risk management across services.
107. The findings were consistent with concerns that had been raised through the former Clinical Commissioning Groups' routine quality surveillance mechanisms, which included:
- a. An instability in NHFT's leadership, with multiple interim appointments and ongoing recruitment at executive levels.

- b. Cultural challenges evidenced by declining staff survey results and workforce concerns relating to high sickness rates, low compliance with mandatory training, and over-reliance on agency staff.
 - c. Deteriorating performance against national mental health standards, particularly in areas such as Early Intervention in Psychosis (“EIP”), Improving Access to Psychological Therapies (now referred to as NHS Talking Therapies), and children and young people’s services.
108. At this time, the Orion Unit was also under investigation by the CQC and closed to new admissions, while Rampton Hospital faced scrutiny by the CQC in relation to people in long-term segregation and staffing shortages.
109. The former Clinical Commissioning Groups’ concerns, alongside issuance of the CQC’s inspection report, represented an increasing number of issues being noted in relation to NHFT, which were indicative of a more systemic problem. As a result, the former Clinical Commissioning Groups met with the CQC and NHS England on 9 July 2019 and agreed to share information and increase surveillance of NHFT. Formal enhanced surveillance of NHFT began in August 2019, as initiated by the NHS England Midlands regional team’s Quality Surveillance Group (“QSG”).
110. At this time, the former Clinical Commissioning Groups supported the intensified oversight and support mechanisms implemented by the QSG, by working with NHFT to implement and monitor recovery action plans across key mental health services.
111. On 25 September 2019, a report was presented to the former Clinical Commissioning Groups’ Quality, Safeguarding and Performance Committees (at a meeting in common) [NHNB0003963], which consolidated the known issues across quality, performance and contracting,

including key findings from the CQC inspection. In addition to the CQC's findings, the former Clinical Commissioning Groups identified:

- a. An increase in suicide rates among people using NHFT services during the period from 1 April 2018 to 31 March 2019, with 47 deaths recorded as apparent suicide and five as confirmed suicide out of 2,519 adult deaths. The former Clinical Commissioning Groups and NHFT had investigated concerns about possible links to long waiting times for psychological therapies, but no specific trends or causes were found.
- b. Services for people experiencing their first episode of psychosis, as well as psychological therapy services, were not consistently meeting national standards. Early Intervention in Psychosis (EIP) services were not fully NICE compliant, and there was a shortage of appropriately trained therapists across the Nottingham and Nottinghamshire area.
- c. The short breaks service for children with complex health needs, funded by the former Clinical Commissioning Groups, was temporarily closed following drug errors, staff shortages, and underperformance in bed occupancy. This closure affected several families, with some children unable to access overnight breaks as a result.
- d. The Orion Unit, a specialist mental health service, experienced repeated closures to new admissions due to a combination of high patient acuity, staffing shortages, and lack of suitable community placements for some patients.
- e. Allegations had been made regarding standards of care at Ling's Bar Hospital (John Proctor Ward), which were under investigation at the time of the report.

- f. Problems with how medicines were managed, including medication errors and lack of robust physical health monitoring after drug administration.
- g. Issues with privacy and dignity, such as male staff observing female patients without informing them, dormitory arrangements impacting privacy, and patient information on whiteboards compromising confidentiality.
- h. Care plans were not always personalised or recovery-oriented, and there were deficiencies in the governance of the Mental Health Act, such as staff not always explaining patients' rights or auditing this process.
- i. Widespread challenges in recruiting and retaining staff, with safe staffing levels not consistently met. Bank staff filled a significant proportion of nursing assistant shifts to cover sickness, absence, or vacancies.
- j. Staff survey results indicated low satisfaction and engagement across NHFT, with a lack of structured staff engagement, concerns about staff not feeling able to raise concerns without fear of retribution, and a decrease in staff perception of opportunities for career progression.

112. The identification of these issues culminated in the former Clinical Commissioning Groups' registering a high risk that patient/service user diagnosis and treatment may not meet the required quality standards, which in turn could result in poor patient experience, adverse clinical outcomes and/or patient safety issues. This led to the former Clinical Commissioning Groups initiating a more comprehensive risk scoping exercise to fully understand the extent of issues regarding the quality and safety of services provided by NHFT. This exercise drew on the CQC findings, NHS England assurance meetings regarding Rampton Hospital, engagement with public health

colleagues regarding children's services, insight visits to community settings, and engagement with NHFT nursing and quality leads.

113. The outcome of the risk scoping exercise was presented to a meeting in common of the former Clinical Commissioning Groups' Quality, Safeguarding and Performance Committees on 22 January 2020 [NHNB0004060]. This provided more granularity to the issues previously identified and highlighted further concerns, which included:

- a. Ongoing gaps in local service provision, such as the lack of local female Psychiatric Intensive Care Unit (PICU) beds, leading to continued use of out-of-area placements, and extended waiting times for key services including paediatric speech and language therapy (with waits up to a year), memory services (with some waits exceeding a year), and end of life care for children (with no weekend or out-of-hours cover for approximately a year).
- b. Increased pressures and risks in adult mental health and community services, including high and rising referrals for attention-deficit/hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) diagnosis and prescribing, persistent consultant psychiatrist vacancies, failure to meet workforce performance targets (appraisals, sickness, staff turnover, and agency usage), and increased violence towards staff, particularly in adult mental health and PICU settings.
- c. Service delivery and safety concerns, such as the absence of a dedicated dual diagnosis service for mental health and substance misuse, Lings Bar Hospital being used for patients with combined complex needs beyond its intended scope, increased fire risk from patients smoking in restricted areas,

and risks to safe care in community nursing services due to staff shortages, changing patient cohorts, and inconsistent completion of Do Not Attempt Resuscitation (DNAR) forms.

- d. Clinical quality and patient safety issues, including concerns about the use and prescribing of Ketamine and Methadone in hospice care, low levels of reporting deaths to the Coroner, challenges in meeting physical health care needs and increased risk of falls for older people on mental health services for older people (MHSOP) wards, and failure to meet targets for physical health checks for patients on the primary care serious mental illness (SMI) register.
- e. Inequities and underperformance in specialist and children's services, such as the tissue viability service for children and young people being inconsistent across Nottingham City and Nottinghamshire County, underperformance in child and adolescent mental health services (CAMHS) activity and eating disorder treatment times, and data quality and contract management concerns, including NHFT's inability to provide a comprehensive overview of service delivery for performance monitoring.
- f. Inconsistent achievement of targets for reducing inappropriate out-of-area placement bed days, with associated cost pressures from the use of private providers.

114. The former Clinical Commissioning Groups adopted a proactive and collaborative approach to addressing the wide range of risks and concerns identified by the risk scoping exercise, as follows:

- a. In response to specific issues relating to service access gaps, workforce shortages and clinical quality concerns, the former Clinical Commissioning Groups worked closely with NHFT and wider system partners – including NHS England, local authorities (including public health), Healthwatch, Health Education England, and Nottingham University Hospitals NHS Trust – to design and monitor targeted recovery and improvement plans for key services such as PICU, CAMHS and end of life care. Recruitment activity was also monitored and revised workforce models pursued to address vacancies and reduce agency usage. Additional actions focused on reducing out-of-area placements, improving waiting times for priority services, and tackling areas of underperformance including memory clinics, paediatric therapies and specialist children's services.
- b. Contract meetings and targeted Quality Insights Visits were increased in frequency, and new performance metrics and strengthened data dashboards were introduced to strengthen monitoring arrangements, with a focus on improved data quality.
- c. Work with system partners continued to centre on intelligence sharing and agreeing shared responses to high-risk areas, supported by clear escalation routes for unresolved or deteriorating risks.
- d. Oversight of required improvements and the tracking of progress was being undertaken through monthly CQC action plan review meetings and staff from the former Clinical Commissioning Groups were also attending internal meetings at NHFT. Meetings were also held between the Executive Management Teams of the ICB and NHFT and a formal 'Board to Board' meeting was held in November 2019.

115. As referenced earlier in this statement, the NHS Nottingham and Nottinghamshire Clinical Commissioning Group was established on 1 April 2020; however, the merger of the six former Clinical Commissioning Groups brought no change to operational arrangements for oversight and monitoring of NHFT.
116. By June 2020, NHFT had made notable progress. A new Executive Management Team had been established, and cultural and safety initiatives were progressing. However, challenges relating to staffing persisted, and although overall rates of staff sickness absence had improved compared to the previous year, COVID-19-related absences were a pressure point.
117. The impact of COVID-19 also introduced new complexities, with a notable increase in community deaths that was attributed to earlier discharges from acute settings and increased patient acuity. Service disruptions, particularly in memory assessment and local mental health teams, had also raised concerns around unmet need and risk stratification.
118. An assurance update was provided to the CCG's Quality and Performance Committee on 24 September 2020 [NHN0004170]. This highlighted that NHFT had strengthened leadership and governance, work was ongoing with CQC actions, and key quality initiatives to strengthen patient safety and improve inpatient and community services had been launched, with the CCG maintaining regular oversight through participation in NHFT's internal meetings, and through the ongoing completion of Quality Insights Visits. The CCG was also monitoring the restoration and recovery of services in response to the COVID-19 pandemic, addressing backlogs and service pressures, and ensuring safe delivery of care. Collaborative work with system partners continued to address challenges in waiting times, out-of-area placements, and

workforce capacity. Despite these advances, the report noted that some actions remained outstanding, such as fully embedding risk assessment practices, and completing the rollout of electronic observation recording. Ongoing challenges were also highlighted in waiting times, out-of-area placements, workforce capacity, and the impact of COVID-19 on community services.

119. Throughout the rest of 2020, the CCG continued to note concerns regarding workforce capacity, governance maturity and the pace of improvements, particularly in adult mental health and community services. NHFT also consistently reported the highest number of serious incidents across the local NHS system, with a significant proportion linked to self-harm, falls, and sub-optimal care of deteriorating patients. These issues were further compounded by the impact of COVID-19, which had significantly disrupted NHFT's operations. Whilst routine contract and quality monitoring processes had been suspended (in line with national policy, as referenced earlier in this statement), the CCG's quality and commissioning teams continued to monitor core safety metrics and meet informally with NHFT. The CQC also continued to meet with NHFT to monitor progress of its improvement plan.
120. Continued monitoring throughout 2021 highlighted improvements at NHFT in terms of strengthened patient safety and clinical oversight. All 'well-led' recommendations from the CQC report published in May 2019 had been completed and several services, including the two-week referral to treatment target for EIP, were showing measurable improvements in access and performance. NHFT had strengthened its governance framework and quality assurance mechanisms and work was being taken forward to address workforce fragility. However, quality improvement initiatives were delayed by the required focus on COVID-19 recovery actions.

121. In March 2022, the CCG identified and registered another high risk relating to rising mental health waiting lists and demand, particularly affecting children and young people.
122. On 28 April 2022, a report was presented to the CCG's Quality and Performance Committee **[NHNB0000752]**, which reviewed progress and challenges in delivering the Long Term Plan for mental health services. The report identified a number of issues specific to NHFT, including persisting workforce shortages and rising demand, causing long waiting times for specialist assessments and inpatient beds, with some waits reaching up to 74 weeks.
123. On 1 July 2022, the ICB was legally established. The organisational transition from the CCG to the ICB did not impact on the level of scrutiny placed on NHFT, as the CCG completed a thorough due diligence and handover process.
124. With the statutory creation of Integrated Care Systems, NHS England issued the NHS Oversight Framework 2022/23 **[NHNB0018961]**. This emphasised a shift in role for ICBs from a traditional commissioning approach (focused on 'top-down' transactional contracting and performance oversight) to a system convening role (focused on partnership-driven, proportionate oversight). This required regional teams to monitor and support local providers.
125. In line with NHS Oversight Framework criteria, NHS England placed NHFT in segment 3. This was informed by the ICB's recommendation to NHS England.
126. Concerns were now extending to services subcontracted by NHFT, with the Priory Hospital Arnold rated 'Inadequate' by the CQC following an unannounced inspection in August 2022.

127. Going into 2023, NHFT continued to face challenges; however, confidence in NHFT's ability to deliver improvements was increasing and whilst the CQC rating remained as 'Requires Improvement', the CQC did note that progress was being made. As a result, the dedicated Quality Improvement Group for NHFT (referenced earlier in this statement) agreed to reduce the frequency of its oversight meetings.
128. A follow-up CQC inspection at Rampton Hospital took place in June 2023. This found that only four of the twelve 'must do' actions had been completed. Enforcement action was considered by the CQC; however, this was not taken forward following acceptance of a comprehensive improvement plan from NHFT.
129. On 29 June 2023, a Prevention of Future Deaths report was issued to NHFT and the ICB. The report highlighted two key failings regarding inadequate involvement of families and carers and poor accessibility of clinical risk information within electronic patient records. The ICB's response to the Coroner on 16 August 2023 **[NHNB0018963]** confirmed that the ICB had reviewed the incident with the GP practice concerned, engaged with NHFT to explore flagging high-risk suicide correspondence to GPs, and developed associated guidance for all GPs in Nottingham and Nottinghamshire.
130. In July 2023, a meeting was held between the Executive Management Teams of the ICB and NHFT to discuss progress against the segment 3 criteria. At the meeting, NHFT expressed an ambition to move to segment 2 and discussions focussed on the conditions that would need to be met for the ICB to make this recommendation to NHS England in line with the NHS Oversight Framework.
131. A letter summarising the discussions at the meeting was sent to NHFT on 3 August 2023 **[NHNB0018962]**, which reaffirmed the ICB's recognition of the work

undertaken to date, the ICB's commitment to supporting the resolution of ongoing challenges, and the actions required of NHFT to enable a recommendation to move to segment 2. The letter confirmed the ICB's position that due to continuing and emerging concerns, NHFT would remain in segment 3.

132. From September 2023, the Patient Safety Incident Response Framework became the mandated approach to patient safety incident response across the NHS. ICBs were directed to support implementation across their respective providers, providing oversight of response plans, monitoring learning themes, and ensuring that insights from patient safety events informed quality at a system level. The ICB worked closely with NHFT in this regard. The ICB also established a Patient Safety Specialist Forum to support Patient Safety Incident Response Framework implementation and learning.

133. The situation with NHFT escalated significantly following the attacks on 13 June 2023. A number of factors increased the level of concern held by the ICB and NHS England at this time. These included concerns regarding the care and treatment of Valdo Calocane, concerns arising from a high number of suspensions of staff for falsifying records in inpatient services, concerns raised by the CQC inspection of Rampton Hospital, and the multiplicity of emerging concerns in relation to Coronial findings and incidents, alongside intelligence from patient feedback. Workforce and capacity issues also continued to present significant access challenges to acute mental health care, which had resulted in long waits for mental health assessment and/or admission for patients who had presented at emergency departments.

134. In February 2024, an update to the ICB's Quality and People Committee **[NHNB0000097]** reported that widespread quality and safety concerns remained. There had been limited progress against the CQC 'must do'

actions, eight Prevention of Future Deaths reports had been issued in the past year, and there were recurring issues in recognising and responding to deteriorating patients. Whilst a number of oversight actions were in place, assurance was limited as improvements were not being made at the scale and pace necessary, with issues continuing to emerge through formal and informal channels.

135. The concerns were compounded by NHS England's regional commissioning team sharing significant concerns about NHFT's standards of care in offender health services. This resulted in a triangulation exercise being undertaken across all commissioners and regulators and the extent and breadth of concerns being seen resulted in NHS England intervening and placing NHFT into segment 4 of the NHS Oversight Framework in February 2024.
136. Segment 4 represents the highest level of oversight under the framework and placed NHFT into the national Recovery Support Programme, which includes enhanced regulatory intervention by NHS England, with formal recovery planning and intensified scrutiny. Under the Framework, the ICB plays a key role in supporting recovery and contributing to oversight, co-ordination, and assurance of improvement actions.
137. In line with the above, an Improvement Oversight and Assurance Group ("IOAG") was set up jointly between the ICB and NHS England's regional team to monitor NHFT's response to the quality and regulatory concerns while they are in the highest category of oversight. The IOAG, which meets monthly, is co-chaired by me as the ICB's Chief Executive and Accountable Officer and NHS England's Regional Medical Director.

138. As part of the enhanced regulatory intervention process, NHFT was directed to produce an Integrated Improvement Plan ("IIP"). Overseen by the IOAG, the IIP has evolved from its conception in March 2024 into a strategic framework for sustainable transformation; consolidating actions required over five core programmes: Patient Safety and Quality, Leading for the Future, Finance and Productivity, People and Culture, and Well-Led Governance. As part of its remit, the IOAG oversees the delivery of actions and ensures that improvements are being delivered within agreed timescales. The 'Safe Now' data (referenced earlier in this statement) has also been reported into the IOAG since June 2024 to support the monitoring of progress and the effectiveness of interventions.
139. Alongside the IOAG process, there are monthly 'Safe Now' meetings with NHFT using shared reporting and metrics to assess progress against the more immediate safety challenges together with the 'Safe Now' dashboard (referenced earlier in this statement), which supports immediate actions for safety and improvement, with appropriate escalations. ICB representatives also attend NHFT's Rapid Improvement Board and associated workstreams to triangulate data and actions.
140. At the time of writing this statement, NHFT continues to be under enhanced oversight in segment 4 of the NHS Oversight Framework, and it is not yet clear when they may be in a position to move to a reduced level of oversight.
141. To summarise, concerns relating to NHFT were first escalated into the former Clinical Commissioning Groups' formal governance arrangements in September 2019. Ongoing concerns relating to NHFT have since remained subject to heightened scrutiny, featuring regularly on the agendas of subsequent Board and committee meetings of the former Clinical Commissioning Groups and then the ICB. This level of Board and committee oversight remains in place to date.

REVIEWS

Prevention of Future Deaths reports

142. During the relevant period under consideration by the Inquiry, the ICB has received one Prevention of Future Deaths report. This was in June 2023, and the ICB's response is set out earlier in this statement.

143. In February 2025, NHFT presented a report to the IOAG resulting from a review they had completed of 12 Prevention of Future Deaths reports that NHFT had received during 2023 and 2024. The report detailed a number of themes from the concerns raised by the Coroner, which included issues relating to NHFT's serious incident investigation processes and the sharing of learning, issues relating to NHFT's candour, openness and honesty when engaging in post death investigations, issues relating to staff support and training, and issues relating to the quality of care provided by NHFT. The report also set out how the actions required by NHFT in response to the Coroner's concerns had been mapped into existing actions contained within NHFT's IIP.

144. Since completing its thematic review, and through its work to implement the actions contained within its IIP, overseen by the IOAG, NHFT has demonstrated improvements in its review and investigation of deaths by enhancing staff knowledge and skills through quarterly training, embedding learning, strengthening collaboration and information sharing, and increasing family involvement. Subsequent Coroner feedback has commended NHFT's openness, transparency, and robust internal reviews, with clear evidence of effective learning from inquest cases.

Reviews commissioned in light of the attacks on 13 June 2023

145. The ICB has not undertaken or commissioned any review or report following the attacks on 13 June 2023 given that a number of reviews or reports were already underway. The ICB has considered at what point a broader review may be appropriate but given the police investigations, the trial, the number of reviews already completed and the commencement of this Inquiry, there has not been an appropriate point for the ICB to commission a further review. However, the ICB's Board and its committees have considered the issues and the broader learning whilst investigations, enquiries and reviews have been ongoing over the last two years.
146. The Section 48 Review was commissioned by the Secretary of State for Health and Social Care in January 2024 and conducted by the CQC. I attach as exhibit **[NHNB0018965]** a paper considered by the ICB's Executive Management Team in April 2024 setting out the ICB's initial response to the Section 48 Review.
147. NHS England commissioned an independent investigation into the care and treatment provided to Valdo Calocane, which concluded its report in January 2025 **[NHNB0018966]**. There were a number of findings in the report relevant to several organisations. The findings in relation to the ICB included that *"There were limitations with the assurance and oversight arrangements at the ICB in 2023. The arrangements were not formalised or robust enough to provide the opportunity to fully identify signals of issues with safety and risk. Nor were the governance arrangements mature enough to triangulate intelligence with partner organisations."*
148. The investigation report detailed that the ICB was not *"fully assured around the ability of the Trust to make or sustain the required improvements."* There was evidence of the ICB monitoring concerns but the arrangements in *"place to assure themselves*

of appropriate action being taken were still maturing and did not allow for the ICB to assure themselves of improvements in a timely manner.”

149. The report also included a finding that *“structures and processes of the governance framework at all levels of the local healthcare system, were not set up for identification and communication of potential and existing issues which combined to increase risks to users of the Trust’s services and others. We found evidence of siloed governance arrangements and little evidence of triangulation of information to enable system wide learning. We found this to be the case from the Integrated Care Board through to Trust processes.”*

150. The report made the following recommendations:

- a. NHFT, the ICB and system partners should review and evidence the effectiveness and reliability of communication processes across all system partners relevant to mental health care, treatment and risk management.
- b. NHFT and the ICB should seek support from existing expertise in the area of risk and governance within their organisations. This should be used to develop structures, processes and procedures that demonstrate the capability to identify and communicate potential and existing issues and risks. This will require the system to develop the ability to triangulate safety critical information to inform existing and emerging issues. This should be a data driven process drawing from both clinical and operational sources.

151. The ICB accepted these findings, as its assurance and oversight arrangements were still developing during its first year of establishment, in line with the nationally required shift to a system convenor role (as described earlier in this statement). These arrangements, which work alongside NHS England’s intensive oversight as

part of the NOF 4 interventions, have now been significantly strengthened in line with the report's recommendations.

152. In February 2025, NHS England published an Independent Mental Health Homicide review **[NHNB0018988]**, which examined the events covered by this Inquiry. The ICB has fully accepted the recommendations from the review and has developed an action plan jointly with NHFT **[NHNB0000019]**, which has been published by the ICB.
153. On 23 April 2025, the IOAG approved NHFT's refreshed IIP for 2025/26 **[NHFT0001005]**. This brought together a focused set of actions required to meet the outstanding recommendations from the Section 48 Review, the independent investigation into the care and treatment provided to Valdo Calocane, the Independent Mental Health Homicide review, and to support NHFT's transition from NOF 4 status. On 23 May 2025, the IOAG approved a set of metrics to be used to monitor and evidence progress in the IIP's delivery **[NHSE0002055]**.
154. Throughout 2025/26, the IOAG has received monthly progress updates in relation to the required improvements by NHFT, alongside monthly monitoring of the 'Safe Now' Dashboard (referenced earlier in this statement). This has enabled ongoing oversight and has highlighted both areas of improvement – such as improved service user and family engagement, reduced out of area placements, strengthened medical leadership and 'ward-to-board' escalation, and real-time safety monitoring – and areas where progress has been more mixed, notably crisis services responses and staffing issues at Rampton Hospital.

155. At the time of writing this statement, good progress is being made, with the majority of actions nearing completion, and there is evidence of broader cultural progress by NHFT. Nevertheless, further work is required to ensure these improvements are fully embedded, sustained, and having the required impact in practice, particularly in light of ongoing financial pressures and the complexity of challenges faced by NHFT. Continued support from the ICB and other partners, as well as enhanced oversight by IOAG and regulatory bodies, remains in place.

RECOMMENDATIONS

156. All the relevant organisations, including the ICB, NHS England and the CQC, knew about the concerns in relation to NHFT, and all such organisations were taking action. However, the complexity of the issues faced by NHFT have meant that sustained improvements have not been embedded in all areas.

157. I have been asked what improvements could be made to increase effectiveness in multi-agency working and to prevent similar outcomes in the future and what recommendations could be made by the Inquiry.

158. I welcome the new operating model for the NHS, as set out in the Department of Health and Social Care's new ten-year health plan for England, "Fit for the Future". When implementing the new operating model for the NHS, it will be important to ensure there is clarity of roles and responsibilities between NHS England, ICBs and NHS providers, and that robust working arrangements between commissioners and regulators continue to be in place.

159. Of equal importance will be the enabling of arrangements for local NHS system partnership working to preserve the culture of openness and transparency between ICBs and NHS providers that has been established since ICBs were introduced.

These partnership arrangements have facilitated collaboration across organisational boundaries, with an emphasis on collective responsibilities and mutual accountability across local NHS systems.

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.

Signature:

GRO-B

Name: Amanda Sullivan

Date: 03.12.2025

Index to the Witness Statement of Amanda Sullivan

<u>Exhibit No.</u>	<u>URN</u>	<u>Document Description</u>
01	NHNB0019534	Letter from NHSE re guidance to manage the COVID-19 pandemic
02	NHNB0009168	All-age Integrated Mental Health and Social Care Strategy 2019-2024
03	NHNB0018986	NHS England Commissioner Guidance for Adult Mental Health Rehabilitation Inpatient Services (Jan 2024)
04	NHNB0018985	NHS England Commissioning Framework for Mental Health Inpatient Services (Feb 2024)
05	NHNB0000167	Three-Year Integrated Mental Health Pathway Strategic Plan (2024/25–2026/27)
06	NHNB0018964	Report to ICB's Strategic Planning and Integration Committee September 2023
07	NHNB0018971	Three-Year Integrated Mental Health Pathway Strategic Plan: Progress update (July 2025)
08	NHNB0018989	CQC Special Review into Mental Health Care at NHFT (Mar 2024)
09	NHNB0018987	NHS England Guidance on Intensive and Assertive Community Mental Health Treatment (Jul 2024)
10	NHNB0000273	Report on Assertive and intensive community mental health care services (Nov 2024)
11	NHNB0000055	Assertive and Intensive Engagement Improvement Plan: Progress report (May 2025)
12	NHNB0019536	Assertive and Intensive Community Mental Health services ICB assessment (Sept 2025)
13	NHNB0019535	Assertive Outreach Deep Dive (Oct 2025)

14	NHNB0003963	Report to Quality, Safety and Performance Committee re quality, performance and contracting (Sept 2019)
15	NHNB0004060	Report to Quality, Safety and Performance Committee re risk scoping exercise (Jan 2020)
16	NHNB0004170	Report to Quality and Performance Committee re risk report (Sept 2020)
17	NHNB0000752	Report to Quality and Performance Committee re Long Term Plan deliverables (April 2022)
18	NHNB0018961	NHS Oversight Framework 2022/23
19	NHNB0018963	Letter to Coroner regarding PFD notice (Aug 2023)
20	NHNB0018962	Letter to NHFT regarding NOF segmentation (Aug 2023)
21	NHNB0000097	Report to Quality and Performance Committee re NHT risk stocktake (Feb 2024)
22	NHNB0018965	EMT paper on the ICB's initial response to the Section 48 Review
23	NHNB0018966	Independent investigation report into the care and treatment provided to Valdo Calocane
24	NHNB0018988	Independent Mental Health Homicide Review (Feb 2025)
25	NHNB0000019	ICB Action Plan in Response to Independent Mental Health Homicide Review
26	NHFT0001005	NHFT Refreshed IIP 25/26 (April 2025)
27	NHSE0002055	Approved IIP Metrics (May 2025)