

Monday, 18 May 2026

1
2 (10.00 am)
3 **THE CHAIR:** Yes, Mr Carr.
4 **MR CARR:** Chair, may I call, please, Dr John Brewin.
5 **DR JOHN BREWIN (affirmed)**
6 **Questioned by MR CARR**
7 **THE CHAIR:** Yes.
8 **MR CARR:** Dr Brewin, you have made a statement for the
9 purposes of this Inquiry dated 15 January 2026.
10 **A.** Yes.
11 **Q.** Is that statement true, to your best knowledge and
12 belief?
13 **A.** It is, yes.
14 **Q.** You were the Chief Executive Officer, CEO of the
15 Nottinghamshire Healthcare NHS Foundation Trust between
16 2019 and 2022.
17 **A.** That's correct.
18 **Q.** That's specifically January 2019 to August 2022.
19 **A.** Yes.
20 **Q.** You'd previously worked as a Consultant Psychiatrist at
21 the Trust between 1995 and 2011?
22 **A.** Yes.
23 **Q.** Were there advantages to you undertaking the executive
24 role, the CEO role, having practised in psychiatry?
25 **A.** I'd like to think so, and certainly my experience

1

1 **Q.** Well, very brief and high level.
2 **A.** Okay, so at a high level, the major changes were that --
3 well, one in personnel, so the Executive Director of
4 Nursing, Dr Julie Attfield, her post -- she moved posts
5 to a new arrangement. So where you see "Executive
6 Director of Local Partnerships" that, essentially, was
7 two big divisions rolled into one. So there was the
8 Mental Health Division and what's called the Community
9 Health Services Division. So that's physical
10 healthcare, the Trust was responsible for physical
11 health services in the county of Nottinghamshire.
12 So one of the things that I did was to split that
13 into two divisions and --
14 **Q.** The Executive Director of Local Partnerships?
15 **A.** -- local partnerships became the division of Mental
16 Health and the Community Health Division. Dr Attfield
17 moved across into becoming the Executive Director for
18 the mental health part of that split. So her nursing
19 post became vacant and it created a view vacancy in the
20 newly formed Community Health Division.
21 **Q.** Aside from personnel changes then, just in terms of any
22 structural changes, was the major change the division of
23 the Executive Director of Local Partnerships?
24 **A.** Yes, so and then the other two that were probably
25 a point of emphasis, so the Director of -- in the bottom

3

1 working through various clinical management roles was
2 that -- I mean, initially, whilst I was able to do both,
3 clinical role and a managerial role, it kept me grounded
4 in the day-to-day, the challenges of working in
5 services, and increasingly aware of the -- the
6 bureaucracy and the governance and the issues that
7 I needed to know to later come on to be Chief Exec of
8 the Trust. So I think it stood me in good stead having
9 a clinical background, yes.
10 **Q.** And to understand the structure, if we look, please, at
11 document WITN0380006, this is the management and
12 structure chart that is about to come on the screen.
13 **A.** Uh-huh.
14 **Q.** We can see there you there towards the top in the middle
15 as Chief Executive, the Chair above you, Dean Fathers,
16 and we see various other executives on your level and
17 then some executive directors below you. This, as you
18 explain in your statement, sets out the position as at
19 January 2019.
20 **A.** That's correct, yes.
21 **Q.** How did the structure change over the course of the time
22 that you were CEO, if it did change?
23 **A.** Yes, so it changed in a number of ways. If I take you
24 through them, feel free to interrupt, because they're
25 quite considerable.

2

1 left-hand corner -- Human Resources, we redescribed that
2 directorate to become the Directorate of People and
3 Culture, so a much bigger remit across the organisation
4 which I think we may come on to talk about in terms of
5 supporting our staff and developing the culture. Then
6 the Director of Business and Developments and Marketing
7 became a broader portfolio, which was the Director of
8 Strategy and Partnerships, so to take a broader remit in
9 terms of working into the broader healthcare system of
10 the county.
11 **Q.** We can take that down. If we go to your witness
12 statement, it's page 12 and it's paragraph 35 and 36 in
13 particular that I'm looking at, where you set out your
14 initial impressions. Paragraph 35, second sentence, you
15 describe:
16 "... a perception that [the Trust] had not been
17 a significant participant in the external health economy
18 within the county and more broadly."
19 What does that mean?
20 **A.** So there are a number of other health trusts within the
21 county, so two large, acute physical healthcare trusts
22 in Nottingham and Mansfield, and there are a number of
23 Primary Care Groups that at the time were I think called
24 Clinical Commissioning Groups, or CCGs, and two local
25 authorities, a city and a county local authority. And

4

1 one of the key points here is that patients presenting
2 with mental health problems right across the spectrum
3 from anxiety and depression through to people with
4 serious mental health illness don't just require
5 services from a mental health trust, they need primary
6 care services from their GPs, and they may need social
7 care from local authorities, and they may often present,
8 for example, in emergency departments in acute trusts.

9 So it's really important to develop professional
10 relationships with these organisations so that we could
11 further develop and improve what's called the Patient
12 Pathways that people with mental illness may go through
13 when they are unwell and in need of services.

14 **Q.** For context, the Trust was a specialist Mental Health
15 Trust, wasn't it? It used to be called a mental health
16 trust, but the services provided were exclusively in the
17 domain of mental health?

18 **A.** Yes, although as I've said, it wasn't just mental
19 health. The Community Division was a provision for
20 physical health, so things, for example, like diabetic
21 nursing, foot-care --

22 **Q.** Was that physical health for mental health patients --

23 **A.** No.

24 **Q.** -- or was that stand alone?

25 **A.** So that's stand alone. It will be things like, for

5

1 are important, the most important thing, the quality of
2 the services that they provide on a day-to-day basis,
3 that we're all pushing in the same direction, and if you
4 lose sight of that and it's all about saving money or
5 all about taking things away, it makes it more difficult
6 to achieve the sorts of things you want.

7 It's not to say that, like I say, that those things
8 in the first part of the sentence are not important,
9 they're critically important, you know, compliance cost
10 savings, but it's about the clinical services that we
11 provide are paramount.

12 **Q.** Paragraph 36 you describe there sub-optimal functioning
13 of the Board.

14 By that are you referring to the fact that, as you
15 go on to describe, "culture, values and behaviours were
16 not given sufficient priority", or is there more to it
17 than that?

18 **A.** I think there's more to it. Yes, culture, values and
19 behaviours weren't given sufficient priority, but there
20 was no clearly identified quality improvement programme,
21 for example. There were quality initiatives and
22 projects but it wasn't pulled together and focused and
23 didn't have a strategic remit behind it. And, as I say,
24 in my statement, the feeling of insularity, if you like,
25 the Board was very focused on the Trust, the

7

1 example, district nurses would have done speech therapy,
2 not for people with mental health problems. And it's --
3 sorry, it was also specialist because of the range what
4 are called forensic psychiatric services. So one of
5 only three Trusts in the country that had a full range
6 of forensic services, low medium, and high secure. And
7 so the fact that Rampton special hospital was part of
8 the Trust meant that we provided national services in
9 that hospital that covered -- that was nationwide.

10 **Q.** The final sentence of paragraph 35 describes:

11 "Internal processes and bureaucracy ... impeding
12 progress, with an overreliance on discussions about cost
13 improvements, compliance, efficiency and processes
14 rather than patients, quality and outcomes."

15 Did you see it as an important part of your role to
16 improve quality and outcomes?

17 **A.** I mean all of the things in that sentence are vitally
18 important.

19 My view was that if there's an over-emphasis on cost
20 improvements, which every Trust has every year to take
21 money out of the budget to make savings, and if there's
22 an over-emphasis on process, it's easy to lose the staff
23 groups. So at the time, 9,500 staff in the organisation
24 and rising, and they need to be, to use a colloquialism,
25 in your boat. They need to see and feel that patients

6

1 organisation, and finding it I think difficult to
2 navigate the changing landscape of what came to be
3 called "the system", so the system of all those
4 different organisations I described working together was
5 part of a national initiative that became the Integrated
6 Care Boards, the ICBs. This was in a period prior to
7 that as that was sort of forming, if you like.

8 **Q.** You considered the Trust hadn't stayed ahead of those or
9 got ahead of those changes?

10 **A.** Yes, yes.

11 **Q.** If we go back in your statement to paragraph 27, page 9,
12 where you describe the first year of your tenure and it
13 being "focused on stabilising [the Trust] ... and
14 beginning to improve the performance metrics ..."

15 When you refer to performance metrics, is that all
16 about -- is that about data, rather than, say, quality
17 and improving outcomes?

18 **A.** No, my inference there is that performance metrics in
19 the whole, so that would -- it may include data but it
20 would also be about outcomes and experience of patients,
21 service users, and staff.

22 **Q.** Well, very early into your tenure there was a CQC
23 inspection --

24 **A.** Yes.

25 **Q.** -- wasn't there? And if we go to page 13 of your

8

1 statement, you describe -- and it's paragraph 38 at the
2 top of the page -- carried out within the first
3 three months of your tenure and you explain the
4 expectation of the Executive Leadership Team "was that
5 there would be a likely deterioration from ... 'good'
6 ... to 'requires improvement'", which is what in fact
7 occurred. We'll look at the report in a moment.

8 What were you told internally were the reasons for
9 the deterioration in performance?
10 **A.** Yeah, it's difficult to put a finger on any particular
11 specific thing. I think there was a general feeling
12 within the executive and within senior staff that I was
13 speaking to that there'd been a general deterioration
14 that was manifest in a number of ways. So for example,
15 there was an annual what's called a National Staff
16 Survey of staff in hospital Trusts and their experiences
17 across a whole wide range of domains, and that -- the
18 score for the Trust had deteriorated over a two or
19 three-year period, I think. And that is taken as
20 a fairly reliable proxy indicator of how a Trust is
21 doing.
22 **Q.** And it was a widely held view, by the sounds of it.
23 A little further down in the paragraph you refer to
24 conversations with multiple colleagues, Board, executive
25 and staff. So was this the feeling throughout the

9

1 **Q.** -- and seniors wouldn't be on notice, wouldn't be aware
2 of what the concerns were?
3 **A.** Absolutely right. Yes. And it's ... I mean,
4 a statement like that is obviously a concern because it
5 points to, you know, concerns across a range of issues
6 within an organisation not least, as I was saying
7 before, this culture that people -- staff didn't feel
8 able to, you know, speak to truth and to raise issues
9 when there were issues to be raised, and that's a poor
10 position to be in.
11 **Q.** Then the seventh bullet point on this page, the one that
12 starts "Where cost improvements were taking place ...",
13 there's a section there dealing with the extent to which
14 clinical advice was taken into account, and the impact
15 on patient care across improvement measurements. Does
16 that chime with what you were referring to before and
17 what you set out in your statement of an over-reliance
18 on discussions about cost improvement and compliance and
19 efficiency?
20 **A.** Yes, it does. Just a little bit of detail on that. So
21 cost improvement, like I say, is a cut to budgets, if
22 you like, and there's a national limit that back then
23 was 3 per cent of a Trust's income should be called
24 a cost improvement. So in an organisation of our size
25 we're talking something to the tune of £15-16 million

11

1 Trust: that it was in decline?

2 **A.** I would agree with that, yes.

3 **Q.** If we look at the 2019 inspection report, it's
4 NHFT0002015 and we can see:

5 As anticipated, the overall rating for the Trust was
6 "Requires improvement" and then individual ratings of
7 "Requires improvement" also for safe response and well
8 led.

9 So it would be clear from this report that whatever
10 was being done needed to change. There were potentially
11 unsafe provisions and care at the hospital and poor
12 governance.

13 **A.** Yes.

14 **Q.** Amongst the particular issues identified in the report,
15 if we turn to page 6 of this document, the second bullet
16 point in the section "Summary of findings", there's
17 reference there to:

18 "The Trust ... not always following best practice in
19 handling ... concerns raised by staff.

20 "Not all staff felt able to raise concerns without
21 fear of retribution."

22 That will be a concern presumably for two reasons:
23 one, because if concerns weren't being raised, then it's
24 difficult for them to be addressed --

25 **A.** Yes.

10

1 worth of value of programmes to be taken out of a trust
2 on an annual basis. So significant amounts of money.

3 **Q.** If we go forward in this document to page 10, in the
4 middle of the page, under the heading "Are services
5 well-led?" The second bullet point there describes:

6 "... acute wards and psychiatric [ICUs] ... as
7 [deteriorating in their rating] to inadequate."

8 Inadequate is the lowest rating, isn't it, that the
9 CQC give?

10 **A.** Yes.

11 **Q.** That would be a cause of significant concern?

12 **A.** Absolutely, yes.

13 **Q.** Those in acute wards and those in Psychiatric Intensive
14 Care units are going to be amongst the most vulnerable
15 of the patients that you're dealing with?

16 **A.** That's true, yes.

17 **Q.** At page 12, towards the bottom of the page, under the
18 heading "Areas for improvement", and this is where the
19 CQC set out steps that must be taken, and under:

20 "Acute wards for adults of working age and
21 psychiatric [ICUs]".

22 The first bullet point up:

23 "The Trust must ensure that there are enough
24 suitable and qualified staff on the ward."

25 One of the points flagged in this report is to why

12

1 the rating had gone down was because of unsafe levels of
2 staffing, wasn't it?

3 **A.** Yes.

4 **Q.** You, as a Trust, would be on notice from this report of
5 the need to address inadequate staffing for safety
6 reasons?

7 **A.** Yes.

8 **Q.** At page 13, and this again is in the list of steps that
9 the CQC is requiring to be taken, which they are saying
10 must be taken, the fifth bullet point down:

11 "The Trust must ensure risk assessments are in place
12 and that they contain all relevant risk information."

13 Again, one of the reasons for the inadequate rating
14 was that management of risk was not being done well, was
15 it?

16 **A.** Yes.

17 **Q.** There are instances that the CQC found where risk
18 assessments weren't made at all and others where they
19 weren't fully developed or didn't contain all the
20 required risk information?

21 **A.** Yes.

22 **Q.** Again, that would be a significant concern?

23 **A.** Yes.

24 **Q.** Going back to your witness statement, and if we go to
25 page 14 where you deal with what happened following this

13

1 addressed. But in addition, from a clinical services
2 point of view, it would be beholden to the executive
3 director that was overseeing that division, that team,
4 to tackle, for example, issues to do with -- take
5 staffing, and if we're understaffed and we've got high
6 vacancy and we've got people leaving, then it's to work
7 with their colleagues to look at how to address that and
8 to attempt to recruit more staff, to encourage staff
9 within the Trust to work on wards as opposed to in other
10 departments, for example.

11 And we also -- sorry, I can't remember the exact
12 dates, it's a wee while ago, would look to strengthen
13 the oversight of these sorts of what we would call
14 quality governance issues so that we became more sighted
15 where, as an executive team and as a Board, what these
16 issues were. Because I think in my report I said that
17 although the headline rating of a reduction to "requires
18 improvement" was expected, I think I was somewhat
19 surprised at the level of concern that the CQC had
20 found.

21 So -- and that's not a good position to be in. You
22 like to think that you're on top of things and know
23 where the issues are, but this was clearly a signal that
24 early in my tenure that that wasn't the case.

25 **Q.** So if we deal with the issue of risk assessments and

15

1 CQC inspection report, you set out, under the heading
2 "Governance Changes" from paragraph 42 onwards and the
3 pages that follow, up until you get to the 2020
4 inspection, various changes to governance and the
5 relationship between the executive and non-executive
6 directors.

7 In particular, if we look on page 15, at
8 paragraph 44 you describe -- 44 and 45 -- a number of
9 new hires, so efforts in recruitment so far as
10 executives are concerned, and paragraph 46 what you
11 describe as "The most significant change ... the
12 creation of a Risk Committee". But that Risk Committee
13 wasn't dealing with clinical risk assessment, was it?

14 **A.** No, that -- no, it wasn't. It was corporate --

15 **Q.** It was concerned with strategic risk.

16 **A.** -- corporate and strategic risk, yes.

17 **Q.** So what steps were taken, between 2019 and 2020, to deal
18 with those issues that the CQC that identified on the
19 ground, as it were, leading to the inadequate rating, in
20 respect of staffing, in respect of inadequate risk
21 assessments?

22 **A.** So from the board perspective, obviously the board is
23 fully briefed on the detailed findings of the report,
24 and we would have done an action plan and a tracker to
25 make sure that the identified actions were appropriately

14

1 you've described putting in place an action plan, but
2 what assurance did the Board get, or what steps were
3 taken to ensure that the Board were assured that risk
4 assessments were properly being undertaken, they were
5 comprehensive? Was there a policy or a task of
6 assessing or dip sampling risk assessments?

7 **A.** Yes, so for example, there'll be a raft of policies
8 around how risk assessments are undertaken and the roles
9 and responsibilities of various professions within the
10 organisation, and they'll be supported by national
11 guidance from bodies, for example, like the Royal
12 College of Psychiatrists, the GMC, about what best
13 practice is. There'd also be training modules for staff
14 to undertake and there will be supervision and appraisal
15 of staff to ensure that they are up to date with those
16 sorts of things.

17 In addition, we created a-- sorry, I can't remember
18 the name of the team, but a quality audit team that
19 would be focused on those areas with the inadequate
20 ratings to undertake quality audits, for example around
21 the completeness of the risk assessments, to make sure
22 that those targets were being met, and help and support
23 teams that were struggling to meet the requirement.

24 **Q.** The next inspection was 2020 and that's at NHFT0001778.

25 This inspection report was published, as we can see,

16

1 23 September 2020 but based on visits in July, so about
2 a year and a half into your tenure. We can see from the
3 heading the focus of this inspection was the acute wards
4 and the Psychiatric Intensive Care units.

5 The overall rating for the service was "requires
6 improvement". So compared to the previous report where
7 we saw it was "inadequate" for this domain, that was an
8 improvement; is that correct?

9 **A.** Yes.

10 **Q.** The domains of safe caring and well-led, they remain the
11 same, don't they, as the previous report?

12 **A.** Yes.

13 **Q.** But you've explained in your statement that as this was
14 a focused report by the CQC, the ratings were unchanged
15 in those domains; they didn't re-rate safety, caring and
16 well-led.

17 **A.** That's correct. My understanding is -- and I think I've
18 put it in my statement -- is that with a focused
19 inspection, that the CQC don't change ratings
20 irrespective of what they find, but the findings are
21 visible in the commentary that they provide. And
22 sometimes the findings can, in a focused inspection, can
23 sometimes appear to be at odds with what the rating is.

24 **Q.** Were you buoyed by this report? Did you feel this was
25 a sign things were going in the right direction?

17

1 pleasing evidence, but it was certainly sense that this
2 was just the first couple of steps on a long journey of
3 improvement, yes.

4 **Q.** If we look at the 2022 CQC Report, CQCM0016478, and this
5 was published in November 2022, so after you'd
6 retired --

7 **A.** Yes.

8 **Q.** -- after you'd stood down from your role. But we can
9 see on the front page, on the date of inspections were
10 March to April whilst you were still in post. And just
11 looking at the ratings on this cover page, "Overall"
12 rating is "Requirements Improvement", so there's no
13 change there from 2019, that's during the inspection at
14 the start of your tenure. "Safe", "responsive" and
15 "well-led", are all "Requires Improvement", and that's
16 the same as the report from 2019.

17 **A.** Yes, sorry.

18 **Q.** The "caring" rating has improved from "Good" to
19 "Outstanding", but "Are services effective?", that has
20 worsened from "Good" to "Requires Improvement".

21 So overall, certainly based on the ratings, it
22 appears not much changed as far as CQC ratings are
23 concerned over the course of your tenure.

24 **A.** Yes. So I would agree. If you look at the headlines,
25 the high-level ratings, you could draw that conclusion.

19

1 **A.** If I may just put a bit of context into this, this was
2 during the first wave of the pandemic, so there'd been
3 a huge change of the way that -- well, the NHS generally
4 and our organisation specifically, was running at the
5 time, and the environments on acute wards were very
6 different from before the pandemic and hence the reason
7 for this focused inspection; CQC inspections had been
8 stood down nationally. And if you see, this July 2020
9 was from the emergence of that first wave.

10 The commentary detailed behind this headline to some
11 extent buoyed us because it was -- there was some
12 positive statements about the wards were -- the staffing
13 on the ward was adequate, staff were kind and
14 compassionate, the environments were clean and well
15 kept, and staff were on top of things like audits. They
16 felt able to raise issues, they were doing appraisals.

17 So there was a sense that, despite everything that
18 the pandemic had thrown at us, we had started to lay the
19 foundation for some changes although there was certainly
20 no sense of complacency. This whole programme that
21 I was trying to roll out was, in my experience,
22 something that would take at least three or four years
23 minimum, irrespective of, you know, of the pandemic
24 hitting after a year.

25 So it was -- there was some -- there was some

18

1 I'd refer to, as I do in my statement, that the
2 commentary that lies underneath that does suggest that
3 there were some quite significant improvements in
4 a number of areas. Two caveats for that: again, I mean
5 I obviously wasn't there when this was published but
6 there was no sense that we were anywhere near to getting
7 to where we needed to be or wanted to be, but by the
8 March 2022, we'd again experienced significant waves of
9 the pandemic and then, for example, I think this -- we
10 were expecting this inspection for quite some time but
11 you may remember the Omicron variant started to really
12 take a hold in the November and December of 2021. So
13 again we were having to cope with significant staff
14 absences, significant outbreaks of Covid on wards, and
15 that would have impinged on a desire to do the things we
16 needed to do to effect more rapid change in this.

17 **Q.** But with something such as managing risk, and this
18 report also identifies issues in the domain of risk, is
19 that something which was impacted by Covid? So not
20 completing risk assessments or completing risk
21 assessments that were incomplete or comprehensive, isn't
22 the issue there a more fundamental one?

23 **A.** Sorry, do you mean --

24 **Q.** How would Covid contribute to staff not completing risk
25 assessments, for instance, or not completing

20

- 1 comprehensive risk assessments?
- 2 **A.** I think for a number of possible reasons, for example,
3 the whole emphasis was on the -- of the organisation was
4 keeping our wards open to be able to continue to provide
5 services. You may remember the -- certainly initially,
6 I think subsequently too, in the various waves of the
7 pandemic, people were very scared, very frightened. It
8 was unknown what we were facing.
- 9 And that pertains to staff as well as patients, and
10 managing these acute ward environments in particular,
11 both in adult mental health but more broadly across the
12 Trust, was -- became even more difficult. I don't know
13 if you've ever been on an acute psychiatric ward, they
14 can be quite alarming places to be.
- 15 And I think that is one of the reasons that some of
16 what you would ordinarily regard as a fundamental
17 completing a risk assessment may have not been people's
18 highest priority. But there was also --
- 19 **Q.** Part of the issue the CQC identified is in some
20 instances is a risk assessment not being completed, but
21 where a risk assessment was completed, it wasn't
22 comprehensive, wasn't done properly?
- 23 **A.** Yes, yes.
- 24 **Q.** That's more difficult to explain by reference to Covid,
25 isn't it?

21

- 1 have as to the safety of this hospital?
- 2 **A.** Yes.
- 3 **Q.** The email itself doesn't set out what the basis of those
4 concerns were. Do you recall what it was the ward
5 managers were telling you was of such concern that it
6 led you to believe, on a CQC visit, you would be closed
7 down?
- 8 **A.** I don't remember all the detail, but the general thrust
9 of their concern and this call to arms was related to
10 staffing, and to having adequately qualified and
11 experienced senior staff on the wards, that the more
12 senior staff on the wards were compromising their
13 ability to spend time on the ward because of other tasks
14 that they had, and right through a list of things like
15 there not being sufficient admin to support their work,
16 and increasing and over-emphasis on what's called bank
17 and agency staff. So these would be staff that aren't
18 part of the ward roster that could be brought in to
19 supplement or complement the shifts, and the sense of --
20 again, noting the time, the sense of exhaustion of
21 having to work in this way with an inpatient population
22 of patients that were probably more unwell than they had
23 been prior to the pandemic because of perhaps delays in
24 getting access to treatment.
- 25 **Q.** Fundamentally, the issue was that of staffing and that,

23

- 1 **A.** I don't think -- I'm not suggesting that Covid was the
2 only reason for this. There was clearly issues with
3 completion of full risk assessments and doing risk
4 assessments to the standard that would be required, for
5 example, in the Trust policy or national guidance, yes.
- 6 **Q.** Can we look at some of the things that happened between
7 the 2019 and 2022 full inspections and go to document
8 WITN0380054. This is an email drafted by you
9 29 October 2021, following a meeting with three ward
10 managers.
- 11 Now, the subject says, "Highbury Hospital" so was it
12 three ward managers from Highbury Hospital?
- 13 **A.** Yes.
- 14 **Q.** This is a discussion that you describe as harrowing and
15 sobering; do you see that in the first paragraph?
- 16 **A.** Yes, yes.
- 17 **Q.** You go on to state that in light of the meeting:
18 "We have reached a point where the services are not
19 safe and we need an immediate response to help support
20 them."
21 Also, you say:
22 "... if CQC arrived, we would be threatened with
23 closure ..."
24 So from the language being used here it appears that
25 these are very significant existential concerns that you

22

- 1 of course, is an issue we see identified by the CQC back
2 in 2019?
- 3 **A.** Yes.
- 4 **Q.** The plan that you set out in the email includes a verbal
5 update at a private board meeting. Why verbal, why
6 a private meeting? Doesn't the level of concern that
7 you have here warrant a far more robust, documented
8 response?
- 9 **A.** This was a very early heads-up, if you like, to the
10 board to do immediately, and we -- subsequently, there
11 would have been papers to the board that described this
12 in much more detail. But I can't remember the date at
13 the top, but say, for example, we met the ward managers
14 on the Friday, the Executive Team met on the Monday, and
15 we could convene a private board meeting for the Tuesday
16 on the -- (*overspeaking*) --
- 17 **Q.** So that was timing because we do have the board minutes
18 and we'll look at some of those, so there was an issue
19 of timing.
- 20 Just further up on the page, you refer to there
21 being a sense of despondency that, despite flagging this
22 since at least June, nothing has happened?
- 23 Now, firstly, is that an example of the kind of
24 issue identified in the 2019 CQC report, essentially the
25 Trust not following best practice when it comes to

24

1 handling concerns by staff?

2 **A.** I think it has some similarities, but I think the point
3 of difference is that perhaps, back in 2019, there was
4 a sense that nobody was really -- was paying much
5 attention. What -- the difference was that, as you're
6 aware, the concern about staffing across the
7 organisation, particularly on acute wards, had been
8 there since 2019, and was an increasing concern, not
9 just in our Trust but in peer trusts and across
10 different hospitals in the county, and I think their
11 sense was that having to manage this endlessly, they
12 were relatively inexperienced ward managers, they felt
13 that despite their best efforts, they weren't making any
14 progress. And I think that was their sense of
15 despondency that they were raising.

16 **Q.** Well, did you get to the bottom of why nothing had
17 happened, despite the fact they had been raising
18 concerns, significant -- existential and significant --
19 concerns, as you describe them, from June?

20 **A.** Yeah, I don't think it's that nothing had happened;
21 I think things that had happened and that we'd attempted
22 to do hadn't worked. And I think there's a difference
23 between those two things.

24 **Q.** So far as the staffing issue, we've seen it flagged in
25 the 2019 CQC Report, if we look at document WITN0380071,
25

25

1 weren't delivering the changes that were required. So
2 we went, for example, to a rolling programme of open
3 adverts. We went to universities to recruit the
4 graduates or the undergraduates that were about to
5 qualify. We looked at developing a raft of nurses
6 called trainee nursing associates and to recruit those,
7 which is a bridge between, if you like, a healthcare
8 assistant and a professionally qualified nurse as a sort
9 of fast-track training we can do.

10 We looked at using additional agency, additional
11 bank, and looked at using financial incentives. So
12 there's a phrase about using winter funding. So
13 recruitments in winter traditionally in the NHS was
14 difficult and there was a premium added to salaries to
15 encourage people to come, and we used that earlier in
16 the year than we would have.

17 **Q.** To try and increase recruitment?

18 **A.** Absolutely, yeah. So I don't want you to get the
19 impression that we were waiting around before
20 intervening. There was a whole programme of work
21 because this was a --

22 **Q.** Given -- just dealing with this point -- given, as we've
23 looked at, this is an issue which is flagged right at
24 the start of your tenure, and it continues to be
25 a problem, and is a significant problem as we're looking
27

27

1 this is a report for an Executive Leadership Team
2 meeting on 18 August 2021 by Julie Attfield. We can see
3 in the bottom two boxes on this page, again the issue of
4 staffing being raised, the purpose of the report is to
5 ask for assistance to implement urgent recruitment
6 actions. Executive summary:

7 "[Adult mental health] inpatients are under extreme
8 staffing pressure and assistance is required to
9 implement urgent recruitment actions."

10 So it seems like this is an issue which has been on
11 the radar for some time. What is being done to deal
12 with it? Why has it taken to a meeting in October for
13 what eventually comes: the improvement plan?

14 **A.** Yes, so that's not to say there wasn't an improvement
15 plan beforehand, but the one in October that we've just
16 discussed was a -- had the broad ownership of the
17 Executive Team. Prior to that, this was managed
18 primarily by the division with additional inputs.
19 I think one of the fundamentals is that there weren't
20 enough staff to fill the posts. We were running at high
21 vacancy, again, not just in our organisation. The
22 ability to recruit and to retain staff, particularly on
23 our acute wards, was extremely challenging, compounded
24 by the pandemic.

25 So, if you like, the usual mechanisms that you'd use
26

26

1 here in late 2021.

2 What do you think were the difficulties that you
3 were having, or what's the reason for the difficulties
4 that you were having staffing your hospital?

5 **A.** So, like I say, it wasn't just our hospital. I think we
6 had some very close working arrangements with the other
7 large Mental Health Trusts in the East Midlands, in the
8 Midlands, and nationally, and it was a common theme of
9 conversation and concern across chief executive groups
10 that I was part of. I can't remember specifically, but
11 the vacancy rate for nursing posts on wards was running
12 nationally at 15-20%. One in six consultant psychiatry
13 posts were unfilled. This was the backdrop of the
14 environment that we were working in to try and continue
15 to run services.

16 So yes, it was extremely important and impacted on
17 quality of services, but it wasn't unique to Nottingham
18 by any stretch.

19 **Q.** Shall we look at the improvement plan that was put in
20 place following your October email. It's document
21 WITN0380070, and this is a document prepared for
22 a leadership team meeting on 17 November 2021. If we go
23 to page 2 of the document, it describes some of the
24 actions being taken.

25 Now, at bullet point 1:
28

28

1 "Ward Managers stop undertaking investigations until
2 April 2022."
3 What was the thinking behind that, and what kind of
4 investigations is that referring to?
5 **A.** So there's a described policy with regard to what
6 a serious incident is within any Trust, and those
7 incidents are investigated by --
8 **Q.** So this is serious incidents in accordance with the
9 Serious Incident Plan?
10 **A.** That's correct. And a Ward Manager would be a commonly
11 used level of expertise to undertake these
12 investigations, and that was again ordinarily what would
13 have been done, but as --
14 **Q.** Is this suggesting that these investigations just don't
15 be undertaken at all or that they be undertaken by
16 somebody other than Ward Managers?
17 **A.** No, again, this -- we were in -- this was crisis point.
18 **Q.** So not undertaken at all?
19 **A.** Well, until April, and they backed up, and there was
20 a backlog. And we -- it's important to say this wasn't
21 just done on a whim. We made sure that, in the gamut of
22 governance changes that were agreed within the pandemic,
23 there's a list of -- derogations is the term -- things
24 that you stop doing and there's a log of those.
25 So this would have been discussed and agreed as, in
29

1 **A.** Yes, so Highbury Hospital, for example, I think is three
2 or four acute wards on that site. I am not sure about
3 the number any more. But, for example, a ward -- I'm
4 recollecting, I can't remember precisely but a ward, for
5 example, instead of taking admissions all the time would
6 have two weeks off, and the other wards would do the
7 admitting, just to give wards space to assess and start
8 treatment programmes for their admissions beforehand.
9 And that would be on a sequential basis and, yes, by
10 dint of what we did, there would be a need for that
11 reduction to be taken up elsewhere.
12 **Q.** And page 4 of this document there's a table which, in
13 the middle, has entries for "Reducing acuity" and
14 "Reducing delayed transfers of care".
15 "Reducing acuity" has "Fully utilise sub-contract
16 beds and ... out of area ..." which we -- you just gave
17 evidence on.
18 The next one "Increased use of discharge to assess
19 and procurement of bespoke placements."
20 What does that mean? Is the "increased use of
21 discharge" an effort to get people out of the hospital?
22 **A.** (Pause) Yes, so again, I can't fully recall the
23 specifics of discharge to assess programme but
24 essentially it means that there's the fast track to get
25 people to be discharged. One of the common reasons in
31

1 the circumstances, we need to free up senior experienced
2 clinical time to help keep the clinical wards viable,
3 and this is what we did.
4 **Q.** So the benefit, as you saw it, was the need to keep the
5 clinical ward viable; the downside presumably is if
6 you're not investigating serious incidents then you're
7 losing the ability to monitor the safety of the service
8 that you're providing?
9 **A.** Not necessarily losing the ability, but reducing the
10 ability.
11 **Q.** You're carrying out investigations, you're not learning,
12 you're not implementing the changes that are needed to
13 avoid similar incidents.
14 **A.** There will be other people continuing to do
15 investigations, not just the Ward Managers. But this
16 was decreed by NHS England at the start of the pandemic,
17 in terms of what governance could be stood down or
18 slowed. The priority, it's very clear in their message,
19 that the priority is to keep frontline clinical services
20 open.
21 **Q.** The next bullet point is: "Wards having respite to
22 admissions ..."
23 And does that mean essentially just stop accepting
24 patients? There's reference to increasing reliance on
25 subcontracted beds and out-of-area placements.
30

1 acute mental health wards to delay discharge is the
2 absence of suitable accommodation. It's often the
3 reason why people get admitted: because their
4 accommodation breaks down. And if there isn't anything
5 for them to go back to, then it will delay a discharge,
6 and have somebody in a bed that doesn't necessarily
7 require an acute bed at that time.
8 **Q.** But ultimately is the response to the perilous condition
9 that you discovered in October -- take on fewer
10 patients, refer fewer patients to subcontracted beds and
11 out of area, and discharge patients -- essentially
12 trying to reduce the patient load?
13 **A.** Yes.
14 **Q.** And this plan was presented to the board, document
15 NHFT0002204, appears to have been presented to the Board
16 7 December 2021. Had the Board been identified of the
17 risks prior to that date?
18 **A.** So I think we saw in the earlier email that we had an
19 urgent Board meeting prior to this, yes.
20 **Q.** So at that meeting, would the Board have been put on
21 notice of the risks in the manner that is set out in
22 this document?
23 **A.** They probably wouldn't have had all the detail that
24 we've just gone through and there certainly wouldn't
25 have been the specifics of the action plan, but they
32

1 would have had a verbal report from myself and my
2 colleagues about what the high-level concerns were, yes.
3 **Q.** This detailed report, page 16 under the heading "Main
4 report detail", what we can see there it's essentially
5 a reference to, as you've already given evidence on,
6 it's problems with staffing, isn't it?

7 If we go to page 18, the penultimate paragraph, that
8 relates to Priory Arnold. And that we've heard evidence
9 about, and from Priory Arnold, that's a private
10 hospital, and at the time, the Trust essentially had
11 a ward at the Priory comprising NHS patients, didn't it?

12 **A.** Yes.

13 **Q.** And in this paragraph it's describing notices being
14 applied following a CQC inspection. The Inquiry -- the
15 Priory was on special measures, wasn't it? It needed
16 CQC permission to admit new patients.

17 **A.** I can't recall that, but I wouldn't disagree with you if
18 you think that's the case.

19 **Q.** Are you able to help with what steps, if any, were taken
20 to ensure patient safety was maintained and safeguarded
21 for those being placed in a private hospital known to be
22 or found to be inadequate by the CQC?

23 **A.** Yes. So this was an issue that had continued to
24 increase the use of these private beds, both within and
25 without the county. At this stage we had developed

33

1 wasn't an out-of-area placement, was it, that was the
2 Priory Arnold was in or around Nottingham --

3 **A.** Yeah.

4 **Q.** -- but the Trust also relied on out-of-area placements
5 and paragraph 156 of your statement, page 50, you
6 describe out-of-area placements as:

7 "... fundamentally detrimental for patients,
8 families and staff ..."

9 **A.** Yes.

10 **Q.** The challenge is that patients are admitted far away
11 from their home, from their family and their support
12 networks and you describe that as delaying recovery and
13 reintegration into society. The Trust was -- and you
14 have explained this in just a couple of lines above
15 what's been highlighted -- a national outlier in that it
16 was using a very high number of out-of-area placements,
17 wasn't it?

18 **A.** Yes. Yes, sorry, yes.

19 **Q.** It's fair to say it was an issue that was there at the
20 start of your tenure?

21 **A.** Yes, it had been an increasing issue, I think, over the
22 preceding couple of years.

23 **Q.** Yes, and here for this plan, the hospital improvement
24 plan, it was actually one of the measures being used.
25 So rather than it coming down, it was ever increasing?

35

1 a much closer working relationship with organisations
2 like Priory Arnold, and the -- one of the significant
3 issues is although it was our, if you like, our
4 patients, it was on their ward and their -- Priory's
5 governance provided the oversight.

6 So that's a major issue in terms of safety and
7 improvement, if you've got two different organisations
8 overseeing this. One of the things that, again,
9 Julie Attfield as director for this service, put in
10 place, was the appointment of a senior, I think
11 associate director, looking at the oversight of the use
12 of contracted beds to look at from a quality perspective
13 of the processes that were undertaken on that ward.

14 So, for example, with regard to patient safety, risk
15 assessments, and to try as best we could to ensure that
16 those issues that would have been identified in a core
17 CQC inspection were covered off.

18 **Q.** This paragraph doesn't address it, does it? And the
19 question was specifically in relation to the fact that
20 there is the findings of the CQC, the hospital is in
21 special measures. Would that not trigger any steps or
22 provisions being put in place by your Trust in respect
23 of patients it is sending there?

24 **A.** Yes, but I'm sorry, I can't recall the detail.

25 **Q.** Now, in addition to the Priory Arnold, because that

34

1 **A.** Yeah, to be blunt, we were in a fix. The provision
2 within the Trust didn't meet the demand with regard to
3 the number of beds required for inpatient services.
4 I feel quite strongly about this. This had become an
5 increasing national issue: that the bed reductions
6 nationally for psychiatric beds in the UK has fallen
7 dramatically over many years.

8 Briefly, for example, in the 1970s there were over
9 100,000 inpatient beds in psychiatry and today there are
10 less than 18. And rightly there's been an emphasis on
11 the development of community care and specialist
12 community services, but in my view, I think there's been
13 an over-reliance on reducing beds, because you can see
14 an admission as a failure of community care, and I don't
15 think that necessarily pertains. I think there is
16 a requirement and not just in Nottingham, yes, it was an
17 outlier initially, we made some good progress on that,
18 but across the country there has not been enough
19 emphasis on the treatment programmes that people with
20 serious mental illness like schizophrenia require. And
21 quite often they require a period of inpatient treatment
22 to enable them to get on a treatment and recovery
23 pathway.

24 **Q.** The Inquiry has heard evidence from Dr Gibson also on
25 the issue of lack of beds, there being insufficient beds

36

1 effectively to serve the population, and he described
2 how that put a pressure on doctors to discharge
3 patients, to free up beds. He described how it had the
4 potential to make Community Treatment Orders less
5 effective because the power of re-call would be
6 meaningless if you didn't have a bed to put somebody in.
7 Do you share those views?

8 **A.** Increasingly difficult for me to see it from a clinical
9 perspective. So I finished clinical practice in 2018
10 when this was an emergent issue. Prior to that, there
11 were usually sufficient beds within a locality. But
12 I would think you'd at least always have a sort of
13 subconscious appreciation of the limited resource of
14 beds, and that would be part of your clinical judgement.
15 However, I would think that, on balance, most
16 experienced clinicians like consultants would be of the
17 view if somebody needed to come into hospital, they
18 needed to come into hospital, despite the best efforts
19 of community care, hence the reason you see this
20 pressure on out-of-area placements and use of
21 subcontracted beds across the country.

22 **Q.** Did you raise issues of either staffing or insufficient
23 beds, the fact that you were having to continue to rely
24 on out-of-area placements at a high rate, despite the
25 issues that you've identified? Did you raise any of

37

1 budgets, and there's an oft-quoted statistic that mental
2 health, in the round, takes about 20% of the NHS need
3 but receives less than 9% of the budget. And that's
4 mental health in primary care, in acute Trusts, not just
5 mental health trusts.

6 So there was always competing factions to bid for
7 additional capital resources, for example, to construct
8 or buy new units, but you're on a playing field with
9 limited budgets across the whole health spectrum so it
10 makes it very challenging.

11 I don't know if that answers your point,
12 particularly, but ...

13 **Q.** You dealt with the ICB. Separately, was it raised with
14 NHS England as well, or would it just be the ICB that
15 you would raise these challenges as to funding problems
16 and resource problems?

17 **A.** Yeah, again there's probably a nuance to that in terms
18 of whether we raised it as a challenge, but in terms of
19 making senior, regional and national leaders aware of
20 the environment that we were working in with constrained
21 resources to provide the services that we needed to
22 provide.

23 So very clearly, within my statement, there's the
24 conversation about acquiring this new acute adult unit
25 that had the right facilities to meet the needs for some

39

1 that with the ICB?

2 **A.** So I can't remember the date that the ICB became a --
3 sorry, I can't think of the word.

4 **Q.** Or the CQC or its predecessor?

5 **A.** So yes. So it was a regular point of concern in terms
6 of both locally within the CCG commissioning groups, who
7 oversaw the commissioning of our services and
8 performance, but also the regional NHS England team that
9 would be the sort of fundamental mechanism up from
10 commissioners and providers, but also we were part of
11 a national mental health provider group that was chaired
12 by the National Clinical Director, Claire Murdoch, and
13 on those calls, particularly during Covid, the concerns
14 about the limited number of acute beds and the use of
15 out of area and spot purchase and the risk concerns that
16 they put into that system were often discussed and well
17 documented.

18 **Q.** What was the response that you got?

19 **A.** There are lots of -- when you're working in the NHS at
20 board level, there are lots of competing interests in
21 terms of how limited resources are used, and from
22 a mental health perspective, you're always cognisant of
23 you might come across the term that mental health
24 services is a Cinderella service, and had to fight what
25 we would regard as a fair proportion of the national

38

1 of the CQC safe care criteria, and the budget required
2 for that, the budgets required to convert some of the
3 dormitory wards in our estate to again meet those same
4 standards was something that we spent a lot of time, at
5 region and nationally, trying to get the backing for.

6 **Q.** If we move away from the concerns raised by staff and
7 the improvement planning response to that, and now look
8 at the concerns being raised by the local coroners, our
9 first document, NHHNB0019232.

10 Whilst that's coming up, is it fair to say that
11 concerns raised by a coroner is always going to be
12 a matter of concern, and a serious issue, because of
13 course where a coroner is raising a concern, it's
14 because they think it may be something that has
15 contributed to death or is a risk for future deaths.

16 **A.** Yes, that's true.

17 **Q.** And at page 5 of this document, please, so this is
18 a report, as we can see dated at the top, dated
19 August 2021, and at page 5 under the heading "Risk
20 Assessment" we have a coroner identifying problems with
21 risk assessment documentation, "detail of risk factors",
22 "rationale", "agreed outcomes".

23 Now, this chimes, doesn't it, with the concerns
24 raised by the CQC in 2019?

25 **A.** Yes.

40

- 1 Q. And if we go now to a document WITN0356017, and these
2 are briefing notes in respect of a meeting in
3 December 2021, we can see again towards the bottom of
4 the page, under the heading "Risk Assessment", the very
5 same concern being raised.
- 6 A. Yes.
- 7 Q. Also concerns on that page about communication between
8 services and lack of family involvement.
- 9 A. Yes.
- 10 Q. Then finally in the review of -- well, penultimately
11 rather in the review of coroner arguments NHNB0012044,
12 this is a report, "Learning from Inquests ...",
13 8 February 2022, bottom two paragraphs under the heading
14 "General Learning":
15 "Lack of involvement of family members/carers ..."
16 And:
17 "Risk assessments ..."
18 And that's what we saw being raised just a few
19 months earlier.
- 20 A. Yes.
- 21 Q. At page 2 of this document, five lines down, an issue
22 raised as:
23 "The discharge process, in particular, sharing risk
24 information with community teams and GP."
- 25 A. Yes.

41

- 1 let's say, with regard to use to restrictive practice on
2 a ward and there'd been lessons to learn from that, then
3 a group of Ward Managers, senior staff, would be
4 appraised of what the issues are that had been raised,
5 where the training has perhaps been updated, where the
6 policy related to that and a training module would be
7 devised for staff to undertake.
- 8 Q. Would that be for the individual cases or would that
9 be --
- 10 A. No, it'd be collated across, so you'd pull things out.
11 For example, if it's risk assessment or if it's use of
12 high-dose psychiatric medication, whether it's
13 restricted practice, you'd pull a theme and you'd make
14 that part of the learning process.
- 15 Q. When we looked at the 2019 CQC report, you made the
16 point that following that there would have been action
17 plans to bring about improvements and to address the
18 concerns that were being raised in 2019. With these
19 problems being raised by the coroner in 2021, did that
20 not cause you concern that whatever measures had been
21 taken in 2019 had been inadequate?
- 22 A. Yeah, of course it did. I mean, you know, these are
23 some of the -- some real fundamentals of provision of
24 care, and I've thought about this in some detail,
25 because it's a recurring theme, isn't it, of serious

43

- 1 Q. So poor information sharing.
- 2 Now, finally in this review of coroner
3 documentation, NHFT0009667, at page 2 of this document
4 in the heading "Executive Summary" in the middle of the
5 page, third paragraph, it describes a Prevention of
6 Future Death Report with reference to or highlighting an
7 issue on risk assessment.
- 8 A. Yes.
- 9 Q. Now, these documents -- and it may be that some of them
10 are coverage the same incident -- but these documents
11 show concerns arising from coroners and from inquests
12 over the course of 2021 into 2022, and the very same
13 concerns raised in the 2019 report.
- 14 Now, firstly, what did you do to address these
15 concerns?
- 16 A. So my recollection is that these were collated and
17 described into a number of learning actions which would
18 have been disseminated across the organisation in
19 a targeted way. So, for example, we'd have what's
20 called a Learning Lesson Bulletin, which doesn't sound
21 very much specifically, but it would collate these as
22 learning points for staff.
- 23 There'd also be, again, probably on a Teams call,
24 because we're in the middle of a pandemic, but there'd
25 be learning fora. So for example, if this is an issue,

42

- 1 incident investigations for us, as a Trust, but also
2 elsewhere.
- 3 And if you look back at other inquiries, other
4 reports on these tragedies, in my experience as
5 a clinical leader but also in my experience as
6 a clinician, these sorts of findings are quite common,
7 and they will be, for example, often critiques of the
8 Trust's oversight of risk assessment processes, Trust's
9 oversight and use of discharge planning or lack of it.
- 10 Q. Just to be clear when you say the findings are common,
11 are you saying the findings are common in investigations
12 arising out of death or serious harm to patients?
- 13 A. Yes.
- 14 Q. That's quite telling, isn't it?
- 15 A. It is. I think --
- 16 Q. The indication is, in order to avoid those sorts of
17 incidents, you need to get on top of things like
18 carrying out proper risk assessments?
- 19 A. I think that's part of the answer. I think it begs an
20 additional question as to why, despite people doing
21 their best efforts, are we not -- are we, in Nottingham,
22 specifically not able to drive that learning and
23 evidence it. My contention is that it doesn't just
24 apply to Nottingham, as you're aware, very sadly,
25 homicides occur due to psychiatric patients on a weekly

44

1 basis in this country, roughly. Perhaps more, depending
 2 on the evidence you review.

3 **Q.** Do you think the answer is that insufficient steps were
 4 taken following the 2019 CQC Report to address the
 5 deficiencies in your Trust with assessing and managing
 6 risk, given what we've just looked at in those coroners'
 7 reports?

8 **A.** I think evidently we did take insufficient steps, but
 9 I don't think we asked the right question, and that's:
 10 what environment do you need to create within a large
 11 organisation to enable learning to be undertaken and
 12 embedded and --

13 **Q.** Do you now have a clearer idea of what that is?

14 **A.** Well, again, I -- in thinking about this in some detail,
 15 I think it goes back to some of the things I was saying
 16 at the beginning. You need to have an organisation that
 17 is signed up to what you're trying to achieve. And that
 18 goes back to a fundamental of having a good
 19 organisational culture, having a clear vision and values
 20 that staff feel inclusive, feel able to raise concerns,
 21 and are up for the challenges. And unless you have that
 22 in place, unless you have adequately resourced core
 23 services, like beds, for example, and staff, and
 24 ideally -- I don't mean this flippantly -- but trying to
 25 do this in the middle of the pandemic also makes it

45

1 **Q.** I'm asking specifically about clinical risk assessment.

2 **A.** Yes.

3 **Q.** Because in circumstances where -- because the CQC is
 4 referring to clinical risk assessment, isn't it, in
 5 their report?

6 **A.** *(No audible response).*

7 **Q.** The coroner is referring to clinical risk assessment,
 8 and in circumstances where issues are being raised as a
 9 matter of concern, isn't that something that does need
 10 to be looked at at executive and board level?

11 **A.** So ordinarily, if you're talking about individual
 12 clinicians and their competence at a procedure such as
 13 undertaking a risk assessment, that would ordinarily go
 14 through either the medical or the Nursing Director
 15 usually, in terms of their overall clinical manager in
 16 the Trust. And if there were concerns that persisted,
 17 as a Chief Executive or board, I may become aware of
 18 that there was a particular issue and concern. But that
 19 would ordinarily be managed outwith the Trust's
 20 management structure, whether through professional
 21 bodies such as the GMC or elsewhere.

22 If, say, for example, as you're describing, there's
 23 a theme of clinical risk assessment issues per se, then
 24 I think, as the CQC identified, then you would look at
 25 it more from a strategic governance perspective from the

47

1 doubly difficult.

2 **Q.** You need proper training on undertaking a risk
 3 assessment, don't you?

4 **A.** Sorry, say again?

5 **Q.** You need proper training on undertaking risk
 6 assessments.

7 **A.** Yes.

8 **Q.** The importance of seeking information from as many
 9 sources as possible.

10 **A.** Yes.

11 **Q.** You need supervision and assessment of risk plans and
 12 risk assessments that have been carried out to make sure
 13 people are doing their job properly.

14 **A.** Yes.

15 **Q.** You describe in your statement, your paragraphs 110 and
 16 111, page 39, essentially what you appear to be
 17 describing here is the fact that clinical risk
 18 assessment issues don't usually reach executive level --
 19 sorry, Executive Leadership Team level because they
 20 would be resolved essentially before they get to that
 21 level; is that a correct interpretation?

22 **A.** Yes, so that's, again, a point of difference between
 23 what we've been talking about, corporate risk
 24 assessments and strategic organisational risk against
 25 tradition --

46

1 Trust.

2 So we'd be sitting there saying: well, we have an
 3 issue here with risk assessments per se, and the
 4 processes around it that enable the Trust to identify
 5 and learn and change aren't working properly, the
 6 individual and their performance and practice is managed
 7 along a different line. Do you follow the --

8 **Q.** I appreciate the point about individuals but the
 9 question I was putting, or the point I was trying to put
 10 is, in light of the concerns that were being raised,
 11 this appears, doesn't it, to be beyond individual areas.
 12 If you've got coroners repeatedly raising it and the CQC
 13 identifying it as one of the reasons they rated your
 14 hospital as inadequate --

15 **A.** Yes.

16 **Q.** -- that is something that should be escalated and --
 17 *(overspeaking)* --

18 **A.** Yes, absolutely.

19 **Q.** The concerns raised by coroners, concerns raised by
 20 staff, were they shared by you with either the CQC or
 21 NHS England?

22 **A.** Sorry, say that again?

23 **Q.** The concerns raised by staff -- so we looked at that
 24 October email --

25 **A.** Yes.

48

- 1 Q. -- when staff were raising concerns, and you thought
2 a CQ inspection might lead to the hospital closing, and
3 then it concerns we've looked at raised by the coroners,
4 were either of those concerns disclosed to the CQC or
5 NHS England? Did you tell them: "Look, these are the
6 problems we're having, I think we might have to close;"
7 or "We've got coroners repeatedly raising issues as to
8 risk assessment with us"?
- 9 A. I can't remember specifically but I think probably yes.
10 Sorry, I can't recall about the detail but --
- 11 Q. Both, or --
- 12 A. Well, ordinarily, we -- I think the CQC would be
13 automatically alerted by the coroner if, for example,
14 there's a Prevention of Future Death Notice, but we
15 would automatically, in the relationship we have had
16 with the CQC, be very open and candid about issues that
17 were arising, because it is important to keep them
18 abreast of the challenges that we were facing.
- 19 So it wasn't just an intermittent inspection with
20 the CQC; we had regular conversations, updates from
21 them, two-way flows of information about our concerns
22 and they would automatically get reports of our
23 performance that they would alert us to that we might
24 not have been aware of.
- 25 Q. Can we deal with issues in respect of EIP in Nottingham,
49

- 1 start, there were significant concerns about the
2 performance of the Early Intervention and Psychosis
3 pathway. I can't specifically recall these. No, sorry.
- 4 Q. If we look at another document, which was created during
5 the course of your tenure, NHNB0004596, and this is an
6 extract:
- 7 "... Long-term Plan - Investment in Mental Health."
8 If we go to page 4 of this document, which has --
9 just go down to the heading: "Early Intervention in
10 Psychosis" halfway down, there it is said:
- 11 "There is a requirement to commission NICE
12 concordant levels of care. Services in Nottinghamshire
13 do not currently meet the required NICE standards."
- 14 A. Yes.
- 15 Q. Then the other page in this document is page 14 where,
16 under the heading towards the bottom of the page "Early
17 Intervention in Psychosis" again, the point is made that
18 without investment, the EIP service will not be
19 delivered in line with NICE standards.
- 20 A. Yes.
- 21 Q. What did you do during your tenure to ensure that the
22 investment was obtained, and steps were taken to ensure
23 that the EIP was NICE compliant?
- 24 A. So the -- I think probably the most significant
25 undertaking was to what's called uncouple the EIP team
51

- 1 starting with WITN0319003. This is a review of the EIP
2 Nottingham, as it says there, dated October 2018. If we
3 go to page 3, the "Executive Summary", we can see in the
4 bottom paragraph a finding that:
- 5 "Care co-ordinators are holding mixed caseloads of
6 between 20 and 27 ..."
- 7 And that's in excess, isn't it, of the recommended
8 or the guideline figure of 15 for a care coordinator?
- 9 A. Yes.
- 10 Q. If we go forward to page 58, the recommendations for the
11 service model, four bullet points up from the bottom,
12 a recommendation is to:
- 13 "Implement care pathway template ... to allow [for]
14 recording and reporting of NICE recommended
15 interventions.
- 16 "Undertake education and awareness raising
17 internally and externally."
- 18 Then:
- 19 "... to ensure that clinicians working with the EIP
20 service users have opportunity to undertake specialist
21 EIP training and supervision."
- 22 Now, these recommendations come from 2018. When you
23 started in your tenure, was your understanding that
24 those recommendations had been implemented?
- 25 A. I can't recall specifically, and I know that when I did
50

- 1 from being embedded within the Local Mental Health Team
2 to enable more focus and specific work from the EIP
3 workers.
- 4 Q. Just on that point, well, shall we look at the national
5 clinical audits --
- 6 A. Mm-hm.
- 7 Q. -- because it divides the periods between the
8 uncoupling, which occurred in your tenure, and the
9 period that followed. So RCPS0000011 and the tables
10 that are set out in the pages of this document show the
11 Royal College of Psychiatry's auditing of the EIP teams
12 in Nottingham. It starts in 2018/2019, and we can see
13 that in all domains on this page, Nottingham is below
14 the national average, isn't it, the national results?
- 15 A. Yes.
- 16 Q. In some respects, quite significantly. So if we look at
17 CBT [therapy for psychosis] -- this is the year 2018 to
18 2019 audit, but if we look at CBT for psychosis, in one
19 team it's 0 per cent and in another it's 5 per cent, but
20 nowhere is it close to 46 per cent?
- 21 A. Yes.
- 22 Q. Now, that is a respect in which the EIP team was not
23 being NICE compliant, isn't it?
- 24 A. Yes.
- 25 Q. Uncoupling the service from the Local Mental Health
52

1 Team, which I think is one of the points you were
2 dealing with a few moments ago, would that help with
3 providing CBPT to EIP patients? Did it make any
4 difference whether the EIP was coupled or uncoupled?
5 **A.** In respect of whether a team had a cognitive behavioural
6 therapy that was trained in that specific area, if one
7 of the LMHTs did have one, their work would be
8 constrained by non-EIP patients requiring similar input.
9 So if you ringfenced a specific post. But uncoupling
10 *per se* wouldn't necessarily do that unless you had a CBT
11 therapist in the newly formed or newly uncoupled team.
12 **Q.** Yes, so what was required to meet the concerns about not
13 complying with NICE was to ensure that there was
14 sufficient therapists, CBT therapists.
15 **A.** One of the things, yes.
16 **Q.** Just on this page we can see different EIP teams listed
17 in the row at the top. The column EIP4505, that's for
18 the Nottingham City Early Intervention in Psychosis
19 team, and is that the team that would have been dealing
20 with VC?
21 **A.** Nottingham City, yes.
22 **Q.** And then if we go -- if we can scroll down, you'll see
23 the rest of the results for 2018/19, but if we go
24 forward to 2019, 2020, again, it's a relatively similar
25 picture, isn't it, to the previous year?

53

1 **Q.** If we go to page 9, the audit for the year '21/'22, and
2 the configuration of the teams has changed. We can see
3 it's 4501, 4502, 4503. And 4502, that is the City
4 South Team. So that is the team that would have been
5 dealing with VC, isn't it?
6 **A.** City -- I believe so.
7 **Q.** So timely access again remains good, but otherwise the
8 results are all below national average, and
9 a particularly low score for CBT and family
10 intervention.
11 **A.** Yes.
12 **Q.** Now we have seen, and they've been provided to you in
13 your documentation, that you were copied into
14 correspondence from the Royal College in respect of
15 these audits.
16 Now, what steps did you take in light of the audits,
17 or in light of the long-term plan, to ensure that the
18 EIP team was performing better and was NICE compliant?
19 What did you actually do?
20 **A.** So, from a chief executive perspective, it's really
21 an oversight of the programme that again was led within
22 the Mental Health Division by Dr Attfield, and I would
23 have had regular conversations with her in her
24 supervision and the executive team, but also informally
25 about the importance of us attempting to do what we

55

1 **A.** It is.
2 **Q.** The first row, "Timely access", is where the teams were
3 best performing, albeit still below national average not
4 by much, but otherwise we can see it's a patchwork of
5 almost entirely red and orange across multiple teams.
6 **A.** Yes.
7 **Q.** Again, CBTs, significantly below the national result.
8 Family interventions also significantly below less than
9 half.
10 If we go forward to 2020 to 2021, this is the second
11 year into your tenure, page 6. We can see improvements
12 at 4505 for CBT, but generally overall for the Trust,
13 the improvement is limited, isn't it? It is still the
14 case that nearly all the teams are underperforming
15 against national averages.
16 **A.** I partly agree. It shows signs of improvements. The
17 timely access has for the first time now performing
18 above the national average.
19 **Q.** Now above the national average.
20 **A.** And there are some indications that the work we're
21 trying to do is having some impact. I think right at
22 the outset, of the -- of this programme, I think there
23 was an expectation that this would be at least a two or
24 three-year programme of change and improvement in
25 ordinary times.

54

1 could to improve the performance --
2 **Q.** But what steps did you understand were being taken by
3 her then, if you discussed it with her?
4 **A.** Well, so she was negotiating with the commissioners to
5 secure additional funding to enable some of these things
6 to be resourced, for example the cognitive therapists,
7 family intervention. And also with the creation of
8 a specialist team, you know, there's an additional
9 resource to support administratively and to staff,
10 a standalone service as opposed to one that's part and
11 parcel of a more generic team.
12 **MR CARR:** Yes, Chair. That might be an appropriate time for
13 the break.
14 **THE CHAIR:** Yes, thank you. We'll take a break now until
15 11.55. Thank you.
16 (11.34 am)
17 (A short break)
18 (11.55 am)
19 **THE CHAIR:** Yes, Mr Carr.
20 **MR CARR:** Thank you. If we go back, please, to document
21 RCPS0000011. Dr Brewin, I'd covered the audit in
22 respect of the years whilst you were CEO. We do have
23 the audit result for the period at the end and
24 following. Page 11 of this document, we can see that
25 for 2022 to 2023, the performance is much better, isn't

56

1 it?

2 **A.** Yes, again, I don't want to sound flippant, but I think
3 this is a really important end to the narrative we've
4 just had about the improvement programme. So there's an
5 expectation this will take a number of years, which to
6 some might sound an awful long time to set up a service
7 and get it compliant, but that's the timeline to do
8 something like this and I think it's particularly
9 important pertaining to EIP services, because it relates
10 to directly to the team that were responsible for some
11 of the care in this case. So it's pleasing to see that
12 we're starting to make some real strides in improvement.

13 **Q.** We can see also in 2023/2024, it is page 13 of this
14 document into page 14, again there are improvements.
15 Now, of course, this is after the period of the care
16 provided to VC, disengaged in 2022 and was discharged in
17 that year.

18 You refer to the improvement plan, what was it that
19 was implemented or effective from the year 2022/2023
20 which couldn't be implemented and effective earlier?

21 **A.** Again, I can't remember all of the details, but one
22 specific challenge was around the recruitment of
23 an appropriately trained cognitive behavioural therapist
24 that specialised in psychosis intervention. It was,
25 I say, a relatively new part of the interventions

57

1 **A.** Yes.

2 **Q.** Were you aware of the lack of admin support to certainly
3 some of the EIP teams which meant that MDT meetings
4 couldn't be minuted?

5 **A.** Yes.

6 **Q.** Were you aware that there was a lack of training to
7 members of the EIP team such that they weren't receiving
8 any training on managing disengaged patients or
9 non-concordance?

10 **A.** Not specifically aware that there was a lack, no.

11 **Q.** On the issue of managing disengaged patients, the
12 Inquiry has heard about Assertive Outreach, both
13 Assertive Outreach principles and Assertive Outreach
14 teams. You will have been working at the time when
15 Assertive Outreach teams existed in Nottingham and by
16 the time you were CEO, they'd been discontinued?

17 **A.** In Nottingham, when I worked in Nottingham, I did more
18 what would be called General Adult Psychiatry, so
19 a broader remit. When I was in Lincolnshire as Medical
20 Director and then Chief Executive, I had half the time
21 clinical post reducing to two sessions a week where
22 I was doing Assertive Outreach work with a specialist
23 Assertive Outreach Team. So I am well aware of the
24 set-up and workings of an AO service, yes.

25 **Q.** An AO service is different, isn't it? It's going to be

59

1 available for people with psychosis and it's
2 traditionally regarded as -- psychoses were regarded as
3 conditions that weren't amenable to psychological
4 interventions and (*unclear*)-- (*overspeaking*) --

5 **Q.** On that point and just reflecting on some of the
6 evidence that the Inquiry has heard from members of the
7 EIP team, and if you can confirm whether or not there
8 was corporate knowledge of some of the issues that EIP
9 team members have given evidence that they were
10 escalating. First, the issue that you just touched
11 upon, a CBTp therapist. We have heard evidence that
12 there was only one of those for the EIP team during the
13 period of VC's care and the wait for that therapist
14 could be over a year. Was that something that had been
15 escalated up, were you on notice of that?

16 **A.** Yes. So we were aware of that and some additional
17 background, there's a relative dearth of appropriately
18 trained CBTp therapists nationally and this was
19 a national programme of recruiting this relatively
20 speciality into the team. So there was a lot of
21 competition to recruit and, yes, we were aware that --

22 **Q.** Aware that the issue that we saw before the break in the
23 2018 report as to CCOs, care coordinators, working with
24 excessive caseloads above 15, were you aware that that
25 was ongoing?

58

1 able to provide more assertive care than another Local
2 Mental Health Team with Assertive Outreach principles?

3 **A.** Yes.

4 **Q.** Were there any steps that you were aware of that were
5 taken to ensure Local Mental Health Teams, the EIP team,
6 were able to effectively and assertively outreach
7 patients? We heard evidence from EIP members of staff
8 that they felt ill equipped to deal with VC who they
9 described as essentially becoming an Assertive Outreach
10 patient on their watch?

11 **A.** Yes, so this was a reality of the demand that the
12 services were under, and a sequelae, if you will, of the
13 withdrawal of resourcing nationally into Assertive
14 Outreach teams, so not just in Nottingham, but a very
15 succinct piece of background. These teams were part of
16 a National Service Framework for mental health in the
17 early 2000s, specialist teams in early intervention,
18 Crisis and Assertive Outreach, and there was significant
19 additional funding nationally to recruit to these.

20 But the Assertive Outreach function was pared down
21 and reduced to the point in some organisations where it
22 was stopped and reabsorbed back into a more general
23 service and that was the case in Nottingham, yes.

24 **Q.** But something is lost, isn't it, when you have
25 a dedicated service for Assertive Outreach and that is

60

1 disbanded in, and a principle is implemented in an
 2 already busy EIP team or already busy LMHT team, the
 3 ability to assertively outreach is not going to be able
 4 to be met as it could with a dedicated team?
 5 **A.** Yeah, it might not be lost totally, because of some of
 6 the principles do apply still within a generic team but
 7 you're right that having a specialist Assertive Outreach
 8 Team did enable skills to develop that would have a much
 9 more assertive approach in terms of, forgive the
 10 language, but keeping tabs on people, tracking people
 11 down, because they don't come to clinic. You need to be
 12 much more assertive in your approach.
 13 **Q.** If we can deal with incidents, incident reporting. Your
 14 statement describes a Serious Incident Review Group, and
 15 what you -- it's page 40, paragraphs 117 and 118, you're
 16 describing in there that some serious incidents -- or
 17 where the:
 18 "... serious incident met the criteria for further
 19 escalation ..."
 20 It would be considered by this group.
 21 But it's not the case, is it, that all serious
 22 incidents would be considered by the group?
 23 **A.** By the SIRG group?
 24 **Q.** Yes.
 25 **A.** No. So incidents are ranked and again, I can't recall

61

1 depending on when it occurred, but all of the others
 2 occurred during your tenure?
 3 **A.** Yes --
 4 **Q.** Do you see under --
 5 **A.** Sorry, yes.
 6 **Q.** Just under the box, the point is made, three lines down:
 7 "Two and possibly three of the reports were of such
 8 poor quality that the panel that felt they should be
 9 reconsidered in their entirety."
 10 That's considering, isn't it, the report into those
 11 incidents?
 12 **A.** Yes, yes.
 13 **Q.** In circumstances where the investigation into serious
 14 incidents are so poor and the question arises: how were
 15 they signed off? Does that reflect poor oversight at
 16 executive level or by the Serious Incident Group?
 17 **A.** It would suggest that, yes.
 18 **Q.** Do you recall what involvement, if any, you had into the
 19 investigations in these cases?
 20 **A.** I'm sorry, I don't have that detail to hand.
 21 **Q.** Our final point is this, please, multi-agency working.
 22 It's dealt with at page 55 and 56 of your statement.
 23 And page 55, paragraph 175, you describe it towards the
 24 end of that paragraph how interactions with the police
 25 were without specific policies and guidance; "it was

63

1 the specific criteria, but the SIRG Group wouldn't
 2 review all those serious incidents, no.
 3 **Q.** But only those which were of the highest rank?
 4 **A.** Yes.
 5 **Q.** The definition of serious incidents in the Trust
 6 guidance it's NHFT0000596, if we go to page 10 of that
 7 document the two bullet points in the middle of the
 8 page:
 9 "Incidents that result in severe/serious harm to one
 10 or more people."
 11 Is one of the definitions and another is:
 12 "Unexpected or avoidable injury to one or more
 13 people that requires further treatment ..."
 14 In respect of VC's history, do you accept that there
 15 was a failure to report, as a serious incident, the
 16 incident involving his neighbour jumping from a window,
 17 fleeing him shortly after his first Mental Health Act
 18 assessment, with the result that she injured her back
 19 and required surgery?
 20 **A.** Yes, I do.
 21 **Q.** NHFT0000518, there is the "Thematic review of homicides
 22 and attempted homicides - 2019 to 2023" at the Trust.
 23 If we look at page 3 of that document, we can see of the
 24 seven cases considered, all but one, 13 June 2023, which
 25 relates to VC, and potentially this 2022 incident,

62

1 seen as 'part of the day job', is what you described at
 2 the end of that paragraph.
 3 Was it appropriate for there to be only informal
 4 arrangements? Thinking of managing risk to public
 5 safety, shouldn't there have been a formalised working
 6 relationship between the Trust and the police?
 7 **A.** So, yes, this is perhaps an omission on my part. At the
 8 time of writing I hadn't recalled that there are
 9 policies that pertained to this and working with the
 10 police and criminal justice system, in working with
 11 what's called MAPPA, public protection agency, and
 12 MARAC, which the risk assessment conference. So there
 13 were policies which the Trust did have in place that,
 14 apologies, at the time of writing this I didn't recall.
 15 **Q.** And finally paragraph 180, page 56, you describe -- and
 16 this is in the context, as I understand it, of working
 17 with the police -- that:
 18 "[The Trust] ... had become disconnected from the
 19 system more broadly and had become insular in the way
 20 that it worked."
 21 Are you reflecting there on your view that there
 22 wasn't sufficient working together with the police?
 23 **A.** That point is a broader one: that within that broader
 24 context that I would include the police in that, yes.
 25 **MR CARR:** Yes, thank you, Chair. Those are my questions.

64

1 **THE CHAIR:** Thank you.

2 Mr Moloney? Ms Cartwright?

3 **Questioned by MS CARTWRIGHT**

4 **MS CARTWRIGHT:** Good afternoon, Mr Brewin. Can I briefly
5 ask your view on some evidence we are going to hear just
6 on the systemic or structural matters.

7 Sorry, the page has just jumped along.

8 Thank you. And you obviously dealt with your time
9 as the Chief Executive, but we're going to hear from
10 Mr Ifiti this afternoon, but he provides in his witness
11 statement his view, that during your period of
12 governance between 2019 and 2022, divisional autonomy
13 lead to inconsistent oversight and limited
14 cross-divisional collaboration. Do you accept those
15 views of you're essentially the person that carried on
16 the baton?

17 **A.** To some extent, I think it's a valid point. So when,
18 right at the start of my testimony today, I discussed
19 that: that the breaking up of what was called local
20 partnerships into three separate divisions, and that was
21 to enable a much sharper and greater focus on the
22 specific issues within those divisions, particularly the
23 mental health one. But I think as those new structures
24 and the change and the improvements the governance
25 overall that we were able to make, there reached a point

65

1 a Chief Operating Officer post. And is there any reason
2 you didn't create that post during the time you were
3 a Chief Executive?

4 **A.** Yes, two reasons. The first was that was initially the
5 thought when I -- we were considering splitting the
6 local services and creating three, that we should
7 attempt to appoint a single Chief Operating Officer. So
8 we advertised for the post nationally but the caliber of
9 applicants wasn't sufficient to -- they weren't
10 sufficiently experienced in that varied field to
11 appoint. So we stuck with the three.

12 The second point was, as I said a minute or two ago,
13 that in my judgement, the required sharp focus
14 particularly on mental health but also on the specialist
15 forensic services, require that real focus, and my
16 concern was that a Chief Operating Officer at that time
17 wouldn't provide that. I think as the organisation, the
18 experience of the executive and board matured in this
19 new way, that there would be a time that a single COO
20 would be appropriate. So I think that both would be
21 true.

22 **Q.** Thank you. You've already dealt with Mr Carr that
23 during the pandemic time incident investigations ceased
24 until I think, April 2022. You've also accepted that
25 the Feven incident should have been subject to incident

67

1 where I'd agree with Mr Majid's statement around it, it
2 did then start to impede to have a broader helicopter
3 view about that, yes.

4 **Q.** And similarly also indicates that that again attempts
5 during your time to integrate physical and mental health
6 services proved unsustainable, resulting in siloed
7 divisions and variable governance with confusion between
8 operational and corporate governance. Would you accept
9 that criticism also of the period of time that you were
10 Chief Executive?

11 **A.** So when I started, there was a confusion, even with
12 those two divisions, where there was a governance stream
13 that went from the director for those services through
14 their own associate directors of governance straight to
15 the individual teams, and there wasn't an overall
16 quality governance office, which I changed with the
17 appointment of the new Nursing Director, and create
18 a whole raft of quality governance posts, Deputy
19 Director of Nursing, Associate Director of Quality
20 Governance, to facilitate that being a Trust-wide office
21 rather than, as you allude to, a confusion of different
22 divisions.

23 **Q.** Then can I ask you, you've obviously identified the
24 roles you created, one of the things that happened
25 subsequently when you left was then the creation of

66

1 reporting; would you agree?

2 **A.** So the -- yes, I'd agree to the second point about that
3 should have been reported and recorded. Just to
4 emphasise that incident investigations weren't stopped,
5 they weren't such a priority and they were backing up,
6 but we still had staff that were undertaking them.

7 **Q.** That's helpful and I think we know, then, with the Feven
8 incident, that incident wasn't part of the backlog
9 because it simply hadn't been reported; would you agree?

10 **A.** If it hadn't been reported, it couldn't have been
11 investigated, no.

12 **Q.** Thank you. And then I think similarly the documentation
13 that deals with other things that changed during the
14 pandemic as well as the different approach to incident
15 investigation, it's right, isn't it, that ward-based
16 audits stopped as well? Is that correct?

17 **A.** I can't recollect if they stopped completely but the
18 amount and volume would have been significantly reduced.
19 They may have been stopped. I can't be certain.

20 **MR CARR:** Thank you very much.

21 **THE WITNESS:** Thank you.

22 **THE CHAIR:** Yes, *(inaudible)*.

23 **NEW SPEAKER:** No, thank you.

24 **Questioned by THE CHAIR**

25 **THE CHAIR:** Yes, thank you. Just a couple of questions,

68

1 Dr Brewin.
 2 Just when you were dealing with the reasons you said
 3 you reflected on, that learning was rather difficult to
 4 embed in relation to the common themes of some of the
 5 reports, and you said that this was something which
 6 appeared to occur nationwide; that's no reason for not
 7 addressing it in Nottingham, is it?
 8 **A.** Not at all. And we, indeed, we did try and address it.
 9 But for me, I think it's a reflective point, having had
 10 the opportunity to look back and perhaps ponder in more
 11 detail reasons why these findings keep occurring and we
 12 couldn't achieve what we were setting out to achieve.
 13 And for me, that was one of the reasons that, as
 14 I discussed, that unless the environment is right and
 15 you do all those things as well, you won't make the
 16 progress that you wish to make.
 17 **THE CHAIR:** Just in relation to your experience of Assertive
 18 Outreach, you said that that had been pared back. Did
 19 you consider, in addressing some of the issues, and in
 20 particular in relation to the serious incidents,
 21 reinstating that?
 22 **A.** We didn't consider it at the point, but I know
 23 subsequently that it's been addressed nationally and
 24 there's an imperative to sort of re-institute Assertive
 25 Outreach teams. I think there's good evidence that they

69

1 tested, yes.
 2 **THE CHAIR:** Yes. Just finally in relation to the Royal
 3 College of Psychiatrists' audits, which we were looking
 4 at before, the Trust was consistently and in fact the
 5 part, City South, that was dealing with VC, appeared to
 6 be consistently good at physical examinations, but not
 7 in relation to mental health?
 8 Do you agree with that? Perhaps the emphasis was on
 9 the wrong thing.
 10 **A.** Racking my brains to -- there were two or three
 11 indicators of physical health that met --
 12 **THE CHAIR:** Were higher than the national average, in fact.
 13 **A.** Yes. So but, for example, I think being weighed and
 14 blood pressure and blood tests, which is an important
 15 aspect of care, and again, I don't want to diminish the
 16 importance of that, but if you've got one or two members
 17 of staff that can do that, it's a relatively easy target
 18 to meet, although we didn't always evidence that. But
 19 the broader church of mental health interventions is
 20 a much more challenging arena.
 21 **THE CHAIR:** Yes. Thank you.
 22 Right. Well, I think what we'll do now is take
 23 a break now until 1.20. We'll take an early lunch
 24 before we hear Mr Majid's evidence. Thank you.
 25 (12.21 pm)

71

1 provide a better standard of care for that patient
 2 group.
 3 **THE CHAIR:** Did you consider whether uncoupling, as you put
 4 it, the EIP services from the LMHT services in fact
 5 creates gaps?
 6 **A.** It's a well-recognised concern and dilemma when you move
 7 from a generic to a specialist service and create
 8 a number of specialist teams, the downside is exactly
 9 that. All of a sudden, you have teams where no one
 10 meets the criteria; whereas a generic team, that doesn't
 11 happen.
 12 And, you know, the positive is that as we have seen:
 13 that if you can adequately resource a specialist team,
 14 you can meet national guidance targets, treatment
 15 targets, that a generic team can't.
 16 It's always a judgement about what's the best
 17 balance.
 18 **THE CHAIR:** The gaps are not simply in that respect, but in
 19 the passing, if you like, the baton from one part of the
 20 organisation to another, it creates those points of --
 21 or pinch points, really, doesn't it --
 22 **A.** Absolutely.
 23 **THE CHAIR:** -- where patients can get lost?
 24 **A.** Absolutely. And in addition, in a constrained financial
 25 environment, those pinch points get really pressure

70

(The short adjournment)

1
 2
 3
 4
 5
 6
 7
 8
 9
 10
 11
 12
 13
 14
 15
 16
 17
 18
 19
 20
 21
 22
 23
 24
 25

72

1		
2		
3		
3	DR JOHN BREWIN (affirmed)	1
4	Questioned by MR CARR	1
5	Questioned by MS CARTWRIGHT	65
6	Questioned by THE CHAIR	68
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		

<p>MR CARR: [6] 1/4 1/8 56/12 56/20 64/25 68/20</p> <p>MS CARTWRIGHT: [1] 65/4</p> <p>NEW SPEAKER: [1] 68/23</p> <p>THE CHAIR: [14] 1/3 1/7 56/14 56/19 65/1 68/22 68/25 69/17 70/3 70/18 70/23 71/2 71/12 71/21</p> <p>THE WITNESS: [1] 68/21</p> <hr/> <p>'21 [1] 55/1 '21/'22 [1] 55/1 '22 [1] 55/1 'good' [1] 9/5 'part [1] 64/1 'requires [1] 9/6</p> <hr/> <p>1</p> <p>1.20 [1] 71/23 10 [2] 12/3 62/6 10.00 [1] 1/2 100,000 [1] 36/9 11 [1] 56/24 11.34 [1] 56/16 11.55 [2] 56/15 56/18 110 [1] 46/15 111 [1] 46/16 117 [1] 61/15 118 [1] 61/15 12 [2] 4/12 12/17 12.21 [1] 71/25 13 [3] 8/25 13/8 57/13 13 June 2023 [1] 62/24 14 [3] 13/25 51/15 57/14 15 [3] 14/7 50/8 58/24 15 January [1] 1/9 15-16 million [1] 11/25 15-20 [1] 28/12 156 [1] 35/5 16 [1] 33/3 17 November 2021 [1] 28/22 175 [1] 63/23 18 [2] 33/7 36/10 18 August 2021 [1] 26/2 18 May 2026 [1] 1/1 180 [1] 64/15 19 [1] 53/23 1970s [1] 36/8 1995 [1] 1/21</p> <hr/> <p>2</p> <p>20 [3] 28/12 39/2</p>	<p>50/6 2000s [1] 60/17 2011 [1] 1/21 2018 [5] 37/9 50/2 50/22 52/17 58/23 2018/19 [1] 53/23 2018/2019 [1] 52/12 2019 [24] 1/16 1/18 2/19 10/3 14/17 19/13 19/16 22/7 24/2 24/24 25/3 25/8 25/25 40/24 42/13 43/15 43/18 43/21 45/4 52/12 52/18 53/24 62/22 65/12 2020 [7] 14/3 14/17 16/24 17/1 18/8 53/24 54/10 2021 [11] 20/12 22/9 26/2 28/1 28/22 32/16 40/19 41/3 42/12 43/19 54/10 2022 [14] 1/16 1/18 19/4 19/5 20/8 22/7 29/2 41/13 42/12 56/25 57/16 62/25 65/12 67/24 2022/2023 [1] 57/19 2023 [4] 56/25 57/19 62/22 62/24 2023/2024 [1] 57/13 2024 [1] 57/13 2026 [2] 1/1 1/9 23 September 2020 [1] 17/1 27 [2] 8/11 50/6 29 October 2021 [1] 22/9</p> <hr/> <p>3</p> <p>35 [3] 4/12 4/14 6/10 36 [2] 4/12 7/12 38 [1] 9/1 39 [1] 46/16</p> <hr/> <p>4</p> <p>40 [1] 61/15 42 [1] 14/2 44 [2] 14/8 14/8 45 [1] 14/8 4501 [1] 55/3 4502 [2] 55/3 55/3 4503 [1] 55/3 4505 [1] 54/12 46 [2] 14/10 52/20</p> <hr/> <p>5</p> <p>50 [1] 35/5 55 [2] 63/22 63/23 56 [2] 63/22 64/15 58 [1] 50/10</p> <hr/> <p>8</p> <p>8 February 2022 [1] 41/13</p>	<p>9</p> <p>9,500 staff [1] 6/23</p> <hr/> <p>A</p> <p>ability [6] 23/13 26/22 30/7 30/9 30/10 61/3 able [12] 2/2 10/20 11/8 18/16 21/4 33/19 44/22 45/20 60/1 60/6 61/3 65/25 about [42] 2/12 4/4 6/12 7/4 7/5 7/10 8/16 8/16 8/20 11/18 16/12 17/1 18/12 25/6 27/4 27/12 31/2 33/2 33/9 36/4 38/14 39/2 39/24 41/7 43/17 43/24 45/14 46/23 47/1 47/11 48/8 49/10 49/16 49/21 51/1 53/12 55/25 57/4 59/12 66/3 68/2 70/16 above [5] 2/15 35/14 54/18 54/19 58/24 abreast [1] 49/18 absence [1] 32/2 absences [1] 20/14 absolutely [6] 11/3 12/12 27/18 48/18 70/22 70/24 accept [3] 62/14 65/14 66/8 accepted [1] 67/24 accepting [1] 30/23 access [4] 23/24 54/2 54/17 55/7 accommodation [2] 32/2 32/4 accordance [1] 29/8 account [1] 11/14 achieve [4] 7/6 45/17 69/12 69/12 acquiring [1] 39/24 across [17] 3/17 4/3 5/2 9/17 11/5 11/15 21/11 25/6 25/9 28/9 36/18 37/21 38/23 39/9 42/18 43/10 54/5 Act [1] 62/17 action [4] 14/24 16/1 32/25 43/16 actions [5] 14/25 26/6 26/9 28/24 42/17 actually [2] 35/24 55/19 acuity [2] 31/13 31/15 acute [17] 4/21 5/8 12/6 12/13 12/20 17/3 18/5 21/10 21/13 25/7 26/23 31/2 32/1 32/7 38/14 39/4 39/24 added [1] 27/14 addition [4] 15/1</p>	<p>16/17 34/25 70/24 additional [9] 26/18 27/10 27/10 39/7 44/20 56/5 56/8 58/16 60/19 address [7] 13/5 15/7 34/18 42/14 43/17 45/4 69/8 addressed [3] 10/24 15/1 69/23 addressing [2] 69/7 69/19 adequate [1] 18/13 adequately [3] 23/10 45/22 70/13 adjournment [1] 72/1 admin [2] 23/15 59/2 administratively [1] 56/9 admission [1] 36/14 admissions [3] 30/22 31/5 31/8 admit [1] 33/16 admitted [2] 32/3 35/10 admitting [1] 31/7 adult [4] 21/11 26/7 39/24 59/18 adults [1] 12/20 advantages [1] 1/23 advertised [1] 67/8 advertises [1] 27/3 advice [1] 11/14 affirmed [2] 1/5 73/3 after [5] 18/24 19/5 19/8 57/15 62/17 afternoon [2] 65/4 65/10 again [32] 13/8 13/13 13/22 20/4 20/8 20/13 23/20 26/3 26/21 29/12 29/17 31/22 34/8 39/17 40/3 41/3 42/23 45/14 46/4 46/22 48/22 51/17 53/24 54/7 55/7 55/21 57/2 57/14 57/21 61/25 66/4 71/15 against [2] 46/24 54/15 age [1] 12/20 agency [4] 23/17 27/10 63/21 64/11 ago [3] 15/12 53/2 67/12 agree [8] 10/2 19/24 54/16 66/1 68/1 68/2 68/9 71/8 agreed [3] 29/22 29/25 40/22 ahead [2] 8/8 8/9 alarming [1] 21/14 albeit [1] 54/3 alert [1] 49/23 alerted [1] 49/13 all [27] 6/17 7/3 7/4</p>	<p>7/5 8/3 8/15 10/20 13/12 13/18 13/19 19/15 23/8 29/15 29/18 31/5 32/23 52/13 54/14 55/8 57/21 61/21 62/2 62/24 63/1 69/8 69/15 70/9 allow [1] 50/13 allude [1] 66/21 almost [1] 54/5 alone [2] 5/24 5/25 along [2] 48/7 65/7 already [4] 33/5 61/2 61/2 67/22 also [25] 6/3 8/20 10/7 15/11 16/13 20/18 21/18 22/21 35/4 36/24 38/8 38/10 41/7 42/23 44/1 44/5 45/25 54/8 55/24 56/7 57/13 66/4 66/9 67/14 67/24 although [5] 5/18 15/17 18/19 34/3 71/18 always [7] 10/18 37/12 38/22 39/6 40/11 70/16 71/18 am [5] 1/2 31/2 56/16 56/18 59/23 amenable [1] 58/3 amongst [2] 10/14 12/14 amount [1] 68/18 amounts [1] 12/2 annual [2] 9/15 12/2 another [5] 51/4 52/19 60/1 62/11 70/20 answer [2] 44/19 45/3 answers [1] 39/11 anticipated [1] 10/5 anxiety [1] 5/3 any [14] 3/21 9/10 25/13 28/18 29/6 31/3 33/19 34/21 37/25 53/3 59/8 60/4 63/18 67/1 any reason [1] 67/1 anything [1] 32/4 anywhere [1] 20/6 AO [2] 59/24 59/25 apologies [1] 64/14 appear [2] 17/23 46/16 appeared [2] 69/6 71/5 appears [4] 19/22 22/24 32/15 48/11 applicants [1] 67/9 applied [1] 33/14 apply [2] 44/24 61/6 appoint [2] 67/7 67/11</p>
--	---	--	--	---

<p>A</p> <p>appointment [2] 34/10 66/17</p> <p>appraisal [1] 16/14</p> <p>appraisals [1] 18/16</p> <p>appraised [1] 43/4</p> <p>appreciate [1] 48/8</p> <p>appreciation [1] 37/13</p> <p>approach [3] 61/9 61/12 68/14</p> <p>appropriate [3] 56/12 64/3 67/20</p> <p>appropriately [3] 14/25 57/23 58/17</p> <p>April [4] 19/10 29/2 29/19 67/24</p> <p>April 2022 [1] 29/2</p> <p>are [61] 4/20 4/22 5/13 6/4 6/17 7/1 7/8 7/11 7/14 12/4 12/14 12/23 13/9 13/11 13/17 14/10 15/23 16/8 16/15 17/20 19/15 19/19 19/22 22/18 22/25 26/7 29/7 30/12 33/19 35/10 36/9 38/19 38/20 38/21 41/2 42/10 43/4 43/22 44/6 44/10 44/11 44/11 44/21 44/21 45/21 46/13 47/8 49/5 50/5 52/10 54/14 54/20 55/8 57/14 61/25 63/14 64/8 64/21 64/25 65/5 70/18</p> <p>are saying [1] 13/9</p> <p>area [11] 30/25 31/16 32/11 35/1 35/4 35/6 35/16 37/20 37/24 38/15 53/6</p> <p>areas [4] 12/18 16/19 20/4 48/11</p> <p>aren't [2] 23/17 48/5</p> <p>arena [1] 71/20</p> <p>arguments [1] 41/11</p> <p>arises [1] 63/14</p> <p>arising [3] 42/11 44/12 49/17</p> <p>arms [1] 23/9</p> <p>Arnold [5] 33/8 33/9 34/2 34/25 35/2</p> <p>around [7] 16/8 16/20 27/19 35/2 48/4 57/22 66/1</p> <p>arrangement [1] 3/5</p> <p>arrangements [2] 28/6 64/4</p> <p>arrived [1] 22/22</p> <p>as [94]</p> <p>Aside [1] 3/21</p> <p>ask [3] 26/5 65/5 66/23</p> <p>asked [1] 45/9</p>	<p>asking [1] 47/1</p> <p>aspect [1] 71/15</p> <p>assertive [18] 59/12 59/13 59/13 59/15 59/22 59/23 60/1 60/2 60/9 60/13 60/18 60/20 60/25 61/7 61/9 61/12 69/17 69/24</p> <p>assertively [2] 60/6 61/3</p> <p>assess [3] 31/7 31/18 31/23</p> <p>assessing [2] 16/6 45/5</p> <p>assessment [21] 14/13 21/17 21/20 21/21 40/20 40/21 41/4 42/7 43/11 44/8 46/3 46/11 46/18 47/1 47/4 47/7 47/13 47/23 49/8 62/18 64/12</p> <p>assessments [21] 13/11 13/18 14/21 15/25 16/4 16/6 16/8 16/21 20/20 20/21 20/25 21/1 22/3 22/4 34/15 41/17 44/18 46/6 46/12 46/24 48/3</p> <p>assistance [2] 26/5 26/8</p> <p>assistant [1] 27/8</p> <p>associate [3] 34/11 66/14 66/19</p> <p>associates [1] 27/6</p> <p>assurance [1] 16/2</p> <p>assured [1] 16/3</p> <p>at [95]</p> <p>at at [1] 47/10</p> <p>at bullet [1] 28/25</p> <p>At page 12 [1] 12/17</p> <p>at page 55 [1] 63/22</p> <p>attempt [2] 15/8 67/7</p> <p>attempted [2] 25/21 62/22</p> <p>attempting [1] 55/25</p> <p>attempts [1] 66/4</p> <p>attention [1] 25/5</p> <p>Attfield [5] 3/4 3/16 26/2 34/9 55/22</p> <p>audible [1] 47/6</p> <p>audit [5] 16/18 52/18 55/1 56/21 56/23</p> <p>auditing [1] 52/11</p> <p>audits [7] 16/20 18/15 52/5 55/15 55/16 68/16 71/3</p> <p>August [3] 1/18 26/2 40/19</p> <p>August 2021 [1] 40/19</p> <p>August 2022 [1] 1/18</p> <p>authorities [2] 4/25 5/7</p> <p>authority [1] 4/25</p> <p>automatically [3] 49/13 49/15 49/22</p>	<p>autonomy [1] 65/12</p> <p>available [1] 58/1</p> <p>average [6] 52/14 54/3 54/18 54/19 55/8 71/12</p> <p>averages [1] 54/15</p> <p>avoid [2] 30/13 44/16</p> <p>avoidable [1] 62/12</p> <p>aware [16] 2/5 11/1 25/6 39/19 44/24 47/17 49/24 58/16 58/21 58/22 58/24 59/2 59/6 59/10 59/23 60/4</p> <p>awareness [1] 50/16</p> <p>away [3] 7/5 35/10 40/6</p> <p>awful [1] 57/6</p> <p>B</p> <p>back [14] 8/11 11/22 13/24 24/1 25/3 32/5 44/3 45/15 45/18 56/20 60/22 62/18 69/10 69/18</p> <p>backdrop [1] 28/13</p> <p>backed [1] 29/19</p> <p>background [3] 2/9 58/17 60/15</p> <p>backing [2] 40/5 68/5</p> <p>backlog [2] 29/20 68/8</p> <p>balance [2] 37/15 70/17</p> <p>bank [2] 23/16 27/11</p> <p>based [3] 17/1 19/21 68/15</p> <p>basis [5] 7/2 12/2 23/3 31/9 45/1</p> <p>baton [2] 65/16 70/19</p> <p>be [104]</p> <p>became [7] 3/15 3/19 4/7 8/5 15/14 21/12 38/2</p> <p>because [28] 2/24 6/3 10/23 11/4 13/1 15/16 18/11 23/13 23/23 24/17 27/21 32/3 34/25 36/13 37/5 40/12 40/14 42/24 43/25 46/19 47/3 47/3 49/17 52/7 57/9 61/5 61/11 68/9</p> <p>become [5] 4/2 36/4 47/17 64/18 64/19</p> <p>becoming [2] 3/17 60/9</p> <p>bed [4] 32/6 32/7 36/5 37/6</p> <p>beds [18] 30/25 31/16 32/10 33/24 34/12 36/3 36/6 36/9 36/13 36/25 36/25 37/3 37/11 37/14 37/21 37/23 38/14 45/23</p>	<p>been [50] 4/16 9/13 18/2 18/7 21/13 21/17 23/23 24/11 25/7 25/17 26/10 29/13 29/25 32/15 32/16 32/20 32/25 34/16 35/15 35/21 36/10 36/12 36/18 42/18 43/2 43/4 43/5 43/16 43/20 43/21 46/12 46/23 49/24 50/24 53/19 55/4 55/12 58/14 59/14 59/16 64/5 67/25 68/3 68/9 68/10 68/10 68/18 68/19 69/18 69/23</p> <p>before [8] 11/7 11/16 18/6 27/19 46/20 58/22 71/4 71/24</p> <p>beforehand [2] 26/15 31/8</p> <p>beginning [2] 8/14 45/16</p> <p>begs [1] 44/19</p> <p>behavioural [2] 53/5 57/23</p> <p>behaviours [2] 7/15 7/19</p> <p>behind [3] 7/23 18/10 29/3</p> <p>beholden [1] 15/2</p> <p>being [30] 8/13 10/10 10/23 13/14 16/4 16/22 21/20 22/24 23/15 24/21 26/4 26/11 28/24 33/13 33/21 34/22 35/24 36/25 40/8 41/5 41/18 43/18 43/19 47/8 48/10 52/1 52/23 56/2 66/20 71/13</p> <p>belief [1] 1/12</p> <p>believe [2] 23/6 55/6</p> <p>below [6] 2/17 52/13 54/3 54/7 54/8 55/8</p> <p>benefit [1] 30/4</p> <p>bespoke [1] 31/19</p> <p>best [10] 1/11 10/18 16/12 24/25 25/13 34/15 37/18 44/21 54/3 70/16</p> <p>better [3] 55/18 56/25 70/1</p> <p>between [14] 1/15 1/21 14/5 14/17 22/6 25/23 27/7 41/7 46/22 50/6 52/7 64/6 65/12 66/7</p> <p>beyond [1] 48/11</p> <p>bid [1] 39/6</p> <p>big [1] 3/7</p> <p>bigger [1] 4/3</p> <p>bit [2] 11/20 18/1</p> <p>blood [2] 71/14 71/14</p> <p>blunt [1] 36/1</p> <p>board [22] 7/13 7/25</p>	<p>9/24 14/22 14/22 15/15 16/2 16/3 24/5 24/10 24/11 24/15 24/17 32/14 32/15 32/16 32/19 32/20 38/20 47/10 47/17 67/18</p> <p>Boards [1] 8/6</p> <p>boat [1] 6/25</p> <p>bodies [2] 16/11 47/21</p> <p>both [7] 2/2 21/11 33/24 38/6 49/11 59/12 67/20</p> <p>bottom [9] 3/25 12/17 25/16 26/3 41/3 41/13 50/4 50/11 51/16</p> <p>box [1] 63/6</p> <p>boxes [1] 26/3</p> <p>brains [1] 71/10</p> <p>break [5] 56/13 56/14 56/17 58/22 71/23</p> <p>breaking [1] 65/19</p> <p>breaks [1] 32/4</p> <p>Brewin [7] 1/4 1/5 1/8 56/21 65/4 69/1 73/3</p> <p>bridge [1] 27/7</p> <p>brief [1] 3/1</p> <p>briefed [1] 14/23</p> <p>briefing [1] 41/2</p> <p>briefly [2] 36/8 65/4</p> <p>bring [1] 43/17</p> <p>broad [1] 26/16</p> <p>broader [8] 4/7 4/8 4/9 59/19 64/23 64/23 66/2 71/19</p> <p>broadly [3] 4/18 21/11 64/19</p> <p>brought [1] 23/18</p> <p>budget [3] 6/21 39/3 40/1</p> <p>budgets [4] 11/21 39/1 39/9 40/2</p> <p>bullet [9] 10/15 11/11 12/5 12/22 13/10 28/25 30/21 50/11 62/7</p> <p>Bulletin [1] 42/20</p> <p>buoyed [2] 17/24 18/11</p> <p>bureaucracy [2] 2/6 6/11</p> <p>Business [1] 4/6</p> <p>busy [2] 61/2 61/2</p> <p>but [99]</p> <p>buy [1] 39/8</p> <p>C</p> <p>caliber [1] 67/8</p> <p>call [5] 1/4 15/13 23/9 37/5 42/23</p> <p>called [15] 3/8 4/23 5/11 5/15 6/4 8/3 9/15 11/23 23/16 27/6</p>
---	---	--	--	---

<p>C</p> <p>called... [5] 42/20 51/25 59/18 64/11 65/19</p> <p>calls [1] 38/13</p> <p>came [1] 8/2</p> <p>can [35] 2/14 4/11 10/4 16/25 17/2 17/22 17/22 19/8 21/14 22/6 26/2 27/9 33/4 36/13 40/18 41/3 49/25 50/3 52/12 53/16 53/22 54/4 54/11 55/2 56/24 57/13 58/7 61/13 62/23 65/4 66/23 70/13 70/14 70/23 71/17</p> <p>can't [19] 15/11 16/17 24/12 28/10 31/4 31/22 33/17 34/24 38/2 38/3 49/9 49/10 50/25 51/3 57/21 61/25 68/17 68/19 70/15</p> <p>candid [1] 49/16</p> <p>capital [1] 39/7</p> <p>care [27] 4/23 5/6 5/7 5/21 8/6 10/11 11/15 12/14 17/4 31/14 36/11 36/14 37/19 39/4 40/1 43/24 50/5 50/8 50/13 51/12 57/11 57/15 58/13 58/23 60/1 70/1 71/15</p> <p>carers [1] 41/15</p> <p>caring [3] 17/10 17/15 19/18</p> <p>Carr [5] 1/3 1/6 56/19 67/22 73/4</p> <p>carried [3] 9/2 46/12 65/15</p> <p>carrying [2] 30/11 44/18</p> <p>Cartwright [3] 65/2 65/3 73/5</p> <p>case [6] 15/24 33/18 54/14 57/11 60/23 61/21</p> <p>caseloads [2] 50/5 58/24</p> <p>cases [3] 43/8 62/24 63/19</p> <p>cause [2] 12/11 43/20</p> <p>caveats [1] 20/4</p> <p>CBPT [1] 53/3</p> <p>CBT [6] 52/17 52/18 53/10 53/14 54/12 55/9</p> <p>CBTp [2] 58/11 58/18</p> <p>CBTs [1] 54/7</p> <p>CCG [1] 38/6</p> <p>CCGs [1] 4/24</p> <p>CCOs [1] 58/23</p> <p>ceased [1] 67/23</p>	<p>cent [4] 11/23 52/19 52/19 52/20</p> <p>CEO [5] 1/14 1/24 2/22 56/22 59/16</p> <p>certain [1] 68/19</p> <p>certainly [7] 1/25 18/19 19/1 19/21 21/5 32/24 59/2</p> <p>Chair [6] 1/4 2/15 56/12 64/25 68/24 73/6</p> <p>chaired [1] 38/11</p> <p>challenge [3] 35/10 39/18 57/22</p> <p>challenges [4] 2/4 39/15 45/21 49/18</p> <p>challenging [3] 26/23 39/10 71/20</p> <p>change [12] 2/21 2/22 3/22 10/10 14/11 17/19 18/3 19/13 20/16 48/5 54/24 65/24</p> <p>changed [5] 2/23 19/22 55/2 66/16 68/13</p> <p>changes [10] 3/2 3/21 3/22 8/9 14/2 14/4 18/19 27/1 29/22 30/12</p> <p>changing [1] 8/2</p> <p>chart [1] 2/12</p> <p>chief [13] 1/14 2/7 2/15 28/9 47/17 55/20 59/20 65/9 66/10 67/1 67/3 67/7 67/16</p> <p>chime [1] 11/16</p> <p>chimes [1] 40/23</p> <p>church [1] 71/19</p> <p>Cinderella [1] 38/24</p> <p>circumstances [4] 30/1 47/3 47/8 63/13</p> <p>city [6] 4/25 53/18 53/21 55/3 55/6 71/5</p> <p>Claire [1] 38/12</p> <p>clean [1] 18/14</p> <p>clear [4] 10/9 30/18 44/10 45/19</p> <p>clearer [1] 45/13</p> <p>clearly [4] 7/20 15/23 22/2 39/23</p> <p>clinic [1] 61/11</p> <p>clinical [25] 2/1 2/3 2/9 4/24 7/10 11/14 14/13 15/1 30/2 30/2 30/5 30/19 37/8 37/9 37/14 38/12 44/5 46/17 47/1 47/4 47/7 47/15 47/23 52/5 59/21</p> <p>clinician [1] 44/6</p> <p>clinicians [3] 37/16 47/12 50/19</p> <p>close [3] 28/6 49/6 52/20</p> <p>closed [1] 23/6</p>	<p>closer [1] 34/1</p> <p>closing [1] 49/2</p> <p>closure [1] 22/23</p> <p>co [1] 50/5</p> <p>co-ordinators [1] 50/5</p> <p>cognisant [1] 38/22</p> <p>cognitive [3] 53/5 56/6 57/23</p> <p>collaboration [1] 65/14</p> <p>collate [1] 42/21</p> <p>collated [2] 42/16 43/10</p> <p>colleagues [3] 9/24 15/7 33/2</p> <p>College [4] 16/12 52/11 55/14 71/3</p> <p>colloquialism [1] 6/24</p> <p>column [1] 53/17</p> <p>come [9] 2/7 2/12 4/4 27/15 37/17 37/18 38/23 50/22 61/11</p> <p>comes [2] 24/25 26/13</p> <p>coming [2] 35/25 40/10</p> <p>commentary [3] 17/21 18/10 20/2</p> <p>commission [1] 51/11</p> <p>commissioners [2] 38/10 56/4</p> <p>commissioning [3] 4/24 38/6 38/7</p> <p>Committee [2] 14/12 14/12</p> <p>common [6] 28/8 31/25 44/6 44/10 44/11 69/4</p> <p>commonly [1] 29/10</p> <p>communication [1] 41/7</p> <p>community [10] 3/8 3/16 3/20 5/19 36/11 36/12 36/14 37/4 37/19 41/24</p> <p>compared [1] 17/6</p> <p>compassionate [1] 18/14</p> <p>competence [1] 47/12</p> <p>competing [2] 38/20 39/6</p> <p>competition [1] 58/21</p> <p>complacency [1] 18/20</p> <p>complement [1] 23/19</p> <p>completed [2] 21/20 21/21</p> <p>completely [1] 68/17</p> <p>completeness [1] 16/21</p>	<p>completing [5] 20/20 20/20 20/24 20/25 21/17</p> <p>completion [1] 22/3</p> <p>compliance [3] 6/13 7/9 11/18</p> <p>compliant [4] 51/23 52/23 55/18 57/7</p> <p>complying [1] 53/13</p> <p>compounded [1] 26/23</p> <p>comprehensive [4] 16/5 20/21 21/1 21/22</p> <p>comprising [1] 33/11</p> <p>compromising [1] 23/12</p> <p>concern [20] 10/22 11/4 12/11 13/22 15/19 23/5 23/9 24/6 25/6 25/8 28/9 38/5 40/12 40/13 41/5 43/20 47/9 47/18 67/16 70/6</p> <p>concerned [3] 14/10 14/15 19/23</p> <p>concerns [34] 10/19 10/20 10/23 11/2 11/5 22/25 23/4 25/1 25/18 25/19 33/2 38/13 38/15 40/6 40/8 40/11 40/23 41/7 42/11 42/13 42/15 43/18 45/20 47/16 48/10 48/19 48/19 48/23 49/1 49/3 49/4 49/21 51/1 53/12</p> <p>conclusion [1] 19/25</p> <p>concordance [1] 59/9</p> <p>concordant [1] 51/12</p> <p>condition [1] 32/8</p> <p>conditions [1] 58/3</p> <p>conference [1] 64/12</p> <p>configuration [1] 55/2</p> <p>confirm [1] 58/7</p> <p>confusion [3] 66/7 66/11 66/21</p> <p>consider [3] 69/19 69/22 70/3</p> <p>considerable [1] 2/25</p> <p>considered [4] 8/8 61/20 61/22 62/24</p> <p>considering [2] 63/10 67/5</p> <p>consistently [2] 71/4 71/6</p> <p>constrained [3] 39/20 53/8 70/24</p> <p>construct [1] 39/7</p> <p>consultant [2] 1/20 28/12</p> <p>consultants [1] 37/16</p> <p>contain [2] 13/12</p>	<p>13/19</p> <p>contention [1] 44/23</p> <p>context [4] 5/14 18/1 64/16 64/24</p> <p>continue [3] 21/4 28/14 37/23</p> <p>continued [1] 33/23</p> <p>continues [1] 27/24</p> <p>continuing [1] 30/14</p> <p>contract [1] 31/15</p> <p>contracted [1] 34/12</p> <p>contribute [1] 20/24</p> <p>contributed [1] 40/15</p> <p>convene [1] 24/15</p> <p>conversation [2] 28/9 39/24</p> <p>conversations [3] 9/24 49/20 55/23</p> <p>convert [1] 40/2</p> <p>COO [1] 67/19</p> <p>coordinator [1] 50/8</p> <p>coordinators [1] 58/23</p> <p>cope [1] 20/13</p> <p>copied [1] 55/13</p> <p>core [2] 34/16 45/22</p> <p>corner [1] 4/1</p> <p>coroner [8] 40/11 40/13 40/20 41/11 42/2 43/19 47/7 49/13</p> <p>coroners [6] 40/8 42/11 48/12 48/19 49/3 49/7</p> <p>coroners' [1] 45/6</p> <p>corporate [5] 14/14 14/16 46/23 58/8 66/8</p> <p>correct [7] 1/17 2/20 17/8 17/17 29/10 46/21 68/16</p> <p>correspondence [1] 55/14</p> <p>cost [7] 6/12 6/19 7/9 11/12 11/18 11/21 11/24</p> <p>could [9] 5/10 19/25 23/18 24/15 30/17 34/15 56/1 58/14 61/4</p> <p>couldn't [4] 57/20 59/4 68/10 69/12</p> <p>country [4] 6/5 36/18 37/21 45/1</p> <p>county [7] 3/11 4/10 4/18 4/21 4/25 25/10 33/25</p> <p>couple [4] 19/2 35/14 35/22 68/25</p> <p>coupled [1] 53/4</p> <p>course [8] 2/21 19/23 24/1 40/13 42/12 43/22 51/5 57/15</p> <p>cover [1] 19/11</p> <p>coverage [1] 42/10</p> <p>covered [3] 6/9 34/17 56/21</p> <p>Covid [6] 20/14 20/19 20/24 21/24 22/1</p>
---	--	---	---	--

<p>C</p> <p>Covid... [1] 38/13 CQ [1] 49/2 CQC [37] 8/22 12/9 12/19 13/9 13/17 14/1 14/18 15/19 17/14 17/19 18/7 19/4 19/22 21/19 22/22 23/6 24/1 24/24 25/25 33/14 33/16 33/22 34/17 34/20 38/4 40/1 40/24 43/15 45/4 47/3 47/24 48/12 48/20 49/4 49/12 49/16 49/20 CQCM0016478 [1] 19/4 create [4] 45/10 66/17 67/2 70/7 created [4] 3/19 16/17 51/4 66/24 creates [2] 70/5 70/20 creating [1] 67/6 creation [3] 14/12 56/7 66/25 criminal [1] 64/10 crisis [2] 29/17 60/18 criteria [4] 40/1 61/18 62/1 70/10 critically [1] 7/9 criticism [1] 66/9 critiques [1] 44/7 cross [1] 65/14 cross-divisional [1] 65/14 culture [6] 4/3 4/5 7/15 7/18 11/7 45/19 currently [1] 51/13 cut [1] 11/21</p>	<p>32/16 41/3 December 2021 [2] 32/16 41/3 decline [1] 10/1 decreed [1] 30/16 dedicated [2] 60/25 61/4 deficiencies [1] 45/5 definition [1] 62/5 definitions [1] 62/11 delay [2] 32/1 32/5 delayed [1] 31/14 delaying [1] 35/12 delays [1] 23/23 delivered [1] 51/19 delivering [1] 27/1 demand [2] 36/2 60/11 departments [2] 5/8 15/10 depending [2] 45/1 63/1 depression [1] 5/3 Deputy [1] 66/18 derogations [1] 29/23 describe [14] 4/15 7/12 7/15 8/12 9/1 14/8 14/11 22/14 25/19 35/6 35/12 46/15 63/23 64/15 described [9] 8/4 16/1 24/11 29/5 37/1 37/3 42/17 60/9 64/1 describes [5] 6/10 12/5 28/23 42/5 61/14 describing [4] 33/13 46/17 47/22 61/16 desire [1] 20/15 despite [7] 18/17 24/21 25/13 25/17 37/18 37/24 44/20 despondency [2] 24/21 25/15 detail [12] 11/20 23/8 24/12 32/23 33/4 34/24 40/21 43/24 45/14 49/10 63/20 69/11 detailed [3] 14/23 18/10 33/3 details [1] 57/21 deteriorated [1] 9/18 deteriorating [1] 12/7 deterioration [3] 9/5 9/9 9/13 detrimental [1] 35/7 develop [3] 5/9 5/11 61/8 developed [2] 13/19 33/25 developing [2] 4/5 27/5 development [1] 36/11 Developments [1]</p>	<p>4/6 devised [1] 43/7 diabetic [1] 5/20 did [30] 2/21 2/22 3/12 6/15 16/2 17/24 25/16 30/3 31/10 37/22 37/25 42/14 43/19 43/22 45/8 49/5 50/25 51/21 53/3 53/7 55/16 55/19 56/2 59/17 61/8 64/13 66/2 69/8 69/18 70/3 didn't [11] 7/23 11/7 13/19 17/15 33/11 36/2 37/6 64/14 67/2 69/22 71/18 difference [5] 25/3 25/5 25/22 46/22 53/4 different [9] 8/4 18/6 25/10 34/7 48/7 53/16 59/25 66/21 68/14 difficult [10] 7/5 8/1 9/10 10/24 21/12 21/24 27/14 37/8 46/1 69/3 difficulties [2] 28/2 28/3 dilemma [1] 70/6 diminish [1] 71/15 dint [1] 31/10 dip [1] 16/6 direction [2] 7/3 17/25 directly [1] 57/10 director [18] 3/3 3/6 3/14 3/17 3/23 3/25 4/6 4/7 15/3 34/9 34/11 38/12 47/14 59/20 66/13 66/17 66/19 66/19 directorate [2] 4/2 4/2 directors [3] 2/17 14/6 66/14 disagree [1] 33/17 disbanded [1] 61/1 discharge [9] 31/18 31/21 31/23 32/1 32/5 32/11 37/2 41/23 44/9 discharged [2] 31/25 57/16 disclosed [1] 49/4 disconnected [1] 64/18 discontinued [1] 59/16 discovered [1] 32/9 discussed [6] 26/16 29/25 38/16 56/3 65/18 69/14 discussion [1] 22/14 discussions [2] 6/12 11/18 disengaged [3] 57/16 59/8 59/11 disseminated [1]</p>	<p>42/18 district [1] 6/1 divides [1] 52/7 division [10] 3/8 3/9 3/15 3/16 3/20 3/22 5/19 15/3 26/18 55/22 divisional [2] 65/12 65/14 divisions [7] 3/7 3/13 65/20 65/22 66/7 66/12 66/22 do [40] 2/2 15/4 20/1 20/15 20/16 20/23 22/15 23/4 24/10 24/17 25/22 27/9 28/2 30/14 31/6 37/7 42/14 45/3 45/10 45/13 45/25 48/7 51/13 51/21 53/10 54/21 55/19 55/25 56/22 57/7 61/6 62/14 62/20 63/4 63/18 65/14 69/15 71/8 71/17 71/22 doctors [1] 37/2 document [25] 2/11 10/15 12/3 22/7 25/25 28/20 28/21 28/23 31/12 32/14 32/22 40/9 40/17 41/1 41/21 42/3 51/4 51/8 51/15 52/10 56/20 56/24 57/14 62/7 62/23 documentation [4] 40/21 42/3 55/13 68/12 documented [2] 24/7 38/17 documents [2] 42/9 42/10 does [9] 4/19 11/15 11/20 20/2 30/23 31/20 34/18 47/9 63/15 does it [1] 34/18 doesn't [10] 23/3 24/6 32/6 34/18 40/23 42/20 44/23 48/11 70/10 70/21 doing [7] 9/21 18/16 22/3 29/24 44/20 46/13 59/22 domain [3] 5/17 17/7 20/18 domains [4] 9/17 17/10 17/15 52/13 don't [19] 5/4 17/11 17/19 21/12 22/1 23/8 25/20 27/18 29/14 36/14 39/11 45/9 45/24 46/3 46/18 57/2 61/11 63/20 71/15 done [8] 6/1 10/10 13/14 14/24 21/22 26/11 29/13 29/21 dormitory [1] 40/3</p>	<p>dose [1] 43/12 doubly [1] 46/1 down [17] 4/11 9/23 13/1 13/10 18/8 19/8 23/7 30/17 32/4 35/25 41/21 51/9 51/10 53/22 60/20 61/11 63/6 downside [2] 30/5 70/8 Dr [10] 1/4 1/5 1/8 3/4 3/16 36/24 55/22 56/21 69/1 73/3 Dr Attfield [2] 3/16 55/22 Dr Brewin [3] 1/8 56/21 69/1 Dr Gibson [1] 36/24 Dr John [1] 1/4 Dr Julie [1] 3/4 drafted [1] 22/8 dramatically [1] 36/7 draw [1] 19/25 drive [1] 44/22 due [1] 44/25 during [12] 18/2 19/13 38/13 51/4 51/21 58/12 63/2 65/11 66/5 67/2 67/23 68/13</p>
<p>D</p>				
<p>data [2] 8/16 8/19 date [5] 16/15 19/9 24/12 32/17 38/2 dated [4] 1/9 40/18 40/18 50/2 dates [1] 15/12 day [5] 2/4 2/4 7/2 7/2 64/1 deal [7] 13/25 14/17 15/25 26/11 49/25 60/8 61/13 dealing [9] 11/13 12/15 14/13 27/22 53/2 53/19 55/5 69/2 71/5 deals [1] 68/13 dealt [4] 39/13 63/22 65/8 67/22 Dean [1] 2/15 dearth [1] 58/17 death [4] 40/15 42/6 44/12 49/14 deaths [1] 40/15 December [3] 20/12</p>	<p>data [2] 8/16 8/19 date [5] 16/15 19/9 24/12 32/17 38/2 dated [4] 1/9 40/18 40/18 50/2 dates [1] 15/12 day [5] 2/4 2/4 7/2 7/2 64/1 deal [7] 13/25 14/17 15/25 26/11 49/25 60/8 61/13 dealing [9] 11/13 12/15 14/13 27/22 53/2 53/19 55/5 69/2 71/5 deals [1] 68/13 dealt [4] 39/13 63/22 65/8 67/22 Dean [1] 2/15 dearth [1] 58/17 death [4] 40/15 42/6 44/12 49/14 deaths [1] 40/15 December [3] 20/12</p>	<p>data [2] 8/16 8/19 date [5] 16/15 19/9 24/12 32/17 38/2 dated [4] 1/9 40/18 40/18 50/2 dates [1] 15/12 day [5] 2/4 2/4 7/2 7/2 64/1 deal [7] 13/25 14/17 15/25 26/11 49/25 60/8 61/13 dealing [9] 11/13 12/15 14/13 27/22 53/2 53/19 55/5 69/2 71/5 deals [1] 68/13 dealt [4] 39/13 63/22 65/8 67/22 Dean [1] 2/15 dearth [1] 58/17 death [4] 40/15 42/6 44/12 49/14 deaths [1] 40/15 December [3] 20/12</p>	<p>data [2] 8/16 8/19 date [5] 16/15 19/9 24/12 32/17 38/2 dated [4] 1/9 40/18 40/18 50/2 dates [1] 15/12 day [5] 2/4 2/4 7/2 7/2 64/1 deal [7] 13/25 14/17 15/25 26/11 49/25 60/8 61/13 dealing [9] 11/13 12/15 14/13 27/22 53/2 53/19 55/5 69/2 71/5 deals [1] 68/13 dealt [4] 39/13 63/22 65/8 67/22 Dean [1] 2/15 dearth [1] 58/17 death [4] 40/15 42/6 44/12 49/14 deaths [1] 40/15 December [3] 20/12</p>	<p>data [2] 8/16 8/19 date [5] 16/15 19/9 24/12 32/17 38/2 dated [4] 1/9 40/18 40/18 50/2 dates [1] 15/12 day [5] 2/4 2/4 7/2 7/2 64/1 deal [7] 13/25 14/17 15/25 26/11 49/25 60/8 61/13 dealing [9] 11/13 12/15 14/13 27/22 53/2 53/19 55/5 69/2 71/5 deals [1] 68/13 dealt [4] 39/13 63/22 65/8 67/22 Dean [1] 2/15 dearth [1] 58/17 death [4] 40/15 42/6 44/12 49/14 deaths [1] 40/15 December [3] 20/12</p>

<p>E</p> <p>email... [4] 24/4 28/20 32/18 48/24</p> <p>embed [1] 69/4</p> <p>embedded [2] 45/12 52/1</p> <p>emergence [1] 18/9</p> <p>emergency [1] 5/8</p> <p>emergent [1] 37/10</p> <p>emphasis [8] 3/25 6/19 6/22 21/3 23/16 36/10 36/19 71/8</p> <p>emphasise [1] 68/4</p> <p>enable [7] 36/22 45/11 48/4 52/2 56/5 61/8 65/21</p> <p>encourage [2] 15/8 27/15</p> <p>end [4] 56/23 57/3 63/24 64/2</p> <p>endlessly [1] 25/11</p> <p>England [5] 30/16 38/8 39/14 48/21 49/5</p> <p>enough [3] 12/23 26/20 36/18</p> <p>ensure [12] 12/23 13/11 16/3 16/15 33/20 34/15 50/19 51/21 51/22 53/13 55/17 60/5</p> <p>entirely [1] 54/5</p> <p>entirety [1] 63/9</p> <p>entries [1] 31/13</p> <p>environment [5] 28/14 39/20 45/10 69/14 70/25</p> <p>environments [3] 18/5 18/14 21/10</p> <p>equipped [1] 60/8</p> <p>escalated [2] 48/16 58/15</p> <p>escalating [1] 58/10</p> <p>escalation [1] 61/19</p> <p>essentially [11] 3/6 24/24 30/23 31/24 32/11 33/4 33/10 46/16 46/20 60/9 65/15</p> <p>estate [1] 40/3</p> <p>even [2] 21/12 66/11</p> <p>eventually [1] 26/13</p> <p>ever [2] 21/13 35/25</p> <p>every [2] 6/20 6/20</p> <p>everything [1] 18/17</p> <p>evidence [15] 19/1 31/17 33/5 33/8 36/24 44/23 45/2 58/6 58/9 58/11 60/7 65/5 69/25 71/18 71/24</p> <p>evidently [1] 45/8</p> <p>exact [1] 15/11</p> <p>exactly [1] 70/8</p> <p>examinations [1] 71/6</p> <p>example [31] 5/8</p>	<p>5/20 6/1 7/21 9/14 15/4 15/10 16/7 16/11 16/20 20/9 21/2 22/5 24/13 24/23 27/2 31/1 31/3 31/5 34/14 36/8 39/7 42/19 42/25 43/11 44/7 45/23 47/22 49/13 56/6 71/13</p> <p>excess [1] 50/7</p> <p>excessive [1] 58/24</p> <p>exclusively [1] 5/16</p> <p>Exec [1] 2/7</p> <p>executive [35] 1/14 1/23 2/15 2/17 3/3 3/5 3/14 3/17 3/23 9/4 9/12 9/24 14/5 14/5 15/2 15/15 24/14 26/1 26/6 26/17 28/9 42/4 46/18 46/19 47/10 47/17 50/3 55/20 55/24 59/20 63/16 65/9 66/10 67/3 67/18</p> <p>executives [2] 2/16 14/10</p> <p>exhaustion [1] 23/20</p> <p>existed [1] 59/15</p> <p>existential [2] 22/25 25/18</p> <p>expectation [3] 9/4 54/23 57/5</p> <p>expected [1] 15/18</p> <p>expecting [1] 20/10</p> <p>experience [7] 1/25 8/20 18/21 44/4 44/5 67/18 69/17</p> <p>experienced [5] 20/8 23/11 30/1 37/16 67/10</p> <p>experiences [1] 9/16</p> <p>expertise [1] 29/11</p> <p>explain [3] 2/18 9/3 21/24</p> <p>explained [2] 17/13 35/14</p> <p>extent [3] 11/13 18/11 65/17</p> <p>external [1] 4/17</p> <p>externally [1] 50/17</p> <p>extract [1] 51/6</p> <p>extreme [1] 26/7</p> <p>extremely [2] 26/23 28/16</p> <p>F</p> <p>facilitate [1] 66/20</p> <p>facilities [1] 39/25</p> <p>facing [2] 21/8 49/18</p> <p>fact [10] 6/7 7/14 9/6 25/17 34/19 37/23 46/17 70/4 71/4 71/12</p> <p>factions [1] 39/6</p> <p>factories [1] 40/21</p> <p>failure [2] 36/14 62/15</p> <p>fair [3] 35/19 38/25</p>	<p>40/10</p> <p>fairly [1] 9/20</p> <p>fallen [1] 36/6</p> <p>families [1] 35/8</p> <p>family [6] 35/11 41/8 41/15 54/8 55/9 56/7</p> <p>far [5] 14/9 19/22 24/7 25/24 35/10</p> <p>fast [2] 27/9 31/24</p> <p>fast-track [1] 27/9</p> <p>Fathers [1] 2/15</p> <p>fear [1] 10/21</p> <p>February [1] 41/13</p> <p>feel [7] 2/24 6/25 11/7 17/24 36/4 45/20 45/20</p> <p>feeling [3] 7/24 9/11 9/25</p> <p>felt [5] 10/20 18/16 25/12 60/8 63/8</p> <p>Even [2] 67/25 68/7</p> <p>few [2] 41/18 53/2</p> <p>fewer [2] 32/9 32/10</p> <p>field [2] 39/8 67/10</p> <p>fifth [1] 13/10</p> <p>fight [1] 38/24</p> <p>figure [1] 50/8</p> <p>fill [1] 26/20</p> <p>final [2] 6/10 63/21</p> <p>finally [4] 41/10 42/2 64/15 71/2</p> <p>financial [2] 27/11 70/24</p> <p>find [1] 17/20</p> <p>finding [2] 8/1 50/4</p> <p>findings [9] 10/16 14/23 17/20 17/22 34/20 44/6 44/10 44/11 69/11</p> <p>finger [1] 9/10</p> <p>finished [1] 37/9</p> <p>first [14] 7/8 8/12 9/2 12/22 18/2 18/9 19/2 22/15 40/9 54/2 54/17 58/10 62/17 67/4</p> <p>firstly [2] 24/23 42/14</p> <p>five [1] 41/21</p> <p>fix [1] 36/1</p> <p>flagged [3] 12/25 25/24 27/23</p> <p>flagging [1] 24/21</p> <p>fleeing [1] 62/17</p> <p>flippant [1] 57/2</p> <p>flippantly [1] 45/24</p> <p>flows [1] 49/21</p> <p>focus [5] 17/3 52/2 65/21 67/13 67/15</p> <p>focused [8] 7/22 7/25 8/13 16/19 17/14 17/18 17/22 18/7</p> <p>follow [2] 14/3 48/7</p> <p>followed [1] 52/9</p> <p>following [9] 10/18 13/25 22/9 24/25 28/20 33/14 43/16 45/4 56/24</p>	<p>foot [1] 5/21</p> <p>foot-care [1] 5/21</p> <p>fora [1] 42/25</p> <p>forensic [3] 6/4 6/6 67/15</p> <p>forgive [1] 61/9</p> <p>formalised [1] 64/5</p> <p>formed [2] 3/20 53/11</p> <p>forming [1] 8/7</p> <p>forward [4] 12/3 50/10 53/24 54/10</p> <p>found [3] 13/17 15/20 33/22</p> <p>foundation [2] 1/15 18/19</p> <p>four [3] 18/22 31/2 50/11</p> <p>four years [1] 18/22</p> <p>Framework [1] 60/16</p> <p>free [3] 2/24 30/1 37/3</p> <p>Friday [1] 24/14</p> <p>frightened [1] 21/7</p> <p>front [1] 19/9</p> <p>frontline [1] 30/19</p> <p>full [3] 6/5 22/3 22/7</p> <p>fully [4] 13/19 14/23 31/15 31/22</p> <p>function [1] 60/20</p> <p>functioning [1] 7/12</p> <p>fundamental [4] 20/22 21/16 38/9 45/18</p> <p>fundamentally [2] 23/25 35/7</p> <p>fundamentals [2] 26/19 43/23</p> <p>funding [4] 27/12 39/15 56/5 60/19</p> <p>further [5] 5/11 9/23 24/20 61/18 62/13</p> <p>future [3] 40/15 42/6 49/14</p> <p>G</p> <p>gamut [1] 29/21</p> <p>gaps [2] 70/5 70/18</p> <p>gave [1] 31/16</p> <p>general [6] 9/11 9/13 23/8 41/14 59/18 60/22</p> <p>generally [2] 18/3 54/12</p> <p>generic [5] 56/11 61/6 70/7 70/10 70/15</p> <p>get [15] 14/3 16/2 25/16 27/18 31/21 31/24 32/3 36/22 40/5 44/17 46/20 49/22 57/7 70/23 70/25</p> <p>getting [2] 20/6 23/24</p> <p>Gibson [1] 36/24</p> <p>give [2] 12/9 31/7</p> <p>given [7] 7/16 7/19 27/22 27/22 33/5 45/6</p>	<p>58/9</p> <p>GMC [2] 16/12 47/21</p> <p>go [24] 4/11 5/12 7/15 8/11 8/25 12/3 13/24 22/7 22/17 28/22 32/5 33/7 41/1 47/13 50/3 50/10 51/8 51/9 53/22 53/23 54/10 55/1 56/20 62/6</p> <p>goes [2] 45/15 45/18</p> <p>going [8] 12/14 13/24 17/25 40/11 59/25 61/3 65/5 65/9</p> <p>gone [2] 13/1 32/24</p> <p>good [10] 2/8 15/21 19/18 19/20 36/17 45/18 55/7 65/4 69/25 71/6</p> <p>got [8] 8/9 15/5 15/6 34/7 38/18 48/12 49/7 71/16</p> <p>governance [18] 2/6 10/12 14/2 14/4 15/14 29/22 30/17 34/5 47/25 65/12 65/24 66/7 66/8 66/12 66/14 66/16 66/18 66/20</p> <p>GP [1] 41/24</p> <p>GPs [1] 5/6</p> <p>graduates [1] 27/4</p> <p>greater [1] 65/21</p> <p>ground [1] 14/19</p> <p>grounded [1] 2/3</p> <p>group [9] 38/11 43/3 61/14 61/20 61/22 61/23 62/1 63/16 70/2</p> <p>groups [5] 4/23 4/24 6/23 28/9 38/6</p> <p>guidance [5] 16/11 22/5 62/6 63/25 70/14</p> <p>guideline [1] 50/8</p> <p>H</p> <p>had [47] 4/16 6/5 9/18 13/1 15/19 18/7 18/18 18/18 23/14 23/22 25/7 25/16 25/17 25/20 25/21 26/16 28/6 32/16 32/18 32/23 33/1 33/10 33/23 33/25 35/21 36/4 37/3 38/24 39/25 43/4 43/20 43/21 49/15 49/20 50/24 53/5 53/10 55/23 57/4 58/14 59/20 63/18 64/18 64/19 68/6 69/9 69/18</p> <p>hadn't [5] 8/8 25/22 64/8 68/9 68/10</p> <p>half [3] 17/2 54/9 59/20</p> <p>halfway [1] 51/10</p> <p>hand [2] 4/1 63/20</p> <p>handling [2] 10/19 25/1</p>
--	--	---	--	---

<p>H</p> <p>happen [1] 70/11</p> <p>happened [7] 13/25 22/6 24/22 25/17 25/20 25/21 66/24</p> <p>harm [2] 44/12 62/9</p> <p>harrowing [1] 22/14</p> <p>has [20] 6/20 19/18 19/19 24/22 25/2 26/10 26/12 31/13 31/15 36/6 36/18 36/24 40/14 43/5 51/8 54/17 55/2 58/6 59/12 65/7</p> <p>have [61] 1/8 6/1 7/23 14/24 20/15 21/17 22/18 23/1 24/7 24/11 24/17 27/16 29/13 29/25 31/6 32/6 32/15 32/20 32/23 32/25 33/1 34/16 35/14 37/6 37/12 40/20 42/18 42/19 43/16 45/13 45/16 45/21 45/22 46/12 48/2 49/6 49/15 49/24 50/20 53/7 53/19 55/4 55/12 55/23 56/22 58/9 58/11 59/14 60/24 61/8 63/20 64/5 64/13 66/2 67/25 68/3 68/10 68/18 68/19 70/9 70/12</p> <p>having [16] 1/24 2/8 20/13 23/10 23/21 25/11 28/3 28/4 30/21 37/23 45/18 45/19 49/6 54/21 61/7 69/9</p> <p>he [3] 37/1 37/3 65/10</p> <p>heading [11] 12/4 12/18 14/1 17/3 33/3 40/19 41/4 41/13 42/4 51/9 51/16</p> <p>headline [2] 15/17 18/10</p> <p>headlines [1] 19/24</p> <p>heads [1] 24/9</p> <p>heads-up [1] 24/9</p> <p>health [45] 3/8 3/9 3/11 3/16 3/16 3/18 3/20 4/17 4/20 5/2 5/4 5/5 5/14 5/15 5/17 5/19 5/20 5/22 5/22 6/2 21/11 26/7 28/7 32/1 38/11 38/22 38/23 39/2 39/4 39/5 39/9 51/7 52/1 52/25 55/22 60/2 60/5 60/16 62/17 65/23 66/5 67/14 71/7 71/11 71/19</p> <p>healthcare [5] 1/15 3/10 4/9 4/21 27/7</p> <p>hear [3] 65/5 65/9</p>	<p>71/24</p> <p>heard [6] 33/8 36/24 58/6 58/11 59/12 60/7</p> <p>held [1] 9/22</p> <p>helicopter [1] 66/2</p> <p>help [5] 16/22 22/19 30/2 33/19 53/2</p> <p>helpful [1] 68/7</p> <p>hence [2] 18/6 37/19</p> <p>her [7] 3/4 3/18 55/23 55/23 56/3 56/3 62/18</p> <p>here [7] 5/1 22/24 24/7 28/1 35/23 46/17 48/3</p> <p>high [10] 3/1 3/2 6/6 15/5 19/25 26/20 33/2 35/16 37/24 43/12</p> <p>high-dose [1] 43/12</p> <p>high-level [2] 19/25 33/2</p> <p>Highbury [3] 22/11 22/12 31/1</p> <p>higher [1] 71/12</p> <p>highest [2] 21/18 62/3</p> <p>highlighted [1] 35/15</p> <p>highlighting [1] 42/6</p> <p>him [1] 62/17</p> <p>hires [1] 14/9</p> <p>his [4] 62/16 62/17 65/10 65/11</p> <p>history [1] 62/14</p> <p>hitting [1] 18/24</p> <p>hm [1] 52/6</p> <p>hold [1] 20/12</p> <p>holding [1] 50/5</p> <p>home [1] 35/11</p> <p>homicides [3] 44/25 62/21 62/22</p> <p>hospital [19] 6/7 6/9 9/16 10/11 22/11 22/12 23/1 28/4 28/5 31/1 31/21 33/10 33/21 34/20 35/23 37/17 37/18 48/14 49/2</p> <p>hospitals [1] 25/10</p> <p>how [10] 2/21 9/20 15/7 16/8 20/24 37/2 37/3 38/21 63/14 63/24</p> <p>However [1] 37/15</p> <p>huge [1] 18/3</p> <p>huh [1] 2/13</p> <p>Human [1] 4/1</p> <p>I</p> <p>I am [2] 31/2 59/23</p> <p>I appreciate [1] 48/8</p> <p>I briefly [1] 65/4</p> <p>I call [1] 1/4</p> <p>I can't [10] 15/11 31/22 33/17 34/24 38/3 49/10 50/25 51/3 61/25 68/17</p> <p>I changed [1] 66/16</p>	<p>I described [1] 8/4</p> <p>I did [2] 50/25 59/17</p> <p>I didn't [1] 64/14</p> <p>I discussed [2] 65/18 69/14</p> <p>I do [2] 20/1 62/20</p> <p>I don't [11] 21/12 22/1 23/8 25/20 36/14 39/11 45/9 45/24 57/2 63/20 71/15</p> <p>I feel [1] 36/4</p> <p>I finished [1] 37/9</p> <p>I hadn't [1] 64/8</p> <p>I know [2] 50/25 69/22</p> <p>I may [2] 18/1 47/17</p> <p>I mean [5] 2/2 6/17 11/3 20/4 43/22</p> <p>I needed [1] 2/7</p> <p>I obviously [1] 20/5</p> <p>I partly [1] 54/16</p> <p>I said [2] 15/16 67/12</p> <p>I say [5] 7/7 7/23 11/21 28/5 57/25</p> <p>I started [1] 66/11</p> <p>I think [52] 2/8 4/4 4/23 7/18 8/1 9/11 9/19 15/16 15/18 17/17 20/9 21/2 21/6 21/15 25/2 25/10 25/14 25/21 25/22 26/19 28/5 31/1 32/18 34/10 36/12 36/15 44/15 44/19 44/19 45/8 45/15 47/24 49/6 49/9 49/12 51/24 53/1 54/21 54/22 57/2 57/8 65/17 65/23 67/17 67/20 67/24 68/7 68/12 69/9 69/25 71/13 71/22</p> <p>I was [9] 2/2 11/6 15/18 18/21 45/15 48/9 48/9 59/19 59/22</p> <p>I worked [1] 59/17</p> <p>I would [5] 10/2 19/24 37/12 37/15 55/22</p> <p>I wouldn't [1] 33/17</p> <p>I'd [5] 1/25 20/1 56/21 66/1 68/2</p> <p>I'm [6] 4/13 22/1 31/3 34/24 47/1 63/20</p> <p>I've [3] 5/18 17/17 43/24</p> <p>ICB [4] 38/1 38/2 39/13 39/14</p> <p>ICBs [1] 8/6</p> <p>ICUs [2] 12/6 12/21</p> <p>idea [1] 45/13</p> <p>ideally [1] 45/24</p> <p>identified [12] 7/20 10/14 14/18 14/25 21/19 24/1 24/24 32/16 34/16 37/25 47/24 66/23</p>	<p>identifies [1] 20/18</p> <p>identify [1] 48/4</p> <p>identifying [2] 40/20 48/13</p> <p>if [78]</p> <p>ifti [1] 65/10</p> <p>ill [1] 60/8</p> <p>illness [3] 5/4 5/12 36/20</p> <p>immediate [1] 22/19</p> <p>immediately [1] 24/10</p> <p>impact [2] 11/14 54/21</p> <p>impacted [2] 20/19 28/16</p> <p>impede [1] 66/2</p> <p>impeding [1] 6/11</p> <p>imperative [1] 69/24</p> <p>impinged [1] 20/15</p> <p>implement [3] 26/5 26/9 50/13</p> <p>Implement care [1] 50/13</p> <p>implemented [4] 50/24 57/19 57/20 61/1</p> <p>implementing [1] 30/12</p> <p>importance [3] 46/8 55/25 71/16</p> <p>important [13] 5/9 6/15 6/18 7/1 7/1 7/8 7/9 28/16 29/20 49/17 57/3 57/9 71/14</p> <p>impression [1] 27/19</p> <p>impressions [1] 4/14</p> <p>improve [4] 5/11 6/16 8/14 56/1</p> <p>improved [1] 19/18</p> <p>improvement [26] 7/20 10/6 10/7 11/15 11/18 11/21 11/24 12/18 15/18 17/6 17/8 19/3 19/12 19/15 19/20 26/13 26/14 28/19 34/7 35/23 40/7 54/13 54/24 57/4 57/12 57/18</p> <p>improvement' [1] 9/6</p> <p>improvements [9] 6/13 6/20 11/12 20/3 43/17 54/11 54/16 57/14 65/24</p> <p>improving [1] 8/17</p> <p>inadequate [11] 12/7 12/8 13/5 13/13 14/19 14/20 16/19 17/7 33/22 43/21 48/14</p> <p>inaudible [1] 68/22</p> <p>incentives [1] 27/11</p> <p>incident [18] 29/6 29/9 42/10 44/1 61/13 61/14 61/18 62/15 62/16 62/25 63/16 67/23 67/25 67/25</p>	<p>68/4 68/8 68/8 68/14</p> <p>incidents [15] 29/7 29/8 30/6 30/13 44/17 61/13 61/16 61/22 61/25 62/2 62/5 62/9 63/11 63/14 69/20</p> <p>include [2] 8/19 64/24</p> <p>includes [1] 24/4</p> <p>inclusive [1] 45/20</p> <p>income [1] 11/23</p> <p>incomplete [1] 20/21</p> <p>inconsistent [1] 65/13</p> <p>increase [2] 27/17 33/24</p> <p>increased [2] 31/18 31/20</p> <p>increasing [6] 23/16 25/8 30/24 35/21 35/25 36/5</p> <p>increasingly [2] 2/5 37/8</p> <p>indeed [1] 69/8</p> <p>indicates [1] 66/4</p> <p>indication [1] 44/16</p> <p>indications [1] 54/20</p> <p>indicator [1] 9/20</p> <p>indicators [1] 71/11</p> <p>individual [6] 10/6 43/8 47/11 48/6 48/11 66/15</p> <p>individuals [1] 48/8</p> <p>inexperienced [1] 25/12</p> <p>inference [1] 8/18</p> <p>informal [1] 64/3</p> <p>informally [1] 55/24</p> <p>information [6] 13/12 13/20 41/24 42/1 46/8 49/21</p> <p>initial [1] 4/14</p> <p>initially [4] 2/2 21/5 36/17 67/4</p> <p>initiative [1] 8/5</p> <p>initiatives [1] 7/21</p> <p>injured [1] 62/18</p> <p>injury [1] 62/12</p> <p>inpatient [4] 23/21 36/3 36/9 36/21</p> <p>inpatients [1] 26/7</p> <p>input [1] 53/8</p> <p>inputs [1] 26/18</p> <p>inquests [2] 41/12 42/11</p> <p>inquiries [1] 44/3</p> <p>Inquiry [5] 1/9 33/14 36/24 58/6 59/12</p> <p>inspection [16] 8/23 10/3 14/1 14/4 16/24 16/25 17/3 17/19 17/22 18/7 19/13 20/10 33/14 34/17 49/2 49/19</p> <p>inspections [3] 18/7 19/9 22/7</p>
--	--	--	--	--

<p>I</p> <p>instance [1] 20/25</p> <p>instances [2] 13/17 21/20</p> <p>instead [1] 31/5</p> <p>instigate [1] 69/24</p> <p>insufficient [4] 36/25 37/22 45/3 45/8</p> <p>insular [1] 64/19</p> <p>insularity [1] 7/24</p> <p>integrate [1] 66/5</p> <p>Integrated [1] 8/5</p> <p>Intensive [2] 12/13 17/4</p> <p>interactions [1] 63/24</p> <p>interests [1] 38/20</p> <p>intermittent [1] 49/19</p> <p>Internal [1] 6/11</p> <p>internally [2] 9/8 50/17</p> <p>interpretation [1] 46/21</p> <p>interrupt [1] 2/24</p> <p>intervening [1] 27/20</p> <p>intervention [8] 51/2 51/9 51/17 53/18 55/10 56/7 57/24 60/17</p> <p>interventions [5] 50/15 54/8 57/25 58/4 71/19</p> <p>into [24] 3/7 3/13 3/17 4/9 8/22 11/14 17/2 18/1 35/13 37/17 37/18 38/16 42/12 42/17 54/11 55/13 57/14 58/20 60/13 60/22 63/10 63/13 63/18 65/20</p> <p>investigated [2] 29/7 68/11</p> <p>investigating [1] 30/6</p> <p>investigation [2] 63/13 68/15</p> <p>investigations [11] 29/1 29/4 29/12 29/14 30/11 30/15 44/1 44/11 63/19 67/23 68/4</p> <p>investment [3] 51/7 51/18 51/22</p> <p>involvement [3] 41/8 41/15 63/18</p> <p>involving [1] 62/16</p> <p>irrespective [2] 17/20 18/23</p> <p>is [138]</p> <p>isn't [20] 12/8 20/21 21/25 32/4 33/6 43/25 44/14 47/4 47/9 50/7 52/14 52/23 53/25 54/13 55/5 56/25 59/25 60/24 63/10</p>	<p>68/15</p> <p>issue [27] 15/25 20/22 21/19 23/25 24/1 24/18 24/24 25/24 26/3 26/10 27/23 33/23 34/6 35/19 35/21 36/5 36/25 37/10 40/12 41/21 42/7 42/25 47/18 48/3 58/10 58/22 59/11</p> <p>issues [27] 2/6 10/14 11/5 11/8 11/9 14/18 15/4 15/14 15/16 15/23 18/16 20/18 22/2 34/3 34/16 37/22 37/25 43/4 46/18 47/8 47/23 49/7 49/16 49/25 58/8 65/22 69/19</p> <p>it [166]</p> <p>it'd [1] 43/10</p> <p>it's [50] 4/12 4/12 5/9 6/2 6/22 7/4 7/7 7/10 9/1 9/10 10/3 10/23 11/3 15/6 15/12 25/20 28/20 29/20 30/18 32/2 33/4 33/6 33/13 35/19 40/13 43/11 43/11 43/12 43/25 52/19 52/19 53/24 54/4 55/3 55/20 57/8 57/11 58/1 59/25 61/15 61/21 62/6 63/22 65/17 68/15 69/9 69/23 70/6 70/16 71/17</p> <p>its [1] 38/4</p> <p>itself [1] 23/3</p> <hr/> <p>J</p> <p>January [3] 1/9 1/18 2/19</p> <p>January 2019 [2] 1/18 2/19</p> <p>job [1] 46/13</p> <p>job' [1] 64/1</p> <p>John [3] 1/4 1/5 73/3</p> <p>journey [1] 19/2</p> <p>judgement [3] 37/14 67/13 70/16</p> <p>Julie [3] 3/4 26/2 34/9</p> <p>Julie Attfield [1] 34/9</p> <p>July [2] 17/1 18/8</p> <p>July 2020 [1] 18/8</p> <p>jumped [1] 65/7</p> <p>jumping [1] 62/16</p> <p>June [3] 24/22 25/19 62/24</p> <p>just [44] 3/21 5/4 5/18 11/20 18/1 19/2 19/10 24/20 25/9 26/15 26/21 27/22 28/5 29/14 29/21 30/15 30/23 31/7</p>	<p>31/16 32/24 35/14 36/16 39/4 39/14 41/18 44/10 44/23 45/6 49/19 51/9 52/4 53/16 57/4 58/5 58/10 60/14 63/6 65/5 65/7 68/3 68/25 69/2 69/17 71/2</p> <p>Just a [1] 68/25</p> <p>justice [1] 64/10</p> <hr/> <p>K</p> <p>keep [5] 30/2 30/4 30/19 49/17 69/11</p> <p>keeping [2] 21/4 61/10</p> <p>kept [2] 2/3 18/15</p> <p>key [1] 5/1</p> <p>kind [3] 18/13 24/23 29/3</p> <p>know [14] 2/7 7/9 11/5 11/8 15/22 18/23 21/12 39/11 43/22 50/25 56/8 68/7 69/22 70/12</p> <p>knowledge [2] 1/11 58/8</p> <p>known [1] 33/21</p> <hr/> <p>L</p> <p>lack [7] 36/25 41/8 41/15 44/9 59/2 59/6 59/10</p> <p>landscape [1] 8/2</p> <p>language [2] 22/24 61/10</p> <p>large [3] 4/21 28/7 45/10</p> <p>late [1] 28/1</p> <p>later [1] 2/7</p> <p>lay [1] 18/18</p> <p>lead [2] 49/2 65/13</p> <p>leader [1] 44/5</p> <p>leaders [1] 39/19</p> <p>leadership [4] 9/4 26/1 28/22 46/19</p> <p>leading [1] 14/19</p> <p>learn [2] 43/2 48/5</p> <p>learning [11] 30/11 41/12 41/14 42/17 42/20 42/22 42/25 43/14 44/22 45/11 69/3</p> <p>least [5] 11/6 18/22 24/22 37/12 54/23</p> <p>leaving [1] 15/6</p> <p>led [7] 10/8 12/5 17/10 17/16 19/15 23/6 55/21</p> <p>left [2] 4/1 66/25</p> <p>left-hand [1] 4/1</p> <p>less [4] 36/10 37/4 39/3 54/8</p> <p>Lesson [1] 42/20</p> <p>lessons [1] 43/2</p> <p>let's [1] 43/1</p>	<p>level [14] 2/16 3/1 3/2 15/19 19/25 24/6 29/11 33/2 38/20 46/18 46/19 46/21 47/10 63/16</p> <p>levels [2] 13/1 51/12</p> <p>lies [1] 20/2</p> <p>light [4] 22/17 48/10 55/16 55/17</p> <p>like [26] 1/25 5/20 5/25 7/7 7/24 8/7 11/4 11/21 11/22 15/22 16/11 18/15 23/14 24/9 26/10 26/25 27/7 28/5 34/2 34/3 36/20 37/16 44/17 45/23 57/8 70/19</p> <p>likely [1] 9/5</p> <p>limit [1] 11/22</p> <p>limited [6] 37/13 38/14 38/21 39/9 54/13 65/13</p> <p>Lincolnshire [1] 59/19</p> <p>line [2] 48/7 51/19</p> <p>lines [3] 35/14 41/21 63/6</p> <p>list [3] 13/8 23/14 29/23</p> <p>listed [1] 53/16</p> <p>little [2] 9/23 11/20</p> <p>LMHT [2] 61/2 70/4</p> <p>LMHTs [1] 53/7</p> <p>load [1] 32/12</p> <p>local [14] 3/6 3/14 3/15 3/23 4/24 4/25 5/7 40/8 52/1 52/25 60/1 60/5 65/19 67/6</p> <p>locality [1] 37/11</p> <p>locally [1] 38/6</p> <p>log [1] 29/24</p> <p>long [4] 19/2 51/7 55/17 57/6</p> <p>long-term [2] 51/7 55/17</p> <p>look [23] 2/10 9/7 10/3 14/7 15/7 15/12 19/4 19/24 22/6 24/18 25/25 28/19 34/12 40/7 44/3 47/24 49/5 51/4 52/4 52/16 52/18 62/23 69/10</p> <p>looked [9] 27/5 27/10 27/11 27/23 43/15 45/6 47/10 48/23 49/3</p> <p>looking [5] 4/13 19/11 27/25 34/11 71/3</p> <p>lose [2] 6/22 7/4</p> <p>losing [2] 30/7 30/9</p> <p>lost [3] 60/24 61/5 70/23</p> <p>lot [2] 40/4 58/20</p> <p>lots [2] 38/19 38/20</p> <p>low [2] 6/6 55/9</p> <p>lowest [1] 12/8</p>	<p>lunch [1] 71/23</p> <hr/> <p>M</p> <p>made [7] 1/8 13/18 29/21 36/17 43/15 51/17 63/6</p> <p>Main [1] 33/3</p> <p>maintained [1] 33/20</p> <p>Majid's [2] 66/1 71/24</p> <p>major [3] 3/2 3/22 34/6</p> <p>make [11] 6/21 14/25 16/21 37/4 43/13 46/12 53/3 57/12 65/25 69/15 69/16</p> <p>makes [3] 7/5 39/10 45/25</p> <p>making [2] 25/13 39/19</p> <p>manage [1] 25/11</p> <p>managed [3] 26/17 47/19 48/6</p> <p>management [4] 2/1 2/11 13/14 47/20</p> <p>manager [2] 29/10 47/15</p> <p>managerial [1] 2/3</p> <p>managers [9] 22/10 22/12 23/5 24/13 25/12 29/1 29/16 30/15 43/3</p> <p>managing [6] 20/17 21/10 45/5 59/8 59/11 64/4</p> <p>manifest [1] 9/14</p> <p>manner [1] 32/21</p> <p>Mansfield [1] 4/22</p> <p>many [2] 36/7 46/8</p> <p>MAPPA [1] 64/11</p> <p>MARAC [1] 64/12</p> <p>March [2] 19/10 20/8</p> <p>March 2022 [1] 20/8</p> <p>Marketing [1] 4/6</p> <p>matter [2] 40/12 47/9</p> <p>matters [1] 65/6</p> <p>matured [1] 67/18</p> <p>may [15] 1/1 1/4 4/4 5/6 5/7 5/12 8/19 18/1 20/11 21/5 21/17 40/14 42/9 47/17 68/19</p> <p>MDT [1] 59/3</p> <p>me [5] 2/3 2/8 37/8 69/9 69/13</p> <p>mean [10] 2/2 4/19 6/17 11/3 20/4 20/23 30/23 31/20 43/22 45/24</p> <p>meaningless [1] 37/6</p> <p>means [1] 31/24</p> <p>meant [2] 6/8 59/3</p> <p>measurements [1] 11/15</p> <p>measures [4] 33/15 34/21 35/24 43/20</p>
---	--	--	---	---

<p>M</p> <p>mechanism [1] 38/9</p> <p>mechanisms [1] 26/25</p> <p>medical [2] 47/14 59/19</p> <p>medication [1] 43/12</p> <p>medium [1] 6/6</p> <p>meet [8] 16/23 36/2 39/25 40/3 51/13 53/12 70/14 71/18</p> <p>meeting [11] 22/9 22/17 24/5 24/6 24/15 26/2 26/12 28/22 32/19 32/20 41/2</p> <p>meetings [1] 59/3</p> <p>meets [1] 70/10</p> <p>members [6] 41/15 58/6 58/9 59/7 60/7 71/16</p> <p>members/carers [1] 41/15</p> <p>mental [37] 3/8 3/15 3/18 5/2 5/4 5/5 5/12 5/14 5/15 5/17 5/18 5/22 6/2 21/11 26/7 28/7 32/1 36/20 38/11 38/22 38/23 39/1 39/4 39/5 51/7 52/1 52/25 55/22 60/2 60/5 60/16 62/17 65/23 66/5 67/14 71/7 71/19</p> <p>message [1] 30/18</p> <p>met [6] 16/22 24/13 24/14 61/4 61/18 71/11</p> <p>metrics [3] 8/14 8/15 8/18</p> <p>middle [7] 2/14 12/4 31/13 42/4 42/24 45/25 62/7</p> <p>Midlands [2] 28/7 28/8</p> <p>might [7] 38/23 49/2 49/6 49/23 56/12 57/6 61/5</p> <p>million [1] 11/25</p> <p>minimum [1] 18/23</p> <p>minute [1] 67/12</p> <p>minuted [1] 59/4</p> <p>minutes [1] 24/17</p> <p>mixed [1] 50/5</p> <p>Mm [1] 52/6</p> <p>Mm-hm [1] 52/6</p> <p>model [1] 50/11</p> <p>module [1] 43/6</p> <p>modules [1] 16/13</p> <p>Moloney [1] 65/2</p> <p>moment [1] 9/7</p> <p>moments [1] 53/2</p> <p>Monday [2] 1/1 24/14</p> <p>money [3] 6/21 7/4 12/2</p> <p>monitor [1] 30/7</p> <p>months [2] 9/3 41/19</p>	<p>more [30] 4/18 7/5 7/16 7/18 15/8 15/14 20/16 20/22 21/11 21/12 21/24 23/11 23/22 24/7 24/12 31/3 45/1 47/25 52/2 56/11 59/17 60/1 60/22 61/9 61/12 62/10 62/12 64/19 69/10 71/20</p> <p>more fundamental [1] 20/22</p> <p>most [5] 7/1 12/14 14/11 37/15 51/24</p> <p>move [2] 40/6 70/6</p> <p>moved [2] 3/4 3/17</p> <p>Mr [10] 1/3 1/6 56/19 65/2 65/4 65/10 66/1 67/22 71/24 73/4</p> <p>Mr Brewin [1] 65/4</p> <p>Mr Carr [5] 1/3 1/6 56/19 67/22 73/4</p> <p>Mr Ifti [1] 65/10</p> <p>Mr Majid's [2] 66/1 71/24</p> <p>Mr Moloney [1] 65/2</p> <p>Ms [3] 65/2 65/3 73/5</p> <p>Ms Cartwright [3] 65/2 65/3 73/5</p> <p>much [13] 4/3 19/22 24/12 25/4 34/1 42/21 54/4 56/25 61/8 61/12 65/21 68/20 71/20</p> <p>multi [1] 63/21</p> <p>multi-agency [1] 63/21</p> <p>multiple [2] 9/24 54/5</p> <p>Murdoch [1] 38/12</p> <p>must [4] 12/19 12/23 13/10 13/11</p> <p>my [23] 1/25 6/19 7/24 8/18 15/16 15/24 17/17 17/18 18/21 20/1 33/1 36/12 39/23 42/16 44/4 44/5 44/23 64/7 64/25 65/18 67/13 67/15 71/10</p> <p>myself [1] 33/1</p> <p>N</p> <p>name [1] 16/18</p> <p>narrative [1] 57/3</p> <p>national [25] 6/8 8/5 9/15 11/22 16/10 22/5 35/15 36/5 38/11 38/12 38/25 39/19 52/4 52/14 52/14 54/3 54/7 54/15 54/18 54/19 55/8 58/19 60/16 70/14 71/12</p> <p>nationally [10] 18/8 28/8 28/12 36/6 40/5 58/18 60/13 60/19 67/8 69/23</p> <p>nationwide [2] 6/9 69/6</p> <p>navigate [1] 8/2</p>	<p>near [1] 20/6</p> <p>nearly [1] 54/14</p> <p>necessarily [4] 30/9 32/6 36/15 53/10</p> <p>need [19] 5/5 5/6 5/13 6/24 6/25 13/5 22/19 30/1 30/4 31/10 39/2 44/17 45/10 45/16 46/2 46/5 46/11 47/9 61/11</p> <p>needed [9] 2/7 10/10 20/7 20/16 30/12 33/15 37/17 37/18 39/21</p> <p>needs [1] 39/25</p> <p>negotiating [1] 56/4</p> <p>neighbour [1] 62/16</p> <p>networks [1] 35/12</p> <p>new [9] 3/5 14/9 33/16 39/8 39/24 57/25 65/23 66/17 67/19</p> <p>newly [3] 3/20 53/11 53/11</p> <p>next [3] 16/24 30/21 31/18</p> <p>NHFT0000518 [1] 62/21</p> <p>NHFT0000596 [1] 62/6</p> <p>NHFT0001778 [1] 16/24</p> <p>NHFT0002015 [1] 10/4</p> <p>NHFT0002204 [1] 32/15</p> <p>NHFT0009667 [1] 42/3</p> <p>NHNB0004596 [1] 51/5</p> <p>NHNB0012044 [1] 41/11</p> <p>NHNB0019232 [1] 40/9</p> <p>NHS [11] 1/15 18/3 27/13 30/16 33/11 38/8 38/19 39/2 39/14 48/21 49/5</p> <p>NICE [8] 50/14 51/11 51/13 51/19 51/23 52/23 53/13 55/18</p> <p>no [19] 5/23 7/20 8/18 14/14 14/14 18/20 19/12 20/6 29/17 43/10 47/6 51/3 59/10 61/25 62/2 68/11 68/23 69/6 70/9</p> <p>nobody [1] 25/4</p> <p>non [3] 14/5 53/8 59/9</p> <p>non-concordance [1] 59/9</p> <p>non-EIP [1] 53/8</p> <p>non-executive [1] 14/5</p> <p>not [53] 4/16 6/2 7/7</p>	<p>7/8 7/16 10/18 10/20 11/6 13/14 15/21 19/22 20/19 20/24 20/25 21/17 21/20 22/1 22/18 23/15 24/25 25/8 26/14 26/21 29/18 30/6 30/9 30/11 30/12 30/15 31/2 34/21 36/16 36/18 39/4 43/20 44/21 44/22 49/24 51/13 51/18 52/22 53/12 54/3 58/7 59/10 60/14 61/3 61/5 61/21 69/6 69/8 70/18 71/6</p> <p>notes [1] 41/2</p> <p>nothing [3] 24/22 25/16 25/20</p> <p>notice [5] 11/1 13/4 32/21 49/14 58/15</p> <p>notices [1] 33/13</p> <p>noting [1] 23/20</p> <p>Nottingham [18] 4/22 28/17 35/2 36/16 44/21 44/24 49/25 50/2 52/12 52/13 53/18 53/21 59/15 59/17 59/17 60/14 60/23 69/7</p> <p>Nottinghamshire [3] 1/15 3/11 51/12</p> <p>November [3] 19/5 20/12 28/22</p> <p>November 2022 [1] 19/5</p> <p>now [21] 22/11 24/23 28/25 34/25 40/7 40/23 41/1 42/2 42/9 42/14 45/13 50/22 52/22 54/17 54/19 55/12 55/16 56/14 57/15 71/22 71/23</p> <p>nowhere [1] 52/20</p> <p>nuance [1] 39/17</p> <p>number [14] 2/23 4/20 4/22 9/14 14/8 20/4 21/2 31/3 35/16 36/3 38/14 42/17 57/5 70/8</p> <p>nurse [1] 27/8</p> <p>nurses [2] 6/1 27/5</p> <p>nursing [8] 3/4 3/18 5/21 27/6 28/11 47/14 66/17 66/19</p> <p>O</p> <p>obtained [1] 51/22</p> <p>obviously [5] 11/4 14/22 20/5 65/8 66/23</p> <p>occur [2] 44/25 69/6</p> <p>occurred [4] 9/7 52/8 63/1 63/2</p> <p>occurring [1] 69/11</p> <p>October [7] 22/9 26/12 26/15 28/20 32/9 48/24 50/2</p>	<p>October 2018 [1] 50/2</p> <p>odds [1] 17/23</p> <p>off [3] 31/6 34/17 63/15</p> <p>office [2] 66/16 66/20</p> <p>Officer [4] 1/14 67/1 67/7 67/16</p> <p>oft [1] 39/1</p> <p>oft-quoted [1] 39/1</p> <p>often [5] 5/7 32/2 36/21 38/16 44/7</p> <p>Okay [1] 3/2</p> <p>Omicron [1] 20/11</p> <p>omission [1] 64/7</p> <p>on [112]</p> <p>one [39] 3/3 3/7 3/12 5/1 6/4 10/23 11/11 12/25 13/13 20/22 21/15 26/15 26/19 28/12 31/18 31/25 34/2 34/8 35/24 48/13 52/18 53/1 53/6 53/7 53/15 56/10 57/21 58/12 62/9 62/11 62/12 62/24 64/23 65/23 66/24 69/13 70/9 70/19 71/16</p> <p>ongoing [1] 58/25</p> <p>only [5] 6/5 22/2 58/12 62/3 64/3</p> <p>onwards [1] 14/2</p> <p>open [4] 21/4 27/2 30/20 49/16</p> <p>Operating [3] 67/1 67/7 67/16</p> <p>operational [1] 66/8</p> <p>opportunity [2] 50/20 69/10</p> <p>opposed [2] 15/9 56/10</p> <p>optimal [1] 7/12</p> <p>or [63] 4/24 5/24 7/4 7/16 8/8 9/18 13/19 16/2 16/5 16/6 18/22 20/7 20/20 20/21 20/25 22/5 23/19 27/4 28/3 29/15 30/17 31/2 33/22 34/21 35/2 37/22 38/4 38/4 39/8 39/14 40/15 42/6 43/8 43/11 44/9 44/12 47/14 47/17 47/21 48/9 48/20 49/4 49/7 49/11 50/8 53/4 53/11 54/23 55/17 57/19 58/7 59/8 61/2 61/16 62/10 62/12 62/12 63/16 65/6 67/12 70/21 71/10 71/16</p> <p>orange [1] 54/5</p> <p>order [1] 44/16</p> <p>Orders [1] 37/4</p> <p>ordinarily [6] 21/16 29/12 47/11 47/13 47/19 49/12</p>
---	---	---	--	---

<p>O</p> <p>ordinary [1] 54/25</p> <p>ordinators [1] 50/5</p> <p>organisation [15] 4/3 6/23 8/1 11/6 11/24 16/10 18/4 21/3 25/7 26/21 42/18 45/11 45/16 67/17 70/20</p> <p>organisational [2] 45/19 46/24</p> <p>organisations [5] 5/10 8/4 34/1 34/7 60/21</p> <p>other [13] 2/16 3/24 4/20 15/9 23/13 28/6 29/16 30/14 31/6 44/3 44/3 51/15 68/13</p> <p>others [2] 13/18 63/1</p> <p>otherwise [2] 54/4 55/7</p> <p>our [16] 4/5 11/24 18/4 21/4 25/9 26/21 26/23 28/5 34/3 34/3 38/7 40/3 40/8 49/21 49/22 63/21</p> <p>out [30] 2/18 4/13 6/21 9/2 11/17 12/1 12/19 14/1 18/21 23/3 24/4 30/11 30/25 31/16 31/21 32/11 32/21 35/1 35/4 35/6 35/16 37/20 37/24 38/15 43/10 44/12 44/18 46/12 52/10 69/12</p> <p>outbreaks [1] 20/14</p> <p>outcomes [5] 6/14 6/16 8/17 8/20 40/22</p> <p>outlier [2] 35/15 36/17</p> <p>outreach [17] 59/12 59/13 59/13 59/15 59/22 59/23 60/2 60/6 60/9 60/14 60/18 60/20 60/25 61/3 61/7 69/18 69/25</p> <p>outset [1] 54/22</p> <p>Outstanding [1] 19/19</p> <p>outwith [1] 47/19</p> <p>over [13] 2/21 6/19 6/22 9/18 11/17 19/23 23/16 35/21 36/7 36/8 36/13 42/12 58/14</p> <p>over-emphasis [3] 6/19 6/22 23/16</p> <p>over-reliance [2] 11/17 36/13</p> <p>overall [8] 10/5 17/5 19/11 19/21 47/15 54/12 65/25 66/15</p> <p>overreliance [1] 6/12</p> <p>oversaw [1] 38/7</p> <p>overseeing [2] 15/3 34/8</p>	<p>oversight [8] 15/13 34/5 34/11 44/8 44/9 55/21 63/15 65/13</p> <p>overspeaking [3] 24/16 48/17 58/4</p> <p>own [1] 66/14</p> <p>ownership [1] 26/16</p> <p>P</p> <p>page [52] 4/12 8/11 8/25 9/2 10/15 11/11 12/3 12/4 12/17 12/17 13/8 13/25 14/7 19/9 19/11 24/20 26/3 28/23 31/12 33/3 33/7 35/5 40/17 40/19 41/4 41/7 41/21 42/3 42/5 46/16 50/3 50/10 51/8 51/15 51/15 51/16 52/13 53/16 54/11 55/1 56/24 57/13 57/14 61/15 62/6 62/8 62/23 63/22 63/23 64/15 65/7 73/2</p> <p>page 10 [2] 12/3 62/6</p> <p>Page 11 [1] 56/24</p> <p>page 12 [1] 4/12</p> <p>page 13 [3] 8/25 13/8 57/13</p> <p>page 14 [3] 13/25 51/15 57/14</p> <p>page 15 [1] 14/7</p> <p>page 16 [1] 33/3</p> <p>page 18 [1] 33/7</p> <p>page 2 [3] 28/23 41/21 42/3</p> <p>page 3 [2] 50/3 62/23</p> <p>page 39 [1] 46/16</p> <p>page 4 [2] 31/12 51/8</p> <p>page 40 [1] 61/15</p> <p>page 5 [2] 40/17 40/19</p> <p>page 55 [1] 63/23</p> <p>page 56 [1] 64/15</p> <p>page 58 [1] 50/10</p> <p>page 6 [2] 10/15 54/11</p> <p>page 9 [2] 8/11 55/1</p> <p>pages [2] 14/3 52/10</p> <p>pandemic [14] 18/2 18/6 18/18 18/23 20/9 21/7 23/23 26/24 29/22 30/16 42/24 45/25 67/23 68/14</p> <p>panel [1] 63/8</p> <p>papers [1] 24/11</p> <p>paragraph [21] 4/12 4/14 6/10 7/12 8/11 9/1 9/23 14/2 14/8 14/10 22/15 33/7 33/13 34/18 35/5 42/5 50/4 63/23 63/24 64/2 64/15</p> <p>paragraph 156 [1] 35/5</p> <p>paragraph 175 [1]</p>	<p>63/23</p> <p>paragraph 180 [1] 64/15</p> <p>paragraph 27 [1] 8/11</p> <p>paragraph 35 [3] 4/12 4/14 6/10</p> <p>Paragraph 36 [1] 7/12</p> <p>paragraph 38 [1] 9/1</p> <p>paragraph 42 [1] 14/2</p> <p>paragraph 44 [1] 14/8</p> <p>paragraph 46 [1] 14/10</p> <p>paragraphs [3] 41/13 46/15 61/15</p> <p>paragraphs 110 [1] 46/15</p> <p>paragraphs 117 [1] 61/15</p> <p>paramount [1] 7/11</p> <p>parcel [1] 56/11</p> <p>pared [2] 60/20 69/18</p> <p>part [19] 3/18 6/7 6/15 7/8 8/5 21/19 23/18 28/10 37/14 38/10 43/14 44/19 56/10 57/25 60/15 64/7 68/8 70/19 71/5</p> <p>participant [1] 4/17</p> <p>particular [8] 4/13 9/10 10/14 14/7 21/10 41/23 47/18 69/20</p> <p>particularly [8] 25/7 26/22 38/13 39/12 55/9 57/8 65/22 67/14</p> <p>partly [1] 54/16</p> <p>partnerships [6] 3/6 3/14 3/15 3/23 4/8 65/20</p> <p>passing [1] 70/19</p> <p>patchwork [1] 54/4</p> <p>pathway [3] 36/23 50/13 51/3</p> <p>Pathways [1] 5/12</p> <p>patient [7] 5/11 11/15 32/12 33/20 34/14 60/10 70/1</p> <p>patients [27] 5/1 5/22 6/14 6/25 8/20 12/15 21/9 23/22 30/24 32/10 32/10 32/11 33/11 33/16 34/4 34/23 35/7 35/10 37/3 44/12 44/25 53/3 53/8 59/8 59/11 60/7 70/23</p> <p>Pause [1] 31/22</p> <p>paying [1] 25/4</p> <p>peer [1] 25/9</p> <p>penultimate [1] 33/7</p> <p>penultimately [1] 41/10</p> <p>people [20] 4/2 5/3 5/12 6/2 11/7 15/6</p>	<p>21/7 27/15 30/14 31/21 31/25 32/3 36/19 44/20 46/13 58/1 61/10 61/10 62/10 62/13</p> <p>people's [1] 21/17</p> <p>per [7] 11/23 47/23 48/3 52/19 52/19 52/20 53/10</p> <p>per se [3] 47/23 48/3 53/10</p> <p>perception [1] 4/16</p> <p>performance [10] 8/14 8/15 8/18 9/9 38/8 48/6 49/23 51/2 56/1 56/25</p> <p>performing [3] 54/3 54/17 55/18</p> <p>perhaps [7] 23/23 25/3 43/5 45/1 64/7 69/10 71/8</p> <p>perilous [1] 32/8</p> <p>period [9] 8/6 9/19 36/21 52/9 56/23 57/15 58/13 65/11 66/9</p> <p>periods [1] 52/7</p> <p>permission [1] 33/16</p> <p>persisted [1] 47/16</p> <p>person [1] 65/15</p> <p>personnel [2] 3/3 3/21</p> <p>perspective [6] 14/22 34/12 37/9 38/22 47/25 55/20</p> <p>pertained [1] 64/9</p> <p>pertaining [1] 57/9</p> <p>pertains [2] 21/9 36/15</p> <p>phrase [1] 27/12</p> <p>physical [8] 3/9 3/10 4/21 5/20 5/22 66/5 71/6 71/11</p> <p>picture [1] 53/25</p> <p>piece [1] 60/15</p> <p>pinch [2] 70/21 70/25</p> <p>place [8] 11/12 13/11 16/1 28/20 34/10 34/22 45/22 64/13</p> <p>placed [1] 33/21</p> <p>placement [1] 35/1</p> <p>placements [7] 30/25 31/19 35/4 35/6 35/16 37/20 37/24</p> <p>places [1] 21/14</p> <p>plan [14] 14/24 16/1 24/4 26/13 26/15 28/19 29/9 32/14 32/25 35/23 35/24 51/7 55/17 57/18</p> <p>planning [2] 40/7 44/9</p> <p>plans [2] 43/17 46/11</p> <p>playing [1] 39/8</p> <p>please [5] 1/4 2/10 40/17 56/20 63/21</p>	<p>pleasing [2] 19/1 57/11</p> <p>pm [1] 71/25</p> <p>point [32] 3/25 10/16 11/11 12/5 12/22 13/10 15/2 22/18 25/2 27/22 28/25 29/17 30/21 38/5 39/11 43/16 46/22 48/8 48/9 51/17 52/4 58/5 60/21 63/6 63/21 64/23 65/17 65/25 67/12 68/2 69/9 69/22</p> <p>points [10] 5/1 11/5 12/25 42/22 50/11 53/1 62/7 70/20 70/21 70/25</p> <p>police [6] 63/24 64/6 64/10 64/17 64/22 64/24</p> <p>policies [4] 16/7 63/25 64/9 64/13</p> <p>policy [4] 16/5 22/5 29/5 43/6</p> <p>ponder [1] 69/10</p> <p>poor [6] 10/11 11/9 42/1 63/8 63/14 63/15</p> <p>population [2] 23/21 37/1</p> <p>portfolio [1] 4/7</p> <p>position [3] 2/18 11/10 15/21</p> <p>positive [2] 18/12 70/12</p> <p>possible [2] 21/2 46/9</p> <p>possibly [1] 63/7</p> <p>post [8] 3/4 3/19 19/10 53/9 59/21 67/1 67/2 67/8</p> <p>posts [5] 3/4 26/20 28/11 28/13 66/18</p> <p>potential [1] 37/4</p> <p>potentially [2] 10/10 62/25</p> <p>power [1] 37/5</p> <p>practice [7] 10/18 16/13 24/25 37/9 43/1 43/13 48/6</p> <p>practised [1] 1/24</p> <p>preceding [1] 35/22</p> <p>precisely [1] 31/4</p> <p>predecessor [1] 38/4</p> <p>premium [1] 27/14</p> <p>prepared [1] 28/21</p> <p>present [1] 5/7</p> <p>presented [2] 32/14 32/15</p> <p>presenting [1] 5/1</p> <p>pressure [5] 26/8 37/2 37/20 70/25 71/14</p> <p>presumably [2] 10/22 30/5</p> <p>Prevention [2] 42/5 49/14</p>
--	--	--	---	---

<p>P</p> <p>previous [3] 17/6 17/11 53/25</p> <p>previously [1] 1/20</p> <p>primarily [1] 26/18</p> <p>primary [3] 4/23 5/5 39/4</p> <p>principle [1] 61/1</p> <p>principles [3] 59/13 60/2 61/6</p> <p>prior [6] 8/6 23/23 26/17 32/17 32/19 37/10</p> <p>priority [6] 7/16 7/19 21/18 30/18 30/19 68/5</p> <p>Priory [7] 33/8 33/9 33/11 33/15 34/2 34/25 35/2</p> <p>Priory's [1] 34/4</p> <p>private [6] 24/5 24/6 24/15 33/9 33/21 33/24</p> <p>probably [7] 3/24 23/22 32/23 39/17 42/23 49/9 51/24</p> <p>problem [2] 27/25 27/25</p> <p>problems [8] 5/2 6/2 33/6 39/15 39/16 40/20 43/19 49/6</p> <p>procedure [1] 47/12</p> <p>process [3] 6/22 41/23 43/14</p> <p>processes [5] 6/11 6/13 34/13 44/8 48/4</p> <p>procurement [1] 31/19</p> <p>professional [2] 5/9 47/20</p> <p>professionally [1] 27/8</p> <p>professions [1] 16/9</p> <p>programme [10] 7/20 18/20 27/2 27/20 31/23 54/22 54/24 55/21 57/4 58/19</p> <p>programmes [3] 12/1 31/8 36/19</p> <p>progress [4] 6/12 25/14 36/17 69/16</p> <p>projects [1] 7/22</p> <p>proper [3] 44/18 46/2 46/5</p> <p>properly [4] 16/4 21/22 46/13 48/5</p> <p>proportion [1] 38/25</p> <p>protection [1] 64/11</p> <p>proved [1] 66/6</p> <p>provide [9] 7/2 7/11 17/21 21/4 39/21 39/22 60/1 67/17 70/1</p> <p>provided [5] 5/16 6/8 34/5 55/12 57/16</p> <p>provider [1] 38/11</p>	<p>providers [1] 38/10</p> <p>provides [1] 65/10</p> <p>providing [2] 30/8 53/3</p> <p>provision [3] 5/19 36/1 43/23</p> <p>provisions [2] 10/11 34/22</p> <p>proxy [1] 9/20</p> <p>psychiatric [9] 6/4 12/6 12/13 12/21 17/4 21/13 36/6 43/12 44/25</p> <p>Psychiatrist [1] 1/20</p> <p>Psychiatrists [1] 16/12</p> <p>Psychiatrists' [1] 71/3</p> <p>psychiatry [4] 1/24 28/12 36/9 59/18</p> <p>Psychiatry's [1] 52/11</p> <p>psychological [1] 58/3</p> <p>psychoses [1] 58/2</p> <p>psychosis [8] 51/2 51/10 51/17 52/17 52/18 53/18 57/24 58/1</p> <p>public [2] 64/4 64/11</p> <p>published [3] 16/25 19/5 20/5</p> <p>pull [2] 43/10 43/13</p> <p>pulled [1] 7/22</p> <p>purchase [1] 38/15</p> <p>purpose [1] 26/4</p> <p>purposes [1] 1/9</p> <p>pushing [1] 7/3</p> <p>put [12] 9/10 17/18 18/1 28/19 32/20 34/9 34/22 37/2 37/6 38/16 48/9 70/3</p> <p>putting [2] 16/1 48/9</p>	<p>R</p> <p>Racking [1] 71/10</p> <p>radar [1] 26/11</p> <p>raft [3] 16/7 27/5 66/18</p> <p>raise [7] 10/20 11/8 18/16 37/22 37/25 39/15 45/20</p> <p>raised [23] 10/19 10/23 11/9 26/4 39/13 39/18 40/6 40/8 40/11 40/24 41/5 41/18 41/22 42/13 43/4 43/18 43/19 47/8 48/10 48/19 48/19 48/23 49/3</p> <p>raising [7] 25/15 25/17 40/13 48/12 49/1 49/7 50/16</p> <p>Rampton [1] 6/7</p> <p>range [4] 6/3 6/5 9/17 11/5</p> <p>rank [1] 62/3</p> <p>ranked [1] 61/25</p> <p>rapid [1] 20/16</p> <p>rate [3] 17/15 28/11 37/24</p> <p>rated [1] 48/13</p> <p>rather [6] 6/14 8/16 35/25 41/11 66/21 69/3</p> <p>rating [11] 10/5 12/7 12/8 13/1 13/13 14/19 15/17 17/5 17/23 19/12 19/18</p> <p>ratings [8] 10/6 16/20 17/14 17/19 19/11 19/21 19/22 19/25</p> <p>rationale [1] 40/22</p> <p>RCPS000011 [2] 52/9 56/21</p> <p>re [3] 17/15 37/5 69/24</p> <p>re-call [1] 37/5</p> <p>re-instigate [1] 69/24</p> <p>re-rate [1] 17/15</p> <p>reabsorbed [1] 60/22</p> <p>reach [1] 46/18</p> <p>reached [2] 22/18 65/25</p> <p>real [3] 43/23 57/12 67/15</p> <p>reality [1] 60/11</p> <p>really [7] 5/9 20/11 25/4 55/20 57/3 70/21 70/25</p> <p>reason [7] 18/6 22/2 28/3 32/3 37/19 67/1 69/6</p> <p>reasons [12] 9/8 10/22 13/6 13/13 21/2 21/15 31/25 48/13 67/4 69/2 69/11 69/13</p> <p>recall [10] 23/4 31/22</p>	<p>33/17 34/24 49/10 50/25 51/3 61/25 63/18 64/14</p> <p>recalled [1] 64/8</p> <p>receives [1] 39/3</p> <p>receiving [1] 59/7</p> <p>recognised [1] 70/6</p> <p>recollect [1] 68/17</p> <p>recollecting [1] 31/4</p> <p>recollection [1] 42/16</p> <p>recommendation [1] 50/12</p> <p>recommendations [3] 50/10 50/22 50/24</p> <p>recommended [2] 50/7 50/14</p> <p>reconsidered [1] 63/9</p> <p>recorded [1] 68/3</p> <p>recording [1] 50/14</p> <p>recovery [2] 35/12 36/22</p> <p>recruit [6] 15/8 26/22 27/3 27/6 58/21 60/19</p> <p>recruiting [1] 58/19</p> <p>recruitment [5] 14/9 26/5 26/9 27/17 57/22</p> <p>recruitments [1] 27/13</p> <p>recurring [1] 43/25</p> <p>red [1] 54/5</p> <p>redescribed [1] 4/1</p> <p>reduce [1] 32/12</p> <p>reduced [2] 60/21 68/18</p> <p>reducing [6] 30/9 31/13 31/14 31/15 36/13 59/21</p> <p>reduction [2] 15/17 31/11</p> <p>reductions [1] 36/5</p> <p>refer [6] 8/15 9/23 20/1 24/20 32/10 57/18</p> <p>reference [5] 10/17 21/24 30/24 33/5 42/6</p> <p>referring [5] 7/14 11/16 29/4 47/4 47/7</p> <p>reflect [1] 63/15</p> <p>reflected [1] 69/3</p> <p>reflecting [2] 58/5 64/21</p> <p>reflective [1] 69/9</p> <p>regard [6] 21/16 29/5 34/14 36/2 38/25 43/1</p> <p>regarded [2] 58/2 58/2</p> <p>region [1] 40/5</p> <p>regional [2] 38/8 39/19</p> <p>regular [3] 38/5 49/20 55/23</p> <p>reinstating [1] 69/21</p> <p>reintegration [1]</p>	<p>35/13</p> <p>related [2] 23/9 43/6</p> <p>relates [3] 33/8 57/9 62/25</p> <p>relation [6] 34/19 69/4 69/17 69/20 71/2 71/7</p> <p>relationship [4] 14/5 34/1 49/15 64/6</p> <p>relationships [1] 5/10</p> <p>relative [1] 58/17</p> <p>relatively [5] 25/12 53/24 57/25 58/19 71/17</p> <p>relevant [1] 13/12</p> <p>reliable [1] 9/20</p> <p>reliance [3] 11/17 30/24 36/13</p> <p>relied [1] 35/4</p> <p>rely [1] 37/23</p> <p>remain [1] 17/10</p> <p>remains [1] 55/7</p> <p>remember [11] 15/11 16/17 20/11 21/5 23/8 24/12 28/10 31/4 38/2 49/9 57/21</p> <p>remit [4] 4/3 4/8 7/23 59/19</p> <p>repeatedly [2] 48/12 49/7</p> <p>report [34] 9/7 10/3 10/9 10/14 12/25 13/4 14/1 14/23 15/16 16/25 17/6 17/11 17/14 17/24 19/4 19/16 20/18 24/24 25/25 26/1 26/4 33/1 33/3 33/4 40/18 41/12 42/6 42/13 43/15 45/4 47/5 58/23 62/15 63/10</p> <p>reported [3] 68/3 68/9 68/10</p> <p>reporting [3] 50/14 61/13 68/1</p> <p>reports [5] 44/4 45/7 49/22 63/7 69/5</p> <p>require [5] 5/4 32/7 36/20 36/21 67/15</p> <p>required [11] 13/20 22/4 26/8 27/1 36/3 40/1 40/2 51/13 53/12 62/19 67/13</p> <p>requirement [3] 16/23 36/16 51/11</p> <p>Requirements [1] 19/12</p> <p>requires [7] 10/6 10/7 15/17 17/5 19/15 19/20 62/13</p> <p>requiring [2] 13/9 53/8</p> <p>resolved [1] 46/20</p> <p>resource [4] 37/13 39/16 56/9 70/13</p>
(29) previous - resource				

<p>R</p> <p>resourced [2] 45/22 56/6</p> <p>resources [4] 4/1 38/21 39/7 39/21</p> <p>resourcing [1] 60/13</p> <p>respect [11] 14/20 14/20 34/22 41/2 49/25 52/22 53/5 55/14 56/22 62/14 70/18</p> <p>respects [1] 52/16</p> <p>respite [1] 30/21</p> <p>response [7] 10/7 22/19 24/8 32/8 38/18 40/7 47/6</p> <p>responsibilities [1] 16/9</p> <p>responsible [2] 3/10 57/10</p> <p>responsive [1] 19/14</p> <p>rest [1] 53/23</p> <p>restricted [1] 43/13</p> <p>restrictive [1] 43/1</p> <p>result [4] 54/7 56/23 62/9 62/18</p> <p>resulting [1] 66/6</p> <p>results [3] 52/14 53/23 55/8</p> <p>retain [1] 26/22</p> <p>retired [1] 19/6</p> <p>retribution [1] 10/21</p> <p>review [8] 41/10 41/11 42/2 45/2 50/1 61/14 62/2 62/21</p> <p>right [13] 5/2 11/3 17/25 23/14 27/23 39/25 45/9 54/21 61/7 65/18 68/15 69/14 71/22</p> <p>rightly [1] 36/10</p> <p>ringfenced [1] 53/9</p> <p>rising [1] 6/24</p> <p>risk [57] 13/11 13/12 13/14 13/17 13/20 14/12 14/12 14/13 14/15 14/16 14/20 15/25 16/3 16/6 16/8 16/21 20/17 20/18 20/20 20/20 20/24 21/1 21/17 21/20 21/21 22/3 22/3 34/14 38/15 40/15 40/19 40/21 40/21 41/4 41/17 41/23 42/7 43/11 44/8 44/18 45/6 46/2 46/5 46/11 46/12 46/17 46/23 46/24 47/1 47/4 47/7 47/13 47/23 48/3 49/8 64/4 64/12</p> <p>risk factors [1] 40/21</p> <p>risks [2] 32/17 32/21</p> <p>robust [1] 24/7</p> <p>role [6] 1/24 1/24 2/3</p>	<p>2/3 6/15 19/8</p> <p>roles [3] 2/1 16/8 66/24</p> <p>roll [1] 18/21</p> <p>rolled [1] 3/7</p> <p>rolling [1] 27/2</p> <p>roster [1] 23/18</p> <p>roughly [1] 45/1</p> <p>round [1] 39/2</p> <p>row [2] 53/17 54/2</p> <p>Royal [4] 16/11 52/11 55/14 71/2</p> <p>run [1] 28/15</p> <p>running [3] 18/4 26/20 28/11</p> <hr/> <p>S</p> <p>sadly [1] 44/24</p> <p>safe [5] 10/7 17/10 19/14 22/19 40/1</p> <p>safeguarded [1] 33/20</p> <p>safety [8] 13/5 17/15 23/1 30/7 33/20 34/6 34/14 64/5</p> <p>said [7] 5/18 15/16 51/10 67/12 69/2 69/5 69/18</p> <p>salaries [1] 27/14</p> <p>same [7] 7/3 17/11 19/16 40/3 41/5 42/10 42/12</p> <p>sampling [1] 16/6</p> <p>saving [1] 7/4</p> <p>savings [2] 6/21 7/10</p> <p>saw [5] 17/7 30/4 32/18 41/18 58/22</p> <p>say [18] 7/7 7/7 7/23 8/16 11/21 22/21 24/13 26/14 28/5 29/20 35/19 40/10 43/1 44/10 46/4 47/22 48/22 57/25</p> <p>saying [5] 11/6 13/9 44/11 45/15 48/2</p> <p>says [2] 22/11 50/2</p> <p>scared [1] 21/7</p> <p>schizophrenia [1] 36/20</p> <p>score [2] 9/18 55/9</p> <p>screen [1] 2/12</p> <p>scroll [1] 53/22</p> <p>se [3] 47/23 48/3 53/10</p> <p>second [6] 4/14 10/15 12/5 54/10 67/12 68/2</p> <p>section [2] 10/16 11/13</p> <p>secure [2] 6/6 56/5</p> <p>see [31] 2/14 2/16 3/5 6/15 6/25 10/4 16/25 17/2 18/8 19/9 22/15 24/1 26/2 33/4 36/13 37/8 37/19 40/18 41/3 50/3 52/12</p>	<p>53/16 53/22 54/4 54/11 55/2 56/24 57/11 57/13 62/23 63/4</p> <p>seeking [1] 46/8</p> <p>seems [1] 26/10</p> <p>seen [4] 25/24 55/12 64/1 70/12</p> <p>sending [1] 34/23</p> <p>senior [7] 9/12 23/11 23/12 30/1 34/10 39/19 43/3</p> <p>seniors [1] 11/1</p> <p>sense [10] 18/17 18/20 19/1 20/6 23/19 23/20 24/21 25/4 25/11 25/14</p> <p>sentence [4] 4/14 6/10 6/17 7/8</p> <p>separate [1] 65/20</p> <p>Separately [1] 39/13</p> <p>September [1] 17/1</p> <p>sequelae [1] 60/12</p> <p>sequential [1] 31/9</p> <p>serious [20] 5/4 29/6 29/8 29/9 30/6 36/20 40/12 43/25 44/12 61/14 61/16 61/18 61/21 62/2 62/5 62/9 62/15 63/13 63/16 69/20</p> <p>serve [1] 37/1</p> <p>service [17] 8/21 17/5 30/7 34/9 38/24 50/11 50/20 51/18 52/25 56/10 57/6 59/24 59/25 60/16 60/23 60/25 70/7</p> <p>services [36] 2/5 3/9 3/11 5/5 5/6 5/13 5/16 6/4 6/6 6/8 7/2 7/10 12/4 15/1 19/19 21/5 22/18 28/15 28/17 30/19 36/3 36/12 38/7 38/24 39/21 41/8 45/23 51/12 57/9 60/12 66/6 66/13 67/6 67/15 70/4 70/4</p> <p>sessions [1] 59/21</p> <p>set [10] 4/13 11/17 12/19 14/1 23/3 24/4 32/21 52/10 57/6 59/24</p> <p>set-up [1] 59/24</p> <p>sets [1] 2/18</p> <p>setting [1] 69/12</p> <p>seven [1] 62/24</p> <p>seventh [1] 11/11</p> <p>severe [1] 62/9</p> <p>severe/serious [1] 62/9</p> <p>shall [2] 28/19 52/4</p> <p>share [1] 37/7</p> <p>shared [1] 48/20</p> <p>sharing [2] 41/23 42/1</p>	<p>sharp [1] 67/13</p> <p>sharper [1] 65/21</p> <p>she [3] 3/4 56/4 62/18</p> <p>shifts [1] 23/19</p> <p>short [2] 56/17 72/1</p> <p>shortly [1] 62/17</p> <p>should [6] 11/23 48/16 63/8 67/6 67/25 68/3</p> <p>shouldn't [1] 64/5</p> <p>show [2] 42/11 52/10</p> <p>shows [1] 54/16</p> <p>sight [1] 7/4</p> <p>sighted [1] 15/14</p> <p>sign [1] 17/25</p> <p>signal [1] 15/23</p> <p>signed [2] 45/17 63/15</p> <p>significant [17] 4/17 12/2 12/11 13/22 14/11 20/3 20/8 20/13 20/14 22/25 25/18 25/18 27/25 34/2 51/1 51/24 60/18</p> <p>significantly [4] 52/16 54/7 54/8 68/18</p> <p>signs [1] 54/16</p> <p>siloed [1] 66/6</p> <p>similar [3] 30/13 53/8 53/24</p> <p>similarities [1] 25/2</p> <p>similarly [2] 66/4 68/12</p> <p>simply [2] 68/9 70/18</p> <p>since [2] 24/22 25/8</p> <p>single [2] 67/7 67/19</p> <p>SIRG [2] 61/23 62/1</p> <p>site [1] 31/2</p> <p>sitting [1] 48/2</p> <p>six [1] 28/12</p> <p>size [1] 11/24</p> <p>skills [1] 61/8</p> <p>slowed [1] 30/18</p> <p>so [125]</p> <p>sobering [1] 22/15</p> <p>social [1] 5/6</p> <p>society [1] 35/13</p> <p>some [43] 2/17 18/10 18/11 18/19 18/25 18/25 20/3 20/10 21/15 21/19 22/6 24/18 25/2 26/11 28/6 28/23 36/17 39/25 40/2 42/9 43/23 43/23 43/24 45/14 45/15 52/16 54/20 54/21 56/5 57/6 57/10 57/12 58/5 58/8 58/16 59/3 60/21 61/5 61/16 65/5 65/17 69/4 69/19</p> <p>somebody [4] 29/16 32/6 37/6 37/17</p> <p>something [12] 11/25 18/22 20/17 20/19 40/4 40/14 47/9</p>	<p>48/16 57/8 58/14 60/24 69/5</p> <p>sometimes [2] 17/22 17/23</p> <p>somewhat [1] 15/18</p> <p>sorry [16] 6/3 15/11 16/17 19/17 20/23 34/24 35/18 38/3 46/4 46/19 48/22 49/10 51/3 63/5 63/20 65/7</p> <p>sort [5] 8/7 27/8 37/12 38/9 69/24</p> <p>sorts [5] 7/6 15/13 16/16 44/6 44/16</p> <p>sound [3] 42/20 57/2 57/6</p> <p>sounds [1] 9/22</p> <p>sources [1] 46/9</p> <p>South [2] 55/4 71/5</p> <p>South Team [1] 55/4</p> <p>space [1] 31/7</p> <p>speak [1] 11/8</p> <p>speaking [1] 9/13</p> <p>special [3] 6/7 33/15 34/21</p> <p>specialised [1] 57/24</p> <p>specialist [12] 5/14 6/3 36/11 50/20 56/8 59/22 60/17 61/7 67/14 70/7 70/8 70/13</p> <p>specialty [1] 58/20</p> <p>specific [8] 9/11 52/2 53/6 53/9 57/22 62/1 63/25 65/22</p> <p>specifically [11] 1/18 18/4 28/10 34/19 42/21 44/22 47/1 49/9 50/25 51/3 59/10</p> <p>specifics [2] 31/23 32/25</p> <p>spectrum [2] 5/2 39/9</p> <p>speech [1] 6/1</p> <p>spend [1] 23/13</p> <p>spent [1] 40/4</p> <p>split [2] 3/12 3/18</p> <p>splitting [1] 67/5</p> <p>spot [1] 38/15</p> <p>stabilising [1] 8/13</p> <p>staff [42] 4/5 6/22 6/23 8/21 9/12 9/15 9/16 9/25 10/19 10/20 11/7 12/24 15/8 15/8 16/13 16/15 18/13 18/15 20/13 20/24 21/9 23/11 23/12 23/17 23/17 25/1 26/20 26/22 35/8 40/6 42/22 43/3 43/7 45/20 45/23 48/20 48/23 49/1 56/9 60/7 68/6 71/17</p> <p>staffing [14] 13/2 13/5 14/20 15/5 18/12 23/10 23/25 25/6 25/24 26/4 26/8 28/4</p>
---	--	--	--	---

<p>S</p> <p>staffing... [2] 33/6 37/22</p> <p>stage [1] 33/25</p> <p>stand [2] 5/24 5/25</p> <p>standalone [1] 56/10</p> <p>standard [2] 22/4 70/1</p> <p>standards [3] 40/4 51/13 51/19</p> <p>start [8] 19/14 27/24 30/16 31/7 35/20 51/1 65/18 66/2</p> <p>started [4] 18/18 20/11 50/23 66/11</p> <p>starting [2] 50/1 57/12</p> <p>starts [2] 11/12 52/12</p> <p>state [1] 22/17</p> <p>statement [20] 1/8 1/11 2/18 4/12 7/24 8/11 9/1 11/4 11/17 13/24 17/13 17/18 20/1 35/5 39/23 46/15 61/14 63/22 65/11 66/1</p> <p>statements [1] 18/12</p> <p>statistic [1] 39/1</p> <p>stayed [1] 8/8</p> <p>stead [1] 2/8</p> <p>steps [13] 12/19 13/8 14/17 16/2 19/2 33/19 34/21 45/3 45/8 51/22 55/16 56/2 60/4</p> <p>still [5] 19/10 54/3 54/13 61/6 68/6</p> <p>stood [4] 2/8 18/8 19/8 30/17</p> <p>stop [3] 29/1 29/24 30/23</p> <p>stopped [5] 60/22 68/4 68/16 68/17 68/19</p> <p>straight [1] 66/14</p> <p>strategic [5] 7/23 14/15 14/16 46/24 47/25</p> <p>Strategy [1] 4/8</p> <p>stream [1] 66/12</p> <p>strengthen [1] 15/12</p> <p>stretch [1] 28/18</p> <p>strides [1] 57/12</p> <p>strongly [1] 36/4</p> <p>structural [2] 3/22 65/6</p> <p>structure [4] 2/10 2/12 2/21 47/20</p> <p>structures [1] 65/23</p> <p>struggling [1] 16/23</p> <p>stuck [1] 67/11</p> <p>sub [2] 7/12 31/15</p> <p>sub-contract [1] 31/15</p> <p>sub-optimal [1] 7/12</p> <p>subconscious [1]</p>	<p>37/13</p> <p>subcontracted [3] 30/25 32/10 37/21</p> <p>subject [2] 22/11 67/25</p> <p>subsequently [4] 21/6 24/10 66/25 69/23</p> <p>succinct [1] 60/15</p> <p>such [7] 20/17 23/5 47/12 47/21 59/7 63/7 68/5</p> <p>sudden [1] 70/9</p> <p>sufficient [7] 7/16 7/19 23/15 37/11 53/14 64/22 67/9</p> <p>sufficiently [1] 67/10</p> <p>suggest [2] 20/2 63/17</p> <p>suggesting [2] 22/1 29/14</p> <p>suitable [2] 12/24 32/2</p> <p>summary [4] 10/16 26/6 42/4 50/3</p> <p>supervision [4] 16/14 46/11 50/21 55/24</p> <p>supplement [1] 23/19</p> <p>support [6] 16/22 22/19 23/15 35/11 56/9 59/2</p> <p>supported [1] 16/10</p> <p>supporting [1] 4/5</p> <p>sure [5] 14/25 16/21 29/21 31/2 46/12</p> <p>surgery [1] 62/19</p> <p>surprised [1] 15/19</p> <p>Survey [1] 9/16</p> <p>system [6] 4/9 8/3 8/3 38/16 64/10 64/19</p> <p>systemic [1] 65/6</p>	<p>target [1] 71/17</p> <p>targeted [1] 42/19</p> <p>targets [3] 16/22 70/14 70/15</p> <p>task [1] 16/5</p> <p>tasks [1] 23/13</p> <p>team [43] 9/4 15/3 15/15 16/18 16/18 24/14 26/1 26/17 28/22 38/8 46/19 51/25 52/1 52/19 52/22 53/1 53/5 53/11 53/19 53/19 55/4 55/4 55/18 55/24 56/8 56/11 57/10 58/7 58/9 58/12 58/20 59/7 59/23 60/2 60/5 61/2 61/2 61/4 61/6 61/8 70/10 70/13 70/15</p> <p>teams [20] 16/23 41/24 42/23 52/11 53/16 54/2 54/5 54/14 55/2 59/3 59/14 59/15 60/5 60/14 60/15 60/17 66/15 69/25 70/8 70/9</p> <p>tell [1] 49/5</p> <p>telling [2] 23/5 44/14</p> <p>template [1] 50/13</p> <p>tenure [15] 8/12 8/22 9/3 15/24 17/2 19/14 19/23 27/24 35/20 50/23 51/5 51/21 52/8 54/11 63/2</p> <p>term [4] 29/23 38/23 51/7 55/17</p> <p>terms [11] 3/21 4/4 4/9 30/17 34/6 38/5 38/21 39/17 39/18 47/15 61/9</p> <p>tested [1] 71/1</p> <p>testimony [1] 65/18</p> <p>tests [1] 71/14</p> <p>than [13] 6/14 7/17 8/16 23/22 27/16 29/16 35/25 36/10 39/3 54/8 60/1 66/21 71/12</p> <p>thank [14] 56/14 56/15 56/20 64/25 65/1 65/8 67/22 68/12 68/20 68/21 68/23 68/25 71/21 71/24</p> <p>that [433]</p> <p>that's [33] 1/17 1/18 2/20 3/9 5/25 11/9 12/16 15/21 16/24 17/17 19/13 19/15 21/24 26/14 29/10 33/9 33/18 34/6 39/3 40/10 40/16 41/18 44/14 44/19 45/9 46/22 50/7 53/17 56/10 57/7 63/10 68/7 69/6</p> <p>their [28] 5/6 9/16</p>	<p>12/7 15/7 23/9 23/12 23/15 25/10 25/13 25/14 30/18 31/8 32/3 34/4 34/4 35/11 35/11 35/11 44/21 46/13 47/5 47/12 47/15 48/6 53/7 60/10 63/9 66/14</p> <p>them [11] 2/24 10/24 22/20 25/19 32/5 36/22 42/9 49/5 49/17 49/21 68/6</p> <p>Thematic [1] 62/21</p> <p>theme [4] 28/8 43/13 43/25 47/23</p> <p>themes [1] 69/4</p> <p>then [27] 2/17 3/21 3/24 4/5 10/6 10/23 11/11 11/22 15/6 20/9 30/6 32/5 41/10 43/2 47/23 47/24 49/3 50/18 51/15 53/22 56/3 59/20 66/2 66/23 66/25 68/7 68/12</p> <p>therapist [4] 53/11 57/23 58/11 58/13</p> <p>therapists [4] 53/14 53/14 56/6 58/18</p> <p>therapy [3] 6/1 52/17 53/6</p> <p>there [100]</p> <p>there'd [6] 9/13 16/13 18/2 42/23 42/24 43/2</p> <p>there'll [1] 16/7</p> <p>there's [27] 6/19 6/21 7/18 10/16 11/13 11/22 19/12 25/22 27/12 29/5 29/23 29/24 30/24 31/12 31/24 36/10 36/12 39/1 39/17 39/23 47/22 49/14 56/8 57/4 58/17 69/24 69/25</p> <p>these [29] 5/10 15/13 15/15 21/10 22/25 23/17 29/11 29/14 33/24 39/15 41/1 42/9 42/10 42/14 42/16 42/21 43/18 43/22 44/4 44/6 49/5 50/22 51/3 55/15 56/5 60/15 60/19 63/19 69/11</p> <p>they [55] 5/5 5/6 5/7 5/13 6/24 6/25 7/2 13/9 13/12 13/18 16/4 16/15 17/10 17/11 17/15 17/20 17/21 18/15 18/16 21/13 23/14 23/22 25/11 25/12 25/13 25/15 25/17 29/15 29/19 32/23 32/25 36/21 37/17 38/16 40/14 44/7 46/19 46/20 48/13 48/20 49/22 49/23 58/9 59/7 60/8 60/8 61/11 63/8 63/15</p>	<p>67/9 68/5 68/5 68/17 68/19 69/25</p> <p>they'd [1] 59/16</p> <p>they'll [1] 16/10</p> <p>they're [2] 2/24 7/9</p> <p>they've [1] 55/12</p> <p>thing [3] 7/1 9/11 71/9</p> <p>things [26] 3/12 5/20 5/25 6/17 7/5 7/6 7/7 15/22 16/16 17/25 18/15 20/15 22/6 23/14 25/21 25/23 29/23 34/8 43/10 44/17 45/15 53/15 56/5 66/24 68/13 69/15</p> <p>think [67] 1/25 2/8 4/4 4/23 7/18 8/1 9/11 9/19 15/16 15/18 15/22 17/17 20/9 21/2 21/6 21/15 22/1 25/2 25/2 25/10 25/14 25/20 25/21 25/22 26/19 28/2 28/5 31/1 32/18 33/18 34/10 35/21 36/12 36/15 36/15 37/12 37/15 38/3 40/14 44/15 44/19 44/19 45/3 45/8 45/9 45/15 47/24 49/6 49/9 49/12 51/24 53/1 54/21 54/22 57/2 57/8 65/17 65/23 67/17 67/20 67/24 68/7 68/12 69/9 69/25 71/13 71/22</p> <p>thinking [3] 29/3 45/14 64/4</p> <p>third [1] 42/5</p> <p>this [126]</p> <p>this is [1] 29/8</p> <p>those [39] 7/7 8/3 8/8 8/9 12/13 12/13 14/18 16/15 16/19 16/22 17/15 23/3 24/18 25/23 27/6 29/6 29/24 33/21 34/16 37/7 38/13 40/3 44/16 45/6 49/4 50/24 58/12 62/2 62/3 63/10 64/25 65/14 65/22 65/23 66/12 66/13 69/15 70/20 70/25</p> <p>thought [3] 43/24 49/1 67/5</p> <p>threatened [1] 22/22</p> <p>three [14] 6/5 9/3 9/19 18/22 22/9 22/12 31/1 54/24 63/6 63/7 65/20 67/6 67/11 71/10</p> <p>three months [1] 9/3</p> <p>three-year [2] 9/19 54/24</p> <p>through [9] 2/1 2/24</p>
---	--	--	---	--

<p>T</p> <p>through... [7] 5/3 5/12 23/14 32/24 47/14 47/20 66/13</p> <p>throughout [1] 9/25</p> <p>thrown [1] 18/18</p> <p>thrust [1] 23/8</p> <p>time [28] 2/21 4/23 6/23 18/5 20/10 23/13 23/20 26/11 30/2 31/5 32/7 33/10 40/4 54/17 56/12 57/6 59/14 59/16 59/20 64/8 64/14 65/8 66/5 66/9 67/2 67/16 67/19 67/23</p> <p>timeline [1] 57/7</p> <p>timely [3] 54/2 54/17 55/7</p> <p>times [1] 54/25</p> <p>timing [2] 24/17 24/19</p> <p>today [2] 36/9 65/18</p> <p>together [3] 7/22 8/4 64/22</p> <p>told [1] 9/8</p> <p>too [1] 21/6</p> <p>top [8] 2/14 9/2 15/22 18/15 24/13 40/18 44/17 53/17</p> <p>totally [1] 61/5</p> <p>touched [1] 58/10</p> <p>towards [5] 2/14 12/17 41/3 51/16 63/23</p> <p>track [2] 27/9 31/24</p> <p>tracker [1] 14/24</p> <p>tracking [1] 61/10</p> <p>tradition [1] 46/25</p> <p>traditionally [2] 27/13 58/2</p> <p>tragedies [1] 44/4</p> <p>trained [3] 53/6 57/23 58/18</p> <p>trainee [1] 27/6</p> <p>training [9] 16/13 27/9 43/5 43/6 46/2 46/5 50/21 59/6 59/8</p> <p>transfers [1] 31/14</p> <p>treatment [8] 23/24 31/8 36/19 36/21 36/22 37/4 62/13 70/14</p> <p>trigger [1] 34/21</p> <p>true [4] 1/11 12/16 40/16 67/21</p> <p>trust [47] 1/15 1/21 2/8 3/10 4/16 5/5 5/14 5/15 5/16 6/8 6/20 7/25 8/8 8/13 9/18 9/20 10/1 10/5 10/18 12/1 12/23 13/4 13/11 15/9 21/12 22/5 24/25 25/9 29/6 33/10 34/22 35/4 35/13 36/2 44/1</p>	<p>45/5 47/16 48/1 48/4 54/12 62/5 62/22 64/6 64/13 64/18 66/20 71/4</p> <p>Trust's [4] 11/23 44/8 44/8 47/19</p> <p>trusts [9] 4/20 4/21 5/8 6/5 9/16 25/9 28/7 39/4 39/5</p> <p>truth [1] 11/8</p> <p>try [4] 27/17 28/14 34/15 69/8</p> <p>trying [7] 18/21 32/12 40/5 45/17 45/24 48/9 54/21</p> <p>Tuesday [1] 24/15</p> <p>tune [1] 11/25</p> <p>turn [1] 10/15</p> <p>two [23] 3/7 3/13 3/24 4/21 4/24 9/18 10/22 20/4 25/23 26/3 31/6 34/7 41/13 49/21 54/23 59/21 62/7 63/7 66/12 67/4 67/12 71/10 71/16</p> <p>two paragraphs [1] 41/13</p> <p>two weeks [1] 31/6</p> <p>two-way [1] 49/21</p> <hr/> <p>U</p> <p>Uh [1] 2/13</p> <p>Uh-huh [1] 2/13</p> <p>UK [1] 36/6</p> <p>ultimately [1] 32/8</p> <p>unchanged [1] 17/14</p> <p>unclear [1] 58/4</p> <p>uncouple [1] 51/25</p> <p>uncoupled [2] 53/4 53/11</p> <p>uncoupling [4] 52/8 52/25 53/9 70/3</p> <p>under [13] 12/4 12/17 12/19 14/1 26/7 33/3 40/19 41/4 41/13 51/16 60/12 63/4 63/6</p> <p>undergraduates [1] 27/4</p> <p>underneath [1] 20/2</p> <p>underperforming [1] 54/14</p> <p>understaffed [1] 15/5</p> <p>understand [3] 2/10 56/2 64/16</p> <p>understanding [2] 17/17 50/23</p> <p>undertake [6] 16/14 16/20 29/11 43/7 50/16 50/20</p> <p>undertaken [7] 16/4 16/8 29/15 29/15 29/18 34/13 45/11</p> <p>undertaking [7] 1/23 29/1 46/2 46/5 47/13 51/25 68/6</p> <p>Unexpected [1]</p>	<p>62/12</p> <p>unfilled [1] 28/13</p> <p>unique [1] 28/17</p> <p>unit [1] 39/24</p> <p>units [3] 12/14 17/4 39/8</p> <p>universities [1] 27/3</p> <p>unknown [1] 21/8</p> <p>unless [4] 45/21 45/22 53/10 69/14</p> <p>unsafe [2] 10/11 13/1</p> <p>unsustainable [1] 66/6</p> <p>until [6] 14/3 29/1 29/19 56/14 67/24 71/23</p> <p>unwell [2] 5/13 23/22</p> <p>up [19] 12/22 14/3 16/15 24/9 24/20 29/19 30/1 31/11 37/3 38/9 40/10 45/17 45/21 50/11 57/6 58/15 59/24 65/19 68/5</p> <p>update [1] 24/5</p> <p>updated [1] 43/5</p> <p>updates [1] 49/20</p> <p>upon [1] 58/11</p> <p>urgent [3] 26/5 26/9 32/19</p> <p>us [6] 18/11 18/18 44/1 49/8 49/23 55/25</p> <p>use [11] 6/24 26/25 31/18 31/20 33/24 34/11 37/20 38/14 43/1 43/11 44/9</p> <p>used [6] 5/15 22/24 27/15 29/11 35/24 38/21</p> <p>users [2] 8/21 50/20</p> <p>using [4] 27/10 27/11 27/12 35/16</p> <p>usual [1] 26/25</p> <p>usually [3] 37/11 46/18 47/15</p> <p>utilise [1] 31/15</p> <hr/> <p>V</p> <p>vacancy [4] 3/19 15/6 26/21 28/11</p> <p>vacant [1] 3/19</p> <p>valid [1] 65/17</p> <p>value [1] 12/1</p> <p>values [3] 7/15 7/18 45/19</p> <p>variable [1] 66/7</p> <p>variant [1] 20/11</p> <p>varied [1] 67/10</p> <p>various [5] 2/1 2/16 14/4 16/9 21/6</p> <p>VC [6] 53/20 55/5 57/16 60/8 62/25 71/5</p> <p>VC's [2] 58/13 62/14</p> <p>verbal [3] 24/4 24/5 33/1</p> <p>very [20] 3/1 7/25</p>	<p>8/22 18/5 21/7 21/7 22/25 24/9 28/6 30/18 35/16 39/10 39/23 41/4 42/12 42/21 44/24 49/16 60/14 68/20</p> <p>viable [2] 30/2 30/5</p> <p>view [10] 3/19 6/19 9/22 15/2 36/12 37/17 64/21 65/5 65/11 66/3</p> <p>views [2] 37/7 65/15</p> <p>visible [1] 17/21</p> <p>vision [1] 45/19</p> <p>visit [1] 23/6</p> <p>visits [1] 17/1</p> <p>vitality [1] 6/17</p> <p>volume [1] 68/18</p> <p>vulnerable [1] 12/14</p> <hr/> <p>W</p> <p>wait [1] 58/13</p> <p>waiting [1] 27/19</p> <p>want [4] 7/6 27/18 57/2 71/15</p> <p>wanted [1] 20/7</p> <p>ward [24] 12/24 18/13 21/10 21/13 22/9 22/12 23/4 23/13 23/18 24/13 25/12 29/1 29/10 29/16 30/5 30/15 31/3 31/4 33/11 34/4 34/13 43/2 43/3 68/15</p> <p>ward-based [1] 68/15</p> <p>wards [21] 12/6 12/13 12/20 15/9 17/3 18/5 18/12 20/14 21/4 23/11 23/12 25/7 26/23 28/11 30/2 30/21 31/2 31/6 31/7 32/1 40/3</p> <p>warrant [1] 24/7</p> <p>was [199]</p> <p>wasn't [23] 5/15 5/18 7/22 8/25 13/2 14/13 14/14 15/24 20/5 21/21 21/22 26/14 28/5 28/17 29/20 33/15 35/1 35/17 49/19 64/22 66/15 67/9 68/8</p> <p>watch [1] 60/10</p> <p>wave [2] 18/2 18/9</p> <p>waves [2] 20/8 21/6</p> <p>way [6] 18/3 23/21 42/19 49/21 64/19 67/19</p> <p>ways [2] 2/23 9/14</p> <p>we [152]</p> <p>we'd [4] 20/8 25/21 42/19 48/2</p> <p>we'll [5] 9/7 24/18 56/14 71/22 71/23</p> <p>we're [9] 7/3 11/25 15/5 27/25 42/24 49/6</p>	<p>54/20 57/12 65/9</p> <p>we've [12] 15/5 15/6 25/24 26/15 27/22 32/24 33/8 45/6 46/23 49/3 49/7 57/3</p> <p>wee [1] 15/12</p> <p>week [1] 59/21</p> <p>weekly [1] 44/25</p> <p>weeks [1] 31/6</p> <p>weighed [1] 71/13</p> <p>well [28] 3/1 3/3 8/22 10/7 12/5 13/14 17/10 17/16 18/3 18/14 19/15 21/9 25/16 29/19 38/16 39/14 41/10 45/14 48/2 49/12 52/4 56/4 59/23 68/14 68/16 69/15 70/6 71/22</p> <p>well-led [4] 12/5 17/10 17/16 19/15</p> <p>went [3] 27/2 27/3 66/13</p> <p>were [121]</p> <p>weren't [12] 7/19 10/23 13/18 13/19 25/13 26/19 27/1 58/3 59/7 67/9 68/4 68/5</p> <p>what [62] 4/19 6/3 8/2 9/6 9/8 11/2 11/16 11/17 13/25 14/10 14/17 15/13 15/15 16/2 16/2 16/12 17/20 17/23 21/8 21/16 23/3 23/4 25/5 26/11 26/13 28/2 29/3 29/3 29/5 29/12 30/3 30/17 31/10 31/20 33/2 33/4 33/19 38/18 38/24 41/18 42/14 43/4 45/6 45/10 45/13 45/17 46/16 46/23 51/21 53/12 55/16 55/19 55/25 56/2 57/18 59/18 61/15 63/18 64/1 65/19 69/12 71/22</p> <p>what's [10] 3/8 5/11 9/15 23/16 28/3 35/15 42/19 51/25 64/11 70/16</p> <p>whatever [2] 10/9 43/20</p> <p>when [23] 5/13 8/15 11/9 20/5 24/25 37/10 38/19 43/15 44/10 49/1 50/22 50/25 59/14 59/17 59/19 60/24 63/1 65/17 66/11 66/25 67/5 69/2 70/6</p> <p>where [29] 3/5 4/13 8/12 11/12 12/18 13/17 13/18 13/25 15/15 15/23 17/6 20/7 21/21 22/18 40/13</p>
---	--	---	---	---

<p>W</p> <p>where... [14] 43/5 43/5 47/3 47/8 51/15 54/2 59/21 60/21 61/17 63/13 66/1 66/12 70/9 70/23</p> <p>whereas [1] 70/10</p> <p>whether [7] 39/18 43/12 47/20 53/4 53/5 58/7 70/3</p> <p>which [30] 4/4 4/7 6/20 9/6 11/13 13/9 20/19 26/10 27/7 27/23 31/12 31/16 42/17 42/20 51/4 51/8 52/8 52/22 53/1 57/5 57/20 59/3 62/3 62/24 64/12 64/13 66/16 69/5 71/3 71/14</p> <p>while [1] 15/12</p> <p>whilst [4] 2/2 19/10 40/10 56/22</p> <p>whim [1] 29/21</p> <p>who [2] 38/6 60/8</p> <p>whole [7] 8/19 9/17 18/20 21/3 27/20 39/9 66/18</p> <p>why [8] 12/25 24/5 24/5 25/16 26/12 32/3 44/20 69/11</p> <p>wide [2] 9/17 66/20</p> <p>widely [1] 9/22</p> <p>will [10] 5/25 10/22 16/14 30/14 32/5 44/7 51/18 57/5 59/14 60/12</p> <p>window [1] 62/16</p> <p>winter [2] 27/12 27/13</p> <p>wish [1] 69/16</p> <p>withdrawal [1] 60/13</p> <p>within [21] 4/18 4/20 9/2 9/12 9/12 11/6 15/9 16/9 29/6 29/22 33/24 36/2 37/11 38/6 39/23 45/10 52/1 55/21 61/6 64/23 65/22</p> <p>without [4] 10/20 33/25 51/18 63/25</p> <p>WITN0319003 [1] 50/1</p> <p>WITN0356017 [1] 41/1</p> <p>WITN0380006 [1] 2/11</p> <p>WITN0380054 [1] 22/8</p> <p>WITN0380070 [1] 28/21</p> <p>WITN0380071 [1] 25/25</p> <p>witness [3] 4/11 13/24 65/10</p> <p>won't [1] 69/15</p>	<p>word [1] 38/3</p> <p>work [9] 15/6 15/9 23/15 23/21 27/20 52/2 53/7 54/20 59/22</p> <p>worked [4] 1/20 25/22 59/17 64/20</p> <p>workers [1] 52/3</p> <p>working [20] 2/1 2/4 4/9 8/4 12/20 28/6 28/14 34/1 38/19 39/20 48/5 50/19 58/23 59/14 63/21 64/5 64/9 64/10 64/16 64/22</p> <p>workings [1] 59/24</p> <p>worsened [1] 19/20</p> <p>worth [1] 12/1</p> <p>would [79]</p> <p>wouldn't [8] 11/1 11/1 32/23 32/24 33/17 53/10 62/1 67/17</p> <p>writing [2] 64/8 64/14</p> <p>wrong [1] 71/9</p> <hr/> <p>Y</p> <p>yeah [8] 9/10 25/20 27/18 35/3 36/1 39/17 43/22 61/5</p> <p>year [14] 6/20 8/12 9/19 17/2 18/24 27/16 52/17 53/25 54/11 54/24 55/1 57/17 57/19 58/14</p> <p>years [5] 18/22 35/22 36/7 56/22 57/5</p> <p>yes [123]</p> <p>you [200]</p> <p>you describe [1] 35/12</p> <p>you'd [8] 1/20 19/5 19/8 26/25 37/12 43/10 43/13 43/13</p> <p>you'll [1] 53/22</p> <p>you're [19] 12/15 15/22 25/5 30/6 30/6 30/8 30/11 30/11 30/12 38/19 38/22 39/8 44/24 45/17 47/11 47/22 61/7 61/15 65/15</p> <p>you've [11] 16/1 17/13 21/13 33/5 34/7 37/25 48/12 66/23 67/22 67/24 71/16</p> <p>your [48] 1/11 2/16 2/18 4/11 4/13 6/15 6/25 8/11 8/12 8/22 8/25 9/3 11/17 13/24 17/2 17/13 19/8 19/14 19/23 27/24 28/4 28/20 34/22 35/5 35/20 37/14 39/11 45/5 46/15 46/15 48/13 50/23 50/23 51/5 51/21 52/8 54/11</p>	<p>55/13 61/12 61/13 63/2 63/22 64/21 65/5 65/8 65/11 66/5 69/17</p>		
---	---	--	--	--