Wednesday, 20 May 2026

(2.25 pm)

THE CHAIR: Yes, Mr Carr.

MR CARR: Yes, if I may call, please, Julie Attfield.

THE CHAIR: Thank you.

JULIE ATTFIELD (sworn)

Questioned by MR CARR

MR CARR: Ms Attfield, you prepared a statement for the purposes of this Inquiry dated 16 January 2026.

A. Yes.

Q. There's one correction you wish to make which is at paragraph 5, and it's the penultimate line of that paragraph. What's the correction?

A. So the correction is that I took up the post of the Executive Director of Local Mental Health Services in May 2019 on an interim basis and then substantively from September 2019.

Q. So the correction is where it says "January 2019" it should say "May"?

A. Yes.

Q. Subject to that correction, is the statement true to the best of your knowledge and belief?

A. It is.

Q. You've set out in your statement your professional background: you're a mental health nurse, you've worked

in mental health -- mental health nurse, yes?

A. Yes.

Q. You've worked in several executive positions for the Nottinghamshire Healthcare Foundation Trust between 2014 and your retirement in December 2022?

A. Yes.

Q. From 2014 to 2016, you were the Executive Director of Forensic Services?

A. Yes.

Q. You were the Executive Director of Nursing from 2016 to 2019?

A. Yes.

Q. Then from May 2019, as you've clarified, until December 2022, you were the Executive Director of Local Mental Health Services?

A. Yes, and can I add for fullness, that before I joined Nottinghamshire Healthcare as a director, I was the Director of Nursing and Operations at Lincolnshire Partnerships for two years.

Q. Yes. In addition to the roles that I have described, you also had two brief stints, as I understand it, as Interim Chief Executive Officer at Nottinghamshire Healthcare Foundation Trust --

A. Yes, that's right.

Q. -- in 2015 and 2018?

A. Yes.

Q. Now, so far as the context for your appointment in May 2019 to Executive Director of Local Mental Health Services, you set that out in your statement. It's page 3, paragraph 10, where you say -- it will come up on screen in a moment -- top paragraph on the page:

"The events ..." on the second sentence:

"The events that led to my leading this portfolio included a high degree of concern raised by regulators, commissioners and staff within the organisation about the quality and safety of services."

Of course, you were working in the organisation yourself. We heard evidence from Mr Brewin that the ratings of the CQC in 2019 were anticipated almost, it was known within the organisation that there was going to be a poor rating at a CQC inspection. Did that reflect your feeling of where the organisation was?

A. I think that it was anticipated, to a degree, yes.

Q. The role of Executive Director, that involved both an operational management aspect, and also being on the Board of Directors?

A. That's correct, yes.

Q. Your chief aim and purpose, given what you've set out at paragraph 10, would be to address the concerns about the quality and safety of services?

A. Yes.

Q. In that context, if we look at the CQC Inspection Report from 2019, it's NHFT0002015, and this is the inspection report that was published in May 2019, so that was the month that you took up the role. We can see that in the top box. But it was based on an inspection from January to March 2019, so just before you took up the executive directorship.

Looking in the bottom half of the page we can see overall the rating requires improvement with "requires improvement" in the domains: "Are services safe? Are services responsive? Are services well led?"

A. Yes.

Q. So the areas demanding change and which ought to have been the focus for you would have been the lack of safety and the poor governance, poor leadership?

A. Yes.

Q. Particular issues identified in the report were in respect of staffing and risk assessment.

A. Yes.

Q. That's right, isn't it?

A. Yes.

Q. If we look at page 12 and heading towards the bottom half of the page, "Areas for improvement" and under:

"Acute wards ...

"The trust must ensure that there are enough suitable and qualified staff ..."

And that's been mandated, isn't it?

A. Yes.

Q. That's something that must be done?

A. Yes.

Q. Then if we look at the section dealing with Acute wards for adults, it's page 22, and psychiatry intensive care units, so this department, as it were, of the Trust. It's at the top of the page, although the overall rating for the Trust was "Requires improvement" just above the "Key facts and figures":

Acute wards for adults in Psychiactric Intensive Care Unit was rated "inadequate", wasn't it?

A. Yes.

Q. That was a worsening since the last inspection --

A. Yes.

Q. -- when it was "Requires improvement"?

A. Yes.

Q. So it's gone backwards since 2017?

A. Yes.

Q. If we go to page 23, so the next page, under "Summary of this service", where there are bullet points, it's the fourth bullet point, this is dealing with the issue of risk, and the CQC have identified that risk was not

always managed well.

There were cases where there were no risk assessments at all and in others they weren't fully developed or didn't contain all the risk information required.

A. Yes.

Q. And that finding would have been one of the reasons that acute wards and Psychiactric Intensive Care was found by the CQC to be inadequate.

A. Yes.

Q. You would have understood that.

A. Yes.

Q. We don't need to go back to it but in the list of things that the Trust must do in this report at the beginning, those sections where the CQC is mandating action, one of them was that it must ensure risk assessments were in place and that they contained all relevant risk information.

A. Yes.

Q. So from that report you would have had an indication, new into the role, but you would have had an indication that risk assessments weren't being conducted to the required standard and action needed to be taken to improve the assessment of risk.

A. Yes.

Q. The assessment of risk in psychiatric care is important, isn't it?

A. *(The witness nodded)*

Q. It's important in all medicine but particularly in psychiatric care.

A. Yes.

Q. Following the directive that steps must be taken, did you implement any changes to the Trust's policy on risk assessment?

A. In terms of the Trust's policy, I didn't make any changes at that point --

Q. Are you where whether any changes were made to the Trust's policy on risk assessment, following the directive from the CQC?

A. Not at that point, no.

Q. Or at any point during your tenure?

A. I know that a great deal of work was done about risk assessment on the wards with staff directly. I know that --

Q. We'll come on to where that was done -- *(overspeaking)* --

A. Sorry, sorry --

Q. We can take it in stages.

A. Sorry, yeah.

Q. I'm not going to forget that point, but we'll come back

to it, but just so that we're clear, so the directive from the CQC, these must be worked on with risk assessment.

Just dealing with the policy, in your tenure, was there any change to the policy on risk assessing in the Trust?

A. Not at that point, no.

Q. Did you implement any changes to the training on risk assessments?

A. Yes.

Q. What changes did you implement?

A. So the Trust had a mandatory training in risk assessment for all staff.

Q. Which was pre-existing?

A. Yes, it was. And also, at that time there was additional face-to-face training available to adult mental health staff.

Q. Was that following the CQC report?

A. That had been in existence prior.

Q. So just so that you're clear, where my questions or what my questions are aimed at --

A. Sorry.

Q. -- no, no need to apologise. There is a report from the CQC identifying that.

A. Yes, yes.

Q. The hospital is not doing risk assessment properly --
A. Right.
Q. -- and as a result there has been a finding of inadequacy.
A. Yes.
Q. And I want to understand what was done --
A. Okay.
Q. -- different to improve the approach.
A. Yes.
Q. We've, I think, established no change to the policy. So in respect of training was there anything new that was done?
A. Yes.
Q. Which was?
A. So additional training was given to all of the staff on the acute wards. I had an action plan in place to deliver the actions in relation to all the CQC requirements. Part of that action plan was about risk assessment and care planning.
Q. Do you recall what the additional training was, how it differed from what --
A. It involved training, retraining all staff. It was local training and it was delivered by practice development nurses, senior nurses, leads, in the units. It was also delivered on what we called the Band 5 to

Band 6 development programme. So an important part of the training was to support newly qualified nurses and those developing.

So also it was included in the preceptorship training, and we dedicated a single, experienced leader to coach each ward directly in improving their standards of practice. You might --

Q. How did it differ to what had been on offer before?
A. Yes, and it was -- you might not see it as training, but actually coaching people, looking at their notes, their records, going into ward rounds with them, looking at incidents, and tying those together in terms of the care plans and risk assessments was actually fundamental to improving the practice, and it is a form of training, in my opinion.
Q. So did you consider that as a result of the training that you've identified, did you consider that there were sufficient assurances that risk assessments were accurate, comprehensive, based on all relevant information from that point going forward?
A. Over time, I collected some audit information, reviewed it monthly, and it covered a number of points from people's care plans based on the Quality Network for Inpatient Services criteria for what is a good care plan and what is a good risk assessment, and it was regularly

audited, I think it was monthly and I reviewed the outcomes of those audits monthly. And we kept that action plan live for several months.
Q. Can we look, please, at document NHNB0012321. This is a document for a Trust Board meeting. It's titled "Learning from Inquests".

Now, in the documents that you've been provided for for the purposes of your evidence today, you'll have seen a number that relate to concerns being raised by the local Coroners?
A. Yes.
Q. The only one that I'm going to go to is this one. I'm not going to go through every document, but if we turn to page 3 and what this report is doing, it's pulling together, isn't it, the concerns across all those other documents?
A. Yes.
Q. At page 3, entry number 2, we can see there an issue identified as to risk assessment, yes:

"... absence of clearly documented risk assessment, not taking into account key risk factors; communication of risk assessment within teams and to other interested persons. [It's been] formally raised as a concern in at least 3 inquests."

Just pausing there, if it's being raised at

inquests, it's being raised in the context of somebody having died?
A. Yes.
Q. So serious cases?
A. Yes.
Q. "... additional inquests that referenced lack of safety ..."

We can see item 5 on that page also raises the issue of discharge.

If we go forward, please, to page 4 of this document under the heading "General Learning" we can see second bullet point: "Risk assessments" and we can see the narrative that follows, and in the bullet point beneath that, more reference to risk assessment on Mental Health Act Assessments.

Now, what's being raised here in this report, in the context of coroners' inquests, it's similar, isn't it, to the concern raised by the CQC three years earlier?
A. Yes.
Q. The shortcomings being identified here, they are similar, aren't they, to the shortcomings that this Inquiry has heard in respect of the risk assessments in VC's case?
A. Yes.
Q. So it would appear that the same issues are arising.

Does that mean that the changes that you described a few moments ago were not effective in changing the Trust's approach to risk assessment?
A. I think that addressing the risk assessments, the patient-centred care, across the whole of the service, was a challenge. And I place that in the context of the service models we had, the staffing that we had, and also the challenges we had over that period in terms of Covid. That's not framed as an excuse, but it's a significant part of the context over that period.
Q. Just on Covid, if there's an issue whereby staff at your Trust are not carrying out risk assessments properly, okay, so not taking into account all the information that they should, not formulating risks appropriately, why is Covid responsible for --
A. Covid's -- no --
Q. -- improper risk assessments or incomplete risk assessments?
A. Covid isn't responsible, but it did have a significant effect on our staffing and it had a significant effect in terms of our senior clinical leaders having to work clinically and having to work to deliver care. Whereas they would have otherwise been auditing, reviewing, providing continuous education and training to staff. And it was very evident for a significant period that

our senior clinicians were required to deliver direct care.
Q. So is your point that because of Covid, in fact although you mentioned earlier in your evidence some differences in training post-the CQC Report, actually, the Trust wasn't able to deliver that training because senior clinicians were too busy as a consequence of Covid?
A. Yeah, they were -- I mean, there were derogations in terms of training and we couldn't deliver face-to-face training at that time.
Q. Right. So just going back, then, to what was done as a consequence of the 2019 CQC Report and what it said about steps must be taken to deal with risk assessment, is the position that there was a notion to do training but because of Covid it couldn't be delivered?
A. No, training was delivered in teams by senior leaders. It was disrupted by Covid. Because senior leaders were delivering care as well as supervising staff.
Q. Following the concerns raised by the Coroners and particularly in circumstances where those are concerns that arise in investigations following deaths, the last document we looked at was a meeting in March 2022, what did you do to remedy the problems that the Trust was having with risk assessment at that stage?
A. So, for an example, I will talk about the work with the

Crisis Team, because the Crisis Team were cited in some of these examples, and we took the Crisis Teams through clinical risk training with our Suicide Prevention Lead. We took them through structured clinical management training. We also provided them with an opportunity around organisational development and their effectiveness and working as a team, and we took them through the process of reviewing the service in terms of core fidelity, which is the way that the Crisis Team works so that they can review their practice.

The Crisis Team also reviewed their Standard Operating Procedure during that period, they reviewed it twice. They reviewed how they communicated with the other teams in the Trust, the ones that they worked jointly with, and they put in new procedures and new ways of working between them, joint and agreed meetings.
Q. So a lot of work with the Crisis Team?
A. Yes. I mean, that's an example.
Q. Can we look at another document, NHFT0003346. This is another report for a meeting. I may have given the wrong reference -- oh sorry, it's page 82 of this document.

This is a report from a meeting in December 2022, Quality and Mental Health Legislation Committee. So this was right at the end of your tenure.

A. After I'd left, yes.
Q. Just after you left?
A. Yes.
Q. So we looked at a document just before you started the CQC report, now we look at one just after you ended it. The other bookmark, as it were.

If we go to page 85, please, this is a document which sets out issues with incidents across the Trust. At the bottom of the page it's dealing with serious incidents in 2021 to 2022, and the final black bullet point it notes, doesn't it, an increase in reports relating to self-harm and violence and aggression?
A. Yes.
Q. Then if we go to page 90, please, towards the bottom of the page-item 5:

"Themes arising out of serious incidents ...21-22."

And this report is summarising, isn't it, the themes that emerge from the investigations that have been carried out, and it describes "several strong key themes"; do you see that in the penultimate line?
A. Yes.
Q. Then over the page if we look at what those strong themes are, we see item number 3:

"Risk assessments including absence of clearly documented risk assessment; not considering key

risk factors; communication of risk assessment within teams and to other interested persons."

So this is really identical to the point from the Coroners and the same issue raised by --

A. Yes.

Q. -- the CQC in 2019.

So do you accept that, looking, as it were, at the two bookends, the CQC Report and what it had to say about risk, this analysis of your Trust's own investigations and what it has to say about risk, one coming just before your tenure, the other just after with the entries from the Coroner in the middle. Do you accept that there was a failure properly to address the deficiencies in risk assessment at your Trust?

A. I don't think the standards had sufficiently improved to the extent that we would have wanted. However, I don't feel it's a reflection of inaction and attempts to improve matters. There were some underlying systemic issues, I feel, that were influencing the situation.

Clearly, the availability of staffing --

Q. To carry out training. Is this a point --

A. Just -- no, staffing, to staff services, and not reliance on temporary staffing. Those sorts of issues are extremely significant in terms of delivering service. I think very influential over that period was

the fact that we'd become at quite a distance from carers and families and patient feedback and patient experience, and I think that there was a time in 2022 where we had to do a lot more work around families and carers and patients being at the centre. And it was re-engaging with a lot of previous activity that we had undertaken in the organisation, getting those activities on board as well.

And there were a considerable amount of investments as well made in senior staffing over that period, because actually the clinical leadership was very significant and needed to improve.

Q. Just focusing on risk assessment, which is what my question was about, and I think at the start of your answer you said it wasn't sufficiently improved. It looks -- looking at what's said on this document and comparing it to what was said in the CQC Report, it looks like it's identifying precisely the same deficiencies; do you agree?

A. Yes.

Q. Not only that, I took you to the start of this report, and what it is reporting is an increase in incidents in the previous year, isn't it?

A. Yes.

Q. Do you accept that there is a link between deficiently

assessing risk and an increase in incidents?

A. There may be, yes.

Q. I've already referred to the evidence heard at this Inquiry as to the risk assessments relating to VC, and you have heard that evidence?

A. Yes.

Q. Do you accept that that evidence shows repeated failures properly to formulate risk and to assess risk in respect of VC?

A. Yes, I do.

Q. In respect of those failures, do you consider that they reflect failures by the individuals concerned, systemic failures, or a mixture of the two?

A. I'd have to say a mixture of the two.

Q. Your statement, it's page 28 of your statement, paragraph 116. Whilst that's coming up, it's a question which follows up from something we were looking at just in the previous document where it talks about an increase in self-harm but also violence and aggression. Yes, so we're looking for page 28 and then on page 28 we'll find paragraph 116.

In that paragraph, you set out some of the work that was done and, in particular, there's reference to the Zero Suicide Lead, and that was to tackle the issues of self-harm and presumably the increase in self-harm in

the Trust?

A. Yes, that's right.

Q. Was there any equivalent in respect of the increase of acts of violence, aggression, or the risk of harm to others?

A. There was -- in the Trust, there was a reducing restrictive practice lead and there were violence and aggression leads in the organisation and as part of our CQC plan, they did come and work in the acute mental health services.

Q. When did they commence their work?

A. That work, to the best of my recollection, would have started around 2020, possibly 2021.

Q. Can we look, it may be related to that, please, at document WITN0354059 and if we go to page 5 of that document, these are minutes from a meeting in November 2021. Page 5, yes, item 5. There are minutes concerning a discussion about community practice for violence and violence and aggression.

A. Yes.

Q. I wonder if you can help us with some of this. So at paragraph 5.7, there's reference there to the:

"... [Acute Mental Health] model of management of violence and aggression being a great model. ... Focus is on reviewing and learning. Forensic wards have MVA

trainers who are ward based."

So what's this discussion about which is being documented here? Perhaps if we can scroll down so we get the rest of the entries on the next page. So down to 5.10. Is the focus here on violence against anybody, or is it mainly just violence within the hospital, so violence to patients, violence to staff?

A. It's the management of the acute presentation of violence, the violence that patients would present whilst they're in inpatient services in the main.

Q. So that's to fellow patients and to staff?

A. Yes.

Q. So this isn't concerned with violence --

A. No.

Q. -- in the community?

A. Not necessarily, no.

Q. So the model being described, that's a model which is to deal with violence on the ward, as it were?

A. It is, but it's also about providing what we would call trauma informed care and ways of talking to patients about their presentation, their behaviours, their impact, and providing them with training about managing their anger, their violence and aggression. So it's not just about a responsive reaction; it is about working with patients as well.

Q. You've described the circumstances of your appointment, the context of your appointment being in respect of those concerns as to quality and safety. We've looked at the 2019 CQC Report that set out the position as it was just before you took up the role.

If we can look at the CQC Report which again reflects the position towards the end of your role, CQCM0016478. Just before we consider those ratings, do you accept that it's fair to say that the success of your tenure can be judged by the extent to which there were improvements in the ratings for the Trust?

A. Yes, as part of the Board, absolutely. Yes.

Q. And if we look at those, overall rating "Requires improvement", no change.

A. That's correct.

Q. Of the five domains rated, there's actually now four which are "Requires improvement" rather than three.

A. Yes.

Q. Effectiveness of services has worsened from "Good" to "Requires improvement".

A. Yes.

Q. That's the change, isn't it. But services, "Are services caring?" that has improved from "Good" to "Outstanding".

A. Yes.

Q. So at best, it depends how you interpret it, but not much change over the course of your tenure?

A. No, and I would say and point the Inquiry to the inspection of Acute Inpatient Services that I think was conducted in March of that year, and the ratings for the acute wards did actually improve but that didn't contribute to the ratings in this report.

Q. Well, the acute ward went from "Inadequate" to "Requires improvement" --

A. Yes.

Q. -- by 2020, didn't it?

A. Yeah, and it did improve in every domain, yes.

Q. But do you accept, because this is a full inspection, the other one, the 2019 one, was a full inspection, and I appreciate there was a focused inspection as well, and sets of inspections, but in respect of the full inspection it would appear, wouldn't it, that, because similar themes are identified in this report, as with the 2019 report?

A. That's correct, although there was a focused inspection of the acute mental health services in 2022, which had an "Improved" rating, not overall, but in all of the domains.

So in addition to the 2020 inspection that wasn't re-rated, there was a further inspection. It doesn't

contribute to this report.

Q. No, but the Trust, as we've established, 2019 the Trust has inspected, "Requires improvement", and 2022, inspected, "Requires improvement", and it's now four domains rather than three, in which it requires improvement. This appears, do you accept, to be a Trust that's not learning the lessons that the CQC is requiring it to? Given it's not moving forward, is it?

A. No. Not sufficiently, no.

Q. Well, not at all, unless it's -- "services caring" have gone up but "services effective" have gone down.

A. Yes.

Q. In your statement you deal with some of the factors to explain it. It's your paragraph 87, it's page 21. Sorry, page 21, paragraph 87. Yes:

"[You] suggest there are any factors that contributed to the Trust being rated as requiring improvement ..."

I just want you to elaborate, please, on some of these. You say the first bullet point:

"The service, clinical, financial, governance, information and cultural implications of the autonomy held by services that contributed to the position in 2019."

What did you mean by that sentence?

A. I think there were many factors that influenced the effectiveness of the organisation during that period and I think that they are a description of several. The service models in 2019 were not always sufficient, in terms of staffing.
Q. So it's describing the position in 2019?
A. Or specification, yes. And they are not rectified immediately. And there has to be a journey to improve that.
Q. Then the second bullet point, that's quite a long sentence, but is that effectively saying the change in leadership didn't bring about change and Covid made things more difficult?
A. Yes.
Q. Then over the page, the third and fourth bullet points, they appear to be identifying what you think needed to be done or should have been done, but it doesn't explain why it wasn't done. Similarly, at paragraph 88, you say, or you refer to changes, the pace not being sufficiently swift?

I mean, weren't you responsible for bringing about the changes in the first two paragraphs and ensuring that they were swift or "sufficiently swift", as described in paragraph 88?
A. Yes, and there is a collective responsibility for the

whole organisation to move forward on a whole host of issues that make services operate in an effective way, provides governance and leadership across the organisation.
Q. As to paragraph 88, when did you first appreciate that the pace of change was too sluggish?
A. I think that during Covid, a number of things that we would have done naturally in the organisation to reshape things like information provision, governance change, structural change, we couldn't do them all during that period. And I think that that was reflected in the reporting and in the Board Assurance Framework where we hadn't been able to move forward in the way that we wanted to.
Q. Your statement describes a lot of issues as they were considered at board level or at executive level. But as we established at the beginning of your evidence, part of your role was operational, was management. Are you able to help us with what you were doing day-to-day operationally to tackle some of those really concerning issues at the Trust?
A. Yes, so having taken up the role, I developed the Operating Framework, the structure, the performance reporting, the oversight of the workforce, the data, the information, and the leadership structures, and the

service models, reviewing those. Working with commissioners. Working with external stakeholders and reviewing the service in terms of the long-term plan. That was the journey that we started on and the journey did change through 2020 and up to 2022.

The organisation was working very differently and so were services. We were in incident control for over two years and that was a very different way of working within the organisation, an escalation process.
Q. Can I deal, please, with a number of discrete issues that arose over the course of your tenure and most of which are dealt with in your statement.

First, the issue of staffing and we looked at the 2019 report and that was a concern raised as to safety and it was something that the CQC said that there must be action on.

Now, if we go forward in time, it's document WITN0380054, and this is an email in respect of which the Inquiry has already had evidence. It's the email from Mr Brewin, dated 29 October, 2021. You are one of the recipients, you're the first named recipient.

This is where Mr Brewin reflects on discussions he'd had with ward managers at Highbury Hospital which he describes as "sobering" and "harrowing" and the Trust having reached a point where services are not safe,

reflects a sense of despondency with the staff, because despite flagging this since at least June nothing has happened and he makes the point that if the CQC arrived, the hospital would be threatened with closure.

Now were you shocked when you received this email or did you already have these concerns?
A. These concerns were not new to me. And I don't believe that they were new to the Executive Team at that point. Maybe flagged and described in that way, I think was a difference. And I give some context to that, if I may. We'd had two staffing reviews conducted in Adult Mental Health between one in 2019 and one in 2022, both highlighted the need for significant increases.

Subsequent to that, there was an extreme need to fill all of the vacancies that those staffing reviews indicated. And we struggled in 2021 to actually get the workforce to achieve those staffing establishments. So we had become reliant on a lot of temporary staffing.
Q. So agency staff and bank staff?
A. Yes.
Q. Just on that point, and we have heard evidence about the difficulties that the hospital was having with staffing over this period, what did you attribute the difficulty with securing sufficient and appropriate numbers of staff to?

A. So there just is not the supply of healthcare professionals, registered nurses, psychologists, CBT therapists and psychiatrists. And actually, even at that point, in 2021, we were struggling to recruit healthcare assistants and admin staff in -- *(overspeaking)* --

Q. So not a resource, not an issue with finance --

A. No, no, it certainly wasn't an issue with finance at all; it was about the available workforce.

Also, in Nottinghamshire, there's a huge amount of choice in where people can work. We'd developed new roles, expanded our community services, so people had a lot of choice in terms of where to work. There were a lot more options. And actually, working in acute inpatient care is so rewarding but it's so challenging.

Q. So market forces, essentially?

A. Yes.

Q. Not enough potential employees and those that are available, there were other, more attractive options?

A. Yes, and a large range of specialist services in the geography creates an additional demand.

Q. Yes, so going back to the email, it's just fallen off the screen momentarily, it's WITN0380054. You said the views here were not new to you. Mr Brewin in his second paragraph says:

"I know that some of you have also had conversations in recent weeks along similar lines."

So were you having conversations with your staff that was leading you to conclude that, upon a CQC inspection, the hospital would be liable to being closed?

A. I'm not sure that I would have described it to that extent. I will say that I brought concerns to the Executive Team in the summer describing the vacancies, and the impact of the use of temporary staffing, both of which had been described in a lot of detail actually at the Adult Mental Health Improvement Board with the full Executive Team. So the level of surprise was probably, I was surprised about if it was a surprise to my colleagues, actually.

And yes, I had been discussing it with staff, very regularly, and personally, chasing down, for example our recruitment pipeline, trying to get people in post quicker from the time they're interviewed to their start date. I had personally been involved in discussions about the staff bank, increasing the staff bank, and about the use of agency staff. And I did know all of the detail about the vacancies and the use of agency staff, and the agency staff use was discussed monthly at the Executive Team.

Q. Yes. So just picking up on that and the implications of using agency and bank staff, and you've explained the reason why you've had to do that: because there were shortages and difficulties hiring staff.

But then, when you're relying on agency and bank staff, are there difficulties or challenges in ensuring that they're working to the same standards as your permanent employees and that they're coming in with a sufficient level of adequate training?

A. Yes. So what we chose to do, in -- at the beginning of Covid, was to -- it was not an easy decision but we chose to recruit some agency staff on what we call regular lines of work, so they work on a very regular basis for us, in the same place. They become part of the team, to an extent, and we can train them, and they can be familiar with our procedures and our patients, yes.

Q. The Inquiry has heard evidence suggesting that at least some agency staff weren't able independently to access RiO records, they had to rely on a colleague to log on, and that sounds sub-optimal. What's your understanding of the systems that were in place for agency staff and their ability to use RiO?

A. I'm surprised that somebody working regularly can't access RiO, if they couldn't, because regular agency

staff did have full access to RiO. It was available and there was a process to do that.

I think the challenge was when they were potentially different staff were given working at short notice, and they wouldn't have had access straight away.

There was a process in place called the Break Glass Procedure where staff could, through a variety of procedures, gain access, but it was not easy, I would reflect.

Q. Then dealing with some of the other steps that were taken, given the staffing concerns, these are addressed in your statement, page 50, paragraph 200. I'll come on to the use of subcontracted beds, but one of the points you make in your statement, it's where you set out a number of bullet points as to the implications of reduced staff, is that you sought to reduce inpatient occupancy to 85% using staffing acuity tools, and an overall risk assessment.

Just to explain what you mean by that, staffing acuity tools, was that looking at the staff that you had available and determining that well: well, actually we can only cope with 85% capacity on a ward?

A. We had a process in place called Safe Care which gives a level of workload or dependency for each patient, and using that, it would describe the level of staffing that

you would require. That level of pressure can actually change on a day-by-day, week-by-week basis, and very much at that point I think we thought that we needed to listen to the staff, who were at that time I think incredibly over-tired, and finding things really difficult, and I think the level of acuity on the inpatient wards in terms of the patients was really challenging. And I think we sought to try and give some temporary respite, yes.

Q. So that was as a consequence of staffing that fewer patients were --

A. Yeah, and it's not --

Q. -- able to be cared for.

A. Yeah, it's not just about staffing; it's about your patients and it's about your environment.

Q. So that's the reference to acuity.

A. Yes.

Q. But in any event, where you have -- or where you're setting out to reduce occupancy to 85%, that is going to put a pressure on the doctors, clinicians, nurses, team, a pressure to discharge patients, isn't it?

A. No, no. I think what we sought to do was temporarily increase our use of some subcontract beds to alleviate that likelihood at that time.

Q. Reflecting on the issue of beds more generally, so on

the one hand there's the issue obviously with hiring staff, but the Inquiry has heard evidence, particularly from Dr Gibson, about -- and in fact Mr Brewin gave evidence on this -- inpatient beds have been reducing with time, and Dr Gibson reflected that there were much fewer beds to deal with a much larger and sicker population, multiple patients in the community at any one time was dangerous, was his evidence, and that need to come in hospital but there aren't beds for them to be in, and a constant pressure to discharge patients back into the community.

Now, quite apart from the staffing pressures that we just touched upon, were you aware of that pressure on clinicians to discharge people because of insufficient numbers of beds?

A. I've reflected on this a lot over recent months. My perspective is that -- I mean, John Brewin himself was very clear about people who needed a bed should have a bed. And our use of the subcontracts in normal circumstances was always to provide good access, and actually up until probably 2021 we managed that, I think, very well.

Q. Just on the subcontract point, sorry to interrupt, but the reason that you're having to subcontract and the reason why you're having to use out-of-area placements

is because you don't have enough beds --

A. Yes.

Q. -- to look after those patients?

A. Yes. This is -- the dilemma for us here is we are listening to staff concerns, we are wanting to support them, and in their clinical judgement and in the clinical judgement of senior leaders, we had to alleviate that pressure and that risk.

So yes, we did choose at that point to increase the number of subcontract beds. It is -- it's a balance, and it's a balance for us all of the time, and I think that, in terms of the pressure to discharge, which may arise from making a decision like this, my strategy and the strategy that I encouraged with the Leadership Team, who were managing this day in, day out, was to actually focus on the people who did not need to be in a bed, but were in a bed and they were the people that we wanted to support not to be in an acute mental health bed.

So --

Q. So how frequently was that that you would have these discussions as to whether or not the patient needed to be in the bed?

A. All of the clinical team, all of the Senior Management Team, discussions with the local authority, the CCG, it's a system issue about patients who don't need to be

in beds that are in beds. We --

Q. So there's a lot of attention on this issue on getting people out of beds --

A. Absolutely, absolutely.

Q. -- *(overspeaking)* -- if you can.

A. Absolutely.

Q. Can we just deal with another couple of documents. Subcontracting I'm going to come on to, but just another couple of documents first, NHNB0011607, and this is an email exchange December 2021. So it's shortly after that October '21 email from Mr Brewin.

If we go to page 2, and in fact if we have that email at the bottom so it's page 2 into 3 so if we can scroll to get both or get the entire email on screen. It's an email from you to Lucy Dadge and Maxine Bunn, and you are requiring an urgent call. You say:

"... next Thursday ... too long to wait. We've been on opel 4 consistently now for most days of the last month".

A. Opel 4 is a level of escalation that we use to describe the situation in terms of staffing and bed availability.

Q. So both staffing and bed. And is Opel 4 as high as it goes?

A. Yes.

Q. "... have been escalating for several weeks that we need

assistance to help move patients who no longer need acute inpatient care out of acute beds, it has made no impact to date. I could do with a prompt discussion as we will be imminently declaring no admission capacity ..."

So you're full, you're struggling to discharge patients.

A. Yes, and that's not patients who we are arranging early discharges for; it's people who are ready to leave. That's the help that we wanted. People who need accommodation, people who need complex onward care packages.

Q. Another document, WITN0329033, this is the same month, this is December 2021, and this is a report which was to be presented by you. It's written by somebody else, Andy Latham, as we can see at the top, but it's just the "Executive Summary" there in the middle of the page:

"Both AMH [that's Acute Mental Health] ... and [Mental Health Services for Older People] ... are experiencing unprecedented challenge on their service provision. The areas report consistently at an Opel 3, where the demand for in-patient beds outstrips the areas capacity to deliver."

So as well as the issues with staffing it sounds like there was issues with insufficient beds as well?

A. There were certainly challenges, yes, with staffing and beds.

Q. And we see if we go forward to the following spring, April 2022 the following year, the first document WITN0329016. This is an email from Anthony Horsnall. He's a police sergeant, as we see at the bottom, and he was making a complaint, wasn't he, which ultimately you responded to in relation to a number of his cases. And ultimately what he was complaining about was access to the hospital, access to beds, wasn't it?

A. Yes.

Q. You deal with that, you respond later that month, 27 April, it's document WITN0329041.

A. Yes.

Q. It's a letter which is about to come up. So this is your letter in response, and you describe there, third line down:

"Levels of acuity and demand for in-patient beds has been unprecedented ..."

You refer then to staff absences and in the following paragraph, second sentence:

"Bluntly, the remedy does not rest solely with Nottinghamshire Healthcare Foundation NHS Trust; we have many in-patients waiting for onward health and social care, including forensic care, which we ... continually

escalate to partners."

You describe that is not the issue; you are making use of subcontracts. So it seems, because we're a few months on from what, as it were, appeared to be the crisis period from October into December and similar issues were arising in April, which is an ongoing problem?

A. It's a fluctuating problem and I think when you read our analysis of our bed use between 2016 and 2022, you can see how there is volatility in the need for beds. And in the periods of high demand, managing that was extremely challenging over that period.

It was regularly discussed at the Board, and the OPEL levels of escalation and the delayed transfers of care were very prevalent in the Integrated Performance Report.

Q. You say fluctuating. The evidence that we've heard -- and some of it is set out in the documents that you've been provided with -- is that in the period approaching your appointment to the Executive Directorship in 2019, the Trust was an outlier, wasn't it, for its use of out-of-area placements, it was a very high user of out-of-area placements?

A. Yes, I think we were rated the sixth worst in the country.

Q. That is a capacity problem, isn't it, rather than space?

A. It's capacity, yes.

Q. What do you think the reason for that is? Is that just a lack of beds in the trust, or is that a lack of local facilities that you can subcontract to, or a combination of the two?

A. At the outset, it's a lack of inpatient beds in the Trust, and then it becomes, by default, a need for subcontract beds or out-of-area spot purchase beds, because there isn't --

Q. So you would agree with Dr Gibson's observation about the lack of inpatient beds, the only point you take issue with is his perception that there's constant pressure to discharge?

A. Yeah, I don't take exception to his perception, because I think that's a very real issue, but the point is correct that the Trust was probably about 40 beds short over that period, acute beds.

Q. Now, in order to plug the gap, you've already referred to it, the Trust subcontracting, so it's using public money, NHS funds, to private independent hospitals to look after NHS patients, and one of those was the Priory Hospital Arnold, and we know that VC went there during his third admission.

A. *(The witness nodded)*

Q. In fact, we heard evidence from the Priory of Dr Gurusinghe that effectively they had one ward which was exclusively for your Trust's patients?
A. Yes.
Q. Now, if we look, please, at CQCM0016484 we are again -- this is the inspection report for the Priory Hospital Arnold published in July 2021 following visits, inspections, in June 2021. So July 2021, that's just a couple of months roughly, isn't it, prior to VC's admission there?
A. Yes.
Q. We can see on the front page "Not rated" but so far as the background is concerned, page 5, in the middle of the page, we can see that the latest inspection or follow-up inspection, March 2021, so it's a paragraph that starts "There have been 17 previous inspections ..." and the last two sentences of that paragraph describe the Priory having been placed into special measures following the previous inspection:

"... Safe [being rated] Inadequate ... Well Led [being rated] Inadequate and [the hospital overall] being rated Inadequate ... Conditions imposed included preventing patient admissions."

So that was the position prior to this inspection.
A. Yes.

Q. Then, if you look at the following paragraph, it goes on to describe that the CQC had:

"... received information of concern from anonymous contacts and from a relative and the ambulance service about incidents [plural] that happened on the wards and the management of patient risk."

Now, what's that -- what that is describing is a pretty concerning picture, isn't it?
A. It was a concerning picture, absolutely, and we worked very closely with them during all of that period to review their compliance actions and their progress, and worked very closely with also the CQC, and followed their line in terms of levels of assurance, and any lifting of the restrictions around them taking admissions.
Q. Well, if that's the concerning starting point, then looking at this report, and if we go to page 10, when it deals with the inspection of acute wards for adults of working age, and of course that is what VC would have been on, middle of the page:

"... service did not have a good track record on safety."

Next paragraph:

"The service did not always manage patient safety incidents well. Staff did not always know how to report

them ..."

Then page 12:

"Action we have told the provider to take."

In the middle:

"Our findings from this inspection demonstrate that governance processes did not operate effectively at ward level and performance and risk were not managed well."

So quite apart from the previous report which had found the Priory to be inadequate in all those domains, put them into special measures, restricted their ability to admit patients, this follow-up report doesn't seem to have been comforting or reassuring at all, does it?
A. The view that we had at the time, I believe it was a view held also by the CQC, is they had seen some level of improvement, as had we. We had reviewed their action plans and we had reviewed the evidence of their action. We had a dedicated senior leader managing the throughput of those patients, and we had our matrons and our Associate Directors of Nursing, myself and others, closely reviewing their progress.
Q. Were you of the view -- following this report or indeed the previous report, were you of the view that this was a suitable place to be looking after your most vulnerable patients, so those who had been detained and those who were in need of inpatient care, or was the

position that you didn't have enough beds and so you had to subcontract somewhere and this was the only option?
A. No, I think that had we not felt assured of their progress and the actions that they were taking, then we wouldn't have continued to place patients there. However --
Q. What was -- looking at what's highlighted on the screen, on the screen, or elsewhere in the report would provide any assurance at all?
A. So it was our senior leaders, including myself, attending the unit and reviewing the actions taken in relation to those compliance issues, looking for direct evidence.
Q. If we look, please, document NHNB0006181. These are minutes of a meeting in September 2021, a Contract Executive Board, and on page 2 of this document, the second box entitled "NHT Quality Assurance Group", it seems that there's some discussion here of Priory Arnold, some suggestion that progress was noted, although the entry is quite brief.

What was the purpose of this discussion, this meeting?
A. Sorry, your question?
Q. What was the purpose of this meeting and this discussion?

A. So this was the Contract -- our Contract Executive Board and this would be the CCG having reviewed the quality oversight of a range of services, discussing with us those arrangements and their current view.

Q. If we go, please, to document WITN0329006. This is a note in respect of a meeting in March 2022, Commissioning Committee, and if we go to page 2 there's a much more detailed discussion about the Priory. If we look in the section dealing with "Executive Summary", third bullet point down, Priory Arnold, it describes "evident quality concerns". It refers to a "recent CQC inspection" where they've been rated inadequate.

Well, by this point in time, the Priory had been rated as inadequate for over a year, hadn't it? It had been in special measures for that period of time.

A. Sorry, it was a year, yes.

Q. Because this is now March '22.

A. Yes.

Q. And remember we looked at a report from July '21 --

A. Yes, yes.

Q. -- but that was reflecting on the fact that the Priory had been inadequate since March '21.

So it doesn't appear recent. Then looking at the bottom of this page, it describes a "Quality Oversight Process". And it says, "where there is

underperformance, improvement actions required".

Was it the view of the hospital, this Board, that the Priory had improved by this point?

A. It was a view that they were addressing the concerns, yes, and that they had started to show signs of improvement, yes.

Q. Ultimately, your view appears to have been -- and this is document NHFT0000822 -- this is a meeting from September 2022. If you go to page 5, we can see who the attendees are. You're one of them. If we go to page 7, you have given an update on the Priory at the top, it's the second and third paragraph at the top of the page. And you appear to be concluding here that the Trust should be disinvesting itself out of the Priory.

A. Yes.

Q. And is the position here that in September '22 you've reached the view that the Priory is no longer a safe place for your patients?

A. I want to explain that comment because it was actually in reference to the whole of the subcontracting arrangement, which mainly was with the Priory. My strategic view was that the Trust should work for a strategy to provide an alternative service, either itself or in a sustainable partnership with another provider, or a provider.

Q. Was that because of safety concerns, or was it for other reasons?

A. It's a lot of things. It's about providing the continuity of care for patients. You know, with VC, had his care all of the time been in the Trust, it would be our clinicians. I mean, you can comment about that, but however, they --

Q. You made the point that there are insufficient beds for that -- *(overspeaking)* --

A. Yeah.

Q. -- so you have to rely on subcontracting, I understand that, but are we now looking at a situation where you are subcontracting to a hospital which is being rated as inadequate by the CQC and the CQC have gone again, there doesn't appear to be much improvement. It's in special measures. The question is: do you reach a point where you say, "This not a safe place for our patients and it is not a safe place to be using public funds to send our patients"?

A. That wasn't the point that I was making at that time. It was --

Q. Understood.

A. -- about a longer term strategy.

Q. Understood. We can take that down. In terms of the Priory and their attitude to safety, we've heard

evidence that VC, whilst admitted there, he returned from a Section 17 leave to the Priory with a hammer, and it appears that the staff at the Priory accepted an explanation that he had it with a view to home decoration, but that was at a point when obviously he was detained and he didn't have accommodation, didn't have any accommodation secured.

Now, whilst the hammer was taken off him it would have been returnable to him on discharge.

Is that something that you consider ought to have given rise to an incident investigation?

A. Yes.

Q. And Mr Waldron, Dave Waldron, a Trust employee, he's the Trust's Bed Manager, he attended a meeting with the Priory, a weekly bed management meeting and we can see that at WITN0389018. Now, Mr Waldron has given evidence on this so I don't need to go through it in detail, but the short point is this: if you go to page -- when it comes up, we'll look at page 6 of the document. Yes, thank you.

We can see an entry there, it's at the top of the page, this is in respect of VC. The final two lines:

"Had a huge hammer with him when first brought to hospital - we are trying to figure out why he felt like that was needed."

Now, in circumstances where one of your employees has gone along and received this information, would you (a), would you expect him to be putting that into the RiO notes?
A. Yes.
Q. Would you expect him to be raising with the Priory what incident investigation they're carrying out into that?
A. I would have expected him to have reported the incident and then the senior manager who was leading on the contract to take that forward, yes.
Q. It would be especially concerning, wouldn't it, where a patient with VC's history and risk profile is turning up with a hammer, and turning up at a hospital that is so poorly rated for safety by the CQC?
A. *(The witness nodded)*
Q. Something that you would want -- you as a Trust would want to ensure was properly dealt with?
A. Yes.
Q. We can take that down. So far as subcontracting, of course, Priory Arnold was a local hospital, it was in the Nottingham area, wasn't it?
You've touched upon the fact that the Trust was one of the worst, I think you described it, as users of out-of-area placements.
Mr Brewin gave evidence that out-of-area placements

are fundamentally detrimental because you're taking the patient away from their community, their family, and local social networks. It delays recovery and reintegration into society. Do you agree with those observations?
A. Yes, yes.
Q. It was the aim, wasn't it, when you came into post, one of the aims of the Trust was to reduce the use of out-of-area placements?
A. Yes.
Q. Is it a fair summary that whilst there was some initial improvement because of the pressures that we've looked at and the issues with staffing, the Trust wasn't able to eradicate the use of out-of-area placements in the way it would have liked?
A. That's true, yes.
Q. If we can turn to look specifically at the EIP service, document NHNB0004596, and what's about to come up is the -- a note on the also NHS Long Term Plan. This is from February 2020.
This is within your tenure. It's considering the long-term plan and how it would apply in Nottingham.
At page 4 of this document, the section, roughly in the middle of the page, on EIP, it identifies a requirement to commission NICE concordant levels of

care because services in Nottingham at that stage didn't meet required NICE standards. Were you on notice of that fact?
A. Yes, I was.
Q. Then, at page 13, under the heading "Early Intervention in Psychosis" it refers to:
"... a 'stand-alone' Early intervention in Psychosis team [being] implemented."
The Inquiry has heard evidence on that, that's the uncoupling, isn't it, that we've received evidence?
A. That's part of it, yes.
Q. What's the other part?
A. The other part is in the region of a need to increase the staffing in EIP, in around 30 whole-time equivalents, over that --
Q. Yes, is that part of it becoming a standalone or that's just another --
A. No, that's an additional need of investment of 30 --
Q. Yes, and that follows in the next paragraph, doesn't it; is that what you're describing?
A. It doesn't actually say that, but yes, part of it.
Q. Now, in terms of what actually happened so far as performance, we can see that in the results of the audit. This is a National Clinical Audit of Psychosis by the Royal College of Psychiatry. It's document

RCPS0000011.
This is from 2018, 2019. I went through these documents with Dr Brewin. And we can suggest -- just looking at this 2018, 2019, we can see, in respect of "Timely access", although it is below the national average, it's the strongest that the EIP teams are performing, isn't it?
A. Yes.
Q. But we can see a number of domains in which the EIP teams are extremely poor, so all those red boxes on screen?
A. Yes.
Q. And particularly "Cognitive behavioural therapy for psychosis"?
A. Yes.
Q. And if we scroll through this, we can see 2019, 2020, just scrolling down. And again, whilst timely access at the top is below national average but it's closer to it, again, poorly performing in many of the domains -- well in nearly all of the domains that are being tracked by the Royal College.
A. Yes.
Q. And we don't see improvement, really, do we, until -- or significant improvement until 2022/2023, so that's page 11. We see bits of improvement, 2021/2022, at

page 9, and then at page 11, 2022/2023. And page 13, 2023/2024, we see that most boxes are either blue or green.

Now just dealing with one point first and it arises from your statement, it's paragraph 44 and page 10 of your statement. And here, you described the key performance metrics that were in performance reports for the Trust's public Board.

A. Yes.

Q. Yes, and you set out a number of key performance metrics that were reported on. And looking at this we can see the only one that is specific to EIP is engagement within two weeks.

A. Yes.

Q. Do you see that?

A. Yes.

Q. That's the one domain, isn't it, where the EIP always performed well?

A. Yes.

Q. But all those other metrics where it performed poorly, they were not in the performance report for the Board.

A. They weren't in the performance report, no. They were reported through the audit reports, actually, at the Quality Committee, in terms of NCAP performance.

Q. Do you think one of the reasons that the EIP was able to

perform well in timely access was because that was one of the domains that was going to be in performance reports going to the Board?

A. No.

Q. Or do you think that's just coincidence?

A. No, I -- there was a differentiation in terms of reporting which was that the NCAP performance was seen as an audit as opposed to performance, a clinical audit as opposed to performance, and that's why it went to the Quality Committee not in the Board IPR.

Q. Now, despite issues being identified with the EIP team from February 2020, as we've seen, when it was noted that the team was not compliant with NICE, certainly on those NCAP results, improvements at the EIP were not seen for a long time. What did you do to bring about improvements in the EIP team during your tenure?

A. So in 2019 I had an immediate discussion with our commissioners about the capacity of the service and the service model. There was an EIP steering group that was chaired by the CCG, the Clinical Commissioning Group. It had been a longstanding group and I escalated the needs for greater investment in 2019.

Q. Escalated to who?

A. To the CCG and in discussion particularly with the Executive Leadership Team. And it's also referenced in

the strategy reports that the Board saw, either at the Board or the Strategy Committee.

Q. So were you aware, because the Inquiry has heard evidence of a number of issues in the EIP team. One of those, and it's already reflected in that February '22 report, lack of funding for a CBTp therapist. So we've heard evidence that there would be waits of over a year to access therapy for EIP patients and Emma Robinson gave evidence that this had been raised with managers, that she was unable to access other psychologists available to local mental health teams.

Were you aware of all those problems with accessing therapy?

A. So in terms of CBTp, CBT therapy for psychosis, in 2019 we had 1.2 CBT therapists and we needed six.

Q. For what, for EIP or across the Trust?

A. Just for EIP. And in the East Midlands there's nowhere to train staff in CBTp. So in 2019, immediately we sent four staff into CBTp training in Hull. So that was the first step to increase the CBTp capacity.

Q. And when did they come on? When did they come on board?

A. They started their training in September 2019. It's two-year training, and they can use their supervised activity in the second year of their training to contribute to NCAP compliant activity.

Q. So in short, aware of the issue; part of the means of addressing the issue was to arrange for some training, which would help obviously in the future. But in the interim, whilst those people were undergoing training, was there or could there be anything to be done or was it --

A. Yes, so we also continued to try and recruit, this very challenging, and we did secure one further CBTp therapist.

Q. So then you had two out of the desired six?

A. Well, two and the trainees, three trainees. My recollection is that in 2022 we had one CBTp therapy vacancy.

Q. We've heard evidence that the care coordinators had excessive caseloads, we've heard evidence that that again was something that was escalated by Emma Robinson. Were you aware that the CCOs were carrying too many cases?

A. In March 2022, I asked for a small, brief internal review of caseloads. The caseload, average caseload, at that time in the report that I had said that the average caseload was 17, which was the same, actually, as the national average reported in that year.

Q. Is that a no, you weren't aware of excessive caseloads?

A. No. Can I add or -- okay.

Q. Lack of administrative support in the South Team in particular, and we've heard evidence that there was a difference because the North Team did have admin support that enabled MDTs to be noted, but the South Team -- and that's the team that VC was treated by -- they didn't have admin support. MDTs were not being minuted. And, again, we heard evidence that this was escalated by both the nursing and consulting staff?

When they referred to escalating, is it you they would be escalating matters to?

A. No, they would be escalating it through the management structure in Adult Mental Health.

Q. Thank you. Were you aware of the lack of administrative support, and that MDT meetings were not being -- inconsistently not being -- minuted in a part of Nottingham?

A. No.

Q. We heard evidence, notably from Abigail Parsonage, reflecting on the care that was provided to VC that in the course of him being their patient he became what she described as an Assertive Outreach patient, which they were ill-equipped to deal with and to manage.

Now, in your statement, it's page 38, your paragraph 153, you refer to Assertive Outreach contract negotiations in 2019 to 2020. What are you talking

about there?

A. So that would be in relation to the entirety of the Local Mental Health Team capacity, which did deliver a level of Assertive Outreach.

Q. So what Assertive Outreach contract negotiations were you having?

A. As this describes, the Assertive Outreach Model, not a standalone service, was integrated into the Local Mental Health Teams, and it would be --

Q. That was pursuant to contracts?

A. Sorry?

Q. Is that the point you're making?

A. Yes.

Q. That was part of the contracting with the ICB?

A. Yes.

Q. And the model, as you describe, it is not a standalone team, but --

A. Integrated.

Q. Well, integrating principles, but something is lost, isn't there. There's a mental health team, so let's say the EIP team, for example, who are already busy. We've heard evidence, actually the CCOs were managing caseloads above recommended levels. They're obviously dealing with potentially really challenging patients. They're not set up, are they, to focus exclusively on

Assertive Outreach?

A. No, they can --

Q. So something is lost compared to having an Assertive Outreach team, to having assertive principles kind of bolted onto another team that already has a full plate?

A. Assertive principles are a part of EIP. It isn't the same as delivering an Assertive Outreach Model.

Q. What steps had you taken to assure yourself that the EIP team were properly undertaking treatment in accordance with Assertive Outreach principles? As I say, we've heard evidence from Ms Parsonage that they felt ill-equipped to deal with an Assertive Outreach patient?

A. Sorry, would you repeat?

Q. What steps did you take to assure yourself that the EIP team were implementing Assertive Outreach principles?

A. They had, as part of their Standard Operating Procedure, their SOP, a description of the delivery of what Assertive Outreach in the context of EIP means. It isn't the same as delivering a full Assertive Outreach approach.

Q. No, I understand that, and I understand there's reference to assertiveness in the operating procedure for EIP. My question is: what steps did you take or did the Board take to see that the EIP team were actually able to implement those principles, if any?

A. In terms of the delivery of the overall approach, I received very frequent, if not weekly, updates about the delivery of the NCAP model, which would include some of the principles around the care delivery.

If there were issues in terms of capacity, that would be escalated to the Daily Demand Group in Adult Mental Health.

Q. So your understanding was -- and you were proceeding on the basis -- that the EIP team were implementing Assertive Outreach principles?

A. What I saw, on a monthly basis, was an Adult Mental Health performance report which described NCAP performance, and within that there were acception reports which described any service pressures and any actions taken in relation to service pressures.

Q. Sorry, what's the answer? Isn't the answer to my question "yes", or were you --

A. I would take assurance from those reports.

Q. So you were proceeding on the basis your understanding was that the EIP team were implementing Assertive Outreach principles?

A. My assurance is about there were no exceptions reported and no risks reported through those processes, and it wasn't also raised in the risk registers and it wasn't raised in the monthly reports I would also receive about

the development of EIP which had a risk section as well.
Q. I've one final topic to deal with and I'm going to deal with it succinctly. It's to deal with -- to do with investigations and you touch upon this in your statement, so incident investigations. And you've referenced the policy and you describe the Serious Incident Review. We've seen that as early as 2019, the CQC were raising issues as to the Trust's incident reporting.
So far as the incident following VC's first Mental Health Act Assessment when a neighbour jumped from a window injuring herself, which necessitated spinal surgery, do you consider that that should have resulted in an incident report?
A. Yes, it should.
Q. And then finally this, it's document NHFT0000518. This is the "Thematic review of homicides ..." by Jonathan Warren. It's August 2024 so it post-dates the time at which you'd already left the Trust, but if we look at page 3 of this document, it considers a number of homicides and attempt homicides in the middle, and we can see that in respect of all of them apart from the one where the full data is 13 June 2023, that's VC, all the others either occurred during your tenure or were signed off during your tenure.

The question is this: what this thematic review describes is reports of poor quality and it says "Two and possibly" -- in the paragraph just under the table:
"Two and possibly three of the reports were of such poor quality the panel felt they should be reconsidered in their entirely [...] Two of the reports contained so many typographical errors it is hard to understand how it managed to pass through any internal or external processes. [...]
"None of the reports showed engagement with families ..."
What this thematic review is detailing is wholly inadequate investigations into the most serious cases; do you agree?
A. Yes.
Q. And do you have any explanation at all as to how it is during your tenure that such poor investigations were signed off and weren't corrected until this thematic review?
A. The only explanation that I feel I can provide relates to the derogations put in place in terms of the sign-off of investigations during Covid. I can't explain it beyond that, I'm sorry.
Q. When we see sign-off, just in the box again, we can see that a number of them have sign-off by Executive

Director. Were any of these signed off by you?
A. I've only seen this report today, and heard reference to it recently. My understanding is that I'd signed off one of the investigations that didn't require to be reviewed. I'm sorry, I've no knowledge beyond that.
MR CARR: Yes, thank you very much indeed.
Chair, those are my questions.
THE CHAIR: Right. Well, we'll take a ten-minute break and then we'll have some further questions if anybody has any. Thank you.
(4.03 pm)
(A short break)
(4.15 pm)
THE CHAIR: Yes, Ms Patrick.
Questioned by MS PATRICK
MS PATRICK: Good afternoon, Ms Attfield. My name is Angela Patrick and I ask questions on behalf of the families who were bereaved on 13 June 2023.
I want to ask you about three things if I have time. The first is about the EIP, the second I want to look again at the Priory, a little, and then finally I'd like to return to risk and the approach to risk.
So you might have heard this morning I asked Dr Elcock who was responsible for ensuring the discharge policy and other policies were embedded in the practice

at the EIP. She said that there was a shared responsibility at board level, at executive level, and at the Board, but that the responsibility for operationalising falls within the Directorate.
Did the EIP fall within your Directorate?
A. Yes, it did, yes.
Q. Thank you.
Now, Mr Carr has taken you to a February 2020 review document of the EIP. I don't want to go back to the document but I want to pick up something you said in response. You said that at the point of it becoming standalone, there was a known need to increase the staffing in the EIP in around 30 whole-time equivalents, and you explained that was an additional need to invest.
Now can you recall, were all 30 of those planned appointments made?
A. Yes. So initially in 2019 we received funding, I think it was for in the region of ten staff, and they were --
Q. Can I interrupt you briefly there, I don't think we need the whole history but --
A. No, sorry.
Q. -- are you satisfied that all 30 were recruited?
A. At the point when the service was uncoupled we were a maximum of three care coordinators short of the full amount. That would have still allowed for a good rate

of caseload.
Q. I don't think that's the same response. You're saying at the point you were three care coordinators short of the full amount when you went over. You said in your response to Mr Carr there were 30 recruitments to -- full-time recruitments that needed to happen. Do you know if the 30 full-time recruitments that were planned in 2020 were actioned?
A. Yes, I do. And at the point of uncoupling there was a normal vacancy rate. That's all.
Q. So the 30 recruitments that were required in 2020, do you know when that full complement of recruitment was achieved?
A. By individual staff group, I can't say absolutely, but I'm fully -- I'm as certain as I can be in 2022, with the exception of a small number of vacancies, possibly in care coordinators, and there was one CBT therapy vacancy.
Q. Okay. I'm sure somebody might be able to assist us with that.
A. Yes.
Q. Now, you've been asked about concerns being escalated up from the EIP and you've said there weren't particular concerns -- and I'm paraphrasing -- that you saw in the business information that was being escalated up, you

didn't see anything in meeting reports or incident reports coming from the EIP suggesting there was a problem with staffing or work pressure?
A. So what I had in place was a monthly performance report. In the monthly performance report it described any pressures. So in the summer of 2022 there were some staffing pressures due to, I think, sickness in one of the North teams, and the report said that there was ringfenced support being given to them and there was recruitment taking place and new staff starting.
Q. Okay. Can you recall that one of the concerns that was expressed by the CQC in 2019 and thereafter may have been, in their reports in that period, 2019-2022, could have been about staff and the inability of staff to feel confident in their ability to report problems?
A. Yes --
Q. -- *(overspeaking)* --
A. -- I mean, that's a key feature of some of the issues that we had in the organisation which I think has been well described.
Q. Yes. Can we look at one part of your witness statement while we're still on this topic. It's WITN0329001, and I'd like to look at page 9, paragraph 39. Can you see that there, Ms Attfield? I don't want to go ahead of it coming up for you.

It says:
"In the same respect, consistency of reporting and processes became more developed ..."
If you skip down to the next sentence:
"At the time of my leaving ..."
And I think you leave at the end of 2022; is that December 2022?
A. Yes.
Q. Yes. So by December 2022:
"... a much needed audit management system was due to be implemented to improve the oversight of audit outcomes and implementation of lessons learnt from incidents. There was more to be done to achieve greater consistency, through centralising policy and procedural development, audit and best practice, ... standardisation and coordinated quality improvement, and greater use of business intelligence reporting."
So on your evidence, acting whatever had been done to respond to the concerns in 2019 and 2022, what you were learning about the business, whether through audits or from lessons learnt, still needed to be improved, didn't it?
A. Yes, it did and I think that we were on a journey as an organisation. A lot of work had been done on quality reporting, safe staffing reporting, incident

surveillance reporting. But there was always more to do, and to be granular about whether changes had been made in practice. There was more to do.
Q. Okay. If we move to the Priory, now we've heard in evidence from your colleagues and others that there was a decision by the CQC sought before VC was placed at the Priory. However, you've already addressed today the assurance steps being taken by the Trust in continuing to contract at all. Do you accept that the Trust retained responsibility for the decision to continue to seek to place patients at the Priory while they were rated inadequate?
A. Yes, it was a Trust responsibility.
Q. Thank you. Now, when the Trust decided to continue sending patients in 2021 after the inadequate rating, did anyone in your team or in the Executive Team or on the Board raise whether any form of enhanced scrutiny of the care being offered at the Priory, whether in terms of risk assessment, care planning or discharge for those patients might be required?
A. I believe that some of those issues were discussed in terms of enhanced surveillance and what that would look like, and that was described to the Board and to board colleagues.
Q. It was discussed; was it put in place?

A. Yes, it was.
Q. Who would have been responsible for that enhanced surveillance?
A. So we put in place a Quality Matron who worked with the Trust Quality Surveillance Team, who did audits and reviews of patients. And before that process was put in place, it was staff within the team and the division, it was the Associate Director of Nursing.
Q. What about enhanced support for patients following their discharge from the Priory?
A. We were very careful about our processes and our communication with the Priory to make sure that we oversaw patient movement and people's discharge.
Q. Sorry, can I pause you there. That's a very general statement: "we were very careful" in your communications with the Priory. Was there a specific system put in place by the Trust which required an enhanced degree of care or support to be provided to patients placed by the Trust at the Priory upon their discharge?
A. There wasn't enhanced support, there was existing support by care coordinators and where there wasn't a care coordinator, that role was fulfilled by the Bed Management Team. Those were the arrangements that were put in place.
Q. Now, September 2022, and the Trust decides to disinvest.

At that point, did anybody consider reflecting on the care of the patients who'd been sent to the Priory by the Trust after March 2021 and that inadequate rating?

Did the Trust think: well, hang on a minute, we're disinvesting, they've been rated inadequate, we've been sending people; should we just check on those patients what the quality of care looked like, where they are now? How they've been discharged?

A. We hadn't done that, no.
Q. Was it considered?
A. I can't recall it being considered, no.
Q. I'd like to move on now to risk and response to risk.

Now, very briefly, you said you didn't take exception to Dr Gibson's perception that there was a constant pressure to discharge.

Now, Mr Carr took you to the part of your statement where you talked about bed reductions during Covid. Now, that figure which we've seen -- and I won't bring it back up unless it would help you -- of 85% occupancy, would that have been communicated to ward staff?
A. Yes, it would have.
Q. Now, the Covid restrictions are lifted largely in the UK in May 2021. Can you recall if the 85% occupancy was lifted before then or after?
A. It was put in place at the end of 2021. It wasn't in

place before then.
Q. It wasn't in place before then.
A. Can I add that in terms of Covid, we were restricted in terms of our dormitories. We couldn't have patients in all dormitory beds, which is a completely separate issue, because of infection prevention and control. So there are issues about what we were allowed to do during Covid.

Also during Covid, we couldn't admit to wards that had an outbreak.
Q. I'm sure we can find out more of that from another witness.

But by October 2021, you'll recall that email Mr Carr took you to from the Highbury Hospital senior staff, couched in incredibly senior terms, wasn't it? You've covered that with Mr Carr.

By that time in October 2021, it was plain for the executive and the board, wasn't it, that there were still problems with unsafe staffing by then?
A. What the Board saw in terms of the safe staffing reports actually highlighted that we were using an increased number of agency staff. It wasn't that we weren't using staff and filling unfilled shifts, we were, but we were using agency staff.
Q. Can I pause you there. That message was stark, wasn't

it?
A. It was stark, and --
Q. And it was being escalated up to the executive, wasn't it?
A. It absolutely was. And it is a stark message and the staff were really exhausted at that point and there was a considerable impact of using agency and temporary staff on those senior leaders.
Q. The Board and the Executive were aware of that problem?
A. They were aware, yes.
Q. Thank you. And we don't, I hope, need to go to it again, but Mr Carr has taken you to the paper for the Board for March 2022, picking up serious concerns raised by the Coroner in summer 2021 and again in December 2021 about learning from deaths, raising concerns about risk assessment, about discharge, about response to incidents, about the involvement of families.

By that time, in March 2022, it would have been clear that the changes required by the CQC as long ago as 2019 had simply not been sufficiently addressed, had they?
A. I don't think they'd all been sustainably addressed, which was evidenced in the March 2022 acute inpatient --
Q. They were still being raised as concerns by a Coroner, raised by a Coroner. You would know that that

information was linked to a concern that these potential failings could be linked to deaths; is that fair?

A. I -- yes, I accept the points you're making about the implications and the relationships between staffing and risk assessment and the likelihood of incidents, potentially.

Q. Was this time, in March 2022, not the time for real urgency? Did anyone on the Board ask: "Hang on, these problems, we're being told about them. They've been running since 2019. Should we be acting urgently to make sure that our clinical risk assessments are safe?"

A. In terms of the Board conversation about that, I don't recall specific conversations about clinical risk assessments, although at the Quality Committee there was discussion about specific incidents and the actions being taken, which included actions about clinical risk assessment, changes to operational policies, and the training of staff.

Q. At that point, recognising in 2022, did anybody think: that this has been going on, we've had these problems live since 2019, should we audit our practice, perhaps sampling some patient records, let's check what may just have gone wrong since 2019?

A. In the middle of 2022 we resumed much more clinical audit and as part of that programme in the first quarter

that we re-established the case note audit. I think we audited over 700 sets of notes, so we did go back to review that work.

Q. But we've seen from your witness statement, I took you to that paragraph at paragraph 39, by the time you left, you thought there was much more to do. There was a much needed new audit system that needed to be put in place, wasn't there?

A. Yes, there was.

MS PATRICK: Thank you. I have no further questions.

THE CHAIR: Yes, Ms Benyounes.

Questioned by MS BENYOUNES

MS BENYOUNES: Good afternoon, Ms Attfield. I ask questions on behalf of the survivors and I want to pick up a topic that Mr Carr ended with and that was in respect of incident reporting.

Could I ask, please, that a paragraph of your witness statement be displayed, WITN0329001. It's page 33 and it's paragraph 132. So you set out there that there'd been concerns about the quality and timeliness of the serious investigation reviews and reports, concerns raised by the coroner about the quality of reports and difficulties in capacity to undertake investigations, especially in the period during and after Covid.

You've set out that in 2019 and 2020 there was a centralised Trust-wide Patient Safety Team put in place. So that was something that was new, and that was overseen by the Trust Lead for Patient Safety; who was that, please?

A. The Trust Patient Safety Lead, I believe at that time, was called Keiran Colton.

Q. And also the Associate Director of Quality; who was that, please?

A. Fiona -- sorry, I can't recall. Fiona. Sorry.

Q. A lady called Fiona?

A. Yeah.

Q. You said that the Patient Safety Team --

A. Sorry, Illingsworth.

Q. Fiona Illingsworth, thank you.

"The Patient Safety Team had responsibility for the overall coordination for incidents and investigations across the Trust, aiming to reduce variation in the management of incidents/serious incident investigations ..."

If we could just go just to the top of 133, if that could fully be displayed.

You say:

"A small resource of central investigation capacity was put in place, later complemented by bank SI

investigators."

So those are agency staff, investigators; is that right?

A. They are employed on the Trust bank and, I believe, mainly people who are, for example, retired clinicians, or managers.

Q. Thank you. And you say:

"In 2020, new procedures were put in place for the processes of sign off of investigations. All Comprehensive investigations and terms of reference [to be] approved by an Executive Director and concise investigations approved by an Associate Director of Nursing."

A. That was the process that was put in place and any deviations from that I believe were related to Covid derogations and would have been recorded through that process.

Q. But that process was set up in direct response to the concerns that had been repeated by that point about the quality and the timeliness of the reviews; that was a response to it?

A. Yes, that's correct.

Q. So can we look, please, to the document that Mr Carr lastly took you to: NHFT0000518. This is the "Thematic review of homicides and attempted homicides ..." It was

commissioned by Diane Hull and it was completed by Jonathan Warren in August 2024.

In response to questions by Mr Carr, you said that the only explanation you could offer about the findings in relation to those seven incident reports was potentially derogations put in place in terms of sign-off during Covid.

A. The only comment I could make in relation to the signing-off of them?

Q. Yes.

A. Not the --

Q. Not the review. This post-dates your tenure, yes.

A. *Yes.*

Q. Can we look at page 3 of the document, please, and just the table there. We can see the seven cases. We know that the fourth, the comprehensive review, that relates to VC's case, and that was a full care scope review.

A. Yes.

Q. We can also see that in respect of the other investigations, that some of those were signed off by an Executive Director, some were signed off by a General Manager, and others by the Associate Director of Nursing.

You can't assist us as to whether you signed off on any of those? You think you signed off one that wasn't

part of the review; is that right?

A. I was informed by -- I asked the same question yesterday and I was advised that I had signed off one of those investigations, so it would have been one of those marked as an "Exec Director".

Q. Mr Devlin, in answers to questions yesterday, he wasn't able to say who the Executive Director, who the General Manager or the Associate Director of Nursing was that signed those off either. But can we look, please, further down in the summation on page 6. Thank you.

So the second paragraph:

"The panel reviewed all seven reports and accompanying documents."

Found that "four of the seven were of poor quality, "two ... needed to be revisited in their entirety". There was surprise to see the 'tabletop' review "given the seriousness of the incident".

And:

"In terms of process there seems to be only limited executive oversight with delays common and limited scopes which further restrained the quality of the reports."

It records specifically:

"It [was] ... unclear who and how reports were signed off, and what scrutiny they had."

So these reviews were incidents that took place during your tenure; the report was later in 2024. But this was after the changes that you've set out were put in place due to the concerns in the incident reporting.

A. Yes, that's right.

Q. So --

A. All --

Q. -- despite those changes --

A. Although, can I just?

Q. Yes.

A. I'm not sure about the timeline between the completion of the reports without going back to the table in terms of --

Q. Shall we go back? Page 3, so you can see the dates of the incidents that were investigated. So we can see there that there are two incidents from 2019, two in 2021, one in 2020 and one in 2022.

A. Then, yes.

Q. Yes. So despite those changes and the clear steps that were taken, there were still clear failings and a lack of clarity as to how the reports were completed and who challenged staff and signed those off at the time.

Do you agree that was a clear failure of the Trust?

A. It should not be, as is described here, in terms of the level of investigation and the quality. I would agree.

Q. It wasn't just a failure; this was serious failure noting the repeated concerns by the CQC, the coroners, from various reports, but also the own leadership knowledge of the Trust with steps that had been put in place to address this?

A. I'd have to agree.

Q. Just one final point, referring back to your witness statement, please, at pages 21 over to 22. It's your paragraphs 87 and 88. They start at the bottom of 21 there.

You suggest there different factors that may have contributed to the Trust being rated as requiring improvement three years after the CQC inspection in 2019. You've set out a number there, you've included issues in respect of governance, you've included issues in respect of further operational pressures.

Do you accept any personal responsibility, as an executive leader, for the lack of sustained improvement between 2019 and 2022?

A. As a senior leader in the organisation, as a Board member and as an Operational Director, yes.

Q. You say at the end of paragraph 88 there, that the pace needed to be "swifter". When did you first form that view, Ms Attfield?

A. I think that 18 months into that journey, so it'll be

the middle of 2020, I think we knew that we'd had difficulty achieving everything that we set out, in terms of culture, vision and values. I think it was a highly challenging climate to operate in.

I think it didn't mean that we weren't attending to and trying to move forward. But yes, it was very challenging.

Q. But by the time, at the end of your tenure, you're of the view that things needed to be swifter despite knowing that 18 months in?

A. I think every portfolio holder in the organisation and Board member would say that we wished that we had progressed further during that period.

MS BENYOUNES: Thank you very much, Chair.

THE CHAIR: Yes, Ms Heaven.

Questioned by MS HEAVEN

MS HEAVEN: Good afternoon, just a few questions in relation to communication with families and carers, please.

You told Mr Carr earlier that there came a point when the Trust realised they'd become distant from carers, and so, in 2022, it was understood the Trust had a lot of work to do around families and carers being placed back at the centre. Do you remember saying that?

A. Yes.

Q. Can we pick this up in your witness statement, please,

it's page 53, and it's paragraph 210, please. So you say this, do you see that there:

"Family involvement had been raised via patient feedback, and in relation to learning from incidents. Carer involvement was a Trust Quality priority in 2021/22 and there was an improvement programme in place to improve practice. The Board were aware from direct feedback from carers and via patient safety reports."

I'm just going to go down to a bit of 211:

"Actions taken to improve this in [Adult Mental Health Services] included the recruitment of Carer Peer Support Workers on inpatient wards, and then onwards into [Adult Mental Health] community services".

Just pausing there, you say earlier in your statement, at paragraph 168, we don't need to bring this up, that from December 2021 carer support workers were introduced.

Can you assist? How many were recruited and were there actually any available in community mental health services for adults?

A. I can't assist on exact numbers but my best recollection is that they were being introduced onto both inpatient wards and in community, particularly Local Mental Health Teams into their staffing models. I'm sorry, I can't answer precisely in terms of numbers. The Trust should

be able to provide that.

Q. Let's go on a bit more, then, in 211, please, to understand the role of the carer support worker:

"The role of carer peer support workers was developed specifically to support people who support a friend or loved one who is experiencing mental distress. Carer peer support workers use their experiences of caring to offer empathy, hope and understanding to others. In this the carer peer support workers offer peer support alongside practical assistance, and joint work with other team members. This being implicit to ensuring that plans meet individual patient and carers needs, and especially at key points of transition such as discharge."

Can we just break that down a bit. So as I understand it, care and support workers ensure that families and carers can feed into care plans, risk assessments, and crisis management plans; is that correct?

A. Yeah, and it's a role within a broader team to develop and support people to have those closer working relationships. It's -- we had done work previously on the Triangle of Care and it was about embedding some of those principles. It was also about putting carers in touch with local support services to broaden the level

of support that they received.

Q. Another function is to ensure that carers and families know how to access services and to ensure good communication between services and the carer?

A. Yes.

Q. I think you just said that, haven't you?

A. Yes.

Q. To build a trusting and therapeutic relationship between the Trust and the carer. I think that echoes really what you've just said, doesn't it?

A. Yes.

Q. Is it right that this must all be done following the staged approach in the Triangle of Care model that you've just mentioned?

A. Yes, that's right.

Q. So practically, then, between 2020 and 2022, so your tenure, were carer support workers actually being allocated to families and carers of patients with a severe and enduring mental illness? And if so, who allocated them?

A. I believe that in the teams, that would be part of the working arrangements. I can't say who did what, when and how many, but that would be part of their role within, particularly in the community services.

Q. Okay, but you're having oversight at this point. Are

you really unable to assist whether carer support workers were being allocated in practice?
-- *(overspeaking)* --
A. I believe that they were working in practice, yes.
Q. Okay. Would it be the care coordinator that would be responsible for that?
A. Yes. Yes, sorry.
Q. Now in the case of VC's family as you know -- well, we know that there's no evidence that the Triangle of Care approach was used. We know that there was no safety netting, no crisis management plan at any point discussed with the family, no rapid access plan. We've heard that VC's family at times struggled to access services and they were never offered a carer support worker despite VC having a serious and enduring mental illness. These were serious failures, weren't they?
A. VC and his family would have benefited a great deal from carer support, yes.
Q. They were serious failures, weren't they?
A. It wasn't an adequate standard of provision in terms of the work with VC's family.
Q. Bearing in mind what you say about the Trust priorities that we've just looked at in relation to families, and bringing them back to the centre, whatever the Trust did with you overseeing it, it was woefully inadequate,

wasn't it?
A. It wasn't sufficient in this case, no.
Q. Are you able to give any insight, then, into why it was inadequate?
A. I think that during Covid there was a considerable distance that had developed in terms of working with carers and personalised in care, and we did take steps into 2022 to reinvigorate all the work around patient feedback and work with carers, and I think over 2022 we started to build up our capacity in terms of doing that. It hadn't reached VC, clearly.

I think that the EIP team during that period, though, did receive training on family work and family interventions. It was part of the work of the team to achieve their NCAP requirements around family support. So there would have been some input definitely to that team by 2022.

MS HEAVEN: Okay, thank you, Chair.
THE CHAIR: Yes, Mr Beer? Mr Beggs?

Questioned by MR BEGGS

MR BEGGS: Do you recall Mr Carr took you to Sergeant Horsnall's complaint of April 2022?
A. I do.
Q. I'm going to see if I can take it quickly. Would you accept that the complaint relating to your treatment of

three patients was detailed?
A. Yes.
Q. Rational?
A. Yes.
Q. Raised legitimately serious concerns?
A. Yes.
Q. One of them, one of those patients was a paranoid schizophrenic in great distress.
A. Yes.
Q. Do you recall? And due to a lack of beds was held in police custody for virtually 30 hours.
A. Yes.
Q. You'd accept, I think readily, that that's a deeply unacceptable state of affairs?
A. Absolutely.
Q. Can we look at your response to that complaint, please. Which is WITN0329041, page 1. It's clear, isn't it, that you don't dispute the facts of the three complaints -- thank you -- and at the end of the letter, you say:

"I know that the current situation has an impact on your work and responsibilities, and we do appreciate the support you provide to our services ..."

And so forth.

But you don't actually offer any concrete solution

to the three complaints.
A. There's a lot of work done between the police and ourselves, or there were, in terms of urgent care and the urgent care pathway. Prior to this, we'd reviewed our Section 140 approach, and our joint policy with the police. So we had existing processes in place to go and review our working together and the impact that we were having on the police, but yes.
Q. No concrete solution offered there?
A. There is a solution -- well, there is a process. There was a Section 140 agreement that we worked on together.
THE CHAIR: You're being asked about in this letter that you wrote.
A. Yes.
THE CHAIR: Is there a concrete solution put in the letter?
A. The Section -- not in the letter, but the police and ourselves are aware.
THE CHAIR: Well, that's answer to your question, Mr Beggs.
MR BEGGS: Thank you, Madam.

Moving swiftly on, and there was another tranche of complaint, wasn't there --
A. Yes.
Q. -- from the police, which you recall this time from a Temporary Sergeant Stephen Mackell; do you recall that?

A. Yes.

(Questions and answers redacted)

THE CHAIR: Mr Beggs, I think this is irrelevant to the issues I'm dealing with, isn't it, and going into those sort of details at this stage isn't appropriate.

MR BEGGS: Madam, it was really just to deal with whether there were any solutions offered for that, but I'll move on.

THE CHAIR: That's a question you can ask.

MR BEGGS: Yes, on that occasion again, I think you'd accept the complaint was a legitimate one?

A. Yes, and there was an appropriate clinical response and there was an investigation.

Q. Can I just finish, it was a legitimate complaint, it was a detailed complaint --

A. It was.

Q. -- and it followed a few months after the one we just referred to.

A. It did, yes.

Q. Finally this, if you can be shown, please, page 56 of your statement, paragraph 219. If you could please read from the second sentence in the third line:

"It is expected ..."

If you just read that to yourself for speed.

A. Yes.

Q. Where you're dealing with potentially dangerous patients; you understand what I mean by that --

A. I do.

Q. -- wouldn't it be sensible to add to the list of people that you describe as being the beneficiaries of information sharing, the local police?

A. Yes, in context of people where that may be necessary, yes.

Q. That's why I preface it by saying where they're potentially dangerous?

A. Yes, yes.

Q. Because it's going to be the police that will have to deal with any incident?

A. Yes.

MR BEGGS: Thank you very much.

THE CHAIR: Thank you.

Mr Beer.

Questioned by MR BEER

MR BEER: Just three short topics, please, Ms Attfield.

Firstly, the CQC ratings. You've been asked questions about the CQC ratings of both the Trust and the Priory, yes?

A. Yes.

Q. I think you know that one of the domains addressed by the CQC in each of its inspections is that of safe or

safety?

A. Yes, that's right.

Q. And that in turn addresses medicines management?

A. Yes.

Q. Risk assessment?

A. *(The witness nodded)*

Q. Learning from errors?

A. Yes.

Q. And then fourthly safeguarding?

A. Yes.

Q. So in the present context, I think you would agree that that domain is particularly important?

A. It is, and challenging for providers, yes.

Q. I think there are 46 pure Mental Health Trusts inspected by the CQC?

A. *(The witness nodded)*

Q. I'm excluding from that number combined and community trusts. Does that number sound about right to you?

A. Yes, yes.

Q. In the domain of safety, would it surprise you to know that 30 of the 46 trusts were rated as inadequate or requiring improvement for the last year that figures are available, 2024 to 2025?

A. It doesn't surprise me in the context of how people are trying to deliver services.

Q. So about two-thirds --

A. Yes.

Q. -- of all Mental Health Trusts were inadequate or required improvement in the domain of safety?

A. Yes.

Q. Do you know why it is that even in 2024 to 2025, two-thirds of Mental Health Trusts in this country are rated as inadequate or requiring improvement in relation to the domain of safety?

A. I'd imagine it's about the management of risk, the access to services and staffing, by and large.

Q. In relation to private providers, what would the Trust be able to do if it could not place patients with private providers that were rated as inadequate or requiring improvement?

A. I think it would present a considerable risk in terms of access to services and the management of clinical risk in the community. I think it would be a very, very difficult situation to manage. If not impossible.

Q. Difficult if not impossible, ie, the system would break down if you couldn't put people into private providers that were inadequate or requiring improvement?

A. I think that that's my reading of people's bed availability and the national availability of beds.

I think it's a considerable challenge, as it was at the

time.
Q. You said against that background that, in the case of the Priory, the Trust took a number of measures or put in place some safeguards when placing patients at the Priory. Was one of those safeguards creating a specific role and getting specific funding to recruit a person to lead the oversight of the subcontracts --
A. *(The witness nodded)*
Q. -- to ensure safety and quality?
A. Yes, there was a dedicated operational manager and a dedicated senior matron to oversee the quality.
Q. Were they two people or one?
A. Two people.
Q. Two people so just tell us about the function of the first.
A. The function of the first was to manage the patients and the delivery of the contract and the clinical processes; and the role of the second one was to review the quality specifically.
Q. Second topic, the caseload of care coordinators. You were asked by Mr Carr whether you were aware of excessive caseloads held by care coordinators, and you said that you had received a written report which showed you that the average was 17 individuals, patients --
A. An average, yes.

Q. -- per care coordinator, yes?
A. Yes.
Q. Then you said to Mr Carr "Can I add something?" But you weren't allowed the opportunity to add something. What was the thing you wanted to add if you can remember now?
A. In the performance report that I received monthly I could see the total number of patients using the service, and based on the vacancy rate could understand the level of capacity in the service. And I could see any escalation in terms of staffing and how that had been responded to.
Q. The average of 17, was that above or below the national average?
A. That was the national average. And I believe the benchmarking in 2022, the National Mental Health benchmarking, per 100,000 of population, we had slightly more staffing capacity in our EIP team than the national average.
Q. Then lastly, in relation to funding, you've said that in the relevant period you were about 40 beds short of what the Trust needed, I assume that's in acute care; is that right?
A. That's acute beds, yes.
Q. Which body was responsible for not providing the funding for the missing 40 beds?

A. The cost of providing the acute adult inpatient services in the year that I took the service over was in the region of £10 million overspent, and that was part of the mental health overall contract.
Q. So who is responsible for providing funding for something like the beds?
A. In my opinion it's the health community, the ICB's responsibility.
Q. So the ICB and then subsequently the CCG?
A. Yes, yes.
Q. Were there conversations or applications about obtaining such funding?
A. So the annual contract round is part of that process. One of the things that we did in 2022 was to commission an external review of the inpatient bed capacity in Nottinghamshire, to work together to have a strategy to resolve that position. It hadn't been progressed at the time I left. But it had been done, the external review had been done, and that would have been in preparation for the contracting round at the end of the financial year.
MR BEER: Thank you very much.
THE CHAIR: Thank you.

Questioned by THE CHAIR

THE CHAIR: Just one question, in relation to paragraph 44

of your statement, and you were asked by Mr Carr about why of the list of effectively key performance metrics at the Trust Public Board meeting, it only included the EIP engagement within two weeks, whereas that was the only successful one at the time, and the others were not. And what you said was that that was due to a differentiation in reporting because NCAP was seen as a clinical audit and it wasn't in the board remit; is that right?
A. That is how the reporting for EIP worked. This is the national target at that time that was set for Trusts to achieve. The NCAP, National Clinical Audit for Psychosis, was reported to the Quality Committee through the clinical audit report. It was seen as --
THE CHAIR: What I am going to ask you was whether -- you had a number of roles within the Trust, didn't you, and the way that it was set up at the time, where some parts of this would have been reported to the Board, some parts not, because they would go through the different committees, that didn't give an overall picture, did it, because you were only presenting here one metric?
A. No, it was only the single metric. It didn't show every aspect of the clinical delivery, no.
THE CHAIR: So in that respect, it wasn't giving a holistic view about how EIP were doing, was it?

A. No.
THE CHAIR: It wasn't a suitable method of reporting?
A. No, and in the portfolio that I held, there are 35 different types of services and this is how it's amalgamated in the performance framework to the Board.
THE CHAIR: But if you're holding a number of different roles you get a number of different streams of information about the same issue, don't you?
A. Yes, and it's my point about business intelligence, actually, and bringing information together across the organisation, yes.
THE CHAIR: But it doesn't help to, as it were --
A. Pinpoint no.
THE CHAIR: -- yes, take one metric out and put it in -- *(overspeaking)* -- does it?
A. No, no, and I know the Trust has done a lot of work on its performance reporting and I think that's absolutely valid.
THE CHAIR: Thank you. Well, we'll finish there, and we'll start again tomorrow. Thank you.
(5.06 pm)
(The hearing adjourned until 10.00 am the following day)

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