Witness Name: Diane Hull
Statement No.:
WITN0133001
Dated: 5 December 2025

THE NOTTINGHAM INQUIRY

FIRST CORPORATE WITNESS STATEMENT OF NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

I, Diane Hull, will say as follows: -

1. I have been Chief Nurse of Nottinghamshire Healthcare NHS Foundation Trust ("**the Trust**") since 31 July 2023. I am authorised to make this statement on behalf of the Trust.

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 requests dated 16 June 2025, 25 June 2025 and 2 July 2025 (the "**Requests**").

3. I initially qualified as an Enrolled Nurse (m) in 1984 and then as a Mental Health Nurse in 1990. I spent the majority of my nursing career in one Foundation Trust with extensive experience working clinically in adult inpatient services and Psychiatric intensive care. I then worked in senior leadership and management roles, including Forensic inpatient and community services, until being appointed as Deputy Chief Nurse. I subsequently held two other Chief Nursing positions at other foundation trusts. I have undertaken several leadership development programmes, including The Kings Fund Athena Leadership for Executive Women, the Institute for Healthcare Improvement's Quality Improvement Leadership Programme, the NHS London Leadership Academy Senior Leaders

development programme and the East London NHS Foundation Trust Clinical Leaders programme. In addition to this I have completed a number of courses to enhance my clinical expertise [NHFT0015799].

4. I would like to begin by saying sorry to the families and friends who have lost loved ones, to those who survived but whose lives will never be the same again and to every single person who may have been impacted by the atrocities of 13 June 2023. I know my apologies will mean little when you have suffered such a terrible and painful loss and I realise that my words may not bring comfort, nor can they undo the terrible harm that has been done. I wish to be clear that I am deeply sorry for the failings, and for the missed opportunities, that have been identified in previous investigations. We are making tangible improvements, which have already resulted in meaningful change. We will continue with commitment and absolute determination to learn from all investigations and to use the additional learning identified from the Inquiry to make further impactful improvements.

5. As set out in section H below, several internal and external reviews have been conducted into the care that the Trust provided directly to Valdo Calocane ("**VC**"), as well as reviews into the related services. The Trust has accepted the findings of these reviews in full and used the learning to take action and accelerate improvements. The Trust has also gone through a substantial programme of other improvements since 2023. These are described in section I below and include matters such as Trust governance, learning from incidents, improving near-real time patient safety data, interagency working, clinical leadership, services and risk, equality and diversity, and engagement with families.

6. This witness statement was drafted on my behalf by the external solicitors acting for the Trust in respect of the Inquiry, with my oversight and input. The Requests received by the Trust on 16 June 2025, 25 June 2025 and 2 July 2025 are broad in scope and go beyond matters which are within my own personal knowledge. As such, this statement is the product of drafting after communications between those external solicitors and a number of senior Trust employees in writing and video conference. I do not, therefore, have personal knowledge of all the matters

of fact addressed within this statement. However, given the process here described, I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief.

7. The remainder of this statement is structured as follows:

   A. Overview of the Trust
   B. Incident and patient safety oversight
   C. External oversight
   D. Overview of mental health treatment at the Trust
   E. Working with independent healthcare providers
   F. Working with other bodies and information sharing
   G. Care provided to VC
   H. Reviews and learning from homicides and attempted homicides
   I. Improvements made and lessons learned
   J. Recommendations

A. Overview of the Trust

8. The Trust's organisational structure and governance has evolved and changed since its establishment in 2000. The reasons for these changes were primarily either as a response to NHS reorganisation; as a result of Trust-initiated change; or in response to external reviews and oversight (for instance, by the Care Quality Commission, ("**CQC**").

9. The National Service Framework for Mental Health was published in 1999. This was a UK government initiative designed to improve mental health services in England, by setting quality standards and issuing a 10-year agenda. The specific standards established for mental health services, along with funded Policy Implementation Guidelines, led to the introduction of Early Intervention, Assertive Outreach and Crisis Intervention teams.

10. The external statutory, regulatory and policy framework within which the Trust operates has also changed over this period. Two periods in particular are worth noting. The first is the changes that came into force in 2012 as a result of the statutory amendments introduced in the Health and Social Care Act 2012. This initial period of statutory change introduced NHS England, Clinical Commissioning Groups ("**CCGs**") and formally established Monitor as the regulator of Foundation Trusts. Providers, like the Trust, were commissioned by NHS England (in relation to certain specified services, including high secure psychiatric services) and CCGs.

11. Trust services over the years have been commissioned by a range of organisations; CCGs /Integrated Care Boards ("**ICBs**"); NHS England at a national level; Midlands NHS England Specialised Commissioning; and, NHS England Health and Justice. In addition, Local Authorities have commissioned the Trust to deliver 0-19 children's services. Trust income in 2024/25 was 44% from NHS England (national and regional), 44% from Nottingham and Nottinghamshire ICB, 2% from the local authorities and the remainder 10% of funds came from other sources.

12. The second key change was the move towards Integrated Care Systems and a less formal commissioner/provider split. This took place from late 2015/early 2016 and culminated in the statutory changes introduced via the Health and Care Act 2022. During this period, the regulation and oversight of Foundation Trusts and NHS trusts was gradually harmonised so that, as of today, the same arrangements largely apply to both.

13. It was also in 2016 that the Five Year Forward View for Mental Health was published by the independent Mental Health Taskforce to NHS England, which set out a strategic plan aimed at improving mental health services and outcomes from 2016 to 2021 [NHSE0000002]. The report highlighted the need for increased funding, improved access to quality care, and a focus on early intervention and prevention. Specifically in relation to the Early Intervention in Psychosis ("**EIP**") service the plan set out a waiting time standard to come into effect in April 2016, as well as an expectation that by 2020/21 60% of people

experiencing a first episode of psychosis would have access to a NICE-approved care package within two weeks of referral.

14. This wider landscape is important as it explains the context within which the Trust operates and the policy framework and national areas of priority that the Trust was required to work within.

15. The other period that is of relevance when understanding how the Trust operated between 2019 and 2023, the period that the Inquiry is particularly interested in, is the Covid-19 pandemic. The Inquiry will be aware of the evidence heard in the Covid-19 Inquiry, chaired by Baroness Hallett, specifically the Second Witness Statement of Amanda Pritchard on behalf of NHS England, which set out what national guidance was provided to mental health providers, and how Covid-19 hospitalisations impacted the delivery of inpatient mental health services, and the Fourth Witness Statement of Professor Sir Stephen Powis, which covers some of the expectations on mental health trusts in relation to supporting the public and existing patients, as well as the impact of Covid-19 on Children and Young People's Mental Health Services.

16. The Trust acknowledges that this was a particularly challenging time for staff, in common with colleagues in other NHS organisations and other front-line public services.

17. Below I will explain in brief the Trust's evolution over the last 25 years and describe its current arrangements.

Establishment

18. The Trust was formally established by statutory instrument (The Nottinghamshire Healthcare National Health Service Trust Order 2000) on 6 November 2000 and became operational on 1 April 2001. The Trust absorbed predecessor bodies such as Nottingham Healthcare NHS Trust (the direct successor to earlier mental health services), Central Nottinghamshire Healthcare NHS Trust, Bassetlaw Hospital and Community Services NHS Trust, and Rotherham Priority Health

Services NHS Trust. Its remit covered medium and high-security forensic services, community mental health, and general community healthcare across Nottinghamshire and parts of neighbouring counties.

19. Nottinghamshire Community Health, which had provided community nursing and therapy services, was dissolved in April 2011. Its services were re-formed under County Health Partnerships, a division of Nottinghamshire Healthcare NHS Trust, allowing fully integrated delivery of mental health, intellectual and developmental disability, forensic and community physical health services from over 120 sites.

20. In March 2015, the Trust was authorised as a Foundation Trust (Pursuant to Chapter 5 of Part 2 of the NHS Act 2006).

21. The Trust is one of three "equivalent" designated high-security mental health providers, alongside Mersey Care NHS Foundation Trust and West London Mental Health NHS Trust (only NHS trusts approved by the Secretary of State for such purposes are able to provide high secure services [NHSE0000020]).

22. The services provided by the Trust include mental health, intellectual and developmental disability and physical health services. Over 11,000 dedicated staff provide these services in a variety of settings, ranging from the community through to acute wards, as well as secure settings. The Trust also provides a wide range of community and home-based services, services for children, young people, adults of working age and older adults supporting their physical and mental health needs as well as providing services for those with an intellectual and developmental disability. These include community-based nursing and therapy teams to meet specific needs, as well as universal services such as health visiting and school nursing for children and families. The Trust provides services to the population of Nottingham and Nottinghamshire, with a combined population of 1.1 million.

23. These services are delivered from facilities such as in-patient settings, children's centres, local health centres, secure settings, GP practices, and people's own

homes. The Trust has also been a significant provider of healthcare to offenders in several prisons across the East Midlands, although at its meeting on 27 March 2025 the Board of Directors made the difficult decision to serve notice on its Nottinghamshire, Lincolnshire, and Leicestershire offender health contracts.

24. The Trust also provides specialist services nationally, including the National High Secure Deaf service, the National High Secure Women's service, the National High Secure Personality Disorder Service and The Nottingham Centre for Transgender Health.

Overview of Foundation Trusts and regulatory framework

25. Foundation trusts are statutory public benefit corporations with a board of directors and have greater financial and operational freedoms than NHS trusts (although the latter have gradually reduced as NHS England harmonised the oversight and regulatory framework it used for NHS trusts and Foundation trusts). Unlike NHS trusts, Foundation trusts are directly accountable to the local community and regulators, rather than centrally to the Secretary of State for Health. They operate within the statutory framework set in the NHS Act 2006 (as amended), the Health and Social Care Act 2012, and applicable national guidance, as issued from time to time by the Department of Health and Social Care and NHS England.

26. The governance structure of Foundation trusts is set out in their constitutions, and include any requirements mandated by Schedule 7 of the NHS Act 2006. The Trust must also follow the Code of Governance for NHS provider trusts published by NHS England, which sets out the overarching framework for the corporate governance of trusts [NHSE0000522]. The current version of the Code of Governance was issued on 1 April 2023 and replaced the previous version, which was issued.

    The Trust's Constitution is a key part of the Trust's regulatory framework and is required by the NHS Act 2006. The Constitution and its incorporated annexes are required to be reviewed annually to ensure it is consistent with legislation and

any applicable national guidance. However, this routine review process was paused nationally during the Covid-19 whilst specific governance arrangements were instigated to deal with the national emergency [NHFT0000548].

27. All healthcare providers in England must also register with the CQC, which is responsible for the monitoring, inspecting, and regulating of healthcare services to ensure they meet fundamental standards of quality and safety. The CQC's specific oversight of the Trust is described in more detail below at paragraphs 175 - 184.

28. Since 2013, when the NHS provider licence was first introduced, the Trust has been required to comply with the conditions contained in its NHS Provider Licence, issued pursuant to regulations made by the Secretary of State. The NHS provider licence was first introduced for foundation trusts in 2013 and extended to NHS trusts from April 2023. It sets out conditions that providers of NHS-funded healthcare services in England must meet [NHSE0000389].

29. Oversight of the provider licence is done by NHS England under the NHS Oversight Framework [NHNB0018961], which provides the framework for overseeing healthcare systems including providers and identifying potential support needs. It includes delivery metrics, against which providers are assessed. This was previously known as the Single Oversight Framework, following its introduction September 2016 and is closely aligned with the CQC's regulatory framework. In April 2024, the CQC and NHS England jointly published new Well-Led guidance for trusts under the Single assessment framework which can be accessed on the CQC website and is applicable to all trusts [CQCM0016438].

30. NHS organisations are allocated to one of four 'segments' under the framework. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment

2 unless the criteria for moving into another segment are met. NHS England's Recovery Support Programme[1] targets support to those with most need.

31. The Trust has been part of NHS England's Recovery Support Programme (Segment 4) since 27 February 2024, having previously been in Segment 3. The re-segmentation was against a backdrop of unusual and high-profile circumstances, including the trial of VC, the CQC's section 48 report (discussed in Section I below), and staff suspensions reported in the press. The initial focus following the section 48 report and entering the Recovery Support Programme was to put in place a series of actions around immediate areas of concern, and then the improvement journey moved towards "business as usual", focussing on areas that needed to make improvements. For example, we launched an independently chaired evidence and assurance group to give us external assurance about improvement actions that had been completed and embedded. We also focussed on engaging colleagues through a range of mechanisms such as "Big Conversations", our Leadership Forum, and our Colleague Reference Group. We launched a number of new leadership development programmes at all levels.

32. The Recovery Support Programme undertook a developmental Well-Led review of the Trust which made a number of recommendations. Those recommendations were incorporated into the relevant programmes within the Trust's Integrated Improvement Plan, which is discussed below at paragraphs 132-137, and is designed to support the Trust's exit from the Recovery Support Programme by March 2026. The Trust took immediate steps to address the developmental Well-Led review recommendations, ensuring alignment with its broader governance and leadership improvements. Progress is being monitored through established oversight mechanisms, and actions are being embedded. One of the recommendations was for the Trust to refresh its focus on developing medical leadership. The Trust subsequently established a Valuing Medical Leadership project team to collaboratively develop a structured strategy to deliver meaningful change in relation to medical leadership at the Trust.

[1] As per the current NHS Oversight Framework, RSP is to be renamed Provider Improvement Programme.

33. The Trust remains committed to continuous improvement and is making ongoing progress in strengthening its leadership, governance, and performance in alignment with national expectations and external assessments.

Trust structure and governance

34. This part of the statement describes the structures and governance of the Trust, including what is in place today and in the process of being further developed and implemented.

35. As described above, Foundation trust governance must comply with applicable statutory, guidance and policy requirements. A core aspect of the Trust's governance is its Constitution [NHFT0000548].

36. Amendments to the Constitution and its related Annexes must be approved by both the Board of Directors and the Council of Governors. The Constitution was last updated in November 2024, and this version remains in place. The Constitution was previously updated on 28 September 2023 [NHFT0000420]. The changes approved on 28 November 2024 are summarised in a paper produced for the Board of Directors for the public board meeting that took place on that date. [NHFT0000818].

37. The Trust has also disclosed to the Inquiry the Trust's annual reports for the previous five years:
    - Annual report – 2023/24, [NHFT0005116]
    - Annual report – 2022/23, [NHFT0015622]
    - Annual report – 2021/2022, [NHFT0015619]
    - Annual report – 2020/21, [NHFT0015621]
    - Annual report – 2019/20, [NHFT0015618]

38. The Trust's governance structure currently in place, and described in further detail below, is as follows:

Council of Governors

39. Foundation trusts are required by the NHS Act 2006 to have a Council of Governors, elected from amongst the membership, comprising local people, patients, carers, and staff. At least half of the governors on the Council of Governors must be elected by the public or patient members; at least three governors must be elected by staff; and at least one governor must be elected by one or more qualifying local authorities.

40. The role of the Council of Governors is to gain assurance, on behalf of the membership and the public, on the organisation's performance, with a particular focus on service quality. It has two main statutory duties: (a) holding the non-executive directors individually and collectively to account for the performance of the Board of Directors, and (b) representing the interests of the members of the Trust as a whole and the interests of the public.

41. The Trust's Constitution sets out matters that are reserved for the Council's decision. These are:

a) The appointment and removal of the Trust`s Chair and non-executive directors.

b) Determination of the terms of service, remuneration and other allowances of the Trust's Chair and non-executive directors.

c) To approve the appointment of the Chief Executive.

d) To approve amendments to the Trust's NHS Foundation Trust Constitution.

e) The appointment and removal of the Trust's External Auditor.

f) To provide views to the Board of Directors on the strategic direction of the Trust and targets for the Trust's performance and in monitoring the Trust's performance in achieving those strategic aims and targets.

g) To hold the Board of Directors to account in relation to the Trust's performance to give the views of the Council of Governors to the directors for the purpose of the preparation of the Forward Plan.

h) To consider and give/withhold approval for applications for a merger, acquisition, merger, separation or dissolution.

i) To consider and give/withhold approval for the Trust to enter into a Significant Transaction (as defined within the Constitution).

j) To be presented with the Trust's annual accounts, any report of the Auditor on them and the Annual Report.

k) To consider resolutions to remove a governor.

l) To respond as appropriate when consulted by the directors.

m) To exercise other functions at the request of the directors.

42. As explained in the Code of Governance for NHS provider trusts [NHSE0000522], the role of Governors is fundamentally different from that of the Board of Directors. The Board of Directors is responsible for the direct running of the Trust and for the strategic leadership of the whole organisation, assuring high quality performance and delivery of all services. By contrast, Governors are not directly involved in matters of operational management, individual specific patient or staff issues, or the handling of complaints.

43. A register of governors is maintained by the Trust, which can be found on the Trust website [WITN0133002]

44. The Trust has disclosed to the Inquiry the meeting notes from the Council of Governors since 2019.

45. The Trust has also disclosed to the Inquiry the update its Chief Executive provided to the Council of Governors regarding the Trust's Integrated Improvement Plan [NHFT0002439].

The Board of Directors, Executive Leadership Team and operational governance

46. NHS boards of directors play a key role in shaping the strategy, vision and purpose of an organisation [NHSE0000522]. They hold the organisation to account for the delivery of strategy and ensure value for money. They are also responsible for assuring that risks to the organisation and the public are managed and mitigated effectively and for ensuring that its obligations to regulators and stakeholders are met. The Trust has disclosed to the Inquiry the Board papers for 2019 – 2023.

47. The decisions reserved for the Board of Directors and the delegated discharge of its responsibilities are set out under a formal Scheme of Delegation [NHFT0013457] defining the allocated responsibilities for making and approving decisions relating to Trust business.

48. The Board of Directors is a unitary board comprising seven executive and eight non-executive directors. Currently there is one non-executive post vacant. The Board makes decisions as a single group and shares the same responsibility to constructively challenge during Board discussions and support the development of proposals on priorities, risk tolerance, values, standards and strategy.

49. All members of the Board of Directors have the same general legal responsibilities to the Trust and have a collective responsibility to act with a view to promoting the success of the organisation to maximise the benefits of the Trust noting the benefit it provides for the public.

50. However, the specific responsibilities that executive and non-executive members of the Board have are as set out in statute and guidance, particularly the Code of Provider Governance.

51. Executive Directors are employees of the Trust, led by the Chief Executive, and are responsible for the day-to-day management of the Trust. The Chief Executive also has specific responsibilities as Accounting Officer, which includes personal responsibility for the propriety and regularity of the public finances, keeping of proper accounts, prudent and economical administration in line with the principles set out in Managing Public Money [WITN0133003], the avoidance of waste and extravagance and the efficient and effective use of all resources in their charge.

52. Non-executive directors are officers of the Trust and are therefore not employees and bring to the Board an independent perspective having a duty to challenge and to hold the executive directors to account.

53. The directors bring a broad range of skills and experience to their roles on the Board, to ensure that there is an appropriate balance with the capability and capacity to meet the requirements of the Trust. The Board of Directors Nominations and Remuneration Committee maintains an overview of the Board's composition. Appointments to foundation trust boards are made independently of NHS England and do not require Secretary of State approval.

54. NHS England has developed a fit and proper person test framework in response to recommendations made by Tom Kark KC in his 2019 review. This also takes into account the requirements of the CQC in relation to directors being fit and proper for their roles. The Trust is compliant with the requirements of the Framework, and this is assured by the Board.

55. The Board of Directors is apprised of Trust level performance through the Integrated Performance Report and the risk-based Board agenda [NHFT0000529]. This report has recently been praised by NHS England as an exemplary example of what such a report should contain. The Board

delegates detailed scrutiny of performance to the Trust Executive through the Trust Quality and Performance Group. Key performance risks are escalated monthly to the Executive via Trust Quality and Performance Group to the Executive Leadership Team meeting, where the latest Integrated Performance Report is also reviewed.

56. The Chief Executive provides overall leadership to the organisation and leads the teams focusing on corporate governance, communications and business development. The Executive Leadership Team is chaired by the Chief Executive and its members include the Trust's Executive Directors. The Extended Executive Leadership Team comprises the Executive Directors plus their deputies. The Trust has disclosed relevant Executive Leadership Team papers to the Inquiry.

57. The Trust is in the process of a phased transition into a new governance structure, to better support organisational accountability, performance, and strategic oversight. The aim of the new operational and executive governance structure is to clarify roles, responsibilities and performance expectations. It has been developed by the Executive Leadership Team, was presented to the Board of Directors in July 2025 as part of the wider Accountability and Performance Framework, and was approved at the same meeting [WITN0133034]. The tables below show the groups reporting to the Executive Leadership Team: Table 1 shows the current Corporate Governance Structure (as at August 2025); and Table 2 shows the proposed Overarching Governance Structure.

Table 1

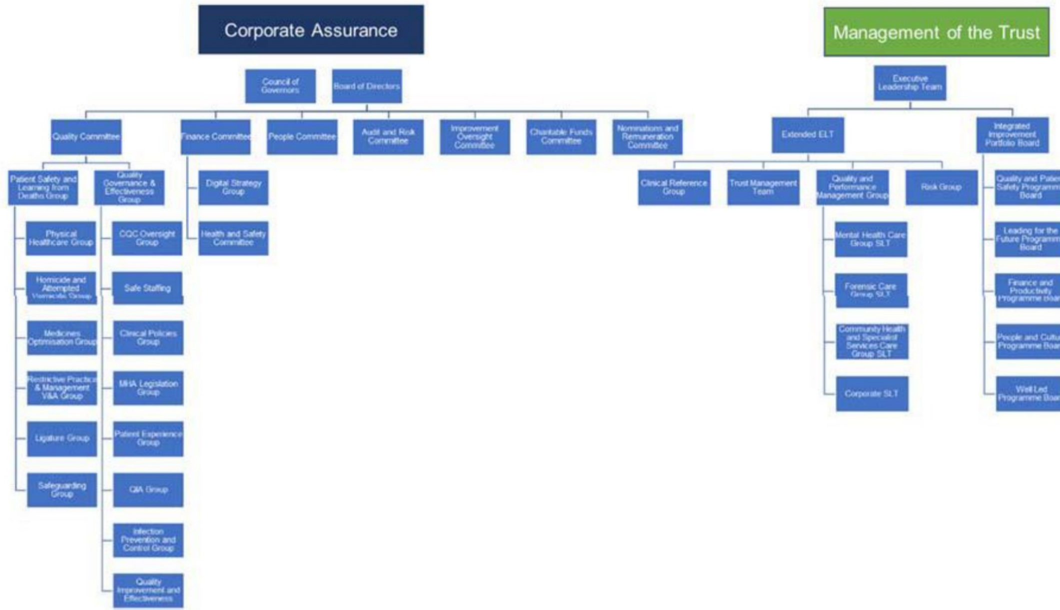
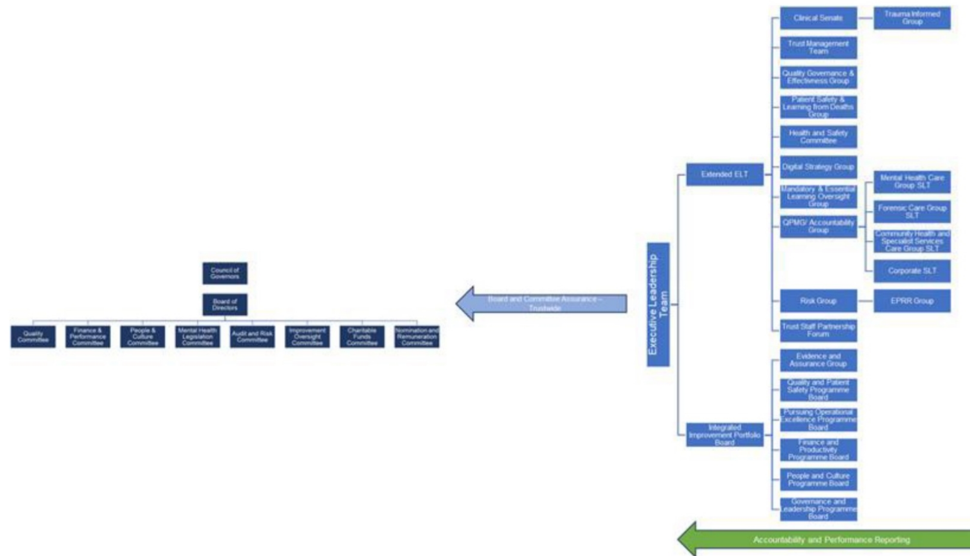


Table 2



Board Assurance Framework

58. The Board takes responsibility for oversight and risk management assurance throughout the Trust and reviews and approves the Board Assurance Framework regularly at its formal meetings [NHFT0000454, p225 - p254].

59. The Trust's strategic objectives form the basis of the Board Assurance Framework. The strategic objectives are linked to key risks, internal controls and assurance sources. Mitigating controls and assurances are recorded and monitored to deliver reasonable assurance for prevention of risks, deterrent to risks arising and management of current risks. The control mechanisms in place are designed to minimise or eliminate the risk of failure to deliver objectives, including robust corporate and performance management frameworks, service level agreements and contract monitoring, policies and procedures.

60. The Board has delegated detailed oversight of the Board Assurance Framework process to the Audit and Risk Committee. This committee assesses the effectiveness of risk management by managing and monitoring the implementation of the Risk Management Strategy; considering findings from internal and external audit reviews; calling executive directors to account for their risk portfolios and monitoring the Board assurance framework at each of its meetings. There have been approximately 16 audits per year, all which have been disclosed to the Inquiry [NHFT0001955, NHFT0004238, NHFT0003075]. The most recent audit relating to the Patient Safety Incident Response Framework ("**PSIRF**") is discussed further below at paragraph 519.

61. The Board Assurance Framework is scrutinised at the formal Board committees for the risks they cover in their remit. The chairs of each committee form the core membership of the Audit and Risk Committee, and it is the responsibility of the chairs to triangulate the assurance against the risks through the Audit and Risk Committee.

Committees

62. Committees support the Board of Directors to carry out their responsibilities. They cover areas such as Quality, Audit, People, and Finance, reporting directly to the board, and are all chaired by a non-executive director.

63. The governance structure of the Trust has evolved, with changes to the committee structure over the years. For example, there was a Quality Governance Review in 2020 [NHFT0014990; NHFT0014979]. These committees have varied over time and **Annex B** contains a table of the committees in place during each financial year since 2019/2020.

64. Of the various committees, a quality committee sets and monitors the quality standards of the Trust. Clinical risk and patient safety are overseen by the Quality Committee, which includes me as Chief Nurse, Executive Medical Director/Deputy Chief Executive and the operational directors. The Board receives regular reports at its meetings encompassing the quality and patient safety aspects for the Trust. The Quality Committee has focused on assurance that the Trust is embedding the lessons learned from incidents. This assurance is reported to the Board. The oversight role played by the Quality Committee is described in further detail below at paragraphs 157-160.

65. Throughout the relevant period of 2019 – 2023, a quality committee has reported to the Board:

    a. Between 2018 and 2019, it was known as the "Quality Committee".

    b. In June 2020, a report was presented to the Board of Directors Public Meeting (agenda item: enc 089): Review of Committee Structure and Terms of Reference. The proposal included combining the Quality, Workforce, and Mental Health Legislation committees into one "People and Quality Committee" which would "act as a point of triangulation which seeks assurance from officers on the appropriateness and effectiveness of, and the adequacy of risk management arrangements" associated with four strands of work, including "quality governance arrangements". The terms of reference of the new "People and Quality Committee" were set out within that report.

    c. From 2021, that committee was split into two, with the "Quality and Mental Health Legislation Committee" continuing the quality aspect.

d. In March 2023, it returned to being called the "Quality Committee".

66. Committees, such as the Quality Committee, delegate various actions to sub-committees, which in turn may set up groups responsible for a specific subject-matter or specific care group. These two layers are more flexible than the committees which report directly to the board and can therefore be established or changed depending on the needs and priorities of the committee overseeing it. **Annex C** contains a table showing various sub-committees and groups of the quality committees in place between 2019 and 2023. Detail about the work of the Quality Committee is set out at paragraphs 157-160.

67. Whilst clinical risk and patient safety are overseen by the Quality Committee, other committees also have a key role to play in the Trust's risk arrangements.

68. The Finance Committee is responsible for the consideration of investment risk. Achievement of efficiency, effectiveness and value for money is central to the Trust's organisational strategy and is one of four key objectives which underpin the Trust's approach to governance.

69. The People Committee focuses on gaining assurance on the effective implementation of the People Plan, with work streams based on the themes from that plan and reflected in the Trust's strategy. The People Committee has oversight of the people related risks. The staff report in the latest annual report provides detail of the progress against each theme in the People Plan [NHFT0000615]. In addition, the Trust has strengthened its provisions for the Freedom to Speak Up arrangements and has used the Freedom to Speak Up reflection tool introduced by the National Guardian's Office to update its Freedom to Speak Up strategy and planned initiative. During the year the Board of Directors and the Audit and Risk Committee received assurance that robust systems and processes are in place to address our people related risks, whereas the People Committee monitored the relevant Key Performance.

70. Overseeing these risk arrangements is the Risk Group, chaired by the Chief Operating Officer. This group takes an operational lens on the management of risks across the Trust and determines the appropriateness of, and manages the implementation of, the robust processes in place to manage and mitigate risks. The chair of the Audit and Risk Committee attends the Risk Group in an observatory capacity.

71. Overall performance is monitored at meetings of the Board of Directors. Performance reports provide data in respect of financial, clinical and workforce together with national targets and objectives. Any areas of concern are highlighted, and mitigating actions taken.

Committees today

72. The following committees are currently in place:
    A. Improvement Oversight Committee
    B. Audit and Risk Committee
    C. People Committee
    D. Quality Committee (incorporating the Mental Health Legislation Committee)
    E. Finance Committee
    F. Nominations and Remuneration Committee
    G. Charitable Funds Committee

73. Following the proposed governance restructure (explained above) there will be a separate Mental Health Legislation Committee as an additional committee.

74. As shown in the diagram at paragraph 38, the Improvement Oversight Committee sits apart from the other main board committees. It is chaired by the Trust Chair and its purpose is to oversee the improvements required for the Trust to exit from National Oversight Framework segment 4 (discussed at paragraph 72 above). Given this purpose, it is a time-limited committee, determined by progress of moving out of segment 4. Paragraphs 132-137 below set out further detail about the Integrated Improvement Plan and its oversight and delivery, for exiting segment 4

75. In addition to these committees, the board of directors is supported by a Strategy Working Group, as shown in the diagram at paragraph 38. It started as the Strategy Committee, which operated between 2020/21 to 2022/23; its purpose was to strategically think through opportunities for the Trust in order to provide feedback to the Board and secondly, to provide assurance to the Board. The Trust's Strategy was approved by the Trust Board in April 2022. The Strategy Committee ceased in 2023 and was replaced by the Strategy Working Group. It is not a formal committee of the Board although it was chaired by a non-executive director.

76. Today, the non-executive directors and executives, through development days, set the vision for the Trust ensuring alignment with national strategies and local needs and by fostering collaboration with partners and stakeholders. The Strategy Group provides 'think tank' capability at Board level (via the development days) to support the development of the Trust's strategic ambitions, and to influence Board decision-making. The Strategy Group was suspended between January 2024 and autumn 2024 so the Trust could focus on the development of the Integrated Improvement Plan. It now meets at least bimonthly.

Board development in the period from 2024

77. A programme of Board development sessions has been held during 2024/25 which has focused on a number of issues including risk management and risk appetites, the progress on the Integrated Improvement Plan, Board skills and capacity, PSIRF, regulatory matters, Well-Led, Freedom to Speak Up, equality, diversity & inclusion and strategy.

Trust Operating/Care group models and service delivery

78. Prior to 2019, the Trust tried to integrate mental and physical health services. This integration was trialled but ultimately did not succeed, leading to tension and uncertainty across services. In 2019/2020, the Trust's operating model gave

devolved responsibilities to the clinical divisions, with varying governance resources to monitor delivery. At this time, there was an Executive Director for Forensics, Executive Director for Mental Health Division and an Executive Director for Community Services Division. While this allowed for autonomy, it also contributed to a siloed culture, with limited cross-divisional collaboration. There was also no clear accountability framework linking divisional governance to corporate oversight. Reporting lines were unclear, and the lack of integration between governance layers made it difficult to ensure consistent standards or shared learning across the Trust. The lack of a unified operating model plus integrated governance limited the effectiveness of overall organisational oversight.

79. At the start of 2020/21, the COVID-19 pandemic meant that Trust leadership and operational capacity was focused on maintaining services. However, there were a number of governance reviews in the divisions in late 2021/2022 and into the following year. In February 2022, the internal auditors gave significant assurance for divisional governance in the Forensic Division and the Community Health Division. The Mental Health Division underwent internal auditing of their divisional governance and reported limited assurance in March 2023. Accountability Review meetings of the Divisions and Corporate Services started in 2022/23 chaired by the Chief Executive Officer.

80. The Executive Director for Mental Health Division left the Trust in December 2022, and the Executive Director for Community Services Division took on leadership for the two Divisions in January 2023. Early in 2023 / 2024, it was agreed that a new Chief Operating Officer post with new Care Group Director posts supported by an enhanced patient safety corporate function would provide greater oversight and be able to give assurance from the Divisions/Care Groups into the Board.

81. Since October 2023, operational management at the Trust has been organised around this "Care Group" model. The three care groups that have been in place since October 2023 are:

a. Mental Health Group

b. Community Health Group

c. Forensic Care Group

82. The three care groups align operational delivery with specialist clinical pathways and local geography, ensuring clear accountability for both quality and performance. In addition, there is a corporate services group that is responsible for the services set out below. Within each care group sits a tripartite leadership team:

    a. Care Group Director (a very senior management post, focused on operational delivery, resource management and performance) who reports to the Trust's Chief Operating Officer,

    b. Care Group Nurse Director (senior nurse accountable for professional standards, patient safety, quality governance and patient experience), who reports to me (as the Chief Nurse), and

    c. Associate Medical Director (senior doctor responsible for governance, and medical workforce) who reports to the Trust's Executive Medical Director.

83. This model was rolled out across the Trust in 2023–24 to strengthen local decision making and improve responsiveness. Five new Care Group Nurse Director roles were created as part of this to ensure senior clinical oversight of the delivery of our services.

84. All three tripartite members have overarching responsibility for ensuring that care groups:

    a. Meet national and local performance targets (e.g. waiting time standards, bed occupancy levels),

b. Adhere to Quality and Safety dashboards (CQC metrics, incident/complaint trends), and

c. Operate within budgetary and workforce constraints.

85. The Chief Operating Officer chairs a monthly Quality and Performance Group, bringing together all Care Groups and corporate leads to review:

a. Key Performance Indicators ("**KPIs**") by service and site including quality and patient safety measures,

b. Risk escalations and mitigation plans,

c. Financial performance against budget envelope, and

d. Quality and patient safety.

86. Each inpatient unit, community service or prison health service has an Associate Director of Operations, an Associate Director of Nursing/Allied Health Professionals and a Clinical Director (operating as a triumvirate). Their responsibilities are:

a. Overseeing day to day staffing, estates and logistics,

b. Chairing local operational meetings (e.g. ward huddles, community team huddles), and

c. Escalating issues up into the triumvirate layer.

87. Associate Directors of Operations maintain a direct "dotted line" relationship with all three triumvirate leads, ensuring that clinical, nursing and operational perspectives are integrated at the front line.

Mental Health Care Group

88. The majority of the Trust's mental health services are provided to the population of the City of Nottingham, Nottinghamshire County and Bassetlaw.

89. The Mental Health Care Group comprises 4 Care Units, each with a triumvirate leadership team to support professional, operation and clinical leadership. They are as follows:

    a. Mental Health Inpatient and Crisis

    b. Older Persons Care Unit

    c. Children's and Young People

    d. Adult Mental Health Community

90. The services are operated out of a number of bases. The main inpatient services are Highbury Hospital, Sherwood Oaks, Hopewood and Blossom Wood. Liaison services are located in the acute hospital providers and across a multitude of GP and health bases.

91. The acute inpatient services provide short-term intensive care in a hospital setting for individuals experiencing severe mental distress that cannot be managed safely in the community, aiming to stabilise symptoms, reduce risk and facilitate a safe return to community-based support.

92. There are currently 11 Local Mental Health Teams across the Trust. These teams have been in a general state of change for a number of years following local and national guidance. This includes new roles such as wellbeing practitioner and nurse associates, along with more established roles. As described at paragraphs 497- 499 below, a review of the EIP service was conducted by Jonathan Warren in 2024.

93. The Local Mental Health Teams provide services to adults with moderate to severe and enduring mental health problems between the ages of 18 and 65. Each team will provide the function of daily triage, assessment, treatment, follow-up and joint working with key stakeholders and other providers of health and non-health services (for example social care, housing, employment and education).

94. The team aims to be a part of the local community, linking in with key stakeholders, in order to support individuals to reach their optimum level of recovery whilst maintaining or building connections with family and community. The team also endeavours to build and maintain close links with primary care, social care and third sector providers in order to provide a comprehensive, holistic service.

95. The care and treatment offer is structured around 5 main clinical pathways covering a number of 'clusters'. A cluster in this context is a global description of a group of people with similar characteristics as identified from a full assessment and then matched to the Mental Health Clustering tool. The 5 main treatment pathways are as follows:

    a. Recovery from anxiety and depression (clusters 4-7): Treatment would include psychoeducation, pharmacological interventions, family interventions and other psychological interventions such as Cognitive Behaviour Therapy ("**CBT**").

    b. Supporting people with complex personality needs (cluster 8): Treatment and care planning would likely focus on engagement, care coordination or lead practitioner, psychological interventions e.g. Dialectical Behaviour Therapy, mentalisation and problem-solving approaches.

    c. Enduring Psychosis (cluster 16 and 17): Treatment for complex psychosis and options could include, psychoeducation, pharmacological interventions, CBT for psychosis, peer support, functioning assessments and interventions. This includes Assertive Outreach.

d. EIP (Cluster 10): Evidenced based structured pathway and monitored through the NCAP audit.

e. Recovery Pathway (clusters 11-15). This will include people with enduring psychosis and complex problems including homelessness, unstable accommodation, involvement with the police and criminal justice system. Treatment and care might include, medication education, management and concordance, CBT for psychosis, family work and psycho-social interventions along with practical help and support.

96. Although there is variation across the 11 teams, a typical funded staffing structure for each Local Mental Health Team is as follows:

Role	Band	Number
Team Leader	7	1
Clinical Team Leader	7	1
Psychologist	8c	0.8
ACP (Advanced Clinical Practitioner (or trainee)	7/8a	1
PCN (Primary Care Nurse)	7	2
CPN (Community Psychiatric Nurse)	6/5	13
Community Support worker	4/3	6.5
Social worker	6	2
OT (Occupational Therapist)	6	1.8
OT Assistant	3	2.5
Peer support worker	3	1
Wellbeing Practitioner	4	1
Trainee Nurse Associate	3	2
Health Improvement worker	4	2

97. Care coordination is the foundation of a high quality, high functioning Local Mental Health Team. Caseloads vary between individuals depending on the

experience of the clinician and the level of acuity and need of the group of patients they are supporting. Within the Trust, caseloads are between 15-25 which benchmarks well with comparator trusts. Vacancy levels across the teams fluctuated during the period in question but were between 2% and 20%.

98. To match need to supply, these teams manage a waiting list. The current average time to first assessment for patients seen by Local Mental Health Teams is 9.6 weeks. The number of patients waiting for Local Mental Health Team assessment is 1,730 for March 2025 (the latest published figures at the time of the Trust receiving this rule 9 request), the highest monthly level for over 24 months. It is noteworthy that between July 2022 and present day, following the Covid-19 pandemic, the total caseload for the Local Mental Health Team has risen from 8,619 to 10,107.

99. As noted above, the structure of the teams is broadly comparable across the teams, as is the operating model. Each team holds a daily Risk Assessment Meeting where all patients at risk are verbally discussed and a weekly Multi-Disciplinary Team ("**MDT**") meeting which prioritises those high-risk patients. There is also a 'duty' system in each team which is covered via an internal rota of Care Coordinators. The role includes taking calls and giving advice to GPs, responding to urgent clinical need during core hours and undertaking joint assessments with the crisis team.

100. The EIP team was originally set up in the early 2000s as a stand-alone team but was integrated into the Local Mental Health Teams in 2018. In early 2021, the decision was made to 'uncouple' the EIP teams from the Local Mental Health Teams. This was to support the teams to be able to improve the outcomes for patients specifically against the core components of Early Intervention guidelines.

101. To facilitate this 'de-coupling', Care Coordinators were released from any Local Mental Health Team work, such as duty and assessments, but remained based within the Local Mental Health Teams. The consultant medical staff remained

within the Local Mental Health Teams and were allocated sessional time to support the EIP teams, meaning there is no dedicated consultant. There is a similar arrangement for psychology and social work.

102. Within the Crisis team, clinical leadership is provided by the Team Leaders, Consultant Psychiatrists, Clinical Psychologists and the Band 7 Clinical Leads. The teams are managed by full time Crisis Resolution/Home Treatment Managers and Clinical Nurse Leads who also have specialist non-medical prescribing roles. The team also includes admin support, framework housing/benefit workers (mental health link workers) and Peer Support Workers, Social Workers and Occupational Therapists.

103. Organograms for the Local Mental Health Services Division (as it was then called) for 2022, when VC was discharged from the Trust, are set out in **Annex A**.

Forensic Care Group

104. The Trust is one of the largest NHS providers of forensic services in the UK and provides services across the full care pathway for several patient groups requiring forensic care within secure and community environments.

105. The portfolio of high, medium and low secure services are grouped as follows and include:

a. Low secure services;

b. Community Forensic Mental Health Services Liaison and Diversion Service Nottingham City & County (commissioned by NHS England Health & Justice and described in more detail below);

c. Mental Health Treatment Requirement Service - City & County (commissioned by NHS England Health & Justice);

d. Community Forensic Intellectual and Developmental Disability service– City & County;

e. Nottinghamshire MBT Service;

f. Assertive Transition Service - IMPACT commissioned service covering Nottinghamshire, Derbyshire and Lincolnshire;

g. Medium secure services for men with mental illness and men with personality disorder;

h. Medium secure services for women requiring enhanced care;

i. Women's Enhanced Medium Secure Service (which will cease in September 2025);

j. The National High Secure Service for Women;

k. The National High Secure Service for Men with a Learning Disability;

l. The National High Secure Service for Men who are Deaf;

m. High Secure Male Mental Illness; and

n. High Secure Male Personality Disorder.

106. Services are delivered from Rampton Hospital (high secure services), Wathwood Hospital and Arnold Lodge (medium secure services), and the Wells Road Centre (low secure services). Community services are delivered from Westminster House, and for health and justice commissioned services police custody, Magistrates courts in the area and Nottingham Crown Court.

107. The Trust has taken the lead role in the development, and subsequent delivery, of a New Care Model approach for the East Midlands for adult secure services through the provider collaborative IMPACT programme working with eight other

providers: Derbyshire Healthcare NHS Foundation Trust, Leicestershire Partnership NHS Trust, Lincolnshire Partnership NHS Foundation Trust, Northamptonshire Healthcare NHS Foundation Trust, Cygnet Healthcare, Elysium Healthcare, Priory Healthcare and St Andrew's Healthcare.

108. Forensic mental health services can be engaged in the following ways:

    a. Our inpatient services receive referrals from inpatient non-secure services, other tiers of secure care, via the Courts, from prison settings or very rarely directly from the community.

    b. IMPACT, the provider collaborative, receives all referrals to low and medium secure services for East Midlands patients, and then has a case management role with referrals to providers, depending on the immediate availability of a service. It also has a quality oversight role for providers.

    c. High Secure services are commissioned by NHS England Specialised Commissioning.

109. The Trust's community services receive referrals from inpatient services (including acute settings); via the courts; from prison settings; from community mental health services; the police or other criminal justice agencies. There is a tiered-model community forensic service; an equivalent service for transforming care cohort patients moving on from secure care; a liaison and diversion service; a mental health treatment requirements service and a mentalisation-based therapy service. Each of these is configured differently, reflective of the service specification and patient population needs.

110. Patients accessing Forensic Services are those who have an identifiable mental disorder such as a mental illness, personality disorder, Autistic spectrum disorder, or alcohol/drug related mental illness. They would have had significant probability of serious harm that has or could lead to life threatening injury or irreversible harm to others. Patients will typically have a history of GBH, fire

setting, stalking and/or serious sexual violence and there should be a suspected link between mental disorder and the risk behaviours.

111. The service offers a number of different levels of intervention:

  a. Advice only.

  b. Assessment of the patient including formulation, advice and recommendations. This assessment could be joint with the referrer.

  c. Working alongside the referring team with the referring team holding care coordination.

  d. Full case management of the patient.

112. The service aims to support patients to live as independently as possible in line with progressive risk reduction strategies, including how to manage crisis, exploring employment and education, understanding personal risk management strategies, learning from past incidents, and developing ongoing support packages.

113. The Forensic service does not offer a crisis service.

114. The Liaison and Diversion service is a Nottinghamshire-wide service designed to work with people at the earliest point of contact with the Criminal Justice system. The staff teams are based within the two Nottinghamshire Custody suites, and the Magistrates Court and Crown court.

115. The service is an all-vulnerabilities model, working with people from the age of 10 upwards. Referrals to this service come via all criminal justice agencies, self-referral or other mental health and learning disabilities agencies.

116. The service offers a screening process, triage or full assessment dependent upon identified need at the time. The service is based upon individuals' consent

to engage. If the individual does not consent to referral/assessment but there is evidence of risk to others or to self this information will be shared with relevant agencies.

117. The key aim of the service is the sharing of information and liaising with services the person is already open to, if applicable. The service offers advice to the police, Healthcare Professionals working within police custody, courts and prisons and refers onto other agencies based upon an individual's need, diverting when appropriate away from the justice system.

118. For those not known to any services, but with an identified need, the team will proactively support that individual to access appropriate services. It can also support individuals through the criminal justice process where needed and the individual accepts this.

119. Referrals can be made for any detainee identified with a vulnerability and referred via the following sources: police, Healthcare Professionals working in police custody, Appropriate Adults, self-referral, carers and family members, Substance Misuse Workers within custody, defence solicitors, Community Mental Health Services or other Trust teams. The service will accept referrals regarding any health or social vulnerability. This includes mental health, learning disability, social and communication difficulties, substance misuse, suicide/self-harm risk, abuse of any kind, homelessness (this list is not exhaustive).

120. All referrals received are screened against Nottinghamshire Healthcare electronic records to determine if there is a known history of contact with services, ensuing that known difficulties, risks or concerns are identified at the earliest opportunity and to support allocation of resources. The service will offer a triage assessment, which is a standardised assessment (an NHS England template) to support a brief assessment of needs, support or discharge (signposting - community services also subcontract a number of services to support service delivery and therefore direct to the most appropriate service). The service requires the consent of the individual to engage in the assessment.

121. The service will provide timely, relevant information to key decision makers in criminal justice agencies to inform outcomes along the youth and criminal justice pathways. The service will agree with criminal justice agencies the relevant information pathways to ensure that information reaches those agencies to inform bail, charging and disposal decisions. Where an individual is remanded to custody, the Criminal Justice Advice forms will also be shared with prison healthcare departments to ensure continuity of information sharing.

122. The Liaison & Diversion service is not commissioned/responsible for fitness to interview assessments or pre-release assessments; these remain the responsibility of the Healthcare Professionals. The Liaison and Diversion service will work closely with Healthcare Professionals to share relevant information and support joint assessments where indicated. The service also offers support and consultation to Healthcare Professionals and the police as required.

Community Health Care Group

123. The Community Health Care Group provides community physical health services for people registered at GP practices in Nottinghamshire. The Group also provides Intellectual and Developmental Disabilities services, and national transgender health services.

124. Some services are also provided to the residents of neighbouring ICB areas, such Derbyshire and Leicestershire, and to other organisations, for example Nottinghamshire County Council, Nottingham University Hospitals and Sherwood Forest Hospitals. The Care Group provides the full range of community services:

    a. Adult services inclusive of urgent and planned community nursing, podiatry, long term conditions and therapeutic provision.

    b. End of life services inclusive of hospice provision and palliative care community nursing.

c. Bedded rehabilitation previously known as community hospitals: these are provided in Lings Bar Hospital.

d. Specialist services (this includes intellectual and developmental disabilities inpatient and community services; Transgender Services, subcontracted clinical input into Substance Misuse services provided by Nottingham Recovery Network both outpatient and inpatient provision.

e. Integrated offender health within prisons – as noted above, in April 2025 the Board made the difficult decision to serve notice on the provision of all offender health services. These services are transferring to other providers during 2025/26.

125. The majority of the above services are provided in the community. The portfolio core services are managed on a locality basis and a range of specialist services managed on a county wide basis.

Corporate Services

126. The clinical care groups and services are supported by a wide range of corporate services. These ensure the efficient and effective operation of the Trust's core businesses and support the delivery of performance and regulatory functions.

127. Corporate services encompass a wide range of generic and specialist functions that support and advise on the delivery of clinical care in the Trust. These services include quality and patient safety, finance and procurement, human resources and workforce development, legal and risk management, estates and facilities management, and digital, data, and technology support. They also include medical and clinical leadership and professional leadership to nursing and allied health professionals and focus on quality, clinical governance and patient involvement. These corporate services are crucial for ensuring the Trust can function effectively

128. The Trust operates a corporate service business partner model for the Care Group which means that most of the corporate services have identified members of their team / individuals that align into a specific Care Group. The benefits include resource sharing, workload division, risk mitigation, diverse perspectives, complementary skills, shared decision-making and also means the business partner can build an understanding of the specific needs of a particular patient cohort and build stronger collaborative relationships clinical and operational teams.

Trust performance framework and quality oversight

129. The Trust's Performance Management Framework was originally developed in 2018/19 [NHFT0015754]. It was revised in 2024 to incorporate advice from NHS England's Recovery Support Programme. At this time, an independent audit was also commissioned to review the arrangements with a view to refining them further in 2024 and 2025, to strengthen reporting and escalation from services to the Board.

130. Since July 2025, the framework has undergone further refinement for the Board and delivery structures [WITN0133034]. These changes align with the Care Group structures and the leadership and governance changes introduced as part of the Integrated Improvement Plan discussed below. Its effectiveness will be monitored through the Quality and Performance Management Group, which is being reconfigured to become the Trust wide Accountability Group.

131. The table below outlines the Accountability and Performance Framework currently in place:

Performance Monitoring Tools

i. Integrated dashboards with KPIs across clinical, operational, financial, and workforce domains.
ii. Tiered reporting structure from ward huddles to Board-level assurance.

iii. Forward-looking tracking using data forecasting and scenario planning.

Escalation and Support Mechanisms

i. Three-tier escalation framework (Local Support → Enhanced Oversight → Intensive Support).
ii. Structured intervention packages (e.g., Rapid Response Teams, leadership coaching, digital transformation).
iii. De-escalation criteria and earned autonomy model for high-performing teams.

Governance and Accountability Tools

i. Standardised meeting agendas and escalation pathways.
ii. Defined roles and responsibilities at all levels (Board, Executive, Care Groups, Teams).
iii. Assurance mechanisms including the Integrated Performance Report, Board Assurance Framework (BAF), and risk registers.

Cultural and Leadership Enablers

i. Leadership visibility through structured 'Go See' visits.
ii. Quality Improvement (QI) methodology embedded at all levels.
iii. Coaching, mentoring, and development programmes for leaders.

Organisation Level	Description	Mechanism	Data	Tools
Level 1 – Operational: Team/ Wards	Monthly performance review led by Team/Ward/Service leaders to focus on	Monthly Meeting	Service KPIs	Ward2Board Online reports

	performance against standards.			
Level 2 – Operational: Services	Monthly performance meetings led by Care Unit leaders to focus on performance against standards.	Monthly Business Meeting Quality and Risk Meeting	Care Unit KPIs	Ward2Board Performance Pack
Level 3 – Care Group: Oversight and Management	Care Group senior level scrutiny of performance against standards.	Monthly Senior Management Meeting Quality and Risk Meeting	Care Group KPIs	Performance Pack
Level 4 –Care Group: Accountability	Care Group level Quality and Performance KPIs dashboards reviewed at Trust Quality and Performance Group through Dashboard. Care Group Performance Assurance Report detailing key performance risks, issues, and mitigations reviewed by the Trust Performance Group alongside latest performance data. Quality reports and People and Culture Performance Reports	Monthly Trust Quality and Performance Group Committee Structure: Quality Committee, People and Culture Committee, Risk Committee	Care Group KPIs	Integrated Performance Report Quality and Performance Dashboard Quality Report People and Culture Performance Report Ad-hoc Reports

	will also cover specific performance monitoring at Trust and Care Group Level.			
Level 5 – Trust:	Board level Integrated Performance report (IPR) focuses on risk and quality in performance. Executive briefing on other aspects of performance such as quality monitoring (such as CQC action plans or ad hoc papers bought to the attention through risk management systems).	Review through Committee Structure	IPR KPIs across Quality, People, Ops	Integrated Performance Report
Level 6 – System: Performance Oversight	Quarterly segmentation process of Nottinghamshire Healthcare by Nottingham and Nottinghamshire Integrated Care Board (ICB) Quarterly Service Review by NHSE of the ICB.	System Oversight Group and ICB Board	NOF KPIs	NOF Dashboard

Integrated Improvement Plan

132. In 2024, the Trust developed a comprehensive Integrated Improvement Plan to make significant and sustainable improvements to how the organisation operates and the care it provides. It captures all the necessary actions, framed around five major programmes, with progress being monitored through established oversight mechanisms. This will ensure that the Trust continues to make ongoing progress in strengthening its performance, leadership and governance in alignment with national expectations and external assessments to maintain patient safety [NHFT0000615 and NHFT0003275].

133. Collaboration has been fundamental to the success of our Integrated Improvement Plan. The Trust has welcomed input from a wide range of stakeholders, including specialist support teams, peer Trusts from across the country, and system partners. Crucially we have also established both a Staff Reference Group and a Patient, Carer and Family Reference Group to actively involve colleagues, patients and patients in the design and delivery of changes to our services and ensure that their vital perspectives remain central to the work of the Trust.

134. The Integrated Improvement Programme has five areas of work for delivering the Integrated Improvement Plan:
   A. Patient Safety and Quality Improvement Programme
   B. Leading for the Future Programme
   C. Finance and Productivity Programme
   D. People and Culture Programme
   E. Governance Programme

135. The Integrated Improvement Portfolio Board (IIPB) is chaired by the Trust CEO and was established by the Executive Leadership Team (ELT) to ensure ongoing monitoring, scrutiny and assurance on the progress and delivery of the Integrated Improvement Plan, including the actions required to meet the findings of the CQC

Section 48 review, and to meet the criteria to successfully exit segment 4 of the National Oversight Framework [NHNB0018961].

136. The IIPB provides regular reports into the Improvement Oversight Committee, to assess progress, challenges, risks and mitigation strategies in the context of the criteria for transitioning from segment 4 of the National Oversight Framework. The Improvement Oversight Committee is chaired by the Trust Chair. The purpose of this Committee is to provide assurance to the Trust Board whether there are robust actions in place to deliver the outcomes required for the criteria for exiting segment 4. [NHNB0018961]

137. The Improvement Oversight and Assurance Board is not a Trust group, but a multi-stakeholder body that is co-chaired by the NHS England Regional Medical Director and the CEO of Nottingham and Nottinghamshire Integrated Care Board. It brings together interested parties from across the local health and social care system to provide strategic oversight of the Trust whilst it is in segment 4. It oversees and gains assurances regarding actions against the Integrated Improvement Plan, in order to help the Trust to make the improvements required to exit segment 4.

<u>Trust policies</u>

138. The policies relevant to the Inquiry's terms of reference have been disclosed to the Inquiry, along with the previous versions that were in place between 2020-2023 [WITN0133032]. Some of these policies are discussed further detail below where relevant.

B. Incident and patient safety oversight

139. The Trust promotes a positive and non-punitive approach to incident reporting, using the electronic reporting system "Ulysses", to assist with learning from incidents. The main policies in place between 2019 and 2023 were:

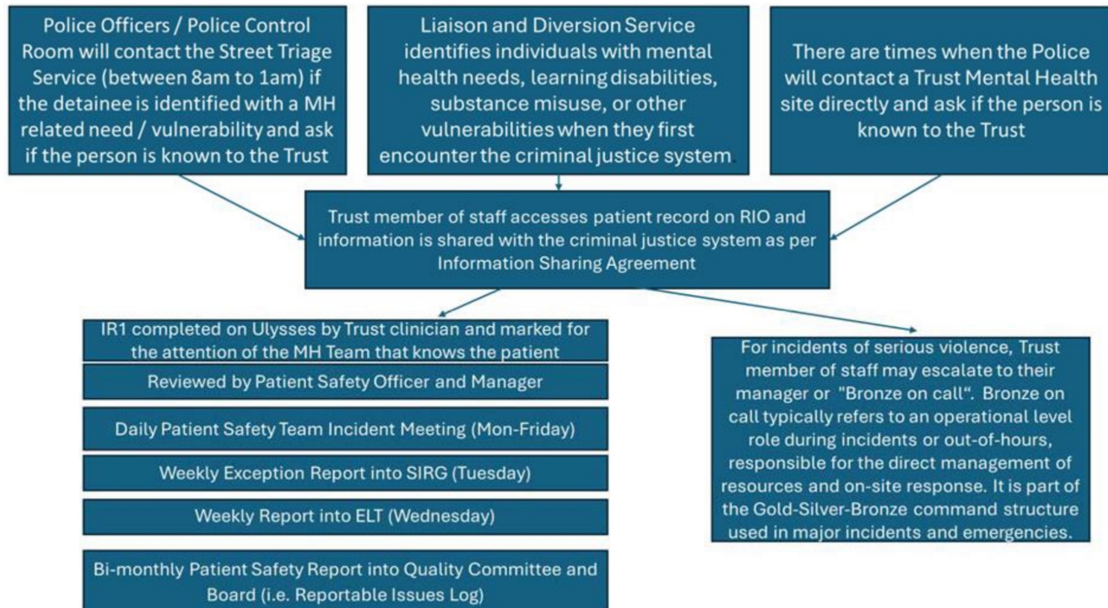
a. *15.01: Reporting of Accidents, Incidents and Near Miss Situations (Implemented August 2017; Issue 13 September 2020*) [CQCM0005588] and

b. *15.02: Managing Serious Incidents (SI) and Reporting and Learning from Deaths (Implemented September 2017; Issue 3 July 2019)* [NHFT0000596].

140. Policy 15.01 was rewritten in 2024 to take account of the changing national and local requirements required by PSIRF and Learning from Patient Safety Events, such as a more proportionate and learning-focussed response to incidents and greater engagement with those affected by incidents. In 2025 the new policy "*15.01: Reporting, Management and Learning from Incidents Policy and Procedure*" [NHFT0009283] replaced the two formerly separate policies. These policies cover the full spectrum of possible harm arising from an incident, from no physical or psychological harm to a fatal event.

Responding to homicides and assaults

141. Incidents of serious violence that occur outside of the Trust are reported into the Trust through several routes, which are shown in the diagram below.



142. In addition to the above, if the serious violence is a 'live' situation, the Trust may also be informed through the Local Resilience Forum (a multi-agency partnership that exists to prepare for and respond to emergencies). This is made up of representatives from local public services, including the emergency services, local authorities, and the NHS, all of whom are designated as Category 1 Responders under the Civil Contingencies Act (2004). In such circumstances, the Trust will consider mobilising its Incident Management Team using the Trust's Emergency Preparedness, Resilience & Response Policy [NHFT0005227].

143. Where a homicide is perpetrated/ allegedly perpetrated by a person who is in receipt or recently discharged from mental health trust care, the NHS England Regional Homicide Team need to be notified of the incident. The Trust will inform the Homicide Team of the progress of the internal investigation, and depending on the complexity can communicate directly with the families involved from the point of the incident. The Trust will complete a Patient Safety Incident Investigation, and this is shared with NHS England Homicide Team who will review the report and decide whether a further independent investigation for the purposes of learning is required.

144. Patient Safety Incident Investigations are often shared with the next of kin / the principal carer of those who are the subject of the investigation, as is clearly envisaged by the Trust's SI policy "*Managing Serious Incidents and Reporting and Learning from Deaths*" 2019 [NHFT0000596]. As such, the Trust's SI regarding the care of VC was shared with VC's mother [NHFT0000484]. However, it is sometimes less clear as to whether these reports can be shared more widely than with the subject's next of kin, given confidentiality obligations to the person who is the subject of the investigation report. In the case of VC, the Trust wished to be as open as possible with the victims' families, whilst balancing its legal duties. Therefore, the Trust obtained KC advice [NHFT0004713] on the extent to which it could share the report with the victims' families and shared an almost entirely unredacted version of the full, final Level 2 Investigation Report with them following receipt of that advice [NHFT0000451].

145. NHS England's Serious Incident Framework 2015 covered the role of regional investigation teams in cases of homicide by those in receipt of mental health care. It set out the process for deciding on an independent investigation, contact with families, and publication of independent investigations.

146. Appendix 1 of the Serious Incident Framework 2015 [NHSE0000058] (which provides guidance on the commissioning of independent investigations into homicides) is clear that decisions around publication, including pre-publication preparation, are led by NHS England, as the commissioner of the independent investigation. Appendix 1 provides that NHS England will publish and share the independent investigation reports on its website, with local publication expected to follow (by relevant commissioners and the provider organisation). It goes on to note that NHS England will publish and share independent investigation reports on its website in an anonymised format, although perpetrators can be named at their request, as can victims or where the families request.

147. As discussed in more detail below, the Trust commissioned a Thematic Review of homicides and attempted homicides 2019 – 2023 in March 2024 to establish whether appropriate learning has happened from previous homicides and attempted homicides. This review is described in section H below. A summary of all homicide/attempted homicide cases between 2020 and 2014 prepared by the Trust's Patient safety Manager has also been disclosed to the Inquiry [NHFT0000603; NHFT0016453; NHFT0008912; NHFT0010772]

Reporting of patient safety incidents

148. Pursuant to Regulation 18 of the CQC (Registration) Regulations 2009, all healthcare providers must notify the CQC of all incidents that affect the health, safety and welfare of people who use services. As explained below, from 2013 this was done via the National Reporting and Learning System and the Strategic Executive Information System ("**StEIS**") for Serious Incidents. There then followed a programme of phased replacement of these systems until June 2024, when the old system was officially decommissioned and all patient safety

incidents were recorded via the Learn from Patient Safety Events ("**LFPSE**") service.

149. In addition to the formal notification process, information is shared through more informal partnership arrangements as part of robust communication agreements.

150. As explained by NHS England's policy guidance [NHNB0017362], Serious Incidents were described as adverse events where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. StEIS, now LFPSE, can be accessed by NHS Commissioners and the CQC.

151. NHS trusts were expected to report Serious Incidents on StEIS within 2 working days of the incident being identified. The Trust was then required to undertake an investigation to ensure that any issues/problems with care delivery were fully understood and the 'root causes' were identified. Prior to the introduction of PSIRF, the NHS England Serious Incident Framework set out three types or "levels" of investigation depending on the nature, severity and complexity of the incident. These were:

    a. **Level 1 – concise internal investigation**, suited to less complex incidents which can be managed by individuals or a small group at a local level.

    b. **Level 2 - comprehensive internal investigation**, suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable.

    c. **Level 3 - independent investigation**, where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/ capability of the available individuals and/or number of organisations involved.

152. Following an investigation, the Trust would then create an action plan to implement any of the findings. The Trust has disclosed to the Inquiry the action plans relating to the various incidents which the Inquiry has asked the Trust to address in the Requests, as detailed in Section H below

153. From 1 April 2024, all providers of NHS-funded secondary care services were required to have implemented PSIRF, with this requirement being underpinned by inclusion in the NHS Standard Contract. PSIRF represents a significant shift in the way NHS trusts respond to patient safety incidents and aims to support organisations in drawing meaningful conclusions from the themes identified from recorded incidents, including learning that is relevant to and actionable by particular organisations and the specific risks in their area of work.

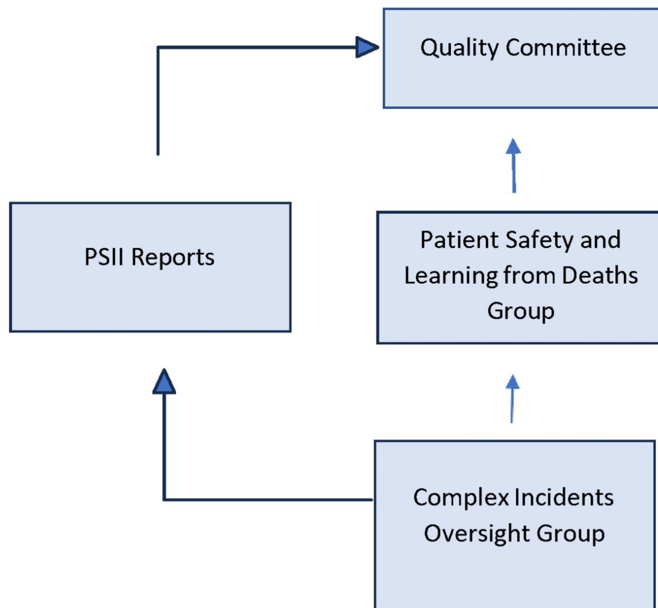
154. Diagrams summarising the Trust's patient safety processes in 2019 [NHFT0016452] and from 2024/2025 [NHFT0000423] have been provided to the Inquiry.

Trust oversight of patient safety incidents

155. Duties and responsibilities regarding the reporting and investigation of all patient safety incidents are in sections 3 and 5 of the Trust's policy 15.01 (2020), and section 3 of the Trust's Policy: 15.01 (2024) [NHFT0012587]. The policies also set out the requirements for reporting incidents to external stakeholders, such as NHS England, Commissioning Bodies, CQC and other interested parties. They describe the process of managing incidents and how the information derived is used by the trust to embed learning and improve the quality of care it provides. As a result of the 2020 Quality Governance Review, a Trustwide Patient Safety team was created. It is the responsibility of the Trust's Patient Safety Team to ensure that the systems and processes for the management of patient safety incidents is comprehensive and robust.

156. The Trust's governance arrangements to oversee the management of Serious incidents following the 2020 Quality Governance Review is set out in the Trust's document "SI Process" [CQCM0005588] The 2024/2025 updated policy 15.01

brought together new groups and greater oversight of patient safety incidents. The governance structure for the oversight of patient safety incidents is now as follows:



The Quality Committee

157. The Quality Committee (formerly known as the "Quality and Mental Health Legislation Committee") meets regularly to receive regular reports on patient safety and quality matters, which include safer staffing, Serious Incidents, inquests, Prevention of Future Death reports, Duty of Candour, and internal quality measuring tools (including the Trust Quality Dashboard). The Quality Committee is asked to note these updates and the accompanying data and assure themselves against the Board Assurance Framework (specifically SR2: Quality, patient safety and care standards risk). Assurance levels are agreed at each Quality Committee meeting and noted in the minutes.

158. The Quality Committee regularly reviewed the data made available through the National Reporting and Learning System, including the number of patient safety incidents and their classification, and Never Events (as defined by NHS England's Never Events policy and framework). Data from the past year was analysed, and actions to be taken to improve the incident rates were agreed to

ensure an improvement in the quality of services. This allowed a national comparison of the data which the Trust used. LFPSE was designed to facilitate this when it replaced the National Reporting and Learning System, however the national implementation has not yet been completed (albeit national comparison data is still available for Never Events). The Trust's Patient Safety Team has a robust oversight and understanding of local data and the Quality Committee reports directly to the Trust Board and provides a highlight report to each Board meeting to inform the Board of its assurances, decisions and any areas of concern. Any issues which require scrutiny by the Board must be flagged by the Quality Committee by the Chair. The Quality Committee reports to the Board annually on its work.

159. All relevant Quality Committee papers have been disclosed to the Inquiry, but we have set out here a summary of some of the type of issues discussed by the Quality Committee to explain how oversight worked in practice and steps were taken to address any concerns. In each case, the Quality Committee was presented with updates and issues, and would discuss them in detail, before making a decision on the level of assurance to provide against the Board Assurance Framework. The papers presented to the Quality Committee specifically state what they were seeking from the Committee, such as whether the updates were for assurance, review or to note:

a. In May 2022, the Quality Committee was made aware that the Trust had received feedback that increased patient risk or intent to self-harm was not always being fully recognised or acted upon. Several measures were agreed to be put into place, including the recruitment of additional staff, staff training, a new suicide prevention programme and increased patient Safety Plans [NHFT0000576].

b. In June 2022, the Quality Committee considered how the Trust had managed the requirements for recording deaths related to COVID-19 from October 2021-March 2022, as well as the increase in community deaths. The Trust committed to further analysis to better understand the background of the deaths. The Quality Committee also acknowledged

learning and changes in practice from Serious Incident investigations, as well as taking into account learning from national teams and other providers [NHFT0002430].

c. In October 2022, the Quality Committee received an update on the implementation plan of Quality Accreditation, a programme of accredited reviews against fundamental standards to ensure continuous improvement and positive outcomes for people who use Trust services. The Quality Committee also discussed the annual Safer Staffing report, and the key areas identified for the next year, including skill mix between teams and the use of Safer Staffing Data at all levels of the Trust [NHFT0003298].

d. In April 2023, the Quality Committee received another update on Safer Staffing and were assured that work was being undertaken across the Trust to ensure that national expectations were being met [NHFT0004353].

e. In June 2023, the Quality Committee was made aware of an increase in the use of mechanical restraints, rapid tranquilisation and long-term segregation, as well as an increase in violent incidents to staff. The committee considered the update and the review processes available, depending on the type of restraint. The Trust Strategy for Restrictive Practice was also presented. Safer Staffing was again discussed, and it was noted by the Quality Committee that staffing remained one of the highest risks under the Board Assurance Framework [NHFT0004538].

f. In December 2023, the Quality Committee was told through the regular Patient Safety and Inquest Report (presented by the Executive Director for Nursing) that issues had been identified relating to the management of incidents at the Trust, and a change in approach was required to provide assurance that learning opportunities were being identified properly. A number of incidents were not being locally investigated or closed in a timely manner, with significant risk to identifying actions, patient safety themes and identifying learning points, as well as the identifying and discharge of Duty of Candour responsibilities. It had been agreed that the corporate

teams would be provided with a list of open overdue incidents, and criteria were set in order for overdue open low/no harm incidents to be closed (from 01/01/21 – 31/10/23) [NHFT0004355]. In addition, the Quality Committee noted that two externally led reviews around the governance of Serious Incidents and the Duty of Candour and would report to the Quality Committee in January and February 2024 [NHFT0001610].

g. In February 2024 the Quality Committee was provided an update on the Governance Review of the management of Serious Incidents. The Quality Committee was advised that the review found that there was a lack of Trust-wide quality improvement programmes, and where they existed, there was a lack of robust quality assurance that they were effective. In addition, there was a severe lack of Trust-wide safety incident investigation, learning and family liaison capacity and capability, and a lack of standardised quality governance structures across the organisation. The review further found that the Trust was not ready for PSIRF, the Duty of Candour was not being performed consistently, and the Trust's external stakeholders for safety were not assured of the ability of the Trust to improve processes. The Committee was informed that external stakeholders had offered to help improve processes and plans were presented for the implementation of PSIRF. As discussed in section I below, significant improvements have been made with the implementation of PSIRF [NHFT0001610].

h. In April 2024, the Quality Committee was presented with an update on the Duty of Candour and the implementation of PSIRF. The Quality Committee was asked to note the PSIRF policy and planned implementation, as well as the growth of the Patient Safety Team. The Quality Committee was told about new Duty of Candour training, as well as a communication plan to drive awareness across Trust staff [NHFT0000457].

i. In June 2024, there was a short update on the ongoing work in Patient Safety, and the Quality Committee agreed that the transition phase from the old systems to new systems were too slow. The Quality Committee also reviewed the Quality Dashboard which set out the measures of incidents

against targets, noting that references to Serious Incidents would no longer be present in reporting due to the national migration to PSIRF [NHFT0000466].

j. In July 2024, the Quality Committee received an update on the review by Helen Collins into the Evaluation of Safety Processes at the Trust. The Quality Committee were informed that 70% of the 132 recommendations were complete, and the remainder were due to be completed by September 2024 [NHFT0000469].

k. In August 2024, the Quality Committee was updated that although learning from Immediate Learning Reviews (as part of PSIRF implementation) was being embedded in the Trust, there was some learning to be implemented from the lack of update of pressure ulcer risk assessment tools. New admission and discharge care plans were developed to trial at one site [NHFT0000507].

l. In October 2024, the Quality Committee was updated on the work ongoing around the Duty of Candour, and the significant progress that had been made to reduce issues. The Quality Committee was told that a centrally dedicated Duty of Candour Lead was due to start on 7 October 2024 [NHFT0003365].

m. In November 2024, the Quality Committee was updated on the Terms of Reference and the first full meeting of the Patient Safety and Learning from Deaths Group, which was held on 16 October 2024. The Homicide and Attempted Homicide Thematic Review was also presented, and the Quality Committee noted that an action plan would be developed and monitored [NHFT0000520].

n. In December 2024, the Quality Committee was again advised that there remained outstanding learning in pressure ulcer care, and to improve

documentation standards and best practice, refresher training had been booked for all staff undertaking data entry on SystmOne [NHFT0000522].

o. In January 2025, the Quality Committee was told that the Trust would be commencing its own PSIRF training which would include the quality of reports, as they had been receiving criticism. The Quality Committee also received an update about the Trust Patient Safety and Quality Improvement Programme, supporting the Trust in the National Recovery Support Programme, the delivery of the actions from the CQC section 48 review, and normal improvement work [NHFT0000527].

p. In February 2025, the Quality Committee was presented with the completed action plan in response to the Independent Evaluation of Patient Safety Processes. In addition, the Board was also provided with an update on the Patient Safety and Quality Improvement Programme, but felt assurance could not be provided until more detail on the work plan had been provided [NHFT0000531].

q. In March 2025, the Quality Committee discussed the Serious Incident reports on homicides and attempted homicides that had been submitted to an independent investigation company. The Quality Committee also discussed the Trust's meetings with VC's family and the victims' families. In addition, the Quality Committee were made aware of high-risk complaints the Trust was dealing with. All the above matters were presented to the Quality Committee for information and assurance [NHFT0000763].

r. In April 2025, the Quality Committee was updated on two Patient Safety Incident Investigations commissioned during November and December 2024. These investigations were in relation to an unexpected unnatural death in an inpatient ward, and an incident of violence in the community. Several safety actions were taken, including bespoke risk training, an inpatient ward learning event and an audit for risk assessments to ensure that they were up to date [NHFT0001837].

160. There are currently three groups that report into the Quality Committee: the Quality Governance and Effectiveness Oversight Group, the Patient Safety and Learning from Deaths Group and the Oversight Assurance Group (for the Theemis action plan). These are discussed further below.

Patient Safety and Learning from Deaths Group

161. The purpose of the Patient Safety and Learning from Deaths Group is to improve the safety of patients receiving care from the Trust's services. It is chaired by me (as Chief Nurse), or in my absence, the Deputy Chief Nurse. The Patient Safety and Learning from Deaths Group is responsible for developing a trust wide approach to patient safety issues which includes recommending workstreams to improve patient care. The Patient Safety and Learning from Deaths Group will provide oversight of this work to ensure a joined-up and consistent response is achieved across the Trust.

162. The Patient Safety and Learning from Deaths Group has the responsibility for the oversight of all deaths as outlined by the Learning from Deaths guidance and all incidents as defined by PSIRF, ensuring the Trust is driving quality and safety improvements by utilising a systematic approach to patient safety incidents.

163. Prior to the Patient Safety and Learning from Deaths Group, there was a Trust Quality Operational Group (incorporating the Clinical incident Review Creating a Learning Environment (CIRCLE)) which provided a high-level forum to oversee and monitor the reporting and review of Serious Incidents, ensuring that recommendations were implemented and that organisational learning had taken place. It would also escalate any appropriate risks to the Quality Committee for inclusion on either the Board Assurance Framework or the Trust Risk Register. Each Division would have its own CIRCLE which would report to the Quality Operational Group. These meetings have now ceased and at Care Group level, replaced by the Care Group Safety and Experience Meetings.

Complex Incidents Oversight Group

164. The Trust has established the Complex Incidents Oversight Group (formerly known as the Homicide, Attempted Homicide Group between June 2024 and February 2025) to provide executive oversight and governance of significant patient safety incidents which meet the threshold under PSIRF. It is chaired by me (as Chief Nurse), or in my absence, the Deputy Chief Nurse. This includes mental health homicides, attempted homicides and complex incidents. The objective of the group is to ensure that a joined-up and consistent response is achieved across the Trust, ensuring that the Trust is driving quality and safety improvements by utilising a systematic approach to patient safety incidents as detailed above. The group meets every 4 weeks (see, for example, [WITN0133026]; NHFT0008667].

<u>Quality Governance and Effectiveness Oversight Group</u>

165. The Trust's refreshed and strengthened Quality Governance and Effectiveness Oversight Group is established to provide assurance to the Quality Committee and Board with regards to the quality of patient care delivered by the Trust. The Trust has disclosed the terms of reference for the Group to the Inquiry [WITN0133033] but, in summary, the Group's duties include the following:

    a. Leading on the development and implementation of a Quality Surveillance Framework that supports the identification of issues causing problems in care through analysis of both quantitative and qualitative information triangulated from a range of sources, including CQC inspections and intelligence, Quality First reviews, incidents, mortality surveillance, complaints, claims, feedback and audits.

    b. Monitoring implementation of, and providing assurance on, the Quality Monitoring Framework for commissioned services;

    c. Leading on the development and implementation of initiatives to improve clinical effectiveness, including ensuring defined timeframes and

responsibilities for programmes;

d. Supporting the Trust's Mental Health Legislation Group to discharge its responsibility through ensuring that the Trust has relevant policies, practice and procedures in place to guide legislative compliance and to plan for future legislative change;

e. Oversee the ongoing development and implementation of the Trust's approach to Continuous Quality Improvement and, relatedly, ensure systems are in place to learn from national reports, confidential inquiries and surveys; and

f. Discharge a range of assurance functions, including receiving assurance from the Care Groups and, where assurance cannot be provided to the Quality Committee and Board, escalate concerns and agree improvement actions.

Oversight Assurance Group

166. The Oversight Assurance Group is chaired by me, to ensure that the actions arising from recommendations from the different investigations following the incident on 13 June 2023 are completed, embedded in practice and have lasting impact on the quality, safety and oversight of care provided by the Trust. It holds action plan owners to account with evidence to support ongoing progress, quality checks the completion of actions through peer review or critical challenge.

167. The group meets twice a month, although there is an expectation that the named leads for each recommendation will meet outside of these meetings. Each month; one meeting reviews the full action plan and the second meeting reviews the evidence against the completed actions in order to report into the externally chaired Evidence and Assurance Group. The Oversight Assurance Group also reports bi-monthly to the Quality Committee and the Trust Board – Private, and actions for both the Trust and the ICB are reported to the ICS Improvement

Group which reports to the NHS England Improvement, Oversight and Assurance Group

Care Group Safety and Experience Meetings

168. Each Care Group (Forensic, Mental Health and Community / Offender Health) holds monthly Safety and Experience Meetings which are chaired by the relevant Care Group Nurse Directors and Care Group Medical Directors. Its role is to improve the safety and experience of patients receiving care from the Care Group services. It is responsible for developing the Care Group-wide approach to patient safety, safeguarding and patient/ carer experience, including recommending workstreams, monitoring outputs and providing assurance. It oversees the implementation of actions as a result of incidents, complaints and experience reviews either locally or externally led, such as by the CQC. The group leads on the development and implementation of the Care Group's safety culture framework. These Care Group Safety and Experience meetings report into their senior leadership team for their own care Group; plus, bi-monthly report into Quality Committee.

Care Group Leadership Team

169. It is the responsibility of the Care Group Leadership Team (Care Group Nurse Director, Associate Medical Director and Care Group Director) to ensure the processes for the management of patient safety incidents is implemented. They are responsible for ensuring that there is a culture of reporting all incidents and near misses within their services via the Trust incident reporting system ("Ulysses") in line with this policy, for ensuring that incidents are reviewed and responded to in a timely manner, and that the principles and Duty of Candour regulations are adhered to.

Significant Issues Review Group / Serious Incident Review Group ("SIRG")

170. Historically, SIRG had been the Serious Incident Review Group, and focussed on incidents across the Trust. From 2024, it became the Significant Issues Review Group, in order to broaden the agenda to include wider quality matters

such as significant incidents, inquest feedback, complaints, and safeguarding. Prior to January 2024, this was chaired by the Associate Director of Quality, reporting directly to me (as Chief Nurse) and I would attend the meetings of this group. From January 2024, my Deputy Chief Nurse started to chair the meetings and since February 2025 it has been chaired by me (as Chief Nurse), or in my absence, the Deputy Chief Nurse. SIRG meets weekly and provides Trust wide oversight of the reporting and management of significant incidents to ensure immediate risks are managed, the appropriate level of investigation is commissioned, the Duty of Candour is applied when required, that staff are supported, and incidents are communicated in an appropriate and timely manner. The Group also identifies any immediate learning to be enacted. Since 10 May 2023, a weekly exceptions report has been shared with the Executive Leadership Team following the meeting, and since October 2023 this has also been shared weekly with the CQC. It does not report directly to the Quality Committee as the Quality Committee continues to receive formal papers on patient safety such as the Patient Safety Exceptions Report (previously titled the Serious Issues Log) which also goes to the Private Board.

171. In contrast to the current arrangements, in the period prior to May 2023, no minutes were taken (although an Incident Log was kept) and a verbal update was given by exception to the Executive Team. The Private Board received a report, but this information was not triangulated with other reports, nor did it identify learning and it is understood now that some incidents and homicides were not reported.

172. The Significant Incident Sign-Off Panel meets weekly to enable, at a senior leadership level, the scrutiny, learning and sign off following the completion of patient safety incident investigations, Domestic Homicide Reviews, Homicide Investigations and Safety Incident Reviews. Its role is to quality assure completed reports, identify potential risks, ensure actions are fit for purpose and recommend work streams which will lead to improving care delivery. Before the Significant Incident Sign-Off Panel signs off the investigations and reviews, the following takes place:

a. The draft investigation / review is submitted by the lead investigator;

b. It is quality checked by the Patient Safety Team, legal team and Family Liaison Officer.

c. It is then sent to the service for internal sign off, safety plan and sharing with family and staff for final comments.

d. The final version is signed off by the Significant Incident Sign-Off Panel.

Patient Safety Huddles

173. The Patient Safety Huddle occurs every week and is chaired by the Patient Safety Lead /Patient Safety Specialist. Its purpose is to provide oversight and review of incidents by the Patient Safety, Family Liaison, Medico-Legal, Safeguarding and Care Group clinical teams. It reviews all significant issues that have occurred since the last meeting, establishes immediate safety risks to agree mitigations and what learning and actions are required. The huddle agrees incidents to be escalated to SIRG (described in more detail) and recommends learning responses.

C. External co-operation and oversight

174. The following bodies, some of which have already been described or referred to earlier in this statement, have a role to play in the way the Trust delivers its services, including in relation to external oversight and assurance:

a. **Secretary of State**. The Department of Health and Social Care plays a significant role in mental health policy and funding. In July 2019, the Government published the Mental Health Implementation Plan for 2019/20-2023/24 to provide a new framework for the delivery of mental health care at the local level [DHSC0000016]. In May 2023, the Government consulted on a its proposed Mental health and wellbeing plan. On 6 November 2025, the Mental Health Bill was introduced in Parliament to deliver on the Labour government's manifesto commitment to modernise mental health

legislation to give patients greater choice, autonomy, enhanced rights and support, and ensure everyone is treated with dignity and respect throughout treatment.

b. **NHS England**. The statutory regulator since 1 July 2022 after taking over this role from NHS Improvement (previously known as "Monitor"). NHS England's NHS Oversight Framework sets out how the oversight of NHS trusts, Foundation Trusts and ICBs operates [NHNB0018961]. We have described in section A above how NHS England's Oversight Framework operates in respect of the Trust.

c. **CQC**. All NHS providers must be registered with the CQC, which is the primary body responsible for regulating the quality of care by way of registration, monitoring, inspection, and the rating services. This is described below. We have also described in section H below the specific power[2] to conduct a special review or investigation into a service when requested or approved by the Secretary of State.

d. **NHS Nottingham and Nottinghamshire ICB** (known as the NHS Nottingham and Nottinghamshire CCG between 1 April 2020 and 30 June 2022). As described in more detail below, the ICB is responsible for planning and managing health services, including quality oversight, within the Nottinghamshire area to ensure that the NHS provides services that meet the needs of the population. ICBs are not permitted to commission healthcare services that NHS England has a duty to commission, unless this has been delegated by NHS England. We describe in section I below the updates being provided to the ICB in relation to the Trust's response to the Theemis report and section 48 investigation, including its Integrated Improvement Plan discussed also above.

e. **Nottingham City Council and Nottinghamshire County Council**. Each Council has a Health and Adult Social Care Scrutiny Committee to fulfil its

[2] Pursuant to section 48 of the Health and Social Care Act 2008

statutory duty of scrutinising local health decisions, strategy, policy and performance. The Trust has disclosed to the Inquiry the updates provided by the Trust to these committees during 2024 and 2025 to date [NHFT0002435, NHFT0004121, NHFT0001237].

f. **The coroner**. Following an inquest or investigation into a death, a coroner has a duty to issue a Regulation 28 Prevention of Future Deaths report to a person, organisation, local authority, government department or agency, where the coroner believes that action to address some of the identified concerns should be taken to prevent future deaths. Receiving individuals or organisations have a statutory obligation to respond to the coroner's Prevention of Future Deaths report and a deadline of 56 days to do so. Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 set out further information and the procedures that apply to reports and responses. The Trust has received 19 Prevention of Future Deaths reports since 2019 but can confirm that all of these related to incidents of natural cause, disease or self-harm. One of the governance changes made by the Trust over the last few years has been to increase oversight of Prevention of Future Deaths reports in order to improve learning from incidents.

CQC inspections

175. The CQC's inspections operate in two main strands: quality inspections and MHA monitoring. In terms of quality inspections, there were two full inspection reports published by the CQC in relation to the Trust within the timeline period:

a. 24 May 2019, following an inspection visit between 22 January and 7 March 2019. The services inspected were: (1) acute wards for adults of working age and Psychiatric Intensive Care Units, (2) community-based mental health services of adults of working age, (3) child and adolescent mental health wards, (4) community mental health services for people with a learning disability or autism, (5) forensic inpatient or secure wards, and (6) mental health crisis services and health-based places of safety [NHFT0002015].

b. 25 November 2022, following an inspection visit between 22 March 2022 and 28 April 2022. The services inspected were (1) long stay rehabilitation mental health wards for working age adults, (2) wards for older people with mental health problems and (3) community-based mental health services for older people [CQCM0016478].

176. Each of these reports found areas of good practice and areas for improvement. The ratings given by the CQC were as follows:

2019 **Rating:**
Overall – Requires Improvement
Safe – Requires Improvement
Effective – Good
Caring – Good
Responsive – Requires Improvement
Well-Led - Requires Improvement

2022 **Rating:**
Overall – Requires Improvement
Safe – Requires Improvement
Effective – Requires Improvement
Caring – Outstanding
Responsive – Requires Improvement
Well-Led - Requires Improvement

177. The Trust has recognised that there were some common themes across the two sets of inspections. These can be summarised as follows:

Risk Assessments/Care Delivery

Themes: Inconsistent application of clinical risk tools, Poor documentation and follow-up of individual risk factors, Delayed or absent updates to care plans and crisis plans, Weak integration of physical health monitoring into mental health care.

2019	2022
Risk assessments lacked relevant risk information. Blanket restrictions were applied without individualised risk assessments. Physical health checks post-rapid tranquilisation were not consistently completed. Observation practices in forensic services had not improved despite prior feedback.	Crisis and contingency plans were missing or not embedded. Falls risk assessments and care plans were incomplete in community inpatient services. Staff did not always follow observation policies. Safeguarding referrals were not always submitted in a timely manner.
Environment **Themes:** Environmental risk assessments not updated, Estates issues not prioritised despite known risks, Refurbishment plans delayed; governance not ensuring timely resolution	
2019	**2022**
Dormitories, privacy breaches (e.g., male staff observing female patients).	Delays in dormitory elimination; 80 patients still sharing rooms. Long-standing maintenance issues (e.g., broken showers)
Medicines Management **Themes:** Lack of monitoring of action plans to improve medicines management, Medicines policy inconsistently applied across services, Poor systematic oversight of medicines safety.	
2019	**2022**
Unsafe storage and transport of medicines in community settings. Inconsistent post-tranquilisation monitoring. Staff did not follow trust policy on medicines.	Omissions in recording self-administered critical medication. Incorrect storage and disposal of prescription pads. Medicines audits not embedded in practice.

Staffing **Themes:** Recruitment and retention were major challenges, Staff morale and engagement at lowest levels nationally, Governance structures not embedded to monitor training and supervision	
2019 Unsafe staffing in acute, forensic, and crisis services. Staff unable to provide 1:1 time or leave for patients	**2022** Insufficient qualified staff in several services. Supervision and appraisal not consistently recorded. Mandatory training compliance below 75%.

178. In addition to the Inspection Reports covering the whole Trust, the CQC conduct focused quality inspections on individual services. The reports from these inspections are all on the CQC's website, which shows an increase in the number of inspections and reports by the CQC since 2023:

Year published on CQC website	Number of CQC reports in relation to the Trust
2019	8
2020	4
2021	1
2022	10
2023	1
2024	19
2025	19

179. By way of example, focused inspections in 2024/2025 included the following services, for which the following ratings were issued:

a. High Secure Hospitals (Rampton): Requires improvement.

b. Acute wards for adults of working age and Psychiatric Intensive Care Units: Requires improvement.

c. Mental Health crisis services and health-based places of safety: Good.

d. Community-based mental health services for adults of working age: Good.

e. Forensic inpatient or secure wards: Good.

f. Long stay or rehabilitation mental health wards for working age adults: Requires Improvement.

180. In terms of the other main strand of CQC inspections, regular MHA monitoring visits occur across all services where the use of the MHA is applied. We anticipate bi-yearly visits and assessments, but this does not always occur at that frequency. Historically, the Trust awaited the final report which when received was sent to the Chief Executive. This was then distributed to the relevant leader to populate the action plan. Oversight would have been primarily within the Care Group with senior sign off and further assurance on progress taking place in the Legislation Oversight Group for each Care Group. More recently, the Trust has implemented a meeting after each MHA monitoring visit, with the team directly involved to understand immediate feedback, learning, and any actions. This is attended by the staff involved, senior Trust leads and is sometimes attended by the CQC. On receipt of the action plan, the Trust Compliance Team meet with the Care Unit Leads and agrees the actions to support completion. Assurance on progress is sighted at the Trust Mental Health Legislation Oversight Group chaired by the Executive Medical Director and Deputy CEO with specific focus on the elements relating to MHA compliance. This Group previously reported to the Quality Committee directly. It was then moved, as part of the Quality Governance review to a sub-group of the Quality Committee. There are further imminent changes to the Quality Governance Structure, with the introduction of a Mental Health Legislation Committee. This, as with all other committees of the Board, will be chaired by a non-executive director and will report directly into the Trust Board.

181. In addition to the two main strands of CQC monitoring, the Trust will engage with the CQC routinely when an enquiry is received. The nature and frequency of these enquiries fluctuate, and can relate to patients, carers and staff. Yearly from 2019 the number of enquiries from the CQC to the Trust are as follows:

   a. 2019 - 26
   b. 2020 - 75
   c. 2021 – 35
   d. 2022 - 41
   e. 2023 – 31

182. As these enquiries concern individuals not connected to the events being examined by the Inquiry, the correspondence with the CQC in this regard has not been disclosed.

183. The Trust's CQC Compliance Team has overall oversight of CQC activity within the Trust. The team sits as part of the core role of the Associate Director of Quality which, in the timeline period of the Inquiry, was the responsibility of the Chief Nurse. All open actions or areas of focus are collated in one central document on the digital platform 'AMaT'. This came into operation in 2022. Prior to that, each Care Group had a process for oversight which was led by a senior lead. All open actions were reported through to the Trust Quality Operational Group, chaired by me as the Chief Nurse and which then feeds into the Quality Committee.

184. In July 2023, a time limited CQC Oversight Group was established to pull together all of the learning across the Care Groups into one meeting which was chaired by me. This group was disbanded and a more bespoke offer to Care Groups implemented to ensure the right level of response, actions and quality are followed and reported on. Similar to the process detailed above for oversight following the MHA monitoring visits, there is a supportive debrief following each quality inspection to understand immediate actions and feedback. The Care Group effectiveness oversight meeting then directly manages actions and

progress, escalating as required. Final sign-off and review of evidence is undertaken and led by me as Chief Nurse

CCG/ICB Quality and safety oversight

185. In the period from 1 April 2013 to 1 July 2022, CCGs had responsibility for commissioning a wide range of healthcare services and for oversight and performance management of commissioned providers. The arrangements within the Nottingham and Nottinghamshire area have evolved over time, culminating in a single CCG covering the geographic area: NHS Nottingham and Nottinghamshire CCG, which was established on 1 April 2020.

186. CCGs have never commissioned specialised services, including high secure psychiatric services, as these were the responsibility of NHS England.

187. The Trust's first interaction with VC was in May 2020 and so I have not described in this statement the arrangements that were in place prior to the establishment of the single CCG for Nottingham and Nottinghamshire.

188. CCGs have, since 1 July 2022, been replaced by ICBs as the local commissioners of healthcare services.

189. The ICB that is the primary commissioner of services from the Trust is NHS Nottingham and Nottinghamshire ICB.

190. As with CCGs, ICBs have a duty to allocate the NHS budget and commission services for the population in the area for which they are responsible. On establishment, ICBs also took on some of the direct commissioning functions of NHS England (such as primary medical services, primary dental services). However, the specific statutory arrangements that apply in relation to specialised services remains the same, although NHS England has begun the process of delegating some of these to ICBs.

191. As was the case for CCGs, ICBs are accountable to NHS England, with NHS England annually assessing ICB performance [WITN0133004]. ICBs hold partners within the system accountable through mechanisms such as joint system plans, partnership agreements, joint committees, and collaboratives. ICBs are expected to commission strategically and assess a variety of services and pathways to guarantee access to high-quality care, enhance outcomes, and reduce disparities within their area.

192. The role of ICBs includes the monitoring of provider performance against their contractual obligations in the NHS Standard Contract, and as part of the ICB's population health strategy. This occurs through regular reporting: each month, the Trust will send the ICB (via email) a Service Quality Performance Report (detailing performance against National Quality Requirements, Local Quality Requirements and the Duty of Candour), Activity and Finance Report and a summary report setting out relevant information on Patient Safety Incidents and the progress of and outcomes from Patient Safety Investigations. The Trust must report to the ICB annually on the outcome of reviews and evaluations in relation to staff numbers and skill mix, and progress against Green Plan.

193. We have disclosed to the Inquiry copies of the of the NHS Standard Contract for the relevant period [NHFT0003349]. Schedule 4 of the 2024/25 Particulars covers information relating to Quality Oversight that the Trust is required to share with the ICB. To reduce the Trust's reporting requirements in this regard, after ongoing discussions between the Trust and the ICB, it was agreed in 2023 that the ICB could have a presence at internal Trust meetings related to Quality, and a senior ICB representative would be invited to Quality Committee meetings. This has enabled the ICB to directly check and challenge as appropriate any issues around the quality and safety of services.

194. The following table provides an overview of ICB presence in quality oversight meetings and examples of summarised/brief information shared:

Meeting Name	Frequency	Information shared within the meeting	Documents sent to the ICB	What the ICB did with the information[3]	Evidence/ supporting documents available
SIRG	Weekly	• Patient Safety Incidents - Serious Incidents • Legal Services - Coroners/ High risk Prevention of Future Deaths overview • High risk/adverse media • Suboptimal staffing/red flag staffing incidents • Complaints • HR • Safeguarding cases	Agenda Serious Incident summaries Escalations report	Oversight triangulation with other information Escalation – Executive briefs for most serious concerns. External escalations to NHSE as appropriate. Internal touchpoint meetings – Information sharing across ICB colleagues	TOR Agenda's Notes from the meetings Executive Leadership Team exceptions report
Trust wide Quality	Monthly	Trust wide quality safety experience information as	Agenda Embedded papers	Oversight triangulation	TOR Agenda's Minutes

[3] This information is based on the Trust's engagement with the ICB

Oversight Group (**TQOG**) Care Group Quality Oversight Groups (**QOG)**		scheduled on the QOG forward planner. Risk. TQOG was an official subgroup of the Trusts Quality Committee. Currently 2 x subgroups – Learning from Patient Safety and Deaths group and Quality Governance, Effectiveness, Oversight Group.	Minutes	with other information. Assurance Exception reporting into ICB Quality Committee Quality Risk Profile Holding up the mirror/check and challenge Internal touchpoint meetings – Information sharing across ICB colleagues	
Safer Staffing Meeting	Monthly	Safer staffing report. Areas of <85% staffing	Report Agenda	Oversight triangulation with other information.	Email to quality ICB inbox Reports

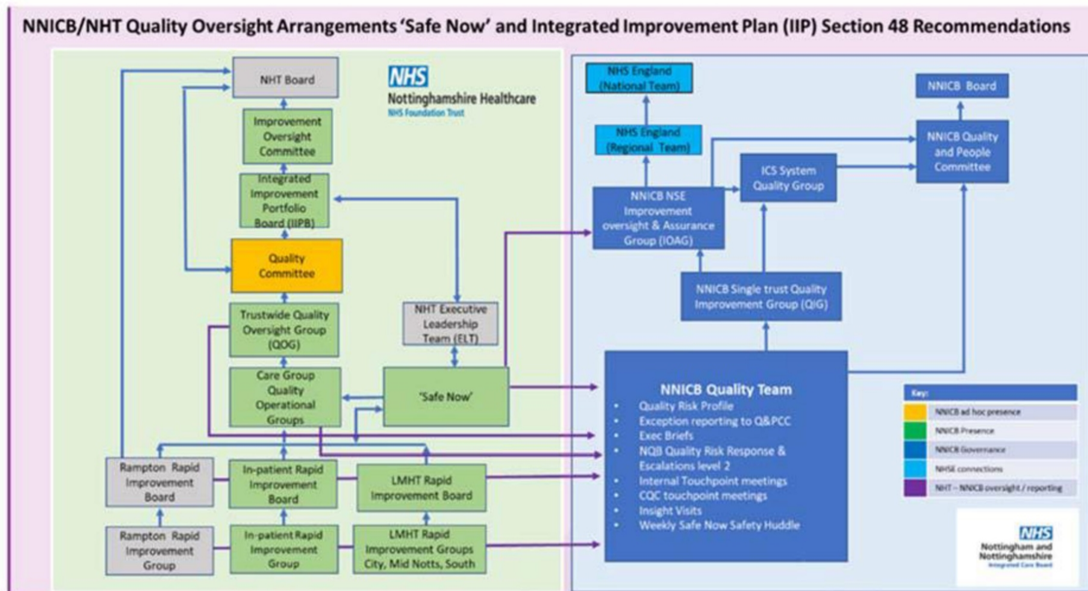
		and >125% staffing levels. Actions taken to address shortfalls		Quality Risk Profile	
Rapid Improvement Groups and Boards Adult Mental Health In-patients Community Health Services Crisis Community Mental Health	Various	Operational areas identified as requiring improvement Progress made against improvement actions Impact of Improvement Challenges/barriers to improvement	Papers to ICB quality inbox/ICB leads.	Internal touchpoint meetings – Information sharing across ICB colleagues Quality Risk Profile	Agenda's Papers
Trust SafeNow operational, overview and steering group	Weekly & Monthly	Community MH Crisis AMH in-patients	Escalation reports	Oversight triangulation with other information. Internal touchpoint meetings –	Reports

				Information sharing across ICB colleagues	
Joint ICB/ Trust quality standards/compliance visits	As required	Lings Bar Hospital Sherwood Oaks Hospital Highbury Hospital Blossom wood (Millbrook) Hospital Crisis teams Local Mental Health Teams	Reports	Quality Risk Profile Oversight triangulation with other information. Internal touchpoint meetings – Information sharing across ICB colleagues	Emails
ICB led Quality Assurance Group (QAG) NNICB[4] Quality inbox	Monthly	Quality concerns	Minutes	Assurance Escalation Holding to account Formal meeting	TOR Agenda's

[4] NHS Nottingham and Nottinghamshire ICB

NNICB Business manage ment team					
ICB led Partner Quality Assuranc e & Improve ment group	Monthly	Quality concerns aligned to the local quality schedule Information sharing across the system	Reports Minutes	Oversight triangulation with other information.	TOR Agenda's

195. The table below describes the ICB/Trust oversight recently introduced to deal with the Integrated Improvement Plan (described in section A above) and remedial action required following the CQC section 48 review (described in section H below), which evidences the shifting/dynamic relationship we had with the ICB to enable Quality oversight.



196. There is also a Mental Health Partnership Board that reports into the ICB Board. It has an independent chair, and the Trust is a member. There are newly forming sub-groups to this Board called Local Delivery Groups. One of the sub-groups is chaired by the Trust's Executive Medical Director and the vice chair is a GP. The Terms of Reference are not yet finalised, and the purpose of the group will be to focus on the collaborative working between the Trust and other health care providers, such as primary care.

National Clinical Audit for Psychosis

197. The National Clinical Audit for Psychosis is commissioned by the Healthcare Quality Improvement Partnership as part of the National Clinical Audit and Patient Outcomes Programme. It started in 2017, succeeding the National Audit of Schizophrenia which was conducted from 2011-2014. The focus of the audit shifted from core services to EIP Teams from 2018 onwards.

198. The audit focuses on 8 core areas the chart below highlights the Trust's performance against these standards for the period in question

Standard	18-19	19-20	20-21	21-22	22-23

Standard 1 - Treatment	60%	70%	85%	82%	83%
Standard 2 – CBTp	20%	20%	12%	24%	49%
Standard 3 – Family Interventions	20%	8%	12%	5%	30%
Standard 4 – Clozapine	30%	48%	40%	42%	NA
Standard 5 – Supported employment and education	15%	18%	20%	20%	29%
Standard 6 – Physical health screening	26%	58%	70%	99%	98%
Standard 7 – Physical Health interventions	15%	48%	63%	97%	98%
Standard 8 – Carer-focused education	31%	25%	21%	32%	NA

199. As can be seen from the above table, significant progress has been made over the period in question with the team showing strong performance in standards 1, 6, and 7 and significant improvements in all other standards.

200. To achieve these improvements the EIP service developed the EIP dashboard in 2020 which gave the team live data and the ability to look at individual

compliance levels. This has been refined and developed over the past 4 years to reflect changes in data collection methods and definitions.

201. As well as ensuring that the team has real time data on performance, the team also enhanced the provision of Family and Care giver roles. This has supported the improvement seen in family interventions which had slipped to as low as 5% of families. It is noteworthy that during this period the EIP service uncoupled from the Local Mental Health Teams as described above.

D. Overview of mental health treatment

Statutory Framework

202. The treatment and care provided by the Trust to patients with mental health disorders is under a framework of legislation and associated legal and clinical guidance. A brief summary is set out here by way of context.

203. The MHA is the main piece of legislation that covers the assessment, detention, consent to treatment, compulsory treatment, and rights of people with a mental disorder (as defined by section 1 of the MHA).

204. A person will be detained under the MHA if they have a mental disorder which requires assessment or treatment in hospital, and they need to be in hospital for their own safety or the safety of other people. Different sections of the MHA have different purposes for detention, for example:

    a. Section 2: Detention for assessment (or assessment followed by medical treatment) for up to 28 days.

    b. Section 3: Detention for treatment for up to 6 months, which can be extended.

205. Approved Mental Health Professionals ("**AMHP**") can apply for a patient to be admitted under the MHA (section 11 and section 13), which needs to be agreed by two doctors (one of which needs to be approved under section 12 of the MHA). The "responsible clinician" has overall responsibility for a patient's care and treatment under the MHA (section 55).

206. The Mental Health Act Code of Practice 2015 provides statutory guidance on the MHA. It is an extensive document of over 450 pages, but it is worth noting here that in addition to practical guidance on matters such as assessment and admission to hospital under the MHA, it sets out "*five guiding principles that underpin the Act*":

a. Least restrictive option and maximising independence

b. Empowerment and involvement

c. Respect and dignity

d. Purpose and effectiveness, and

e. Efficiency and equity.

207. The Mental Capacity Act 2005 ("**MCA**") sets out the principles and procedures for adults who lack the capacity to make specific decisions for themselves. It helps to ensure that decisions made for them, such as in relation to their health, are made in their best interests. The MCA also works on principles of least restriction, and that a person must be assumed to have capacity unless it is established that they lack capacity

<u>Guidance</u>

208. Whilst the legislation and Code of Practice focus on the frameworks for assessment and treatment of patients detained under the MHA, the guidelines issued by the National Institute for Health and Care Excellence ("**NICE**") concerning mental health focus on the management and treatment of specific

mental disorder. For example, Clinical Guidance CG178 from March 2014 deals with "*Psychosis and schizophrenia in adults: prevention and management*" [NHSE0000539], covering areas such as EIP services, assessment and care planning, psychological and pharmacological treatment options, subsequent episodes of psychosis, and promoting recovery and possible future care. CG178 is supported by a Quality Standard "*QS80: Psychosis and schizophrenia in adults 2015*" [CQMC0028993] and also refers to more general guidelines applicable to the wider treatment of patients with mental health disorders:

Title	Year	NICE reference
Decision-making and mental capacity	2018	NG108
Decision-making and mental capacity.	2020	QS194
Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence	2009	CG 76
Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes	2015	NG5
Multimorbidity: clinical assessment and management	2016	NG56
Patient experience in adult mental health: improving the experience of care for people using adult NHS mental health services	2011	CG136
Patient experience in adult mental health services	2019	QS14
Shared decision-making	2021	NG197
Supporting adult carers	2020	NG150

209. It is worth noting that the following topics are identified on the Mental Health Guidelines section of the NICE website as "*key topic areas we're proposing to actively monitor*" and may therefore be subject to change:

a. Early intervention in psychosis services.

b. Pharmacological treatment options for:
    i. Adults with FEP [first episode psychosis] or early schizophrenia
    ii. Subsequent acute episodes of psychosis or schizophrenia
    iii. Adults with schizophrenia in remission.

c. Psychological and psychosocial interventions for adults with schizophrenia or psychosis, including in remission.

d. Depot / long-acting injectable antipsychotic medication.

e. Interventions for people whose illness has not responded adequately to treatment.

Principles of mental health care provision

210. The Trust provides mental health care across a wide range of mental health conditions each with a varying degree of severity and presentation. These conditions can range from mild, temporary distress to severe, persistent illnesses such as schizophrenia and dementia. Our patients and available support are a complex and varied landscape as such it is impossible to describe a 'typical' approach to the management of patients.

211. Good mental healthcare is built on several key principles that prioritise the individual's well-being, safety and rights. These principles include patient centeredness, cultural competence, empowerment, evidence-based practice, equitable access and safety. Within adult mental care services there are acute and crisis services typified by the inpatient service and the crisis teams and the

longer-term community teams characterised by the Local Mental Health Teams and EIP service.

212. The move between these two types of services requires planning and collaboration to ensure a smooth transition for the patient. This requires a focus on person-centred care, effective communication and clear pathways. Discharge from inpatient care is an acknowledged high-risk period and is subject to a rigorously monitored 72 hour follow up process. This is a standard practice in mental healthcare, ensuring that individuals discharged from inpatient care receive timely support and assessment within 72 hours of leaving hospital. The Trust's Policy states that this follow up should be face to face whenever possible (section 6.1.1.20 of Policy) [NHFT0003340].

213. Most teams will accept referrals from any source but have different target timescales. For example, the EIP team for example has a 2-week assessment target, whereas the Local Mental Health Teams will screen referrals and prioritise urgent cases, and crisis services have a 4-hour target for urgent referrals. Transfer between teams is managed by the referral process and the relevant MDTs, with all staff having access to the electronic patient records, as discussed below.

214. Community Mental Health patients are monitored through a combination of regular check ins and assessments. This includes tracking mental state, symptom severity, ability to cope with stress and engagement in positive social interactions. We also check on physical healthcare and lifestyle issues. The frequency of visits and targeted monitoring will be developed via a patient's care plan and reviewed via the MDT. We do not use any remote monitoring technologies such as 'tagging' or vital signs and activity monitoring in the mental health services.

Care planning

215. Care planning in general is a collaborative process between the individual receiving support and the healthcare professionals. It should aim to provide a personalised plan to address mental health needs and overall wellbeing. It

involves identifying needs, setting goals and outlining strategies to support recovery and independence. Effective care planning ensures that individuals are actively involved in decisions about their care and have a clear understanding of how their needs will be met. It is important to seek to involve patients in decisions about their care as much as possible, even if they lack capacity. The agreed plan must:

a. Identify the intervention and anticipated outcomes.

b. Record all actions necessary to achieve the agreed goals.

c. In the event of a disagreement, include reasons.

d. Give an estimated timescale by which the outcomes or goals will be achieved or reviewed.

e. Detail the contribution of all agencies involved.

f. Include appropriate crisis and contingency plans.

216. The guiding principles that underpin the legislation should be integral to the process of care planning. The care plan should reflect not only the patient's needs but also their strengths, diverse needs, cultural and ethnic background in order to move away from the promotion of the individual as a set of problems and needs, but as a whole person with both strengths and weaknesses. There needs to be an emphasis on inclusion within the community and citizenship. For patients that lack capacity, the MHA's Code of Practice sets out that care planning, including planning for discharge must follow the steps set out in Section 4 of the MCA for determining the person's best interests.

217. Review and evaluation of the patient's care plan should be ongoing. At each review meeting the date of the next review must be set and recorded. The patient, any member of the care team, or carer is able to ask for a review at any time. Reviews should be every 12 months as a minimum standard unless the patient

requires reviews on a more frequent basis depending on complexity, needs assessment and risk.

Positive and Dynamic risk assessment: concepts and practice

218. The Trust promotes positive risk-taking, enabling patients to engage in informed therapeutic risks supporting recovery, within mitigated safety plans. Positive risk-management is a fundamental principle in the best practice of managing risk, for example "*Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and others in Mental Health Services" (Department of Health 2009*) [DHSC0000038] explains that there is a balance between improving the patient's quality of life and plans for recovery, whilst remaining aware of the safety needs of the patient, their carers and the public. This paper notes that over-defensive practice is bad practice because avoiding all possible risks is not good for the patient or society in the long term and can be counterproductive. It goes on to state that as long as a decision is based on the best evidence, information and clinical judgment available, it will be the best decision that can be made at the time. Risk assessment is recognised as a dynamic process requiring continuous review based on changes in patient presentation, circumstances, or engagement. Risk assessment, formulation, and management are integrated into ongoing therapeutic relationships and planning, developed collaboratively with patients and carers.

219. As explained in further detail below, MDT involvement is an expected standard, with routine discussion of risk in MDT meetings to incorporate diverse clinical perspectives and avoid siloed decision-making.

220. Patients and carers are also actively engaged in risk and safety planning in line with personalised care principles. Co-produced risk formulation and safety plans are standard practice.

221. Staff have a duty to communicate and escalate changes in risk promptly across involved teams and services, supporting coordinated, responsive care.

Identification, assessment and management of risk

222. Risk to others (including carers and staff) is routinely assessed during initial and ongoing psychosocial assessments and incorporated into risk formulation. Considerations include history of violence or aggression, the nature of the risk to others, the likelihood that harm will result, and the severity of any potential harm, the patient's current mental state, access to means, and social/environmental factors.

223. When risk to others is identified:

    a. Multi-agency processes may be engaged (e.g., MAPPA, safeguarding).

    b. Individualised risk management plans are developed, incorporating interventions such as de-escalation strategies, medication adjustments, and environmental modifications.

    c. Specialist input from forensic services, safeguarding teams, and senior clinicians is sought as appropriate.

224. The Trust is actively engaged with emerging national guidance on managing risks to and from others and contributes to regional and national developments, such as NHS England's "*Staying Safe from Suicide*" guidance (2025) [NHFT0002229] and findings from the National Confidential Inquiry into Suicide and Safety in Mental Health, as detailed below.

Frequency and timing of risk assessments

225. Clinicians in mental health services need to be able to perform a risk assessment for patients they work with, including where there may be risks to others. Risk assessment is treated as a live, ongoing process that requires continuous evaluation and co-production wherever possible. This approach is detailed within

the Trust's "*Clinical Risk and Safety Policy*" (01.23, version 1, October 2024) [NHFT0003231], which reflects current best practice and national standards.

226. Risk assessments are reviewed and updated regularly and whenever there is a significant change, including:

    a. change in clinical presentation or social circumstances

    b. missed appointments or disengagement from services

    c. admission to or discharge from hospital, and/or

    d. new disclosures or concerns regarding risk.

227. Routine risk assessment review points include:

    a. at admission and discharge,

    b. following leave from inpatient care, and

    c. after incidents or near misses.

228. These reviews align with Care Programme Approach cycles but are supplemented by real-time updates guided by clinical judgement and patient need.

229. Forensic services have specialist expertise in assessing risk of violence (including risk of physical harm, sexual harm, harm to self, harm to others) and associated treatment interventions to manage future risk. As explained below, a referral can be made with a view to admission to a forensic inpatient environment where a patient is liable to detention under the MHA and the referring clinical team considers that the risks posed by the patient are such that a care transfer may be necessary. An access assessment, usually performed by a consultant

forensic psychiatrist, will determine whether this is proportionate and reasonable, or whether expert advice and guidance is more clinically appropriate.

230. In some contexts, clinicians in mental health services may have concerns about the longitudinal risk (the risk over time with continuous monitoring of risk factors), to others that may be presented by a patient, who may not be detained in hospital or where the care pathway is towards a community setting. They may make a specialist community forensic service referral to seek clinical advice, liaison and case consultation, clinical assessment, to collaborate with a specific focused area of risk, or to fully case-manage a patient with complex needs.

Tools for assessing and managing risk

231. The Trust utilises structured electronic templates within the Rio patient record system which are focused on personalised care and used to enable:

  a. Psychosocial assessment,

  b. Risk and safety formulation, and

  c. Risk and safety management, and crisis and safety planning

232. A rapid improvement review of these tools is currently underway to improve how they:

  a. support narrative, person-centred assessments rather than checklist or category-based approaches,

  b. enable dynamic safety planning consistent with current best practice, and

  c. enhance access to historical information to improve continuity of care.

233. In terms of person-centred risk formulation, the Trust has continued to move away from generic risk scoring tools to prioritising person-centred, collaborative risk formulation. Within updated Clinical Risk and Safety training, clinicians are trained to explore context, meaning, and protective factors alongside risk, using structured tools such as the 5 Ps (Predisposing, Precipitating, Perpetuating, Protective, and Presenting factors). This approach is trauma-informed, formulation-led, and reflective of guidance.

234. A review of the Clinical Risk and Safety form on Rio has taken place and is being redesigned as part of a wider update for the core assessment forms on RIO. Implementation is expected to begin by January 2026 with ongoing monitoring and review of its implementation

235. There are also frameworks and tools which are used to support risk and safety assessment and management. These include:

a. The HCR-20 is a tool used by mental health professionals, primarily in forensic services, to help assess and manage the risk that a person might become violent. The tool helps teams to make informed decisions by combining these factors with clinical judgement. It supports creating personalised safety and care plans to manage risks effectively [WITN0133024].

b. The Suicide Assessment Framework is also used which guides further understanding of suicidality, including self-harm.

c. Child and Adolescent Mental Health Services use 'CARAS' the Child & Adolescent Risk Assessment Suite as appropriate to support risk and safety assessment and management, and this also focuses on formulation and safety planning within its approach [WITN0133007, WITN0133008, WITN0133009, WITN0133010, WITN0133011, WITN0133012, WITN0133013, WITN0133014, WITN0133015, WITN0133016, WITN0133017, WITN0133018, WITN0133006]

236. Clinical judgement is strongly encouraged by the Trust alongside use of structured proformas and tools.

Training and guidance on risk assessments

237. Training and supervision emphasise balancing safety with patient autonomy, embedding risk management as a shared, therapeutic process.

238. The nationally mandatory training framework is set by NHS England [WITN0133005] Clinical Risk and Safety training that supplements the national mandatory training framework within the Trust addresses suicidality, self-harm, risks to and from others, and therapeutic risk-taking. This training is role-specific and is mandated for clinical staff. This training is aligned with the National Confidential Inquiry into Suicide and Safety in Mental Health findings and 2022 NICE guidelines on self-harm and suicide prevention, particularly in promoting collaborative, person-centred safety planning and recognising the importance of personalised strategies to manage distress, which were more recently reiterated in NHS England's "*Staying Safe from Suicide*" guidance (2025), and supporting the shift from static risk stratification to personalised, collaborative safety planning.

239. The training includes in particular:

a. Suicide and self-harm awareness and response [NHFT0018412], and

b. Clinical Risk and Safety training, with context-specific content for inpatient, community, Child and Adolescent Mental Health Service, crisis, and liaison teams [NHFT0015794], [NHFT0004239], [NHFT0018411], [NHFT0018413].

240. Prior to 2023, training included face-to-face sessions and e-learning modules available via the Trust's E-Academy, complemented by diploma and degree-level courses in psychosocial interventions and clinical risk assessment.

241. Updated Clinical Risk and Safety training started November 2024 in inpatient areas as part of the Mental Health Fundamentals of Care Skills day. This is now included as an essential 3-yearly training module for inpatient staff trust wide with content targeted towards the different clinical areas. Learning and Development teams are monitoring this training within the 3-yearly essential training requirement for Clinical Risk and Safety. The previous e-learning has also been updated to reflect this content and went live on 9 October 2025.

242. Governance and oversight of the risk assessment process has also improved:

   a. The new Trust Clinical Risk and Safety policy was written in 2024 [NHFT0003231], and the risk governance structure revised, with a new Trust Clinical Risk and Safety Panel to provide regular oversight of risk management processes, training, themes and escalations across care groups.

   b. The use of data has been improved to include a Clinical Risk and Safety and SafeNow dashboards, and AMaT (audits) to help identify trends and support targeted interventions — for example, risk assessments, crisis and safety planning, and discharges.

   c. Risk Management Meetings have also been reviewed and provide increased oversight.

   d. Risk training and risk assessment compliance are now monitored through improvement group and have improved.

243. The Trust has disclosed materials relating to the training received by staff, as well as the training records for each member of staff employed by the Trust who interacted with VC [NHFT0015601-NHFT0015617].

<u>Management of Treatment</u>

Role of the MDT

244. The MDT in community mental health teams (including Local Mental Health Teams, Crisis teams and EIP teams) is a group of healthcare professions from various disciplines who collaborate to provide comprehensive care to individuals within the team. The team typically include psychiatrists, mental health nurses, clinical psychologists, social workers and Occupational Therapists. In all the teams they would meet at set times, for example weekly, and review high risk patients, new patients and any patients that Care Coordinators were concerned about or wanted further support with their care and treatment.

245. In addition to the above, some teams come together daily in a 'safety huddle' to rapidly review concerns and others will have separate referral meetings. Each patient under care coordination would usually have an MDT review at least every 6 months, even when stable. The MDT would have had access to VC's electronic patient file.

246. No agendas for MDT meetings were prepared by the EIP team for patients in their care. Instead, the general practice was for each healthcare professional to discuss their caseload each week at the meeting. It was the responsibility of the person bringing a case to the MDT (in the case of EIP patients, often the patient's Care Coordinator) to record on the Trust's electronic database "Rio" anything discussed within the MDT meeting related to that patient. The Rio notes for VC have been disclosed to the Inquiry, which indicate any actions recorded in this regard.

247. As we have explained in section I below, one of the improvements that has been made by the Trust since June 2023 has been to improve record keeping at MDT meetings. During the period 2019-2023, only some teams within the Trust had administrative support to help with the taking of minutes at MDT meetings. This did not include the City South EIP team which had responsibility for VC. Accordingly, the Trust does not hold any minutes of the MDT meeting that took place on 22 September 2023 where it was decided to discharge VC back to his GP.

248. It is now Trust policy that minutes are kept of all MDT meetings, which includes a log of any actions to be taken.

The role of the Care Coordinator

249. Care Coordinators work as part of a MDT to develop and implement care plans, assess needs and review progress. They play a key role in supporting our patients in several of our teams, including Local Mental Health Teams and EIP teams. They are typically registered professions such as nurses, social workers and occupational therapists. They are the named person responsible to support the patient and to support people to navigate complex mental health systems.

250. Care Coordinators undertake comprehensive assessments to understand an individual's mental health condition, social circumstances and overall needs. This may involve gathering information from the individual, their family and other relevant professionals. Based on this assessment they collaborate with the individual to create a personalised care plan. The plan outlines specific interventions, support and services required to address the individual needs to promote their recovery.

251. Care Coordinators are expected to regularly monitor the patient's progress, assess the effectiveness of the care plan, and adjust it as needed. This may involve regular check ins, home visits and communication with family members and significant others. They are also responsible for bringing together feedback from other professions involved in the persons care e.g. medical staff, psychology staff and occupational therapists.

252. Risk is a sub section of the overall assessment and, as such, the Care Coordinator plays a vital, but not solo, role in assessing and managing risk associated with a patient's condition. They work to identify potential risks, develop strategies to mitigate those risks with both the person and to others. The assessment should include identifying potential risks to self-harm, harms to others, neglect and exploitation. This involves collecting information from the

person, their family and other healthcare professionals. Based on the assessment, the Care Coordinator develops a risk formulation or a detailed understanding of the factors contributing to the identified risk. This may involve analysing risk factors, past history, current mental state and intent.

253. As part of the care planning process described above, the Care Coordinator works with the patient to develop a risk management plan to identify key interventions and strategies to minimise and manage identified risks. This plan may include medication management, therapy, support groups, crisis intervention strategies and safety planning.

254. It is unusual for a Care Coordinator to also be authorised to prescribe medication or provide individual therapy (although some are qualified in CBT for psychosis or are non-medical prescribers). They play a vital role in facilitating communication to the relevant prescriber, educating patients about potential side effects and assisting with adherence. It is the prescriber's responsibility to ensure safe and appropriate prescribing practices and to take accountability for prescribing decisions. Prescribers should also be able to justify their decisions and actions and ensure that a correct record of prescribing is maintained.

255. The Care Coordinator also plays a key role as part of the mental health team in preparing the patient for discharge from the mental health team (discharge from inpatient care does not follow the same pattern). This should involve a care plan review, a discharge assessment to determine future need, and a contingency plan if the person needs to reengage with services. Consideration should be given to mental health stability, individual needs including pharmacological, social and housing, family and carer involvement and support services. If a patient disengages from service, it is expected that the Care Coordinator, supported by the rest of the team would review the risk of the patient, involve where possible the family members and support network, review issues of capacity of the patient to disengage and to make reasonable attempts to contact the individual. Where appropriate, further discussions should take place with primary care clinicians such as GPs. It is ultimately the Responsible Clinician's decision to discharge a patient based on the information supplied to them.

Patient records

256. The Trust currently maintains paper and electronic records for patients. In relation to the latter, the Trust uses two systems: Rio and SystmOne. The three Care Groups described in section A above use these systems as follows:

    a. Mental Health Care Group: Rio Local

    b. Forensic Care Group: Rio Forensic

    c. Community Health Care Group: SystmOne (At the time that VC was arrested, the Offender Health Directorate was under the Forensic Care Group but was moved to the Community Health Care Group in January 2024. To confirm, no records relating to VC were held by the Community Health Care Group or Forensic Care Group at the time of the incident. Documents held by the Offender Health Directorate (both from Rio Forensic whilst under the Forensic Care Group, and from SystmOne whilst under the Community Health Care Group) while VC was detained at HMP Nottingham following his arrest have been disclosed to the Inquiry) [NHFT0002009].

257. These systems are role-based with clinical and support colleagues having access based on their need to enable the delivery and/or support of direct care.

258. They are separate systems, meaning that a record updated on one system would not automatically update the other. The record will contain information from all disciplines from within the relevant Care Group, plus contacts made to enable a holistic understanding of the patient. In practice, it is not necessary for staff treating a patient to move between the different systems, they will only need to use the system applicable to their care group. For example, if a patient has been at Rampton and moves to a lower-security service, the care relevant information will be passed to the new care team, who will use Rio Local for all of their interactions and documentation in relation to the patient. The Trust also

maintains an Electronic Master Patient Index for each patient that records every instance in which a patient comes into contact with the Trust. Through this master index, staff can establish which services a patient has been under at the Trust, and therefore know which systems they need to access in order to obtain the full records. For patients who move between care groups, staff can then request access to view the records of the other care group to enable continuity. Below is a screenshot of the Electronic Master Patient Index for VC.

Search for patient across Trust systems

Surname: CALOCANE
Trust ID:
Source: All Systems
Forename: valdo
Date of Birth: dd/mm/yyyy
Reset Form Values
NHS Number:
Gender: All Genders
Search the MPI

	Source	Title	Original System ID	Forename	Surname	Date of Birth	Date of Death	Gender	Address	NHS Number	NHS Number Verified?	Registered GP Practice	Registered GP Practice Code	Email	Date Record Changed	Marked as Deleted	Physically Removed from Source System?
Details	System One RiO Local RIO FORENSIC	Mr	5001285	Valdo	CALOCANE	04/09/1991		M	CRIPPS HEALTH CENTRE, UNIVERSITY PARK NOTTINGHAM, NOTTINGHAMSHIRE, NG7 2QW	GRO-D	Yes	C84023 - THE UNIV OF NOTTINGHAM HEALTH SERV			13/05/2025 06:35:00	No	No

Page 1 of 1 1 Total Results 1 Records Per Page 8 A maximum of 1000 records will be returned for any search

259. A full day's Rio training is provided to all staff that have access to the system. Access is not granted until the training has been completed.

260. Screenshots of the Rio screen for VC's records have been disclosed to the Inquiry, to demonstrate the view that staff would have had at the time of treating VC [NHFT0003401].

261. When a staff member logs into Rio, they will be presented with a summary screen which enables easy navigation to the core documents which are required. The system is also tailored to suit the user's clinical location and access. For example, an inpatient nurse's home screen will be focussed on inpatient tabs and data. The appearance and focus will vary to best suit the user, although the general layout is the same:

   a. The front screen on Rio is tabulated at the top to enable a focussed direction to areas such as important dates / information, uploaded documents, family

/ carer communications and information, contacts, physical health, and care planning portal.

b. Beneath the tabs is a panel for alerts. This will be anything that requires staff to have immediate knowledge of, such as episodes of violence, suicide attempts, allergies, or other specific risks requiring immediate awareness. In VC's case, there were 5 alerts relating to violence. That summary panel can be clicked to reveal further details.

c. To the right of the screen is a navigation pane containing the links to care records. For example, progress notes, core assessment, risk and safety assessments are clearly identified:

    i. Progress notes will contain a full record of progress notes added by members of the MDT, such as MDT meetings and discharge planning discussions. The user viewing the records can either scroll through the continuous run of entries in date-order, or it is searchable by key words. A user adding a progress note types a narrative onto the progress note and it will be saved with the date and user's name.

    ii. Risk Assessments and Care Plans are stand-alone forms rather than the continuous run of progress notes. The user adding an entry clicks a button to generate a new form. This pulls through all information from previous forms and adds them to the new form, onto which the user adds the update to the assessment or plan. The user viewing the record can then click between the versions.

262. The progress notes can be filtered to allow viewing from the first point of contact with the Trust. Records are written in chronological order unless specifically indicated otherwise. There is also a search function which can either filter by key words or professional discipline to enable ease of access to information.

263. When reviewing risk and safety assessments for example, each iteration of the assessment brings forward what was previously documented and allows a

further update. Information can be amended when adding to the new/latest version of the document. Previous versions cannot be amended. This enables version control and also consistency with static information remaining available to the reader. This is the same process for the core assessment, which is a medical assessment at the point of hospital admission and care plans are also pre-populated based on historical information and updated chronologically. A limited search function is also available.

264. There are some documents that are unable to be uploaded onto Rio, such as medication cards and electrocardiograms. These documents are kept in a separate paper file, along with any other records that may have not been uploaded to Rio for some other reason such as where they predate the introduction of the electronic patient record. The paper file is sent to offsite storage upon discharge. In VC's case, this paper record was returned to the Trust in connection with the various reviews described below that took place following the incident on 13 June 2023, and a copy has been disclosed to the Inquiry. [NHFT0014978]

265. The Trust also has access to the NHS Spine (https://digital.nhs.uk/services/spine) to identify individuals as needed. The NHS Spine allows information to be shared securely through national services such as the Electronic Prescription Service, Personal Demographics Service, National Care Records Service, e-Referral Service and the Patient Flags Service API.

Notts Care Record

266. The Nottinghamshire Health and Care Portal was introduced in 2018 as a community-wide programme designed to allow health and social care providers in the region to share a patient information summary. The portal enables access to a shared record, giving Trust healthcare professionals access to a range of essential patient information from different health and social care organisations across Nottinghamshire. It can be accessed directly from both within SystmOne and Rio. The portal provides information to those with a legitimate relationship with a given patient. The initial project was led by Nottingham University

Hospitals NHS Trust with collaboration from those organisations who contribute data sets to the Portal. The data sets provided by the Trust includes: Care Coordinator, Care Programme Approach, MHA Status, Admission Status, Outpatient Status, Referrals (Open and Closed), Mental Health Alerts (including known allergies), Appointments Attending (including outcomes) and future appointments. The Portal also includes data sets from the acute hospitals, GPs and Nottinghamshire County Council. Papers for this portal went through the ICB and the Trusts' Digital Information Programme Board.

267. This portal will shortly be replaced by the Notts Shared Care Record, which is an ICB led collaboration. This will enable a more joined up and coordinated record in a collaboration between GP, hospital, community, mental health and social care services across Nottingham and Nottinghamshire. This is going through final stages of testing and is expected to be available to healthcare professionals in September 2025. The relevant business case went through the ICB and the Trusts' Electronic Patient Record DigiCare Programme Board.

Mental Capacity Act assessments

268. Where there is reason to doubt a person's capacity to make a certain decision or decisions in a certain domain, an MCA assessment will be undertaken. If this concludes that they lack the relevant decision-making capacity, then that decision must be made in their best interests. The best interests process within the MCA will be followed and properly documented.

269. There are no statutory required forms for mental capacity assessments and best interests decision making (apart from as part of the Deprivation of Liberty Safeguards ("**DOLS**")). A record of a mental capacity assessment and/or best interests decision may be evidenced either in a Rio or SystmOne entry record, by use of a separate template, within a care plan document, or included on the Rio or SystmOne templates. Any record should be in appropriate detail, commensurate with the complexity of the decision in question. Simple decisions

may require only a few lines of analysis, whereas more complex decisions will require a great deal more work and evidence

270. The Trust recognises that all employees should have requisite awareness of the MCA. Training is provided in-person or by e-Learning [NHFT0015324]. The two MCA Senior Practitioners from the Mental Health Legislation Team offer monthly opportunities for face-to-face training throughout the year, which is hosted by Learning & Development. They also provide *ad hoc* training on request from individual teams. In addition, documentation workshops are facilitated by the MCA Practitioners. The workshops focus on supporting attendees to increase their skills and knowledge in relation to evidencing decision making regarding patient consent, mental capacity and best interests' decisions.

271. There are MCA eLearning packages for Community Physical Health (minus the MHA/MCA interface element), for Forensics and Child and Adolescent Mental Health Service (minus the DOLS element) and for Adult Mental Health, Mental Health Services for Older People and Intellectual and Developmental Disability services. On induction, all registered staff are requested to complete this as part of their e-learning requirements.

272. The MCA folder on the Trust's intranet, "Connect", available to all staff 24 hours a day, has the following clickable headings which will then lead to further advice and guidance documentation:

    a. Meet the Team

    b. Mental Health Legislation Newsletter

    c. A -Z of the Mental Capacity Act 2005

    d. Codes of Practice

    e. MCA Information

    f. DOLS information

g. Mental Capacity Assessments Toolkit

h. Advance Care Planning

i. IMCA Service

273. The Mental Health Legislation Team also publishes a regular newsletter which is circulated around the Trust. The team's two MCA practitioners and the Head of Mental Health Legislation are available during the week for more detailed case specific advice and guidance on MCA matters, and they in turn have access to the Trust solicitor, and external legal advice where warranted.

274. The Trust Policy "01.08 Mental Capacity 2005" [NHFT0015226] is on The Trust intranet "Connect" in folder: 01 Patient Care.

Tools or proformas in place used to assess capacity

275. There is no general statutory form for the assessment of capacity. Nevertheless, the Trust provides proformas and ample guidance on the MCA part of Connect. In addition, forms/ proformas to assist with capacity assessment/ best interests decisions are available within the Rio system for ease of completion. The general advice which is given to all clinicians is always to make good records of decisions made and in as much detail as the complexity of the decision warrants. Many decisions can be recorded in the patient's Rio notes and would not require the use of a separate form, but that form is always available to use for more complex decisions. SystmOne also has an MCA assessment/ best interests proforma for use where indicated.

<u>Depot medication</u>

Overview

276. Antipsychotic medicines are mainly used to treat mental health conditions such as schizophrenia and other psychoses. There are various different antipsychotic

medications that are available, and the choice of which medication to use will vary between different patients, according to their individual needs and presentation. NICE Clinical Guidance CG178 [NHSE0000539] states that the choice of antipsychotic medication should be made by the patient and healthcare professional together (taking into account the views of a carer if the patient agrees), with information provided as to the likely benefits and possible side effects of each drug.

277. As with many other medications, there are different dosages and means of administration of antipsychotic medications, which requires patient-specific analysis to establish the correct medication treatment plan. These are available in oral formulations (such as tablets) which usually need to be taken daily, or as depot injections that are administered at a defined interval. Depot injections contain the antipsychotic drug and a base that allows medication to be released into the body over a sustained period. They are administered into the deltoid or gluteal muscle, depending on the preparation.

278. Depending on the patient presentation and the active antipsychotic, depot antipsychotics may need to be given every week to every 6 months. Depots usually take some time to work, and it is common to be on oral antipsychotic initially. This is to ensure the antipsychotic is efficacious/tolerable, help guide the dosage of the depot and to be in line with licensing requirements. The benefits and side-effects of antipsychotic medication administered via depot are the same as if taken orally.

279. CG178 suggests considering depot antipsychotic medication in the following scenarios:

   a. Patient choice: those who prefer to receive their antipsychotic medication in this way after an acute episode.

   b. Where the avoidance of covert non-compliance (either intentional or unintentional) with oral treatment is a clinical priority within the treatment plan.

280. Any decision to administer antipsychotic medication by depot injection will be made with a number of factors in mind, including the patient's capacity and Best Interests considerations. CG178 recommends taking into account the patient's preferences and attitudes to regular intramuscular injections and organisational procedures such as home visits and the location of clinics. It recommends particular consideration of the risks and benefits of the drug regimen. The individual circumstances (medical & social), presentation, risk, history, capacity, any physical health contraindications, and MHA status of each patient would need to be considered when deciding if a depot medication is appropriate and this may change over time [WITN0133019] [NHSE0000539] [WITN0206010, pages 9 and 22].

Trust Depot Guidance

281. To build on CG178 and apply it at a local level, the Trust has adopted "*Guidance on the* Administration *to Adults of Oil-based Depot and other Long-acting Intramuscular Antipsychotic Injections*", 7th Edn, (August 2023) [NHFT0003918] which was produced by a range of independent clinicians and experts, commissioned by Janssen-Cilag Ltd. This is hosted on the Trust's intranet "Connect" by navigating to: "Clinical Resources" > "Pharmacy and Medicines Optimisation" > "Trust Wide Medicines Resources" > "Long Acting Injections", or it can be found as the first result via a keyword search for "Depot" from the homepage. It contains comprehensive guidance on many aspects of depot injections: different drugs available; dosage; practical procedures and administration; plus, detailed guidance as to the decision to initiate depot. Earlier versions of this guidance, for example 5th Edition June 2016 and 6th Edition July 2020, were also hosted on Connect.

282. The document sets out some guiding principles, including that the document is an "*opportunity to offer the experienced practitioner a flexible framework within which they may make appropriate clinical judgments*" in recognition of the fact that there cannot be a quantitative or definitive criteria for depot. Paragraph 3.4 notes that "*medicines optimisation is an individualised person-centred approach*

to the use of medicines that involves engaging with patients to get their medicines right for them. It ensures the best possible outcomes by minimising risk and maximising benefit using evidence-based decision making. It requires effective patient engagement and professional collaboration."

283. Expanding further on the fact that the decision for a depot has many factors to consider, section 6 of the guidance sets out the advantages and disadvantages from a healthcare professional's perspective, and separately from a patient perspective, noting that healthcare professionals' perceptions of the advantages and disadvantages may differ from those of patients. The lists from the guidance are set out below in table format:

6.2 Advantages of depot and other long-acting antipsychotic injections from a healthcare professional's perspective include:	6.3 Disadvantages of depot and other long-acting antipsychotic injections from a healthcare professional's perspective include:
• Reduced necessity for tablets or capsules to be taken on a daily basis. • Reduced uncertainty about the amount of medicine taken or not taken. • No influence of first pass metabolism thus improved bioavailability. • More consistent delivery of antipsychotic with more stable plasma levels over time which can minimise side effects sand reduce variations in symptom control.	• Pain, erythema, swelling at the site of injection as well as nodule formation, particularly with oil-based injections. • Risk of damage to nerves, arteries or veins. • If side effects occur, they will be prolonged until the plasma level falls. • There may be an allergy to an oily vehicle; hence the necessity for a test dose of the oil-based depot formulations. • The need to confirm efficacy of, and tolerability to, the oral formulations of the non-oil- based

• A wider window of opportunity to re-engage assertively with a patient if they refuse an injection as plasma levels take longer to decline after the last dose than with oral formulations. • Earlier detection of non-adherence which can be followed up quickly, resulting in potentially reduced relapse rates, leading to better outcomes. • Possibly reduced risk of admission with potential resultant cost savings. • Potentially reduced need for repeat prescriptions since the dosing interval of such formulations can be up to 6-monthly depending on the product. This may also lead to cost savings. • Longer intervals between administration can reduce the need for frequent clinical appointments which could be beneficial to patient employment, travel and holidays and enable more clinical time to be allocated to psychosocial interventions.	long-acting injections where required and practical. • It can take several weeks for plasma levels to reach steady state. • Injection technique competence, assessment and training are required. • Potential logistical difficulties which may arise from the need to administer an injection to a patient who is in employment. • The requirement to attend a traditional 'depot clinic' may be considered stigmatising by some but research has highlighted the opposite may be true, with patients valuing contact with other patients and staff as well as the medication management interventions available to them there. • Some people have a dislike or even a phobia of needles. • Social embarrassment and the need for chaperoning and gender matching depending on patient preference and the choice of injection sites available within the product license. • Staffing and medicine storage issues.

• Reduced risk of accidental or deliberate self-harm through overdose. • The potential to enhance the therapeutic relationship and partnership working with the patient and their carers (if appropriate) by the regular frequent contact required	• The fact that depot injections have been viewed by some as stigmatising and coercive.
6.5 Advantages of depot and other long-acting injections from a patient perspective	6.6 Disadvantages of depot and other long-acting injections from a patient perspective:
• You don't have to remember to take your medicines every day. • You don't have to worry about family or others reminding you to take your medicine. • You don't have to worry about accidentally forgetting to take your medicine. • Injections may be a better way of ensuring that you get the medicine you need to keep you well than tablets or capsules. • Tablets and capsules can serve as a daily reminder that 'You are ill'. • Injections can be given every 1 to 6 weeks and allow you more freedom to get on with your life and put your illness behind you.	• Some people don't like needles. • You have to expose your buttocks, thigh, or shoulder – this may be embarrassing. • You may have to wait around until the nurse finds a chaperone. • The injection might be painful, and the injection site may be sore afterwards. • Some people develop nodules or lumps at the site of the injection. • Some people can get nerve damage if the injection is given badly or at the wrong site. • If side effects occur, they may persist for several weeks after the injection is stopped. • Some feel that an injection stigmatises them or that they are

• Injection clinics can be a source of social interaction for some people – and there may also be educational material available there. • If you forget to go for your injection, someone will remind you. • You may have fewer side effects with an injection (because the levels in the blood don't go up and down so much). • You don't have to remember to take your medicines with you if you go away for a short holiday.	being forced to have treatment against their will.

284. The guidance has three further sections focussing on the patient within the decision:

a. Section 8 on "Patient Experience" reiterates that "*the choice and formulation of antipsychotic should be a joint decision between the patient and their clinician taking into consideration the risks and benefits of the treatment including the relative potential of individual antipsychotics to cause side effects*". It sets out ways in which the depot can be tailored to the needs and preferences of the patient, such as the environment they are administered, and injection site.

b. Section 9 on "Patient Choice and Shared Decision Making" goes into further detail about the process of making the actual decision, as there are many factors that the patient will wish to consider and all of these should be thoroughly explored in a person-centred manner with the clinical team. It also signposts to practical tools which can assist with facilitating patient choice.

c. Section 11 on "Consent to treatment in England and Wales" which signposts clinicians to CQC guidance, Mental Health Act 2007, MCA, and recommendations in NICE Guideline NG108 on decision making and mental capacity. It sets out the key principle of capacity, that a patient must be assumed to have capacity unless it is established that they lack capacity. It advises that if there is any doubt as to capacity, a documented assessment must be done before a depot injection can be given. It notes that obtaining consent from a patient is a complex process and must take into consideration the patient's ability to understand information and must not involve any coercion of the patient to agree to treatment. It notes that "*Patients who are on a Supervised Community Treatment Order (CTO) cannot be compelled to accept treatment they absolutely refuse unless they are recalled to hospital and their section 3 reinstated*".

Community Treatment Orders

285. Community Treatment Orders ("**CTO**") were introduced by the Mental Health Act 2007. A CTO is an option available under the MHA for when a patient is ready for discharge (but not complete discharge from MHA liability). They can be suitable for those patients who need support to return to the community to help them remain well but need to be under some degree of support and observation, together with the ability to recall them to hospital in the event that it becomes necessary.

286. The patient would be a detained inpatient in hospital subject to a section 3 (or unrestricted forensic section such as section 37) of MHA. The patient's Responsible Clinician consults with the MDT and appropriate discharge planning is undertaken. The decision is a clinical decision based on the patient's current and likely presentation, and a robust risk assessment. There would need to be

some confidence that the patient understands what a CTO is, and the obligations placed upon them (although a CTO remains an option under the MCA if the individual lacks capacity). The MHA Code at provision 29.31 advises that conditions should be clearly and precisely expressed so that the patient can readily understand what is expected. It also states that it is important that for the CTO to be successful, that the patient agrees to keep to the conditions, or try to do so, and that patients have access to the help they need to be able to comply (provision 29.33) and that while they have a CTO in place, they are not completely free from any MHA liability. The Court of Protection can have a role in consenting to treatment on behalf of a patient who lacks capacity.

287. The CTO is put in place by the Responsible Clinician and an AMHP using a statutory form, CTO1. The legal criteria for putting a patient onto a CTO are set out in the MHA. It is noted that the Mental Health Bill 2025 proposes to amend these criteria.

288. In summary, the current criteria are as follows:

a. The patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;

b. It is necessary for their health or safety or for the protection of other persons that they should receive such treatment; subject to their being liable to be recalled ... such treatment can be provided without their continuing to be detained in a hospital;

c. It is necessary that the responsible clinician should be able to exercise the power... to recall to hospital, and

d. Appropriate treatment is available for them.

289. There are two mandatory conditions in all CTOs:

a. to make themselves available for medical examination for purposes of renewal, and

b. to allow completion of Second Opinion Appointed Doctor certificate.

290. Non-compliance with either of these two mandatory conditions will result in recall to hospital.

291. The Responsible Clinician and the AMHP can set discretionary conditions. These can only be made if they agree they are necessary or appropriate for one or more of the following reasons:

a. to ensure the patient receives medical treatment

b. to prevent a risk of harm to the person's health or safety, and/or

c. to protect other people.

292. The Code of Practice states that discretionary conditions should be as minimum a number as is necessary to achieve the aims, and they should be clear and least restrictive. The Supreme Court confirmed that conditions cannot have the effect of depriving the person of liberty. Where a patient who lacks capacity to consent to their living arrangements, a Court of Protection order or a DOLS authorisation will be necessary to run concurrently with the CTO.

293. Failure to comply with these discretionary conditions does not in itself mean the person will be recalled. However, such a failure can be taken into account in considering whether the patient needs to be recalled for treatment in hospital (e.g. non-compliance with medication). Discretionary conditions can be varied by the Responsible Clinician (Form CTO 2).

294. In this case, the underlying section 3 or 37 of the MHA is only suspended. The patient will then leave the hospital and is known legally as a community patient. The patient will be subject to recall to hospital and potentially following recall; the

CTO could be revoked. That would end both the CTO and the underlying section 3 or 37.

295. A CTO cannot be put in place unless an AMHP is in agreement. In addition, it is the Responsible Clinician and the AMHP together who set the discretionary conditions in each and every CTO. The Trust's CTO policy 2016 (later incorporated into the wider Mental Health Legislation Policy and Procedure Manual 2025) sets out the relevant requirements in detail as follows:

> ***Process***
> *During ward round, it is identified that the patient is making progress – a discussion is held about possible plans towards discharge and a CTO is considered. The ward team will identify who will be completing the risk assessments and care plans for discharge. This should be discussed with the MDT including the community team which will be involved in a discharge package and an Approved Mental Health Professional (AMHP).*
>
> *The ward should identify a person to invite the community team and request an AMHP to attend the next ward round. The MDT/community team are an integral part of the discussions that take place to decide if the CTO is appropriate and the least restrictive option. A community team may have a much better idea of the challenges a patient may present in the community which could be quite different from a ward/hospital setting.*
>
> *The family/friends may also have valuable input to what would be helpful and practical to maintain recovery in the community and may want to be part of the ward round (if the patient is in agreement with the being there).*
>
> *The RC is the lead professional regarding a CTO and must be clear that the legal requirements are met before signing the CTO. The RC needs to make contact with the community RC and offer them the opportunity to be involved in the meeting or at least discuss the idea with them.*

Services

Early Interventions in Psychosis (EIP)

296. We have briefly described the EIP service above in section A. This service provides assessment and treatment for people aged 14-65 experiencing their first episode of psychosis or at risk of developing psychosis. The aims of the service are:

a. To provide early assessment and treatment of the symptoms of psychosis.

b. To provide a range of interventions.

c. To provide support for family and significant others.

d. To work with other agencies to support the person.

e. Getting help early gives someone experiencing psychosis the best chance of getting better more quickly.

297. The EIP service including the At Risk Mental State pathway is for:

a. People with a first episode or first presentation of psychosis, irrespective of the person's duration of untreated psychosis.

b. People aged between 14 and 65.

c. People who have not received treatment for psychosis with antipsychotic medication that commenced over 12 months ago.

d. People registered with GP practices covered by Nottingham and Nottinghamshire ICB (people resident outside of the ICB's boundaries will be assessed on a case-by-case basis).

298. Acceptance will be based on symptom presentation rather than diagnostic criteria.

299. NHS England's document "*Implementing the early intervention in psychosis access and waiting time standard*" [NHSE0000032] encourages services for people with an At Risk Mental State and that this group is provided with access to psychologically informed treatment to prevent transition to psychosis. It recommends that patients require a period of active treatment lasting up to two years, plus regular monitoring for at least another year after treatment.

300. The service provide a variety of interventions depending on the assessed need of the patient and the agreed care plan. Core treatments are based on NICE guidance (see paragraphs 208-209 above) and include:

a. Early detection and assessment within two weeks of referral.

b. Care co–ordination under the Care Programme Approach within two weeks of referral.

c. Specific ongoing assessment and intervention around comorbidity e.g. alcohol, substance misuse, depression.

d. Comprehensive assessments and interventions including housing, income, finance, physical health care and practical support.

e. Pharmacological treatment; patients may be offered medication. This should be low dose, with the side effects clearly explained. Initial commencement of medication should be reviewed within a six-week period.

f. Adults with a diagnosis of schizophrenia that has not responded adequately to treatment with at least two antipsychotic drugs will be offered clozapine.

g. All patients are offered evidence-based psychological interventions suggested by NICE guidelines for First Episode Psychosis, including

individual CBT for psychosis and family interventions, offered as a first line treatment.

h. Robust clinical supervision structures. Care Coordinators will receive regular clinical supervision.

i. Early vocational assessments with a focus on valued social roles including access to education and occupation.

j. Outreach work, prevention and awareness programmes for example, adults who wish to find or return to work are offered supported employment programmes.

k. Robust physical health care assessments and monitoring. All patients should be offered routine physical health care checks, at least yearly.

l. All service-users are offered combined healthy eating and physical activity programmes as well as help to stop smoking.

m. Carers of service-users will be offered carer-focused education and support programmes.

n. An assertive approach to engagement to reduce the risk of patients being lost to services and potentially experiencing a longer duration of untreated psychosis. To assertively engage in situations where patients miss multiple appointments or are resistant to working with the team. The EIP will be flexible and creative in the approaches it uses to establish engagement with 'hard to reach' patients.

301. In addition, patients have access to additional psychologically informed interventions as needed and where acceptable to the patient. These specialist interventions adopt a causal interventionist approach and target factors associated with the onset and maintenance of psychotic symptoms. The

specialist interventions build on and compliment the interventions provided as part of the core service provision:

a. Worry Intervention.

b. Sleep Better Feel Better.

c. Coping with Voices and Visions.

d. Thinking Fast and Thinking Slow.

e. Enhancing social inclusion and recovery.

f. Cognitive Therapy for patients presenting with an At Risk Mental State for transition to an episode of psychosis.

302. EIP staff with appropriate training would be expected to contribute to the provision of specialist interventions under supervision.

303. Risk will be assessed using agreed tools and recorded on the clinical record system within 48 hours of the initial assessment. It should include an assessment that considers risk to self, others suicide and risk from others and be coproduced with the patient and shared if relevant with other agencies.

304. As explained above, risk assessment is not a static procedure; rather, it is be reviewed and updated regularly to reflect changes in a patient's condition and circumstance, using a personalised approach which requires rapport building and collaboration. Evidence shows that the safest care is that which is personalised and highly responsive to need and risks. Therefore, it should be thorough and include any relevant detail regarding biological, psychological and social factors, and be alert to any changes or anticipated changes in personal circumstances and risk and safety factors. This will include being responsive to additional detail shared by the patient, family, carers and other professionals. Risk assessment also includes strategies to manage and mitigate the agreed

risks, which are responsive to the patient's needs to increase safety to patients, their family and carers, staff, and the public. Risk cannot always be eliminated, and for positive outcomes, some positive risk-taking may be required but this will always be within a formulation of risk and safety, with the aim of reducing risk and increase safety.

305. Each patient is allocated a named individual who is primarily responsible for follow up of the patient and feedback to the core team at MDT meetings. Monitoring of the patients was via 1:1 meetings, discussion and feedback from friends and families and professional judgement.

306. In relation to medication concordance, it is the Trust's experience that about 50% of patients with severe mental illness do not take their medication correctly or completely stop taking them. The Trust therefore takes a collaborative approach to medication concordance. Patients and professionals work together to make informed decisions about medication and ensured that patients preferences and values were respected. Interventions may include practical support for example simplifying medication regimes, utilizing reminders, fostering strong patient staff relationships and providing psych-education and motivational interviewing.

307. Disengagement in mental health services is a significant problem particularly with those patients with early onset diagnosis and therefore it is crucial that the team and the Care Coordinator develop a strong and trusting relationship with the patient. The team use a variety of methods of engagement ranging from low intensity interventions such as appointment reminders, text messages and phone calls and flexible appointment systems through to more high intensity interventions such as assertive community follow up including not accepting initial patient refusal as the endpoint of treatment rather assertively and consistently trying to engage patients.

308. The Royal College of Psychiatrists 'Quality Standards for Early Intervention in Psychosis Services' [NHSE0002336] recommend a maximum caseload of 15 patients. The Trust has generally maintained caseloads below this number with occasional exceptions to this. Reasons for this vary but include patients ready

for discharge waiting for other services, patient preference for early access to services. All caseloads are kept under review via supervision with team leaders.

309. As described at paragraphs 497-499 below, a review of the EIP service was conducted by Jonathan Warren in 2024.

Assertive outreach

310. Assertive Outreach teams are specialised community-based teams that work with patients who experience difficulty in engaging with traditional mental health services. These teams employ a proactive assertive approach to engage and support individuals in their own environments. As was the case at many other mental health trusts, these were merged into the Local Mental Health Team in 2017/18, and integrated as one of the pathways (Cluster 11-15 pathway) described above at paragraph 5.

311. These teams are carrying out a variety of functions and managing patients across the entirety of the spectrum of mental disorders and as such the focus on hard to engage patients can get lost in the volume of referrals and required treatments and the spectrum of disorders managed by the teams Referrals have increased over the past 5 years.

312. Other teams such as the EIP Team have an element of assertive outreach built into their design. Caseloads are small (typically between 12 and 16) which enables a more assertive approach than the Local Mental Health Team. They differ from a standalone assertive outreach team in that they have a Care Coordinator approach (a single responsible clinician) whereas a typical Assertive Outreach team will have a 'team approach' to each individual patient.

Working with GPs

313. The Trust is also a provider of integrated teams managing district nurses, occupational therapists and falls specialists linked with GP practices. GPs play a vital role in the treatment of mental health disorder. Much of mental health

demand falls to primary care, and the increase in demand for primary care services generally can also effect the care that can be offered to patients with mental health issues. As a result, a variety of services have been developed to meet the increasing demand for mental health services; for example, NHS talking therapies. Whilst it is clear that Local Mental Health Teams should support primary care for those patients with serious mental illnesses, gaps remain for patients with complex social needs, such as childhood trauma who may not reach the threshold for the Local Mental Health Teams, creating a gap in care. This is understandably frustrating for primary care which it is hoped the Primary Care Mental Health Practitioner role will support (see below).

314. GPs are generally informed of changes to care and treatment rather than intimately involved in those decisions. Given the primary care workload, it would not be possible to engage them in every decision in relation to each patient. This includes risk decisions. Inpatients and Local Mental Health Teams are expected to notify the GP about a patient's admission, discharge and changes to treatment within a set timeframe.

315. The Trust has employed Health Improvement Works since October 2021 [NHFT0014996]. These are embedded within Local Mental Health Teams and located within GP practices across Nottingham. They see patients with moderate to severe mental health needs where there is a level of complexity and/or where previous attempts at referring to services has not been successful. As well as seeing people in GP practices, the practitioners will have clear pathways in place to step up patients to the community mental health teams both in adult mental healthcare and older persons mental health services based on complexity, risk and support needs.

Crisis services

316. Crisis services are designed as the 'first point of call' to anyone experiencing a mental health crisis at anytime, anywhere across Nottingham or Nottinghamshire. The service is provided in conjunction with 'Turning Point', a voluntary organisation. The service is designed to meet the "*core fidelity*

standards". These were devised as part of the "*Crisis Care Concordat*" (2014), [WITN0207010] a national agreement between services involved in the care and support of people in Crisis. The standards include response times, gatekeeping parameters, team make-up and treatment.

317. The Crisis Line is supported by the Crisis Resolution and Home Treatment Team, which as explained above, provides a 24-hour, 7 day a week service to adults with a serious mental illness, in an acute crisis which is so severe that without intervention from this service, the patient would be likely to require admission to hospital. The team aims to act to prevent hospital admission by providing intensive interventions in the community. In such cases where admission has been necessary the Crisis Resolution and Home Treatment Teams will consider a package of care aimed at accelerating the date of discharge and reducing the length of the admission. The Crisis Resolution and Home Treatment teams offers a number of services including an intensive community-based treatment, support, information, education, medicine management; for a period of up to 6 weeks and support, information and education for relatives and carers; and referrers.

318. The service typically provides care and treatment to adults over the age of 18 with significant mental health problems presenting in an acute mental health crisis.

319. Following triage and information gathering a telephone call is made to the individual or their family/ carer by a band 6 clinician and an assessment appointment is negotiated based on current presentation and risk. Crisis Resolution and Home Treatment staff will endeavour to meet with the individual within 4 hours or 24 hours of receiving the referral. Occasionally, individuals will advise Crisis Resolution and Home Treatment staff that they do not wish to be seen within 4 hours or on that day, at this point a more suitable time for an assessment can be negotiated providing there are no immediate concerns.

320. Engagement with Crisis Resolution and Home Treatment is crucial for an assessment to be conducted, meaning that the team cannot enforce an

assessment. In such circumstances risk factors should be considered and a decision made as to whether any further action is required that day, or whether it is reasonable to wait until the following day to make a further attempt to re-engage or to discuss with the referrer.

321. Where initial contact cannot be made by telephone with the referred individual, two further telephone attempts will be made within a 24-hour period. If this remains unsuccessful an unannounced visit will be made by 2 members of the team staff if this is deemed safe to do so. The visit will enable staff to complete a brief risk assessment and negotiate a further appointment for an assessment visit. If following a 'cold call' Crisis Resolution Home Treatment staff are still unable to gain face to face access to the individual the referrer, GP and any other involved agencies will be informed. Consideration will be given at this time to the necessity of contacting the Emergency Services to report concerns regarding the individual's well-being.

322. There are 5 possible outcomes after assessment:

a. Acceptance onto Crisis resolution/Home treatment caseload – Assessment and Treatment at home;

b. Arranged Hospital Admission/ MHA Assessment;

c. Haven House a 6 bedded crisis house with 24-hour support;

d. Not an appropriate referral for Crisis Resolution Home Treatment and discharge to GP/referrer; or

e. Signpost to another service.

323. Once a person is accepted into the team the treatment options include:

a. Regular review including MDT.

b. Practical problem solving, support and advice. i.e., help with benefits, housing etc.

c. Ongoing Risk assessment and safety planning as required.

d. Ongoing Needs assessment.

e. Intensive support and frequent contact – these may consist of several home visits and telephone calls each day.

f. Medication will be supplied by Crisis Resolution Home Treatment where appropriate.

g. Medication Management and careful attention and avoidance/reduction in side effects of medication when required.

h. Patients' involvement in decision making and monitoring of effect of medication.

i. Ongoing liaison with Care Coordinator or other involved workers encouraging joint visits and care planning where possible.

j. Education about mental health and crisis.

k. Identifying and developing understanding of the factors contributing to the crisis.

l. Collaborative work to improve engagement.

m. Easy access to help 24 hours a day.

n. Psychological approaches.

o. A post crisis well-being plan to be created wherever possible.

324. National guidance [NHSE0000115] indicates that safe staffing is defined by the ability to meet service functions (access, waiting times, visits, supervision and training). The Core Fidelity scale provides that a team's caseload is considered not too high if the median caseload is no more than 25 service users per 14 full time equivalent clinical staff. The Trust aims to meet this standard in its workforce planning for crisis services. The Core Fidelity scale also provides that if the caseload is up to 30, 14 full time staff is considered to be partially met.

Risk Management

325. Since approximately 2015/16, the Crisis Team has utilised a Red, Amber, Green **("RAG")** clinical risk rating system and clinical decision tool related to care planning. Since it was introduced, it has become integral to how the team is run.

326. Patients on RED rating are most at risk and may require admission and will present a risk to themselves and others. These patients can be new or existing patients where the risk has increased or has remained unchanged over a period. A patient on RED rating may need a more intensive home treatment package which usually involves increasing contact to a minimum of once per day. The aim of crisis intervention is to always try to support care in the community where possible. Interventions might include focussed medication concordance support, psychoeducation and working with families.

327. Patients new to the service may be placed on RED rating for a period of up to 72 hours following an initial assessment to support and ensure a clear assessment is undertaken and mental state and risk can be adequately assessed. This rating can however be amended based on a clinical discussion. For example, an MDT may provide an appropriate rationale for reduction in RAG status.

328. Patients on RED rating are discussed daily in multi-disciplinary meetings to discuss ongoing risk and risk management plans, which may include a change in the RAG rating.

329. Patients on AMBER rating will have undergone a period of treatment and no longer require such an intense home support package, and therefore daily home visits may no longer be necessary. A patient on AMBER rating may have 2-3 home visits per week and telephone contact as required.

330. Patients on GREEN rating should have a discharge plan/date in place and are considered to be towards the end of their treatment with the service.

331. Where there has been a significant event, i.e., a significant change in presentation or increase in risk, a next day appointment should be generated. This appointment should be undertaken by at least one registered clinician.

332. As part of the band 6 Duty Workers role as shift coordinator, all home visits and appointments should be assessed in order to allocate the most appropriate staff for the contact. The allocated clinician may be changed at short notice and the decision to allocate may depend on gender, number of staff required and skill mix.

Discharge from crisis

333. Patients can expect:

   a. Multi-disciplinary review prior to discharge.

   b. Sufficient supply of medication delivered where appropriate.

   c. Liaison and involvement with Community Teams when discharged planning where required.

   d. Referrals completed to appropriate services in order to access ongoing care and treatment and joint visits where appropriate prior to discharge and Crisis Resolution Home Treatment to confirm acceptance onto alternative service and to inform the patient of the outcome and timeframe.

e. Discharge care plan to be sent to the patient, carer (where appropriate), GP, Care Coordinator and Consultant detailing medication on discharge with on-going responsibility for further prescriptions (usually GP), brief details on reasons admitted to Crisis Resolution Home Treatment and interventions received, follow up care including outpatients' appointments, referrals to other teams and emergency contact numbers.

f. Discharge summary to be sent within 7 days to the patient, carer (where appropriate), GP, Care Coordinator and other involved clinicians detailing medication on discharge with on-going responsibility for further prescriptions (usually GP), brief details on reasons admitted to Crisis Resolution Home Treatment and interventions received. Follow up arrangement including outpatients' appointments, referrals to other teams etc. and emergency contact numbers. In the case where prescribing information is required within a shorter time frame Crisis Resolution Home Treatment medic/non-medical prescribers/ Crisis Resolution Home Treatment clinicians should contact GP by telephone /email with required information and record this in the electronic patient record.

g. If a member of the public rings with concerns about a patient who has recently been discharged from Crisis Resolution Home Treatment, there should be additional consideration regarding attempting to call the patient to offer support or advice.

<u>Disengagement and non-concordant patients from Mental Health Services</u>

334. The Trust recognises 'disengagement' as an umbrella term capturing several different clinical scenarios: from patients not attending or being brought to their initial appointments, non-attendance at follow up appointments resulting in disengagement from the treatment phase of their care pathway, or staff attending a patient's home and being unable to gain access to the patient. Furthermore, patients who present with multiple disadvantages such as homelessness and/ or drug and alcohol misuse introduce layers of complexity and vulnerabilities/ safety

needs and can impair those patients' ability to meaningfully and consistently engage.

335. Managing disengaged patients is a complex and difficult task requiring a multi-faceted approach. The practice should include a variety of responses including the following:

a. Understanding disengagement: this might be due to previous poor experience of services, a lack of trust or fear of stigma, or alternately past trauma or disorganised or delusional thinking.

b. Building trust and rapport: engagement and reengagement takes time, effort and persistence. Many of our staff are trained in motivational interviewing to help patients understand the benefits of engagement. These techniques are coupled with offering practical advice and support to address social issues along with working on collaborative goal setting to support the patient to engage with their own treatment.

c. Service delivery: if direct contact is sporadic or difficult, teams like the EIP Team have the capacity to take a more assertive outreach approach and engage the patient within their own environment wherever this might be. Appointments and locations should be offered that are convenient for the patient. Families, carers and significant others need to be engaged, supported and offered psychoeducation to support the professional care team.

336. Managing medication concordance is a subset of disengagement, where many of the same or similar interventions are utilised. Poor insight, negative attitudes to medication and adverse side effects of antipsychotics, lack of social support, cognitive deficits and a poor therapeutic alliance with the care providers are all strong predictors of non-adherence to medication.

337. Interventions to support adherence start with the development of a strong therapeutic alliance between the care givers and the patient. This needs to be built on trust and open honest communication, including consideration of cultural factors and shared decision making. This also enables the most effective use of interventions such as motivational interviewing and psychoeducation. Other methods include simplifying medication regimes as far as possible and collaboration with friends and family.

338. Whilst there are blood tests to confirm concordance, the Trust (although yearly bloods for side effects of anti-psychotics are recommended) do not routinely use these, with the exception of certain medication (Clozapine and Lithium) again due to potentially lethal side effects.

339. Engaging patients who pose a risk to others is another multi layered approach, requiring a strong emphasis on patient involvement and collaboration, whilst reducing risks and promoting safety (both to the individual and the community). The corner stone is the development of a comprehensive risk assessment understanding the nature and likelihood of harm and potential triggers and any existing plans. This should support the development of a collaborative risk management plan. The plan should outline specific strategies to mitigate identified risks including medication management, therapies, crisis intervention plans and environmental adjustments.

340. For some patients a more assertive and intensive approach is required, as outlined above, and understanding support networks who can support the patient and care givers is essential. CBT has been shown to help patients develop coping mechanisms, manage emotions and reduce impulsivity. All patients should have detailed crisis and contingency plans for how to respond in a crisis.

341. It is important to understand that each patient is unique and risk minimisation strategies need to be tailored around the individual's specific needs and circumstances.

342. The "*Did Not Attend (DNA)/Was Not Brought (WNB)/Cancellations and Management of Patients who Disengage from Trust Services*" policy (the "**DNA Policy**") [NHFT0015501] promotes the engagement and involvement of adults/young people and their carers/families in patient care. It ensures that staff have consistent processes to follow, consider risks when a patient does not attend/ was not brought/ cancels a planned appointment in hospital, outpatients, community clinical/community place, or the patient's own home. It does not impact on an individual's right to make informed choices and decisions about their care and treatment.

343. It is a clear expectation that all patients will be valued as active participants and experts in the planning and management of their own health and wellbeing, ensuring that the outcomes and solutions developed have meaning to the person in the context of their whole life, leading to improved chances of being successfully supported: this aligns and triangulates with the Trust's Delivery of Personalised Care policy.

344. The Trust follows NHS England guidance (Guidance to ICBs on intensive and assertive community mental health care, 2024) [DHSC0000101] to the effect that patients who require Assertive Outreach and/ or Intensive support will not be discharged via the Did Not Attend pathway.

Discharge decisions

345. Discharges and transfers of care have a significant impact on the safe and effective continuation of care, experience and outcomes. There are also increased clinical risks in cases of discharge and transfers in care.

346. For these reasons, discharges and transfers are approached and underpinned by a core set of principles, placing the person at the centre and recognising them as leaders in their own care. Equally, families and carers are respected and valued as being a huge source of support for our patients as well as holding a wealth of information and knowledge about the people we care for. As such,

involving families and carers in discharge planning as early as possible is a clinical priority for teams across the Trust.

347. Discharge planning begins immediately upon teams understanding people's health and safety needs and agreeing patient-centred goals. This is an important principle because our aim is to support and enable people with mental health conditions to recover and safely rebuild lives of quality and of their choosing, as independent from services as possible. Sometimes this means recognising and upholding people's right to make capacitous choices, even when they are assessed to be 'unwise', whilst upholding the Trust's statutory duties to section 117 aftercare and public safety.

348. As discharge plans reflect people's needs as whole people, the involvement of relevant external agencies i.e. social care, probation and safeguarding is critical, as is the timely sharing of information throughout people's care within the Trust and post discharge, thus ensuring the safe and effective continuation of personalised care.

349. Discharges from one mental health service to another is determined by the clinical needs of the people we care for. The expectation is that plans will be formulated, and decisions will be made in collaboration with all those involved in the patient's care including patients, families and carers, and the MDT.

350. Clinical examples of this may include a patient of a Local Mental Health Team whose mental health and safety needs are increasing, and the responsible team are unable to safely meet them. As such the responsible clinical team refer to the Crisis Home Treatment and Resolution Team ensuring timely access to safe and effective care, delivered by the right people, with the right skills, at the right time. A further example of this would be if someone detained under the MHA presents as acutely mentally unwell and increased risks of violence and aggression toward others, requiring a Psychiatric Intensive Care Unit bed to enable the safe and effective continuation of care within an appropriate environment. Should provision within the Trust be at maximum capacity, then a referral to an

independent mental healthcare inpatient provider would be considered, as described below.

351. In most cases, discharge from the Trust back to the care of the GP is planned following a care plan review involving MDT discussion/ review and actively incorporating the views of patients, their family and carers, and any voluntary or independent sector agencies providing care or support to the patient. In most cases, discharge from the Trust occurs when a patient no longer presents with significant or complex health and safety needs and their needs are best met by services available within primary care.

352. Exceptions to this may occur if the patient disengages or moves away unexpectedly. In this instance, teams refer to the DNA Policy.

353. In some instances, patients are discharged with an 'open appointment' offer. An open appointment is an agreement between patients and a service that upon a patient being formally discharged and should the need arise, patients can contact the team directly (within a defined time period i.e. 3 months) and request an appointment, serving as a safety net. The expectation is that these requests will be honoured, and a suitable appointment will be issued. Ideally this will be with a staff member known to the patient or a previous named healthcare professional, to ensure continuity.

354. Where people have disengaged with services and have no significant clinical risks or concerns, patients are discharged with what is referred to an "open 2/52". This means that the patient has 2 weeks from point of the letter being written to contact the service and arrange an appointment. Should people respond outside of this window, there is an expectation that an appointment will still be offered, allowing autonomy in practice. This practice is more prominent in community mental health services, primary care-based services and tertiary services such as Liaison Psychiatry.

355. The Trust has been working to strengthen our quality oversight of discharge by benchmarking against critical quality metrics, starting with discharges from

inpatient mental health services for which we are actively monitoring on our quality performance. To support improvement and reduce variation in clinical practice, it has developed a Discharge Checklist, aligning with the Department of Health's recent publication "*Discharge from Mental Health Inpatient Setting*" [NHSE0000305] and the NHS England guidance "*NHS Continuing Healthcare and NHS Funded Nursing Care*" [WITN0133020].

Quality metrics for mental health services

356. There are various national standards whose compliance is monitored through the CQC and other external bodies that provide a benchmark of the quality and effectiveness of the services that are provided within the Trust.

357. From 2020, when the Divisional Groups were supported with devolved leadership, there were a number of forums which supported the oversight of quality metrics. Tools used during this period included "Ward 2 Board" metrics, Integrated Performance Reports, performance reports, business meetings, quality audits and quality governance leads supported. Reports were also generated from corporate teams such as patient safety, complaints and compliance that guided the Divisions to understand their position.

358. A quality escalation process was utilised to support the level of oversight required by services and led by the Executive Director of Nursing.

359. A more local framework was used to also support areas of identified increased risk to enable a focussed review on quality and to ensure evidence of improvement was demonstrated.

360. A review of quality governance was commissioned in 2022 by the Executive Director of Nursing to continue to support and enhance the development and maturity of this process [NHFT0014993].

361. Further steps were taken in 2024 to enhance the development of quality metrics in light of the action plan put in place following the CQC's section 48 inspection

described in Section H below. This resulted in the implementation of SafeNow, which was a new system for quality performance oversight with clinical and operational leaders exploring/ understanding variation in our quality performance, sharing learning (with equal priority to what is working well) and identify themes for improvement (informing quality improvement and professional development strategies).

362. The SafeNow dashboard has also allowed the Trust to have oversight of all patients discharged due to disengagement, emergency readmissions and compliance with 72hr follow ups. This dashboard is not only a system for oversight, but also a key tool to identify and drive improvement. It has continued to grow and develop into an established and trusted approach to safety, oversight and improvement. The SafeNow dashboard is described in further detail below at paragraphs 521-526.

363. The Trust has also introduced a mandatory monthly audit within teams in the Mental Health Inpatients Care Unit, measuring the process of discharge from point of admission. This audit tool aligns with the Department of Health's best practice guidelines and triangulates with principles of the Trust's *"Continuity of Care Principles Standard Operating Procedure"* - ensuring the safe continuation of care upon discharge or transfer to another mental health provider.

364. The Trust is in the process of replicating this approach, establishing quality oversight of discharge within the Community Mental Health Services Care Unit. Additionally, Did Not Attend/Was Not Brought/Was Not Seen forms part of the Quality and Risk agenda for the Care Groups and is supported with relevant incident reports from the incident reporting system (Ulysses) and applied information reports from Rio and SystmOne and other relevant clinical systems which will capture such data.

E. Working with independent healthcare providers

365. The Trust strives to facilitate inpatient placements within a familiar community setting, where:

   a. Patients maintain links with their social support network,

   b. Patients can remain connected to their community, faith and, where indicated, their employers and/or educational providers, and

   c. Community health and social care workers can continue to contribute to care and maintain therapeutic relationships, in person wherever possible.

366. The Trust admits a proportion of patients to independent health care providers every year. This is either within the geographical footprint of Nottinghamshire (in area private provision) or outside Nottingham (out of area private provision). Admissions to an independent healthcare provider is a last resort when a bed within the Trust is unavailable or does not meet the individual needs of the patient. Out of Area beds can be geographically located anywhere in the country.

367. **A table outlining the number of** independent sector admissions within and out of area between June 2019 and June 2023 has been disclosed to the Inquiry [WITN0133021].

368. Between 2019 and 2023, to meet population need and improve access to appropriate care within patients' usual communities (as opposed to out of area beds), the Trust increased its subcontracted acute mental health bed provision from 21 to 59 (increase of 38 inpatient mental health beds) within Nottingham and Nottinghamshire. This provision was inclusive of 49 mixed sex acute mental health beds and 10 female Psychiatric Intensive Care Unit beds.

369. Patients can be placed appropriately out of area for several reasons, for example if the patient is a staff member, or there are safeguarding concerns for the patient if placed locally. The Trust also does not have psychiatric intensive care provision

for female patients, so any female patients requiring a Psychiatric Intensive Care Unit admission would be admitted to an independent health care provider.

370. Where the Trust commissions a specialist bed out of area, to meet patient health and safety needs, this is not considered inappropriate. Where a patient is placed outside of the Nottingham footprint due to lack of available beds, this is considered an inappropriate out of area admission.

371. The Trust recognises that patients who are placed in out of area beds can experience increased distress, as can their families and carers. Patients can feel isolated, and families may not always have the means or be physically able to travel to see their loved ones. This can impact not only the experience of patients' families and carers but their involvement in care and treatment. Furthermore, this can increase clinical risks and reduce patient outcomes, prolonging recovery and increasing length of stay.

372. The Trust has invested significant resources to improve how patients smoothly move through services within the Trust, and to strengthen oversight of out of area and spot purchase beds through the safe and optimal care pathway. The Trust's Standard Operating Procedures [NHFT0000425] have been strengthened to ensure parity for all our patients irrespective of clinical pathway. The infrastructure within the Trust has been strengthened with the introduction of leadership roles and growing the bed management/ out of area team, thus increasing capacity. Within the "*Continuity of Care Principles Standard Operating Procedure*" [NHFT0000425], the Trust has also taken steps to support patients, families and carers and introduced external provider accountabilities relating to escalating concerns to the Trust, which in turn will trigger escalation within the Trust.

373. The Trust is also working to implement 'zero activity' contracts with all independent sector healthcare providers, in which, the "*Continuity of Care Principles Standard Operating Procedure*" will be embedded alongside locally agreed KPIs, inclusive of critical quality, safety and operational metrics and clinical risk escalation pathways.

Identifying an appropriate placement

374. Upon receipt of referral for an inpatient admission, the Crisis Resolution Home Treatment Team will meet with the patient (and with family or carers where appropriate and with patient consent) to conduct an assessment of need, making considerations in relation to the suitability of home treatment as an alternative to inpatient admission, working to principles of the least restrictive option.

375. Where an MHA Assessment is required, this will be led by the relevant local authority, with support from a Trust Consultant Psychiatrist and GP, wherever possible.

376. The referrer will ensure completion of and/ or update the patient's electronic healthcare records (using Rio) including the Core Assessment, Risk and Safety Assessment, Summary and Care Plan, Rio/ Safeguarding Alerts and Progress Notes.

377. Upon receiving confirmation that an inpatient admission is required, the Bed Management Team will create a bed form on Rio and add patients on the bed waiting list.

378. The team will take into account the following key considerations in relation to the appropriateness of clinical placements, ensuring referrals are made to care providers who are able to meet the patient's health and safety needs, within 1hr of a formal request for an inpatient bed being made:

   a. Is the inpatient unit best placed to meet the needs of the patient as a whole person?

   b. Is there a bed within the Trust network?

   c. Is the most appropriate placement the closest to the patient's usual place of residence?

d. If it is not the closest care provider yet is best placed to meet the patient's needs, what arrangements are in place to support the patient, family and carers to remain connected and enable family/ carers to remain involved in care (with patient consent)?

e. Does the receiving inpatient unit have access to the Trust's electronic patient records? If not, then what information sharing arrangements are in place to assure safe and effective continuation of care?

f. If internal transfers take place, are these for clinical need? An example of this would be step up or down from a Psychiatric Intensive Care Unit bed.

379. Where an out of area placement is found to be the most appropriate option at the time of admission, the Crisis Resolution Home Treatment Team will discuss this with the patient and family/ carers (where appropriate and with patient consent), as part of the admission process. Guidance is available to ensure conversations are supportive, reassuring and reflect personalised care and principles of continuity.

Continuity of care and information sharing

380. All clinical areas within the Trust network, including subcontracted services delivering inpatient mental healthcare, have access to the electronic patient records held on Rio (subcontracted services have 'read only' access). The Trust also implements and maintains Information Sharing Agreements with subcontracted providers to ensure access to electronic patient records within a legal framework. Information sharing agreements stipulate access for both quality oversight and the safe continuation of care within a legal framework.

381. For external spot-purchase beds, and in alignment with the "*Continuity of Care Principles Standard Operating Procedure*" [NHFT0000425], the Bed Co-ordinator shares proportionate and relevant information that supports safe

transitions upon admission and discharge, ensuring the continuation of safe and effective care and treatment.

382. Information is shared proportionately to ensure safe transitions at critical points of care, enabling the safe and effective continuation of care. At the point of referral, the minimum information shared as standard procedure will include:

a. Patient demographics

b. Contact name and number of the Next of Kin and/or nearest relative

c. Advanced directives

d. Up to date risk assessment, core assessment and summary/ formulation

e. Progress notes from past 7 days

f. Latest MDT review minutes

g. Copy of medication card

h. Pending tribunals, meetings/ appointments

i. Contact name and number for any agencies involved in the patients care (i.e. Community Psychiatric Nurse, social worker)

j. COVID risk assessment (COVID-19 status, symptoms, last covid test, vaccination status)

k. AMPH report

l. Any mobility/physical health issues, and

m. Any current safeguarding issues.

383. In the past, there have been some delays in external providers accessing Rio due to:

a. External provider staff must attend the Rio training before they are able to access the system. Upon being booked onto the training, there has been variation in attendance.

a. Login and passwords expire after 3 months meaning that if external staff do not access the system within this timeframe, they need to commence the process for these to be re-issued – resulting in a delay in accessing the system.

384. Any concerns or issues are encouraged to be escalated to the Trust at the time, and this is also a standing agenda item within the monthly operational meetings held with the external healthcare providers as a formal escalation pathway.

385. Each week, the external provider shares the record of the patient's MDT meeting with the Trust's Bed Co-ordinator. The Bed Co-ordinator then uploads this to the Trust's patient's electronic record.

386. External providers notify the Trust of any complaints or patient safety events involving a Trust patient as soon as possible, yet not exceeding 24hrs. Providers share 24/ 72hr/60-day reports, and the Trust works with the provider to understand any learning: both what went well and areas for improvement.

387. Upon discharge, the external provider shares information with the Trust, which as a minimum will include:

a. MDT record

b. Discharge care plans

c. Risk assessment

d. The '*Health of the Nation Outcome Scales*' assessment conducted at the point of admission and discharge

e. Explicit plans for 72hr follow up

f. Overview of the patient/ family/ carer experience, and

g. Discharge summary, shared with the Trust and the GP within 72hrs of discharge.

388. These documents will be uploaded by the Bed Co-ordinator to the patient's electronic care notes on receipt. However, the independent provider will not provide a full copy of a patient's medical records unless requested to do so by the Trust.

<u>Discharge decisions</u>

389. The Trust works collaboratively with external providers as compassionate commissioners and critical friends, ensuring that patient rights are upheld and, where appropriate, discharge plans are compliant with section 117 aftercare. In alignment with the "*Continuity of Care Principles Standard Operating Procedure*" [NHFT0000425], the Bed Management Team remains closely connected to the treating clinicians and ward staff by monitoring patient care, experience and progress. They attend patients' MDT meetings and discharge meetings, working with external providers to plan for discharge. Activities include making timely referrals to social care/ other agencies, supporting transitions into rehabilitation environments or step-down facilities and leading repatriation to the Trust. The team acts as an essential conduit between Trust and the external provider, keeping both the Trust and the external provider connected as we unite to meet the patient's needs - striving to improve safety, experience, and outcomes and ensure parity for all our patients, irrespective of clinical pathways.

390. As described above, the Trust Care Coordinator is expected to attend their patient's MDT reviews and discharge meetings, contributing to ongoing care plan formulation (including discharge) and maintain their therapeutic relationship with patients and agreeing plans for 72hr follow ups. Ideally, attendance will be in person although we accept that this is not always possible and online attendance is an acceptable alternative.

Repatriation

391. In cases where patients' safety needs do not allow admission to a specific unit and an admission to another unit is required- wherever possible the patient will be prioritised for repatriation to their local inpatient unit within 7 days

392. The Bed Management Team and Out of Area Bed Co-ordinator will support the prioritisation of patients for repatriation to inpatient wards closer to their usual place of residence.

393. Daily Demand Meetings provide an escalation pathway to monitor and explore any concerns, complaints or distress that may arise secondary to being in an out of area placement. Repatriation of patients back to their local area is monitored during this meeting as part of the assessment of overall daily capacity and flow, including patients in an out of area A & E awaiting an inpatient bed and immediate plans are made. The Out of Area Bed Co-ordinator is responsible for actioning these plans and liaising with out of area providers and maintaining the patient's electronic record.

Quality oversight

394. As placing commissioners, the Trust maintains quality oversight of individual care yet does not maintain oversight of quality/ improvement of the hospital/provider.

395. The Trust has worked to strengthen systems for quality, safety and operational oversight, delivering parity across clinical pathways. This includes working through how we connect with ICBs as host commissioners: working across

systems to be assured that the care our patients receive meets quality standards and improving system capability to share learning.

396. Quality oversight is established and maintained in alignment with the Trust's "*Continuity of Care Principles Standard Operating Procedure*" developed following NHS England's publication of the "*Continuing Healthcare Framework*" in 2018 (revised 2022), which delivers national expectations for quality oversight of admissions to independent sector providers.

397. In December 2021, the Trust appointed a clinical quality lead for subcontracted services who is responsible for ensuring that the care being delivered within subcontracted services meets quality standards.

Contractual oversight

398. The in-area independent sector provision was provided by the Priory Group in 2019-2023. There was a subcontract arrangement in place, with subcontracted beds as an extension of Trust's inpatient bed provision and were all classified as 'in area' beds.

399. Contract review meetings took place on a quarterly basis to ensure contractual compliance and oversight on the quality and performance of the service provision. Monthly operational meetings were scheduled to identify any service delivery issues, focusing on patient safety, incidents, safeguarding and complaints or compliments. Any subsequent issues were escalated up through the contract review meeting process. As set out above, Priory Group were able to access patient records on a read-only basis and the services were able to directly refer patients to the hospital rather than via Priory Group's central referral system. Announced and un-announced quality visits also took place on a quarterly basis.

400. Quality and operational oversight is established and maintained in alignment with the Trust's Quality Assurance Framework for subcontracted services. This framework delivers a systematic, integrated approach to oversight of

subcontracted services: identifying quality, operations, contracting and performance as the 4 pillars required to wrap around subcontracted services-delivering robust oversight. Once tested, this framework was first ratified in August 2023 and introduced into practice.

401. Prior to August 2023, from 2016 two core oversight processes were led by the Mental Health Care Group. This was made up of operational oversight meetings that focussed on quality and performance, and were attended by commissioners, sub-contract leads, and operational and performance colleagues. In addition, quarterly contract review meetings took place and were chaired by the Mental Health General Manager and were focussed on monitoring the delivery of the contract. The updated process focusses more on real time quality monitoring and has an enhanced governance and escalation process.

402. Within the Quality Assurance Framework is the model for quality oversight-developed in alignment with the National Quality Board's Quality Surveillance Group and Risk Summit Guidelines. The purpose of this framework is to:

    a. Deliver a model for oversight of subcontracted services.

    b. Establish and embed routine reporting pathways.

    c. Develop and embed a pathway for urgent escalations.

    d. Align practice across the Trust.

Clinical oversight

403. In the instance of a patient safety event involving a Trust patient, the external provider reports this to the Trust's Out of Area Bed Co-ordinator and the Bed Management Team at the earliest opportunity, yet not exceeding 24hrs, delivering an overview of the incident and including the level of harm and actions taken. The Out of Area Bed Co-ordinator will notify a Clinical Manager for Flow, complete an incident report and notify the Trust Safeguarding, Safety Quality

team, Business & Performance team, the Care Unit Head of Nursing and Care Group Director. The Out of Area Bed Co-Ordinator will record on the Trust patient records in instances where patients are being cared for outside of the Trust network. The Clinical Manager for Flow and the respective community team will contact family/carers to offer support and reassurance and maintain contact with the independent sector hospital to review incident and offer support.

404. The care provider will share all relevant documentation relating to the incident including the 24hr, 72hr and 60-day reports.

405. Should concerns/ complaints or evidence of distressed patients/ family/ carers secondary to the quality of care being delivered and/ or the impact of an out of area placement, the care provider will report this to the Out of Area Bed Co-ordinator at the earliest opportunity, not exceeding 24hrs. The Out of Area Bed Co-ordinator will escalate this to the Trust Clinical Manager for Flow, Patient Advice and Liaison Service and Business & Performance Manager. Additionally, the Out of Area Bed Co-ordinator will escalate issues of this nature to the Daily Demand Meeting. Concerns around quality of care will be escalated to the Mental Health Quality & Risk Group and the Quality Operational Group where appropriate.

406. Upon attending ward rounds, the Out of Area Bed Co-ordinator or Care Coordinators will collect data relating to integrated working, patient and family/ carer experience/ involvement and quality of care planning, ensuring plans for discharge and follow up align with section 117 aftercare and effective plans for 72hr follow ups have been arranged. The Out of Area Bed Co-ordinator or Care Coordinators will ensure this record is uploaded to the Trust's patient record. This data will be reported weekly to the Out of Area Bed Co-ordinator to review and include within their weekly report to the Trust Clinical Manager for Flow, the Finance team and Business & Performance team.

407. The Trust Out of Area Bed Co-ordinator will collect data around length of stay, care provider responsiveness, delayed discharges and people who are in an inpatient bed and ready for discharge yet are unable to be discharged for social

reason during the weekly independent sector hospital oversight meeting. The Out of Area Bed Co-ordinator will ensure this information is documented and escalated through weekly system calls.

408. The Out of Area Bed Co-ordinator will collate the data collected by themselves and received from the independent sector hospital and report to the Trust Clinical Manager for Flow, the Business and Performance team and the Finance team, weekly.

409. The Trust Clinical Manager for Flow or Service Manager for Out of Area and the Out of Area Bed Co-ordinator will escalate concerns to the weekly system escalation calls with ICBs and local authorities.

410. Where the Trust attends a site and has quality concerns about non-Trust patients, we will raise this with the provider at the time, identify the commissioner and raise a safeguarding alert. The Trust will with then liaise with the commissioning Trust to share our concern, requesting the commissioning Trust to follow up. An incident report will be raised within the Trust (as a third-party incident). This information will be shared in the Daily Demand Meeting and Serious Incident Group where appropriate.

F. Working with other bodies and information sharing

<u>Working with local authorities</u>

411. Local authorities have significant responsibilities for mental health care, particularly in social care and community support, under the Care Act 2014 and the MHA. Specific responsibilities include:

    a. Section 117 aftercare services. Councils are required to provide aftercare services to individuals discharged from hospital under certain sections of the MHA.

b. Advocacy Services. Local authorities commission advocacy services including Independent Mental Health Advocates under the MHA and Independent Mental Capacity Advocates under the MCA.

c. Councils are responsible for authorizing DOLS in care homes and hospitals.

d. The responsibility for AMHPs. These are registered professionals who are approved by the relevant local authority for a period of five years. They can be social workers, psychiatric nurses, occupational therapists or chartered psychologists. AMHPs are responsible for considering and arranging assessments under the MHA, as discussed in more detail below at paragraphs 268- 275. If the patient lacks capacity, the AMHP will need to apply to the county court. It is the AMHP's responsibility to involve the patient, their family and carers where possible to explore and consider the least restrictive option and alternatives to detention. They work with a number of other professionals including hospitals, the police, care homes, housing providers and homeless outreach teams.

412. The Integrated Care System brings together the Trust and the local authorities to help plan and deliver joined up services. There are various operational interfaces including a flow escalation meeting and the unplanned and emergency care board. On a day-to-day basis, since the expiry of joint service delivery under a Section 75 agreement (under the NHS Act 2006 which led to the withdrawal of local authority employed social workers from the Local Mental Health Teams to ensure they met the targets in the Care Act 2014), the Trust has utilised NHS funding to directly employ social workers as Care Coordinators. These will also at times work as AMHPs.

413. If a patient is in a service with Trust employed social workers, for example the EIP service, they will be involved along with other team members in supporting the discharge of patients from the team. AMHPs are not involved in the discharge of the patient or the care planning beyond the initial placement unless, for example, a CTO is being considered. Adult social care may become involved in

the care planning and discharge planning if the patient has social care needs, for example housing.

414. We have described above how the CareCentric record allows for information to be shared between health and social services in relation to the case of a patient.

Information sharing with other healthcare providers

415. The Trust will share relevant information with other healthcare providers as part of any referral process. It is the Trust's policy to respond to any requests from other providers for additional health records in a timely manner so as not to hinder the provision of healthcare. Sub-contracted providers will also have direct access to the Trust's electronic patient records, as explained above at paragraphs 380-382.

416. Policies, procedures, and guidance is available to staff when such situations arise (see 12.09 (formerly 7.09)) [NHFT0015701]. Staff are able to seek support and advice from local clinical colleagues as to the appropriateness of the request, as well as the Trust's Data Security and Data Protection Team and Caldicott Guardian. The Caldicott Guardian is supported by the Trust Data Protection Officer, and Deputy Data Protection Officer who are also available to provide support and advice.

417. Staff are all required to complete the NHS England Data Security e-learning module on an annual basis, and this training includes questions and scenarios relevant to information sharing. For new starters, the Trust has a Core Induction event at which the Data Security and Data Protection Team deliver a presentation. This includes information sharing advice, plus key contacts and intranet sites where further information is available. Local inductions can also include this information.

418. Clinical teams will have key points of contact within their service from whom they are able to seek advice and support when information sharing situations and queries occur. At local business meetings and team meetings, topics such as

this will be discussed, including the use of social media, use of mobile devices and professional boundaries as relevant to this topic.

419. Staff are aware that the sharing of information needs to be proportionate to the situation or query in hand, and they must assess the risk to the patient, or others, and ensure that information shared is appropriate to mitigate that risk and ensure the continuation of care for the patient. A log of the information shared should be recorded within Rio.

Information sharing with the police

420. The Trust's Multi Agency Public Protection Arrangements sets out the steps to be followed so that the Trust is able to fulfil its legal responsibilities regarding the notification of and sharing information relating to those offenders who are covered by the Multi Agency Public Protection Arrangements (also known as MAPPA, the statutory process through which the police, probation and prison services work together with other agencies to manage the risks posed by violent and sexual offenders in order to protect the public) [NHFT0000424].

421. The Trust also has a Police Liaison Policy [NHFT0000456] that supports all memoranda and joint protocol between the Trust and those police forces and criminal justice agencies within whose boundaries the Trust operates. The aim of the policy is to support positive joint working and the appropriate flow of information between the police, the Trust and their partners and all criminal justice agencies in fulfilling the shared responsibilities towards the public. The Trust is currently in the process of agreeing a new Memorandum of Understanding with Nottinghamshire Police.

Information sharing with patients and families

422. Patients should be kept informed by health professionals and be involved in their own care as per clinical guidance within the Trust. Patients also can request copies of their files by making a Subject Access Request.

423. The Trust would not normally share information, or would limit the information shared where:

a. There are safety or safeguarding concerns relating to those individuals who have requested or have a duty as a carer, as determined by the safeguarding/clinical teams.

b. The patient objects or refuses for information to be shared with family members/carers.

424. Where the patient is deemed not to have the capacity to consent, and the clinical team determine it is in their best interests or, in these situations, where someone holds a Lasting Power of Attorney, disclosure may still occur, such as where it is necessary to keep them safe and/or to prevent serious harm.

425. The Trust has disclosed to the Inquiry the following relevant policies in relation to information sharing:

a. 12.01 Information Systems Security [NHFT0015695]
b. 12.06 Records Management [NHFT0015698]
c. 12.03 Clinical Information Systems, Access and Audit [NHFT0015696]
d. 12.04 Secure Handling of Information [NHFT0015697]
e. 12.07 Registration Authority [NHFT0015699]
f. 12.08 Information Systems Data Quality [NHFT0015700]
g. 12.09 Access to Information [NHFT0015701]
h. 12.14 Information Risk Management [NHFT0015702]
i. 12.19 Data Protection [NHFT0015703]
j. 06.01 Safeguarding Children [NHFT0002828]
k. 06.04 Safeguarding Adults at Risk [NHFT0015692]
l. 13.07 Multi Agency Public Protection Arrangements [NHFT0000424]
m. 08.03 Involvement of Patients and Carers [NHFT0015694]
n. 08.01 Information Sharing Between Professionals Patients and Carers [NHFT0012786]

Barriers to information sharing

426. The Trust does not consider there are currently any significant legal barriers to relevant bodies working together and sharing information sharing. On a day-to-day basis and when delivering patient care, staff are aware of a duty to share relevant information, where appropriate, to ensure the continuation and best care for patients, especially where there is an urgent situation or when there are safeguarding concerns. Multi agency information sharing agreements and arrangements are also in place that cover specific circumstances and events. These agreements do not limit the sharing of information, as and when it is appropriate to do so.

427. However, it can sometimes be difficult in practise to balance the need to share information with the need to protect patient confidentiality and the UK General Data Protection Regulation. In the Trust's experience, some external bodies and clinical staff are sometimes too risk averse to sharing information for fear of breaching a patient's confidentiality. Whilst the Notts Care record is a positive example of good progress in this regard, the Trust recognises that more could still be done to promote best practice. In the case of VC, the fact that the Trust was not made aware of the bench warrant that was issued on 22 September 2022 is an example of where information sharing systems and practices could be improved.

G. Care provided to VC

428. In the Request of 16 June 2025, the Inquiry asked that a chronology set out the interactions between the Trust and VC, or relating to VC, up to 13 June 2023 and that the names of the professionals involved were also included. As the Inquiry has also asked that the Trust to disclose all medical records relating to VC [NHFT0000003-107, 111-118, 125, 127, 163, 108, 169, 173, 177-298, 312, 322, 325, 328-42, 355, 357 358, 363, 368-370, 399, 401, 406, 408, 416, 545, 549, 997, 1575, 1794, 1962, 2009, 2048, 2370, 2546, 2579, 3029, 3132, 3400, 4360, 4444, 4554, 4574, 4627, 4635, 4909, 4927, 7522-7525, 8584, 8585, 11856, 14433, 1443-1448, 14459, 14619, 14622-14625, 14635-14704, 15048], the Trust

has expanded the timeline of the chronology to include the care provided at HMP Nottingham between 17-20 June 2023. This chronology is exhibited to this statement at WITN0133040.

429. In terms of the methodology for the chronology, the approach taken was to review VC's patient records (both electronic and paper), so as to provide the detail requested above. The information contained in the chronology has been taken directly from the entries made in these records, although some spelling and other typographical errors have been corrected for ease of reading.

430. In summary and to answer some of the specific questions raised in the Request:

a. The Trust first provided care to VC from 24 May 2020 until when he was last discharged on 22 September 2022.

b. During this time period, VC was treated by two independent providers. On 11 September 2021, he was transferred from Highbury Hospital to Cygnet Victoria House Darlington when he was admitted. On 1 October 2021 he was transferred to Priory Hospital Arnold, Bestwood Ward (which is in Nottingham), following conversations about step-down on 28 September 2021. He remained at Priory Hospital Arnold until his discharge on 22 October 2021. At the time of VC's care with Cygnet Group and the Priory Group, the Trust received updates and discharge letters but would not receive the full records. Post-incident, the Trust requested VC's healthcare records from both the Priory Group and Cygnet, but only the latter have been received to date.

c. VC subsequently received care at HMP Nottingham between 17-20 June 2023. The Trust were contracted at the time to provide healthcare services at HMP Nottingham.

d. For the avoidance of any doubt, the Trust did not provide healthcare services to VC whilst he was detained by Nottinghamshire Police and held in custody between 12 and 17 June 2023. The Trust is therefore not in a

position to assist the Inquiry in relation to whether there was any drug testing or toxicology reports from this period.

e. Once VC was moved to HMP Manchester, the Trust did not provide any further direct care to him, although discussions were held with NHS England to discuss which High Secure Hospital should assess him and which hospital would be suitable. It was agreed not to admit VC to Rampton High Secure Hospital in this regard.

431. In addition to the Trust's records shared with the Inquiry, from which exhibit WITN0133040 is taken, there are two further events of which the Trust is aware, between VC and a Health Improvement Worker working for the Trust:

a. A text message sent to VC on 21 November 2022, requesting contact from him to arrange a yearly health check due to the medication he was taking.

b. A telephone call to VC on 1 March 2023, seeking to book him in for a physical health check due to the medication he was on. VC declined, saying that he did not need any health checks.

432. These entries had been retrospectively added to the Trust's SystmOne Health Improvement records in December 2023 [CHCA0000030] and had therefore not been picked up by the Trust's previous searches of VC's records up to June 2023 when the incidents occurred. As those retrospective entries referred to EMIS, the Trust has undertaken checks with Cripps Health Centre where VC was registered to a GP. Cripps Health Centre has confirmed that their records show that corresponding entries were made by the same Health Improvement Worker, on 22 November 2022 and 1 March 2023 [CHCA0000030]. They were also able to confirm that on 1 March 2023, VC was one of 14 of their patients viewed and contacted by the Health Improvement Worker as part of routine monitoring.

433. The role of a Health Improvement Worker is to support the physical healthcare risks associated with a severe mental illness such as schizophrenia. A Health Improvement Worker is not a mental health professional, and they may not have

mental health experience, as their focus will be on any physical health complications of psychotropic medication. Their role is set out in the Trust's Health Improvement Worker Standard Operating Procedure [NHFT0014996]:

> "*People with a Severe Mental Illness (SMI) die on average 15-20 years earlier than the general population often due to the under identification or poor management of their cardiometabolic risk factors.*
>
> *NHS England has provided guidance 'Improving physical healthcare for people living with severe mental illness (SMI) in primary care'. A key part of this is ensuring people on the SMI register receive an annual health check that covers cardio metabolic risk factors, general physical health inquiry, relevant national screening programmes & medicine reconciliation and monitoring. [p3]*
> ***Health Improvement Worker** (HIW) support and engage with people on the SMI register using the standard operating procedures set out in this document to have their cardiometabolic risk factors measured. Also, support the people in understanding their physical healthcare risk factors, how to manage their risk factors and a plan for ongoing monitoring and management of the risks under the supervision of a state registered clinician. In addition, the HIW will support and engage people on the LMHT caseloads who require physical healthcare intervention such as medication monitoring." [p5]*

434. The Health Improvement Worker role, is a Band 4 position specifically focused on monitoring the physical health and lifestyle of patients with severe mental illness, responding to the national drive to undertake such monitoring given the increased morbidity in this patient group. They will attend GP practices and obtain a list of all patients registered to the practice who have a severe mental illness, and then contact them to offer the physical health check. They are essentially working for the GP practice in this respect. The role is purely task-focussed and they will not make assessments based on their findings but report them back to the GP (or Trust clinician where appropriate), in the same way that a healthcare support worker might take bloods or do blood pressure checks. As per the Standard Operational Procedure, the primary records system used by the Health Improvement Team is SystmOne, which is also the system used by

most GP practices in Nottingham and Nottinghamshire. Health Improvement Workers would be expected to record their contacts in SystmOne. Far fewer GP practices in the area use EMIS as their system, in which case the Health Improvement Worker would also be expected to add to the EMIS record, as occurred in the case of VC. Appendix F of the Standard Operational Procedure states that the physical health check results can be entered into Rio "as required". This is because the Rio system is used by community and inpatient teams, so would only be necessary to use where the patient was open to these services, which VC was not at this time.

Immediate actions taken by Trust following the incident on 13 June 2023

435. At 8:51am, on 13 June 2023, the Trust was informed by the ICB Emergency Preparedness, Resilience and Response ("**EPRR**") Manager that the East Midlands Ambulance Service had called a major incident. The ICB convened a Health Strategic Command Group at 9:30am which was attended by the Trust's Acting Executive Director of Mental Health services (as EPRR Lead for the Trust) and Strategic Head of EPRR and Counter Terrorism. The Trust's Acting Executive Director of Mental Health services mobilised an internal Trust group called the Incident Control Team which met at 10:30am that same day. Its purpose was to provide leadership and direction across all areas of the Trust business, to minimise disruption to patient services and provide support into the major incident if required. By 12:30pm, the police had declared Operation Hendrix as there was no risk of further casualties / VC had been detained. East Midlands Ambulance Service stood down the major incident at 3:50pm.

436. The Trust was asked by Nottinghamshire Police that same day to do a Rio check to ascertain if VC was open to mental health services and for his home address. The Trust was informed by the police that VC had been arrested on suspicion of 3 counts of murder and 3 counts of attempted murder.

437. After it had been confirmed that VC had received Trust care, the Trust established an Incident Response Meeting that same day. This group met daily until 23 June and then changed its name to the Incident Response Leadership

Group. The purpose was to agree the scope of the initial internal investigation, respond to any information / actions in relation to Operation Hendrix, communicate with staff and respond to media enquiries. This group was chaired by the Acting Executive Director of Mental Health services and was comprised of the full senior team, including the Chief Executive. The group met regularly up until early 2024 when VC was sentenced.

438. On 20 June 2023, the incident on 13 June 2023 was noted by the Trust's SIRG.142 This resulted in the Trust's Patient Safety Manager reporting the matter as a Serious Incident on StEIS. The Trust's Patient Safety Manager completed the Initial Management Review and submitted this to the ICB and NHS England on 29 June 2023. Based on the level of restriction required when discussing the incident, the main conversations and planning were undertaken in the Incident Response Group. This enabled robust collective oversight of actions and updates on a frequent basis.

439. Given the seriousness of the incident, the Trust decided that a "level 2" comprehensive internal investigation was required. The steps taken by the Trust in this regard are described in more detail at paragraphs 475-489 below. The Trust's Deputy Chief Nurse also met with NHS England's regional Chief Nurse and regional Mental Homicide Lead to ensure that NHS England had all relevant information.

440. As another immediate action, the Trust took steps on 14 June 2023 to ensure access to VC's medical records on the Rio system were restricted, with access subject to an approvals process managed by the Information Governance Team and the Trust's Head of Data Security and Data Protection (who is also the Trust's Data Protection Officer). The Trust has audited access to VC's records and can confirm that there was no inappropriate access to VC's Trust medical records by any staff or third parties (the Trust is able to audit access that occurs through the digital footprint recorded on the Rio system).

441. The Trust is however aware of the involvement of two of its members of staff in the investigation by the Nottingham University Hospitals NHS Trust ("**NUH**") into

unauthorised access of its medical records. The investigation is ongoing and no conclusions have been reached in relation to those staff. The Trust continues to liaise with NUH and will update the Inquiry accordingly, in due course.

442. The Trust recognised that during the necessary investigative processes which would necessarily follow the incident that some limited people would require sight of VC's medical records. Therefore, a copy of VC's medical records were added to a secure MS Teams channel so that individuals with specific access rights could be granted access to view the notes for a limited period of time. This meant that they would all view a fixed copy of the records, which reduced the need for the records to be accessed via Rio.

443. The Trust also corresponded directly with VC's family and the bereaved families and surviving victims at various points following the incident on 13 June 2023. After receiving advice from the police, the bereaved families and surviving victims received letters from the Trust's Chief Executive on 7 December 2023: [NHFT0000494], [NHFT0000495], [NHFT0000496], [NHFT0000500], [NHFT0000499], [NHFT0000502], [NHFT0000497], [NHFT0000498], [NHFT0000501]. However, this is an area where the Trust has recognised that delays and a lack of clarity around the interaction between the criminal processes and the Trust's incident review impacted on the way in which it engaged with those affected by VC's crimes. It has expanded on this later in the statement describing lessons learned and improvements made. The Trust has disclosed to the Inquiry the correspondence with the families since 13 June 2023, as well as the internal documents that underpinned the Trust's responses to questions asked by the families [NHSE0000824, NHSE0000825, NHSE0000826].

Reflections

444. The Trust has stated publicly, and reiterates here, that it accepts in full the findings and recommendations made by the external reviews carried out to date in relation to the care provided by the Trust to VC. The Trust's reflections are necessarily informed by that underlying position.

445. It is important to acknowledge that each review to date has been carried out for a specific purpose, within a particular framework, and each has had limitations. It is for the Inquiry to explore this and determine what further avenues of investigation it wishes to explore but the Trust notes, for instance, that the Level 2 Comprehensive Investigation interviewed some staff; the Independent Homicide Investigation commissioned from Theemis by NHS England also included interviews with some staff, but more limited engagement seems to have been provided by the University of Nottingham (who declined to be interviewed) and Nottinghamshire Police. The Trust understands that neither of these investigations sought the views of the AMHP, whose role has been described earlier in this statement and whose participation at key stages of VC's care is evident from the Chronology. The Trust's view, therefore, is that there remain key aspects where further exploration is needed, including through obtaining evidence from individuals who were involved in VC's care. This is particularly important where the documentary record is lacking.

446. However, in producing this witness statement, I have reflected, alongside others in the Trust's Senior Leadership Team, on what the key reflections are that we have in relation to VC's case and we have identified the following:

Topic	**Reflection**
Shared decision-making	In reviewing the chronology, there were issues around effective shared decision that include: • Inconsistent record keeping, with examples of good practice but also instances where poor record keeping is evidenced (including, at key points, a lack of any recorded decision). VC's final discharge on 22 September 2022 is a key example of poor record-keeping. • Effective team working is not always evidenced, with the voice of the wider team with a role in

	caring for VC not always being heard when Responsible Clinician decision-making is recorded. This is particularly important where the same Responsible Clinician may not be present during each admission and so clear and consistent liaison as an MDT, backed up by clear record keeping, is needed to enable a good understanding of longitudinal risk. • Interactions with VC are inconsistently documented, and the steps taken in response to these interactions are not always clearly noted. This makes it difficult to understand why and how some clinical decisions were made. Documented records explaining clearly what options were considered is not available at the point of VC's final discharge in September 2023. See below for more on discharge specifically. • We agree with the conclusions in the Theemis report that risk, especially longitudinal risk, is not well understood outside of a forensic services context. The Trust considers that there may be a benefit to national work on this (see Area for Improvement 2 – Risk, page xxvi). • As a Trust, we continue to reflect on how skills and expertise between different services could best be shared, including whether in cases such as VC, community teams could draw more on forensic community service risk assessment expertise. Community Forensic Consultation Clinics have been implemented and to assess risk to others as part of a holistic assessment that incorporates risk reduction and safety strategies.

The Trust's management of engagement with VC	• The documentation and thought process around management options explaining the Trust's approach to engaging with VC was not reflective of best practice, particularly in the later period of his care between February and September 2022. • The Trust has reflected on whether disengagement is a reason to discharge and whether we should discharge in their absence, particularly in cases such as VC's where disengagement is a known feature of deteriorating mental health. The Trust has updated its policy on discharge to make a differential approach to disengagement, which supports a holistic understanding of disengagement. This is evidenced in both the Trust's updated DNA Policy and in the updated Transfer and Discharge policy [NHFT0003340], both of which are described in detail elsewhere in this statement. As a key underlying principle, the DNA Policy emphasises: "*the importance of professional curiosity in understanding risk and non-attendance/non-engagement, including issues with mental capacity*". It incorporates clear stepped decision-making, including through flowcharts.
Risk assessment	• Reflecting on risk assessments carried out in respect of VC, the key aspect that does not appear to have been adequately considered is the risk VC presented to the community. • This is particularly evident in the context of the final months of care provided to the VC in the period from February to September 2022. The

	Trust has reflected on and worked to strengthen the process around discharge and risk assessment as part of discharge planning. This is described below and the table that follows paragraph 514. • Risk assessments carried out in the earlier stages of the Trust's care for VC did evidence a more thorough approach, including clear and effective engagement with VC's family. • The Trust has reflected on the important, but distinct, role that a longitudinal risk assessment, as well as a dynamic risk assessment process, provides in enabling a robust approach to overall risk assessment. It is clear that in the context of VC's care this was not always done well, and the Trust has described in this statement the work it has done to improve how risk assessments are carried out, including sharing expertise and learning from community forensic services.
Discharge	• There are a number of reflections to draw from the discharge process, both in terms of good practice (VC's first two discharges from Trust inpatient services showing evidence of clearly documented, risk-informed decision-making) and areas for improvement, including around how partners (primary care, the University of Nottingham) were actively involved in later discharge decisions and seen as key parts of wider multi-disciplinary team caring for VC. • When reflecting overall on the way in which the Trust managed VC's discharge from service in September 2022, the Trust's clear reflection is

	that the risk assessment carried out in advance was not effective and failed to adequately consider the risk VC presented to the community. The Trust has strengthened its policy on discharge and is more confident now in the approach that would be followed to enable a differential approach. • The poor documentation hinders an understanding of how the decision to discharge was reached, including what options (other than discharge or in advance of a discharge decision) were considered, if any, at the time. To date, the Trust's understanding of what was considered at the MDT has not been meaningfully added to by the external reviews or the internal processes carried out by the Trust (which included seeking further information from those present at the final MDT meeting at which the discharge decision was taken). • The Trust has also reflected on areas of good practice on the first admission, particularly the effective liaison between the Responsible Clinician, VC's mother and the University of Nottingham early on during VC's care. VC's Responsible Clinician also documents ringing the Crisis Team before discharge and requesting a face-to-face visit post discharge (noting that this was in COVID-19 with social distancing in place, so this emphasised an appropriately risk-informed approach to follow-up care). Documented consideration and planning is also recorded to take effect in the event that VC moved out of area.

	• In contrast, at the point of VC's final discharge, there is no evidence that his family were consulted or advised. There is also no evidence to explain how the concerns shared by the University of Nottingham were acted on or how the GP was involved in discharge planning. The Trust has described later in the section of this statement dealing with Lessons Learned the work it has begun around improving working with primary care partners and other stakeholders.
Learning from incidents	• Prior to the events involving VC, the Trust had recognised that it needed to improve the way it enabled effective learning from incidents and to embed a culture of learning from ward to Board. • Since the incident, the Trust has made significant progress in its learning and response to incidents, which is described in more detail below in the Lessons Learned section of this statement. This improvement work has included work to strengthen escalation and oversight arrangements, as well as the quality of incident response and the routine and effective sharing of learning, using a variety of ways of doing this. • Relatedly, the Trust has reflected on how it enables and supports corporate memory to support thematic learning from incidents. This is an NHS-wide challenge, but the Trust continues to reflect on the importance of digital systems that enable effective organisational repositories as a key enabler of improved corporate memory, alongside a systematic approach to learning, delivered in a range of ways. The

	digitisation of systems has enabled the Trust to more easily retain records of incidents, learning and sharing these with staff. • The Trust has also recognised that the lessons learned from incidents and investigations need to be embedded more quickly to ensure that staff turnover has less of an impact on the delivery of change. • The Trust has also identified as areas for potential recommendations specific reflections on the way in which victims and/or their families are involved in the learning from incidents process and the lack of clarity around what information can be shared and, where there are limitations on this, why this is.
Culturally appropriate care	• As a Trust which provides care to multicultural, diverse communities, we have reflected that we need to have a thorough knowledge, understanding and respect of cultural context. We must ensure we recognise how a person's cultural background influences their understanding of mental health, their experiences of mental illness, the expression of emotion, willingness to disclose, and caution around trusting people where there is an absence of representation or perceived power imbalance. We must be able to consider how this can impact on engagement and the acceptance of interventions. The Trust is now actively using demographic data to utilise culturally appropriate interventions (e.g. team meetings using the Assertive Outreach Dashboard) supported by training, collaboration

	with partners, a new approach to participation and the implementation of NHS England's Patient and Carer Race Equality Framework.
Multi agency coordination when responding to complex incidents	• The Trust has reflected on the difficulties in the process of working with other bodies in responding to complex incidents, and that it can be difficult to understand what communication is appropriate at which stage. During the initial response to the incident, the Trust has reflected that it was not always clear at what point actions could be taken while there were ongoing criminal processes in place. This lack of clarity contributed to delays in the way that the Trust carried out its response to the incident and a lack of clarity around when it was unable to contact families of VC's victims. • Since the incident, the Trust has worked closely with Nottinghamshire Police to introduce clearer and improved arrangements to govern how we work together as partners. • Further work remains to be done in terms of broader partnership working, particularly in relation to primary care and the universities. • However, while the Trust has introduced strengthened local arrangements working with Nottinghamshire Police, the Trust's view is that this is an area where further reflection in the forum of the Inquiry would be beneficial, particularly with the interests of the families affected by incidents in mind. While each incident is unique, a clear framework that guides common steps and provides clear ways of working on case-specific aspects would be

	beneficial and minimise delays in way that agencies respond to incidents where multi-agency involvement is required.

H. Reviews and learning from homicides and attempted homicides

447. We have explained above the investigation and review process generally that is undertaken following any patient safety incidents, as well as the role of the more recently established Complex Incidents Oversight Group to provide executive oversight and governance of significant patient safety incidents. The Trust keeps track of all serious incidents, including homicides committed by mental health patients [NHFT0000603; NHFT0016453; NHFT0008912; NHFT0010772].

448. As the Inquiry is aware, there have been several reviews conducted by the Trust and external bodies following the incident on 13 June 2023, some of which concerned the delivery of mental health services at the Trust generally and others relating to the care provided to VC specifically. Each of the reports produced following these reviews has been provided to the Inquiry by the Trust. The below summary is intended to assist the Inquiry understand any additional context for these reviews that is not apparent from the reports and to confirm the steps taken by the Trust in relation to any recommendations made.

449. This section describes:

    a. The 2004/2005 Independent Inquiry that was conducted by a barrister following 2 homicides in the Nottingham area;

    b. The Serious Incident reviews conducted by the Trust following attacks in GRO-C 2023 by GRO-B and the GRO-C 2023 attack by GRO-B GRO-B

    c. The Independent Evaluation of Trust Safety Processes that was commissioned prior to the incident on 13 June 2023;

d. The specific patient safety investigation that was conducted following the incident involving VC on 13 June 2023 (the "**Level 2 Investigation**");

e. The subsequent external reviews that were conducted by the CQC and NHS England into this incident ("**Theemis Report**");

f. The three reviews commissioned by the Trust regarding the performance of the EIP, Crisis and Local Mental Health Teams; and

g. The Thematic Review of homicides and attempted homicides between 2019 – 2023 that was commissioned by the Trust ("**Thematic Review of Homicides**").

Other homicide / attempted homicide cases

2004/5 Independent Inquiry

450. The Inquiry has asked the Trust to set out what learning and/or changes were made as a result of the barrister led Inquiry that reported in 2004 and 2005 following two homicides involving patients of the Trust. At the time, Health Circular (94)27 required an independent inquiry be held where an individual has been in receipt of psychiatric services prior to a homicide.

451. The first homicide related to "Patient B" being convicted of murder on GRO-C GRO-C 2000. GRO-B had sought and received mental health support two months prior to the homicide.

452. The second of these homicides related to "Patient A" being found guilty of the manslaughter GRO-C 2000. Patient A had been in receipt of mental health services from the Trust during a period of only 24 hours prior to the homicide.

453. Nottingham Health Authority (and subsequently Gedling Primary Care Trust following it becoming the relevant commissioning body) commissioned an independent inquiry to examine the care and treatment provided to Patient B and Patient A in order to learn lessons and improve services by considering these two incidents. However, given the very different factual circumstances of each patient, the inquiry decided to publish two separate reports.

454. In relation to Patient B, the inquiry found that the killing was unpredictable and unforeseeable [NHFT0015834]. However, it made the following recommendations:

    a. A local policy across NHS trusts and social services be implemented that addresses the needs of deaf mental health services users.

    b. Services could be improved by: improving facilities in the Accident and Emergency Department; access to 24 hour interpretation services; guidance given to junior psychiatrists on when to seek advice; 24 hour crisis advice service for deaf users and professionals; an admissions policy which can be understood by users and staff; a review of records and information systems across the Trust; information on ethnic and cultural traditions be made available to clinicians; risk assessment documentation be completed at the point of discharge; the system of social work allocation be reviewed; and an integrated service with the social services County Deaf Team be reviewed and considered.

455. The Trust acknowledges that the finding in this report stating that the risk assessment documentation should be updated at the point of discharge was similar to a finding made by the Level 2 Investigation into VC.

456. In relation to Patient A, seven areas of concern were identified [NHFT0004541]:

    a. Probation and police need mental health training;

    b. Families need to be heard, with interpreters if necessary;

c. Families need culturally sensitive support;

d. Intermittent nursing observation has inherent weaknesses;

e. Risk assessment should involve family members;

f. When a detained patient is missing the situation is urgent; and

g. There was a failure to detain Patient A in hospital.

457. Again, the Trust acknowledges that the need to involve families was something that was also relevant in the reviews conducted into VC's care.

458. The Trust developed action plans to respond to the above recommendations and disseminated learning to staff [NHFT0015834, NHFT0004541]. Board papers discussing the Independent Inquiry have also been disclosed to this Inquiry, although given the passage of time it is likely that there were further internal documents that existed at the time that are either no longer available or difficult to locate. The Trust will continue to reflect throughout this Inquiry in relation to whether there was a failure to learn from these events; if learning took place but was lost over time, and, if so, what factors contributed to that failure.

Level 2 investigation for GRO-B *(* GRO-C *2023)*

459. The Request dated 2 July 2025 asks the Trust to explain the reviews conducted following attacks GRO-B in GRO-C 2023. Relevantly, GRO-B was arrested on suspicion of GRO-C grievous bodily harm with intent having GRO-C

460. GRO-B H GRO-D

GRO-D

remains under the care of the Trust today. GRO-D

GRO-D

461. The incident was discussed by the Trust's Serious Incident group on 21 February 2023 and reported on StEIS the following day [NHFT0015790]. It was agreed at the meeting that a "level 2" comprehensive investigation was needed, although this was paused due to the ongoing police investigation. The Trust was informed on 16 January 2024 by the police that the Serious Incident investigation could commence.

462. The Trust decided that an independent chair for the Level 2 investigation regarding GRO-B was appropriate for external scrutiny. Psychological Approaches was commissioned to provide the independent chair and produce the report (as explained below, Psychological Approaches were also commissioned to conduct the investigation in respect of VC and the same chair was appointed). The process of the investigation and methodology are set out on page 4 of the Level 2 investigation report regarding GRO-B and the qualifications of the panel are set out on page 6 [NHFT0015791].

463. GRO-D

464. GRO-D

GRO-D

465. The report was received by the Trust on 10 May 2024 and approved by the Trust on 26 November 2024. The Trust fully accepted the findings made by the panel. Overall, the investigation found that the care provided by the EIP service was good, as was the record-keeping of the Care Coordinator. However, the following 7 key learning points were identified (actions taken by the Trust following the report in bold, followed by progress against those actions):

a. **Capacity under the MCA - to improve the understanding that the staff have of the MCA and when capacity should be used as a term.** Action completed.

b. **Medication drop off – to have a more consistent approach to medication drops across EIP in terms of the purpose and expectations associated with the task and that this could then be incorporated into relevant operating procedures.** RAG rated as amber. There is more work to be done on the medicine management policy across the Trust. There is good audit evidence that staff are assessing people when delivering medicines.

c. **Risk formulation and safety planning - many staff find the concept of risk formulation difficult to understand and lack confidence and skills in safety planning. A combination of approaches were suggested to make progress.** RAG rated as amber. Policy and training is in place but there is further work to be done on auditing the impact.

d. GRO-D

e. **Out of area management - GRO-D GRO-D However, without written guidance or procedures within the Trust, there is scope for inconsistency in management in the future. There are particular nuances in balancing the risks of managing a case at a distance with the potential for disengagement if transferred in the short to medium term. Given that EIP in particular looks after students from overseas, GRO-D GRO-D it would be helpful for EIP to develop some written guidance based on the good practice evidenced in this case.** RAG rated as green. The Assertive Outreach work is strengthening work with people out of areas. In addition, a new quality improvement project has started on positive engagement with people. This new project will conclude in autumn 2025.

f. **Liaison with police regarding offending behaviour - the panel recognise that breaching an individual's confidentiality in relation to their offending history needs to be proportionate to the level of risk concern. It may be that the Trust's Local Security Management Service offers a means of improving the flow of information between clinical teams and the police, without allowing a disproportionate breach of confidentiality.** RAG rated as amber. If immediate information needs to be shared this is done between the Trust services and the Police Liaison Officers and / or Street Triage services so risk can be assessed and managed. On a monthly basis, any issues can be taken to the Police Liaison Oversight Group. The work being done by the police and Trust on the Memorandum of Understanding will finalise the enabling governance process.

g. **The role of families in working with patients who are challenging to engage – this recommendation covers ensuring that the family perspective is included in any Trust wide improvements made to working with those who pose challenges in terms of engagement. It**

also recommends that improvements should include more sustained engagement with families post-incident, beyond that associated with the Duty of Candor, and to provide advice to families regarding access when discharging a patient from Trust services. RAG rated as amber / green. This is being addressed through the wider Trust work on Patient and Family Liaison. e.g. 'Think Family' agenda, Duty of Candor post incidents and the improvements made to the policies, e.g. Reporting, Management and Learning from Incidents Policy and Procedure and the DNA Policy.

Independent Evaluation of Trust Safety Processes

466. In early 2023, the Trust's Executive Leadership Team recognised that there was a growing volume of Serious Incidents, many of which were similar in nature and/or overdue for investigation. In addition, there was a notable increase in inquests and Prevention of Future Death reports. The Executive Leadership Team was deeply concerned about such trends, and the efficacy of system learning from previous events. The Executive Leadership Team was also concerned about the risks this created for patient quality, safety, and experience, as well public confidence in the Trust as a provider of healthcare, its regulatory compliance, and its continued ability to sustainably deliver commissioned services.

467. To minimise these risks, a high-level improvement plan was considered by the Executive Leadership Team on 7 June 2023, with an outline of what resources were required to support delivery [WITN0133022].

468. This resulted in an independent evaluation of patient safety processes at the Trust being commissioned, with a specific focus on incident reporting, investigation, learning/improvement and Duty of Candour. The evaluation was conducted between September and November 2023 by Helen Collins, an Independent Safety Specialist and Registrant Senior Nurse with over 30 years of experience of patient safety and quality working at National level as well as regionally and locally in tertiary, acute, mental health, community, forensic and

commissioning sectors. The methodology used by Ms Collins is set out in section 3 of her final report dated 11 January 2024 [NHFT0000423].

469. The evaluation found several areas of good practice as well as areas for learning and improvement. The positive findings included:

a. Overwhelming commitment to work with the health care system to improve the Serious Incident process.

b. Clarity on safety problems, openness to change, focus on system rather than individual failings.

c. Good safety culture within the middle and senior management level in the organisation.

d. Highly professional senior personnel working on safety (noting particularly safety, governance, quality surveillance and family liaison teams, the Associate Directors and Heads of Nursing).

e. Consistency in both the numbers, types, and methods of identifying and reporting incidents and escalating them, and in accordance with Trust policy and procedure 15.01 (the policy is discussed in detail at paragraphs 155 - 156).

f. Positive distribution of harm levels - most incidents are no or low harm (average combined 51,058 (91%)).

g. An advanced and highly effective quality dashboard.

h. Some already established Trust-wide quality improvement projects (suicide prevention, pressure damage, falls, restrictive practices).

i. Duty of Candour training.

470. The areas for improvement concerned:

a. A devolved governance of the Trust-wide projects was not overseen by the more senior personnel;

b. A lack of Trust-wide quality improvement projects addressing a number of repetitive problems identified within the Trust

c. A lack of capacity and capability in Trust-wide safety incident investigations, learning (i.e., quality improvement) and family liaison.

d. A lack of standardised quality governance structures and processes.

e. Extensive safety intelligence (some of which was considered to be excellent) but lacked focus and benchmarked data and was duplicated in different reports.

f. The Trust was lagging behind other NHS trusts in relation to PSIRF implementation.

g. The Duty of Candour was not being performed consistently.

h. The Trust had yet to confirm arrangements for the Trust-wide learning from non-coronial deaths by a Medical Examiner and responsible clinical teams.

i. The Trust's external stakeholders for safety were not assured of their ability to improve their safety processes and manage the repetitive problems they faced.

471. Ms Collins made 132 recommendations in her report. These findings were presented to the Trust's Executive Leadership Team on 31 January 2024 [NHFT0000422]. The Trust has disclosed its action plan in relation to the implementation of these recommendations [NHFT0015037, p.20]. On 11 March

2025, the Quality Committee agreed that there was good assurance that all recommendations had been implemented [NHFT0000763].

Level 1 concise investigation for GRO-B *(*GRO-C *2023)*

472. The Inquiry in its Request dated 2 July 2025 also asked the Trust to explain the reviews conducted in respect of the care provided to GRO-B GRO-B who was arrested for Grievous Bodily Harm with intent after stabbing GRO-C GRO-C on GRO-C 2023. The Trust had contact with GRO-B GRO-D was still providing care to them at the time of the incident GRO-D GRO-D The Serious Incident was reported on StEIS on 18 April 2023 [NHFT0015672].

473. The Trust, using the Serious Incident Framework 2015, commenced a Level 1 Concise Internal Investigation on 18 April 2023, with the report being received on 14 July 2023 and approved on 1 August 2023 [NHFT0015864]. GRO-D

GRO-D

474. There was one finding from the level 1 investigation which was that when teams visit supported accommodation to deliver medication, they should make attempts to see the patient on a face-to-face basis wherever possible and, if a patient has not been seen, there should be a discussion about the need for a further follow-up visit. The Trust put in place an action plan on 17 July which has been delivered [NHFT0015864]. The Trust can confirm that no clinicians involved in the care of GRO-B were also involved in the care of VC.

Level 2 Investigation for VC following events on 13 June 2023

475. As noted above, the Trust reported the incident involving VC that occurred on 13 June 2023 as a Serious Incident on StEIS on 20 June 2023 [NHFT0000583]. Given the seriousness of the incident, the Trust decided that a Level 2

comprehensive investigation was required, but that an independent chair was appropriate.

476. On 6 July 2023, Psychological Approaches was commissioned to provide an independent chair and produce the report. The process of the investigation and methodology are set out on page 4 of the Level 2 Investigation report and the qualifications of the panel are set out on page 6 [NHFT0008807]. It is important to note that the purpose of the investigation was not to examine any competence or capability issues.

477. On 20 July 2023, Nottinghamshire Police requested that the investigation be paused given the given the live criminal investigation that was ongoing. As a result, the tabletop review of VC's clinical record was delayed until October 2023 and staff interviews were conducted in November 2023 [NHFT0008391].

478. On 7 February 2024, the Trust held a meeting to discuss the draft report. The draft report was also shared with NHS England to assist with the Terms of Reference for their independent homicide review [NHFT0009799].

479. An updated report was received by Trust on 7 February 2024 [NHFT0009799]. This report was approved and shared with ICB and NHS England's regional team on 1 March 2024. The report was then finalised by Psychological Approaches on 15 March 2024 [NHFT0000452].

480. On 18 March 2024, an introductory letter was sent to VC's mother, explaining the role of a Family Liaison officer, and the process of a Serious Incident Investigation. The Trust offered to meet with her to discuss this further [NHFT0000453].

481. The internal investigation panel examined the care provided by the Trust to VC from the first contact it had with him in May 2020 until his discharge back to his GP in September 2022. The report considered that VC's risk of violence to others was moderate overall rather than high, exclusively driven by a deterioration in psychotic symptoms, and that no reasonable risk formulation in September 2022

would have anticipated a fatal attack perpetrated on strangers with a weapon. The report noted several aeras of good practice, including in terms of contact with family, collaboration between teams and thoughtful care provided by the EIP team.

482. However, the panel identified some learning points, detailed throughout the report. The Trust fully accepted the findings made by the Panel. These included:

a. Discharge planning reflected an inpatient focus on VC's presentation in the present as a snapshot view of someone with a recent relapse and relatively quick short-term recovery, rather than taking a longer-term view of VC's pattern of behaviour, risks and needs with consideration of what might be required for successful community management.

b. There was limited operational oversight of discharge from private hospital in 2021.

c. There was a lack of clarity in the EIP single operating procedures regarding the relationship between the Crisis team and EIP services when a patient is on the EIP caseload but referred to the crisis team.

d. Although the weekly team review meeting was well attended and well used by staff, there was no formal type of RAG rating/zoning/traffic light system for discussion of patients.

e. The clinical decision to detain under Section 2 rather than Section 3 of the MHA was not in keeping with the fundamentals of the legislation as laid out in the Code of Practice; and there was sufficient criteria met in January 2022 for Section 3 to have been applied to VC. The report does note however that the decision lies within the clinical expertise of the clinicians undertaking the MHA, and clinicians have autonomy in their practice and decision making, and the requirement to use the least restrictive option.

f. There was sufficient evidence from VC's behaviour over the preceding two years to lend weight to the importance of instigating depot medication – and therefore placing VC on Section 3, and a CTO in order to enforce it longer term for the benefit of longer-term community management. The report notes that this was a finely balanced decision and recognises that it is an area of clinical judgment where different professionals may reach different conclusions

g. It would have been appropriate to inform VC's family of his discharge, and to advise them how to access services should they have concerns in the future.

h. The Trust did not write to VC directly to inform him of his discharge, which would have been good practice.

i. VC's care plan should have been reviewed in August 2022, and concerns – albeit possibly unfounded - should have been raised when VC requested his notes.

j. The EIP team should have successfully achieved a face-to-face review of VC in September 2022 to determine his mental state prior to discharge.

k. With VC's discharge from hospital, it would have been appropriate to review the written care plan and risk assessment, including consideration of how future non-concordance with medication, disengagement from services and deteriorating mental health might be responded to (that is, the relapse/crisis and contingency plans).

l. Given VC's risk profile when psychotic in the community, a risk formulation and future crisis plan ought to have been shared with his GP.

m. Neither the EIP team or the inpatient team were insensitive to or ignorant of the possible implications of culture and ethnicity on VC's insight and compliance, although there are opportunities to develop the teams'

understanding and management of cultural and diversity implications for their patients still further.

n. On balance, too much emphasis was placed on complying with VC's priorities for his education, and insufficient weight given to the risks associated with non-concordance.

o. There was a failure of teams to record in a way that reflected their professional thinking, and their rationale for decision-making - this was a crucial omission in this case, as VC presented the teams with particularly complex dilemmas.

483. As a result of these findings the panel identified 10 learning points for the Trust around improving clinical records, the discharge process, risk management and other internal processes. As recommended, the Trust developed a SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Action plan to address these matters [NHFT0010858].

484. The Trust wrote again to VC's mother on 2 July 2024 [NHFT0000470]. This letter explained the commissioning of the Serious Incident Investigation into the past care and treatment of VC, and that the report from this investigation had informed the Trust action plan. The letter stated that VC had given permission for the Trust to share the report with his mother, and that the Trust was in the process of reviewing and redacting the report. A meeting had been planned for 3 July 2024 and was re-arranged in order for the redacted report to be provided in advance of that meeting.

485. The Trust wrote to VC's mother on 19 July 2024 [NHFT0000484], as well as a copy of the full redacted Level 2 Investigation report, and the Trust action plan. A meeting was arranged for the 30 July 2024.

486. The victims' families had received a letter from the Chief Executive of the Trust on 7 December 2023 [NHFT0000494, NHFT0000495, NHFT0000496, NHFT0000497, NHFT0000498, NHFT0000499, NHFT0000500, NHFT0000501,

NHFT0000502], informing them that the Serious Investigation was planned and stating that the Chair of the investigation team would make contact with them, explain the process and ask for any suggested questions to be included in the investigation. The letter further stated that the families would have the opportunity to meet with members of the investigation panel if they wished, and any questions or concerns could be put in writing to either the Serious Investigation Chair or the Trust Chief Executive. In the event, this did not happen prior to the Serious Incident Investigation being concluded, and the Trust has apologised for this.

487. Given the ongoing discussions with the victims' families following the December 2023 letter, and at the time of the Level 2 Investigation report being finalised, the Trust asked Psychological Approaches to produce a summary SI report that could be shared with them. The summary report, redacted terms of reference, and redacted action plan were subsequently sent to the families on 18 July 2024 [NHFT0010857], [NHFT0010858]. The Trust has recognised and identified, including in its correspondence with the families of the deceased,the areas of learning it has in terms of the SI process.

488. As described earlier in this statement, following subsequent discussions and a meeting between the Trust and the families of the deceased victims in August 2024, the Trust commissioned a KC to provide advice on the disclosure of the Level 2 Investigation report and an almost completely unredacted copy of the report was then disclosed accordingly [NHFT0000487].

489. On 3 July 2025, an updated action plan providing evidence against the 10 Learning Points was presented to the Complex Incidents Oversight Group. On the 24 November 2025, a scrutiny panel was held to review the evidence to support the sign off of the actions. The meeting was chaired by me (as Chief Nurse) and it was agreed the evidence supported the closure of the actions. The minutes from the meeting are due to be presented to the Complex Incidents Group on 4 December 2025 for final sign off. There is a further meeting planned for the 27 January 2026 to ensure actions are embedded.

CQC section 48 investigation

490. Following the conviction of VC in January 2024, the Secretary of State for Health and Social Care commissioned the CQC to carry out a rapid review of the Trust pursuant to section 48 of the Health and Social Care Act 2008.

491. The Trust received an initial request for information from the CQC on 6 February 2024, followed by further requests on 8, 12, 13, 14, 15, 20, 21 and 26 February and 7 March 2024. A spreadsheet detailing each of these requests and the Trust's response has been disclosed to the Inquiry [WITN0133029]. It is important to note, however, that this was a review of the records only and the CQC did not interview any staff members when conducting its investigation. Accordingly, whilst the Trust has accepted the findings made by the CQC it is important for the Inquiry to understand the limitations of the review.

492. The review was published in three parts:

a. The first two parts, relating to the CQC's assessment of patient safety and quality of care provided by the Trust, and progress made at Rampton Hospital since the CQC's last inspection in July 2023 were published in March 2024 [CQCM0016517].

b. The third part, a rapid review of the available evidence related to the care of VC was published in August 2024 [CQCM0016517].

493. In summary, the CQC found that there was no single point of failure in relation to the care provide to VC, but it did identify a series of errors, omissions, and misjudgements. Key among these from the August 2024 report, were:

a. Inconsistent approaches to risk assessment. Risk assessments minimised or omitted key details and did not make explicit the serious and immediate nature of the risk VC posed to himself and others, and the known issues that would increase the risk.

b. Care plans: Whilst care plans followed national guidance, teams did not always take a holistic approach, which hampered their ability to identify risk factors. This reflected concerns in the first report around inconsistent care planning.

c. Engagement: Whilst teams took steps to follow up and re-engage people, there were large gaps between visits in the records for VC and 3 of the 10 benchmarking cases. VC's family contacted the Trust to raise concerns on a number of occasions but the information they provided was not consistently acted on. There was no evidence that VC's family, GP, university or the police were consulted when he was discharged back to his GP.

d. Medication management: VC's preferences around medication were not balanced with other information and there was evidence that he was not taking his medication.

e. Depot / CTO: There was no evidence of discussion of depot medication or a CTO until VC's fourth hospital admission. Whereas a depot injection and CTO could have facilitated recall to hospital, as he was being held under s2 MHA, it was not legally possible to discharge him using a CTO.

   However, the Trust notes that the chronology at exhibit WITN0133040 of this statement shows that there is evidence of depot medication being considered earlier than the fourth admission from 28 January 2022. These discussions took place in July 2020 and are reflected in his summary care plan of 28 July 2020. Depot discussions are also recorded on 17 September 2021.

   The Theemis report also refers to depot discussions in July 2020 and September 2021.

   Elsewhere in the s48 review, the CQC notes that:

- "In 3 of VC's inpatient hospital admissions there are references to a depot injection, but VC consistently declined this, stating that he preferred to take oral medicine...we are concerned that the team did not adequately balance VC's wishes with other information they may have held and what may have been in his best interests. This could be seen as a missed opportunity, as his detention under the MHA presented the possibility of changing his medicine to be able to treat his symptoms more robustly." (this relates to point d, above) and

- "there is no mention of a CTO, *combined* with the use of depot injection, until his fourth admission" (emphasis added).

We would therefore suggest that this finding from the CQC is intended to refer to there being no evidence of discussion of depot medication combined with a CTO until VC's fourth admission, rather than there being no discussion of depot until that point.

f. Discharge: The decision to discharge VC back to his GP in September 2022. The evidence over the course of VC's illness and contact with services and police indicated beyond any real doubt that VC would relapse into distressing symptoms and potentially aggressive behaviour. Discharging VC back to his GP, due to his lack of engagement with mental health services, did not adequately consider or mitigate the risks of relapse and violence.

494. The CQC also found that if the decision had been made to treat VC under section 3 of the MHA on his fourth admission to hospital further options would have been available for his care and treatment in the community.

495. The CQC made nine recommendations to the Trust and seven to NHS England. The Trust accepted all of these recommendations and developed an action plan to implement them. The Trust has disclosed to the Inquiry a copy of the plan showing progress against each recommendation [NHFT0004228].

Service and homicide reviews

496. In August 2023 the Trust also considered it necessary in light of the events involving VC to conduct a review into the performance of the EIP team. It was subsequently decided to commission further reviews into the Crisis services and Local Mental Health Teams, as well as a thematic review of homicides, for quality assurance purposes. Jonathan Warren, a retired Chief Nurse and Chief Executive, was commissioned to carry out these reviews.

EIP review

497. The Trust wanted an independent view of the functioning of the EIP team with a particular focus on how decisions to discharge are made. Given the focus on the functioning of a specialist clinical team, Jonathan Warren elicited the support of Dr Olivier Andlauer, an EIP consultant and Clinical Director from East London NHS Foundation Trust [NHFT0000461].

498. The terms of reference and methodology are outlined in the opening paragraphs of the report but in short included a document review, an audit of 15 case records, interviews with staff and observations of clinical meetings, and meetings with one user and one carer.

499. The report was delivered to the Trust on 21 December 2023. Five recommendations were made, set out below in bold text, followed by a summary of the progress against these recommendations:

a. **The Trust should review the number of bases that the EIP operate from, there are several options available to the Trust and the risks and rewards of each option should be balanced.** Progress is RAG rated as Amber. The team have taken the approach to firstly ensure that the current estate used by the teams is as good as possible. This included working with the Trust's estate utilisation team to review the current occupancy and space. As a result, improvements have been made to the Musters Road base and the Hope centre base and improvements are ongoing at Manor Road, as the county south bases were identified has having the most need.

EIP leaders were part of the preparation for the move to Byron House and the proposed move away from Marlow House. The plan for the latter is to base the Central and North teams together and following this, we will review the option of co-locating City South and East, both with the intent to merge the teams in the future. We have also supported the Team Leaders and Clinical Team leaders to have dedicated time at each base. This ongoing work relied heavily on recommendation 2. There has also been some initial scoping with the team regarding the options to gather their views. The EIP model has also been included in the Assertive and Intensive Community Mental Health Care and Local Mental Health Team redesign with the option of 3 teams rather than 2.

b. **On balance we think that there should be dedicated Consultant input into the team rather than sessional input from the Local Mental Health Teams.** Progress is RAG rated as Red to Amber. An options appraisal is to be presented by end of July reporting into Community Improvement Group. The Community Improvement Group reports into both the Patient Safety and Quality Improvement Group and the Pursuing Operational Excellence Group sub-groups of the Integrated Improvement Portfolio Board.

c. **The Trust should consider how to introduce the role of Psychology, Social work and Occupational Therapy into the service. It may be that as Care Coordinators leave that the funding is repurposed into the specialised disciplines**. Progress is RAG rated as Amber. The Care Group Director is looking to other psychologists across the Group to support this service. Other actions being taken to mitigate risks include:

   i. Psychological interventions (non-Family Interventions related) - Additional training for CBT for psychosis therapists.
   ii. Since the report, EIP North team has recruited an Occupational Therapist to work on the At Risk Mental State pathway. The aim of the role is to offer focused Occupational Therapy interventions.

d. **The team should review its expectation around documenting discharge.** Progress is RAG rated as Amber to Green. Changes to practice include the use of a discharge checklist, MDT template (to support pre discharge discussions), clinical note template / aide memoir, and audit of each discharge. The teams are auditing their use of the new templates and checklists with a feedback loop on progress to the teams via focus team briefing updates, workshop, business/ team meetings and supervision. SafeNow work is embedded as business as usual, including the review of people discharged through disengagement.

e. **There should be a regular quality audit cycle within the team in addition to the NCAP [National Clinical Audit of Psychosis] standards. This should include the following:**

   a. **Documentation around disengagement and discharge** – Completed. "Did Not Attends" audit is now in place and a monthly discharge audit is in situ for every discharge, with the aim to move towards using AMaT
   b. **Declined referrals**. – Completed. Currently being auditing/ reviewed as part of discharge audit, with feedback given to leadership team and clinical directly by Service manager. Space to discuss decline data in monthly EIP performance meeting and Quality Oversight Groups.

   c) Prescribing practices- Completed. No additional actions, routine audits are in place, led by the pharmacist.

   d) Delayed transfers to Local Mental Health Teams – Completed. Operationally, we have a report in place that identify patients in their last year, 6 months and those over the 3-year pathway, this is discussed as in the EIP leadership team monthly to ensure that plans are in place and focussed on where the greatest need is. This is reported and escalated to the weekly Patient Tracker List and monthly business meeting. There is no current audit in place.

Crisis services review

500. Following the completion of the EIP review, the Trust asked Mr Warren to conduct a similar review of the Trust's Crisis team. As this was a review of a specialist team, Mr Warren sought support from Rahul Bhattacharya, a former Crisis consultant and now an Associate Clinical Director at East London NHS Foundation Trust [NHFT0000462]

501. The terms of reference and methodology are set out in the report and followed a similar approach to the EIP review. The report was delivered on the 22 April 2024. Five recommendations were made and the progress against these recommendations is summarised below:

    a. **The Trust should embark on an OD [Organisational Development] programme within the crisis team to ensure that direct care staff are involved in the review of the recent and upcoming changes.** Progress is RAG rated as Amber. Staff are involved in workstreams that form the Crisis improvement group and have contributed to the process mapping of current provision and identifying barriers, challenges and what is going well. This is an integral part of the organisational development improvement work going forwards

    b. **The opportunity to develop a sense of team and purpose around the various crisis provision within the City and County should be grasped.** Progress is RAG rated as Amber. The core function and purpose of the teams is a core part of the crisis improvement group and linked to the above recommendation.

    c. **The team should review its communication on discharge to ensure that relevant risk information is passed to the receiving teams. MHA status should be clear as key patient information in EPR [Electronic Patient Records] along with Responsible Clinician and named Care Coordinator.** Progress is RAG rated as Amber to Green. The discharge document has been reviewed, refined, agreed through governance

processes and the changes have been made to the Rio templates, as jointly owned documents for Local Mental Health Teams and Crisis Teams. Pilots have been undertaken and the new templates will fully 'go live' across adult mental health in September 2025, to ensure that the teams are aligned. The other elements of the action are being reviewed as part of the 'documentation' subgroup of the crisis improvement group.

d. **The estate provision around the 111 (2) [the public number to call for urgent mental health support] team and potentially for the City and County South CRHTs should be reviewed.** This is complete and RAG rated Green. A review has taken place, and a solution identified which has been agreed for the 111(2) team. It is now in mobilisation phase, moving 111(2) team creates extra space for the crisis teams.

e. **A Trust and Team response to the growing demand and increase in waits for the crisis service is required. This should take a 'test and learn' approach involving direct care staff.** Progress is RAG rated as Amber. Capacity and demand work has been completed for the 111(2) service and is under way for the crisis service, these reviews have involved frontline staff. Waits in the crisis services are monitored through the trusts SafeNow process and any issues in meeting response times are escalated in the daily escalation meetings to gain support and resource from across the services.

Local Mental Health Teams review

502. In parallel to the Crisis review, the Trust also asked Mr Warren to conduct a review of the Local Mental Health Teams team. Given the specialist nature of the Team, Mr Warren asked Mr Tony Madden, a former Deputy Borough Director at East London NHS Foundation Trust, to support the review [NHFT0000545].

503. The report was delivered to the Trust in March 2024. Seven recommendations were made, and the progress is summarised below;

a. **Teams need to be intimately involved in any changes going forward, this should include any change ideas, implementation, and the identification of measures of success**. Progress is RAG rated as amber. Team Leads, Clinical Leads, Medical Leads, Professional Leads have standing invites to the Community Improvement Group, as well as to many of the task and finish groups or subgroups generated from the work of the Community Improvement Group and we actively engage staff with questionnaires linked to pieces of change work. The Associate Director of Nursing and Associate Director of Operations have sessions booked with each community team to talk through the learning from the VC case and engage staff in discussions about the improvement work being undertaken. Medical colleagues will often cite not having enough time to be involved in change work, even if they have a desire to do so, therefore discussions are taking place with the new Deputy Clinical Directors and Associate Medical Director regarding job planning, to enable medical colleagues to be more involved in change. Professional leads have been integral to reviewing Internal Working Instructions and job descriptions, as well as advising on governance oversight systems.

b. **There should be a time of consolidation and titration rather than transformation and innovation – the focus should be on relieving the core functions of the LMHTs [Local Mental Health Teams] of the burden of their work. This could include medication drops, some outpatients, depot clinics**. Progress is RAG rated as amber. There is a Community Medication Forum, chaired by the Associate Director of Nursing who is actively working with Senior Pharmacy colleagues to review all medications administered by the Trust. Feedback is being collated by pharmacy technicians on the rationale for the retention of non-specialist drug administration. This feedback will inform an action plan to support the move away from this approach. The management of depot clinics and clozapine clinics are being reviewed by senior pharmacy colleagues. Other core functions of the Local Mental Health Teams are also under review, such as MDT, Duty, Risk Meeting, with a view to ensure that the current

meetings/systems have structured guidance, are consistently delivered, and are auditable.

c. **The role of the Consultant Psychiatrist within the teams needs to be clarified.** Progress is RAG rated as amber. The role of medical outpatient clinics is to be included within the Local Mental Health Teams Internal Working Instructions and will be reported into the Community Improvement Group.

d. **The teams should be encouraged to have time to reflect on what is going well within their team and any changes they may like to make. They should take a test and learn approach to this.** Progress is RAG rated as amber. Increased resource for Quality Improvement has been commissioned for the Mental Health Care Group, with training sessions for leaders within the Care Unit taking place over the coming months. This will ensure that there is a consistent methodology to Quality Improvement change implementation, to support change to take place at a local level. Many teams have team meetings, with an agenda which is set by the team. More work is needed to ensure that they have time to focus on what is working well.

e. **There should be an opportunity for the clinical leads, team managers, and consultants for each sector to meet regularly to build strong relationships and to learn from each other.** Progress is RAG rated as amber. The Care Unit Senior Leadership Team has proposed a new leadership model, which would replicate a quadrumvirate model of leadership which is replicated from the team, through to cluster then to a care unit level, supporting weekly meetings of the key leads at every level. This would ensure that there is development of relationships between key leaders and a point of escalation for the teams, clusters, and care units. There will be a need for organisational change to realise the full model, a meeting in July should give the final approval for this model, with a view to undertaking the organisational change required in September 2025.

f. **Performance measures and data collection should be reviewed in their entirety. They need to be designed by the teams to ensure that the data they get supports the functioning of the team rather than that of central bodies.** Progress is RAG rated as amber. There has been an increase in patient safety information being collated and reviewed on a weekly basis. It is important to work closely with the teams to try to ensure that the way in which the data needs to be collated is easy to find, or documents are easy to populate. We review data requests regularly based on the feedback of teams – which can be evidenced through the Patient Tracker List discussion and SafeNow discussions.

g. **Patients should only be held under the LMHT [Local Mental Health Team] if they are receiving or waiting for active treatment from the Local Mental Health Team not so they can access duty systems**. Progress is RAG rated as amber. Although a number of services have been stood down from needing to be open to a Local Mental Health Team (Neurodevelopmental Specialist Service and Intellectual and Developmental Disability service) there are services which still require a patient to be open to a Local Mental Health Team, further work is needed on this recommendation.

Thematic Review of Homicides

504. Following the completion of the above reviews, the Trust asked Mr Warren to Chair a panel of internal and external experts to review the homicides and attempted homicides that had occurred within the Trust over the previous 5 years. The Trust identified 7 reports as meeting the criteria for the review (5 homicides and 2 attempted homicides). A further 3 reports fell within the timeframe of the report but were unfinished at the time of the review [NHFT0000518].

505. The entire panel reviewed each report and gave feedback at bi-weekly meetings. They then met for a whole day face to face to identify themes from the report. The report was delivered to the Trust in August 2024. Three main clinical themes

were identified concerning: (1) Poor engagement, lack of follow up and risk assessment; (2) delays and waits; and (3) multi-agency working, including safeguarding. The expert panel made 5 recommendations as a result.

506. On 3 July 2025, an updated action plan providing evidence against the 5 recommendations was presented to the Complex Incidents Oversight Group. Four of the five recommendations are complete. The recommendation that is incomplete is: '*the Trust should revisit two of the incidents in their entirety to ensure that the opportunity for learning is maximised*'. The authors of the review suggest that this will be a good test if the new measures outlined by the Trust are starting to be embed. The two incidents have been reviewed and the reports drafted. They will go to the Quality Committee in August for assurance.

507. The Trust has not disclosed to the Inquiry any of the medical records or Serious Incident reports related to the 7 cases reviewed during the thematic review but would be willing to discuss any such request if the Inquiry considers it needs to review these materials.

<u>Theemis review</u>

508. NHS England commissioned Theemis Consulting Ltd to carry out an independent investigation into the care and treatment provided to VC by NHS services between May 2020 and June 2023. The Trust was sighted on the terms of reference prior to their final sign-off. The report was finalised in January 2025 [NHSE0000298].

509. The findings contained within the Theemis report were similar to those findings detailed above in the preceding internal and external investigations that had been conducted. This included errors, gaps and missed opportunities in relation to the approach taken to the assessment of risk, shared decision-making across teams at the Trust, communication with VC's family, communication with the police, the discharge process (including the failure to put in place a CTO), and organisational risk management at the Trust.

510. Theemis issued 12 recommendations, 10 of which were directed at the Trust.

511. The Trust accepted all of these recommendations and developed an action plan to implement them. The Trust has disclosed to the Inquiry a copy of the plan showing progress against each recommendation [NHFT0015678].

512. On 10 July 2025, the Quality Committee received an update on the progress being made against each recommendation, from the Trust's Oversight Assurance Group [NHFT0015679]. In summary, there are 10 recommendations with 75 actions with progress summarised as follows:

a. 19 are considered complete and awaiting approval

b. 34 are on track to meet exit date

c. 11 are within the remit of the ICB

d. 6 are off track with an emerging risk of not meeting the exit date

e. 5 are off track with high risk of not meeting the exit date.

Employment investigations/fitness to practise

513. The Trust has recognised that in light of the findings made by the various internal and external reviews discussed above that it is appropriate for it to consider whether any disciplinary investigations need to be conducted, or regulatory referrals made, in relation to any of the employees who were involved in the treatment provided to VC. The Trust has also been engaged in discussions with the General Medical Council and Nursing and Midwifery Council about the events in question. These processes, including the Maintaining High Professional Standards ("**MHPS**") framework that applies to doctors where there are any concerns about competence or capability, are ongoing but the Trust will keep the Inquiry updated as and when these processes conclude and it will disclose any relevant materials that arise from the investigations. To date, this has included

the terms of reference for three MHPS investigation – [NHFT0004741]; [NHFT0015049]; [NHFT0015050] and the final report following a disciplinary investigation into the conduct of VC's car coordinator at the point of his final discharge (including the statements taken in connection with that investigation) [NHFT0004872].

I. Improvements made since the event and lessons learned

514. As set out in Section H above, the Trust has begun to make the necessary improvements identified in the various internal and external reviews discussed above, with a specific focus on patient safety, quality and experience. In addition to actions described above, we have set out in this section the other improvements that have been made by the Trust since the events on 13 June 2023. In some cases, work had commenced in advance of the events involving VC, and this is particularly the case in relation to the improvement work to the Trust's governance and learning from incidents. Pre-existing improvement work was reviewed and adapted or added-to to reflect the events involving VC. The table below summarises key changes made since this period, before being described in more detail.

Table summarising lessons learned, and key associated changes made

Topic	Lesson learned	Key changes made/in progress
Learning from incidents	Improvements needed in the systems and processes to enable effective learning from incidents	Alongside the Trust's response to the CQC's section 48 inspection, the Trust commenced a sustained and multi-stranded programme of work to improve the way it learns from incidents. This included commissioning the reviews described above and an ongoing programme of Board development and work to strengthen governance

		around the response to and learning from incidents (described below). This included implementation of PSIRF. The Trust has also implemented sector-leading changes to improve the availability, analysis and escalation of data. This is described below. Looking at the key changes made since 2023, this includes: • Clear and effective immediate learning and action, facilitated through SIRG. • Dedicated and aligned patient safety managers and reviewers working as part of each Care Group, to enable continuous learning. • Clear PSIRF priorities with Quality Improvement capability and capacity aligned sharing of information learning in a range of ways, including through Information bulletins, talking heads and more formal events, including the Trust's recent Patient Safety Conference, which included 250 attendees from the Trust and a range of speakers,

		including those with lived experience and external experts. • A structured approach to learning Webinars • Strengthened arrangements for the oversight of Coroner's Prevention of Future Deaths reports • Enhanced escalation routes, implementation of strengthened arrangements for Board oversight. Since the refresh of the Integrated Improvement Plan in early 2025, the Care Group Improvement Groups now report into the Patient Safety and Quality Improvement Programme Board, chaired by the Chief Nurse, then into the Integrated Improvement Portfolio Board, chaired by the CEO and then into the Improvement Oversight Committee chaired by the Trust Chair.
Improved near-real time data	Improvements needed in the data available to enable closer to real-time monitoring of key safety data and metrics.	The Trust has recognised the importance of having access to timely data, alongside clear processes to govern the way the data is used and acted on. It has implemented a number of sector-

		leading improvements in this context and is working to share its learning with other mental health providers nationally. Key improvements made are described in detail elsewhere in this statement but include: • SafeNow dashboards • Assertive Outreach dashboard • Physical Health dashboard • 'Ward to Board' reporting and escalation, utilising the data available through the dashboards. Safety huddles on wards are held and enable rapid escalation to the appropriate decision-making level. • Effective use of the dashboards is monitored and assured through the strengthened executive and Board arrangements.
Interagency working	The need to improve information sharing with external bodies	The Trust and Nottinghamshire Police have worked (through the Police Liaison Oversight Group) to make expectations of communication explicit via a Memorandum of Understanding. The Trust has agreed the draft, and the police are currently going

		through their final internal information governance checks before finalising. This is in addition to enhancing joint working where there are specific patient risks that require further cross organisational understanding/ actions. The Trust is working through the forum of the Integrated Care Partnership to strengthen partnership working with primary care. The ICP Mental Health Partnership Board is co-chaired by the Trust Medical Director. This work is ongoing and will take time to fully implement and embed. The Trust recognises that clearer routes for escalation and information sharing between it and the universities would be beneficial and there is more that could be done to take this forward. More broadly, the Trust is an active participant with safeguarding boards / core members at Multi Agency Public Protection Arrangement meetings.
Clinical leadership	There were gaps in governance in relation to quality oversight and an	The Trust has strengthened its established clinical leadership arrangements within each care group, recognising the importance

	identified gap in terms of clinical leadership.	of clinical leads in providing group-based leadership on quality and clinical governance. These roles include Care Group Nursing Directors, supported by Associate Directors of Nursing. Community Matrons increased in core community services, their role being to be available to support and provide clinical expertise to teams. The Trust also prioritises the development of clinical leaders to ensure they are equipped to run services safely. We have also explained at paragraph 32 above the Valuing Medical Leadership project to collaboratively developed a structured strategy to deliver meaningful change in relation to medical leadership at the Trust. The Trust also now has Leadership Development programmes for leaders at all levels: • Aspiring Leaders – for bands 2-4 • Emerging Leaders – for bands 5-6 (clinical and non-clinical pathways) • Rising Leaders – for bands 7-8b

		In terms of increased clinical roles, this has included: two additional Assistant Medical Directors (one of which has a focus on Adult Mental Health), increasing Clinical Directors from 1 to 4 at Rampton Hospital plus all Clinical Directors now have deputies with dedicated time.
Clinical services	Improvements required following reviews by Jonathan Warren and NHS England/ICB	The ongoing work to improve the services provided by the EIP and crisis teams are described above in section H above.
Clinical risk	The need for Personalised assessment of risk across community and inpatient teams	In October 2024 the Trust introduced a new 01.23 Clinical Risk and Safety Policy, alongside: • a new programme of training for staff, • new Trust Clinical Risk and Safety Panel • new SafeNow program • updates to Rio • Focus on risk to others and longitudinal risk • Clear guidance on risk assessment meetings
Disengagement and discharge	To have improved visibility of the people who meet Assertive Outreach criteria and of those people where lack of engagement is a risk factor	Trust DNA policy now includes expected actions and standards for clinical teams in the event of non-engagement.

		The Trust has placed an increased focus on training and embedding this for staff. Clinical pathways have been redesigned to create more flexible access outside 9-5. The Trust has placed a new emphasis on the need for clinician responsibility / accountability instead of patient responsibility. There are new quality metrics associated with discharge, monitored through SafeNow. The Assertive Outreach dashboard tells staff how many missed contacts a patient has and how to follow up – so there is clarity and oversight. The Trust has created very clear quality metrics that need to be completed to comply with the discharge process. This is reported weekly through SafeNow and the governance around that process. Additional monitoring provided if the patient meets the Assertive Outreach criteria. The 8 discharge standards are:

		• Updated at Discharge - Risk assessment • Updated at Discharge - Care planning • Patient view • Carer view • MDT support • Follow up plans – included responsible persons • DNA features • Discharge Summary to all relevant parties.
Equality, diversity and inclusion	To reduce disparities in mental health service access and outcomes	Local Mental Health Teams are currently developing enablement strategies linking with local communities and faith leaders inclusive of training being supported by the Equality and Diversity Lead. Implementation of the patient and carer race equality framework, including national support employing more peer support workers. Identifying demographics – Assertive Outreach dashboard. The Assertive Outreach dashboard monitors background to better enable effective interventions. 40% of patients are dual heritage or black British (this % is from the last dashboard and fluctuates) –

		designing services to enable communities to be confident and safe in accessing services Participation Strategy is under development for delivery in September 2025 and will focus on hearing the voices of marginalised traditionally ignored communities. Four strong Equality, Diversity and Inclusion networks for staff – they are critical friends on our pro-equity approach (see more below). Health Inequalities work (see below) The Severe and Multiple Disadvantage Group (representing people with co-occurring experiences (3 or more) of mental ill-health, problematic substance and/or alcohol use, domestic and sexual violence or abuse, homelessness and interaction with the criminal justice system) came to present to Executive Leadership Team on 6 November 2024 and have also presented to the ICB board. There is a strong Board commitment to an inclusive culture.

		The launch of Our People Plan in November 2022 – this included an ambition to be a pro-equity organisation. The term 'pro-equity' refers to the Trust's work to create a culture where equality, diversity and inclusion is the 'golden thread' through everything we do, and where there is a true sense of belonging for staff. Our 2024/25 NHS Workforce Race Equality Standard data has improved in 3 out of 5 domains. Our 2024/25 Workforce Disability Equality Standard data has improved in 3 out of 4 areas. We have the highest disability declaration rate in the country, which we feel demonstrates that our colleagues feel they belong and can bring their authentic self to work.
Engagement with families	To strengthen engagement with carers, families and friends of patients	The creation of a new of Carers Strategy, enhanced by the employment of a new Associate Director of Participation and Co-Production, is supporting greater integration of families in their loved one's care. Surgeries, drop-in sessions, and a Trust wide conference have occurred stressing the need for genuine inclusion.

		Patient and Family Reference Group Implemented a Youth Impact Board. A Trust Carers Leads recruited to community services – they will be in post by September 2025. The carers lead will work within care units with dedicated carer peer support workers. Inpatient services have regular carer and family support and information meetings. Additionally, there is a dedicated carers online feedback service. Carer Peer Support workers have been recruited. The Duty of Candour Officer commenced post in October 2024 to provide support for services and assurance for the Trust. This has included bespoke discussion with clinical teams and leads to provide education and advice that is incident specific. A monthly training session covering the statutory and professional Duty of Candour is delivered monthly by the Family Liaison. There is also a weekly drop-in session for staff. This has

		result in a significant reduction in Duty of Candour incidents (210 in 2023; 29 in 2024 and 5 in 2025 to date). The Family Liaison team was established in April 2022 and to date have supported 419 patients and families following an incident. The current caseload is 112. The purpose of the Family Liaison team is to offer holistic, impartial support and signposting for families following a patient safety incident and supports their involvement in any review that follows. The team can also support families to attend the inquest. The role aims to complement the work of the clinical team and reviewers. The Family Liaison Team work within the core principles of PSIRF, supporting families and patients when a patient safety incident occurs. This includes an individualised approach supporting the patient/family to meet with the reviewer(s), developing Terms of Reference for the review, sharing any questions or concerns, updating them throughout the process, support to receive the draft report and provision of pen portraits of their loved ones.

		Carers surgery – these are regular. A patient and carer group was held in December 2024, and a carer event in February 2025 was attended by 128 carers. From this, a carers plan was developed with 6 core actions. Triangle of Care assessments have increased by 100% in 2025, in terms of the number of teams who are completing assessments. These are all reviewed by a carer and staff to ensure actions are taken. The Patient and Carer Reference Group has been created to support induction training for staff.
Governance	To strengthen the governance for quality and patient safety accountability	As detailed in section A of this statement, there have been substantial governance changes at the Trust, some of which commenced before the events concerning VC and the subsequent reviews. The programme of changes has included: • Refresh and mobilisation of SIRG, complex incidents group, patient safety and learning from deaths group, Integrated Improvement Plan, Theemis action plan oversight group and care

		group quality governance processes. • A governance review, and training on governance, including Quality and Performance meetings, Strategic Transformation and Efficiency Group, Senior Leadership Team and leadership development, sessions on triumvirate leadership, and Executive Leadership Team increased visibility. • An externally led Executive Team development plan • New executive appointment process with external stakeholders • Rebranded care groups and external recruitment of new Care Group Directors • Moving Offender Health into Community Health • Quality and performance turnaround director appointed • Cultural change – the organisation is more open and honest. Evidence shows there is more speaking up happening and we know the desire to learn when things

		don't go wrong is happening, and a shift from blame. • Our relationships are more open, including with the CQC, and we respond with a sense of urgency. • We triangulate data and take a thematic focus, instead of narrowly focusing on an incident. • Leadership try to drive the cultural change that was needed – from ward to board.

Health Inequalities

515. The Trust's strategy "Making a Difference for 2022 – 2027" [CQCM0027394] set out clear ambitions for the Trust to play a leading role in tackling health inequalities, and for its services to focus on this. Given that the Trust was still in pandemic recovery, the first 2 years of the period were focused on consolidation, so from 2022-24 the Trust concentrated on sustaining its existing system Health Inequalities leadership and developing specific pieces of work to understand more about Health Inequalities in the delivery of Trust services. During this period, the Trust continued to lead the Integrated Care System Health Inequalities Oversight Group (chaired by John Brewin, Chief Executive, and then by Jan Sensier, Executive Director of Partnership and Strategy). They have worked closely with the Directors of Public Health for Nottingham and Nottinghamshire to lead this group with support from ICB colleagues. Through the work of this group, good practice from providers within the system has been shared. In 2023/24, the ICB identified funding to tackle health inequalities, which was developed into a Health Inequalities Innovation Fund and the Oversight Group was engaged in developing the criteria, methodology and assessment for allocating this funding, such as supporting four Place Based Partnerships (and

the Trust has supported mental health groups in each of the partnerships), and Severe Multiple Disadvantage and Integrated Neighbourhood Team programmes.

516. The Trust also set up an internal Health Inequalities Group, chaired by an Associate Medical Director who is a senior Public Health Consultant (ex-Director of Public Health), supported by its own population health unit and has two public health doctors employed. The Trust group provides regular updates to the Quality Committee and reports to the Trust Executive. It is also planning a 90-minute deep-dive session on Health Inequalities to the extended Executive Leadership Team and a Board Development session.

PSIRF

517. The Trust launched PSIRF in March 2024. The introduction of PSIRF has fundamentally shifted how the NHS responds to patient safety incidents for learning and improvement. It advocates a coordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected and embeds patient safety incident responses within the wider improvement system. It supports the introduction of a range of system-based approaches to learning, with considered and proportionate responses to patient safety incidents and thematic reviews being undertaken to develop safety improvement plans.

518. The Trust has made a significant investment in creating a dedicated, well-resourced patient safety team with the experience and expertise required. The implementation of PSIRF has seen the application of a range of system-based approaches to learning from patient safety incidents, alongside compassionate engagement and involvement with those affected by these incidents. As we have continued to embed this, with patient safety managers aligned to each care group, we have seen learning forums, summits and events across the organisation leading to greater understanding with notable improvements in practice. This has been supported by a strengthened and robust safety oversight and governance process.

519. The Trust's internal auditors have completed a review of PSIRF for 2024/25. They examined the effectiveness of controls in place in accordance with the Public Sector Internal Audit Standards. The final report was delivered on 23 April 2025 and shows comments on two areas: implementation and governance of the PSIRF and training [WITN0133030] [WITN0133036]; [WITN0133037]; [NHFT0009285]; [WITN0133038]; [WITN0133039] Significant assurance was given for the implementation and governance of the PSIRF with a generally sound framework of governance, risk management and control designed to meet the objectives of the system under review, and controls are generally being applied consistently. Limited assurance was given on PSIRF training, and this remains an area where the Trust is actively working to address this.

520. The Trust is reviewing the level 1 PSIRF training which has been implemented across the Trust and consideration being given to mandating this as a core training requirement. At present, the NHS Core Skills Training Framework does not mandate this training. The Trust is committed to supporting the implementation and knowledge of PSIRF and is has therefore made the local decision that this training will be mandated as a core requirement at the Trust.

SafeNow Dashboard

521. SafeNow was developed in response to the CQC section 48 recommendations as a way to review key safety indicators on a weekly basis and identify any issues and patterns across our services [NHFT0001252]. It enables robust triangulation of metrics that were previously held separately across different systems, drawing on multiple digital platforms including Rio, AMAT and Ulysses.

522. The dashboard presents key safety indicators and the expected standard for each indicator. It then shows the current, previous and trend value for each safety indicator. It provides a simple, visual representation of the indicators in near-real-time tracking of data, where possible, allowing for proactive responses to potential issues and fostering a culture of continuous improvement.

523. SafeNow is available to anyone with a Trust email address. It currently covers safety metrics for our Adult Mental Health and Older People's Mental Health Services including inpatient wards, community services and crisis services. This includes how long patients are waiting for services or beds, how well wards are staffed, how well we are assessing risk and the proportion of critical feedback received. The list of metrics reviewed has evolved over the last 18 months, currently tracking around 50 metrics, such as metrics on outcomes for patients whose referral has been declined, and patients who have disengaged. There is now a process of refinement to ensure that the system remains user-friendly and focuses on core metrics.

524. The reporting process follows a structured weekly cycle as data is pulled from the various systems each Sunday. Clinical leads come together in a weekly meeting, led by the Care Group Nurse Director, to explain the data and identify any areas of concern. The process involves reviewing metrics highlighted as being of concern, then drilling down for a detailed analysis and completion of exception repots where needed. Therefore, each week, all metrics are reviewed in detail by senior clinical teams, as they can drill down to individual patient level, to understand the data. Actions are then taken to address any issues, and these are reported to the Executive Leadership Team. The system enables identification of patterns, such as wards that are consistently flagging red, which allows for targeted enhanced support. The SafeNow dashboard content and associated actions are also reported on monthly to NHS England.

525. The Trust has been at the forefront of developing a system of this kind, and Trust representatives have presented the system at events to demonstrate its benefits. Since SafeNow was implemented in May 2024, the Trust have seen a significant improvement in many areas, such as the number of risk assessments updated within the last 4 weeks for our ward patients which is now at 98%. We have also seen an improvement in the number of patients who have had their physical health issues escalated appropriately to a senior clinician, from 60% in May when SafeNow was launched to 94% now.

526. SafeNow dashboards have also been developed for High Secure Services, Offender Health Services, with Child and Adolescent Mental Health Service and Intellectual and Developmental Disability Services next in the Trust-wide roll out.

<u>Review of assertive and intensive support services</u>

527. Following the publication of the CQC's section 48 review, NHS England asked in its 2024/25 NHS Priorities and Operational Planning Guidance that all ICBs "*Review their community services by quarter two 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge*" [NHSE0000839]. NHS England also published national guidance in July 2024 "Guidance on intensive and assertive community mental health treatment" [DHSC0000163]. ICBs were asked to use this guidance to review policies and practices to identify and provide appropriate care to people with severe mental illness who might need intensive and assertive community care [NHSE0000839].

528. As a result, the Trust conducted a review of assertive and intensive support services through a facilitated workshop with partner organisations and by using the NHS England Maturity Index Self-Assessment Tool [NHFT0004334]. Based on the information provided for the review, and notwithstanding the positive developments and improvements made since the CQC's section 48 findings, the ICB was not assured that the services provided by the Trust were able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow up [NHFT0004334].

529. The review identified 12 gaps, barriers, and challenges to meet the needs of the group of patients requiring assertive engagement in line with the national guidance. This included that the Trust did not have a dedicated Assertive Outreach Team or associated Standard Operating Procedure, which resulted in inconsistencies in practice. Other issues around caseloads, clinical pathways, training, risk assessments and the use of CTO, amongst other things.

530. Following the review, an Assertive and Intensive Engagement Improvement Plan was developed during October 2024 to address the gaps highlighted in the self-assessment. This plan has been disclosed to the Inquiry [NHFT0001278]. Much of the action taken has related to patient safety and quality, and as of the end of May 2025 13 actions have been completed and 15 are in progress.

531. One of the completed actions is that a dashboard has been developed that includes metrics such as when risk assessments and care plans were last completed, when the patient was last seen and the number of "Did Not Attends" plus Equality, Diversity and Inclusion information as examples. The metrics are all 'pulled' from Rio and the team meets weekly to review this data and problem solve together to improve care. Much like the SafeNow dashboard, this too is not only a system for oversight, but also a key tool to identify and drive improvement.

J. Recommendations

532. The Trust has described above the extensive improvement work that it has commenced in the period since the events involving VC and which, in some cases, remains ongoing. This work is grounded in promoting and embedding a culture of learning, so as to drive improvements in care and openness when things do go wrong. The Trust, working with the other bodies described in this statement, has sought to proactively address issues raised by VC's case and it is therefore hoped that many areas that might have required a recommendation have already been addressed. This reflects the Trust's confidence, reinforced by the oversight it has had from external partners, in the work it has done to implement the recommendations from the three reviews to date carried out in response to the events involving VC, as well the wider improvement work described in this statement.

533. The Inquiry will also be familiar with the concerns that have been raised about the lack of effective implementation of recommendations made by previous

inquiries. The Trust is supportive of a careful and structured approach to the development of recommendations, and I have read, and agree with, the proposals set out by the Health Services Safety Investigation Body in its report "Recommendations but no action" [WITN0133023].

534. There are, however, some initial points that the Trust would like to make, in the context of potential recommendations:

a. There is an ongoing legislative reform programme in relation to the MHA 1983, and this will need to be taken into account in the context of any recommendations around CTOs or similar.

b. A clear national position around when incident investigation reports relating to homicide and attempted homicides are publishable would be beneficial and ensure a consistent approach is taken by all those involved in responding to such incidents. The Trust's view is that reports into homicides and attempted homicides should be published.

c. Similarly, a national repository of independent homicide investigations would be welcomed.

d. The Trust has also described above the local work it is currently in the process of completing, alongside Nottinghamshire Police, to develop a clear framework that guides how each organisation responds to an incident such as a homicide, to try and avoid some of the delays and uncertainty that occurred in responding to the events involving VC. A nationally consistent framework may be something that the Inquiry considers helpful to explore as it proceeds with its work.

e. The NHS 10 Year Plan presents both an opportunity and risk in terms of ensuring that the needs of those with severe mental health conditions are not negatively affected by the development, and consequential resourcing, of neighbourhood health arrangements. The Inquiry will no doubt hear evidence as to the adequacy of resourcing, both in terms of funding and

staff, in the context of caring for people with severe mental health conditions. It is likely that some of this evidence will underline the impact on prevention that inadequate resourcing may have.

f. In the Trust's experience, secondary and tertiary providers of mental health care are often expected to make their staff available to support new care initiatives, such as neighbourhood care, without any necessarily increase in funding to support this. This can have a consequential impact on the availability of resources to support those with severe mental health needs. It also has an impact on staff, who may find themselves being asked to support mild to moderate mental health needs, rather than the more severe conditions they may have wanted to specialise in and which attracted them to working at the Trust in the first place. In considering potential recommendations, the Trust would welcome exploration by the Inquiry of ways in which ring-fencing or alternative protections could be built-into neighbourhood mental health plans and priorities to ensure there is no unintended impact on secondary and tertiary care.

535. Finally, the Trust welcomes the proposals in the 10 Year Plan and in the Dash Review around the renewed role for the National Quality Board and the adoption of national quality standards, with mental health as a priority area. The Trust would welcome clear national outcome measures for mental health, so as to prioritise and focus improvement work and funding accordingly.

Conclusion

536. The Trust welcomes this opportunity to engage with the Inquiry and assist it in fulfilling its Terms of Reference. The Trust recognises the vital importance of the Inquiry's work and wishes to support this as much as possible.

537. The Trust has taken the opportunity to learn and reflect on the events described in this statement and will continue to do so throughout the duration of the Inquiry. The Trust recognises that the Inquiry's recommendations will assist with this

learning and the Trust commits fully to engaging with these recommendations as and when they are issued by the Inquiry.

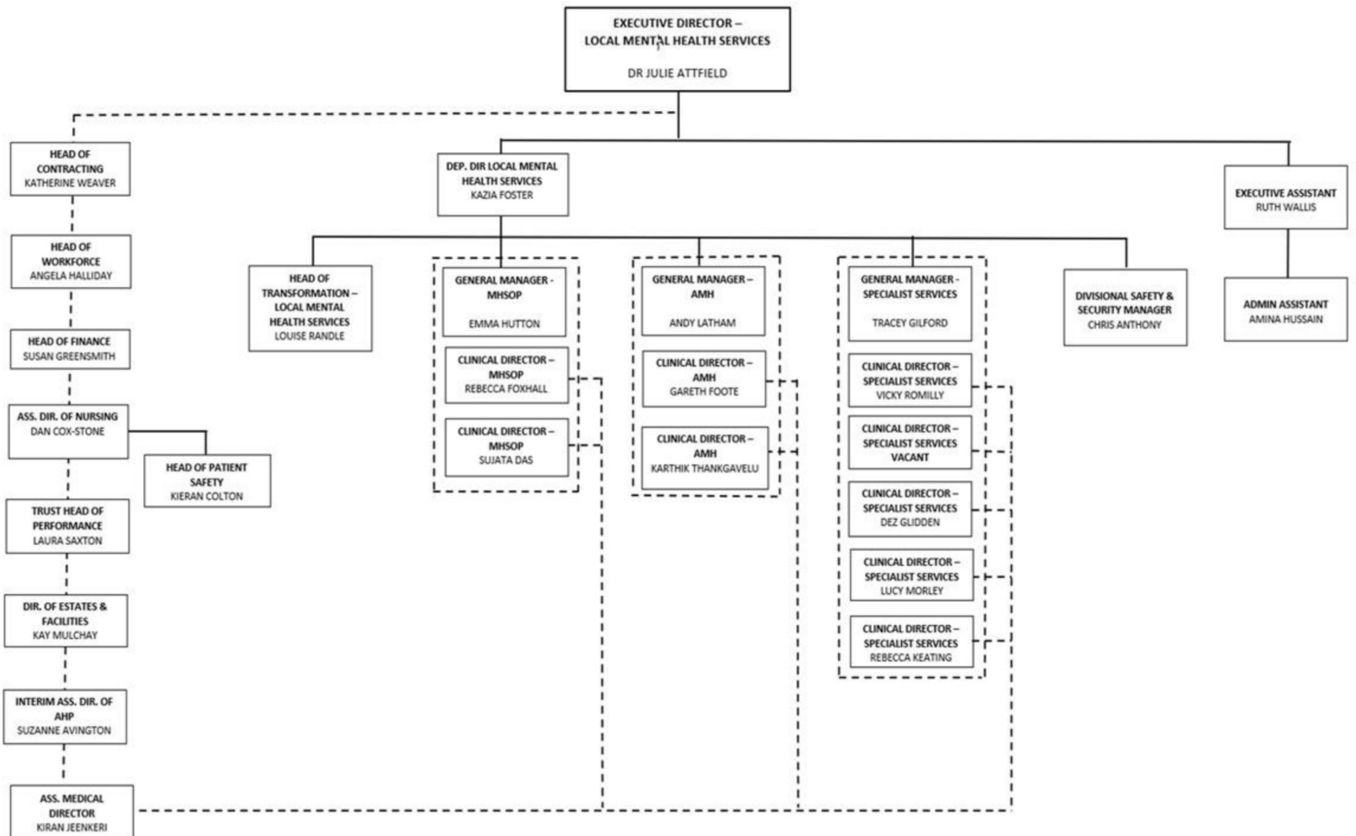
Statement of Truth

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

Signed: GRO-B

Dated: 05 December 2025

Annex A – 2022 Organograms for the Local Mental Health Services Division



ADULT MENTAL HEALTH DIRECTORATE ORGANISATIONAL CHART
SEPTEMBER 2022

Nottinghamshire Healthcare
NHS Foundation Trust

CLINICAL DIRECTORS
Karthik Thangavelu &
Gareth Foote

LEAD CONSULTANTS
Karthik Thangavelu
Ruth Shaw
Shweta Mittal
Abed Hosam
Chinyere Iheonu
Chris Schofield

GENERAL MANAGER
Andy Latham

CLINICAL DIRECTOR
Gareth Foote

CLINICAL SPECIALIST
Michelle Malone

CLINICAL & STRATGIC LEAD PD PATHWAY
Andrea Cockram

CONSULTANT CLINICAL PSYCHOLOGIST
Gareth Foote
CLINICAL NURSE SPECIALIST
Lindsay Barratt

HEAD OF NURSING
Ben Holyoak

GOVERNANCE LEAD
Louise McGrory

MATRONS
Richard Danks – Mid Notts & Bassetlaw
Charlotte Gater – City
Sally Redgate (Community)
Louise Stubley – Physical Healthcare Matron
Yvette Stones – Physical Healthcare Matron

MID NOTTS/BASSETLAW OPERATION MANAGER - ACUTE
Jo Hill

MID NOTTS /BASSETLAW ACUTE SERVICE MANAGER
Sian Trainor

MID NOTTS WARD MANAGERS
Kirsty Aveyard - Orchid
Adam Fletcher – Lucy Wade

BRACKEN HOUSE UNIT MANAGER
Darren Whitford

BASSETLAW B2 WARD MANAGER
Emma Hobson

OT LEAD (Acute)
Karyn Jellis (Maternity Leave cover)

MID NOTTS OPERATIONAL MANAGER - COMMUNITY
Kerry Watson

MID NOTTS COMMUNITY SERVICE MANAGER
Tracey Houghton

LMHT TEAM LEADERS
Marie Dove – Ashfield
Becky Jones – Mansfield
Sharron Jones – Newark & Sherwood
Jane Thorpe - Bassetlaw

MID NOTTS /BASSETLAW CRISIS SERVICE MANAGER (including 136 Suite)
Michael Thomas

BASSETLAW CRHT & LIAISON TEAM LEADER
Nicola Aisthorpe

MID NOTTS CRHT TEAM LEADER
Carla Eggleston

BUSINESS & PERFORMANCE MANAGER
Debbie Dolan

ADMIN/ PERFORMANCE MANAGER
Mandi Rana

STEP 4 LEAD
Alison Smith

CITY OPERATIONAL MANAGER - COMMUNITY
Tracey Taylor

CITY RECOVERY COMMUNITY SERVICE MGR
Marion Taylor

DEAF/CARER SUPPORT SERVICES TEAM LEADER
Lucy Gilbert

LMHT TEAM LEADERS
Nic Brougham – East
Helen Taff- South
Jade Sowe (Acting) – North
Kevin Somerton - Central

CITY CRHT SERVICE MANAGER (including 136 Suite & Street Triage
Alison Harrison/Melanie Davies

CITY CRHT TEAM LEADER
Josephine Baker (Acting)

BED MANAGEMENT/ STREET TRIAGE & CASSIDY SUITE
Melanie Davies

RECOVERY COLLEGE
Helen Brown

IPS SERVICE (City & County)
Julie Swann/Sangita Dhawan (Job share)

OT LEAD (Community)
Jayne Steed

COUNTY SOUTH OPERATIONAL MANGER - COMMUNITY
Sarah Taylor (Acting)

Service Manager Homelessness Substance Misuse Service
SallyAnn Summers

THORNEYWOOD MOUNT
Rob Missing

GEDLING LMHT
Jesca Chigome

COUNTY SOUTH RECOVERY SERVICE MANAGER
Tanya Hobbs (Acting)

COUNTY SOUTH LMHT TEAM LEADERS
Margaret Donnelly (Acting)– Broxtowe & Hucknall
Stephen Hall – Rushcliffe

COUNTY SOUTH CRHT SERVICE MANAGER
Michael Taylor

COUNTY CRHT TEAM LEADER
Chantelle Woodfield

DPM TEAM LEADER
Olufemi Ogundipe

OPERATIONAL MANAGER – CITY/COUNTY SOUTH ACUTE
Ruth Gadd

INPATIENT SERVICE MGR
Steve Hill

WARD MANAGERS
Esmee Ryder _ The Willows
Becky Ash – Redwood 1
Hannah Rush - Redwood 2
Suzanne Leo – Rowan 1
Lauren Henson (secondment) Rowan 2

EIP STRATEGIC LEAD
Vidyah Adamson (career break)

SERVICE MANAGER – EIP, Family Intervention and Carer Support Teams
Kelly Simpson

EIP TEAM LEADERS
Emma Robinson
Stephen Laird

FAMILY INTERVENTION TEAM

Version 11 – September 2022

Annex B – table of the committees in place during each financial year since 2019/2020

Financial year	List of committees
2019/20	• Audit Committee • Quality Committee • Finance & Performance Committee • Workforce, Equality & Diversity Committee • Mental Health Legislation Committee • Nominations & Remuneration Committee • Charitable Funds Committee/Corporate Trustees Committee
2020/21	• Audit Committee • People and Quality Committee • Finance & Performance Committee • Nominations & Remuneration Committee • Charitable Funds Committee/Corporate Trustees Committee • Strategy Committee
2021/22	• Audit Committee • People, Culture, Equality and Inclusion Committee • Quality and Mental Health Legislation Committee • Finance & Planning Committee • Nominations & Remuneration Committee

	• Charitable Funds Committee/Corporate Trustees Committee • Strategy Committee • Commissioning Committee
2022/23	• Audit Committee • People, Culture, Equality and Inclusion Committee • Quality and Mental Health Legislation Committee • Finance & Planning Committee • Nominations & Remuneration Committee • Charitable Funds Committee/Corporate Trustees Committee • Strategy Committee • Commissioning Committee
2023/24	• Audit & Risk Committee • Quality Committee (incorporating the Mental Health Legislation Committee) • People Committee • Finance & Performance Committee • Nominations & Remuneration Committee • Charitable Funds Committee/Corporate Trustees Committee

Annex C - Table showing examples of sub-committees and groups reporting into quality committees between 2019 and 2023

Year	Committee	Group
2019	**Quality Committee**	
	Patient Experience and Service Improvement Sub Committee	Service Improvement & Involvement Group
		Patient Experience & Complaints Group
		Recovery Strategy Group
	Health, Safety & Emergency Preparedness Sub Committee	Medical Devices Group
		Manual Handling Advisory Group
	Clinical Effectiveness Sub Committee	Medicines Optimisation Group
		Research Governance Committee
		Trust Physical Healthcare Steering Group
	Trustwide Strategic Safeguarding Sub Committee	Domestic Violence & Abuse Subgroup
		Learning & Improvement & Quality Assurance Subgroup
	Infection Control Sub-Committee	
	Trust CIRCLE	Suicide & Self Harm Group
		Mortality Review Group
		Violence Reduction Group
		Ulysses Oversight Group
		Serious Incident Review/Domestic Homicide Review Sub-Group
	Mental Health Legislation Committee	Mental Health Associate Managers Forum
		Mental Health Legislation Operational Group
2020	**Quality Committee**	
	Health, Safety, Security and Emergency Planning Committee	Manual Handling
		Medical Devices

Year	Group	Sub-group
		Statutory Compliance Group
	Trustwide Strategic Safeguarding Leadership Group	Safeguarding Leads Assurance and Improvement Group
	Trustwide Infection Prevention and Control Committee	
	Quality and Safety Operational Group	Serious Incident Review Group (SIRG)
		Medicines Optimisation Group
		Trust Scientific Committee
		Physical Healthcare Steering Group
		Recovery Strategy Group
		Mortality Surveillance Group
		Clinical Systems Group
		Clinical Safety Environment Group
		Division Quality Groups
		Quality Learning Forum
2021	**Quality Committee & MH Legislation Committee**	
	Mental Health Legislation Operational Group	
	Quality Operational Group	
	Learning Forum	
	Health Inequalities Group	
2022	**Quality Committee & MH Legislation Committee**	
	Mental Health Legislation Operational Group	
	Quality Operational Group	
	Learning Forum	
	Health Inequalities Group	
2023	**Quality Committee & MH Legislation Committee**	
	Mental Health Legislation Operational Group	Divisional LOG meetings (x3)
	Quality Operational Group	Learning and Improvement Forum
		Research Operations Group

		CRIS Oversight Group
		Trust Infection, Prevention & Control Group
		Trust Medicines Optimisation Group
		Trust Restrictive Interventions Group
		Trust Safer Staffing Group
		Trust Involvement and Volunteering Group
		Trust Safeguarding Strategic Group
		Trust Learning from Deaths Group
		Trust Serious Incident Review Group (SIRG)
		Trust Physical Healthcare Group
		Trust Advanced Clinical Practice Oversight Group
		Learning Forum
		Health Inequalities Group

Index to the First Witness Statement of Diane Hull (on behalf of NHFT)

No.	URN	Description
1.	NHFT0015799	CV of Diane Hull
2.	NHSE0000002	Report compiled by the independent Mental Health Taskforce to the NHS in England Re: The five year forward view for mental health
3.	NHSE0000020	Report compiled by NHS England, Re: Schedule 2 - The services
4.	NHSE0000522	Code of Governance for NHS Provider Trusts
5.	NHFT0000548	Policy Document, Re: NHFT Constitution, NHFT
6.	NHSE0000389	NHS Provider Licence
7.	NHNB0018961	NHS England System Oversight Framework
8.	CQCM0016438	CQC Full Guidance on assessing Well Led question
9.	NHFT0000420	Policy Document, Re: Nottinghamshire Healthcare NHS Foundation Trust Constitution, NHFT
10.	NHFT0000818	Briefing pack for Board of Directors Meeting (in Private) to be held on 28/11/2024, Nottinghamshire Healthcare NHS Foundation Trust, circulated on 27/11/2024
11.	NHFT0005116	Annual report – 2023/24
12.	NHFT0015622	Annual report – 2022/23
13.	NHFT0015619	Annual report – 2021/2022
14.	NHFT0015621	Annual report – 2020/21
15.	NHFT0015618	Annual report – 2019/20
16.	NHSE0000522	Policy document Re: Code of governance for NHS provider trusts, NHS England
17.	WITN0133002	Exhibit - Meet your Governors _ Nottinghamshire Healthcare NHS Foundation Trust
18.	NHFT0002439	Report dated 28/04/2025 compiled by Ifti Majid [NHFT], Re: Chief Executive Update to Council of Governors
19.	NHFT0013457	Scheme of Reservation and Delegation
20.	WITN0133003	Managing Public Money

21.	NHFT0000529	Integrated Performance Report (page 38), 30 January 2025
22.	WITN0133034	Approval of new operational and executive structure, July 2025
23.	NHFT0000454	Briefing pack for Board meeting (public) to be held on 28.03.24, NHFT, circulated on 25.03.24
24.	NHFT0001955	Report dated 27/10/2019, compiled by Nottinghamshire Healthcare NHS Foundation Trust, Re: Board Assurance Framework
25.	NHFT0004238	Report dated 27/04/2020, compiled by Nottingham Healthcare NHS Foundation Trust Re: Board Assurance Framework
26.	NHFT0003075	Report dated 01/03/2025 compiled by NHFT re: Board Assurance Framework (BAF): March 2025
27.	NHFT0014990	Policy Document, Re: ORGANISATIONAL CHANGE PROPOSAL PAPER CONFIDENTIAL – FOR STAFF CONSULTATION, Fiona Illingsworth/Anne-Maria Newham
28.	NHFT0014979	Report dated 06/10/20, compiled by NHFT Re: Governance Review Staff Meeting 6th October 2020
29.	NHFT0000615	Policy Document, Re: Our People Plan, "Diverse, Inclusive and a Great Place to Work", Underpinning the Trust's Making a Difference Strategy, Nottingham Healthcare NHS Foundation Trust
30.	NHFT0015754	Trust Performance Management Framework 2023
31.	WITN0133034	Trust Performance Management Framework 2025
32.	NHFT0000615	Policy Document, Re: Our People Plan, "Diverse, Inclusive and a Great Place to Work", Underpinning the Trust's Making a Difference Strategy, Nottingham Healthcare NHS Foundation Trust
33.	NHFT0003275	Report dated 20/11/2024, compiled by Nottinghamshire Healthcare NHS Foundation Trust, Re: Integrated Improvement Plan IOAG Update: Progress against S48 Recommendations
34.	NHNB0018961	Policy Document, re: NHS Oversight Framework, by NHS England
35.	WITN0133032	NHFT current and previous policies

36.	CQCM0005588	Policy Document, Re: Reporting of Accidents, Incidents and Near Miss Situations, NHFT
37.	NHFT0000596	Policy Document, Re: Managing Serious Incidents and Reporting and Learning from Deaths, NHFT
38.	NHFT0009283	15.01: Reporting, Management and Learning from Incidents Policy and Procedure, 2025
39.	NHFT0005227	Emergency Preparedness, Resilience & Response Policy
40.	NHFT0000596	Managing Serious Incidents and Reporting and Learning from Deaths Policy, 2019
41.	NHFT0000484	Letter from Ifti Majid, Chief Executive Officer, NFT, to Celeste Calocane, re: update on actions regarding the tragic incident related to Valdo Calocane
42.	NHFT0004713	Note of advice, 13/08/24, Galina Ward KC
43.	NHFT0000451	Report dated 15/06/2023, compiled by Jackie Craissati, Joanne Parry, Rachel Lees, NFT, Re: Level 2 Comprehensive Investigation Report
44.	NHSE0000058	Policy document, re: Serious Incident Framework, NHS England Patient Safety Domain
45.	NHFT0000603	ELT paper, Internally commissioned thematic homicide and attempted homicide review, March 2024
46.	NHFT0016453	Briefing on homicide cases for Mette Vognsen, NHS England, dated 26.02.24
47.	NHFT0008912	Briefing on incidents of attempted homicides and significant incidents: (2019 – Current) of NHFT
48.	NHFT0010772	Briefing from Dr Jess Sokolov to Diane Hull on learning from homicides and attempted homicides over five year period (commencing January 2019), dated 31/05/24
49.	NHNB0017362	Policy Document. Re: Serious Incident Framework - Supporting learning to prevent recurrence, NHS England.
50.	NHFT0016452	Trust's patient safety processes, 2019
51.	NHFT0000423	Report dated 11/01/2024, Compiled by Helen Collins, Independent Safety Specialist and Registrant Senior Nurse, Re: Independent Evaluation of Nottinghamshire Healthcare Foundation Trust Safety Processes
52.	NHFT0012587	Policy document RE: Reporting, Management and Learning from Incidents Policy and Procedure Policy: 15.01, NHFT

53.	CQCM0005588	Policy Document, Re: Reporting of Accidents, Incidents and Near Miss Situations, NHFT
54.	NHFT0000576	Briefing pack for EO Quality & Mental Health Legislation Committee meeting to be held on 26/05/22, NHFT, circulated on 26/05/2022
55.	NHFT0002430	Briefing pack for Q&MHL Committee meeting to be held on 14/06/22, Nottinghamshire Healthcare NHS Foundation Trust, circulated on 13/06/22
56.	NHFT0003298	Briefing pack for Quality & Mental Health Legislation (Q&MHL) Committee meeting to be held on 13.10.22, NHFT, circulated on 25.10.22 (Reading Room)
57.	NHFT0004353	Briefing pack for Quality and MHL meeting to be held on 04/04/2023, Nottinghamshire Healthcare NHS Foundation Trust, circulated on 31/03/2023
58.	NHFT0004538	Briefing pack for Quality and Mental Health Legislation (MHL) Committee meeting to be held on 06.06.2023, NHFT, circulated on 06.06.23
59.	NHFT0004355	Briefing pack for Quality Committee meeting to be held on 05/12/2023, Nottinghamshire Healthcare NHS Foundation Trust, circulated on 04/12/2023
60.	NHFT0001610	Briefing pack for Quality Committee, meeting to be held on 06/02/2024, Nottingham Healthcare NHS Foundation Trust, circulated on 05/02/2024
61.	NHFT0000457	Briefing pack for Quality Committee meeting to be held on 09/04/2024, NHFT, circulated on 08/04/2024
62.	NHFT0000466	Briefing pack for Quality Committee meeting to be held on 04.06.24, NHFT, circulated on 03.06.24
63.	NHFT0000469	Briefing pack for Quality Committee meeting to be held on 02.07.24, NHFT, circulated on 02.07.24
64.	NHFT0000507	Briefing Pack for Quality Committee Meeting to be held on 29/08/2024, NHFT, circulated on 23/08/2024
65.	NHFT0003365	Briefing Pack for Private Quality Committee to be held 1 October 2024, NHFT Quality Committee, circulated on 25/09/2024
66.	NHFT0000520	Briefing pack for Quality Committee meeting to be held on 12.11.24, NHFT, circulated on 12.11.24
67.	NHFT0000522	Briefing pack for Quality Committee meeting to be held on 10.12.24, NHFT, circulated on 10.12.24

68.	NHFT0000527	Briefing pack for Quality Committee meeting to be held on 14.01.25, NHFT, circulated on 14.01.25
69.	NHFT0000531	Briefing pack for Quality Committee meeting to be held on 11.02.25, NHFT, circulated on 11.02.2025
70.	NHFT0000763	Briefing Pack for Quality Committee meeting to be held on 11/03/2025, NHFT, circulated on 10/03/2025
71.	NHFT0001837	Briefing pack for Quality Committee meeting to be held on 10/04/2025, NHFT, circulated on 09/04/2025
72.	WITN0133026	Minutes from Homicide & Attempted Homicide Oversight Group, 6 June 2024
73.	NHFT0008667	[DRAFT] Minutes of Meeting re: [Homicide & Attempted Homicides Oversight Group], dated 15/07/2024.
74.	WITN0133033	Terms of Reference for the Homicide & Attempted Homicide Oversight Group, dated 17.03.25
75.	DHSC0000016	Policy document. Re: NHS Mental Health Implementation Plan 2019/20 – 2023/24, NHS
76.	NHNB0018961	Policy Document, re: NHS Oversight Framework, by NHS
77.	NHFT0002435	Report dated October 2024, compiled by NHFT. Re: Nottinghamshire Healthcare NHS FT: Integrated Improvement Plan update. Briefing for Nottinghamshire County Health and Adult Social Care Scrutiny Committee
78.	NHFT0004121	Briefing for Nottingham Health and Adult Social Care Scrutiny Committee, Re: NHFT: Patient Involvement, dated 01/03/2025
79.	NHFT0001237	Report, dated 01/01/2025, compiled by NHFT. Re: Mental Health Inpatient Safety Briefing for Nottingham Health and Adult Social Care Scrutiny Committee - January 2025
80.	NHFT0002015	Report dated 24/05/2019, compiled by CQC Re: Nottinghamshire Healthcare Foundation Trust Inspection Report, Inspection 22/01/2019 to 07/03/2019
81.	CQCM0016478	Report dated 25/11/2022, compiled by CQC, Re: Nottingham Healthcare NHS Foundation Trust
82.	WITN0133004	NHS England, Annual assessment of integrated care boards 2023/24
83.	NHFT0003349	NHS Standard Contract 2024/25 compiled by NHS England RE: Mental Health and Learning

84.		Disabilities/Autism Services, Nottinghamshire Healthcare Trust dated 01/02/2024
85.	NHSE0000539	NICE Clinical Guidance CG178, March 2014, "Psychosis and schizophrenia in adults: prevention and management"
86.	CQCM0028993	NICE Quality Standard "QS80: Psychosis and schizophrenia in adults 2015"
87.	NHFT0003340	Policy Document, re: Transfer and Discharge, by Deputy General Manager, Adult Mental Health, NHFT
88.	DHSC0000038	Policy document dated 20/11/2015 compiled by the Department of Health RE: Best Practice in Managing Risk Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services
89.	NHFT0002229	Guidance Re: Staying safe from suicide, NHS England
90.	NHFT0003231	Policy Document, Re: Clinical Risk and Safety Policy, NHFT
91.	WITN0133024	HCR-20 tool
92.	WITN0133006 WITN0133007 WITN0133008 WITN0133009 WITN0133010 WITN0133011 WITN0133012 WITN0133013 WITN0133014 WITN0133015 WITN0133016 WITN0133017 WITN0133018	Child & Adolescent Risk Assessment Suite documents
93.	WITN0133005	NHS England, National Mandatory Learning People Policy Framework, Action needed to save up to 200,000 days of staff time following changes to statutory and mandatory training

94.	NHFT0015338	Clinical Risk and Safety training, with context-specific content for inpatient, community, Child and Adolescent Mental Health Service, crisis, and liaison teams
95.	NHFT0015601-NHFT0015617	Training records for each member of staff employed by NHFT who interacted with VC
96.	NHFT0002009	Medical records of Valdo Calocane from 17/06/2023 to 14/07/2023, HMP Nottingham, HMP Manchester re Patient Record
97.	NHFT0003401	Medical Records of VC from 24/05/2020 to 13/06/2023, Nottinghamshire Healthcare NHS Foundation Trust Re: Alerts, Assessments, MHA/MCA Details, All HoNOS, Core Documents and CPA
98.	NHFT0014978	Medical Reports of Susan Pratt, NHFT, re: Compilation of documents related to VC
99.	NHFT0015226	Policy document Re: 1 – PATIENT CARE, MENTAL CAPACITY ACT 2005, NHFT
100.	WITN0133019	MIND guidance on depot injections and antipsychotics
101.	WITN0206010	BAP Guidelines on pharmacological treatment of schizophrenia
102.	NHFT0003918	Guidance, Re: Guidance on the Administration to Adults of Oil-based Depot and other Long-acting Intramuscular Antipsychotic Injections, Jacquie White and Celia Feetman
103.	NHSE0000032	Implementing the early intervention in psychosis access and waiting time standard, NHS England guidance
104.	NHSE0002336	Royal College of Psychiatrists 'Quality Standards for Early Intervention in Psychosis Services'
105.	WITN0207010	Criss Care Concordat, 2014
106.	NHSE0000115	National guidance on safe staffing
107.	NHFT0015501	Did Not Attend (DNA)/Was Not Brought (WNB)/Cancellations and Management of Patients who Disengage from Trust Services, NHFT policy
108.	DHSC0000101	NHS England guidance (Guidance to ICBs on intensive and assertive community mental health care, 2024)
109.	NHSE0000305	Guidance, Re: Discharge from mental health inpatient settings, Gov.UK Department of Health & Social Care
110.	WITN0133020	NHS England guidance "NHS Continuing Healthcare and NHS Funded Nursing Care"

111.	NHFT0014993	Slides from Quality Governance Workshop, 21 April 2022
112.	WITN0133021	A table outlining the number of independent sector admissions within and out of area between June 2019 and June 2023
113.	NHFT0000425	Policy document re: continuity of Care Principles Out of Area Placements/ Spot Purchase Beds, NFT
114.	NHFT0015701	Policy Document, Re: Access to Information Policy - 12.09, NHFT
115.	NHFT0000424	Policy Document, Re: Multi Agency Public Protection Arrangements, by NHFT
116.	NHFT0000456	Policy Document, Re: Police & Criminal Justice Liaison Policy, Chris Anthony, Local Security Management Specialist, NFT
117.	NHFT0015695	12.01 Information Systems Security Policy
118.	NHFT0015698	12.06 Records Management Policy
119.	NHFT0015696	12.03 Clinical Information Systems, Access and Audit Policy
120.	NHFT0015697	12.04 Secure Handling of Information Policy
121.	NHFT0015699	12.07 Registration Authority Policy
122.	NHFT0015700	12.08 Information Systems Data Quality Policy
123.	NHFT0015701	12.09 Access to Information Policy
124.	NHFT0015702	12.14 Information Risk Management Policy
125.	NHFT0015703	12.19 Data Protection Policy
126.	NHFT0002828	06.01 Safeguarding Children Policy
127.	NHFT0015692	06.04 Safeguarding Adults at Risk Policy
128.	NHFT0015694	08.03 Involvement of Patients and Carers
129.	**NHFT0012786**	08.01 Information Sharing Between Professionals Patients and Carers Policy
130.	NHFT0000003-107, 111-118, 125, 127, 163, 108, 169, 173, 177-298, 312,	All medical records relating to VC

	322, 325, 328-42, 355, 357 358, 363, 368-370, 399, 401, 406, 408, 416, 545, 549, 997, 1575, 1794, 1962, 2009, 2048, 2370, 2546, 2579, 3029, 3132, 3400, 4360, 4444, 4554, 4574, 4627, 4635, 4909, 4927, 7522-7525, 8584, 8585, 11856, 14433, 1443-1448, 14459, 14619, 14622-14625, 14635-14704, 15048	
131.	CHCA0000030	Trust's SystmOne Health Improvement records
132.	NHFT0014996	Health Improvement Worker Standard Operating Procedure
133.	NHFT0000494	Letter from Ifti Majid, Chief Executive Officer, NFT, to Sharon Miller, re: update on actions regarding the incident in Nottingham in Jnue 2023.
134.	NHFT0000495	Letter from Ifti Majid, Chief Executive Officer, NFT, to Wayne Birkett, re: update on actions regarding the tragic incident of June 2023 related to Valdo Calocane
135.	NHFT0000496	Letter from Ifti Majid to Marcin Gawronski, re: update on actions regarding the tragic incident of June 2023 related to Valdo Calocane
136.	NHFT0000500	Letter from Ifti Majid, Chief Executive Officer, NFT to Elaine Newton, Re: update on actions taken by Trust so far and moving forwards
137.	NHFT0000502	Letter from Ifti Majid to David and Emma Webber, Re: Condolence

138.	NHFT0000497	Letter from Ifti Majid to Darren Coates, re: update on actions regarding the tragic incident of June 2023 related to Valdo Calocane
139.	NHFT0000498	Letter from Ifti Majid to Lee Coates, Re: Condolence
140.	NHFT0000501	Letter from Ifti Majid to James Coates, Re: Condolences
141.	NHFT0000499	Letter from Ifti Majid to Sanjoy Kumar and Sinead Kumar, Re: Condolence
142.	NHSE0000824	Letter from Ifti Majid, CEO, NHFT to James Coates, via Neil Hudgell, Hudgell Solicitors, re: Answers to questions posed to NHFT in August 2024
143.	NHSE0000825	Letter from Ifti Majid, CEO, NHFT to Dr Sanjoy Kumar and Sinead Kumar, via Neil Hudgell, Hudgell Solicitors, re: Answers to questions posed to NHFT in August 2024
144.	NHSE0000826	Letter from Ifti Majid, CEO, NHFT to Mr David and Mrs Emma Webber, via Neil Hudgell, Hudgell Solicitors, re: Answers to questions posed to NHFT in August 2024
145.	NHFT0003340	Policy Document, re: Transfer and Discharge, by Deputy General Manager, Adult Mental Health, NHFT
146.	NHFT0015834	Policy Document, Re: Action Plan in Response to the Report of the Independent Inquiry into the Care and Treatment of Sarwat Al-Assaf, by NHFT
147.	NHFT0004541	Report dated 01/11/2005, compiled by Gedling Primary Care Trust, Nottingham, Re: Report of the Independent Inquiry into the Care and Treatment of Patient A
148.	NHFT0015790	Report dated 22/02/2023, compiled Nottinghamshire Healthcare NHS Foundation Trust, North Midlands, Re: Serious Incident Reporting Document
149.	NHFT0008807	Report dated July 2024, compiled by NHFT and Psychological Approaches, Re: Level 2 Comprehensive Investigation Report
150.	WITN0133022	High-level improvement plan considered by the Executive Leadership Team on 7 June 2023
151.	NHFT0000423	Report dated 11/01/2024, Compiled by Helen Collins, Independent Safety Specialist and Registrant Senior Nurse, Re: Independent Evaluation of Nottinghamshire Healthcare Foundation Trust Safety Processes

152.	NHFT0000422	Report dated 30/03/2023, compiled by Helen Collins, Independent Safety Investigator/Registrant Nurse, re: Final Report Independent Evaluation into Safety Processes at Nottinghamshire Healthcare NHS Foundation Trust.
153.	NHFT0015037	Briefing Pack for Quality Committee Reading Room, meeting to be held on 11/03/2025, NHFT, circulated on 11/03/2025 (page 20)
154.	NHFT0000763	Briefing Pack for Quality Committee meeting to be held on 11/03/2025, NHFT, circulated on 10/03/2025
155.	NHFT0015672	Report dated 18/04/2023, compiled by NHFT, Re: Serious Incident Reporting Document
156.	NHFT0015864	Level 1 Concise Investigation, GRO-B 1 August 2023
157.	NHFT0000583	Report dated 18/03/2024, compiled by Nottinghamshire Healthcare NHS Foundation Trust, Re: Serious Incident Reporting Document
158.	NHFT0015791	Report dated July 2024, compiled by NHFT and Psychological Approaches, Re: Level 2 Comprehensive Investigation Report
159.	NHFT0008391	Email from Rachel Limb [NHFT] to Amy Kaye [NHFT]; Re: NHFT References: 2023-11981 517936 (VC) and case 2023-13323 521259 GRO-B
160.	NHFT0009799	Email from Rachel Limb (NHFT) to Justine Rosser (NHFT), Laura Belshaw (NHFT) Diane Hull (NHFT) and others, RE: FW: Final version (subject to our meeting today) VC
161.	NHFT0000452	Letter from Amy Kaye to Celeste Calocane, re: investigation and arrest of Valdo
162.	NHFT0000453	Letter from Amy Kaye to Mrs Celeste Calocane re: Valdo Calocane
163.	NHFT0010858	Serious Incident Review Action Plan
164.	NHFT0000470	Letter from Ifti Majid to Celeste Calocane, re: Incident investigation of Valdo Calocane
165.	NHFT0000484	Letter from Ifti Majid, Chief Executive Officer, NFT, to Celeste Calocane, re: update on actions regarding the tragic incident related to Valdo Calocane
166.	NHFT0010857	Policy Document, Re: [Terms of Reference – personal details redacted Nottinghamshire Healthcare NHS Foundation Trust (NHCFT)Internal Trust Serious Incident (SI) Investigation], NHFT

167.	NHFT0000487	Report dated 15/03/2024, compiled by NFT, Re: Level 2 Comprehensive Investigation Report
168.	NHFT0010858	Report undated, compiled by NHFT, re: SI 2023 - 11918 Action Plan Summary of Learning
169.	WITN0133029	Spreadsheet detailing each request from the CQC re section 48 review and the response of NHFT
170.	CQCM0016517	Report compiled by CQC, Re: Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust (Full Book) [26 March 2024]
171.	NHFT0004228	Report dated 05/2025, compiled by Nottinghamshire Healthcare Foundation Trust Re: Section 48 Recommendations Status
172.	NHFT0000461	Review Report, compiled by Jonathan Warren, Olivier Andlauer, Re: Nottingham EIP review
173.	NHFT0000462	Review Report, Re: Nottingham CRHT and associated Crisis Service review
174.	NHFT0000545	Medical Report, [unknown date], compiled [unknown] Re: Review of LMHTS
175.	NHFT0000518	Report dated 01/08/2024 compiled by Jonathan Warren, NHFT Re Thematic review of homicides and attempted homicides 2019 – 2023
176.	NHSE0000298	Report dated January 2025, compiled by Theemis Consulting Ltd, Re: Independent investigation into the care and treatment provided to VC
177.	NHFT0015678	Report compiled by NHFT Re: Spreadsheet of areas for improvement
178.	NHFT0015679	Report dated 30/03/2023, compiled by NHFT, Re: Progress on the implementation of the recommendations from the independent investigation into the care and treatment provided to VC.
179.	NHFT0004741	Policy Document, Re: Investigation, Terms of Reference (Investigation re: Doctor Karthik Thangavelu's involvement and decision-making re: Valdo Calocane's care), NHFT

180.	NHFT0015049	Policy Document, Re: Investigation, Terms of Reference (Investigation re: Doctor Faizel Seedat's involvement and decision-making re: Valdo Calocane's care), NHFT
181.	NHFT0015050	Policy Document, Re: Investigation, Terms of Reference (Investigation re: Doctor Tuhina Lloyd's involvement and decision-making re: Valdo Calocane's care), NHFT
182.	NHFT0004872	Report dated 18/06/2025, Re: NHFT PRIVATE AND CONFIDENTIAL INVESTIGATION REPORT into Gary Carter
183.	CQCM0027394	Trust Strategy - Making a Difference for 2022 – 2027
184.	WITN0133030	PSIRF Audit Report, 2024/25
185.	WITN0133036	Suite of PSIRF Audit Report materials
186.	WITN0133037	Initial Learning Review Training Support Sessions
187.	NHFT0009285	Learning Response Training, January 2025
188.	WITN0133038	PSIRF Training flyer
189.	WITN0133039	Job description for NHFT Patient Safety Lead and Patient Safety Specialist
190.	NHFT0001252	Report dated September 2024, complied by NHFT re: SafeNow Report
191.	NHSE0000839	Report dated 14/11/2024 compiled by Kate Burley, Deputy Head of Mental Health Commissioning, Re: Assertive and Intensive Community Mental Health Care- Review and Action Plan
192.	DHSC0000163	Guidance, Re: Guidance on intensive and assertive community mental health treatment, Claire Murdoch and Dr Adrian James - NHSE
193.	NHFT0004334	Policy Document, Re: Community Mental Health Service Review, ICB Maturity Index Self-Assessment Tool, NHSE (Midlands)
194.	NHFT0001278	Assertive and Intensive Engagement Improvement Plan
195.	WITN0133023	Health Services Safety Investigation Body report "Recommendations but no action"
196.	WITN0133040	Chronology of the healthcare treatment provided to VC by the Trust between 24 May 2020 and 20 June 2023
197.	NHFT0015324	MHA/MCA Training information: list of in person training slides
198.	NHFT0018412	Suicide Awareness for Professionals [slides]

199.	NHFT0004239	Personalised Care and Clinical Risk and Safety Training session for LMHT, Crisis and EIP Teams [slides]
200.	NHFT0015794	Fundamentals of Care; Mental Health Skills [slides]
201.	NHFT0018411	Personalised Care and Clinical Risk and Safety Training session for OPCU Community Teams [slides]
202.	NHFT0018413	Clinical Risk and Safety Training – eLearning