Witness Name: Diane Hull

Statement No.: WITN0133041

Dated: 19/01/2026

THE NOTTINGHAM INQUIRY

SECOND WITNESS STATEMENT OF DIANE HULL

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.

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 October 2025 (the "**Request**"). This is my second witness statement in connection with this Inquiry as I am the signatory for the Trust's corporate statement.

3. 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. Where the questions in the Request received by me on 16 October 2025 go beyond matters which are within my own personal knowledge, I have had contact with a number of senior Trust employees in writing and video conference to aid in this response.

Background and professional qualifications

4. I set out my background and professional qualifications in my First Witness Statement to the Inquiry, but I have set them out again here. I initially qualified as an Enrolled Mental Health Nurse in 1984 and then as a Registered Mental Health Nurse in 1990. I have over thirty five years of experience in both clinical and operational leadership roles, in a variety of settings including primary care, inpatient and forensic services. I spent the majority of my nursing career at East London NHS Foundation Trust with extensive experience working clinically in adult inpatient services and psychiatric intensive care. After working clinically, I stepped into senior leadership and management roles, including forensic inpatient and community services, until being appointed as Deputy Chief Nurse.

5. I was subsequently successful in achieving Chief Nursing positions at three Foundation Trusts: Sussex Partnership NHS Foundation Trust, Norfolk and Suffolk NHS Foundation Trust, and Nottinghamshire Healthcare NHS Foundation Trust, commencing my role in July 2023 and remaining in that position since. 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.

My role

6. As the Chief Nurse / Director of Nursing, Allied Health Professions and Quality I am responsible for providing visible and professional leadership to the nursing, allied health professional and psychological professions workforce. In partnership with the chief medical officer, I am responsible for ensuring the Trust has effective clinical governance and clinical safety. My role works as part of an executive

triumvirate with the Chief Medical Officer and the Chief Operating Officer, to ensure that services are delivered in line with Trust's vision and values, that clinical risks are effectively managed, staff wellbeing is supported and staff are effectively engaged. As an executive/voting member of the Trust Board and Executive team, I am expected to support the development of an open, engaging and inclusive culture for service users and staff that encourages excellence in clinical practice, facilitates team working and multidisciplinary delivery of care. To enable the fulfilment of my role as Chief Nurse, I participate fully as a member of the Trust Board and Executive Leadership Team.

Key Strategic Responsibilities

7. I am responsible for providing professional advice to the Trust on matters relating to nursing and allied health professions and I am the executive lead for:

    a. Safeguarding of adults and children
    b. Patient safety
    c. Patient experience including complaints management
    d. Infection prevention and control / tissue viability
    e. Quality improvement
    f. Clinical and quality governance
    g. Professional development and training for nursing, allied health professional and psychological professions staff
    h. Relationship with Care Quality Commission ("CQC") including registration, compliance with standards and organisation rating
    i. Serious incidents and management of external reviews
    j. Restrictive Practice
    k. Safer Staffing establishments
    l. Inquests

8. I manage our internal safeguarding team, which enables me to have awareness of safeguarding incidents and any concerns in regard to safeguarding internally,

and within the system. As Chief Nurse, I have oversight of safeguarding reviews, and attend safeguarding boards. This enables me to have a thematic understanding of any safeguarding issues and analysis and allows me to provide adequate oversight. The safeguarding team produces reports, which I present at Quality Committee and the Board (the safeguarding report is presented annually to the Board). **[NHFT0017440, NHFT0017439, NHFT0017720].**

Governance of the Trust

9. I have set out in my First Witness Statement to the Inquiry the governance structures of the Trust, and I do not propose to repeat them in detail here.

10. I am also aware that the governance structures of the Trust have been further explained in the First Witness Statement of Ifti Majid, the Trust's Chief Executive. Briefly, the Board of Directors is supported by defined committees, including the Quality Committee, which I chair. Each has a specific remit with transparent reporting lines, enabling triangulation of assurance across quality, workforce, performance, and finance.

11. Services are organised into three Care Groups: *Mental Health*, *Community Health and Specialised Services*, and *Forensic Services*. Each Care Group is led by a triumvirate (Care Group Director, Nurse Director, and Associate Medical Director), ensuring shared clinical and managerial accountability and consistent governance standards across the Trust.

12. The Accountability and Performance Framework **[NHFT0017627, NHFT0015913]** – approved by the Board in September 2025 – establishes a clear escalation pathway from Care Group to Board. It defines the mechanisms for monitoring, performance review, and assurance reporting, ensuring that risks, incidents, and performance issues are identified, discussed, and addressed at the appropriate level.

Changes in governance structures

13. It was apparent to me soon after starting in post that the Nursing Directorate needed to restructure to enable us to drive the quality, safety, experience agenda and support the Trust in making the improvements required. The implementation of the Care Group Operating Model 2023–2024 (as described in paragraphs 81-87 of my First Witness Statement) was also key to this:

    a. In October 2023, the Trust replaced its former divisional model with three Care Groups (Mental Health, Community Health, and Forensic).
    b. The introduction of triumvirate leadership teams within each Care Group has strengthened multidisciplinary decision-making, ensured shared clinical and operational accountability, and created consistent governance standards across all service areas. Co-developing the concept of triumvirate leadership with our clinicians and Care Groups has made a significant impact on increasing the clinical voice in both operational and corporate governance.

14. This restructure involved the introduction of Care Group Nurse Directors in each of the Care Groups. This ensured patient safety, quality and experience oversight seen at Trust level could be mirrored in each Care Group. In turn, this has greatly enabled the flow of safety and quality information to go from ward to board with greater oversight, understanding and scrutiny. The Quality Oversight and Effectiveness group, which I chair, has ensured again the flow and scrutiny of quality information in a more forensic manner. **[NHFT0002828].**

15. This restructure also resulted in the formal separation of Patient Safety and Quality - with a separate Associate Director leading each group. In addition, the Trust introduced separate leads for Quality Improvement (QI), Physical health and Participation. This has provided clarity and ensured that we have clear expectations, parameters, and sign off for papers before they are submitted.

16. These changes were based on learning from my previous roles as Chief Nurse, and I used my experience to bring clarity about what good data looks and feels like. In turn, I can more easily provide feedback on the quality of reporting and

data presented at Committee meetings. This has ensured that the Trust is bringing in expertise in all areas, and there has been an overall strengthening and bringing of focus. This implementation has lent real credibility to the governance structures.

17. The development of SafeNow and the Quality Dashboard has also ensured meetings below the Quality Committee and the Board have the correct level of robustness and challenge before they reach the Quality Committee.

18. I have also been responsible for various other changes that were necessary to bring about organisational change. First, I implemented changes to the patient safety governance systems, which included strengthening the Significant Incident Review Group **[WITN0263059]** to include all aspects of patient safety - staffing, Freedom To Speak Up, complaints, safeguarding, people and culture and compliance.

19. Under my leadership, this has changed from a meeting which only focused on the grading of incidents to one which looked at immediate learning and actions with the ability to triangulate and understand patient safety in its entirety. This was supported by the implementation of the Patient Safety Incident Response Framework ("PSIRF") and the embedding of a safety culture. To me, a safety culture is an environment which is collaboratively crafted, created and then nurtured to ensure really good, high quality safe care. The foundations of this are: continuous learning and improvement, support, psychologically safe teams, and enabling and empowering speaking up supported by shared values, beliefs, behaviours and expectations alongside strong leadership. The application of systems thinking, supportive oversight and compassionate engagement of those impacted is critical to achieving this. In addition, a formal weekly reporting structure was put into place where I report on the SIRG meeting to ELT. I consider that the move from incident reporting to incident learning has improved the embedding of a safety culture and allowed the Trust to ensure that we are not waiting for reports but rather taking immediate action as and when required. It also allows for real time triangulation of data and the ability to identify themes and

cross-Trust issues more easily. I consider that this change to SIRG has been fundamental to the creation of a learning culture especially because there is extensive representation from Care Groups and professional groups and allows for robust conversations and sharing of information.

20. Second, I introduced a Complex Incidents Meeting **[NHFT0017640]**, a bi monthly Patient Safety and Learning from Deaths meeting **[NHFT0017651]**, and a Patient Safety Incident Investigation sign off group **[NHFT0017664]**, all of which I chair, to ensure that much more detailed reports are sent to the Quality Committee and the Board. I felt that there was an absence of the patient voice within the existing governance structures and I wanted to measure quality by the experience of those who use services. I consider it vital that within all of our governance structures staff are talking about the impact on patients and families we provide care and support for.

21. Third, in June 2024, the Quality Committee moved from bi monthly to monthly meetings. These have also been restructured, in order to ensure the Committee can hear directly from a Care Group. This creates greater connectivity and also brings depth to other reports – I believe there is real value in Care Groups sharing experiences and information and thematic learning. The Patient Safety Report **[NHFT0017675]**, presented at Quality Committee, also now looks at horizon scanning, looking outwards and learning from other organisations with an understanding of the national context. The questioning and curiosity of those attending, encouraged by me, has enabled us to strengthen and develop our report writing - for example in our safer staffing report, we no longer just focus on numbers of incidents but other factors, such as the percentage of bank staff working at that time, the skill and experience of staff, and the impact of that mix. Triangulating all of these variables has in turn improved assurance levels. There is a greater focus on the 'why', which is supported by the curiosity and questioning of NEDs as well as the confidence and experience of executives.

Relationship between Executive Directors and Non-Executive Directors

22. Prior to starting at the Trust, I was able to attend a two-day Board development session with both executives and non-executive directors ("NEDs"), which focused on us getting to know each other, our values, beliefs and experiences which may have influenced or impacted on who we are today. These two days created an opportunity to understand each other as individuals and as a collective board.

23. There had been a number of changes to the Board since I started at the Trust. Relationships have always felt respectful, but in the early stages of forming and developing the cohesion and clarity of a unitary Board, there was a sense of challenge, which I welcome and continues to this day appropriately. I believe that seeking and welcoming challenge is essential to support improvement.

24. These changes were positive and showed stability and consistency within the Trust at a senior level, although I reflect that due to the changes, cohesion can take time. I felt that there was an acceptance of the need to establish ourselves as Board members individually, whilst also working together to formulate effective collective change in the Trust.

25. There were some further changes with four Non-Executive Directors ("NEDs") leaving throughout 2023 and 2024 and the arrival of three new NEDs. There are regular Board development sessions with opportunities for developing relationships outside of the formal Board meeting process, these coupled with increased visibility has brought more depth to relationships.

26. There has always been challenge from the NEDs particularly in the sub committees to the Board. I consider that the arrival of the new NEDs has brought further challenge, curiosity and triangulation to questioning around the patient safety and quality agenda, which I have welcomed and brings a robustness and equity across all subcommittees and at Board level.

27. I present a number of papers at Quality Committee and the Board. Since I came into post, there has been a noted improvement in the quality of the papers, the data and the ability to triangulate, an understanding of the detail and consideration of the impact of what is being reported. There is not an immediate acceptance of what is presented, but rather, NEDs seek clarification, understanding and actively challenge any perceived stalling in improvement, robustness of the actions or if they feel we are being in any way too optimistic. This has led to more mature, transparent conversations where there is sometimes a need for difficult decisions to be made and a more intelligent and effective approach to patient safety.

28. The interrogation of data in meetings has been strengthened by the robustness of the subcommittees, the improvement in the quality of papers, and the further development of the Integrated Performance Report ("IPR"). We have increased the number of quality metrics to ensure they are current and represent actual and potential quality concerns, defined the standard and expectation and use the narrative to bring greater understanding, detail and impact to the data and Statistical Process Control charts. The Integrated Improvement Plan, using a pragmatic approach, clearly defines not only the areas of concern, but the improvement interventions with measurement mechanisms - bringing together the CQC section 48 actions, the improvement groups and the Theemis action plan. The triangulation opportunities this brings, as well as the focus and detail of the Integrated Improvement Plan, coupled with confidence of those presenting (who are now more established in their roles) has meant the senior Committees and the Board are receiving far better assurance.

Board of Directors

29. As I set out in paragraph 54 of my First Witness Statement to the Inquiry, the Board of Directors is apprised of Trust level performance through the Integrated Performance Report and the risk-based Board agenda **[NHFT0017687]**. 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.

30. I receive and present a report weekly to ELT on SafeNow, which identifies escalations and immediate actions. **[NHFT0017695, NHFT0017696]**. I also present a report and SafeNow dashboard to the monthly Improvement Oversight and Assurance Group ("IOAG") meeting **[NHFT0017441, NHFT0017442]**. At the end of the week, I chair a 'huddle' with Care Group Nurse Directors and Associate Directors. In these meetings, we consider SafeNow, safer staffing in the context of learning, understanding and identifying and responding to any emerging areas of concern or risk.

31. In terms of legislative compliance, I lead on compliance with CQC. I have regular engagement meetings, both informally and formally with CQC. I meet monthly with Tracy Newton from CQC – these meetings are not documented but the aim of them is to build and maintain relationships, sharing information, and clearing up points of clarification. These meetings are not documented to keep them informal and in turn maintain a robust level of communication. In between these I inform her of any incidents or concerns – which is further supported by the weekly sharing of SIRG minutes. The formal engagement meetings are led by CQC, who set the agenda, and attended by the Executive Team and the Chair of the Trust **[NHFT0017454]**. I chair a CQC action oversight group and report into both the Quality Committee and the board on compliance.

32. Following any CQC assessment or inspection of a service, we will on the day, or shortly after, receive initial high-level feedback with a summary note sent to the CEO and myself **[NHFT0017501]**, with a letter of acknowledgement and any initial thoughts sent back to CQC immediately **[NHFT0017539]**. We will then receive a draft report with an opportunity to complete a factual accuracy check. Once this is completed, the draft report is sent back to the CQC with a detailed covering letter **[NHFT0017555]**. The final report will then be sent back via the portal and to the CEO who will ensure it is forwarded to me **[NHFT0017578]**. This

is shared with the team that had been inspected, the Care Group Leadership Team and reported to the Quality Committee **[NHFT0017587]** and to the Public Board **[NHFT0001330, p.146-151]**

Escalation to myself, the Executive Team and the Board

33. There are a number of ways in which issues with care can be escalated to the Executive, the Board and myself which I have set out below. Alongside these formal escalation processes, I personally ensure I am available, open and responsive to staff, patient and family feedback and concerns. To do this, I ensure that I am visible and present and meet with staff through formal and informal routes.

34. I start each week with a huddle with Care Group Nurse Directors, and as set out earlier in this statement, I have meetings at the end of the week with them and all quality, patient safety, safeguarding and physical health leads to enable the sharing of intelligence and learning. I meet with the Associate Directors of Nursing from each of the care units (ten in total), which provides an informal forum to discuss concerns, share good practice, think about the local and national context but most importantly it's an opportunity to come together, reflect and share. In addition, I meet with people who would like to provide feedback this may also be through the complaint process, the families of those patients who are involved in serious incidents, and I conduct ward visits regularly.

35. I have attended most sites within the Trust to facilitate learning events, and I am actively involved in executive open forums, staff induction, and a range of other forums. My message is consistent; as Chief Nurse, I want to hear from people – whether these are concerns or celebrations. I meet regularly with families through either the complaint or incident process and always look to continue those relationships to enable learning. I have presented at a number of internal and external conferences/ events – being clear about the importance of connectivity. I also meet monthly with the Freedom to Speak Up Guardian individually and

weekly via the SIRG meeting and always offer to meet with people where there may be concerns.

36. I directly manage the Care Group Nurse Directors who regularly escalate concerns to me directly both formally and informally. The formal mechanisms are through established forums, meetings, committees or supervision. I meet with people informally through MS Teams calls and messages, check ins, sporadic phone calls and meeting people face to face. I am in regular, most likely daily contact with them. We have two huddles a week, monthly supervisions, regular check ins and a relationship where escalation, discussion and sharing of concerns is expected and encouraged.

37. In addition to this we have the weekly SIRG meeting, bimonthly Quality Oversight and Effectiveness meetings, Patient Safety and Learning from Deaths meetings, Quality and Performance meetings and monthly Improvement Oversight Groups. As the Chair of several of these groups, I enable discussion and promote open debate and consideration to establish improvements.

38. SIRG includes representation and presentation from the patient safety, quality, legal, complaints, compliance, safeguarding, employment relations and Freedom To Speak Up teams. It provides time to focus on incidents, inquiries, high risk complaints and any other significant risks that have occurred in the preceding week. The presentations include pertinent aspects of the treatment and care provided to patients with an opportunity for triangulation and immediate actions. A formal SIRG Exceptions report is presented by me to the weekly Executive Leadership Team (ELT) meeting which allows for discussion and challenge.

39. Complex Incidents Reviews are scrutinised and considered at a weekly sign off panel, which is chaired by myself and the Associate Director. A bi monthly Complex Incidents review meeting, attended by the clinical leads and directors Trust wide is fed into the Quality Committee via Exceptions reporting.

40. I am included in the circulation of all patient safety incident forms. I approve,

scrutinise and sign off complaints, have weekly meetings with the quality team and daily touchpoint meetings with the Associate Director for Patient Safety. Our end of week huddle is attended by leads for quality, patient safety, physical health, AHP, infection prevention and control, participation and patient experience as well as Care Group nurse directors with a focus on escalation and sharing.

41. The SafeNow dashboard **[NHFT0017616]** currently provides over 330 quality metrics across 98 teams and is continuing to be further rolled out across the organisation. It creates weekly data and compliance against safety/ quality standards providing clear evidence of actual and emerging issues. The data is used to drive and measure improvement or taken action where there are concerns. There is a clear and robust governance process wrapped around this, which includes weekly reporting to the ELT, oversight from the Integrated Care Board ("ICB") and reports into the Integrated Oversight Assurance Group monthly.

42. The IPR is supported by a quality and performance meeting attended by the leads from all Care Groups. This reports into both the finance committee and ELT and then to Public Board meeting, again bringing transparency and a means of escalation.

43. Outside of formal board meeting structures urgent concerns can be communicated to the whole Board by briefings. The Board itself receives reports where issues with care are documented, discussed often with dedicated actions which may include deep dives, thematic analysis or increased support.

44. The Executive team facilitate 'Big Conversations' across the entire Trust, there is an active Freedom To Speak Up team with champions in all areas who report to Executives and into Board. The Big Conversations are executive led engagement sessions with teams across the Trust. The executive team tour the organisation to ensure that they meet staff across the many services to hear the voice of the staff group but to also share the key issues in the Trust at the time. This can be

in person or feedback can be provided online. The quality standards programme includes NEDs and governors, NED and executive visits, executive open forums and increased visibility and presence to provide opportunity for directly communicating concerns.

45. As a Board, we continue to promote an open culture, where staff, patients and families feel safe to raise concerns, there is collaboration and inclusion in change or improvement, in order to achieve continuous learning and improvement of safety risks.

Information from Ward to Board and consideration by the Executive team

46. In the summer of 2023, when I joined the Trust, there was limited detail to the flow of information particularly in terms of patient safety with a focus on actual incidents without describing immediate learning, actions and impact. I felt that this indicated that there was an absence of triangulation and thematic analysis. For example, I was surprised when first joining the Trust at how the communications department often presented the detail around incidents which then prevented the clinical detail and context being understood. There was limited information around patient experience within reports which further restricted the ability to triangulate.

47. Refinement and development of the Integrated Performance Report, the Quality and Performance meeting (now named the Accountability Meeting, **[NHFT0017617]**), as well as the SafeNow dashboard and the much improved SIRG (Significant Incident Review) meeting has ensured information including data and qualitative triangulation is seen by the Executive Team with clear escalation, action and implementation plans.

48. My view is that these developments can only occur through the quality of the reports which are being presented to Committees. This has been evidenced by improvements in assurance ratings, the detail and a cultural move away from

managing sub committees to embracing the conversation, the challenge and the learning. This is the main way the executive can be presented with the correct level of information, but other developments can be achieved through other means, such as other meetings or patient forums and workshops.

49. In addition to this, the subcommittees of the Board are chaired by a NED, attended by other NEDs and other executives and in these committees time is spent looking at, understanding and challenging information/reports with a report from each of these going to the public Board. This is helpful because NEDs bring the objectivity, wealth of experience, opportunity to challenge through different perspectives and understanding. I consider that the gravitas, experience and bearing that NED chairs have brought to committees has been a positive change since I joined the Trust.

50. Both the IPR and SafeNow provide an opportunity to see improvement or deterioration over a period of time allowing data to measure and drive improvement or effectiveness of interventions. There is also the ward to board dashboard which all members of the organisation can access, again providing an extensive range of data around key quality/ safety and performance metrics.

51. The experience of people using our services, carers, families, communities, and our staff are reflected and represented through sub committees of the Board and subsequently reported into the public Board meeting. During the board meeting there is an in-person patient or carer story presented in addition to a spotlight on a specific service via video. They focus on the direct experience of patients, carers and staff. Complaints, safeguarding and patient experience reports strengthen the flow of information.

52. The creation of three Care Groups with triumvirate leadership at both the senior and care unit level has significantly improved both communication and the flow of information, Care Group Directors attend the extended ELT (Extended Leadership Team meeting). The TMT (Trust Management Team meeting)

provides oversight of strategic operational issues which reports into ELT alongside executive led professional meetings. **[NHFT0017618 and NHFT0017619]**

53. The development of SafeNow, strengthening of quality standards visits, NED and executive visibility has seen positive change to the connectivity with colleagues working "on the ground" coupled with the development of the integrated improvement plan with its focused and bespoke improvement projects.

54. Executive open forums, and The Big Conversation adds to the ability to hear directly from colleagues and ensure they have the opportunity to share what is happening in their areas of work whilst also being part of the improvements.

55. The Executive Open Forum **[NHFT0017620]** is an online opportunity to hear from the executive team and then ask questions and hear direct answers from the executive team. This happens monthly and has on average 300 attendees, and it is also recorded and shared via our social media platforms. Staff can ask questions anonymously or using their name which I consider allows people to feel safe in asking difficult, probing questions or to seek clarity around things they have heard within the Trust. An Executive attends a team or site base and meets with as many people as possible facilitating a 'big conversation', initially about the Integrated Improvement Plan but as this has progressed it has led to conversations around concerns, ideas for improvements and sharing of information. **[NHFT0017621]**.

Concerns about mental health services

56. Prior to me starting my role, there was a CQC inspection of Rampton Hospital where there were a number of immediate concerns raised, and the service was rated inadequate. As soon as I was in post, I became involved in the response and then led the Rapid Improvement Group **[NHFT0017622]** which initially

focused on the immediate regulatory action and concerns raised alongside overall improvement work required. With significant support within the Trust, this piece of work involved supporting, challenging and relentlessly working on the quality agenda and supporting the patient voice. In November and December 2023, CQC inspected our older adult inpatient services **[CQCM0016525]**, and our working age adult inpatients **[NHFT0000581]**. Concerns were raised in both of these reports, with a rating of 'inadequate' given for each service line.

57. Before these 2023 inspections, and when I was very new in post, myself and Laura Belshaw, the Deputy Chief Nurse, were concerned about our inpatient services and so I created a Rapid Improvement Group **[NHFT0017622]** working with the wards, Care Group leaders, clinicians, quality, safety and experience teams with support from system and external partners. I chaired this meeting and ensured we had a clear improvement plan, supported by improvement interventions, milestones, timescales, and mechanisms to measure impact.

58. In addition to this, we were informed of the CQC Section 48 special review which again highlighted both improvements and concerns. I have set out the relevant regarding the CQC Section 48 review at paragraphs 490-495 of my First Witness Statement.

59. In August 2023, following the tragic events involving Valdo Calocane (VC), the Trust considered it necessary to seek external assurance on the adequacy of specific mental health services – specifically the Early Intervention in Psychosis ("EIP"), Crisis and Local Mental Health teams. I have described these reviews and subsequent action taken in paragraphs 496-503 of my First Witness Statement and do not propose to repeat that detail here. Briefly, I commissioned both the review of the Crisis team and LMHT ("Local Mental Health Team") team and sourced people with the appropriate expertise and experience to do these. Laura Belshaw, when in the interim Chief Nurse role, agreed with the Executives that there was a need to commission a review of the EIP service. Once in post, I supported the commissioning process by again finding suitable reviewers to undertake this review.

Integrated Improvement Plan

60. I have set out the background of the Integrated Improvement Plan in paragraphs 132-137 of my First Witness Statement. The Integrated Improvement Plan was initiated to deliver significant improvement as a response to the CQC Section 48 review and with the aim of meeting the criteria for exiting segment 4 of the NHS England National Oversight Framework. I understand that Ifti Majid, in his witness statement to the Inquiry, has given further background to the Integrated Improvement Plan.

61. The Integrated Improvement Plan brings together all necessary actions into a single, coherent framework, structured around five major programmes of work:

    a. Patient Safety and Quality Improvement Programme – focused on improving clinical safety, care standards, and service delivery across all settings.
    b. Leading for the Future Programme – designed to build leadership capability and resilience throughout the organisation.
    c. Finance and Productivity Programme – aimed at ensuring financial sustainability and improving operational efficiency.
    d. People and Culture Programme – supporting workforce development, staff wellbeing, and the creation of a positive and inclusive organisational culture.
    e. Governance Programme – strengthening internal controls, accountability, and decision-making processes to ensure transparency and effectiveness.

62. I was the lead for the quality and safety part of the Integrated Improvement Plan **[NHFT0000615 and NHFT0003275],** initially chairing a number of rapid improvement groups, restructuring and strengthening the patient safety team

function across the Trust alongside the development of the total quality management approach.

63. Laura Belshaw, Deputy Chief Nurse, worked with the Trust's digital team and then the Care Group Nurse Directors to develop the SafeNow dashboard and put in place the original SafeNow governance structure which has now been further strengthened and includes system support and oversight.

64. Alongside the Chief Nursing Information Officer and safer staffing lead with support from the Deputy Director of Finance, I provided a panel for sign off for establishment reviews using the Mental Health Optimal Staffing Tool, professional judgement and incident data. The establishment review paper was taken to both Finance Committee **[NHFT0017625]** and Quality Committee **[NHFT0017626]** before going to the Board **[NHFT0017629]**. I lead on participation and experience, and I restructured the team providing clarity around the ambition, purpose and direction. This included bringing together participation, co-production, recovery college, volunteers and the peer support worker offer. The development of the improving care together plan clearly defines the need to work differently and more collaboratively with our communities, increase opportunities to volunteer, participate and utilise the expertise of experts by experience to drive meaningful improvement in care.

65. As Chief Nurse, I am the Senior Reporting Officer and lead for the Quality, Safety and Experience programme of work. I have ensured there is a clear plan, ownership with named people across the organisation taking responsibility for areas of improvement. We also have as part of this, the support, challenge and active involvement of external bodies such as NHS England, MHIST (Mental Health Improvement Support Team) and the Chief Nurse from the ICB, which provides further robustness to the process.

Board management of risk

66. The absolute fundamentals to my role are around quality, safety and experience, in particular around patients. I consider that risk is the front and centre of that. At every single level of my role I am looking at and considering risk.

67. In relation to patient safety and monitoring clinical risk, I am provided with every single clinical incident form that a staff member fills out, whether it is about a staffing issue, an act of aggression or self harm etc. Where I am concerned, require more information or need to understand what actions have been taken, I will either contact the Care Group nurse director or Associate director directly, speak with patient safety or at times if its staffing or roster related speak with the Chief Nursing Information Officer ("CNIO") and safer staffing lead

68. I have daily touch points with the Associate Director of Patient Safety – looking at if any incidents have come in on that day, what has happened, and any subsequent action points required and who those should be assigned to.

69. From an operational perspective, as set out earlier, I manage all Care Group Nurse Directors, and I hold Monday morning and Friday afternoon 'huddles'. Whilst these meetings will involve a discussion of all events in the Care Group, I am determined that these are risk driven, and I actively encourage the Care Group Nurse Directors to escalate any risk concerns to me. Open and frank discussion of risk is a key part of the culture I have tried to implement since my appointment at the Trust and I believe the 'huddles' are an effective way of doing this. My view is that escalations should not only be pushed up to Committees but to me directly, and I believe that more regular meetings, such as the 'huddles' ensure that I can have oversight on a daily basis on patient safety, quality and risk.

70. The SIRG meeting has been expanded in order to enable us to triangulate those risks. In addition, the weekly SafeNow dashboard and the associated Quality Metrics are an integral part of my management of risk – these are provided to me weekly, and I look at them every Tuesday and report to ELT on a Wednesday. I review this data carefully, and where necessary will follow up with the relevant people to enable me to provide a full report to ELT. If an incident has happened within a Care Group I consider it my responsibility to understand the risk within the organisation and pass that to the ELT, the Quality Committee and the Board.

71. I sign off Patient Safety Incident Investigations (PSII) weekly and I constantly review these with risk in mind, ensuring that any themes and consistent issues relating to risk can be escalated accordingly.

72. I am responsible for the Strategic Risk (SR2) on the Board Assurance Framework that relates to patient safety. This risk focuses on safety and quality, with clear risk scores, identification of the risk, mitigations, actions. I am responsible for reviewing the risk, the mitigation, the actions, ensuring regular deep dives happen and that the Board Assurance Framework entry truly reflects the risk, that the actions are within time frames and the risk score truly reflects the current situation. I review the risk at Risk Committee and ensure it is presented with an appropriate level of detail and candour at the Quality Committee. I have a responsibility for ensuring this is a live document and truly reflects and represents the current position alerting any concerns.

73. I have described the Board Assurance Framework in detail in my First Witness Statement at paragraphs 58-61, and I understand this has also been set out in the First Witness Statement of Ifti Majid. The Board and I monitor and manage strategic and operational risk through our governance framework that integrates the Board Assurance Framework, operational risk registers, and a clear escalation process. Oversight is exercised through regular Board and Committee review, supported by monthly reporting, independent audit, and a culture of openness and continuous improvement. This ensures that risks to patient safety, staff wellbeing, financial sustainability, regulatory compliance, and organisational reputation are identified, owned, and managed effectively at every level of the Trust.

74. The Board Assurance Framework and risk registers are vital tools in reporting more widely and, but I consider that these are reflective of the real time risks that I am aware of on a daily basis. I never want to be surprised by an entry on the Board Assurance Framework. My role is to consider risk in its entirety and consider how each strand of risk, strategically and operationally connects together. For me, strategic and operational risk are interlinked, and my role in patient safety for the Trust requires me to continually manage risk and ensure robust oversight. The Board Assurance Framework provides useful strategic oversight framework – but in addition to that, I consider that my role requires me to focus on knowing and understanding the risks presented on the Board Assurance Framework, and thinking about the operationalising of methods to

manage these. The Board Assurance Framework is effective in providing focus on risks, particularly in Quality Committee meetings, where it is spoken about at the beginning and end (in reviewing specific risks and mitigations), but I do not consider that it can be effective in isolation.

75. In addition, as part of my role, I sign off complaints at the Trust, and so I see concerns about services and risk through these. Complex complaints are now brought to SIRG meetings – a change I introduced - and I consider that this is an effective way for concerns to be triangulated and the risks from complaints to be considered in detail. In addition, as part of my role, I meet with the families of deceased patients, after the patient has sadly died. Families provide an invaluable insight, and whilst their feedback is not focused on risk, I consider that their feedback can be extrapolated to understand where risk arises. When you are caring for patients with conditions of such complexity, risk is dynamic and changeable. The insight of families enables us to understand where we have not assessed risk properly and provides a hugely helpful method in which to get feedback on risk.

76. I do not attend the Audit and Risk Committee but refer the Inquiry back to my First Witness Statement which sets out detail on this Committee at paragraphs 60-61.

Ensuring those in patient facing roles can assess risk

77. Many of the improvements introduced at the Trust over the last few years, including the quality of risk formulation and safety plans, Waiting Well initiatives, personalised care processes, and response times in crisis service, have focused on the clinical team's ability and capacity to assess and manage risk. Examples of this are the improvement of clinical risk assessment training, which moved from eLearning to face to face and has an increased focus on formulation, longitudinal risk, risk to others and safety planning. The training is being delivered by dedicated experienced clinicians. **[NHFT0015073]**

78. Approved Clinical Practitioners (ACP) now have an identified role in the community to deliver team based clinical risk training. In August 2025, the rate for staff having completed this training in the Community Teams was 89% **[NHFT0015209]**, with the staff reporting increased understanding of the core concepts of clinical risk and improved confidence within the practitioner's clinical practice.

79. To support clinical risk training, specific safety planning training is being completed supported by the new Personalised Care Policy **[NHFT0017630]**, which has a greater focus on protective factors and utilising interventions to minimise risk.

80. Community mental health teams have regular risk assessment (RAM) meetings, which have been strengthened by active clinical leadership and presence. There are daily Safety Huddles on all our wards and community teams where the multi-disciplinary team discuss patient safety concerns to proactively identify risks and improve communication.

81. We are also creating opportunities to learn from when things go well and not so well, providing greater depth to risk assessment and its wider understanding, by strengthening the patient safety culture using learning events to understand, challenge and learn.

82. In 2025, the Trust introduced community matron roles which focus on safety, quality and patient experience. This builds on the strengthening of clinical leadership in all teams, ensuring clinical and risk context is front and centre of all conversations.

83. We have been able to gain assurance that all of the improvements have led to the desired outcomes through quality standards visits, risk assessment audits, and the introduction and implementation of SafeNow which reports on risk

assessment and safety planning compliance weekly and is overseen by Care Group leadership team, reporting to Executive Leadership Team and Improvement Oversight and Assurance Group. **[NHFT0014335]**

84. In addition, the Assertive Outreach dashboard has been introduced which reports weekly on risk assessment and safety planning for patients who meet the criteria for this service.

Board training on risk assessment and management

85. I am aware that Ifti Majid, in his witness statement, has set out details on the training provided to Board members on risk assessment and management. I have undertaken the same training as him and continue to do so. Therefore, I have not repeated the detail in this statement.

September/October 2023 deep dive review of BAF and subsequent actions

86. In September and October 2023, a deep dive review of the Board Assurance Framework was undertaken by the Deputy Chief Nurse due to a number of concerns both from internal and external regulation and intelligence relating to quality and safety **[NHFT0017631, NHFT0017632, NHFT0017633]**. There was an acknowledged need to strengthen systems and processes alongside a restructure which would ensure central and local clinical and quality expertise. This was presented to the Quality Committee on 5 December 2023 in the Board Assurance Framework report **[NHFT0004355].**

87. We had a number of actions and mitigations identified but felt the escalation in risk to extreme represented the extent of these challenges and the need to sustain and embed the improvements required. On 25 January 2024, the Quality Committee escalated the 'Quality and Safety of Patient Care' to an 'extreme risk' accordingly **[NHFT0000 454, p. 14 .** I felt it was important to present in an honest, transparent but measured way the concerns and assure Quality Committee with

transparency about the actions we would be taking. As Chief Nurse I believe it is important to have a relentless focus on Quality and safety but with rigorous oversight and challenge from both Quality Committee and the Board.

88. There were a number of key actions subsequently taken, which included:

    a. Rapid Improvement groups, chaired by me the Chief Nurse
    b. Significant investment into the patient safety team with clear leadership from leaders with both the experience and expertise this included the implementation of PSIRF and the creation of a patient safety culture
    c. Care Group Nurse Directors within each Care Group, leading the quality and safety agenda
    d. Changes and improvements to quality and safety governance and oversight
    e. Introduction of the SafeNow dashboard
    f. Oversight and robustness of reporting which included triangulation with clear actions

89. The Rapid Improvement Groups (RIGs) were established to oversee progress against Improvement Plans for services experiencing significant variation in quality and performance which require external leadership. The decision to initiate the RIG process is made by the Executive Team as a result of concerns over quality prompting the need for additional support and oversight. In the cases detailed here, the decisions were also in response to the findings highlighted during CQC Inspections, and the section 48 review.

90. The role of the group is to offer support to the prescribed actions/change strategies set out in the improvement plan, tackle obstacles where they arise and undertake check and challenge. Leads for areas of the plan submit a highlight report which details progress and levels of assurance. Experience points to a key success factor being the level of engagement of front-line staff in the improvement work and its impact locally. The aim is for each ward or team to drive local improvement, ensuring ownership and targeted support rather than a blanket approach. First line assurance is provided through the Care Unit Governance

arrangements.

91. There were five Rapid Improvement Groups for the following services:

    a. Adult and older adult inpatient services **[NHFT0017634]**
    b. LMHTs **[NHFT0017635]**
    c. Crisis teams **[NHFT0017636]**
    d. Rampton Hospital **[NHFT0017622]**
    e. Offender Health, initially just covering Lowdham Grange but then changed to cover all Offender Health sites **[NHFT0017637]**

92. Each one was then chaired by me as Chief Nurse with attendance from Care Group senior leaders, care unit leads, system partners, NHS England and the NHS England Mental Health Support Team, Royal College of Nursing, CQC and professional leads. An update report was provided to the Quality Committee June 2024 Quality Section of Board Assurance Framework report. **[NHFT0000466].**

93. The changes to the Integrated Improvement Programme resulted in these improvement groups being the key drivers and enablers of this part of the programme. The responsibility for chairing them as part of the accountability framework sat with the Care Group Nurse Directors but reported into the Integrated Improvement Programme oversight meeting chaired by me. The Improvement groups used data to drive and measure improvements, whilst using QI methodology and approach to simplify and provide greater opportunities to embed. This ensured there was ward and team ownership, that improvement opportunities ideas and interventions were designed and delivered by them. We were very clear about what needed to be achieved but created opportunities for teams to consider the methodology whilst delivering at pace.

94. The Rapid Improvement Group for Rampton continues to be chaired by myself with external partners including our 'buddy' Trusts Broadmoor and Ashworth. The role of the 'buddy' Trust was to enable independent feedback from a peer specialist service. This allowed an enhanced learning and improvement environment with the aim of mitigating areas of risk and sharing best practice.

Serious incidents and Learning from Deaths

Historical monitoring of Serious Incidents

95. Historically, prior to my commencement in role, the Trust had a Serious Incident Review Group chaired by the Chief Nurse or her Deputy. This group reviewed all serious incidents making decisions about the type of investigation required, how to disseminate learning and reviewed incident reports once signed off in Divisions. It is my understanding that there was not a routine serious incident report to the Executive Team; however, learning was shared with the Executive team in relation to feedback, outcomes and risks from inquests. This was generally done through the communications report to the Executive Team meeting and on occasion a specific report was entered for more complex Inquest preparation or feedback.

96. Incidents were discussed at the Quality Oversight Group which shared an escalation report with each Quality and Mental Health Legislation Committee. **[for example, NHFT0003520]**

97. Historically the Board received a report in the confidential session called the Reportable Issues Log **[for example, p.10, NHFT0002074]**, which updated the Board on the most serious incidents and any immediate action taken. It also shared an update and learning from inquests.

98. The Reportable Issues Log was the paper that provided a briefing to the Board of Directors which included complex serious incidents and significant quality issues within the board reporting framework. It was originally introduced in January 2013. The paper was introduced to provide a systematic reporting process, a component of the Board Assurance and Escalation Framework approved by the Board in December 2012 **[NHFT0017638]** and the initial Reportable Issues Log was provided in January 2013. It was not a cumulative

document but an elevator of reportable issues. It tracked previous actions and informed the Board of new significant issues that had occurred in the preceding month.

99. The Reportable Issues log was changed to the Patient Safety Exception report in May 2025 to strengthen the triangulation of incidents, complaints, legal and safeguarding and ensure there was genuine time to discuss at Board. **[NHFT0015003]** It specifically focuses on patient safety issues and triangulate/ update on previous safety responses. This report includes Patient Safety, Inquest, Safeguarding and Complaints to inform the Board of emerging and existing safety risks. It also includes actions taken to prevent recurrence and updates on previous incidents. The paper is compiled by the relevant trust leads, overseen by the Associate Director of Patient Safety and considered initially at the Quality Committee before being presented to the Trust Board. The Quality Committee is chaired by a Non-Executive Director and attended by 3 other Non-Executive Directors and 5 Executive Directors, and the paper is thoroughly considered by the committee members to understand the detail to provide challenge and support. Thematic Reviews are also presented to the Quality Committee.

100. Thematic reviews occur usually following triangulation from either SIRG, Patient safety and Learning from Deaths, complex incidents or via quality visits or SafeNow. If we see a trend or need to understand more, there may be a need for a deeper dive. An example of this was on one of our wards we saw two incidents both relating to physical health concerns. Upon examination of the data and the background, we identified an increase in preceptorship nurses, and we wanted to understand this further. Our findings were then presented to Quality Committee **[NHFT0017639]**.

101. The Patient Safety Exceptions report forms one of the strands of communicating incidents to the Trust Board as the Patient Safety team provide Briefings on specific high-risk incidents, include triangulation in Learning from Deaths reports, via the SIRG exceptions reports and provide updates ongoing investigations via

the Executive Leadership Team and Quality Committee in dedicated papers.

102. The purpose of the Reportable Issues Log (now Patient Safety Exceptions Report) is for the Board to be sighted on notable events for information and triangulation. This is not the only means of the Board being updated as when a complex high-risk incident occurs, the details are shared immediately with the executive team via a phone call and receipt of blue light notification. The Patient Safety Team complete briefings which are shared with the executives and the Chief Executive who decide whether the Chair and the full Board need to be notified. The incident details are discussed within the weekly SIRG meeting, the notes of this are shared with the Executive Leadership Team through the SIRG Exceptions report, presented by the Chief Nurse. Updates and triangulation are reported through the Patient Safety and Learning from Deaths meeting in a Patient Safety Paper and a Learning from Deaths Quarterly report. These reports are shared through a range of Board level committees, chaired and attended by executive and non-executive directors.

103. The Patient Safety Exceptions report is a standing agenda item **[NHFT0017687]** presented by the Chief Nurse under 'Our Care' section and included in the Board forward planner. There is a presentation of each incident by introducing the person concerned, briefly bringing the Board's attention their story, presenting what had occurred and the actions in place to mitigate future risks. The Trust no longer waits for comprehensive investigations to be completed as actions and review is commenced at the point of the incident. An anticipated improvement is the quality of the Board minutes to more adequately take note of the discussions that occur from the presentation of the paper.

104. It is my understanding from reviewing papers and speaking to Executive colleagues that not all serious incidents were discussed at the Executive Team or the Board. When I started there was no bespoke serious incident report to the Executive team and reporting, in my experience, was often led through the Associate Director of Communications focusing on reputational impact from

inquests. On occasion, I understand some individual patient learning was brought through the Executive Team but not as a standing item.

Monitoring and actioning recommendations arising from Serious Incidents

105. Prior to my commencement in my role in July 2023, I understand that from May 2023 the Chief Executive changed the Executive Team agenda to have a specific item giving feedback to the Executive on serious incidents, via the Serious Incident Review Group presented by the Chief Nurse. This report included all serious incidents and related learning. **[NHFT0017641].**

106. Later in October 2023 we introduced specific reporting to the Quality Committee, which would receive a report summarising serious incidents, themes and giving detail of specific learning in each Care Group **[NHFT0015022]**. The introduction of this report presented the Quality Committee with a detailed analysis of serious incident and patient safety data, e.g. December 2023, 677 open Serious Incidents, closure rate of Incident Reports ("**IR2s**'") was 13% in timeframe and Duty of Candour at 40% completion.

107. Today, the weekly Executive Leadership Team receives an update in writing **[NHFT0017642]** from what is now called the Significant Incidents Review Group. The report covers all serious patient safety incidents, detailing the incident including the name of the individual and their personal circumstances (which I feel is very important in reminding the Executive Team of the catastrophic personal nature of the information they are receiving). It also shares immediate learning and actions for the assurance of the Executive Team, as well as outcomes from Inquests, any issues with complaints, Freedom to Speak Up, Safeguarding or high-risk staffing concerns. These latter areas are vital to ensure triangulation of safer services is enabled. From 2024 for complex incidents, briefings are shared with the Executive Leadership Team that detail immediate learning and actions to mitigate against further risk.

108. Currently the Quality Committee receives a by-monthly patient safety report **[NHFT0017643]** that details the numbers of serious and moderate incidents, learning from PSIRF reviews, with assurance on actions taken. With the investment in the Patient Safety Team, increased oversight by improved reporting and a focus on enabling and supporting staff, there has been noticeable improvements – as compared with December 2023, October 2025, the number of open PSIRF learning responses is at 29, closure rate of IR2s' is 80% in the required timeframe and Duty of Candour is at 100% completion. With the introduction of the Mortality process in June 2024, as described in the Learning from Deaths framework, from November 2024, the committee is now presented with the Learning from Deaths quarterly report. This contains the learning from demographics and physical causes of death, together with actions from the recently introduced Structured Judgement Reviews. This paper brings together all Learning from Deaths, including inquests, PSIRF and mortality and describes all of the actions and improvements. This is subsequently presented to Public Board.

109. The Board receives a Patient Safety Exceptions report which was the previous Reportable Issues Log but now focuses on learning through immediate actions and updates on previous significant incidents. It is presented initially at the Quality Committee who provide the principal source of assurance to the Board on the safety and quality of mental health services. It is a running log and so as serious incidents are updated or moved into a coronial process, updates come back to the Board. **[NHFT0017644, NHFT0017687].**

110. The Significant Incident Review Group and the reporting process to the ELT has been amended, since January 2024, to ensure that the Executive Team receives assurance on serious incidents, immediate learnings and actions taken. **[NHFT0017645]**.

111. Following the changes to the Care Group operating model, the Significant Incident Review Group and the quality assurance process in place in Care Groups reports through the quality and performance framework which provides

assurance on completion of agreed actions from initial and PSIRF investigations. In addition, the establishment of the new Patient Safety and Learning from Deaths Group in July 2024 has the specific role on behalf of the Executive Team to ensure learning, themed and specific actions are completed in relation to patient safety incidents.

PSII/ SIR scrutiny group

112. This group is chaired by me and is presented with final reports to ensure their focus and investigations are robust and comprehensive and agree further actions where required both Care Group and strategically. The reports are presented by the authors to the group of Care Group Quality Directors and relevant clinical experts. **[NHFT0017664].**

Complex Incident Group

113. Commencing in June 2024, this group is also chaired by me, and provides oversight and governance of significant patient safety incidents. This includes mental health homicides, attempted homicides and complex incidents. Report, action plans and IIRs are shared with Clinical Directors and Care Group Quality Directors for scrutiny and establish further actions/ trust wide learning. **[WITN0263061].**

Care Group Patient Safety and Experience Group

114. Rollout commenced for all Care Groups in January 2025. This group is co-facilitated by Care Group Leadership and Patient Safety, the goal of the meeting **[NHFT0017646, NHFT0017647, NHFT0017650]** being to improve the safety and experience of patients receiving care from the Care Group. It includes safety, safeguarding, patient/ carer experience and recommends workstreams. It oversees and shares learning that has been identified through feedback from service leads, Safety Action plans, Immediate Learning Reviews, Structured Judgement Reviews, SafeNow data, Restrictive Practice, Inquests and service user and carer experience. Actions are allocated for Care Group level improvements such as change in Standard Operational Procedures, local training

needs and shared through Team supervision/ business meetings. Where there are more strategic, trust wide requirements, the Care Groups feed into the Patient Safety Learning from Deaths Group which I chair.

Identifying themes and recurring issues from Serious Incidents

115. For the incidents that do not meet the threshold for a full patient safety incident investigation, these will be discussed in the Patient Safety Meetings, Patient Safety and Learning from Deaths Group and where there is a suspected theme, this may be identified through SIRG. In these meetings, we will talk about recurring incidents and themes, and how these can be managed. The aim is to be looking all the time at themes and clusters of incidents and review anywhere where there could be learning across the organisation. For example, presently, we have got a violence reduction collaborative; this is led by our Trust wide Reducing Restrictive Interventions lead, our Clinical Director for reducing restrictive interventions and our Associate Director of QI, sponsored by me. The collaborative has representation from all of our inpatient services across all Care Groups. Using QI methodology and incident data we can understand in detail antecedents, behaviour consequences and have a range of improvement ideas we are testing out with a commitment to significantly reduce violence whilst improving both the patients and staff experience. Feeling safe and being safe is fundamental to providing a safety culture – we are thinking all the time about how we learn more.

116. If themes arise, we will ask the Patient Safety team to do a review, and report back to me. We also undertake After Action Reviews, that are part of the PSIRF framework. These reviews focus on learning and actions supported by understanding and sharing detail chaired in the main by our patient safety team. Services have embraced these with a commitment to continuous learning.

117. PSIRF offers a range of tools, and it is an excellent framework to enable the Trust to look at an incident thematically, but I consider that we now have in place other

methods that provide us with other options to review themes too, such as the SafeNow dashboard, QI collaboratives, Performance and Quality Accountability meetings, and improvement groups.

118. As stated earlier, with improved reporting into committees, improved governance and improved learning, we have moved from just managing the incidents into the learning, mitigation and actions agenda. In my first few months at the Trust, staff would read out incidents in meetings and only assess how they should be graded. In SIRG, we now talk about 'why' – and what we could do differently. Our approach – specifically in committee meetings – is more sophisticated, more evidenced based, and is more probing, and I consider that it is more effective in identifying themes and meaning our approach is less one dimensional. I consider that our approach feels much more focused on promoting patient safety as opposed to incident management.

Groups within the Trust that monitor Serious Incidents and Learning from Deaths

119. I refer the Inquiry back to my First Witness Statement, specifically paragraphs 156 -173, where I have set out in detail the Trust's governance structure for the oversight of patient safety incidents, and the groups within the Trust that monitor serious incidents and Learning from Deaths. For groups that were not covered in my First Witness Statement, I have set out the detail on these below.

<u>The Risk Group</u>

120. The Trust Risk Group meets monthly, chaired by the Chief Operating Officer or another Executive in her absence, performs horizon scanning, monitors high-level and emerging risks, and advises the ELT on the adequacy of controls. It plays a central role in fostering a proactive, risk-aware culture and ensures that strategic risks remain aligned with the Board's defined risk appetite. The Group also provides regular assurance to both the ELT and the Audit and Risk Committee on behalf of the Board and in accordance with the Board's risk

appetite to inform refinement of the Risk Management Strategy and Policy. **[WITN0263043]**

121. The Risk Group was established to;

    a. to foster an open, anticipatory, adaptive and proactive risk-aware culture in which people are actively engaged

    b. ensure risk is kept under prudent control on behalf of the Board and in accordance with the Board's risk appetite - maintaining an effective control system and minimising over-exposure to harm

    c. horizon scanning, challenging, and keeping material risk under review at all times; and

    d. improving organisational resilience

122. The group systematically challenges, reviews and scrutinises risk across all Care Groups and corporate services to ensure that the correct strategy is in place to manage and mitigate risks. The group monitors the risk management policy and strategy as well as reviewing organisational risk registers as needed.

123. The Risk Group assists the Board of Directors in defining what is an acceptable risk to the organisation, supported by the risk appetite as defined in the Risk Management policy and makes recommendations to the Executive Leadership Team on priority risk areas and appropriate actions.

124. The group reviews the Board Assurance Framework document at every meeting and provides the Audit and Risk Committee and Board with assurance that its relationship with the organisational risk register has been maintained.

125. The group does this through receiving reports from the clinical and corporate Care Groups which will provide detail of any key emerging risks and horizon scan for future potential risks. This includes summary information about external visits from associated agencies.

Rapid Improvement Groups (RIG) – monthly

126. The purpose is to provide direction, control and oversight to ensure successful delivery of the programme and project it oversees. It brings together priority improvements e.g. Section 48 CQC, Themis report, CQC inspections. There are 5 Improvement Groups:

    a. Rampton Hospital
    b. Acute Inpatient mental health
    c. Older Persons Care Unit
    d. Offender Health
    e. Community mental health and Crisis Services.

127. The Improvement Groups are led by the relevant Care Group Nurse Directors and discuss project updates and escalate risks to the Quality Oversight Group and Senior Leadership Team meeting. The risks related to the Improvement Group are reviewed through this meeting.

128. The decision to initiate the RIG process was made by the Executive Team as a result of concerns over quality, prompting the need for additional support and oversight in response to the findings highlighted during CQC Inspections, and the section 48 review.

129. The role of the group is to offer support to the prescribed actions/change strategies set out in the improvement plan, tackle obstacles where they arise and undertake check and challenge. Leads for areas of the plan, submit a highlight report which details progress and levels of assurance. Experience points to a key success factor being the level of engagement of front-line staff in the improvement work and its impact locally. The aim is for each ward or team to drive local improvement, ensuring ownership and targeted support rather than a blanket approach. First line assurance is provided through the Care Unit Governance arrangements.

130. The Rapid Improvement Groups ("RIGs"), although not directly related to serious incidents and deaths, do support their learning by making overall improvements to care. The RIGs report to the Quality Committee and are included in the summary to Board. Since the refresh of the IIP, the RIGs have become focused improvement groups and are central to the Improvement Programme reporting into the IIP board and NHS England led Improvement Oversight Assurance Group.

Quality of Serious Incident reports

131. When I joined the Trust, I considered that the quality of Serious Incident reports was substandard. One of my main priorities in my early tenure was to improve this, and I consider that they are now of a much higher quality.

132. The PSIRF training is really important and has helped us with the approach to Serious Incident reports, and enabled staff to be aware of the PSIRF requirements. We now have Patient Safety Managers attached to each Care Group, and we have skilled and dedicated investigators who understand the Trust well. We only use external staff for investigations where increased objectivity is required.

133. I am very clear that the quality of reports is paramount, and both I and the Associate Director of Patient Safety are very clear about expectations and parameters of what should be included. It is vital that staff understand that we want to learn from the incident and be respectful of a person who has died or come to serious harm. Now, each report includes a pen portrait, which ensures that the Trust and its staff does not lose sight of the person or family who have been affected. I am clear that early family involvement is so important, and we have introduced a new sign off process which includes a family agreeing the draft report. I also ensure that reports are given far more challenge, scrutiny and oversight at a senior level and this has resulted in reports of a much higher

quality.

134. The process for all incidents is described in the Reporting, Management and Learning from Incidents Policy (15.01). When an incident is submitted, it is graded by the clinician using the Learning from Patient Safety Events (LFPSE) grading scale. All incidents are reviewed by the Patient Safety Team to ensure the grading is correct and escalate to Patient Safety Managers where there are immediate concerns.

135. Lower level incidents are actioned and closed through Ulysses by the Service Manager / Lead. They are subject to analysis through presentation to the Care Group Safety and Experience meeting and Patient Safety and Learning from Deaths Group to establish areas of risk, themes or where further investigation is required.

136. Significant incidents are reviewed immediately through Immediate Learning Review process; details of the incident are shared by the use of briefings to Care Group and Executive Leads which is all presented weekly to SIRG and then Executive Leadership Team. Throughout the whole process, where there are improvements identified, these are actioned immediately.

137. Significant, high-risk incidents, IIRs and briefings are presented to the Complex Incident Group where Terms of Reference and investigation panel are agreed with updates as they become available. Draft final reports are submitted for comment before being presented to the Trustwide PSII / SIR Scrutiny panel. Final signoff for SIRs is the responsibility of the Associate Director of Patient Safety and the more complex, high-risk incidents and PSIIs, I sign off.

Introduction and implementation of PSIRF

138. I have set out the background to the Trust's introduction of PSIRF in my First Witness Statement to the Inquiry, at paragraphs 517-520. I am aware that the Trust commenced transition to PSIRF in April 2024, as opposed to Autumn 2023, as per NHS England's guidance **[NHSE0000054]**. As I understand, in June 2024,

the ICB signed off all providers PSIRF plans by 1 April 2024, and the Trust met the ICB deadline of 1 April 2024 for the implementation of PSIRF.

139. In April 2024 the trust introduced PSIRF. It enabled a significant change to occur in relation to management, oversight and learning from incidents. It commenced professionalising Patient Safety Teams, and focussed trusts on using resources to enable greater learning.

140. Therefore, when I joined PSIRF had not been introduced. There was a plan in place, but it required a lot of additional work. The Trust recruited additional staff with experience, and invested in a dedicated patient safety team (see paragraph 518 of my First Witness Statement). The process of developing PSIRF needed clear communication and buy in from all sectors and Care Groups, we needed to get as many people as involved as possible, and operationalised in the right way. The Trust also ran a series of workshops explaining the new PSIRF framework and how it would operationalise in practice.

141. The implementation of PSIRF has had an impact with our relationships with coroners, as PSIRF has meant that not every patient safety incident requires a full investigation. PSIRF allows learning from incidents without the need for a full review – for example, with other tools like After Action Reviews, or Immediate Learning Reviews. I understand that full reviews have historically been used by coroners in their own investigations, and so having the expert Patient Safety team in place has enabled us to provide clear parameters, clarity and understanding to coroners, and manage these relationships effectively.

142. We have seen reduction in full reviews, as there are not as many patient safety incidents as there were under the previous framework. In 2022 /23, there were 439 cases declared on StEIS in contrast to 2024/2025 where 77 were reviewed through the PSII and SIR process. I consider that the current system provides a framework for much more thorough and robust reviews with a focus on learning. One of the tools PSIRF recommends is After Action reviews. So far this year (2025), there have been 16 completed with a further 17 in progress, with the

majority of these being requested by the services themselves. **[NHFT0015932, NHFT0017653, NHFT0017654].** There is more real time learning, and more team ownership as we are now focussing on the 'why' instead of the 'who'. PSIRF has enabled the Trust to consider why incidents happen and how the learning should be understood, I ensure that learning is shared across all Care Groups, and we do not lose sight of the families who have been affected. Having an embedded Patient Safety Team rather than bank workers means permanent Trust employees can form relationships with people, and they are committed to their investigations, which is vital for learning. In February 2025 an audit of the implementation and related actions from the independent evaluation of safety process' review (Helen Collins) was completed by 360 Assurance. It found significant assurance in the implementation and governance of PSIRF. **[NHFT0017433]**

Executive Leadership Team concerns about increased volume of Serious Incidents and PFDs in early 2023

143. During 2023 the Trust received a significant increase in Prevention of Future Death reports (PFDs), in total 8. During the preceding five years from 2018 to 2022 it had received in total 5 PFDs inclusive. During this period, with courts proceedings mainly being held virtually, there was a reduction of cases being heard leading to delays. In 2023, there was a focus on recovery with a resulting increase in the number of complex inquests being held. The PFDs received by the Trust in 2023 related to deaths in 2018, 2019, 2021 and 2022.

144. The Board becomes aware of a potential PFD when an incident occurs and findings from that incident illustrate there are errors or omissions in care. The Board receives notification of a complex incident via direct immediate contact with Executives, complex incidents are shared in detail with the Executive team, trust wide clinical and operational directors weekly through Significant Issues Review Group. They were previously reported through the Quality Operational

Group through to Quality Committee.

145. Subsequently, the Legal team update the Trust through weekly updates via the Significant Issues Review Group of the risk of a PFD is shared with the leadership team through the presentation of the Significant Issues Review Group Exceptions report to the Executive Leadership Team weekly.

146. The families are supported through a dedicated member of the Family Liaison Team who facilitate meetings with the Chief Nurse to listen to concerns and agree actions going forward.

147. PFDs are received directly from the coroner to the Chief Executive who is responsible for the acceptance and response to the report. Full responses are shared through the Complex Incident Oversight Group and reported through the Patient Safety and Learning from Deaths Group to the Quality Committee.

148. As the Executive team were sighted on the risks of incidents and inquests, receipt of an increasing number of PFDs was acknowledged and subsequent thematic reviews and actions were introduced to further understand and respond to mitigate future risks both in the care provided and the legal process. This included introduction of experienced clinical expertise in preparation of an inquest, thematic reviews of reasons of coroner concerns and a focus on improving the care and treatment where risks were known and further identified.

149. The Trust introduced a quarterly Learning from Deaths report **[NHFT0017655]** which contains the details of complex inquests, where the learning/ actions presented thematically, shared through Quality Committee to the Board.

150. Further thematic reviews have been completed to benchmark the Trust with other similar trusts and establish what learning can be derived **[NHFT0017656]**.

151. The Board continues to receive notification of a complex incidents via direct immediate contact with Executives, supported by the introduction of Patient Safety Briefings (include chronologies, incident details, areas of concern and immediate actions) which are shared with Board members and included on the Patient Safety Exceptions report to the Board post consideration at the Quality Committee. Complex incidents are shared in detail with the Executive team, trust wide clinical and operational directors weekly through Significant Issues Review Group.

152. After a very short period in post Ifti Majid was concerned about the number of PFDs, the relationship with the coroner and the governance supporting the whole quality and safety agenda. He was aware there was a very small team who had experienced changes in leadership with interim cover in place. He commissioned a review (Independent Evaluation of Trust Safety Processes, described in detail below) and asked the then interim Chief Nurse Laura Belshaw to source an appropriate person. I was then given the task and the opportunity to ensure there was a Patient Safety Team in place with the level of expertise and experience required whilst waiting for the comprehensive review of patient safety and quality rather than waiting to receive it.

Independent Evaluation of Trust Safety Processes

153. In 2023 the Trust's Executive acknowledged that there was a need to improve safety governance, and to understand this further the Chief Executive commissioned the Independent Evaluation of Trust Safety Processes which took place from September to November 2023 **[NHFT0000423]**. This was a comprehensive review involving appraising all related policies and procedures, reviewing more than 100 reports and speaking to 109 people, both internal and externally (coroners, CQC and commissioners). It provided expert opinion on specific areas which required improvement to guide the trust.

154. The review took a little longer than expected, as there was a need to find a

suitably experienced, highly credible external consultant. Subsequently, we also needed to ensure this could fit in with their availability. The review itself was detailed, thorough and robust with extensive time taken to meet with teams, stakeholders and to fully understand the current function as well as how it was operationalised. There was an acknowledgement that a review of this quality would indeed take time. However, it should also be noted we started improvements to the safety processes long before completion of the review.

155. The final report was presented to the Executive Leadership Team on 31 January 2024 **[NHFT0017657]** alongside a dedicated action plan. The report included a significant number of recommendations, with the action plan led by the recently employed Patient Safety Experts. Leads for each of the actions were agreed and it was included/ complimented the Patient Safety Strategy action plans **[NHFT0001610].**

156. In summary, the action taken by the Trust included a review of relevant policies and guidance, and there was significant investment to resource a patient safety team which included dedicated investigation leads and a Patient Safety Partner. As explained above, there was also a review of governance which lead to the introduction of Care Groups and Trust wide Safety meetings, alongside the implementation of PSIRF, Learning from Deaths and the new Medical Examiner process. Duty of Candour and inclusion of families was also completely reviewed, supported by guidance, training and mentorship.

157. Incident reporting was and will continue to be a focus in supporting staff to be open and have more understanding as to what is reported. Improvements to the electronic incident system (Ulysses) were made to make reporting less complex and time consuming and enabling data to be more focussed for staff and clinical experts.

158. The action was overseen initially by the Executive Leadership Team **[NHFT0017721, NHFT0017725, NHFT0017726, NHFT0017727]**, and in June 2024, 70% of the actions had been completed. The actions were completed by

January 2025 **[NHFT0017658]** and closed via Quality Committee in March 2025 **[NHFT0017658].**

159. My particular role in the cases that occurred prior to me starting in post was to oversee the progress, actions, and learning through the multiple groups/ committees which I chair or attend. I also meet with the families involved, scrutinise the reports and learning and ensure learning is incorporated in Improvement Groups. I present the Patient Safety Exceptions report to both the Quality Committee and the Private Board to ensure that the Board understands and has oversight of complex incidents which occur in the trust, ensuring scrutiny and appropriate challenge. In addition, I present the SIRG exceptions report to the Executive Leadership Team and individual Briefings.

160. In in collaboration with staff, service users, families, clinical and operational leads and the Board, I lead on setting the vision, building a safety culture and overseeing systems to prevent harm. This involves leading the response to incidents, ensuring staff can raise concerns without fear, and implement evidenced based practices to improve care and learn from missed opportunities.

161. I attend and present at Learning Events, and conferences where learning is shared both internally and nationally.

Responding to incidents of serious violence

162. The Trust has a Police and Criminal Justice Liaison policy, updated in June 2025 **[WITN0263069]**, which identifies the need for regular liaison between the Trust and police via the Police Local Operational Groups (PLOG) to enable joint oversight of investigations. The improved working relationship with Nottinghamshire police has enabled more cross organisation information sharing. There is an understanding of the responsibilities of each organisation in sharing information in regard to risk where the person is at risk of committing or has

committed a serious crime against another person.

163. Initial contacts with the Trust are through the Liaison and Diversion Teams, based in police custody, who complete mental health screening of detainees. Where the patient is or has been receiving services from the Trust, the Liaison and Diversion Teams relay required mental health information to the custody suite and inform the Trust of the incident via the on-call rota and or the Ulysses patient safety incident system.

164. The Trust Street Triage team, working with the police in response to incidents occurring in public where there are mental health concerns, also raise with the Trust where a patient is under or has been under mental health care.

165. The clinical care teams also raise incidents when it is known to them. As soon as any clinical team is made aware of an incident this will be escalated to the patient safety team and the Care Group Nurse Director for that specific area immediately to ensure action and communication takes place without any delay

166. The communications team review local incidents to establish whether the person was connected to the trust and raise to the awareness with the patient safety team.

167. The Trust/police liaison meetings (which include Care Group, security, safeguarding, Patient Safety and Executive representatives) have a responsibility for information sharing and agreeing actions from significant incidents. The Trust also has representation on Multi Agency Public Protection Arrangements (MAPPA strategic group. [**NHFT0000424**]

168. On receipt of a notification that such an incident has occurred, the Patient Safety Team lead on reviewing the initial information, gathering and clarifying the facts internal and external to the Trust which are available at that time. The Executive

team would be briefed immediately, usually by the Patient Safety Lead directly, but also where necessary via the on-call rota and through the Blue Light incident process (Incident which is escalated to all Trust Leads immediately through email). A full briefing is compiled and shared with the executive team and as necessary the full Board. Immediate actions to mitigate immediate risks are agreed and reviewed throughout the investigation process.

169. The Briefing is shared with the Care Group leads and where necessary the Trust arranges an Incident Co-ordination group to provide strategic oversight of the incident and the forum for communicating, exchanging information and co-ordinating multiple investigations.

170. Staff support and contact with families leads are agreed and arranged.

171. Details of the incident are discussed, and minuted at the weekly Significant Incident Review Group meetings, with a briefing shared through Exceptions reporting to the Executive Leadership Team. The information, updates and learning are shared formally with the Board via the Quality Committee in the Patient Safety Exceptions report. The ICB attends this meeting. In complex incidents, direct contact is made via the Patient Safety Team and the exec team to the ICB, NHS England and the CQC to inform them.

172. The incident is shared externally with relevant commissioners and regulators via a notification email – this was previously through the StEIS system, which has now been replaced by LFPSE. The LFPSE system is currently unable to share immediate notifications, which is challenging to navigate and impacts on analysis locally. The strengthened relationship with the ICB, NHS England and CQC enables direct contact, giving early notification of a serious, complex incident to compliment the formal methods of reporting. This relationship ensures early sharing but equally a shared response or actions by seeing incidents from a system perspective.

173. The Immediate Incident review (72-hour report) is shared internally with the Care Group, externally to commissioner and regulators and to the trust clinical leads through the Complex Incidents Oversight group (introduced in June 2024). **[WITN0263061]**

174. Where a Homicide is committed by a patient who is in receipt of Trust care, NHS England's Regional Homicide Team are informed. All patients who have been in receipt of Trust care within 12 months are automatically in scope for full review under a nationally mandated PSII. Where a patient was previously under the Trust care, a review of the contacts, care provided, and timeframes is completed and shared with the Regional Homicide team for consideration as to whether the incident needs to be comprehensively reviewed by the Trust.

175. The Trust will allocate a Family Liaison Lead to family members and contacts occur at the earliest point to offer support, contact information, information about the process and commence engagement with the investigation.

176. Where a further investigation is required, the Draft Terms of Reference are shared for comment with the Care Group Leads, the Complex Incident Oversight Group, the families affected by the incident and NHS England Regional Homicide Team. The panel and investigator are agreed based on specialism and objectivity; panel members sourced external to the trust with relevant expertise.

177. Learning commences at the point of the incident becoming known, and actions taken where required. An immediate review of the case files, calls, CCTV which would include liaison with clinicians involved occurs to identify any areas of concern. Examples of immediate actions have been a review of caseloads, both individual patients, and team, waiting lists, adherence to protocols e.g. MAPPA/ MOSOVO and the team's adherence where additional information, guidance is made available. Professional practice concerns when identified are managed through the professional lead and Human Resources process'.

178. The investigation is overseen by the Patient Safety Specialist through weekly

Touch Point meetings and as required, areas of concern are highlighted through the process. Updates are shared through the Complex Incident Oversight Group and included in the Patient Safety Exceptions report to Quality Committee and Board. There are regular Touch Point meetings with NHS England Regional Homicide Team and commissioners to review the process and any findings from the investigation.

179. The draft report is shared for comment with families (subject to oversight from the Information Governance team), through the Complex Incident Oversight Group, the trust Scrutiny panel with Care Group leads, and NHS England Regional Homicide Team. Once agreed the Safety Action plan is created by the Patient Safety Team, Clinical and Care Group Leads and shared through the above process for comment.

180. Actions are overseen through the Care Group Leadership Team in the Safety and Experience meetings, overseen by the Complex Incident Oversight Group. Safety Action plans are reviewed within six months by the Complex Incident Oversight Group to review impact and evidence to support. This involves reviewing completion, learning and embedding of the learning both locally and across the organisation. This also ensures incidents are disseminated across the Trust alongside actions taken and improvements made. Dependant on the actions, the learning may be circulated through the Immediate Incident review, Learning Events, guidance from both internal and external subject experts and circulated through the internal mechanisms of the Care Group. This methodology also ensures the Care Group leadership are accountable for completion of actions.

181. The Trust has also recently introduced, in April 2025, a new Reporting, Managing and Learning from Incidents Policy (15.01) **[NHFT0012587]** which includes initial management and responsibilities, the Incident Co-ordination group, and specific sections on mental health Homicides, with guidance to external reporting. It provides further guidance on engaging both the perpetrator and victims' families,

and how to obtain contact details where necessary through Police Family Liaison Leads.

Review of historic incidents

182. Historic incident information is also periodically reviewed by the Trust to understand whether there are patterns or themes and establish whether previous recommendations were similar and effective. Since 2023 there have been the following thematic reviews (not exhaustive) that have examined incidents of serous violence:

a. There was a briefing for the Executive Leadership Team on 1 May 2024, which sought to capture all previous cases of people known to the Trust who had been charged with murder/attempted murder since 2019. It pulled together brief histories, learning and recommendations. [**NHFT0017659, NHFT0017661, NHFT0017662**]. Includes case details, learning/ recommendations, practice changes/ impact, engagement with families and evidence of completion. Shared with Clinical Directors/ Executives in the Complex Incident Oversight Group.

b. This was followed by a briefing to NHS England on 15 May 2024, which provides the details of 4 specific incidents from 2022 to date of submission. It provided chronologies, summaries of identified areas of improvement and shared actions taken. [**NHFT0017663**]

c. NHS England – Learning from Homicides/ Attempted Homicides 13 May 2024. Provided NHS England with brief summary of learning and actions, triangulating learning from previous incidents. [**NHFT0017665**]

d. There was a further briefing to NHS England on 31 May 2024 to establish themes from homicides and attempted homicides from January 2019 to date of submission. 10 cases were identified and a thematic review to establish themes was shared which included diagnosis, risk to others, demographics,

victims and family contact through the investigations.

e. As explained in my first statement at paragraph 496 and further below, Jonathan Warren was later commissioned by the Trust to undertake a Thematic Review of Homicides and Attempted Homicides 2019 to 2023. **[NHFT0000518]**

Action taken following particular acts of violence committed

183. The Inquiry have asked me to explain the actions taken by the Trust as a result of several acts of violence committed since 2022 by patients who had or were receiving treatment from the Trust. For the incidents that occurred after 31 July 2023 (the date I came into post), I become aware by direct contact from the relevant Care Group Lead, the Patient Safety Leads and the Blue Light Incident circulation, as described earlier. For those incidents that preceded my appointment, I have relied on documents held by the Trust and speaking with those who managed these at the time.

184. When the new Associate Director for Patient Safety commenced in post in January 2024, we agreed that there was a need for me to have sight of all complex incidents which had occurred over the last five years, in particular homicides and attempted homicides. This work was completed and formed part of confidential briefing I provided to ELT on 11 September 2024 **[NHFT0017728, NHFT0017730]**.

185. I am aware that in his witness statement, Ifti Majid has also covered the Trust's knowledge and actions of some of the cases below, particularly for those which preceded my appointment as Chief Nurse.

GRO-B

186. The Trust were made aware of the incident on 9 August 2022, this was reported through the Trust Incident Reporting system (Ulysses) on 10 August 2022 **[NHFT0018400]**. This was reported as a Blue Light incident (this severity of harm rating enables automatic notification to senior managers and clinical leads in the event that the grading is deemed major or catastrophic for their immediate oversight). A briefing was shared by the Patient Safety Team on 10 August 2022 to the Executive Team providing incident details and an overview of contacts and care provided by the Trust. **[NHFT0018401]**. I first became aware of this incident following a confidential briefing on homicides on 15 February 2024 **[NHFT0008656]**.

187. The incident was discussed at the Trust Significant Issues Review Group (SIRG) on 16 August 2022 where an overview of the incident was provided, including details of GRO-B contact and treatment with Trust mental health services. **[WITN0263097]** It was agreed the case met the Serious Incident Framework; it was reported on StEIS on 16 August 2022 **[NHFT0004778]** and investigation level confirmed. In April 2024 following completion of the criminal trial, the case was released by the police for the trust to investigate. An independent chair from Psychological Approaches Ltd was appointed to lead the panel to review the Trust's care and treatment of GRO-B

188. Details of this incident were included the Reportable Issues Log (now called Patient Safety Exceptions Report) paper dated 6 September 2022. **[NHFT0004569]**

189. The case was discussed at the Trust Homicide Oversight Assurance Group (HOAG) (now called Complex Incident Oversight Group) on 24 September 2024 when a draft investigation report was available for review. **[NHFT0015874]**

190. The final report and action plan was reviewed at the PSII/SIR Scrutiny Panel on 2 May 2025. **[NHFT0004778]**

191. An Initial Management Review (IMR) was completed at the time of the incident [**NHFT0017666**]. A concise investigation was commissioned, however under the proposals of the Patient Safety Incident Response Framework (PSIRF) the investigation was undertaken as a Patient Safety Incident Investigation (PSII) with an independent chair from Psychological Approaches Ltd and an independent Consultant Psychiatrist. The report was submitted in draft in August 2024 and reviewed at HOAG on 24 September 2024 [**NHFT0015874**]. Following completion of the investigation and report an action plan was developed. [**NHFT0004778**]

192. Clinical Risk Training was enhanced to provide face to face mandatory training from dedicated clinical risk experts. The clinical supervision template [**NHFT0017667**] now incorporates the requirement to review clinical records as part of supervision to ensure staff take account dynamic risk and where possible, specify factors likely to increase the risk of dangerousness and those likely to mitigate violence.

193. The triage tool used by Liaison and Diversion has been strengthened to improve assessment and signposting [**NHFT0017668**].

194. The Trust introduced a procedure where people self-discharge from A&E due to long delays they are followed up and referred onto other services as appropriate. In addition, a review of Trust Liaison Psychiatry teams/ policies is currently being commissioned.

GRO-B

195. The Trust were made aware of the incident on 14 February 2023, this was reported as a Blue Light incident via the Trust reporting system on 16 February 2023 [**WITN0263070**]. An email briefing was shared the same day by the Patient Safety Team to the Executive Team providing incident details and an overview of

contacts and care provided by the Trust **[WITN0263071]**. I first became aware of this incident following a confidential briefing on attempted homicides on 15 February 2024 **[NHFT0008656]**.

196. The incident was discussed at Trust SIRG on 21 February 2023 **[NHFT0016458]**, an overview of the incident was provided, including details of GRO-B contact and treatment with Trust mental health services. It was agreed the case met the Serious Incident Framework; the incident was reported on StEIS on 22 February 2023 **[NHFT0015790]** and the investigation level was confirmed. In February 2024 following the completion of the criminal trial, an independent chair (Psychological Approaches Ltd.) was approached to lead the panel to review the Trust's care and treatment of GRO-B

197. Details of this case were included the Reportable Issues Log paper dated 30 March 2023. **[NHFT0000592]**

198. The case was discussed at the Trust Homicide Oversight Assurance Group (HOAG) on 12 August 2024 when a draft investigation report was available. **[NHFT0008661]**

199. An IMR was completed at the time of the incident. **[NHFT0017669]** A comprehensive investigation was undertaken with the appointment of an independent chair from Psychological Approaches Ltd.

200. On 10 May 2024 a draft investigation was received **[NHFT0015791]** and shared with members of the Executive Team for review on 13 May 2024 and was reviewed further at HOAG on 12 August 2024 **[NHFT0008661]**. An action plan was developed following investigation. The report was approved by me on 26 November 2024, following further amendments to the report. **[NHFT0017670]**

201. The incident involving GRO-B was also part of the internally commissioned thematic homicide and attempted homicide review, as referenced earlier in this statement.

202. As a result of this incident, risk training has been enhanced for community mental health services which includes capacity and risk to others. EIP Internal Working Instructions were updated to include purpose and expectations in relation to medication drop offs.

203. A Trust wide Clinical Risk and Safety Policy has been developed. [**NHFT0003231**]

204. Community mental health and community forensic interface meetings now occur to support clinical discussions.

205. A review of the Police and Criminal Justice policy in collaboration with the police was commissioned to improve the flow of information between clinical teams and the police.

GRO-B

206. The incident took place on GRO-C 2023, and the Trust were made aware of this case on 11 April 2023 via the Trust incident reporting system as a Blue Light incident. [**WITN0263073**]. I first became aware of this incident in May 2025, via a briefing. [**NHFT0017674**]

207. On 18 April 2023 the incident was discussed at Trust SIRG, with an overview of the incident and GRO-B contacts with Trust mental health services provided [**NHFT0016456**]. It was agreed the case met the Serious Incident Framework, the incident was reported on StEIS on 18 April 2023 and concise investigation level confirmed. [**NHFT0015672**]

208. An IMR was completed at the time of the incident [**NHFT0015865**]. A concise investigation was undertaken and completed in July 2023. The review was completed within the Trust and action plan developed. [**NHFT0015864**]

209. Learning was identified relating to medication drop offs, ensuring a patient is seen when this takes place as opposed to medication being handed over to support workers based at a patient's accommodation. This was discussed within the Team Meeting on 8 August 2023 when the investigation report was shared and discussed. [**WITN0263074**]

GRO-B

210. The incident took place on **GRO-C** 2023. The Trust were made aware of this case on 4 July 2023 via the Trust incident reporting system as a Blue Light incident. [**WITN0263075**] I first became aware of this incident following a confidential briefing on attempted homicides on 15 February 2024 [**NHFT0008656**].

211. On 11 July 2023 the incident was discussed at Trust SIRG, with an overview of the incident and GRO-B contacts with Trust mental health services provided [**NHFT0016002**]. It was agreed the case met the Serious Incident Framework, the incident was reported on StEIS on 12 July 2023 [**NHFT0004751**] and comprehensive investigation level confirmed. The case was included in the Reportable Issues Log papers dated 27 July 2023 and 30 November 2023. [**NHFT0001284, NHFT0000416**]

212. An IMR was completed at the time of the incident. A comprehensive investigation was commissioned, with an independent chair from Psychological Approaches Ltd. [**NHFT0004751**] The report was submitted in draft on 29 May 2024 and reviewed at HOAG on 15 July 2024 and 12 August 2024 [**WITN0263077, NHFT0008661**]. Following completion of the investigation and report an action plan was developed. The draft report was reviewed at PSII/SIR Scrutiny Panel on 28 February 2025 [**NHFT0004751**]. The final report was approved by the Deputy Chief Nurse on 31 March 2025.

213. There was liaison with other stakeholders involved in this case, for example on 15 February 2024 a meeting took place with Police and other interested stakeholders for updates on the criminal proceedings. **[NHFT0015972, NHFT0015975]**

214. A key area of learning was ensuring that documentation within clinical records reflected clinical discussions that had taken place, particularly within Multi-Disciplinary Team (MDT) meetings.

215. The EIP team devised a template within the EIP service to guide teams in the required standards for recording clinical discussions and a cycle of audit was put in place to monitor compliance against these standards.

216. In relation to discharge, the EIP team devised a discharge checklist to be used as an aide memoir and guide conversations and documentation to ensure the discharge is clinically appropriate and robust.

217. There are monthly EIP discharge audits in situ, which gives direct feedback to clinical staff.

218. Oversight of this via monthly EIP, CRT and Family Services Quality Operational Group and the Community Mental Health Improvement group.

219. A SafeNow audit is in place to identify those patients who have a risk history and have been discharged following a period of disengagement so they can be identified, re-reviewed and options considered.

220. Waiting lists and the Waiting Well process has been implemented through this process – where Waiting Well was a PSIRF priority in 2024/2025, the reduction of harm incidents, ceasing in July 2025 has resulted it is no longer being a Priority in 2025/2026.

221. In respect of family involvement all EIP staff are required to undertake the improved Think Family training.

222. The Trust's Serious Incident Policy and procedure has been re-written (Reporting, Managing and Learning from Incidents policy and Procedure 2025) and the process strengthened for executive oversight of the most serious incidents. **[NHFT0012587]**

GRO-B

223. The Trust were made aware of the community incident on 29 May 2024 when reported as a Blue Light incident via the Trust reporting system the same day. The incident within the prison took place on **GRO-C** 2024 and the Trust were again notified of this as a Blue Light incident via the reporting system on the same day **[WITN0263078**, **WITN0263079]**. I received notification via the incident reporting Blue Light system. An update and subsequent confidential briefing were provided to the Executive Team on 15 July 2025. **[NHFT0015879]**, in addition to reporting through SIRG.

224. On 3 June 2024 the case was escalated to SIRG, and on 4 June 2024 with an overview of the incident and GRO-B contacts with Trust mental health services was provided **[NHFT0015880]**. It was agreed the case met the PSIRF and a PSII was commissioned. The subsequent incident that took place on **GRO-C** 2024 was escalated and discussed at SIRG on 2 July 2024 **[NHFT0015881]**. It was agreed that the second incident would be included within the already commissioned PSII. The case details were reported on the SIRG Summary Report (now called the SIRG Exceptions Report) dated 4 June 2024 **[NHFT0015880]**. Both incidents were included in the Reportable Issues Log paper dated 26 September 2024 **[NHFT0001807]**.

225. An Immediate Learning Review (ILR – previously referred to as an Immediate

Management Review) was completed at the time. A PSII was commissioned with an independent chair from Psychological Approaches Ltd appointed, alongside an independent Consultant Psychiatrist.

226. The terms of reference for the PSII were reviewed at HOAG on 15 July 2024 and 12 August 2024 [**NHFT0015884**]. Reports were completed and submitted on 13 November 2024 and followed factual accuracy and internal sign off the reports were presented at HOAG on 6 March 2025 [**WITN0263080**] and PSII/SIR Scrutiny Panel on 20 June 2025 [**NHFT0015885**].

227. As a result of this incident, the Community Forensic Team have reviewed and improved the process of risk assessment, particularly HCR-20, as explained in my First Witness Statement.

228. The Community Forensic Team completed bespoke staff training for when to involve the Ministry of Justice when a patient is conditionally discharged, and risks are changing. This involved direct training/ supervision from Ministry of Justice Leads and the Associate Medical Director.

229. Bespoke MAPPA (Multi Agency Public Protection Arrangements) training has been completed.

230. The Standard Operating Procedures now includes guidance for community forensic teams when a person is remanded to prison to ensure that clinical information is transferred and handed over. [**NHFT0016005**]

GRO-B

231. The incident took place on **GRO-C** 2024 and was reported the same day as a Blue Light incident via the Trust reporting system [**WITN0263081**]. I received

notification via the incident reporting Blue Light system. A confidential briefing was shared by Patient Safety Team with the Executive team on 12 December 2024. A briefing was shared with NHS England Midlands Independent Homicide Investigation Team on 12 December 2024. [**NHSE0001134**].

232. The case was reviewed at the Trust SIRG on both 10 December 2024 and 17 December 2024 [**NHFT0016003**, **NHFT0016004**] to provide an overview of the incident, including details of GRO-B contact and treatment with Trust mental health services, immediate learning and actions. In line with PSIRF a PSII was commissioned.

233. The case details were included in the SIRG Exceptions Report dated 10 December 2024 and 17 December 2024 [**NHFT0016003**, **NHFT0016004**]. The incident was included in the Reportable Issues Log paper dated 30 January 2025 [**NHFT0000779**, **p.22**].

234. An ILR was completed at the time of the incident and telephone recordings between service and patient/family were shared with me on 10 December 2024. [**WITN0263082**, **WITN0263090A**, **WITN0263090B, WITN0263091A, WITN0263091B**] A meeting was held on 10 December 2024 [**WITN0263083**] with Associate Director of Nursing, Care Group Nurse Director, Clinical Team Leaders, Operational Manager, Service Manager and Patient Safety Team to discuss incident the incident and to identify immediate learning and actions. An After-Action Review (AAR) occurred on 6 January 2025 [**NHFT0016457**] where both good practice was highlight and recommendations for improvement defined. The review determined that the crisis team service involved were to develop new internal working instructions to ensure patients who use substances do not face exclusion from accessing services and are thoroughly triaged.

235. The areas of learning identified are to ensure the risk assessment is updated to reflect current clinical presentation which is now audited by the Care Group Leadership Team through actions taken where improvements are required. Crisis Resolution Home Treatment (CRHT) Triage form will be audited to ensure it is

completed to the required standard and Discharge and Transfer policy has been reviewed (August 2025) to ensure greater involvement of community service on discharge. [**NHFT0017676**]

236. In addition, there is now guidance ensuring that all patients are categorised for an urgent 4 hour or 24 hour response by the Crisis Teams. Internal Working Instructions were updated to ensure that patients who use substances are not excluded from services and receive thorough triage. [**NHFT0017677**]

237. Bespoke substance misuse training has been delivered to the Crisis Teams.

GRO-B

238. The incident was reported via the Trust reporting system on 15 November 2024 [**NHFT0015973**, **NHFT0015974**]. The incident was discussed at Patient Safety Huddle on 25 November 2024 [**WITN0263084**] A confidential briefing completed at the time of the incident, which was shared with me on 25 November 2024 [**NHFT0017681**].

239. This was escalated to Trust SIRG on 26 November 2024, an overview of the incident was provided, including details of GRO-B contact and treatment with Trust mental health services. The case was included in the SIRG ELT Exceptions Report dated 26 November 2024 [**NHFT0014969**]. Details of the case were included the Reportable Issues Log for the reporting period: 13 November 2024 – 23 December 2024 [**NHFT0000779**]. In line with PSIRF, a Safety Incident Review was commissioned.

240. An ILR was completed at the time, and it was agreed the incident met the PSIRF requirements and a Safety Incident Review was commissioned. A draft Safety Incident Review report is completed [**WITN0263115 p.2-3, WITN0263116 p.2-3**] and will be presented to the PSII / SIR Scrutiny panel and the Complex Incident

Meeting in November 2025.

241. The actions being taken include the development of an induction pack for a care co-ordinator which defines roles, responsibilities and expectations, including frequency and purpose of visits.

242. The Trust is working implement the new Personalised Care Policy, which was ratified in October 2025, reflecting national policy change and sets out the clear expectation that all patients will be valued as active participants in their care. **[NHFT0017630]**

243. Review of outpatient process and standards to ensure a consistent approach. The new Clinical Risk training, which includes formulation continues to be implemented across the Local Mental Health Teams.

244. Escalation to the Mental Health daily sit rep meeting is in place, attended by clinicians whose patients are waiting for a bed. The meeting includes risk escalation and contingency planning whist waiting.

National data and incidents referenced in the Theemis report

245. Theemis requested evidence of *'Serious Incidents reported in relation to patient violence from 2019 to 2024'.* This evidence was submitted on 26 April 2024 and contained details of 19 serious incidents, one of which was VC. The Theemis report [**TCLT0000818**] notes 15 incidents between 2019 and 2023. For completeness, I have included data relating to the 18 incidents other than VC.

246. As explained above, NHS England ceased using the National Report and Learn System in 2024. Trusts were previously able to compare cause factors with other Trusts nationally. This is not possible under the Learning from Patient Safety Events system, where currently the Trust cannot access this type of detail.

247. The National Confidential Inquiry into Suicides and Homicides (NCISH) ceased collecting and reporting on homicide data in 2022 **[NHFT0010666]**. Their data between 2012 and 2022 illustrates they were notified 5,794 homicides convictions in the general population. Of these, an estimated 637 patients had been in recent (within 12 months) contact with mental health services were convicted of a homicide offence. This is an average of 58 per year in the UK.

248. Office of National Statistics (ONS) reported for the year ending March 2024 that there were 570 victims of homicide in England and Wales, a 3% decrease in the previous year. The ONS note that as these figures are so low, interpretation needs to be done with caution.

249. Comparison of the Trust's data on incidents where serious violence has occurred in the past 5 years (01.04.2019 to 01.04.2024) were
    a. 3 in 2019,
    b. 2 in 2020,
    c. 4 in 2021,
    d. 3 in 2022
    e. 5 in 2023 (including VC).

250. More recently, and outside of the dates above:
    a. 3 in 2024 – Post April 2024
    b. 2 to date in 2025

251. The Trust includes in its data incidents where the Trust is aware the person has been charged rather than convicted of the offence. The data includes family members. The Trust uses data about individuals being charged as using data for those convicted of an offence would cause a long delay in the usability of the data.

252. Analysis is challenged by how we perceive the word 'serious' as it is subjective, the small numbers, and the Trust services and processes that will have changed

over this period. Harm is considered serious when the impact is permanent or long term, not just severe at the time. It includes physical and psychological harm if the effects are lasting.

253. The NHS England Homicides Team are aware of mental health homicides per trust; however, they do not circulate the data but do publish homicide reports.

254. All of the incidents below make note of where there were established improvements to care required. NHS England departed from the requirement to assess whether the incident was predictable or preventable in early 2020 and in 2022 stopped the requirement to clarify an incident as predictable and/or preventable with the introduction of the Patient Safety Incident Response framework.

255. Prior to commencement in my role as Chief Nurse in July 2023, the Chief Executive commissioned the Helen Collins Independent Evaluation of Trust Safety Processes due to the Board's concerns that the Trust was not adequately investigating and learning from incidents. **[NHFT0000423]**

256. Changes to the investigation, learning and actions from all incidents have improved the oversight and the focus of learning. The organisations capacity for systemic change, an increasingly blameless culture, and proactive dissemination of lessons has embedded positive change within the Trust. We are moving past the immediate event management (although where lessons are learnt there is immediate sharing) to avoid quick fixes and address deeper, systemic causes. We include diverse perspectives, conducted by a cross functional team leading to more diverse points of view and comprehensive understanding.

257. We review incidents more systematically to establish sustainable change. Together with the active involvement of clinicians, patients and families we evaluate the effectiveness of the impact of change ensuring it achieves the desired outcome. I consider that the number of incidents that now occur fall in

line with what we expect, and the new system and dedicated Patient Safety team ensures that they are considered properly

Thematic Homicide Review

258. The Thematic Homicide report [**NHFT0000525**] was presented to the Executive Leadership Team in September 2024 [**NHFT0017683**]. The trust accepted the recommendations and initiated an action plan for the recommendations. An update of the action plan was presented to the Complex Incident Group – February 2025 [**NHFT0017684**].

259. The 5 recommendations were:
    a. Serious Incident policy required re writing
    b. Two investigations of poor quality revisited to ensure learning is maximised
    c. Audit is designed to identify patients who have a risk history and have been discharged following a period of dis-engagement
    d. To continue embedding the Waiting Well improvements
    e. Review Think Family educational package

260. The previous Serious Incident policy has been discontinued and replaced with the trust PSIRF policy and plan (available on the trust internet) and the Reporting, Management and Learning from Incidents policy and procedure. There is a real focus on inclusion, improving culture and mitigating risk, moving away from incident management.

261. The report Thematic Homicide Review report [**NHFT0000525**] noted two cases from 2019 and 2021 were of such poor quality that they therefore required further investigation to ensure the learning was known. The trust commissioned a partner mental health trust to release trained investigators to complete the secondary investigation to provide oversight and objectivity. These reports have been presented to the Trust in draft and are to be reviewed through the Complex Incident Oversight Group.

262. In 2025 the trust implemented an Assertive Outreach model which introduced standards for engagement, contacts and medical review. It focuses on the requirement for flexible engagement and working in a person-centred way with people who live their lives with Severe Mental Illness.

263. A profile report for people under community services that may require assertive outreach (this includes risk history and disengagement) is reported monthly and shared within Assertive Outreach Oversight Group. Expansion of the SafeNow exception reporting and oversight of risk history. Every patient is then reviewed to establish if they require a more assertive approach. SafeNow is a weekly review of key safety indicators, to identify any safety issues and understand patterns across services.

264. The Waiting Well process has been reviewed as part of the wider improvement plans. Key stake holders were engaged, and patient feedback was also considered. An updated process was established with a focus on patient need, complexity and risk. Wider access to self-help and sources of support was also strengthened utilising local system based such as NOTTALONE digital platform, Sanctuaries and other sources of support from wider Voluntary Care Sector services such as MIND. Compliance is overseen by the SafeNow weekly oversight meeting. The current compliance remains met, with continual improvement.

265. The Trust's Safeguarding team have revised the Think Family strategy which was launched 8 October 2025 [**NHFT0015900**]. The Strategy sets out the Trust's 3 major aims to recognise, respond and refer and the actions to support. This strategy will be underpinned by and delivered through clear pathways into and out of Nottinghamshire Healthcare as well as across and between all of its services. By implementing the 'Think Family' safeguarding strategy at every level, Nottinghamshire Healthcare will, with its partners, improve outcomes for adults, children, families and communities, through the timely provision of safe, caring,

integrated and effective, well led services. The Level 3 Think Family training has been strengthened to enhance staffs understanding of how the Think Family agenda influences their practice.

266. There is improved focus of improving the trusts engagement with families post incident as described in the Reporting, Management and Learning from Incidents policy. Staff understanding and knowledge of Duty of Candour both professionally and regulatory has been supported by a dedicated Duty of Candour lead, reviewed Duty of Candour policy and procedure and training (included in Patient Safety and bespoke Compassionate Engagement). The resulting impact can be seen by Family Liaison survey from families and staff– Quality Committee paper November 2025 and the reduction of Duty of Candour open incidents from 1004 in February 2024 to 0 in March 2025.

267. As set out earlier in this statement, I was aware that the quality of comprehensive incident reports (formerly known as Serious Incident reports prior to the implementation of PSIRF) required improvement. Families had raised concerns that there were excluded from the completion of the report and where they were shared, it was the completed investigation. This had led to the need to provide re opening of reports, complaints and addendum reports for the coronial inquiry. The Trust had received concerns directly from the coroner, one being a Prevention of Future Deaths report solely due to poor investigation in March 2024 **[NHFT0017685]**.

268. Areas raised as concerns by the coroner in 2023 and 2024 from deaths and investigations from 2018 until 2023 were:

    a. Inadequate review and incident investigation following a death. The coroner instructed a further full investigation of care, focussing on all of the elements identified within the course of the inquest. PFD received only for this element of trust involvement.
    b. Complete lack of candour, openness and honesty when engaging in post

death investigations

c. Inadequate review and incident investigation following a serious suicide attempt or a death.
d. The Serious Incident Investigation process did not identify the issues in care
e. The quality of the Trust's investigation report and lack of sufficiently robust process of review.

269. The Trust used bank investigators, who lacked appropriate expertise and were selective about the investigations they would complete. They lacked focus, specialist knowledge and were difficult to understand from an inquest, family and clinical staff perception. They lacked timeliness of submission (in October 2023 670 reports awaiting completion) and illustrated poor involvement with families (Duty of Candour open incidents in 2023 were 1004). This emphasised a lack of focus and proportionality as to what was investigated, leading to an absence of real time learning and actions and an over reliance of ambiguous action plans formerly known as QIPs (Quality Improvement plans). Families were rarely involved in compiling the Terms of Reference for an investigation, excluded from the investigation and the reports therefore did not accurately reflect the person they knew, cared for and cared about.

270. The signing of completed reports was not always at a senior level with limited scrutiny and challenge and not used/ shared in trust wide learning or learning events.

271. The Trust engaged Helen Collins (an independent Safety Specialist) to complete a review of the trust's incident reporting, investigations, learning/ improvement and duty of candour safety. The Independent Evaluation of Nottinghamshire Healthcare Foundation Trust's Safety Process' (reported January 2024, **NHFT0000423**) found in relation to the quality of reports a lack of capacity and capability in the safety investigations. Recommendations included the trust recruitment of dedicated investigators. Alongside this review, as the trust acknowledged the need to improve, there additional reports/ reviews completed

which focused on EIP, Offender Health, CRHT and CMHTs.

272. In September 2024 the trust appointed a dedicated team of clinicians to complete all complex incident investigations, supported by additional training to ensure consistency, engagement and objectivity. The training included dedicated sessions from Morgan Human Systems, a nationally recognised training team. Where an incident is significantly complex a review panel is allocated to include experts. Decisions, through SIRG, agree the degree of objectivity required and therefore panels include both internal and external experts where required.

273. There is now a full Patient Safety Team, a Patient Safety partner who brings service user experience, to support the process of investigation together with a dedicated Family Liaison Team. The team review all reports for quality checking prior to submission at the Scrutiny Panel meeting. The team leads from January 2024 are very experienced and very senior Patient Safety Leads who worked previously in other mental health NHS trusts nationally, and have assisted the team to understand where, how and why improvements are required. The leads bring seniority, expertise, experience and clinical credibility creating an opportunity for the trust response to change to safety issues. The team has an open culture to feedback and improvements, supported by supervision and leadership oversight.

274. The sign off process of investigation reports is through a formal Scrutiny Panel weekly meeting. The role of the panel is to scrutinise the reports, provide recommendations for improvement and share learning. The group has been strengthened to include the use of the HSSIB Learning Response Review and Improvement tool.

275. Complex incidents reports are reviewed and scrutinised through the Complex Incident Oversight group where the report is presented and shared with trust wide clinical leads – for recommended improvements and sharing full report for allocation in associated workstream groups. Final sign off is completed by the

Chief Nurse.

276. In February 2025 the Coroner gave formal verbal feedback to the Trust as to the improvements made (Improvement, Oversight and Assurance Group February 2025).

277. The Coroner's feedback stated that both the Trust and its staff were open and transparent during the inquest process, including admissions made where appropriate to do so, as well as reflections within staff statements and Patient Safety reports.

278. The coroners were complimentary about the quality of the Trust internal reviews / investigation reports and the fact that introduction of PSIRF had not negatively impacted on the usefulness of the reports from a coronial perspective.

279. Key issues and learning points are still being identified as appropriate and this has been noted.

280. A confidential survey focussing on obtaining feedback from families when they have been involved in a significant incident and the adequacy of support offered by the Family Liaison Team - reported to the Patient Safety and Learning from Deaths group in October 2025. The vast majority of families reported feeling that they were able to ask questions, share their experiences and feel part of the review. [**NHFT0017686**]

Staffing levels, outsourcing and discharge planning

281. I am aware that in his witness statement to the Inquiry, Ifti Majid has provided details around staff levels and resourcing, which I endorse. In particular, I agree with his assessment in relation to nursing staffing.

282. I am aware that following the 2021 staffing establishment investment, recruitment and retention within adult mental health inpatient wards have remained a significant challenge leading to a high vacancy rate across these services. These difficulties led to prolonged shortfalls in substantive staffing, particularly among registered mental health nurses' professional group. The situation was further compounded by the overall increase in staffing numbers across inpatient services, which intensified recruitment pressures. Wider mental health community transformational programs and the creation of new, attractive community-based roles and a national context of workforce shortages of mental health nurses, impacted the local mental health nursing workforce availability. Together, these factors contributed to a sustained period of staffing instability across inpatient areas and difficulties in meeting, until recently, the recommended staffing establishments with substantive staffing.

283. Overall, staffing deployment within Adult Mental Health services has consistently met planned levels. Instances of significantly low staffing have been rare and infrequent. This has been largely due to the use of bank and agency staff, which has helped maintain establishment levels and cover gaps caused by sickness and absence. Despite overall staffing being met, a key area of pressure has been maintaining the agreed planned staffing levels for registered nurses within inpatient mental health services specifically, ensuring the consistent deployment of two registered nurses during both day and night shifts. To address this challenge, several strategies have been implemented. These include the deployment of senior clinical staff to support ward shortfalls, international nurse

recruitment to strengthen the workforce, increased oversight from senior leaders to identify and manage rostering gaps, and the enhancement of local, dynamic decision-making with a focus on meeting the needs of service users.

284. Since 2022, the Trust has been working tirelessly to reduce its reliance on bank, agency, and overtime staffing to cover workforce shortfalls, recognising the impact that an unstable workforce can have on the consistency of patient care. These efforts have gained momentum over the past two years, resulting in the elimination of off-framework agency use, a significant reduction in overall agency staffing, and the successful recruitment to the majority of vacancies within Adult Mental Health Inpatient services. The Trust is also on track to substantially reduce its reliance on bank staffing across inpatient and community services, further strengthening workforce stability and enhancing the quality of care.

285. Given the dynamic nature of safety within inpatient mental health services, professional judgment at the local level is essential to identifying situations where staffing may be perceived as unsafe or ineffective. In the absence of an objective measure for unsafe staffing, it is necessary for local teams to report staffing incidents to highlight when safe staffing has not been achieved despite local interventions. However, similar to the low reporting of areas substantially below planned staffing, there has been limited reporting of unsafe staffing or red flag incidents across adult mental health services particularly where harm has occurred as a result. This suggests a need to strengthen reporting mechanisms and foster a culture where concerns about staffing safety are consistently identified and escalated.

Impact of staffing deficiencies

286. From 2024, following in-depth conversations at People Committee and Board, it was felt that our staffing levels had improved in the vast majority of services and the people Board Assurance Framework ("BAF") risk was now about employee and engagement and morale, which had deteriorated post-COVID.

287. Staffing deployment within Adult Mental Health services has, overall, consistently met planned levels, with instances of significantly low staffing being rare and infrequent. This has largely been achieved using bank and agency staff, although this approach has resulted in a less consistent workforce, which can impact the continuity and quality of care provided to service users. The overall use of temporary staffing across the Trust has been reported and monitored via the People and Culture Committee supplemented by the Safer Staffing Paper which is presented to the Quality Committee.

288. A persistent area of pressure has been maintaining the agreed staffing levels for registered nurses within inpatient adult mental health services, particularly ensuring the consistent deployment of two registered nurses during both day and night shifts. This specific risk, along with the broader challenge of Safe Staffing, is reflected on the Trust's Board Assurance Framework.

289. As recruitment into inpatient areas has led to a noticeable shortfall in experienced nurses, with a high proportion of the workforce still within their preceptorship period and challenges in providing support from more senior colleagues. While these recruitment efforts have helped to fill staffing gaps numerically, they have resulted in a reduction in the overall experience level across inpatient teams, with many nurses either newly qualified or within the early years of their professional registration.

290. To address these challenges, the Trust has implemented a range of strategies. Senior clinical staff have been deployed to support wards during shortfalls and provide mentorship, international nurse recruitment has been undertaken to strengthen workforce capacity, and senior leaders have increased their oversight to proactively identify and manage rostering gaps. Additionally, local decision making has been enhanced to ensure staffing arrangements remain responsive to the needs of service users and the acuity of care required.

How were staffing levels monitored?

291. As the overall processes around Safer Staffing across the trust, have been strengthened since 2019, with the establishment review process developed to ensure it is in keeping with the National Quality Board (2016) **[NHSE0000115]** expectations and the 'Developing Workforce Safeguards' guidance from NHS Improvement (2018) **[WITN0263087]** developing workforce safeguards. Establishment reviews are, now identified as bi-annual, with all areas of the trust undertaking reviews at the same point in time, to allow more effective governance reporting. The setting of establishments is now signed off by myself as the Chief Nurse for the trust, ensuring that the reviews have used an evidence based staffing tool (where they exist), professional judgement and consideration of outcome measures.

292. In 2020, the trust first acquired a licence to use the Mental Health Optimal Staffing Tool (MHOST), and its application has been used for the establishment reviews. This tool has provided some checks and balance for the establishment review process and the adult mental health inpatient areas have consistently benchmarked well against its recommended staffing establishments.

293. Routine staffing monitoring is detailed within the Integrated Performance Report, which is reviewed monthly by the Quality Committee. This includes metrics related to substantially low staffing levels and staffing related incident reporting. In addition, a formal weekly escalation process is in place, with significant staffing incidents forming a standing agenda item at the Significant Incident Review Group, which I chair. Dynamic risks are managed in real time by the Care Group and Care Unit leadership teams. Where necessary, escalations are progressed to the Executive Leadership Team via a briefing paper, **[NHFT0017642]** ensuring that significant incidents and issues are appropriately understood and addressed at an executive level.

294. A quarterly Safe Staffing assurance report is presented to the Quality and

Effectiveness Oversight Group [**NHFT0017688**]. This report provides detailed information on areas where staffing levels have been significantly above or below plan referred to as 'Hot Spot' areas. It also includes an overview of establishment review processes and associated recommendations, a thematic analysis of staffing related incidents, and performance metrics for E-Rostering. Additionally, it compares actual headroom use against planned headroom allocations. A similar report is submitted to the Quality Committee and Board on a bi-annual basis [**NHFT0015868**]. We now have the SafeNow dashboard, which reports weekly on staffing levels above 125% and below 85%, subsequently reported into the Executive Leadership Team weekly and the monthly NHS England IOAG meeting. [**NHFT0017442**]

Role of Quality Committee in relation to staffing

295. The Quality Committee oversees the implementation of the National Guidance for Safer Staffing through a regular safer staffing paper. [**NHFT0000763**] This paper includes; assurance that the Nursing Staffing Establishment Reviews have been undertaken in keeping with the National Quality Board (2016) [**NHSE0000115**] and NHS Improvement (2018) expectations [**NHSE0000145**]; a summary of any proposed changes to nursing staffing establishments within the inpatient areas of the trust; a summary of key hot spot areas and staffing related incidents alongside any identified actions / mitigations which were being put in place.

296. Whilst the Quality Committee has specific responsibility for oversight of safer staffing governance and associated actions, the People Committee is responsible for oversight of the broader selection of people metrics which allow Board members to take assurance on staffing levels and colleague engagement across the Trust.

297. The Committee received a 'People Performance Report', which included metrics such as turnover, sickness absence, clinical supervision levels, mandatory

training levels and Appraisal levels. The People Performance Report evolved over time to include additional metrics, allowing the Committee an overall view on people matters at the Trust.

298. At Board, the oversight on staffing matters from both Committees would be reported in a highlight report. In addition, the Integrated Performance Report provides the Board with metrics on both safer staffing and wider people metrics which have previously been assessed by the Board Committees underneath them.

Safer Staffing meeting

299. I did not attend the Safer Staffing meeting and therefore am informed on the role of the meeting and its role through previous papers and conversations with those who did attend.

300. The Trust wide Safer Staffing Group was established in 2020 [**NHFT0017689**] in recognition of the need for effective oversight of nurse staffing within inpatient services, and to address the absence of a dedicated forum for nurse leaders across the Trust to collaborate on this area. Its creation enabled the identification of staffing deficiencies and facilitated the sharing of learning between services that would not ordinarily be connected. I understand that this was professionally led and chaired by the Deputy Director of Nursing, and the group included attendance from associate directors of nursing, heads of nursing, the safer staffing matron, and heads of workforce. Meetings were held monthly, with quarterly reporting into the Quality Oversight Group, chaired by the Executive Director of Nursing.

301. Initially, the group aimed to support the development of a consistent approach to safer staffing across inpatient areas, contribute to policy development, oversee the establishment review process, and provide a structured forum for nurse

leaders to highlight 'Hot Spot' areas where staffing levels had fallen significantly below planned levels. These discussions focused on the potential impact on patient care and safety, leading to the development of exception reports and agreed actions to address concerns, or to provide a forum for nurse leaders to escalate issues that had not been sufficiently addressed.

302. Over time, the group became a key forum for the development of the Trust's safer staffing portfolio, aligning internal processes with national expectations set out by the National Quality Board (2016) and NHS Improvement Workforce Safeguards (2018) **[NHSE0000115, NHSE0000145]**. This included the introduction of the evidence-based MHOST, the implementation of annual formal reviews of staffing establishments, the development of the Trustwide Safer Staffing Policy (1.18) **[NHFT0017690]**, and the introduction of staffing related incident reporting, including red flag staffing incidents, alongside greater oversight of key staffing related data and insights.

303. Although the group held no operational responsibility for staffing deployment, its primary purpose was to provide assurance around identifying areas where staffing was not safe or effective, problem-solving with professional leadership for the identified area, sharing strategies that had proven effective elsewhere, and serving as an escalation mechanism for issues where actions taken had not achieved the required impact on patient safety or quality of care. Escalations were made via the Quality Operational Group.

304. In 2024, the group was formally disbanded following a focused streamlining of governance groups across the Trust. Strategic oversight of staffing transitioned to the Quality and Performance Group, led by the Chief Operating Officer, with assurance and accountability for safe staffing held by the Care Group Triumvirate within this space. The Care Group Nurse Directors oversee quality/ safety issues related to staffing as central to delivery of effective care through daily demand meetings, and safety huddles. Additionally, staffing deployment including the use of temporary staffing, vacancy management, E-Rostering performance, and

establishment changes is now overseen via a weekly Workforce Performance Group chaired by the Executive Director of People and Culture.

305. In addition to this we now have a dedicated agenda item on the weekly SIRG meeting, and Safer Staffing reports are presented at the Quality Committee and at the Board. Reporting has improved with the cementing of the Safer Staffing Leads role in addition to the Chief Nursing Information Officer and the triangulation which now occurs with safety indicators. In addition to numbers we review skill mix, proportion of bank/agency staff, and staff experience including preceptorship nurses. The robustness of discussion and challenge particularly at Quality Committee ensures good oversight.

Concerns about inadequate staffing levels

306. Since starting in post on 31 July 2023, Safer Staffing reports have been presented to the Quality Committee and the Board alongside the People's Committee report which provides the information for recruitment, retention, and sickness. In addition to this staffing has been discussed at Quality and Performance management meetings using the IPR (Integrated Performance Report). Since the introduction of the SafeNow dashboard wards with over 125% and under 85% staffing are reported weekly and presented to Executive Leadership Team and monthly to the NHS England IOAG meeting.

307. Although there have at times been challenges with staffing, there has always been agreement to fill to the agreed number of staff per shift which is often above establishment numbers due to observation levels, acuity, and the complexity of care. The additional staffing required has been established through the use of bank and agency staff, with bank staff predominately being our substantive staff who do additional shifts. Of course, numbers do not always equate to people feeling that staffing numbers are adequate as numbers do not include experience, confidence and expertise, which is really important. We encourage staff on our wards to report via an IR1 (Ulysses incident report) anytime that they feel staffing

does not meet requirements and I personally access all these incident forms.

308. Ensuring we have the right number of staff with the right skills is absolutely critical to delivering safe, compassionate care. To enable this we have a full establishment review annually, using the MHOST tool, professional judgement, triangulation with incidents, complaints, concerns and use of observations. We then have a less in depth review every six months, both reviews are done with services and our Safer staffing /CINO lead which is then presented to me for check, challenge, support and sign off. This is reported to the Quality Committee, the Finance Committee and the Board.

309. In June 2024 we carried out a full establishment review across all our inpatient services which was presented to the Trust Board for agreement and sign off in September 2024 **[NHFT0000516]**. Included in the recommendations of this review was a proposed increase in staffing numbers due to the high levels of additional staffing being used due to enhanced observations and a resulting over reliance on bank / agency staffing. The review presented that establishments needed to reflect actual need, and that substantive staff would bring stability, consistency and continuity. The Board agreed to an increase of 19.34 Whole Time Equivalent ("WTE") to the nursing establishment.

310. In total there was an overall increase to nursing budget of 97.83 WTE with an increase of 11.72 WTE to community health services, 19.34 WTE to mental health services and 66.7 WTE to forensic services including Rampton hospital, with a total investment of £3.5 million.

311. We actively recruited into the vacancies in our community mental health and crisis teams who presently do not report through the Safer Staffing. When the pathways redesign is complete this will be reviewed to enable us to report using the same process. Currently vacancies in these teams are reported through the SafeNow dashboard.

Context / National Policy Direction in relation to staffing levels

312. The NHS Long Term Plan (LTP) published in 2019 [NHSE0000014] came with increased funding for mental health services. There was particular focus on increasing access to Talking Therapies and improving pathways to make them more comprehensive and integrated for people with severe and enduring mental health. The LTP plan specified that this transformation should be across all age adult services, children and young people, perinatal and crisis services. The NHS Mental Health Implementation Plan [**NHSE0000013**] was introduced as a framework to guide the delivery of the LTP ambitions.

313. Alongside these national service transformation targets, workforce targets were set to ensure sufficiently trained people and roles to fulfill transformed pathways. This was supported by the LTP Analytical Tool which apportioned funding, activity and workforce requirements and was utilised to set local requirements within the implementation plans submitted to NHS England. Locally 80 WTE extra roles were recruited during the stabilise and bolster phase in 2019/20 and 2020/21. This phase notably included investment into and transformation of the Early Intervention in Psychosis (EIP) pathway.

314. I am aware that in the Trust, in September 2020, a business case proposal was submitted to the Severe Mental Illness ("SMI") Transformation Programme Board relating to developments in the EIP pathway [**NHFT0017731**]. It was identified that the previous workforce model and the associated financial envelope available for the Nottinghamshire Early Intervention in Psychosis (EIP) service did not support the Mental Health Long Term Plan requirement. This requirement set out that EIP services must extend their access criteria to include service users aged between 14-65 years (previously 14-35) and those with an At Risk Mental State for psychosis. There was also a requirement to achieve NICE concordant standards at a Level 3 by 2020/21 (Performing Well) and be able to maintain the standards thereafter. The investment made at that time and the changes to their operating model can be seen in today's service.

Board oversight relating to staffing levels

315. I am aware prior to my commencement in my role in July 2023 that in response to concerns raised about staffing levels, particularly those identified in the 2022 CQC Inspection Report **[CQCM0016478]**, the Trust and its Board took a series of actions aimed at both addressing staffing shortfalls and mitigating risks to patients and the public.

316. On 1 November 2022, the draft CQC Well-Led report was shared at the Private Board **[NHFT0002074]**. One of the key themes identified was the need to address safe staffing across the Trust. Although the report had not yet been published, it was disseminated to senior leaders at both corporate and divisional levels, to staff involved in hosting the inspections, and to commissioners of services.

317. On 26 January 2023, the Establishment Review Report was presented at the public Board meeting **[NHFT0000905]**. This report provided an update on establishment reviews conducted over the previous 12 months. All inpatient wards across the Trust had undergone a review in accordance with the National Quality Board (2016) expectations and NHS Improvement (2018) guidance **[NHSE0000115, NHSE0000145]** on developing workforce safeguards. The outcomes of these reviews were monitored and supported through the Trust-wide Safer Staffing Group and the Quality Oversight Group.

318. Further assurance was provided on 25 May 2023, when the Safer Staffing and Establishment Reviews Report was presented to the Public Board **[NHFT0002312]**. This six-monthly update outlined progress on establishment reviews and confirmed ongoing compliance with regulatory requirements under National Quality Board (2016) and NHS Improvement (2018) expectations **[NHSE0000115, NHSE0000145]**. The report also highlighted key 'hot spot' areas across the Trust and detailed the work being undertaken to improve staffing levels in those areas. It included assurance on project work initiated by the Safer

Staffing Group to the Trust's overall staffing position.

319. The Safer Staffing and Establishment Reviews Report continues to be presented to the Board every six months. It serves as a key mechanism for escalating concerns and outlining mitigations related to staffing establishments, ensuring that risks to patient safety are actively managed and addressed.

320. On 28 June 2023, the Executive team agreed to create a 'new' CQC Compliance Oversight Group (CQC-COG) which was responsible for providing the Trust Board with assurance on regulatory compliance. A subgroup of the Quality Oversight Group (QOG) with responsibility to scrutinise CQC action plans and evidence of progress toward compliance; the group will make recommendations to QOG to sign off and close individual actions. This group took responsibility for addressing staffing issues.

Staffing Actions

321. As I was not in post at the time, my understanding is that following the approval of the 2022-2027 'Making a Difference' Strategy in March 2022 [**NHFT0017694**], the Trust developed Our People Plan [**NHFT0003484**, **NHFT0015981**] which outlined the People and Culture programmes of work we would progress to realise the ambitions within that strategy. I am aware this action has also been set out in the witness statement of Ifti Majid.

322. Our People Plan was approved at a Board meeting in November 2022 [**NHFT0000901**] and was refreshed in November 2023 in light of the learning from year 1 of delivery and also the publication of the 10-year Workforce Plan for the NHS. In November 2024, a full refresh was not undertaken and instead we aligned Our People Plan programme of work for 2025 to the People & Culture Integrated Improvement Plan 24/25.

323. Our Integrated Improvement Plan is the mechanism by which we deliver actions and recommendations that came from the various reviews into the care and treatment of VC as well as actions emerging from feedback mechanisms such as staff survey, engagement with colleagues through the Trust and other regulatory feedback from the CQC and NHS England.

324. In my experience and in line with our integrated improvement plan there are two areas to be improved when seeking to improve staffing: recruitment and retention.

325. In relation to the former, actions directly related to the recruitment process have included:

    a. Time to recruit has been reduced, this is the time from advertising a post to sending the contract to the new member of staff from 92 days (Feb 23) to 50 days in September 2025.
    b. Creation of a senior recruitment guidance document that changes how we recruit to senior roles in the Trust and focusses on the Trusts pro equity approach and includes for the first time having recruitment diversity guardians on senior recruitment panels. This is essential to bring about the changes to the way we lead the organisation.
    c. Establishment reviews carried out in mental health and forensic services that resulted in investment to increase staffing levels
    d. Recruitment incentives and premiums approved and deployed to support recruitment
    e. Inclusion guardians trained and appointed to support recruitment that better reflects local communities
    f. Vacancy control panels delegated to Care Groups to help speed up the recruitment process
    g. Continual rolling adverts for key hard to fill posts such as Band 5 ward based staff
    h. Turnover reduced from over 15% in Autumn 2022 to consistently at 10-11%, despite transfers out of services
    i. Agency spend reduced from a peak of £2.8 million per month in May

2023, to £600-800k per month now. Using less agency and temporary staffing has a direct improvement on the experience and outcomes people have using our services

326. In relation to retention, the following work has been done:

a. Development and launch of a bespoke Leadership development, offering programmes at all leadership levels from band 2 to Board members, underpinned with management essentials modules on key skills required to lead.
b. Staff Wellbeing service which provides Occupational Health, Staff Counselling and a range of wellbeing support services such as peer support groups, mental health first aiders, etc
c. Creating Compassionate Cultures OD programme
d. Development of a well utilised Freedom to Speak Up service
e. Improvement in rostering practice, with rosters being issued 6 weeks in advance over 95% of the time now, compared to 40% in summer 2023. Most rosters now issues 12 weeks in advance.
f. Work to reduce sickness – though accept that hasn't had great impact yet
g. Understanding the things that are taking staffs capacity for example in patient therapeutic observations so looking to the QI collaborative for developing revised approaches
h. Increased opportunities for engagement and speaking up
i. Using data differently – safe now dashboard live view of inpatient staffing fill rates
j. revamped long service awards

National factors in regard to staffing problems

327. Speaking as the professional and executive lead for nursing and AHPs, I am aware that staffing challenges in mental health nursing account for around a third of all nursing vacancies in England with more than 13,000 posts left unfilled –

[**NHFT0017697**]. Experienced staff are leaving due to difficult working and pay conditions, leaving inexperienced staff with little time to learn the role from those with vital clinical experience.

328. The NHS Long Term Workforce Plan [**NHFT0017698**] needs the number for mental health nursing to increase by 93% by 2031/2 yet the number of applicants to study nursing has fallen by 26% in the years 2023/4.

329. The reasons for this are varied:

a. Increased demand in mental health services due to public awareness, the demanding nature of the role combined with stress leads to higher rates of burnout.

b. Historically, nursing was viewed as an attractive role by young people, seen as a vocation, working for an employer (NHS) that you can be proud of, the numbers of people who started and continued working in the role throughout their working lives was significant. Training course changes, requirements of obtaining a degree and the plentiful opportunities in other careers matched to financial benefit has seen the numbers of applicants decrease over time.

c. During the COVID pandemic, nurses had to work in exhausting, high stress roles which prompted many of them to leave the profession or retire. The combination of this and health issues (Long COVID) worsened existing nursing shortages. Retirement surged post COVID and specifically affected mental health services as staff with Mental Health Officer Status had the opportunity to take their retirement earlier at 55. The decrease in experienced staff numbers has disrupted the balance of inexperienced staff who bring new ideas, being mentored and supervised by experienced staff.

d. The need for mental health services has evolved over the last 15 years, with many more people seeking support for distressed related behaviour, psychological injury and trauma. Together with serious and complex mental illness there is an expectation of generic mental health services such as wards and community teams to provide care for people with very

differing needs. Due to this change, there has been an increasing need to have specialist mental health roles in services such as Primary Care, Acute hospitals, and wellbeing services which has led to the dilution in the core workforce.

Trust factors

330. Locally, the Trust is a large, complex organisation which provides a wide range of service. The geographical area of Nottingham is bordered by many other mental health trusts in addition to having a number of private providers, opportunities for health care professionals are competitive.

331. There are currently two local universities who provide mental health nursing, Occupational Therapy, Physiotherapy and Psychology courses and we have improved the Trust offer by strengthening clinical leadership, moving away from operationally driven services to clinically led. It is of note that the improvements in the services being clinically focused has assisted in reducing the numbers of nurse vacancies.

The impact of Covid on the Trust

332. The Theemis report **[TCLT0000818]** noted that since 2019 there have been several factors that have influenced the quality and assurance of information provided to the Trust Board. Theemis heard evidence that the quality of the papers were poor and committees listened to presentations without challenge, accepting what was presented. They made note that there were attempts to address these issues, but the Covid pandemic stopped the progress.

333. Although I was not working in Nottinghamshire Healthcare at this time, the area highlighted in the Theemis report to me reflects the position of many Trust leaders during the Covid pandemic of not being able to be visible or

present in the same way they had previously. This impacted on oversight which limited the ability to obtain assurance and triangulation of service provision.

334. Covid restrictions meant that meetings occurred remotely, the normal visits to services had to cease and services had to work to new guidance with unfamiliar requirements. Leaders were required to work clinically, including executives due to the need to deliver vaccines and support people during frightening and uncertain times. The priority was surviving COVID.

335. However, due to the speed of change that was required because of Covid and the significant safety issues related to this, I was impressed by how quickly consideration, consultation and change occurred when led by clinical experts. Equally, as a professional lead for nursing and AHPs, I was proud of their fortitude, bravery and commitment to continue to offer the best care to patients regardless of the pressure they were working under and the risk involved.

336. There was an increased need for mental health services, particularly due to social isolation, the impact of delayed physical health care which had secondary effects on the population's mental health and a noticeable increase in the prevalence of anxiety and depression.

Targets and/or requirements for adult mental health services

337. The Trust Board via the Executive team monitors 23 Key Performance Indicators ("KPIs") most of which are part of the NHS national mental health KPIs. The table below gives the details of the targets with a commentary on achievement over the last 5 years. I am aware that Ifti Majid, in his statement to the Inquiry, has also set out the below information.

Performance metrics: Mental Health	TARGET (2024/25)	2020/21	2021/22	2022/23	2023/24	2024/25	Comments
Individual Placement Service placements	1045	-	639	901	1220	1055	Target increased over time with investment, consistently met.
Discharges followed up within 72hrs	80%	85.4%	81.8%	83.5%	83.1%	85.1%	Consistently met
Serious Mental Health (SMI) Physical Health Checks (inpatients)	none	41.0%	64.6%	71.0%	72.9%	75.8%	Internal metric to mirror system primary care target
Proportion of Acute admissions with no prior contact (All inpatients)	none	-	30.9%	21.3%	13.0%	15.1%	Metric introduced in December 2021 (MHS106b)
Proportion of Acute admissions with no prior contact (Black, Asian and Minority Ethnic)	none	-	-	23.8%	13.4%	13.8%	No target, this is data only. Subset to metric above
Rate per 100,000 population of people in adult acute mental health beds with a length of stay over 60 days (rolling 3 months)	8.0	-	8.8	8.4	10.6	11.5	New metric to be reported Nov 2025 onwards - Proportion of adult inpatients discharged with a length of stay exceeding 60 days (rolling 3 months)
Rate per 100,000 population of people in older acute mental	8.0	-	10.4	11.8	10.5	11.6	New metric to be reported Nov 2025

health beds with a length of stay over 90 days (rolling 3 months)							onwards - Proportion of older adults over 65 years with a length of stay exceeding 90 days (rolling 3 months)
Crisis Response: very urgent patients seen within 4 hours	none	-	-	-	68.6 %	75.7 %	New national metric introduced in 2023/24
Crisis Response: urgent patients seen within 24 hours	none	-	-	-	62.2 %	58.4 %	New national metric introduced in 2023/24
Liaison Psychiatry Services: Referral from ED seen in 1 hour	70%	83.4 %	83.4 %	82.7 %	87.4 %	81.9 %	Target now being consistently met
Liaison Psychiatry Services: Referral from Ward seen in 24 hours	70%	90.1 %	84.6 %	81.4 %	77.2 %	80.4 %	Target now being consistently met
Emergency Department 12 Hour Breaches	zero	3.2	6.9	9.1	16.6	22.3	Performance linked to AMH bed availability
Patients clinically ready for discharge	none	-	57.7	41.6	43.3	56.8	Metric introduced in 20/21 - driven by Older Persons Care Unit patients awaiting specialist placements
Community Mental Health access (2+ contacts)	14,550	-	13,565	13,474	13,900	16,232	Target now being consistently met, with

							significant Year on Year increase in performance
EIP treatment within two weeks of referral	60%	-	83.6 %	84.2 %	81.7 %	86.7 %	Consistently met
Local Mental Health teams (weeks) Assessment waited time	18 weeks	-	-	7.2	8.2	8.3	Local standard
Psychological Therapies assessment average waited time	8 weeks	-	-	11.9	20.2	18.5	Local standard
Memory Assessment Services assessment average waited time	12 weeks	-	-	12.5	13.0	14.0	Local standard
Active inappropriate adult acute mental health out of area placements	zero	-	-	-	-		Detailed covered in other response

338. The only metric that has not been met this year is the number of patients clinically ready for discharge. The solution to improving this metric is multiagency and older persons care unit specialist placements, outside of hospital, would reduce these people waiting for beds in hospital.

339. More detail for all these KPIs are monitored through the Quality and Performance Group that reports in the Executive Leadership Team.

Concerns about service capacity for adult mental health services

340. Since commencing my role in 2023, I discuss capacity related issues in the Executive Leadership Team, chaired by the CEO each month when we are receiving levels of assurance and escalations from the Quality and Performance

Management Group. This in turn then feeds the escalations that go to the Board as part of the Integrated Performance Review.

341. The type of escalations or issues raised in these discussions include;
    a. Demand for adult or older adult mental health beds
    b. Length of stay on adult mental health wards
    c. Waiting lists for services like local mental health teams, perinatal services
    d. Response times in ED and for crisis services – driven by demand

Actions taken by ELT and feedback into Board

342. SafeNow was developed in response to the CQC section 48 recommendations as a way to review key safety and quality indicators on a weekly basis and identify any issues and patterns across our services. The SafeNow dashboard is shared with the Executive leadership team and this gives specific escalations for us to discuss that include areas again such as waiting times, speed of being seen by crisis services, seeing patients within 72hours of a hospital discharge. The dashboard is updated weekly which enables us to see, understand and triangulate data regarding the safety of services with a focus on patient and priority areas.

343. There are a separate set of quality metrics for inpatients, community mental health services and crisis services with this now in place at Rampton. Safe Now enables system wide governance to be put into place with the ability to see detail at patient, team, ward, care unit level, and allows learning and thematic analysis. SafeNow is nationally recognised as an excellent tool for improvement and safety.

344. These escalations from both SafeNow and the quality and performance management group have led to the Executive Team ensuring that the current components of our integrated improvement plan address the themes of

escalations.

a. Primary target list and revised Waiting Well process for LMHTs
b. Agreement to invest in more staffing resources in the Crisis Access Line (this supports timely urgent access to services but also releases capacity within the crisis team to inreach onto adult wards to assist with timely discharge by offering enhanced support)
c. A detailed improvement plan to reduce reliance on locally provided independent sector beds [**NHFT0018409**]
d. A coproduced QI based review of the adult mental health community pathway [**NHFT0018408**]
e. Alignment of Assertive Outreach Teams
f. Place based delivery of Early Intervention Teams
g. Liaison with primary care colleagues around referrals, access when needed and alternatives in the community – carried out through work in the mental health system partnership board.

345. These workstreams are discussed at Board meetings to provide assurance to Non-Executive Directors related to concerns such as waiting lists, independent sector bed usage and inpatient length of stay.

Out of area / private bed placements

346. An 'out of area placement' for acute mental health in-patient care happens when a person, with assessed acute mental health needs who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of the usual local network of services normally this refers to being admitted out of the local County boundary.

347. I believe treating people close to their home, their families, their friends and their support is critical for recovery. Being treated within local Trust services enables continuity, consistency and ensures a more seamless pathway particularly if they are already being supported by a community team with care coordinators being

more able to attend ward reviews. Engagement, connection and forming trusting and therapeutic relationships is essential when caring for someone within inpatient services. This is also helped by previous relationships, and discharge planning and purposeful admission is easier if it is all provided by the same organisation. When patients are placed in independent sector beds it is important we have quality monitoring and oversight in place, and that we ensure families are supported – feedback should be sought in the same way it would if the Trust was providing care.

348. It has been a national target for many years to eliminate patients being sent out of the local County for mental health bedded care. It is fair to say that across the county there has been mixed success in doing this, with some Trusts having significant amounts of patients admitted out of their local area due to demand pressures. This is a national target, and the number of out of area placements are reported monthly to NHS England.

349. Risks and disadvantages of out of are placement noted in the Old Problems New Solutions – Improving Acute Psychiatric Care for Adults in England (Lord Nigel Crisp 2016) [**WITN0263130**] are:

    a. Family have difficulty visiting
    b. Away from social networks
    c. Poor use of NHS money as expensive
    d. Negatively effects safety issues (NCISH)
    e. Care team have difficulty being active in decision making and continuing close contact which can result in longer stays

350. In 2024, the HSSIB (Health Service Safety Investigations Body) investigated '*Harm caused by mental health out of area placements'* [**NHFT0017699**] and their finding were:

    a. Patients, families and carers rarely want an out of area placement and their choice and opinions are not always taken into consideration when

decisions about out of area placements are made.

b. Patient, family and carers' wishes and preferences, as required in the Mental Health Act 1983: Code of Practice are not documented by health and care staff or monitored during Care Quality Commission inspections.
c. Out of area placements can increase patients' length of stay in hospital and therefore contribute to harm to patients.
d. Advocacy services are vital for a patient to be able to put forward their views for consideration in decision making about their care, but advocacy is not always offered to patients.

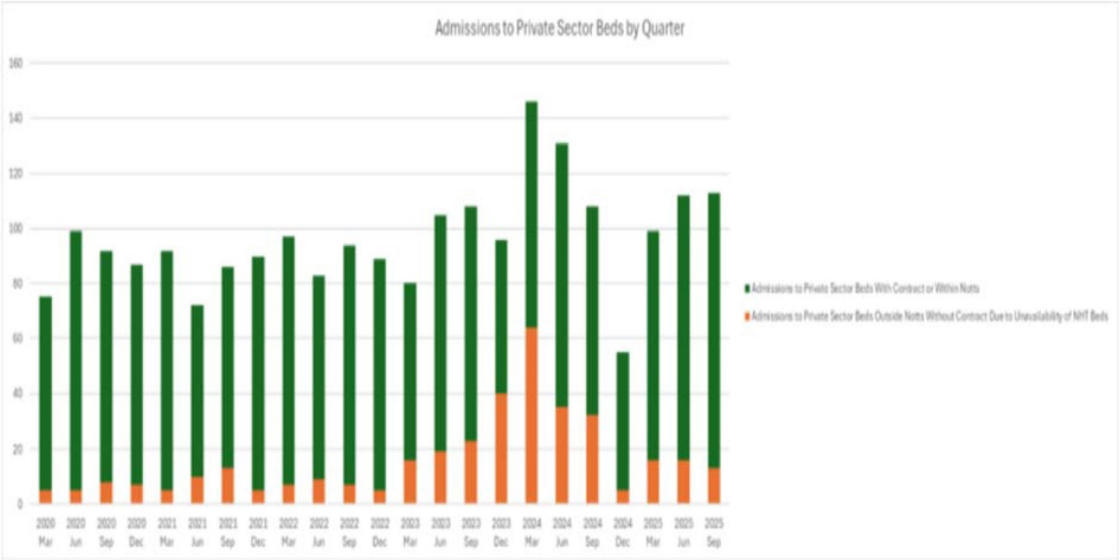
351. Alongside these factors, the use of these beds increases the risk of psychological and emotional harm as increases distress, isolation and impacts recovery. The systemic and long-term consequences are longer lengths of stay, a lack of continuity of care, and higher readmission rates.

352. Lord Crisp notes in his recommendations that out of area placements would not be tolerated for patients with physical health care needs and calls for parity of esteem.

353. In Nottingham and Nottinghamshire, there are 3 cohorts of beds for adults:

a. In our Trust, we have an adult bed base of 132 plus 25 beds in a private provider with whom we have a very close working relationship
b. In Nottinghamshire but out of the above Trust bed base, we use independent sector providers such as the Priory
c. Out of Nottinghamshire area, these beds are known as Out of Area beds.

354. Below is the number of patients admitted to private sector inappropriate out of area care since 2020 (orange) and those admitted to private sector contracted and in Nottinghamshire (green)



355. Current and recent use of out of area (Nottinghamshire) beds is very low as can be seen from the table above.

356. Our focused work on mental health inpatient care has been to reduce firstly reliance on out of area beds (cohort 3), now we are focusing on reducing the use of independent sector beds in Nottinghamshire (cohort 2) until we can rely on just our internal bed base (cohort 1). Our reason for focusing on reducing the use of independent sector beds in Nottinghamshire is that regardless of this being an in area placement, we recognise that patients who are placed with a 'new' (i.e. non Trust) service provider can experience increased distress, as can their families and carers as it is more difficult to maintain continuity of care.

357. As set out in the Witness Statement of Ifti Majid, it should be noted that there will always be appropriate use of out of area beds for example if any of our 11500 staff need admitting to maintain their privacy, dignity and confidentiality we have reciprocal arrangements with other providers.

358. In addition, 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 **[NHFT0017735]** 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", 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.

359. The Trust Board and Finance and Performance Committee receive regular reports and escalations on this workstream.

Impact of staffing levels and service capacity

360. I am aware that Ifti Majid has provided detail on this point in his Witness Statement and I endorse what he has set out. As noted above, it is important to note the difference between Out of Area (outside of Nottinghamshire) beds and the use of in Nottinghamshire Independent sector beds. Current and recent use of out of area (Nottinghamshire) beds is very low as can be seen from the table above.

361. Out of area placements are monitored very closely and discussed at ELT, Quality and Performance Meetings and the Board. There is a clear expectation these should only be used if clinically appropriate.

362. Since I have been in post, I do not believe staffing levels on our inpatient wards have directly affected the Trust's use of out of area placements or reliance on independent sector beds in Nottinghamshire. We have not had to close Adult Mental Health Trust provided beds due to lack of staffing.

363. We know that the number of admissions per 100,000 population is about in line

with the national average. However, our average length of stay is longer than the number of people who are medically fit for discharge but awaiting some form of follow up service such as accommodation. It is these last two factors in my opinion that mean we need to use independent sector to provide beds in Nottinghamshire.

364. Capacity and demand is complex, and in 2016, a report by the Independent Commission on Acute Adult Psychiatric Care, chaired by Lord Crisp **[WITN0263130]** found significant issues with patients being sent out of local areas and noted that rather than an issue with the number of beds per day the issue was driven by people being in hospital longer than needed and a lack of alternatives to admission.

365. Focusing on Nottinghamshire, while the evidence is clear about increased length of stay and people ready for discharge but awaiting a non-Trust intervention, we know that our community services are under pressure both local mental health teams and crisis teams. This pressure emanates from both increased demand and potentially from staffing-related issues. Not just vacancies but sickness and time away from work.

366. This is the way in which staffing issues can be linked to bed availability. Like many other organisations, the Trust is seeing high levels of complexity, people presenting with distress and illness related behaviours which require skilled often intensive interventions which can impact on both community teams and our inpatient services

367. Given the Trust's out of area placements are low, it is the use of independent sector to provide beds in Nottinghamshire that very much concerns the Board. Progress on the improvement plan, which forms part of our integrated improvement plan, is discussed at each meeting and we have had a series of deep dives in the use of beds at our Finance and Performance Committee.

368. The actions related to this programme of work include:

a. Admission process and alternative
b. Reduction in LOS - through effective ward rounds/MDT
c. reducing those who are clinically ready for discharge - through working with partners (Multi Agency Discharge Events)
d. Reducing cost of beds - contracting/income
e. Ensuring consistent processes/governance in place – such as bed meetings

369. As Chief Nurse, I am equally mindful of the quality of care when we place patients in the independent sector and minimally used out of area beds. We do have a quality oversight function and there are 2 processes by which we oversee quality in these beds:

a. The Bed Management team oversee 'individual patients' care when in an out of area bed using the continuity of care principles. Reporting goes through contract review meetings and there are Key Performance Indicators specifically related to out of trust beds.
b. Jen Thomson, is the Trust's dedicated central quality lead for this area, and she has oversight of 'subcontracted' now spot purchased beds at a provider level. She uses an established quality framework to assess quality and safety and supports providers to improve where required. This reports to the Quality Oversight and Effectiveness group which I chair and to the Quality Committee. The mental health Care Group have a daily review meeting to discuss all patients in out of area/independent beds – this is chaired by Care Group Director with a focus on discharge, care, interventions and purposeful admission

Concerns about inappropriate or premature discharge

370. There was a concern relating to the unexpected discharge from Priory Arnold in October 2021 when VC was discharged without the Care Co-ordinator or family's

knowledge back to his home address. In addition, there were concerns noted relating to the unexpected discharge from the community Early Intervention team to his GP in September 2022 as the family were not engaged, VC himself was not informed or seen face to face to understand his risks. This was included in the internal Serious Incident Review of March 2024 (Psychological Approaches) **[NHFT0000451]** and the Theemis report **[NHFT0000530]** made reference to the absence of robust discharge processes which resulted in limited consideration and effectiveness of transfer and the management of risk. Theemis also noted that disengagement is an accepted reason for discharge. I agree with the conclusions made within the reports that the discharge from the Priory and the EIP Team were inappropriate, and they were completed without the engagement of the family and/or the clinical team. Because of this, improving discharge is one of our key priorities and integral to the work we are completing within our Integrated Improvement Plan.

371. The incident was presented to the Significant Issues Review group on the 20 June 2023 **[NHFT0017700]** and the incident was included in the Reportable Issues Log to the Private Board on 27 July 2023 **[NHFT0001284]**.

<u>New discharge processes</u>

372. In light of service user disengagement, EIP procedures were revised to include the need of face-to-face review before discharge to another agency.

a. The EIP Standard Operational Procedure has been updated to include discharge standards which detail the requirement to complete face to face contact prior to discharge.
b. The Service Manager audit discharges from the EIP team each month to ensure standards are met. This has moved to electronic audit, becoming part of Care Group performance targets.
c. The EIP team have implemented a Quality Improvement project 'Good early engagement assists people remaining connected to the team'.

d. The transfer and discharge policy has been reviewed to ensure the voice of the community services is reflected in discharge planning from inpatient services.
e. The Trust has developed an electronic system which tracks people who are considered of high risk and have not been seen for more than one appointment so appropriate consideration and actions can be taken.
f. The EIP team have introduced a daily clinical risk meeting where patients of concern are discussed.

373. Clinical information sharing

a. The Continuity of Care policy has been updated with progress monitored through key performance indicators. [**NHFT0017708**]
b. Improved robust quality assurance frameworks to oversee services delivered by external care providers.
c. Introduced electronic patient discharge letters to enhance communication and the Notts Care Record is being implemented to support secure, joined up care across health and social care services.

374. Care planning

a. Introduction of the new Personalised Care policy to provide clear guidance on safety planning, risk assessments, care planning and discharge.
b. Clinical Harm risk training has been completed by 89% of community mental health staff to improve confidence and understanding.
c. Supervision policy updated to include a structured review of care plans and risk assessments.

375. Joint clinical decision making - we are part of the national culture of care project with a number of our adult and older adult wards participating in this. Alongside the national mentoring, support and workshops, we appointed a dedicated participation lead to ensure this work was co-produced and cofacilitated. One of the improvement pieces of work includes co production workshops to improve

inpatient ward rounds and MDT meetings.

Specific incident - GRO-B incident number GRO-D [Reportable Issue] [NHFT0000818]

376. The Inquiry has asked me about a specific case that was entered on the Reportable Issues Log on 28 November 2024.

377. GRO-B was sadly found deceased GRO-B had been open to Crisis teams and the Homelessness team prior to death. GRO-B had been known to Liaison and Diversion in June 2024 following GRO-C GRO-C , GRO-B

GRO-B

378. The incident was reported to SIRG on 24 September 2024 [**NHFT0017709**] and was included in the Exceptions Report to the Executive Leadership Team. The incident was included in the Reportable Issues Log presented to the Quality Committee and the Board of Directors on 28 November 2024. [**NHFT0000818**]

379. Whilst no immediate learning identified by the service during their review of this case, they did undertake safety action relating to disengagement as detailed below:

    a. All disengaging patients discussed in MDT and if discharge felt to be indicated, all other services involved in a patients care to be informed of this. All disengaging patients listed for discussion at MDT meetings which happen four days per week.
    b. The use of 3-day letters/texts discontinued in line with NHS England

[1] Section 136 of the Mental Health Act 1983.

guidance.

c. The briefing contained in the Reportable Issues Log is the immediate summary of the facts known within 72 hours to ensure there is appropriate notification to relevant commissioners and review any immediate safeguarding concerns requiring action.

380. The subsequent Safety Incident Review found that whilst GRO-D

GRO-D

381. The inquest for GRO-B is yet to be heard.

Family involvement in care and discharge planning

382. As part of the restructure of Care Groups, the Trust recognised that engagement is central to all improvements and therefore appointed an Associate Director of Participation, Co-Production, and Patient and Carer Experience to lead a co-produced carers Involvement Strategy which has included:

a. Appointment of a Carer and Family Participation lead who is leading the recruitment of carers peer support workers. There are currently 16 in post and 33 Carer Leads across all the Care Groups.

b. Development of carer and family information booklets

c. Have introduced a PCREF (Patient and Carers Race Equality Framework) steering group to lead on local implementation with NHS England support [NHFT0017711]

d. The importance of involving families is now included in the mandatory clinical risk training

e. Introduced a Patient and Carer reference group to provide advise on and oversee the trusts progress on the Integrated Improvement Plan from a patient, carer and family perspective. [WITN0263024]

f. Implemented Triangle of Care with carer awareness co-produced e-learning package developed which 1706 staff and volunteers have completed during the past three years. Care awareness and Triangle of Care is included in the mandatory training package for staff for inpatient settings. Care Groups complete a Triangle of Care self-assessment every 12/18 months and implement actions accordingly.

g. Compassionate Engagement training provided by the Family Liaison team which is aimed at those who have a lead role in engaging and involving people affected by a patient safety incident.

h. Face to face carers event held in February 2024

i. Involvement of families following a patient safety incident is central to the trust PSIRF training

Multi-agency working

383. Since joining the Trust on 31 July 2023, I have seen an improvement in our relationship with the police at all levels.

384. In Adult Mental Health services, we have a robust engagement / collaboration structure which has been strengthened considerably over the last 18 months and includes weekly meetings with the police, matrons, service managers and Care Group Nurse Directors to discuss any ongoing cases which are of particular concern or issues which have occurred over the previous week which need our attention. They also lead on the review of joint protocols and procedures - for example the Police and Criminal Justice Liaison policy, updated in June 2025 [**WITN0263069**], which identifies the need for regular liaison between the trust and police via the Police Local Operational Groups (PLOG) to enable joint oversight of investigations. These monthly meetings are separated in focus, one being for Community Mental Health whilst the other three review inpatient concerns/ cases.

385. The Trust are attendees of the Neighbourhood Offending and Risk Management Team meetings.

386. The Trust and Nottinghamshire police have a co commissioned post who works within the Mental Health Care Group; a Trust Partnership Officer who is a police appointed Police Constable. The role is funded by the Trust and has been in place for 18 months.

387. Within the community mental health team, we have established a regular interface meeting with the co-commissioned officer regarding any cases whereby mental health services required additional support and multi-agency input, this was established in early 2025.

388. Jointly the Trust is agreeing the Terms of Reference of a Potentially Dangerous Persons Panel. The group will share risks of individuals who are deemed a risk to others but do not meet the threshold of MAPPA **[NHFT0000424]**. The safeguarding service and the police have progressed the Potentially Dangerous persons panel which is due to be implemented in November 2025.

389. The Rampton Hospital is supported by a Police Local Operational Group, the groups role being to maintain consistent and regular liaison between the police and Rampton Hospital. It promotes partnership working, clear and effective lines of communication, joint learning and oversight of ongoing criminal investigations and prosecutions.

390. From a strategic point of view there are now meetings with the Patient Safety team with regards incident management and access to families where criminal prosecution is occurring, and with the Safeguarding team re sharing pertinent clinical risk information.

391. I meet monthly with Assistant Chief Constable Sukesh Verma. This meeting is not recorded. This is a relationship that has developed and strengthened quickly with us sharing information, concerns and thinking strategically about constantly improving how we work together. There is good collaboration, honesty and transparency and I often contact him outside of the more formal meetings if I need information or have any concerns. Examples of improved collaboration are his presentation at our Nursing and Lived Experience conference, and we have offered to support bespoke training required by the police.

392. In summary, the improved working relationship with Nottinghamshire police has enabled more cross organisation information sharing. There is an understanding of the responsibilities of each organisation in sharing information in regard to risk

where the person is at risk of committing or has committed a serious crime against another person.

Operational perspective for multi-agency working

393. From an operational delivery perspective there are points of tension where we often have escalations being discussed through various Integrated Care Board infrastructure, for example;

a. the nationally known lack of social care capacity which can cause delays in us being able to discharge patients from inpatient care in a timely way. This has been escalated and discussed directly with both Nottingham and Nottinghamshire Councils and through the ICB
b. The Right Care, Right Person (RCRP) is a Police partnership approach which aims to ensure that individuals in mental health crisis are seen by the right professional, to improve outcomes and the experience for people who need mental health support. It also applies to calls to Police regarding concerns about welfare.
c. There is tension around the availability and use of 136 Suites when the Police need to bring somebody into a place of safety. This is mainly due to the 136 suites being full potentially due to not having beds available to admit people who require detention post 136 assessments. Executives have occasions when they have to assist the availability through direct input and liaison with other services/ organisations.
d. Where a significant incident has occurred, the trust has a duty to be open and honest with those affected. This can cause tension where the police have concerns that our contact with families may interfere with their investigation and subsequent prosecution.

Legal perspective for information sharing

394. From a legal perspective and having the correct information sharing agreements in place I am unaware of anything escalated that suggests these are not correct or not suitable for the appropriate exchanging of clinical information to support good joint working.

Operational perspective for information sharing

395. On a day-to-day basis and when delivering patient care, staff are aware of a duty to share relevant information, where appropriate. This is to ensure the continuation and best care for patients and as necessary the public, especially where there is an urgent situation or when there are safeguarding concerns. These agreements do not limit the sharing of information, as and when it is appropriate to do so.

396. 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 GDPR. In the Trust's experience, some external bodies and clinical staff are sometimes too risk adverse 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.

Circumstances where the Trust would discuss patient care or information with family members

397. The Trust promotes sharing, involving and agreeing patients care and their care plans with patients' families. Generalised information and advice on care can always be shared. To enable the sharing with families of clinical information, confidential to the person, consent either verbally or in writing is sought. The onus

is on what, who and when the person is happy to share with the family to promote agreement. This requires staff to check at regular periods to ensure the patients opinion of sharing has not changed.

398. Where a patient lacks capacity to consent to sharing clinical information, there is an assumption that the patient would want the family to be kept up to date of their general condition unless they have previously indicated otherwise. The Trust promotes the use of advocates to enable patients to have advice and support to make these decisions.

399. There are exceptions where there are risks to the family/ and or public where limited clinical information would be shared in respect of the relevant risk. The exceptions are when harm to self or harm to others is evident.

400. Guidance is available through the trust policy on Information Sharing Between Professionals, Patients and Carers (08.01) **[NHFT0012786]** supported by training sessions offered by the Family Liaison team which assists staff to understand the differences between being open and duty of candour and therefore how to be open and transparent about the care they are providing.

401. The Reporting, Managing and Learning from Incidents policy (15.01) 2025 **[NHFT0012587]** includes a specific section on communicating to families involved in mental health homicides. It gives trust staff modes of communicating to include and share information with both the perpetrators and the victims' families.

VC's family

402. VCs mother raised concerns in the Theemis investigation (Independent Investigation into the care and treatment provided to VC) that she was not actively involved or communicated with in regards discharge planning. There were times when VC's mother was involved and included in the decisions around care,

however, there was no involvement or communication when VC was discharged from EIP Team.

403. The Reportable Issues log from 28 March 2024 [**NHFT0000455**] notes that VC's mother did not feel she had received the support required until this point. The VC Update presented to the Executive Leadership meeting 2 September 2024 that VC's family were visited at home on 30 July 2024 by the Chief Nurse and Family Liaison where a full report was shared.

404. In the course of providing this statement, I have been made aware that the summary of a meeting that took place between the Trust and the Calocane family on 30 July 2024 was not sent at the time, as intended. Following a follow-up request from Mrs Calocane, this has now been provided and a copy is exhibited **[NHFT0017443]** with the accompanying letter apologising for this oversight **[NHFT0017444]**

Victims and affected victims' families

405. The Reportable Issues Log on 30 May 2024 [**NHFT0000464**] referenced that NHS England and Theemis had met with the victims' families who had requested a copy of the Serious Incident report. The Trust were not included in this meeting. Advice was being sought from the trusts Caldicott Guardian, Information Governance and Patient Safety Team after consultation with the NHS England Homicide Team.

406. The Reportable Issues Log on 25 July 2024 **[NHFT0000486]** noted to ensure that the confidential details of VC and third party information was not shared; instead a Summary Report was written by the authors (Psychological Approaches) which contained details relating to the Trust's learning and actions. In addition, a redacted Terms of Reference for the Trust's Serious Incident investigation was to be shared.

407. The Reportable Issues Log on 26 September 2024 [**NHFT0000525**] notes following the meeting of the 6 August 2024 with the victims' families it was agreed to share the full Serious Incident report and makes reference to the 108 questions which had been received by the trust, as referenced in my First Witness Statement to the Inquiry, at paragraph 443 and the statement of Ifti Majid.

Overview of Improvement Work for Assertive & Intensive Treatment Within Adult Community Mental Health Teams

408. As explained above, following receipt of the first part of Care Quality Commission Section 48 special review work commenced on developing key areas for improvement. Alongside this there was also wider care unit and Care Group structural changes with the introduction of triumvirate leadership teams including new roles such as Care Unit and Care Group Associate Director of Nursing, Allied Health Professionals & Quality for mental health community services who's focus, and drive would include the forthcoming improvement works for Assertive & Intensive treatment within community mental health services.

409. Guidance was published by NHS England in July 2024 [**NHFT0017445**] functioned as a request for local integrated care boards and providers to review their Assertive & Intensive treatment services to inform local improvement plans and return the outcome of the review by Q2 24/25.

410. The Trust facilitated a workshop on the 9 September 2024 which was completed with key partners, and staff to complete a self-assessment against the NHS England Assertive & Intensive Maturity Index and developed an improvement plan.

411. The review identified that out of the 14 core domains, 3 were rated as being in

place and working well which included Governance, policy and legislation. The remaining 11 domains were rated as yes as being in place but needed improvement.

412. **"Function, Clinical Pathway & Workforce:** Attention needed for workforce ability to sustain assertive approach, responsiveness and caseloads. Clinical pathway predominantly met requirement but needs improvement for access to Psychological interventions, pathways for complex cases, forensic working, wider community services and street outreach approach. Workforce in place but most areas need improvement such focused training for A&I approach, pathway design (not currently ring fenced), clinical model.

413. **Risk Assessment & Legislation:** Key area of improvement is risk training & formulation, positive results for safeguarding. In terms of legislation more work is needed to provide assurance regarding Community Treatment Orders ("CTOs") and adherence to policy.

414. **Interface & Recovery**: Covered with Trust procedures but more work needed to

embed within clinical model and community approach. Bespoke work needed for patient Outcomes, working with families and patient coproduced careplans.

415. **Diversity**: More work required to ensure workforce diversity to meet patient needs, informed by data and networking, positive for staff training.

416. **Medication**: overall met however improvements needed regarding oversight of compliance with medications / side effects.

417. **Experts by Experience:** key areas met but work to be done regarding Peer Support Worker ("PSW") / Lived experience involvement with policy & coproduction.

418. **Discharge & Data:** Discharge policy specifically in place for this cohort, oversight of discharges via Patient Tracker List ("PTL") however improved oversight required for assurance. Data field requires focused work which will be linked to the clinical model.

419. **Policy:** All areas working well and met.

420. **Governance:** Majority of areas have been met however further improvements ongoing such as PSRIF, learning events & shared practice sessions.

421. Following the review, it was also agreed to have a focused steering group for the oversight and delivery of Assertive & Intensive treatment improvement work that would report into the Adult Community Oversight and Assurance group. **[NHFT0017446]** A paper was developed and presented to the Trust Executive Leadership Team on the 18 September 2024 **[NHFT0017447]** and to the Integrated Care Board meeting by the ICB on the 14 November 2024 **[NHFT0017451]**.

422. As per identified within the review an Assertive & Intensive Oversight and Assurance Group was established on the 25 October 2024 by the newly appointed Care Group Nurse Director for community mental health services with the purpose being to plan, oversee and ensure completion of key improvement work. The improvement plan was also shared and discussed within the NHS England Improvement, Oversight & Assurance group identifying the outcome of the review, any gaps and key actions for improvement [**NHFT0017452**].

423. On the 28 October 2024, the outcome of the review for Assertive & Intensive treatment was discussed within the Rapid Improvement Board for ongoing oversight and reporting governance. [**NHFT0017453**] The outline of the review and Maturity Index was discussed. A timeline of subsequent key points, reviews and work is outlined below.

- 06.11.24: Trust & ICB meeting following NHS England request for any funding requirements to deliver Assertive & Intensive treatment
- 07.11.2024: Improvement plan and progression of works discussed and updated within Community Improvement Group
- 08.11.2024: Outcome or review and Improvement plan presented to partners at Nottingham Community Safety
- 13.11.2024: NHS England funding requirement submitted. [**NHFT0017468**]
- 15.11.2024: Progress update presented to Local Mental Health Team Rapid Improvement Board [**NHFT0017469**]
- 26.11.2024: Progress update discussed at Care Group Accountability meeting. [**NHFT0017491**]
- 27.11.2024: Progress update and wider benchmarking update discussed in Regional Assertive & Intensive treatment meeting [**NHFT0017492**]
- 10.12.24 Outcome of review of Assertive & Intensive treatment discussed within Trust Quality Committee alongside action plan.
- 02.01.2025 Progress update reviewed and discussed within Community Improvement Group [**NHFT0017493**]
- 08.01.2025: Progress update reviewed and discussed within Rapid

Improvement Group [**NHFT0017494**]

- 22.01.2025: Development and launch of Assertive & Intensive clinical dashboard which identifies patient group, risk assessment compliance, last seen, DNA rate and EDI date regarding patient group [**NHFT0017497**]
- 28.01.25: Progress update within Care Group Accountability meeting [**NHFT0017498**]
- 29.01.25: Progress update and outcome of review shared and discussed within regional meeting. [**NHFT0017499**]
- 05.02.25: NHS England correspondence from Clare Murdoch & Dr Adrian James to ensure review of actions plans to date and ensure actions including learning from the Independent homicide review of Nottingham tragedies. [**NHFT0017500**]
- 06.02.25: Progress update and review of outstanding actions discussed within community improvement group. [**NHFT0017502**]
- 12.02.25: Progress update discussed within Rapid Improvement Group. [**NHFT0017503**]
- 26.02.25: Progress update, Bench marking exercise discussed and national review update discussed [**NHFT0017526**].
- 06.03.25: Progress update and plan reviewed and discussed within Community Improvement Group. [**NHFT0017527**].
- 23.04.25: attendance at regional AO meeting [**NHFT0017528**]
- 29.04.25: AO update position given in Care Group accountability meeting. [**NHFT0017534**]
- 30.04.25: Joint Trust & ICB AO update paper based on progress review presented to Executive Leadership Team. [**NHFT0017535**].
- 30.04.25: Joint Trust & ICB meeting to review AO action plan in line with Nottinghamshire independent homicide review to ensure action plan covers all learning from Nottinghamshire Homicide review
- 15.05.25: AO review and improvement plan progress presented to Trust Quality Committee. [**NHFT0019581**]
- 27.05.25: AO Update reported into Care Group Accountability meeting. [**NHFT0017537**]

- 28.05.25 Joint ICB & Trust AO Oversight and Assurance meeting to review action plan and progress.

- 18.06.25 Joint ICB & Trust meeting with G. Owen, Care Group Nurse Director, Shaiyan Rahman (ICB Deputy Medical Director & Kate Burley ICB Deputy Head of Mental Health Commissioning to discuss profiling report used to identify AO patients.

- 23.06.25 Joint ICB & Trust AO oversight & Assurance meeting against improvement plan and developments alongside review and planning for submission of new NHS England benchmarking document [**NHFT0017538**].

- 24.06.25 AO challenges reported on Care Group Accountability report. [**NHFT0017540**]

- 25.06.25 Attended and presented at the regional AO meeting around the work Nottinghamshire has done in relation to mental health & Homelessness. [**NHFT0017541**]

- 28.06.25 AO Oversight & Assurance meeting completed jointly with ICB. Overall progress reviewed, timelines and evidence review. [**NHFT0017542**]

- 27.08.25 Trust & ICB jointly reviewed the progress of AO and Risk Training and agreed the completion of the NHS England benchmarking document. The key documents from the review and the papers reviewed at the meeting are exhibited here. [**NHFT0017545, NHFT0017546, NHFT0017547, NHFT0017548**]

- 03.09.25 AO benchmarking review paper completed and reported to Executive Leadership Team. [**NHFT0017549**].

- 10.09.25 AO benchmarking review reviewed and discussed within regional meeting. [**NHFT0017551**]

- 30.09.25 AO Oversight & Assurance meeting. Reviewed progress to date and updated overall improvement plan. [**NHFT0017553**].

- 09.10.25 AO review as completed in September 2025 and reported in Appendix ZC discussed and presented at Trust Quality Committee. [**NHFT0019582**]
- 22.10.25 Attended Regional AO meeting and presented work developed by Nottingham services in relation to AO – Medicine reconciliation and working with families. The agenda and both presentations are exhibited here. [**NHFT0017556, NHFT0017557, NHFT0017558**]
- 24.10.25 Attended NHS England Trust Improvement, Oversight & Assurance meeting to present progress on AO improvement plan and deep dive [**NHFT0017559**].
- 30.10.25 Trust AO Oversight & Assurance meeting to review progress, evidence and update overall improvement plan. [**NHFT0017560**].

November 2025 Update Position

424. Work has progressed well to date in line with the Improvement plan. The clinical pathway for people that require assertive & intensive treatment is at the heart of focus of intervention. Work has been completed to identify patients that may require assertive & intensive treatment, and this patient profiling is part of business-as-usual oversight and reporting. Improved governance of the input that people are receiving in relation to assertive & intensive treatment and now forms part of business-as-usual quality and safety reporting via a weekly oversight group. In terms of workforce we have aligned a number of staff to work dedicated to this pathway to support and enable intensive input with wider plans in scope to move to a dedicated team as the next step currently anticipated for Q4 25/26.

425. In terms of workforce, we have developed a bespoke training needs analysis and training delivery plan. Work has been completed regarding having clear quality and safety standards regarding transfers of care from this pathway and quality standards in relation to the delivery of personalised care which has demonstrated good compliance from the completion of quality audits. Further work is planned in relation to Quality Improvement work to continue to strengthen and improve

patient involved, and further enablement strategies to meet the needs of local populations from an Equality, Diversity & Inclusion perspective. Additional digital dashboard oversight is planned to capture frequency of medical reviews anticipated to be in place by Q425/26. Overall, we have a much improved governance structure to ensure oversight, escalation for support and oversight of clinical interventions in line with the personalised care framework with clear operating guidance and no discharges from services due to dis-engagement.

Reviews commissioned following the attacks on VC

426. I have set out the background of the reviews and investigations commissioned following the attacks by VC at paragraphs 496-513 of my First Witness Statement and provide additional detail about my personal involvement here.

A Level 2 StEIS investigation in relation to VC

427. I commenced the Chief Nurse role on 31 July 2023. Part of the responsibilities of my role is to oversee Patient Safety and Quality, and therefore I was updated as to the discussions in relation to the Serious Incident Investigation being commissioned and organised. On the 29 June 2023 the Trust leads, led by the Acting Chief Nurse, met with the NHS England Regional Homicide Team and agreed that a Level 2 Serious Incident Investigation be completed by a panel chair external to the Trust who was on the NHS England Framework of approved reviewers.

428. Psychological Approaches were commissioned by the Trust that same day with internal panel members without personal knowledge or contact with VC care to assist – experienced mental health senior nurse and a forensic consultant psychiatrist.

429. This detail was reported through the Reportable Issues log 27 July 2023, presented by the then Acting Chief Nurse to the Board of Directors. **[NHFT0001284]**

430. The Terms of Reference were shared with me on 7 August 2023 after agreement from the NHS England Regional Homicide team. I was aware that due to the criminal investigation, the police had only allowed sharing of the medical notes with the investigation team on the 26 July, however the Trust was further advised on 7 August 2023 **[NHFT0012612]** that no investigation was permitted. The police only allowed the review of notes from 2 October 2023 **[NHFT0012612]** and staff to be interviewed from 14 November 2023. The families were not allowed to be contacted.

431. On 7 February 2024, Psychological Approaches met the Care Group Director, the Deputy Chief Nurse and myself to share the draft report and to provide comments **[TCLT0000818]**.

432. On 15 March 2024, the Trust received the final report and shared with the ICB and NHS England **[TCLT0000818]**.

433. On 18 March 2024, the investigation report **[TCLT0000818]** was shared with my executive colleagues and the Private Board on 28 March 2024 [**NHFT0000455**] together with a draft action plan and the proposed NHS England Theemis Homicide Investigation Terms of Reference. I presented the report highlighting several points of learning and subsequent discussion by Board members.

434. The VC update report (Board paper) described the learning points highlighted from the report. In brief the learning and findings concerned:

    i. Documentation and decision making

    ii. Discharge planning

    iii. Clinical Judgment and positive risk taking

435. Additional Learning points included:

    iv. The Standard Operating Procedure to describe relationship between CRHT and EIP

    v. Consideration as to the diversity and cultural implications for service users including monitoring of the MHA and use of depot medication

    vi. Consider urinary testing to confirm adherence to medications

vii. Clear process of discharge from private out of area hospitals

436. A Team brief was written and a Team Feedback meeting facilitated by myself and the Chief Executive took place on 18 March 2024 **[NHFT0017561]**. The face-to-face meeting shared the brief and action plan and was attended by the report authors, myself as Executive Lead, the AMHs Leadership Team and the clinical teams involved. A single addendum was added to the report on request of the Trust to ensure all areas of risk indicators are included.

437. Progress of the implementation of the SI action plan which had 4 overarching recommendations and 10 learning points is through the Complex Incidents Oversight Group.

438. The actions taken by the Trust to date have included:

a. New mandatory risk assessment training implemented which includes risk to others – Community mental health Teams are 89% compliant
b. Trust wide clinical Risk policy developed
c. EIP Standard Operating procedure amended to include
    a. Actions to take if a person is disengaging from the services
    b. Standards for discharge which includes the need to complete a face-to-face assessment
    c. Daily Team Risk meeting in place to review patients who are considered at risk
d. Quality of discharge has been audited by the Service Manager and actions taken if discharge standards have not been met
e. EIP Quality Improvement project focusing on early engagement with the team to enable ongoing contact with the team
f. EIP Staff supervision template revised to ensure that care records are reviewed as part of the process. This has now been included in the revised Trustwide Supervision policy
g. Learning event facilitated in August 2024 attended by over 80 staff which was chaired by an external facilitator and included local and external speakers.
h. To support information sharing with other health care providers, an electronic discharge summary has been developed and went live on

03.11.2025. Prior to this, the EIP Team developed a proforma for discharge letter to the GP

i. Readmissions are reported and reviewed as part of the Safenow dashboard
j. Quality Assurance framework for subcontracted beds in place, supported by Continuity of Care Principles for Out of Area and spot purchase beds

439. The remaining action that is in the process of being implemented is quality standards for MDT meetings and ward wounds for inpatient services.

CQC section 48 review

440. On 26 January 2024, the Trust was notified that a section 48 special review would take place. The intention and the detail was formally published on 30 January 2024, clearly stating there would be two parts to this review, with Part 1 focusing on patient safety and quality of care at the Trust and progress made at Rampton Hospital. The CQC set out that Part 2 would focus on the care and treatment of VC and exploring wider patient safety concerns or systemic issues at the Trust with a review of 10 further cases. Requests for information started on 6 February 2024 [**WITN0133035**] and Part 1 was published in March 2024 and Part 2 in August 2024 [**CQCM0016517**].

441. There were a number of key findings identified with recommendations from both Part 1 and Part 2. I have covered the detail of this review in paragraphs 490-495 of my First Witness Statement.

Theemis report

442. I have given the background and update on the Theemis report in paragraphs 508-512 of my First Witness Statement and do not propose to set them out again here. The Executive Leadership Team received a draft of the Theemis report and

action plan in January 2025 [**NHFT0017562, NHFT0017563**]. The ELT, Quality Committee, Trust Board and NHS England Improvement Oversight and Assurance Group have received papers on progress since this time.

443. Theemis interviewed clinicians involved in VC's care, Executive Leads [**TCLT0000821**], the NED Chair of the Quality Committee and corporate staff who oversaw out of area placements.

444. To ensure the trust had sufficient oversight of both the internal Serious Incident investigation and the Theemis investigation, the Homicide and Attempted Oversight Group (now Complex Incidents Group) was established in June 2024. This was to provide executive oversight and governance of significant incidents, chaired by myself (Chief Nurse) co-chaired by the Deputy Medical Director and Nursing Directors. With the senior trust clinical leads, we monitor progress of PSIIs and any emerging risks, review completed drafts to ensure key areas of learning have been identified and ensure staff and family support is in place.

445. There were 12 recommendations, 2 of which were for NHS England, 10 of which were for the trust (3 also involving the ICB). In summary, the key areas of learning:

    a. Implement the recommendations from previous reviews (SI and Section 48)
    b. Review the Serious Incident policy to ensure it reflects PSIRF
    c. Define positive family engagement looks like and develop effective process' to support
    d. Develop systems and process' to enable sharing of risk information across clinical care settings
    e. The Trust, ICB and police should come together to review the effectiveness and reliability of communication processes
    f. Governance arrangements to be improved to ensure risks are known
    g. Policy development and reviews to ensure current and reflect the work undertaken by the trust
    h. Peer support – the trust must ensure there is a robust peer support offer for people
    i. Care planning to involve individuals and their families and introduce systems to ensure it is occurring

j. Joint decision making, focussing on the need for inpatient and community services to work together to result in a cross system understanding of how risks differ in the two settings

Referrals to the NMC in respect of nursing professionals who provided care to VC

446. A professional review of nursing practice was carried out in August 2024, overseen by the Deputy Chief Nurse and reported to me as Chief Nurse **[NHFT0017564, NHFT0017565, NHFT0017566, NHFT0017574]**. The purpose of the review was to establish if improvements and further actions were required in relation to the professionals involved in VC's care. Clinicians involved in VC's care were from a nursing and medical background (no Allied Health Professionals actively inputted) therefore the review was completed by senior nurses from the Patient Safety team and the Associate Medical Director. It considered:
    a. The chronology of clinical events created by a Registered Nurse Patient Safety Manager – which was further developed to enable a review of individual professional practice
    b. Complaints and inquiries which had been received in relation to specific professionals
    c. Statements available or obtained through the review
    d. Clinical notes
    e. Codes of Practice related to relevant professionals:
        i. General Medical Council - Good Medical Practice (2024) **[NUHT0000045]**
        ii. Nursing and Midwifery Council. The Code – (Jan 2024) Professional standards of practice and behaviour for nurses, midwives, and nursing associates **[NUHT0000058]**
    f. The following Trust policies:
        i. 10.14 (Version 4) Maintaining High Professional Standards in the Modern NHS (Secretary of State 2005) which outlines the procedure for handling concerns about doctors' conduct, capability, and ill health. This policy refers to the Trust's 10.10

Conduct Policy and Procedure **[NHFT0018402]**

ii. 10.10 (Version 11) Conduct Policy and Procedure – 7.1 & Appendix 1 - Expected Standards of Behaviour Gross Misconduct – ill treatment or mishandling of service users or carers or any other form of negligence, including dereliction of duty and for the avoidance of doubt, sleeping whilst on duty **[NHFT0017713]**

447. This review found that the practice of two nursing registrants were considered not to be in line with requirements of the NMC Code of Practice, and therefore further information including statements were obtained. The areas of concern were documentation, evidence of consideration of risk and sharing of risks with external partners:

448. The professional review specific to nursing was presented by the Patient Safety Lead to the Operation, Clinical, HR and Patient Safety Leads overseen by the Chief Nurse in September 2024 and as a consequence formal and informal actions were implemented in relation to robust supervision, reflective practice and case load management were implemented in relation to 1 nurse (Team Leader SH) and a formal investigation into GC (VC's most recent care co-ordinator) was commenced.

449. The professional review was shared with the Executive Leadership Team in September 2024 **[NHFT0017580]**.

450. A formal investigation into GC was commenced, however due to his subsequent absence from work (sickness), the formal process was protracted. On 20 August 2025, the Associate Director of Operations wrote to GC confirming the outcome of the conduct investigation confirming that after investigation the trust confirmed that there was evidence to support the following allegations **[NHFT0006105]**:

a. You did not recognise Patient V's serious mental illness, his

symptomology and risk factors and implement robust patient safety plans.

b. You did not identify Patient V's poor engagement and non-concordance with prescribed medication and the impact that this had on his mental health and risks.
c. You did not follow up on actions relating to Patient V's care, including discharge.
d. There was inadequate documentation of risk, including care plan and risk assessment.
e. You did not act in accordance with expected standards of professionalism and accountability.

451. As GC had already resigned without notice from the employ of the Trust, a full disciplinary hearing would not have been appropriate. The letter relays that a formal referral to the NMC was to occur.

452. The NMC referral was submitted on 13 August 2025 [**NHFT0017581**]. The NMC indicated that they are undertaking a Fitness to Practice investigation (Ref 107457/2025), which is ongoing [**NHFT0017581**].

453. Once the formal investigation for GC was completed, a further review of all the nurses who had contact with VC was conducted to ensure that all factors were considered and taken into account. This led to further inquiries into 2 nurses (Team Leader SH and Community Service Manager ER), 1 of whom was involved in the initial review, in relation to oversight and management of the discharge process.

454. A further meeting was undertaken on 1 August 2025, led by me, to assess the areas of practice identified for further review of the 2 nurses. This meeting concluded that no further formal processes were to be pursued by the Trust and robust management and oversight was in place. However, we requested that the NMC consider a supportive review of the conduct of the 2 nurses, and documents were submitted to the NMC on the 20 August 2025 [**NHFT0017714**]. We are

awaiting the outcome of this.

455. There was a meeting of Extra Ordinary Improvement Oversight and Assurance Group on 13 August 2025 where leads the Trust, NMC, and NHS England in attendance convened to oversee/ agree the above plan [**NHFT0017582**].

Other actions taken in response to the attacks committed by VC

456. The learning from this tragic incident has been significant and were summarised in the 15 May 2025 Quality Committee presentation/ paper **[NHFT0015033]**

Clinical Leadership

457. Although they were not introduced as a response to the attacks committed by VC, the introduction of Care Groups has been significant. Each Care Group Nurse Director has a specific role alongside the Associate Medical Director to lead on quality, safety, patient experience and clinical governance. This is mirrored at care unit level with an Associate Director of Operations, an Associate Directors of Nursing and a Clinical Director. This model ensures we are clinically led with a relentless focus on the clinical context and quality.

458. In addition to this we have seen Community Matrons increased in core community services, their role being to be available to support and provide clinical expertise to teams.

Service and homicide reviews

459. I have set out the full details of the service and homicide reviews commissioned by the Trust in response to the attacks committed by VC, in paragraphs 496-507 of my First Witness Statement.

Assertive Outreach / engagement

460. In July 2024, NHS England tasked Integrated Care Boards (ICBs) to review community services for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge. The Trust has an Assertive Outreach Oversight Group who meet weekly to oversee pathway developments and includes the ICB. A role of this group is to oversee the completion of the national maturity index (benchmarking tool) to assess the service provision for patients who require an assertive outreach approach. Based on the results, an action project plan was created to improve and strengthen the

current service provision. These include:

461. Development of the pathway's internal standards (expected contact frequency)
462. Pilot for personalised care plans co-produced with people who have lived experience – Personalised Care Policy based on national guidance currently (November 2025) being consulted on.
    a. Introduction of Patient Rated Outcome Measures (PROMS)
    b. Commissioned specific psycho-social intervention training
    c. Patient and listening events delivered
463. Development of a specific Assertive Outreach clinical dashboard which includes total patient demographic, compliance with risk assessment and care plans and the number of appointments not attended. This information is reviewed weekly to ensure robust and assertive plans are in place alongside the opportunity to escalate any need for additional support

Clinical Risk

464. The existing clinical harm and risk training has been enhanced to provide face-to-face interactive scenario based on the staff's area of clinical practice. It includes key concepts such as risk to others, domestic violence, risk formulation, involvement of families, inclusive of longitudinal consideration and how this supports the development of robust risk management plans.

465. The Trust developed a new Clinical Risk and Safety Policy (October 2024) **[NHFT0003231]** which provides governance and oversight of implementation and escalation of clinical risk and safety issues.

466. Change in role of Trust Lead for Suicide and Self-harm – role now Nurse Consultant for Suicide, Self-harm and Clinical Risk and Safety therefore including risk to others.

467. Further amendments to RIO systems in progress to improve understanding of expectations, improve accuracy of documentation and to avoid unnecessary duplication.

468. Compliance with Clinical Risk and Safety Policy is measured and monitored through the newly introduced SafeNow program. SafeNow is scrutinised weekly and now includes compliance with safety plans using Audit Management and Tracking (AMAT). This will continue to be scrutinised weekly alongside clinical practice and improvement work with monitoring and oversight through Quality Oversight Groups. An Exceptions Report is shared weekly with the Executive Leadership Team.

469. Next steps are the development of joint supervision with Safeguarding Specialists to support access to supervision and support around clinical risk and safety issues.

470. Trust Safety Planning guidance has been updated to include NHS England guidance published in early April 2025. [**NHFT0017583**]

Updated Clinical Risk and Safety training

471. The trust has updated clinical risk and safety training to include the principles of personalised care and clinical risk and safety assessment and formulation, management and safety planning [**NHFT0015073**]. It uses tailored case studies to revisit throughout sessions with a focus on longitudinal assessment.

472. The training is now face to face, moving away from e learning to enable discussion and active staff contribution.

473. Training delivery plans have been implemented in stages, to allow the content to be adapted for different clinical areas and co-produced / co-delivered with Learning and Development and clinical leaders.

474. Targeted training for community teams includes additional focus on:
    b. Clinical risk and safety issues in the community

c. Engagement issues
d. Managing risk and safety as a team
e. Managing risk and safety with others (outside the team)

Disengagement and discharge

475. The Trust policy Did Not Attend/ Was Not Brought/ Cancellations and Management of Patients who Disengage from Trust Services (01.01) **[NHFT0017584]** now includes expected actions and standards for clinical teams in the event of non-engagement. These standards have been interlinked with the weekly SafeNow measures which identifies any patients who have been discharged due to non-engagement. Every single patient is reviewed and safety, appropriateness discussed with safety mitigations put in place.

476. The focus of training was set out in policy is to ensure disengagement is not a reason for discharge with greater emphasis placed on the clinical team to ensure patients continue to be involved in their care.

Equality and Diversity

477. The 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.

Families

478. 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.

479. Staffs understanding of Duty of Candour has been increased by the Family Liaison team by active support, expertise and mentorship – creating an environment where staff feel confident in having more sensitive conversations, being open and transparent. This has enabled the adherence and closure of regulatory Duty of Candour incidents from 1008 (April 2024) to all being closed

within timeframe (March 2025). 'Compassionate Engagement' training following incidents with patients and families is the focus of monthly Family Liaison and PSIRF training, supported by standards in the new Reporting, Management and Learning from Incidents policy (15.01) **[NHFT0009283],** PSIRF policy and plan. The new policy incorporates specific guidance for engaging all families involved in Homicides – providing methods for communication to both to the perpetrator and victims' families.

480. A feedback survey has been collated from the families involved in communication with the trust post an incident via the Family Liaison team. The findings are to be presented to the Quality Committee November 2025 in the Family Liaison paper. Overall, the responses from the families were positive with the majority people responding agree or strongly agree to the multiple-choice questions. The improvements include developing a range of information leaflets to support families further.

481. Bimonthly meetings with the police, HR colleagues and the Patient Safety Team have enabled the Trust to have flexibility of contact with families even when a criminal investigation is occurring – all families have access to the trust Family Liaison Team for support and information with the ability to explain the constraints or sharing information where it may risk the criminal proceedings. The Chief Nurse has regular touch point meetings with Nottinghamshire Assistant Chief Constable which has assisted cross organisational working and communications.

482. The recently reviewed June 2025 Police and Criminal Justice Liaison policy **[WITN0263069]** between the Trust and police makes expectations of communication explicit, in addition to enhancing joint working with police where there are specific patient risks that require further cross organisational understanding/ actions. The trust safeguarding team are agreeing a defined process of sharing risk information with police where there is risk evident but does not reach the threshold of requiring MAPPA oversight.

483. The Trust is focussing on the language and approach used, so the focus is person centred and compassionate and opposed to being operationally led.

484. In summary, the family is now involved in all aspects of a review. They receive draft Terms of Reference for comments where they can include their questions/

request for clarification. Final reports are shared in draft prior to submission for their oversight and corrections. Where there is more than one inquiry, the internal trust teams work cohesively to provide a single open response written in a manner that supports the families understanding.

Patient Safety

485. Post the VC incident an external review of the Evaluation of Safety Processes at the Trust was commissioned (with Helen Collins as chair), as set out earlier in this statement.

486. With the introduction of an enhanced Patient Safety team, the Trust now has Patient Safety Managers attached to Care Groups to provide expert knowledge, engagement and challenge, Patient Safety Partner to make the voice of the patient inclusive of discussions/ decisions and dedicated reviewers with specialist training to complete all the investigations of complex cases in the trust. The premise is to enable a Safety Culture by supporting an open environment for staff to raise and learn from experiences.

487. The team is moving the Patient Safety agenda from incident management to incident mitigation and emphasising the importance of patient safety in clinical care – not just a response when things do not go as planned. The team facilitates learning events, inclusively written bulletins, After Action Reviews for active and immediate learning in teams which provide a safe, non-hierarchical environment to share perceptions. A trust Patient Safety Strategy has been developed and is currently going through consultation.

488. In January 2024, the Trust commissioned an external Thematic Review of Homicides and Attempted Homicides (chaired by Jonathan Warren and involving national clinical experts). The detail of this is set out in my First Witness Statement at paragraphs 504-507.

489. Specific to VC, the Patient Safety team are leading on both trust wide and local team learning events to feedback what impact this has for both individuals and the trust. These have provided staff ability to contribute and comment on briefings and action plans. The Chief Nurse has shared the trust learning, actions and impact at the regional Chief Nurse event, the national Chief Nurse event and with

the Boards and staff at Tees Esk and Wear, and Southwest Yorkshire mental health trusts. There has been 31 Leaning Events, the majority being face to face to feedback the learning and actions taken with further planned.

490. To provide independent evaluation of the Trusts implementation of Patient Safety Incident Response Framework (PSIRF) and related actions from the Evaluation of Safety process, in April 2025, an audit was completed by 360 Assurance which demonstrated significant assurance **[NHFT0017433]**. It found the trust had introduced a suite of resources to support staff which capture the Trusts commitment to the new way of working. The Patient Safety Team had expanded in size, confidence and knowledge and was able to demonstrate learning from incidents and how this informs quality improvements. Further actions are to implement the recently developed training package for clinical staff on PSIRF policies and processes with projected targets of adherence.

491. The Ulysses system now contains a dashboard for all staff to make available incident data to understand where to focus change initiatives.

492. A conference was held 3 June 2025 **[NHSE0002219, NHFT0017586]** which focuses on all the learning from VC, including family feedback, compassionate engagement with patients and staff affected by complex incidents, introduction of Safety 1 and 11, national learning from homicides and inquiries.

493. Jacqui Dyer – (an independent health and social care consultant, with lived experience, and a background in adult mental health commissioning) spoke at the Trust Carers Conference and has committed to supporting Patient and Carer Race Equality Framework work. We have as part of the integrated improvement board work established a patient and carer reference group in partnership with Healthwatch, which ensures patients, families and carers are not just influencing but part of all our improvement workstreams.

Governance

494. The 360 Assurance audit notes 'the governance of PSIRF evolved during the first year of implementation to meet the needs of the Trust. It includes clear oversight of the patient safety priorities and learning responses to incidents. Each priority has named leads and governance routes, and this enables the Trust to drive

forward actions and report their progress regularly.' **[NHFT0017433]**

495. Examples of this are:

a. A review of the weekly Serious Incident Review Group (SIRG) to include Safeguarding, Legal, Freedom to Speak Up and Complaints team to both inform and commission actions in response to clinical incidents. Reported weekly to the Executive Leadership Team meeting.
b. Introduction of the Patient Safety and Learning from Deaths Group (chaired by the Chief Nursing officer) where trust learning and actions are reported from the newly introduced Care Group quality meetings, the Safety and Experience meeting.
c. Complex Incident Group where the highest risk incidents are discussed and actioned
d. Daily Incident Management group and Trustwide Safety huddle which established clinical risks, ensure they are shared and works cohesively to establish safety actions
e. Learning from Deaths, introducing the Medical Examiner and Mortality processes and panels to learn from the deaths of people to improve lives.
f. The quarterly Learning from Deaths paper brings together all learning from incidents in relation to deaths – specifically Inquests, Safeguarding domestic homicide reviews and PSIRF actions.
g. Bimonthly Patient Safety Exceptions, report which includes high risk incidents, Inquiries and actions from legal, safeguarding and complaints teams. This is presented to the Quality Committee and Private Board for information, notes actions, and provides updates.

Reflections

496. The Trust has stated publicly, and in paragraph 444 of my First Witness Statement, and I reiterate it 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. My reflections are necessarily informed by that underlying position. As stated in paragraph 445 of my First Witness Statement to the Inquiry, 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.

497. I refer the Inquiry back to the table of reflections at paragraph 446 in my First Witness Statement, the content of which I support.

Additional actions the Trust could have taken

498. The findings, learning, considerations and recommendations from the three reviews into the care and treatment of VC have been extensive and as can be seen from the evidence submitted, this been a driver for action and sustainable improvements in so many areas across the Trust.

499. In reflection, I do think we should have considered peer support worker allocation at an earlier stage in VC's care. I believe the engagement, connection and support from someone who had lived experience from the same cultural background could have supported engagement, and the opportunity to support insight, awareness and compliance with treatment options. In addition to this, family interventions were not formally offered where the evidence shows outcomes for this are very positive. In addition, this would have supported his family and enabled the use of a range of interventions.

500. The reviews have highlighted the importance of risk assessment and reduction strategies, longitudinal risk in the context of risk to others and the need to manage relapse. These, alongside not exhausting all treatment options, and the lack of consideration in the decision making process of discharge are the pertinent actions we could and should have taken.

Information from and with external agencies or persons

501. Reviewing and reflecting on the information now in the public domain, I do feel there were areas that from my understanding we were not aware of that may have changed our risk profiling, involvement and possibly some of our decision making for example:

    a. We were not told about VC's failure to attend Court
    b. There was a violent incident at work which we were not aware of
    c. I am not sure we were fully aware of the detail and impact of incidents in the community, in particular the incident where VC entered someone else's accommodation and they jumped from a window, the assault on police officers and the incident with people he was flat sharing with. Although we had the summary, I am not sure we had the level of detail regarding his intent and impact.

502. The Trust accepts in full the findings of the Internal Serious Incident report by Psychological Approaches **[NHFT0000451]** where it was found the Trust did not share or engage the GP at the point of planning for discharge. Where the expectation is for a supportive and planned discharge the communication with the GP did not make note of VC's mental health difficulties and risk profile.

503. Post discharge, VC did not engage with contacts from his GP, which may have alerted the trust to concerns if they had been raised.

504. The university shared information where they had concerns with both the community and inpatient teams. It is also established that the Trust shared relevant and timely information with the university. The Theemis report **[TCLT0000818]** makes note that whilst this is positive, the same information was not shared with the GP who was providing a clinical service and responsible for providing support when VC was in the community.

505. There were limited effective processes in place for ensuring the sharing of knowledge between the Trust and the Police to inform estimation of risk and insight on effectiveness of care and treatment. The incidents where VC demonstrated risk to the public, had occurred in the community and had involved the police. Where VC was detained for assessment under the mental health act the trust became aware however there were examples where the trust was not informed - VC's failure to attend court, the violent incident at work. The university shared an incident with the trust where VC refused to allow a fellow university student to leave the student accommodation however when the trust requested more information, the police were unable to provide.

Questions from families of deceased victims

506. The Trust was requested to answer a total of 111 questions by the families [**CYGN0000006**], 19 of which came as a result of the meeting with the families and the Executive team 6 August 2024. 89 additional questions were received 19 August, and a further 3 questions, 12 November 2024. [**NHFT0000523, NHFT0000524**]

507. Our intentions were to be as open and honest as we were able to and respond as comprehensively and as quickly as possible. Where it took four months to provide the response, the time taken was to ensure we had all the information available to enable us to provide accurate answers. To ensure objectivity, I requested the Trust engage with external, experienced professionals to lead the staff interview sessions, and an external lead to organise the collation of information and formulation of the response. There were two requests within the questions that presented challenges for disclosure – staff names and sharing the correspondence between the trust and the Calocane family.

508. The Trust made the decision not to disclose staff names as some members of staff were subject to internal trust processes and may have been reported to their regulatory bodies such as the GMC or NMC after completion of the internal

process. The concern we had was that if staff were named prematurely there was a risk that in such a high-profile case, they may become the subject of online speculation and comment, criticism in the media or attack in some other public setting. Not only would this adversely affect the member of staff, but it may also have prejudiced any referral to a regulatory body, or outcome of that referral. The Trust explained it therefore needed to balance its duty of candour with our duty of care. We recognised how this may have felt, and the decision was made only after significant consideration.

509. We responded to the first 19 questions on 31 October 2024 via the families' solicitors. The Trust included in the response the correspondence between the trust and the police as had been requested by the families for their information. **[NHFT0000523, NHFT0000524]**.

510. The 89 questions were responded to on 4 December 2024, with the additional 3 questions responded to 5 December 2024.

511. The families requested further clarification to questions 1 – 19, which the Trust responded to on the 14 January 2025. **[NHFT0000523, NHFT0000524]**

512. My role in answering the questions was to oversee the process of response, and review the information to ensure its adequacy, striving to be as open as the trust was able to be within the legally advised confines to the obligations of confidentiality. I was part of the Executive Team's decision in agreeing final responses and submissions of information/ correspondence and reports.

513. In ensuring the answers given were comprehensive, the decision-making clinical staff involved in VC's care were re-interviewed by panels led by external professional leads, there was a review of all documentation, and the trust obtained further information from other organisations.

514. The initial 19 questions related to why the families had not been involved immediately post incident. The Trust's response was to acknowledge that the

circumstances were complex, particularly as the legal case was on going and therefore adhered to the police request not to pursue the investigation. However, with hindsight the Trust should have been more proactive and even if it did not engage the families of VC's victims for the purposes of progressing its investigation, it should have sought to engage with compassion the victims' families and surviving victims' families to offer as much emotional or practical support as possible.

515. Within the response to the 19 initial questions the Trust was asked for all the documentation, communications and a chronology of contacts with the police which was included in the response of 31 October 2024. On the 11 November 2024 the families requested clarification in relation to the bundle of correspondence that had been submitted as they were unclear whether some communication was missing **[NHFT0017715]**.

516. The Trust responded on 13 January 2025 clarifying email trails with an additional email plus notes of meeting between the trust and police FLO's shared **[NHSE0000870, NHSE0000871, NHFT0017716]**. Where there was a request to share the correspondence with VC's family, the Trust took the decision that notwithstanding the desire for openness transparency and compassion, there was a justifiable boundary surrounding the correspondence between the Trust and the perpetrator's family. The Trust did not consider that disclosure of this material would meaningfully advance any understanding with this part of the process and therefore were not in a position to disclose this material. We were, however, mindful of how this may have felt and the impact on our relationship with VC's family.

Remaining 92 questions

517. On the 4 December 2024 in the Trust's response **NHSE0000851]**, it was acknowledged that the remaining 92 questions took time to collate. A selection of questions requested the names of individual staff members to be shared. The Trust took the decision not to share the names in the response as some members

of staff were subject to internal trust processes and may have been reported to their regulatory bodies such as the GMC or NMC after completion of the internal process.

518. The Trust explained that if staff are named prematurely there was a risk that in such a high-profile case, they may become the subject of online speculation and comment, criticism in the media or attack in some other public setting. Not only would this adversely affect the member of staff, it might also prejudice any referral to a regulatory body, or outcome of that referral. The Trust explained it therefore needed to balance our duty of candour with our duty of care. I recognise how this may have felt but we felt that needed to make a decision which did not compromise any subsequent process.

519. In summary, regrettably the Trusts response took longer than we would have preferred, however we wanted to ensure that it was fully comprehensive, included documents and communications to support understanding and context. The response to the questions did not include the sharing of correspondence or meeting notes between the Trust and the Calocane family as had been requested. The reason for this was that there is a justifiable boundary surrounding the correspondence and it would not advance understanding for this part of the process. The NHS England Independent Homicide investigation was being completed at the time and therefore the families were advised that there was an expectation that many of their questions would be answered more fully in the review and it was important that in answering questions we did not pre-empt or anticipate the findings of that review. The response to the questions was therefore limited to the facts available at that time.

Contact with survivors of the attacks, families of the victims and VC's family

520. It is important to say that I, with absolute sincerity, apologise to all the survivors of the terrible attacks, to the families and to all those impacted. We could and really should have provided so much more support and information in a timelier responsive manner and in multiple ways dependent on preference and need. I am truly sorry. There was a need to not compromise any police or criminal

investigation and there was a need to work within the parameters set, however we should have been more assertive in negotiating our position to ensure we were present, visible, and connected with both survivors and families. Although we ensured we followed the correct process and adhered to recommendations this allowed delays in us offering the support people really needed from us.

Initial contact

521. The Trust makes every effort to communicate with families immediately after an incident. It is with huge regret that due to the nature of the tragic events, the complexity of the subsequent police investigation and the trusts willingness to follow the police advise left the families without contact for a significant time. With hindsight, we absolutely acknowledge we should have been more proactive in our relationship with the police, pressing them further and even if we could not have engaged the bereaved families for the purposes of undertaking an investigation or learning lessons, we could have sought to engage them to extend condolences and offer emotional or practical support.

522. There was a significant delay (29 November 2023) in obtaining contact details and names of those affected and their families, which again, the trust should have raised with the police more formerly to expedite.

523. The first contact with Mrs Calocane occurred on 19 February 2024 [**NHFT0012243**], post completion of the criminal prosecution due to the police's request that contact at an earlier phase could jeopardise their investigation and prosecution.

524. Our delay in contact, lack of engagement with families in the review and initial offering of information to provide support is of deep regret. Since coming into post we have taken actions to prevent such a recurrence by improving the relationship with the police through the introduction of Patient Safety and Executive liaison meetings and implemented in April 2025 the new Reporting, Managing and Learning from Incidents Policy which includes initial management and responsibilities, the Incident Co- ordination group, and a specific section on

Mental Health Homicides, which provides expectations of engagement both the perpetrator and victims' families. The police were involved in this development and are more aware of the expectations of Duty of Candour.

Sharing of reports

525. Summary reports were provided to both the victims' families and the people who had been affected as the full report contained detailed clinical information, and the trust did not, at that time have consent to share.

526. The summary report was written by Psychological Approaches and sent 18 July 2024 to the victims' families to share the learning, actions and recommendations. **[NHFT0015639], [NHFT0000487], [NHFT0015640]**

527. The Trust's Chief Executive CO wrote to all those affected by the incident to offer to meet in order to share the findings of the investigation on 5 July 2024, to which we received a response from Mr Wayne Birkett and his partner. **[NHFT0018405]** I, and the CEO met with Mr Birkett and his partner on 28 August 2024 where the summary report was shared, and the findings were discussed.

528. The summary report was shared with Mrs Newton (Ian Coates' partner) 12 August 2024 when I and the Chief Executive met with her.

529. Sadly, we have never received a response to this or other correspondence from Ms Sharon Miller or Mr Marcin Gawronski.

530. The full report, redacted of staff names, was shared with the victims' families 20 August 2024. The Trust sought to balance its data protection obligations, including the ongoing duty of confidence it had in relation to VC with our desire to be open. The Trust sought advice from a KC to help it in assessing where this balance lay. **[NHFT0015639, NHFT0004287, NHFT0015640]**. Having considered that advice and having engaged further with the Independent Chair of the Serious Incident Investigation Panel, the Trust decided to disclose the Serious Incident Investigation report to the victims' families in almost completely unredacted form.

531. The full report, redacted of staff names, was shared with Mrs Calocane (mother) by secure file transfer on 19 July 2024 [**NHFT0000484**]. Mrs Calocane had

requested this to occur in preparation for my visit to her home on 30 July 2024 when we discussed the report and its findings with her and the Calocane family.

Personal contacts with families and those affected

532. On 19 February 2024, following our communication to the police which indicated the Trusts' intention to contact VC's family on the 14 February, the Trust Family Liaison Lead contacted Mrs Calocane, which is summarised in the letter of 18 March 2024 [**NHFT0000453**]. The letter stated arrangements to meet Mrs Calocane at her home, apologises for delays in communication and provides an explanation of the process for both the internal and independent investigations. Our meeting on 30 July 2024 provided an opportunity for the family to discuss the report, to understand their perspectives and inform them of the focus of the improvements and learning for the Trust. Actions agreed in the meeting were for the family to have the opportunity to meet with the author of the report, and another meeting with myself. These offers continue to be available at any point it may be helpful for the family.

533. On 6 August 2024, along with executive colleagues, I met with the families of Barnaby Webber, Grace O'Malley Kumar and Ian Coates in London. **[NHFT0001837]** We discussed the summary report, offered an absolute apology for the delay in our communication and the obvious impact of such a devastating event. We agreed to respond to further questions that the family had not resolved from the Summary report and establish whether the full Serious Incident Investigation report could be shared.

534. I exchanged emails with Elias Calocane in February 2025 **[NHFT0017589, NHFT0017590]** as he requested clarification of the diagnosis of his brother following the publication of the Theemis review which he found was confused from the Trusts perspective. Within the email exchange I offered a further meeting and offered the clinical teams understanding of his brothers diagnosis.

535. I, and the Chief Executive, met with Ms Elaine Newton (Ian Coates partner) and her sister on the 12 August 2024 to share the summary report and offer a copy. The Trust Family Liaison Officer was present to offer support both pre and post meeting. I offered Ms Newton an apology for what had occurred and for the missed opportunities. We were able to offer explanations as to service, treatment

and mental health act clarifications. We offered further support and signposting and contact with the Family Liaison Lead if they required. I received an email from Ms Newton on 9 February 2025 where she expressed her lack of trust and confidence in the trust and NHS [**NHFT0017591**].

536. The Chief Executive and I met with Wayne Birkett and his partner Tracey on 28 August 2024 at their home. The summary report was shared and there was an apology offered for the missed opportunities. Mr Birkett and his partner talked about the continuing significant impact of the event on Mr Birkett and his family. The two investigations and their process' were explained and clarifications offered on aspects of the care provided. There was an offer of a further meeting and ongoing support through the Family Liaison Lead.

537. I am aware that the Chief Executive wrote to all those affected following the Theemis investigation on 4 February 2025 offering a meeting with myself to provide support and further clarifications where helpful. [**NHSE0000888**, **NHSE0000889, NHSE0000890** **NHFT0017592, NHFT0017594, NHFT0017595, NHFT0017596, NHFT0017597, NHFT0017599, NHFT0017601, NHFT0017602, NHFT0017603, NHFT0017604]**

Improvements that could be made to multi-agency working and information sharing

538. Significant improvements to collaborative working and the cross organisational sharing of risk information with the police is now in place particularly the establishing of the Dangerous Persons Policy, the update and co agreed review of the Police and Criminal Justice Liaison policy (13.04) **[WITN0263069]** and the liaison meetings at all levels, corporately and within our Care Groups, all of which has created opportunities for sharing, understanding and joint decision making. The development of these relationships coupled with clarity and purpose feel much more robust. As part of our learning and implementation of recommendations we are establishing more solid relationships with primary care colleagues, and we are an active partners in the system mental health boards.

539. Currently in development is the Mental Health High Risk Oversight Panel

(Potentially Dangerous Persons Panel), supported by the Dangerous Persons Policy, being led by the police. This will be for patients who are not convicted and under any other offender management program but where there are concerns that they may cause significant harm to others. In development is a police recruitment process to support, and a trust developed referral pathway. The Police are leading the actions and are recruiting presently, the Trust is arranging the Memorandum of Understanding and referral pathway. The new panel will bring more robust, provide improved governance, and better skill mix and expertise to enhance the current informal sharing of information and decision making.

540. There is a need for more sophisticated sharing of records and information, exploring and exhausting the advantages of digital platforms and creating robustness to interface meetings. In particular, it would be good to have national agreement re-record sharing between independent providers and other partners with a nationally driven shared expectations and guidance

541. More co location, neighbourhood working could further strengthen relationships and create the conditions for focus and cohesion

<u>Improvements that could be made in the Trust, or to mental health services provision generally</u>

542. The Trust has used the learning from the tragic incident of 13th June 2023, the subsequent reviews and the work we continue to do as part of the Integrated Improvement Programme to drive a number of the changes required to enable and embed improvements.

543. The national and regional work focussing on Assertive Outreach/engagement for people with a serious and enduring mental illness, I believe, will be instrumental in providing safer, more intensive and focused care. Working with and caring for people with a serious mental illness, often with associated complexities and health inequalities requires teams who have the skills, expertise and

understanding. This, with the opportunity to spend time connecting, engaging and building trusting relationships where risk, safety, recovery and hope can be central to care delivery will enable positive outcomes. I do not think we should underestimate the skill, expertise and time to deliver all of this in an impactful way. Offering a service outside the 9-5 Monday to Friday window where the responsibility for engagement is placed not on the patient or their family but on the team is essential in providing safe, therapeutic care to this group of people using services. Recently, in Nottingham this is confined to only our inpatient and crisis services.

544. Developing Assertive Outreach teams should not be at the detriment of the CMHT offer, it must not be an either/ or, but both. Although national guidance and focus has been incredibly helpful, its implementation will require additional resources along with training, support and supervision to deliver the skilled interventions required. At a time when there are considerable financial challenges and constraints this feels very difficult although we do know from our early work in Nottinghamshire this approach can impact on inpatient use as well as relapse prevention.

545. As we and other organisations continue with pathway redesign which embraces the Ten-Year Health Plan [NHSE0000014, **NHFT0017692**], I do think reducing duplication, fragmentation, silo working and multiple team and clinician involvement must be considered. Continuity, consistency and clarity are important when caring for people with a serious mental illness and this is demonstrated through the learning from VCs care.

546. Creating a workforce who can provide the specialist care that people need across the breadth of services we and other mental health trusts provide is something I believe we need to focus on more. Improved training both pre and post registration and for our unregistered workforce must be considered with mandatory training including true understanding of risk, patient safety planning and formulation alongside psychosocial interventions and family work. I think compliance should not be just about numbers but about impact. In addition to

this a greater focus on cultural competence with confidence to provide care and treatment whilst maintaining relationships

547. I am not sure nationally we talk enough or do enough about the impact of stigma and how the fear of discrimination experienced by those suffering a serious mental illness, particularly schizophrenia, can prevent the seeking of help or the accepting of a diagnosis and treatment. I think there is so much more we could and should be doing with our communities to change the perception and understanding of Schizophrenia.

548. I know all Trusts will have their own forums, conferences and ways of sharing learning from incidents, I think it would be helpful for us to have more regional and national learning events where we can think together about the why, the actions and improvements in their entirety. Locally and nationally, we have people with extensive experience and expertise, professional, experts by experience, families working in a range of organisations doing exceptional work, how can we use this knowledge to further develop the services we provide with a relentless focus on improvement and of course patient and public safety.

549. There is a need for absolute clarity on our offer to those suffering from a serious mental illness. NICE offers exceptional guidance, how can we compel people and organisations to deliver against the guidance and for it to become a mandatory offer. The conflicting demand on mental health services, I believe may have diluted the offer we provide.

550. The pathways and access from acute mental health services into forensic services are perceived to be more complicated with changes to funding and how they now operate, accessibility alongside equity is so important

551. Finally, when you look at the number of people treated by the NHS in England as a whole, about 20% of those patients are being treated by mental health services. In other words, mental illness is responsible for around a fifth of the

total disease burden, yet the funding is mismatched, with the allocation of NHS funding for mental health being 8%. **[NHFT0017605, NHFT0017607, NHFT0017608]**. Whilst I acknowledge there are improvements that can be made to services at Trust level, I consider that this mismatch does make it difficult to offer the level and breadth of service required within the current national need, and that nationally we require a reconsideration of resource allocation. This is even more vital considering the evidence that the economic and social costs of mental ill health are thought to massively dwarf the spending on services **[NHFT0017609].**

Recommendations

552. There has been so much exceptional work done nationally to raise understanding, awareness, and acceptance of mental health, and I believe that this has increased demand in services. The media campaigns supported by VSE, national experts and high-profile individuals have most definitely led to people feeling more confident to ask for help, to talk about mental health and suicidality. There needs to be a greater focus on the continuing stigma and misinterpretation of serious mental illness acknowledging that many people internalise public stigma leading to shame and a reluctance to seek help or adhere to treatment. I have made reference to this earlier in this statement, and I do believe this is an improvement that can be made at Trust level. Treating people and preventing relapse whilst promoting recovery will support the prevention agenda. There is a need for system and national anti-stigma initiatives as I believe the changing of the perception of mental illness will improve outcomes. This is of vital importance but needs to be led and endorsed at a national level or it will not have the right impact.

553. I further consider that conflicting demands may impact and dilute our offer in respect of treating patients suffering from a serious mental illness. Since Covid, we have seen an increase in people accessing our services with a range of varying and unmet needs, often experiencing psychological distress, trauma and

needing support. This is now a vitally important part of the service we offer, and we must be able to help those patients in need. However, whilst the Trust should provide an extended range of services often complex, I would like to see consideration given for ringfenced resources for seriously mentally ill patients.

554. As set out above at paragraph 544, NICE guidance, such as that on treating schizophrenia, provides a very helpful framework but it is still only guidance and is not universally adhered to. As stated in the paragraph above, treating seriously mentally ill patients is enormously complex and cannot be seen solely in the prism of one piece of guidance, but consistency across organisations and teams within Trusts is important. The NICE guidance of treatment should not be the 'gold standard' – it should be the minimum level staff are aiming to achieve, and it may even be helpful for it to be mandatory to follow this guidance.

555. Earlier in this statement, I referenced the need to de-stigmatise and promote understanding of serious mental illness. It is well recognised that there is a race disparity in detention rates and black men are more likely to be detained under the Mental Health Act, and more likely to be put on a Community Treatment Order (CTO) **[NHFT0017610, NHFT0017611, NHSE0000024, NHFT0017613]**. I do consider that there is vital work to be done, at a local and national level, to improve the awareness of serious mental illness in ethnic minority communities and ensure that active work is taking place to de-stigmatise these illnesses and encourage people to access help at an earlier stage. In my experience, the overrepresentation of young black men being detained under the Mental Health Act can be correlated to patients not accessing health services earlier, when doing so could have potentially avoided detention or a CTO. We cannot ignore the overrepresentation of black men in mental health services, and we must strive to always implement the least restrictive interventions, but this must not prevent us treating people in a safe, compassionate and therapeutic way. I do believe that the real impact of de-stigmitisation will be a reduction in hospitalisation but this cannot only be achieved at Trust level – it must be led and endorsed nationally. The Patient Care and Race Equality Framework **[NHFT0017614]** is an excellent foundation for this.

556. I believe that national and Trust leaders need to consider the parity of esteem with the resources available, and acknowledge the growing complexity associated with mental illness. Given this, it is even more vital that we are providing safe, therapeutic, intervention-based care. There are compelling arguments that rather than measuring access to services, we should be increasing equity by looking at outcomes [**NHFT0017719**]. It is possible that the focus within national policy on measuring access to services rather than measuring the outcomes for patients has had an inadvertent disadvantageous impact on people with severe mental illness. Given the long term effects of the COVID-19 pandemic, we should anticipate that there will be a huge future impact on mental health services [**NHFT0017615**]. A change in policy and approach in relation to parity of esteem will enable us as Trust leaders to meet increased demand whilst ensuring those who suffer from severe mental illness can access the services they need.

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: 19/01/2026

Index table for Diane Hull's Second Witness Statement

Number	URN	Title of Document
1.	**NHFT0017440**	Quality Committee quarterly report Oct 2023 Q1.docx
2.	**NHFT0017439**	Appendix 1 to safeguarding report.docx
3.	**NHFT0017720**	Appendix i Safeguarding Annual Report.pdf
4.	**NHFT0017627**	Accountability Framework-Public Board July 2025.docx
5.	**NHFT0015913**	24b. App 1 version 2 Accountability and Performance Framework (21 x 29.7 cm) [IM19].pdf
6.	**NHFT0002828**	06.01-Issue-10-Safeguarding-Children.pdf
7.	**WITN0263059**	Terms of Reference for Significant Issues Review Group
8.	**NHFT0017640**	Terms of Reference for Complex Incidents Oversight Group Revised July 2025.docx
9.	**NHFT0017651**	Patient Safety and Learning from Deaths Group ToR September 2024.docx
10.	**NHFT0017664**	Patient Safety Incident Investigation ToR - September 2025.docx
11.	**NHFT0017675**	Patient Safety Exceptions Report Final 21.08.25 - 21.10.25.docx
12.	**NHFT0017687**	Minutes of the Public Board of Directors 25 September 2025.docx
13.	**NHFT0017695**	27.10.2025 ET SafeNow Report Template V2.pptx
14.	**NHFT0017696**	Extended ELT notes 29.10.2025 approved by BS CHAIR.docx
15.	**NHFT0017441**	Minutes of the NHT IOAG Meeting - July 2025.docx
16.	**NHFT0017442**	Unratified Minutes of the NHT IOAG Meeting - September 2025.docx
17.	**NHFT0017454**	CQC Provider Engagement Meeting minutes docx.docx
18.	**NHFT0017501**	20241015 Rampton October Assessment HighLevel Feedback.docx
19.	**NHFT0017539**	High level Feedback Response Letter Adwick and Eden17.10.2024.pdf
20.	**NHFT0017555**	202041220 to CQC High Secure Draft report and FA letter_.pdf
21.	**NHFT0017578**	Confirm upload to CQC CQC Assessment Action Plan Ramton Hospital 20240114.msg
22.	**NHFT0017587**	CQC Status Report - Inspection and Action Plans.docx
23.	**NHFT0001330**	Private Board CQC Rampton Hospital Report DRAFT.docx
24.	**NHFT0017616**	ET SafeNow Monthly Report November 2025.pdf
25.	**NHFT0017617**	Quality and Performance Group Accountability Group Terms of Reference.pptx
26.	**NHFT0017618**	Draft Extended ELT Terms of Reference.pptx
27.	**NHFT0017619**	TMT - ToR V3 19.09.24 [IM22].docx
28.	**NHFT0017620**	Executive Open Forum.docx
29.	**NHFT0017621**	CEO presentation to CoG Big Convos Oct 25.pptx

30.	**NHFT0017622**	Rampton Improvement Group (RIG) ToR v2 June 2025 v2.pptx
31.	**CQCM0016525**	CQC3-66 Inspection Report Published Mar24.pdf
32.	**NHFT0000581**	2023 Acute wards for adults of working.pdf
33.	**NHFT0000615**	Policy document titled "Our People Plan"
34.	**NHFT0003275**	Powerpoint presentation titled Nottinghamshire "Healthcare Foundation Trust Integrated Improvement Plan IOAG Update: Progress against S48 Recommendations20 November 2024"
35.	**NHFT0017625**	Finance Minutes 19 August 2024.docx
36.	**NHFT0017626**	Quality Committee Draft Minutes 1 Oct 2024v1.docx
37.	**NHFT0017629**	26 September 2024 Board Confidential Minutes.docx
38.	**NHFT0015073**	Rule 9 Information Request. Clinical Risk and Safety Training - report summary.docx
39.	**NHFT0015209**	MH Clinical Risk Assessment and Management elearning-Mental Health.pdf
40.	**NHFT0017630**	01.19-Issue-2-Delivery-of-Personalised-Care Policy 2025.pdf
41.	**NHFT0014335**	Integrated Improvement Portfolio Board Terms of Reference
42.	**NHFT0017631**	Appendix 2 BAF SR2 Deep Dive Report to ARC Nov 2023 v0.1 (1).docx
43.	**NHFT0017632**	Appendix 2 BAF SR2 Deep Dive Report to ARC Nov 2023 v0.1.docx
44.	**NHFT0017633**	BAF report Dec 2023 v1.docx
45.	**NHFT0004355**	Quality Committee - 5 December 2023.pdf
46.	**NHFT0000454**	Board meeting (Public) 28 March 2024.pdf
47.	**NHFT0017634**	AMH RIG ToR v1.0 12.11.25.pptx "Terms of Reference – AMH Improvement Group"
48.	**NHFT0017635**	CIG RIG ToR v1.0 16.05.25.pptx "Terms of Reference – Community Improvement Group"
49.	**NHFT0017636**	Crisis IG ToR June 25.pptx "Terms of Reference- Crisis Improvement Group"
50.	**NHFT0017637**	Offender Health RIG OAG ToR v1.pptx "Terms of Reference – Offender Health Oversight and Assurance Group"
51.	**NHFT0000466**	Quality Committee - 4 June 2024.pdf
52.	**NHFT0003520**	Q&MHL Committee 15_02_2022.pdf
53.	**NHFT0002074**	Briefing pack for Private Board of Directors meeting to be held on 01/11/2022, NHFT, published on 27/10/2022.
54.	**NHFT0017638**	January 2013 Board Minutes.docx
55.	**NHFT0015003**	Briefing for Private Board of Directors dated 29th May 2025
56.	**NHFT0017639**	Quality Committee Minutes 14 August 2025 v3 checked by DL.docx
57.	**NHFT0017641**	ELT Minutes 15.05.2024.docx
58.	**NHFT0015022**	Minutes of Meeting Re: Quality Committee - 3 October 2023.
59.	**NHFT0017642**	ELT SIRG Report 04.11.25 Final.docx
60.	**NHFT0017643**	Quality Committee Minutes 14 August 2025 v3 checked by DL.docx
61.	**NHFT0017644**	Quality Committee Minutes 11 September 2025 (2).docx
62.	**NHFT0017645**	ELT Minutes 3.01.2024.docx
63.	**WITN0263061**	Complex Incidents Oversight Group Terms of Reference
64.	**NHFT0017646**	CHS ToR Safety and Experience Group.pptx

65.	**NHFT0017647**	Forensic Services Terms of Reference - Quality , Safety and Experience.pptx
66.	**NHFT0017650**	Terms of Reference Care Group Patient Safety and Experience Group Mental Health.pptx
67.	**WITN0263043**	Risk Group Terms of Reference
68.	**NHSE0000054**	NHS England » Patient Safety Incident Response Framework.pdf
69.	**NHFT0015932**	3 - Appendix 1 - Patient Safety Incident Response Plan 2024-2025 FINAL DRAFT 11.03.2024 [IM27].pdf
70.	**NHFT0017653**	Appendix 2 - NHT Patient-safety-incident-response-policy-Nottingham Healthcare.docx
71.	**NHFT0017654**	PSIRF Framework signed off at March 2024 Board meeting.docx
72.	**NHFT0017433**	NHFT0017433 - NHCFT 2425 06 PSIRF Final Report.pdf
73.	**NHFT0017655**	Learning from Deaths Q2 2024-2025_se.docx
74.	**NHFT0017656**	PFD Benchmarking.docx
75.	**NHFT0000423**	FINAL REPORT OF INDEPENDENT EVALUATION OF PATIENT SAFETY PROCESSES AT NOTTINGHAMSHIRE HEALTHCARE FOUNDATION TRUST.docx
76.	**NHFT0017657**	ELT Minutes 31.01.2024.docx
77.	**NHFT0001610**	Briefing pack for Quality Committee, meeting scheduled for 06/02/2024
78.	**NHFT0017721**	ELT - Action plan update for the Independent Evaluation of Safety Processes at Nottinghamshire Healthcare NHS Foundation Trust.msg
79.	**NHFT0017725**	ELT 26 June 2024 Audit Action Plan update Patient Safety Incidents.docx
80.	**NHFT0017726**	FINAL REPORT OF INDEPENDENT EVALUATION OF PATIENT SAFETY PROCESSES AT NOTTINGHAMSHIRE HEALTHCARE FOUNDATION TRUST.docx
81.	**NHFT0017727**	Independent Evaluation of Patient Safety Processes Action Plan - June update_ v2.docx
82.	**NHFT0017658**	Quality Committee Reading Room - 11 March 2025.pdf
83.	**WITN0263069**	Policy 13.04 – Police & Criminal Justice Liaison Policy
84.	**NHFT0000424**	13.07a (Issue 3) MAPPA Procedure.pdf
85.	**NHFT0012587**	Policy document RE: Reporting, Management and Learning from Incidents Policy and Procedure Policy: 15.01, NHFT
86.	**NHFT0017659**	ELT - Appendix 1.docx
87.	**NHFT0017661**	ELT - Appendix 2.docx
88.	**NHFT0017662**	ELT -Cover paper Briefing on incidents of homicide attempted homicides and complex incidents April 2024.docx
89.	**NHFT0017663**	Briefing to NHSE 15 May 2024.docx
90.	**NHFT0017665**	Briefing to NHSE 13 May 2024.docx
91.	**NHFT0000518**	Thematic review of Homicides and attempted Homicides 2019 Final.docx
92.	**NHFT0017728**	LT Paper - Thematic Homicide and Attempted Homicide Review September 2024.docx (
93.	**NHFT0017730**	Thematic review of Homicides and attempted Homicides 2019 App 1.docx
94.	**NHFT0018400**	NOTT1_RV019_00000391.xlsx
95.	**NHFT0018401**	NOTT1_RV003_00017925.msg
96.	**NHFT0008656**	Confidential briefing on homicides – 15 February 2024

97.	**WITN0263097**	SIRG Meeting minutes – 16 August 2022
98.	**NHFT0004778**	Report dated 02/05/2025, compiled by NHFT Re: ABOUT PATIENT SAFETY INCIDENT INVESTIGATIONS
99.	**NHFT0004569**	Exec Team 31_08_22.pdf
100.	**NHFT0015874**	134. Homicide & Attempted Homicide Oversight Group Minutes 24 Sept 2024 [IM98].pdf
101.	**NHFT0017666**	**GRO-B** 466448 IMR AMH DPM 2022-17624.docx
102.	**NHFT0017667**	Clinical Policy Template.docx
103.	**NHFT0017668**	Triage tool and guidance (002).pdf
104.	**WITN0263070**	**GRO-B** Blue Light incident
105.	**WITN0263071**	Email re GRO-B incident, 16 February 2023
106.	**NHFT0008656**	15.02.24 Briefing Serious Incident Attempted Homicide Near Miss cases 2020 to current date.docx
107.	**NHFT0016458**	SIRG discussion Meeting Notes (21 February 2023) SIRG discussion [IM104].pdf
108.	**NHFT0015790**	Report dated 22/02/2023, compiled by NHFT Re: Serious Incident Reporting Document
109.	**NHFT0000592**	Private Board Meeting - 30_3_23.pdf
110.	**NHFT0008661**	Homicide and Attempted Homicide Group Agenda 12.08.2024.docx
111.	**NHFT0017669**	IMR - **GRO-B** - 497414 IMR EIP Gedling Manor Road AMH MHS 2023-3890.docx
112.	**NHFT0015791**	Report dated July 2024, compiled by NHFT and Psychological Approaches, Re: Level 2 Comprehensive Investigation Report.
113.	**NHFT0017670**	2023-3890 GRO-B Report FINAL REPORT SIGNED OFF BY D. HULL.docx
114.	**NHFT0003231**	Policy Document, Re: Clinical Risk and Safety Policy, NHFT
115.	**WITN0263073**	**GRO-B** Blue Light Incident
116.	**NHFT0017674**	Briefing **GRO-B** ELT 2023.05.03 (2).docx
117.	**NHFT0016456**	18th April 2023 **GRO-B** SIRG Meeting Notes.pdf
118.	**NHFT0015672**	Report dated 18/04/2023, compiled by NHFT, Re: Serious Incident Reporting Document
119.	**NHFT0015865**	Report dated 9/4/2023, compiled by NHFT, re:[CONFIDENTIAL INTITIAL MANAGEMENT REVIEW SERIOUS INCIDENTS AND DEATHS]
120.	**NHFT0015864**	Report dated 20/12/2023 compiled by NHFT Re: Case Note Review/Level 1 Concise Investigation: Incident Analysis
121.	**WITN0263074**	Minutes of City South LMHT Business Meeting – 8 August 2023

122.	**WITN0263075**	GRO-B Blue Light Incident
123.	**NHFT0016002**	SIRG discussion 11 July 2023 [IM116] S.xlsx
124.	**NHFT0004751**	Report dated: 01/12/2024, compiled by Lisa Dakin, Bebe Fahy and Lynn Hallam, Re: PRIVATE AND CONFIDENTIAL Level 2 Comprehensive Investigation Report
125.	**NHFT0001284**	Briefing pack for Public Board Meeting to be held on 27/07/23, NHFT, circulated on 20/07/23
126.	**NHFT0000416**	Private Board Meeting - 30 November 2023.pdf
127.	**WITN0263077**	HOAG Minutes – 15 July 2024
128.	**NHFT0008661**	Homicide and Attempted Homicide Group Agenda 12.08.2024.docx
129.	**NHFT0015972**	Meeting with Police and stakeholders 15 February 2024 [IM125].doc
130.	**NHFT0015975**	Minutes Op Horus Gold 15.02.24 [IM125].doc
131.	**NHFT0012587**	Policy document RE: Reporting, Management and Learning from Incidents Policy and Procedure Policy: 15.01, NHFT
132.	**WITN0263078**	GRO-B incident notification
133.	**WITN0263079**	GRO-B Blue Light Incident
134.	**NHFT0015879**	174. Briefing re GRO-B 20240715 v2 [IM129].docx
135.	**NHFT0015880**	175. SIRG Summary Report 04 06 2024 Final Report [IM130].docx
136.	**NHFT0015881**	176. ELT - SIRG Exceptions Report 02.07.2024 [IM131].docx
137.	**NHFT0001807**	Briefing pack for private board meeting to be held on 26/09/2024, NHFT, circulated on 20/09/2024
138.	**NHFT0015884**	181. Homicides and Attempted Homicides Oversight Group May 2024 [IM136].docx
139.	**WITN0263080**	HOAG Minutes – 6 March 2025
140.	**NHFT0015885**	184. PSII SIR Sign Off Panel Minutes 20.06.25 [IM138].docx
141.	**WITN0133024**	HCR-20 (Risk assessment process)
142.	**NHFT0016005**	Standard Operating Procedures for community forensic teams regarding prison remand [IM139].docx
143.	**WITN0263081**	GRO-B Blue Light incident
144.	**NHSE0001134**	20240126 SoS call Notts HC 20240126 FINALv3.docx
145.	**NHFT0016003**	SIRG reviews 10 December 2024 [IM142].docx
146.	**NHFT0016004**	SIRG reviews 17 December 2024 [IM143].docx
147.	**NHFT0000779**	Board of Directors Meeting (in Private) 30 Jan 2025 (1).pdf
148.	**WITN0263082**	Telephone recording between GRO-B s family and services
149.	**WITN0263090A**	Telephone recording between GRO-B s family and services
150.	**WITN0263090B**	Telephone recording between GRO-B s family and services (transcript)
151.	**WITN0263091A**	Telephone recording between GRO-B s family and services
152.	**WITN0263091B**	Telephone recording between GRO-B s family and services (transcript)
153.	**WITN0263083**	GRO-B Incident Meeting – 10 December 2024
154.	**NHFT0016457**	2024-AAR GRO-B 618108 FINAL VERSION SIGNED OFF BY J.ROSSER Completed QIP.pdf
155.	**NHFT0017676**	01.15-Issue-6-Transfer-and-Discharge Policy 2025.pdf
156.	**NHFT0017677**	Crisis-Resolution-Home-Treatment-Team-Internal-Working-Instructions-IWI.docx

157.	**NHFT0015973**	GRO-B ncident report 15 November 2024 at 14.30 [IM151].PDF
158.	**NHFT0015974**	GRO-B incident report 15 November 2024 at 18.49[IM151].PDF
159.	**WITN0263084**	Patient Safety Huddle - 25 November 2024
160.	**NHFT0017681**	FW_ confidential briefing GRO-C
161.	**NHFT0014969**	Report dated [unknown] compiled by Rachel Limb [NHFT] re: Significant Incidents and Review Group (SIRG) Exceptions Report, presented at Executive Leadership Team (ELT) meeting held on 26/11/2024.
162.	**NHFT0000779**	Board of Directors Meeting (in Private) 30 Jan 2025 (1).pdf
163.	**WITN0263115**	Minutes Complex Incidents November 2025 para 384.docx
164.	**WITN0263116**	Minutes of the Complex Incidents Oversight Group – 6 November 2025
165.	**TCLT0000818**	2023-11918 517936 Investigation Report VC Final Version Signed off by D. Hull.docx
166.	**NHFT0010666**	Annual report 2025.pdf
167.	**NHFT0000423**	FINAL REPORT OF INDEPENDENT EVALUATION OF PATIENT SAFETY PROCESSES AT NOTTINGHAMSHIRE HEALTHCARE FOUNDATION TRUST.docx
168.	**NHFT0000525**	Board of Directors Meeting (in Private) 26.09.24.pdf
169.	**NHFT0017683**	ELT Minutes 11.09.2024.docx
170.	**NHFT0017684**	Homicide Attempted Homicide Oversight Group Minutes 06.03.25 V2 (1).docx
171.	**NHFT0015900**	207. Think Family Strategy for enquiry 2025 [IM159].docx
172.	**NHFT0017685**	Reg 28 Report - After Inquest LYALUSHKO A V 02012023.pdf
173.	**NHFT0017686**	Survey Results and Review of Family Liaison Service Quality Committee 13.11.2025.docx
174.	**NHSE0000115**	nqb-guidance.pdf- Policy Document. Re: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time, National Quality Board.
175.	**WITN0263087**	NHS Improvement guidance – Developing workforce safeguards
176.	**NHFT0017688**	Safer Staffing Report.docx
177.	**NHFT0015868**	09-2025 - Safer Staffing Report [IM171].docx
178.	**NHFT0000763**	Quality Committee - 11 March 2025 (4).pdf
179.	**NHSE0000145**	Safer_staffing_mental_health.pdf- Policy Document. Re: Safe, sustainable and productive staffing. An improvement resource for mental health, National Quality Board, NHSI
180.	**NHFT0017689**	226. Safer Staffing Group - TOR (updated Jan-22).docx
181.	**NHFT0017690**	01.18-Issue-4-Trustwide-Safer-Staffing-Policy.pdf
182.	**NHFT0000516**	Agenda for EO Board Meeting to be held on 10/06/24, NHFT, circulated on 07/06/24
183.	**NHSE0000014**	nhs-long-term-plan-version-1.2 2019.pdf
184.	**NHSE0000013**	nhs-mental-health-implementation-plan-2019-20-2023-24.pdf
185.	**NHFT0017731**	Early Intervention in Psychosis Service Funding Proposal August 2019.docx
186.	**CQCM0016478**	20221125 Nottinghamshire Healthcare NHS Foundation Trust Inspection Report.pdf

187.	**NHFT0000905**	Briefing pack for the Public Board meeting to be held on 26.01.23, NHFT, circulated on 25.01.23.
188.	**NHFT0002312**	Public Board Meeting - 25_5_23.pdf
189.	**NHFT0017694**	Trust-Strategy-FINAL-Single-Pages-for-Printing.pdf
190.	**NHFT0003484**	Policy Guidance re: Our People Plan, NHFT
191.	**NHFT0015981**	Our People Plan October-2023 [IM180].pdf
192.	**NHFT0000901**	Public Board of Directors - 1_11_22.pdf
193.	**NHFT0017697**	Royal College of Nursing responds to Th...pd
194.	**NHFT0017698**	NHS Long Term Workforce Plan
195.	**NHFT0018409**	Mental Health Beds Delivery Plan v0.3.xlsx
196.	**NHFT0018408**	Coproduced QI based review of the adult mental health community pathway
197.	**WITN0263130**	The Commission to review the provision of acute inpatient psychiatric care for adults – final report
198.	**NHFT0017699**	HSSIB Report.pdf
199.	**NHFT0017735**	Continuity of Care OOA and Spot Purchase Beds V3 December 2023.docx
200.	**NHFT0000451**	Report dated 15/06/2023, compiled by Jackie Craissati, Joanne Parry, Rachel Lees, NFT, Re: Level 2 Comprehensive Investigation Report
201.	**NHFT0000530**	Independent-investigation-into-the-care-and-treatment-provided-to-vc.pdf
202.	**NHFT0017700**	Agenda SIRG 20.06.2023.docx
203.	**NHFT0001284**	Agenda Pack for Private Board Meeting to be held on 27/07/23, NHFT, circulated on 21/07/23
204.	**NHFT0017708**	17.15-Version-4-Business-Continuity-Management-Procedure.pdf
205.	**NHFT0000818**	Board of Directors Meeting (in Private) 28 Nov 2024.pdf
206.	**NHFT0017709**	ELT - SIRG Exceptions Report 24.09.2024 (1).docx
207.	**NHFT0017711**	PCREF- TOR
208.	**WITN0263024**	Patient, Carer & Family Reference Group Terms of Reference
209.	**NHFT0012786**	Policy Document, re: Information Sharing Between Professionals, Patients and Carers, NHFT
210.	**NHFT0012587**	Policy document RE: Reporting, Management and Learning from Incidents Policy and Procedure Policy: 15.01, NHFT
211.	**NHFT0000455**	Board meeting (Private) 28.03.24.pdf
212.	**NHFT0017443**	Letter following meeting with VC family on 30.7.2024 v3 BJ comment(77640663.1).docx
213.	**NHFT0017444**	Letter to Mrs Calocane re actions 12.11.2025 v3.docx
214.	**NHFT0000464**	Board meeting (held in Private) 30 May 2024 (1).pdf
215.	**NHFT0000486**	Board of Directors Meeting (in Private) - 25 July 2024.pdf
216.	**NHFT0000525**	Board of Directors Meeting (in Private) 26.09.24.pdf
217.	**NHFT0017445**	NHS England » Guidance to integrated care boards...pdf
218.	**NHFT0017446**	Improvement Group Terms of Reference (002).docx
219.	**NHFT0017447**	Appendix A Report to ELT Sept 224.docx
220.	**NHFT0017451**	Appendix B ICB Meeting 20 September 2024.docx
221.	**NHFT0017452**	Appendix C Outcome of review.pptx
222.	**NHFT0017453**	RIG Progress CQC Oct 24.docx
223.	**NHFT0017468**	Appendix E NHSE Funding Requirements.xlsx
224.	**NHFT0017469**	Appendix F Progress Update presented to LMHT RIG.docx

225.	**NHFT0017491**	Appendix G Progress discussed at Care Group Accountability Meeting.pptx
226.	**NHFT0017492**	Appendix H Progress update and wider benchmarking Reg Assertive Meeting.docx
227.	**NHFT0017493**	Appendix I Community Improvement Group.docx
228.	**NHFT0017494**	Appendix J - RIG.docx
229.	**NHFT0017497**	Appendix K Development and launch of Assertive and intensive clinical dashboard.pptx
230.	**NHFT0017498**	Appendix L Progress to Accountability Meeting.pptx
231.	**NHFT0017499**	Appendix M Progress discussed with regional meeting.docx
232.	**NHFT0017500**	Appendix N NHSE correspondence.docx
233.	**NHFT0017502**	Appendix O Progress Update Community Improvement Group.docx
234.	**NHFT0017503**	Appendix P Progress discussed with RIG.docx
235.	**NHFT0017526**	Appendix Q Progress update.docx
236.	**NHFT0017527**	Appendix R Progress update.docx
237.	**NHFT0017528**	Appendix S Attendance at regionl AO meeting.docx
238.	**NHFT0017534**	Appendix T AO update to Care Group Accountability.pptx
239.	**NHFT0017535**	Appendix U Joint Trust and ICB AO update.docx
240.	**NHFT0019581**	Appendix V AO Review and improvement to QC.docx
241.	**NHFT0017537**	Appendix W AO Update to Care Groupo Accountability meeting.pptx
242.	**NHFT0017538**	Appendix X Joint ICB and Trust oversight and assurance mtg benchnarking.xlsx
243.	**NHFT0017540**	Appendix Y AO challenges reported to Care Group Accountability.pptx
244.	**NHFT0017541**	Appendix Z Regional AO meeting.docx
245.	**NHFT0017542**	Appendix ZA AO Oversight and assurance meeting.docx
246.	**NHFT0017545**	Appendix ZB Assertive Outreach Careplan Audit.docx
247.	**NHFT0017546**	Appendix ZB Presentation.pptx
248.	**NHFT0017547**	Appendix ZB Trust abd ICB Joint Review of benchmarking document.xlsx
249.	**NHFT0017548**	Appendix ZB Trust and ICB Joint review (b).docx
250.	**NHFT0017549**	Appendix ZC AO benchmarking.docx
251.	**NHFT0017551**	Appendix ZD AO benchmarking review.docx
252.	**NHFT0017553**	Appendix ZE AO Oversight and Assurance Meeting update on overall improvement plan.pptx
253.	**NHFT0019582**	Appendix ZF AO review completed in Sept 2025.docx
254.	**NHFT0017556**	Appendix ZG Presentation One.pptx
255.	**NHFT0017557**	Appendix ZG Presentation Two.pptx
256.	**NHFT0017558**	Appendix ZG Regional AO Meeting.docx
257.	**NHFT0017559**	Appendix ZF NHSE Trust Improvement Oversight and Assurance Meeting.pptx
258.	**NHFT0017560**	Appendix ZG Trust AO oversight and assurance meeting.pptx
259.	**NHFT0012612**	Email from Joanne Parry (NHFT) to PSYCHSPPROACHES1, England (NHSE), Rachel Lees (NHFT) and Rachel Limb (NHFT), Re: Update re: reviewing notes and police agreement October 2023 NHFT References: 2023-11981 517936 (VC)
260.	**NHFT0017561**	Staff Briefing VC SI Report 2023-11918docx.docx

261.	**WITN0133035**	Requests for information report Part 1
262.	**CQCM0016517**	Requests for information report Part 2
263.	**NHFT0017562**	Appendix 1 - NHSE Independent investigation into the care and treatment provided to VC action plan V2._ (002).docx
264.	**NHFT0017563**	VC Action Plan Report V2.docx
265.	**TCLT0000821**	TCLT0000821 - fid9679_--_Meeting_for_independent_investigation-20240808_140438-Meeting_Recording_Transcript_Chief Nurse (002).docx
266.	**NHFT0017564**	Appendix 1.docx
267.	**NHFT0017565**	Appendix 2 Statement from Sharon Heath.docx
268.	**NHFT0017566**	Professional Review GC 2023 - 11918 docx.docx
269.	**NHFT0017574**	Professional Review Sharon Heath.docx
270.	**NUHT0000045**	Good-Medical-Practice-2024---English-102607294.pdf
271.	**NUHT0000058**	Professional standards of practice and behaviour for nurses, midwives and nursing associates
272.	**NHFT0018402**	10.14 (Version 4) Maintaining High Professional Standards in the Modern NHS (Secretary of State 2005)
273.	**NHFT0017713**	10.10 (Issue 11) Conduct.pdf
274.	**NHFT0017580**	ELT - Professional review staff involved in the care and treatment of VC - September 2024.docx
275.	**NHFT0017581**	GC 107457 Letter dated 4 November 2025 - referrer.pdf
276.	**NHFT0017714**	IOAG Professional Practice Review Update 18th September 2025 - never sent updated to 23 September.pdf
277.	**NHFT0017582**	IOAG Professional Practice Review Update 13th August 2025.docx
278.	**NHFT0015033**	Briefing for Quality Committee meeting to be held on 15/05/2025, circulated on 14/05/2025, NHFT
279.	**NHFT0003231**	Policy Document, Re: Clinical Risk and Safety Policy, NHFT
280.	**NHFT0017583**	NHS England » Staying safe from suicide.pdf
281.	**NHFT0015073**	Rule 9 Information Request. Clinical Risk and Safety Training - report summary.docx
282.	**NHFT0017584**	01.08-Issue-12-Did-Not-Attend-DNA-Policy.pdf
283.	**NHFT0009283**	15.01 (Issue 1) Reporting Management and Learning from Incidents Policy and Procedure.docx
284.	**NHSE0002219**	Learning from Incidents Agenda (1).pdf
285.	**NHFT0017586**	Learning From Incidents Conference (1).pptx
286.	**NHFT0000451**	Report dated 15/06/2023, compiled by Jackie Craissati, Joanne Parry, Rachel Lees, NFT, Re: Level 2 Comprehensive Investigation Report
287.	**CYGN0000006**	Outstanding Questions submitted on behalf of the Webber, O'Malley-Kumar and Coates Families 19th August 2024.pdf
288.	**NHFT0000523**	FAMILY RESPONSES (additional questions) (FINAL).docx
289.	**NHFT0000524**	Families Questions - responses VC.pdf
290.	**NHFT0017715**	11 November 2024 Email.msg
291.	**NHSE0000870**	Supplementary bundle_Redacted(71251850.1).pdf
292.	**NHSE0000871**	Aide memoire notes_Redacted.pdf
293.	**NHFT0017716**	2025 01 13 - letter to Hudgell Solicitors(71234739.1).docx
294.	**NHSE0000851**	VC - Letter re questions to JS 04.12.24.pdf
295.	**NHFT0012243**	Email from Amy Kaye to Celeste Mendes and family liaison RE: 517936 - Contact from Family Liaison

296.	**NHFT0015639**	Policy Document, Re: Terms of Reference – personal details redacted Nottinghamshire Healthcare NHS Foundation Trust (NHCFT)Internal Trust Serious Incident (SI) Investigation, NHFT
297.	**NHFT0000487**	Report dated 15/03/2024, compiled by NFT, Re: Level 2 Comprehensive Investigation Report
298.	**NHFT0015640**	Report undated, compiled by NHFT [Unknown Author], re: SI 2023 - 11918 Action Plan Summary of Learning
299.	**NHFT0018405**	Wayne Birkett email.msg
300.	**NHFT0004287**	Report dated 15/03/2024, compiled by Mr C of Nottinghamshire Healthcare NHS Foundation Trust, Re: PRIVATE AND CONFIDENTIAL: Level 2 Summary Report of Valdo Calocane
301.	**NHFT0000484**	Letter from Ifti Majid to Celest Calocane Re: serious incident investigation into Valdo Calocane
302.	**NHFT0000453**	Letter from Amy Kaye to Mrs Celeste Calocane re: Valdo Calocane
303.	**NHFT0001837**	Quality Committee - 10 April 2025 (3).pdf
304.	**NHFT0017589**	Email exchange with Elias Calocane 2.msg
305.	**NHFT0017590**	Email with Elias Calocane.msg
306.	**NHFT0017591**	Email from Elaine Newton (partner of Ian Coates).msg
307.	**NHSE0000888**	Letter from Ifti Majid, Chief Executive, NHFT, to Dr Sanjoy Kumar and Sinead Kumar, re: Independent Investigation into the care and treatment of Valdo Calocane by Theemis Consulting Ltd publication
308.	**NHSE0000889**	Letter from Ifti Majid to Mr David and Mrs Emma Webber, re: publication of Theemis report and offer to discuss
309.	**NHFT0017592**	DH167 Dr & Mrs Kumar 4.02.2025.docx
310.	**NHFT0017594**	Elaine Newton 4.02.2025.docx
311.	**NHFT0017595**	Marcin Gawronski 4.02.2025.docx
312.	**NHFT0017596**	Mr Mrs Calocane 4.02.2025.docx
313.	**NHFT0017597**	Mr Mrs Webber 4.02.2025.docx
314.	**NHFT0017599**	Mr J Coates 4.02.2025.docx
315.	**NHFT0017601**	Mr Kumar Response 2.06.2025.docx
316.	**NHFT0017602**	Sharon Miller 4.02.2025.docx
317.	**NHFT0017603**	Valdo Calocane 4.02.2025.docx
318.	**NHFT0017604**	Wayne Birkett 4.02.2025.docx
319.	**NHSE0000890**	Letter from Ifti Majid to Mr James Coates, re: publication of Theemis report and offer to discuss
320.	**NHFT0017692**	SIRG Att A Ulysses Report 29.6.23.xlsx
321.	**NHFT0017605**	Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf
322.	**NHFT0017607**	college-report-cr242_protecting-the-mental-health-of-people-seeking-sanctuary.pdf
323.	**NHFT0017608**	Mental Health 360 _ Review Of Mental Health Care _ The King_s Fund.pdf
324.	**NHFT0017609**	MHF_TFR_Tackling_mental_health_delphi_study_report.pdf
325.	**NHFT0017610**	PLOS Report.pdf
326.	**NHFT0017611**	The Lancet Article.pdf
327.	**NHSE0000024**	mental-health-clinically-led-review-of-standards (1).pdf
328.	**NHFT0017613**	Good practice in relation to access, experience and outcomes for Black men in mental health services.

329.	**NHFT0017614**	NHS England » Patient and carer race equality framework.pdf
330.	**NHFT0017719**	Increasing equity in access to mental health care a critical first step in improving service quality.
331.	**NHFT0017615**	CentreforMH_Covid19EvidenceSoFar-2.pdf
332.	**NHFT0006105**	20 August 2025 letter to GC