Witness Name: Iftikhar Majid

Statement No: WITN0263001

Dated: 07 January 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF IFTIKHAR MAJID

I, Iftikhar Majid, will say as follows: -

1. I have been Chief Executive Officer ("**CEO**") of Nottinghamshire Healthcare NHS Foundation Trust ("**the Trust**") since 1 December 2022.

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 requests dated 6 October 2025 (the "**Request**").

3. I drafted this statement, with support from the external solicitors acting for the Trust in respect of the Inquiry, in writing and by video conference. I also had some assistance from subject matter experts at the Trust, also in writing and by video conference, for instance in locating a document. At all times this was my direct oversight.

Career background and qualifications

4. I trained as a mental health nurse at St Georges Hospital in London from 1985 to 1988, and then worked clinically from 1988 until 2001 in a variety of mental health inpatient and mental health community settings in services in South West London, Nottinghamshire and Derbyshire.

5. In 2001, I took the decision to move into operational management roles and

moved into a role where I led the strategic and operational development of the Community Mental Health Services within a defined geographical location (the High Peak and Derbyshire Dales) within Derbyshire. In this role I had joint accountability to both North Derbyshire Community Healthcare NHS Trust and Derbyshire County Council for health and social care staff including devolved social care budgets as a result of a joint agreement known as the North Derbyshire Confederation of Mental Health Services which was a pooling of specialist mental health staff and their associated budgets in the area in an aim to provide more integrated care.

6. From 2002 until 2008 I undertook more senior general management roles with a widening portfolio of service responsibility that focused on community mental health services, addiction services as well as information management and technology services. These general management roles culminated in my leading the whole of the Community Care Business Unit (Division) for Derbyshire as part of Derbyshire Mental Health NHS Trust in 2006

7. I was appointed a Director in 2008 at Derbyshire Mental Health NHS Trust (which became Derbyshire Healthcare NHS Foundation Trust), which became ultimately the Chief Operating Officer and Deputy CEO in 2013. This portfolio covered operational delivery, estates, facilities and informatics. In these roles I retained full Executive responsibility for all clinically facing services as well as support services such as Business Performance, Business Intelligence, Information Technology, Pharmacy, Transformation Programme Assurance, and Contracting.

8. In June 2015 I became the acting CEO at Derbyshire Healthcare NHS Foundation Trust. I was appointed substantively to the position in October 2017. As Chief Executive of what was a growing mental health, learning disability and Children's Trust, I fulfilled the full accounting officer role, ensuring that all regulatory and contractual obligations were met and that the Trust had in place appropriate systems and processes to ensure sound governance and exceptional service delivery. I led the Trust from being Care Quality Commission ("**CQC**") rated 'Requires Improvement', with some services rated inadequate, serious governance concerns, and one of the poorest staff survey outcomes nationally to being CQC rated 'Good' and one of the best in sector staff survey

Trusts. As a CEO In Derbyshire, I was very active within the system, leading on Anchor Institution work (which refers to large 'fixed' organisations in a community working together to use their assets for the good of the local community focusing on increasing local employment opportunities for example or purchasing from local suppliers to stimulate the local economy), being the CEO lead for the Derbyshire Provider Collaborative and the Chair of the Derbyshire System mental health partnership Board.

9. In December 2022 I applied for and was successful in becoming the CEO for Nottinghamshire Healthcare NHS Foundation Trust ("the Trust") which is a large complex provider of local mental health and community health services as well as providing forensic mental health services and prison health services across a regional footprint and providing one of three High Secure Hospitals in England. In addition, the Trust hosts a nationally recognised research facility, The Institute of Mental Health, as well as delivering national Gender Identity Services.

10. I have been privileged to hold several national roles within the mental health sector including being the Chair of the NHS Confederation National Mental Health and Learning Disability Network and the co-chair of the NHS Confederation National Black and Minority Ethnic (BME) Leaders Network which I did for about 4 years until April 2025.

11. As well as being a registered mental health nurse I hold various management qualifications such as the Post Graduate Certificate in Health Service Management and the Post Graduate Diploma in Management Studies (Sheffield Hallam University) as well as having been chosen to be part of cohort 1 for the NHS Top Leaders Development Programme in 2010. I no longer practice clinically, although I have retained my registration.

Structure of and approach to this statement

12. My statement adopts the following structure:

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13. As I have described above, I became Chief Executive of the Trust at the end of 2022. I cannot speak from personal knowledge about the arrangements that were in place prior to this time. In describing why changes have been made since I came into post, I have sought as far as possible to refer the Inquiry to relevant documents to assist it with understanding what the position was like prior to the period when I commenced in role and I have throughout referred where appropriate to the knowledge I have gained as a result of conversations I have had with a wide range of individuals at the Trust.

My role as Chief Executive of the Trust

14. As the CEO, I am responsible to the Chair and the Board of Directors of the Trust for the development and implementation of strategy, for the delivery of high-quality healthcare and the delivery of the financial and operational performance of the Trust. I ensure that the affairs of the Trust are conducted with the highest standards of integrity, probity and governance and ensure that the Trust is run in the most efficient and effective manner, building on and sustaining the Trust's reputation as a provider of high-quality integrated healthcare.

15. As the CEO, I am the Accounting (Accountable) Officer with overall executive responsibility for the effective management of the Trust. I am accountable for ensuring that all the statutory duties of the Trust are met as well as the requirements of Corporate Governance together with adhering to the terms of authorisation and license requirements for the Trust. The Trust's Constitution places specific limits on the CEO's authority and imposes various requirements on the Trust [**NHFT0000548**].

16. This involves working with the unitary Board members in developing, promoting and delivering the Trust's vision, values, aims and strategic objectives. We

ensure that the Trust Board is equipped to direct and develop the Trust to discharge its duties effectively and efficiently and to understand, assess and manage strategic, reputational and operational risk; and produce, review and revise the Trust's business plan to ensure that it will achieve the Trust's vision and strategy.

17. I am expected to lead, develop and inspire an Executive team to support the delivery of each executive member's delegated responsibilities, and drive the desired organisational culture, underpinned by effective teamworking, which will be role modelled at the most senior level of the Trust.

18. Visible and accessible leadership is key as a CEO to ensure I can develop effective dialogue with staff, partners in the local health and social care economy and appropriate external organisations and develop effective working relationships with staff which create a climate of openness, transparency and learning.

19. As CEO I act as a driver for equality, diversity and inclusion (known within the Trust as 'pro-equity'), both as an employer and a provider of services.

20. It is my role as CEO to establish and maintain systems of control and limits of delegation, strong systems for performance management, appropriate accountability frameworks to ensure escalation of risks and appropriate decision-making processes.

21. Maintaining a strong network of partners both within Nottinghamshire and more broadly is an essential part of the role to ensure learning, support and challenge from peers and peer organisations.

22. Within 6 months of the start of my tenure the operating environment and the needs of the Trust required me to vary my focus. The events that happened in June 2023 - both the horrific triple homicide in Nottingham, but also the first CQC report into Rampton **[WITN0263002]** moved my attention from a focus on medium term cultural change to that of bringing about quality improvement and improvements for our workforce with a need to focus on rapid change to enhance safety. This has meant my priority focus has been more on the control environment internally and on working with regulators - both the CQC and NHS England, to bring about a shift in their assurance and confidence in the Trust's ability to bring about change.

PART A: GOVERNANCE

Governance Structures

23. There are two aspects of governance I consider – operational governance, which is the structures and processes we have in place to manage the organisation and corporate governance, which is the responsibility of the whole Board of Directors and consists of the structures in place to assure the Board we are delivering our organisational strategy as well as regulatory and contractual obligations. As CEO, it is my responsibility to ensure that governance arrangements are rooted in clear accountability, transparent decision-making and a shared commitment to delivering safe, high-quality and sustainable care.

Corporate Governance

The Board

24. The Board **[WITN0263003]** is a unitary board, comprising seven executive directors (including myself as CEO, the Executive Medical Director and Deputy CEO, Executive Director of Nursing, Quality and Allied Health Professionals, Executive Director of Finance, Executive Director of People and Culture, Chief Operating Officer, and Executive Director of Partnerships and Strategy) and eight Non-Executive Directors, with one Non-Executive post currently vacant. As part of our ambition to be a high functioning unitary Board we must operate as one team, sharing collective responsibility for our decisions. Every member should contribute to open, constructive challenge and the development of our priorities, risk tolerance, values, standards and strategic direction.

25. As with all NHS organisations, the Scheme of Delegation **[NHFT0013457]** defines those decisions reserved for the Board and the responsibilities delegated to committees and the Executive, ensuring clarity about where authority sits for all aspects of Trust business.

26. All directors share the same legal responsibilities to act in the best interests of the Trust and to promote its success for the benefit of the public. While executive and non-executive members have distinct statutory responsibilities, these are grounded in the principles set out in the Code of Governance for NHS provider trusts **[NHSE0000522]**

27. The are a number of reporting mechanisms the Board uses to support assurance on quality, safety and regulatory and contractual performance. All Board committees share a highlight report to each Board meeting identifying areas of risk and concern. The Board monitors performance through an Integrated Performance Report ("**IPR**") **[NHFT0000529, page 38]** and a regulatory performance report **[WITN0263004]**. The regulatory performance report is a relatively new addition from November 2024 Board. The whole Board agenda is now risk-based, for example at our most recent Board meeting we reviewed assurance papers on winter preparation **[WITN0263005]** and the workforce race equality standard **[WITN0263006]**.

28. It is worth noting the NHS England Director of Making Data Count observed our public Board meeting and provided verbal positive feedback. They commended the clarity, confidence and ownership demonstrated by Executive Directors, the quality of Non-Executive challenge informed by a strong understanding of Statistical Process Control, and the Board's balanced focus on both areas of strong performance and areas requiring improvement. They particularly noted the active use of data by frontline teams and described the meeting as "perhaps the best board observation" they had undertaken. They also described the Integrated Performance Report as an "exemplary" document, praised its rigorous quality assurance, and recognised the minimal external support required in its development. This feedback reinforces that while our reporting cycle may create a short time lag due to the assurance steps involved, the Board's use of data is strong, mature and embedded.

29. Committees will highlight reports and reviews of the Board Assurance Framework ("**BAF**"), which in turn keep the Board focused on risk and risk mitigation.

Board Committees

30. The Board is supported by a number of committees, each chaired by a Non-Executive Director and accountable directly to the Board. These committees provide detailed scrutiny, assurance and oversight across key areas of governance on behalf of the Board.

31. The **Quality Committee [NHFT0004742, 25 May 2023]** oversees clinical quality, patient safety and the embedding of learning from incidents. Its

membership includes the Executive Director of Nursing, Quality and Allied Health Professions ("AHPs"), the Executive Medical Director/Deputy CEO and the Trust's Chief Operating Officer. The Committee provides the Board with assurance on the quality of care and issues relating to safety across the Trust.

32. The **Finance & Performance Committee [WITN0263007]** focuses on financial sustainability, financial risk and value for money, supporting delivery of one of our key strategic objectives: efficiency and effectiveness. At the Board meeting on 25 September 2025 **[WITN0263008, p.9-10]**, we amended the terms of reference to extend the scope of the Committee to cover operational performance matters, rather than its previous focus on finance performance. This change reflects a common approach in the NHS. This Committee also seeks assurance on delivery of our estates and digital strategies.

33. The **People Committee [WITN0263009]** oversees implementation of the Trust's People Plan, monitors people-related risks, and provides assurance on culture, workforce development and Freedom to Speak Up ("**FTSU**") arrangements. The FTSU arrangements are explained further at paragraph 129 of my witness statement. The People Committee seeks assurance around staffing issues related to recruitment and recruitment processes, morale, leadership and leadership development and the Quality Committee seeks assurance on the quality and safety impact of staffing related issues.

34. The **Audit and Risk Committee [WITN0263010]** provides assurance that the Trust has effective structures, processes and controls for managing clinical and corporate risks and maintains an effective integrated system of governance, risk management and internal control through independent and objective review of financial and corporate governance across all Trust activities, ensuring compliance with NHS laws, guidance and regulations.

35. The **Improvement Oversight Committee [WITN0263011]**, chaired by the Trust Chair, is a time-limited committee focused on delivering the improvements required for the Trust to exit from National Oversight Framework Segment 4/5and the Recovery Support Programme ("**RSP**") **[NHNB0018961]**. An explanation of the Recovery Support Programme can be found at paragraphs 30-33 of the First Witness Statement of Diane Hull **[WITN0133001]**.

36. The **Nominations and Remuneration Committee [WITN0263012]** maintains

oversight of the Board's composition to ensure the right balance of skills, experience and diversity to meet the Trust's needs. With the recent changes of Non-Executive Directors, I believe we have a good mixture of Non-Executive Directors with previous clinical, financial and business experience.

37. The **Charitable Funds Committee [WITN0263013]** oversees the management and governance of the Trust's charitable funds. Its primary purpose is to ensure that charitable funds are administered in accordance with statutory requirements, legal obligations, and best practices as outlined by the Charities Commission. The Executive Director of Finance holds defined operational responsibility for oversight of these funds, while all Board Directors serve as Trustees.

38. The Charitable Funds Committee is tasked with a range of duties, including:

    a. Ensuring legal compliance and proper administration of charitable funds.

    b. Establishing and maintaining robust governance arrangements, policies, and procedures.

    c. Monitoring the financial position of the funds through regular reports.

    d. Overseeing appropriate and purposeful expenditure.

    e. Setting and reviewing the investment policy and performance of fund managers.

    f. Reviewing the annual report, accounts, and audit findings.

    g. Shaping and reviewing the strategic approach to fundraising and fund utilisation.

39. The Charitable Funds Committee meets at least twice a year and reports its activities to the Board. Its Terms of Reference are reviewed annually to ensure continued relevance and effectiveness.

40. Following a governance restructure in September 2025 the Board approved, a separate **Mental Health Legislation Committee [WITN0263014]** to be established to strengthen oversight of our statutory responsibilities under the Mental Health Act 1983 ("**MHA**").

41. While the Board is responsible for developing and monitoring delivery of the Trust Strategy, there is a need for ongoing assessment and evaluation of the

changes in the environment we are operating in as a Trust, as well as changes to national policy. This requires dedicated time and therefore the Board is also supported by a **Strategy Working Group [WITN0263015],** which replaced the former Strategy Committee. While not a formal committee, it provides a forum for strategic thinking, horizon scanning and development of proposals to inform Board decision-making.

Council of Governors

42. Foundation Trusts are required by the NHS Act 2006 to have a Council of Governors, elected from amongst the membership, comprising local people, patients, carers, and staff. At least half of the governors on the Council of Governors must be elected by the public or patient members; at least three governors must be elected by staff; and at least one governor must be elected by one or more qualifying local authorities such as local universities or local authorities. **[NHFT0000548]**

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

44. The Trust's Constitution **[NHFT0000548]** sets out the Council's responsibilities and the matters that are reserved for the Council's decision. These are:

    a. *The appointment and removal of the Trust`s Chair and non-executive directors (section 26, pages 17-18; paragraph 5.1.1(i), Annex 5, page 91)).*

    b. *Determination of the terms of office, remuneration and other allowances of the Trust's Chair and non-executive directors (section 35, page 24; paragraph 5.1.1(ii), Annex 5, page 91).*

    c. *To approve the appointment of the Chief Executive (paragraph 29.2, page 20; paragraph 5.1.2, Annex 5, page 92).*

    d. *To approve amendments to the Trust's NHS Foundation Trust Constitution (section 46, page 29).*

e. *The appointment and removal of the Trust's External Auditor (paragraph 40.2, page 26; paragraph 5.1.1(iii), Annex 5, page 91).*

f. *To provide views to the Board of Directors on the strategic direction of the Trust and targets for the Trust's performance and in monitoring the Trust's performance in achieving those strategic aims and targets (paragraph 5.1.3, Annex 5, page 92).*

g. *To hold the Board of Directors to account in relation to the Trust's performance (paragraph 16.1.1, page 13).*

h. *To give the views of the Council of Governors to the directors for the purpose of the preparation of the Forward Plan (paragraph 5.1.2(ii), Annex 5, page 92).*

i. *To consider and give/withhold approval for applications for a merger, acquisition, merger, separation or dissolution (paragraph 47.1, page 30; paragraph 5.1.1(vi), Annex 5, page 92).*

j. *To consider and give/withhold approval for the Trust to enter into a Significant Transaction (as defined within the Constitution) (paragraph 47.2, page 30; paragraph 5.1.1(vii), Annex 5, page 92).*

k. *To be presented with the Trust's annual accounts, any report of the Auditor on them and the Annual Report (paragraph 44.1, page 28; paragraph 5.1.1(iv), Annex 5, page 91).*

l. *To consider resolutions to remove a governor (paragraph 5.1.1(v), Annex 5, page 92).*

m. *To respond as appropriate when consulted by the directors (paragraph 5.1.2(iv), Annex 5, page 92).*

n. *To exercise other functions at the request of the directors (paragraph 5.1.4, Annex 5, page 92).*

Operational Governance

45. While the whole Board of Directors plays a central role in shaping the Trust's strategy, vision and purpose. It is predominantly the Executive Directors and their substructure who are held to account for delivering that strategy, ensuring value for money and meeting our obligations to regulators, partners and, most

importantly, the public we serve.

Executive Directors

46. As Chief Executive, I am responsible for the day-to-day management of the Trust and hold the statutory role of Accounting Officer. This carries personal responsibility for the proper use of public funds, the regularity and propriety of expenditure, and the efficient and effective use of all resources under my charge, consistent with the standards set out in Managing Public Money **[WITN0133003]**.

47. Our Executive Directors lead the operational, clinical, financial and workforce delivery of the Trust, while our Non-Executive Directors provide independent scrutiny and challenge, bringing a breadth of external experience and professional expertise.

48. The detailed scrutiny for operational governance is delegated by the Trust Executive via the Quality and Performance Group **[WITN0263016]** into Care Groups, which escalates key risks and performance issues monthly to the Executive Leadership Team ("**ELT**").

49. I chair the ELT, which brings together all Executive Directors. The ELT provides corporate leadership and ensures that strategic decisions and issues relating to strategic and operational risks are implemented effectively.

50. In order to better engage with the organisation's senior leaders, to make more informed decision making, to increase ownership of decision making and to strengthen resilience and continuity in decision-making I instigated a regular meeting known as the Extended ELT, which comprises the Executive Directors, plus their deputies **[WITN0263017]**.

Trust Service Delivery Model – The Care Groups

51. The Trust's operating model has changed significantly since I joined the Trust. In my view, earlier attempts to integrate physical and mental health services proved unsustainable, resulting in siloed divisions and variable governance with confusion between operational and corporate governance. It is my view that between 2019 and 2022, divisional autonomy led to inconsistent oversight and limited cross-divisional collaboration.

52. I introduced a new Care Group operating model that was approved by the Trust

Board at its Nominations and Remuneration Committee on the 13 April 2023. The purpose of this structure was to deliver stronger integration between clinical, operational, and corporate governance functions, and clearer accountability from care delivery at the front line to the Board. The revised structure was implemented from October 2023 (see also WITN0133001 paragraphs 81 – 129 for full details of the Care Group Models and service delivery).

53. Since November 2023, the Trust has been organised into three clinical delivery focused care groups which are supported by our corporate services:

    a. Mental Health Care Group

    b. Community Health and Specialised Services Care Group

    c. Forensic Care Group

54. These groups align service delivery with clinical pathways and geographical areas, ensuring that each has clear accountability for quality, safety, performance and financial management.

55. Each Care Group is led by a triumvirate leadership team comprising:

    a. A Care Group Director, responsible for operational delivery and resources, reporting to the Chief Operating Officer;

    b. A Care Group Nurse Director, accountable for professional nursing standards, patient safety and experience, reporting to the Executive Director of Nursing, Quality and AHPs; and

    c. An Associate Medical Director, responsible for medical governance and workforce, reporting to the Executive Medical Director.

56. Five new Care Group Nurse Director roles were established to strengthen senior clinical oversight and assurance.

57. The Chief Operating Officer, a post I introduced in 2023, chairs a monthly Quality and Performance Group bringing together all Care Groups and corporate leads to review key performance indicators, risk escalations, mitigation plans, and financial and quality performance. From October 2025 this group became the Accountability Group, as part of the new accountability framework **[WITN0263018]**

58. Given the strong academic and practical evidence that shows a triumvirate leadership structure improves both the focus on quality and safety and operational delivery and to that end at service level, each inpatient unit, community service and prison health service operates through a local triumvirate of:

    a. Associate Director of Operations,

    b. Associate Director of Nursing/Allied Health Professionals, and

    c. Clinical Director.

59. This ensures the integration of clinical, nursing and operational perspectives at the front line, supported by clear escalation routes into the Care Group structure and, ultimately, to the Executive and the Board.

Accountability and Performance Framework

60. This change to Clinical Care Group structure came into effect on 31 July 2025, with the approval of a new Accountability and Performance Framework **[NHFT0015005]**, which has since become a cornerstone of our governance arrangements. This Framework formalises the principles, structures, and processes that underpin how the Trust operates, ensuring clarity of roles, responsibilities, and lines of accountability from frontline services through to the Board. It provides a consistent approach to performance management, risk escalation, and assurance, supporting a culture of transparency, responsiveness, and continuous improvement. The framework reflects learning from previous governance challenges and has been instrumental in embedding the new Care Group operating model, strengthening the alignment between operational delivery, clinical leadership, and corporate oversight.

Changes to Governance structures

Why has change happened during my tenure as CEO?

61. In both January and April 2023 **[NHFT0000905]** I shared my early reflections with the Board in relation to operational governance and some immediate changes I felt needed making. I made it clear I was not criticising previous structures but noting that the current environment needed alternative approaches.

62. I spoke about needing to:

a. Improve divisional Connectivity – the historical structure (2019-22) lent itself to management of a Chain of organisations rather than a cohesive and connected single entity. I was also concerned that previous Divisional structure did not support cross service learning nor did it enable rapid and structured escalation of risks and issues to the ELT and the Board.

b. Improve connectivity, joint working and thereby effectiveness between clinical services and corporate enabling services.

c. Reinforcement of the triumvirate leadership model which must be the leadership spine through the organisation in order to engage and involve both clinical and operational leaders and to appropriately create a sense of shared ownership for performance and quality improvement.

d. Ensure decision making was located at the correct places in the operational structure, and that it was as near to frontline delivery as possible.

e. Balance operational management as specialism with specialist knowledge of delivery areas.

f. Support clarity of good operational and corporate assurance/governance.

g. Support our interactions with the Integrated Care System, ensuring we were involved in conversations regarding capacity and structural alignment.

h. Review the number of voting members on the Board.

Operational Governance Changes – The Executive Structure

63. I sought and received agreement from the Board Remuneration and Appointments Committee **[WITN0263019]** to make a number of changes to the Executive Team: (Q1 2023)

a. Increasing the Medical Director to 1.0 Whole Time Equivalent ("**wte**")

b. Change from having three Executive Operation Directors, to a single Chief Operating Officer

c. Create three Managing Director posts one for each Division or Delivery Unit – these were Very Senior Manager ("**VSM**") banded posts and postholders will be experts in the relevant area of service delivery. They routinely do not sit on the Board or Committees but are on occasion invited for specific topics by the Chief Operating Officer.

d. 'Re-establish' and recruit to the 1.0wte a Director of Corporate Governance with a supporting infrastructure.

e. The development of the triumvirate leadership approach through all layers in the operational part of the organisation.

64. I felt strongly that the Executive Team needed its own development programme and I commissioned a programme to commence late in 2023, once I had appointed a new Executive Director of Nursing and AHPs. This programme is still in place today.

Further organisational governance changes from Q3 2023 to date

65. The Executive Team changes were only the tactical first stage of improvement and were then augmented from late 2023 to today through:

a. Opening up the organisation to external scrutiny and support from peers - for example this has involved support from other NHS High Secure providers, other CQC Outstanding rated NHS providers (such as Northamptonshire Healthcare) and the commissioning of various service and function reviews, For example West London NHS Trust helped us with establishment reviews at Rampton. Merseycare NHS Trust helped us with rolling out models to help us with reducing long term segregation, Northamptonshire Healthcare NHS FT helped us by having an Executive Director Chair our independent Evidence and Assurance Group (see [Corporate Witness Statement paragraphs 31, 167 and 487] for further details about this group.

b. Overhauling our approach to change and improvement through reviewing the rapid improvement groups.

c. Changing our approach to Prevention of Future Death reports ("PFDs") oversight, significantly reducing the number of outstanding incident review forms, implementing the use of after action reviews, transitioning

rapidly but effectively to use the Patient Safety Incident Response Framework ("PSIRF") approach to serious incident management.

d. Changing our approach to how people waited for services, developing an access policy, re writing our risk assessment and discharge policies **[NHFT0003231**, **NHFT0003340]** and implementing new risk assessment training.

e. Increasing the visibility of the Executive Team (I have now completed approximately 230 visits to clinical/support teams and professional groups). We have refreshed the Trust Management Group ("**TMG**"), which is the group of deputy and associate directors that often does much of the tactical decision making in the Trust, **[WITN0263020, WITN0263021]** and developed a decision-making group that brings together the TMG and the Executive Team, known as Extended ELT.

f. Codeveloping 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.

66. What might be seen as a simple estate move to move the Trust HQ from a non-patient site to one of our in-Patient Hubs at Highbury Hospital in Nottingham has been influential in reenforcing our increased focus on patients and their families and further supports increased visibility by the senior team.

67. We have radically overhauled engagement across the organisation having completed 86 'Big Conversations' **[WITN0263022]** since June 2024. These are specific meetings between Executives and clinical/support teams with an attendance of about 2065 staff. We now have a vibrant Colleague Reference Group **[WITN0263023]** and Patient and Carer Reference Group **[WITN0263024]** both actively involved in decision making. We have a monthly 'open forum' which all 11,500 colleagues are invited to attend and pose questions on any subject to members of the Executive Team. Our four colleague led equality, diversity and inclusion ("**EDI**") networks **[WITN0263025]** are going from strength to strength both in terms of members and influence.

68. We have invested heavily in our leaders. All leaders at whatever grade or seniority now have a specific programme of development available to them within the Trust.

69. I have described above just a few examples of changes made to organisational and operational governance structures and processes. Some of these were driven by the increased regulatory scrutiny following the tragic events of the 13 June 2023 but many were in train prior to the Section 48 report **[CQCM0016517]**, the Independent Homicide review **[NHFT0000518]** and the various CQC reports **[NHFT0002015**, **NHFT0001778**, **CQCM0016478]**.

70. It is my view the Trust now operates within a strengthened and more coherent operational governance framework that provides clear lines of accountability from ward to Board, improved integration of quality and performance oversight, and consistent leadership at operational level.

71. These arrangements are designed to ensure that executive and Board-level assurance is directly informed by operational performance and risk intelligence, supporting the delivery of safe, high-quality, and sustainable care.

Corporate Governance Changes

72. Changes have been made to enhance the focus and efficiency of these structures. This started with my bringing in Peter Howie, a specialist 'advisor' in early 2023 to enhance the Boards understanding of good NHS Corporate Governance. I have outlined the main areas that have undergone change in the following paragraphs.

73. Development of Board Committee Assurance:

    a. In 2023, the Quality Committee was reinstated as a stand alone entity, re-establishing a clear, single line of assurance to the Board on quality and patient safety.

    b. In 2023 the Strategy Committee was changed to a Strategy Group to recognise it was not a formal assurance group.

    c. In 2025 the Finance Committee took on responsibility for operational performance.

    d. In 2025 the Board approved the setting up of a Mental Health Act Legislation Committee to enable the Quality Committee to focus on the growing quality and safety agenda.

74. Strengthening Quality Governance and Patient Safety Oversight:

a. On the 21 February 2024, the centralised patient safety team was augmented when funding was agreed to add an additional 12.7 WTE staff. The team was enhanced by the recruitment of Patient Safety Clinical Managers dedicated to a Care Group, Patient Safety Partners to bring the voice of the patient into the team, dedicated PSIRF Investigation reviewers, Duty of Candour Lead, an administrator to oversee Learning from Deaths, led by a Patient Safety Specialist.

b. The Managing Serious Incident and Reporting and Learning from Deaths policy (15.02) **[NHFT0000596]** was revised in 2024/25. This was replaced in April 2025 to become the Reporting, Managing and Learning from Incidents policy (15.01), reflecting the changes as a consequence of the implementation of the PSIRF framework. **[NHFT0012587]**

c. As required under the PSIRF framework, the Trust also developed a Patient Safety Incident Response policy **[NHFT0012587]** and PSIRF plan, both of which were implemented in April 2024. The Policy and Plan **[NHFT0008708]** was refreshed in 2025 to change local priorities.

d. In 2024 a unique patient safety tool called 'SafeNow' was implemented by the Trust and is now being rolled out over all service areas. Further detail on SafeNow can be found at paragraphs 521-526 of the First Witness Statement of Diane Hull.

e. In 2024 and 2025 there was an increased focus on the compliance, understanding and oversight of duty of candour; significant progress has been made to reduce the backlog and ensure incidents are closed within the agreed timeframe.

f. In 2024 work was done to routinely use CCTV and electronic observation records to improve compliance with therapeutic observations processes.

75. Evolution of the Performance and Accountability Framework:

a. The first Performance Management Framework was established in 2018/19 but the feedback I have received was it provided limited escalation mechanisms.

b. Following external review through NHS England's RSP and independent audit in 2024 **[NHSE0001384]**, the framework was revised to improve

accountability and escalation.

c. A further internal audit in April 2025 informed the new Accountability and Performance Framework, which was approved by the Board in July 2025 **[NHFT0015005]**, which now provides a clear route for assurance from Care Groups to the Board.

76. Implementation of the Care Group Operating Model 2023–2024:

a. In November 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.

77. I now describe the Trust's governance structure as being based on three integrated components:

a. **Board and Committee Assurance** – The Board of Directors is supported by clearly defined committees, including the Quality Committee, Finance Committee, and People Committee. Each has a specific remit with transparent reporting lines, enabling triangulation of assurance across quality, workforce, performance, and finance.

b. **Operational Governance** – 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.

c. **Accountability and Performance Framework** – Approved by the Board in July 2025, this framework 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.

78. It is my view that collectively, these arrangements and the changes I have

described represent a significant strengthening of how operational and corporate governance operates in practice, embedding consistent leadership accountability, improving the flow of information, and aligning operational delivery with executive and Board oversight.

79. Structures now have established clear accountability and escalation routes from frontline services through the Executive Team to the Board. They strengthen quality governance and patient safety oversight not just in Board committees but through the Care Groups and use data in a much more integrated way to drive change and identify risk both clinical and operational. Importantly we now have in place a more transparent framework for decision making and operational assurance.

80. The current governance structure reflects several years of deliberate improvement and refinement. Each phase of change has been led by the ELT and approved by the Board of Directors to address identified weaknesses, strengthen accountability, and improve assurance.

Relationship between Executive and Non-Executive Directors

81. It is my view that there are multiple factors that impact on the relationship between Executives and Non-Executive Directors on a Board and how well that Board is able to operate in a unitary style.

My experience of the relationship between Executives and Non-Executive Directors as I joined in 2022

82. During my 'due diligence' before I joined the Organisation I spoke to many Executives and Non-Executives, read various reports such as the 2022 CQC inspection **[NHFT0001997]** and observed a Board session. Whist the Trust as a whole was rated Requires Improvement in the 2022 CQC inspection and needed to deliver substantial actions to make sustained change, I was encouraged by the section that spoke about the Board relationships. For example the CQC's narrative from 2022 report **[NHFT0001997]** found that "*Non-Executive and Executive Directors were clear about responsibilities, that the Chief Executive had built a strong and collaborative culture, and that challenge was met positively and transparently*."

83. However, I observed and heard that relationships between Executive and Non-

Executive Directors were professional but perhaps not mature, and this was something I could see in my early Board meetings. Challenge tended to be more of a superficial nature and was often met by a more defensive response from Executives. Assurance seemed to rely heavily on narrative reporting rather than triangulated evidence, by which I mean rather than referencing data or feedback from staff or patients or the content of other reports, responses to challenge tended to be the thoughts or views of a single Executive Director This dynamic, in my view, resulted in the depth of assurance not being as comprehensive as it could be. Challenge tended to follow a pattern of a single question followed by a defensive response, with limited follow-up or deeper interrogation. In a more mature board dynamic, I would expect to see multiple levels of challenge from Non-Executive Directors, with 2-3 rounds of questioning that probe deeper into the assurance being provided. Instead, challenge appeared reactive, responding primarily to what was being read in the paper at that moment rather than drawing connections across different reports or identifying inconsistencies between statements made at different points in the meeting. It was rare that Executives would contribute beyond their portfolio or that more than 1 Executive Director or Non-Executive Director would engage in a challenge conversation. This meant opportunities were missed to triangulate information or to challenge contradictions, such as pointing out when an Executive's current statement differed from something said earlier in the meeting or conflicted with information in other reports

84. I feel that one of the drivers of this was the turnover of the Executive Team during 2022. In this year the Trust had 3 CEOs (the previous substantive CEO, an interim, then myself from December) and three new Executives were recruited - Executive Directors of Finance, Strategy and People respectively) all first time Board Executive posts and while they were all experienced in their portfolio areas it was a step up moving into an Executive position. In addition, during 2022 there was an acting up arrangement in place for several months as the previous Executive Director of Nursing covered the CEO position. In addition, at the start of 2022, 3 new Non-Executive Directors joined the Trust with a fourth joining in June 2022. This level of turnover had an impact on the functioning of the Board.

Relationships between Executives and Non-Executive Directors today

85. Today the relationship between Executive and Non-Executive Directors is open, respectful and characterised by constructive challenge within a clear framework of accountability. Non-Executive Directors provide proportionate scrutiny of Executive performance, and that challenge is welcomed and acted upon. Importantly, there is also cross Executive challenge as well as cross Executive supporting assurance at Board meetings. Challenge often goes deeper with multiple levels of questioning rather than a simple challenge and response and this results in a more comprehensive understanding of risk and assurance levels.

86. The whole Board has had development through the Board Development Programme, **[WITN0263026]**, which reinforces this dynamic by encouraging the building of both individual and collective capability. It has included training on the CQC Single Assessment Framework, Freedom to Speak Up, inclusive recruitment and integrated performance reporting, alongside workshops on strategic versus operational leadership, equity, and implementation of PSIRF. Periodic skills-mix reviews and peer learning ensure the Board maintains the right balance of expertise and diversity and continues to assess itself against the CQC Well-Led Framework [**CQCM0016438**].

87. Challenge and assurance are embedded through both formal and informal mechanisms. Each Board Committee - Quality, Finance and Performance, and People - is chaired by a Non-Executive Director, supported by Executive leads, and provides structured opportunities for scrutiny and assurance. In addition, Board development sessions, strategy workshops and joint service visits promote shared understanding and strengthen collective ownership of priorities and risks.

88. External assessments confirm the improvements made. The NHS England Recovery Support Team's Well-Led review (2024) **[NHSE0001506]** later observed appropriate challenge and support in Board committees and noted Non-Executive Director attendance at rapid-improvement groups to gain assurance.

89. These findings reflect the progress made in embedding a culture of constructive challenge, openness and mutual trust. Non-Executive Directors now seek

assurance through triangulated data, committee scrutiny and direct engagement with staff and service users, and the Executive Team responds with transparency and candour.

90. My view is that having been together as a team for some 3 years, and having had the benefit of both team and individual development, the Executive Team is much stronger, more effective and cohesive than it was, and this has impacted the dynamic at Board meetings. Executives are much more willing to consider challenges from Non-Executive Directors as being an opportunity to widen their approach to providing assurance rather than it seen as a threat responded to defensively.

91. While further work is under way to ensure consistency of assurance across all Care Groups, the relationship between Executive and Non-Executive Directors is now more mature, transparent and effective, supporting the Board's statutory duties.

Board monitoring of mental health services

My early tenure – 2022/early 2023

92. Historically operational oversight of mental health services sat within Divisions, led by the relevant Executive Director. Divisional outputs were primarily channeled through Accountability Review Groups **[WITN0263018]**, which served as the initial forum for performance reporting and assurance. However, my feedback was that these meetings often focused on service showcases rather than systematic performance interrogation, limiting their effectiveness as escalation mechanism and the root for escalation from the then Divisions through to the Board were not clear to me.

93. Quality and performance assurance oversight for mental health services was primarily exercised through the Quality Operational Group (QOG) **[NHFT0015033]**, a direct sub-group of the Quality & Mental Health Legislation Committee (Q&MHLC) and was chaired by the Executive Director of Nursing. The QOG brought together divisional intelligence, triangulated key indicators from the IPR, and considered quality, safety, and performance themes across all Divisions. Issues requiring escalation were reported into the Q&MHLC, a formal sub-committee of the Board.

94. The Q&MHLC **[WITN0263014]**, chaired by a Non-Executive Director, comprised both Executive and Non-Executive members and was responsible for oversight of quality governance, patient safety, and compliance with mental health legislation. Supporting the committee, the Mental Health Legislation Operational Groups (LOGs) provided assurance specifically in relation to the application of the Mental Health Act, including detention processes, rights, and statutory compliance. The LOGs reported into the Q&MHLC, reporting on legislative matters rather than on wider service quality or performance

95. The Board of Directors sought assurance through the Q&MHLC and through direct presentation of the IPR at public Board meetings. However, in the absence of a Chief Operating Officer, there was no single executive lead responsible for triangulating cross-divisional performance. As a result, the Board's view of overall mental health service quality and performance was sometimes fragmented.

96. Sub-groups of the QOG — including the Serious Incident Review Group, Learning from Deaths Group, Safeguarding Strategic Group, and Infection Prevention & Control Committee — provided additional layers of assurance. However, those groups operated largely in parallel rather than within a fully integrated governance framework, and their outputs were not always triangulated through a single, consolidated route to the Board. My view is that this contributed to variability in how assurance was generated and how mental health service performance was monitored at a strategic level.

97. The IPR is the primary tool that was and is used by the Board to monitor the adequacy and effectiveness of mental health services. Presented at each public meeting of the Board of Directors, the IPR consolidates operational, quality, workforce and financial metrics across all Care Groups, with a dedicated section for mental health performance. It draws on national datasets (including the Mental Health Services Dataset and NHS England Operational Planning metrics), as well as internal systems and assurance reports. My view is that mental health based metrics nationally are less well developed than metrics in other NHS sectors such as acute physical healthcare.

98. I understand that historically, performance and quality oversight relied on standalone reports and limited triangulation between operational, clinical, and

financial data. While service metrics were monitored, there was less consistency in escalation and assurance mechanisms between care groups.

99. In 2022 metrics routinely reported on included:

    a. 72 hour discharge follow up

    b. Early Intervention in Psychosis ("**EIP**") 2 week engagement

    c. Patients placed out of area

    d. Physical health check compliance

    e. New patient admissions

    f. Long lengths of stay admissions

    g. New community referrals getting 2 or more contacts

    h. Improving Access to Psychological Therapies ("**IAPT**") performance data

    i. Mental Health Minimum Data Set ("**MHMDS**") compliance

    j. Emergency Department ("**ED**") 12 hour breaches

    k. Delayed transfers of care

100. Whilst the areas reported on have remained fairly constant (as the national mental health performance data metrics have remained relatively unchanged), in terms of how performance data was used at the Trust, the observation I had in the period after I first joined was that because there was no Chief Operating Officer role to pull together and make links between performance from all Divisions conversations were siloed and so opportunities for cross Divisional learning or sharing of best practice relating to performance was not strong. There was also very limited support from Division to Division in dealing with performance issues.

101. In addition, different divisions had various reporting and accountability structures and I did receive feedback from some of my early visits to services that staff and more 'junior' leaders found it difficult to understand where decisions were made and how things were escalated and to whom.

Current arrangements

102. The Board monitors the adequacy of mental health services through a

structured framework of accountability, assurance, and performance oversight, aligned with the Trust's Accountability and Performance Framework. The Chief Operating Officer now has oversight of this framework and before that through the Quality and performance meeting structure she was able to overview operational performance of the Trust as a whole: moving resources or focus as needed.

103. This approach provides clear lines of accountability from ward to Board and ensures that oversight is informed by triangulated data on quality/safety, performance, workforce, and finance.

104. The Board reviews performance using a suite of key indicators that assess access, flow, quality, safety, and outcomes, recognising as these are based on national reporting requirements they have not changed greatly, but the Chief Operating Officer has clear accountability for delivery and reporting of these metrics These include:

Inpatient Flow Key Performance Indicators ("**KPIs**")

a. Discharges followed up within 72 hours
b. Inappropriate Out of Area Placements
c. Physical Health Checks (Inpatients)
d. Acute admissions with no prior contact (overall and by ethnicity)
e. Long length of stay metrics (>60 and >90 days)
f. Readmissions within 28 days
g. Emergency Department 12-hour breaches
h. Patients clinically ready for discharge
i. Bed days for Older Adult Mental Health (dementia wards)

Access KPIs

a. Children and Young People ("**CYP**") Eating Disorder waiting times (urgent/routine)
b. Individual Placement Support (IPS) trajectories
c. Perinatal access

d. Early Intervention in Psychosis (EIP) waiting times

e. Community Mental Health access (2+ contacts)

f. Assessment waiting times for Local Mental Health Teams and Child and Adolescent Mental Health Services ("**CAMHS**")

g. Crisis response times (urgent and very urgent)

Legislative Compliance

a. Mental Capacity Act 2005

b. Mental Health Act 1983

105. These metrics are reviewed alongside workforce indicators (safe staffing, sickness, turnover, supervision compliance) and financial data, allowing the Board to evaluate both service capacity and quality outcomes.

106. During 2024 the Trust, with some support from the Integrated Care Board ("**ICB**") developed a further suite of metrics that emerged from mental health services referred to as 'Safe Now' **[WITN0263027]**. This is a dashboard of:

a. 35 in-patient mental health metrics covering areas like number of patients waiting for a bed, use of the section 136 suite, physical healthcare compliance, staffing levels, risk and safety audit compliance, restrictive practice elements such as seclusion episode's, medication issues and discharge planning

b. 24 Community Mental Health metrics including areas such as waiting list management, number of patients needing crisis intervention while waiting, people discharged due to compliance, re referrals, risk assessments and safety plans, vacancy rates, critical patient feedback

c. 14 Crisis and home treatment metrics including risk assessments up to date, safety planning, patients seen within 4 and 24 hours, incidents of moderate harm, vacancy rates, proportion of feedback critical from patients and various metrics linked to the crisis access phoneline.

107. These metrics are reviewed daily in ward teams as part of the 'clinical huddle' and are escalated through the Care Group structure and reviewed at the ELT meetings. The information informs the discussion related to the IPR. A Quality of Care review paper goes to the Quality Committee bi-monthly which is a sub-

section of the overall IPR. It contains some but not all of the Safe Now metrics but also has additional metrics. In addition, a report goes to the Improvement Oversight and Assurance Group **[WITN0263028]** chaired by the ICB CEO and Regional Medical Director.

108. The Quality Committee - chaired by a Non-Executive Director - provides the principal source of assurance to the Board on the safety and quality of mental health services. It undertakes deep dives into incidents, complaints, mortality reviews, and patient experience, and ensures CQC compliance through systematic reviews and learning summaries. Findings are escalated to the Board via highlight reports and supplemented by the Audit and Risk Committee and People Committee to ensure comprehensive assurance across domains.

109. Under the Accountability and Performance Framework, performance oversight now follows a clear, tiered structure:

    a. Ward and Team Huddles: Identify and escalate risks daily.

    b. Care Group Senior Leadership Teams (SLTs): Review performance weekly and feed into the Accountability Group.

    c. Accountability Group: Provides monthly oversight of Care Group performance, escalating risks and themes to the ELT.

    d. ELT: Conducts deep dives and escalation reviews, providing assurance to Board Committees and the Board itself.

110. The Board also gains direct insight through Quality Visits **[WITN0263029],** Board-to-Floor engagement, and service user feedback, ensuring that oversight extends beyond metrics to lived experience. Since 2023, governance has been strengthened to integrate performance reporting, escalation, and assurance, replacing siloed reviews with a coherent structure that links frontline performance to strategic accountability.

111. The introduction of Care Groups in 2023/24 and the standardisation of Accountability Meetings have improved the consistency and visibility of mental health service oversight. Regular deep dives on key risk areas such as crisis services, community access, and Out of Area Placements, now inform Board and committee discussions, ensuring early intervention and responsive improvement actions.

112. These changes have significantly improved the adequacy and transparency of Board oversight. It is my view that the current framework provides:

    a. A single, integrated view of quality, operational, and financial performance.

    b. Clear escalation pathways from team level to Board.

    c. Systematic monitoring of statutory compliance with the Mental Health Act and Mental Capacity Act.

    d. Greater consistency of assurance through Care Group accountability structures.

    e. Increased Board visibility through structured visits and engagement.

113. The result is that the Board and operationally the Executive now receive timely, triangulated assurance and can act on early warning signs, ensuring that governance supports the delivery of safe, high-quality, and sustainable mental health services.

Escalation of care issues

114. The Trust has established clear and multiple routes through which issues with the care provided can be escalated to me as CEO, the ELT and, where appropriate, to the Board of Directors. These routes are embedded within the Trust's systems of internal control and assurance framework.

115. Each route connects to a defined governance pathway. Concerns raised are reviewed at Care Group level, escalated to the ELT where appropriate, and, if required, referred to the Quality Committee, Audit and Risk Committee, or Board of Directors.

Operational escalation

116. This occurs through the line management structure. Immediate or significant concerns regarding patient safety or quality of care are escalated from frontline teams through service and care group leadership, and onwards to the relevant Executive Director. The Trust's Care Group operating model provides clear accountability through the triumvirate leadership structure of Care Group Director, Nurse Director, and Associate Medical Director, who in turn report to the ELT. Concerns can be raised and acted upon through multiple routes,

including:

117. Operational escalation within Care Groups, led by the triumvirate of Care Group Director, Nurse Director, and Associate Medical Director through regular performance meetings or safe now escalations

118. Escalations through the various rapid Improvement meetings/structures the Trust has in place:

    a. Patient and carer feedback, including complaints, Care Opinion submissions, and engagement through the Patient Experience Team. Care Opinion is the independent NHS feedback website for patients, family members and carers. The Trust's Patient Experience Team are a central point of contact for patients, family members and carers to provide feedback and raise concerns about services provided by the Trust.

    b. Staff escalation mechanisms, including the FTSU Guardian (see paragraph 129).

    c. Regulatory and system oversight, including feedback from the CQC, NHS England, and the Integrated Care Board.

    d. Other external escalations for example from Members of Parliament, Healthwatch or the CQC

    e. Internal assurance processes, including internal audit, incident reporting, thematic reviews, and clinical audit outcomes.

    f. Feedback from visits to teams, general engagement routes such as 'Big Conversations' (see paragraph 124) or the monthly Executive Team Open Forum as well as escalation through direct emails. The Executive Team Open Forum is a live MS Teams event for all colleagues across the Trust which I host with members of the Executive Leadership team. The forum covers all the latest hot topics in the Trust. The event is open to all regardless of role, team, or service and is available to colleagues working across any site.

119. The Quality and Performance Group (or from October 2025, the Accountability Group), chaired by the Chief Operating Officer, meets monthly to review performance, risks and incidents across all Care Groups. Issues requiring executive or Board oversight are escalated to the ELT.

120. The ELT, which I chair, reviews significant incidents, emerging risks, and serious performance or quality concerns, determining whether matters should be escalated to the Board or a Board Committee.

121. Issues with potential regulatory, reputational or strategic impact are reported directly to the Board of Directors or the Quality Committee through the Executive Team, depending on their nature

122. In addition to these formal structures, there are also direct escalation routes available to staff and service users, including the Freedom to Speak Up Guardian, the Patient Safety Incident Response Framework, and the Complaints and Patient Experience teams.

123. Beyond these formal mechanisms, I actively seek feedback from colleagues across the organisation. I receive and respond to emails daily from staff at all levels, and I have undertaken a significant numbers of service visits each year (234 since I joined the Trust) to hear directly from teams and service users. These visits are a vital source of insight and help ensure that concerns are surfaced and addressed in real time.

124. We also hold regular "Big Conversations" across the organisation, where I and other Executive Directors speak openly with staff about challenges, priorities, and opportunities for improvement. These sessions foster transparency and trust, and often surface issues that may not be captured through formal reporting channels.

125. Quality improvement initiatives and clinical audit are embedded across the Trust and provide further mechanisms for identifying and addressing concerns. These programmes enable teams to systematically review care delivery, identify areas for improvement, and implement changes that enhance safety and outcomes. Findings from clinical audits and quality improvement projects are reported through governance structures and contribute to organisational learning.

126. In my view, these means of escalation are generally effective, with clear routes for concerns to reach me and the Board. Improvements over the past two years — including strengthened care group accountability, better data integration within the IPR, and closer alignment between operational, quality, and risk functions — have enhanced the timeliness and visibility of escalation. In

addition, the ability to triangulate the more formal assurance feedback detailed above with direct feedback on the experience of colleagues and patients and families is what in my view adds depth to the various escalation routes. This is something I consider has developed and improved over the last 2 years.

Escalation to Board Committees (Corporate Escalation)

127. The Quality Committee, chaired by a Non-Executive Director, provides detailed scrutiny and assurance on clinical quality, safety, and patient experience. It receives reports on serious incidents, complaints, safeguarding, CQC compliance, mortality reviews, and thematic learning. Any concerns regarding systemic or unresolved risks are escalated to the Board through Committee reporting.

128. In addition, the Audit and Risk Committee, also chaired by a Non-Executive Director, provides independent assurance on the effectiveness of the Trust's systems of internal control, including risk management, internal audit, and the integrity of assurance processes (as set out above at paragraph 34). Issues relating to governance or control failures that may impact care quality are escalated from the Audit and Risk Committee to the Board.

129. The FTSU Guardian provides regular reports to the People Committee and the Board **[WITN0263101]** to ensure that concerns are heard and acted upon. This is an important report that shows the Board and People Committee a range of data, including: the number of concerns raised, themes emerging from those concerns, and then (to ensure more detail is seen) it breaks them down by Care Group and Corporate areas. Importantly, the report also shares what has been done to mitigate the risks and concerns. For example, in May 2025 the paper to the Board spoke about high numbers of concerns about culture and shared some of the work around the work with managers and leaders. In addition, the report shared examples of where managers engaged with the process and made changes. The FTSU report therefore provides assurance on actions taken in response to concerns raised particularly as the report comes to the ELT prior to Board so If any further action is required, specific actions are allocated to Executive Directors for follow-up and resolution. The FTSU Guardians also participate in operational triangulation meetings, enabling us to look at any service hotspots that are flagging issues with complaints, FSU escalations and

serious incidents. This ensures that concerns raised through the FTSU process are integrated with other feedback mechanisms and governance processes.

130. The Trust's BAF **[WITN0263030]** integrates these escalation and assurance processes, mapping key risks to strategic objectives and identifying the sources of evidence by which assurance is obtained. The BAF is reviewed quarterly by the Board and informs its assessment of the adequacy of internal control.

Assurance of escalation routes

131. The effectiveness of escalation mechanisms and controls is assessed annually through both: the Annual Governance Statement, which forms part of the Trust's Annual Report and is reviewed by both internal and external auditors before approval by the Audit and Risk Committee and the Board; and through feedback from external reviews, thematic analysis as well as governance reviews such as the RSP developmental well led review.

132. Other sources of assurance include CQC inspections, NHS England oversight meetings, internal audit reviews, and external benchmarking. Findings and improvement actions from these external assurance processes are routinely reported to the Board and monitored through the Improvement Oversight Committee and Quality Committee.

133. However, like all complex healthcare organisations, the system relies on consistent application and professional judgment. Ongoing work to strengthen governance maturity at Care Group level through the maturing of the Accountability Framework, improving real-time intelligence, and maintaining open lines of communication with staff will further enhance the effectiveness of escalation and assurance in practice. The ongoing communication through the organisation of how the accountability framework will work, where decisions get made will also make it easier for colleagues to understand where to escalate concerns to.

<u>Concerns about mental health services</u>

134. During my tenure as CEO of the Trust, concerns have been raised about the adequacy of some mental health services at the Trust. These have been surfaced through a range of formal and informal mechanisms and have been addressed systematically through the Trust's strengthened governance,

assurance, and performance management arrangements.

135. The Trust now operates a mature system of internal control, underpinned by the Accountability and Performance Framework. This ensures that issues relating to quality, safety, or adequacy of mental health services can be identified, escalated, and addressed promptly.

Concerns Raised

136. Across my tenure, the main themes of concern have related to:

a. Patient safety and risk management – including variation in care planning, risk assessment compliance, observation practice, and therapeutic engagement that relate to individual patients' care. For example, patient complaints and when I have met families as part of that process and the various reports into the care and treatment of Valdo Calocane ("**VC**") also reference concerns around how well individual risk assessments reflect the risk an individual poses to the wider community.

b. Access and capacity – most often within crisis services but in other local mental health teams as well, inpatient flow, and specialist mental health pathways.

c. Workforce resilience – recruitment, retention, and safe-staffing pressures affecting service continuity. I would add that leadership styles and approaches have also been raised with me and the Executive team.

d. Governance and data quality – the need for stronger integration of quality, performance, and risk intelligence with more clarity about what the routes of escalation are and what assurance needs to be sought at what level in the organisation, often described as where do decisions get made.

137. These concerns were raised by frontline staff, patients and carers, regulators, and system partners such as the ICB and Primary Care. Between 2022 and 2024, several regulatory reviews most notably the CQC and internal audits identified weaknesses in assurance and operational consistency that required targeted improvement.

138. In August 2023, following the tragic events involving VC, the Trust considered it necessary to seek external assurance on the adequacy of specific mental

health services (see [CWS paragraphs 494 – 502] for full details).

139. An independent review of the Early Intervention in Psychosis (EIP) Team was commissioned **[NHFT0000461]** to provide an objective assessment of the team's functioning, with a particular focus on how decisions to discharge patients were made and documented. Given the clinical specialism required, Jonathan Warren (a retired Chief Nurse and NHS CEO) led the review and was supported by Dr Olivier Andlauer, Early Intervention in Psychosis Consultant and Clinical Director at East London NHS Foundation Trust.

140. Following this, the Trust commissioned further independent reviews into Crisis Services **[NHFT0000462]** and Local Mental Health Teams **[NHFT0000545]**, as well as a thematic review of homicides **[NHFT0000518]**, to provide comprehensive quality assurance and learning across the broader mental health portfolio. These reviews were completed under Jonathan Warren's oversight and reported through the Trust's governance framework, with findings and recommendations presented to the ELT, Quality Committee and Board of Directors.

141. The commissioning of these reviews demonstrated the Board's commitment to transparency, external scrutiny, and continuous learning, ensuring that any systemic weaknesses were identified and addressed promptly.

Actions Taken

142. In response to concerns and findings from internal and external sources, the Board and the Executive Team have taken decisive action to strengthen the adequacy and resilience of mental health services. Key actions include:

    a. Launching the Integrated Improvement Plan ("**IIP**") **[NHFT0003275]** in 2024, setting out five targeted programmes addressing patient safety, leadership, culture, governance, and financial sustainability.

    b. Strengthening Care Group accountability through monthly Accountability Meetings (These are the refreshed Quality and Performance Meetings) chaired by the Chief Operating Officer **[WITN0263018]**, with escalation through the Accountability Group to the Executive team and Board.

    c. Improving data integration and visibility through enhancements to the IPR, enabling near-real-time monitoring of quality and performance

metrics through Safe Now.

d. Enhancing governance linkages between quality, performance, and risk functions to support early escalation and triangulated assurance.

e. Investing in workforce initiatives through the People and Culture Programme, focusing on recruitment, retention, wellbeing, and leadership. This resulted in significantly reducing the time to hire and reducing the Trusts staff turnover rate to a 2 year low.

f. Investing in increased staffing establishments through various establishment reviews.

g. Embedding patient and staff voice in service redesign through the Patient, Carer and Family Reference Group, Freedom to Speak Up reporting, and thematic learning reviews.

h. Launching a review of the Adult community Mental Health clinical pathway.

i. Reviewing how patients wait for services to ensure increased safety

j. Developing an observations collaborative **[WITN0263031]** to overview how we deliver and develop therapeutic observations.

k. Developing a Quality Improvement ("**QI**") strategy **[WITN0263032]** and priorities led by clinical leaders.

l. Involved Mental Health Improvement Service in developing and improving our community service's

m. I commissioned an external review of Serious Incidents and safety processes in the Trust. **[NHFT0000423]**

n. Introduction of waiting list oversight meeting **[WITN0263033]** – across all areas – sharing good practice.

o. Primary Target Lists approach to waiting list management used in acute hospitals for increased focus applied across majority of areas.

p. Risk assessment and the Transfer and Discharge policies rewritten **[NHFT0003231, NHFT0003340]**; new risk assessment training very well received and peer led; improvements in patient involvement with their care.

q. Commissioned a review led by Healthwatch about Community mental Health Services and developed an action plan accepting all the recommendations. **[NHFT0003597]**

143. Assurance on these actions is provided through the Quality Committee and Improvement Oversight Committee, which monitor progress against agreed trajectories and reports to the Board.

144. My view is that earlier in my tenure, escalation mechanisms and data flows were less consistent across the former divisional structures, escalating issues to the Executive was not structured and assurance was largely retrospective. For example, there was not a structured weekly report to the Executive detailing serious incidents, and feedback was often presented by the communications representative from a reputational rather than learning perspective. Since 2023, the introduction of Care Groups and the recent implementation of the Accountability and Performance Framework have delivered greater clarity, timeliness, and consistency of oversight. Now weekly we have a formal report presented by the Director of Nursing to the Executive Team that triangulates patient safety incidents, feedback from Coroners, Complaints, Safeguarding and Section 42 of the Care Act 2014 issues and high-risk staffing issues. This is a significant change and improvement.

145. The Trust's governance maturity has improved markedly, enabling a more proactive and transparent response to emerging risks. Regulators and system partners, including the CQC and NHS England, have acknowledged this progress through ongoing engagement.

146. Concerns about the adequacy of mental health services have been taken seriously and are being addressed through sustained executive focus, independent review, and system-wide collaboration. The Trust operates a transparent, data-driven, and externally validated approach to identifying, escalating, and resolving concerns.

147. I do accept that challenges remain in areas such as demand management and workforce resilience, but I am of the view that the systems and processes for assurance and accountability are stronger and continue to mature and that this will support improvement in areas where challenges remain. As CEO, I remain committed to ensuring that concerns are heard, understood, and acted upon

swiftly, and that the Trust continues to improve the quality, safety, and adequacy of the mental health services it provides., I remain committed to ensuring that concerns are heard, understood, and acted upon swiftly, and that the Trust continues to improve the quality, safety, and adequacy of the mental health services it provides.

CQC inspection and report – November 2022

148. The CQC published a series of inspection reports in November 2022, one month prior to my appointment as CEO of Nottinghamshire Healthcare NHS Foundation Trust. These inspections covered ten of the Trust's sixteen core services, alongside a Trust-wide Well-Led review. The overall rating was "Requires Improvement," with four of the five domains – including "Safe" and "Well-Led" – receiving the same rating. **[CQCM0016478]**

149. While the 2022 inspections were completed before my tenure began, the findings were a critical reference point in shaping the strategic priorities of my leadership and the Trust's collective response. The inspection reports had begun a process of improvement that was expanded and further developed as we identified areas for change early in my tenure at the trust. Upon joining the organisation in December 2022, I worked closely with the ELT and the Board of Directors to ensure a coordinated, transparent, and accountable response to the CQC's findings.

Strengthening Leadership and Governance

150. We undertook a comprehensive review of the Trust's governance structures, resulting in clearer lines of accountability and improved oversight at both divisional and corporate levels.

151. A CQC Oversight Group **[WITN0263034]**, chaired by the Executive Director of Nursing, was established to monitor progress against all CQC-related actions. This group reports directly into the ELT and the Quality Committee.

152. We invested heavily in nurse leadership capacity across the Care Groups, recognising the pivotal role of nursing in driving safety, quality, and cultural change.

153. A Risk Summit was convened in response to safety concerns at Rampton Hospital, leading to the formation of the Rampton Hospital Improvement Board

[WITN0263035] and then Improvement Group, which continues to oversee sustained progress. The original risk summit purpose was to create an immediate rapid improvement plan and was attended by a range of professionals including medical and nursing leaders, transformation experts, local leadership team, communications and engagement, and people services colleagues from an organisational development perspective as well as recruitment perspective. This group became the Rampton Improvement Group and attendance was widened to include NHS England and the CQC.

Embedding Quality and Compliance

154. Each Divisional Quality Operational Group was tasked with developing and overseeing action plans in response to the CQC's requirement notices. **[WITN0263105, WITN0263106, CQCM0017659, CQCM0017664, CQCM0019835, WITN0263107, WITN0263108, WITN0263109, WITN0263110, WITN0263111]** These groups reported monthly into the Trust wide Quality Oversight Group, which in turn provided assurance to the Quality and Mental Health Legislation Committee and the Board.

155. The Quality Standards Team commenced a schedule of service visits to assess progress against compliance actions. Findings were escalated as needed to the Executive and Quality Committee.

156. A significant focus was placed on the Fundamental Standards of Care, ensuring that every service understood and could evidence compliance with the core expectations of safe, effective, and person-centred care.

Strategic Infrastructure and Service Improvement

157. The opening of Sherwood Oaks Hospital in November 2022 partly addressed one of the CQC's enforcement notices regarding dormitory accommodation in mental health wards. This was a major milestone in the Trust's transformation programme and a tangible improvement in patient dignity and safety. There is one ward left to address at Highbury Hospital and preliminary work will commence by end of March 2026. The actual work will start during the financial year 2026/27 and will be completed the following year.

Board-Level Oversight and Assurance

158. The Board committed to a programme of deep dives into areas of concern,

including governance, workforce, and safety culture.

159. The BAF was refreshed to ensure alignment with the CQC findings, with enhanced scrutiny of controls, mitigations, and sources of assurance. **[NHFT0002354]**

Integrated Improvement Plan

160. In 2024, the Trust initiated a comprehensive IIP to deliver significant and sustainable improvements to the way the organisation operates and the quality of care it provides. This decision was taken in response to a range of external assessments, including the Care Quality Commission (CQC) Section 48 review **[CQCM0013499]**, and in recognition of the need to meet the criteria for exiting segment 4 of the NHS England National Oversight Framework **[NHSE0000518]**.

161. The IIP was developed to ensure that the Trust could strengthen its performance, leadership, and governance in line with national expectations, while maintaining a clear and unwavering focus on patient safety.

162. In addition, the 'legal undertakings' **[NHFT0000818, p.27-36]** given to the Trust specified the need to develop and deliver an IIP.

Development of the IIP

163. The process of developing the IIP was important in itself and in early 2024 we created a forerunner to the Plan which detailed all required actions from learning including from PFD reports, outstanding actions from the CQC and other regulators, investigations, staff survey feedback, actions to support the relicensing of Rampton Hospital. This was a very detailed approach and through discussion with NHS England, it was agreed our priority should be to focus on the more immediate regulatory requirements which by necessity led to a focus on the various Section 48 recommendations and findings. The CQC recommendations **[NHFT0002106, NHFT0003265**, **CQCM0016523]** from their inspections of Rampton Hospital and Adult and Older Adult Mental Health Inpatient Services and more latterly the recommendations from the Theemis Independent Homicide Review **[NHFT0000530]**.

164. As the CEO it was my responsibility to develop this plan and ensure it met the improvement needs of the Trust, but that it also was accepted by NHS England and the NHS England RSP.

What is the IIP?

165. The Integrated 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.

166. Each programme is underpinned by a detailed set of actions and milestones, with progress monitored through robust governance and oversight mechanisms. To provide strategic direction and assurance, the Integrated Improvement Portfolio Board ("**IIPB**") was established by the ELT and is chaired by me, as CEO. **[NHSE0001329]** The IIPB is responsible for overseeing the delivery of the IIP, ensuring that all actions are implemented effectively, that risks are identified and mitigated and that the Trust remains on track to meet the criteria for exiting the RSP.

167. The IIPB reports regularly to the Improvement Oversight Committee, which is chaired by the Trust Chair. This Committee plays a critical role in assessing progress, identifying risks, and providing assurance to the Trust Board that the Plan is being delivered with rigour and that the necessary outcomes are being achieved.

168. In addition, the Improvement Oversight and Assurance Group - a multi-stakeholder body co-chaired by the NHS England Regional Medical Director and the Chief Executive of the Nottingham and Nottinghamshire Integrated Care

Board - provides strategic oversight of the Trust's improvement journey. This Board brings together system partners and stakeholders from across the local health and social care system to ensure that the Trust's improvement efforts are aligned with broader system objectives and that sufficient assurance is provided regarding the delivery of the IIP. As the CEO I lead the Executive Team's input into the Improvement Oversight and Assurance Group. **[NHFT0014335]**

169. In addition, we have had two RSP Review Meetings with the National NHS England Executive Team as part of providing assurance to the national executive team about the approach we were taking to improvement, challenging what we were doing, and evidence of outcomes to show where that improvement was happening. as part of the Trust being in the RSP to review progress against our IIP **[NHSE0001506, NHSE0001744]**.

170. Collaboration has been central to the development and implementation of the IIP. The Trust has actively welcomed input from a wide range of stakeholders, including specialist support teams, peer NHS Trusts, and system partners. We have also established both a Staff Reference Group and a Patient, Carer and Family Reference Group, which have played a vital role in shaping the Plan and ensuring that the voices of staff, patients, carers, and families are embedded in the design and delivery of service improvements.

171. As CEO, I have taken personal responsibility for leading the Trust through this period of improvement. I have chaired the IIPB, ensured alignment across the ELT, and maintained close engagement with system partners and oversight bodies. I have also worked to ensure that the Trust remains focused on its core purpose —providing safe, high-quality care to the people we serve — while building the organisational capability required for long-term success.

Progress against the delivery of the IIP

172. Since the launch of the IIP, the Trust has made demonstrable progress across all five programme areas. We have strengthened our governance arrangements, improved leadership visibility and accountability, enhanced patient safety protocols, and increased staff engagement. The Trust has shown a clear trajectory of improvement, and our oversight bodies have recognised the effectiveness of our approach and the commitment of our teams to sustained change.

173. At our second RSP Review meeting with NHS England National Executive Team on 6 December 2024 there was recognition of the significant progress made by the Trust since our RSP entry meeting. **[WITN0263036]** We had a review Board to Board meeting with the NHS England Midlands Regional Team on the 8 October 2025 where we were able to provide a significant level of assurance about our IIP progress and discuss the various risks associated with the Trust current financial situation. **[WITN0263037]**

174. While there is still work to do, I am confident that the IIP provides a strong foundation for continued progress. The next phase of the plan moves us from some of those tactical responses to regulatory requirements into developing and delivering the components including cultural change related to ensuring change and improvement is sustainable. We remain fully committed to delivering the actions required to exit segment 4 and to embedding a culture of continuous improvement across the organisation.

175. Improvements delivered through the IIP include:

    a. Embedded a stronger patient safety culture, supported by the rollout of PSIRF.

    b. Introduced the "Waiting Well" process, including risk stratification and compliance monitoring. The Waiting Well process provides information to patients on the steps that they can take, and the support they can access, while waiting for an appointment with a mental health professional or for a transfer to another service. It also provides clarity to the leaders of the services on the number of patients waiting and how long they waiting for. The Waiting List Oversight Group is a subgroup of the Quality and Performance Management Group (QPMG). The group brings together appropriate parties from within the Trust to provide a mechanism for obtaining evidence for assurance of waiting list, waiting time reduction and implementation of waiting well across the Care Groups [**NHFT0016016**, **p.3-4**].

    c. Strengthened risk assessment practices and assertive outreach work.

    d. Deployed the Safe Now Dashboard, embedding a Quality Improvement (QI) approach to real-time safety monitoring.

e. Advanced Safe Wards initiatives to improve therapeutic environments and reduce restrictive practices.

f. Delivered targeted improvements in response to Section 48 findings, including oversight of 18-week waits and waiting list management.

g. Achieved a sustained reduction in inappropriate out-of-area placements over 18 months.

h. Commenced a Care Group restructure, moving toward a clinically led and operationally partnered model.

i. Designed the Digi-Care programme and have delivered some of the projects within the programme such as embedding the Trust's digital strategy and implementing clinical digital champions. The Digi-Care programme aims to improve how we use digital systems in our trust. It focuses on making technology work better for staff and patients, ensuring our digital tools are easy to use, efficient, and support high-quality care. **[WITN0263112]**

j. Undertook pathway redesign across Adult Mental Health Services, including Crisis, Local Mental Health Teams ("**LMHTs**"), acute inpatient care, and services for older people.

k. Launched a Monthly Leadership Forum **[WITN0263038]** for the Trust's 200 most senior leaders.

l. Delivered four Leadership Development Programmes for Bands 2–8b. **[NHSE0001963, p.10]**

m. Introduced the Valuing Medical Leadership Programme, offering bespoke Organisational Development ("**OD**") and leadership development for medical staff.

n. Rolled out a Ward Manager Development Programme at Rampton Hospital.

o. Commenced Extended Executive Leadership Development and OD in July 2025.

p. Established a coaching network, implemented 360-degree feedback, and refreshed HR training across the organisation.

q. Strengthened the Trust's system interface, with active participation in Place-Based Partnerships, Integrated Care System programmes, and Health Scrutiny Committees.

r. Enhanced public confidence through open communication, Healthwatch engagement, and transparent updates on improvements.

s. Improved Board oversight, with regular updates on CQC Section 48 undertakings, Theemis actions, and significant safety incidents.

t. Increased visibility through Non-Executive Director and Governor visits and approved a new Trust Accountability Framework.

176. The Improvement Oversight Committee continues to monitor IIP progress quarterly, ensuring strategic alignment and assurance.

PART B: RISK ASSESSMENT AND MANAGEMENT

177. In responding to questions on risk management, I will distinguish between strategic (corporate) risk management and clinical risk management, as they serve distinct but interrelated purposes within the Trust's overall system of governance and assurance.

Strategic Risk Management

178. Strategic risk management operates as an organisational control mechanism designed to safeguard the Trust's strategic objectives, operational integrity, and statutory obligations. It focuses on risks that could compromise the delivery of the Trust's long-term goals — such as financial sustainability, regulatory compliance, workforce resilience, digital infrastructure, and organisational culture.

179. These risks are identified, assessed, and managed through formal governance structures including the BAF, the Corporate Risk Register, and are overseen by the Audit and Risk Committee, the ELT, and the Risk Group with escalations being made to the Board of Directors. This framework enables the Board to maintain a clear line of sight on the principal risks to strategy delivery and to ensure that mitigations are both effective and evidence-based.

Clinical Risk Management

180. Clinical risk management operates at the level of patient care and professional

practice. It is inherently dynamic and individualised, focusing on the identification, assessment, and management of risks to patient safety and the quality of clinical outcomes. Clinical risk is governed through professional and statutory frameworks including clinical supervision, continuing professional development (CPD), peer review, incident reporting, and thematic learning reviews. Oversight is provided through quality governance structures, which ensure that learning from incidents and audits informs safe and effective practice.

181. While strategic risk management ensures the resilience and accountability of the organisation as a whole, clinical risk management safeguards the safety and integrity of individual care decisions. The two domains are interdependent: information from quality governance, incident learning, and patient safety reviews informs the Trust's corporate risk registers and, in turn, the Board's understanding of systemic risk.

Linking Strategic and Clinical Risk Management

182. There is a direct link between strategic risk and clinical risk as it is the Trust's responsibility discharged by the Executive and the Board to share thematic learning with clinicians and clinical teams, to ensure teams and clinicians have opportunities for reflection and learning through supervision and have role based training that is amended to take account of strategic thematic learning. The Executive and Board are also accountable for ensuring the correct policies, procedures and best practice documents are available and disseminated.

183. As CEO, I am accountable to the Board of Directors for ensuring that the Trust has in place an effective and comprehensive system for the monitoring and management of both strategic and operational risk. Together with the Board, we have embedded a structured framework, underpinned by our Risk Management Strategy **[CQCM0023093, WITN0263039]** and the Risk Management Policy **[WITN0263040]**, which ensures that risk management is integral to governance, decision-making, and day-to-day operations across the organisation.

Risk Management Framework - both strategic and clinical

Strategic Risk Oversight (Board Assurance Framework – BAF)

184. The Board monitors strategic risks through the BAF, which provides a

structured method for identifying, assessing, and managing the principal risks to achieving the Trust's strategic objectives.

185. The detailed operational aspects of the BAF, including Executive Director ownership of strategic risks, risk appetite statements, assurance ratings, escalation mechanisms, and the specific review processes by the Board and Audit and Risk Committee, are set out comprehensively in paragraphs 204, 215 - 226 below.

186. Where risks exceed the Board's defined tolerance, urgent remedial actions are directed and monitored, with progress reported back to the Board and relevant Committees.

Operational Risk Oversight (Risk Register and Escalation Framework)

187. Operational risks are managed through the Trust's electronic risk management system (Ulysses), which captures risks at Care Unit, Care Group, Corporate, and team levels.

188. Each risk has a designated Risk Owner and Person Responsible, with accountability for ensuring that risks are reviewed, scored, and mitigated in line with agreed timescales.

189. Risks are categorised and scored using a 5x5 impact/likelihood matrix. Significant risks (scored 15+ or with an impact score of 5) and all Extreme risks (20–25) are escalated to the Trust Risk Group and reported to the Board.

190. The Risk Escalation Framework **[WITN0263041]** ensures that unresolved or high-impact risks are escalated promptly from frontline teams through Care Units and Care Groups to the executive level and, where necessary, to the Board.

191. Monthly monitoring reports are produced by the Risk Manager, highlighting significant and overdue risks, and these are reviewed by the Risk Group, chaired by the Chief Operating Officer, before being escalated to the Audit and Risk Committee and the Board.

Committee and Governance Structures

192. The Audit and Risk Committee provides assurance to the Board on the effectiveness of the Trust's risk management and internal control systems (see

paragraphs 237 to 240 for further detail); the Finance Committee, People Committee, and Quality Committee each review risks relevant to their remit, including deep-dive reviews of BAF risks proportionate to their score and profile; and the Trust Risk Group **[WITN0263042, WITN0263043]** meets monthly to review high-level risks, horizon scan for emerging risks, and ensure alignment with the Board's risk appetite.

193. This layered governance structure ensures that both strategic and operational risks are subject to scrutiny, challenge, and assurance at the appropriate level.

Monitoring, Reporting and Continuous Improvement

194. The Trust Risk Manager produces monthly Significant Risk Reports and quarterly Extreme Risk Highlight Reports, which are reviewed by the Risk Group and escalated to ELT and the Board.

195. Internal Audit provides annual independent assurance on the effectiveness of the risk management framework, contributing to the Annual Governance Statement **[WITN0263044, p.112]**

196. The Trust undertakes an annual Risk Maturity Assessment **[WITN0263045]** to evaluate and strengthen its risk culture, ensuring continuous improvement.

197. Lessons learned from incidents, complaints, audits, and external reviews are systematically incorporated into risk registers and the BAF, ensuring that learning informs future risk management.

Culture, Training and Engagement

198. The Board and I have prioritised the development of a risk-aware but not risk-averse culture, encouraging open reporting and constructive challenge.

199. Training is provided at all levels, including induction modules for new staff, masterclasses, refresher sessions, and leadership training for managers.

200. Staff are supported with accessible guidance, workshops, and risk clinics, ensuring that risk management is embedded in everyday practice.

201. The Board and I monitor and manage strategic and operational risk through our governance framework that integrates the BAF, 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.

Role of the Board in risk management policies

202. In this witness statement, I am providing my view on this topic question for the time period following my appointment. As CEO, I am accountable to the Board of Directors for ensuring that an effective and integrated system of risk management operates across the Trust. Risk management is recognised as a core component of corporate governance and a key enabler of organisational resilience, informed decision-making, and public accountability.

203. The Board of Directors sets the overall direction and tone for risk management. There is a formal review each year of the risk appetite levels held by the Board to inform a review of the BAF. Through this process the Board defines the Trust's risk appetite, approves the Risk Management Strategy, and receives regular assurance that risks are identified, assessed, and mitigated appropriately. The Board reviews the BAF at its meetings, with supporting assurance from the Audit and Risk Committee, and receives an annual statement of assurance through the Annual Governance Statement.

204. The Board's oversight is supported by a committee structure that provides targeted scrutiny:

205. The Audit and Risk Committee provides independent assurance on the adequacy and effectiveness of the Trust's risk management systems, internal controls, and governance processes.

206. The Quality, Finance, and People Committees each review specific categories of strategic risk relevant to their remit, escalating significant issues or emerging trends to the Board.

207. The Board undertakes scheduled deep dives into principal risks each year, proportionate to their severity and strategic relevance.

Role of the Executive Leadership Team

208. The ELT, which I chair, is responsible for operationalising the Trust's risk management strategy and ensuring that risk processes are embedded in day-

to-day management. Executive Directors are individually accountable for managing risks within their portfolios, maintaining risk registers, and ensuring effective mitigations. The ELT reviews the corporate and strategic risk profile monthly, supported by intelligence from the Risk Group which reports directly into ELT.

209. The Risk Group, chaired by the Chief Operating Officer or another Executive in their 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 to inform refinement of the Risk Management Strategy and Policy.

210. The creation and review of risk management policies and strategies is a shared responsibility across the Trust's leadership and governance structures:

    a. The Board sets the strategic direction, determines risk appetite, and provides oversight and assurance.

    b. The CEO and ELT operationalise the strategy, ensuring risks are actively managed and aligned with organisational priorities.

    c. The Risk Group and the Board Committees provide the analytical and assurance infrastructure that underpins continuous improvement.

211. As CEO, I ensure that strategic risk management remains embedded in our organisational culture, continuously reviewed for effectiveness, and aligned to the delivery of safe, high-quality, and sustainable care.

Board training on risk assessment

212. On appointment, all members of the Board receive dedicated one-to-one training and coaching from the Trust's Head of Risk Management and Board Assurance Lead. **[WITN0263046]** This induction ensures that each Director develops a clear understanding of the Trust's Risk Management Framework, including the design and purpose of the BAF, the process for determining and applying risk appetite, and the principles of risk escalation, control, and assurance.

213. This initial training is supplemented by tailored coaching and guidance

throughout the year, enabling Board members to deepen their understanding of emerging risks, regulatory expectations, and the integration of risk management into strategic decision-making. The Trust's approach emphasises practical application, using live examples from the BAF and corporate risk registers to support learning.

214. The Board also undertakes an annual risk management development session **[WITN0263047]** for all Board members. This session provides a structured review of the BAF, focusing on:

    a. Deep dives into principal risks and their mitigations;

    b. The adequacy and effectiveness of controls and assurance mechanisms;

    c. Re-evaluation of the Trust's risk appetite and tolerance levels; and

    d. Alignment of risk exposure with strategic objectives and the external operating environment.

215. These activities are intended not only to build technical capability but also to cultivate a shared, risk-aware culture at Board level. As a result, Non-Executive and Executive Directors are equipped to provide informed scrutiny, challenge, and assurance on the Trust's management of strategic and operational risk.

Board Assurance Framework

Core Purpose of the BAF

216. The BAF is a central component of the Trust's governance and risk management system. Its primary purpose is to provide the Board of Directors with structured, evidence-based assurance that the organisation is effectively identifying, managing, and mitigating the principal risks to achieving its strategic objectives.

217. The BAF links each strategic objective to its associated risks, sets out the controls and mitigations in place, and identifies the sources of assurance that demonstrate the effectiveness of those controls. This provides the Board with a clear line of sight from strategic risk to operational delivery and enables informed decision-making within the Trust's defined risk appetite.

218. The BAF also functions as a dynamic management tool — not just a static record — used by both the Board and the ELT to prioritise improvement actions,

inform resource allocation, and test the resilience of existing controls. It supports transparency, accountability, and alignment between operational and strategic risk oversight. I acknowledge that it is a complex tool and feel it works best when staff are familiar with it and use it dynamically.

219. The BAF is formally reviewed and approved at meetings of the Board of Directors **[WITN0263048]**. It is subject to detailed scrutiny by the Audit and Risk Committee, which receives an updated BAF and risk management report at each ordinary meeting. The Committee provides independent assurance on the adequacy of the Trust's systems of internal control, calling Executive Directors to account for their respective risk portfolios.

220. In addition, other Board Committees — including the Finance, People, and Quality Committees — review specific risks aligned to their remit, ensuring triangulation of assurance across quality, workforce, performance, and finance domains. Chairs of these committees form part of the core membership of the Audit and Risk Committee, reinforcing coherence and connectivity across the assurance system.

221. Deep-dive reviews of high-scoring or emerging risks are scheduled annually, proportionate to their significance and strategic relevance. The findings of these reviews inform updates to the BAF and shape the Board's forward planning.

The Effectiveness of the BAF

222. In my view, the BAF is an effective and mature mechanism for strategic risk monitoring and management at senior leadership level. It provides the Board and ELT with a single, integrated view of the Trust's principal risks and the assurances available to support sound governance and decision-making.

223. The effectiveness of the BAF and the wider risk management framework is tested and validated annually through internal and external audit. The Head of Internal Audit Opinion has consistently confirmed the adequacy and effectiveness of the Trust's risk management systems, and the Annual Governance Statement, reviewed by external auditors, provides further independent assurance of their robustness **[WITN0263049, WITN0263050, WITN0263051]**.

224. In June 2024 the head of Internal Audit Opinion stated "we issued a significant

assurance opinion for our work on the BAF: we also issued significant assurance in 2023/24" **[WITN0263052, WITN0263053]**. The NHS England developmental Well Led review report in January 2025 acknowledged that areas of improvement such as reporting the BAF position at committees had been actioned and found the focus on BAF at the Board Committees and the Board is robust and adequate time is spent to discuss the mitigations/actions **[NHSE0000463]**.

225. Historically, risk management relied on multiple registers and inconsistent assurance reporting across divisions. Since 2022, the BAF and risk management arrangements have been strengthened enabling direct alignment between strategic risk, performance oversight, and operational accountability. This has enhanced the quality of assurance received by the Board and improved the visibility of risk ownership at all levels of the organisation.

Concerns about risk assessment and management

Strategic Risk Management Concerns

226. Although the reports arising from VC's conduct contained detailed exploration of clinical decision making, elements of them raised issues concerning strategic risk, for example in relation to the Board's role in creating the right environment, systems, templates, communications and learning to support clinical decision making. These concerns are as follows:

    a. The CQC Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2 published in August 2024 **[CQCM0013499]** raised inconsistent approaches to risk assessment was an issue in VC's case, the 10 benchmarking cases and reflected findings from their wider review of the Trust. The focus was predominantly on how and what was included in operational risk assessment and management although I want to acknowledge that the Board and my role is to create the right environment, with the correct policies in place, the right training to support clinical practice and the judgements that clinical colleagues make about clinical care.

    b. The Theemis investigation **[NHFT0000530]** is more detailed in its findings about both the operational risk management and the corporate responsibilities for systemic and systematic approach to risk

management including the absence of assurance to the Board on risk management issues, the absence of Trust discharge policy and template, poor systematic approach to the communication of risk across agencies and the Trust Board not having visibility of sub-contracted providers of inpatient beds.

227. In addressing these concerns, the Trust has established a comprehensive Risk Management Framework **[WITN0263054]**, embedded across all levels of the organisation — from Care Units and Care Groups to Corporate Departments and the Board. This framework ensures that risks are systematically identified, assessed, monitored, and escalated as appropriate. Risk management is recognised as a core organisational responsibility, supported by clearly defined governance arrangements.

228. Operational and corporate groups within Care Groups and Corporate Departments review and approve risks at the appropriate level. These groups are responsible for validating risk scores, assessing the adequacy of controls, and determining whether escalation is required. The Trust's Risk Escalation Framework provides clear guidance for escalating unresolved or high-impact risks to senior leadership, including the Risk Group, the ELT, and ultimately, the Board of Directors.

229. At a strategic level, the BAF serves as the principal tool for monitoring key risks. The BAF is reviewed regularly by the Board and its Committees. The Audit and Risk Committee receives reports on the BAF at each meeting and undertakes in-depth reviews of high-priority risks. The effectiveness of the Trust's risk management arrangements is further validated through independent assurance provided by internal and external audit, including the Head of Internal Audit Opinion and the Annual Governance Statement, which confirm that the systems of internal control and risk management are operating effectively. These external assessments of the risk management systems and processes are undertaken annually.

Clinical Risk Management Concerns

230. In terms of the assessment and management of clinical risk at an individual patient level, while this was not escalated from clinical services, the Trust has had concerns raised particularly through CQC inspections for example the CQC

Section 48 review, and serious incident review findings about individual clinical risk management processes with some of the common themes relating to:

a. Timeliness of completion of risk assessments
b. The breadth and depth of risk assessments including not adopting a longitudinal approach
c. The regularly with which individual clinical risk assessments were updated
d. Actions taken to address these concerns included:
e. Risk assessment and discharge policies rewritten
f. New risk assessment training very well received
g. Improvements in patient involvement with their care planning and risk assessments
h. Robust local clinical audit process put in place to support over view of clinical risk management

231. It is my understanding the Trust offered clinical risk training both through an e-learning package which was managed by the Learning and Development Department and until the COVID-19 pandemic, the Mental Health Care Group was delivering an additional enhanced face to face package. The bespoke package was co delivered by a patient and carer and clinician. It involved crisis planning, care planning and involvement. [**NHFT0015158**, **NHFT0015587**] There is now both updated e-learning and face to face training that is focused on personalised care, involvement and dynamic assessment [**NHFT0015073**, **NHFT0015295**, **NHFT0015209**]

Audit and Risk Committee

232. The Audit and Risk Committee is a formally constituted committee of the Board of Directors of Nottinghamshire Healthcare NHS Foundation Trust. It provides independent assurance to the Board regarding the effectiveness of the Trust's systems of integrated governance, risk management, and internal control. The Committee is chaired by a Non-Executive Director and comprises other Non-Executive Directors, including the chairs of the Board's other formal committees – namely the Finance Committee, People Committee, and Quality

Committee. This membership structure ensures triangulation of assurance across the Trust's strategic and operational domains. The Committee operates under formally approved Terms of Reference, which are reviewed annually to ensure alignment with regulatory requirements and the Trust's governance needs. **[WITN0263010]**

233. The Audit and Risk Committee meets at least quarterly and receives a BAF and comprehensive risk management report at each meeting. It undertakes deep dives into high-profile and strategically significant risks on a scheduled basis, proportionate to their score and potential impact. The Committee also reviews findings from internal and external audits, challenges Executive Directors on their risk portfolios, and monitors the implementation of the Trust's Risk Management Strategy.

234. Prior to the establishment of the Audit and Risk Committee in its current form, the Trust operated a separate Risk Committee **[WITN0263055, WITN0263056]**, which focused specifically on oversight of organisational risk. The functions of that predecessor body have since been integrated into the broader remit of the Audit and Risk Committee, streamlining governance and strengthening alignment between risk management, assurance, and financial oversight.

ARC Role in Risk Management Policies

235. The Committee has played a key role in overseeing the development and review of the Trust's risk management policies and strategies, ensuring that they remain fit for purpose, compliant with regulatory expectations, and aligned with organisational objectives.

236. At an operational level, the Risk Group provides a critical mechanism for active monitoring, escalation, and mitigation of risks across the Trust. Chaired by the Chief Operating Officer, the Risk Group meets monthly and oversees high-level risks emerging from Care Groups, Care Units, and Corporate Departments. Its objectives include fostering a risk-aware culture, maintaining oversight of material risks, horizon scanning for emerging risks, and strengthening organisational resilience. All extreme risks (scored 20–25) are reviewed promptly, with Director or Deputy Director-level ownership and accountability for mitigation plans. The Risk Group consolidates intelligence from operational governance meetings, challenges assumptions, and ensures alignment with the

Trust's strategic objectives and risk appetite. The Group also considers cross-cutting risks, including Infection Prevention and Control, Estates, Digital Services, and People and Culture, to ensure system-wide consistency.

The oversight of Clinical Risk management

237. The Audit and Risk Committee does not directly oversee individual clinical decision-making, which is the responsibility of registered professionals within their statutory and professional frameworks. Clinical risk management operates at the level of patient care and professional practice and is inherently dynamic and individualised, focusing on the identification, assessment, and management of risks to patient safety and quality of care.

238. Assurance regarding clinical risk evaluation is provided through multiple, complementary mechanisms:

    a. *Quality Governance Structures*: Each Care Group and Care Unit maintains robust quality governance arrangements, including regular team meetings, clinical supervision, peer review, and audit. These structures ensure that learning from incidents, near misses, complaints, and thematic reviews informs safe and effective practice.

    b. *Professional Oversight:* Registered clinicians are supported and held accountable through continuing professional development (CPD), mandatory training, supervision, and appraisal. Specialist leads provide guidance on complex cases, and escalation pathways ensure that high-risk situations are appropriately managed.

    c. *Incident Reporting and Thematic* Learning: The Trust operates a structured incident reporting system. All incidents, particularly those involving patient risk, are logged, reviewed, and analysed. Learning is disseminated through reports, training, and team briefings, ensuring that systemic issues are addressed and practice improvements embedded.

    d. *Quality Committee Oversight:* The Audit and Risk Committee receives assurance regarding clinical risk through reports from the Quality Committee. This includes monitoring of serious incidents, safeguarding, Mental Health Act compliance, and wider patient safety data. Executive Directors, including the Executive Medical Director and Executive

Director of Nursing, provide regular updates via the Reportable Issues Log, now called the Patient Safety Exceptions Report which is a paper that is presented to the Board to escalate significant clinical risks to the Board where necessary. The decision to change the name of the Reportable Issues Log to the Patient Safety Exceptions Report took place in the Quality Committee of 11 March 2025 [**NHFT0000763, p.101**] and was enacted at the Board meeting on 25 May 2025 [**NHFT0015006, p.199**].

e. *Integration with Corporate Risk Management*: Information from quality governance, audits, and incident learning informs the Trust's operational and strategic risk registers. This ensures that individual patient-level risks contribute to the Board's understanding of systemic or organisational risk.

239. Reporting through the Trusts 'Safe Now' process ensures compliance in key clinical areas with mandatory risk assessment completion.

240. Through these combined structures – the Audit and Risk Committee, the Risk Group, operational governance arrangements, and quality governance processes — the Board and ELT receive comprehensive assurance that risk is actively monitored, managed, and escalated across the organisation. This layered, triangulated approach ensures that both strategic and clinical risks are appropriately identified, evaluated, and mitigated, including risks posed by patients. While clinical and strategic risk operate at different levels, their interdependency ensures that patient safety underpins organisational decision-making, systemic learning is embedded across the Trust, and continuous improvement is supported at all levels of governance and operational delivery.

PART C: SERIOUS INCIDENTS AND LEARNING FROM DEATHS

Historical monitoring and review of Serious Incidents

241. Historically, 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.

242. Incidents were shared with the Quality Committee and the Divisional Quality and risk groups

243. Historically the Board received a report in confidential session called the Reportable Issues Log which updated the Board on the most serious incidents and any immediate action taken. It also shared an update and learning from inquests.

244. 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 (Currently the most serious cases are shared with 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

Changes to how serious Incidents are reported and monitored

245. From May 2023 I 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 did include all serious incidents and related learning.

246. Later in 2023 we introduced specific reporting to Q&MHLC which would receive a report summarising serious incidents, themes and giving detail of specific learning in each Division became **[NHFT0015023, p. 208-222]**.

247. Today every ELT receives an update in writing **[WITN0263057]** from what is now called the Significant Incidents Review Group ("**SIRG**"). The report covers all serious patient safety incidents, details the incident including the name of the individual and their personal circumstances (which in my opinion, is very important in reminding the Executive Team of the catastrophic personal nature

of the information they are receiving); it shares immediate learning and actions taken for assurance of the Executive Team. The Report also shares outcomes from Inquests as well as any issues with complaints, safeguarding or high risk staffing issues. These latter areas are vital to ensure triangulation of safer services is enabled.

248. Currently the Quality Committee receives a bi-monthly patient safety report **[WITN0263058]** that details the numbers of serious and moderate incidents, learning from PSIRF reviews, with assurance on actions taken. The Committee also receives a Learning from Deaths quarterly report which brings together learning from data, investigations and coronial enquiries.

249. The Board receives a similar report that details complex patient and staffing issues/incidents, legal issues, high level complaints and safeguarding issues. This report has a significant focus on actions and learning. It is a running log and so as serious incidents are updated or moved into a coronial process, updates come back to the Board.

250. In addition, for the most serious incidents that happen, I would expect an immediate call from the Chief Nurse or Medical Director to alert me to the circumstances, the immediate actions needed and next steps

251. The significant incident review group and the reporting process to the ELT has been amended, since May 2023, to ensure that the Executive Team receives assurance on a serious incident; immediate learnings and actions taken are reported.

252. Following the changes to the Care Group operating model, SIRG and the quality assurance process that is now in place in Care Groups, reports are made through the quality and performance framework which provides assurance on completion of agreed actions from initial and PSIRF Reviews. In addition, the update of the Patient Safety and Learning from Deaths Group 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.

253. The ELT undertook a specific piece of work during 2023/24 to reduce overdue actions related to IR2 incident reports. We now monitor this each time we meet through the Safe Now dashboard to ensure early sight of any action

backlogs occurring.

Governance groups relating to Serious Incidents

Quality Committee

254. The Quality Committee oversees clinical quality, patient safety and the embedding of learning from incidents. Its membership includes the Executive Director of Nursing, Quality and AHPs, the Executive Medical Director/Deputy CEO and the Trusts Chief Operating Officer. The Committee provides the Board with assurance on the quality of care and issues relating to safety across the Trust.

255. The Quality Committee delegates various actions to sub-committees, which in turn may set up groups responsible for a specific subject-matter or specific care group. These two layers are more flexible than the committees which report directly to the board and can therefore be established or changed depending on the needs and priorities of the committee overseeing it.

256. It contains a dedicated Patient Safety, Care and Experience section where routinely safety papers and presentations are shared e.g. Patient Safety Paper, Learning from Deaths Paper, Physical health Care, Safeguarding. Bespoke reports and thematic reviews **[WITN0263104]** are also considered, all of which would have been previously presented to the Patient Safety and Learning from Deaths Group.

257. The BAF is a standard agenda item and the Chair of the Quality Committee makes note of escalations/ risk to bring to the attention of the Board via an Exceptions report and escalated internal control issues to the Audit Committee.

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

258. Historically, SIRG had been the Serious Incident Review Group **[WITN0263059]** and focussed on incidents across the Trust. During my time as CEO (with effect from 2024), it was reconstituted as the Significant Issues Review Group, in order to broaden the agenda to include wider quality matters such as significant incidents, inquest feedback, complaints, and safeguarding. The abbreviation remained as "SIRG".

259. Prior to January 2024, SIRG was chaired by the Associate Director of Quality, reporting directly to the Chief Nurse (Executive Director of Nursing

and AHPs) and the Chief Nurse would attend the meetings of this group.

260. From January 2024, the Deputy Chief Nurse started to chair the meetings and since February 2025 it has been chaired by the Chief Nurse. In its current form, SIRG meets weekly and provides Trust wide oversight of the reporting and management of significant incidents to ensure immediate risks are managed, the appropriate level of investigation is commissioned, the Duty of Candour is applied when required, that staff are supported, and incidents are communicated in an appropriate and timely manner. SIRG also identifies any immediate learning to be enacted.

261. Since 10 May 2023, a weekly exceptions report has been shared with the ELT following the meeting. This practice has continued despite the other changes described in paragraphs 245-253 above. Since October 2023, demonstrating openness and candour, this report has also been shared weekly with the CQC.

262. SIRG does not report directly to the Quality Committee as the Quality Committee continues to receive formal papers on patient safety such as the Patient Safety Exceptions Report (previously titled the Serious Issues Log) which also goes to the Private Board.

Risk Group

263. 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

264. 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. **[WITN0263043]**

265. 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 [NHFT0003519, p19] and makes recommendations to the ELT on priority risk areas and appropriate actions.

266. The group reviews the BAF document at every meeting and provide the Audit and Risk Committee and Board with assurance that its relationship with the organisational risk register has been maintained.

267. 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.

Quality Governance and Effectiveness Oversight Group

268. Previously the Trust's Quality Oversight Group, it changed in April 2025 to the Quality Governance and Effectiveness Oversight Group **[WITN0263060]**. It was refreshed and strengthened to provide assurance to the Quality Committee and Board with regards to the quality of patient care delivered by the Trust. In summary, the Group's duties include the following:

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

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

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

d. Supporting the Trust's Mental Health Legislation Group to discharge its responsibility through ensuring that the Trust has relevant polices,

practice and procedures in place to guide legislative compliance and to plan for future legislative change;

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

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

Complex Incidents Oversight Group

269. From June 2024 during my time as CEO the Trust has established the Complex Incidents Oversight Group (formerly known as the Homicide, Attempted Homicide Group between June 2024 and February 2025) to provide executive oversight and governance of significant patient safety incidents which meet the threshold under PSIRF. **[WITN0263061]** It is chaired by the Chief Nurse, or the Deputy Chief Nurse. This includes mental health homicides, attempted homicides and complex incidents. The objective of the group is to ensure that a joined-up and consistent response is achieved across the Trust, ensuring that the Trust is driving quality and safety improvements by utilising a systematic approach to patient safety incidents as detailed above. The group meets every 4 weeks and part of its remit is to ensure that agreed actions that sit as part of the most serious patient safety incidents are completed

The Patient Safety and Learning from Deaths Group

270. This group was refreshed in April 2024, and the purpose of the Patient Safety and Learning from Deaths Group is to improve the safety of patients receiving care from the Trust's services. **[WITN0263062]** It is chaired by the Chief Nurse or the Deputy Chief Nurse. The Patient Safety and Learning from Deaths Group is responsible for developing a trust wide approach to patient safety issues which includes recommending workstreams to improve patient care. The Patient Safety and Learning from Deaths Group will provide oversight of this work to ensure a joined-up and consistent response is

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

Patient Safety Incident Response Framework

271. The implementation of the Patient Safety Strategy was delayed nationally because of the COVID-19 pandemic - this caused delay in the implementation of PSIRF, which was finally published in September 2022. Trusts were required under the NHS Standard Contract to have in place the PSIRF plan and policy ratified and published by April 2024. The Trust had completed its transition to PSIRF by August 2024.

272. Whilst there was an implementation plan in place, during 2023, the Patient Safety Team had significant change in leadership and sickness. In addition, both the Head of Patient Safety and the Associate Director of Quality, whose portfolios included Patient Safety left the Trust in 2023. Whilst this led to a delay in the implementation of PSIRF, it did enable significant transformation, investment of the Patient Safety Team leading it to become more effective.

273. Throughout this period the Patient Safety Team was actively working with ICB colleagues across the Integrated Care Board and other Commissioners of Trust services, as part of the Patient Safety Specialist Group. Part of the work of this group was to adopt, where possible, a coordinated approach across all providers to the transition to PSIRF. The Trust agreed that implementation would be completed by April 2024 with the ICB – together with other providers in the Nottingham and Nottinghamshire footprint.

274. Mobilisation arrangements were supported by a PSIRF Planning Workshop on 18 September 2023 **[WITN0263063]** where PSIRF workstreams were presented and leads agreed; provided service users, carers, staff and external organisations to understand PSIRF and be an active part of the transition. A PSIRF Implementation Project Board was established in October 2023 with Terms of References for each workstream agreed **[WITN0263064]**.

275. Following the independent review of the Trust's Serious Incident processes that I commissioned, completed by Helen Collins in January 2024

[**NHFT0000423**]; there was agreement to complete a rapid roll out of PSIRF supported by the PSIRF lead who came into post the same month.

276. The Board received the PSIRF Framework and signed it off for publication at the March 2024 Board meeting [**NHFT0008708, NHFT0008819, NHFT0002064, p.97**].

277. On the 27 June 2024 the Board received training around PSIRF at its Board Development Day.

278. Despite the original delay in transition to PSIRF, 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 **[WITN0263065]**. It found significant assurance in the implementation and governance of PSIRF.

Increase in Serious Incidents and Prevention of Future Death Reports

Increase in PFDs

279. PFDs are sent directly from the coroner to myself as the CEO and I am responsible for the acceptance and response to the report. As the new CEO at Notts Healthcare I had concerns about the volume of PFDs compared to what I was familiar with from being the CEO of a neighboring NHS mental health trust. All PFDs were reported to the Trust Executive Team meeting which is where this concern arose.

280. During 2023 the trust received a significant increase in PFDs – 8 in total. During the preceding five years from 2018 to 2022 it had received a total of 5 PFDs. During this period, with court 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.

281. The PFDs received by the trust in 2023 related to deaths in 2018, 2019, 2021 and 2022. I did ask for comparative data for the number of PFDs issued to other Trusts covering a similar service group to ours in order to benchmark my sense that we had more than expected however this data was not able to be obtained.

Increase in Serious Incidents

282. I had similar concerns about the number of Serious Incidents ("**SIs**") within the Trust. The table below provides the total number of SIs reported every year in the Trust. I do recall that when asking for comparable data my Patient Safety Team cautioned me that the difficulty of comparing numbers against other Trusts is that the decision to raise a serious incident can be influenced by a number of things, including the culture of reporting. Trusts with an open reporting culture may seem to raise more incidents on the Strategic Executive Information System ("**StEIS**"). While accepting that, as the table below shows there has been an increase in SIs in the Trust:

Total number of SIs	
2019	401
2020	292 (Covid)
2021	369
2022	442
2023	449
2024*	1st Jan – 31st March 2024 (Prior to Implementation of PSIRF) 37 1st April – 31st December (Post implementation of PSIRF) 69
2025	(First 6 months) 42. Estimate for year of 84

*PSIRF was introduced so caution should be taken when comparing numbers pre and post this date.

283. To give further context, the Trust's data on incidents where serious violence has occurred in the past 5 years (01.04.2019 to 01.04.2024) is as follows;

a. 3 in 2019,

b. 2 in 2020,

c. 4 in 2021,

d. 3 in 2022

e. 5 in 2023 (including VC).

284. More recently, and outside of the dates of the Inquiry:

a. 3 in 2024 – Post April 2024

b. 2 to date in 2025

Concerns related to Coronial Process

285. In addition, I was concerned about the feedback we were hearing in relation to coronial processes, the quality of Trust serious incident reports some of which at this time were undertaken by a specialist provider (SANCTUS) in terms of identifying contributing factors and developing clarity around lessons for sharing across the Trust.

286. I was also concerned that we were not supporting colleagues well enough through both the serious incident process and through any coronial process. My view was we were often sending too junior staff who were neither able to speak strategically about any changes or improvements that had come about post incident investigation. I also heard feedback directly from colleagues that they did not feel supported personally. This lack of visibility of senior staff in my view contributed to the number of PFDs being issued.

287. It was these concerns that led me to ask the Acting Chief Nurse to source an independent investigator to review the whole serious incident process. This is the Helen Collins report referenced at paragraph 275 [**NHFT0000423**].

288. In addition, with the purpose of bringing about change whilst the Helen Collins review was taking place, the ELT on 7 June 2023 received a Quality Improvement Plan **[WITN0263066]** that addressed the Management of Serious Incidents, Inquests, Learning from Deaths (LFD) and the transition to PSIRF.

289. At the June 2023 ELT meeting the ELT supported the improvement plan and requested a business case be developed **[WITN0263067]** and submitted to STEG in support of delivery. The business case and associated spend was completed and approved at an extraordinary Strategic Executive Group (STEG) meeting on 14 June 2023. The review and investment supported the gap analysis around governance of investigations, candour and learning which would inform priority areas of work for the new Head of Patient Safety and

support our PSIRF implementation.

290. The concerns I had that resulted in the Independent Review of the Trusts Serious Incident process were taken to the Quality Committee in February 2024, on behalf of the Board, where a full update was provided on the findings and proposed actions **[NHFT0001610, p45 - 61]**. In addition, in July 2024 a detailed report on the progress against the action plan was discussed at the Quality Committee **[NHFT0000469, p.70 -73]**.

291. Helen Collins, who is an Independent Safety Specialist and Registrant Senior Nurse with over 30 years of experience of patient safety and quality working at national level as well as regionally and locally in tertiary, acute, mental health, community, forensic and commissioning sectors was commissioned to do a full review of the serious incident policy and process.

292. The review into the Trust's Serious Incident processes, was comprehensive and involved 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.

293. The final report was presented to the ELT on 31 January 2024 alongside a dedicated action plan **[NHFT0000423]**. 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 **[NHFT0010339]**.

294. In addition, the ELT agreed to bring back the writing of incidents reports in house. The reason this decision was made was because before 2024, the patient safety team used a bank pool designated for investigations, as the care groups felt that they did not have the capacity to complete the investigations in a timely way. Some of these staff lacked appropriate expertise and were selective about the investigations they would complete. At this time, the Trust also used an external company used for the most complex and unfortunately, these investigations were sometimes also of poor quality and had inaccuracies. A team was substantively appointed in September 2024 which included some of the original bank staff with the right skills.

295. The concerns that I had which led to the Independent Evaluation of Nottinghamshire Healthcare's Safety Processes were mainly driven by emerging concerns relating to the corporate processes around serious incident reporting and learning. There was not a direct link between the clinical decisions taken in the case of VC and the terms of reference for the review. I do accept that there is a link around the process of learning and sharing learning through the Trust that is of relevance to the care and treatment VC received prior to his discharge, however while sharing learning from Serious Incidents was part of the review the link to VC was not.

296. The series of reviews and changes to policy and process in the aftermath of the tragic events of the 13 June 2023 did not rely on Helen Collins report, for example:

a. We immediately locked down access to VC medical records held by our Trust;

b. Developed a programme to immediately review all outstanding Incident Report Level 2 (IR2s);

c. Significantly changed the way we use data to report risks (Safe Now dashboard);

d. Introduced a waiting list oversight meeting to provide evidence of waiting list reduction, waiting time reduction and implementation of the new waiting well process across the Trust. **[NHFT0016016, p.3-4].**

e. Developed and implemented an access policy

f. Changed our risk assessment and Transfer and Discharge policy (01.15), developing a 9 point checklist for discharges **[NHFT0003340, WITN0263068]**

g. Changed the Trust risk assessment training

297. In terms of the timeline for the Helen Collins Review

a. June 2023 - ELT decided to proceed with the Review and to request extending the Patient Safety Team

b. Early Sept 2023 - Helen Collins was instructed by the Trust

c. 26 Sept 2023 - I met Helen Collins

d. 6 Dec 2023 - Presented initial findings to ELT

e. 31 January 2024 - Presented final report to ELT

f. 31 January 2024 – ELT approved and submitted to QOG 21 March 2024

g. 2 July 2024 – the Full report was submitted to the Quality Committee.

298. In February 2024 the Quality Committee was provided with an update on the Review of the management of Serious Incidents. The Quality Committee was advised that the review found that there was a lack of Trust-wide quality improvement programmes, and where they existed, there was a lack of robust quality assurance that they were effective. In addition, there was a severe lack of Trust-wide safety incident investigation, learning and family liaison capacity and capability, and a lack of standardised quality governance structures across the organisation.

299. The review further found that the Trust was not ready for PSIRF and the Duty of Candour was not being performed consistently, and the Trust's external stakeholders for safety were not assured of the ability of the Trust to improve processes.

300. In summary, policies and guidance were reviewed, and there was significant investment to resource a patient safety team which included dedicated investigation leads and Patient Safety Partner). A review of incident governance with the introduction of Care Group and Trust wide Safety meetings, implemented PSIRF, Learning from Deaths and Medical Examiner process occurred. Duty of Candour and inclusion of families was completely reviewed supported by guidance, training and mentorship. 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 way that we use the electronic incident system (Ulysses) to make reporting less complex and time consuming and enabling data to be more focussed for staff and clinical experts.

301. We have developed Ulysses dashboards that provide visibility of data from Trust level down to individual wards, ensuring all staff have access to clear, actionable insights. In addition, we are introducing Excellence Reporting, a system that empowers staff to proactively document and celebrate examples of

outstanding care. This initiative not only recognises positive practice but also fosters a culture of learning, collaboration, and continuous improvement across the organisation.

302. Additionally, we are currently developing functionality within Ulysses to capture and manage Safety Action Plans, which will be trialled in Forensics to ensuring that actions are recorded, tracked, and monitored effectively. This enhancement will strengthen governance processes, improve accountability, and provide greater visibility of progress against safety-related objectives

303. The action was overseen initially by the ELT, which can be seen by the June 2024 update paper **[WITN0263099, WITN0263100]** where 70% of the actions had been completed. The actions were completed by January 2025 and closed via Quality Committee in March 2025 **[NHFT0013000]**.

304. The Trust accepted the findings from this report in full and have delivered against the required actions. For example:

    a. The Trust has invested in family liaison capacity and capability and now has regular positive feedback from families supported;

    b. We have a new Quality Improvement Team with agreed priorities across the Trust and champions trained in each Care Group leading programmes of work;

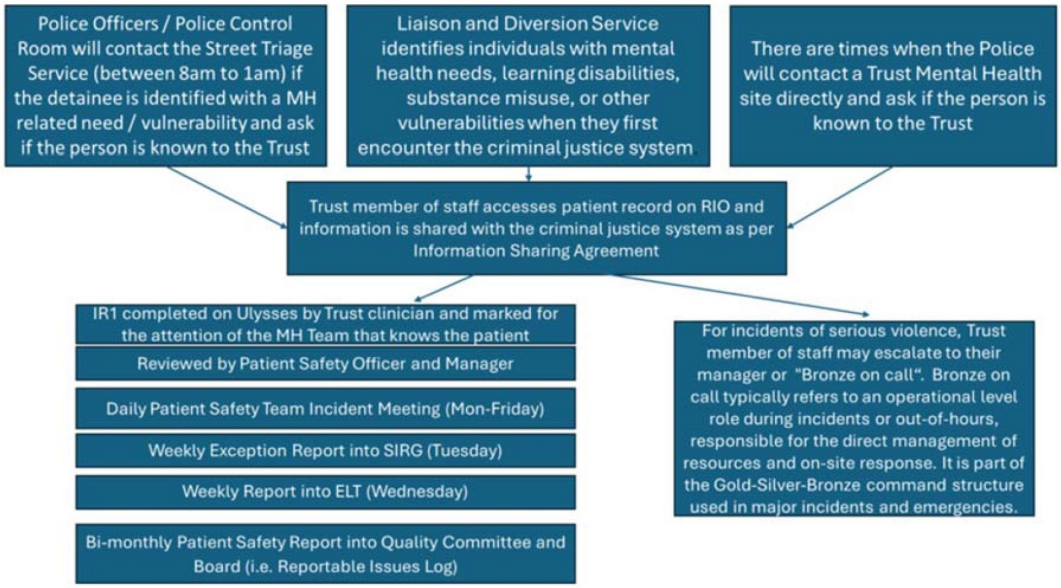
    c. Our compliance with Duty of Candour regulations have significantly improved and today with a reduction of Duty of Candour open incidents from 1004 in February 2024 to 0 in March 2025; **[NHFT0001837, p.11]**

    d. The trust now supports learning events for staff involved in significant incidents routinely. For example, following VC we have now held 31 specific learning events for staff to attend and discuss learning

<u>Reporting of incidents of serious violence</u>

How the Trust and Board would become aware that a former patient has committed a violent act

305. Incidents of serious violence that occur outside of the Trust are reported into the Trust through several routes, which are shown in the diagram below (produced for the purposes of the Trust's Corporate Witness Statement).



306. The Trust's Street Triage team, working with the police in response to incidents occurring in public where there are mental health concerns, will raise with the Trust where a patient is under or has been under mental health care. The Street triage team have access to the police reporting system and also record their contacts in Rio and where required report incidents onto Ulysses. This then feeds into the Patient Safety process and care group oversight of incidents.

307. If patients or former patients are involved in crime and are in police custody, initial contacts with the Trust can go through the Liaison and Diversion Teams who complete mental health screening of detainees. Where the patient is or has been under the trust services 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.

308. The clinical care teams raise incidents when it is known to them by raising the incident on Ulysses and in the patient record Rio, which is then picked up by the patient Safety Team

309. In addition to the above, if the serious violence is a 'live' situation, the Trust may also be informed through the Local Resilience Forum (a multi-agency partnership that exists to prepare for and respond to emergencies). This is made up of representatives from local public services, including the

emergency services, local authorities, and the NHS, all of whom are designated as Category 1 Responders under the Civil Contingencies Act 2004. In such circumstances, the Trust will consider mobilising its Incident Management Team using the Trust's Emergency Preparedness, Resilience & Response Policy [**NHFT0005227**].

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

311. The Trust has the following policies and procedures that give guidance on managing incidents involving serious violence

    a. Learning from Deaths Policy [**NHFT0000596**]

    b. Patient Safety Incident Response Plan and Policy [**NHFT0008825**]

    c. Being Open and Duty of Candour [**NHFT0003028**]

    d. Reporting, Managing and Learning from Incidents Policy [**NHFT0015629**] 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 guidance on engaging both the perpetrator and victims' families, and how to obtain contact details where necessary through Police Family Liaison Leads.

    e. Police and Criminal Justice Liaison policy, updated in June 2025, 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. **[WITN0263069]**

312. On receipt of the notification that such an incident has occurred, the Patient Safety Team leads 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, the Chief Nurse by the Patient Safety Lead directly, where necessary via the on-call rota and through the Blue Light incident process (which is an incident that is escalated to all Trust Leads immediately through email). If necessary, I am contacted by the Chief Nurse or Medical Director. 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.

313. 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.

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

315. Details of the incident are discussed, and minuted at the weekly SIRG meeting with a briefing shared through Exceptions reporting to the ELT. The information, updates and learning are shared formerly 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 executive team to the ICB, NHS England and the CQC to inform them.

316. The incident is shared externally with relevant commissioners and regulators via a notification email – was previously through the StEIS system however this has been discontinued by NHS England and replaced with Learning from Patient Safety Events ("LFPSE"). The LFPSE system is currently unable to share immediate notifications. 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.

317. The Immediate Incident review (72-hour report) is shared when it becomes available 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).

318. Where a Homicide is committed by a patient who is in receipt of trust care, the

NHS England 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 Patient Safety Incident Investigation ("PSII") **[WITN0263113]**. Where a patient was previously under the trust care, a review of the contacts, care provided, and timeframes is completed and shared with NHS England Regional Homicide team for consideration as to whether the incident is comprehensively reviewed by the trust. This is shared with NHS England Homicide Team who review the report and establish whether a further independent investigation for the purposes of learning is required.

319. For serious violent incidents that are not overseen by the NHS England Regional or National Mental Health Homicide team, the PSIRF framework directs that the local NHS provider is responsible for carrying out **[WITN0263114]**;

    a. A proportionate and systems-based response. The Trust will determine the most appropriate method for learning, using a range of tools beyond a full-scale investigation if the situation does not warrant it. The focus is on understanding how an incident happened due to systemic issues, rather than blaming individuals.

    b. An incident response plan. The Trust's own Patient Safety Incident Response Plan (PSIRP) guides the process. This plan outlines the Trust's local priorities for investigation and the rationale behind them.

    c. Compassionate involvement of affected individuals. A core principle of PSIRF is the compassionate engagement and involvement of patients, their families, and staff who have been affected by the incident.

    d. The use of specialist staff. The Trust has appointed specialist investigators who are trained in the PSIRF methodology to ensure that investigations are conducted with the correct expertise.

    e. Escalation and oversight. Any risks and learning from the incident will be escalated and reviewed through the Trust's governance routes as described below to ensure that the learning is shared and acted upon.

    f. Reporting to external stakeholders. The Trust may be required to report incidents to external stakeholders such as the ICB and ensure effective

communication and information sharing.

320. The Trust allocates 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.

321. 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.

322. 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 (Multi-Agency Public Protection Arrangements) and MOSOVO (Management of Sexual Offenders and Violent Offenders in the UK), 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'.

323. Dependant on the actions required learning is 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.

324. Historic incident information is reviewed to understand whether there are patterns or themes and establish whether previous recommendations were similar and effective.

325. The final signed off PSIRF reports are now shared at the Complex Incident Group which is chaired by the Chief Nurse. Action plans are also monitored in this forum for delivery.

326. Learning events are now routinely delivered for more serious cases of harm with both the direct team and also wider teams to support learning. Where overarching systems issues are identified by patient safety learning responses

outside of trust priorities, a safety improvement plan will be developed. These will be identified through the Trust's existing governance processes.

327. There are a number of more general ways for sharing learning:

a. Briefings, sharing learning from PSIRF responses directly with team, Safety Together Newsletter, Ulysses Patient Safety dashboard, Ward and Team meetings, Connect Patient Safety Forum, Safety Actions Learning module on Ulysses – responsibility of the Patient Safety Team

b. Review, changes and amendments to policies, guidance and Standard Operating Procedures (SOP) based on national best practice. Consistency across services of SOPs - responsibility of the Deputy Chief Nurse

c. Safety & Experience Meetings at Care Group level, Monthly learning forums co-facilitated by Patient Safety Team, Patient Safety Partner and nominated person(s) in the Care Group/Unit. Delivered in a range of ways (face to face, Teams) supported by briefings – responsibility of the Care Group Leadership Team

d. Bite-size evidence summaries linked to Patient Safety shared with staff and on Connect Patient Safety Forum – responsibility of Knowledge Services

e. Each Care Group to identify key learning to be shared via a live event each quarter – learning could be local, regional or national – responsibility of the Care Group Nurse Director

f. Range of Conferences, Suicide Prevention, Learning from Patient Safety and Engaging Families – responsibility of the Patient Safety Team.

Patients Involved in Serious Violence

GRO-B

328. The Trust were made aware of the incident involving this individual on 9 August 2022, and this was reported through the Trust Incident Reporting system (Ulysses) on 10 August 2022 **[WITN0263094]**. 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 **[WITN0263095]** to the Executive Team providing incident details and an overview of contacts and care provided by the Trust.

329. 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

330. Details of this incident were included in the Reportable Issues Log to Board (now called Patient Safety Exceptions Report) paper dated 6 September 2022 **[NHFT0005974, p.73]**.

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

332. An update was shared with the Board on 28 November 2024 **[NHFT0000818 p.25-26 and 37-65]**, noting family liaison continue to engage with family and that there was no inquest date yet set.

333. The Board received an update on the 30 January 2025 **[NHFT0012524]** to say the draft report from Psychological Approaches had been submitted to the Trust and the timeline and next steps were shared with the Board. GRO-D

GRO-D

334. The final report and action plan was reviewed at the Patient Safety Incident Investigation/ Safety Incident Review (PSII/SIR) Scrutiny Panel on 2 May 2025. **[NHFT0004778].**

335. As a result of the GRO-B incident, Clinical Risk Training was enhanced to provide face to face mandatory training from dedicated clinical risk experts.

336. The clinical supervision template 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.

337. In addition, the triage tool used by Liaison and Diversion has been strengthened to improve assessment and signposting.

338. The Trust has introduced a process where should people self-discharge from A&E due to long delays, they are followed up and referred onto other services as appropriate.

339. A review of the Trust Liaison Psychiatry teams and policies is currently being commissioned and we are anticipating completion by the end of February 2026

GRO-B

340. 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, WITN0263072, p.4]**

341. 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 investigation level 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

342. Details of this case include the Reportable Issues Log paper received by the Board on 30 March 2023 **[NHFT0000592, p.15]**.

343. The case was discussed at the Trust HOAG on 12 August 2024 **[NHFT0008661]** when a draft investigation report was available.

344. An update was provided to the Board on 28 November 2024 **[NHFT0000818, p.51]** noting continued involvement of family liaison and progress signing off the final report post review at HOAG.

345. An Immediate Management Review ("IMR") was completed at the time of the incident. A comprehensive investigation was undertaken with the appointment of an independent chair from Psychological Approaches Ltd.

346. On 10 May 2024 **[NHFT0015791]**, a draft investigation was received 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 the investigation, and the report was approved by the Chief Nurse on 26 November 2024, following further amendments to the report.

347. The incident involving GRO-B was also part of the internally commissioned thematic homicide and attempted homicide review. The Chief Nurse commissioned a thematic review to bring together homicide incidents (over a period from 2019-2023) to review the learning and establish whether there were any service-related themes that required further focus and improvements. [**NHFT0000518**] The review included all the incidents of homicides or attempted homicides where a person was either in active receipt of care or who had been discharged. The review was commissioned in January 2024 and concluded in August 2024. The review had an independent chair with a panel of external and internal experts who reviewed each of the incident reports. A series of recommendations were made and an action plan was developed.

348. As a result of the GRO-B incident, the following changes were made:

a. Risk training has been enhanced for community mental health services which includes capacity and risk to others.

b. EIP Internal Working Instructions were updated to include purpose and expectations in relation to medication drop offs. **[NHFT0001219]**

c. A Trust wide Clinical Risk and Safety Policy (01.23) has been developed in October 2024. [**NHFT0003231**]

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

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

GRO-B

349. 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]**.

350. 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 **[NHFT0015672]** and a concise investigation level was confirmed

351. 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]**

352. 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 **[WITN0263074, p.4]** when the investigation report was shared and discussed.

GRO-B

353. 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]**

354. On 11 July 2023 the incident was discussed at Trust SIRG **[NHFT0016002]**, with an overview of the incident and GRO-B contacts with Trust mental health services provided. It was agreed the case met the Serious Incident Framework, the incident was reported on StEIS on 12 July 2023 **[NHFT0004751]** and a comprehensive investigation level was confirmed.

355. The case was included in the Reportable Issues Log papers received at Board dated 27 July 2023 and 30 November 2023 **[NHFT0001284, p.26, NHFT0000416, p.9-36].**

356. The Board was updated on 28 November 2024 to state that the final draft report and safety plan had been submitted and sign off was awaited **[NHFT0000818, p.14-15]**. Family liaison services continue to engage, and no inquest date has been set.

357. The Board received an update on the 30 January 2025 to say the draft report from Psychological Approaches had been submitted to the Trust and the timeline and next steps were shared with the Board **[WITN0263076]**.

358. An IMR was completed at the time of the incident **[NHFT0004751]**. A comprehensive investigation was commissioned **[NHFT0004751]**, with an independent chair from Psychological Approaches Ltd. 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.

359. 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.

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

361. As a result of the incident involving GRO-B the following changes were made within the Trust:

    a. Ensuring that documentation within clinical records reflected clinical discussions that had taken place, particularly within Multi-Disciplinary Team (MDT) meetings. The 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.

    b. 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.

    c. There are monthly EIP discharge audits in place, which give direct

feedback to clinical staff. Oversight of this via monthly EIP, Crisis Response Team ("**CRT**") and Family Services Quality Operational Group and the Community Mental Health Improvement group.

d. SafeNow audits are 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.

e. 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.

f. In respect of family involvement all EIP staff are required to undertake the improved Think Family training. The Think Family approach recognises that people do not live in isolation, and so when there are concerns about possible abuse or neglect within a 'family' situation, there is a need to think about the needs of the whole family regardless of whether it is an adult or child that you are working with.

g. The Trust's Serious Incident Policy and procedure has been re-written **[NHFT0015629]** and the process strengthened for executive oversight of the most serious incidents.

GRO-B

362. The Trust were made aware of the community incident on GRO-C 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]**

363. An update and subsequent confidential briefing were provided to the Executive Team on 15 July 2025. **[NHFT0015879]**.

364. On 4 June 2024 the case was escalated to SIRG **[NHFT0015880]** with an overview of the incident and details of GRO-B contacts with Trust mental health services were provided. It was agreed that 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.

365. The case details were reported on the SIRG Summary Report (now called the SIRG Exceptions Report) dated 4 June 2024 **[NHFT0015880]**.

366. Both incidents were included in the Reportable Issues Log to the Board in a paper dated 26 September 2024 **[NHFT0014944]**.

367. The Board received an update on 28 November 2024 **[NHFT0000818, p.51-52]** stating that the family liaison team continued to engage and noted that the completed draft report would be presented at HOAG and then to the new confidential section of the Quality Committee

368. The Board received an update on the 30 January 2024 **[WITN0263076]** to say the draft report from Psychological Approaches had been submitted to the Trust and the timeline and next steps were shared with the Board.

369. 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.

370. The terms of reference for the PSII were reviewed at HOAG on 15 July 2024 and 12 August 2024. **[NHFT0015884]**

371. Reports were completed and submitted on 13 November 2024 and followed factual accuracy and internal sign off the reports were presented at HOAG on 06 March 2025 **[WITN0263080, p.2]** and PSII/SIR Scrutiny Panel on 20 June 2025. **[NHFT0015885]**

372. As a result of the incident involving GRO-B the following changes were made within the Trust:

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

b. 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 the Ministry of Justice Leads.

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

d. 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

373. 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]**.

374. A confidential briefing was shared by the Patient Safety Team with the Executive team the same day.

375. A briefing was shared with NHS England Midlands Independent Homicide Investigation Team on 12 December 2024 **[NHSE0001134]**.

376. The case was reviewed at the Trust SIRG on both 10 December 2024 and 17 December 2024 to provide an overview of the incident, including details of GRO-B contact and treatment with Trust mental health services, immediate learning and actions. **[NHFT0016003, p.2, NHFT0016004, p.3]** In line with PSIRF, a PSII was commissioned.

377. The case details were included in the SIRG Exceptions Report dated 10 December 2024 and 17 December 2024 **[NHFT0016003, p.2, NHFT0016004, p.3]**.

378. The incident was included in the Reportable Issues Log paper presented to the Board dated 30 January 2025 **[NHFT0015876, p.3]**.

379. An ILR was completed at the time of the incident and telephone recordings between service and patient/family were shared with the Chief Nurse on 10 December 2024 **[WITN0263082, WITN0263090A, WITN0263090B WITN0263091A, WITN0263091B].**

380. A meeting was held on 10 December 2024 with the Associate Director of Nursing, Care Group Nurse Director, Clinical Team Leaders, Operational Manager, Service Manager and Patient Safety Team to discuss the incident and to identify immediate learning and actions **[NHFT0016003, p.2, WITN0263083]**. An After-Action Review (AAR) occurred on 6 January 2025 where both good practices were highlighted and recommendations for improvement were defined **[NHFT0016457]**. 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.

381. As a result of the incident involving GRO-B he following changes have been made:

a. As the Patient Safety Incident Investigation (PSII) remains in progress, the actions following the incident have been taken from the After-Action Review.

b. Guidance for referral, initial processes and categorisation has been provided to the Crisis Teams.

c. Internal Working Instructions updated to ensure that patients who use substances are not excluded from services and receive thorough triage.

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

GRO-B

382. The incident was reported via the Trust reporting system on the 15 November 2024 **[NHFT0015973, NHFT0015974].** The incident was discussed at Patient Safety Huddle on 25 November 2024 **[WITN0263084, p.8-9]**. A confidential briefing completed at the time of the incident.

383. The incident 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 in the Reportable Issues Log for the reporting period 13 November 2024 – 23 December 2024 **[NHFT0012525],** and presented to the

Quality Committee on 15 January 2025, and Board on 30 January 2025.

384. 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 Safety Incident Review report is complete and was presented to the PSII / SIR Scrutiny panel and the Complex Incident Meeting in November 2025. **[WITN0263115, p.2-3, WITN0263116, p.2-3]**

385. As a result of the incident involving GRO-B, there is now the option to escalate cases to the Mental Health daily sit rep meeting, attended by clinicians whose patients are waiting for a bed. The meeting includes risk escalation and contingency plans whist waiting.

Incidents between 2019-2023 of patients under the care of the Trust

386. I want to acknowledge that one incident has a profound consequence for the victims of the crime and each one must be seen as a tragedy. I also want to acknowledge the complex interaction between individual characteristics, lifestyle and the physical, social and economic environment, i.e. the wider determinants of health, especially in terms of the relationship between mental illness and violence. Trying to provide a rationale for whether the number of incidents in the Trust is expected or unexpected is challenging.

387. There is no easily available data on the number of patients discharged from NHS Trusts perpetrating serious violence towards members of the public to make a meaningful comparison to this Trust.

388. The relationship between mental illness and violent crime is complex, whilst some mental health conditions contribute to an increased risk of violent behaviour, most individuals with mental illness are not violent and are more likely to be victims of violence rather than perpetrators.

389. Risk factors that influence the risk of violence include diagnoses such as Schizophrenia or bi-polar disorder. In addition, incidents are often complicated by additional factors such as drug abuse or non-adherence to treatment.

390. There is some national data available on the number of Homicides perpetrated by people with a mental illness. The National Confidential Inquiry into Suicide and Safety in Mental Health Annual Report 2025 [**NHSE0000483, p.22**] states that between 2012 and 2022 there were an estimated 637 homicides by patients

in touch with or recently in touch with mental health services, an average of 58 per year. Across the UK the data states that about 11% of people convicted of homicides were known to mental health services.

391. The UK population (according to the 2022 census from the Office of National Statistics) was 67.6million people and in Nottingham and Nottinghamshire the population at same census was 1,148,432. Given the average of 58 homicides by mental health patients per year, and 637 homicides over the 11 years, it could be extrapolated that an average of 1.026 homicides per year for a population the size of Nottinghamshire could be expected. However, I would emphasise that this is purely based on calculations I have done to inform this statement and not on any independently verifiable data. As I have said above, there is a lack of data in this area on which to base an informed analysis of the incidence of homicides on a geographic or provider basis.

392. This does not take into account the increased complexity of patient services by the Trust given our more complex forensic population.

393. I wish to stress that the figure I mention is not seen as an allowable number - the only answer to that is 0. I merely attempt to extrapolate a national average. In addition, I am very conscious that there have been a number of occasions where a single person known to mental health services has carried out multiple homicides.

394. I can, however, state that in the last 5 years there have been 6 patients known to the Trust who have been convicted of Homicide. Details of these have already been disclosed to the Inquiry.

How could the incidents be prevented?

395. I believe the key to prevention is to apply systematic learning across multi agencies and thematic learning in individual Trusts. This involves collecting data on incidents to identify root causes and themes, and using this information to inform and improve training, policies, multi agency working and health care environments.

396. Other actions that the national evidence would suggest would reduce the risk of violence as I understand it are as follows:

    a. Early identification and Intervention, including strengthening the systems

to identify individuals at risk of harming others and ensuring timely access to support and treatment

b. Integrated care and risk management – providing comprehensive care that addresses mental health, substance misuse and social factors simultaneously, alongside structured risk assessment.

c. Staff training and development – Ensuring staff are trained in recognising warning signs

d. Enhance community support – working closely with families, carers and community assets to provide robust support networks that reduce isolation

e. Learning from individual incidents.

397. We are working towards improvements in each of these areas and they all feature as part of our IIP.

398. I do feel confident that the Trust today does have a robust process in place for responding to and identifying immediate learning. Furthermore, our current reporting and escalation process is strong with clear accountability for monitoring actions and learning.

399. I believe that these incidents have been considered by the Trust and learning has been made as can be evidenced by various changes to policy and processes. I am very aware that for learning to be embedded, we have to have the correct organisational controls and the correct individual clinician actions. The two are distinct but interdependent; organisational controls create the environment in which clinicians work, and clinicians' actions deliver the care within that framework. I am confident that the Trust has strengthened organisational controls which are the high-level, systemic structures and processes to ensure quality, safety, and performance across the entire Trust such as presenting data as information that leads to real time action, creating opportunities for learning such as learning events, agreeing escalation processes, strengthening training and strengthening appropriate clinical policies.

400. Individual clinicians' actions are the decisions, skills, and judgement they use when providing direct care to a specific patient, underpinned by national and

local clinical guidelines and pathways. It is this second part that is more 'variable' in my view, because as well as being reliant on good training, supervision, and appraisals backed up by relevant clinical audit, it also relies on what is happening for the clinician at the time in their team - for example variables such as capacity, caseload and leadership. In my view, embedding is not just about the individual incident but also about those more trust wide cultural changes we are still developing about leadership style and changes in clinical pathways that are underway but not completed.

Thematic Homicide Review

401. The Thematic Homicide report was presented to the ELT on 11 September 2024 – **[NHFT0018407]** The Trust accepted all the recommendations and initiated an action plan for the recommendations.

402. An update of the action plan was presented to the Homicide and Attempted Homicides Oversight Group in March 2025 **[WITN0263117, p.3-5]**. The following paragraphs detail the five recommendations, and the progress made against that recommendation.

403. Recommendation 1 - Serious Incident policy required re-writing:

    a. The previous Serious Incident policy has been discontinued and replaced with the trust PSIRF policy and plan (reference, previously disclosed) and the Reporting, Management and Learning from Incidents policy and procedure. The focus now is on inclusion, improving culture and mitigating risk, moving away from incident management. **This recommendation is delivered.**

404. Recommendation 2 - Two investigations of poor quality revisited to ensure learning is maximised:

    a. The report Thematic Homicide Review report **[NHFT0000518]** 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 (Tees, Esk and Wear Valleys NHS Foundation 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 **[WITN0263118, NHFT0015688, WITN0263119] This recommendation is partially delivered.**

405. Recommendation 3 - Audit is designed to identify patients who have a risk history and have been discharged following a period of disengagement:

a. 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. **[NHFT0015955, p.1-3]**

b. 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 – this report has been presented nationally as an example of good practice. **[WITN0263085]** Expansion of 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. **This recommendation is delivered.**

406. Recommendation 4 - To continue embedding the waiting well improvements:

a. A new process has been implemented and adjusted following feedback from teams and patients. Waiting Well reports through SafeNow and the policy and associated guidance has been reviewed. It is appropriate to continue to review and adapt our approach to waiting well and waiting list management as we evaluate progress and performance. **Recommendation is delivered**

407. Recommendation 5 –

a. In addition, the Level 3 Think Family training has been strengthened to enhance staffs understanding of how the Think Family agenda influences their practice. There is also improved focus of improving the trusts engagement with families post incident as described in the Reporting, Management and Learning from Incidents policy.

b. The Trust have worked to improve staff understanding and knowledge of the Duty of Candour both professionally and as a regulatory requirement. This has been supported by a dedicated Duty of Candour lead, a review of the Duty of Candour policy **[NHFT0003028]** 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 which will be reviewed by the Quality Committee on 11 December 2025 **[NHFT0015899, WITN0263102]**. There is also a reduction of Duty of Candour open incidents from 1004 in February 2024 to 0 in March 2025 [NHFT0015034]. As part of ongoing assurance, this is to be reviewed again in Quality Committee on 11 December 2025 **[WITN0263120]**. **This recommendation is delivered.**

408. In addition, the Trust Safeguarding team have revised the Think Family strategy which was launched 8 October 2025 **[NHFT0015900]**. The Strategy sets out the trust aims to recognise, respond and refer and the actions to support delivery. This strategy will be underpinned by and delivered through clear pathways into and out of the Trust as well as across and between all of its services. By implementing the 'Think Family' safeguarding strategy at every level, the Trust 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 Strategy will ensure that the Trust services in this area will continue to evolve.

PART D: STAFFING

Staffing levels, outsourcing and discharge planning

How staffing levels are set

409. In order to provide improved calculation and oversight of mental health inpatient ward nursing staffing needs across the Trust, a Safer Staffing Matron was employed in 2019.

410. The postholder has led on the implementation of the NHS England 'National Quality Board's Standards on Safe Staffing (2016) **[NHSE0000115]** and provides a consistent specialist point of contact across the Trust for nursing safer staffing matters.

411. Ward Nursing Staffing levels are set as a core baseline through an establishment review process. The tool used to support the establishment review process for the MH inpatient areas is the Mental Health Optimal Staffing Tool (MHOST), see paragraph 413 below **[WITN0263086]**. The outputs from this are used, as part of the establishment review process, triangulated against professional judgement and outcome measures to inform the decision making / recommendations.

412. The tool provides two measures for us to use to support the decision making, a recommended WTE (including and excluding Headroom) and the recommended Care Hour per Patient Day (CHpPD).

413. We have been committed to implementing the NHS England 'National Quality Board's Standards on Safe Staffing.' In doing so, we have drawn on the recommendations within the National Quality Board's 'Safe, Sustainable and Productive Staffing' Guidance (2016) **[NHSE0000115]** alongside the National Quality Board's 'Safe, Sustainable and Productive Staffing: An improvement resource for mental health' Guidance (2018) **[NHSE0000145]** and NHS Improvement's 'Developing Workforce Safeguards' Guidance (2018) **[WITN0263087].**

414. However, it is important to highlight that there remains no national NHS guidance which outlines the actual staffing levels per numbers and acuity of patients in mental health settings. This is very different to physical health hospital wards where this guidance is published by NHS England.

415. In the absence of a definitive view on the staffing of mental health inpatient areas, Health Education England (which has been abolished), commissioned a tool to support mental health NHS organisations in establishing safe staffing levels for wards. This is called the Mental Health Optimal Staffing Tool (MHOST). The MHOST tool is an evidenced based tool that calculates clinical staffing requirements in mental health wards based on patient needs (acuity and dependency). **[WITN0263086]** However, the tool always has to be used in conjunction with clinical professional judgement.

416. In addition, the Royal Collage of Psychiatrists published a set of 'Standards for Inpatient Mental Health Services' (2019) **[WITN0207003].** These standards provide guidance on appropriate systems that should be in place for nursing

staff to respond to low or unsafe staffing levels, how they should report this and how these staffing levels can be escalated within the service. The standards state that a duty doctor should be able to attend the ward within 30 minutes in the event of an emergency. Staffing related incidents were all reviewed by the Safer Staffing Matron who in turn provided a summary of the concerns reported, directly supported areas as required and shared the learning across the Trust. The incident reporting system was also updated to reflect the correct reporting categories to enable ease of reporting and analysis.

How has this process has been adapted since 2019?

417. In terms of process, this has changed since 2019 as the process for the reviews was that they would be undertaken, and a bi-annual report was presented to the Quality Oversight Group, Quality Committee and then the Public Board. If any changes were being requested through the establishment reviews these would be taken forwards by the executive director in conjunction with the General Manager for the service via an investment case / business case.

418. However, there are many factors that impact on the daily demand of staffing and therefore, whilst there is a core baseline establishment set, the staffing need is dynamic and changes across wards on a daily basis. Staffing might become compromised due to increased sickness or staff absence or alternatively, the needs of the patient group at that time become more acute and hence they need more staff to support their care. Conversely, if patient occupancy or acuity is low, this can enable redeployment of staff from one ward to another. Patient acuity is now reviewed daily with local measures and controls in place to manage this in line with what is required. This is a formal process called the Joint Safecare (Daily) Meeting, formerly known as the Daily Demand Meeting.

419. The Joint Safecare (Daily) Meeting **[WITN0263088, WITN0263089]** looks at the wards collectively to understand how best to deploy staff and where the gaps are and how this can be mitigated. This is operationally led with professional support to ensure that the resources are used effectively

420. The Safer Staffing Matron led a Trust wide training programme to enable front line leaders to complete the MHOST in line with the unique clinical requirements

of that setting. For example, the Adult Mental Health service ("**AMH**") ran two set periods of 28 days per year to collect their data which would be utilised as part of the establishment review.

421. Establishment reviews at the Trust typically involve the voice of clinical leads, finance colleagues, Human Resources, and operational leads. The needs of the services are reviewed based on the triangulation of this information. Establishment reviews of mental health inpatient wards have taken place bi-annually at the Trust since 2019.

422. In 2021 an investment of £1.817m was agreed by the Trust as a result of the establishment review of mental health inpatient services. **[NHFT0015897, NHFT0015959]** This saw an increase in headcount by 1 staff member per shift across all of the acute mental health wards and the psychiatric intensive care units ("**PICUs**"). In addition, a number of additional AHPs were funded to support broader MDT working.

423. In 2024, a further investment of £400,000 was agreed following the establishment review process. **[NHFT0015902]** This time, a need to be able to flex the ward staffing on a daily basis was identified and therefore a decision was made to recruit to a 'peripatetic team' of Healthcare Assistants ("**HCAs**"). This was an increase of 32 WTE to support this function across the mental health inpatient units. The peripatetic function enables robust dynamic deployment of staff across the 24/7 rota to meet the needs of the wards acuity at that time. In having access to this flexible team of HCAs, use of agency workers was able to be reduced which in turn improves consistency and quality of patient care.

Current staffing levels

424. Adult mental health acute inpatient wards' current staffing model is: 6 staff on the early shift (2 registered nurses, 4 healthcare assistants), 6 staff on the late shift (2 registered nurses, 4 healthcare assistants), 5 staff at Night (2 registered nurses, 3 healthcare assistants). In addition, there is 1.0 wte peer support worker, 1.0 wte activity coordinator, 1.0 wte ward administrator and 1.0 wte Ward Manager. In addition a number of AHP staff support patient activities and inreach into the ward. AHPs will carry out a number of roles on a ward, including formal specialist assessments of how occupational therapy assessments may

help an individual's recovery. They also provide a specialist opinion to help with planning care and treatment, creating activities to maintain and promote people's independence, preparing people for discharge by assessing and improving their living skills. These activities could be individual or group-based depending on need. As well as more formal therapeutic activities AHP support staff would also help by running groups designed to provide distraction and diversion which is known to have a positive impact on violence and aggression on in-patient wards.

425. The current PICU inpatient ward staffing model is: 8 staff on the morning shift (2 registered nurses, 6 healthcare assistants), 8 staff on the afternoon shift (2 registered nurses, 6 healthcare assistants), 7 staff on the night (2 registered nurses, 5 healthcare assistants). In addition, there is 1.0 wte peer support worker, 1.0 wte activity coordinator, 1.0 wte ward admin and 1.0 wte Ward Manager. In addition a number of AHP staff support with patient activities by reaching into the ward.

426. The staffing establishments in place anticipates 1 enhanced observation to be absorbed into the overall staffing numbers and any further enhanced observations to be additionally recruited into with an additional HCA shift via Bank. The ward manager / deputy ward manager / senior nurse on site has the ability to increase staffing, following a professional judgement review of skill mix and patient needs on the wards.

427. For community and crisis staff staffing, the use of the core fidelity standards were used for the latter and the former was part of mental health transformation which was developed and invested in with collaboration with the ICB.

Board and Committee oversight

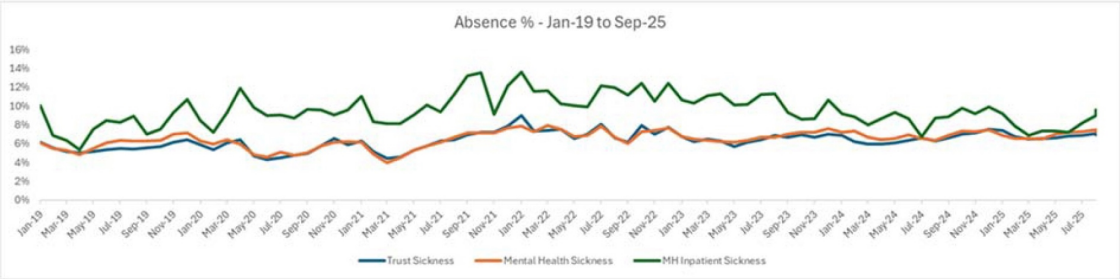
428. The current agreed mental health inpatient establishments versus actual staffing levels are reported to Quality Committee and Board through the IPR.

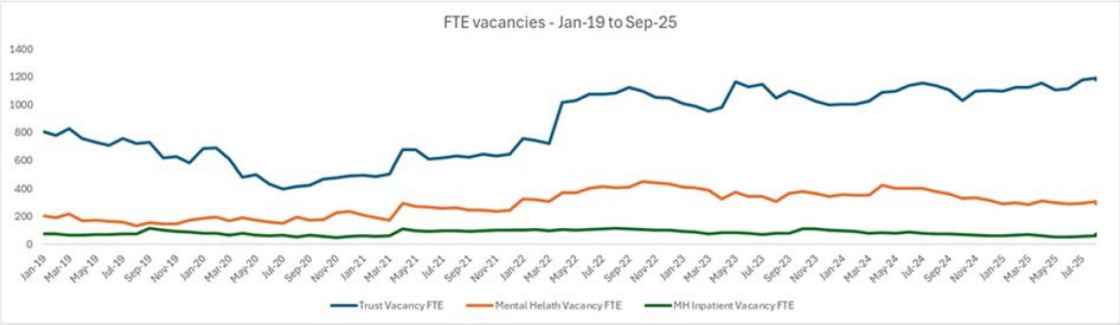
429. The Board are able to see wards which were staffed at below 85% and above 125% of their agreed establishment. As set out above, often there is a clear clinical rationale as to why this is the case (reduced or increased patient acuity or occupancy). However, the Board are able to confirm and challenge the

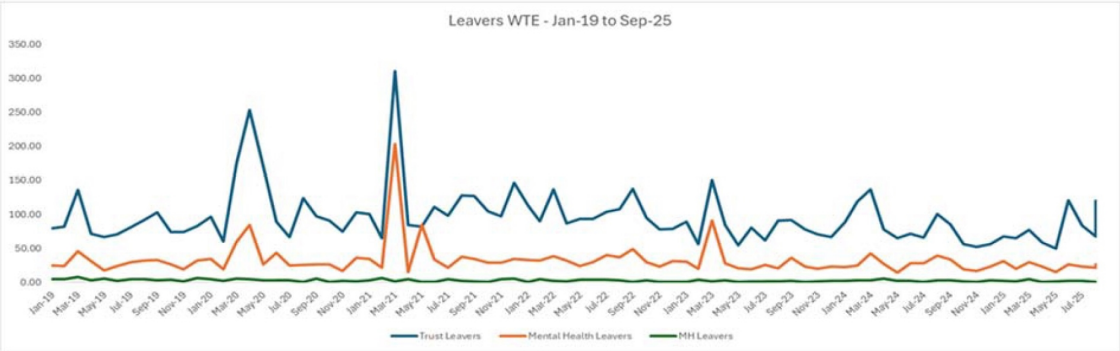
drivers of low of high staffing through these reports.

430. Turnover, vacancies and sickness absence by team and service are overseen by the Trust's Accountability Meetings, which have been known by a range of other names over time. **[NHFT0006110, WITN0263092]** At these meetings, any areas of concern are escalated and actions put in place to address. For example, during recent years we have had specific recruitment campaigns to recruit inpatient mental health teams, as well as to attract bank staff to provide that flexibility of staffing.

431. The People & Quality Committee also review Trust and Care Group levels of turnover, vacancies and sickness absence and request action where concerns are raised. I have attached below charts that show Trust absence rates, FTE Vacancies, % vacancies and leavers wte from January 2019 to September 2025







432. The following guidance was monitored and implemented

Royal College of Psychiatrists (2019), Standards for Inpatient Mental Health Services.

433. "The ward/unit has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: A method for the team to report concerns about staffing levels; Access to additional staff members; An agreed contingency plan, such as the minor and temporary reduction of non-essential services. [Type 1]" - [**WITN0207003** – page 14, section 19.1] This standard was met via the Daily Demand Meeting within AMH services, with a formal escalation mechanism in place and any contingency plans able to be enacted by the operational teams. In addition, the Monthly Safer Staffing Group provided an assurance escalation forum for the clinical teams for any sustained periods of low staffing against planned staffing levels. This meeting would also share the learning and details of safer staffing reported incidents and to explore where actions might not have mitigated the risk.

434. "The ward/unit is staffed by permanent staff members, and unfamiliar bank or agency staff members are used only in exceptional circumstances, e.g. in response to additional clinical need. [Type 2]" [**WITN0207003** – section 19.2] Due to the vacancy factor within AMH, the wards have historically used higher than planned levels of Bank and Agency staffing. As a result this standard was not being met consistently across all areas.

435. To address recruitment challenges, the Trust implemented various initiatives including offering registered nurses a ‘golden hello’ incentive, retention incentives for those remaining in employment for 3 years, and innovative advertisement campaigns involving local communities in open days and events.

436. In 2022, the Trust developed a People Plan to set the direction on making the Trust a great place to work [**NHFT0000615**]. Since then, Trust-wide turnover has reduced by ~5%.

National Quality Board (2016), Safe, Sustainable and Productive Staffing & National Quality Board (2018), Safe, Sustainable and Productive Staffing: An improvement resource for mental health. [NHSE0000115, WITN0263086]

437. Establishment reviews were being undertaken bi-annually using the framework from both documents, Right Staff, Right Skills, Right Place and Time [**NHSE0000115**].

438. Right Staff - Evidence Based workforce planning. Professional judgement. Comparing staffing with peers.

439. Right Skills - Mandatory Training, development and Education. Working as a multi professional team. Recruitment and Retention.

440. Right Place and Time - Productive working and eliminating waste. Efficient deployment and flexibility. Efficient employment and minimising agency.

NHS Improvement (2018), Developing Workforce Safeguards

441. Establishment reviews were supplemented, with the use of an Evidence Based Staffing Tool (where they existed), which was triangulated alongside outcome measures and professional judgement.

442. Establishment reviews were being undertaken bi-annually using the framework of Right Staff, Right Skills, Right Place and Time (NQB, 2016; NQB, 2018) and where an evidence based staffing tool existed its use, triangulated against professional judgement and outcome measures. The wards themselves, had a staffing establishment in keeping with the Mental Health Optimal Staffing Tool (MHOST) recommendations. The safer staffing matron supported the roll out of the MHOST tool and delivered the training to local leads/ teams.

<u>Impact of staffing deficiencies</u>

443. I feel it important to note that deficiencies in staffing do not necessarily mean a ward is funded or recruited to below its establishment level. The deficiencies felt may result from temporary absence, e.g. sickness and/or increased demand

for staffing numbers due to increased clinical activity, in particular the use of therapeutic observations to manage increased mental ill health acuity.

444. Regardless of the cause, poor staffing affects the ward team's ability to provide the very best individualised care for our patients. It can mean that there are less therapeutic activities for patients. It also limits the time staff have to spend with each individual patient and their family. This in turn can result in longer stay in hospital for a person away from their family

445. Fewer staff can impact on the ability to proactively manage incidents, increase waiting times and affect the ability to develop, therapeutic and meaningful relationships. When vacancies are covered by bank and agency staff, this can lead to a lack of consistency of care on the ward as staff do not get to know the patients and vice versa.

446. For staff, high vacancy and sickness levels impacts on their overall wellbeing. It can cause other staff to need to take time off due to burnout and stress.

447. There has been a people related risk on the Trust's strategic risk register (the BAF) for a long time. [**WITN0263121, NHFT0000516 p.166-169, WITN0263122, NHFT0003330 p.179-182**] These are documented below by year. It is fair to say that from 2019 until 2024, the people BAF risks focused on concerns about staffing levels. 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 BAF risk was now about employee and engagement and morale, which had deteriorated post-COVID.

Monitoring of staffing levels

448. The use of the MHOST had been undertaken across the inpatient areas and used to inform the decision making / recommendations from senior leaders during staffing establishment reviews. These reviews ultimately resulted in investment in more staff for mental health services in 2021 and 2024.

449. The Board historically received regular safer staffing and establishment review reports. These reports each made reference to the National Quality Boards Safe Sustainable and Productive Staffing Guidance, January 2018 [**NHSE0000145**], MHOST Tool in 2022 and Royal College of Psychiatrists ("RCPsych") 2019 standards. The Board were well aware of the tool, the reports received set out

the tools being used and then the report was constructed against those standards.

450. The annual Safer Staffing Report for 2021/22 was in the reading room of the Trust Board papers in November 2022 **[NHFT0015903]**. It provided a useful summary over the previous 12 months. It detailed a number of challenges around staffing, but also presented a number of opportunities to innovate, introducing new roles to enhance the quality of care, safety and experience. The report contains sections on:

a. Safer Staffing Governance Framework
b. Inpatient Establishment Review Process
c. Acuity and Dependency Monitoring
d. Trust Wide Safer Staffing Group
e. CQC feedback from Forensic Medium and Low Secure
f. Safer Staffing Ward Posters
g. Workforce Profiling / Skill Mix
h. Establishment Review Process for Community Teams
i. Trust Wide Safer Staffing Policy
j. Staffing Related Incidents
k. 'Hot Spot' Wards
l. Qualified Nurse Vacancies
m. Bank and Agency Use
n. Skill Mix
o. E-Roster and SafeCare
p. Establishment Reviews
q. Using Safer Staffing Data

451. The Board also received and receives the IPR which details the current staffing position across the Trust. The Board were sighted on pressures and concerns in relation to staffing and information as received in multiple reports.

Current position

452. A formal process that reviews the staffing establishment (i.e. how many staff of what grade are needed on each shift) is well embedded in governance processes for mental health in-patient areas led by Care Group nurse directors and signed off by the Chief Nurse.

453. We increased staffing establishments in our adult mental health and forensic Care Groups following establishment reviews in June 2023. This included forensic establishment reviews supported by peer high secure hospitals.

454. A dynamic staffing review process is in place across all care units with formal escalation process and incident reporting processes in place for any unsafe staffing processes including a route to Board escalation as needed **[NHFT0015868]**

455. The current IPR and safer staffing dashboard both detail risks with staffing levels Quality Committee sees the quality dashboard part of the IPR bi monthly, The safer staffing reports which we have built on to include proportion of bank /agency to overall numbers reported preceptorship nurses, triangulation with incidents.

456. The Trust transitioned from paper rosters to an electronic rostering system in 2017 and has continuously strengthened its approach to workforce planning and safe staffing utilising this system. In 2018, rostering 'confirm and challenge' meetings were introduced within inpatient areas to ensure senior clinical oversight of safe staffing and rostering decisions.

457. Today, the rostering process is governed by a Trust-wide Electronic Rostering Policy [**WITN0263123**], which sets out our rostering governance arrangements. Rosters are developed using HealthRoster and must be fully approved through a two-tier validation process at least 12 weeks in advance, enabling proactive workforce management. Level 1 validation is completed by the Roster Manager, who ensures the roster meets operational indicators and adjusts as needed. Level 2 approval is undertaken by a Senior Manager, who reviews the roster for compliance with defined parameters and assesses any potentially unsafe staffing periods. The system is therefore more sophisticated, providing better control for staff as they can see the rosters well in advance.

458. A weekly nursing safer staffing governance group has been established to oversee fill rates, temporary staffing deployment and e-roster performance.

459. The Board currently receives specific papers on safer staffing and establishment reviews every 6 months the last one received in July 2025. **[NHFT0015005]** The paper aims to provide the Board with an overview of the current safer staffing position within the Trust. Assurance that there is clear oversight of risks and that mitigations are being put in place and planned work to address any root causes.

460. In addition, the Board also receives information in the IPR in two places:

    a. Under the Quality and Safety section the Board sees information relating to in-patient staffing levels in particular where staffing levels have needed to exceed 100% due to demand and acuity and any areas where staffing levels have not been achieved. In addition, specific information about nursing vacancy rates is also shared.

    b. Under the People and Culture section we receive assurance around indicators such as vacancy rates, turnover rates, time to recruit and sickness levels.

Personal Awareness of staffing concerns

461. Given the role I held as Chair of the NHS Confederations National Mental Health Network, I was aware that staffing of both mental health inpatient and community services was very challenging as this was something that was reported at Network Board meetings by many Mental Health Trusts. This was particularly the case for band 5 ward based nurses and non-specialty community-based staffing. In addition, I moved to the Trust having been the CEO at Derbyshire Healthcare NHS Foundation Trust where I was also used to challenges filling particularly in-patient vacancies, though to a lesser extent given difference in the sizes of the organisations.

462. Prior to taking up post, I was able to meet with a number of Executive Directors and Directors of the Clinical Divisions (as they were at that point), as well as visiting Rampton Hospital and being able to speak to staff there. Staffing and vacancies was something that was raised with me at during these conversations.

463. Staffing levels related concerns are something that are regularly raised with me, other Executives and the broader leadership team. The types of concerns raised are generally about either vacancies and speed of recruitment and that may include a perception of vacancies being held or levels of acuity and demand being higher and staff are not able to meet all the demands on their time.

464. These sorts of concerns are raised in the following ways:

a. Through formal assurance reports that go to the ELT, The Board or Board Committees (this would include escalations from Care Groups);

b. Through various engagement events such as the Executive Open Forum or Big Conversations;

c. From visits to clinical teams;

d. From escalations from the Freedom to Speak Up Guardians;

e. On occasions when patients attend the Board meeting, they have raised issues of low staffing levels, an example of this occurred in September 2025 **[WITN0263103]**.

Role of the Quality Committee in staffing

465. The Quality Committee oversees the implementation of the national guidance for safer staffing through a regular safer staffing paper. **[NHFT0015868]** This paper includes assurance that the Nursing Staffing Establishment Reviews have been undertaken in keeping with the National Quality Board (2016) and NHS Improvement (2018) expectations; 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.

466. 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. The Committee received a 'People Performance Report' (2020 – 2023) **[NHFT0015935, NHFT0015934]** 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.

467. At Board, the oversight on staffing matters from both Committees would be reported in a highlight report. In addition, the IPR 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

468. The Safer Staffing meetings **[WITN0263093]** were started in 2020 and disbanded in 2024. The purpose of the meeting was to ensure that all clinical services have sufficient and appropriately skilled staff, enabled to deliver safe, effective and sustainable care, is responsive and centred on the needs of our patients and is delivered by caring, compassionate, highly skilled and valued staff.

469. For inpatient services the focus was on those staff that take part in the 24 hour rotational roster in order to safely care for their patients and carry out all the tasks necessary to provide excellent care and ward management. For community services this focus will be on all staff who are delivering care.

470. Where effective staffing had not been achieved, the group would sense check the local mechanisms that were put in place to escalate the issues in a timely and effective manner, and those short-term actions used. Where the issues were more systemic, or occurred frequently, the group would problem solve which alternate solutions should be put in place, possibly initiate formal Establishment Reviews, and escalate the issues to the ELT and the Trust Board as appropriate.

471. The group was responsible for setting the formal schedule of Establishment Reviews required across the Trust, will review the outcomes of each review and monitor the progress of any actions put in place. In addition, the group would regularly review and update the Trust Wide Safer Staffing Policy every 2 years and confirm the operational actions and structures put in place on each site to maintain compliance with it.

472. The group would set Safer Staffing standards, which meet the National Quality Board (2016) expectations **[NHSE0000115]**, the Developing Workforce

Safeguards (NHS Improvement, 2018) **[WITN0263087]** recommendations and the CQC's Fundamental Standard and lead the development and implementation of Safer Staffing related strategies to support the overall Trust Strategy.

473. The Establishment Review Process would set the budgeted establishment for in-patient areas, defining what the optimal staffing is, monitor the dynamic staffing requirements across all Trust in-patient sites and identify those wards that fail to deploy at least 80% of the required Care Hour per Patient Day and ensure were in place to learn from national reports, surveys and inquiries including incidents within the trust.

474. Operationally, safer staffing is now reviewed daily in the huddles and safer staffing governance group.

475. Strategically, Staffing is now overseen in the Quality and Performance meeting which is a collective oversight and assurance process attended by the senior triumvirate in the care group and led by the Chief Operating Officer. **[WITN0263016]**

476. The workforce optimisation group, chaired by the Executive Director of People and Culture and looks at work force optimisation and including establishments, bank, agency and temporary staffing use across all professional groups.

477. 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 was introduced as a framework to guide the delivery of the LTP ambitions.

478. 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.

479. 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. 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 (LTP) 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 the National Institute for Health and Care Excellence ("**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 in relation to staffing levels

480. 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.

481. On 1 November 2022, the draft CQC Well-Led report was shared within the Private Board [**NHFT0001997**]. 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.

482. On 26 January 2023, the Establishment Review Report was presented at the Public Board meeting **[NHFT0015906]**. 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 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.

483. Further assurance was provided on 25 May 2023, when the Safer Staffing and Establishment Reviews Report was presented to the Public Board **[NHFT0015909]**. This six-monthly update outlined progress on establishment reviews and confirmed ongoing compliance with regulatory requirements under National Quality Board (2016) and NHSI (2018) expectations. 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.

484. 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.

485. On 28 June 2023, the ELT agreed to create a 'new' CQC Compliance Oversight Group (CQC-COG) which was responsible for providing the Trust Board with assurance on regulatory compliance **[WITN0263034]**. 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

486. My understanding is that following the approval of the 2022-2027 'Making a Difference' Strategy in March 2022 **[CQCM0027394]**, we developed Our People Plan which outlined the People and Culture programmes of work we would progress to realise the ambitions within that strategy.

487. Our People Plan was approved at Trust Board in November 2022 **[NHFT0003484, NHFT0015981]** 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 IIP 24/25.

488. Our IIP 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.

489. In my experience and in line with our IIP there are two areas to be improved when seeking to improve staffing:

490. Actions directly related to the recruitment process:

a. Time to recruit (this is the time from advertising a post to sending the contract to the new member of staff) has been reduced from 92 days (February 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

491. Work done that supports retention:

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 has not 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

Reasons for staffing issues

National factors

492. I think it worth noting that even prior to the COVID-19 pandemic the mental health sector was known nationally to have issues with recruitment particularly for nurses and more latterly AHPs. It is my view that this emanated from stopping bursaries and the nursing diploma qualifications nationally and moving to degree nursing which has impacted on the pipeline.

493. There have also been changes to the levels of acuity and the level of emotional disregulation as a presenting factor by patients particularly in inpatient settings and I have had feedback that this is not as attractive a setting to work in as it has been previously. This is coupled with my view that students exiting training are less confident in clinical settings than under previous education regimes.

494. Nationally there is a legacy of some more experienced mental health practitioners having 'mental health officer status' on their pension and so retiring at 55 – we saw a post COVID-19 surge in retirements.

495. There is also significant pay competition in a number of ways:

    a. Competition with local private providers that offer higher salaries

    b. Competition with some NHS organisations offering pay incentives

    c. Internal competition with the various mental health investment standard monies finding rapid expansion of some different and potentially seen as less pressured community posts that both inpatient and community mental health services ("CMHT") staff are drawn to

496. In the acute sector, large numbers of experienced staff were able to be recruited from overseas, whereas this was much more difficult in mental health services given the specific qualification requirements i.e. the requirement to be a Registered Mental Health Nurse ("**RMN**") not a Registered General Nurse ("**RGN**").

Trust factors

497. Not only has the Trust experienced these national factors, I also think we have to recognise that culture and leadership as well as the high level of regulatory scrutiny have had an impact on staff satisfaction which in turn has led some colleagues to leave the Trust.

498. Equally demands on staff capacity have increased significantly and again this has resulted in some colleagues leaving the Trust to take up other less pressured roles both within and outside the NHS.

499. We have a significant number of Independent Sector Providers within the local area that act as a draw for Trust staff given the increased remuneration

on offer.

Start of tenure as CEO (January 2023)

500. At the January 2023 Board meeting, I shared some of my immediate observations recognising how early this was in my tenure. [**NHFT0000905, p.6**]. I note that my observations are similar to the findings of the Theemis report for that period. I suggested that:

a. We needed to think about how we shared learning and apply best and emerging practice across services;

b. We must focus on getting the basics right in both our clinical standards but also the culture we create, how do we create an environment where colleagues can talk openly about how it feels to work here and to have their concerns responded to quickly, to stop discrimination more than that being anti-discriminatory, making sure colleagues have a good environment to work in, have enough peers at work in teams with them and have the right tools to do their job;

c. How we work together to connect our teams – I recognized that I felt there was silo working within services and the Clinical Divisions.

501. In addition, I have always been clear from the start of my tenure as saying that 2022 was a year of significant change for the Trust at a most senior level with high turnover and recruitment of new Executives and Non Executives.

Theemis Report (February 2025) and the subsequent period

502. I have said in public on a number of occasions that I fully accept all of the recommendations identified in the report and commit to lead the Trust to deliver the required improvements in a timely way that embraces the essence of good quality improvement, i.e. a focus on the patients and their families as well as our colleagues.

503. Whilst I was not working for this Trust at the time of COVID-19, I can apply my experiences of leading a mental health Trust through this very difficult time period.

504. I had been working in the Trust for just over 2 years when the Theemis report was published and my experiences from leading a different organisation

at the same time VC was receiving care and treatment in Nottinghamshire do match some of those noted in section 7 of the report for example **[NHFT0000530]**:

a. Increased staff absences, leading to severe service pressures.

b. Reduced capacity in services due to social distancing and infection prevention and control ("**IPC**") measures.

c. Reduced face-to-face contact across clinical and corporate services with many staff working from home for long periods.

d. While there was more system working particularly around capacity in acute hospitals, there was less focus in my experience on mental health providers.

e. Implementation of some new services at significant pace that resulted in some teething problems that continued in some cases after COVID-19 (Crisis 24 help lines for example)

505. I would also note that there was national 'permission' to adopt governance light ways of operating which resulted in less committee meetings and no Committee or Board meetings in person. Policies and procedures were extended rather than formally reviewed.

506. I feel it would be remiss not to note that there was also increased severity of mental health problems linked to the pandemic which is widely acknowledged nationally. There was work done that showed the mental health 'impact tail' from COVID-19 would be present for a number of years post COVID-19. I was hearing this through my national roles as well as observing it in my previous Trust and therefore it was no surprise to see these impacts in the Trust.

507. I would also add that I think the impact on colleagues working in the Trust as well as demand for services and the legacy financial impacts went on to have an impact through 2023 and into 2024 in my view.

PART E: SERVICE CAPACITY TARGETS AND REQUIREMENTS

508. The Trust Board via the ELT monitors 23 Key Performance Indicators ("KPIs"), most of which are part of the NHS national mental health KPIs **[WITN0263124]**. The table below (taken from the IPR) gives the details of the

targets with a commentary on achievement over the last 5 years.

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) Adult and older adult acute admissions for patients with no contact in the prior year with mental health services; NHS

							Digital; Mental Health Services Monthly Statistics
Proportion of Acute admissions with no prior contact (Black, Asian and Minority Ethnic)	none	-	-	23.8 %	13.4 %	13.8 %	
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 health beds with a length of stay over 90 days (rolling 3 months)	8.0	-	10.4	11.8	10.5	11.6	New metric to be reported Nov 2025 onwards - Proportion of older adults over 65 years with a length of stay exceeding 90 days (rolling 3 months)
Crisis Response: very	non	-	-	-	68.6	75.7	New national

urgent patients seen within 4 hours	e				%	%	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 YoY increase in performance
EIP treatment <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

509. 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.

510. More detail for all these KPIs is monitored through the Quality and Performance group that reports in the ELT.

Concerns about service capacity

511. During my time as CEO, we have discussed capacity related issues in the ELT 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.

512. 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 acute hospital Emergency departments and for crisis services – driven by demand

Actions taken by ELT and feedback into the Board

513. SafeNow was developed in response to the CQC section 48 recommendations as a way to review key safety indicators on a weekly basis and identify any issues and patterns across our services [**CQCM0013499, NHFT0015911**]. The SafeNow dashboard is shared with the 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.

514. 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 IIP address the themes of escalations. There have been and are specific pieces of work underway initiated through this process:

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 reach onto adult wards to discharge people earlier with enhanced support)

c. A detailed improvement plan to reduce reliance on in area independent sector beds

d. A coproduced QI based review of the adult mental health community pathway

e. A review of the community capacity given over to working with people with complex trauma (personality disorder hub review)

f. Alignment of Assertive Outreach Teams

g. Place based delivery of Early Intervention Teams

h. 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.

515. These same programmes of work are discussed in Board meetings by way of giving assurance about Non-Executive Director concerns raised around areas such as waiting lists, independent sector bed usage and bedded care length of stay – all related to capacity issues linked to increased demand.

Out of Area placement rates

516. 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.

517. 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 staggering 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 by the ICB **[WITN0263098, p.41]**.

518. 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 at Mill Lodge which is a private provider with whom we have a very close working relationship; ("Cohort 1")

b. In Nottinghamshire but out of the above Trust bed base, we use independent sector providers such as the Priory; ("Cohort 2")

c. Out of Nottinghamshire area, these beds are known as Out of Area beds ("Cohort 3").

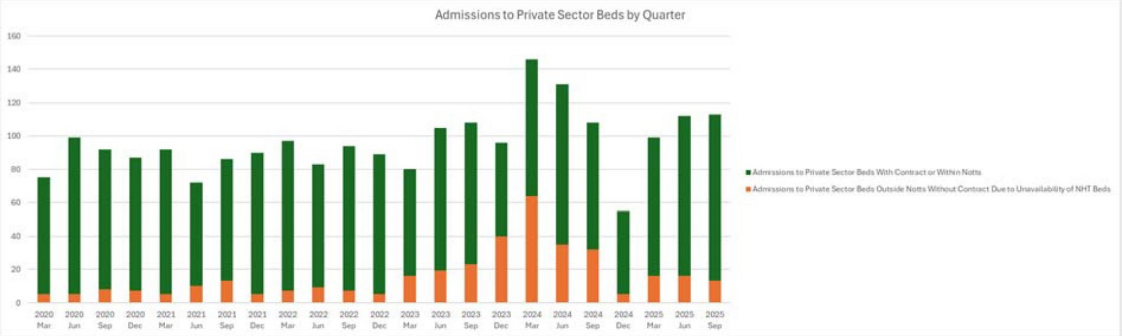
Use of adult mental health beds for people living in Nottinghamshire

519. Our focused work on mental health bedded 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 now on reducing the use of independent sector beds in Nottinghamshire is that regardless of this being an in area placement, I 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. It can increase clinical risks and reduce patient outcomes, prolong recovery and increase length of stay.

520. It is worth noting that there will always be appropriate use of out of area beds - for example if any of our 11,500 staff need admitting, we have reciprocal arrangements with other providers in the same way there may be certain circumstances where a patient wants admitting nearer to family for instance.

521. The below graph (taken from the IPR) shows 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).



Note: In the above graph, low patient numbers per quarter (less than 5 people) have been rounded up or down to avoid individuals being identifiable.

522. I would note that VC required an independent provider placement in September / October 2021 because the Trust did not have an empty bed. VC was admitted into a sub-contracted in area placement (independent sector provision) cohort 2 as above. VC first went to Cygnet Victoria House in Darlington as he was assessed to require a Psychiatric Intensive Care facility. He was then subsequently transferred to an Adult Acute Mental Health bed at to the Priory Arnold which is a sub-contracted in area placement (independent sector provision) cohort 2 as above.

523. The core of our work around beds is to ensure patients have the optimal length of stay. Having an increased length of stay and being an inpatient for too long

or having a short length of stay can be damaging because both extremes have negative consequences. Prolonged hospital stays can lead to decompensation, including complications from loss of confidence, reduced mobility and hospital-acquired infections, while excessively short stays can result in premature discharge and inadequate care, potentially leading to readmission.

524. 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 [NHFT0000425] have been strengthened to ensure parity for all our patients irrespective of clinical pathway. The infrastructure within the Trust has been strengthened with the introduction of leadership roles and growing the bed management/ out of area team, thus increasing capacity. Within the "Continuity of Care Principles Standard Operating Procedure", 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.

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

Impact of staffing on out-of-area placements

526. It is helpful to again note the difference between Out of Area (outside of Nottinghamshire) beds and the use of in Nottinghamshire Independent Sector beds.

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

528. Since I have been CEO, 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.

529. We know that the number of admissions per 100,00 population is about in line with the national average. However, our average length of stay is longer as is 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.

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

531. 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. In this way, it is possible to link staffing issues to bed availability.

532. 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 exorcises the Board. Progress on the improvement plan which forms part of our IIP 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.

533. There are 4 key actions related to this programme of work that include:

a. Improve pre-admission processes which is about agreeing with clinicians and managers a reduction trajectory for IS bed usage. Continue to ensure that we are not placing patients outside of Nottinghamshire and work with community and inpatient clinicians to strengthen purposeful admissions

b. Enhance Ward Processes through the use of an admissions checklist with clear 72 hour formulations and care plans. Introducing peer MDT coaching, piloting daily ward reviews and strengthen complex case reviews

c. Strengthen System working to help Reducing those who are clinically

ready for discharge - through working with partners MADE (Multi Agency Discharge Events), scoping opportunities for more step-down beds, review discharge to assess processes

d. Strengthen patient flow process governance through streamlining meeting cadence, use of tracker for all out of area placements and calling IS providers to accountability meetings, increased focus on escalation processes and use of Operational Pressures Escalation Levels Framework ("**OPEL framework**") and more senior leadership at governance meetings contracting/income.

Concerns about premature or inappropriate discharge

534. During my time as CEO, I have not had any concerns raised directly to me about premature discharge of a patient or patients apart from through the various investigation reports relating to the care and treatment of VC.

535. As set out above, there does seem to be more of an issue currently with patients staying too long in a hospital bed.

536. Discussion and challenge at the Board in my time has been focused on the changes to the Transfer and Discharge policy and the introduction of the new 8 stage discharge process, which is monitored through the SafeNow dashboard on a weekly basis.

PART F: MULTI AGENCY WORKING

537. The Trust has in place the various information sharing agreements and policies that I would expect to see for an Organisation working in the mental health sector.

538. The agreements can cover specific purposes for information sharing including but not limited to third party access to clinical systems, outsourced care provision, decommissioning of services, onboarding of services, research, other specific projects of work.

539. The templates used for the agreements are in accordance with the Information Commissioner and NHS England guidelines. The agreements set out:

a. the purpose of sharing information what information is shared

b. legal basis for sharing of information

c. those involved in the sharing

d. when information will be shared

e. data quality

f. retention of data

g. security

h. access

i. compliance with the agreement

j. indemnity

k. monitoring, review and amendment

l. termination of the agreement

m. signatures of those with authority to sign on behalf of their organisation

540. The Trust are party to a number of multi agency arrangements including Multi Agency Public Protection Arrangements (MAPPA), Multi Agency Risk Assessment Conference (MARAC), Preventing Radicalisation (Prevent). Information and guidance for Trust staff is available on the Intranet (Connect), training is available, as well as supporting documentation.

541. I would note whilst there are sharing agreements in place, this does not prevent information sharing for purposes such as direct care, risk assessment and management, safeguarding purposes, and events when there is a need to share information on a proportionate basis with other providers.

542. We have previously disclosed to the Inquiry the following relevant policies in relation to information sharing:

a. 12.01 Information Systems Security [**NHFT0015695**]

b. 12.06 Records Management [**NHFT0015698**]

c. 12.03 Clinical Information Systems, Access and Audit [**NHFT0015696**]

d. 12.04 Secure Handling of Information [**NHFT0015697**]

e. 12.07 Registration Authority [**NHFT0015699**]

f. 12.08 Information Systems Data Quality [**NHFT0015700**]

g. 12.09 Access to Information [**NHFT0015701**]

h. 12.14 Information Risk Management [**NHFT0015702**]

i. 12.19 Data Protection [**NHFT0015703**]

j. 06.01 Safeguarding Children [**NHFT0002828**]

k. 06.04 Safeguarding Adults at Risk [**NHFT0015692**]

l. 13.07 Multi Agency Public Protection Arrangements [**NHFT0000418**]

m. 08.03 Involvement of Patients and Carers [**NHFT0015694**]

n. 08.01 Information Sharing Between Professionals Patients and Carers [**NHFT0012786**]

543. The Trust holds information as part of our Record of Data Processing Activities (ROPA) which is maintained by the Trust Data Protection Team with regular reviews taking place to ensure the arrangements are timely and sharing agreements are still required. The log contains the Trust reference number, title of the agreement, organisations involved with the Trust in the sharing arrangements, and the date the agreement was signed off. The full ROPA contains further information including the date the agreement is due to expire or is due for review. **[WITN0263131]**

Information sharing with other healthcare providers

544. The Trust will share relevant information with other healthcare providers as part of any referral and ongoing care process. It is the Trust's policy to respond to any requests from other providers for additional health records in a timely manner so as not to hinder the provision of healthcare. Sub-contracted providers are also able to have direct access to the Trust's electronic patient records, as explained in paragraphs 380-382 in the First Witness Statement of Diane Hull.

545. Policies, procedures, and guidance is available to staff when such situations arise (see 12.09 (formerly 7.09)) [**NHFT0015701**].

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

as this will be discussed, including the use of social media, use of mobile devices and professional boundaries as relevant to this topic. Staff are also able to seek support and advice from the Trust's Data Security and Data Protection Team and Caldicott Guardian. A Caldicott Guardian **[WITN0263125]** is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly. All NHS organisations and local authorities which provide social services must have a Caldicott Guardian. The Trust's Caldicott Guardian is the Executive Medical Director, Dr Susan Elcock. The Caldicott Guardian is supported by the Trust Data Protection Officer, and Deputy Data Protection Officer who are also available to provide support and advice.

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

Information sharing with local authorities

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

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

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

c. Councils are responsible for authorising Deprivation of Liberty Safeguards ("DoLS") in care homes and hospitals.

d. The responsibility for AMHPs. AMHPs are responsible for considering and arranging assessments under the MHA. If the patient lacks capacity, the AMHP will need to apply to the County Court. It is the AMHP's responsibility to involve the patient, their family and carers where possible

to explore and consider the least restrictive option and alternatives to detention. They work with a number of other professionals including hospitals, the police, care homes, housing providers and homeless outreach teams.

Information sharing with the Police

549. The Trust's Multi Agency Public Protection Arrangements sets out the steps to be followed so that the Trust is able to fulfil its legal responsibilities regarding the notification of and sharing information relating to those offenders who are covered by the Multi Agency Public Protection Arrangements ("MAPPA"). **[NHFT0000418]** MAPPA is the statutory process through which the police, probation and prison services work together with other agencies to manage the risks posed by violent and sexual offenders in order to protect the public).

550. The Trust also has an information sharing agreement in place with the police that supports all memoranda and joint protocol between the Trust and those police forces and criminal justice agencies within whose boundaries the Trust operates. The aim of the agreement is to support positive joint working and the appropriate flow of information between the police, the Trust and their partners and all criminal justice agencies in fulfilling the shared responsibilities towards the public. The Trust is currently in the process of agreeing a new information sharing agreement with Nottinghamshire Police. I understand the final version of this agreement is currently with Nottinghamshire Police for their signing. **[NHFT0009272, WITN0263126]**.

Information sharing within the Integrated Care System

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

social services in relation to the case of a patient.

Relationship with the Police

Operational/ Service Relationship

552. On a day to day basis, the Trust and police operate closely, examples include the Trust's Mental Health Liaison and Diversion service that operate out of police custody suites and courts to support individuals with mental health, learning disability, or substance misuse issues who enter the criminal justice system. Another example is the Trust's Street Triage Service where our mental health nurses work alongside police officers to respond to incidents where a person is in mental health crisis. The goal is to provide immediate, appropriate support in the community, diverting individuals from Emergency Departments or police custody and ensuring they receive mental health care more quickly. This can involve giving advice to police officers, completing mental health assessments at the scene, and connecting the individual with further support. I have visited the street triage service and have witnessed close working relationships between Trust staff and the police officers that I believe contribute to better outcomes for people with mental ill health in a public place.

553. We also have a police liaison officer in place in the Trust whose role is to facilitate good joint working and escalate any issues raised.

554. We also have a local service interface, as the Mental Health Care Group is also able to take any issues to the monthly Police Local Operational Group meeting **[NHFT0015915]**.

Strategic relationship

555. In addition, the Trust works jointly with the police through the ICB MH Partnership Board and the Local Authorities Safeguarding Adults Boards **[NHFT0015916, NHFT0015918]**. Since being in the CEO role, I believe that the relationship with the police has become more formal and strengthened particularly through the MH Partnership Board. I have witnessed some great joint presentations between police and Trust leaders and we have had some open and honest exchanges of views when discussing new policies such as the Right Care Right Person approach adopted by the Police nationally.

556. My Chief Nurse meets monthly with the Acting Assistant Chief Constable and

they liaise between meetings as required on ad hoc matters. He came to speak at the Trust's Nursing Conference on collaboration, and in my view this says much about how he now views the relationship between our organisations

Mental Health High Risk Oversight Panel

557. I am also aware that the Trust's Head of Safeguarding is working with the Police through the Potentially Dangerous Persons Panel. She has informed me that the Police have had a potentially dangerous person's process in place for many years although it could have been described as 'dormant' and partners were not previously aware of the process. I am led to understand that this process was mobilised differently across the country and not well known to agencies. Over the past 18 months, the Trust's safeguarding lead for MAPPA has worked closely with the Police to improve how we work together on this potentially dangerous persons process.

558. In doing this work we, as a Trust, have referred several patients that have come to the attention of the safeguarding Single Point of Access and assessed for the potentially dangerous persons pathway. When cases of concern come to the Trust's safeguarding team, the lead will seek advice from the Police team and if the case is not MAPPA eligible, they will be sent to the Police to review and establish if they are eligible for their potentially dangerous person pathway. If they are MAPPA eligible, the potentially dangerous persons pathway is not necessary. The Police make the decisions around whether cases are eligible for MAPPA or potentially dangerous person pathway. The Police use the national MAPPA guidance updated in 2024 that sets out eligibility criteria which is in four categories [**NHSE0002321**]. I am informed that until now, the Police have not had a dedicated team to manage MAPPA nominals or people who are potentially dangerous. They have recently been given funding to set up the Neighbourhood Offender Risk Management (NORM) team. As part of this they are setting up a strengthened potentially dangerous persons panel and we are actively involved with them in ensuring mental health services are able to refer in and share risk information. A governance process is required to enable a legal and proportionate approach, so we are jointly developing a MOU and will be consulting on their referral pathway.

559. In the Trust, it is our intent to call this pathway the Mental Health High Risk

Oversight Panel as to ensure the negative connotations of identifying a patient as 'potentially dangerous' could be stigmatising. We have MAPPA training for staff where the above is covered, and we have an extensive MAPPA work plan **[NHFT0000424]** that will cover the work of the mental health high risk oversight panel once it is mobilised. I understand that the Police are aiming for mobilisation by the end of November 2025 and I understand that this is dependent on the release of recruited staff.

Concerns about multi-agency working

Operational perspective for multi-agency working

560. 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 City 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. This is a potential issue in terms of the Police not attending a patient's home should we have concerns about them. We have had significant conversations in Nottinghamshire to try to mitigate this risk and I describe it as a potential risk as I have not had this specifically raised as an issue to me directly.

c. There is tension around the availability and use of section 136 Suites (i.e. places of safety for the purposes of s.136 MHA) when the Police need to bring somebody into a place of safety. This is mainly due to the section 136 suites being full, potentially due to not having beds to further move patients into. There has been occasions when this has been escalated directly to me by the Assistant Chief Constable and we then took steps to resolve the issues being raised at that time by moving patients to create section136 capacity.

d. Cross over between our SI process and criminal process causing delays.

561. In terms of information sharing, this can be examined from 2 perspectives;

562. Legal perspective for information sharing:

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

563. Operational perspective for information sharing:

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

b. However, it can sometimes be difficult in practise to balance the need to share information with the need to protect patient confidentiality and the UK General Data Protection Regulation. In the Trust's experience, some external bodies and clinical staff are sometimes too risk 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.

Information sharing with families

564. The Trust will share patient information with families and carers based on the patient's explicit, informed consent, or when it is in the patient's best interest if they lack capacity. Patients can choose who to share information with, how much to share, and can change these preferences at any time. The Trust will record these choices in the patient's record. If a patient's objection to sharing information could prevent safe care, a clinician will discuss the potential consequences with them, but the patient's wishes are generally respected unless there is a legal requirement or risk of harm.

565. The Trust policy Information Sharing Between Professionals, Patients and Carers (08.01) **[NHFT0012786]**, provides guidance to staff on appropriate and proportionate information sharing. The Trust policy Mental Capacity Act 2005 (01.21) **[NHFT0000759]** provides guidance to staff on the Trust's obligations in regard to this subject matter. Training is available and the Mental Health Legislation team have guidance available on the Trust Intranet (Connect). **[NHFT0015722]**

566. There are a number of reports both historically and currently that are received by the Board that identify issues with Families and carers particularly about the fact that they are not engaged in care.

567. This is mentioned in - complaint reports, learning from deaths reports and in more specific cases the patient safety exceptions report.

568. In the CQC Section 48 report it notes that the Trust should ensure that, *in line with national guidance and best practice, staff are aware of the importance of involving and engaging patients' families and carers and that they do so in all aspects of care and treatment, including at the point of discharge, with patient consent. The Trust should ensure that where patients do not give consent, this is reviewed on a regular basis in line with best practice and on all the available information available to the multidisciplinary team.* **[CQCM0016518, p41]**

569. Work has been done to improve how we share information and engage an individual's family such as:

    a. Trust induction now includes core messages on having carer and family involvement in place.
    b. A Carer 'talking head' video regarding the importance of their involvement developed and being circulated.
    c. Co-produced carers guide developed and shared electronically.
    d. Lived experience participants engaged in Community Improvement Group meetings through Partners in Mind. Partners in Mind are an independent, voluntary co-production group, specialising in mental health across the NHS, social care, Voluntary, Community and Social Enterprise sectors. They formed in April 2024 to support the mental health system across Nottingham and Nottinghamshire, as part of the Integrated Care System (ICS) Mental Health Programme strategy. They

are funded for 3 years from the ICB. The membership of Partners in Mind includes people, their family members and carers, with relevant lived and learnt experience of mental health services.Lived experience participants involved and presenting at Community Improvement development events, including discussion on pathway to co-production

e. Lived experience participants involved in development / refresh of waiting well resources as mystery shoppers
f. Patient and carer participation feedback seen growth of 113% for Local Mental Health Teams **[WITN0263127, p.32]**
g. Refreshed the Personalisation Policy that was co-produced with families and includes risk assessment.
h. 2024 audit results of accredited triangle of care self-assessment audits show 152 wards and that services went through self-assessment.

PART G: REVIEWS COMMISSIONED FOLLOWING THE ATTACKS ON 13 JUNE 2023

Level 2 StEIS Investigation

570. The process, findings and recommendations of the Level 2 StEIS Investigation were considered and discussed by myself, the ELT and the Board as follows:

a. On 6 July 2023, Psychological Approaches was commissioned to provide an independent chair and produce the report **[TCLT0000818]**. It is important to note that the purpose of the investigation was not to examine any competence or capability issues. On 20 July 2023, Nottinghamshire Police requested that the investigation be paused given the given the live criminal investigation that was ongoing. As a result, the tabletop review of VC's clinical record was delayed until October 2023 and staff interviews were conducted in November 2023. **[NHFT0016060]**

b. On 7 February 2024, the Trust held a meeting to discuss the draft report **[TCLT0000818]**. The draft report was also shared with NHS England to assist with the Terms of Reference for their independent homicide review. An updated report was received by Trust on 14 February 2024 **[TCLT0000818]**. This report was approved and shared with ICB and NHS England's regional team on 1 March 2024. The

report was then finalised by Psychological Approaches on 15 March 2024 [**NHFT0000452**].

c. The report was discussed at the Trust ELT on the 28 February 2024 **[NHFT0015922]**. The full report was received and the conclusions and recommendations accepted for escalation directly to Board given the timings of the next quality committee.

d. The report was received in full by the Board on the 28 March 2024 **[NHFT0000455, p.42-43]**. As well as receiving the report the Board was told about a learning forum for staff based on the findings scheduled for April 2024. The Board did focus its discussion on learning not just from this report but from the various reports that were to be completed in relation to VCs care and treatment.

e. The Board fully accepted the findings made by the Panel.

571. My understanding of the key findings are [**NHFT0000452**]:

a. Discharge planning reflected an inpatient focus on VC's presentation as a snapshot view of someone with a recent relapse and relatively quick short-term recovery, rather than taking a longer-term view of VC's pattern of behaviour, risks and needs with consideration of what might be required for successful community management.

b. There was limited operational oversight of discharge from private hospital in 2021.

c. There was a lack of clarity in the EIP single operating procedures regarding the relationship between the Crisis team and EIP services when a patient is on the EIP caseload but referred to the crisis team.

d. Although the weekly team review meeting was well attended and well used by staff, there was no formal type of RAG rating/zoning/traffic light system for discussion of patients.

e. The clinical decision to detain under Section 2 rather than Section 3 of the MHA was not in keeping with the fundamentals of the legislation as laid out in the Code of Practice; and there was sufficient criteria met in January 2022 for Section 3 to have been applied to VC. The report does note however that the decision lies within the clinical expertise of the

clinicians undertaking the MHA, and clinicians have autonomy in their practice and decision making, and the requirement to use the least restrictive option.

f. There was sufficient evidence from VC's behaviour over the preceding two years to lend weight to the importance of instigating depot medication – and therefore placing VC on Section 3, and a Community Treatment Order ("CTO") in order to enforce it longer term for the benefit of longer-term community management. The report notes that this was a finely balanced decision and recognises that it is an area of clinical judgment where different professionals may reach different conclusions

g. It would have been appropriate to inform VC's family of his discharge, and to advise them how to access services should they have concerns in the future.

h. The Trust did not write to VC directly to inform him of his discharge, which would have been good practice.

i. VC's care plan should have been reviewed in August 2022, and concerns – albeit possibly unfounded - should have been raised when VC requested his notes.

j. The EIP team should have successfully achieved a face-to-face review of VC in September 2022 to determine his mental state prior to discharge.

k. With VC's discharge from hospital, it would have been appropriate to review the written care plan and risk assessment, including consideration of how future non-concordance with medication, disengagement from services and deteriorating mental health might be responded to (that is, the relapse/crisis and contingency plans).

l. Given VC's risk profile when psychotic in the community, a risk formulation and future crisis plan ought to have been shared with his GP.

m. Neither the EIP team or the inpatient team were insensitive to or ignorant of the possible implications of culture and ethnicity on VC's insight and compliance, although there are opportunities to develop the teams' understanding and management of cultural and diversity implications for their patients still further.

n. On balance, too much emphasis was placed on complying with VC's priorities for his education, and insufficient weight given to the risks associated with non-concordance.

o. There was a failure of teams to record in a way that reflected their professional thinking, and their rationale for decision-making - this was a crucial omission in this case, as VC presented the teams with particularly complex dilemmas.

572. As a result of these findings the panel identified 10 learning points for the Trust around improving clinical records, the discharge process, risk management and other internal processes, as set out at Appendix IV / pages 48 – 51 of the report. The ELT approved the draft action plan on the 24 April 2024. **[WITN0263096]**

573. The latest review of the action plan for this review was on 3 July 2025, where an updated action plan providing evidence against the 10 Learning Points was presented to the Complex Incidents Oversight Group **[NHFT0010812]**.

574. All but one action are now completed. The one action waiting for update is the review of ward reviews and MDT meetings within inpatient services.

575. This final action will go to the complex incidents oversight group for sign off in late November then evidence and assurance group which is an independently chaired group made up of representatives from various stakeholders including staff and patients to review and assess the evidence. We have also arranged for a Peer Audit of these actions to be completed in May 2026 as a check for continued embeddness.

CQC Special Review

576. The review was published in three parts:

a. The first two parts, relating to the CQC's assessment of patient safety and quality of care provided by the Trust, and progress made at Rampton Hospital since the CQC's last inspection in July 2023 were published in March 2024 [**CQCM0013499**].

b. The third part, a rapid review of the available evidence related to the care of VC was published in August 2024 [**CQCM0013499**]

577. For the third part of the CQC special / rapid review, in summary, the CQC

found that there was no single point of failure in relation to the care provide to VC, but it did identify a series of errors, omissions, and misjudgements. Key among these from the August 2024 report, were:

a. Inconsistent approaches to risk assessment. Risk assessments minimised or omitted key details and did not make explicit the serious and immediate nature of the risk VC posed to himself and others, and the known issues that would increase the risk.

b. Care plans: Whilst care plans followed national guidance, teams did not always take a holistic approach, which hampered their ability to identify risk factors. This reflected concerns in the first report around inconsistent care planning.

c. Engagement: Whilst teams took steps to follow up and re-engage people, there were large gaps between visits in the records for VC and 3 of the 10 benchmarking cases. VC's family contacted the Trust to raise concerns on a number of occasions but the information they provided was not consistently acted on. There was no evidence that VC's family, GP, university or the police were consulted when he was discharged back to his GP.

d. Medication management: VC's preferences around medication were not balanced with other information and there was evidence that he was not taking his medication.

e. Depot / CTO: There was no evidence of discussion of depot medication or a CTO until VC's fourth hospital admission. Whereas a depot injection and CTO could have facilitated recall to hospital, as he was being held under s2 MHA, it was not legally possible to discharge him using a CTO.

    i. However, the Trust notes that the chronology provided in the Corporate Witness Statement shows that there is evidence of depot medication being considered earlier than the fourth admission from 28 January 2022. These discussions took place in July 2020 and are reflected in his summary care plan of 28 July 2020. Depot discussions are also recorded on 17 September 2021.

ii. The Theemis report [**NHFT0000530**] refers to depot discussions in July 2020 and September 2021.

f. Elsewhere in the s48 review, the CQC notes that:

i. "In 3 of VC's inpatient hospital admissions there are references to a depot injection, but VC consistently declined this, stating that he preferred to take oral medicine...we are concerned that the team did not adequately balance VC's wishes with other information they may have held and what may have been in his best interests. This could be seen as a missed opportunity, as his detention under the MHA presented the possibility of changing his medicine to be able to treat his symptoms more robustly." [**CQCM0016518, p35**], and

ii. "there is no mention of a CTO, combined with the use of depot injection, until his fourth admission" [**CQCM0016518, p38**]

iii. We would therefore suggest that this finding from the CQC is intended to refer to there being no evidence of discussion of depot medication combined with a CTO until VC's fourth admission, rather than there being no discussion of depot until that point.

g. Discharge: The decision to discharge VC back to his GP in September 2022. The evidence over the course of VC's illness and contact with services and police indicated beyond any real doubt that VC would relapse into distressing symptoms and potentially aggressive behaviour. Discharging VC back to his GP, due to his lack of engagement with mental health services, did not adequately consider or mitigate the risks of relapse and violence.

h. The CQC also found that if the decision had been made to treat VC under section 3 of the MHA on his fourth admission to hospital further options would have been available for his care and treatment in the community.

578. The CQC made nine recommendations to the Trust and seven to NHS England. The Trust accepted all of these recommendations and developed an action plan to implement them. The Trust has disclosed to the Inquiry a copy of the plan showing progress against each recommendation. [**NHFT0002439**]

579. Actions taken to learn from the review and implement recommendations include:

a. The IIPB chaired by myself was established by the ELT to ensure ongoing monitoring, scrutiny and assurance on the progress and delivery of the IIP, including the actions required to meet the findings of the CQC Section 48 review, and to meet the criteria to successfully exit segment 4 of the National Oversight Framework.

b. The IIPB provides regular reports into the Improvement Oversight Committee, which includes a CQC Section 48 update, to assess progress, challenges, risks and mitigation strategies in the context of the criteria for transitioning from segment 4 of the National Oversight Framework. The Improvement Oversight Committee is chaired by the Trust Chair. The purpose of this Committee is to provide assurance to the Trust Board whether there are robust actions in place to deliver the outcomes required for the criteria for exiting segment 4.

c. From March 2025 the Board also now receives in public an update on all regulatory actions (Regulatory Report) which includes a breakdown of progress against all the Section 48 actions.

d. The output of the Improvement Oversight Committee then goes to the Improvement Oversight and Assurance Board, which is not a Trust group, but a multi-stakeholder body that is co-chaired by the NHS England Regional Medical Director and the CEO of Nottingham and Nottinghamshire Integrated Care Board. It brings together interested parties from across the local health and social care system to provide strategic oversight of the Trust whilst it is in segment 4. It oversees and gains assurances regarding actions against the IIP including the CQC Section 48 recommendations, in order to help the Trust to make the improvements required to exit segment 4. **[NHFT0015930]**

Internal Review of EIP Team

580. The report titled Nottingham EIP review was delivered to the Trust on 21 December 2023 [**NHFT0000461**]. Five recommendations were made, set out below in bold text, followed by a summary of the progress against these

recommendations:

a. **The Trust should review the number of bases that the EIP operate from**, there are several options available to the Trust and the risks and rewards of each option should be balanced. Progress is RAG rated as red. The team have taken the approach to firstly ensure that the current estate used by the teams is as good as possible and this has included work around space utilisation and proposed base changes. However, the wider need which was highlighted in the review was around the number of EIP team-based services, staff self-reporting isolation due to the service configuration model and lack of resilience in teams due to current configuration. To address the core issue identified within the review, the proposed model is to align the EIP service into three place based operating models which also align to the geographical footprint of Nottinghamshire. Proposed model changes and operational configuration will report into the Improvement Group and Care Group Senior Leadership Team (SLT) by way of governance and reporting.

b. **On balance we think that there should be dedicated Consultant input into the team rather than sessional input from the Local Mental Health Teams.** Progress is RAG rated as Red to Amber. As described above, work on realigning the EIP service to a place-based model continues. A project plan is being developed, and discussions with the medical consultant body will take place. The Trust is undertaking a review of consultant job planning, and this will support this piece of work. Progress will be reviewed monthly in the Community Improvement Group, that reports into both the Patient Safety and Quality Improvement Group and the Pursuing Operational Excellence Group sub-groups of the Integrated Improvement Portfolio Board.

c. **The Trust should consider how to introduce the role of Psychology, Social work and Occupational Therapy into the service. It may be that as Care Coordinators leave that the funding is repurposed into the specialised disciplines**. Progress

is RAG rated as Amber. Work has progressed to align the service model to the standards outlined in Early Intervention in Psychosis Network ("**EIPN**") standards by the Royal College of Psychiatry. Plans are in place to recruit place-based Psychologists. Other actions being taken to mitigate risks include:

i. Psychological interventions (non-Family Interventions related) - the EIP service now has access to Cognitive Behavioural Therapy for Psychosis ("**CBTp**") in the form of Cognitive Behavioural Therapy ("**CBT**") practitioners

ii. Since the report, EIP North team has recruited an Occupational Therapist to work on the At Risk Mental State pathway. The aim of the role is to offer focused Occupational Therapy interventions.

d. **The team should review its expectation around documenting discharge.** Progress is RAG rated as Amber to Green. There are now clear standard clinical expectations regarding the discharge process from the EIP and associated planning and documentation. This includes:

i. The use of a discharge checklist.

ii. MDT template (to support pre discharge discussions).

iii. Clinical note template / aide memoir.

iv. Implementation of a business-as-usual quality audit on discharge.

v. Focused workforce learning sessions which have included

vi. Team briefing updates, workshop, business/ team meetings and supervision.

vii. SafeNow work is embedded as business as usual, including the review of anyone discharged due to disengagement.

e. **There should be a regular quality audit cycle within the team in addition to the NCAP [National Clinical Audit of Psychosis]**

standards. This should include the following:

i. Documentation around disengagement and discharge – Completed. "Did Not Attends" audit is now in place and a monthly discharge audit is in situ for discharges completed on Audit Management and Tracking (AMaT) system and reporting into care unit and care group oversight and improvement groups.

ii. Declined referrals. – Completed. Currently being auditing/ reviewed as part of the discharge audit, with feedback given to leadership team and clinical directly by Service manager. It is now possible to discuss decline data in monthly EIP performance meeting and Quality Oversight Groups.

i. Prescribing practices - Completed. No additional actions, routine audits are in place, led by the pharmacist.

ii. Delayed transfers to Local Mental Health Teams – Completed. Operationally, we have a report in place that identify patients in their last year, 6 months and those over the 3-year pathway, this is discussed as in the EIP leadership team monthly to ensure that plans are in place and focused on where the greatest need is. This is reported and escalated to the weekly Patient Tracker List and monthly business meeting. There is no current audit in place.

Internal Review of Crisis Team

581. The report titled Nottingham Crisis Resolution and Home Treatment Team ("**CRHT**") and associated Crisis Service review was delivered on the 22 April 2024 [**NHFT0000462**]. Five recommendations were made and the progress against these recommendations is summarised below:

a. The Trust should embark on an OD (Organisational Development) programme within the crisis team to ensure that direct care staff are involved in the review of the recent and upcoming changes. Progress is RAG rated as Amber. Staff are involved in workstreams that form the Crisis improvement group and have contributed to the process mapping of current provision and identifying barriers, challenges and what is going well. This is an integral part of the organisational development improvement work going forwards.

b. The opportunity to develop a sense of team and purpose around the various crisis provision within the City and County should be grasped. Progress is RAG rated as Amber. The core function and purpose of the teams is a core part of the crisis improvement group and linked to the above recommendation.

    i. The teams were facing a lot of change around the crisis line and the merging of two teams at that time and it was felt to be a fortuitous time for them to engage with our flagship OD programme: Creating Compassionate Cultures (CCC); this is a 10 month in person programme. The ethos of this programme is one of sustainable change through peer led reflection and discussions. The teams have now completed this programme and in order to continue this cultural work, they all now have access to the TED survey system. The Trust's Culture, Engagement and OD team offer an evidence-based Team Engagement and Development tool called TED. This is specifically for Managers across the Trust who lead teams. TED is a key part of our Organisational Development (OD) offer and will also link closely with our Quality agenda. It also links directly to the NHS Staff Survey and People Promise.

    ii. They were also provided with slide content from the CCC sessions after each session with the open invitation to contact OD if they wanted to discuss anything further.

c. The team should review its communication on discharge to ensure

that relevant risk information is passed to the receiving teams. MHA status should be clear as key patient information in EPR ("Electronic Patient Records") along with Responsible Clinician and named Care Coordinator. Progress is RAG rated as Amber to Green. The discharge document has been reviewed, refined, agreed through governance processes and the changes have been made to the Rio templates, as jointly owned documents for Local Mental Health Teams and Crisis Teams. Pilots were undertaken and the new templates went 'live' across adult mental health in September 2025, to ensure that the teams are aligned. Further engagement with staff has since taken place to ensure the e-discharge summary meets the needs of all teams across AMH. Feedback has now been collated, and the document has been updated and the next version went live on the 03 November 2025. Communications are currently being circulated to all teams and guidance developed by the Rio trainers to support completion of the document.

d. The estate provision around the 111 (the public number to call for urgent mental health support) team and potentially for the City and County South CRHTs should be reviewed. This is complete and RAG rated Green.

    i. A review took place, and a solution was agreed for the 111(2) team. The CAL team were previously located in the 'Tall Trees' building on the Highbury Hospital site. The team were allocated several small offices that were not conducive to a call centre environment and limited quality oversight of calls and peer support. The team worked with the Property and Space team to find a suitable, cost-effective alternative that provides a call centre environment with suitable acoustics, is safe and secure for overnight working and within proximity to the on-site crisis teams. A proposal to move to the 'Underwood' building, with a circular movement between 3 teams was agreed by SLT and ELT. Minor, low-cost building works took place to meet the requirements of the team, and the team successfully moved on the 12th August 2025, ahead

of schedule. The team celebrated the move and have reported to the improvement group that the move has provided a cohesive team environment, resulting in better quality oversight, peer support which contribute to an enhanced patient experience. The on-site crisis teams and beds management team are currently piloting overnight co-location in the Underwood building to further enhance the effectiveness, patient flow and patient experience.

e. A Trust and Team response to the growing demand and increase in waits for the crisis service is required. This should take a 'test and learn' approach involving direct care staff. Progress is RAG rated as Amber. A crisis improvement group was established in December 2024 with robust governance in place. The programme is split into 3 workstreams; Clinical pathways and processes, quality standards and alternatives to crisis (system led), each with detailed programme plans, milestones, and monthly reporting, including locally agreed improvement trajectory to meet locally agreed KPIs for crisis 4 and 24 hour waits, CAL abandoned calls and time taken to answer. The CAL was initially prioritised and following a capacity and demand review of the CAL, a business case was developed to increase capacity in the CAL by increasing the recovery worker WTE by 9WTE. This was agreed by SLT and ELT in June 2025. There have been 4 rounds of recruitment, and we have now successfully recruited to all vacant posts. Seven recovery workers will have started in post by the end of Q3, with the final two post holders starting in Q4. The increased capacity will allow the team to meet locally agreed KPIs by the end of Q4.

582. We are currently in the process of completing capacity and demand modelling for the crisis teams, alongside an establishment review. High impact improvements to core processes have been identified to support the local improvement trajectory which include:

a. explore process around allocating appointments at triage when 4-hour appointment identified

b. Develop guidance and expectations regarding patient choice and escalation process when at risk of breeching

c. Review processes regarding calls, with a focus on out of hours when there is no admin

d. Deep dive on Did Not Attends ("DNAs") to support patient choice and barriers to access

e. Explore additional local reporting that excludes patient choice and DNAs

f. Review process for timely access to translators

583. The author (Jonathan Warren) attended the ELT on 17 April 2024 to lead a discussion on his findings about the review of LMHTS and Crisis Services. **[WITN0263129]**

Review of Local Mental Health Team

584. The report was sent to the Deputy Care Group Director and Chief Nurse on the 22 March 2024 with feedback to the teams involved on the 16 & 17 April 2024. [**NHFT0000545**] Seven recommendations were made, and the progress is summarised below:

a. Teams need to be intimately involved in any changes going forward, this should include any change ideas, implementation, and the identification of measures of success. Progress is RAG rated as Green. As part of the wider improvement plan for community mental health teams a number of actions were completed to ensure team involvement and participation is included. Key actions taken included;

i. Team Leads, Clinical Leads, Medical Leads, Professional Leads have standing invites to the Community Improvement Group, as well as to many of the task and finish groups or subgroups

ii. We have actively engaged staff with questionnaires / voting linked to pieces of change work, change ideas and definition of care work agendas.

iii. The Associate Director of Nursing and Associate Director of

Operations have sessions booked with each community team to talk through the learning from the VC case and engage staff in discussions about the improvement work being undertaken.

iv. Medical colleagues will often cite not having enough time to be involved in change work, even if they have a desire to do so, therefore discussions are taking place with the new Deputy Clinical Directors and Associate Medical Director regarding job planning, to enable medical colleagues to be more involved in change. This process will be supported by the move to a new job planning process once this has been ratified by the stakeholders involved.

v. Professional leads have been integral to reviewing Internal Working Instructions and job descriptions, as well as advising on governance oversight systems.

vi. Key Quality Improvement initiatives have been developed in the true sense of QI ensuring core workforce engaged and involved from the inception.

vii. Core service improvement work linked to service pathways, reorganization have involved staff from each core community mental health team alongside key partners and people with lived experience.

b. There should be a time of consolidation and titration rather than transformation and innovation – the focus should be on relieving the core functions of the LMHTs [Local Mental Health Teams] of the burden of their work. This could include medication drops, some outpatients, and depot clinics. Progress is RAG rated as amber.

i. There is a Community Medication Forum, co-chaired by the Associate Director of Nursing and lead mental health pharmacist. A key area of focus is a review of all medications administered by the Trust alongside feedback that is being collated by pharmacy technicians on the rationale for the retention of non-specialist drug administration. This feedback will inform an action plan to support the move away from this

approach.

ii. The management of depot clinics and clozapine clinics are being reviewed by senior pharmacy colleagues to support and consider any changes that would improve productivity.

iii. A wider piece of work is underway reviewing the configuration of services to support and align to the Mental Health Community Framework.

c. The role of the Consultant Psychiatrist within the teams needs to be clarified. Progress is RAG rated as amber. The role of medical outpatient clinics is to be included within the Local Mental Health Teams Internal Working Instructions and will be reported into the Community Improvement Group.

d. The teams should be encouraged to have time to reflect on what is going well within their team and any changes they may like to make. They should take a test and learn approach to this. Progress is RAG rated as Green. To support teams to consider and reflect on what is working well, teams have been supported to have the following;

i. Bespoke sessions facilitated by NHS England to reflect and be part of change ideas.

ii. Time out and Breakaway sessions.

iii. Team away days planned and in place.

iv. Increased resource for Quality Improvement has been commissioned for the Mental Health Care Group, with training sessions for leaders within the Care Unit taking place over the coming months. This will ensure that there is a consistent methodology to Quality Improvement change implementation, to support change to take place at a local level. Many teams have team meetings, with an agenda which is set by the team.

e. There should be an opportunity for the clinical leads, team managers, and consultants for each sector to meet regularly to build strong relationships and to learn from each other. Progress is RAG rated as amber. The Care Unit Senior Leadership Team has proposed a new

leadership model, which would replicate a quadrumvirate model of leadership which is replicated at a team level and placed based level. This has been delayed due to wider recruitment challenges and wider restricting. This is expected to be in place by Q4 25/26.

f. Performance measures and data collection should be reviewed in their entirety. They need to be designed by the teams to ensure that the data they get supports the functioning of the team rather than that of central bodies. Progress is RAG rated as green. There has been an increase in patient safety information being collated and reviewed on a weekly basis. As this core work has evolved, teams and senior leads have been pivotal in the evolution and development of data, dashboards and teams being engaged to support them and use this as a key enabler as part of their role and areas of accountability. We have reviewed data requests regularly based on the feedback of teams – which can be evidenced through the Patient Tracker List discussion and the SafeNow oversight group and dashboard.

g. Patients should only be held under the LMHT [Local Mental Health Team] if they are receiving or waiting for active treatment from the Local Mental Health Team not so they can access duty systems. Progress is RAG rated as amber. Although a number of services have been stood down from needing to be open to a Local Mental Health Team (Neurodevelopmental Specialist Service and Intellectual and Developmental Disability service) there are services which still require a patient to be open to a Local Mental Health Team, further work is needed on this recommendation and this generally relates to services that are researched based and funded.

585. The author (Jonathan Warren) attended the ELT on 17 April 2024 to lead a discussion on his findings about the review of LMHTS and Crisis Services **[WITN0263129]**.

<u>NHS England Independent Investigation (Theemis)</u>

586. The findings contained within the Theemis report were similar to those findings detailed above in the preceding internal and external investigations that had been conducted **[NHFT0000530]**. This included errors, gaps and missed

opportunities in relation to the approach taken to the assessment of risk, shared decision-making across teams at the Trust, communication with VC's family, communication with the police, the discharge process (including the failure to put in place a CTO), and organisational risk management at the Trust.

587. Theemis issued 12 recommendations, 10 of which were directed at the Trust.

588. I accepted all of the recommendations at both a public Board meeting and at the Annual Members meeting again held in public. The Trust developed an action plan to implement them. The Trust has disclosed to the Inquiry a copy of the plan showing progress against each recommendation **[NHFT0015678]**.

589. On 10 July 2025, the Quality Committee received an update on the progress being made against each recommendation, from the Trust's Oversight Assurance Group **[NHFT0015679]**. In summary, there are 10 recommendations with 75 actions with progress summarised as follows:

    a. 19 are considered complete and awaiting approval

    b. 34 are on track to meet exit date

    c. 11 are within the remit of the ICB

    d. 6 are off track with an emerging risk of not meeting the exit date

    e. 5 are off track with high risk of not meeting the exit date. **[NHFT0015930]**

590. The Theemis Report was considered by myself, the ELT and the Board and progress continues to be reviewed. The Board instructed that the Oversight Assurance Group be established (chaired by the Chief Nurse) to ensure that the actions arising from recommendations from the different investigations following the incident on 13 June 2023 are completed, embedded in practice and have lasting impact on the quality, safety and oversight of care provided by the Trust. It holds action plan owners to account with evidence to support ongoing progress, quality checks the completion of actions through peer review or critical challenge.

591. This group meets twice a month, although there is an expectation that the named leads for each recommendation will meet outside of these meetings.

592. Each month; one meeting reviews the full action plan and the second meeting reviews the evidence against the completed actions in order to report

into the externally chaired Evidence and Assurance Group. The Oversight Assurance Group also reports bi-monthly to the Quality Committee and the Private meeting Trust Board, and actions for both the Trust and the ICB are reported to the ICS Improvement Group which reports to the NHS England Improvement, Oversight and Assurance Group

Other actions taken in response to the attacks

593. In addition to the reviews set out above, other actions taken in response to the attacks include:

a. Gold command incident response post the attacks on the 13th June 23 was led by the Chief Operating Officer

b. The electronic and paper records relating to VC's Trust mental health records were locked down to prevent entries or non authorised viewing.

c. Review of suitability of which high secure estate VC was admitted to led by the Medical Director

d. There have been Nursing and Medical professional practice reviews carried out for those clinicians involved in the care and treatment of VC. In some cases this has led to further internal investigations and disciplinary processes, including the instigation of the Maintaining High Professional Standards framework **[WITN0263128]** in relation to doctors.

e. A series of briefings to all staff and leaders including the Council of Governors, led by myself relating to the publication of the various reports including S48 review, Independent Homicide Review and entry into NHS Oversight Framework 4

PART H: REFLECTIONS, IMPROVEMENTS AND RECOMMENDATIONS

Reflections

Reflections on care provided to VC

594. I fully agree with the reflections shared with the Inquiry as part of the Trust's Corporate Witness Statement (First Witness Statement of Diane Hull) however within those wider thoughts are some which for me had a higher impact, as follows:

a. The issue about risk assessments being siloed and not longitudinal.

While this is something familiar to colleagues who have worked in forensic care my view is that this is something that most mental health practitioners could benefit from further learning on. I am pleased with the way we have amended our risk assessment training to include this along with consideration of public safety as well as risk to an individual or staff.

b. The two issues relating to effectiveness of MDT working, hearing all clinicians voices and recording the clinical decisions is something that resonated as an important reflection much more broadly for us than just in mental health services.

c. Whilst there has been a practice widely in the NHS as well as our Trust of discharging people who disengage from Services, my reflection is that in the instances relating to VC, this was not in line with best practice, linking to the issues I mention earlier about longitudinal risk management. I am assured that significant work has been done to remind and educate clinicians in the Trust about discharge practice, best evidence and changes we have made to the policy – as clinicians asking why something happens, in this case why somebody disengages is a vital part of practice.

595. There were some positive aspects of care particularly early on that are also worth reflecting on as we can learn from this too. Early engagement with VC's family was strong, his early discharges from in-patient services were good as was some of the evidence around engaging health partners as well as family.

596. Engaging with families even when an individual withholds consent for sharing certain aspects of care is so important and I have to reflect in the latter stages of our care for VC, we did not do that as well as we could have done.

597. My final reflection is on the wider issues of quality improvement the Trust has been going through to move a culture from one of defensiveness to one of openness and learning so as clinicians, leaders and managers we open ourselves and our teams up to external scrutiny with the purpose of learning and developing and ultimately improving care. This is something I am very pleased about as I feel we have seen significant shifts in developing an open learning culture over the last 2 years particularly.

Additional actions the Trust could have taken

598. The internal serious incident review, Part 1 of the CQC Special Review and the Themis review were very comprehensive resulting in many recommendations relating to things that impacted on the care and treatment of VC, clinically, operationally and more strategically. Myself and the Board as a whole have welcomed and accepted these recommendations. Given their comprehensive nature I feel they have covered all the actions and points of learning the Trust needs to consider and deliver.

599. That said, there has also been a series of actions that have come from our engagement with the both families of the victims of VC, VC's family and those who survived the attacks of 13 June 2023. The actions here are about how we liaise with families of victims following a serious violent act, how we liaise with the Police to get the balance right between our Duty of Candour and need to support families and their criminal processes and how we continue to engage families when the patient has asked us not to.

Reflections on information sharing within the Trust

600. Reviewing 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 and involvement 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. We had no feedback from primary care after we discharged him – had he attended the practice at all, had he presented for any physical health checks or illness and if so did the GP practice have concerns, which they have alerted us to them if there were any.

Communication with families

601. I have spent a lot of time considering as a CEO the best ways to communicate with families following such tragic circumstances as the events of the 13 June 2023. I have made open and honest apologies to the families and friends of Grace, Barnaby and Ian and to those whose lives were changed so significantly by the awful events. I have made those apologies in public, in the media and to some of those effected in person. I am very conscious that nothing I say can change the events that happened and changed people's lives irrevocably but this will not stop me reflecting, apologising and doing my best as a senior NHS Leader to ensure we as a Trust recognise where we could have done things differently, being prepared to seek out help and support from those known as experts to ensure we bring about consistent and sustained change.

602. During the initial response to the incident, I realised that it was not always clear at what point actions could be taken while there were ongoing criminal processes in place. This lack of clarity contributed to delays in the way that the Trust carried out its response to the incident and a lack of clarity around when it was unable to contact families of VC's victims and survivors. For this lack of clarity, I apologise and hope that a potential recommendation could be specificity on the way in which victims and/or their families are involved in the process of learning from incidents and clarity around what information can be shared and, where there are limitations on this, why this is. This should be a multi agency agreement, applied consistently nationally.

603. On behalf of the Trust, I have corresponded with the families of the victims of the dreadful attacks, with those who survived and with the family of VC either directly or more latterly through their legal representatives. After receiving advice from the police, the bereaved families and surviving victims received letters from the myself on 7 December 2023 **[NHFT0000494], [NHFT0000495],[NHFT0000496],[NHFT0000500],[NHFT0000502],[NHFT0000497], NHFT0000498],[NHFT0000501], [NHFT0000499].**

604. I found this delay unacceptable at the time and continue to do so today. As already stated, the lack of clarity around the interaction between the criminal processes and the Trust's incident review impacted on the way, we engaged with those affected by VC's crimes. I wanted it to be noted that the letter sent to

Grace, Barnaby and Ian's families was out of date in terms of the timeline of the investigation. This was a mistake that must have compounded the distress of the families, and I have apologised sincerely in person for this error.

605. Our Patient Safety Incident investigations are often shared with the next of kin / the principal carer of those who are the subject of the investigation, as is clearly envisaged by the Trust's SI policy "*Managing Serious Incidents and Reporting and Learning from Deaths*" 2019 **[NHFT0012587]**. As such, the Trust's SI regarding the care of VC was shared with VC's mother **[NHFT0000484]**. However, it is sometimes less clear as to whether these reports can be shared more widely than with the subject's next of kin, given confidentiality obligations to the person who is the subject of the investigation report. In the case of VC, I and the Board wished to be as open as possible with the victims' families, whilst balancing its legal duties. Therefore, the Trust obtained KC advice **[NHFT0004713]** on the extent to which it could share the report with the victims' families and shared an almost entirely unredacted version of the full, final Level 2 Investigation Report with them on 18 July 2024 following receipt of that advice **[NHFT0004713]**.

606. Myself, the Medical Director and Chief Nurse met with the families of the deceased victims in August 2024 **[NHFT0001837, p.8-22]**. Following this, the Trust commissioned a KC to provide advice on the disclosure of the Level 2 Investigation report and an almost completely unredacted copy of the report was then disclosed accordingly **[NHFT0015639], [NHFT0004287], [NHFT0015640].**

607. In addition, following our meeting with the families of the 3 victims in London we received a significant number of detailed questions which we formulated a response to and replied on the 4 December 2024 **[NHFT0000524]**.

Engagement with VC's family after the incident

608. The Trust wrote again to VC's mother on 2 July 2024 **[NHFT0000470]**. This letter explained the commissioning of the Serious Incident Investigation into the past care and treatment of VC, and that the report from this investigation had informed the Trust action plan. The letter stated that VC had given permission for the Trust to share the report with his mother, and that the Trust was in the process of reviewing and redacting the report. A meeting had been

planned for 3 July 2024 and was re-arranged in order for the redacted report to be provided in advance of that meeting.

609. The Trust wrote to VC's mother on 19 July 2024 **[NHFT0000484]** and provided a copy of the full redacted Level 2 Investigation report, and the Trust action plan. A meeting was arranged for the 30 July 2024.

Recent communication

610. In March 2025, the Quality Committee discussed the Trust's meetings with VC's family and the victims' families. In addition, the Quality Committee were made aware of high-risk complaints the Trust was dealing with. All the above matters were presented to the Quality Committee for information and assurance **[NHFT0001837]**.

611. I received further communication from Dr Kumar at the end of May/early June 2025 requesting a series of further answers to questions. I responded to Dr Kumar and Dr O'Malley through their solicitor to explain our view that the Inquiry was the appropriate forum in which issues can be considered including the naming of clinicians involved in VC's care. **[NHSE0002076, NHSE0002079]**.

Concluding comments on Improvements

612. The Trust has described to the Inquiry the extensive improvement work that has commenced in the period since the events involving VC and which, remains ongoing. This work has been driven by our reflections as a Trust as well as the recommendations for improvements made now by a number of external authors (including the CQC) on the care and treatment of VC, the services involved and indeed broader Trust services.

613. This work is grounded in promoting and embedding a culture of learning, so as to drive improvements in care and openness when things do go wrong. The Trust, working with partners, has sought to proactively address issues raised by VC's case and it is therefore hoped that many areas that might have required a recommendation are already underway and captured in our internal improvement plan.

614. This reflects the Trust's confidence, reinforced by the oversight it has had from external partners, in the work it has done to implement the

recommendations from the three reviews to date carried out in response to the events involving VC.

615. I do feel that there have been many great innovations and new service models funded as part of big improvements in services for people with mental health difficulties and importantly this has been backed nationally by new investment. That said I do feel the development of new service models such as the community mental health framework may have reduced the focus and emphasis on those with the most severe mental illness. Therefore I feel the work we are doing around assertive outreach services, the development of our assertive intervention register is a significant step forward and one I know is being pushed nationally following a letter from the National Director of Mental Health to all mental health Trust CEOs and medical Directors on the 26 July 2024. The letter shared guidance on intensive and assertive community mental health treatment and requested systems carry out a review of local provision led by ICBs to be completed by 30 September 2024 **[NHFT0001275, WITN0155047, NHSE0000289]**

616. In light of some of our experiences around information sharing which are more in the practicalities rather than the legal framework increased national guidelines on this would help and support clinical practice.

Recommendations for the Inquiry

617. There has already been some National guidance about the importance of assertive outreach teams and approaches for those individuals at risk of disengagement. I can recall the significant detail that formed part of the specification as part of the original National Service Framework and Policy Implementation Guidance that set up Assertive Outreach teams. These teams were very effective in working with those individuals who were reluctant to engage with mental health services and who were higher risk. I believe that fidelity to that type of model could be a preventative factor in reducing the likelihood of dreadful incidents like those VC perpetrated happening again. I would support there needing to be more consistent and enhanced specifications for what model these teams should operate. In addition there is a danger that in order to reestablish standalone assertive outreach teams, general community mental health teams are negatively impacted if no further resources are

ringfenced.

618. Throughout my career, I have observed that the focus of specialist mental health service providers (such as the Trust) has become more diluted because of the expansion of services aimed at those who are less severely mentally unwell. These services include 'Improving Access to Psychological Services (Talking Therapies)', mental health primary care services and even some of the more specialised mental health services like community eating disorder services. While vital, these have pulled resources by way of experienced staff away from working in 'core mental health secondary services' (i.e. Community Mental Health Teams, which are referred to as Local Mental Health Teams "LMHTs" at the Trust). Much guidance and expectations have been established for such services, with new metrics introduced, for example around the number of perinatal contacts. However, we have not seen equivalent focus on metrics for severe mental illness, such as schizophrenia. My view is that there is a risk that the 10-year Health Plan will place greater emphasis on wellbeing and prevention. While this is appropriate, from a severe mental illness perspective, we must ensure that the skills and resources for this cohort sit in specialist services to avoid a further dilution of these services. Ringfencing responsibility and accountability for the severely mentally ill population, coupled with clarity and fidelity to delivery models for services such as Assertive Outreach and Early Interventions mentioned above, could have a preventative impact in future.

619. It is my experience that flow of both patients and in some regard advice and support is not always smooth between general adult mental health services commissioned through ICBs and Forensic services generally commissioned through NHS England specialised commissioning, which are delegated to provider collaboratives. Given the further delegation of commissioning responsibility to ICBs this might be an area more guidance is needed to ensure rapid and timely advice is available from forensic specialists even if patients do not strictly meet the criteria for admission to those specialist services.

620. In the section of this statement around communicating with families I alluded to the fact much clearer guidance is needed about when a healthcare provider can investigate an incident that has occurred when it crosses over with a criminal investigation. I reflect that this causes distress to victims and families

of victims and more national clarity from the Inquiry would be helpful.

621. As we start to consider the changes to the Mental Health Act 1983 it would be useful if any recommendations around the use of the MHA and CTOs would be done in the context of those changes.

622. Finally, there is much that we have learned from the process of the care and treatment we provided to VC being reviewed a number of times and I can see real benefit from having a national repository of learnings from homicides in the mental health sector.

Statement of Truth

I believe the facts stated in this witness statement are true. I understand that proceedings for contempt of court 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 in its truth.

Signed: GRO-B

Dated: 07/01/2026

Index to First Witness Statement of Iftikhar Majid

No.	Inquiry URN	Document Description
1	NHFT0000548	Nottinghamshire Healthcare NHS Foundation Constitution
2	WITN0263002	First CQC report into Rampton
3	WITN0263003	Board of Directors Terms of Reference
4	NHFT0013457	Scheme of Reservation and Delegation
5	NHSE0000522	Code of Governance for NHS Provider Trusts
6	NHFT0000529	Board of Directors (in Public) 30 Jan 2025
7	WITN0263004	Example Regulatory Performance Report – 25 September 2025
8	WITN0263005	Winter Planning 25/25 – Board Assurance Statement
9	WITN0263006	Workforce Race Equality standard papers from most Board of Directors meeting – September 2025
10	NHFT0004742	Quality Committee Terms of Reference
11	WITN0263007	Finance & Performance Committee Draft Terms of Reference
12	WITN0263008	Public Board of Directors - 25 September 2025
13	WITN0263009	People & Culture Committee Terms of Reference
14	WITN0263010	Audit and Risk Committee Terms of Reference
15	WITN0263011	Improvement Oversight Committee Terms of Reference
16	NHNB0018961	NHS Oversight Framework – June 2022
17	WITN0133001	First Witness Statement – Diane Hull
18	WITN0263012	Nominations and Remuneration Committee Terms of Reference

19	WITN0263013	Charitable Funds Committee Terms of Reference
20	WITN0263014	Mental Health Legislation Committee draft Terms of Reference
21	WITN0263015	Strategy Working Group Terms of Reference
22	WITN0263016	NHT Workforce Performance Group Papers
23	WITN0263017	Terms of Reference - Extended Executive Leadership Team
24	WITN0263018	Quality and Performance Management Group - Terms of Reference
25	NHFT0015005	Accountability and Performance Framework
26	NHFT0000905	January 2023 CEO Board paper
27	WITN0263019	EO Noms and Rem Committee - April 2023
28	NHFT0003231	NHFT Clinical Risk & Safety Policy
29	NHFT0003340	NHFT Transfer & Discharge Policy
30	WITN0263020	Trustwide Management Group Terms of Reference – 21 November 2023
31	WITN0263021	Trustwide Management Group Terms of Reference – 19 September 2024
32	WITN0263022	CEO Presentation - Big Conversations update October 2025
33	WITN0263023	Colleague Reference Group Terms of Reference
34	WITN0263024	Patient, Carer & Family Reference Group - Terms of Reference
35	WITN0263025	LGBT+ Staff Network - Terms of Reference
36	CQCM0016517	CQC special review of mental health services at NHFT
37	NHFT0000518	NHFT Thematic review of homicides and attempted homicides 2019 - 2023
38	NHFT0002015	CQC NHFT Inspection Report – 24 May 2019
39	NHFT0001778	CQC Inspection – Acute wards for adults of

		working age and psychiatric intensive care units – 23 September 2020
40	CQCM0016478	CQC NHFT Inspection Report – 25 November 2022
41	NHFT0012587	NHFT Reporting, Managing and Learning from Incidents policy
42	NHFT0000596	NHFT Managing Serious Incidents and Reporting and Learning from Deaths
43	NHFT0008708	PSIRF Patient Safety Incident Response Plan 2024-2025
44	NHSE0001384	NHSE Recovery Support Programme – Diagnostic Stocktake May 2024
45	NHFT0001997	CQC Inspection Report – 25 November 2022
46	WITN0263026	Board Development Plan: October 2024 – March 2026
47	CQCM0016438	CQC Assessment framework
48	NHSE0001506	RSP Entry Meeting Action Note
49	NHFT0015033	Quality Operational Group (QOG) Terms of Reference
50	WITN0263027	'Safe Now' Update Position – 3 November 2025
51	WITN0263028	NHFT Improvement Oversight and Assurance Group - Terms of Reference
52	WITN0263029	Quality Committee Report to Council of Governors – 28 May 2025
53	WITN0263101	Freedom to Speak up Annual Report – 29 May 2025
54	WITN0263030	Latest BAF Report to Board
55	NHFT0000461	Nottingham Early Intervention in Psychosis (EIP) review
56	NHFT0000462	Nottingham CRHT and associated Crisis Service review
57	NHFT0000545	Review of Local Mental Health Teams
58	NHFT0003275	Integrated Improvement Plan (IIP) Terms of

		Reference
59	WITN0263031	QI Collaborative Therapeutic Observations - Terms of Reference
60	WITN0263032	Continuous Quality Improvement Strategy May 2025
61	NHFT0000423	Independent Evaluation of NHFT Safety Processes
62	WITN0263033	Waiting list oversight meeting - Terms of Reference
63	NHFT0003597	Healthwatch review of Community Mental Health Services and action plan
64	WITN0263034	Trust Care Quality Commission Oversight Sub-Group - Terms of Reference
65	WITN0263035	Terms of Reference - Rampton Improvement Group
66	WITN0263105	Letter from CQC to CEO NHFT – 8 January 2024.
67	WITN0263106	Rampton NoD Removal Letter – 16 October 2024
68	CQCM0017659	20190722 Final Version RGP1-7196384685
69	CQCM0017664	20190911 Nottinghamshire Healthcare NHS Foundation Trust RGP1-7196384685 Letter to not adopt FINAL
70	CQCM0019835	20220526 Notts Healthcare - 29a WN post legal review
71	WITN0263107	20230823 NOP to impose a condition V7 FINAL
72	WITN0263108	20231027 NHFT HMP LG S31
73	WITN0263109	20231115 NOP HMP LG v4 post legal review
74	WITN0263110	20250102_144745_NoD_Vary_Rem_Cond-Agrd
75	WITN0263111	Letter from CQC New Registration Document Removal of NoD
76	NHFT0002354	2022 CQC Action Plan
77	CQCM0013499	CQC s.48 Nottingham Review

78	NHSE0000518	NHS Oversight Framework 2025/26
79	NHFT0000818	NHFT Boad of Directors Meeting – 28 November 2024 ['legal undertakings']
80	NHFT0002106	CQC 'High secure hospitals' inspection report – published 17 January 2024.
81	NHFT0003265	CQC 'Wards for older people with mental health problems' inspection report – published 1 March 2024.
82	CQCM0016523	CQC 'High secure hospitals' inspection report – published 24 February 2023.
83	NHFT0000530	Theemis Investigation Report into the care and treatment provided to VC – January 2025.
84	NHSE0001329	Integrated Improvement Portfolio Board (IIPB) - Terms of Reference
85	NHFT0014335	Integrated Improvement Portfolio Board (IIPB) - Terms of Reference
86	NHSE0001744	RSP Review Meeting Action Note – 6 December 2024
87	WITN0263036	Meeting note from 6 December 2024 with NHS England National Executive Team
88	WITN0263037	Meeting note from 8 October 2025 Board to Board meeting with NHS England Midlands Regional Team
89	NHFT0016016	Terms of Reference for waiting list oversight meeting
90	WITN0263112	Integrated Improvement Plan Programme Board – 4 December 2025
91	WITN0263038	Example agenda from Monthly Leadership Forum (most recent one)
92	NHSE0001963	Leadership papers describing Leadership Development Programmes for Bands 2-8b
93	CQCM0023093	Risk Management Strategy (2021-26)
94	WITN0263039	Risk Management 2026 – 2031 – Strategy on a Page.

95	WITN0263040	18.14 - Risk Management Policy [version 5]
96	WITN0263041	Risk Escalation Framework
97	WITN0263042	Risk Group Terms of Reference [v1.8]
98	WITN0263043	Risk Group Terms of Reference [v1.9]
99	WITN0263044	NHFT Annual Report and Accounts 2024/25 incl Annual Governance Statement
100	WITN0263045	Annual Risk Management Maturity Assessment Report
101	WITN0263046	Board training slides on risk assessment
102	WITN0263047	Annual risk management development session agenda
103	WITN0263048	BAF Update to Board – November 2025
104	WITN0263049	Audit and Risk Committee; Internal Audit Progress Report – November 2025
105	WITN0263050	NHFT Audit Progress Report – November 2025
106	WITN0263051	360 Assurance Internal Audit Progress Report – 6 November 2025
107	WITN0263052	Audit and Risk Committee; 2023/24 Head of Internal Audit Opinion and Annual Report
108	WITN0263053	360 Assurance 2023/24 Head of Internal Audit Opinion and Annual Report
109	NHSE0000463	NHS England developmental Well Led review report (January 2025)
110	WITN0263054	Risk Escalation Framework – December 2024
111	NHFT0015158	Clinical Risk Assessment – August 2020
112	NHFT0015587	Clinical Risk Assessment – Everybody's business?
113	NHFT0015073	Rule 9 Information Request – 31 October 2025
114	NHFT0015295	Clinical Risk Assessment and Management – training package
115	NHFT0015209	Clinical Risk Assessment and Management; Mental Health – training package

116	WITN0263055	Audit and Risk Committee Terms of Reference (V3 Draft)
117	WITN0263056	Risk Committee Terms of Reference (version 1)
118	NHFT0000763	Quality Committee – 11 March 2025
119	NHFT0015006	Public Board of Directors Meeting – 29 May 2025
120	NHFT0015023	NHFT Quality Committee 1 August 2023 - Compliance, progress and learning from incidents, complaints and Duty of Candour
121	WITN0263057	ELT Meeting 4 November 2025 - Significant Incidents and Review Group (SIRG) Exceptions Report
122	WITN0263058	Private Board of Directors 13th November 2025 - Patient Safety Exceptions Report
123	WITN0263104	Board Assurance Framework: November 2025
124	WITN0263059	Significant Issues Review Group – Terms of Reference February 2025
125	NHFT0003519	Risk Management Policy (version 1).
126	WITN0263060	Terms of Reference for Quality Governance and Effectiveness Oversight Group
127	WITN0263061	Terms of Reference for Complex Incidents Oversight Group Terms of Reference July 2025
128	WITN0263062	Patient Safety and Learning from Deaths Group Terms of Reference - July 2025
129	WITN0263063	PSIRF Planning Workshop materials (18 September 2023)
130	WITN0263064	PSIRF Implementation Project Board Terms of References for each workstream
131	NHFT0008819	Patient Safety Incident Response Policy
132	NHFT0002064	NHFT Board Meeting (Public) 28 March 2024
133	WITN0263065	360 Assurance audit of PSIRF implementation

		(February 2025) date on document is April 2025
134	WITN0263066	Quality Improvement Plan (7 June 2023 ELT)
135	WITN0263067	Business case for STEG (June 2023)
136	NHFT0001610	Quality Committee February 2024 update on findings and proposed actions
137	NHFT0000469	Quality Committee July 2024 detailed report on progress
138	NHFT0010339	The NHS Patient Safety Strategy
139	WITN0263068	E-mail 6 November 2025 - 9 point checklist for discharges
140	WITN0263099	Independent Evaluation of Patient Safety Processes – updated 18 June 2024.
141	WITN0263100	Executive Leadership Team – 26 June 2024 – Action Plan Update
142	NHFT0013000	Quality Committee March 2025 closure paper
143	NHFT0015034	Quality Committee Reading Room – 10 April 2025
144	NHFT0005227	Policy 17.06 – Emergency Preparedness, Resilience & Response (EPRR)
145	NHFT0008825	PSIRF Patient Safety Incident Response Plan 2024-2025
146	NHFT0003028	Policy 15.05 – Being Open and Duty of Candour
147	NHFT0015629	Policy 15.01 – Reporting, Management and Learning from Incidents Policy and Procedure
148	WITN0263069	Policy 13.04 - Police and Criminal Justice Liaison policy (updated June 2025 – version 7)
149	WITN0263113	NHSE Guide to responding proportionately to patient safety incidents – v1.3 September 2025
150	WITN0263114	NHSE PSIRF - 23 September 2025
151	WITN0263094	Trust Incident Reporting System (Ulysses) Report
152	WITN0263095	E-mail chain: Blue light incident – 466448

153	WITN0263097	SIRG Meeting Notes – 16 August 2022
154	NHFT0004778	StEIS report (16 August 2022) – PSII 466448 2022-17624
155	NHFT0005974	NHFT Exec Team – Meeting 31 August 2022
156	NHFT0015874	HOAG discussion (24 September 2024)
157	NHFT0012524	Board update – Reportable Issues Log (30 January 2025)
158	WITN0263070	Blue Light Incident Details (16 February 2023)
161	WITN0263071	Email briefing to Executive Team 16 February 2023 (FW: Blue Light Incident – 497414)
160	WITN0263072	Communications and Engagement Briefing – 22 February 2023
161	NHFT0016458	SURG Meeting Notes – 21 February 2023
162	NHFT0015790	Serious Incident Reporting Document – 22 February 2023
163	NHFT0000592	Private Board Meeting – 30 March 2023
164	NHFT0008661	HOAG agenda (12 August 2024)
165	NHFT0015791	Psychological Approaches Final Report [July 2024]
166	NHFT0001219	Updated EIP internal working instructions
167	WITN0263073	Blue Light Incident Details (11 April 2023)
168	NHFT0016456	SIRG Meeting Notes – 18 April 2023
169	NHFT0015672	Serious Incident Reporting Document – 18 April 2023
170	NHFT0015865	Initial Management Review
171	NHFT0015864	Case Note Review / Level 1 Concise Investigation
172	WITN0263074	City South LMHT Business Meeting (8 August 2023)
173	WITN0263075	Blue Light Incident Details (4 July 2023)
174	NHFT0016002	SIRG discussion (11 July 2023)

175	NHFT0004751	Trust Investigation Report - Final Signed Off Version
176	NHFT0001284	NHFT Public Board Meeting – 27 July 2023
177	NHFT0000416	NHFT Public Board Meeting – 30 November 2023
178	WITN0263076	GRO-B – Search of private Board papers from July 2023 to September 2025
179	WITN0263077	Minutes of HOAG meeting on 15 July 2024 [ratified]
180	NHFT0015972	Meeting with Police and stakeholders [Operation Horus Gold Meeting] - AGENDA (15 February 2024)
181	NHFT0015975	Meeting with Police and stakeholders [Operation Horus Gold Meeting] - MINUTES (15 February 2024)
182	WITN0263078	Community Incident Blue Light (29 May 2024)
183	WITN0263079	Blue Light Incident Details (29 May 2024)
184	NHFT0015879	Executive Team briefing, dated 15/7/24 to Board
185	NHFT0015880	SIRG Weekly Outcome Report (4 June 2024)
187	NHFT0015881	SIRG Exceptions Report (2 July 2024)
187	NHFT0014944	Reportable Issues Log (26 September 2024)
188	NHFT0015884	Homicides and Attempted Homicides Oversight Group – Terms of Reference [V2 May 2024]
189	WITN0263080	Minutes of HOAG meeting (6 March 2025)
190	NHFT0015885	PSII/SIR Scrutiny Panel (20 June 2025)
191	WITN0133024	Appendices HCR 20
192	NHFT0016005	Community Forensic Team Operational Policy - Standard Operating Procedures for community forensic teams regarding prison remand
193	WITN0263081	Blue Light Incident Details (9 December 2024)
194	NHSE0001134	Briefing to NHSE Midlands Independent Homicide Investigation Team (12 December 2024) – SoS call from Notts HC

195	NHFT0016003	SIRG Exceptions Report (10 December 2024)
196	NHFT0016004	SIRG Exceptions Report (17 December 2024)
197	NHFT0015876	Reportable Issues Log (30 January 2025)
198	WITN0263082	Initial Learning Review – IR1 Number: 618108
199A	WITN0263090A	Telephone recordings from 7 December 2024
199B	WITN0263090B	Transcript of telephone recordings from 7 December 2024
200A	WITN0263091A	Telephone recordings from 8 December 2024
200B	WITN0263091B	Transcript of telephone recordings from 8 December 2024
201	WITN0263083	Minutes of Blue Light Incident – Strategy Meeting – 10 December 2024
202	NHFT0016457	After-Action Review summary report (6 January 2025)
203	NHFT0015973	Blue Light Incident Details - 15 November 2024 @ 16.30
204	NHFT0015974	Blue Light Incident Details – 15 December 2024 @ 18.49
205	WITN0263084	Patient Safety Huddle (25 November 2024)
206	NHFT0014969	SIRG Exceptions Report (26 November 2024)
207	NHFT0012525	Reportable Issues Log (13 November 2024 - 23 December 2024)
208	WITN0263115	PSII and SIR Panel Minutes – 31 October 2025
209	WITN0263116	Minutes of the Complex Incidents Oversight Group – 6 November 2025
210	NHSE0000483	Annual report 2025
211	NHFT0018407	ELT Minutes – 11 September 2024
212	WITN0263117	Minutes of Homicide and Attempted Homicide Oversight Group – 6 March 2025
213	WITN0263118	Minutes of the Complex Incidents Oversight Group – 3 July 2025

214	NHFT0015688	PSII report template – incident no. 412301.
215	WITN0263119	PSII report template – incident no. 2019/1083 Re-investigation
216	NHFT0015955	Assertive and Intensive Community Mental Health Care – Action Plan review and update
217	WITN0263085	Review of Assertive & Intensive Community Mental Health Treatment – Quality Committee 15 April 2025
218	NHFT0015899	Review of Family Liaison Service – Quality Committee 13 November 2025
219	WITN0263102	Review of Family Liaison Service – Quality Committee 11 December 2025
220	WITN0263120	Patient Safety Paper DRAFT – Quality Committee 11 December 2025
221	NHFT0015900	NHFT Think Family, Safeguarding and Public Protection Strategy
222	NHSE0000115	NHSE National Quality Board's 'Safe, Sustainable and Productive Staffing' Guidance (2016)
223	WITN0263086	Mental Health Optimal Staffing Tool (MHOST)
224	NHSE0000145	NQB Guidance January 2018 – Safe, sustainable and productive staffing; an improvement resource for mental health.
225	WITN0263087	NHS Improvement's 'Developing Workforce Safeguards' Guidance (2018)
226	WITN0207003	Royal College of Psychiatrists - 'Standards for Inpatient Mental Health Services' (2019)
227	WITN0263088	Daily Demand Management Meeting Agenda - Blank
228	WITN0263089	AMH Inpatient Sitrep Meeting Agenda - Blank
229	NHFT0015897	2021 investment of £1.817m establishment review documentation

230	NHFT0015959	Short Form Business Case
231	NHFT0015902	2024 investment of £400,000 establishment review documentation – Finance Committee 19 August 2024
232	NHFT0006110	NHFT Accountability Review – LMHS 20/6/22
233	WITN0263092	NHFT Corporate Division Accountability Review – 25 August 2020
234	NHFT0000615	NHFT People Plan – June 2022
235	WITN0263121	Minutes of Board of Directors Public Meeting – 26 September 2024
236	NHFT0000516	BAF Risk SR1 – Public Meeting 26 September 2024
237	WITN0263122	Minutes of Board of Directors Public Meeting – 28 November 2024
238	NHFT0003330	BAF Risk SR1 – Public Meeting 28 November 2024
239	NHFT0015903	Annual Safer Staffing Report for 2021/22 (November 2022 Board papers)
240	NHFT0015868	Safer Staffing Paper – Quality Committee 9 October 2025
241	WITN0263123	Policy 10.19: Electronic Rostering (v2).
242	WITN0263103	Minutes of the Board of Directors – Public Meeting – 25 Sep 2025 [ratified]
243	NHFT0015935	People Performance Report to People Committee – 7 November 2025
244	NHFT0015934	People Performance Report
245	WITN0263093	Safer Staffing meetings Terms of Reference (2020-2024) – with tracked changes
246	NHSE0000014	The NHS Long Term Plan
247	NHFT0015906	Establishment Review Report (26 January 2023 Public Board)
248	NHFT0015909	Safer Staffing and Establishment Reviews Report (25 May 2023 Public Board)

249	CQCM0027394	NHFT 'Making a Difference' Strategy 2022 - 2027
250	NHFT0003484	Our People Plan (November 2022)
251	NHFT0015981	Our People Plan (November 2023 refresh)
252	WITN0263124	Mental Health Services Monthly Statistics, Performance September 2025
253	NHFT0015911	SafeNow dashboard
254	WITN0263098	Monthly out of area placements report to NHS England by ICB.
255	NHFT0000425	NHFT Community of Care Principles
256	WITN0263130	Independent Commission on Acute Adult Psychiatric Care report (February 2016, Lord Crisp)
257	NHFT0015695	12.01 Information Systems Security
258	NHFT0015698	12.06 Records Management
259	NHFT0015696	12.03 Clinical Information Systems, Access and Audit.
260	NHFT0015697	12.04 Secure Handling of Information
261	NHFT0015699	12.07 Registration Authority
262	NHFT0015700	12.08 Information Systems Data Quality
263	NHFT0015701	12.09 Access to Information
264	NHFT0015702	12.14 Information Risk Management
265	NHFT0015703	12.19 Data Protection
266	NHFT0002828	06.01 Safeguarding Children
267	NHFT0015692	06.04 Safeguarding Adults at Risk
268	NHFT0000418	13.07 Multi Agency Public Protection Arrangements
269	NHFT0015694	08.03 Involvement of Patients and Carers
270	NHFT0012786	08.01 Information Sharing Between Professionals Parents and Carers

271	WITN0263131	Record of Data Processing Activities (ROPA) Asset Register
272	WITN0263125	The Caldicott Guardian's Role
273	NHFT0009272	Information Sharing with the Police
274	WITN0263126	Data Sharing Agreement between NHFT and Nottinghamshire Police – DRAFT – final amendments 12 November 2025
275	NHFT0015915	Police Local Operational Group meeting - Terms of Reference
276	NHFT0015916	Nottingham and Nottinghamshire Adult and Children's Mental Health Partnership Board Terms of Reference
277	NHFT0015918	Nottingham City Safeguarding Adults Board Constitution June 2023
278	NHSE0002321	MAPPA Guidance – Updated Apr 2024
279	NHFT0000424	Policy 13.07a – MAPPA – Issue 3 (September 2017).
280	NHFT0000759	Procedure 01.21 – Mental Capacity Act 20025
281	NHFT0015722	MHL Policy and Procedure Manual – June 2025
282	CQCM0016518	CQC3-46 full_book_special-review-mental-health-services-nottinghamshire-healthcare-nhs-foundation-trust-part-2 (1)
283	WITN0263127	Mental Health Care Group Oversight Report – Quality Committee 9 October 2025
284	TCLT0000818	Investigation Report VC – 24 February 2024
285	NHFT0016060	E-mail chain.
286	NHFT0000452	VC Report Final - 15 March 2024
287	NHFT0015922	Notes of ELT meeting (28 February 2024)
288	NHFT0000455	Board receipt (28 March 2024)
289	WITN0263096	Draft action plan (24 April 2024) SI 2023 – 11918 Action Plan v2
290	NHFT0010812	Updated action plan to CIOG (3 July 2025)

291	NHFT0002439	Chief Executive Update to Council of Governors
292	NHFT0015930	SafeNow Oct 2025 IOAG 1
293	WITN0263129	'Approved notes of the Executive Leadership Team (ELT) Meeting' – 17 April 2024
294	NHFT0015678	Trust action plan
295	NHFT0015679	Quality Committee progress update – July 2025
296	WITN0263128	Policy 10.14 - Maintaining High Professional Standards in the Modern NHS – December 2023 (v4)
297	NHFT0000494	Letter to Sharon Miller – 7 December 2023
298	NHFT0000495	Letter to Mr Wayne Birkett – 7 December 2023
299	NHFT0000496	Letter to Marcin Gawronski – 7 December 2023
300	NHFT0000497	Letter to Mr Darren Coates – 7 December 2023
301	NHFT0000498	Letter to Mr Lee Coates – 7 December 2023
302	NHFT0000499	Letter to Dr Sanjoy Kumar and Sinead Kumar – 7 December 2023
303	NHFT0000500	Letter to Elaine Newton – 7 December 2023
304	NHFT0000501	Letter to Mr James Coates – 7 December 2023
305	NHFT0000502	Letter to David and Emma Webber – 7 December 2023
306	NHFT0000484	Letter to Mrs Celeste Calocane – 19 July 2024
307	NHFT0004713	Note of Advice – 13 August 2024
308	NHFT0001837	Minutes of Quality Committee held on 11 March 2025
309	NHFT0015639	NHFT SI Investigation Terms of Reference – Personal Details Redacted
310	NHFT0004287	Level 2 Summary Report – 'Mr C'
311	NHFT0015640	SI 2023 – 11918 Action Plan Summary of Learning
312	NHFT0000524	Answers to Family Questions concerning VC

313	NHFT0000470	Letter to Mrs Celeste Calocane – 2 July 2024
314	NHSE0002076	Letter from Dr Kumar to Ifti Majid – 28 May 2025
315	NHSE0002079	Response from Ifti Majid to Dr Kumar – 2 June 2025
316	NHFT0001275	NHSE Guidance to ICBs on intensive and assertive community mental health care
317	WITN0155047	Letter from NHSE – 26 July 2024
318	NHSE0000289	ICB Review Template