Witness Name: Julie Attfield
Statement No: WITN0329001
Dated: 16 January 2026

THE NOTTINGHAM INQUIRY

WITNESS STATEMENT OF JULIE ATTFIELD

I, Julie Attfield, will say as follows: -

Introduction

1. This statement is being given from the best of my recollection three years after leaving Nottinghamshire Healthcare NHS Trust ("the Trust"). I have had limited access to information from within the Trust during the time given to prepare this statement. Where I cannot give exact answers, I will refer to my best representation of practices and policies at the time.

2. This witness statement was drafted on my behalf by the external solicitors acting for the Trust in respect of the Inquiry, with my oversight and input, following discussions in writing by email and by video conference.

Background

3. I registered as a Mental Health Nurse in 1989 at North Lincolnshire School of Nursing. Over the years 1997 – 2010, I studied part-time for a BSc (Hons) in Advanced Professional Practice, an MSc in Health Policy and Organisations, and an MA in Research Methods, as part of a Dr of Philosophy completed in 2010, all with the University of Nottingham.

4. I worked in clinical, education and management roles related to mental health until 2012. In 2012, I took my first Board Position.

5. I joined the Trust in 2014 as the Executive Director of Forensic Services. In 2016, I moved to the post of Executive Director of Nursing, then taking up the portfolio of Executive Director of Local Mental Health Services ("LMHS") in January 2019, until retiring in December 2022.

6. I undertook two brief periods as Interim Chief Executive Officer ("CEO") in 2015 and 2018 to cover for absence. I undertook the regional Aspiring Directors Programme prior to becoming a Director and attended subsequent training for new Directors in Board Development training and appraisal.

7. I maintained contributions to published papers about mental healthcare delivery until 2017.

8. The role of Executive Director for LMHS was twofold and involving being a member of the Board of Directors and providing operational management and leadership to the LMHS Division. The LMHS Division provided mental health services for people of all ages. The Division also included Improving Access to Psychological Therapy Services (when these were provided by the Trust), Learning Disability Services and regional Gender Services.

9. As a Board member, my responsibilities were to play a key role in shaping the strategy, vision and purpose of an organisation. I was involved in strategy development with the Board, internal refreshes of service and clinical strategies, and the enabling strategies, i.e. the People, Estate, Nursing, etc. The Board role included holding the organisation to account for the delivery of the strategy, operational performance, risk management, quality, and to ensure value for money. Board responsibilities included being responsible for stewardship and assuring that risks to the organisation and the public were managed and mitigated effectively. The Board worked collectively to promote a culture of honesty, openness, trust and debate with the main aim of the collective Trust Board being to provide high standards of health care.

10. With regard to the role of Executive Director of LMHS, I assumed this role in May 2019 after the arrival of John Brewin as CEO. The events that led to my leading this portfolio included a high degree of concern raised by regulators, commissioners and staff within the organisation about the quality and safety of services. I moved from the Director of Nursing role to take up the Executive Director role for the LMHS Division.

11. The services in the Division - and in particular the Adult Mental Health Services ("AMHS") - were not meeting national performance targets or maintaining quality standards, and in significant difficulty. There were 1,186 whole-time equivalent staff in the AMHS Directorate, and it had an operating budget of £71.3m which was 41.26% of the total Division budget in 2022.

12. My executive role was to manage and lead the operational and clinical delivery of the LMHS Division (as part of that overall portfolio which included wider services), ensuring performance and day to day service management. My responsibilities included working with Executive colleagues to improve the safety and quality for those services and working in partnership to implement the organisation's strategy and vision. I was the Executive lead for specific programmes of organisational, service and organisational change, i.e. public consultation, business planning, relocation of services.

13. In 2019, there were significant improvements required to leadership, performance management and governance in the LMHS Division and only 2 members of the Division's previous Senior Leadership team remained. Concerns over the structure, culture, quality and viability of services were at the forefront. Supported by the Executive Team, I worked from that point to develop a senior management team and structure across all the services that would support improvement. This process included an internal restructure and the separation out of the portfolio of physical health services, and consolidation of lines of reporting into 3 clinical Directorates: Specialist Services, Mental Health Services for Older People and Adult Mental Health Services (AMHS). This process involved appointing an Associate Director of Nursing, Associate Director of Mental Health Services, Clinical Directors (where they were missing), and introducing Heads of Nursing and Lead Allied Health Professional roles.

14. During 2019 - 2020 there was a review of the management structure itself within the AMHS Directorate, and similarly within the Specialist Services Division.

15. In the structure of the Divisions Senior Leadership Team, we aligned the three key professional lead posts to report to the Medical and Nursing Directors for improved line of sight. An experienced external operational leader was seconded in to bolster capacity, and in agreement with the ELT a service line leadership model was implemented which aimed to combine clinical and management responsibilities, each group of services having Clinical Directors, a General Manager and Head of Nursing. We began a process of improving the delivery of services, reporting at divisional level for finance and operational performance, quality and risk. These processes replicated at service Level. There were later broader changes to quality governance systems with the aim of centralising processes and oversight.

16. I remained in this role through the Covid pandemic and retired in December 2022.

Governance generally

17. In general terms, the Board ("the Board") of Directors (led by the Chair and including Executive Directors and Non-Executives) oversaw a committee structure. Committees had a number of sub-groups to manage work programmes, and provide risk escalation and assurance, and to maintain key regulation requirements. The CEO led the Executive Leadership Team ("ELT") to deliver the day-to-day operations and requirements of the organisation.

18. The Board of Directors had in place a Board Assurance and Escalation Framework setting out the process of escalation from "ward to board", with clearly defined accountability for managing, assessing and accepting risk.

19. The Trust had a Risk Management Strategy which is reviewed on a regular basis and sets out the leadership, responsibility and accountability arrangements for risk management. These responsibilities are then taken forward through a Board Assurance Framework, a Risk Register structure and business and performance management processes enabling the coherent and effective delivery of risk management throughout

the organisation. This is supported by a broad range of risk management associated policies, procedures and processes.

20. The Audit Committee reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal controls across all the Trust's activities.

21. The Committee Structure to the Board in 2021 - 2022 included the:

- Audit Committee
- People, Culture, Equality and Inclusion ("PCE&I") Committee
- Quality and Mental Health Legislation ("QMHL") Committee
- Finance & Planning ("F&P") Committee
- Strategy Committee
- Nominations & Remuneration Committee
- Corporate Trustees Committee, (Charitable Funds)
- Commissioning Committee

22. There was a Risk Committee which reported to the Audit Committee chaired by the Chief Executive involving the full ELT. The aim of the Risk Committee at that time was to provide risk escalation and assurance to the Audit Committee over the standard of risk management across the organisation and the implementation of the Risk Strategy.

23. The Trust had in place a Council of Governors. Their role was to hold the non-executive directors individually and collectively to account for the performance of the board of directors.

24. The Executive Team was responsible for overseeing the delivery of the executive responsibilities and operational delivery of the three clinical divisions and the corporate services. There were named Directors for specific portfolios: estate, quality and safety, strategy, medical, nursing and allied health professional, finance, information management, performance and technology, safeguarding, health and safety, infection prevention, and control and performance. Over time, there were specific roles for corporate governance, Director of Corporate Affairs. The CEO chaired periodic

Accountability Reviews aimed at improving delivery of performance, implementation of strategy, quality and transformation.

25. Within the operational services there were quality governance structures: each Division and Directorate had quality governance arrangements, including regular team meetings, overseeing a range of activities including review of and responding to complaints and patient feedback, review of actions taken in relation to incidents and audits and monitoring and making improvements in respect to compliance. These structures sought to ensure that learning from incidents, complaints, and reviews informed safe and effective practice.

26. In terms of professional oversight, registered clinicians were supported and held accountable through continuing professional development ("CPD"), mandatory training, supervision, and appraisal. Specialist leads (e.g. safeguarding, restrictive practice, zero suicide) and leadership posts were in place to support and provide guidance on complex cases and escalation pathways ensure that high-risk situations are appropriately managed.

27. The Trust had in place a structured incident reporting system. All incidents, particularly those involving patient risk, were logged, reviewed, and analysed. Learning was disseminated through reports, training, and team briefings, with specialist lead input to support improvement.

28. The Audit and Risk Committee received assurance through reports from Committees of the Board and the Quality Committee oversaw the 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, which escalated significant clinical risks to the Board.

29. The collective purpose of the structure aiming to deliver effective corporate governance, contribute to better organisational and system performance and improvement.

30. Governance structures were revised in relation to the Committees of the Board with involvement of all Executive and Non-Executives. There had been external reviews of governance (e.g. there was a Quality Governance Review in 2020 and further in response to internal self-assessments and internal audit against governance standards which recommended changes).

31. There were onward reviews of the structure of the meetings, groups and their workplans and reporting requirements to the Board Committees. For example, the reporting lines from the Staff Staffing Group, Learning from Deaths Group and Quality Oversight Group reporting to the QMHL Committee. The purpose of these groups was to bring leadership to the key priorities and accountabilities across the entire organisation. These groups sought to maintain standards, ensure best practice, manage priorities and plans, and to escalate non-compliance and risk. The Divisional and Directorate operational and clinical leaders were increasingly present in Trust-wide meetings and processes i.e. members of the Trust safe staffing groups, involved in its developments, work plans and escalations.

32. Terms of reference for Committees of the Board were reviewed annually at the Committees and the Board. The Audit Committee received reviews of the other Committees. The Care Quality Commission ("CQC") Well led inspection in 2022 [CQCM0016478] reflected that these changes had been made.

33. Committee changes enabled increased opportunities for oversight, highlighting of risks and challenges related to AMHS. Highlighting workforce pressures via the People Culture Equality and Inclusion (PCE&I) Committee; [WITN0329002], and review of mental health transformation and inpatient bed provision at the Strategy and Commissioning Committees ref meeting papers [NHFT0005148; WITN0329036; WITN0329004; WITN0329003]. Within the Strategy Committee papers there are details of the staffing resource challenge for LMHS teams, in addition to overall workforce considerations at the PCE&I Committee. The Committees were in relation to AMHS to be able to scrutinise plans, albeit at a relatively high level, understand the changes in services intended in the long term plan for mental health and how changes were being made to services, staffing capacity challenges, and in particular a more strategic consideration of the position on the use of out of area beds [NHNB0007330].

34. 'Transformation Plans' are the service plans, including those for the AMHS and relate to overall change in line with the Five Year Forward View for mental health, expanding access to services and aiming for earlier intervention. These plans were developed in partnership with the Clinical Commissioning Group ("CCG"), discussed with the CQC at relationship/partnership meetings, in the local authority's oversight and scrutiny committees, Integrated Care System ("ICS") planning meetings and reviews with NHS England. The priorities were fed into health community planning assumptions in the ICS planning processes and returns, from both an investment, prioritisation and workforce stance. These being detailed to the Board [NHFT0005035].

35. Examinations of sub-contracted bed use referred to in this statement includes non-Trust beds provided in Nottinghamshire for adult mental health patients for acute care and Psychiatric Intensive Care Unit ("PICU") via sub-contracts and any spot purchased out of area bed capacity. Female PICU beds were not provided by the Trust and the Trust commissioned these on behalf of the CCG. The use of subcontract beds was regularly reported and reviewed at the ELT and escalated there for specifically weekly oversight in 2021. Beyond the ELT, historically at the Board Committees, this had been considered at the Finance Committee but then increasingly so at the Commissioning Committee in terms of quality. And prior to these Committees at the Public Board meeting on the 28/11/19 [NHFT0005024]. This was an example of increasing oversight via the Committees and risk escalation.

36. The use of subcontract beds in respect of quality concerns services and our own waiting time progress was reviewed at the at the Commissioning Committee [WITN0329037; WITN0329007; WITN0329038; WITN0329006]. The paper at the Strategy Committee in November 2022 [WITN0329030], particularly allowing a broader consideration for this group of patients.

37. Operational risks were reviewed via the Risk Committee chaired by the CEO with the full ELT. Extreme risks in the LMHS were in relation to unprecedented demand on services and workforce capacity, the quality of the clinical environment, clinical standards compliance, and compliance with the warning notice for the eradication of dormitories. Observations about the role of the Risk Management Committee and the implementation

of the risk management framework were highlighted in [CQCM0016478]. Operational risk was increasingly at the forefront for staff managing high demand and resource pressures. The Board saw details of the waiting times for patients beyond its routine Integrated Performance Report [WITN0329008].

38. Quality governance particularly under the QMHL Committee did change with the intention of becoming more centralised, less devolved and with the provision of increased oversight. This saw a greater emphasis on Trust-wide leadership and consistency. Key changes were made especially in relation to safe staffing, incident reporting and learning from deaths, with service representation at Trust-wide Groups, and increased oversight.

39. In the same respect, consistency of reporting and processes became more developed in reference to incident reporting, ward-based quality dashboards, safe staffing and incident surveillance reporting. At the time of my leaving, a much-needed audit management system was due to be implemented to improve the oversight of audit outcomes and implementation of lessons learnt from incidents. There was more to be done to achieve greater consistency, through centralising policy and procedural development, audit and best practice, through standardisation and coordinated quality improvement, and greater use of business intelligence reporting.

40. My reflection would be that whilst standards of governance, oversight and assurance had improved, there remained challenges in the management of information from a business intelligence perspective, further centralisation of governance and in respect of the capacity at service level for quality improvement. Whilst every individual has duties in terms of their roles and in particular those in leadership, clinical and management positions to make improvements and maintain standards. My reflection would be that further centralisation, business intelligence, and standardisation would have been aided by more timely policy review and an overall accountability and performance framework to bring about greater consistency, clear delineation of responsibilities and subsequently the activities undertaken and information needed to support the processes for this.

41. I cannot comment on the relationship between the Executive Directors and the Non-Executive Directors since leaving the Trust in 2022.

42. Before I left the Trust, the relationships between the Non-Executive and Executive Directors were on the basis that I would have expected between the roles. I believe that relationships did allow for challenging, open and constructive debate. The Board did undertake collective activities to set the organisation's strategy, vision and values, and aimed to be collectively responsible for directing and supervising the organisation. The Board had been observed by regulators and auditors and observations supported the delineation of roles, respective responsibilities and evidence of constructive challenge [CQCM0016478]. I believe external assessments confirmed an improvement journey. The CQC Well-Led inspection (2022) [CQCM0016478] 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.

43. The Board monitored the adequacy of the mental health services using a number of metrics and narrative information. These included performance metrics, patient feedback, staff feedback, audit and incident reporting, and patient safety data.

44. Key performance metrics at the Trust Public Board meeting by way of the Integrated Performance Report [NHFT0007612] for AMH only targets included:

- Discharges Followed up within 72 hours
- EIP: Engagement within 2-weeks %
- Out of Area Placements vs Trajectory – Notts
- Out of Area Placements vs Trajectory - Bassetlaw
- Total Non NHT placements
- Mental Health patients: % Assessment started within 18 weeks
- Mental Health patients: total number of patients assessed within 18 weeks
- Physical Health Check - SMI (inpatients)
- Inpatient admissions for people who have had no previous contact with community mental health services
- Inpatient admissions for people who have had no previous contact with community mental health services: BAME (Black, Asian and Minority Ethnic)
- Acute adult mental health long hospital spells (Notts and Bassetlaw Trust Beds Only) per 100,000 population, per rolling quarter

- Acute adult mental health long hospital spells (including subcontract, spot and other CCGs) per 100,000 population, per rolling quarter
- Acute older adult mental health long hospital spells per100,000 population, per rolling quarter
- Adults & Older Adults with Serious Mental Illness (SMI) - Receiving 2 or more contacts
- Liaison Services assessed within 1 hour %

45. The Board received supplementary information about waiting times and performance and were able to consider and challenge actions being taken to recover performance and onward assurance. [WITN0329008].

46. Quality metrics at the Trust Board level reporting were reported for the whole of the LMHS Division aggregated with other services whilst being able to identify points and trends for escalation in specific services. This dataset included:

- number of never events
- complaints
- incidents
- friends and family test
- under-18 admissions to adult beds
- number of patients whose detentions exceed the legal time limits of their section 3
- safeguarding referrals

47. Similarly, AMHS data was included in the Board level and Committee workforce metrics, such as sickness, turnover, vacancy rates, employee relations, appraisals, supervision, turnover and safe staffing. Board members were able to review quality metrics at the QMHL Committee through Quality Surveillance Reports and Patient Safety Reports.

48. Reports related to actions being taken in response to CQC actions were presented to the ELT, QMHL Committee and the Board. AMHS were included in reports to this QMHL Committee, e.g. Infection Prevention and Control, National Patient Survey, Clinical Audit, Mental Health Act Legislation, Complaints and Patient Feedback, Mortality Surveillance and Learning Reports, safe staffing reports, etc.

49. There were specific examinations of out of area bed use, [WITN0329009; WITN0329010], and responses to safe staffing reviews at the Board and Finance Committee [NHFT0015897].

50. The Trust had a number of ways in which issues with the care provided by the Trust could be escalated to the ELT, the Board, and I.

51. The Trust had a Being Open and Duty of Candour policy [NHFT0003028] which encouraged transparency about the care being provided. There were specific policies and expectations associated with reporting incidents, such as 'Duty of Candour' and 'Speaking Up'. 'Freedom to Speak Up Guardians and Champions' had become established in the Trust, and there was oversight of issues raised in the ELT, PCE&I Committee and the Board of Directors Annual Freedom to Speak Up Reports and updates. There was work undertaken in relation to culture and values which was refreshed in 2019/2020 and continued as detailed in the Staff Survey Response Update [WITN0329011; WITN0329012]. This work was central to supporting staff experience more broadly and for staff to feel safe and confident to speak up and raise concerns. Being able to speak out about concerns is largely cultural, personal and the cornerstone of delivering high quality patient care [TCLT0000398].

52. The work to encourage speaking up was continually revisited. Between May 2021 and March 2022 the Trust was one of 3 pilot sites working with NHSEI colleagues to raise awareness of FTSU with BME workers and build confidence in the speaking up process, advise on how the FTSU guardian recruitment process can be more inclusive, understand some of the specific challenges that BME staff face to speaking up and what would make it easier for them to speak up.

53. Issues related to care and the quality of services were escalated in person, either through conversation and correspondence with all of the executives, by staff, or patients, or carers, or the public, or other agencies. With the exception of the period in the pandemic visits to services were undertaken by Board members and Trust Governors and conversations could lead to concerns being expressed directly. Concerns could be raised by staff-side organisations in partnership meetings and escalated via the line

management structure through the use of management and clinical supervision, risk registers and incident reporting. Risk registers were held at directorate, divisional and Trust levels. Concerns were also raised via the complaints process, and through the Trust patient feedback process (including Patient Opinion).

54. I felt that there had been a shift towards openness and candour, and this was more visible in terms of escalation. There had been observations to support this, i.e. the Acute Adult Inpatient CQC report in 2022 [CQCM0019736] in which staff suggested that they felt able to raise any concerns without fear, and they were actively encouraged to speak up.

55. That said, I would recognise that people do not always speak up because they do not feel it is safe to do so, or that they have raised concerns before and not been listened to. This is not to say efforts to change were not being made. These I feel would have been to greater effect had the more systematic work on embedding the Trust values, leadership development and quality improvement not been disrupted through 2020 to 2021.

56. Information flows from the ward to the Board did improve, with the flow of data and narrative from ward to Board level being more visible through the Committees. Management of information flows, reliability, sharing data between information systems, data quality and oversight was a challenge and continually being worked upon. The flow of information from the ward to the Board for all service lines from a capacity, performance, human resource, quality and safety perspective needed to be increasingly visible and granular. Business intelligence processes alongside the audit management system which was being implemented was needed to strengthen oversight and reduce variation. Significant work was undertaken to improve data quality, reporting and at the time of my leaving an audit management system was being implemented to strengthen oversight and reduce variation.

57. Observations in the CQC report for Acute Inpatient Services 2022 [CQCM0019736] highlighting that:

> *"The trust had developed governance structures to monitor the safety of the ward environments, performance, and risk. All wards held monthly governance meetings*

which had an agenda including safeguarding, health promotion, lessons learned and medications management. The trust produced monthly oversight reports which supported managers to monitor safeguarding, risk and key performance issues which included compliance with training. Managers used this data to identify any shortfalls and introduce plans to make improvements. There were daily, weekly, and monthly checks in place which focussed on key areas such as infection prevention and control, restrictive practice, physical health, staffing and incident management."

58. At the time of my leaving, quality surveillance reporting had been rolled out to team level for a real time approach to reviewing patient safety incidents helping risk mitigation and improvement plans and supported governance and escalation.

59. Notwithstanding that improvements could be made in relation to the use of data; I believe that the Board were aware of service pressures and staffing and specially in relation to AMHS inpatient services of what was happening on the ground. To draw this to the Boards' attention, operational updates were included in the CEOs' regular Board Report drawing upon, when necessary, Escalation Level ("OPEL") reporting to reflect the level of pressure in services. The assessment of these levels informed by levels of access to services, staffing and business continuity. The Board also had sight of these considerations in the regular Board assurance and significant risk reports to the Board.

60. What was happening in on the ground conversations were discussed at the Board in relation to the Integrated Performance Report. The Board heard from patients and staff directly at the Board, seeing information through regular reports at the Committees in terms of the workforce, quality and workforce metrics, staff 'pulse' survey reports and incident reporting oversight at the Quality Committee. Operational pressures were further summarised in reports highlighting Derogations and Decisions and Operational updates i.e. Winter Pressures directly at the Board, [NHFT0003849].

61. In terms of a shared understanding with the ELT, there were weekly verbal briefings (and daily when required). These reflected numbers of patients for waiting times for beds, the status of the Section 136 suite occupancy, details of staffing levels, incidents and any other service pressures. ELT had weekly oversight of bed use including Out of Area Placements Days, including Sub-Contract and Spot Purchase, PICU patients waiting for

Forensic beds and the status of access to beds in the subcontracts. The ELT with the exception of the CEO received escalation on a rota basis though an on-call command structure, this included provision for responding to incidents and managing bed, and when required staffing pressures and approval of spot purchase beds.

62. ELT reviewed actions being taken in terms of the sufficiency of risk mitigations, action plans and option appraisals particularly in relation to Adult Mental Health Staffing. For a period, AMH Inpatient Services were the focus of an Improvement Board, chaired by the CEO which included the full ELT, corporate leads and colleagues from within AMH, to support a clear and shared understanding of risks, their impact and mitigation. They were focused deep dives, papers related to managing both staffing and clinical pressures, e.g. acute inpatient bed scenario modelling, workforce incentives, waiting list initiatives and service change.

63. My reflections are that these were illustrative and relative to the escalation through the Trust risk management process, and observable through the work of the Committees reporting to the Board.

64. Concerns were raised by the CQC, NHSE (largely in relation to out of area), the Coroner, commissioners, staff, and by way of patient feedback. Deficiencies about the community mental health services had been raised by staff internally primarily in relation to staffing and the quality of services, prior to my taking up this post. And latterly by the Police in relation to access to beds in April 2022, and I refer to this in reply to the answer about operational risk and in relation to multiagency working.

65. When I took up the Mental Health Operational Executive role, the Crisis Resolution and Home treatment services were not core fidelity compliant. This refers to the [WITN0329014], published by University College London.

66. The Early Intervention Pathway was not being delivered to National Clinical Audit of Psychosis ("NCAP") standards [RCPS0000008; RCPS0000028] and there were lengthy waits for other services.

67. There were quality concerns over a range of issues in the inpatient acute services, including staffing issues, out of area placements, the care environments and compliance with standards. It became evident that the funding and staffing of key service lines was not adequate.

68. In taking up this role, actions that I took thereafter included:

- Implementing a management and leadership structure. Working as promptly as possible to fill vacancies in clinical and leadership roles (a full/new divisional leadership team). The leadership structure agreed at the ELT and later bolstering of this enhance clinical leadership capacity by way of Clinical Directors, Service Level Head of Nursing roles, Lead Allied health Professionals roles, etc.

- I put in place a divisional performance and governance structure to support improvement and oversight. Waiting time oversight and management, and staffing were key priorities, as well as capacity and demand. We secured line of sight over as many key data items as possible, reflecting activity, the workforce, safety and quality.

- After appraisal, we took forward multiple business cases, gaining investment and implementing findings from safe staffing reviews, taking business cases to the CCG, Finance Committee, and Board where required. Specific examples were the Business Cases for the Crisis Resolution and Home Treatment Team, and Early Intervention in Psychosis Services.

- With the support of the People Director, we opened up all avenues to recruit for vacancies and sought to improve all aspects of recruitment, people management and temporary staffing. This ranged from implementing findings of establishment reviews, working with HR to strengthen the bank, gaining support for new roles, and reviewing service and staffing models.

- Working with Executive colleagues and commissioners, we used a service review process, including national priorities to understand the service shortfalls and gain investment to address these. We held negotiations to address capacity and funding

gaps as swiftly as possible. The outcomes of this - including bids for national funding allocations - led to the prioritisation described in the Transformation reports to the ELT, Board and Committees and were outlined in Trust and ICS planning priorities.

- Community transformation priorities within the Trust and ICS plans were agreed in 2019 with targeted investment at that point and onward to:
  - Achieve a Core Fidelity compliant Crisis Resolution and Home Treatment Service (this was an expansion of the existing service), substantively funded in the financial year 2020/21.
  - Implement a NCAP Standard compliant Early Intervention in Psychosis Service, funded two waves 2020/2021 and 2021/2022.
  - Bolster the Severe Mental Illness Capacity in Local Mental Health Teams.
  - And provide increased provision beyond AMHS related to eating disorders, perinatal mental health and child and adolescent mental health.

69. In leadership terms there was increasing focus on clinical and professional accountability, professional leadership, supervision, and standards of care. Cultural change supported by Trust-wide work on vision and values, and locally driven leadership changes and improved oversight of supervision and standards. This being a clear focus onward from the position in 2019.

70. We commenced reviews of the use out of area beds, which detailed the considerations of out of area and subcontract bed use. In seeking to improve the strategic consideration of the use of out of area beds, we negotiated with the CCG to commission a joint external review into the use of acute inpatient care beds [NHNB0007331].

71. In terms of tracking progress, the Trust had a GIRFT review in 2020 by the national lead highlighting improvement and noted the work of the crisis service [NHFT0004289]. The EIP service progressed towards compliance with NCAP standards. And in 2021 there was a revisit of capacity plans by way of an external review e.g. [NHNB0007331].

72. In seeking to improve overall aspects of compliance with the ELT and especially with the Director of Nursing ("DON") and Associate DON reviewed progress of the actions and assurance in relation to addressing improvement requirements from CQC reports. Where available we drew upon best practice and evidence in these considerations, seeking through the operational structure improved compliance with Trust Policies and Procedures.

73. In undertaking improvements to services and standards, we sought to do this in a way that involved all professions in the plans and changes. Specific consideration was given to training, supervision, competency, job roles, professional leadership and the cultural changes required.

74. I had oversight of actions taken to bolster and improve access to the severe mental illness pathway which included Individual Placement and Support (to assist with employment), introducing physical health workers, access to substance misuse worker capacity, implementing a pathway for people with personality disorders, with the aim of positively impacting out of area bed use. There was an alternative pathway provided for people with ADHD to release clinical capacity. There was a review of how patients waiting were managed, and a consistent model of triage was implemented. There had been the recruitment of primary care mental health workers as per the national plan, at the point of my leaving these were relatively new posts and intended to work in Primary Care Networks, with GPs, in supporting earlier access to treatment.

75. We developed large cohorts of Nurse Associates to aid the staffing pipeline and were implementing the Moving Forward programme to train and employ mental health social workers to work in LMHTs. Implementation of these plans was impacted during Covid and all changes (aside from recruitment) were halted.

76. Broadly speaking, considerations about staffing and impact on transformation plans were highlighted by peers in discussions the Regional Mental Health Oversight Group ("RMHOG"), although our position did have increased challenge due to prior staffing baselines in the crisis, EIP and inpatient services. In terms of transparency and

increasingly through the time of Covid we reported all our bed and staffing pressures to commissioners, and NHSE Trust specific meetings.

77. I have been asked to comment on the following reports published by the CQC:

   a. In May 2019, the CQC published the report of its routine inspection of the Trust [NHFT0002015]. The overall rating for the Trust was "*Requires improvement*". Three of out five areas assessed (including "*safe*" and "*well-led*") were rated as "*Requires improvement*". The report identified issues with the executive team, staff engagement, staffing levels (including in the adult acute admission wards) and learning from incidents. The safety rating for acute wards and psychiatric intensive care units ("*PICUs*") was "*inadequate*". The CQC required the Trust to take various remedial actions including, in relation to adult acute wards and PICU, to ensure there were enough suitable and qualified staff on adult acute wards and ensure that there were effective governance structures.

   b. In September 2020, the CQC published the report of its inspection of the Trust's acute wards for adults of working age and PICUs [NHFT0001778]. The overall rating for the service was "*Requires improvement*". In respect of the questions "*Are services safe*?" and "*Are services well-led*", the rating was "*Inadequate*".

   c. In November 2022, the CQC published the report of its routine inspection of the Trust [CQCM0016478], which was carried out in March and April 2022. The overall rating was "*Requires improvement*". Four out of five areas assessed (including "*safe*" and "*well-led*") were rated as "*Requires improvement*". The CQC issued a section 29 warning notice on 21 October 2022 in respect of these findings [CQCM0001817].

78. To avoid repetition, I will reply to staffing and out of area ("OOA") beds under those questions.

79. Throughout the timeframe of these reports, discussion, monitoring and seeking assurance took place at the Divisional Quality and Risk Meetings, the ELT, QMHL Committee and the Board. This refers to Trust-wide Well Led actions and actions in specific core services including AMHS. AMHS as a specific service was the focus of a

specific Improvement Board chaired by the CEO and services were subject to reviews by the Quality First approach, the Trust-wide approach to internal accreditation and improving standards. This involved providing specialist support directly to the services and enabled review and improvement.

80. In 2019, there was a view that services needed the right underlying conditions to improve, as well as an improved management and leadership structure, supported by broader quality governance structure changes, improvement of the estate and an organisation-wide approach to quality improvement. There was to be a unified Trust-wide Quality Improvement approach underpinned by a major refresh of the Trust's values and priorities, and a Trust Quality Improvement Team, deployed an approach to focused service level quality improvement work called 'Quality First'. This was in the style of an internal quality review and accreditation process.

81. Specifically in respect to AMHS, we held a workshop in May 2019 with AMHS and the ELT, and AMHS staff met with the full Board at a Board Development session. The aim was to have a reset and a new direction of travel and to support alignment from the ward to the Board, supported by a review of the Trust vision and values, and ensuring that the onward plans and considerations took in to account the full range of improvements needed. The Trust onward started to mobilise quality improvement methods from a central resource, and there was an increased emphasis throughout the Trust on activities related to culture and values from an organisational development perspective.

82. For a period, I led the public consultation for the relocation of the services and was the Executive Lead of the organisational change for the move of services from Workshop to Mansfield. The Sherwood Oaks unit was commissioned in November 2022, so that acute AMHS were dormitory free. There were still dormitories in MHSOP to be addressed at the time of my leaving.

83. In terms of the actions taken to address compliance in LMHS, this involved work with the Executive Director of Nursing, AMHS staff, corporate leads and the broader Executive Team reviewing progress against compliance actions specifically in relation to acute inpatient services. This involved a wide range of actions, and seeking assurance and

evidence of compliance up to the reinspection of the acute inpatient services in 2022 and after that reinspection an onward plan.

84. With service and professional leads, we reviewed practices and oversight across a range of standards, i.e. physical healthcare indicators, clinical risk assessment and care planning, clinic room standards, staffing, ligature audit and rectification, rapid tranquilisation monitoring, discharge standards. There was a continual and increased emphasis on professional leadership, development and accountability. We used the Trust Quality First approach to work with individual ward teams, and provided increased oversight, supervision and capacity for practice development across the inpatient services. All acute adult inpatient wards had a senior experienced buddy/coach whose focus was to support and educate staff in the development of safe clinical risk assessment, trauma-informed care and inclusive care planning. There was line of sight of key improvement topics from physical healthcare indictors, to reporting incidents, timeliness and quality of risk assessments, discharge planning.

85. ELT oversight continued, and there was the reinspection of the service in March 2022, published in November 2022 [WITN0329015] evidencing changes made.

86. With specific regards to [NHFT0000592], I left the Trust prior but can confirm that there were plans in place against the improvements required in all the core services that had been inspected in the LMHS Division.

87. I suggest there are many factors that contributed to the Trust being rated as requiring improvement 3 years after the 2019 inspection. Factors that could be considered include:

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

- Turnover in the ELT and changes in senior leadership positions, changes in operational and corporate leadership and the breadth of cultural and service change required had not reached a sustained improved position and Covid impacted the climate for improvement.

- Whilst governance and the use of information improved, more improvement was needed, and staffing challenges were without question a highly significant factor through this period. These coupled with bed pressures due to the subcontract bed availability and delays to the estate modifications adding to operational pressures.

- There remained the need for continued centralisation of governance, coordinated deployment of improvement techniques, and improved business intelligence and increased capacity for clinical leadership.

88. My reflection on leaving the Trust in 2022 would be that there had been learning from previous inspections, but that the operating climate was more challenging, the improvements intended needed to be consolidated and the pace of change swifter. And onward refined through an organisation wide overarching performance and governance framework and changes in organisational structure to ensure swift coordinated pace of change and evidenced improvement.

Risk Assessment

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

90. Strategic risk management operated as an organisational control mechanism designed to safeguard the Trust's strategic objectives, operational integrity, and statutory obligations. It focused 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.

91. These risks were identified, assessed, and managed through formal governance structures including the Board Assurance Framework ("BAF"), the Corporate Risk Register, and oversight by the Audit and Risk Committees, at Divisional and Service Level. This framework enabled the Board to maintain a line of sight on the principal risks to strategy delivery and to ensure that mitigations were effective.

92. In contrast, 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"), incident reporting, quality improvement and continuous learning. Oversight was provided through clinical governance structures, management and clinical supervision seeking to secure learning from incidents and audits to inform safe and effective practice.

93. 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.

94. The Board of Directors set the overall direction and tone for risk management. It defined the Trust's risk appetite, approved the Risk Management Strategy, and received regular assurance that risks are identified, assessed, and mitigated. The Board reviewed the BAF at its meetings, with supporting assurance from the Audit Committee, and receives an annual statement of assurance through the Annual Governance Statement.

95. The Board's oversight was supported by a committee structure that provided scrutiny:

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

- The Quality, Finance, Commissioning, Strategy and PCE&I Committees each reviewed specific categories of strategic risk relevant to their remit, escalating significant issues or emerging trends to the Board.

96. The ELT, as members of the Risk Committee, were responsible for operationalising the Trust's risk management strategy and ensuring that risk processes are embedded in day-to-day management. Executive Directors were accountable for managing risks within

their portfolios, maintaining risk registers, and ensuring effective mitigations. The Risk Committee chaired by the CEO reviewed emerging risks, and the adequacy of controls. This played a central role in fostering an increasingly risk-aware culture and that strategic risks remain aligned with the Board's defined risk appetite. The Risk Committee provided assurance to the Audit Committee to inform refinement of the Risk Management Strategy and Policy.

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

- The Board set the policy direction, determined risk appetite, and provided oversight and assurance.

- The CEO and ELT operationalised the strategy, seeking to ensure that risks were actively managed and aligned with organisational priorities.

- The Risk Committee and the Board Committees provided the analytical and assurance infrastructure that underpins improvement.

98. All Executive and Non-Executives received one-to-one training and coaching from the Trust's Head of Risk Management and Board Assurance Lead. This ensuring that all Directors developed 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.

99. There was tailored coaching and guidance 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 emphasised practical application, using live examples from the BAF and corporate risk registers to support learning.

100. The Board also undertook an annual risk management development session. This session provided a structured review of the BAF, focusing on:

- Deep dives into principal risks and their mitigations;
- The adequacy and effectiveness of controls and assurance mechanisms;
- Re-evaluation of the Trust's risk appetite and tolerance levels; and
- Alignment of risk exposure with strategic objectives and the external operating environment.

101. These were intended to build technical capability and cultivate a shared, risk-aware culture at Board level. All Directors equipped to provide informed scrutiny, challenge, and assurance on the Trust's management of strategic and operational risk.

102. The BAF was a central component of the Trust's governance and risk management system. Its primary purpose was 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.

103. The BAF linked each strategic objective to its associated risks, setting out the controls and mitigations in place, and identified the sources of assurance that demonstrate the effectiveness of those controls. This provided 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.

104. The BAF functioned as a dynamic management tool used to prioritise improvement actions, inform resource allocation, and test the resilience of existing controls. It supported transparency, accountability, and alignment between operational and strategic risk oversight.

105. The BAF was formally reviewed and approved at regular meetings of the Board of Directors. 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 provided independent assurance on the adequacy of the Trust's systems of internal control, calling Executive Directors to account for their respective risk portfolios.

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

107. In my view, the BAF was an increasingly effective mechanism for strategic risk monitoring and management at senior leadership level. It provided the Board and Executive Leadership Team with a single, integrated view of the Trust's principal risks and the assurances available to support governance and decision-making.

108. The effectiveness of the BAF and the wider risk management framework was 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.

109. I would say that in the use of these tools there are improvements that can be continually made in the information being used to support the underpinning risk management processes and improving alignment between strategic risk, performance and accountability. The position in 2022 reflected the position at the time in terms of maturity in embedding the Trust Risk Management Strategy.

110. In 2022, we were in a period of increased demand for beds across the Trust and difficulty in arranging onward pathways and discharge.

111. In regards to the management of organisational risk, at the height of the bed pressures in AMHS in 2022, the Police wrote to the Trust through the PALS and complaints department about the delays to admissions of four patients between the period of the 28th of March and 7th April 2022, via a letter and a subsequent email which was unusual in terms of communications from the police. [WITN0329016; WITN0329017].

112. I believe that these instances were known at the time as part of operational escalation. It had been widely requested that delays to admissions were reported by Incident Reports ("IR1") and instances of patients for whom Nottingham was not their home residence and requiring repatriation or direct admission to their home Trust was raised with NHSE/I at the Trusts' request at RMHOG, and an agreed regional protocol put in place to address this. I replied to the Police by way of letter dated 27/4/22 [WITN0329041]. I note that the letter was copied to John Brewin CEO, and I believe discussed it with him.

113. In the same respect the Trust had also received a complaint from the Police who raised concerns about the care of a patient GRO-B, whilst GRO-D at Bassetlaw [WITN0329018], and at Highbury Hospital – raised on the GRO-D 2022 by email to the Patient Advice and Liaison Service ("PALS") and Complaints Department. I advised the Police of actions taken directly on the GRO-D 2022 GRO-D GRO-D and this subsequently proceeded to a Level 3 investigation [WITN0329019]. The escalation of their initial concern was acted on at service level. There was a weekly dialogue with the ELT in relation to this serious incident.

114. In relation to clinical risk management, this operates at the level of direct patient care and professional practice. This is an individualised activity focusing on the identification, assessment, and management of risks to safety and patient outcomes. Clinical risk is governed through professional frameworks and responsibilities and is supported by supervision, professional support, professional development, incident reporting, improvement plans and appraisal. Oversight is provided through clinical governance, operational management and leadership structures, aiming to ensure that continuous learning promotes effective and safe care delivery.

115. Actions taken to improve standards at service level included increased practice development capacity for inpatient services, use of standards-based audits (e.g. (QNWA) [WITN0329020] and increases had been made to inpatient psychology and assistants as part of safe staffing reviews. This was particularly important to the work on acute inpatient wards to promote trauma informed care. A Band 5 development programme was put in place specifically to support newly qualified staff in their clinical practice including standards of risk assessment and care planning, a process of ward

budding whereby a senior clinicians supported each ward in improving the quality of risk assessment, multidisciplinary working and safe discharge planning. The 2022 CQC inspection of acute inpatient services [CQCM0019736] reflected that:

> *'The trust had improved the management of risk to patients since the last inspection in 2019. Staff now ensured that risk assessments were in place and that they contained all relevant risk information, including how to prevent and reduce individual risk for patients, this included personal evacuation plans, where appropriate. Multidisciplinary staff discussions determined the level of risk for each patient, developed a risk management plan and agreed the level of observation needed'.*

116. The Annual Patient Safety report at the Quality & MHL Committee, 13 October 2022 [pages 82-99 of NHFT0003346] described a specific example of learning from incidents which involved the review of the Crisis Resolution Home Treatment ("CRHT") Operational Procedure amended in December 2021 to take into consideration the learning from inquests. This included expectations of risk assessment, referral and communication, and a specific tailored training programme for CRHT staff including Structured Clinical Management ("SCM") and Dialectical Behavioural Therapy ("DBT"), managing crisis telephone calls and working with young people in crisis. The report describes that onward support was continued for the team from the Zero Suicide Lead, and there was broader Learning and Development input to support continuous learning and reflective practice spaces to augment and embed this learning. There was a review of communication processes between the LMHTs and CRHTs by use of case examples in order to jointly share learning and discuss practice issues, as well as developing and maintaining good working relationships. The learning considered the use of patient and carer feedback processes, carer peer support and onward monitoring of key performance indicators were put in place for onward monitoring.

117. Examples of specific changes made to the provision of services in response to identified improvements needed in relation clinical risks were capacity in teams for access to substance misuse support for people with a dual diagnosis (the co-occurrence of a mental disorder and substance misuse), capacity was developed for all LMHTs. A Neurodevelopmental Specialist Service ("NESS") was established, from 1st April 2021, to offer diagnosis and post-diagnostic support for autistic people. NESS provided training

and development of competence in AMHS to support assessment, care planning, advice, and crisis support for autistic people with mental health conditions in the community. These were specific examples taken to improve risk assessment and management learning arising from incidents.

118. The QMHL Committee on the 16/8/22 appraised the Suicide Prevention Annual Report [NHFT0015020] detailing the onward plan for clinical risk training. The plan recognised that training alone does not achieve embedding of learning into practice or operational and quality improvements and the onward provision of specialist expertise, clinically based engagement and support, and tailored training and facilitated team learning, clinical tools and safety planning tools were thoroughly considered.

119. These interventions were to be prioritised for teams who experience greater exposure to suicide and self-harm and to ensure that there is related learning to promote safe and responsive services. It was described that there had been wider developments and the re-establishment of the Trust-wide Suicide Prevention Strategy Group, suicide prevention champions/network, Community of Practice and partnership working for Real Time Surveillance across agencies and that the internal dashboard for suicide and self-harm related data had been rolled out so that suicide data and learning themes were reviewed through divisional structures and further to this clinical Risk Assessment and care planning were agreed as Trust Quality Priorities in 2022.

120. In 2022 the Audit Committee was the formal committee of the Board of Directors which provided independent assurance to the Board regarding the effectiveness of the Trust's systems of integrated governance, risk management, and internal control. The Committee was chaired by a Non-Executive Director and comprised of other Non-Executive Directors, including the chairs of the Board's other formal committees as well as designated Executive Directors.

121. This structure aimed to ensure that there was comprehensive and effective assurance for all the functions of the organisation. The Committee had formal Terms of Reference, which were reviewed annually to ensure alignment that the governance processes within the organisation met regulatory standards. The Committee considered internal and external audits and monitored the implementation of the Trust's Risk Management

Strategy [WITN0329021]. It received regular risk management report and appraised the effectiveness of the BAF.

122. The Trust had a separate Risk Committee, which focused specifically on oversight of organisational risk chaired by the Chief Executive reporting to the Audit Committee. The Risk Committee played a role in overseeing the development and review of the Trust's risk management policy and strategy, ensuring that they were fit for purpose, and this was a mechanism for the active monitoring, escalation, and mitigation of risks across the Trust. The Risk Committee received risk reports from the three clinical Divisions and Corporate Departments. Its objectives were to foster a positive risk management culture, maintain oversight of risks, consider emerging risks, and improve resilience and risk mitigation. The Risk Committee reviewed escalation from operational governance meetings, challenged the sufficiency of mitigations, and sought to ensure alignment with the Trust's strategic objectives and risk appetite.

123. The Audit or Risk Committees did not directly oversee individual clinical decision-making, whilst there is a relationship between clinical and strategic risk. The ELT and the Board responsibilities were to ensure that policies and procedures incorporate best practice and learning from incidents.

124. The combination of structures – the Audit Committee, the Risk Committee, operational governance, and quality governance processes sought to provide assurance that risk was being actively monitored, managed, and escalated. It aimed to ensure that strategic and clinical risks were appropriately identified, evaluated, and mitigated.

Serious incidents and learning from deaths

125. There was a weekly group led by the Associate Director of Quality, with the Director of Nursing or their Deputy (as a core member), to review serious incidents ("Sis"), the Serious Incident Review Group ("SIRG"). From this group there was direct verbal feedback to the ELT, the focus on those SIs that reached the threshold for a comprehensive investigation and consideration of immediate onward actions. For example, when there had been an inpatient death, I visited the ward promptly to review the circumstances of the incident, consider immediate actions with heads of service,

review our contact with families and support the ward team. Not to do this promptly and personally would be a rare exception and would in such a case be undertaken by my deputy.

126. There was a Trust-wide Patient Safety Group, to provide central oversight of the SI investigation process and tracking of actions arising from investigations being implemented. At a Divisional level the Associate Medical Director within the MHS Division, Directorate Leads and the Patient Safety Team met monthly to review investigations and had oversight of the implementation of recommendations. A further additional weekly meeting was introduced to support the review of the quality of investigations. I took escalations about timeliness, service changes or difficulties with the implementation of actions at the Divisional Quality and Risk meeting. This could be over a range of issues such as staffing, buildings, training, service specifications, etc. Where there were complex action plans, I oversaw selected SI plans directly at the Divisional Quality and Risk Group. I will reflect that during and following Covid there had been a backlog of investigations in AMHS escalated, and options were considered for increasing investigation capacity and reinforcing the need for the implementation of the audit monitoring system.

127. There was also a Quality Oversight Group ("QOG") whose role was to ensure that there were robust quality governance and oversight arrangements in place across all services, and to provide information to the QMHL Committee that reflected the effectiveness of this. The group oversaw the development of the Quality Surveillance Dashboard and its onward reporting and use. Where appropriate, the dashboards used identified statistical outliers for each metric/indicator and where relevant included trends. QOG provided oversight and where possible working with services to determine what further actions should be taken if any areas of concern have been identified.

128. The QMHL Committee oversaw the standards for patient safety and learning from incidents and the Board received reports including patient safety information, and the role of the QMHL Committees was to seek assurance that the Trust was implementing the learning from incidents and provide an assessment of assurance to the Board. The Committee had oversight of SIs, prevention of future deaths reports and patient safety

incident data. This information was used to consider incident rates and improvement actions, and assessment of the effectiveness of learning.

129. At Divisional level there were two groups led by the Associate Medical Director of the Division including the patient safety team, one to track the implementation of changes by way of action plans arising from incidents and the other to review the quality of SI reports. I took escalations from that process at the Divisions Quality and Risk Group. On occasions I undertook increased oversight of improvement plans and with others oversight of service change. For example, regarding concern related to continuity and out of area bed use I remained sighted on the changes made to the bed management processes and had direct communication with the provider concerned. I undertook - after discussion with colleagues - to review the subcontract arrangements and that there had been a review of the shared pathway protocols between the Trust and subcontract organisations, particularly around admission and discharge, aimed at improving the continuity.

130. There were Divisional and individual service level monthly Quality and Safety Meetings. Their role was to improve the safety, effectiveness and experience of patients receiving care from the services directly. Those groups had responsibility for implementing patient safety recommendations, safeguarding and improving patient/ carer experience, and providing assurance. Locally, they oversaw the actions implemented as a result of incidents, complaints and experience reviews, both local or externally led (e.g. CQC). They also maintained the services risk register. There were improvements to be made in Directorate and Divisional oversight and capacity to do this work, and the necessity for a more coordinated approach to improvement, management of information, and the implementation of lessons learnt consistently across all the services.

131. In 2022, quality surveillance reporting had been rolled out to team level, with patient safety reports and increasing clarity and granularity. This involved the use of descriptive numerical data using statistical process control charts to identify trends. This involved service-level identification and delineated between types of incidents. Reports had been able to provide narrative themes/descriptions of reoccurring issues. The patient safety team had developed reporting and trend analysis of incidents, triangulation of incidents,

and started to identify hot spots and potential patient safety risks. The use of this information was rolled out to team meetings and other forums.

132. There had been concerns about the quality and timeliness of SI reviews and reports, concerns raised by the coroner about the quality of reports and difficulties in capacity to undertake investigations especially in the period during and after Covid. In 2019/2020, there was a centralised Trust-wide Patient Safety team put in place overseen by the Trust Lead for Patient Safety, and Associate Director of Quality. The Patient Safety Team had responsibility for the overall co-ordination of incidents and investigation across the Trust, aiming to reduce variation in the management of incidents/serious incident investigations between directorates/divisions and enable a consistent approach in the appointment of investigators, preparation of terms of reference and ensuring investigators had points of contact to discuss investigations and concerns.

133. A small resource of central investigation capacity was put in place, later complemented by bank SI investigators. In 2020, new procedures were put in place for the processes of sign off of investigations. All Comprehensive investigations and terms of reference approved by an Executive Director and concise investigations approved by an Associate Director of Nursing.

134. There was independent 2-day training for investigators on a Systems Based Approach intended to eliminate variation in the quality of reports. In 2022, to further improve the quality of investigation reports, and their oversight and sign-off of investigations, a specific weekly group was put in place, led by the Associate Medical Director in the LMHS Division, including the Deputy Director of Nursing from the LMHS Division, Patient Safety Manager, Family Liaison Manager, Trust-wide Clinical Lead Suicide Prevention Lead and Head of Patient Safety. This group reviewed the quality of all SI Investigations in the LMHS Division. The group had the remit to review the overall quality of the report, examine family engagement, ensure the recommendations and reviewing that the resulting quality improvement plans were fit for purpose and were required feedback to investigators if reports were not sufficiently robust.

135. Overall, these actions for the comprehensive investigations, did bring a level of improvement but there were remaining challenges in the capacity to undertake investigations in 2022.

136. The SIRG was put in place to discuss SIs in terms of outcome for the individual involved, critical incidents or incidents where there might be reputational issues. Incident reporting and SI management included harm caused by patients to third parties. This involved the process the grading of incidents and selection of level of investigation:

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

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

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

137. Learning would be actioned via the same processes as for a SI via an action plan against the recommendations, subject to the same processes for oversight of recommendations and their implementation. There were also processes in place related to Domestic Homicide Reviews and LeDeR (Learning from Lives and Deaths Review Programme) reviews for people with Learning Disabilities. Domestic Homicide reviews featured in safeguarding processes and reporting.

138. I have been asked to comment on the following patients who were under the care of the Trust at the time of, or shortly before, committing serious acts of violence:

   a. Patient GRO-B GRO-C GRO-D GRO-D and the incident was reported on StEIS August 2021 Reportable Issues Log, [NHFT0004539, pg. 10].

b. GRO-C GRO-D GRO-D [NHFT0004539, pg. 10].

c. GRO-B who fatally stabbed GRO-D 2022. GRO-B was known to Liaison Psychiatry, but had not been seen or assessed GRO-D GRO-D

d. GRO-B, who stabbed GRO-D GRO-D 2023. GRO-D was under the care GRO-D at the time of GRO-D offences.

139. To avoid confusion, I will refer to the serious acts of violence as "Patient GRO-B, "Highbury patient" GRO-B

140. I left the Trust in December 2022. I was aware of the incidents which occurred before I left the Trust.

141. I do not recall specifically how I was advised in each instance. Details of the incident relating to GRO-B was included in the 6 September 2022 reportable issues log at the Private meeting of the Board of Directors [NHFT0015873].

142. In relation to GRO-B and the Highbury patient, the minutes of the Private Board meeting on 3 August 2021 reflect that the Board of Directors were informed and assured by the report [NHFT0004539, pg. 9] [NHFT0003806, pg. 6].

143. In relation to GRO-B the minutes of the Private Board meeting from 6 September 2022 reflect that the Executive Director of Nursing, AHP's and Quality presented the Reportable Issues Log to ensure the Board was aware of the most serious incidents and other significant issues within the Trust [NHFT0015873] [NHFT0000822, pg. 7-11].

144. In respect to GRO-B, I am not able to reply having left the Trust in December 2022.

145. Given the timeline of my leaving the Trust, the timeline of the reports themselves and from the information I have been provided I cannot verify onward discussions at the Board or Committees in respect of these incidents.

146. In respect of Patient GRO-B having been reviewed at the SIRG on 13.07.21, [WITN0329022] was signed off on the 04.07.22 based on the use of a Case Note Review/Level 1 Concise Investigation: Incident Analysis [WITN0329023], taken from the review of healthcare records undertaken by Patient Safety Investigation Lead. I cannot confirm that myself or the Board considered the findings of the report, and I have not been able to verify from the information that I have been provided that the actions stated on the action plan for completion by the 12/2/23, after I had left the Trust, have been completed.

147. In respect of the Highbury Patient, having been reviewed at the SIRG on 25.5.21 a Comprehensive Investigation by a three-person internal panel was undertaken and the investigation completed on the 8/6/22, [WITN0356080 WITN0329042]. There had been liaison with the Midlands Region Independent Investigation Review Group noted on the 27/3/22 that this incident would not be subject to an independent investigation. I cannot from the information available confirm that I considered the findings or that this has been considered by the Board.

148. In respect of GRO-B this was discussed at the Serious Incident Review Group on the 16/8/22 [WITN0329024]. And a Comprehensive Investigation with an external chair by a three-person panel was undertaken and completed on the 2/5/2025. I cannot verify onward regarding the consideration of the findings of the report due to the timeline, and further confirmation should be sought from the Trust regarding the findings of the report and the implementation of the recommendations.

149. On the basis of my replies provided, I cannot confirm the changes made in response to these incidents.

150. I would not infer that 15 serious violent incidents to the public related to the Trust's services over the period of 2019-2023 is expected because of a rise in acuity or the number of patients. The number of patients accessing services may have increased, and

there may be perceived or actual rise in acuity (as a feature of increasing ill health) but I would view these as factors as opposed to a cause.

151. In terms of improvement, consideration should be given to, safer inpatient ward provision, early follow up after discharge, the provision of a 24 hour crisis resolution and home treatment service, personalised risk management, family engagement in risk management, no out of area admissions, provision of safe staffing, assertive outreach, and interventions to reduce alcohol and substance misuse.

152. It is not to suggest that a level 2 review may not be sufficient: my experience has been that leadership of investigations by appropriately skilled professionals external to the Trust bring huge benefits to the learning process by way of their independence. As part of the process being engaged in onward learning and reflection directly with clinicians, the services involved and the organisation, are a valuable and powerful approach to learning and improvement. It also provides an increased level of assurance.

Staffing levels, outsourcing and discharge planning

153. The following guidelines or requirements were applied and full details of staffing establishments and workforce metrics, can be provided by the Trust;

   a. For inpatient services headroom was benchmarked and 23% applied. For inpatient services including the PICU the Mental Health Optimal Staffing Tool (MHOST) was used as part of the establishment review process, and establishments reflected these assessments. Increased investment changes confirmed at the Finance Committee and the Trust Board as required and referenced in safe staffing reports to the Board.

   b. Staffing for the crisis teams were based on the standards used for crisis services staffing established the nationally advocated criteria, the Core Crisis Resolution Team Fidelity Scale.

   c. For EIP, we used National Clinical Audit of Psychosis ("NCAP") standards [WITN0329040; WITN0329044] already referenced to underpin staffing models.

d. For LMHT - which included Assertive Outreach contract negotiations held in 2019-2020 - in respect of AMHS staffing, there was work with a capacity and demand model at the request of commissioners. It is reflected in the Trust's safe staffing reports that to consider safe staffing in the LMHT, there had been adapted use of MHOST tool.

154. Overall staffing models were set against CCG service specifications reflecting the scope and capacity of the service required. Funding for increasing services over this period was expected from the CCG baselines and central transformation funds which were released nationally in phases. Throughout 2019 – 2021, the bids and business cases for local investment and national funding were jointly approved by the Trust and the CCG. National bids were jointly approved by the CCG and went through NHSE gateways and would not proceed without the use of the appropriate evidence base and calculator tools where they were available. Likewise, the national allocation for inpatient funding use was underpinned by Hurst reviews.

155. We took opportunities to be involved in national developments where we could and the Trust was a pilot site for the implementation of Mental Health Clinically Led review of standards, the models and measurements for improving access to emergency mental health care. Our preference was to be included in developments and ensure going forward that our services modeling was increasingly fit for purpose, and also that clinical staff could be included in national developments.

156. The Trust Safe Staffing Group were responsible for the provision of regular establishment reviews and oversaw their implementation.

157. The Trust had developed its use of staffing tools following the Carter mental health pilot project, and went on to use the mental health optimal staffing tool across the inpatient areas which informed daily demand management reviews. The staffing tool showed how changes in patient need and staff demand fluctuated informing onward staff planning and opportunities for redeployment of staff from one ward to another. Patient acuity was reviewed daily and controls in place to manage this via the daily demand meeting.

158. Insofar as safe staffing levels were met; these were not sufficiently met by substantive staff. The impact of deficiencies in staffing changed over time in different services. Originally, staffing levels in crisis teams greatly affected crisis access and availability of home treatment, and there was a consequential impact upon the numbers of patients with mental health problems accessing A&E. Overall, this position improved by 2021 when the capacity of the crisis service increased. There were less delays allocating care coordinators than there had been previously, although LMHT vacancies impacted on capacity to deliver prompt access, whilst improvements had been made.

159. With regards to inpatient services, the insufficient numbers of appropriately trained staff had an impact on shift fill rates, staff morale and patient care. There was concerning impact on staff and patient satisfaction due to staff shortages. Use of agency staff in inpatient services - albeit delivered where possible by consistent workers - was not equivalent to permanent employees.

160. The most common manifestation for patients on wards was that they could not always access staff when they needed to, had less opportunities for psychological interventions and timely reviews of their care. There could be delays in managing healthcare needs, and challenges arising from incidents. This undermined staff's ability to provide safe and effective care, and compliance, whilst every opportunity was taken to mitigate risks and improve this. Levels of inpatient staffing did impact how many beds could be used in inpatient wards.

161. In terms of further monitoring of rostering practices or shortfalls, there were dashboards for human resource and rostering metrics with line of sight at team, service, division and Trust level. The overview of these were discussed at the PCE&I Committee and in the Integrated Performance Report at ELT and the Board. On a weekly basis, Operational Directors provided updates at ELT on staffing pressures, discussed in terms of specific service need and risks, and periodic papers were tabled to that effect. My deputy or I would advise the Incident Control group daily of the OPEL, and after this period ELT continued to be advised of the status weekly or in real time.

162. Operationally, there were daily situation reporting, cascade and escalation processes in the place. This allowed oversight and changes to be made, and onward planning. This

formed part of the OPEL reporting process. The work of the safe staffing group was integral to improving the staffing models, better rostering practice and development of new roles. To support this there was visibility over a range of metrics, including vacancy rates, sickness absence, turnover, roster fill rates, and visibility of the recruitment pipeline. I reviewed cross Division workforce metrics and deep dives into temporary staffing, safe staffing incident reports, and a mental health staff pipeline report.

163. The Board and the PCE&I Committee reviewed a range of workforce metrics. In 2021, the Board approved the investment of £1.817m in response to the establishment review of AMH inpatient services. This was an increase of 1 staff member per shift and additional AHPs were funded to improve multidisciplinary working. Similar increases were made in MHSOP.

164. The QMHL Committee had the responsibility for safe staffing, monitoring and escalation to the Board in consideration of the annual Safe Staffing report. Broader workforce considerations were reviewed at the PCE&I Committee, covering a range of metrics and the Trust People Plan. The annual report to the QMHL Committee provided a summary of the key areas within the Safer Staffing Annual report, highlighting changes made to the establishment review process, the developments within acuity / dependency monitoring and details of key projects within the trust wide safer staffing group.

165. The safer staffing group reported to the Quality Committee insofar as overseeing the process of staffing reviews and ensuring that all clinical services have sufficiently skilled staff, to enable safe, effective and sustainable care. The group set staffing standards, to achieve the CQC's Fundamental Standard and the National Quality Board (2016) expectations, and led on good practice on rostering and staff allocations. It also reviewed the use of bank and agency staff and oversaw the safe staffing workplan. The group interrogated data related to staffing in particular rostering, the use of bank and agency, staffing related incidents, and escalating staffing concerns to the Executive Team. Senior leaders from the services were members of the group, as well as Associate Director professional leads. The group were able to make changes to staffing practices and escalate where resource and changes were needed. For example, where teams were impacted by any issues such as finance or recruitment.

166. For inpatient services, the focus was on those staff that took part in the 24hr 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.

167. 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 and escalate the issues to the Executive Leadership Team as appropriate.

168. The following are examples of overall actions taken in relation to AMHS staffing, from December 2021 onwards, provide some further context and these actions were continued and strengthened:

- We had moved to rolling/open recruitment for all clinical posts including open days, working with the universities to enhance opportunities to attract new registrants.

- We developed our use of safe care (a combined tool for staffing and safe care) to track staffing requirements against patient need.

- We sought to improve our rostering oversight with measures for fill rates and improved standard of rostering, and this was overseen operationally in the Trust Safe Staffing Group.

- We delivered a Band 5 development programme to support newly qualified staff and their progression to Band 6 positions, with a view to retaining staff.

- There were widespread social media recruitment approaches.

- Continuing to recruit to psychology and Occupational Therapy capacity on the wards.

- Introduced carer support roles.

- Agreed regular lines of work by agency staff.

- We recruited at scale for the Trainee Nurse Associate pipeline, working with the University of Derby.

- We reviewed and increased the scale of the Trust internal Bank (temporary staffing arrangements).

169. In relation to staffing at Highbury Hospital, John Brewin took a paper Highbury Improvement & Business Continuity Plan to the Private session of the Board on the 7th of December 2021 [WITN0329025] which detailed the actions taken at the height of the staffing pressures. There was a focused improvement plan for Highbury Hospital reviewed by ELT, and AMHS colleagues considering the status of staffing, impact on care delivery and the actions being taken. This plan informed from the perspective of the ward teams, the quality of the care being delivered, and had a focus specifically on staff recruitment and retention. Members of the Executive Team visited the site to consider the sufficiency of the mitigations and the actions taken with AMHS colleagues. And there was a subsequent deep dive review at the PCE&I Committee.

170. Examples of actions taken over that period included:

- The recruitment team provided on-site support for Ward Managers.

- Workforce Advisor was provided for every ward to help review sickness and increase workforce availability.

- We had an independent review (by workforce professionals external to the Trust) of the ward rosters at Highbury to establish any areas for improvement which could alleviate staffing pressures.

- There was an increase of administration staff to support the wards.

- We commenced the pilot of medicine assistant roles.

- We maintained on the wards the staff redeployed from the 136 suite, community personality disorder service and maintained the seven registered staff from non-clinical roles on the wards for 1-3 days per week.

- Reviewed again agency use for consistent lines of work.

- Increased operational manager capacity by changes to the role.

- Reviewed the use of recruitment and retention incentives and after benchmarking implemented an Intensity Premium Payment for PICU staff.

- Made improvements in recruitment (timescales) and the responsiveness of the Trust Bank (temporary staffing) and further increased Bank capacity.

171. We used the staffing and ward-based acuity tools to review patient care and staffing and this fed into daily demand management and escalation. Specifically in terms of patient flow, we maintained the cap of 8 patients on the PICU and procured an extra 4 acute inpatient beds via the subcontracts until March 2022, seeking to reduce occupancy levels for a period. We accelerated further work in the multi-agency discharge events process to help support capacity and improve the flow of patients.

172. In relation to [NHFT0002204], the initial Highbury action plan remained live for 3 months and was amended with new actions added. I met weekly with the ward managers, corporate support staff and senior leaders at Highbury, to review staffing, patient acuity and the mitigations. Wider ELT members also attended, and Board members reviewed progress via operational updates, and monitoring of workforce, quality metrics and through the respective committees.

173. At the point of the CQC Adult Inpatient Mental Health Report in March 2022 [CQCM0019736] we reviewed the Highbury Plan and replaced it with a AMH Improvement plan that included all the AMH wards on the other 2 sites. And there was a review again of contingencies and staffing at Highbury at the ELT July 2022, and review of AMH bank and agency use prior in June 2022.

174. Discussions about workforce challenges were continually live at the Board, and PCE&I Committee, and the Trust response overseen in the Trust People Plan. Workforce planning submissions and discussions with Health Education England ("HEE") and NHSE reflected current shortfalls and growth in terms of future plans. In 2022 the volume of demand was not met by traditional routes (i.e. nurse training), or HEE initiatives and whilst actions were in place to improve the pipeline these still had to progress sufficiently to improve supply, notwithstanding positive developments and implementing new roles.

175. The Trust had two periods of support from NHSE, for focused support for recruitment and retention. The Trust was an early adopter of new roles, for example, Non-Medical Responsible Clinicians, Peer and Carer Support Workers and Nurse Associates. The Trust had one of the largest early cohorts of Nurse Associates in the country with the University of Derby. In recruitment terms, we were attentive to opportunities to broaden professional roles working in multidisciplinary teams and use of appropriate third sector skills.

176. We started to train small cohorts of mental health social workers and overseas recruitment was in development when I left the Trust. We had worked extensively on social media, campaigns, recruitment fairs, block and open recruitment, open days, attending schools and universities, and a broad range of community media and advertising. In retention terms, we used recruitment and retention premiums as far as was felt to be possible, including a Christmas and Summer bank incentives, and incentives for new recruits. We offered flexible working, and retire and return, and had progressed apprenticeship roles. These developments were done in discussion with other organisations locally and using benchmarking.

177. We did make some step changes to our approach to caring for our staff and had an improved staff survey in the MH Division by 2022. The CQC Inspection [CQCM0016478] highlighted the attention being given to staff support and wellbeing. We were supported by the trust organisational development team in our 'You Said We Did' work with staff, to improve the working climate. The Trust Bank and Occupational Health arrangements were refreshed.

178. However, the use of agency staff - particularly in inpatient services - served to highlight the struggle to meet demand post-Covid. Concerns about this were reviewed regularly by the ELT, shared by the Board, and at the PCE&I Committee. We took opportunities to share experiences with colleagues at the Regional Mental Health Group about good practice, and new roles and deploy these. Whilst the Human Resource Director did similarly through their networks and structures.

179. It is a factor that within the Trust portfolio and geographical footprint, there are extensive forensic and additional specialist services which increase demand for all professions. Within this, staff can seek better renumerated opportunities than are available within AMHS. Staff morale and working conditions were highlighted in the staff survey as an influential factor, which made the values and culture work central. Whilst the total mental health workforce was increasing, the increases in newly qualified staff and vacancies needing to be mitigated by the use of temporary staffing.

180. COVID-19 was both a clinical and operational crisis for mental health Trusts. It created severe strain on workforce capacity and positively accelerated service innovation (especially digital). It also resulted in significant service change at rapid pace and subsequent service disruption and inconsistency. The impact on secondary mental health service delivery was significant. During the early lockdowns (e.g., March/April 2020), services saw a fall in referrals and then followed a significant increase in urgent presentations.

181. This may have been associated with people being less likely to present at services. However, this impacted on the acuity of clinical presentation when seeking help later. Post-COVID, extra demand due to deferred access (people who would have been referred earlier), deterioration of symptoms among people with existing mental illness and the effects of the pandemic associated with loneliness and the financial impacts of the pandemic.

182. Government guidance on the management of infection risk was updated regularly with services being required to be dynamic to accommodate. To manage infection risk, face-to-face appointments were replaced by telephone or video, day-services paused, inpatient and community teams reorganised. While remote delivery allowed continuity, it

provoked concerns of access barriers (e.g., for people without digital access or for whom remote is less appropriate) and potential deterioration of care for those with more severe/complex needs. Working from home and Microsoft teams was introduced, bringing about further challenges of cohesive team working.

183. Managing outbreaks, contact tracing to manage infection, adhering to Government guidance and balancing the need to physically see patients, presented daily clinical challenges which impacted on leadership capacity. There would also no doubt have been an impact on service user experience and satisfaction during this time. Although initial referrals dropped, and latterly it was unclear whether the post pandemic surge would continue to be reflected at a population level. Alongside rising demand in 2022 constrained capacity: infection-control, social distancing, redeployment of staff, burnout, and workforce shortages affected service capacity.

184. The delivery of staff training and induction for example was modified to adherence to guidance. For example, reduced face-to-face learning and a different induction to new roles and responsibilities will have shaped a cultural shift in team functioning. Also, moving away from the office environment, impacted on the informal office-based informal support and supervision which is fundamental when managing and balancing the complexity of secondary mental health services.

185. We had to prioritise staff available for priority services, on reduced staff numbers, and we consistently reviewed prioritisation ensuring that for example where we were responsible for medicine management provision for community patients there were no disruptions to this, and their monitoring. Our experience was that there were no real opportunities for mass clinical redeployment, all measures were reviewed by a Clinical Reference Group chaired by the Medical Director reporting to the Incident Control Group and in line with NHSE Guidance for Mental Health Services.

186. In service delivery at the Regional Mental Health Oversight Group ("RMHOG") – where my equivalent colleagues met – there were opportunity to discuss the impacts of workforce loss and how they were managed, albeit that those were brief high-level discussions. The loss and consequential impact on service delivery was consistent with other Trusts. In specific instances, I contacted other Trusts directly to share information

about how services were being affected and what derogations and mitigations were being put in place, and found these were also comparable. We had national benchmarking at that point to compare our rate of resuming face-to-face contacts in comparison with other Trusts. Absence levels - and mitigating actions including redeployments and service changes and derogations were reported into Board discussions and Board members had sight of derogations. When national guidance became available in relation to mental health care delivery, we were in line with this.

187. To illustrate how this was managed in services, the AMHS Directorate used a multi-professional Daily Demand Management ("DDM") meeting to co-ordinate and manage patient flow and available beds. They took into account a number of factors including, staffing levels, in-patient hot-spots, Covid management of staff absence, patients with Covid, cohorting of patients who had Covid, were symptomatic or were isolating, and staff and patient testing. The DDM was the fulcrum for the overall bed management processes, co-ordinating assessment and admissions from all areas of the Directorate via a Crisis Team. The Crisis Team undertook gate keeping assessment and allocating patients to beds across the City and County of Nottinghamshire, including the use of sub-contracted beds. The DDM met daily at 9.15am and reported into the ICT System by 10am. They stated an OPEL assessment of the overall stress, the demand and pressure that the health care settings were under. These assessments fed onward into the wider Division, Trust and ICS escalation.

188. What had not been anticipated on the back of Covid and the contingencies and redeployment of staff, and in tandem with the staffing pressures in AMHS was the build-up of investigations, although this was flagged throughout Covid. The leadership capacity of the professional leads and managers who undertook the oversight of improvement plans from SIs was impacted. These key leadership postholders diverted into part clinical roles and/or managing mitigations as part of contingency plans, this had a consequential impact in investigation capacity and the implementation of lessons learnt from incidents into 2022. Particularly after Covid into 2022 there was collective concern about the health and wellbeing of staff hence the specific considerations of retention and the close work with ward teams in the Highbury Plan.

189. Mental Health contracting overall was led by the Directors of Finance with input from services including myself. A comprehensive reply on contract terms and their changes should be sought from the Trust. And there was a period when specific monitoring was ceased due to COVID. Changes to operational work and governance arrangements during Covid were reported and reviewed as decisions and derogations.

190. The [WITN0329026] included measures for EIP engagement against a 2-week wait, and the December 2020 performance was 88% against a target of 60%, and the Local Mental Health Team 18-week target for treatment was 96.3%. For December 2021, performance reported in the February 2022 Board IPR, the performance against the EIP engagement target was 93% (against the 60% target) and 93.4% patients starting treatment with 18 weeks.

191. To recover the wait position after Covid we sought to improve access to medical follow up after assessment, use of a waiting times dashboard, telephone clinical triage of all patients within 24 hours of referral, and seeking to increase capacity within the LMHTs includes new roles such as psychology assistants, recruiting to vacancies, targeted agency recruitment and working with MIND to provide where clinically appropriate the use of Stabilisation and Resilience Groups, as well as LMHT based groupwork and increased psychological therapy capacity. These actions were monitored in a waiting time recovery plan described to ELT in the papers [WITN0329027].

192. There had been concerns related to the existing service model in the community and the capacity of inpatient services. This included concerns about the use of out of area beds and the Trust had been an outlier in national performance. Lengthy waits for LMHTs were evident [WITN0329029].

193. In May 2019, it was agreed that Crisis Transformation would be an immediate strategic priority for the Trust and implementation of a stand-alone EIP service. To support these changes, we implemented a single point of access, and the nationally recommended crisis helpline. These changes featuring in the Trust Integrated Business Plan and ICS mental health plans.

194. Specific actions taken in relation to community service capacity included working with third sector organisations to provide mental health coaching, and personalised support

where appropriate. This also included review of referrals management processes, implementing a waiting well policy and we also began to introduce groupwork and digital wellbeing packages. Substance misuse worker capacity was introduced, patients with ADHD were provided with an alternative care pathway. The actions taken are included in the previously referenced Transformation Reports to the Board and Strategy Committee, and further information in the waiting times reports. [WITN0329008].

195. After 2019, subcontract capacity changes were discussed at the ELT, at ICT (Incident Control Team during Covid) and onward at the Finance and Planning committee and reported in the Integrated Performance Report at the Board. In relation to reducing out of area and subcontract bed use, it was envisaged that a standard compliant crisis service would positively impact bed usage. The wards used daily board rounds, a structured daily meeting where teams would review the progress of patient's treatment and prepare any discharge arrangements that were required. The Trust used both crisis house and step-down capacity (for people awaiting accommodation).

196. We also provided housing worker capacity to help progress people's accommodation needs. We had developed after a GIRFT follow up review the work for a group of patients whose onward care did not require acute inpatient care but long-term alternative provision. For these patients we used the MADE (Multiagency Discharge Events) process. Extra capacity was introduced with the opening of Sherwood Oaks (9 beds) and a jointly commissioned external review was undertaken related to acute inpatient bed use, referred to as the Niche report [NHNB0007331] and consideration of the onward strategy [WITN0329030].

197. Under normal circumstances, the subcontract capacity was sufficient to manage flow without undue pressure.

198. The risks of out of area and private bed use generally relate to the experience, consistency, quality and continuity of care. Even though the subcontract services were local to us, the quality of these varied and there were points of patient transition that had failed and had been highlighted by investigations. In seeking to address these risks we reviewed our continuity of care principles in March 2022. These outlined for providers the processes of pre-admission, admission, the role of the Trust's bed management

team, admission, discharge planning and discharge arrangements, patient transfer, the role of the care coordinator, reporting of incidents, information sharing and monitoring arrangements.

199. In terms of change over time there was escalating concern related to compliance with standards and subsequent regulatory action on two subcontract sites: the CCG and NHSE sighted on these also. We sought to mitigate risks with enhanced quality oversight, enhancing our bed management roles to support the continuity of care principles, and diverting activity where we could to other subcontract sites. We did seek mutual aid from other Trusts but were not successful, and we used spot purchase beds further afield when these were necessary and available. We reviewed actions in discussion with the CCG, reflected these challenges at the Regional Mental Health Oversight Group ("RMHOG") and in individual meetings with the NHSE regional lead to seek any alternative provision.

200. Staffing levels and service capacity did affect the use of sub-contracted beds, which is not to say other processes were not in place to manage patient flow. And there were other factors that influenced bed use the following are specific examples;

- During Covid there was a 20-bed loss in the Trust due to restrictions related to infection prevention and control. This related to patient cohorting and isolation requirements.

- Wards with outbreaks were for periods not able to take new admissions.

- In review of the staffing pressures at Highbury Hospital we sought to reduce inpatient occupancy to 85%, this was supported by staffing acuity tools and overall risk assessment in related quality and patient safety.

- We had a CQC Notice of Decision to stop admissions to one acute ward in February 2020 and reduced occupancy over several weeks before gradual increase.

- Particularly in relation to the PICU there were high levels of patients with challenging clinical presentations when workforce loss was at its greatest, and onward into 2022.

I recall sustained periods of 4 to 1 staff to patient care for concurrent patients. The ward environment and staffing could not sustain the normal bed capacity, and the beds were capped at 8. I visited the PICU on a number of occasions, to review mitigations and the quality and safety of the service.

- The opening of Sherwood Oaks in 2022 allowed for an immediate increase in capacity and a further additional 16 bed ward which was at the point of my leaving the Trust used as a decant to progress the further eradication of dormitories.

201. Over the period of 2019-2022, the Trust had significant ward environment challenges in the North of the County until the acute inpatient beds were re-provided at Sherwood Oaks. The previous accommodation had to have extensive ligature removal works to dormitories and on occasions particularly at Bassetlaw where the Trust were tenants in acute Trust accommodation where basic facilities on occasion failed, and assessment in these instances was such that patient numbers had to be temporarily limited. Maintaining services in this quality of environment as the largest acute wards in the Trust was not acceptable. Hence, the Board took an appraisal of the case for change to move out of these services on the 1st December 2020, and delays in the reprovision at Sherwood Oaks impacted services in 2022.

202. I had concerns about sub-contracted bed use and these concerns were shared by the Board which saw the use of out of area beds regularly brought to the Boards attention in the Integrated Performance report, and in reviews of subcontract activity at the Finance and Planning Committee. The necessity to subcontract as principle is not what you would wish for, but in the situation of demand beyond the Trusts own capacity, extra provision was a necessity. There were specific discussions about the onward provision to this effect eg the paper at the 28th January 2021 Finance and Performance Committee & AMH service line review [WITN0329035] and in the joint commissioning of an external review of bed capacity in Nottinghamshire detailed at the Strategy Committee on the 21/11/22 [NHNB0007330].

203. Within the overall subcontract provision in two units (Priory Nottingham and Mill Lodge at Kegworth) used Nottinghamshire patients were rated Good by the CQC, and our experiences working with these services reflected that. The primary concern had been

sustaining continuity of care principles and quality concerns in relation to the use of beds at Priory Arnold and East Midlands. Discussions about these are reflected in the minutes of the Private Board meeting on 1/2/22 [NHFT0003395 in the discussion related to the Highbury Improvement and Business Continuity plan, where a Non-Executive Director raised concern about the subcontracted services. The Board were aware CQC sanctions applied to the Priory services, actions taken by the Trust in response, and this became a focused consideration at the Commissioning Committee.

204. In terms of actions taken in relation to this the Trust had a manager whose role was to manage the operational interface with the subcontract providers and then a dedicated senior matron to directly oversee the quality of the services with direct oversight from the Trust central quality team. There were meetings to review the service delivery, including to Director level between the Trust and the Priory Group. The oversight of the contracts and their quality implications discussed particularly at the Commissioning Committee in 2022 [WITN0329037; WITN0329007; WITN0329006]. The update from these discussions provided to the Board in the Highlight reports from the Commissioning Committee in the Public Board papers on the 5/4/22 and 4/10/22 [WITN0329032; WITN0329031]

205. In relation to further action - as observed by Dr Ian Davidson's revisit of our GIRFT review – we sought to address the onward pathway for patients on acute wards with longer complex needs, i.e. discussion at the quality committee in December 2021. This group of patients did not meet the criteria of a delayed transfer of care, but their needs could be met if there were available alternative provision. We progressed this work in 2021 onwards with ICS escalation [WITN0329033] and we had taken discussion of this specifically to the contract Executive Meeting at the CCG. This specific issue was discussed at the Board in relation to the IPR as there had been a series of reviews and workshops in the ICS. If the longer-term needs of this cohort of patients could be met sooner, and their timely access to the right provision addressed, then acute inpatient bed capacity would be regained.

206. I cannot comment on matters beyond December 2022.

207. Discharge processes from inpatient wards were reflected in the themes arising out of serious incidents in 2021-22 in the Annual Patient Safety Report [pages 82-99 of NHFT0003346]. Extra support had been put on to the wards to oversee the quality of care, risk assessments and discharge planning. The 2022 inspection of the acute inpatient services by the CQC [CQCM0019736] made observations about the improved quality of these, and the inspection report particularly makes specific reference to observations about discharge and bed management.

208. There were periods when access to beds including any spot purchase bed capacity across the country was limited. Whilst all conversations about beds or any other capacity were framed in the terms of patient need, it needs to be considered how pressure on beds, lack of longer-term care options may affect the therapeutic choices that clinicians make. We sought to make the issue of discharge more visible in service-line reporting, including in the Board IPR levels of patients accessing services who were previously known to services, in addition to traditional reporting of readmission rates. This was to help further consider this and beyond the readmission rate key performance indicator.

209. We were mindful of these considerations in the planning of bed use, reviewing for example by way of overall context we repeatedly benchmarked our inpatient activity, looking at the Trusts NHS Benchmarking Club reports [WITN0329034] (although this data did exclude subcontract activity). We considered how our bed management practices compared to others, and assessments of our length of stay. These were important considerations in the external review of bed use, and in particular the onward strategy for inpatient bed provision in Nottinghamshire.

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

211. Actions taken to improve this in AMHS included the recruitment of Carer Peer Support Workers on inpatient wards, and then onwards into AMH community services. The role of carer peer support workers was developed specifically to support people who support a friend or loved one who is experiencing mental distress. Carer peer support workers

use their experiences of caring to offer empathy, hope and understanding to others. In this the carer peer support workers offer peer support alongside practical assistance, and joint work with other team members. This being implicit to ensuring that plans meet individual patient and carers needs, and especially at key points of transition such as discharge. Their role is very powerful in supporting cultural change and broader connections between the individual teams and their local carers' support networks.

212. There was a coproduced guide to better support staff about carers and confidentiality. The principles about how to work with patients who do not wish the details of their care to be disclosed had been included in training, supervision and carer support developments. The emphasis to absolutely use the information provided by carers within risk assessment and management, to be able to support carers compassionately when patients do not wish their information to be shared, and for multidisciplinary discussion when sharing information has a potential to impact safety so that there is full consideration about disclosure. Staff guidance was that if colleagues felt there was a safeguarding risk to the patient or others by sharing or not sharing information, they have a duty of care to follow the Trust Safeguarding policy and escalate individual cases.

213. In addition to this and specifically in AMHS a Family Intervention Team ("FIT") was put in place to support all community and inpatient teams in improving their working together with carers, under the principles of Behavioural Family Therapy ("BFT"). The intention to improve information sharing information with the families about the service user's mental health issues, experience and treatment. Educating staff from the direct perspective of carers and emphasising the significance of carers, patients and staff working together in recognising early signs of relapse and planning care where possible together. The training by the FIT promoted positive communication, to underpin problem solving skills and stress management for families. Their work carried a positive profile towards the end of 2022, with a particular focus on EIP services.

214. The Board were sighted on these developments through reports to the QMHL Committee, Involvement, Experience, Volunteering and Carers Directional Plan Reports, detailing the assessments for the services self-assessments against the Triangle of Care in 2022. In April 2022 the QMHL Committee recommended that improving practice in

relation to writing care plans in partnership with patients/service users and/or their families where appropriate became 1 of the 3 Trust Quality priorities for 2022/23 [TCLT0000509], with related outcome measures.

Multi-agency working

215. Information is shared in different ways in different settings: some services have direct shared access to information (i.e. shared access to clinical systems), others rely on sharing data and clinical information by communication directly (i.e. letters, verbal communications, reports etc.). I believe the Trust had in place multiple information sharing agreements and protocols. These were developed between the Trust and other agencies, by the Information Governance Team. The agreements included specific purposes for information sharing including the purpose of sharing information, what information is shared, legal basis for sharing of information, the parties involved, when information is shared, data quality, retention of data, security, access, compliance with the agreement, indemnity, monitoring, review and amendment, termination of the agreement. The agreements bear the signatures of those with authority to sign on behalf of their organisation.

216. Information could be shared for the purposes of direct care, risk assessment and management, safeguarding, to maintain safety when there is a need to share information on a proportionate basis with other agencies. Trust staff are supported in multi-agency working and information sharing by policies, procedures, protocols, information and guidance and additionally, they are able to contact members of the Data Security and Data Protection (formerly Information Governance) team, the Trust Caldicott Guardian and Deputy Caldicott Guardian, the Senior Information Risk Owner ("SIRO"), Data Protection Officer, Deputy Data Protection Officer, and senior colleagues who will assist, guide and advise on information sharing.

217. Information shared could include relevant and proportionate information taken from the patient clinical record and content shared is dependent on the organisation making the request, the reason for sharing the information, and the assessment of risk at the time. It is expected that information relevant to direct care provision is shared in a timely manner between organisations.

218. During the care of the patient, requests for information sharing from other agencies and providers may be received. These requests are considered and responded to, again sharing information that is appropriate and proportionate. Requests can be received and responded to directly by the clinical team involved in the patient's care or via the Access to Information Team (within the Data Protection Service).

219. Clinical records between mental health and primary care were not shared and it is acknowledged this did not fully support having a contemporaneous knowledge the patient's care. It is expected that on discharge, information is shared with the General Practitioner, other health and social care providers who will provide onward care. This information can take the form of a discharge letter, reports, copy of records, and documents related to multi-agency meetings.

220. There was in place a Police & Criminal Justice Liaison Policy and attached Trust Document. This includes decisions to contact the police, and responsibilities for sharing investigation, incidents and liaison. The Trust had a Street Triage Team ("STT") working with Nottinghamshire Police and when notified about a police incident involving an individual with a potential mental health problem, they had access to the patients' clinical records and were able to provide advice when not present at an incident or when accompanied by a Police Officer in a response situation.

221. I believed that the working relationship between the Trust and the police had generally been good at an operational level and had direct positive feedback from street triage which supported this. We sought to enhance working with the Police and had a dedicated officer work at Highbury Hospital in Bulwell from August 2022 and we had a specified senior manager who worked closely with the Police for liaison, considering the management of violence and aggression, managing absconsions and our working together for the provision for heath based places of safety under the provisions of the Mental Health Act.

222. In response to incidents, the Police were supportive and for example when moved our 136 suite at Sherwood Oaks in Mansfield these developments were collaborative. I had not been alerted to deficiencies in communication between the Trust and the Police in

relation to Police National Computer ("PNC") checks. My reflection, however, and more specifically with reference to the Police concerns raised about access to beds in April 2022, is that having being in liaison for other matters, I could also have liaised with the officers directly and in person to enhance multi-agency working. I was not aware of the police's refusal to share information about VC or any other patients, or lack of intervention should the Trust report patients missing. I would have absolutely been able to raise this with the Police Mental Health Lead.

223. Having the correct information sharing agreements in place, I had not received escalation to suggest that arrangements were not correct or not suitable for the appropriate exchanging of clinical information to support good joint working. Having undertaken the role of Caldicott Guardian previously, I would have expected that the designated individual to have been alerted to any risks and issues concerning information sharing between the Trust and various agencies. I was not aware of concerns, and if I had been I would have sought to address and escalate if required.

224. There were good examples of joint working with social care working together to secure timely access to Mental Health Act Assessments in mental health liaison services and improvements on the Transforming Care agenda. Relationships were positive operationally, but generally without the benefit of co-location (as in some health communities) and shared provision under Section 75. I do not recall concerns about information sharing, or this being raised at a service level.

225. We had worked particularly together through Covid with social care and primary care in the sharing of information and reviews of vulnerable patients, with ease of relationships and information flow.

226. In relation to primary care, we had been able to appoint primary care mental health workers to work with GPs (1 per Primary Care Network) across Nottinghamshire. The roll out of the single point of access was a development worked on jointly with Primary Care.

227. The Trust would 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. Staff would record these choices in the patient's record. If a patient's objection to sharing information could prevent safe care, a clinician would discuss the potential consequences with them, but the patient's wishes are generally respected unless there is a legal requirement or risk of harm.

228. The Trust has policies and guidance on information sharing between professionals, patients and carers and Mental Capacity Act which assist in supporting staff when sharing information related to a patient's care with their family.

229. It is important for staff to remember the Caldicott Principle that, "*the duty to share information can be as important as the duty to protect patient confidentiality*". Information sharing needs to be proportionate and with the patient having provided consent as to the level of information to be shared. Staff were asked to revisit this topic on a regular basis with the patient, and carer, and update the electronic patient record accordingly.

230. 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.

231. The Board were aware particularly through carer feedback that 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. In relation to this, Carer involvement was a Trust Quality priority in 2021/22 and the Board saw examples of actions taken to improve practice, particularly recruitment of Carer Peer Support Workers and there had been coproduction of a new guide to better support staff about carers and confidentiality.

232. There were instances of positive practice highlighted in respect of the shared knowledge of VC in the EIP team, and instances of positive communications with VCs family and

good liaison between the EIP and CRHT. There were also instances where poor decision-making and omissions which contributed to a series of events which meant that he did not receive the care and treatment that he needed, and the care offered was not in accordance with best practice.

233. Whilst the complexities faced by mental health professionals in the delivery of treatment for people with serious mental health issues are significant and there needs to be continuous improvements in the adequacy of services, their specification and oversight. There were opportunities in VCs care pathway for alternative treatment decisions and risk prevention.

234. Understanding the full range of events related to VCs actions and the response of all agencies will serve to improve multiagency risk management and improve clinical outcomes and public safety.

235. I have been away from the Trust for 3 years, and considerations have already been made by specific and broader investigations insofar as:

- There was opportunity for VC to be detained under Section 3 of the Mental Health Act 1983 commensurate with the knowledge of the risks posed, particularly at the point of his last inpatient admission.

- VCs recuring lack of concordance with medication and other therapies warranted the prescription of a depot injection and possibly a Community Treatment Order thereafter and more should be understood about those treatment decisions.

- When VC was lost from contact with the service he should have been reported as missing and not been discharged to the care of his GP.

- VC's risk assessment and management plan should have consistently accounted for his longitudinal presentation, poor adherence to treatment, lack of insight and the information provided by his family.

236. More consideration needs to be given to triangulating the offences committed by VC with the care he received from the Trust. I do not fully understand the extent of VC's association with the police at the time that he was receiving care from the Trust or onward.

237. It is suggested that on the 18th of January 2022 that Trust staff contacted the Police regarding an alleged incident involving VC at the University the day prior, and that information could not be shared and that a message would be passed on to a senior officer. I am not sufficiently aware of information that was not shared beyond this.

238. There were many instances of effective joint working between the Trust and the Police in Nottinghamshire. I hope this Inquiry will allow for a better understanding of decisions made by all parties and the barriers to information sharing and providing effective care and treatment, in this instance and more broadly.

239. The sharing of clinical information between mental and primary care is not sufficient to give either party a full and contemporaneous knowledge of each other's involvement and is reliant on the human 'push and pull' of information. This would be greatly improved by the integration of systems and support improved risk management and continuity of care.

240. I deeply regret that the safeguards in place did not make known the absence of the information sharing between the police and the Trust, or the inadequacies in the care of VC. If I had known, I would have certainly intervened.

241. Going forward, there should be multiagency reviews similar to the methods of a Domestic Homicide Review for mental health serious incidents, involving multiple agencies to bring about improved multiagency working including the sharing of information.

242. Recommendations have already been made in the Theemis Report and by the CQC and are applicable to all providers. NHSE has directed NHS Trusts to take actions to improve services detailed in guidance to ICBs on intensive and assertive community mental health care. Actions have as far as I understand been taken at the Trust in response to this incident and broader learning and improvement.

243. There may be consideration of a formal joint process between the Police and Mental Health Services to share knowledge of mental health patients (defined by category of incidents and clinical risk profile), by way of a dataset, subsequent procedures, and the joint risk management plans for these patients. This process would include Domestic Homicide, forensic mental health, and safeguarding expertise and be overseen and accountable.

244. Nationally the following may be considerations:

- A mental health patient safety programme for intensive and assertive community mental health care. To support recommendations made by NHS England, and actions already taken in Trusts to improve safety and outcomes, and capture and share learning.

- A national audit of intensive and assertive community mental health care.

- Whether a Never Event (patient safety) Approach can be applied to the pathway for intensive and assertive community mental health care.

- Multiagency data sharing standards.

- Trusts should have in place standalone adequately resourced Assertive Outreach Teams, whereby this is their dedicated function.

245. Improvements previously suggested could form the basis of recommendations. In addition, there may be learning from this Inquiry to consider in the implementation of pending revised Mental Health Policy.

246. The Inquiry may also seek to make broader recommendations about the mental health workforce, multiagency working and access mental health services.

247. The devastation arising from these events is irreversible and safeguards must be put in place to ensure these tragic events do not reoccur. The learning and subsequent changes made across the Trust have been, and will continue, to be undertaken to

prevent such a tragedy happening again. The recommendations from the Inquiry will support the Trust, and organisations more broadly in providing better care and treatment for people with serious mental health issues and protect the public.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: GRO-B

Dated: ____16 January 2026______________

Index to First Witness Statement of Julie Attfield

No.	URN	Document Description
1.	CQCM0016478	Report dated 25/11/2022, compiled by CQC, Re: Nottingham Healthcare NHS Foundation Trust
2.	WITN0329002	20th January 2022 Paper, Highbury & Adult Mental Health Staffing
3.	NHFT0005148	Report Re: Serious Mental Illness, Pathway Transformation Plans Update, to be presented in NHFT Strategy Committee meeting on 05/11/2020
4.	WITN0329036	Strategy Committee Mental Health Long Term Plan Transformation Plan Update 10 May 2021
5.	WITN0329004	Strategy Committee Mental Health Long Term Plan Transformation Plan Update 17 May 2022
6.	WITN0329003	Commissioning Committee Contract Assurance Update 2 September 2022
7.	NHNB0007330	Acute inpatient bed scenario modelling report [For Strategy Committee, meeting to be held on 21/11/2022]
8.	NHFT0005035	Report Re: Mental Health Community Services Transformation, to be presented at Board of Directors - Public Meeting on 04/08/2020
9.	NHFT0005024	28/11/19 Paper Out of Area Placements
10.	WITN0329037	Contract assurance update 30/9/22
11.	WITN0329007	Subcontract update 4/7/22
12.	WITN0329038	02/9/22 LTP & MH Transformation
13.	WITN0329006	25/3/22 Contracts with reputational or quality concerns
14.	WITN0329030	21/11/22 Acute Adult Inpatient Strategy (strategy committee)
15.	NHFT0007612	Integrated Performance Report (IPR) ELT Paper 26th May 2021
16.	WITN0329008	Board Paper Local Mental Health Services Waiting Time Position and Plan – 1/3/22
17.	WITN0329009	Finance Committee Out of Area bed use reviews on 1/8/22
18.	WITN0329010	Finance Committee Out of Area bed use reviews on 28/1/21
19.	NHFT0015897	Finance Committee 15/2/21 Adult Mental Health Nursing Establishment Review
20.	NHFT0003028	Being Open and Duty of Candour
21.	WITN0329011	Staff Survey Response Update
22.	WITN0329012	15/5/22 PCE&I Committee
23.	TCLT0000398	Board Annual Freedom to Speak Up Report 2021 1/6/21
24.	CQCM0019736	2022 CQC inspection of acute inpatient services
25.	NHFT0003849	Operational Update Response to Omicrom and Winter Pressures (Board 1/3/22)

26.	WITN0329014	Core Fidelity Scale Version 2 Core Crisis Team Resolution Team Fidelity Scale – Version 2
27.	RCPS0000008	National Clinical Audit of Psychosis 2019/20 Royal
28.	RCPS0000028	National Clinical Audit of Psychosis – Early Intervention in Psychosis Audit 2021/22
29.	NHNB0007331	Niche report
30.	NHFT0004289	Quality Committee 2021.12.21 report GIRFT Mental Health Reviews
31.	NHFT0002015	Report dated 24/05/2019, compiled by CQC Re: Nottinghamshire Healthcare Foundation Trust Inspection Report, Inspection 22/01/2019 to 07/03/2019
32.	NHFT0001778	Report dated 23/09/2020, compiled by CQC, Re: Acute wards for adults of working age and psychiatric intensive care units
33.	CQCM0001817	Letter from Jenny Wikes [CQC] to Anne-Maria Newham [NHFT], re: Section 29A Warning Notice
34.	WITN0329015	reinspection of the service in March 2022, published in November 2022
35.	NHFT0000592	Board Pack for NHFT Board Meeting (Private) on 30/03/2023, dated 05/04/2023
36.	WITN0329016	Email Patient GRO-B admission
37.	WITN0329017	Police complaint from PS Anthony Horsnall regarding incidents on 29 and 30 March 2022.
38.	WITN0329041	Letter dated 27/4/22
39.	WITN0329018	Email with police complaint regarding GRO-D Bassetlaw Hospital - police incident GRO-D
40.	WITN0329019	Letter from Anthony Horsnall dated 18 October 2022, regarding Highbury Hospital patient.
41.	WITN0329020	Quality Standards for Acute Inpatient Services for Working Age Adults published by the Royal College of Psychiatry
42.	NHFT0003346	QMHL Committee 13/12/22 Patient Safety – Annual Report 2021-2022
43.	NHFT0015020	QMHL Committee on the 16/8/22 appraised the Suicide Prevention Annual Report
44.	WITN0329021	Trust's Risk Management Strategy
45.	NHFT0004539	August 2021 Reportable Issues Log
46.	NHFT0015873	6th September 2022 reportable issues log
47.	NHFT0003806	Private meeting of the Board 7/9/21
48.	NHFT0000822	Private Board of Directors – 4/10/22
49.	WITN0329022	SIRG on 13.07.21, the Serious Incident investigation report
50.	WITN0329023	Case Note Review/Level 1 Concise Investigation: Incident Analysis
51.	WITN0356080	2021-10951 MF 392336 Comprehensive Investigation FINAL VERSION SIGNED OFF BY L. BELSHAW

52.	WITN0329042	SIRG notes 25.05.25
53.	WITN0329024	Serious Incident Review Group on the 16/8/22
54.	WITN0329040	NCAP EIP 2020-2021
55.	WITN0329044	NCAP EIP-2019-2020-audit-report---typeset-09-09-20
56.	WITN0329025	Highbury Improvement & Business Continuity Plan to the Private session of the Board on the 7th of December 2021
57.	NHFT0002204	Briefing pack for private Board of Directors meeting to be held on 07.12.21, NHFT, circulated on 07.12.21
58.	WITN0329026	2/2/21 Board Integrated Performance Report
59.	WITN0329027	LMHT Waits (7th July 2021)
60.	WITN0329029	Baseline Waiting Times Report, Finance & Planning Committee 3/10/19
61.	WITN0329035	28th January 2021 Finance and Performance Committee & AMH service line review
62.	NHFT0003395	Private Board meeting on 1/2/22
63.	WITN0329032	5/4/22 Public Board Paper titled Highlight Report
64.	WITN0329031	Public Board Meeting Highlight Report - Commissioning Committee; 30 September 2022
65.	WITN0329033	Stranded Patient Update - 22nd December 2021, ELT Paper
66.	WITN0329034	Trusts NHS Benchmarking Club reports for 2020/21
67.	TCLT0000509	Quality-Report-2022-2023