Witness Name: Dr John Brewin

Statement No: WITN0380001

Dated: 15 January 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR JOHN BREWIN

I, Dr John Brewin, will say as follows: -

Introduction

1. I am the now retired Chief Executive Officer ("**CEO**") of Nottinghamshire Healthcare NHS Foundation Trust ("**NHFT**").

2. I make this statement to assist the Nottingham Inquiry ("**the Inquiry**"), in response to a request made under Rule 9 of the Inquiry Rules 2006, dated 2 December 2025 ("**the Request**"). In this statement, I discuss my recollections and experience of being CEO of NHFT between 2019 - 2022, covering:

    a. My career and role,

    b. Governance & CQC Reports,

    c. Monitoring of Mental Health Services

    d. Escalation of Issues

    e. Assessment of Risk,

    f. Serious Incidents and Learning from Deaths,

    g. Staffing Levels and Outsourcing,

h. Multi-Agency Working, and

i. Reflections.

3. This witness statement was drafted with assistance from the external solicitors acting for NHFT in respect of the Inquiry, under my direct supervision and with my substantive input, following discussions conducted by email and video conference. I also had assistance from former colleagues at NHFT, by email, video conference, and in-person meetings, for instance in locating a document or retrieving information. At all times this was with my direct oversight.

4. I retired on 31 August 2022. Given the passage of time since the period to which the Request relates (2019 – 2022), I have requested various documents from NHFT to aid my recollections, which have been provided and which I exhibit throughout this statement where relevant.

5. The policies, Terms of Reference, and other documents referred to in this statement relate to the position as I understood it during my tenure at NHFT. I was not involved in any changes made since August 2022.

Career and Role

6. I attended Nottingham University Medical School from 1981 to 1986 and obtained degrees in Bachelor of Medical Sciences (BMedSci), Bachelor of Medicine and Bachelor of Surgery (BMBS). Following this, I undertook two years of house jobs (a period of post-medical study that medical doctors must complete, also known as residency, hospital work, postgraduate training, or clinical attachments) before commencing a junior psychiatry rotation based in Leicestershire between 1988 and 1991. I obtained membership of the Royal College of Psychiatrists during this time (MRCPsych) and this enabled me to progress to senior training. I then undertook my senior psychiatry training in a joint post between Nottingham Mental Health Services and the University of Nottingham, where I was Honorary Senior Registrar and Lecturer between 1991 and

1994. During this time, I undertook training placements in general adult psychiatry, psychiatry of old age, child and adolescence, forensic, rehabilitation, perinatal and academic psychiatry. During this period, I was approved under Section 12 of the Mental Health Act 1983 as a Responsible Clinician. I retained this approval until 2018 when I finished clinical practice.

7. During the early 1990s I worked closely with the academic department of psychiatry whilst continuing clinical practice and undertook departmental research and published a number of papers on the epidemiology of psychosis and schizophrenia as part of a Research team. Nottingham was also a World Health Organisation training centre for Schedules for Clinical Assessment of Neuropsychiatry (SCAN). I have exhibited to this statement an article explaining SCAN [WITN0380002]. In brief, it is a recognized semi structured interviewing process for clinicians and is closely aligned to the International Classification of International Diseases for Mental Disorders (also known as ICD 10).

8. I obtained a consultant post for the then Nottingham Mental Health Trust in 1995 and worked for the trust in a number of roles until 2011. I was principally a general adult psychiatrist working with a sector community mental health team and with inpatient services based at the Queen's Medical Centre in Nottingham. From 2002 to 2008 I was Clinical Director for general adult psychiatry, psychotherapy and eating disorders and from 2008 to 2011 I was Associate Medical Director before leaving for a new role as Medical Director in Lincolnshire Partnership Foundation Trust (LPFT).

9. I was Medical Director at LPFT from 2011 to 2014. During this period, I continued approximately half-time with clinical psychiatry practice working with the Assertive Outreach Psychiatry teams. From 2013 (initially as interim CEO) I was the CEO in LPFT until 2018.

10. I returned to the Nottingham Mental Health Trust, which had been established as a Foundation Trust since I left in 2011, and had become NHFT. I was appointed to NHFT as CEO and commenced in January 2019, until my retirement at the end of August 2022.

11. I am fully retired and have not held any other roles since I left NHFT.

Move from Clinical to Management Roles

12. As my consultant career progressed, I developed an increasing interest in management and leadership. I was committed to ensuring the provision of the highest quality services for people with mental illnesses and helping services to develop and meet these varied needs. Having trained in former asylum hospitals and subsequently worked in modern district general hospitals with expanding community care, I was familiar with the benefits of both models. During the 1990s, and subsequently, the NHS was transforming to a more business-minded model of operation and there were opportunities for doctors to engage in management training and leadership programmes. I found this rewarding and, aligned with my ability to continue in clinical practice, I was able to contribute to discussions and plans around service development and improvement. For example, I advocated to the health authority for funding of new pharmaceutical treatments and contributed to the design plans for Highbury Hospital.

13. Since the commencement of my management and leadership roles around 2002, I undertook a number of local, national and international education and training courses. Most notably, I was able to attend a two-week INSEAD programme (Institut Européen d'Administration des Affaires business school) in France, sponsored by the NHS. I also undertook a study program tour with a number of CEOs to health facilities in Washington DC and Boston in the United States. More latterly as part of the development of the new Sustainability and Transformation Partnerships ("**STP**"), I participated in another NHS sponsored two-week study and education programme split between the UK and Yale University in Connecticut in 2018/19. This was hosted by the Yale Global Health

Leadership Initiative in partnership with the NHS Leadership Academy. 11 teams of three multi-agency senior leaders were selected from across the UK to participate. These programmes gave insights into how different countries funded and ran their health systems. They were focused on how to develop clinical leadership roles with a particular emphasis on culture, teamwork, and outcomes.

14. I had been fortunate enough to be able to work as a consultant psychiatrist up until the end of 2018, albeit with a significantly reduced caseload, and so I was able to keep up my annual medical appraisal and licence to practice. However, the scope and demands of the CEO role at NHFT were considerably greater than those at LPFT and I concluded that it would not be possible to fulfil both roles to the requisite standard. Therefore, I stopped clinical practice at the end of 2018. I found that working in clinical services throughout a significant period of my management and leadership career proved extremely beneficial in terms of having a close view of the challenges and tasks of working at the front line of health services and continued to inform my work as a member of the Board, the executive team and being a CEO. Many of the psychological approaches used in clinical work helped inform my leadership approach. For example: the importance of active listening; understanding non-verbal approaches to communication; recognising the power of the sub-conscious; and how teams and groups can function more collaboratively.

15. One of the fundamental impacts this had for me was the importance of continuing to put the patient and their families at the forefront of conversations about finances, efficiencies, and governance, as it is, in my view, relatively easy to become too distanced from this when working in corporate teams.

16. The other significant issue for me personally was the importance of the culture of an organisation, and this was one of the significant learnings I took from the time I spent as CEO at LPFT. Very broadly speaking, for me, culture means 'the way we do things around here' although it can sometimes be seen as the softer side of leadership and

management. I think it is a fundamental aspect of how to enable people to be their best when they come to work and provide the highest quality professional services they can, whether this be in clinical or corporate services.

17. At that time, around 2017-2019, there was an emerging cohort of medical doctors who had become CEOs in both acute, community and mental health service trusts. As a collective of approximately 12-13 people (out of the approximately 250 trusts at that time in England), we met on several occasions to discuss our experiences and, from a medical perspective, how we could encourage and support doctors considering entering management and leadership roles. This work was supported by Chris Hobson who was the CEO at NHS Providers. Four or five of us were psychiatrists by background, and I have reflected on whether there is something about the field of psychiatry which led us into these management positions or perhaps being good listeners and our clinical skills meant that we were well-suited to these roles. Whilst informative, I do not recall this group lasting in the longer term, however there was an overwhelming view of the importance of increasing clinical experience into senior leadership roles in the NHS. This was thought to be lagging behind when compared with other health systems in the USA and Europe, for example.

Move from LPFT to NHFT

18. Prior to commencing my role as CEO at NHFT, I was aware of the context and challenges facing the organisation, having maintained contact with former colleagues whilst working at LPFT. There were a number of measures of trust performance that I used as a gauge of organisational health, including the NHS National Staff Survey and the CQC Reports. LPFT had experienced a relatively successful period of significantly improved performance in NHS National Staff Survey over a number of years, both in terms of improvements from the previous year's performance, but also improvements compared with peer trusts. LPFT had also significantly improved its CQC ratings over a period of several years, from initially being rated as 'requires improvements' with some

'inadequate' scores in some domains, to being 'outstanding' in a number of areas and having a strong 'Good' overall rating by the time of my departure. I have exhibited to this statement the CQC's reports for LPFT in 2015 and 2018 [WITN0380003] and [WITN0380004].

19. By contrast with the success and improvements I had been part of at LPFT, the external perception was that NHFT's performance had deteriorated, from being one of the top mental health trusts nationally in the early part of the 2010s, to declining performance being apparent externally towards the end of that decade, with declining NHS National Staff Survey scores both year-on-year and relative to peer trusts. I relish a challenge, having overseen improvements at LPFT. Having been a medical student in Nottingham, and spent a significant period of my career there, I felt both an emotional connection to NHFT, and that I was well-positioned to help to address the issues NHFT was facing.

Role of CEO

20. The CEO role at NHFT was in essence similar to CEO roles for other hospital trusts at the time, as set out in the job description and person specification [WITN0380005]. The role was to be responsible to the Board for the development and implementation of strategy, the delivery of high-quality care and the delivery of the financial and operational performance of NHFT. The CEO is the Accountable Officer of NHFT.

21. One of the principal roles is to ensure the effective running of the Executive Leadership Team ("**ELT**") and to make sure that their portfolios, job descriptions and performance is effective and of a high quality. This is an important aspect of the CEO role from my perspective, and relevant to many of my responses below. I was not often involved in detailed conversations with executives about their internal teams' work, as I focussed on the functioning of the ELT and Board, particularly culture, strategy, building external partnerships and working towards improved outcomes. This enabled me to take a more objective view of overall performance, though it means I delegated much of the

operational detail to colleagues who were better positioned to oversee those matters. Consequently, some of my responses may lack specific detail in areas that fell within their remit, and I will highlight such instances in this statement.

22. Upon commencing my CEO role at NHFT, the senior management structure was as set out in the structure chart of January 2019 [WITN0380006]. I was responsible to the Chair of NHFT. My direct reports were the ELT:

    a. Executive Medical Director

    b. Executive Director of Nursing

    c. Executive Director of Finance and Procurement

    d. Executive Director of Local Partnerships (mental health and community services)

    e. Executive Director of Forensic Services

    f. Director of Human Resources (Non-voting)

    g. Director of Business Development and Marketing (Non-voting)

23. I also had direct reports who were not members of the Board or the ELT:

    a. Trust Secretary

    b. Director of the Institute of Mental Health

    c. Head of Communications

24. The role also entailed a broadening perspective at the time in 2019 of the development of what was then called STPs, which have subsequently been developed into the Integrated Care Systems (ICSs). This had a broader remit of working more closely and in an integrated way with other system providers, whether it be acute trusts, primary care, universities, local authorities and the third sector.

<u>Overview of my tenure and Covid-19</u>

25. Upon commencing at NHFT, my initial priorities were to review the ELT and its function and to ensure it was fit for purpose for the challenges ahead, to review with the Chair the functioning of the Board, and to support staff in an increasingly challenging financial environment.

26. As described above, NHFT was experiencing difficulty navigating the challenging environment with regard to financial pressures, the quality improvement agenda, and the rising challenge of staff recruitment and retention.

27. Therefore, the first year of my tenure as CEO was focused on stabilising NHFT and beginning to improve the performance metrics to enable longer-term improvements in these key performance indicators. My view was that this would be best achieved through a programme focused on organisational culture, staff engagement and the co-production of a patient-focused strategy involving enthusiastic staff, to enable both the required internal improvements and, equally importantly, reconnection with the broader health and social care system.

28. My time at NHFT was largely broken into two very different eras: the first from when I started in January 2019 to February 2020; and the second part from February 2020 onwards until my retirement in August 2022. The reason for this was the outbreak of the COVID-19 pandemic, which led to the declaration of NHS Level 4 National Incident on the 30 January 2020 and the detailed letters to healthcare providers from NHS England and NHS Improvement (as it was at the time), dated 17 March 2020 [CQCM0027411] and 31 July 2020 [WITN0380007], which detailed the organisational response required to the pandemic. NHS England also published on its website a letter dated 26 January 2021 to all CEOs of trusts regarding reducing burden and releasing capacity to manage the COVID-19 pandemic [WITN0380008].

29. Therefore, the first part of my tenure was very much centered on organisational turnaround, a restatement of the culture and values of NHFT, co-production with staff,

patients, service users and working with the broader health economy. The second part from the outbreak of the pandemic was as described in those letters from NHS England and NHS Improvement. A significant amount of my time as CEO was spent working at NHS Level 4 National Incident with many "derogations", i.e. a relaxation in the usual regulatory, governance and other working arrangements. For example, a suspension of CQC inspections and working in very different ways with patient groups and with other health providers. Many of the previous governance and reporting functions were also stood down and there was a total focus on trying to ensure that key services remained viable. I exhibit to this statement examples of derogations and Emergency Terms of Reference for the Board and committees from April 2020, January 2021 and February 2021, to reflect what was required during that time [WITN0380009], [pages 19 – 24, NHFT0003538], [pages 8 – 9 NHFT0005991], and [WITN0380010].

30. This is important context to my period as CEO of NHFT, and relevant to many of the questions asked by the Inquiry in the Request. I will therefore provide specific examples of the changes that were required as a result, where applicable.

Governance & CQC Reports

Governance Structure

31. The governance structure when I arrived at NHFT was as follows:

    a. The Council of Governors ("**CoG**") to which the Board was accountable, and which I attended regularly [WITN0380078].

    b. The Board of Directors: a unitary board of Executive and Non-Executive Directors which met monthly, both in public and in private, which I attended.

    c. Board Committees, chaired by the Non-Executive Directors, and which the CEO was not a member of initially. I have exhibited the relevant Terms of Reference to this statement:

i. Quality [NHFT0004747].

ii. Workforce, Equality and Diversity, also Senior Independent NED – [WITN0380011].

iii. Finance and Performance – [WITN0380079].

iv. Audit [WITN0380080].

v. Mental Health Legislation [WITN0380012].

d. The Executive Leadership Team ("**ELT**") of Executive Directors, which met weekly, and I attended. The ELT was responsible for overseeing the operational delivery of both clinical and corporate services across NHFT. Its functions included monitoring performance in relation to quality, finance, and workforce matters; promoting NHFT's organisational values through leadership, culture development, and staff engagement initiatives; and ensuring that the Board received accurate and timely information concerning performance metrics and risk management.

e. We later developed a Senior Leadership Team ("**SLT**") comprising of executive deputies and professional leads. This reported to the ELT (see Terms of Reference for further details [WITN0380013]).

32. When I commenced in 2019 there were two operational arms within NHFT. The first was called Local Partnerships with a single executive director reporting to the CEO. Local Partnerships included both Mental Health services and Community services. There was also a forensic services directorate which had a separate executive director reporting to the CEO.

Initial impressions

33. One of my initial tasks as CEO was to review these management and governance structures, as it was clear from individual feedback sessions with executives, Board

members and staff during site visits that these structures were impeding effective communication between NHFT's operational services and the executive and Board. My conclusions at the time are summarised below.

34. These conclusions were derived from numerous conversations across NHFT. I made regular visits to sites across NHFT's estate. I also met with senior leaders in local stakeholder organisations, the CCGs, acute trusts, NHS England regional colleagues and local authorities. This feedback was consistent and aligned with internal commentary from colleagues within NHFT.

35. My first impressions were of a broader staff group of approximately 9,000 who were predominantly positive, appreciative of the health and environmental challenges, and keen for change and progress. There was a perception that NHFT had not been a significant participant in the external health economy within the county and more broadly. Internal processes and bureaucracy were impeding progress, with an over-reliance on discussions about cost improvements, compliance, efficiency and processes rather than patients, quality and outcomes.

36. From multiple informal internal and external stakeholder discussions, my impression was that there was significant criticism that the executive and the Board were not functioning optimally, and that culture, values and behaviours were not given sufficient priority. In discussions with the Chair, it was clear that a review of Board roles, ELT portfolios and reporting structures was required to enable improvements in these areas.

37. In Board development sessions and in conversations with the Chair, similar discussions took place regarding the functions of the Board and Board committees, which at the time did not include a specifically identified Risk Committee (discussed in detail below).

2019 CQC Report

38. The CQC inspection of 2019 commenced very shortly after I took up the role of CEO: I had joined in January 2019, and the CQC inspections were 22 January to 7 March 2019,

with the report being published in May 2029. Before I started at NHFT, I was aware that NHFT was due a formal full CQC inspection within a month or two of my arrival. The expectation of the then ELT was that there would likely be a deterioration from the previous 'good' rating to 'requires improvement'. Given the short space of time between my arrival and the inspection, it was not possible to do anything in particular to prepare for it, or change the approach. I had a good understanding of the requirements of a CQC full inspection from work in LPFT which had been successful. I was aware of some of the difficulties at NHFT from conversations with multiple colleagues on the Board, the executive and staff. In my experience it is difficult to judge as to what the CQC inspectors will find and what the issues may be. In LPFT we had been a case study published by the CQC on how to improve [pages 20 – 23 (internal pages 19 – 21) CQCM0016462].

39. I recall that shortly after I started at NHFT, the CQC's lead inspector told me that NHFT's relationship with the CQC inspectorate had previously been poor. Part of the CEO's role is to build relationships with senior CQC personnel, and I felt that the change in leadership was an opportunity to grow the relationship between NHFT and the CQC, although unfortunately, the CQC team changed after the 2019 inspection therefore we did not have that element of continuity. The Board and ELT made it a priority to ensure that the inspection results were taken in good faith and seen as an opportunity to learn and improve. This coincided with the development of an internal programme of increased executive visits across all services.

40. The Request summarises the 2019 CQC report as:

    a. "In May 2019, the CQC published the report of its routine inspection of NHFT [NHFT0002015]. The overall rating for NHFT was "*Requires improvement*". Three out of five areas assessed (including "*safe*" and "*well-led*") were rated as "*Requires improvement*". The report identified issues with the ELT, 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 NHFT 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."

41. As a Trust, we were already beginning to tackle some of the issues before the CQC published the report in May 2019, as they were issues that I had already identified in my initial impressions (above) such as trust culture and Board and executive functioning. However, I would say that I was perhaps less aware of the issues the CQC identified on the acute wards.

Governance Changes

42. In light of my initial impressions, and the CQC report in May 2019, there was a need for the governance structures to change, therefore papers went to the Remuneration Committee recommending changes [WITN0380014, page 7 - 13]. The Remuneration Committee is a committee of the board, chaired by the Chair, which meets as and when required. The main function of this committee is planning for, identifying and appointing candidates to fill executive director positions on the board and for determining their remuneration and other conditions of service [WITN0263012].

43. Initially there were changes in the ELT to strengthen the executive oversight and input into mental health services. We now had three operational directorates: community services; mental health services; and forensic services. The initial thinking and discussion with the ELT and board was that we would seek a single chief operating officer (COO) by going to national advert to create a new post that would cover all three directorates, with an operational director per directorate. However, following national advertisement of the position, there were no candidates with suitable experience to cover all three operational directorates, noting especially that the Forensic Services

Directorate included both medium secure and one of the only three high secure hospitals (Rampton Hospital) in the country.

44. We therefore agreed that we would have three separate Executive Directors for Mental Health, Community, and Forensic Services, and these were appointed to in the following months. For example, Julie Attfield, the then Director of Nursing and Quality moved to become the Executive Director of Mental Health Services, having had previous experience in this operational role.

45. Other changes within the corporate directorate included: the Director of Business Development and Marketing portfolio was re-described as Director of Partnerships and recruited to; estates were transferred to the Executive Director of Finance Information and Estates; and the HR director's role became Executive Director of People and Culture. The portfolios of the remaining executives in the corporate directorate, i.e. the Executive Director of Nursing, the Executive Medical Director, were largely unaltered. The Trust Secretary / Director of Corporate Affairs and the Associate Director of Communications continued in their roles, reporting to me. When the Head of Communication left NHFT on 30 September 2020, the post was changed to Associate Director of Communications and the new postholder started on 1 February 2021. The Executive Director of People and Culture was a shared post between Sherwood Forest Hospitals NHS Foundation Trust and the NHFT since 2 September 2019. When the NHFT Secretary left the post, Sherwood Forest Hospitals NHS Foundation Trust's Director of Corporate Affairs worked across both SFH and the Trust from 1 April 2021.

46. The most significant change to the committees structure was the creation of a Risk Committee following our own internal assessments (a Governance and Risk Management Report by 360 Assurance in June 2020 [WITN0380015]), and the assessment from the Grant Thornton external audit that we had commissioned concluded in August 2020 [NHFT0004957]. These found that more sustained and improved focus was required in this domain. This new Risk Committee reported to the

Board. In the first instance, as CEO I chaired the Risk Committee (the role of Chair would pass to a Non-Executive Director once the committee was up and running), which included members of the ELT and non-executive directors' input on a monthly basis. I have exhibited its terms of reference to this statement [WITN0263056].

47. Although some changes were initiated in 2019, moving into 2020, the COVID-19 pandemic understandably had a significant impact on the role and function and the priorities of NHFT.

48. It is difficult to ascertain improvements that specific changes made during this period (from the beginning of 2019 until the beginning of 2020) had, largely on account that these changes were numerous and interdependent, making it impossible to isolate the effect of a single intervention. It was critically important to recruit the right candidates into the executive team to create the environment for the Trust to flourish. I was prepared for this to take time, as the work on culture and values is broad based, and inclusive: the objective of improving staff morale for better patient outcomes was a longer term endeavour. Also, with the beginning of the COVID19 pandemic, the immediate priorities of the organization, along with everybody else nationally, changed almost overnight and even in retrospect it is difficult to isolate the specific impact of individual changes.

49. However, there were clearly some significant improvements in that first year. The NHS National Staff Survey results 2020 showed NHFT to be one of the sixth most improved nationally [WITN0380016]. We had improved in many domains in comparison to our previous performance and also in comparison to peer trusts nationally. There was a real sense that the Board had started to become more effective and had begun to focus on key issues. For example, we had introduced a patient story to begin Board meetings on a regular basis, which exposed non-clinical staff to have at first hand the experience of patients and carers.

50. The Trust had also started to work much more closely with other local organisations, this was at the time that clinical commissioning groups (CCGs) were being merged and forming sustainability and transformation partnerships, these included both acute trusts within the county: Sherwood Forest Hospitals NHS Foundation Trust and Nottingham University Hospitals NHS Trust, and both city and county local authorities.

51. I also set in train other changes across the Trust. The introduction of the concept of "One Trust" that had a core management structure for directorates [WITN0380017] was essentially a triumvirate management structure that included a Clinical Director, general manager and quality lead for all directorates, for consistency of approach. An internal governance review (by 360 Assurance), allied to an external assessment by Grant Thornton of our Well-led functions (as above) resulted in significant changes. The splitting of the People and Quality Committee into separate Board committees and the creation of the Risk Committee (as above). A raft of new posts were created to address shortfalls and sharpen focus on key areas; Safer Staffing, deputy Director of Nursing, family liaison team, suicide lead, quality lead for subcontracted services, CQC compliance lead, restrictive practice lead and deputy associate director of quality. Improvement Boards were created, again to focus on essential action and drive improvement (as above).

<u>The Relationship between Executive and Non-Executive Directors</u>

52. When I commenced in 2019, I found that the relationship between the executive directors and the non-executive directors was affable, friendly and comfortable. However, the Board meetings were long, sometimes lacked focus, had no direct input of patient experience, and would sometimes include verbal reports on action items and other matters, rather than written documentation. There was some challenge from non-executives, but this was rarely pursued in any depth, and my view was that this in part was due to the long-standing nature of some of both the executive and non-executive appointments.

53. Over the period of my office this was addressed on a regular basis, and it was something that I worked with NHFT's Chairs to address. The idea of "critical friend" and challenge is a fundamental function of boards, and I felt it was crucially important to ensure that this holding to account challenge and questioning was welcomed as the right thing to do.

54. The functioning and relationships within the Board was an important piece of work which I jointly led with the Chair, largely through Board Development sessions. These sessions would include our own discussions and learning about different topics, but we would also use external sources to inform the Board about best practice. I exhibit to this statement agendas from various sessions in 2019 – 2022, which included:

    a. Vision values and purpose, input from senior leads, CCG, Citycare (community provider), acute Trust; and internal leads from operational divisions [WITN0380018].

    b. Building an effective Board, developing purpose and leadership culture, connecting with the wider organisation, short- and longer-term planning (internal) [WITN0380019].

    c. Equality diversity and inclusion, input from professional leads and new care models programme manager (NHSE) [WITN0380020].

    d. Information Governance training, Making Data Count (NHS improvement) [WITN0380021].

    e. Strategic review of previous year (2019) and looking ahead at national regional and local picture including new commissioning models, Provider Collaboratives and purchase of in-patient facility locally (St. Andrews to become Sherwood Oaks) [WITN0380022].

    f. Review of Board committees, risk management and assurance from BAF, CQC preparations [WITN0380023].

g. Cyber security presentation (external), working jointly with private providers in specialist are (external), risk appetite review, team behaviours charter [WITN0380024].

h. CQC inspection preparation including well-led and specific Board prep. [WITN0380025].

i. INstitute for Mental health review (external input) and broader review of research programmes [WITN0380026].

j. Freedom to Speak-up self-assessment and Board training, East Midlands Alliance joint working with the other 4 MH Trusts in the region, review. Developing our provider Collaborative offer. NHS national staff survey results [WITN0380027].

k. Maintaining high professional standards (external legal input), review of risk appetites and tolerances, strategic risks and BAF refresh, health inequalities work, safeguarding IPC training [WITN0380028].

l. Review and proposals to develop the Quality Improvement programme [WITN0380029].

55. I have exhibited to this statement a chart showing Executive and Non-Executive Director changes between 2019 – 2022 [WITN0380030] which shows that there was significant turnover of both non-executive and executive directors in the early 2020s. This was due to retirements and the moving on of some individuals who had been in post a number of years. This initially led to perhaps a delay in the formation of a cohesive and coherent functioning executive and board due to this change in personnel, but my view was that in 2021-22 the board and ELT were developing an effective working relationship characterised by appropriate challenge and focus on improvement.

56. Although the turnover of Executives and Non-Executive Directors would have produced challenges in any event, I strongly feel that the Covid-19 pandemic halted much of the

improvement work that we had envisioned and started to implement in 2019, as clinical priorities completely changed how we had work and function (as set out above).

2020 CQC Report

57. The CQC published a further report in relation to NHFT in 2020, which the Request summarises as:

    a. "In September 2020, the CQC published the report of its inspection of NHFT'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*"".

58. The CQC reports referenced from May 2019 stated that the safety ratings for acute wards and psychiatric intensive care units were inadequate and a reinspection of those areas in 2020, reached the same conclusion. The CQC reports were considered and discussed by the ELT and presented to the Board [NHFT0000829] and [NHFT0001208]. The first was a verbal update pending the publication of the report and the second references a more detailed response.

59. I think it important to clarify the sequence of events with regard to these CQC inspections. The published inspection of May 2019 states the overall rating for NHFT as 'Requires Improvement' which was a reduction from 'Good' (in 2012). Adult wards and PICU were overall 'Inadequate', including 'Inadequate' for Safe and Well-led domains.

60. The re-inspection by the CQC occurred in July 2020 during the first wave of the pandemic and was therefore a focused inspection. Most of the improvement work in NHFT had been stood down since March 2020, on instruction from NHS England, which had necessarily limited the progression of works following the 2019 inspection.

61. This re-inspection was published in September 2020 [NHFT0001778] The ratings for Adult wards and PICU overall had improved from 'Inadequate' to 'Requires

Improvement', though the ratings for the Safe and Well-led domains remained 'Inadequate'. Despite stating that the Safe and Well-led domains remained 'Inadequate', the text in the report says:

a. "The service provided safe care. The ward environments were safe and clean. The wards had enough staff to meet the needs of the patient group. Staff assessed and managed risk well" (p2).

b. "Leaders of the service had the skills to ensure the wards were managed safely" (p2).

c. "Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of services they managed and were visible in the service and approachable for patients and staff" (p4).

d. "Staff felt respected supported and valued…They felt able to raise concerns without fear of retribution" (p4).

e. "Staff engaged actively in local and national quality improvement activities" (p4).

62. I found these words encouraging and in my mind I would not consider this to reflect a rating of 'inadequate'. When providing the rating for each of the three domains (safe, caring, and well-led) and stating that the rating remained the same, the report says "*This was a focused inspection. We did not re-rate the core service and the rating stayed the same, please refer back to the comprehensive inspection published 24 May 2019 for detailed findings.*" (pages 2, 3, 4). I therefore understood that the ratings remaining the same (but the narrative apparently being at odds with that) was because this was a focussed inspection, and so CQC protocol was for the rating to remain the same, as stated in the report. Therefore, my view was that some improvements had been made (as reflected in the improved overall rating, and the narrative within the report) but there

was still much work to do. In retrospect I think we could have made more progress if the pandemic had not happened.

63. My response and recollections, which are referenced in the Board papers appended [NHFT0002372], were that it was vitally important to acknowledge that the CQC findings were signals of deeper underlying issues, which an action plan alone would not necessarily resolve. This was evidenced, in part, by the lack of progress in certain areas between the May 2019 and September 2020 reports. Whilst I felt that we were making progress as a an ELT and Board, and the culture work was under way, it was very early days and we knew that there were other deep seated issues, which the CQC had picked up on. Therefore, the relative lack of progress on CQC ratings was not a surprise, and as noted above, I understood the ratings could not be changed on a focused inspection, but the narrative showed some improvements.

CQC reports and NHFT's Response

64. As CEO, I was ultimately accountable for the progress of work in response to CQC reports, which was monitored regularly by the Board. However, the work itself was coordinated through the executive.

65. The Executive Director of Nursing takes the main leadership of this task, taking the lead in preparation for, and response to the CQC. Their team co-ordinate the liaison with the CQC and with the ELT. More broadly, they are responsible for sharing the findings and plan with the organisation and the co-ordination of action responses, improvement and learning. This was of course also an executive function too, as they would take responsibilities relevant to their portfolios. The results and response would be presented to the Board and subsequently an action plans [WITN0380031] and [WITN0380081][1] addressing key concerns was developed and worked through.

[1] A full action plan is not available for the 2020 report [NHFT0001778], because the actions were "should do's" rather than "must do's", which are managed within the relevant division.

66. More broadly, a variety of workstreams were undertaken, overseen by the ELT. This included developing a closer professional working relationship with the CQC lead inspectors, visiting high performing Trusts (east London, Northampton) and helping staff showcase the improvement work they were undertaking. Specific workstreams were developed addressing facility issues, for example looking at ligature risks and potential for eradicating the use of dormitory accommodation across the estate. We also included wider stakeholder groups such as the Council of Governors and service user groups to help inform our strategy.

67. My view in 2019 – 2020 was that the significant changes required related to the culture and values of NHFT, and how we worked with staff to enable them to identify problems, raise issues and progress matters themselves, rather than adopting traditional hierarchical approach of directive instructions to complete the CQC action plan.

68. My recollection is that one of the biggest challenges at this time was the recruitment and retention of staff willing to work on acute psychiatric wards. There had already been issues with staff numbers prior to the pandemic, but the pandemic exacerbated this position, and we were aware that this difficulty was not unique to our organisation.

69. I felt it was important to address through dedicated Improvement Boards, which I chaired as CEO. We had an Improvement Board for Adult Mental Health, Ling's Bar Hospital (part of the Community Services Division) and Rampton Hospital (part of the Forensic Services Division). The Terms of Reference for these Improvement Boards are set out in the exhibits to this statement [WITN0380032], [WITN0380033], [WITN0380034] and [WITN0380035]. This approach enabled greater focus and clarity regarding the issues and long-running challenges that had prevented improvement.

70. We had Non-Executive Director involvement in all the Improvement Boards. There was also external scrutiny and contribution from the CQC, the CCG and, in the case of

Rampton Hospital, NHS England Commissioners. This enabled much greater transparency and sharing of good practice from elsewhere, where appropriate.

71. We also introduced a mechanism to ensure that the completion of actions was evidenced by sustainable change, rather than merely updating action plan status indicators. Before any action was identified as complete, there had to be evidence that the change achieved was embedded within the service. This was often undertaken through visits and discussions with staff who had been involved in the ward changes.

November 2022 CQC Report (inspection conducted March April 2022)

72. In November 2022 (after I stepped down as CEO), the CQC published the report of its routine inspection of NHFT [CQCM0016478], which was carried out in March and April 2022 (while I was still CEO). The overall rating was "Requires improvement". Although the overall rating had remained the same, there were improvements in some domains which had led to some progress overall, as shown when looking at how the detailed ratings across all services changed across the years, as demonstrated by the colour coded ratings exhibited to this statement, demonstrating improvements within individual domains [WITN0380036], [WITN0380037], [WITN0380038], [WITN0380039], and [WITN0380040]. My recollection is that from a culture and values perspective, we were beginning to make significant progress. For example, the November 2022 CQC report found that NHFT's corporate governance structure had been reviewed, redeveloped and improved. This long-standing issue had been resolved prior to my retirement. The National Staff Survey 2021 showed significant improvements.

73. As set out earlier, the COVID-19 pandemic, the derogations and the focus on Trust work had a significant impact during a substantial part of this period. The impact of the pandemic on normal governance processes, the halting of CQC inspections and the reprioritisation of work to enable NHFT to continue to provide, wherever possible, its core services for people with mental illness cannot be underestimated.

74. Whilst we continued to prioritise the provision of safe services, some of the detailed core work that would be required to enable CQC ratings to improve was of secondary priority for a considerable period, and I do not consider this to be evidence of a failure by NHFT to learn.

75. For example, the identification and removal of potential ligature points on wards should be a relatively straightforward task and can be completed in short period of time. The change from dormitory bed provision to single room en-suite facilities is a programme of work that can take years due to constraints including capital funding availability, site acquisition challenges, and competing priorities within the local health economy.

Monitoring of Mental Health Services

76. Overall, the Trust used multiple mechanisms to monitor the adequacy of mental health services, including:

a. **Integrated Performance Report** (IPR): Presented at every Board with a mental health services section, combining metrics on safety, quality, operational performance, workforce and finance in Statistical Processing Chart (SPC) format showing concerns, escalations and trends. Data included Restrictive Practice, Incidents, Pressure Ulcers, and Complaints, as shown on pages 30–55 of the Public Board of Directors meeting on 5 July 2022 [NHFT0001173] and pages 32–60 of the March 2022 board papers [NHFT0003849].

b. **Patient Experience (qualitative and quantitative):** Reports to Adult Mental Health Improvement Board, Quality Committee and Board covering all patient experience activities including interviews and forums. During 2020-2022, division-specific patient involvement reports came to the AMH Improvement Board, for example pages 12-17 of the AMH Improvement Board of 15 November 2021

[WITN0380041].

c. **Patient and Staff Stories:** Presented at the beginning of all Board meetings, rotating around NHFT with the mental health division presenting at least three times annually. A full programme was planned yearly to ensure all Trust areas had opportunity to present. During Covid-19 these were reduced but resumed through virtual meetings, enabling direct patient and carer voices to reach the Board. The Executive Director of Nursing ensured stories were prepared with support from ward managers and communications team. A summary report of Board stories, including top concerns from the Mental Health division on page 5 [NHFT0001289, page 92-98].

d. **National Staff Surveys and pulse surveys:** Annual survey conducted by external company Picker, with results broken down into teams and divisions. The HR Director presented findings annually to Board explaining actions to address areas of concern. Staff Survey details for 2022 covering Mental Health Services at page 115 [NHFT0003341]. A quarterly National Pulse Survey complemented the overall staff survey from July 2021 as a Prime Ministerial requirement for all Trusts.

e. **Speaking up data and stories:** Reports to Board from the Speaking up Guardian, who reported directly to the CEO. Data was broken down by division while maintaining individual anonymity. [pages 16-21 NHFT0003766]

f. **Coroner feedback:** Provided through Executive meetings with the coroner.

g. **Safer Staffing establishment reviews and reporting (including**

vacancies, bank and agency usage): Regular reports were provided to the Quality Committee, People Committee, Adult Mental Health Improvement Board, and Board. Reports were division-specific and presented by a safer staffing matron. Examples are provided in the safer staffing section, below [pages 104 – 112 NHFT0004943].

h. **Infection Control and Prevention data and audits:** The Infection Control team provided these, escalating from the Infection Prevention and Control Meeting to the Quality Committee and Board. During Covid-19, reports covered outbreaks, ward closures, and handwashing/cleaning audits. A new National IPC Board Assurance template was introduced in 2020 for annual Board reporting. The author held the Director of Infection Prevention and Care (DIPC) role throughout their tenure as Executive Director of Nursing [NHFT0001844 pages 36 - 38] and [WITN0380042].

i. **MHA audits and feedback:** Independent Mental Health Advocates (IMHAs) conducted individual ward audits and provided feedback to NHFT. These were compiled into reports for the Quality Committee, for example – [pages 90 – 92 NHFT0003520] and [WITN0380043]. The Medical Director held responsibility for presenting them to committee and Board.

j. **Board to ward visits:** These visits provided valuable insights from patients, staff and families. All Non-Executive and Executive Directors participated on a rotating basis. Visits were reduced during peak Covid-19 but resumed when safe. The CQC reviewed visit logs as an indicator of Board visibility in clinical areas. Logs were maintained in the Executive Assurance Visits April 2019 to March 2020 [WITN0380044], Executive Assurance Visits April 2021 to March 2022

[WITN0380045]. A guide for conducting and recording visits was provided [WITN0380046] along with a template for completion [WITN0380047].

k. **Healthwatch:** Executive Directors met regularly with Healthwatch (approximately four times annually) to gain insights from patients and families. Meetings were facilitated by the Head of Involvement and attended by the CEO and sometimes the Executive Director of Nursing. I have exhibited an example agenda to illustrate the areas discussed [WITN0380048] The Director of Strategy and Partnerships assumed this role from April 2022.

l. **Quality First Team:** Created in 2020 as part of the Governance Review [NHFT0014979], this team conducted quality audits across NHFT, initially focusing on areas rated 'inadequate' or 'requires improvement' by the CQC, later expanding to areas with concerning Mental Health Act visit feedback and increased incidents. Audits were reported to the Quality Committee using a template [WITN0380049] with sample reports provided [WITN0380050] and [WITN0380051].

m. **Culture Awareness Tool:** From early 2021, a Culture awareness tool [WITN0380052] was rolled out for ward staff to conduct their own culture assessments, using CQC self-assessment documentation and additional questions. This was ward and division-specific, with each division managing its own outcomes and improvement activity. Seven-minute briefing posters were produced to support staff understanding of closed versus open cultures [NHNB0015820].

n. **Place Audits**: Place audits primarily assessed the ward environment and safety, rather than the adequacy of clinical services. While they

could highlight environmental factors that might affect care delivery, the adequacy and effectiveness of mental health services were evaluated through separate mechanisms such as service reviews, incident monitoring and patient feedback.

o. In 2021, as part of follow-up actions from CQC inspection, the Forensic Director engaged Anna Pridmore, an external consultant, to conduct a review of Clinical Governance arrangements at Rampton Hospital. Following the completion of this review, the ELT commissioned Ms Pridmore to undertake a broader assessment of NHFT's Corporate Governance structures. Ms Pridmore, together with the Associate Director of Quality, subsequently led a workshop on 21 April 2022 with senior leaders across NHFT to explore and agree upon proposed changes to the clinical governance arrangements, as documented in the accompanying presentation [NHFT0014993].

77. An example of the Board Integrated Performance Reports reports that went to board meetings is appended [WITN0380053].

78. My recollection is that this was across a number of domains, including measurements of people, quality, finance and well-led. The ELT devoted considerable time to ensuring the performance report was relevant and focused, enabling the Board to identify areas requiring challenge and to understand key risk and governance concerns. Generally speaking, I was sighted on the summary outputs and exception reporting of much of the above. These would be discussed either with individual executives or jointly before going to Board. Board to ward visits were more of a qualitative measure/view of teams both clinical and corporate and were an important window into how NHFT was performing.

79. Two areas that I focussed on as being markers of the adequacy of mental health services were staffing and out of area placements, which I discuss below.

Escalation of Issues

80. There were a number of means by which issues around care provided by NHFT could be escalated to myself or the ELT or the Board, including formal escalation pathways, such as incident reporting. Incidents at NHFT were reported using the electronic incident reporting system "Ulysses", which is a system for incident reporting widely used by providers of NHS healthcare as part of local incident management arrangements. This would result in serious issues being regularly reported up to the ELT and as appropriate, the board.

81. There were an increasing number of methods of escalation that we developed as a result of staff feedback. These included, for example, the development of the freedom to speak up role (in line with National policy), which empowered staff to feel confident and able to report issues around care provision. This was an area that, as part of the culture and values work, was revamped and enlarged to encourage a more positive culture around raising concerns. This became, I think, a useful conduit for concerns about services to be raised and responses and actions achieved.

82. I also had a culture of an open-door policy whereby I encouraged people to contact me with regard to any issues around the provision of care in NHFT, whether by e-mail, letter or face to face appointment. This could be staff, patients, family, external stake-holders. Much of this was incorporated within the new culture that we were attempting to develop, focused on trust, acting honestly with respect, working compassionately and within a broader team.

83. Informal feedback during my time was that the impact of these changes did empower staff to raise issues where they may have felt they previously could not. Of course, this is sometimes difficult to quantify as can often be seen as simply an increased number of incidents and concerns being reported, although I always considered that this was a good thing.

84. Other pathways for escalation of issues included the following. Details would reach me either directly (Healthwatch, site visits), or from other conversations with executives, Board members and the communications teams:

a. Clinical Audits

b. From Healthwatch

c. During Board to Ward visits

d. Directly from Mental Health Act visits

e. Directly from any CQC visits and inspections

f. Through NHFT's formal complaints process

g. Directly from MPs

h. Directly from the coroner

i. Quality First visits

j. Involvement and Experience team

85. I felt assured that with these multiple and varied inputs, I was cognisant of issues relating to patient care across NHFT. I always worked on the principle that the Board should be sighted on key issues too, and the way the Board was starting to function facilitated better conversations and plans as to how to tackle various concerns. Unfortunately, again, this is an area where perhaps we did not have the same focus as a consequence of COVID to really embed this culture across the whole organisation to its maximum effectiveness.

86. The Inquiry has asked whether any concerns were raised about the adequacy of mental health services provided by NHFT. One of the functions of a CEO is to be receptive to issues being raised when they arise, which was consistent with my approach in this role.

87. Across all services within the Mental Health Services division, concerns were regularly raised regarding a broad range of issues, including the facilities from which services were provided, their maintenance and upkeep, the funding required to continue to provide and improve services in the directorates, and staffing levels.

88. As set out above, there were NHFT governance mechanisms that were in place in terms of Incident reporting, which would often record instances and concerns with regard to the adequacy of services provided across these directorates, plus the Freedom to Speak up Guardian [NHSE0002306].

89. Adult mental health services were under constant pressure during my tenure. There were both longer standing issues (e.g. outdated facilities and dormitories) and more recent challenges such as the increasing acuity of admissions and staffing problems. These were experienced most significantly across in-patient areas. They were a regular topic of discussion with the Executive Director Julie Attfield, who I had asked to take on the role in early 2019, as the Local Partnerships were being split back into two separate divisions, and the Executive Director who had been in-post was leaving.

90. More specifically, following the first wave of the COVID-19 pandemic there were concerns about the increasing use of out of area placements (OAA). The recruitment and retention of inpatient staff was difficult and vacancies were increasing. During the Spring of 2021 we discussed these at length both individually and as part of the wider ELT and at Board. Senior leaders across AMH were having daily calls to resolve staffing cover on shifts and manage admissions and discharges. Action plans were in place to attempt to reduce vacancy rates and sickness. At this point, my understanding of the situation was that it was challenging but stable, as set out in the Integrated Performance Reports that went to the Board in March and May 2021 [pages 26 – 39 NHFT0003766] and [pages 36-62 NHFT0004589].

91. By August 2021, the staffing levels had deteriorated further, especially at Highbury Hospital in Nottingham. The use of bank and agency staff was also rising. A detailed briefing from Julie Attfield came to the executive in August, actions were noted and updates on progress came in November 2021 [pages 5 – 9 NHFT0002204] and [pages 5 – 7 NHFT0003395].

92. The following are examples of actions undertaken:

    a. Ward managers stopped working on investigation reporting, to focus on clinical work,

    b. Admissions were capped onto acute wards and PICU,

    c. More sub-contracted beds were commissioned locally,

    d. Diversion of clinicians working in non-clinical posts to the in-patient areas

    e. The implementation of "winter" financial incentives.

    f. There was a full review of the IT equipment available to ward staff and an IT technician was on site to troubleshoot technical issues.

    g. Additional administrative support was provided to the wards.

93. I met with three ward managers from Highbury Hospital along with Executive Directors for Strategy and People on 29 October 2021 to hear their concerns [WITN0380054]. They felt services were not safe and wanted an immediate response. They were concerned that despite flagging issues since June 2021, nothing had improved. I instigated an urgent executive meeting on 1 November 2021 [WITN0380055] and updated the Private Board on 2 November [pages 5 – 9 NHFT0002204]. I committed to developing further actions to manage and resolve these concerns, including increased visibility of the executive at Highbury Hospital and getting further support into the wards. It was agreed that this was an organisational priority. This period coincided with a further

wave of the pandemic (the Omnicron variant) and as cases rose nationally, so did numbers locally. The NHS was once again put on highest incident level 4, as set out in NHS England's letter of 13 December 2021, which meant that these improvements were even more challenging to implement [NHNB0011658].

94. My recollection is that there were improvements as a consequence of these actions and these were monitored through the ELT and Board, for example in Board Meetings in December 2021 and January 2022 [pages 5 – 7 NHFT0003395] and [WITN0380056]. This work resulted in the Highbury Hospital Improvement and Business Continuity Plan and a deep dive into staffing at the People and Culture Committee [WITN0380057]. This work was then expanded across other inpatient areas in AMH and more broadly, and became the AMH Improvement Plan [NHFT0008146].

Assessment of risk

Strategic and Operational Risk Management

Board Assurance Framework and Strategic Risk Oversight

95. There are two strands of risk that are monitored and managed within a healthcare organisation: strategic and operational.

    a. Strategic risks would be monitored and managed via the Board Assurance Framework ("**BAF**"). Through this, each Executive would have oversight of particular risk areas, and before each board, they would meet with the risk and assurance lead to update the BAF.

    b. Operational risks would be managed at service and division levels and recorded on divisional risk registers and escalated to BAF or trust-wide risk register when needed.

96. In 2019 when I commenced as CEO, risk monitoring and management consisted primarily of Board oversight of operational and corporate performance metrics through

standard reporting mechanisms, as can be seen in the Board Integrated Performance Reports. There were the subcommittees of the Board and each of these sub-committees had some oversight of risks pertinent to their domains but it was evident that the interdependent risks were being identified and mitigated and resolved. For example a financial pressure (finance committee) may result in a cost-saving programme reducing staff skill-mix on wards (quality committee) with a resulting risk decreased staff satisfaction and vacancies (HR/People committee). However, during the first few months of my arrival, the Non-Executive Directors and the ELT felt that one of the areas where performance could be improved was the strategic oversight and monitoring of risks generally.

97. This view was confirmed by the content of the CQC inspection of May 2019. As a consequence of our own assessment and the external inspection, we commissioned a Well Led review by Grant Thornton. This resulted in a final report dated August 2020 [NHFT0004957]. This Well Led review was timely, as NHFT had not had one for several years, and would also help inform us more broadly from a well-led framework perspective as to whether there were other areas of concern around strategic governance that we had not identified.

98. In summary, of the eight domains, which included 1) leadership capacity and capability; 2) vision and strategy to deliver high quality sustainable care; 3) culture of high quality sustainable care; 4) clear responsibilities, roles and systems of accountability supporting governance; 5) clear and effective processes for managing risk, issues and performance; 6) appropriate and accurate information being effectively processed, challenged and acted; 7) people who use services, public staff and external partner engagement involved support high quality services and 8) robust systems and processes for learning continuous improvements and innovation; the only domain rated red was domain 5 (clear and effective processes for managing risk, issues and performance). All other domains were rated amber or green, although improvements

were required in those areas. Improving and resolving risk oversight was the biggest concern, which aligned with our own view.

99. In discussions with the ELT and during Board Development sessions, we undertook a review of how this function was performed at Board and executive level. The review concluded that although on paper we had the right processes in place, they were not functioning optimally. An example of this was the BAF, which was impressive in its scope and detail, but the actions, embedding of actions, completeness and progress had become a lengthy narrative with a lack of discipline around completion.

100. On closer scrutiny by Board members, it became clear that the BAF and Risk Register (BAFRR) were not fit for purpose, and a significant piece of work was commissioned to deconstruct and rebuild it using external expertise (Shirley Higginbottom and Anna Pridmore). I have exhibited to this witness statement various documents that went to the Board and/ or ELT in relation to this work [WITN0380058], [NHFT0007067], [NHFT0007066], [NHFT0005997], [NHFT0005192] and [WITN0380059].

101. Training on the BAF was provided to members of the Board in Board Development sessions in terms of understanding what strategic risks were, the difference between strategic and operational risk, and how mitigations worked. This included being able to quantitatively measure risk in terms of severity and likelihood using a cross-tabulated scoring system to rank risks as high, medium or low, for example. This led to improved understanding and ownership of the whole process. I have exhibited to this statement relevant Board Development documents [WITN0380054]] and [WITN0380028], [WITN0380060] and [WITN0380061].

102. This focused on the Board identifying in development sessions the key strategic risks for the organisation and then describing the required mitigations and how these would be implemented. Over time, this was regarded as successful in that the Board had full ownership of the new product, understood its genesis and evolution, and was able to

focus on the priorities around strategic risk management and the emergent issues that arose through the directorates and divisions from an organisational risk perspective. [WITN0380061].

Risk Management Policies

103. The Board retained strategic oversight of the management of risk and was involved via Board Development sessions in the strategic reset helping shape the structure of the new BAF and the reporting requirements. The ELT maintained oversight of risk management policies. The Director of Corporate Affairs attended ELT meetings to present policy reviews and recommendations for amendments, including those relating to risk management policies and strategies. Risk management policies and strategies were developed, managed and updated by the Head of Corporate Governance. The Trust operated under a five-year strategy for risk management set out in the "Risk Management Strategy 2021 – 2026" [WITN0380062] and [WITN0380082]. From October 2020, NHFT established a Risk Committee, chaired by me as CEO, which reviewed significant risks, outstanding audit recommendations, the BAF, risk scoring, risk management policy and strategy, and divisional risk registers (as set out below).

Audit and Risk committees

104. DDDThe Quality Committee was chaired by the Non-Executive Director responsible for quality and supported by the Director of Nursing and Quality. It included some elements of risk oversight. As part of the overall review of strategic and organisational risk I felt that the function of risk had become too buried in directorate and divisional work and across various Board committees in 2019-20 and that it had become quite opaque as to the strategic risk concerns. This accorded with the Grant Thornton review. The Grant Thornton review recommended a separate Risk Committee. Therefore, through Board Development sessions and ELT discussions, we created the Risk Committee around February 2021 to ensure greater focus and clarity on formulating our strategic risk

programme. The Risk Committee was formed on a temporary basis and established as a Board committee. Unusually, it was chaired by me as the CEO, rather than a Non-Executive Director. Its membership included me as Chair, members of the ELT, some Non-Executive Directors, and risk managers. This separate Risk Committee consolidated the risk function as a single focus for this work, which would benefit NHFT in the longer term. It dealt with strategic risks and high level operational risks [WITN0263056].

105. The Risk Committee minutes were treated as Board subcommittee minutes and were therefore reported to the Board. It is also my recollection that the other Board subcommittees had sight of these to ensure alignment from a risk perspective across the Board subcommittees.

106. I do not recall the specifics of the role of the Risk Committee or Quality Committee in the creation of new risk management policies, but believe that the Risk Management team responsible for reviewing and writing the new policies would have used the Risk Committee and Quality Committee to ensure that these were complete and fit for purpose.

Clinical Risk Management

107. Clinical risk is distinct from the strategic and operational risk management set out above.

108. Clinical risk management assessment is predominantly, but not solely, undertaken by psychiatrists, psychologists, nurses and AHPs, through their own clinical teams, clinical team leads and professional leads, including nurse managers, clinical directors and medical directors

109. As a clinician, I was regularly involved in the clinical assessment and risk assessment of patients with serious mental illness. In the latter part of my clinical career at LPFT from 2011 to 2018, I almost exclusively saw patients with enduring mental illness,

namely paranoid schizophrenia, bipolar disorder, serious personality disorder and comorbidities of drug and alcohol dependency.

110. The knowledge, skills and experience in clinical risk assessment are acquired over time with adequate supervision and training. This function is ultimately overseen from a medical perspective by the Executive Medical Director and, for other clinical staff, usually through the Executive Director of Nursing and Quality.

111. By the time matters escalated to ELT level, individual clinician performance would rarely, if ever, be discussed, as there were mechanisms in place to monitor, for example, higher professional training and performance across the different professions.

112. It is therefore important to emphasise the difference between strategic, organisational and clinical risk assessments, the process of undertaking these, and where the accountabilities sit within NHFT. My recollection is that both in LPFT and NHFT, accountability for clinician performance sat with the Nursing and Medical Directors, and the ELT and the Board would take assurance from those executives that the correct processes were in place for ensuring adherence to professional body requirements, for example around clinical risk assessment.

113. I cannot recall any specific instances where issues were raised through the ELT meetings or Board subcommittee meetings regarding whether clinicians were evaluating risk correctly. However, I would not necessarily have expected this to occur at this level, as such matters would have been resolved by the aforementioned executives and their teams.

114. One specific example is the liaison model that was in place through the General Medical Council (GMC) or Nursing and Midwifery Council (NMC) for discussing with those bodies issues of concern regarding a clinician's practice where concerns had been raised through their clinical directors or professional management teams. This was something

that I undertook in my medical director role in Lincolnshire, and I know the Medical Director at NHFT had a similar arrangement.

115. I adopted the same approach when I undertook the same role in NHFT, whereby there were not necessarily formal concerns that would trigger an investigation or review, but rather informal conversations and advice about how to identify an individual clinician who may have been struggling with a specific issue, such as clinical risk assessment. However, I do not recall a specific example of this.

Serious incidents and learning from deaths

Management of Significant/Serious Incidents

116. The Board had policies and protocols in place for the monitoring of serious untoward incidents (SUIs). There was a well-embedded incident reporting process collated by Ulysses. These were monitored by directorate management teams and escalated in accordance with the relevant protocols, such as the Managing Serious Incidents policy [NHFT0000596]. This enabled the appropriate level of scrutiny, as not all incidents described as serious required escalation to the executive or Board.

117. A group called the Serious Incident Review Group (SIRG) – [NHFT0013458] which included clinicians, managers and administrators, collated this information and data. The SIRG met weekly and was attended by both the Medical Director and Director of Nursing and Quality. This provided a direct link into the ELT and Board as SIRG escalated matters to the ELT, who decided if the matter needed to be further escalated to the Board.

118. A serious incident that met the criteria for further escalation was brought to the ELT, where it was discussed and actions were agreed and monitored through the ELT until resolved. On occasion, incidents were of sufficient concern to be raised at the Board. My recollection is that this was most often done in the private session of the Board under

the heading of Reportable Issues Log (RIL). The Board would then monitor the progress of the resulting actions either through the private Board or to public Board as required.

119. The level of detail in which they were discussed varied depending on the seriousness of the incident. My recollection is that initially these may have been verbal reports, but the Board would require written detail of such incidents, which would be provided in accordance with the process [WITN0380083 / NHFT0007053].

Monitoring and actioning recommendations from serious incidents

120. In addition to this oversight by the ELT and the Board, there were often consequences resulting from the incident that would require monitoring through the Board subcommittees. These would be referred to the appropriate committee agendas, most likely the Quality Committee, which would encompass organisational and clinical issues relating to serious incidents. Other mechanisms that I was aware of for monitoring and actioning recommendations would include:

    a. CIRCLE
    b. Learning from Deaths Group
    c. Patient safety Annual report
    d. Quality Oversight and Approval of Death related Serious Incidents Investigations meetings
    e. Mortality Surveillance and learning from Death report
    f. Patient Safety Team
    g. Monthly bulletins to staff
    h. Trust-wide Learning Forum.

Incidents of Serious Violence

121. The Inquiry has asked what mechanisms existed for NHFT to become aware that one of its patients or former patients had committed a violent act against a member of the public. It is important to distinguish between current patients and former patients.

122. Current patients involved in such incidents would, by definition, trigger an incident report if they were involved in a violent act against a member of the public, and this would be responded to through the mechanisms described above. For example, there were internal mechanisms for escalating to the executive and Board, policies in place to deal with such incidents, and SIRG had a function in responding to these incidents.

123. I am not aware that NHFT had specific policies in place to deal with such incidents involving former patients, although I would have expected that if such incidents did occur and NHFT was informed, whether through an administrative desk or a clinical team, the response would vary depending on the incident, such as provision of clinical information, discussions with police, or the routine incident response protocols that would be used for other serious incidents, would be used where necessary.

124. The response of NHFT would depend on the details of such an incident. For example, a clinical team might become aware of a former patient known to them and would respond appropriately, most likely by providing a reassessment if indicated. If an administrative or corporate team became aware, they would, if appropriate, inform the relevant clinical team of such an incident.

125. This would be described in the terms of reference regarding incidents involving current patients, including when a review was required, the different levels of serious untoward incident reporting, and when additional scrutiny would have been required in discussion with the commissioning bodies, NHS England and the CQC, who would have been informed of serious incidents. There were occasions when the severity necessitated an external review, and we would,

through the office of the Medical Director and/or Director of Nursing, commission external bodies to undertake such reviews [NHNB0017362]. Suncus was the NHSE Framework for approved SI investigators (page 41).

126. In considering former patients involved in serious violence, the response is significantly different and more difficult to summarise, largely because NHFT may not have been aware of such incidents involving former patients. It is important to note that NHFT had a very large number of patient contacts on a weekly, monthly and yearly basis, and the throughput of patients and service users across all services was high, meaning that at any given time there would be a large number of former patients in the community. Some would have continued to have active illness and would be monitored through primary care services or voluntary services. Other patients would have been either discharged or did not wish to have continued follow-up in statutory services. Therefore, it is difficult to quantify the precise numbers of former patients and also difficult to describe their risk profile.

127. Consequently, there were no formal mechanisms in NHFT for it to become aware of former patients being involved in acts of violence unless it was informed of such incidents. This would depend on the extent of the violence and the seriousness of the incident. Unless it involved Trust staff directly, NHFT would be very dependent on reports from, for example, family members, primary care teams, members of the public or the police for such information to come to NHFT's attention.

128. Learning from incidents was something that had been identified in some of the culture and values work and the regular conversations that we had with staff in services and more broadly across NHFT. There was no central repository for collating learning from such instances and a lack of consistent process for this function. Where learning was occurring, it was piecemeal and difficult to evidence. This was addressed by the development of the Learning Lessons Bulletin, coordinated through the Director of

Nursing's office as one of the aspects of the quality improvement work that was ongoing in NHFT at the time. We were then able to disseminate learning across the organisation from such incidents and ensure that teams were able to put this learning into practice, such as via "Learning the Lessons" bulletins [WITN0380063] and [WITN0380064].

Staffing Levels and Outsourcing

Staffing Guidelines and Policies

129. A common issue across NHFT, but especially in mental health services at this time, was the pressure on staffing and the ability to provide adequate staffing levels, particularly on inpatient wards. These were rightly seen as more difficult areas to work in due to the patient populations they served. Staff recruitment was sometimes difficult, particularly for more experienced staff, and recruitment and retention numbers remained challenging throughout my tenure and increased as the pandemic progressed.

130. This was compounded by the challenges to inpatient environments during the pandemic. This was perhaps more pronounced in adult mental health services, where many people presented with symptoms of persecution and paranoia and, in the initial stages, had to be nursed and cared for by people wearing masks and had to comply with health and safety protocols for the prevention, where possible, of the spread of COVID-19.

131. The staffing levels required across the different services of NHFT were informed by national guidance and professional bodies regarding what was appropriate, for example, for the size and staffing of adult mental health acute wards, intensive care units and specialities within community care. I have exhibited examples of such guidance to this statement [WITN0380084], [WITN0380065], [NHFT0011893] and [NHSE0000145].

132. Before addressing the detail of my responses on staffing levels more broadly, it is important to note that safe staffing in all its aspects was one of the most important and concerning issues for NHFT. This was the case from when I started at the beginning of

2019, and these concerns were compounded by the impact of the pandemic. In conversations with local, regional and national colleagues , I know this was a common experience among CEOs and directors of nursing. In my view, there are multiple factors relating to this, which I address later in my response.

133. The Trust followed the guidelines set out in NHFT policy, which was based on the guidance set out by NHS England and the National Quality Board. The safer staffing reports came to the Quality Committee and Board regularly throughout the year. Staffing was a significant issue for the ELT across all three divisions in terms of ensuring adequate staff numbers to provide clinical services. I exhibit a Safer Staffing Report that was presented to the board on 1 March 2022, by way of example [pages 104 – 112 NHFT0004943]. I also note that the CQC report of September 2020 states that adult wards "provided safe care....were safe and clean....had enough staff to meet the needs of the patient group".

134. In my view, the impact of these deficiencies would affect patient experience, whether through waiting times for access, for example in community teams, or the relative lack of staff time for treating and caring for patients on wards.

135. There were regular discussions in the ELT regarding how to mitigate these concerns, and a number of programmes were put in place as described below. I do not recall any specific instance where services had to be suspended due to lack of sufficient staff cover to provide a safe clinical environment.

136. Staffing levels were reviewed regularly by the ELT and overseen at Board level by the Quality Committee, with input from the People and Culture Committee, whose HR function related to the recruitment and retention of staff.

137. A number of programmes were put in place to address the ongoing issue of safe staffing. This is referenced in some detail, for example, in the day zero CQC presentation

in 2022 [WITN0380066]. There is a slide that describes safe staffing as being one of the five high-level organisational risks. The work in place included:

a. The creation of a Trust-wide safe staffing matron post with a team to collate and oversee this work

b. The use of evidence-based staffing tools, mental health optimal and safer nursing care.

c. The creation of best practice establishment reviews.

d. Workforce profiling to innovate and review skill mix.

e. Visibility of safe staffing across the organisation, with the concept of Board to ward being seen as critically important, and regular updates and information posts in the internal Trust newsletter (called Connect)

f. There was also a monthly staffing hotspot analysis, which included a review of patient safety, incidents, quality, experience and workforce issues.

138. This work was overseen by the Director of Nursing and Quality and reported to the Quality Committee via the ELT and to the Board [pages 16 – 19 NHFT0015013].

139. It is difficult to quantify any risk to patients and the public posed by inadequate staffing levels. This is partly because risk is a broad category, and the risk of a delay in accessing services, for example, has the potential to prolong symptoms and delay recovery, which is a significant detriment. At no time do I recall concluding, either as CEO or as a member of the ELT, that the relative lack of staffing in some areas posed a specific risk to the public.

Causes of staffing problems

140. As mentioned above, staffing had been an increasing and ongoing issue from my commencement with NHFT in 2019, and was not unique to NHFT, as other trusts were in similar circumstances. There are probably a number of reasons, which I identify below.

141. In particular, staffing in mental health services had become an increasing issue over a period of time following my commencement in the role. One factor frequently discussed was that working in inpatient environments was perceived as relatively unattractive, which included shift work and antisocial hours in clinical environments that could be extremely challenging for newly qualified staff, for example. This applied particularly to nursing and allied health professional staff rather than medical staff.

142. There was a culture of staff wishing to leave inpatient services and move into the community as soon as possible, which would result in less need for working shifts and antisocial hours. Again, this applied particularly to nursing and allied health professional staff, rather than medical staff. It is important to mention the relative unpopularity of working in mental health services for medical staff, which has been a long-standing issue. Recruitment to full establishment of consultants had also become a developing issue over a period of years.

143. Therefore, in both cases (medical staff, nurses and AHPs) NHFT was incurring increasing expenditure on agency staff to fill vacancies. This was probably one of the mitigations that had the biggest impact and enabled us to continue to provide services. Unfortunately, from a financial perspective, this was expenditure that was not budgeted and put significant cost pressure on our financial system.

144. Different services and geographical areas within NHFT had their own local issues with regard to recruitment. For example, Rampton Hospital is in a relatively geographically isolated location in North Nottinghamshire with a limited local population from which to recruit.

145. The above was compounded by the impacts of the pandemic and the requirement to change the way of working almost overnight, particularly on wards but also in community teams. Staff themselves were subject to numerous new health and safety requirements regarding the use of PPE and became aware of the potential increased risk of becoming infected with the COVID-19 virus of unknown severity. This led to ward environments becoming clinically very challenging places in which to work. As described previously, one example of this was having to care for people on adult mental health or intensive care wards who may have been experiencing significant paranoia and related symptoms as part of their illness, while receiving care from people wearing gloves, masks and gowns.

146. The impact of COVID-19 was ongoing for a period of time and was still impacting ward and community team function well into 2022, albeit in different waves. My reflection is that, over and above the specifics of the response to COVID-19, the broader societal issues of the pandemic had a detrimental impact on our ability to recruit and retain staff despite the mitigations described above. That was certainly my recollection and understanding until I left in the summer of 2022, as shown in weekly Covid workforce reports to ELT, examples of which are exhibited to this statement [WITN0380067], [WITN0380068] and [WITN0380069].

147. The adult mental health inpatient bed capacity was described in the commissioning contracts with the clinical commissioning groups at a specific financial figure and number, which I cannot recall, but it will be detailed in the contracts that we signed each year with the lead CCG.

148. Mental health generally, and adult mental health more specifically, did not have waiting time requirements for the use of inpatient beds, although there was, for example, waiting time monitoring for community services such as talking therapies (IAPT - Improving Access to Psychological Therapies).

149. The absence of waiting times for adult mental health inpatient admission was due to the fact that the vast majority of people being admitted in recent times to adult inpatient services were detained under the Mental Health Act 1983 and, by definition, required urgent admission to services.

150. However, as described above, in recent years the capacity of a trust's local services was regularly breached, and therefore people who needed to be in an inpatient mental health service had to be admitted out of area, to their detriment in as much that they were away from their families and friends, detached from their immediate support networks and local community services.

151. When I joined NHFT at the beginning of 2019, NHFT was identified both regionally and nationally as an outlier for excessive use of out-of-area beds. It had been difficult to implement successful improvements in this domain for some time. This was probably an example of the previous executive leadership structure's inability to focus on some of the key risks at the time, and an example of the Board being unable to lead and drive the change required to improve this situation.

152. In response to this specific question about capacity, I do not think that NHFT met the requirements, in that the in-house bed capacity was exceeded. In addition, the length of stay across adult mental health wards had increased and was regarded as relatively high in comparison to peer trusts. NHS England's Getting it Right First (GIRFT) team provided data in this respect, showing that it was a national issue. I have exhibited to this statement the pages of the GIRFT reports showing out of area statistics [pages 82 – 88 NHFT0001202].

153. The increased use of out-of-area placements specifically, and the ability of adult mental health services to manage both safe staffing issues and the broader impacts of the pandemic more generally , were discussed regularly by the ELT. I took the

decision in November 2021 to review the functioning of this directorate, particularly at Highbury Hospital, where the majority of the inpatient wards were housed.

154. I asked the ELT members to be more visible at Highbury and to offer their specific areas of expertise to help support the Executive Director for Mental Health Services at the time, whether in terms of safe staffing solutions, a review of recruitment and retention processes, quality monitoring or incident monitoring, to galvanise and support what was an extremely challenged service.

155. This was discussed regularly at the ELT and summary reports were taken to the Board to keep it apprised of actions in place and progress achieved, examples of which are exhibited to this statement [WITN0380070], [WITN0380071] and [pages 15 – 20 NHFT0002204].

Service Capacity and Out of Area Placements

156. This was a national issue for mental health services and was a key performance indicator that was regularly performance-managed at county, regional and national level. Upon my commencement in 2019, Nottingham was a national outlier in the number of out-of-area placements that were used, and this led to a sharp focus on the ability to discharge people promptly to create beds and enable a reduction in out-of-area placements. Out-of-area placements are regarded as fundamentally detrimental for patients, families and staff, as they often mean that at points of crisis, even when being detained under the Mental Health Act, people are admitted away from their families and their local social networks, which delays recovery and reintegration into society.

157. Within the first year, there had been significant improvements in the out-of-area requirements in Nottingham, and there had been a sustained focus on enabling timely discharge and, wherever possible, reducing admissions outside of the county. This was in part facilitated by the use of private inpatient mental health facilities in the county. Although they were technically recorded as out-of-area because they were outside the

NHS, there were at least benefits for patients and families in that they were relatively local to where they lived.

158. As stated, NHFT's use of out of area beds was high and we were on the national radar for the numbers. The progress made is set out in the exhibited documents of Out of area placement weekly reports to ELT [WITN0380072], [WITN0380073], [WITN0380074], [WITN0380075], [WITN0380076], and [NHFT0004157 pages 19 – 33]. As this was a high priority for NHFT there was an increased focus on in-patient ward processes and through discussions with the Clinical Directors and General Managers with myself and the new executive director for Mental Health services. In particular there was an emphasis on more formal discharge planning and exploring issues of delay, often to my recall related to lack of suitable accommodation.

159. As mentioned previously, this had become a national issue and, in my view at the time and on reflection, was in part related to the continued reduction of inpatient services for mental health patients over many years. There was a view that an inpatient admission was potentially a failure of community care provision, and that inpatient admission was a relatively expensive provision that, if possible, could be avoided with people being cared for in the community.

160. In my view, the number of beds available had decreased to a point where they were not sufficient to provide adequate inpatient services for these patients, and this led to the increased use of out-of-area and private sector facilities both locally and nationally. Private companies were more agile and able to either buy or build inpatient facilities that met the specific requirements for mental health patients, whereas the NHS found it much more difficult to do this in an extremely constrained financial environment.

161. We were fortunate to be able to purchase a relatively new inpatient facility from the private sector close to Mansfield. This became Sherwood Oaks Hospital, which NHFT

took over in November 2020 and, after refurbishment and conversion to an open adult site, commenced using in December 2022.

162. As described, the pandemic did compound the out-of-area challenge, but there had been significant improvements in the headline rates from when I commenced at NHFT to when I left. On reflection, I do not think this is something that NHFT can address on its own for the reasons stated above.

163. It is difficult to ascertain or conclude with certainty that there was a correlation between staffing levels and out-of-area placements. Out-of-area placements had become a feature prior to staffing levels becoming quite so concerning, i.e. through 2017-18.

164. Out-of-area placements were a regular item in ELT discussions and were taken to the Board, which took oversight and ensured that there was an appropriate response to the concerns being raised both locally and nationally.

165. I do not recall any specific instance of concerns being raised regarding inappropriate or premature discharge prior to the pandemic, when it was easier to visit and have conversations with teams on the ground. It was not unusual to hear about concerns regarding the size of community caseloads. These would be conversations with staff who may have been reluctant to discharge people. Their caseloads were full and hence there was a wait in the community for new patients to be taken on by care coordinators, for example.

166. The issue of delayed discharge from inpatient wards is multifactorial and would include, for example, an absence of community staff with spaces on their caseload or the absence of suitable accommodation, whether independent or supported housing with appropriate community oversight. This was a common theme of conversation, but I do not recall whether these specific issues were escalated to the Board in terms of

inappropriate or premature discharge. These issues would have been included in conversations about staffing levels, use of out-of-area beds, etc.

Multi-Agency Working

167. I have been asked by the Inquiry to consider Multi-Agency Working and information sharing. In response to this, I will split the answer into two main parts. The first relates predominantly to the sharing of information about patients and service users, as I think this falls under a slightly different heading than the broader information sharing that NHFT undertook with other bodies.

168. Overall, the holding and sharing of all information was overseen by the Information Governance Department in NHFT and under the Data Protection policies [NHFT0015703] and [CQCM0024346].

169. In broader terms, with regard to the sharing of patient-related information, the guidance largely falls under the heading of data protection and privileged information protocols. In as much that is clinical information provided by patients is essentially confidential and retained and maintained by the appropriate clinical team in safe and secure ways, often using digital records with appropriate safeguarding. There are rules regarding where and when these can be overridden and personal information shared with other bodies. A prime example of this would be if clinical information provided is of such concern, where there is risk to self or others, that clinicians would ordinarily consider this a reason for other bodies to be informed. For example, sharing of patient information with primary care colleagues, tertiary healthcare providers, acute trusts, voluntary bodies and also local authorities, particularly social work officers, and the police, who were regularly involved in undertaking both formal and informal assessments of patients with either known or potential mental illness.

170. In my view, these patient-related information protocols were well understood by individual clinicians and by clinical teams, and were accepted as part of good practice.

171. With regard to less formal identifiable patient information, the regulations regarding sharing were less proscribed. For example, during my time at NHFT, there was the development of a much more coherent body of health providers, community providers and social service providers that was initially referred to nationally as Sustainability and Transformation Partnerships (STPs) and subsequently became Integrated Care Partnerships (ICPs). These comprised senior leaders from hospital trusts, both mental health, community and acute, ambulance services, primary care, commissioners, and local authorities that had the responsibility for setting the strategy for the provision of healthcare in all its forms across the county.

172. In that regard, as these developed, there was increasing sharing of data and resource information between these bodies, which began to meet on a monthly or bimonthly basis.

173. A good example of when these two different aspects of information sharing would overlap is at a Board meeting of the Integrated Care Partnership, when one of the trust providers might provide an example of a case history to highlight particular aspects of multi-agency working or shared care. These were often well received but obviously led to the potential for breaches of confidentiality. However, wherever possible, these were done in the presence of the patient or service user, who were usually keen to volunteer their experiences of care to share with a broader audience and to highlight aspects that may have been deficient or, indeed, particularly successful. I have exhibited to this statement an Integrated Care Board agenda by way of example [WITN0380077].

174. The process I have described of larger organisations beginning to work together was iterative and I know has continued nationally. My view at the time was that the process

and protocols in place had sufficient safeguards to protect against inappropriate sharing of information, but I would not be surprised if, since I retired, there are more prescriptive policies in place to reinforce these protections.

Relationship with the Police

175. My recollection of the relationship between NHFT and the police is at two different levels. The first is perhaps best referred to as the day-to-day relationship between clinical services generally and the local police, who would be called regularly for help with potentially dangerous clinical assessments in the community and would occasionally be called to clinical environments if there were significant incidents and people's safety was at risk. The police would, of course, be involved directly with calls to consider taking action under the Mental Health Act, where they have a statutory duty that enables them to detain people who in their opinion warrant a Mental Health Act assessment. These arrangements by and large worked well across NHFT in the main clinical centres and did so without the requirement for specific policies and guidance, as it was seen as 'part of the day job'.

176. During my time as CEO both at LPFT and NHFT, this regular practice had become more challenging, particularly from a police force perspective, and I remember there being concerns raised nationally. I cannot provide specific references regarding the amount of time it was taking for police to undertake these mental health assessments and the increased wait required for mental health services to attend and complete them. However, I do not think this was simply a Nottinghamshire or East Midlands issue, but one that had become a national concern.

177. The other aspect of the relationship with the police was at a more strategic and senior level. My recollection is that there was limited contact between senior healthcare officers and senior police officers. This was not for any specific reason other than that it had never been established.

178. That is not to say that there was not forward thinking in terms of how services could adapt, for example, there was the implementation of a community psychiatric nurse sitting with the police handling desk and being present in their vehicles to jointly do assessments, which would not uncommonly entail seeing people that were known to services and this was extremely well received when it was introduced.

179. However, on reflection, the lack of senior-level contact and discussion of strategic issues was a deficit in the multi-agency work that NHFT undertook.

180. My recollection is that when starting with NHFT and commencing my programme of getting to know the local stakeholders from other organisations, a regular piece of feedback was that NHFT had become disconnected from the system more broadly and had become insular in the way that it worked.

181. This was regular feedback from multiple sources and was included in the culture and values work that we initially undertook in 2019 to ensure that, from a strategic perspective, we responded to this feedback positively and became a valued and central partner in the broader work of the local health and social care economy

182. I particularly felt this was important from a mental health perspective, as it is detrimental to broader aspects of patient care, rehabilitation and overall well-being if mental health services are seen in isolation. For example, there is an often-quoted statistic that 90% of all mental health care is provided in primary care, and no matter how large a secondary care trust is, the patients they see are the tip of the iceberg.

183. Also, in relation to the description above of the development of more system working at county level, it was imperative for me that NHFT became an integral partner in how the local system worked and took responsibility not only for the mental health aspects of provision, but for a broader view in terms of the health and well-being of the population in the county.

184. At the time of my retirement NHFT was actively involved and leading in the evolving healthcare system in Nottinghamshire and more broadly across the east Midlands. NHFT was lead provider for the East Midlands forensic mental health Provider Collaborative (IMPACT), which commissioned and provided in-patient beds across the five counties. I chaired the Board for this from the outset in 2021. Within the county of Nottinghamshire, there were newly formed Integrated Care Providers (ICPs) working in a geographically defined area, and NHFT led for the south of the county with GPs and local authorities involved. I chaired this Board from the outset in 2021. NHFT was also a core member of the East Midlands Alliance, working strategically with the other four county mental health trusts (Derbyshire, Leicestershire, Northamptonshire and Lincolnshire) again to develop joint strategy, share good practice and improve quality. This was usually at a CEO level but evolving workstreams would involve executives.

185. During the pandemic NHFT took the lead role jointly with the lead commissioning group to oversee the vaccination response. I chaired the Covid oversight Board for the county. Following on from the pandemic, health inequalities became a major national topic due to the differential impact of the virus in different demographic groups. Again on behalf of NHFT I chaired the newly formed multi-agency Health Inequalities Board, reporting to the STP then ICP Boards. It included members from CCGs, acute Trusts, Local Authorities and public health departments from 2021. NHFT was part of the local provider collaborative with the two acute trusts in the county, Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust. This was a new initiative to explore better organisational alignment, develop joint strategies and share good practice. This was largely at a senior leader level and was in its early stages as I retired.

Information sharing with patients' families

186. In terms of when NHFT would discuss a patient's care or otherwise share their information with a patient's family, I can provide my perspective from both NHFT Board

and clinician perspective. As referenced earlier, clinical teams and individual clinicians are clear about the boundaries regarding sharing of personal confidential information. This would only ever be indicated if there were particular concerns regarding the safety of the patient, family or others, and was not a particular issue that was raised, in my recollection, at the ELT or Board.

187. There may have been circumstances where confidentiality had been breached, and the individual clinical teams would need to respond if this had been raised as a complaint or a serious untoward incident. I cannot recall specifics where that had been the case, although it does happen from time to time. The Board receives an annual report from the Senior Information Responsible Officer (SIRO) on data security serious incidents [pages 56-64 NHFT0001173] and [pages 31 – 32 NHFT0003916].

188. I do not recall that the executives or Board were made aware of concerns relating to information sharing with patients' families. I do know that it was more likely that families would be concerned that they had not been consulted or informed of issues by clinical teams, and the most common response to that was that there was a specific request from the patient that information not be shared. The matter then relates to the patient's capacity to understand the nature of the request not to share and the potential risks of not doing so, which would be a decision for the clinical team to make.

Reflections

189. Overall, I am pleased with the positive improvements made during the first pre covid time including huge increase in National Staff Survey scores, great place to work, positive staff feedback, Board turnaround, executive appointments, system working and additional new contracts (commissioning).

190. This was always going to be a longer term project with a 5 year time-line and a continual refresh of strategy and objectives. The pandemic had a massive detrimental impact on this work as we refocussed our response to Covid-19. Overall as a Trust this

response was as good as it could have been in the circumstances: we maintained core services and developed positive working practices with the wider health and care system.

191. I have been asked by the Inquiry whether I have any reflections regarding the way that information was shared between NHFT, other healthcare providers and other agencies / persons. At the time I was in post, and subsequent to this investigation, of the many things that we discussed and thought about, the information sharing agenda was not a high priority. There were no major concerns or issues that I can recall. There was a major piece of work with the changes to the Data Protection Act (DPA) but this centered more on the Trust's responsibilities around handling patient information.

192. As to whether there are any improvements that could be made locally and nationally to multi-agency working and information sharing to increase effectiveness in preventing similar outcomes in the future, I think this is a difficult area to balance, between the confidentiality of the patient as against the needs to protect the wider public. Mental health services have struggled to find this balance over many years. There can always be improvements made to working relationships across multiple agencies to aid information sharing both at a senior executive level and in the local teams.

193. The Inquiry has asked what improvements I think could be made to NHFT or the healthcare sector generally in mental health services provision and, in particular, the care of mentally ill patients who may pose a risk to the safety of others. I was not at NHFT at the time of the events on 13 June 2023, nor involved in any of the investigations, so at this stage I can only comment in broad terms that the following are crucial aspects in mental health services provisions, and are areas which can be continually improved:

a. Maintaining high standards of clinical knowledge and skills around clinical assessment, including risk assessments.

b. Emphasising the core skills needed for: differential diagnosis, treatment planning, and appropriate liaison with family, next of kin and carers.

c. The provision of appropriate and timely services dependent on the nature of their illness, for example, access to appropriately trained and staffed teams and access to local facilities that meet the required safety of accommodation standards and access to appropriately trained staff in the management of these conditions.

194. I think the impact of service change decisions, e.g. bed closures, can have gradual detrimental effects over a number of years. During this time personnel may change and there is no organisational or system learning. Therefore there is no link made between cause and effect. A national strategy of the reduction in mental health beds, I think skews the focus as to what types of service provision are important and prioritised. I think there is an overall lack of appropriate acute beds in the NHS for patients with serious mental illness.

195. The assessment of risks in patients with serious mental illness is never black and white and judgements have to be made, in often changing circumstances. Mental health practitioners have grappled with these challenges over many years, a balance always has to be struck between individual personal freedoms and the wider safety concerns of the population at large. If the balance is shifted to a more risk averse position, patients may be treated in more restrictive environments for longer than is needed. A balance needs to be made that ensures high quality clinical practice, that is, knowledge skills and experience is valued and that the assessment of risk is part and

parcel of this, not a separate entity. This needs to be embedded in the organisational culture and having senior clinical leaders is an imperative to enable this.

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: 15/01/2026

Index to First Witness Statement of Dr John Brewin

No.	Inquiry URN	Document Description
1.	WITN0380002	Schedules for Clinical Assessment in Neuropsychiatry: article explaining SCAN
2.	WITN0380003	CQC's reports for LPFT in 2015
3.	WITN0380004	CQC's reports for LPFT in 2018
4.	WITN0380005	Chief Executive & Accounting (Accountable) Officer - job description and person specification
5.	WITN0380006	Senior Management Structure Chart - 7 January 2019
6.	CQCM0027411	Letter from NHSE and NHSI re NHS RESPONSE TO COVID-19 dated 17 March 2020
7.	WITN0380007	Letter from NHSE re: Third Phase of NHS Response to COVID-19 dated 31 July 2020
8.	WITN0380008	NHSE's website letter to all CEOs re: Reducing burden and releasing capacity to manage the Covid - 19 pandemic dated 26 January 2021

9.	WITN0380009	Decisions and Derogation Master Log
10.	NHFT0003538 (pages 19 – 24)	Emergency Board and Committee ToR dated 7 April 2020
11.	NHFT0005991 (pages 8-9)	Board of Directors (Public Meeting) Emergency ToR dated 2 February 2021
12.	WITN0380010	COVID-19 Business Continuity ToR for Board and Committees dated January 2021
13.	WITN0380078	FT Constitution - Dated February 2018
14.	NHFT0004747	Quality Committee ToR dated 5 March 2019
15.	WITN0380011	Workforce, Equality and Diversity, also Senior Independent NED ToR dated 11 June 2018
16.	WITN0380079	Finance and Performance ToR dated 7 February 2019
17.	WITN0380080	Audit Committee ToR approved on 6 February 2018
18.	WITN0380012	Mental Health Legislation ToR updated November 2019
19.	WITN0380013	Senior Leadership Team (SLT) ToR dated May 2021
20.	CQCM0016462	CQC Driving improvement Report: Case studies from seven mental health trusts
21.	NHFT0002015	CQC Report dated May 2019
22.	WITN0380014	Nomination and Remuneration Committee dated 29 August 2019
23.	WITN0263012	Nominations and Remuneration Committee ToR for Board - approved on 30 March 2017
24.	WITN0380015	Internal assessment - Governance and Risk Management Report by 360 Assurance in June 2020
25.	NHFT0004957	Board of Directors (Public Meeting) - External Well-Led Review – Action Plan dated 3 November 2020
26.	WITN0263056	Risk Committee Terms of Reference approved November 2020

27.	WITN0380016	NHS Staff Survey Results 2020
28.	WITN0380017	One Trust core management structure for directorates
29.	WITN0380018	Board Development Agenda: Vision, Values and Purpose – Session One dated 27 June 2019
30.	WITN0380019	Board Development Agenda: Building an effective Board dated 29 August 2019
31.	WITN0380020	Board Development Agenda: Equality, Diversity and Inclusion dated 22 October 2019
32.	WITN0380021	Board Development Agenda: Information Governance training, Making Data Count dated 10 December 2019
33.	WITN0380022	Board Development Agenda: Strategic review of previous year (2019) and looking ahead - dated 21 January 2020
34.	WITN0380023	Board Development Agenda: Review of Board committees, risk management and assurance from BAF, CQC preparations dated 11 February 2020
35.	WITN0380024	Board Development Agenda: Cyber security presentation (external) dated 10 March 2020
36.	WITN0380025	Board Development Agenda: CQC inspection preparation including well-led and specific Board prep dated 29 June 2020
37.	WITN0380026	Board Development Agenda: INstitute for Mental health review (external input) and broader review of research programmes dated 11 Dec 2020
38.	WITN0380027	Board Development Agenda: Freedom to Speak-up self-assessment and Board training dated 9 March 2021
39.	WITN0380028	Board Development Agenda: Maintaining high professional standards dated 13 Apr 2021

40.	WITN0380029	Board Development Session: Review and proposals to develop the Quality Improvement programme dated 23 November 2021
41.	WITN0380030	Executive and Non-Executive Director changes between 2019 – 2022
42.	NHFT0001778	CQC inspection report dated 23 September 2020
43.	NHFT0000829	Public Board Papers dated 25 April 2019
44.	NHFT0001208	Public Board Papers dated 30 May 2019
45.	NHFT0002372	Public Board Minutes dated 31 October 2019
46.	WITN0380031	Core and Well Led Tracker dated 2019
47.	WITN0380081	CQC Action Plan Update from December 2021 – Update for AMH 16 February 2022, dated 3 February 2022
48.	WITN0380032	Adult Mental Health Improvement Board ToR dated 30 June 2020
49.	WITN0380033	Improvement Board for Lings Bar Agenda dated 28 June 2021
50.	WITN0380034	Lings Bar Hospital Improvement Board presentation dated 28 June 2021
51.	WITN0380035	Rampton Improvement Board Minutes dated 13 September 2019
52.	WITN0380036	Trust Activity Ratings Poster dated 24 May 2019
53.	WITN0380037	Trust ratings poster dated 16 October 2019
54.	WITN0380038	Trust ratings poster dated 24 January 2020
55.	WITN0380039	Trust ratings poster dated 27 May 2020
56.	WITN0380040	Trust ratings poster dated 31 March 2021
57.	NHFT0001173	Public Board of Directors Minutes dated 5 July 2022
58.	NHFT0003849	Public Board of Directors Minutes dated 1 March 2022

59.	WITN0380041	AMH Inpatient Improvement Board Minutes dated 15 November 2021
60.	NHFT0001289 (pages 92-98)	Public Board of Directors re: Review and learning from Patient, Staff, Carer Stories - 6 month update dated 6 September 2022
61.	NHFT0003341	Public Board of Directors Minutes Staff Survey dated 5 April 2022
62.	NHFT0003766 (pages 16 – 21)	Public Board of Directors Meeting Minutes: Freedom To Speak Up dated 2 March 2021
63.	NHFT0004943 (pages 104 – 112)	Public Board of Directors Meeting Minutes: Safer Staffing dated 1 March 2022
64.	NHFT0001844 (pages 36 – 38)	Public Board of Directors Meeting Minutes: Infection Prevention Control dated 27 August 2021
65.	WITN0380042	Infection prevention and control board assurance framework dated 12 February 2021
66.	NHFT0003520 (pages 90 – 92)	Quality & Mental Health Legislation Committee paper dated 15 February 2022
67.	WITN0380043	Mental Health Legislation: Quarterly Report 2021 – 2022 Quarter 3
68.	WITN0380044	Board Walk Visit Log: Executive Assurance Visits April 2019 to March 2020
69.	WITN0380045	Board Walk Visit Log: Executive Assurance Visits April 2021 to March 2022
70.	WITN0380046	Board Walks and Council of Governor (CoG) Assurance Visits - Updated June 2020
71.	WITN0380047	Board Walk Feedback Template

72.	WITN0380048	NHFT & Healthwatch update meeting dated 22 October 2021
73.	NHFT0014979	Governance Review Presentation dated 6 October 2020
74.	WITN0380049	Quality Standards Assessment Guide Template
75.	WITN0380050	Quality Standards Report Rowan 2 dated 22 May 2023
76.	WITN0380051	Quality Standards Report Redwood 2 dated 27 and 28 July 2022
77.	WITN0380052	Culture of Care Review Tool
78.	NHNB0015820	Closed- Cultures 7 minute briefing poster
79.	NHFT0014993	Quality Governance Workshop presentation dated 21 April 2022
80.	WITN0380053	Public Board Minutes re: Integrated Performance Report dated 12 March 2021
81.	NHSE0002306	Freedom to speak up national Policy eBook dated 2 June 2022
82.	NHFT0003766 (pages 26-39)	Public Board Minutes re: Integrated Performance Report dated 2 March 2021
83.	NHFT0004589 (pages 36-62)	Public Board Minutes re: Integrated Performance Report dated 4 May 2021
84.	NHFT0002204 (pages 5-9)	Private Board minutes dated 2 November 2021
85.	NHFT0003395 (pages 5-7)	Private Board minutes dated 7 December 2021
86.	WITN0380054	Email re: Highbury Hospital; urgent; in confidence dated 29 October 2021

87.	WITN0380055	Diary Entry re: Please prioritise Urgent Exec Meeting re Highbury Hospital dated 1 November 2021
88.	NHNB0011658	Omicron operational letter dated 13 December 2021
89.	WITN0380056	ELT Minutes re: Highbury Improvement Plan version 8 - dated 19 January 2022
90.	WITN0380057	People Culture equality and Inclusion Committee Minutes dated 20 January 2022
91.	NHFT0008146	AMH Inpatient Improvement Board Minutes dated 16 May 2022
92.	WITN0380058	Board Assurance Framework slides for Board workshop dated 22 September 2020
93.	NHFT0007067	Report from Anna Pridmore on proposed changes to Board Assurance Framework and Risk Management dated September 2020
94.	NHFT0007066	Appendix 1 Summary of the outcome of the ELT workshop meeting held on 12 August 2020
95.	NHFT0005997	Appendix 2 Briefing paper on using CQC Key Lines of Enquires dated September 2020
96.	NHFT0005192	Appendix 3 Slides for writing a risk statement
97.	WITN0380059	Appendix 4 Draft framework 7 September
98.	WITN0380060	Board Development Session dated 5 October 2021
99.	WITN0380061	Board Development Session dated 28 April 2022
100.	WITN0380062	Trust Risk Management Strategy 2021 – 2026
101.	WITN0380082	Appendix 1 Risk man strategy 2021 - 2026
102.	NHFT0000596	Managing Serious Incidents and Reporting and Learning from Deaths Policy
103.	NHFT0013458	Serious Incident Review Group ToR dated November 2020

104.	WITN0380083	Private Board of Directors minutes dated 1 June 2021
105.	NHFT0007053	Private Board of Directors minutes re: Reportable issues log dated 1 June 2021
106.	NHNB0017362	NHS England Serious Incident framework dated 27 March 2015
107.	WITN0380063	Trustwide Lessons Learnt Bulletin Highlighting Lessons from Complaints, Serious Incidents and Audits dated January 2022
108.	WITN0380064	Lessons Learnt Bulletin Highlighting Lessons From Complaints, Serious Incidents and Audit Activity dated February 2021
109.	WITN0380084	In-Patient Safe Staffing Policy dated July 2020
110.	WITN0380065	In-Patient Safe Staffing - Essential Guidance to Defining and Managing Nurse Staff Resources
111.	NHFT0011893	Trustwide Safer Staffing Policy dated 8 July 2022
112.	NHSE0000145	National Quality Board Safe, sustainable and productive staffing publication
113.	WITN0380066	CQC Well-led presentation dated April 2022
114.	NHFT0015013 (pages 16-19)	Quality and Mental Health Legislation Committee re: Safer Staffing 6 Monthly Report dated 12 August 2021
115.	WITN0380067	National SitRep dated 4 May 2021
116.	WITN0380068	National SitRep dated 16 March 2021
117.	WITN0380069	National SitRep dated 30 March 2021
118.	NHFT0001202	Getting It Right First Time Report – Trust's Adult Crisis and Acute Care dated January 2020

119.	WITN0380070	Executive Leadership Team (ELT) meeting re: Highbury Improvement Plan Version 2 dated 17 November 2021
120.	WITN0380071	ELT Report dated 18 August 2021
121.	NHFT0002204 (pages 15 – 20)	Private Board Meeting re: Highbury Improvement and Business Continuity Plan dated 7 December 2021
122.	WITN0380072	Out of area placement charts dated 27 June 2021
123.	WITN0380073	Out of area placement charts dated 25 July 2021
124.	WITN0380074	Out of area placement charts dated 8 August 2021
125.	WITN0380075	Out of area placement charts dated 26 December 2021
126.	WITN0380076	Out of area placement charts dated 27 March 2022
127.	NHFT0004157 (pages 19 – 33)	Public Board of Directors Integrated Performance Report dated 2 February 2021
128.	NHFT0015703	(Issue 3) Data Protection Policy dated March 2023
129.	CQCM0024346	(Issue 1) Data Protection Policy dated March 2019
130.	WITN0380077	Integrated Care System Board agenda dated 15 February 2019
131.	NHFT0001173 (pages 56-64)	Public Board of Directors re: Senior Information Risk Owner (SIRO) Annual Report dated 5 July 2022
132.	NHFT0003916 (pages 31 – 32)	Data Security Serious Incidents 01 April 2021 to 31 March 2022
133.	CQCM0016478	CQC NHFT Inspection Report dated 25.11.2022