Witness Name: Paul Devlin

Statement No.:

WITN0390001

Dated: 12 February 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF

PAUL DEVLIN

I, Paul Devlin will say as follows; -

Introduction

1. I was the Chair of Nottinghamshire Healthcare NHS Foundation Trust ("**NHFT**") between January 2020 and December 2025 when I left the organisation following completion of my second three-year term. I no longer hold any NHS role.

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 9 December 2025 ("**the Request**"). In this statement, I discuss my recollections and experience of being Chair of NHFT.

3. This witness statement was drafted by me, 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 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.

Background

Pre-NHS Board career

4. Prior to my NHS Board career, and following a degree in Psychology at Hull University, I had 26 years working in health-related roles and organisations, predominantly national charities.

HIV/AIDS Work (1988-1997)

5. From 1988, I spent nine years in the HIV/Drugs field, starting with two years as the sole paid worker for OXAIDS, a local charity providing volunteer-led support and education on HIV/AIDS. The organisation was built around providing community-based support at a time when HIV was poorly understood and with almost minimal effective healthcare interventions, resulting in very short lifespans, as well as being in a national social context of fear and prejudice.

6. Following a one-year contract (1990 – 1991) as a Project Worker at the Federation of Independent Advice Centres, where I designed and delivered HIV training for advice centres throughout England, I joined the London Borough of Tower Hamlets Social Services as Training Officer – HIV/Drugs, spending two

years (1991 – 1993) designing and delivering training on HIV and drugs for staff in all services across the borough.

7. In 1993 I joined The HIV Project, a London-based organisation focused on driving best practice in the delivery of HIV-related education and care throughout England. At the time of joining, this was an NHS department, but it became a standalone charity whilst I was there. My role was to design and deliver professional development modules for HIV trainers ("Training the trainers" courses), to write good practice guidance for professional trainers, and to carry out training commissions on behalf of the organisation. This work directly influenced the approaches to training delivery on HIV throughout England.

8. During this time, I completed post-graduate studies in Training & Development, in Management Competency, and in Human Resource Development, awarded by South Bank University and the Institute of Personnel & Development. These academic studies informed my design of development and training modules, and also informed my later work in NHS Boards, including leading them as Chair, as I learned skills to enable groups to work effectively together, to manage challenging discussions, and to enable them to become "more than the sum of their parts".

Age Concern (1997-2007)

9. In 1997 I left The HIV Project, and I joined Age Concern England (a precursor of Age UK), which was a national organisation providing strategic, political, and organisational support to over 400 autonomous local Age Concern charities. I held three different roles at Age Concern England:

    a) National Development Manager: Quality & Training (1997 – 2003)

b) Head of the Federation Secretariat (2003 – 2006)

c) National Trustee Support Manager (2006 – 2007)

10. As Head of the Federation Secretariat, I developed expertise in governance including, but not limited to, charity law, the roles of Trustees and Boards, and the good governance of service contracts with public sector bodies including the NHS. I was also responsible for maintaining best practice at a national level, including interaction with NHS England and its equivalent national bodies in Scotland and Wales.

11. I led the design of tools that member groups and organisations had to complete and be assessed against to demonstrate their ability against expected standards in practice, including in good governance, under their assurance framework "*Quality Counts*". This role gave me a strong grounding in governance, Board responsibility and oversight, the delivery of services to marginalised people, driving best practice in services, and challenging providers where services fell short of reasonable expectations from service users.

12. My year as National Trustee Support Manager was leading a project which delivered training to the trustees that made up the charitable Boards of all 400+ autonomous organisations, to enable them to understand and carry out their functions as the Board with legal responsibility for their local organisation.

13. In my last year at Age Concern England, I obtained my first NHS Board role, as a Non-Executive Director at NHS Derby & Derbyshire NHS Primary Care Trust ("PCT"). I will detail my NHS roles, after covering the rest of my non-NHS career.

Further Charity Roles (2007-2014)

14. In 2007 I spent a year as the National Director of Services for Headway, the Brain Injury Association, a UK-wide role in which I was responsible for supporting (and occasionally challenging) local, autonomous organisations and groups delivering services for those affected by brain injury. This work required knowledge of the legislative and regulatory framework for charities in Northern Ireland, Scotland and Wales, as well as in England.

15. In 2008 I began a five-year appointment as Head of Inclusion at Action for Children, a national role to establish, manage and lead the charity's UK-wide equality, service user participation, customer service, and volunteering portfolios, supporting local delivery through the network of local Action for Children groups and projects.

16. In 2013 I was appointed the first Chief Executive of Healthwatch Birmingham, the local consumer champion working with Birmingham's complex network of health and social care commissioners and providers. I spent a year establishing the organisation and representing service user and public voices direct to commissioners and providers, including in formal settings such as the Health & Wellbeing Board, the Quality Surveillance Group, and the Better Care Fund Board.

Consultancy Work (2015-present)

17. Since my days at Action for Children, I have occasionally been asked to deliver consultancy on specific projects to a variety of organisations. In 2015 I formalised my consultancy by establishing *Because It Matters Ltd*, a small organisational consultancy company specialising in Governance, Leadership,

Planning, Team Building, Equality, Strategy, and Individual Coaching. [Exhibit: WITN0390002]. I still co-own the company.

18. Through Because It Matters Ltd, I have become recognised for my expertise in the support and development of Boards and senior leaders, with a reputation for a strong knowledge of good governance, particularly in healthcare. My client group has included NHS England, NHS Leadership Academy, NHS Providers, and local and national Healthwatch, as well as other local and national health-related organisations. I have consistently given *pro bono* coaching on leadership and career development to senior leaders from under-represented backgrounds.

19. Through my consultancy I became an Associate of NHS Providers, the membership organisation of NHS Trusts providing services throughout England, and am a key member of the team designing and delivering their Board development programmes, including *New Non-Executive Director induction* [Exhibit: WITN0390003], *New Executive Director induction* [Exhibit: WITN0390004], contributing to their Aspiring Chairs and Aspiring Executive Directors programmes, and leading their *Essential Chairing Skills* and other programmes. I have been commissioned by NHS Providers for bespoke pieces of work with member organisations on governance-related matters, and I am regarded as an experienced Chair who can support and challenge others. I have led and contributed to workshops at NHS Providers national conference and chaired their 2025 national Governor Focus conference [Exhibit: WITN0390005].

20. Through Because It Matters Ltd, I have also written occasional blogs on aspects of good governance and Board culture [Exhibit: WITN0390006].

21. Since my departure from NHFT, I am currently continuing with my consultancy work through Because it Matters Ltd.

22. Alongside my paid roles, I held voluntary (unpaid) Board roles as a director or Trustee at three organisations, between 2002 and 2021.

NHS Board Roles

<u>Derby & Derbyshire NHS Primary Care Trust (2007-2015)</u>

23. In 2007 I was appointed to my first NHS Board role, as a Non-Executive Director of NHS Derby & Derbyshire PCT, which I continued in through to the dissolving of PCTs in 2013. In this role, I became a senior Non-Executive Director, chairing the Resource & Investment Committee which advised the whole Board on its spend of a £1.6bn commissioning budget, and being a member of the Audit Committee.

24. I was one of three Non-Executive Directors to have their term of office extended to oversee the transfer of commissioning to the new Clinical Commissioning Groups (CCGs). As part of this transition, I uniquely brought local clinical leaders into the Resource & Investment Committee prior to the formation of CCGs to help accustom them to the commissioning environment, applying my knowledge of good governance, and recognising a gap in the understanding of governance in the local GP community.

25. I was a Non-Executive on the Shadow Board of Erewash CCG and was part of the team that secured its formal recognition through the rigorous NHS England CCG authorisation process.

Lincolnshire Partnership NHS Foundation Trust (2015-2021)

26. In 2015 I was appointed to my first NHS Trust Chair role, at Lincolnshire Partnership NHS Foundation Trust ("LPFT"). After a three-year term, I was successful in being confirmed for a second three-year term, which I completed at the end of April 2021 (LPFT's Constitution limited the Chair to two three-year terms, aside from in "extraordinary circumstances"). LPFT provides mental health and learning disability services across Lincolnshire, including low- and medium-secure forensic services and a range of other in-patient and community services.

27. During my period of office at LPFT I aimed to be an influential, politically astute system leader, engaging with a diverse range of sometimes conflicting politicians, commissioners, providers and other stakeholders, including NHS bodies, local authorities, the police, faith leaders, and community groups.

28. I provided Board-level leadership to cultural transformation programmes that led to increased staff and patient involvement, leadership development, and the design and embedding of new organisational values and leadership behaviours.

29. As with all providers of mental health services, during my time at LPFT there were some serious incidents, including patient self-harm and harm to others, and, sadly, some tragic deaths, both of service users and, rarely, caused by service users. I instilled and led a Board culture of candour and full reflection on practice, seeking out improvements that were required and driving a culture of learning, not blame, whilst maintaining individual and organisational responsibility. I led and oversaw the introduction of a risk appetite framework to help the Board confidently assess new ways of working and potential service

changes, and to hold Board-level assurance of the organisational skills to manage and deliver complex services, including mental health services that carry inbuilt elements of clinical and service risk.

30. In my penultimate year at LPFT, the country was hit by the COVID-19 pandemic, which I address later in this statement.

31. In 2016, whilst at LPFT, I became a Specialist Advisor (Governance) for the Care Quality Commission ("CQC"), a role I held for seven years. During this time, I contributed to 20+ full and Well Led inspections of a variety of providers of mental health and learning disability services, including NHS Trusts and some private providers. My experience in governance and as a Chair led to me acting as chair of many full inspections and being brought in by the CQC to advise in particularly challenging circumstances, including where they had serious concerns about the governance capabilities of providers. Through my time with CQC, I saw first-hand the standards of governance that contributed to ratings from "Inadequate" to "Outstanding" and also understood the critical assessment of Boards' oversight and assurance roles in the delivery of services and how that is – and should be – separate from individual clinical assessments of risk with individual patients and service users.

32. When I joined LPFT, Dr John Brewin was the Chief Executive there. We worked together until he moved to NHFT in January 2019 and had developed a strong professional relationship which helped us drive improvements at LPFT.

<u>NHFT - Appointment (2019)</u>

33. During 2019, when it became known that the previous Chair at NHFT would be finishing at the end of the calendar year, Dr Brewin and I discussed whether I

might be interested in applying for the role, given that we both felt that our joint focus on improvement at LPFT would be transferable to NHFT. Whilst the timing, given I was committed to completing my full term of office at LPFT was not ideal, I spent time weighing up the opportunity. I knew NHFT was a larger trust, with a wider range of mental health services (including being one of the three high secure forensic service providers in the country) along with its range of community services. I became aware of some of the issues NHFT had at that time, including a sense of an historical "blame culture" reportedly felt by some staff, that potentially meant staff felt less able to report concerns to senior managers. There were some specific improvement challenges (such as the experience some staff had of racism, the best use of data, and Board culture) that mirrored, albeit on a larger scale, issues I had faced at LPFT which, alongside Dr Brewin, I believe we had demonstrably improved, as shown through the National Staff Survey and significantly improved CQC ratings. I have exhibited to this statement the CQC's reports for LPFT in 2015 and 2018 [Exhibit: WITN0380003] and [Exhibit: WITN0380004].

34. I was appointed Chair at NHFT in November 2019, to begin at the start of January 2020 [Exhibit: WITN0390007]. Following my first three-year term, I was appointed to a second and final three-year term which was completed at the end of December 2025. The six-year limit is consistent with the NHS *Code of governance for NHS providers trusts [*Exhibit: NHSE0000522, section C, para. 2.13 and para. 4.3]. Confirmation of the completion of my first three-year term and the appointment to the second term is provided in Chair and NED Terms of Office and Re-appointment document dated 13 October 2022 [Exhibit:

WITN0390008], and the accompanying minutes of the Council of Governors meeting, 13 October 2022 [Exhibit: NHFT0000602].

35. Conscious of chairing two NHS Trusts for a period of 15 months, and given CQC criticism of my predecessor for being on multiple boards outside NHFT within the CQC's 2019 report [Exhibit: CQCM0016473, p.5] I deliberately and explicitly stepped back all my other work commitments such as my CQC Specialist Advisor work and my "Because It Matters Ltd" consultancy, so as to give appropriate time to the Chair roles at both LPFT and NHFT. This period of "joint running" was explicitly tested at interview by NHFT's Council of Governors, NHS England, and a Chair of another Trust who acted as an independent advisor.

36. I joined NHFT with some clear ambitions regarding the Board and NHFT. These included recognising that the CQC's full 2019 inspection a few months prior to my joining was not strong, including in its assessment of aspects of Board level leadership [Exhibit: CQCM0016473, p.5). In the process of applying for the Chair role, I had a number of "due diligence" conversations to find out more about the organisation and others' perspectives of it. These included talking with my predecessor Chair, the Lead Governor, some Executive and Non-Executive Director Board members, and NHS England.

37. As a result of my due diligence, I concluded that the Board culture had historically not been as strong a "unitary Board" as it should have been, and that this was something the Chief Executive, Dr John Brewin, was keen to improve, alongside other cultural changes he was already leading. I refer to this in more detail later.

38. I was clear that as a part of my appointment, a drive towards organisational improvements (including in the quality of some of NHFT's services, as an

employer of choice, and in the leadership of the organisation at Board level) were needed, and that my understanding of the Chair's and the Board's roles in good governance, and analysis of what I could bring personally, was an element in my successful appointment.

NHFT - COVID-19 Context

39. However, within my first weeks at NHFT, COVID-19 emerged.

40. This is an important piece of context for my leadership and governance role at NHFT, as it framed the initial period as Chair and is inextricably linked to the governance of the organisation then, and for much time since.

41. On 10th January 2010, in my second week of office, NHS England issued its first guidance on infection prevention and control for seasonal respiratory infection including SARS-CoV-2 [Exhibit: WITN0390009]

42. A Level 4 national incident was declared on 30th January 2020 (with further details set out in NHS England's letter to all NHS Trusts on 2 March 2020 [Exhibit: WITN0390010] and next steps being circulated to all NHS Trusts on 17 March 2020 [Exhibit: CQCM0027411]), in my first month at NHFT. This was significant for Trust Boards, and for their Chairs, as the declaration enabled NHS England nationally to take command and direct all health service resources across England through a nationally coordinated effort. This has been recognised as the fastest and most far-reaching repurposing of NHS services, staffing, and capacity in its history, and had direct impact on the governance of all NHS Trusts, including NHFT.

43. During the first two years of the COVID-19 pandemic, NHFT (like all NHS Trusts) was regularly instructed by NHS England to review its governance, for example

its Board and Committee Terms of Reference, to ensure it was predominantly focused on responding to the COVID-19 pandemic. This was relayed to NHS Trusts via a letter from NHS England on 28 March 2020, titled "Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic" [Exhibit: WITN0390011] and via communication on 26 January 2021 titled "Reducing burden and releasing capacity to manage the COVID-19 pandemic" [Exhibit: WITN0380008]. It was expected that Trusts would set aside "usual" governance, such as most routine reporting, stopping most Board Committees, reducing the agendas of the Board to focus principally on responding to the COVID-19 pandemic, and allowing some policies to continue beyond their formal review/renewal dates. Such changes were enacted within NHFT and are captured in documents such as:

a) "Emergency Board and Committee Terms of Reference" 7 April 2020 [Exhibit: NHFT0005085],

b) "Business Continuity Terms of Reference for Board and Committees" 5 January 2021 [Exhibit: WITN0354022],

c) "Emergency Board and Committee Terms of Reference" 2 February 2021 [Exhibit: WITN0354021].

44. The Board's initial decision on reducing governance, in line with national direction, was taken at its public meeting on 7 April 2020 [Exhibit: WITN0390012].

Role as Chair

Contractual Overview and Framing Documents

45. I was contracted as Chair for two-and-half to three days per week, though I have regularly contributed more time than this, including outside office hours and at weekends.

46. My role as Chair was framed in a number of key documents:

a) The NHS *Code of governance for NHS provider trusts* [Exhibit: NHSE0000522]

b) The NHS Leadership Academy resource, *The Healthy NHS Board 2013* [Exhibit: WITN0390013]

c) The Nolan Principles of Public Life [Exhibit: WITN0390014]

d) NHFT's Constitution [Exhibit: NHFT0000548]

e) *The Insightful NHS Provider Board 2024* [Exhibit: NHSE0002368]

Key Responsibilities

47. The *Code of governance for NHS provider trusts* [Exhibit: NHSE0000522] sets out some specific responsibilities for the Chair, which I have always seen as key to my effective functioning as a Chair:

a) Section B, para 1.1 states that, "The chair leads the board of directors and, for foundation trusts, the council of governors, and is responsible for its overall effectiveness in leading and directing the trust. They should demonstrate objective judgement throughout their tenure and promote a culture of honesty, openness, trust and debate. In addition, the chair facilitates constructive board relations and the effective contribution of all

non-executive directors, and ensures that directors and, for foundation trusts, governors receive accurate, timely and clear information."

b) Section B, para 1.2 clarifies that there are limits to the powers of the Chair and others: "Responsibilities should be clearly divided between the leadership of the board and the executive leadership of the trust's operations. No individual should have unfettered powers of decision."

c) Section B, paras 2.1 to 2.4 sets out specific responsibilities for the Chair to facilitate good governance: "2.1 The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues. 2.2 The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role. 2.3 The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular and ensuring a constructive relationship between executive and non-executive directors. 2.4 A foundation trust chair is responsible for ensuring that the board and council work together effectively."

48. *The Healthy NHS Board 2013*, [Exhibit: WITN0390013 chapter 5, p42], outlines the specific roles of Board members. Whilst 12 years old, this information has been a critical driver for my approach to being Chair, as it clearly delineates responsibilities between the Chair, the Chief Executive, and other Board members, enabling my understanding of what the role of Chair *is*, and

importantly, what it *is not*. This chapter has been summarised by NHS Providers into a slide used in a number of its Board Development programme training events, including *Non-Executive Directors Induction* and *Executive Director Induction* programmes [Exhibit: WITN0390003 and Exhibit: WITN0390004], both of which I regularly facilitate as an Associate Trainer for NHS Providers (as set out above). This document remains current and is complemented by the more recent *The Insightful NHS Provider Board 2024* [Exhibit: NHSE0002368]. The more recent document focuses more on the overall roles of the Board, rather than the roles of those within it.

49. The Nolan Principles of Public Life [Exhibit: WITN0390014] should be "live" in NHS Boards, and I expect these principles to always be adhered to by my Board colleagues and by myself.

50. The NHFT Constitution [Exhibit: NHFT0000548] sets out aspects of its Chair's responsibilities in relation to leading the Council of Governors (Annex 6) and leading the Board of Directors (Annex 7).

Visibility and Engagement Strategies

51. An important function as Chair is how visible I am in the organisation, and to those using our services. In a Trust as complex as NHFT, with a workforce of over 11,000 staff, true visibility can be difficult to achieve. However, I took deliberate steps to be as visible as I could be, including:

    a) On arrival, changing access to the Chair's electronic calendar so all members of staff could see exactly what I was doing, when, and where, on behalf of NHFT.

b) Encouraging direct contact from staff, whenever in discussions with them on service visits, and listening to and engaging with staff and those using services. These visits are well-reflected in my monthly Board reports, recorded in the papers of Board meetings, such as on 6 October 2020 [Exhibit: WITN0390015], 7 September 2021 [Exhibit: WITN0390016] and 25 January 2024 [Exhibit: WITN0390017].

c) Hearing directly and in person from patients or carers at the start of all public Board meetings (on rare occasions, this would be in the confidential part of the Board meeting, when required by the sensitive nature of the service the patient had experienced), and encouraging the Board hearing of poor experiences in these patient stories so learning could be derived from them, rather than focusing only on "positive" patient stories, such as during the Board meeting of 25 September 2025 [Exhibit: NHFT0017687, pg. 1-2].

d) Attending, and often speaking at, a wide range of internal and community-facing conferences and events, such as the "Embrace the Change Conference" run by NHFT's EMBRace Network in June 2023 [Exhibit: WITN0390018].

e) Meeting regularly with the leaders of all of NHFT's staff networks (EMBRace: BME Staff Network; LGBT+ Staff Network; Disabled Staff Network, and Armed Forces Staff Network), and with their members, including at their *ad hoc* request as well as when scheduled.

Board Effectiveness and Culture

52. A key part of my role as Chair is enabling the Board to be as effective as it can be. In practice, this means establishing – and holding – a strong culture of trust, challenge, and unitary (not unified) responsibility, in a context of clear values.

53. From the point of joining the organisation, I conducted intentional scrutiny of Board papers in the context of them enabling the Board to take its best decisions. For example, in December 2019 I reviewed the November Board of Directors papers (my predecessor's last meeting) and raised with the Chief Executive some reflections on ways they might be improved, as set out in my email to Dr John Brewin dated 10 December 2019 and its attachment [Exhibit: WITN0390019 and Exhibit: WITN0390020]. This was also demonstrated in my first Board meeting on 4 February 2020, as the minutes reflect my summing up comments such as, in relation to the Board Assurance Framework ("BAF") item, "Paul summarised explaining the working of the risks needed to be clearer with appropriate actions and timelines identified. It was important that the Board were unanimously aware of what the risks were and what actions were associated to demonstrate a shared understanding" [Exhibit: NHFT0005020].

54. At Board meetings before my leadership, there had been a practice of allowing non-Board members to present items directly in the Board meeting as part of its formal session. I take the view that it is best practice for members of the unitary Board to present agenda items, as they are responsible for any subsequent decisions, so I decided that this was how Board meetings, from April 2020, would proceed. The only exceptions to this are:

a) A regular paper presented by the Freedom to Speak Up Guardian on key themes coming through that route of hearing from staff, which NHS England direct should be presented in person by the Guardian. This was agreed at the Board meeting of 27 July 2023 [Exhibit: WITN0390021].

b) Specific formal governance items led by the Director of Corporate Governance.

55. My approach to Board challenge is summarised in a blog "Top Tips for Elegant, Respectful Challenge in the Boardroom" [Exhibit: WITN0390022], which sets out how I expect effective challenge to be carried out. This is important to enact in Boards, as it enables confident challenge as well as candour, ownership, and taking responsibility for the need for improvement where things have not gone as planned, without fearing a blame culture.

56. I regularly used Board Development days as opportunities to set out expectations of how we work together as an effective Board, scheduling time to specifically focus on our behaviours and ways of working, including at Board Development days in March and June 2020 [Exhibit: WITN0380024 and Exhibit: WITN0380025]; July 2021 [Exhibit: WITN0390023]; March, May, and September 2022 [Exhibit: WITN0390024, Exhibit: WITN0390025 and Exhibit: WITN0390026]; February 2024 [Exhibit: WITN0390027]; and April 2025 [Exhibit: WITN0390028], where I facilitated the process. This work was informed by my earlier career and academic studies in group facilitation, outlined previously.

57. I applied learning from my experiences as Chair of LPFT to inform my personal approach to chairing NHFT. For example, in my first year at LPFT, following a full CQC inspection, LPFT received an overall rating of "Requires

Improvement", including "Inadequate" in the Safe domain and "Requires Improvement" in the Well Led domain [Exhibit: WITN0380003]. I led a change in the organisation's attitude to regulators, ensuring an openness to difficult feedback and assessment, and a drive to improve against assessments with a spirit of non-defensiveness and candour. When I completed my second term at LPFT, the CQC ratings published on 22 June 2020 had improved overall to "Good", with the Safe domain improving to "Good" and Well Led improving to "Outstanding" [Exhibit: WITN0390029]. The changes in culture at Board level that I led were subsequently referenced in a best practice case study on LPFT published as part of CQC's *Driving Improvement: Case studies from seven mental health trusts* document [Exhibit: CQCM0016462]. I brought this cultural approach to NHFT's engagement with, and response to, all CQC inspections in my time.

Section 48 Review and Recovery Support Programme

58. The CQC conducted a rapid review of NHFT (under section 48 of the Health and Social Care Act 2008) following the conviction of Valdo Calocane ("**VC**") in January 2024. The first two parts relating to patient safety and quality of care were published in March 2024 [Exhibit: CQCM0013499], and the third part, a rapid review of the care provided to VC, was published in August 2024 [Exhibit: NHFT0000568]. NHFT entered NHS England's Recovery Support Programme against this backdrop in February 2024.

59. I took various decisions in how to carry out the role of Chair in the context of the Section 48 review and NHFT formally moving into NHS England's Recovery Support Programme.

60. Internally, it was important I was visible to our staff, alongside the Chief Executive, to show full Board ownership of the situation and to be explicit about our candour in approaching all aspects of the Section 48 review. This was evidenced in my attendance at a number of staff leadership events, and in the way I reflected on the Section 48 review, as well as the tragic circumstances that had led to it, in public Board meetings and many other public and internal Trust settings (for example the Board meeting dated 27 March 2025, and AGM of 20 September 2024 [Exhibit: WITN0390030 and Exhibit: WITN0390031]).

61. Externally, I was an active part of all the formal meetings between NHFT's Executive Team and NHS England's Regional Executive Team, as they held us to account on delivering against the Recovery Support Programme requirements. I also personally attended and took part in the Recovery Support Programme Entry and Review meetings (17 July 2024 and 6 December 2024, respectively) with NHS England National Executive Directors, to be held to account for Board ownership of the improvement work NHFT was, and is, engaged in, as per the summary letters from Dr Dame Emily Lawson of NHS England following the meetings [Exhibit: NHSE0001506 and Exhibit: NHSE0001744].

Partnership Working and System Leadership

62. Another aspect of my role as Chair is in relation to partnership working.

63. NHFT's patients and other service users use, and are impacted by, other services, such as those provided by other NHS organisations, the Police and other emergency services, Local Authorities, and third sector and faith-based organisations and groups. NHFT is also a very significant employer, predominantly in Nottinghamshire, and as such has a real

opportunity to be what the Aspen Institute terms an "anchor institution" [Exhibit: WITN0390032]; i.e. an organisation based in, and having the potential to enhance, local communities. Enabling NHFT to be a good partner and anchor institution is something I was committed to on joining NHFT, particularly given the developing partnership landscape of the Integrated Care Board ("ICB") and Integrated Care Partnership. The drive towards more formal partnership working included expectations from NHS England that Trust Boards would actively move to collaboration not competition, which was a move from the previous competitive landscape. This informed my period as Chair, including in driving my direct contributions to the local Integrated Care System.

64. Whilst at LPFT I had been an active member of the Lincolnshire Sustainability and Transformation Partnership (the precursor to ICBs), and I brought that same commitment to system working into my role in Nottinghamshire. In practice, this meant being an active member of the shadow ICB Board (prior to its formal establishment as a statutory body in July 2022) and participating in developmental work alongside the formal governance meetings of the ICB. This included regularly meeting with other local Trust Chairs, which helped inform approaches to good governance, for example, through a regular Chair/Chief Executive meeting with colleagues from Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust to support and challenge colleagues and ourselves, and to explore ways of working together as effectively as possible for our local communities.

65. I regularly stepped into governance roles within the ICB beyond the formal expectations on me, in the spirit of good partnership working, for example,

chairing the group that oversaw the recruitment of the ICB's current Chair, Dr Kathy McLean.

66. From July 2022, the formal ICB Board structure no longer included Trust Chairs (by statute), but I remained an active member of an informal Chairs group that met quarterly up until the clustering of ICBs in 2025.

67. At NHFT we were the first successful Lead Provider organisation in a mental health provider collaborative, through our leading on the provision of forensic mental health services in the East Midlands. In this role, we were held to account by NHS England in the commissioning of low- and medium-secure services in the East Midlands (see minutes of Extraordinary private Board on 22 September 2020 [Exhibit: TCLT0000383]). NHFT was an inaugural member of the East Midlands Alliance, which is the formal partnership structure of East Midlands mental health providers working in partnership together.

68. At the time I joined NHFT, it had a small number of services in Bassetlaw that were under the auspices of the South Yorkshire ICB, so NHFT was consequently a member of the South Yorkshire Mental Health, Learning Disability and Autism Provider Collaborative. I represented NHFT in that Provider Collaborative from January 2020 through to March 2023, when Bassetlaw NHS services formally moved into the Nottingham & Nottinghamshire ICB.

69. NHFT had a leadership role in the South Nottinghamshire Place Based Partnership since it was established in 2019. Its Board was chaired by NHFT's Chief Executive, Dr John Brewin, acting as Convenor. This formal partnership arrangement brings together a range of providers on a much more local footprint and includes local GPs and District Councils. Following Dr Brewin's announced

departure, rather than add this group to the responsibilities of the interim Chief Executive, Anne-Maria Newham, I took on the Convenor role, from August 2022 until November 2023. This was a deliberate decision to continue to support strong local partnership working.

70. My approach to good partnership working was also evident as the COVID-19 pandemic emerged. As well as attending weekly and monthly Chair-level meetings in the ICB footprint, and with NHS England regionally and nationally, I was a member of a regular "Bishop's breakfast meeting" hosted by the Bishop of Southwell, and involving the Chief of Nottinghamshire Police, the Chief Executive of Nottinghamshire County Council, the High Sheriff, and local senior faith leaders. This enabled partnership connections to be held at a strategic level between organisations that were also working very actively in partnership at an operational level.

71. During the COVID-19 pandemic, I also contributed governance advice to others, for example through the Good Governance Institute's "Governance during the Covid-19 Pandemic" session for Chairs on 26 March 2020 [Exhibit: WITN0390033], and a blog on "Being a Chair of a Board in troubled times" dated 17 March 2020 [Exhibit: WITN0390034] which was shared with all Chairs in the Midlands region by the NHS England Regional Director, Dale Bywater [Exhibit: WITN0390035], alongside a paper titled "Board Leadership and Performance in Crisis" by Russell Reynolds Associates [Exhibit: WITN0390036].

Governance generally

72. The expected role of the Board of Directors and its members is set out in *The Healthy NHS Board 2013* [Exhibit: WITN0390013] and in *The Insightful NHS*

Provider Board 2024 [Exhibit: NHSE0002368], and these drive the way in which I focus the Board.

Board Membership and Recruitment

73. As Chair, I had responsibility for ensuring the Board was as effective as possible. An element of this is striving to ensure the best skills for the Board (at that time and into the short-term future) are represented in its members. There were a number of changes in Board membership during my six years, as there will be in every NHS Trust Board in the country. These were driven by a range of factors, including career progression and other opportunities, planned retirement, ill-health, and completion of time-limited terms of office. Whilst Executive Director appointment decisions were decided upon by the Nominations & Remuneration Committee (made up of Non-Executive Directors, and chaired by me), they were always directly informed by the Chief Executive and their recommendations. For the most part, I was not formally part of Executive Director interview processes (as other Non-Executive Directors, such as a Committee chair, would take part), though I was directly involved in interviews for the appointments of Dr Elcock as Medical Director, Diane Hull as Executive Director of Nursing, Quality & AHPs, Anne-Maria Newham as Interim Chief Executive, and of Ifti Majid as Chief Executive, as these were senior Executive post appointments.

74. I led on the recruitment processes and appointments in every change to the Non-Executive Director members of the Board since I joined. Each recruitment round reflected skill sets and attributes I identified as needed at that point in time, with recruitment materials and processes designed to best deliver those additional skills.

75. In December 2020 we went out to recruit to a Non-Executive Director vacancy. I specifically sought candidates who were experienced in challenging a Board in delivering its responsibilities in equality and diversity. Following a strong field, I persuaded the Council of Governors and Board to amend the NHFT Constitution so that *two* appointments could be made, beginning January 2021, to enable their different, but compatible, skill sets and experiences to be brought in [Exhibit: NHFT0004701and Exhibit: TCLT0000385].

76. Later that year, following one Non-Executive Director completing their second full term, and two others stepping down early to prioritise other roles, we successfully recruited three Non-Executive Directors, adding additional skills in finance, community engagement, and partnership working, from February 2022.

77. The Audit Chair (with the specific qualification requirements that role carries) completed their second full term and was replaced in June 2022 (with no gap between the two posts arising).

78. In July 2024, after the unplanned resignation of a Non-Executive Director through serious ill-health, and recognising the full capacity of the remaining Non-Executive Directors, I sought the co-option, for up to 12 months, of an experienced Non-Executive Director from a neighbouring Trust, with experience of quality and finance in a mental health services provider, which was approved by the Council of Governors and NHS England (with support from the Recovery Support Programme) [Exhibit: NHFT0003385]. This person was subsequently appointed as a substantive Non-Executive Director through an open recruitment process in February 2025. The February 2025 recruitment process also appointed two other Non-Executive Directors who were recruited specifically to bring a clinical background, and experience in oversight of complex projects,

following the departure in January 2025 of one Non-Executive Director completing their second full term, and another being unable to renew for a second term for personal reasons.

79. In February 2025 approval was sought, and gained, from the Council of Governors and NHS England to extend, by one year, the tenure of an experienced clinical Non-Executive Director who was coming to the end of their second three-year term (as set out in the minutes of the Council of Governors Meeting of 15 October 2024 [Exhibit: NHFT0003684] and email of 3 June 2024 from Moira Durbridge, Improvement Director of the National Recovery Support Team, NHS England [Exhibit: WITN0390037]). As Vice Chair, they would also bring continuity between my departure at the end of my second term, and my replacement getting established and well-embedded.

80. Each Non-Executive Director recruitment drive gave me an opportunity to consider the skill set and experience of Non-Executive Directors in carrying out the assurance and scrutiny role. This directly influenced the focus of recruitment, such as:

    a) January 2021 appointments included one with strong NHS clinical experience and one with non-NHS scrutiny experience.

    b) February and June 2022 appointments included two with NHS Non-Executive Director experience in scrutinising and assessing data, one with a non-NHS lay scrutiny approach, and one with experience of being a government minister and senior MP.

c) February 2025 appointments included two with previous Non-Executive Director experience and one with strong civil service scrutiny experience.

81. Appointments who were new to the NHS, at my request, attended the NHS Providers *Non-Executive Director Induction* two-day programme [Exhibit: WITN0390003], which explicitly addresses in detail assurance and how to effectively seek this.

Board and Committees Structure and Function

82. The Board establishes Committees of the Board which enable more detailed scrutiny of Trust business. The functions of Board business which are given most scrutiny within the Committees has always included audit, quality, finance, performance, workforce, equality and diversity, and nominations and remuneration. The terms of reference, which set out the specific areas of responsibility for each Committee (including their title and their membership) are reviewed at least annually:

a) Quality Committee Terms of Reference dated September 2024 [Exhibit: WITN0390038],

b) People and Culture Committee Terms of Reference dated September 2025 [Exhibit: WITN0390039],

c) Audit and Risk Committee Terms of Reference dated September 2025 [Exhibit: WITN0390040], and

d) Finance and Performance Committee Terms of Reference dated 25 September 2025 [Exhibit: WITN0390041].

83. Board Committees are chaired by a Non-Executive Director and have a membership such that Non-Executive Directors are in the majority. Alongside the formal membership of the Committee, there will be other attendees to ensure well-informed discussion of papers.

84. Board Committees can receive escalations and formal papers from a range of sub-committees and other groups. These are outlined in the Terms of Reference of each Board Committee.

85. Committees have always been able to escalate concerns, as well as report on where they have sought and attained assurance on progress of Trust business. In the meeting in April 2022 this was formalised into a Committee Highlight Report. An example is exhibited to this statement, "Highlight Report – Strategy Committee on 22 March 2022" which went to the Board of Directors Public meeting 5 April 2022 [Exhibit: WITN0390042] using an agreed template that enabled Committee chairs to:

    a) escalate matters of concern or key risk
    b) explain positive assurances gained
    c) identify gaps in assurance
    d) identify major actions commissioned
    e) confirm any decisions taken

Changes to Governance Structures

86. It is good practice for the Board of Directors to review its committees on an annual basis, and to consider their scope and continued appropriateness in helping the Board transact its decisions. At different times in the life of a Trust,

there will be different focuses that will benefit from attention in a specific Board Committee and, from time to time, new Committees may need to be established, and others disbanded. There is – and should be – a regular review of the scope of Board Committees, recognising that the changing landscape of the NHS and emerging local pressures and priorities mean that committees' focus should never be set in stone, so as to ensure the best use of this important part of the Board's governance. I set out a number of changes in the following paragraphs. Changes that were as a direct result of instruction from NHS England as part of the response to the pandemic were not driven by a desire to improve Committee effectiveness, but rather to free up Boards, Committees and senior staff so as to focus on responding to the pandemic.

87. Alongside the formal Board Committees, NHFT has a Charitable Funds Committee through which the Board of Directors acts as the Corporate Trustee of the NHFT charity. This is not technically a *Board Committee*, but because of its membership, is listed alongside the formal Board Committees that are part of the formal governance structure of NHFT.

88. When I joined NHFT at the beginning of 2020, the Board Committees giving assurance to the Board were:

    a) Audit Committee

    b) Quality Committee

    c) Finance and Performance Committee

    d) Workforce, Equality & Diversity Committee

    e) Mental Health Legislation Committee

    f) Nominations & Remuneration Committee

89. Following the outbreak of the COVID-19 pandemic and early national guidance, at the 7 April 2020 Board [Exhibit: WITN0390012], it was agreed to:

    a) Enact emergency Board and Committee terms of reference [Exhibit: NHFT0005085], in line with the national guidance;

    b) Streamline the agenda of the Board to focus primarily on reporting to the Board on actions being taken to maintain sufficient patient safety and quality standards, staff safety and health and wellbeing, operational resilience and financial governance; and

    c) Suspend the terms of reference and membership of Board Committees for a period of three months (from 18 March 2020), with proportionate decision-making put in place for decisions that could not be postponed (consisting of two Non-Executive Directors and one Executive Director).

90. As a result of the national instruction to streamline governance, the Board Committees were reduced to:

    a) Audit Committee

    b) People and Quality Committee

    c) Finance and Performance Committee

91. In 2020/21, the Board also introduced a Strategy Committee (Terms of Reference, as agreed and ratified by the Strategy Committee on 2 July 2020 and by the Board on 4 August 2020 [Exhibit: WITN0390043]), which was designed to be an opportunity for Executive Directors and Non-Executive Directors to explore longer-term strategic direction, sometimes including early-stage ideas and forward-looking initiatives rather than fully formed concepts, which was different

to the more formal processes of other Committees. This helped to improve Committee effectiveness by bringing a focus on these types of strategic discussions.

92. In 2021/22, as the NHS emerged from periods of COVID-19 lockdown, the Committee structures were reviewed with some revisions to their focus (and some titles). The changes made were driven by a desire to return to a fuller level of Committee scrutiny than the changes made during the pandemic had allowed for. As such they did bring improvement in Committee governance. The reset Committees were:

    a) Audit Committee.

    b) People, Culture, Equality and Inclusion Committee – The name change and increased areas of explicit responsibility reflected the importance of focusing on the culture of the organisation, as experienced by our staff, and recognising a shift from Equality & Diversity to a more active focus on *Inclusion* as part of improving in this area.

    c) Quality and Mental Health Legislation Committee – This reinstated a focus on mental health legislation, but not as a separate Committee as had been the case prior to the COVID-19 pandemic. The intent was positive, and helpful as Committees re-established their full responsibilities post-pandemic. However, in 2025 the Board revisited the effectiveness of its scrutiny of the Mental Health Act and concluded that a re-established a Mental Health Legislation Committee would bring even further focus. This was approved at its

November 2025 meeting (see its Terms of Reference [Exhibit: WITN0390044], and the Board decision [Exhibit: WITN0390045 *These are currently in draft and will be ratified in the committee's 2026 meeting*]).

d) Finance & Planning Committee – The focus on planning reflected the significantly changed landscape of service provision as NHFT emerged from the pandemic and sought to ensure effective service delivery in the post-COVID environment, including recognition that there would be (at that time unidentified) impacts on services arising from the pandemic's effect on those needing to use its services. The removal of "performance" in the Committee's title was partly driven by a desire to simplify the focus of Committees, along with a recognition of improving scrutiny at the full Board, through the Integrated Performance Report ("IPR") and a desire to minimise duplication in governance. The Board reintroduced Performance to the Terms of Reference of the Committee in 2024 in a drive to ensure even more robust coverage of Performance matters. This was in addition to the improved scrutiny at the Board rather than hindsight suggesting it had been less effective than the previous arrangement.

e) Nominations & Remuneration Committee.

f) Strategy Committee.

93. At this time, the Board also established a Commissioning Committee (Terms of Reference, as updated and reviewed by the Commissioning Committee 4 July 2022 [Exhibit: WITN0354112]), recognising the NHS England move to a provider

collaborative model with provider organisations taking on commissioning responsibility for specific areas of NHS delivery across a number of Trusts and other providers, which first met on 31 January 2022 (Minutes of Commissioning Committee 31 January 2022 [Exhibit: CQCM0027312]). NHFT was already a lead provider (i.e. commissioner) for low- and medium-secure mental health services, and this new Committee brought an assurance route for the Board regarding our commissioning capability and potential commissioning opportunities.

94. In October 2020 a Risk Committee was established (Terms of Reference [Exhibit: WITN0390046] and Minutes of the Risk Committee meeting 21 October 2020 [Exhibit: WITN0390047]. This was set up as an operational group rather than a formal Board Committee (so was not part of the formal Board governance), though was observed by a Non-Executive Director to ensure that possible content which needed to be considered in a formal Board Committee was duly escalated. This was in direct response to one of the recommendations of the Grant Thornton Well-Led Report of NHFT, dated August 2020 [Exhibit: WITN0356018].

95. In 2023/24, the review of Committees confirmed the following Board Committees:

    a) Audit & Risk Committee – This brought the work that was previously solely scrutinised through the operational Risk Committee into a formal Board Committee with joint Non-Executive Director and Executive Director scrutiny. The operational Risk Committee still operates at the operational level.

    b) Quality Committee (incorporating the Mental Health Legislation Committee) – This change simplified the title of the Committee to

Quality Committee, whilst still having responsibility for mental health legislation scrutiny.

c) People Committee – The simplified title change recognised the stronger embedding of culture, equality and inclusion in the work of the Board, whilst the remit of the Committee retained the focus on these elements.

d) Finance & Performance Committee – The return to a *performance* focus reflected the Board's recognition that performance needed explicit scrutiny at a committee level and was a return to the Committee remit prior to and in the early part of the COVID-19 pandemic.

e) Improvement Oversight Committee – This was introduced to provide a high-level scrutiny of the improvement activity of the Integrated Improvement Plan instigated in response to the Section 48 review.

f) Nominations & Remuneration Committee.

96. The Strategy Committee reverted to a less formal Strategy *Group* (i.e. operating outside the formal Board governance structure). In part, this was a recognition that the type of discussion that worked well in this forum was different to the more standard Board Committee approach: the most valuable content of those meetings had been the early stage, more open dialogue regarding strategic direction, which was not typical of formal Committee proceedings, where strategic discussions are driven by more thoroughly worked through proposals to enable scrutiny and decision-making. If an idea was to be progressed beyond the Strategy Committee, it would be taken to a different appropriate Committee for

formal consideration. The move away from being a committee proved helpful for those involved in its discussions, though in 2025 the Board re-set the forum as a committee, and approved a two-part Terms of Reference that enabled both types of discussion to explicitly take part in the Strategy Committee. This brought the added benefit of bringing a direct Highlight Report to the Board of Directors as a matter of course (see Board minutes of 27 November 2025 [Exhibit: WITN0390045] and Strategy and Partnership Committee Terms of Reference [Exhibit: WITN0390048]).

97. The Commissioning Committee was disbanded as it was felt to have run its course in informing the Board on its commissioning roles.

98. Changes to Committees were made with deliberation and were (aside from the 2020 changes to reduce the volume of governance, as required by NHS England to ensure priority focus on responding to the COVID-19 pandemic) driven by a desire to enact Board business as effectively as possible, and to challenge the Board on their efficacy in enabling this scrutiny. At times, such as the introduction of the Improvement Oversight Committee, the decision came from a need for the Board to add scrutiny to a particular area of work. At other times, changes were made because the Board recognised a previous structure or change was not delivering as effectively as it needed to. An example of this was bringing risk into the explicit remit of the Audit Committee, as a full Board Committee with Non-Executive Director membership, rather than its previous operational status, to give Non-Executive Directors a stronger understanding of operational risks that may need escalating to the full Board.

99. The NHS landscape has continued to change throughout my time at NHFT, and it is important that Boards are able to respond to those changes, whether universal

(like the COVID-19 pandemic), cultural (like changes in understanding and expectation on employers and providers regarding equality, diversity and inclusion), or in response to specific serious issues (such as the Section 48 review).

100. It is my view that the Board Committees operated well enough to deliver their terms of reference, whilst always being open to improvement to reflect changing understanding of governance needs, changing priorities in focus, the need to meet requirements of regulators, and changing corporate risks. The Grant Thornton review carried out in August 2020 [Exhibit: WITN0356018, p9] explicitly reviewed Committees' performance and stated that "All Committees are well run" and that "[they] observed an appropriate level of challenge from the NEDs and good response from the Executives. The Board meetings in particular were well-led and there is a good process in place for upward reporting from Committees to the Board." However, the report raised concerns about the management of risk, and this included committee scrutiny of risk. As a result, as explained later, NHFT instigated changes to the BAF, including the scrutiny and ownership of each Strategic Risk by a committee, and the introduction of the Risk Committee to respond to the concerns raised.

101. I first instigated the practice of formally reflecting on the effectiveness of meetings as a last item of business as an "AOB" in the April 2020 Board meeting, as set out in the Board minutes of 7 April 2020 [Exhibit: WITN0390049]. From November 2020, this became a formal agenda item on all Board meetings and Committee chairs subsequently introduced the practice into their committee agendas. This enabled the meeting to reflect on how it has transacted its business, and also to review whether it has been focused on its full remit, in ways

that led to appropriate assurance discussions. The Committee Highlight report template, which brings formal feedback from Committees to the full Board (for example [Exhibit: WITN0390042] includes specific feedback to Board on these reflections.

Relationship between Executive and Non-Executive Directors

102. The roles of Executive Directors and Non-Executive Directors within the Board and its Committees are clearly delineated in *The Healthy NHS Board 2013* [Exhibit: WITN0390013] and further supported in the unitary Board principles set out in *The Insightful NHS Provider Board 2024* [Exhibit: NHSE0002368].

103. On joining NHFT, I used early conversations with all Board members to set out my expectations of how I expected relationships between all members to be. This included:

a) My understanding of the unitary Board meaning challenge should come from Non-Executive Directors to Executives,
from Executive Directors to other Executives, and from Executives Directors to Non-Executives.

b) My construct of "elegant, respectful challenge" as set out in the blog "Top Tips for Elegant, Respectful Challenge in the Boardroom" [Exhibit: WITN0390022] to encourage good challenge on content.

c) An expectation that every Board member is well-prepared for their meetings.

d) That potential challenges that need detailed response would be signposted in advance to those presenting papers to enable them to

bring full responses in the meeting rather than to be put on the backfoot or to have to delay a response until a later meeting.

e) An expectation that Board and Committee business would always be conducted in the meeting and not in side- or "corridor-meetings", even if useful answers had been provided outside the formal meeting.

f) An expectation that the Board should always get accurate information and assessments, such as in relation to performance, or quality, even if not positive or as expected.

g) My own participation in discussions in every Board meeting where I would personally ask questions and challenge colleagues (for example public Board minutes from 5 April 2022 [Exhibit: WITN0390050] and 26 September 2024 [Exhibit: WITN0263121], and private Board minutes from 28 March 2024 [Exhibit: WITN0390051].

104. My reflection is that these expectations, and the ways in which I made them explicitly as part of setting out how I approach being a Chair, brought change to the working of the Board. For some colleagues (both Executive Directors and Non-Executive Directors) what I was describing about an explicit unitary Board and its clear strategic responsibilities seemed new to them, including for some in their first NHS Board role. As with any change process, individual Board members responded to the changes at different paces, ranging from longer change journeys for some who had been in their role for some time and did not have prior experience of me as a Chair, to others who knew my style of chairing

from my previous role, and those who joined the organisation and the Board once these ways of working had been established as the default way of working.

105. Alongside the one-to-one supervision I gave Non-Executive Directors, where we were able to talk about how the Board would work, I explored my expectations in one-to-one introductory meetings with Executive Directors, both with those already in post when I arrived, and with new appointments throughout my period of office. I also brought my expectations into discussions with any colleagues who stepped up into interim roles or temporarily stood in for Executive Directors in Board meetings.

106. Coupled with the changes in the ways in which we were working, and the timing of these changes being in the context of the COVID-19 pandemic, there were some significant structural changes that likely brought further challenge for some Executive colleagues, to different degrees. These included the Chief Executive making changes to Executive portfolios, and changes to managerial roles within the Divisions, as well as changes to the members of the Executive Team. Whilst I supported all these decisions as being right for delivering the direction of challenge the Board had set, their implementation was for operational leaders rather than for me.

107. In the 26 September 2024 Private Board [Exhibit: NHFT0000525 p26-36 and Exhibit: NHFT0017629], we discussed the *Thematic review of homicides and attempted homicides 2019 – 2023* [Exhibit: NHFT0000525 p 24-36]. I was concerned at that time that some of the poor practice in robustly investigating and reporting on those incidents may have included not escalating them to the Board in a timely fashion. Whilst it is clear that incident reporting had since improved (demonstrated by the more detailed reports that now include specific sections on

lessons learned, and clear timelines of actions taken in reviewing and overseeing each serious incident) this analysis of some less good practice prior to 2023 helped drive the development of the current more robust investigating and reporting to Board practices.

108. I have at times within Board meetings challenged Executive Directors along the line of "Whilst I trust you, what is the *evidence* for that statement?" This is an appropriate intervention for a Non-Executive Director to test out assurance rather than accepting reassurance. At the time of joining NHFT, I felt that reassurance was not always further tested to seek assurance. A challenge for Non-Executive Directors in assessing data and information is to consider the scale of what they are not cognisant of, whether others (including Executive Directors) may know, and whether or not information is unavailable, available but unknown, or potentially deliberately being withheld. I have sought to bring this type of analysis of what is known and unknown to my Board scrutiny as a way of helping me ensure I bring appropriate Non-Executive Director curiosity and challenge.

109. Within the cohort of Non-Executive Directors I inherited in 2020, there was a range of practice in relation to challenge: from seeking a level of operational detail that is inappropriate for Non-Executive Directors who should be focused on assurance of process and practice, through to an acceptance of reassurance without sufficient supporting evidence or testing it to gain assurance. As time progressed, all improved their approach to evidence testing in their roles at NHFT.

110. It is my assessment that all Non-Executive Directors whom I have appointed, or re-appointed for a second term, understand my expectations regarding

effective challenge and their responsibilities in this regard. I am confident that the current cohort of Non-Executive Directors challenge explicitly, both at Board level and within Board Committees.

111. I am confident that different opinions and perspectives can be, and are, voiced within Board and Board Committee meetings, including if a Non-Executive Director has a uniquely different perspective to all other voices in the room. I am similarly confident that my own views were open to challenge by Non-Executive and Executive colleagues within Board meetings.

Information flow from the Executive Directors to Non-Executive Directors

112. In my view, Non-Executive Directors at NHFT are provided with sufficient information by Executive colleagues to perform their assurance and scrutiny role.

113. Throughout my time at NHFT, this has been consistently tested and assessed, including through Board Development Sessions (for example, on 10 December 2019 [Exhibit: WITN0390052], 11 February 2020 [Exhibit: WITN0354039], and 29 June 2023 [Exhibit: WITN0390053]) and through the introduction of statistical process control charts (Making Data Count) as a methodology to enable trends to be clearly measured and to articulate more clearly the appropriate focus on areas of concern. This methodology was introduced to Board reporting at a Board Development Session on 10 December 2019 [Exhibit: WITN0390052], as part of a national roll-out, but was also driven by Dr John Brewin and me following its previous successful introduction as a tool at LPFT.

114. This methodology rapidly became a key tool in the reporting of performance to the Board and its Committees through the IPR, for example the IPR from the Public Board of Directors on 27 November 2025 [Exhibit: WITN0263098].

115. A review session led by the NHS England "Making Data Count" team was part of the Board Development session on 29 June 2023 [Exhibit: WITN0390053], and their national Director observed the public Board meeting on 26 September 2024 [Exhibit: WITN0263121] and fed back positively on the ways in which the Board used the data to inform its discussions and challenge [Exhibit: WITN0390054].

116. Committee Highlight reports to Board, which come after every Committee meeting, include specific sections where the Committee chair can highlight assurances sought, gained and (if not gained) subsequent actions needed, including escalation to the Board for its specific attention if assurance has not been gained after repeat seeking.

117. Throughout NHS Boards, there is a tension that needs to be held regarding the level of detail Non-Executive Directors need in order to consider themselves assured by the data they are presented with. This varies from person to person and may be driven by previous experience or a perception of not being sufficiently aware of operational data. It is my expectation, however, that the level of scrutiny considered in Board Committees is more detailed than that taken to the full Board, as the Board must hold a broader, more strategic overview of the organisation and the "so what?" of the data assessments.

118. All Committees, but particularly the Quality Committee and People Committee (in all their iterations), will, from time to time, have a "deep dive" into a particular area of concern, whether by service, outcomes, progress etc. Deep dives are an opportunity for deliberate exploration into a level of detail greater than the usual level considered in Committees (for example Quality Committee 4 June 2024 deep dive into pressure ulcers [Exhibit: WITN0390055], People and Culture Committee 12 December 2025 deep dive into Vacancies [Exhibit: WITN0390056],

and the Finance Committee Highlight report 29 May 2025 Board referencing a deep dive into private sector bed usage [Exhibit: WITN0390057].

119. Board agendas and papers should hold a strategic oversight function and resist being drawn deeply into operational data. This is in part driven by the scale of services of any NHS Trust, but more importantly for the legal governance role of the Board maintaining oversight, not stepping into operational decision making. This, in my view, includes not stepping into individual patients' clinical decision-making, which sits with the professionals providing their clinical care.

120. With regard to clinical decision-making, the Board should be able to assess the policy and practice frameworks clinicians operate in, should understand where there are pressures (such as the impact of low staffing, high demand, high acuity, or external commissioning demands). However, it is not, in my view, for the Board to assess or direct individual clinical decisions in the care of individual patients.

Board Monitoring of Mental Health Services

121. The Board monitors mental health services through a section of the IPR, which is taken to every Board meeting. The IPR for the November 2025 Board is provided as an example [Exhibit: WITN0263098]. This is the key performance tool the Board uses, though it is triangulated by Board members with other sources of information such as Board patient stories (referred to elsewhere in my statement) and personal site visits.

122. My approach to chairing the discussion on this item is that I expect the IPR discussion to usually take the most time compared with other items. It is important that highlights from the report are brought to the attention of the Board

by the presenting Executive, with subsequent discussion and challenge, but that Board members can ask questions about any element of data presented in the paper, whether specifically highlighted or not.

123. The Report summarises key data in a standard format, that has developed over years of use with small changes to improve it through various iterations.

124. NHFT utilises Statistical Process Control (SPC) charts as a way of enabling useful information to be accessible to the full Board. Having successfully introduced this tool whilst at LPFT, I was keen it was used well at NHFT. A Board Development Session just prior to my joining brought the tool into NHFT, and I championed SPC charts throughout my time, including through a review session led by NHS England's Making Data Count team on 29 June 2023.

125. The IPR section on mental health services captures:

a) National and local Key Performance Indicators on inpatient flow and on access, summarising whether we are on target for achieving the measure and, importantly, using SPC tools to indicate whether any variation over a period of time is positive, negative, or within expected variation. Where there is positive or negative variation, this is further analysed in terms of whether there is a trend to be concerned about. Any area of variation for concern is then explored further, with information on what the variation is, what the reasons are for that variation (if known), and what actions are in place to mitigate it.

b) A series of specific performance metrics including:

i. The number of patients in acute and PICU private beds at the end of the week (including Out of Area placements);

ii. The number of acute patients in private beds at the end of the month against the improvement trajectory;

iii. The number of patients in inappropriate Out of Area Placements at the end of the month against the improvement trajectory;

iv. The number of patients waiting for more than 12 hours on a mental health pathway in an Emergency Department;

v. The percentage of patients seen within an hour/24 hour of referral to Laision Services in Emergency Departments;

vi. The percentage of patients on acute wards seen within 24 hours of referral to Liaison Services;

vii. Percentage of Very Urgent and Urgent referrals seen face to face with 4 hours /24 hours by Crisis Resolution and Home Treatment team;

viii. Crisis Line call data, including total calls received, call abandonment rate, calls not answered by any service, average waiting time, average call duration and time of day or night of calls;

ix. The average time to first assessment for patients seen/ waiting to be seen and waiting to be seen by the Local Mental Health Team;

x. The number of patients waiting and their average wait times for assessment by the Memory Assessment Services team;

xi. The number of patients waiting for assessment by CAMHS Community Team, and their average wait time for assessment;

xii. The number of patients waiting over 18 weeks for assessment by the Paediatric Speech & Language Service; and

xiii. The number of patients waiting over 18 weeks for assessment by the Paediatric Community Occupational Therapy Service.

126. Each SPC chart shows trend data going back over a sufficient number of data points (15 or more) to enable expected variance to be calculated, which enables performance outside expected variance to be readily identified. The charts also enable a focus on proper trend data as opposed to one-off changes that are standard variations, whilst also enabling extraordinary variation to be scrutinised. The SPC charts are accompanied by a robust narrative that enables the Board to test actions being taken in response to what the data is presenting.

127. The IPR enables a Non-Executive Director like me the chance to scrutinise “ward to Board” data, and the wider report enables the performance data for mental health services to be triangulated with accompanying Trust data (presented through similar tools) on aspects of quality, safety, workforce (including safe staffing), and finance.

128. In 2024, in response to challenges in the Section 48 review, NHFT developed its “Safe Now” dashboard [Exhibit: WITN0390058]. This is aimed at giving operational leaders throughout the organisation access to up to the day data on

key metrics relation to safety and quality. Data from the “Safe Now” dashboards informs the data that comes to the Board through the IPR but is at an operational level too detailed to be appropriate for Board scrutiny.

Escalation of Issues to the Board

129. There are many ways in which issues with the care provided by NHFT can be, and are, escalated to me, separate from the formal routes to the Board of Directors.

130. I meet or speak with the Chief Executive very regularly – rarely less than weekly – both in scheduled meetings (a combination of supervision, update, planning, and reflection) and unscheduled contact, as needed. This means the Chief Executive is able to update me on the emergence of a care issue as soon as they consider it necessary, without waiting for a scheduled meeting. During the years, such conversations have been had at all hours from the early morning until late at night, and on all days of the week and weekend, regardless of whether they are days allocated in my calendars as “Trust days”.

131. In practice this has enabled me to be given a “heads up” to an emerging care issue without the Chief Executive feeling a need to have gathered detail that a formal investigation step would bring. Key to that early conversation would be a discussion on the most appropriate time to alert other Non-Executive Directors, and whether they should be informed ahead of a formal, scheduled opportunity. Factors that affect that timing will include the level of detailed information available, the seriousness of the care incident, whether there is likely to be an early decision required by the Board, what the levels of wider awareness are (e.g. other partner organisations, staff, and media).

132. All NHS Trusts are expected to have a Freedom to Speak Up service offer that enables staff to raise a range of concerns, including matters which may affect provision of care.

133. Key elements in our Freedom to Speak Up offer have included:

a) A named Non-Executive Director as a link contact to the Board,

b) Open access for the Freedom to Speak Up Guardian: to the Chief Executive, to me as Chair, and to a named lead Non-Executive Director

c) Regular scheduled meetings between the Freedom to Speak Up Guardian and the Chief Executive and the Chair, both together and separately

d) Regular access to the People Committee (in all its iterations) and, since November 2023, direct regular input to the public Board of Directors by presenting a formal update report (as set out in the minutes of the Public Board Meeting of 27 July 2023 [Exhibit: WITN0390021]).

134. These tools have meant I have been able to be confident the Freedom to Speak Up Guardian has always been able to raise with me directly, and in a timely way, any concerns regarding care that they have been alerted to. I am confident they have also always been able to similarly raise concerns directly with the link Non-Executive Director and with the Chief Executive.

135. A second route for me to hear directly about care issues is through service visits. As is clear from my Chair's reports to the Board (for example 6 October 2020 [Exhibit: WITN0390015], 7 September 2021 [Exhibit: WITN0390016] and 25

January 2024 [Exhibit: WITN0390017]), I have sought to maintain a schedule of visits throughout my time at NHFT, directly visiting services. These visits are deliberately not "stage managed" and would always build in time for me to have one-to-one conversations with any staff, without their line managers, and for me to hear directly from patients themselves. I would regularly ask patients about their experience being in the service I was visiting. Bearing in mind that many of our in-patient services are, by definition, services where patients do not have choice in being there, this tended to give very real examples of their experience. Themes I would hear would include positive experience of individual staff, frustration at the impacts of staff pressures (e.g. on therapeutic activities that were limited due to staff being moved), frustrations with plans to move on from services not moving as fast as they would hope, and practical issues such as feedback on food or access to outside space. Where I heard patient feedback, I would feed information on this back through my regular meetings with the Chief Executive or possibly raise directly with an appropriate Executive Director so that the matter could be properly explored through appropriate operational routes. I was always alert to the potential for a conversation with me as Chair to inadvertently circumvent operational reporting, whilst at the same time being conscious to ensure poor experiences or care concerns were flagged and followed through on.

136. My Non-Executive Director colleagues (and NHFT's volunteer Governors) also had programmes of service visits that enabled them to triangulate direct experience of "front line" staff and patients and carers with what was reported through formal papers in Committees or the Board.

137. All Executive Directors regularly visit services too, including specifically outside their direct area of responsibility.

138. The Board receives formal escalations of issues through a number of routes including operational papers to Committees, referenced in Committee Highlight reports at Board; the IPR; Freedom to Speak Up regular reporting on key themes they are working with; and issues raised through Executive Director engagement in the organisation, such as through the Big Conversation meetings, reported through the Chief Executive's report to Board. Since February 2021, we were also able to reinstate a Patient Story (which was suspended due to COVID) at the start of the Board meeting to frame the meeting in real lived experience. In practice, this story would occasionally be from a carer perspective and occasionally would be taken in the private Board at the request of the patient, given the service and/or their circumstances. The minutes of Board meetings demonstrate that the stories would most often reflect on improvements the patient (or their carers) had seen or wanted to see. I instigated an annual review of patient stories to help the Board assess whether at a thematic level, rather than in relation to the individual patient, improvements had taken place (for example the Annual Report on Feedback from Patient and Carer Stories taken to Board meeting on 30 May 2024 [Exhibit: WITN0390059]). In May 2025 it was agreed that this report should be included in the Involvement, Engagement and Volunteering service report to Quality Committee, which would feed through to the Board in the usual way through the Committee Highlight Report.

139. In the 28 January 2020 Council of Governors' meeting, at my suggestion, the Council introduced a formal Governor Log which enabled a formal record of

Governor concerns to be logged and reported on in subsequent public Council of Governors meetings [Exhibit: NHFT0000784, p7].

140. People who are not satisfied with the care they receive from NHFT will occasionally raise this with external bodies, who then bring it to our attention. These routes can include MPs, the CQC, Healthwatch Nottingham & Nottinghamshire, and local politicians. There are robust processes in place for dealing with complaints raised in these ways. For my part, I would raise any concern directly with the Chief Executive and they would link it through to NHFT's Patient Advice & Liaison Service who would deal with the complaint through the normal complains policy (Procedure 19.03, Complaints Procedure dated August 2025 [Exhibit: WITN0390060]).

141. Some MP offices have occasionally sent complaints on behalf of a constituent directly to me. On receipt I would always forward it to the Chief Executive to ensure an appropriate operationally led response is given to the MP. I would not expect complaints raised with the CQC or with Healthwatch Nottingham & Nottinghamshire to be referred to me and have no recollection of this happening. On one occasion I had a local Councillor raise concerns about a Mental Health ward directly with me (and at the same time, with the Chief Executive).

142. Occasionally, and particularly in the aftermath of the VC case, my attention has been drawn to patient or carer concerns via the public media. These have on some occasions related to historical cases from many years before my time at NHFT. In all such cases I have sought assurance on any actions NHFT committed to, from the Chief Executive. For example, where local or national media reported on cases they regarded as similar to the VC case (for example the BBC News article from 15 August 2024 "Woman angry at NHS after son

killed her father" regarding an incident in 2009 [Exhibit: WITN0390061]) that I was not aware of, I asked that they were reviewed where possible, to understand if there was specific learning to add to our improvement plan.

143. Whilst such instances were rare, when I was directly informed of a poor experience affecting a patient or their loved one , I would refer them to the appropriate formal routes, and also, subject to their consent, share their contact details with relevant Trust staff who could provide a more comprehensive response, and take any necessary follow-up action.

144. NHFT instigated an internal engagement tool called "Big Conversations" in June 2024. These were designed as opportunities for Executive Directors to engage with staff in a series of planned visits that enabled staff to tell leaders about any issues concerning them, and which occasionally could include matters impacting on care of patients. I attended various of these events.

145. All of these sources of concerns regarding care serve to offer triangulation with formal data that come to the attention of the Board and its Committees. They enable formal policy and procedure to be tested with real life examples and can bring depth and colour to formal quantitative data. By definition, I would not be aware of examples of poor care which had not been able to be raised through any of the varied routes I have identified.

Adequacy of NHFT mental health services

146. In all NHS Trusts, concerns are raised regularly about the adequacy of services. These may come from patients, their families and carers, from staff (both formally, through electronic incident reporting and the Freedom to Speak Up service, or informally through engagement with senior colleagues), or external

people or bodies such as Healthwatch, local politicians, other Healthcare providers such as GPs, or the CQC, including from their Mental Health Act visits. In NHFT, we also sometimes get concerns raised through service visits carried out by Non-Executive Directors and Governors. An example of concerns being raised and responded to is the introduction of an operational Adult Mental Health Improvement Board, instigated by Dr John Brewin as Chief Executive (Adult Mental Health Improvement Board Terms of Reference, dated 30 June 2020 [Exhibit: WITN0380032]). Actions taken by the Improvement Board were reported to the private Board in December 2021 [Exhibit: WITN0329025], including the development of the Highbury Hospital Improvement and Business Continuity Plan which informed a deep dive into staff in the People & Culture Committee in January 2022 (Highbury & Adult Mental Health Staffing Deep Dive report to People, Culture, Equality & Inclusion Committee meeting of 22 January 2022 [Exhibit: WITN0329002).

147. The types of concerns raised would tend fall into categories such as staffing (including the increased use of agency staff who might be less familiar with a service and/or patient group than NHFT staff), poor behaviours, "culture" (which is a broad heading that might include factors such as leadership, staff behaviours, a lack of patient focus, racism or other discrimination), the physical environment, inconsistency in care and care records, and access to the open air and "outside" in-patient units. The impact of the COVID-19 pandemic and sustained pressures from providing services during particularly intense waves of infection rates added to many of the pressures that impacted upon concerns.

148. Concerns in care were also exacerbated by the steady increase in both demand and the acuity presented by patients needing adult mental health

services. This may reflect a direct impact of the pandemic, such as increased isolation or people feeling unable or not wanting to engage with services at an earlier stage of illness, meaning that people presented with more acute symptoms. For those who may have been doing well in their recovery, the pandemic may have caused a relapse in their improvement journey, as a result of isolation, or fear for example.

149. In terms of actions in response to concerns being raised, first and foremost I, and the Board, would expect that operational leaders would be using the range of mitigations in their toolkit, such as moving staff temporarily to support others (including clinically-trained staff who were in non-clinical role moving into direct clinical roles), expanding the commission of sub-contracted beds including out of area, and accessing additional support (e.g. digital solutions and non-clinical support) that could free up more clinical time.

150. It should be recognised, though, that mitigations are often double-edged, as they also have effects such as taking staff away from other important functions, increasing the distance from home of a patient, or adding to organisational costs in ways which were not funded directly by commissioners. At a Board level, these more complex factors are important, as we – and I as Chair – have increasingly been held to account by commissioners and regulators, including NHS England, for delivering on the quality of services for all those who need them, whilst making financial savings. The annual planning process has become more robust, with NHS England more strongly challenging plans and progress against them, reflecting national NHS England expectations on hitting quality targets within strict financial envelopes. This has included Trusts being called to more "holding to account" meetings by ICBs and NHS England, as was the case for NHFT.

151. In our regular one-to-one meetings, I would hear directly from the Chief Executive about particular pressure points and, importantly, of the actions being considered and taken to try and ameliorate the situation. These less formal discussions did not replace keeping the Board updated on pressures and actions. Throughout my time as Chair, the Board would be regularly appraised of specific pressures in a number of ways, including:

a) The IPR, which enabled responsive actions to be highlighted, questioned, or suggested (for example the IPR from the Public Board of Directors on 27 November 2025 [Exhibit: WITN0263098]).

b) Highlight reporting from key Board Committees, especially the Quality Committee (for example as reflected in minutes of the Board meeting on 29 May 2025 [Exhibit: WITN0390062]) and the People Committee (for example as reflected in minutes of the Board meeting on 29 May 2025 [Exhibit: WITN0390063]).

c) Freedom to Speak Up reporting (for example as reflected in minutes of the Board meeting on 30 January 2025 [Exhibit: WITN0390064]).

d) Patient stories (for example as reflected in minutes of the Board meeting on 25 September 2025 [Exhibit: NHFT0017687]).

e) My Chair's report (for example 6 October 2020 [Exhibit: WITN0390015], 7 September 2021 [Exhibit: WITN0390016] and 25 January 2024 [Exhibit: WITN0390017]), and the Chief Executive's report (for example 26 January 2023 Exhibit: NHFT0015914]).

152. The Board has taken some specific actions to support work to tackle longer-standing concerns. The introduction of the Accountability and Performance

Framework (as set out in the report "Accountability and Performance Framework" which went to the Board meeting of 31 July 2025 [Exhibit: NHFT0015005, p331]) is an example of where improving the robustness of governance and reporting has given a stronger framework for concerns to be identified and escalated in a more timely way than previous mechanisms had sometimes allowed. It is much more clear on expected responsibilities in leadership roles, and when escalation should take place and what that can look like. This includes escalation that reaches Board Committees and the Board.

153. Since the events of June 2023, the Board has taken additional overt actions, such as commissioning independent reviews such as those into the Early Intervention in Psychosis (EIP) Team [Exhibit: NHFT0009015], Crisis Services [Exhibit: NHFT0000462], Local Mental Health Teams [Exhibit: NHFT0000545], and the review of homicides [Exhibit: NHFT0000518]. The Board also commissioned Healthwatch Nottingham & Nottinghamshire to carry out a review into Community Mental Health Services (Healthwatch Nottingham & Nottinghamshire, Specialist Mental Health Services report November 2023 [Exhibit: CQCM0016521/ NHFT0003597]) which was reported to Board on 30 November 2023 [Exhibit: WITN0390065]. This practice of proactively seeking out additional assurance, of seeking to look for concerns elsewhere in the organisation (other than the place reported from) and investing in independent reviews has been important and is evidence of the attitude of openness I have strived to lead in the Board. Prior to the VC incident there were similar reviews of services, for example, a review of patient transition from CAMHS to adult services, prompted by research carried out by young people, either in our care or previously, through M2K (a charity) (the report "Update on the Young People

Transition into Adult Services Work" went to the Board meeting on 28 September 2023 [Exhibit: WITN0390066]).

154. The Integrated Improvement Plan is a good example of the Board's approach to a breadth of improvement and learning (Integrated Improvement Plan [Exhibit: WITN0390067] and Integrated Improvement Plan Progress [Exhibit: WITN0390068]). Its five programmes (Patient Safety & Quality Improvement, People & Culture, Leadership & Governance, Pursuing Operational Excellence, and Finance & Productivity) frame improvement work that goes beyond the specific requirements of the Section 48 review and into wider Trust improvements.

155. The People Committee drove improvements in aspects of staffing, including reducing the time from appointment to starting work, enhancing our wellbeing service (building on responding to sustained need through the COVID-19 pandemic to keep a strong, confidential, individualised wellbeing offer to enable staff to seek support earlier), and improving our leadership development programmes.

156. The Board encouraged and endorsed a renewed focus on patient and care voice, responding in part to criticism from regulators and from the Section 48 review. This has led to strong patient and carer voices having influence on service redesign and has also been explicitly built into the processes the Board uses to ascertain when actions in the Integrated Improvement Plan can be signed off as "achieved". The establishment of the Evidence and Assurance Group as an independently chaired body with members external to NHFT to test out evidence of the achievement of actions in the Improvement Plan gives added confidence in the robustness of actions.

Integrated Improvement Plan 2024

157. The Integrated Improvement Plan [NHNB0000116] was put in place in 2024 as a mandated requirement of the enforcement actions imposed by NHS England, as a result of NHFT being placed into the national Recovery Support Programme. The Regulatory Enforcement Undertakings (Letter from NHS England to NHFT, dated 25 November 2024 [Exhibit: NHSE0001711] with draft Legal Undertakings Letter [Exhibit: NHSE0001710], which were considered in the report titled "NHS England Enforcement Undertakings" which went to Board on 28 November 2024 [Exhibit: NHFT0015893]) placed on NHFT included the requirement that we produce and deliver an Integrated Improvement Plan that addressed immediate patient safety concerns, stabilised governance and leadership arrangements, demonstrated timely progress against mandated actions, and provided assurance to NHS England and the CQC. It also set out milestones that needed to be passed in order for NHFT to exit National Oversight Framework 4. The initial Integrated Improvement Plan [Exhibit: WITN0390067] was covered in a report to the Quality and People Committee on 17 April 2024 [Exhibit: NHNB0000116] and was approved at the Board on 30 May 2024 (report "Section 48 Improvement Plan" which went to the Board on 30 May 2024 [Exhibit: WITN0390069] and was covered in the minutes of that meeting [Exhibit: WITN0390070].

158. In order to ensure strong Board oversight of the Integrated Improvement Plan, the Board agreed to establish a new Improvement Oversight Committee (per the report "Improvement Oversight Committee – Terms of Reference" which went to the Board meeting on 28 March 2024 [Exhibit: WITN0390071] and the Terms of Reference dated October 2024 [Exhibit: WITN0263011]). The Board took the

deliberate, and rare, decision to set this Committee up with the Chair as the Committee chair and the Chief Executive as the Senior Responsible Officer. This is the only time I have, as Trust Chair, been a formal part of a Board Committee (other than the Nominations & Remuneration Committee), as it goes against usual best practice in ensuring assurance oversight of Committees at the full Board. However, the Board recognised the importance of pace and clear full oversight on the delivery journey against the Integrated Improvement Plan and considered that it would benefit from such unusual governance. I chaired a monthly meeting of the Improvement Oversight Committee until its Terms of Reference were reviewed by the Board at its meeting on 29 October 2024 (Report "Improvement Oversight Committee – Revised Terms of Reference" [Exhibit: WITN0390072] and meeting minutes [Exhibit: WITN0390073]) when the focus on the Committee moved to oversight of progress against the quarterly metrics of the Improvement Plan, and the meeting's cycle moved to quarterly.

159. Progress against the Plan is considered in the Improvement Oversight Committee and at the full Board. It was last discussed at the Board, and a RAG rating summary is captured in the papers that went to the Improvement Oversight Committee on 25 November 2025 [Exhibit: WITN0390074]. The paper provides detail behind the headline report that shows that, of the five Integrated Improvement Programmes, three (Patient Safety & Quality Improvement, People & Culture, and Leadership & Governance) were assessed as being on track to meet their metrics by the scheduled National Oversight Framework exit date (March 2026), and the remaining two (Pursuing Operational Excellence, and Finance & Productivity) were assessed as being off track with emerging risk of not meeting their metrics by the exit date. The explanations for being off track

were scrutinised and understood, as was the operational response to actions to ameliorate those positions. The actions themselves were overseen by operational colleagues rather than by the Integrated Oversight Committee.

160. My personal role in the Integrated Improvement Plan has been to lead the Board oversight (both directly as Board Chair, and through chairing the Integrated Oversight Committee) of the establishment of the Plan and its review. Minutes of the Integrated Oversight Committee demonstrate that I was always an active contributor in the Improvement Oversight Committee, as well as chairing its business (see examples of minutes of the Improvement Oversight Committee on 30 August 2024 [Exhibit: WITN0390075], 25 March 2025 [Exhibit: WITN0390076], and 27 May 2025 [Exhibit: WITN0390077]).

161. Also, recovery contributed to the occasional Executive to Executive meetings held with NHS England Regional Executive Team and the review meeting with the NHS England National Executive Team (see letter dated 20 December 2024, summarising the meeting held on 6 December 2024 [Exhibit: NHSE0001744]).

Risk Assessment

Board Assurance Framework

162. The Board is responsible for holding a strategic oversight of operational risks, including ownership of strategic risks.

163. Strategic risks are captured in the BAF. This is a tool to enable the Board to know what NHFT's key strategic risks are, and that they are being managed effectively.

164. The overall BAF comes to the Board of Directors on at least a quarterly basis (for example the report "Review of SR6 (partnership risk) and Board Assurance

Framework (BAF) Review which went to Board meeting on 29 May 2025 [Exhibit: WITN0390078]). However, each key risk is allocated to a Board Committee and gets further scrutiny at every Committee meeting. Board Committee highlight reports to Board reference their BAF discussions, including highlighting any concerns the Committee considers it needs to escalate to the full Board (for example the "Quality Committee Summary report" which went to Board meeting on 29 May 2025 [Exhibit: WITN0390062] and the "People Committee Highlight Report – 09 May 2025" which went to Board meeting on 29 May 2025 [Exhibit: WITN0390063]). This Committee scrutiny includes the Audit & Risk Committee reviewing the process of the BAF at all its meetings to test confidence that the processes of the BAF are delivering what they need to, as well as testing out its content.

165. The purpose of the BAF is to give the Board a planned and systematic approach to the identification, assessment and mitigation of the risks that could hinder NHFT achieving its strategic goals. It therefore contains information regarding internal and external assurances that organisational goals are being met. Each risk has mitigations and action plans specified against them and has a senior leader as the Senior Responsible Officer who "owns" the risk.

166. The BAF:

a) Provides timely and reliable information on the effectiveness of the management of major strategic risks and significant control issues

b) Facilitates the escalation of risk and control issues requiring visibility and attention by senior management, through giving a cohesive and comprehensive view of assurance across the risk environment

c) Provides an opportunity to identify gaps in assurance needs that are vital to the organisation, and to address them

d) Provides critical supporting evidence for the production of an Annual Governance Statement

167. The BAF that came to the November 2025 Board is exhibited to this statement as an example [Exhibit: WITN0356026]. The Board will often discuss the guidance of the Committee to changes in BAF ratings. As seen in the minutes of the Board June 2022 and November 2024, the Board carefully considers recommendations and occasionally, as evidenced in the minutes of the Board meeting of May 2024, decided not to take a recommendation to change a rating (see Board minutes from 7 June 2022, 30 May 2024, and November 28 2024, as examples [Exhibit: WITN0390079, Exhibit: WITN0390070 and Exhibit: WITN0263122]).

168. The organisation has many risks that are captured through operational risk registers. However, the BAF is designed to focus on a small number of high-level strategic risks. This does not preclude a specific operational risk coming to the attention of a Board Committee or the Board, if escalation requires that, but means the Board holds its strategic responsibility and does not get drawn into managing local operational risks.

169. Clinical risk assessment for individual patients sits with clinicians and, in terms of governance, does not get Board scrutiny.

170. NHFT uses a standard 5 x 5 risk scoring matrix rating the *Likelihood* of a risk and the *Impact/Severity* of the risk. Any downgrading of risk scores in the BAF is decided upon at Board, taking advice from the Board Committee which holds the

responsibility for scrutinising that risk. Whilst those recommendations are often supported, they are not always agreed, as full Board takes account of wider context in its decision-making (see Board minutes from 7 June 2022, 30 May 2024, and November 28 2024, as examples [Exhibit: WITN0390079, Exhibit: WITN0390070 and Exhibit: WITN0263122]).

171. As part of its oversight of the BAF and holding organisational risk, the Board annually reviews its risk appetite in relation to each Strategic risk in the BAF. This enables the Board to describe its appetite for risk on a scale of *Avoid – Minimal – Cautious – Open – Seek* for key elements of our business, *Financial/Value for money*, *Regulatory*, *Quality*¸ *People*, and *Reputation*. This scale is based on "Board guidance on risk appetite" dated May 2020 from the Good Governance Institute [Exhibit: WITN0390080]. The Board has amended the risk appetite over time, sometimes increasing the level of risk being held and sometimes reducing it.

172. The creation and review of the BAF was directly the responsibility of the Board. Each iteration of the BAF has been scrutinised by the Board, both within formal meetings, and in Board Development time, where more detailed consideration of the rationale behind the BAF, and considering of ratings, language, clarity, etc. were explored.

173. In terms of other risk management policies and strategies, the Board's work on setting the strategic direction of the organisation and agreeing our risk appetite, as described above, provides a framework for the Chief Executive and his Executive Team to then manage their operation.

174. The Risk Committee provides operational leadership of risk (as set out in the Risk Committee Terms of Reference [Exhibit: WITN0390046] and Minutes of the Risk Committee meeting on 21 October 2020 [Exhibit: WITN0390047]), and all Board Committees consider risk through the elements of the BAF assigned to them.

175. During my time as Chair, the Board has spent dedicated time within its Board Development days on aspects of risk assessment and management:

a) 11 February 2020 – On understanding the principles of a BAF, agreeing the ways in which we would use the BAF as a Board, and exploring our Risk Appetite [Exhibit: WITN0354039]

b) 10 March 2020 – On Risk Appetite [Exhibit: WITN0380024]

c) 13 April 2021 – On Risk Appetite and Tolerance [Exhibit: WITN0390081]

d) 5 October 2021 – On Strategic Risks and a BAF refresh [Exhibit: WITN0390082]

e) 28 April 2022 – On BAF Risk Appetite Statements [Exhibit: WITN0390083]

f) 19 May 2023 – On BAF, Risk Appetite Framework, Risk Assurance [Exhibit: WITN0390084]

g) 25 April 2024 – On Risk Appetite levels [Exhibit: WITN0390085]

h) 24 April 2025 – On BAF refresh [Exhibit: WITN0390028]

176. The BAF is *part* of the effective means of risk monitoring and management by senior leadership, but only part of this. It is important to stress that risk

management is principally led and managed by operational leaders rather than Non-Executive Directors, though oversight and scrutiny of the BAF and its elements is carried out by Board Committees and the Board. Risk monitoring also includes direct operational monitoring of the risks below the Strategic Risks of the BAF, through to a more local team-manager led monitoring and management of local risks that properly are recorded in operational risk registers.

Concerns About Risk Management

177. My responsibility as Chair of the Board is to understand how different risks are managed, and to ensure that the Board and I are scrutinising at an appropriate level. This can be in relation to the scale of the risk (such as those risks specifically recorded in the BAF), and occasionally in relation to a more local risk that might have a significant impact (such as an outbreak of Legionella's at the then new Sherwood Oaks Hospital before Christmas in 2022). Soon after I joined NHFT, we commissioned Grant Thornton to carry out a Well-Led review. They reported in August 2020 Exhibit: WITN0356018]. In their review they flagged a number of concerns regarding risk management, two of which they rated as High risk: the need to update the BAF and risk registers, and to establish a Risk Committee. All the recommendations made by Grant Thornton were accepted and implemented. The specific changes to the BAF that were recommended (e.g. regarding updating, detailing inherent scores and target scores, and assigning risk appetite) were all adopted, and endorsed through the Board development days on risk, including the first available date after the Grant Thornton report, held on 22 September 2020, which specifically covered the changes to the BAF Board development agenda 22 September 2020 [Exhibit: WITN0354070]).

178. However, it is also important that I hold the Board's level of scrutiny at the high level that is its responsibility, rather than getting drawn into more detailed risk management that is the responsibility of operational leaders throughout the organisation. Holding this distinction in responsibility is a part of my role.

179. The CQC inspection of 2019 referenced aspects of risk a number of times [Exhibit: NHFT0002015]. Some of its assessment was positive (e.g. in its well-led summary, they reference that the Board kept high impact risks under regular monthly review through the BAF – [Exhibit: NHFT0002015, p6). However, other areas of concern were highlighted in the same report, including:

a) "Staff and clinical engagement and culture was not specifically defined as one of the organisations [*sic*] top risks" [p10]

b) Inconsistent evidence of patient risk assessments being in place

c) Patient blanket restrictions needed to be individually assessed

d) Risk was not always managed well in acute wards for adults of working age and psychiatric intensive care units, including inconsistency in care records recording risk information

180. The Board had oversight of the detailed action plan in response to the 2019 inspection, which was reviewed, including ahead of later CQC inspections:

a) Report "CQC Well-Led inspection 2019" that went to the Board meeting on 30 May 2019 [Exhibit: WITN0390086],

b) Report "CQC Update – Core and Well Led Plan" that went to the Board meeting on 31 October 2019 [Exhibit: NHFT0005214],

c) Report "CQC response and Preparation" that went to the Board meeting on 4 August 2020 [Exhibit: NHFT0006170],

d) Report "CQC response and Preparation" that went to the Board meeting on 6 October 2020 [Exhibit: NHFT0007548])

181. The CQC Special Review [Exhibit: NHFT0000568 and Exhibit: CQCM0013499] carried out in response to the Section 48 raised some concerns regarding inconsistent approaches to clinical risk assessment. It is important to clarify that individual clinical risk is – rightly – managed by a patient's clinical team and rests with them. However, the Board has responsibility for ensuring appropriate policies and support such as training is in place to enable those clinicians to feel confident in the organisational context, they take their clinical decisions within.

182. The Theemis report [Exhibit: NHFT0000530] highlighted some risk concerns a lack of assurance to the Board such as in the Board not being well-sighted on inpatient bed subcontracted providers. In response to the Theemis report's concerns, we set in place a Risk Management Framework that now ensures that risks are systematically identified, assessed, monitored, and escalated through a clear guidance framework which includes, if necessary, the Board. I understand this will be covered in more detail by the Chief Executive.

183. As set out above, Board Committees hold responsibility for key risks in the BAF, and these inform the oversight of the Board. The Audit and Risk Committee, on behalf of the Board, also has a role in scrutinising risk.

Audit and Risk Committee

184. The most recent Terms of Reference for the Audit and Risk Committee, approved at the September 2025 Board meeting, are provided [Exhibit: WITN0390087). This is a formal Board Committee, which is different from the Risk Committee, which is an operational group, chaired by the Chief Executive, and attended by the Chair of the Audit and Risk Committee as an observer. The Risk Committee is considered above at paragraph [94].

185. The Committee is established to provide assurance to the Board that NHFT has in place:

   a) Structures, processes and controls for the effective management of clinical and corporate risk to support with the delivery of NHFT's strategic objectives

   b) An effective system of governance, risk management and internal control, by means of independent and objective review of financial and corporate governance, risk management across NHFT's activities ensuring compliance with the law, guidance and regulations governing the NHS

186. The Terms of Reference set out how it carries out its roles and responsibilities in relation to:

   a) Governance and internal control

   b) Internal audit

   c) External audit

   d) Counter fraud

e) Financial reporting and financial stewardship

f) Freedom to speak up

g) Management and risk assurance process

h) Emergency preparedness resilience and response

i) Information governance and cybersecurity

187. The membership of the Audit and Risk Committee consists of a Non-Executive Director chair, and four Non-Executive Directors who are chairs of other Board Committees. This enables strong links and scrutiny of the breadth of areas of responsibility of the Committees of the Board. The chair of the Audit Committee is recruited as a specific Non-Executive Director role, with an expectation that that person has, amongst their skill set, a financial qualification. Unlike the other Committees, it is not a role that any other Non-Executive Director could automatically be allocated to. The current chair of the Committee is Susan Sunderland.

188. The Non-Executive Director members are supported by senior operational colleagues and regular attendees who are expected at its meetings are listed in the Terms of Reference.

189. The Audit & Risk Committee does not have, and has not had, responsibility for monitoring and reviewing the evaluation of risk by clinicians. This properly sits within local clinical management and is informed by clinicians' professional responsibilities and accountabilities, rather than being subject to scrutiny by Board Committees.

190. The Audit & Risk Committee was, and is, responsible for ensuring risks that can affect clinical risk, such as staffing, funding, estate, etc., as monitored by other Board Committees through the BAF, are well-monitored.

191. This functionality is also tested out on occasion by our internal auditors, and every year by our external auditors, in engagement with the Audit & Risk Committee.

<u>Serious incidents and learning from deaths</u>

Monitoring and Review Processes

192. In NHS services, including those of NHFT, when incidents occur it is important for staff, leaders, and the Board to understand what constitutes a "serious" incident, and how that gets managed and, if needed, escalated. In practice, there are a number of escalation points between a local incident and the Board which in many cases will be sufficient in demonstrating their appropriate management and monitoring, such as Team Leaders, Care Division leadership, and Executive Director.

193. When I arrived at NHFT there were policies in place for monitoring and escalation of serious untoward incidents (SUIs) (Policy 15.02: Managing Serious Incidents (SI) and Reporting and Learning from Deaths, dated July 2019 [Exhibit: WITN0390088]. These set out the organisation's approach to monitoring SUIs, and if and how escalation should take place.

194. The Serious Incident Review Group (whose 2025 Terms of Reference are exhibited at [Exhibit: WITN0263059]) was a weekly meeting that included clinicians and managers and was attended by the Medical Director and the Director of Nursing & Quality. This Group could escalate matters to the Executive

Team, which could then escalate to Quality Committee and/or Board if assessed as being appropriate and proportionate. Items that were deemed as sufficient to be escalated to the Board were brought in the form of a Reportable Issues log, to the private part of the Board. An incident might subsequently be reported into the public Board too. An example of the Reportable Issue log paper that went to the private Board on 1 June 2021 is exhibited to this statement [Exhibit: WITN0390089]. This gives a sense of the level of information given to the Board, with a summary of actions that had been taken or were planned. It is my reflection that the Board is now more thoroughly aware of not only incidents, but of their implications for learning into other services, and that the processes we now have in place (detailed below) are more robust and timelier than they were a few years' ago. This is evidenced in the greater detail recorded in Board minutes, for example in the minutes of the private Board on 28 March 2024 [Exhibit: WITN0390051].

195. From a Chair's perspective, I did not have access to the Serious Incident Review Group, and nor should I, in line with our governance. However, I was, along with my Non-Executive Director colleagues, reliant on all steps of the escalation process being robustly applied. This is an example of one of the areas where as Chair, I would "not know what I didn't know" and relied on the processes and my colleagues for appropriate escalations to be made. Incidents would be flagged with the Quality Committee or the Board, and the fact that almost all private Board meetings, throughout my time at NHFT, included a paper on Reportable Issues gave me confidence that I was made aware of such incidents proportionately and appropriately. My formal awareness of such incidents would regularly be triangulated by verbal alerts I would get from the

Chief Executive, flagging that an incident had taken place. Such alerts would be made as early as felt appropriate and have on occasion been through contact out of hours or at the weekend, rather than being restricted to scheduled meetings. My usual practice with such a conversation would be to understand the limited picture known at that point, to understand the response for the patient and/or family and carers, and to understand the support put in place for staff involved (notwithstanding any formal procedures that may emerge), and to deliberately not seek a level of detail that was either not immediately available at such an early stage. I consider this good practice as a Chair and was deliberate in not seeking detail until it was brought in an appropriate way to my attention through the Board, as outlined in the policy.

196. Whilst the operational oversight of serious incidents sits with the Executive Team and other senior leaders, I am aware that, in 2023, the Chief Executive brought into the Executive Team agenda a formal standing item, to formalise what I understand to have been custom and practice previously. He also ensured an explicit report was similarly brought to the Quality Committee that summarised not only any serious incidents, but also the themes already identified within them, and an assessment of learning that was being disseminated, whether within a service, within a division or Care Group, or indeed, across the organisation. These changes have brought much more immediate learning to the fore and have then fed through to the improved reporting of serious incidents to the Board, both through the Quality Committee and directly. An example of this is Quality Committee's bi-monthly patient safety report (for example the "Patient Safety Exceptions Report" which was taken to the Board meeting of 13 November 2025 [Exhibit: WITN0263058]) that highlights incidents and learning from PSIRF

reviews, as well as outlining actions being taken and assurances on them that can be tested.

Patient Safety Exceptions Report

197. The Quality Committee and the Board also receive information on any incidents that have reached Coroners' courts. This has explicitly led to feedback from Coroners, and the report has a section on "lessons learned" in relation to incidents, so as to draw the Board's attention and scrutiny (and challenge) to learning.

198. The Board report has developed into the Patient Safety Exceptions Report (see Exhibit: WITN0390090 for the "Patient Safety Exceptions Report" taken to the 27 November 2025 Board meeting, for example) but was previously the Serious Incidents Log. The Patient Safety Exception Report was introduced in May 2025, after agreement at the Quality Committee in March 2025. This now provides the Board with information on:

   a) Complex patient and staff incidents and "never events"

   b) Legal issues

   c) High level complaints

   d) Major safeguarding concerns

   e) Inpatient suspect suicides

   f) Homicides and attempted homicides

   g) Inquests and any Prevention of Future Deaths notices

199. It also captures actions relating to each case and learning from the case and how it is being disseminated.

200. There have been periods over the last few years when NHFT's ability to effectively learn lessons has been called into question by Coroners. This led to an increase in Prevention of Future Deaths notices. The current picture for NHFT is that we have reduced the numbers of Prevention of Future Deaths notices being received. In part, Coroner's conclusions have, whilst recognising the seriousness of events and where things had gone wrong, recognised and expressed confidence in the plans in place to take action as a result. Patient Safety Exceptions Report of from the 29 May 2025 Board and 25 September 2025 Board meeting minutes confirm cases where Coroners have explicitly decided not to apply Prevention of Future Deaths Reports in all cases [Exhibit: WITN0390091 and Exhibit: WITN0356003].

201. The key route to the Board monitoring progress of actions arising from serious incidents is through the regular Patient Safety Exceptions Report. The report includes information on cases that are still in progression and also draws out key themes which the Board is then able to focus on in its discussions.

202. If there are specific recommendations that fall to an area of responsibility of a committee (for example Quality Committee or People Committee), these would be identified for that Committee to consider and, if needed, to report back to Board on.

Committees & Groups concerned with Serious Incidents and Learning from Deaths

203. I have set out above the role and composition of the Quality Committee, as a Committee of the Board, and have indicated how I hold an arms-length relationship with the Committee in order that I can scrutinise assurance from it in

the Board meeting. I am not a member of the Quality Committee and have only attended to observe its ways of working in practice, and to triangulate that with what I see through its reporting and papers, with what I hear from its chair and the other Non-Executive Director members, and reflections on meetings I may hear directly from Executive colleagues in attendance, or indirectly via the Chief Executive. The Quality Committee is expected to receive and scrutinise reports on serious untoward incidents and learning from deaths reports, and to ensure the Board has appropriate oversight of them. This then complements the Board's own discussions on these matters. The following bodies also have a role in relation to serious incidents and learning from deaths:

a) The Significant Incident Review Group;

b) The Patient Safety and Learning from Deaths Group;

c) The Risk Group; and

d) The Quality Oversight Group

204. These are titled "Group" so as to distinguish them from Board *Committees* with their formal Non-Executive Director involvement. As Chair, I am not conversant with their specific roles, other than them informing the work of Board Committees. I am therefore not familiar with the operational colleagues who are members of, or attendees of, these Groups. I do not attend any of their meetings. This is consistent with the role of the Chair of NHFT and is an important example of the separation of strategy and operational leadership in NHFT.

PSIRF Implementation

205. I understand that in September 2022, NHS England introduced the Patient Safety Incident Response Framework (PSIRF). In doing so, NHS England stated

"Organisations are expected to transition to PSIR within 12 months of its publication, and transition should be complete by Autumn 2023" [Exhibit: NHSE0000054].

206. The Board took a paper at its 28 March 2024 meeting recommending the approval of our PSIRF plan and policy (Report titled "Implementation of Patient Safety Incident Response Framework (PSIRF), including PSIRF Priority Plan and Policy" [Exhibit: NHFT0008708] and its appendices [Exhibit: NHFT0008708 and Exhibit: WITN0390093]). It outlined what was my understanding regarding the timetable for its introduction, which was that, following its publication in September 2022, NHFT was required to have a ratified plan and policy in place and published by April 2024, with transition to PSIRF to be completed by August 2024.

207. The Board's approval of the plan and policy at the March meeting therefore met the transition requirements.

208. The minutes of the 28 March 2024 Board meeting confirm this decision [Exhibit: WITN0390094] and also record that I requested that the Quality Committee maintained oversight of PSIRF and to test its application to bring assurance to the Board.

Volume of Serious Incidents and Prevention of Future Deaths Reports

209. Through the Board's papers on serious incidents and specifically on Prevention of Future Deaths notices, I was aware of the concerns of the Executive Directors (for example in the minutes of Private Board on 25 May 2023 which reference concern at the quantity and an expressed push to act to reduce the number [Exhibit: TCLT0000353]). These concerns were shared by Non-

Executive Directors and by me. The Board's discussions on the papers taken included reflections on the volume of both incidents and Prevention of Future Deaths notices.

210. A review of NHFT's Safety Process was commissioned in August 2023 by the Executive Team, to be carried out by Helen Collins (see the Final Report of Independent Evaluation of Patient Safety Processes at Nottinghamshire Healthcare Foundation Trust [Exhibit: NHFT0017721, NHFT0017725, NHFT0017726, NHFT0017727] for confirmation of the setting of the Terms of Reference in August 2023). This was an operational commission, and I would expect that it was designed to inform the oversight of the Executive Team. It was not commissioned by the Board, and is not something I was sighted on, though I was aware of its commission, and that it informed later reporting to the Board.

211. The Quality Committee was attended by Helen Collins for a discussion on the work she was undertaking, at its 3 October 2023 meeting [Exhibit: TCLT0000570] (subsequently reported on to the 30 November 2023 Board, [Exhibit: WITN0390095, p77]), so the Committee was aware of it at that stage, as was I, from the November Board meeting.

212. The review, its findings and the subsequent action plan were reported to Quality Committee in July 2024 after discussions at the Executive Leadership Team:

a) Report "Final Report of the Independent Evaluation into Safety Processes at Nottinghamshire Healthcare NHS Foundation Trust" which went to the 31 January 2024 Executive Leadership (ELT) Meeting [Exhibit: WITN0390096],

b) Report “Action plan update for the Independent Evaluation of Safety Processes at Nottinghamshire Healthcare NHS Foundation Trust – author Helen Collins January 2024” which went to the Executive Leadership Team meeting on 26 June 2024 [Exhibit: WITN0263100],

c) Report “Action plan update for the Independent Evaluation of Safety Processes at Nottinghamshire Healthcare NHS Foundation Trust – author Helen Collins January 2024” which went to the Quality Committee meeting of 2 July 2024 [Exhibit: WITN0390097], [Exhibit: NHFT0000423] and [NHFT0000469]).

213. The review was a thorough piece of work, both in terms of its internal scope and its engagement with external partners. With hindsight, the review may be perceived as having taken a considerable period of time. However, it is important to note that other improvement activities were not suspended whilst that report was being prepared. In particular, NHFT sought to be as responsive as possible in the immediate aftermath of the June 2023 events, including identifying ways in which we could more immediately learn lessons from what may have occurred within our areas of responsibility.

214. Operational changes that were instigated immediately, on receipt of the report, and were reported to Board, included:

a) The introduction of the “Safe Now” dashboard (formally implemented May 2024)

b) An immediate thorough review of waiting lists to understand who was on waiting lists, and what contact they had had, informing a new “Internal Waits & Waiting Well Management AMH Procedure” dated

22 June 2024 [Exhibit: WITN0390098] that was quickly implemented, begun on receipt of the report

c) The introduction and wide dissemination of a revised Policy 01.15: Transfer and Discharge [Exhibit: NHFT0017676], which included a nine-point checklist for discharges

215. From my perspective as Chair, the Quality Committee was kept abreast of the work being undertaken by the Collins review, though I was not directly updated on it, in line with governance responsibilities previously set out.

216. The recommendations of Helen Collins' Independent Evaluation of Safety Processes were accepted by NHFT: first by the Executive Leadership Team in June 2024 [Exhibit: WITN0263100], then (following being accepted by the Quality Oversight Group in March) by Quality Committee at its July 2024 meeting [Exhibit: WITN0390097]). Given the operational nature of the commission, actions taken on the back of the recommendations did not wait for the Committee's approval but were acted on from the point of acceptance by the Executive Team.

217. All the actions were completed and signed off by the Quality Committee as complete at its 11 March 2025 meeting [Exhibit: NHFT0013000].

Violent Incidents - Reporting Mechanisms

218. It is a sad fact is that in circumstances where there has been an incident of serious violence involving patients or former patients of the NHFT, we are only alerted to a violent act having been committed after the event. How NHFT becomes aware of such an incident will depend on a number of factors:

a) If a violent act takes place within a NHFT service, staff will be immediately aware, and our patient safety protocols will apply.

b) If a violent act takes place in the community, notification to NHFT may be through a variety of routes including from the patient's family or carers, if our connection with the patient is known; via another health service such as primary care or Accident and Emergency; or via other emergency services including the Police.

c) If the violent act has been perpetrated by a former patient, NHFT may only become aware after the fact from other agencies such as the Police.

d) Sometimes NHFT may only become aware of a violent act by local or national media reporting of an incident, when checks against our own patient lists can be made.

219. Policy 15.01 "Reporting, Management and Learning from Incidents policy and Procedure" dated 15 April 2025 [Exhibit: WITN0390099], sets out NHFT's systems-based approach to dealing with all such incidents, in a "Just and Restorative Culture" model that prescribes "acting with compassion, treating people fairly and justly and embracing a learning culture; where if something goes wrong, we seek first to understand." This is an NHFT-specific model, though many other Trusts use a similar "Just and Restorative Culture" approach.

220. There are a range of people who will potentially be made aware of violent incidents, including services relevant to the perpetrator, a number of layers of operational leadership, up to and including Executive Directors and the Chief Executive, and Non-Executive Directors, Governors and myself as Chair. This will

take place both informally and through the formal routes set out in the Reporting, Management and Learning from Incidents policy and Procedure [Exhibit: WITN0390099].

221. It is my understanding that, in all cases of incidents of serious violence involving patients or former patients there would be a level of review of care of that patient. The severity of the incident would steer the level of review, but in all cases, I would expect a review to ascertain whether there were lessons to learn regarding the care, or gaps in care, provided. In looking at historical cases, there may be limitations on available evidence to draw on, however.

222. Again, the positioning of learning within NHFT will depend in part on the scale and seriousness of the incident. Learning would be expected to be identified and actioned by the local multi-disciplinary team, and through the Care Group, to Quality Committee, and in serious cases, including where deaths had occurred, to Board. Specific actions may be shared with managers and clinicians with an Action Working Group. In some cases, learning will be shared with external bodies such as CQC and NHS England. A Pre-Significant Incident Review Group, attended by the Patient Safety Team, Safeguarding and Family Liaison, and chaired by the Patient Safety Lead, would consider if the review met requirements for a referral to another body. A Trust-wide Significant Incident Review Group meeting, chaired by the Deputy Chief Nurse or Deputy Medical Director would then review the incident and learning opportunities.

223. Our approach to applying the Patient Safety Incident Response Framework is driven by a commitment to openness and learning, and learning would also be offered to patients, their families and carers, and victims and their families and carers.

Specific Cases (2022-2024)

224. The Inquiry has asked me to consider six cases where individuals were under the care of NHFT at the time of, or shortly before, committing serious acts of violence, which the Inquiry has summarised as follows:

a) GRO-B *who fatally stabbed* GRO-C *2022.* GRO-B *was known* GRO-D *but* GRO-D *discharged.*

b) GRO-B *who* GRO-C GRO-C *2023.* GRO-B *under was the care of the* GRO-D *team* GRO-D *at the time of* GRO-B *offences.*

c) GRO-B*, who* GRO-C GRO-C *2023 and attempted to stab a member of the public.* GRO-B GRO-B *suffered a fatal stab wound during the attack.* GRO-B *had been discharged by* GRO-D GRO-D *in March 2023, having been previously diagnosed with* GRO-D GRO-D

d) GRO-B *who repeatedly stabbed a man* GRO-C GRO-C *2024. At the time* GRO-B *was under the care of the* GRO-D GRO-D *and had a diagnosis of* GRO-D GRO-D GRO-C GRO-B GRO-C GRO-C *while in custody.*

e) *Patient* GRO-B *who was arrested on suspicion of stabbing* GRO-C GRO-C *2024.* GRO-B *had*

been referred to GRO-D *on* GRO-D *but was not initially accepted for* GRO-D *caseload.* GRO-B *f* GRO-D GRO-D GRO-D *[Exhibit: NHFT0000779 pp. 20-32].*

f) *Patient* GRO-B *who was arrested on suspicion of* GRO-C GRO-C *2024.* GRO-B *had a diagnosis of* GRO-D *and was a patient* GRO-D GRO-B *had been referred for inpatient admission on* GRO-D GRO-D *[Exhibit: NHFT0000779 pp. 20-32].*

225. When acts such as these occur, I am usually informed by the Chief Executive of there having been an incident, with a confirmation that usual investigative processes are in place. At this point, it is highly unlikely that there will be more than high level information on the incident, and it is important for me in my role not to pre-empt the proper investigative processes that are underway, once I have confirmed they are in place. This would always be made clear to me at that stage.

226. In all such cases I may have become aware of the incident, though not the perpetrator's link to NHFT, through national or local media coverage. Where there was an obvious link to Nottinghamshire, I may have proactively contacted the Chief Executive to ask whether there was a known connection to NHFT.

227. I would then wait for formal notification, usually through the papers coming to the next private Board meeting. In a more high-profile incident, known more widely internally or externally, I would expect verbal briefings from the Chief Executive as appropriate. However, these would not be taken as replacing formal briefings but rather would be opportunities for me to be updated on processes being followed properly.

228. I would expect subsequent Board papers to provide an update on all such incidents until a full resolution had been completed.

229. The reportable issues log from the private Board papers referred to in each case are set out below:

a) GRO-B reportable issues log 6 September 2022 [Exhibit: WITN0390100, p2]: I first became fully aware of the circumstances of the incident and of the care history GRO-B had with NHFT through the September 2022 private Board papers, which I will have accessed two to five days prior to the meeting. This will be similar for Non-Executive Directors of the Board. I would expect Executive Directors to have been aware earlier, either through direct involvement in oversight of the initial investigation, or through pre-Board discussions on Board papers at the Executive Leadership Team.

b) GRO-B reportable issues log 25 May 2023 [Exhibit: WITN0390101, p1]: In the case of GRO-B the circumstances came to my attention in a similar way in the papers for the May 2023 private Board meeting.

c) GRO-B reportable issues log 27 July 2023 [Exhibit: WITN0390102, p1]: In the case of GRO-B the circumstances came to my attention in a similar way in the papers for the July 2023 private Board meeting.

d) GRO-B reportable issues log 25 July 2024 [Exhibit: WITN0390103, p3]: In the case of GRO-B the circumstances came to my attention in a similar way in the papers for the July 2024 private Board meeting.

e) **Patient GRO-B** reportable issues log 30 January 2025 [Exhibit: WITN0390104, p3]: In the case of Patient GRO-B, the circumstances came to my attention in a similar way, in the papers for the January 2025 private Board meeting.

f) **Patient GRO-B** reportable issues log 30 January 2025 [Exhibit: WITN0390104, p2]**:** In the case of Patient GRO-B the circumstances came to my attention in a similar way, in the papers for the January 2025 private Board meeting.

230. All the people listed above were discussed by the Board at the meetings identified, and subsequently with updates against each one of them.

231. At the Board meeting, the Executive Director of Nursing, Quality & AHPs takes the full Board through what was known of the incident, and explains the investigative processes undertaken since. She will also always update the Board on other pertinent factors, including contact with the patient, support offered to victims or their families, and impact on other patients in the service (if appropriate) and impact on staff involved in the care of the patient.

232. As Chair, I am acutely aware that each of these incidents is profound, with great impact on a number of lives, and I ensure that appropriate time is given to each case, recognising they revolve around people, as patients and victims. I also recognise that there is an impact in discussing such difficult cases for Board members, though this is, of course, a part of our duty of scrutiny and oversight.

233. Extracts of the private Board discussions in relation to the relevant Reportable Issues Log papers referencing these six people have been exhibited to this statement (Minutes of Board papers: 6 September 2022 [Exhibit: TCLT0000374], 25 May 2023 [Exhibit: TCLT0000353], 25 July 2024 [Exhibit: WITN0390105], 27 July 2023 [Exhibit: WITN0390021] and 30 January 2025 [Exhibit: WITN0390106]). They include references to:

a) More detailed reviews at the Quality Committee

b) Board members drawing out themes that are similar between these, and previous, cases

c) Confirmation of learning that has already taken place and how it was being shared across appropriate services

d) Confirmation of specific actions regarding staff, such as referral to professional bodies, and involvement in Coroner reviews

e) The importance of a written record of Board oversight of the progress of learning from incidents

f) Outcomes from any legal processes, including Coroner reviews

234. All of these cases led to reviews of potential learning in the delivery of care across services. From my perspective, as Chair, I am confident that learning has

been proactively sought and, where found, will have been disseminated through relevant services.

235. The Inquiry has noted that the Theemis report [Exhibit: NHFT0000530] notes 15 incidents between 2019 and 2023 of patients under the care of NHFT or who had been discharged from NHFT perpetrating serious violence towards members of the public. My understanding is that the number of 15 incidents between 2019 and 2023 is, sadly, consistent with the numbers of incidents of serious violence and homicide perpetrated by patients under the care of mental health services nationally, and reflects the large number of patients we care for at NHFT and the acuity of the illness some of those patients have. This is based on an extrapolation of national data drawn from the National Confidential Inquiry into Suicide and Safety in Mental Health [Exhibit: NHSE0000483].

236. Within each of these incidents, there will always be learning for NHFT, and this may include a recognition of specific actions NHFT could have taken which would mean they might have been prevented. Our review mechanisms frame our approach to such learning, but this is also triangulated with reviews carried out by others, including Coroners, that will also identify learning and potential gaps in care that could have, if dealt with, potentially prevented an incident.

237. There is a fundamental challenge for us as a society in how we expect people who are mentally unwell to be cared for, and what we expect from services providing care in terms of assessing the potential risk of violent harm to others. Unless we opt, as a society, to keeping people in in-patient services for very long periods of time with a low threshold of risk appetite, we have to work within what are acceptable levels of risk and uncertainty, recognising that, sadly, this will

mean tragedies do occur. This is evident from the national data and is not unique to NHFT. Where tragedies subsequently occur, that level of risk will, with hindsight, likely be regarded as unacceptable, especially for those whose lives were directly and dreadfully affected by the incident. However, the difficulties in predicting serious violent acts and then taking action to restrict those potential perpetrators indefinitely is a complex area of policy that requires a much larger discussion and broader set of decision-making than one individual Trust can take.

238. This is something I hope the Chair of this Inquiry will consider making recommendations on to NHS England and the government.

239. The incidents reflected on in the Theemis report were not as thoroughly considered by NHFT as they would be now. NHFT has reviewed its learning and mechanisms for learning and recognised that we had not previously been as thorough as we could have been. This includes, for example, the timeliness of carrying out investigations, which is now more robustly begun and monitored; the reporting of incidents to Board, which is now expected and prioritised; and the application of the duty of candour and a genuine learning culture, which is more explicit than previously.

240. Acknowledging where our actions or inactions may have contributed to serious incidents is important and something the Board has reiterated its commitment to on multiple occasions over the period of time since June 2023. This has directly driven our determination to support our people to do better in all aspects of care, including in our discharge policy and practice.

Thematic Homicide Review

241. NHFT commissioned a Thematic Homicide Review which produced its report in August 2024 [Exhibit: NHFT0000525 pp.24-36]. This thematic homicide review was commissioned as we wanted to establish whether appropriate learning had been taken from previous homicides and attempted homicides.

242. All the recommendations were accepted by the Executive Leadership Team in September 2024, with an action plan initiated to implement them all. Confirmation of the acceptance of the recommendations was made by the Board at its meeting later that same month [Exhibit: NHFT0000525 p26-36 and Exhibit: NHFT0017629].

243. Detail of progress against the recommendations provided by operational colleagues confirms that the majority of the recommendations have been completed, with recommendation 2 needing its draft reports to be reviewed by the Complex Incident Oversight Group to be completed.

Staffing Guidelines and National Requirements

244. Like most organisations providing mental health services across the country, NHFT has staffing challenges which, at times impacts on maintaining adequate staffing levels. This can be affected by service area, and by level of experience. During my time at NHFT, staffing was also impacted greatly by the COVID-19 pandemic, not just during the waves of the COVID-19 pandemic, when we were dealing with significant increases in staff sickness, including where outbreaks may have taken place in a staff group of a particular service, but also in the post-pandemic phase of NHS readjustment, where many staff reconsidered their

personal career plans and many took early retirement, or moved to other Trusts to seek to move on from the challenges of the COVID-19 pandemic.

245. NHFT follows national guidance from regulatory guidance documents: National Quality Board, 2016 [Exhibit: NHSE0000115]; NHS Improvement, 2018 [Exhibit: WITN0390107], plus the Care Quality Commission (CQC) regulation 18 (Health and Social Care Act, 2008) [Exhibit: WITN0390108]. NHFT has a policy "Trustwide Safer Staffing Policy, 01.18" in place to reflect national expectations and regulatory requirements around safer staffing [Exhibit: NHFT0017690]. However, there is no national guidance on expected staffing levels against numbers or acuity of mental health patients, which is different from the position in physical health settings.

246. At Board, we hold an oversight on staffing levels, including receiving reports on safe staffing and establishment reviews (a paper titled "Safer Staffing and Establishment Reviews" was taken to the Board meeting of 27 November 2025 [Exhibit: WITN0390109]). These give assurance that national policy requirements are met, whilst highlighting areas of specific challenge and concern, such as in the Mental Health, Forensic Health and Community Services Care Groups. Establishment reviews are carried out twice a year.

247. The Quality Committee scrutinises Trust data in more detail prior to the Board's consideration, and Board papers take account of any specific area of concern highlighted by the Committee.

248. There are a number of operational tools brought to bear on assessing staffing level needs, such as a Daily Demand Meeting which can assess demand and whether to, for example, move staff from one setting to another to ease

pressures. As Chair, this is not activity that is appropriate for me to be involved in, though I am aware it takes place as a mechanism to best manage staffing pressures.

249. The Board will take decisions on investing in staffing as a result of recommendations from staffing reviews. For example, in 2021 a £1.817m investment was approved for mental health inpatient services (set out in the report "Adult Mental Health Nursing Establishment Review" which went to the Finance and Performance Committee meeting of 15 February 2021 [Exhibit: NHFT0015897] and Short Form Business Case dated 26 June 2020, updated 10 November 2020 [Exhibit: NHFT0015959], which increased the headcount in all our acute mental health wards and the PICU, funded some additional Allied Health Professionals; and in 2024, a further £400,000 was approved as the result of an establishment review ("Establishment Review (Trust-wide)" which went to the Finance Committee meeting on 19 August 2024 [Exhibit: NHFT0015902]), which enabled the recruitment of 32 whole time equivalent Healthcare Assistants. The Board IPR regularly captures information on a number of staffing metrics, including data on:

a) Safer Staffing (including staffing levels on wards, vacancy rates, staffing incidents, shift fill rates, incidents of violence to staff, hate incidents, Freedom to Speak Up concerns),
b) Turnover,
c) Supervision,
d) Mandatory training,
e) Appraisals,

f) Vacancies,

g) Recruitment process time,

h) Sickness,

i) Agency and Bank usage,

j) Employee relationship cases.

250. With all the metrics, if they are off-track beyond standard levels (as measured through the SPC process), information on reasons and actions being taken is included in the Board information and will invite further Board exploration to test assurance (see IPR from May 2025 Public Board by way of example [Exhibit: WITN0390110]).

251. The specific staffing requirements and levels in each of the teams referred to are known at an operational level and are not familiar to me. It is my role to seek assurance on whether or not safer staffing is achieved through the reviews referred to above.

Impact of Staffing Deficiencies

252. Staffing level deficiencies can be because of a number of reasons, not just because of questions about establishment levels, including, for example, the impact of staff illness, or acuity in another ward requiring the prioritising of staff being moved to cover that area.

253. Staffing deficiencies do have an impact on patient experience. This is something we hear directly from patients in Board patient stories from time to time, when patients report, for example, a reduction in therapeutic activity as a result of staff challenges. Waiting times for some services can also be affected by

staffing levels. Waiting times and whether they are affected by staffing levels are explored in the IPR, as discussed above at paragraphs [125] - [128].

254. Gaps in substantive staff can result in increased use of bank and agency staff, which may mean patients are being supported by unfamiliar staff who they have not built an individual relationship of trust with.

255. Where there are pressures on staffing, there can be an impact on the wellbeing of other staff who are potentially working under more pressured circumstances.

256. The BAF includes a staffing risk and has done for many years; this is in part because of the potential impact of staffing pressures on our ability to provide the best services. This is similarly reflected in the BAFs of most NHS Trusts and is by no means unique to NHFT.

Board Monitoring of Staffing Levels

257. In my time at NHFT, the Board has always monitored safer staffing and taken a safer staffing and establishment review, as mentioned earlier. I understand that the NHS Mental Health Staffing Framework [Exhibit: NHSE0000104], Mental Health Optimal Staffing Tool, and the RCPsych 2019 Standards for Inpatient Mental Health Services [Exhibit: WITN0207003] have all been regularly used to inform the setting and monitoring of safer staffing. However, these tools are operational and are not directly used or considered by the Board or me, but I understand that they inform the reports that we consider.

258. The annual Safer Staffing Report is made available to the Board. It highlights challenges for NHFT and how they are being responded to and summarises the many actions that are considered by operational leaders in relation to staffing.

This report is also scrutinised by the People Committee, on behalf of the wider Board. I exhibit to this statement the Annual Staffing Report 2021 – 2022 [Exhibit: NHFT0011882] and the Annual Staffing Report 2022 – 2023 [Exhibit: WITN0390111].

259. The IPR taken at every Board meeting always has a People section which includes information on staffing pressures. In the Statistical Process Control charts for services, where staffing has an impact, this is recorded in the analysis alongside the charts (for example the IPR from the Public Board of Directors on 27 November 2025 [Exhibit: WITN0263098]).

Quality Committee Role in Staffing

260. The Quality Committee scrutinises NHFT's approach to safer staffing against the expectations of national guidance, through a regular "safer staffing" paper (for example the "Safer Staffing Paper" that went to the Quality Committee meeting of 9 October 2025 [Exhibit: WITN0390112]. This enables the Committee to consider whether it takes assurance on Nursing staffing establishment reviews and any changes to nursing staffing levels being considered.

261. The Committee considers information on key "hot spots" within Trust services that have a staffing element to them and also considers staffing impact on specific serious incidents.

262. The focus of the Quality Committee on staffing is triangulated at Board level with the work of the People Committee, which has a broader oversight responsibility regarding staffing levels. The People Performance Report (for example one taken to the People Committee meeting on 7 November 2025 [Exhibit: NHFT0015935] and its appendix [Exhibit: NHFT0015934]) provides that

Committee with metrics on people performance such as turnover, sickness absence, and clinical supervision.

263. Highlight reports from each of these Committees come to the full Board, as previously reflected. This means Board discussions on staffing is well-informed at both an organisation-wide level and a specific service level.

264. The Safer Staffing Meeting was an operational meeting that operated from 2020 to 2024 and focused on reviewing staffing across clinical areas.

265. It was an operational group that I have no direct knowledge of, including its membership, attendees or specific powers, though I believe it reported to the Quality Committee.

Board Discussion of Staffing Concerns

266. Staffing concerns have always been a regular area of discussion at the Board, through the IPR, highlight reports from Board Committees (including People, Quality, and Finance), discussion on patient stories, my Chair's report and the Chief Executive's report, and in the context of the various annual reports that come to Board for scrutiny and sign off. In addition, staffing matters are regularly raised and discussed at the Council of Governors, whether from staff Governors or other Governors who may be responding following a visit to a service.

267. There have been many Board-approved responses to safe staffing issues. For example, as part of the CQC inspection visit in 2022 [Exhibit: CQCM0016478], the Chief Executive gave a "Day Zero" presentation in April 2022 [Exhibit: WITN0390113] that captured specific work including the creation of a Safe Staffing Matron, the introduction of best practice reviews, and the application of new workforce profiling tools.

268. In response to the 2022 CQC Inspection Report, the Board took specific actions. At its 1 November 2022 private Board meeting [Exhibit: WITN0390114], we took an item on the draft Well-Led report. This draft was shared with a wider group of key senior leaders to immediately begin assessing how to respond to the challenges set out in the report.

269. The 26 January 2023 public Board took an Establishment Review report [Exhibit: NHFT0015906] which provided an updated on all the establishment reviews of the previous year. This was further supported in the 25 May 2023 public Board meeting which considered the "Safer Staffing and Establishment Reviews" paper [Exhibit: NHFT0015909], which provided the usual Saffer Staffing and Establishment Review data and assurance that has previously been referred to.

270. As part of its oversight of responding to the CQC's inspections, the Executive team created a CQC Compliance Oversight Group which has subsequently fed through to Board a regular "regulatory compliance" assessment, enabling the Board to consider and seek assurance on our compliance with various regulatory activities, including the 2022 CQC report, the CQC s48 special review, and recommendations from the Theemis review (for example, the Regulatory Report taken to the Board Meeting of 31 July 2025 [Exhibit: WITN0390115]).

271. In November 2022, the Board approved NHFT's People Plan [Exhibit: NHFT0003484 and Exhibit: NHFT0015981], which has subsequently been reviewed by the Board, including in 2025, aligning it to the Integrated Improvement Plan put in place following the CQC s48 special review. Progress against the metrics in the Integrated Improvement Plan is monitored by the

Improvement Oversight Committee which I chair and is reported on to Board through the Committee's Highlight Report.

272. A specific improvement we have seen resulting from our focused work on staffing levels has been the reduction in the time taken from advertising a post through to giving a new member of a staff a contract. In February 2023 this was 93 days but has reduced to 50 days by September 2025.

273. An impact of staffing challenges includes increased use of agency and other temporary staffing. We have successfully reduced our agency spend by 75% since May 2023 which, along with being a financial saving, means we are reducing our reliance on staff who may be less familiar with services and with our ways of working and NHFT Values, and probably have less strong relationships with patients.

274. We have introduced a specific leadership development programme at all levels from the Board through to Band 2, which supports leadership and also serves to "grow our own" leaders of the future.

275. In the midst of two years of very difficult scrutiny for our people, it has been important to find ways of celebrating the good work our people do every day of the year, across all our services, in often-challenging circumstances. Our annual OSCARS staff excellence event continues to be an important window on recognising the good work of our people, whist not diminishing our focus on improving the areas where we fall below what we, and those using our services, should expect.

Root Causes of Staffing Problems

276. Staffing problems at NHFT need to be firstly placed in the national context of challenges faced across the whole of the NHS. There has been an ongoing national debate about the funding of the NHS for many years, and specifically across the last 15 years with different investment decisions being taken by government that have put pressure on all NHS Trusts. In addition, for many of those years, mental health services have been referred to as “Cinderella services”, reflecting a national focus on physical health care, and specifically within that, on acute physical health services. National decisions, such as the decision to stop nursing bursaries, had a direct impact on staffing levels in Trusts such as NHFT.

277. Over recent years the acuity of those being cared for in our mental health services has steadily increased. This has particularly been seen since the COVID-19 pandemic and partly reflects direct impacts of the COVID-19 pandemic on both increasing the severity of those with mental health issues, and in making it more difficult for people with mental health issues to access services at an early stage of their illness.

278. Some specific professions in mental health specialisms have particular pressure, including in some Consultant roles, and in Allied Health Professionals.

279. During the COVID-19 pandemic, the impact of working full shifts in extensive PPE cannot be overstated. This made delivery of care even more challenging and, for some of our patients, they found receiving care from staff in PPE difficult in ways which exacerbated some of their challenging behaviours, which then impacted negatively on the care environment staff were working in.

280. Staff recruitment from overseas has seemed to be easier for securing staff to work in acute physical health than in securing staff for mental health roles that require additional specific qualifications.

281. For NHFT, I know that our performance as a good employer is a factor for prospective staff who will be assessing whether to join us or a neighbouring Trust (such as those in Derbyshire, Leicestershire, or Lincolnshire). Regulatory scrutiny and media scrutiny does have an impact on the attractiveness of a Trust, as has been seen across the country, and both have had impact on our own recruitment drives.

282. We have in recent years sought to redress some historic poor behaviours such as tackling racism that was more prevalent when I joined NHFT than it is now. The Board drew specific attention to its actions to reduce racism in its April 2022 meeting where it considered a paper on the 2021 National Staff Survey results [Exhibit: WITN0354044]. This paper highlights that NHFT needed to ""improve the experience at work of BME colleagues" and outlines actions already taken, including getting Divisional EDI leads into post, supporting the BME Network, increases in BME colleagues in posts including at senior levels, and having six High Impact Actions in the Recruitment & Retention plan. COVID-19 Impact on Operations

283. The Theemis Report [Exhibit: NHFT0000530] makes observations and findings about the impact of Covid upon the hospital under section 7 of the report, specifically beginning at p.183 under the heading "7.5 Oversight, assurance, risk assessment and management". The references in the Theemis report, section 7.5, regarding the impact of COVID-19 pandemic and the impact it had on the operations of NHFT, particularly on oversight, assurance, risk

assessment and management, are accurate, but, in my view, severely incomplete. In particular, the finding that the impact of COVID-19 "*may have* compounded existing issues around organisational structure and change" (my emphasis) is not sufficient. It is my view that the COVID-19 pandemic *definitely* compounded these issues.

284. The statement of an interviewee which recognises that references to COVID-19 need be made with care, so as to not excuse gaps in appropriate practice is correct, and I endorse this approach to reflecting on the COVID-19 pandemic. However, as I have set out earlier, the impact was immense and brings important context to any consideration of the actions of the Board, clinicians, and indeed the work of regulators such as the CQC and NHS England.

285. I have already outlined the arrival of a SARS-CoV-2 alert on my 10th day in post, followed by the NHS moving into a Level 4 national incident giving NHS England direct command of the whole of the NHS (which, in practice, means direct *instruction* to Trusts rather than types of "guidance") before the end of my first month, with emergency Board and Committee Terms of Reference being instigated formally from the April 2020 Board meeting ("Emergency Board and Committee Terms of Reference" 7 April 2020 [Exhibit: NHFT0005085).

286. My subsequent Chair's reports to Board meetings give some further context to the impact on my role as Chair, including:

a) The unrelenting impact on all our staff

b) Multiple weekly NHS England, peer, and system meetings

c) Recognition of the challenges for all staff, including Board members, of working in PPE

d) A shift to virtual means (e.g. MS Teams) for meetings, which required the installation of a whole IT communication technology with supporting access for large numbers of staff now working remotely, along with learning how to work effectively through such technology. Whilst this has now become fully embedded and very familiar, it is important to remember this was new territory for the vast majority in the NHS, including our Board members

e) Early planning for "restoration, recover and reset", though implementation took longer over repeated cycles than initially hoped for by government

f) A key focus on the expectation that the Board held oversight on the key priority of the government and NHS England – our response to the COVID-19 pandemic (Chair's Report 2 June 2020 [Exhibit: WITN0390116])

g) A reset of my personal visits to services, including Adult Mental Health Services (carried out in the context of full spatial and PPE restrictions) from June 2020 (Chairs Report 4 August 2020 [Exhibit: NHFT0007027])

h) Virtual engagement with staff, through virtual tools including podcasts, large online meetings, online Q&A sessions, and moving annual events to virtual formats (Chair's Report 2 June 2020 [Exhibit: WITN0390116])

i) Responding to multiple waves of the COVID-19 pandemic

j) Concern at the sustained personal and professional impact of the COVID-19 pandemic on staff, particularly clinicians and others providing direct care, but also support colleagues in sustained working at home, and on senior leaders continuously working very long hours, and recognising personal losses (including deaths of some colleagues) experienced by staff (Chair's Report 2 June 2020 [Exhibit: WITN0390116])

k) A continued desire to "restore" NHS services evident within the second wave of the COVID-19 pandemic, whilst recognising none of this was straightforward (Chair's Report 2 June 2020 [Exhibit: WITN0390116])

l) Personally giving leadership to other Chairs and Non-Executive Directors on our roles in governance (such as chairing national meetings for Non-Executive Directors on behalf of the Good Governance Institute referred to in my 3 November 2020 Chair's report to Board [Exhibit: WITN0390117])

m) A focus on the delivery of vaccines across Nottingham and Nottinghamshire, including reaching parts of our communities that held some vaccine resistance (Chair's Reports 1 December 2020 [Exhibit: WITN0390118], 2 February 2021 [Exhibit: WITN0390119], and 2 March 2021 [Exhibit: WITN0390120])

n) The lifting of emergency Terms of Reference from May 2021 (Chair's Report 4 May 2021 [Exhibit: WITN0390121]), whilst maintaining non-face-to-face ways of working, e.g. holding the 2021 formal Annual

Public meeting virtually (Chair's Report 1 June 2021 [Exhibit: WITN0390122])

o) A return to more normal ways of working in November 2021, but in a context of cumulative pressures both directly from COVID-related impact on the physical and mental health of patients, and on the volume of backlog as the country began to emerge from the COVID-19 pandemic (Chair's Reports 7 September 2021 [Exhibit: WITN0390016], 2 November 2021 [Exhibit: WITN0390123], and 7 December 2021 [Exhibit: WITN0390124])

p) The reintroduction of Level 4 NHS England command and control in January 2022 in response to the omicron variant of COVID-19 (Chair's Report 1 February 2022 [Exhibit: WITN0390125])

q) The cautious reintroduction of face-to-face Board meetings under strict spatial guidelines (Chair's Reports 5 April 2022 [Exhibit: WITN0390126], 3 May 2022 [Exhibit: WITN0390127] and 7 June 2022 [Exhibit: WITN0390128])

287. Throughout this period, particularly at times of high infection rates and great public impact, especially in the early months of the COVID-19 pandemic, Non-Executive Directors (including me) were concerned about the impact on our Executive Team, recognising that, for substantial periods, they were operating in sustained uncertainty, high levels of direct contacts from NHS England and government (through hundreds of direct instructions, often multiple times in a day, all days of the week, and occasionally directly countermanding actions already instigated).

288. For Non-Executive Directors, there was an added frustration of being under explicit national instruction through derogations not to do service visits, to work from home where possible, and to have fewer governance meetings with reduced agendas. This was in no way unique, and was a factor raised in many of the regular regional and national Chairs meetings (coordinated by NHS England and the Good Governance Institute, amongst others) that I attended.

289. Such concerns were voiced to me within an informal (and un-minuted) Non-Executive Director weekly virtual "catch up" meeting I established, as a tool to help keep colleagues engaged and informed, as I was much more directly involved than they were able to be (which is a normal reflection of the fact that they are expected to give four to five days per month to the role, compared with my 11 – 13 days per month), as well as in one-to-one conversations.

290. As a result, as we emerged from waves of the COVID-19 pandemic, there was some Non-Executive Director reflection on how to ensure our Board challenge remained robust and did not inadvertently get diluted by concern about the personal impacts of the COVID-19 pandemic on our Executive Director colleagues. At the time, I was keen to hold unitary Board scrutiny as robustly as in normal times whilst being mindful of the unprecedented pressures colleagues were experiencing in responding to the pandemic. Whether every challenge that might have been brought in less difficult times was brought, it is not possible to say. For my part, I sought to maintain my challenge, though was very deliberate about also recognising the impact of the COVID-19 pandemic on all staff, including our Executive Directors, and sought to bring compassion into all of my interactions.

291. My first two and a half years as Trust Chair were within a direct context of the NHS and the country responding to an unprecedented public health crisis. It is important to place those two and half years in the context of learning about a new infection, developing new ways of working, operating within severe social and professional restrictions and new ways of working, rather than falling into the trap of applying 2025 levels of knowledge and understanding in hindsight.

Service Capacity Targets

292. NHFT has a range of metrics that apply to its adult mental health service capacity. These are set by our commissioners, who have processes in place to monitor achievement against them, including escalation of concerns if necessary. However, these are operational targets and, as Chair, I am not aware of each detailed metric, but rather hold an oversight role, through Board, of achievement against such performance metrics. My understanding is that the only metric we are currently not achieving relates to discharge rates, and this is complicated by solutions not being solely within our gift (e.g. the availability of care placements for older people sits in others' remit but would have a significant impact on our discharge rates).

<u>Service Capacity Concerns and Actions</u>

293. The IPR regularly highlights concerns on service capacity, including demand for adult and older adult mental health beds, length of stay on adult mental health wards, waiting times and waiting lists, crisis service response times, and response times in emergency department settings.

294. The discussions and actions at Board follow on from this type of data coming to Board, and actions taken include:

a) The robust assessment and revision of waiting well processes for local mental health teams

b) Investing further staffing and funding into the crisis action line

c) An improvement plan to reduce our use of independent sector bad capacity within Nottinghamshire

d) A review of the adult community mental health pathway based in robust quality improvement tools, and coproduced with those using and providing such services

e) The alignment of assertive outreach teams

f) Increased, and improved, liaison with primary care on referrals, access, and alternative ways of supporting people in the community

g) A continued drive to reduce the use of out of area beds, as we know these often result in a poorer patient experience, as patients are treated further from home

Out-of-Area Placements

295. Out of area concerns have often been discussed in the Board throughout my time at NHFT (for example, the Board meeting of 27 July 2023 [Exhibit: WITN0390021, p.9]).

296. It would not be correct to make a causal link from staffing challenges to out of area bed use, as the reasons for it being an option to consider in a given case are more complex than that suggests. We have not seen the closure of our own beds as a result of staffing gaps which then necessitated out of area bed use.

297. It is helpful to distinguish between appropriate and inappropriate out of area beds as a precursor to looking at out of area (usually defined for NHFT as outside Nottinghamshire) beds *per se*. It can sometimes be appropriate to place someone out of area for reasons such as the service they require is just not available within area, for example, because of its specialism or because of the level of acuity presented, but even then, it can be detrimental to the patient experience due to being further from home and from known and trusted social networks. Occasionally, a bed may be technically out of area, but in practice be geographically closer to a patient's home, and they would choose to be cared for there, as opposed to somewhere technically in area, but further to travel. Alongside this, there is inappropriate out of area bed use, where it is necessary as there is no capacity in an in-area service, despite that service being most appropriate.

298. The Board is clear that inappropriate out of area provision tends to bring negative impact on patient experience. I am also aware that, for our care, longer than average lengths of inpatient stay is assessed as being a factor in then requiring out of area bed usage.

299. NHFT has made good inroads into out of area bed use and are now focused on reducing our usage of non-Trust, in area, beds. This has been explored though a deep dive at the Finance Committee ("Finance Committee - Highlight Report from 28 April and 6 May" which went to the Board meeting of 29 May 2025 [Exhibit: WITN0390057]).

Discharge Concerns

300. I do not recall any incidences when inappropriate or premature discharge was raised directly with me, or with the Board. I am aware that, following the VC case (where I understand that inappropriate or premature discharge was raised by VC's family and others), there have been some other cases reported in the media reflecting families' unhappiness with inappropriate or premature discharge. It is my understanding that each of those cases was reviewed operationally, though at least one was historical in nature.

301. In the light of the potential of premature discharge being a factor in the care of VC, there has been much attention given to our discharge policy, with the rapid introduction of a nine-point discharge review that now must be done prior to discharge (Policy 01.15: Transfer and Discharge [Exhibit: NHFT0017676]).

302. Contrary to premature discharge, I am aware of a family complaint about a loved who they believe has been held in an in-patient learning disability setting too long.

Multi-agency working

Information Sharing Protocols

303. Patient-related information, particularly clinical information, is confidential and must be managed in safe and secure ways that respect confidentiality. This is an important principle which forms a part of our data usage training that I have regularly taken (see Essential Training Record [Exhibit: WITN0390129] and Personal Training Grid [Exhibit: WITN0390130]) and is covered by NHFT's Data Protection Policy 12.19 December 2023 [Exhibit: NHFT0015703]. There are clear and express rules as to when it is appropriate to override confidentiality, and

these are very limited, such as if there is an assessed risk of harm to self or others that means other agencies could be given information. Such agencies may include other health professionals, the Police, and Local Authorities.

304. It is expected that clinicians are well-versed in the limits of patient-safety protocols and adhere to them.

305. I am aware that NHFT is party to some multi-agency arrangements including Multi Agency Public Protection Arrangements (MAPPA), Multi Agency Risk Assessment Conference (MARAC), and Preventing Radicalisation (Prevent).

306. There are a number of operational protocols that apply to the operational sharing of patient data between NHFT and other healthcare agencies. However, I am not party to their use, as I do not access patient data myself, as it is inconsistent with my role as Chair.

307. NHFT does have an information sharing agreement in place with the Police with co-terminus areas of operation to us. This aims to frame good working relationships between us and the Police.

308. As a key member of the Nottingham & Nottinghamshire ICB, NHFT is committed to principles of good partnership working, and I have outlined earlier my contributions to partnership working in the context of the ICB.

309. NHFT's Council of Governors includes five Appointed Governors – posts that are allocated to external organisations to provide their own representative as a Governor. These are: a single representative of the University of Nottingham and Nottingham Trent University; a third sector organisation; Healthwatch Nottingham & Nottinghamshire; Nottingham City Council; Nottinghamshire County Council. We currently have a vacancy for the Universities Governor which has been

vacant since May 2024. We have been actively encouraging the University of Nottingham and Trent University to agree an appointment to this role between them.

Relationship with Police

310. The police are very aware of the challenges of mental ill-health and NHFT has developed strong operational relationships to support the police in their interactions with people with mental ill health. Whilst the principles of joint working are understood and set out in protocols, in practice I am aware of a national debate on the amount of police time that is taken up dealing with mental health, with one police force (not Nottinghamshire) recently taking a public stand against continued support of people with mental ill health.

311. I am aware that NHFT did have a process in place to provide a community psychiatric nurse in the call handling suite and out with police active in the community, to assist with mental health assessments, but this was stood down when the street triage team was introduced in 2019. NHFT's street triage service has grown in strength and serves to divert people with serious mental health issues who are engaged by the police from acute accident and emergency services to NHFT's services. Operational leaders are better placed than me as Chair to describe further specific examples of work to improve the relationship and partnership practice with the police.

312. Whilst I do not have specific evidence of operational impact, I am sure that occasions where partnership working was very publicly criticised as not being strong, as was the case in the VC tragedy, will have tested partnership working.

313. I am aware of work by NHFT's operational leaders that seeks to improve relationships between ourselves and the police, such as through the Mental Health Partnership Board. At NHFT's 2025 Nursing and Lived Experience Conference on 23 September 2025 [Exhibit: WITN0390131] the Acting Assistant Chief Constable spoke warmly on the collaboration he now sees. Whether or not operational partnership between NHFT and the police is as strong as it can be is better considered by operational leaders.

Concerns About Multi-Agency Working

314. In 2022 NHFT carried out a short piece of engagement work with a range of local partners to seek their views of how good a partner organisation NHFT was (see paper titled “External Partnership Survey Findings” which was taken to the Strategy Committee on 21 November 2022 [Exhibit: WITN0390132], “Highlight Report - Strategy Committee on 21 November 2022” which was taken to the Board meeting of 6 December 2022 [Exhibit: WITN0390133], Board Minutes of 6 December 2022 [Exhibit: WITN0390134]. The feedback we got was more critical than our self-assessment had been, and led to reflection and discussion at the Board and subsequently informed a more proactive approach to partnership working. Themes we scored less well on were "we communicate openly and transparently", "we do what we say we will do", and "we are successfully delivering our aims and outcomes". The findings of the survey informed the development of the ‘Taking Forward Big Questions” that went to Strategy Working Group in April 2023 [Exhibit: WITN0390135].

315. I am aware of tensions within the ICB, where NHFT has escalated concerns, for example regarding a lack of social care provision that can cause delays in appropriate discharge from NHFT services.

316. There have been occasions reported to me by the Chief Executive when NHFT's Section 136 suites have been full and the police have needed to place someone in a place of safety. Whilst those situations were resolved, the fact they had to be escalated so far is challenging.

317. In recent years, NHFT has been strong (within a just and restorative framework) in its internal investigations of staff involved in serious incidents. Our desire is always to complete these as speedily as possible, recognising the pressure such investigations bring to individuals, but also to services if staff are taken out of a service whilst being investigated. There have been examples where the police have told us we cannot proceed with an internal investigation until a criminal process has been completed, which has, on occasion, caused frustration and delay.

Information Sharing with Families

318. On 24 June 2023 I attended a Rampton Hospital social visitors event on "Caring for carers" [Exhibit: NHFT0009050]. This was part of a quarterly programme of engagement events particularly focused at supporting and engaging with families and carers of patients in our high secure forensic services. I had the opportunity to talk with, and listen to, carers about their experiences and some of that discussion focused on the provision of information.

319. One conversation focused on the family of a patient who were struggling with a perceived reluctance on the part of NHFT to share information on their loved one's health and progress. The challenge for us as a provider is that our duty of care is focused on the patient themselves, and if, as was the case with the family I was in conversation with, that patient has explicitly and repeatedly said that they

do not want their family and loved ones to have access to information about their health and care, we have a legal duty to abide by this desire.

320. Clinicians do work with patients to seek ways of sharing some information with loved ones, such as getting agreement to share general health information, or to agree with the patient specific areas of their health that they are happy to have shared. However, families can be left feeling their love for a family member is being "blocked" by the organisation, when the duty we have to the patient, and the patient's own desires, are preventing more open sharing.

321. With patients with severe mental illness, this can be complicated further by the perception of an individual's capacity to take a decision. Clinical colleagues are experienced in the consideration of capacity in relation to specific decisions and seek to apply assessment of capacity in relation to each specific decision.

Reviews

322. Following the attacks committed by VC on 13 June 2023, various reviews were commissioned by, or in relation to NHFT. I set out below a brief summary of each.

A level 2 StEIS investigation

323. I was aware of this report, and it was received in full by the Board at its March 2024 meeting (see paper titled "VC Update and report" which was taken to the Board meeting of 28 March 2024 [Exhibit: NHFT0000455] [Exhibit: WITN0390136] and Appendix SI2022 – 11918 [Exhibit: WITN0390137]) where we discussed learning from this, and other reports.

324. Learning points included

a) NHFT's oversight of discharge from and between subcontracted private providers

b) Reviewing the interaction between the crisis team and the EIP

c) Aspects of VC's clinical care where learning may be taken, such as in the use of sections of the Mental Health Act, and the finely balanced nature of deciding on the use of depot medicine

d) Tools to prioritise team review meetings

e) More robust pre-discharge actions

f) Reflection on how to work with information regarding an unavailable patient

325. The Board fully accepted the findings of this report, and action plans to meet these were incorporated into the overall VC response action plans during the Board meeting of 28 March 2024 [Exhibit: WITN0390094].

CQC Reviews

326. I was aware of the CQC's section 48 Special / Rapid Review [Exhibit: NHFT0000568 and Exhibit: CQCM0013499] at each stage of the publication of its three parts and had sight of early drafts which NHFT was invited to give factual accuracy commentary on.

327. Key learning points from this review are that the CQC found that there was no single point of failure in relation to the care provided to VC. It did however identify a number of errors, omissions and misjudgements, including:

a) Inconsistent approaches to risk assessment

b) Care plans not always helping identify risk factors

c) Engagement gaps with VC and with VC's family

d) Medication management, including decisions on depot medication, although our analysis of the report is that it was inconsistent in its assessment of whether or not depot had been considered, as the report itself identified occasions when it had been

e) Discharge decision-making

328. The findings and the recommendations were all accepted by the Board and discussed during the Board meeting of 26 September 2024 [Exhibit: WITN0263121, p.2]. The recommendations were incorporated into the action plan which has been shared with the Inquiry [Exhibit: NHFT0002439].

329. Since March 2025 the Board has taken a public update on all the regulatory actions in place, including a breakdown of progress against all the Section 48 actions.

330. Following the Section 48, the CQC engaged robustly with NHFT using their recently introduced intense inspection regime involving more frequent, but smaller scale, site visits rather than solely relying on their more usual larger-scale inspections. Between June 2024 and November 2025, the CQC conducted 64 visits, resulting in 40 site reports. The cumulative picture from these inspections is of the CQC seeing evidence of gradual, but sustainable, improvements (see Regulatory Report from Public Board of Directors dated 31 July 2025 [Exhibit: WITN0390115 (Appendix 1)]).

331. The CQC carried out a Well Led inspection in September 2025. That inspection resulted in the Trust retaining its "Requires Improvement" in the Well Led domain. I was interviewed as part of that inspection. Through the usual

"factual accuracy" process NHFT responded to the draft report although I understand that not all of the further evidence the Trust provided was incorporated into the final report [Exhibit: WITN0390138], which was published after I left the Trust. I understand that the Chief Executive will address this process in more detail.

332. It is my expectation that the current Board will have oversight of an action plan as a result of the published report.

Internal Reviews (EIP, Crisis, LMHT)

<u>An internal review of NHFT's EIP team [Exhibit: NHFT0009015]</u>

333. Whilst aware of the review, I was not previously aware of its specific content, as this is an internal operational review rather than a strategic one to inform the deliberations of the Board.

334. It makes a number of operational recommendations which were accepted by the operational leaders and Executive Directors.

<u>An internal review of NHFT's crisis team [Exhibit: NHFT0000462]</u>

335. Whilst aware of the review, I was not previously aware of its specific content, as this is an internal operational review rather than a strategic one to inform the deliberations of the Board.

336. It makes a number of operational recommendations which were accepted by the operational leaders and Executive Directors.

A review of NHFT's local mental health team [Exhibit: NHFT0000545]

337. Whilst aware of the review, I was not previously aware of its specific content, as this is an internal operational review rather than a strategic one to inform the deliberations of the Board.

338. It makes a number of operational recommendations which were accepted by the operational leaders and Executive Directors.

Theemis [NHFT0000530]

339. I was previously aware of this report, and it was discussed at the Board on 27 March 2025 [Exhibit: **WITN0390030**].

340. Its findings were consistent with those of the previous reviews considered above.

341. All the recommendations were accepted at the public Board [Exhibit: **WITN0390030**, p2] and again in the Minutes of the Annual General Meeting and Annual Members' Meeting 18 September 2025 [Exhibit: WITN0390140], and the subsequent action plan has been shared with the Inquiry [Exhibit: NHFT0015678].

342. The Quality Committee considered an update on progress against this report's actions at its meeting in July 2025 (report titled "Progress on the implementation of the recommendations from the independent investigation into the care and treatment provided to VC" taken to the Quality Committee meeting of 10 July 2025 [Exhibit: WITN0390141]).

Other Actions Following June 2023

343. My first responses to the attacks were at an emotional level at the emerging news story of the tragedy that had taken lives and had changed for ever the lives of those families whose loved ones had been killed and those people who had suffered life-changing injury.

344. As it became evident that VC had previously been in the care of NHFT, it was clear to me that this tragedy would have an immediate and long-lasting impact on NHFT, on our people, on those who use or could use our services, and on our communities.

345. As Trust Chair, I re-focused my work and other priorities to be able to give attention and time to supporting my leadership team in their response to the tragedy. In such circumstances there are so many unknowns and uncertainties, and so much fast-moving data, demands for information, and so many people, including in our patient groups, our staff and volunteers, and our communities, who are experiencing such a range of emotions including sadness, fear, and anger, finding ways to help the organisation navigate through whilst holding true to our values was important to me.

346. I increased my personal presence in the organisation, both in terms of numbers of days, but also in terms of visibility with colleagues.

347. The frequency of my contact with the Chief Executive and other Executive colleagues, other Board members, and the Council of Governors all increased. I would speak with the Chief Executive at least daily. I joined parts of a couple of Executive Team meetings to express my support for them in their management of NHFT's response. I pro-actively engaged with the NHS England Midlands

Regional Director at a national event, so he could understand my approach to supporting my team.

348. In response to Governors who were understandably anxious to know whatever there was to know, I instigated four confidential (and un-minuted) briefing sessions on the Section 48 review (30 January 2024, 27 February 2024), and on the national homicide report (4 February 2025, 12 February 2025). These were time-limited meetings to share what we could share on aspects of progress in relation to the incident, to the Section 48 review, and to any other factors that it was felt could helpfully be considered in this way. Governors sign a code of conduct in which they commit to confidentiality. This meant that in these meetings we could give them advance notice of information that was due to go into the public domain, such as key themes from the imminent publication of the sections of the Section 48 review. In the sessions, Governors understand that we were limited with the detail we could sometimes share, but it was important to be as transparent with them as possible. The briefing sessions did not replace the formal Council of Governor meetings where updates are standard parts of the Chief Executive's update report to the Governors (for example on 16 January 2024 [Exhibit: WITN0390142] and 28 April 2025 [Exhibit: NHFT0002439]).

349. The Chief Executive, some Executive Directors, and I proactively met with peers from Greater Manchester Mental Health NHS Foundation Trust to explore learning from them about their experience in dealing with tragedy.

350. I took opportunities at our public meetings (e.g. Board meetings and Annual Public Meetings) and in internal meetings to explicitly voice NHFT's apologies for missed opportunities in the care of VC.

Reflections

Reflections on VC's Care

351. My reflections are as a non-clinician, so are not intended to second guess the clinical decisions made by colleagues: these have been scrutinised by others with an appropriate clinical understanding, and their reflections have been placed before the Inquiry.

352. The fact that there are a number of aspects of our services, ways of working, and key policies including on discharge, that have changed and improved since the care given to VC tells me we did not give as good care as we could have, for which I am sorry. I do believe that, were we providing care for him under the current ways of working, that his care would be better than it was. An example of this is the nine-point discharge policy the Trust now operates which gives a clear checklist of actions that should have been taken prior to any discharge (revised Policy 01.15: Transfer and Discharge [Exhibit: NHFT0017676]).

353. I am aware that VC, as a Black man, is from a community recognised as historically having often received poorer services from NHS mental health services in the UK. The Centre For Mental Health's publication *Pursuing Racial Justice in Mental Health* [Exhibit: WITN0390143], whilst built around experiences in Bradford and Craven has clear messages for the whole country, including Nottingham and Nottinghamshire, on what this different experience can be.

354. The Theemis report [Exhibit: NHFT0000530] confirms the known national data on not only prevalence of psychotic disorder in Black people being 3.5 times higher than in White people, but also that there is a disproportionate use of Community Treatment Orders (by a factor of ten). It is right that clinical

colleagues considered the race of VC and there is evidence in the Theemis report that this was considered in relation to ways to possibly better engage with him, in case race was a factor getting in the way of engagement.

355. I do reflect that that the systemic context of racism in mental health, as well as in our wider society, has brought an additional negative lens to some of the public discussion of this tragedy, and I very much hope the Inquiry will consider race in mental health provision in its recommendations from the work of this Inquiry.

356. I have expressed elsewhere in this statement my reflections on the impact of the COVID-19 pandemic on mental health services, and the services provided by NHFT. I have also reflected on the long-term resource challenges faced by mental health services, including finance and some staffing issues. All of these impacted on the care provided to VC.

357. The above are presented as reflections rather than as rationalisations of care that was not as good as I would have wanted it to be, and which I believe, in parallel circumstances would be better today than it was at the time of treating VC.

Additional Actions

358. I have been asked whether I consider that there are additional actions that the Trust could have taken in respect of VC. A number of reviews have already considered this point. Where specific recommendations were made, I, as part of the Board, accepted those recommendations and subsequent action plans are being completed on implementing them.

359. I have reflected many times on actions we might have taken in respect of VC. Whilst I cannot bring a clinical perspective to whether clinical decisions would

have been taken differently, the current nine-point discharge process would perhaps have given more confidence that a wider range of factors had been considered. At a Board level, if we had had the current more robust reporting on explicit learning from serious incidents in place at the time of VC's care, we may have had learning that would have already been acted upon and changed aspects of his care. I reflect this as a generality rather than in relation to specific examples of practice that have subsequently changed. I set out elsewhere in this statement my reflections on the quality of NHFT's relationship with the police.

Information from External Agencies

360. In considering whether or not NHFT should have been provided with more information about VC by external agencies or persons, I am very aware of hindsight and current knowledge influencing that consideration.

361. There are, and were, specific safeguarding and other partnership arrangements in place regarding what should happen when the police encounter an individual with suspected mental health issues. Whether these were appropriately applied in this case will be considered by the Inquiry. However, I would underline the importance of testing what actually happened with what should have happened in line with such partnership arrangements, and not bringing a higher bar of expectation with the hindsight of the subsequent horrific outcomes.

362. One area where I think the Trust should have been provided with more information in a timelier way is in relation to VC's discharge from The Priory. The Level 2StEIS investigation [Exhibit: TCLT0000818, p42] states that 'VC [was] discharged from private provider ward without the EIP CCO or VC's mother being

informed'. However, the Theemis report [Exhibit: NHFT0000530, p59] states 'On 22 October 2021 VC was discharged home from the independent provider. The Trust notes suggest that EIP Care Coordinator 1 was not informed. The records suggest that EIP contacted the independent provider to ascertain what had occurred during the previous day's ward round. The Care Co-ordinator was informed that VC had been discharged on that day. However, the notes from the independent hospital provider described that EIP Care Coordinator 1 was informed about his discharge.' It seems to me that, through the lens of either report, the sharing of information on VC's discharge was not clear or timely, and this should have been better handled.

Information Sharing Between Agencies

363. I have been asked by the Inquiry whether I have
any reflections regarding the way information was shared between the Trust, other healthcare providers and other agencies/persons. I do not have additional reflections beyond those made earlier in response to questions on partnership working.

Adequacy of Information to Affected Parties

364. I have been asked by the inquiry whether the Trust has provided adequate information to the survivors, families of the victims, and family of VC. The judgement of what constitutes "adequate information" is complex and individual. In considering whether or not NHFT has provided adequate information to survivors, the families of victims, and to VC's family, I am aware that each of them have, at times, been critical of NHFT in this regard.

365. Overall, I do not fully accept this criticism, whilst understanding it. NHFT has to balance a range of duties, as a provider of care, and as an employer, alongside a desire for openness and the prompt sharing of information. This does not mean we could not have done better at times.

366. The events of 13 June 2023 were shocking and traumatic for so many in the country, whether connected with Nottingham, with the provision of services by the NHS or the Police, and whether connected to survivors of the attacks, the victims of the attacks, or to VC himself. I continue to seek to better understand actions NHFT could make to contribute to work to potentially decrease the risks of such tragedies occurring in the future, especially at a strategic, Board level.

367. In my view, the Duty of Candour, introduced in 2014, brought into legislation an expectation of openness and honesty when things go wrong that I have always thought part of the right and proper way of approaching the provision of services. The importance of appropriate and real apology is something I consider part of the culture of organisations. In the past there had been a perception that organisations like the NHS, and indeed some of the national charities I worked for previously, should not apologise for failings in services as it was tantamount to accepting direct responsibility for any subsequent impact. I find such resistance to apology as uncaring.

368. The Duty of Candour specifically focuses on where those directly using services have been failed – in this case, the patient, VC. In practice, however, I have always sought to apply the principles of openness and apology to as wide as group as circumstance requires, such as carers and other family members, and victims of actions.

369. The provision of information to those affected by incidents is not simple, and as an NHS provider, we have specific duties regarding confidentiality that have to be managed and can sometimes mean that information cannot be shared. In the VC case there have been examples of requests that brought a need to consider different confidentiality elements, for example, requests to breach employment confidentiality and name specific clinicians referred to anonymously in the Theemis report, and requests to have access to the patient records of VC. In each case of a request, NHFT applied its confidentiality policies (see "12.19 Trust-Wide Data Protection Policy" dated December 2023 [Exhibit: NHFT0015703] and "12.04 Secure Handling of Information" dated January 2024 [Exhibit: NHFT0015697], duty of candour ("Policy 15.5 Being Open and Duty of Candour" dated November 2022 [Exhibit: NHFT0003028]) and also took legal advice.

370. The duty of care and confidentiality NHFT has to patients, and to our staff, has been at times been challenging for survivors, the families of victims, and for VC's family, and I understand the frustration that can be felt when NHFT is perceived as withholding information. However, we have to balance openness of information with the duties of confidentiality and care we hold. An example of this is demands that survivors and the families of victims have repeatedly made of NHFT to name the clinicians who were involved in the care of VC. It is my understanding that our duty as an employer prevents us from disclosing this information, and this duty has been behind our continued resisting those requests. This position was reinforced in conversations at the Board of Directors and repeatedly in my discussions with the Chief Executive. We have, as a Board, throughout this tragedy, sought to be as open and transparent as we could be, in

the spirit of our commitment to duty of candour, but also in wanting to demonstrate learning and improvement.

371. In relation to VC's family involvement, the Theemis report is clear that their voice was not effectively considered in relation to the dynamic evaluation of risk, nor in the decisions to discharge VC from NHFT services. The report acknowledged that the structural limitations that got in the way of family involvement sat with the wider system as well as with NHFT's practices. Theemis recommended we should define what positive family engagement looks like and we have sought to improve this (see "Regulatory Report" taken to the Board meeting of 27 November 2025 [Exhibit: WITN0390144]).

372. Since the tragic events of June 2023, we have sought to offer a range of engagement and support to VC's family, to survivors, and to the families of the victims. There has been very understandable variable response to our offers, though I remain certain that it is right we reach out and offer support and engagement, whilst respecting others' decisions not to take up such offers. I am also aware that such offers can feel to some as if they add to the pain and grief already experienced.

373. I have been explicit in many public statements (including written and verbal reports in the public Board, and at our Annual Public Meeting) to reiterate my, and NHFT's, apologies for any actions or inactions that contributed to the tragedy. I have supported our senior leaders in their engagement with survivors, the families of victims, and the family of VC. As is usual practice, it is for our operational leaders to hold that direct engagement rather than me individually. However, I would not, and have not, refused any request to meet personally with any of those affected by this tragedy.

Improvements to Multi-Agency Working

374. I hope this Inquiry is able to make some specific recommendations on how to improve local and national multi-agency working and information sharing.

375. Whether partnership arrangements that are currently in place in Nottingham are fully fit for purpose is something the Inquiry is considering and will advise on. Similarly, whether or not local multi-agency working and information protocols that were in place were used as they should have been, will be considered. Specific recommendations to NHFT and other partner organisations will be welcomed.

376. I fully understand the desire to try and ensure a tragedy such as this "never happens again" anywhere in the country and share the desire for learning to change practice so that we can minimise homicides by people known to mental services, if not eliminate them fully. However, I would caution that the practical impact of any proposals is taken into account.

377. For example, it may be considered that, had the police liaised with NHFT at various points having been in contact with VC, not because of a specific mental health concern (for which processes to share information already existed), but solely because he was a known past mental health patient, then the tragedies would have been averted. Whilst this may be true in this specific case, we need to understand the impact such a change in practice would have.

378. There are many thousands of people who have used the services of NHFT, and this is replicated in every other NHS mental health provider throughout the country. If each time a person known to have had previous contact with mental health services was somehow to be re-referred to the NHS on police intervention,

even if their mental health was *not* a factor worrying the police, the potential scale of those referrals would overwhelm current commissioned services. It also then asks the question of what interventions mental health services would be expected to make at that point, and whether the individual's right to refuse care (assuming capacity) would somehow be over-ridden.

379. Rather than seek to suggest specific improvements from one dreadful case, it is my view that a much more fundamental conversation about mental health in our society is needed, in which partnership working – as a part of the response to mental health in our society – can then be more properly considered.

380. The various reviews that have already taken place have identified aspects of improvement that NHFT has accepted and which I know other mental health providers have also considered.

381. If there are further specific improvements that come from this Inquiry, I hope they will be enacted by mental health providers and others, in the same way that NHFT has sought to approach all the review recommendations it has seen to date.

Recommendations for the Inquiry

382. I am confident that most NHS Trust leaders, including Chairs of Boards, hold a desire to learn from tragedies and to minimise the chances of tragedies recurring. However, the NHS, as with many other parts of public, private, independent, and charitable service provision, has a long history of formal Inquiries that have set out clear, well-intentioned recommendations, and unfortunately finding themselves repeating recommendations made by others before them.

383. It may be helpful if the Chair of this Inquiry, in recognising where her recommendations reiterate those of previous Inquiries, considers the changes needed to more strongly ensure sustained delivery of changed practice. This will extend beyond individual organisations to the whole of the NHS and to our wider government and society.

384. There is a need for the whole country to have an open, honest conversation about serious mental illness, and how it is understood, managed, and treated. And there is a need for a national conversation on the risk of attacks that result from mental ill-health and the implications of a desire for full prevention of such attacks.

385. Every year there are many homicides and other acts of violence carried out by people with serious mental ill-health, including by people known to mental health services. Each one of these is a tragedy – for the victims, survivors, and indeed, perpetrators of such attacks. However, the prevention of such attacks is complex for society to address.

386. The predictability of homicide by a person with serious mental ill-health is poor. This raises serious questions for society on how we respond to serious mental ill-health.

387. The current 10-Year Health Plan includes a drive towards more care in the community and away from in-patient, hospital-based care. This intent applies to mental health care as well as physical health care.

388. We need to decide, as a society, whether we seek to understand and live with the inherent risks of care in the community, striving to minimise those risks with comprehensive services and education of society in how we live with and

alongside those with mental health issues, recognising that as a result, it is impossible to prevent all homicides as a result, however tragic will be for those directly involved. Or whether, as a society, our desire for making our communities 100% safe is such that we revert to restricting those with any form of serious mental ill-health from a life in our communities and wider society, such as by locking them in secure settings for an unlimited length of time.

389. I believe that proposing government steps up to lead such a challenging debate in society would be one of the strongest ways in which the Chair of this Inquiry could value the lives of all those affected by this tragedy.

390. When tragedies occur it is understandable human nature to try and understand who can be held responsible for that tragedy. In cases of tragedies perpetrated by people with serious mental ill-health, the desire to hold people other than the individual perpetrator accountable are understandable and can be exacerbated by society's response to a tragedy, including by the media and in social media.

391. In cases regarding perpetrators with serious mental ill-health, we need a societal understanding of the uncertainties in clinical risk and the complexities of the unpredictability of violent acts in most cases of mental ill-health. This sits uncomfortably with those seeking to apportion blame (as opposed to responsibility).

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: 12 February 2026

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4.	WITN0390005	Highlights from NHS Providers' Governor Focus Conference 2025
5.	WITN0390006	Because it Matters – Paul's Blogs
6.	WITN0380003	Lincolnshire Partnership NHS Foundation Trust CQC's reports 2015
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8.	WITN0390007	Paul Devlin Initial Appointment Letter 29.11.19
9.	NHSE0000522	NHS England Code of governance for NHS provider trusts Chairs Terms References highlighted

10.	WITN0390008	Chair and NED Terms of Office and Re-Appointment
11.	NHFT0000602	Minutes of the Council of Governors Meeting 13.10.2022
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13.	WITN0390009	[Withdrawn] Infection prevention and for winter 2021 to 2022 - GOV
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60.	NHFT0003385	Extraordinary Council of Governors Minutes 11 June 2024 - PD
61.	NHFT0003684	Council of Governors Minutes 15 October 2024cs
62.	WITN0390037	Email Craig Sharples to Paul Devlin 12.11.2024. RE NHFT NEDs Extension

63.	WITN0390038	Quality Committee Terms of Reference approved by Board on 26 Sept 24
64.	WITN0390039	People and Culture Committee Terms of Reference approved at Board Sept 2025
65.	WITN0390040	Audit and Risk Committee Terms of Reference
66.	WITN0390041	Finance and Performance Committee Terms of Reference dated 25 September 2025
67.	WITN0390042	Highlight Report - Strategy Committee from Public Board of Directors – 05.04.2022
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71.	WITN0354112	Updated - Commissioning Committee Terms of Reference
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75.	WITN0356018	Grant Thornton: Nottinghamshire Healthcare Well-Led final report issued to NHFT August 2020

76.	WITN0390048	Strategy and Partnership Committee Terms of Reference 2025
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137.	WITN0390085	Agenda from Board Development Session 25.04.24
138.	WITN0354070	Board Development Agenda 22.09.2020
139.	NHFT0002015	CQC inspection of 2019
140.	WITN0390086	"CQC Well-Led inspection 2019" that went to the Board meeting on 30 May 2019
141.	NHFT0005214	CQC Update – Core and Well Led Plan to Board - 31 October 2019
142.	NHFT0006170	CQC response and Preparation" that went to the Board meeting - 4 August 2020
143.	NHFT0007548	CQC response and Preparation" that went to the Board meeting - 6 October 2020
144.	NHFT0000530	Theemis report
145.	WITN0390087	Audit and Risk Committee Terms of Reference
146.	WITN0390088	15.02 (Issue 3) - Managing Serious Incidents
147.	WITN0263059	Significant Issues Review Group Terms of Reference Final February 2025
148.	WITN0390089	Reportable Issues Log from Private Board of Directors – 01.06.2021

149.	WITN0263058	97. Patient Safety Exceptions Report Final Draft 21.08.25 - 21.10.25
150.	WITN0390090	Patient Safety Exceptions Report from Private Board of Directors - 27 November 2025
151.	WITN0390091	Patient Safety Exceptions Report from Private Board of Directors 29 May 2025
152.	WITN0356003	Ratified Private Board of Directors Minutes 25 Sept 2025
153.	NHSE0000054	NHS England Patient Safety Incident Response Framework (PSIRF)
154.	NHFT0008708	Patient Safety Incident Response Framework Policy and Plan
155.	WITN0390093	Patient Safety Incident Response Framework Policy and Plan Appendix 2
156.	WITN0390094	Minutes from Board meeting (held in Public) 28 March 2024
157.	TCLT0000353	Minutes from Private Board Meeting - 25.05.23
158.	NHFT0017721	Executive Leadership Team - Action plan update for the Independent Evaluation of Safety Processes at Nottinghamshire Healthcare NHS Foundation Trust

159.	NHFT0017725	Executive Leadership Team 26 June 2024 Audit Action Plan Update Patient Safety Incidents
160.	NHFT0017726	Final Report of Independent Evaluation of Patient Safety Processes at Nottinghamshire Healthcare Foundation Trust
161.	NHFT0017727	Independent Evaluation of Patient Safety Processes Action Plan - June update_ v2
162.	TCLT0000570	Quality Committee Ratified Minutes 3 October 2023. V2
163.	WITN0390095	Public Board Meeting - 30 November 2023
164.	WITN0390096	Final report of the independent evaluation into safety processes from Executive Leadership Team 31.01.2024
165.	WITN0263100	Action plan update for the Independent Evaluation of Safety Processes at Nottinghamshire Healthcare NHS Foundation Trust – author Helen Collins January 2024
166.	WITN0390097	Action plan update for the independent evaluation of safety processes from Quality Committee - 2 July 2024
167.	NHFT0000423	Quality Committee meeting of 2 July 2024

168.	NHFT0000469	Quality Committee July 24 Update to action plan for review in safety processes (Helen Collins)
169.	WITN0390098	Internal Waits Waiting Well Management AMH Procedure
170.	NHFT0017676	01.15 Issue 6 Transfer and Discharge
171.	NHFT0013000	Quality Committee March 25 closure paper
172.	WITN0390099	15.01 Issue 1 Reporting Management and Learning from Incidents Policy and Procedure
173.	NHFT0000779	Patient MG REPORT
174.	WITN0390100	Reportable Issues Log from Private Board of Directors – 06.09.2022
175.	WITN0390101	Reportable Issues Log from Private Board Meeting – 25.05.2023
176.	WITN0390102	Reportable Issues Log from Private Board Meeting - 27 July 2023
177.	WITN0390103	Reportable Issues Log from Board of Directors Meeting (in Private) - 25 July 2024
178.	WITN0390104	Reportable Issues Log from Board of Directors Meeting (in Private) 30 Jan 2025
179.	TCLT0000374	Minutes from Private Board of Directors - 6 Sept 2022

180.	WITN0390105	Minutes from Board of Directors Meeting (in Private) 25.07.24
181.	WITN0390106	Minutes from Private Board of Directors - 30.01.25
182.	NHSE0000483	National Confidential Inquiry into Suicide & Safety in Mental Health Annual report 2025
183.	NHSE0000115	National Quality Board, 2016
184.	WITN0390107	Safestaffing June 2018
185.	WITN0390108	Regulation18 - staffing 1767107180
186.	NHFT0017690	01.18 Issue 4 Trustwide Safer Staffing Policy
187.	WITN0390109	Safer Staffing and Establishment Reviews from Public Board of Directors - 27 November 2025
188.	NHFT0015897	2021 Investment of £1.817m establishment review
189.	NHFT0015959	Short Form Business Case 10 November 2020
190.	NHFT0015902	£400k investment Establishment Reviews
191.	WITN0390110	Integrated Performance Report from Public Board of Directors Meeting - 29 May 2025
192.	NHSE0000104	Mental Health Optimal Staffing Tool
193.	WITN0207003	RCPsych 2019 Standards for Inpatient Mental Health Services

194.	NHFT0011882	Annual Staffing Report 21-22
195.	WITN0390111	Annual Staffing Report 22-23
196.	WITN0390112	Safer Staffing Paper from Quality Committee - 9 October 2025
197.	NHFT0015935	People Performance Report to People Committee
198.	NHFT0015934	People Performance Report to People Committee Appendix
199.	CQCM0016478	CQC inspection visit Report 2022
200.	WITN0390113	CQC Well-led presentation Dr John Brewin - Chief Executive April 2022
201.	WITN0390114	CQC Draft Inspection Report from Private Board of Directors - 01.11.2022
202.	NHFT0015906	Public Board - Establishment Review report - 26 January 2023
203.	NHFT0015909	Safer Staffing and Establishment Reviews paper May 2023
204.	WITN0390115	Regulatory Report from Public Board of Directors 31 July 2025 (1)
205.	NHFT0003484	Board approved NHFT's People Plan November 2022
206.	NHFT0015981	Board approved NHFT's People Plan

207.	WITN0354044	Staff Survey 2021 Results from Public Board of Directors – 05.04.2022
208.	WITN0390116	Chair's Report 2 June 2020
209.	NHFT0007027	Chairs Report 4 August 2020
210.	WITN0390117	Chairs report from Public Board of Directors – 03.11.2020
211.	WITN0390118	Chair's Reports 1 December 2020
212.	WITN0390119	Chairs report from Public Board of Directors 2 February 2021
213.	WITN0390120	Chairs report from Public Board of Directors Meeting 02.03.21
214.	WITN0390121	Chairs report from Public Board of Directors Meeting – 04.05.2021
215.	WITN0390122	Chairs report from Public Board of Directors – 01.06.2021
216.	WITN0390123	Chairs report from Public Board of Directors – 02.11.2021
217.	WITN0390124	Chairs report from Public Board of Directors – 07.12.2021
218.	WITN0390125	Chairs report from Public Board of Directors – 01.02.2022
219.	WITN0390126	Chairs report from Public Board of Directors – 05.04.2022
220.	WITN0390127	Chairs report from Public Board of Directors – 03.05.2022

221.	WITN0390128	Chairs report from Public Board of Directors – 07.06.2022
222.	WITN0390129	PD - Essential grid
223.	WITN0390130	PD - Personal training grid
224.	NHFT0015703	12.19-Issue-3-Data-Protection-Policy
225.	WITN0390131	Nursing Conference September 2025
226.	WITN0390132	External Partnership Findings Paper from Strategy Committee 21.11.22
227.	WITN0390133	Highlight Report - Strategy Committee on 21 Nov 22 from Public Board of Directors – 06.12.2022.pdf
228.	WITN0390134	Minutes of from Public Board Meeting - 06.12.2022
229.	WITN0390135	Taking Forward Big Questions Strategy Group
230.	NHFT0009050	Summer event day poster 24th June 2023
231.	NHFT0000455	Board Receipt 28 March 2024
232.	WITN0390136	VC Update and report" to Board - 28 March 2024
233.	WITN0390137	Serious Incident review (Appendix SI2022 – 11918)
234.	WITN0390138	NHFT Final Report
235.	**WITN0390030**	Minutes from Public Board of Directors Meeting - 27.03.25

236.	NHFT0015678	Annual General Meeting and Annual Members' action plan
237.	WITN0390140	Draft Minutes of the Annual General Meeting and Annual Members' Meeting September 2025
238.	WITN0390141	Progress on the implementation of the recommendations from the independent investigation report from Quality Committee - 10 July 2025
239.	WITN0390142	CEO presentation to COG April 24
240.	NHFT0002439	CEO presentation to CoG April 2025
241.	WITN0390143	The Centre For Mental Health's publication Pursuing Racial Justice in Mental Health
242.	TCLT0000818	VC Level 2 STEIS report
243.	NHFT0015703	12.19-Issue-3-Data-Protection-Policy
244.	NHFT0015697	12.04-Issue-9-Secure-Handling-of-Information
245.	NHFT0003028	15.05-Issue-8-Being-Open-and-Duty-of-Candour
246.	WITN0390144	Regulatory Report from Public Board of Directors - 27 November 2025